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Family-related risk factors and their associations with behavior problems of children in foster care

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FAMILY-RELATED RISK FACTORS AND THEIR ASSOCIATION WITH BEHAVIOR
PROBLEMS OF CHILDREN IN FOSTER CARE

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ABSTRACT

Children in foster care are at risk for problems associated with breakdowns in their ecological system. Possible explanations for this may be that children's daily interactions in early childhood are primarily with their parents. The relationship between child and parent (the dyad) is a crucial part of the way children grow and develop. Past research focuses on the child's behavior problems as separate and isolated instead of focusing on the behavior problems as a symptom of the dysfunction in the dyad. This study explored the role of two specific risk factors for children in foster care and how these may influence their daily behaviors and wellbeing, parental mental illness and prenatal substance exposure. This study used Child Behavior Checklist scores as a measure for children's daily behaviors. Data analyses include quantitative group- and case-level information retrieved from clinical records. Ecological systems theory is used as a framework to understand the dimensions of problems associated with child maltreatment and foster care placement. Results suggested that children in foster care who have been exposed to a parent with mental illness experience more behavior problems than children who have not been exposed to a parent with mental illness. Case level data suggested that age upon entry into foster care, duration of exposure to parental mental illness, number of placements, and children's diagnoses could possibly be linked to more behavior problems for children in foster care.

Keywords: Foster care, risk factors, children, resiliency, systems, dyad

CHAPTER 1: INTRODUCTION

Over 400,000 youth in the United States reside in foster care at any one time (United States Department of Health and Human Services [USDHHS], 2012). Over half of the youth in foster care have entered the system as a result of pre-care trauma ranging from neglect and prenatal substance exposure to physical, verbal, emotional, and/or sexual abuse (Badeau & Gesiriech, 2004). Other youth enter into care for reasons such as loss of a parent(s) due to death or delinquent behaviors (USDHHS, 2003). Once the state removes the child from the home of the parent or guardian and assumes responsibility for the child, the child is then considered in *foster care* and in state custody *(*Badeau & Gesiriech, 2004).

According to Tarren-Sweeney and Hazell (2005), children in foster care experience long lasting medical and psychological problems. Pre-care trauma and transitioning into the foster care system puts these children at high risk for future negative outcomes in multiple areas in life including learning deficits, delinquency, illegal substance abuse, mental health disorders, and incarceration (Fraser & Robinson, 2010; Jee, Conn, Szilagyi, Blumkin, Baldwin, & Szilagyi, 2010). Children in the foster care system find their current and future development and wellbeing at risk.

The purpose of this project is to examine the role of two specific risk factors for children in foster care and how these may influence their daily behaviors and wellbeing, parental mental illness and prenatal substance exposure. The data analysis includes quantitative group- and case-level information that relies on clinical records. The purposes of studying both types of information are to demonstrate how clinicians can systematically link clinical data sources and thus to promote evidence-based practice. Ecological systems theory is used as a framework to

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understand the dimensions of problems associated with child maltreatment and foster care placement.

Ecological Systems Theory

In 1977, Bronfenbrenner introduced a multi-faceted concept in human development known as Ecological Systems Theory (EST). Brofenbrenner's theory is one of the most well known theories in the social science field. EST's core components rest on the idea that different systems of a person's life continuously interact and influence one another. Brofenbrenner (1977) named these systems the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. These systems vary from person to person depending largely on interactions, relationships, and environment. The five systems are defined within the context of children in foster care, and examples are given to further the understanding of each system.

Microsystem

A microsystem contains the developing individual and the individual's most immediate social influences (Hung, Algood, Chui, & Lee, 2011). A microsystem includes interactions between the child and his/her siblings, biological parents, caregivers, and peers. From the developing child's point of view, microsystems are those social relationships in which the child has direct interactive experiences. The microsystem also includes the individual's activities performed in order to maintain these relationships (Bronfenbrenner, 1977). Children in foster care can suffer emotional deficits throughout the process of being removed from the biological parent(s) care even if the parent(s) is the perpetrator of abuse (Jantz, Geen, Bess, Andrews, & Russell, 2002). Trauma may be present in the child's biological family, but relationships are still being built and influencing the child's daily development (Hung et al., 2011). Interconnections throughout the microsystem are reflected in the larger mesosystem.

Mesosystem

The mesosystem is composed of multiple microsystem interactions within an individual's life. It is essentially a web of interconnections between microsystems (Bronfenbrenner, 1977). Understanding the mesosystem helps researchers to understand the individual's interactions with foster parents, foster siblings, and broader foster family members such as aunts and uncles as well as social experiences outside the family, such as in school, church, and neighborhood.

An analysis of the mesosystem may enable child welfare workers to understand interactions between biological parents and foster parents. Green and Goodman (2010) found that positive relationships between biological parents and foster parents increase the likelihood of biological parents' visitations with the child. Schweiger and O'Brien (2005) found that maintaining contact with biological parents, regardless of previous parent/child relationship damage, has long lasting benefits in providing a sense of security and attachment for children in foster care. Logically, if the child is in immediate danger then contact would not be in the best interest of the child. Schweiger and O'Brien specifically address parents who are not an immediate threat to the safety of their children.

Exosystem

An exosystem includes influences on an individual's daily settings but are not part of the individual's immediate environment. An exosystem includes expanding influences such as community and media (Bronfenbrenner, 1977). For example, an employer fires an employee of 10 years. This employee is a foster parent of a four year-old boy who is starting school in two months. The foster parent now has reduced means for financial support of the child and increased emotional distress. Lack of financial support and increased emotional distress may influence the family dynamic. The employer may not know the employee has a foster child, but

firing the employee affects the child's wellbeing indirectly. Therefore, this reflects the indirect influence of the exosystem on the child's development.

Macrosystem

The macrosystem is composed of cultural and societal rules and norms that create a broad context for the individual's larger life system (Bronfenbrenner, 1977). The macrosystem or *cultural blueprint* includes ethnicity, religion, gender, as well as social policies that shape the social norms and rules within an individual's system (Eamon, 2001). Eamon coined the term *cultural blueprint* for the macrosystem because it functions as a sort of map for how cultural prescriptions outline individual development. These cultural components may, however, exacerbate rather than alleviate problems for children in foster care. For instance, African American children in foster care are greatly over-represented and have a higher chance of living below the poverty threshold than their majority counterparts (Strozier & Krisman, 2007). This evidence suggests that cultural patterns of historic racial discrimination are reflected in the child welfare system. Researchers and/or foster care social workers may overlook the importance of broader, more indirect influences of the macrosystem on a child's development because it may not show itself daily in a child's life.

Chronosystem

The chronosystem involves changes throughout the lifespan that influence an individual or his/her environment (Bronfenbrenner, 1977). These changes can occur naturally throughout an individual's lifecycle. The chronosystem is an ever-evolving system that has to do more with broader historical events that directly impact an individual. For example, in 1986, the federal government indicated that many children in foster care were not equipped to transition out of foster care at the age of 18. The Title IV-E Independent Living Initiative was passed to reduce

this growing social problem. According to the USDHHS (2001), funding and flexibility for the

Independent Living Program doubled shortly after the passage of Title IV-E. Individuals up to

21 years old who were once in foster care could now receive more services regarding housing

because of the passage of Title IV-E. This piece of legislation has since been amended, but the

initial passage in 1986 still affects children presently in 2012. This example is used to show a

snapshot of what is included in the ever-evolving chronosystem, as historical change can affect

any level of the social ecology. Title IV-E only addresses a portion of the dilemmas that put

foster care children at risk for negative life outcomes.

CHAPTER 2: LITERATURE REVIEW

Risk Factors for Children in Foster Care

Fraser, Richman, and Galinsky (1999) broadly defined risk as the likelihood that an individual or multiple individuals in a family, community, or organization will experience a future event associated with a potentially harmful circumstance. Fraser and colleagues further described risks as markers of commonality in certain characteristics that make it more likely for one population over another to experience a harmful outcome. Richman and Fraser (2001) more specifically defined risk as one harmful factor or combination of factors that may increase negative life outcomes for an individual. Risk factors may have biological roots, biosocial origins, and/or an environmental basis (Richman & Fraser, 2001). Biological traits include being diagnosed with Attention Deficit Disorder or being born with Human Immunodeficiency Virus (HIV) contracted from the biological mother. Biosocial traits can be considered possessing a risk-taking temperament with little impulse control. Lastly, some risk factors are contextual such as living in high poverty, high crime areas (Fraser, Richman, & Galinsky, 1999). The examples of risk factors discussed above put an individual's development and wellbeing in jeopardy. For the purpose of this study, the concept of risk is narrowed to focus specifically on risk factors for children in foster care. Risk factors for children in foster care include trauma experienced before, during, and after a child comes into the foster care system.

Youth entering foster care are at high risk for social isolation, developmental delays, and poor mental health (Mendes & Moselehuddin, 2004). Foster care children who are victims of pre-care trauma are more likely to repeat grades, have lower scores on standardized tests, and experience behavioral problems (Eckenrode, Laird, & Doris, 1993). The California Youth Connections (2006) reported that over 80% of children in foster care are held back by the third

grade. Scherr (2007) found that 24% of children in foster care had been expelled due to behavior issues (ex. fighting, damaging property, skipping class, etc.) at least once in their school time. The percentage regarding expulsion was three times higher than that of their non-foster care counterparts.

Race of children in foster care also plays an influential role in determining potential life outcomes. Strozier and Krisman (2007) found that a disproportionate number of minority children were placed in foster care, specifically African-Americans. Whereas Caucasians comprise 78% of the US population, and African-Americans 13% (U.S. Census Bureau, 2010), they represent 40% and 30%, respectively, of the foster care population (National Foster Care Review Coalition, 2009). Children with special educational, developmental, or behavioral needs are also over-represented in the foster care population (Dicker, Gordon, & Knitzer, 2001).

Scherr (2007) found that children in foster care are five times more likely to have special needs when compared to children who were not in foster care. Scherr specifically investigated 31 studies via four meta-analyses to look at special education eligibility rates, grade retention rates, and disciplinary rates of children in foster care from multiple countries. These variables reflected issues surrounding behavioral problems such as expulsion, learning disabilities such as Attention Deficit Disorder, and developmental delays such as speech difficulties for the children in this sample. Foster care youth are four times more likely to experience a more specific special need, developmental delays, than that of the general population (Dicker, Gordon, & Knitzer, 2001). Some developmental delays include but are not limited to blindness, deafness, hearing impairment, emotional disturbance, intellectual disability, orthopedic impairment, language impairment, or difficulties in reaching developmental milestones (National Dissemination Center for Children with Disabilities, 2010). Disturbances in the microsystem, the immediate influences

on the child, may increase the likelihood of special needs due to the separation of the child and biological caregiver (Jantz, et al., 2002). Children coming into foster care suffer all too often from this disturbance or traumatic separation. According to Rutter (1981), disturbances of attachment in the microsystem *(*caregiver and child attachment) bring about intense immediate emotional distress for the infant expressed through crying episodes, poor eating and sleeping habits, and other regulatory problems*.* More long lasting effects of child-caregiver separation include lower weight and physical growth, lack of empathy, increased social isolation, and decreased ability to form secure, healthy attachments (Bowlby, 1980). Developmental delays may become apparent at infancy and have the potential to affect the child throughout adulthood.

The combination of a disturbed microsystem and the negative effects of this disturbance may increase the need for specialized services for foster care youth. Although a large number of children in foster care are in need of mental health and special education services, many receive inadequate services or no services at all. Gaps in services can be attributed to poor collaboration between agencies, poor identification of physical and mental health problems, lack of continuing care, lack of ongoing communication between all parties involved, and little access to specialized services (American Academy of Pediatrics, 2002). The high incidence and wide range of special needs for youth in foster care and the multiple barriers to receive services for these special needs contributes to the increased vulnerability of the foster care population.

According to the American Academy of Child and Adolescent Psychiatry ([AACAP], 2008), children are particularly vulnerable to developing mental illness when a parent has one or more of the following illnesses: bipolar disorder, attention deficit hyperactive disorder, schizophrenia, alcoholism, depression or drug abuse. Research is not consistent as to what components of parental mental illness pose threats of high risk for children. Common threads,

however, have been identified, including the child's direct exposure to parent symptoms, particularly exposure to hostile or aggressive behavior (Rutter, 1966, Webster-Stratton et al., 2001). This study addresses the specific risks of parental mental illness and prenatal substance exposure to children in foster care that are discussed in the following sections.

Risks Associated with Parental Mental Illness

Among the many reasons for children's exposure to parental maltreatment and entry into the foster care system, parental mental illness has been consistently identified as a major risk (Hinshaw, 2004). In 2009, a projected 80 million people in the United States were suffering from a diagnosable mental disorder. Two thirds of the 80 million were women who were parents. Over half of the men represented in the 80 million were parents (Kessler et al., 2005). Parents with mental illness face complex layers of issues such as trying to balance work, relationships, and parenting while attempting to cope with the symptoms of their illness. These factors may hinder their parenting abilities. Because of the societal stigma attached to mental illness, many parents do not seek help and continue to suffer in silence. This painful silence impedes parent/child communication and can lead to a breakdown in the family microsystem (Hung et al., 2011). The aforementioned research studies, as well as those by Rutter (1966) and Smith (2004), investigated parental psychiatric disorders and their negative influences on children. The samples drawn for these studies, however, only had children from the general population, not children who resided in foster care. Foster care children are likely to be especially affected, in general, by parental mental illness, but this is an understudied area.

Parental mental illness is mainly assessed throughout the literature by an interview followed by a clinician's diagnosis or by a standardized health questionnaire like that of the Malaise inventory (Hinsaw, 2004; Smith, 2004). The proportion of children in foster care with

parents who have mental illness, however, is unreported. This study hopes to raise awareness of this issue and aid in changing that trend. It is likely that many parents of children in foster care go undiagnosed until the family is investigated by child protection agencies. This means that these children have probably been exposed to severe symptoms of parental mental illness for a significant time. Rutter (1966) stated that the simple label of a parental mental diagnosis is not as significant as the symptoms of the illness, and their subsequent impact on parenting and the dyadic relationship. Multiple parental illnesses share common symptoms that may result in the disruption of parenting abilities. For example, impulsivity, verbal outbursts, unpredictable behavior, lack of planning, and poor decision-making may be symptoms in varying extents of personality disorders, schizophrenia, and depression (Smith, 2004). The child may view these symptoms as *normal* parental behavior due to the common occurrence of the symptoms in the child's daily experiences with the parent. To understand how a parent's mental illness affects a child, researchers may find it useful to see the illness from the point of view of the child. Some children have described understanding their parent's mental illness as the process of realizing that something was *different* about their parent (Fjone, Ytterhus, & Almvik, 2009). Some children's definitions of mental illness is shaped by *well* family members who have explained it to them in some way, or the children accidentally overheard family members' conversations about it (Mordoch, 2010). Often children find out the harsh reality of parental mental illness at a very young age through negative experiences with the parent. Regardless of the way a child comes to find out about their parent's illness, the impact of the illness on the child and the risk it poses for that child makes it a necessary topic for social science research.

Some studies question whether the risk of parental mental illness is because of the effects of an unstable, stressful living environment and/or a child's genetic make-up (Slominski, 2010).

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Other studies' explanations for the risk include a combination of genetic inheritance, parenting quality, lack of stimulation, relationship issues and other unfavorable experiences for children (Grant, 2000; Nicholson, Sweeny, & Geller, 1998). Whatever the specific mechanisms, it appears clear that the impact of parental mental illness on children involves a complex interplay of parent and child characteristics as well as other circumstances in the child's environment and experience.

Children dealing with parental mental illness are at risk for poor cognitive development and multiple learning disabilities. Hinshaw further discussed that these cognitive, emotional and behavioral difficulties often lead to diagnosable psychiatric disorders and other risk factors for children exposed to parental mental illness. As indicated in the previous section, children with parents who have been diagnosed with a mental illness are at risk for developing bipolar disorder, attention deficit hyperactive disorder, schizophrenia, alcoholism, depression, or drug abuse (AACAP, 2008). In comparison with their peers, children exposed to parental mental illness are more likely to have a negative view of themselves, excessive guilt and shame, and social difficulties including social isolation (Hinshaw, 2004). Hinshaw was describing the internalizing behavior problems children may experience when dealing with a parent with a mental illness. Internalizing factors that are measured by the Child Behavior Check List (CBCL) are whining, worrying, somatic symptoms such as stomach/head ache, avoiding eye contact, limited affect, and being withdrawn.

Risks Associated with Prenatal Substance Exposure

The use of illicit substances during pregnancy exposes children to potentially harmful chemicals while in the womb. This exposure often increases the likelihood of emotional, cognitive, and physical deficits in children across their lifespan. In 2011, a projected 22 million

Americans, ages 12 or older, were currently illicit drug users and used in the past month. Illicit drugs include marijuana, cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used non-medically (U.S Substance Abuse and Mental Health Services Administration, 2011). Over half (51.8%) or 133.4 million Americans at or above the age of 12 reported drinking in 2011. Chasnoff (2001) found that around every 90 seconds, a toxin-exposed infant is born in the United States. The number of foster care children that have been prenatally exposed to substances is undetermined, but the effects of the exposure are clearly stated. Prenatal substance exposure of children to drugs or alcohol is considered a paramount threat to the wellbeing of children entering into foster care today and in the future (Barbell & Wright, 1999). In utero exposure to toxins associated with the mother's substance abuse or dependence is reason for removal of the child from her care and placement in state custody.

Children who were substance exposed may have detrimental developmental/cognitive delays and physical problems. Substance exposed infants are at risk of developmental delays, hyperactivity, irritability, bone and muscle deficits, hydrocephalus, organ malformations, and physical deformities (SAMHSA, 1993a, 1993b). Infants with tendencies toward irritability and hyperactivity can be unpredictable and challenging for their foster care placements (Slinning, 2004). Children dealing with delays and behavioral issues from substance exposure may have special unique needs compared to their non-exposed counterparts. This can create difficulty when trying to find the right foster care placement for that child. Barth, Courtney, Berrick, and Albert (1994) indicated that up to 60% of infants with prenatal substance effects have at least one foster care placement. Further affirming prenatal drug exposure as a risk, Slinning (2004) reported that even if children are placed in adequate foster placements, impulsivity and attention-

related behavior problems are still prevalent for children who were drug exposed. These attention-related behavior problems and impulsivity are among the externalizing behavior problems measured in the externalizing scale of the CBCL.

Instability of Foster Care Placements and Other Associated Risks

This section explores other risk factors that may be related to behavioral disturbances for children in foster care. One such risk is the number of times a child is placed in various homes while in foster care. Transitioning from one environment to another can cause children in foster care to experience instability in the most important areas of their lives, particularly in relationships with caregivers, in peer relationships, and in education (Conger & Finkelstein, 2003). As the rate of school mobility increases, so does the likelihood of academic failure (Zetlin, Wienberg, & Shea, 2010). Pecora and colleagues (2006) observed that foster care children with fewer placements were more likely to graduate high school before exiting the foster care system. Children with more placements have greater difficulty in school and endure more hardships as adults.

Psychosocial risks such as homelessness, poverty, unemployment, teen pregnancy, and incarceration and the circumstances associated with these risk factors, appear to stretch over the life-course for children in foster care. Over 40% of foster care youth become homeless within 18 months of emancipation (Juvenile Justice Study Committee, 2002). Folse's 2003 San Francisco study found that emancipated adults, or children who aged out of foster care, earned approximately $56 less weekly than individuals who did not enter state custody at any time. Not only do inadequate financial resources inhibit emancipated adults, but also so do high birth rates within two to four years of being emancipated. This proportion is highlighted when compared to the national population birthrate of women from ages 18 to 22. Approximately 4 million births

take place annually across the United States, and mothers between the ages of 18 to 22 make up 34.2% of that number (Center for Disease Control, 2012). In comparison, over 50% of women ages 18 to 22 who have exited the foster care system become mothers (USDHHS, 2012). Financial strain and childbearing leave little room for secondary education. Foster care children make up only 10% of college students, and only 1% actually graduate from college (Casey Family Programs, 2003). As risk factors accumulate, some foster care children turn to crime. Freundlich and Morris (2004) found that children in care are five times more likely to be involved with the criminal justice system. Courtney, Terao, and Bost (2004) estimated that 25% of all foster care youth will be incarcerated within three years of emancipation. Researchers attempt to combat the multitude of risk factors for emancipated youth through identifying and utilizing key protective personality traits such as resiliency.

Components of Resiliency: A Protective Factor

When a child has the components of resiliency, this child has the ability to maintain and regain adequate functioning in the face of adversity (Fraser & Terzian, 2005). Fraser and Terzian described the sequence of events leading to a resilient child: a risk must be present in the child's life at some point, overcoming that risk occurs, and a successful outcome emerges due to the presentation and overcoming of said risk. According to Richman and Fraser (2001), a resilient child takes full advantage of resources within themselves and throughout their social ecologies to counteract a threat. Specifically, resilient children may have a greater chance of lowering the odds of negative outcomes as a result of risk. Resiliency can be measured in different ways according to the purpose of a research study. Researchers such as Lazarus and Folkman (1984) measured resiliency as the degree to which an individual is able to cognitively and behaviorally adapt in an effort to manage internal and external demands. Lee, Draper, and

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Lee (2001) measured resiliency in terms of social connectedness, or the perception of how close a child is to the world around them. Resiliency is the product of protective factors known to buffer the negative effects of experiences for a child, and promotive factors, known as traits that promote the growth of a child (Sameroff & Seifer, 1983). Protective factors such as educational achievement act as a buffer for the child when risk is present, while factors such as social skills promote growth for the child whether risk is present or absent. An example of a promotive factor could be a supportive and involved teacher. Promotive factors exert positive effects on developmental outcomes (Sameroff & Seifer, 1983). Comprehensive exploration of protective and promotive factors may help researchers to find preventative interventions and services to produce a desired outcome in the presence of multiple risk factors (Fraser, Richman, & Galinsky, 1999). This study does not systematically investigate protective and promotive factors, but acknowledges the importance of defining them for the purpose of exploring a child's complete ecological system.

This thesis research addresses a limited selection of important risk factors facing many foster children. It involves a secondary analysis of data collected by mental health clinicians in the course of their routine treatment of children involved in the foster care system. As such, this project demonstrates the value of systematic analysis of clinical assessment data, and thus represents a modest attempt at enhancing evidence-based social work practice.

Research Questions and Hypotheses

Research question 1 explores the relationship between parental mental illness and foster children's behaviors. It specifically asks whether selected parental mental illnesses are associated with behavior problems of children in foster care.

H1: The presence of a parental mental illness is associated with more behavior problems of children in foster care as indicated by the composite scores of the Child Behavior Check List (CBCL), while the absence of parental mental illness is associated with fewer behavior problems.

Research question 2 focuses on the effects of prenatal substance exposure on behaviors. Specifically, is there a relationship between prenatal substance exposure and behavior problems of children in foster care?

H2: The presence of prenatal substance exposure is associated with more behavior problems of children in foster care as indicated by the composite scores of the CBCL, while the absence of prenatal substance exposure is associated with fewer behavior problems.

Case Level Research Question

Research question 3 investigates whether a sub-sample of children, three children with the highest scores for behavior problems and three children with the lowest scores for behavior problems, could be further differentiated on the basis of other case-related data, including reason for referral, age upon entry into care, number of placements, type of placements, and special needs. Research question 3 is exploratory, therefore no hypotheses are proposed. This type of case level data may be valuable for clinicians in generating ideas for interventions based on the contrast of children with more behavior problems with others with few behavior problems

CHAPTER 3: METHODS

The data used in this study were taken from a family mental health clinic in the southeastern region of Louisiana. All personal identifiers in the data were removed prior to delivery of data to the researcher. Participants are children and parents who were referred to the mental health clinic over the last seven years from the Department of Children and Family Services in Louisiana. Various data such as the nature of the home and school environment, number of foster care placements, mental/physical health issues, and behavior problems are contained in the database.

There were 42 children and 35 biological mothers in this study. In three families, there were more than one child involved in the study; one family with 3 siblings and two families with 2 siblings. The dataset contained 42 CBCLs (36 CBCLs 1.5 to 5 years and 6 CBCLs 6-18 years) with composite and subscale scores. The dataset identified 22 female and 20 male children. One child and one mother from the dataset were excluded from the analysis because of missing data in his/her record regarding parental mental illness and prenatal substance exposure. The dataset used was de-identified, and consents were obtained from the clinic by biological parents and foster parents to use information for research purposes. The Institutional Review Board of Louisiana State University approved this study with exemption status (See Appendix).

Measures

This study proposes to investigate associations between the presence/absence of parental mental illness and prenatal substance exposure and behavior problems of children in foster care. The CBCL was used in order to operationalize children's behavior problems. For this study, foster care parents completed the CBCL.

The CBCL is one of the most widely used measures of child behavior problems (Achenbach & Rescorla, 2001). It has been translated into 85 languages and administered in

more than 35 cultures, with numerous affirmations of its reliability and validity (Berube &

Achenbach, 2009). The CBCL for ages 1.5 - 5 years is comprised of 100 problem items: 99

closed items and one open-ended item, which requests the respondent to add any additional

problems not previously listed. The respondent is requested to rate each item, based on the

preceding two months, as 0 for *not true,* 1 for *somewhat or sometimes true,* and 2 for *very true or

often true* (Achenbach & Rescorla, 2001). The CBCL for ages 6 to 18 has 118 items that

describe specific behavioral and emotional problems, plus two open-ended items for reporting

additional problems. Caregivers rate their child for how true each item is now or within the past

six months using the same scale as for the younger version (Achenbach & Rescorla, 2001).

Scales for the CBCL include the Internalizing scale (36 items), the Externalizing scale (24

items), Other problems (30 items) and the composite score, Total Problems (100 items). The

Internalizing scale was comprised of 4 categories: Emotionally Reactive, Anxious/Depressed,

Somatic Complaints, and Withdrawn. The Externalizing scale was comprised of 2 categories:

Attention Problems and Aggressive Behavior. The Total Problems composite score consisted of

the Internalizing, Externalizing, Sleep Problems and Other Problems scales. The scoring of the

CBCL involves transforming raw scores into "T scores" which are standardized on 100-point

scales. If a child scores between 0 and 64 the child is considered within the normal range for

behavior problems, if a child scores between 65 and 69 the child is considered within the

borderline range of clinical behavior problems, and if a child scores a 70 or above then the child

is considered within the clinical range of behavior problems. Clinical range indicates that these

children are experiencing severe behavior problems that may impair their functioning.

Indicators of Prenatal Substance Abuse and Mental Illness

Variables in this study were assessed from the case records of the family/children, indicated by the presence or absence of each risk factor. The independent variables for this study were the presence or absence of parental mental illness and the presence or absence of prenatal substance abuse, both categorical variables measured at the nominal level. The presence or absence of prenatal substance exposure was assessed at birth or self-reported by the biological mother of the child. The clinician assigned to the case assessed parental mental illness. Indicators were recorded as binary variables, where 1 indicates presence of prenatal substance exposure and/or parental mental illness and 0 indicates absence of prenatal substance exposure and/or parental mental illness. According to the dataset, 21 children's mothers had a diagnosed mental illness, while 20 children's mothers had no diagnosed mental illness. The dataset also indicated that 24 children had been prenatally substance exposed, while 17 children were not prenatally substance exposed. The dependent variables of this study are the Internalizing score, Externalizing score, and Total Problems score of the CBCL measured at the ratio level.

Data Analysis

Data were entered into SPSS. An independent groups t-test, two-tailed, was conducted to compare the means of children's behavior problems in relation to mothers' substance abuse and mental illness. This test was chosen because the researcher in this study is interested in investigating how parental mental health and prenatal substance exposure is associated with children's CBCL scores. For the case related data, 6 children were identified, the 3 lowest and 3 highest on the Total Problems CBCL scores, and case-related comparisons of the following elements were conducted: Reason for referral, age into care, number of placements, type of placements, parental diagnoses (if any), and children's diagnoses (if any). The purpose of this

level of analysis was to further explore possible differences among children that might help to account for behavior problems, as a way to learn more about these children's circumstances as well as point the way toward future research.

CHAPTER 4: RESULTS

This chapter reports the means, standard deviations, and ranges for the three CBCL variables. Case related data results broken down by the three highest and three lowest scores on the CBCL are reported in the following section. The CBCL variables are as follows: Internalizing, (M=53.73, SD=13.19), Externalizing (M=53.7, SD= 13.6), Total (M=53.6, SD= 13.02). CBCL Internalizing scores ranged from 29 to 78. CBCL Externalizing Scores ranged from 28 to 82. CBCL Total Problems scores ranged from 28 to 79. For the Internalizing scores, 7 children (%) scored in the clinical range, 8 (%) in the borderline range, and 27 (%) in the normal range. For the Externalizing scores, 10 children (%) scored in the clinical range, none in the borderline range, and 32 (%) in the normal range. For the total problems scores, 8 (%) children scored in the clinical range, 5 (%) in the borderline range, and 29 (%) in the normal range.

The variables were normally distributed as indicated by the Skewness statistic of Internalizing Problems at .02, Externalizing Problems at .09, and Total Problems at .11, with the Skewness standard error at .41. The Kurtosis statistic also indicated normalized distributions; Internalizing Problems is reported at -.63, Externalizing Problems at -.39, and Total Problems at -.42, with Kurtosis standard error at -.8.

For hypothesis 1, a significant difference was found among children's behavior problems for mothers with and without histories of mental illness. The t-value for differences in Internalizing was (t= 2.04, p= .05), Externalizing (t= 1.83, p< .1), and Total problems (t= 1.87, p< .1). Internalizing behavior problems were significantly different at the level of .05 and externalizing and total scores were marginally significant at the .1 probability level. This means

that children of parents with a mental illness scored significantly higher in internalizing behavior problems than children who did not have parents with mental illness.

For hypothesis 2, no significant difference was found among children's behavior problems for mothers who did and did not abuse substances at birth. The t-value for differences in Internalizing was ($t= .16$, $p= ns$), Externalizing ($t= .08$, $p=ns$), and Total problems ($t= .48$, $p= ns$). This means that children who were prenatally exposed to substances did not score any higher or lower than children who were not prenatally exposed to substances.

Case Related Data

This section reports results regarding research question three. Factors including reason for referral, age into care, number of placements, type of placements, parental diagnoses (if any), and children's diagnoses (if any) were examined in the records of six selected children and parents, the three children with the highest Total Problems scores and the three lowest Total Problems scores. All information discussed in this section was retrieved from an intake form, clinical progress notes completed by the assigned clinician, and CBCL scoring sheets located in the case records. The 3 highest scores were computed to be 79 (clinical range), whereas the lowest scores ranged from 28 to 30, within normal parameters. As mentioned previously, the scoring of the CBCL reflects transformed standardized scores on a 100-point scale. Clinical range indicates that these children are experiencing severe behavior problems that may impair their functioning. For confidentiality purposes, the six children discussed throughout the remainder of this paper will be referred to as Child A, Child B, Child C, Child D, Child E and Child F.

Child A

Child A was referred to the family mental health clinic for unspecified behavior problems. Child A scored one of the highest Total Problems scores on the CBCL, 79 (clinical range), which is consistent with behavior problems and the information provided on the intake regarding reason for referral. Child A came into foster care at the age of 6, and was placed twice with nonrelatives during his/her stay in foster care. According to the case progress notes, Child A came into care heavily medicated, but the name of the medication was not reported. Medication was prescribed for symptoms of depression: crying episodes, suicidal ideation, and sadness. Child A was placed with his/her younger sibling, Child B.

Child B

Child B was referred to the family mental health clinic for inadequate care. Child B scored one of the lowest total scores on the CBCL, 29. Child B came into foster care at the age of 2, and was placed with his/her older sibling, Child A, in a nonrelative placement twice during his/her stay in foster care. Child B had no documented diagnoses according to the case intake and progress notes.

Child C

Child C was referred to the family mental health clinic for adjustment and separation issues and suspected Post Traumatic Stress Disorder. Child C scored one of the highest Total Problems scores on the CBCL, 79 (clinical range). Child C came into care at the age of 4, and was placed eight times during his/her stay in foster care. Child C was placed with relatives, also known as kinship care, various times until a final adoption placement with nonrelatives. Child C had no documented diagnoses according to the case intake and progress notes.

Child D

Child D was referred to the family mental health clinic because Child D's biological mother and the mother's boyfriend physically abused Child D who scored one of the highest Total Problems scores on the CBCL, 79 (clinical range). Child D was placed in kinship care twice during his/her stay in foster care. Child D came into foster care at the age of 4. Child D's diagnoses included Attention Deficit-Hyperactive Disorder and Oppositional Defiant Disorder. Child D was medicated for the aforementioned disorders with unspecified medication at the time of the intake.

Child E

Child E was referred to the family mental health clinic because of prenatal substance exposure to cocaine and heroin. The biological mother did not specify the amounts used during pregnancy, but did admit to using at that time. Child E tested positive for cocaine and heroin at the time of birth. Child E scored one of the lowest Total problems scores on the CBCL, 30. Child E was placed into foster care shortly after his/her birth, having one placement on record. No other information regarding foster care placements was noted in the record. Child E had no documented diagnoses according to the case intake and progress notes.

Child F

Child F was referred to the family mental health clinic due to parent/child relationship problems. Child F scored one of the lowest Total Problems scores on the CBCL, 28. Child F came into foster care at the age of 4, and was placed twice during his/her foster care stay. Child F's foster care mother gave up custody to another placement because she did not think she could adequately handle Child F's behavior issues.

It is unknown how long Child F resided in the first foster care placement. Child F had no

documented diagnoses according to the case intake and progress notes.

CHAPTER 5: DISCUSSION

Duration of Exposure to Parental Mental Illness

The ages of the children with the highest behavior problems at the time of their placement in foster care were 4, 4, and 6 and the kids with the lowest behavior problems at the time of their placement in foster care were birth, 2, and 4. This suggests, on the simplest level, that more problematic behavior problems are associated with older age at first placement, which is illustrated with the cases of the two siblings, Child A and Child B. The older sibling, Child A (age 6), scored the highest in Total Problems with a clinical range score of 79 and the younger sibling, Child B (age 2), scored the lowest in Total Problems with a score of 29. The older sibling had spent from birth to 6 years with the biological mother, while Child B spent only from birth to 2 years. Child A came into foster care heavily medicated for mental and behavioral issues, which were at the wrong dosages according to the case record. Both siblings were placed in the same foster home. According to the record, the biological mother of this sibling pair did not have an indication of substance abuse, but did suffer from multi-axis mental illnesses, including Bi-Polar Disorder I and Borderline Personality Disorder. Child A experienced longer exposure to symptoms of the aforementioned disorders, and provides an illustration of the association of parental mental illness with children's behavior problems.

Number of Placements

Of the 3 highest scoring cases, Child C had a total of 8 placements during his/her foster care period. The placements consisted of mostly kinship care (with relatives of child) and ended with an adoptive home with a non-kin family. These transition factors were explored in the previous section of this paper, *Risk Factors*. This is the only case of the 6 that the number of placements was over 2.

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Diagnoses

Child D had one of the 3 highest Total Problems scores on the CBCL. Child D was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) prior to the administering of the CBCL. The record did not specify if Child D was medicated for these diagnoses prior to or at the time when the CBCL was administered. The child came into foster care for reports of physical abuse from the biological mother, but the mother also reported using multiple drugs while pregnant and after the child's birth. Child D's prior diagnoses include symptoms that consist of externalizing behaviors being measured by the CBCL. Impulsivity and Hyperactivity are among some of Child D's symptoms and problems covered on the CBCL. The high score on the CBCL affirms the diagnoses for Child D.

CHAPTER 6: CONCLUSION

Children in foster care are influenced by risk and protective factors across the lifespan. From zero to approximately six years old, children's primary social interactions take place within the immediate family system, particularly the parent/child relationship. This study explored selected risk factors within this system that are particularly relevant for children in foster care. Results of this research study suggest that more behavior problems, particularly internalizing behavior problems, of children in foster care are associated with exposure to parental mental illness. This study has revealed that this association can be detected through the routine screening commonly found in mental health clinics, even when some of this information is not particularly precise, as was the case in the categorizations of parent mental illness collected in this study. While mental health clinicians typically collect various types of information about their clients, they may not necessarily be aware of the linkages that exist across these types of information such as parental mental illness and behavior problems in children. This study combines case level data and systematic group-level analyses to try and shed some light on these linkages because of their particular value in evidence-based practice for clinicians in mental health clinics. This study contributes to the existing literature in that it conducts statistical analyses on variables relevant to particular cases in a mental health clinic allowing clinicians to identify needs of clients more efficiently and institute treatment modalities and interventions for those clients. This study suggests that servicing a child's needs means servicing the child's family system with particular emphasis on the dyad, also known as the child-parent relationship.

Clinicians encountering children referred for behavior problems would benefit in assessing and identifying risk factors within the child's family system such as mental illness in parents. The case level analyses illustrate the important role of maternal mental illness, in

particular by the siblings Child A and Child B. The youngest child scored among the lowest 3 on the CBCL, while the eldest child scored the highest. This study suggests that exposure to the symptoms of parental mental illnesses are associated with more behavior problems for children like Child A. These suggestions are limited in that only some variables were the focus for this examination. Most existing studies of the influence of parental mental illness on children have been researched in the general population. Some of these studies have found linkages between children's internalizing behavior problems and parental mental illness (AACAP, 2008; Hinshaw, 2004; Mordoch, 2010). Little research to date, however, has focused on the narrower population of children in foster care. The suggestions of this study ultimately are building blocks for generating and developing ideas that could possibly aid clinicians in their practices and particularly respond to the needs of foster children.

Prenatal substance exposure was not significantly associated with children's behavior problems according to the data analysis in this study. Research on risks associated with prenatal substance abuse emphasizes early developmental risk in the neo-natal period, with less clear risks over time (SAMHSA, 1993a, 1993b; Slinning, 2004). Environmental risk factors such as parental mental illness may have a more long-standing effect on a child's behavior because of the presence of the illness in everyday interactions and activities throughout the child's life.

Limitations

This study is limited in several ways, the first of which is the sample size. The smaller a sample size, the less confidence the researcher has that the dependent variable has a relationship with the independent variable. This makes any association between variables less powerful. If this study had more participants, the researcher's confidence increases that the independent variables (parental mental illness and prenatal substance exposure) influenced the dependent variable

(children's behavior problems). This study also did not take into account, in the statistical

analyses, multiple potentially relevant variables such as the number of times a child is moved in

foster care. The case-level data did examine this as a potential factor in influencing a child's

behavior. Children's resilience is largely influenced by the amount of protective factors in place

to buffer the effects of risk factors presented to them within their social ecologies. This study did

not attempt to examine interrelationships of protective factors that may have influenced or

buffered the impact of the selected risks (parental mental illness and prenatal substance

exposure).

Implications

Future research that this thesis points to is the question of how exposure to multiple

behavioral symptoms of a parent's mental illness may be associated with specific behavior

problems. Further research can use the case level data to learn more about the unique yet

common conditions that effect a child's care and quality of life. Perhaps the quality of care can

mitigate some of the multiple risk factors foster care children face in their day-to-day

interactions. Researchers might examine what is considered *unstable* and *stable* environments

for the child. This would include a statistical analysis of protective factors such as various forms

of social support, not only risk factors analyzed in this study. It is also essential to the wellbeing

of the child to explore the differences in internalizing and externalizing behavior problems for

children who deal with parental mental illness. The aggressive, impulsive child is referred to

mental health services more often from teachers because of the nature of their behavior problems

(acting out), while the withdrawn, quiet child may be overlooked. A child is already identified

as *at risk* once the child enters into care, so it is the job of the school social worker and

caseworker working the foster care case to work closely in identifying and treating not only the

commonly noticed external problems, but the deeper internalized problems for foster care

children. Researching topics as mentioned above provide clinicians with a more effective way of

enhancing the quality of care and wellbeing for children in foster care. This study and future

studies could potentially enhance the wellbeing and quality of life for children in foster care,

which may increase the likelihood of more successful outcomes in the long run for them.

REFERENCES

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age forms & profiles.* Burlington, VT: University of Vermont Research Center for Children, Youth, & Families.

Adoption and Foster Care Analysis and Reporting System (2011). *Preliminary Data: FY 2011.* Washington, DC. Retrieved from http://www.acf.hhs.gov/programs/cb/ stats_research/afcars/tar/report13.htm

American Academy of Child and Adolescent Psychiatry (2008). Children of Parents with Mental Illness.www.aacap.org/galleries/FactsForFamilies/39_children_of_parents_with_mental_ ill- ness.pdf.

American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. (2002). Health care of young children in foster care. *Pediatrics, 109.* 536-541.

Badeau, S. & Gesiriech, S. (2004). *A child's journey through the welfare system.* Retrieved from http://pewfostercare.org/docs/index.php?DocID=24

Barbell, K., & Wright, L. (1999). Family foster care in the next century. *Child Welfare, 78,* 3-14.

Barth, R.P., Courtney, M., Berrick, J.D., & Albert, V. (1994). From child abuse to permanency planning: Child welfare services, pathways, and placements. Hawthorne, NY: Aldine de Gruyter.

Beˊrubeˊ, R. L., & Achenbach, T. M. (2009). *Bibliography of published studies using the ASEBA.* Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Bowlby, J. (I980). Attachment and loss, Vol. 3: *Loss, sadness and depression.* New York: Basic Books.

Brofenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist, 32,* 513-531.

California Youth Connections. (2006). *Barriers facing foster care youth: National and local statistics about emancipating foster youth.* Retrieved from www.childrensprojectsb.org/pages/stats.shtml#S7.

Casey Family Programs. (2003). *Assessing the effects of foster care: Early results from the Casey National Alumni Study.* Retrieved from www.casey.org.

Chasnoff, I. (2001). The nature of nurture: Biology, environment, and the drug-exposed child. Chicago: National Training Institute Publishing.

Conger, D., & Finkelstein, M. (2003). Foster care and school mobility. *The Journal of Negro Education, 71, 97*–103.

Courtney, M.E., Terao, S., & Bost, N. (2004). *Midwest evaluation of the adult functioning of former foster youth: Conditions of youth preparing to leave state care*. Chicago: Chapin Hall Center for Children at the University of Chicago.

Department of Child and Family Services. (2012). *National youth in transition database.* Retrieved from www.dcfs.louisiana.gov/youthlink.

Dicker, S., Gordon, E., & Knitzer, J. (2001). Improving the odds for the healthy development of young children in foster care. New York, NY: *National Center on Children in Poverty.*

Eamon, M. K. (2001). The effects of poverty on children's socio-emotional development: An ecological systems analysis. *Social Work, 46,* 256-266.

Eckenrode, J., Laird, M., & Doris, J. (1993). School performance and disciplinary problems among abused and neglected children. *Developmental Psychology, 29,* 53-62.

Fjone, H. H., Ytterhus, B., & Almvik, A. (2009). How children with parents suffering from mental health distress search for 'normality' and avoid stigma: To be or not to be . . . is *not* the question. *Childhood* 2009; 16: 461–77.

Folse, M. (2003). *Improving independent living outcomes for emancipated foster youth in San Francisco.* University of California, Berkeley.

Fraser, M., & Robinson, B. (2010). Bridging child youth work and brain research: Enhancing social and academic learning opportunities for developmentally at-risk children. *Relational Child and Youth Care Practices, 1*, 64-70.

Fraser, M. W., Richman, J. M., & Galinsky, M. J. (1999). Risk, protection, and resilience: Toward a conceptual framework for social work practice. *Social Work Research, 23*(3), 131-143.

Fraser, M. W., & Terzian, M. A. (2005). *Risk and resilience in child development: principles and strategies of practice.* In G. P. Mallon & P. M. Hess (Eds.), Child welfare for the 21st century: A handbook of practices, policies, and programs (pp. 55-71). New York, NY: Columbia University Press.

Freundlich, M., & Morris, L. (2004). *Youth involvement in the child welfare and juvenile justice systems: A case of double jeopardy?* Retrieved from www.heysf.org.

Grant B (2000) Estimates of U.S children exposed to alcohol abuse and dependence in the family. *American Journal of Public Health* **90:** 112–5

Green, Y. R., & Goodman, C. C. (2010). Understanding birthparent involvement in kinship families: Influencing factors and the importance of placement arrangement. *Children and Youth Services Review, 32*, 1357-1364.

Hinshaw, S. P. (2004). Parental mental disorder and children's functioning: Silence and communication, stigma and resilience. *Journal of Clinical Child and Adolescent Psychology. 33:* 400–11.

Hung, J., Algood, C., Chiu, Y., & Lee, S. (2011). An ecological understanding of kinship foster care in the United States. *Journal of Child and Family Studies, 20(6),* 863-872. doi: 10.007/s10826-011-9454-3

Jackson, S. & Martin, P. (1998). Surviving the care system: Education and resilience. *Journal of Adolescence, 21,* 569- 583.

Jantz, A., Geen, R., Bess, R., Andrews, C., & Russell, V. (2002). *The continuing evolution of state kinship care policies.* Retrieved from http://www.urban.org/publications/310597.html

Jee, S., Conn, A., Szilagyi, P., Blumkin, A., Baldwin, C., & Szilagyi, M., (2010). Identification of social-emotional problems among young children in foster care. *Journal of Child Psychology and Psychiatry, 51,* 1351-1358. doi:10.1111/j.1469-7610.2010.02315.x

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62(6),* 593-602.

Lazarus, R.S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Juvenile Justice Study Committee (2002). Life after Foster Care. League of Women Voters of California Education Fund. Retrieved from *http://www.ca.lwv.org/jjds/chap6.html).*

Lee, R.M., Draper, M., & Lee, S. (2001). Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. Journal of Counseling Psychology, 48(3), 310–318.

Mendes, P., & Moselehuddin, B., (2004). Graduating from the child welfare system: A comparison of the UK and Australian leaving care debates. *International Journal of Social Welfare, 13*, 322-229.

Mordoch, E. (2010). How children understand parental mental illness: You don't get life insurance. What's life insurance? *Journal of the Canadian Academy of Child and Adolescent Psychiatry. 19:* 19–25.

National Dissemination Center for children with Disabilities (2010). Developmental Delays Criteria. Sept 2010. Retrieved from http://nichcy.org/disability/specific

National Foster Care Review Coalition. (2009). *Meeting the educational needs of children in foster care: A national perspective.* Retrieved from http://nfcrc.files.

National Kids Count program (2011). *Data by states: Baltimore, Maryland.* http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=WA=4464

Center for Disease Control (2012). National Vital Statistic Reports. *Births: Final Data for 2010.* Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf

Nicholson J, Sweeny E, Geller J (1998). Mothers with mental illness 2. *Psychiatry Serv.* 643–9.

Pecora, P., Williams, J., Kessler, R., Hiripi, E., O'Brien, K., Emerson, J., Herrick, M., & Torres, D. (2006). Assessing the educational achievements of adults who formerly were place in family foster care. *Child and Family Social Work, 11*, 220-231.

Richman, J., & Fraser, M. (Ed.). (2001). *The context of youth violence: Risk, resilience, and protection.* West Port, CT. Praeger.

Rutter, M. (1981). *Maternal deprivation reassessed (2nd ed.)*. Harmondsworth: Penguin.

Rutter, M. (1966) *Children of Sick Parents: An Environmental and Psychiatric Study.* Institute of Psychiatry Maudsley Mono- graphs No. 16. Oxford University Press, London.

Sameroff, A. J., & Seifer, R. (1983). Familial risk and child competence. *Child Development, 54(5),* 1254.

Scherr, T. (2007). Educational experiences of children in foster care: Meta analyses of special education, retention and discipline rates. *School Psychology International, 28*, 419-436.

Schweiger, W. K., & O'Brien, M. (2005). Special needs adoption: An ecological systems approach. *Family Relations, 54,* 512-522.

Slinning, K. (2004). Foster placed children prenatally exposed to poly-substances: Attention-related problems at ages 2 and 4 1/2. European Child & Adolescent Psychiatry, 13(1), 19-27.

Slominski, L. J. (2010). The effects of parental mental illness on children: Pathways to risk to resilience from infancy to adulthood. University of Michigan. Retrieved from http://deepblue.lib.umich.edu/bitstream/handle/2027.42/77750/lslomins_1.pdf?sequence=1

Smith, M. (2004). Parental mental health: Disruptions to parenting and outcomes for children. *Child & Family Social Work,* 9(1), 3-11. doi:10.1111/j.1365-2206.2004.00312.x

Strozier, A. L., & Krisman, K. (2007). Capturing caregiver data: An examination of kinship care custodial arrangement. *Children and Youth Services Review, 29,* 226-246.

Substance Abuse and Mental Health Services Administration. (1993a). Improving treatment for drug-exposed infants. Washington, DC: United States Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (1993b). Pregnant, substance-abusing women. Washington, DC: United States Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2011 national survey on drug use and health: Summary of national findings,* NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD.

Tarren-Sweeney, M., & Hazell, P. (2005). Mental health of children in foster care and kinship care in New South Wales, Australia. *Journal of Pediatrics and Adolescent Medicine, 152,* 255-262.

United States Census Bureau. (2010). State and country quick facts. Retrieved from http://quickfacts.census.gov/qfd/states/00000.html

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2012). *The AFCARS report – Preliminary FY2011 estimates as of March 2003.* Washington, D.C.: U.S. Government Printing Office. http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport19.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2003). *The AFCARS report – Preliminary FY2001 estimates as of March 2003.* (8): 1-7. Washington, D.C.: U.S. Government Printing Office. http://www.acf.dhhs.gov/programs/cb/publications/afcars/

Webster-Stratton, C., Reid, M. J., Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in headstart. *Journal of Clinical Child and Adolescent Psychiatry 30:* 283–302.

Zetlin, A.G., Weinberg, L. A., & Shea, N.M. (2010). Caregivers, school liaisons, and agency advocates speak out about the educational needs of children and youths in foster care. *Social Work, 55*(3), 245-255.

APPENDIX

Application for Exemption from Institutional Oversight

Unless qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/projects using living humans as subjects, or samples or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption.

Institutional Review Board
Dr. Robert Mathews, Chair
203 B-1 David Boyd Hall
Baton Rouge, LA 70803
P: 225.578.8692
F: 225.578.6792
irb@lsu.edu | lsu.edu/irb

➢ Applicant, Please fill out the application in its entirety and include the completed application as well as parts A-E, listed below, when submitting to the IRB. Once the application is completed, please submit two copies of the completed application to the IRB Office or to a member of the Human Subjects Screening Committee. Members of this committee can be found at http://appl003.lsu.edu/osp/osp.nsf/$Content/Humans+Subject+Committee?OpenDocument

➢ A Complete Application Includes All of the Following:
(A) Two copies of this completed form and two copies of parts B thru E.
(B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1 & 2)
(C) Copies of all instruments to be used.
　　•If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.
(D) The consent form that you will use in the study (see part 3 for more information.)
(E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB.
　　Training link: (http://cme.cancer.gov/clinicaltrials/learning/humanparticipant-protections.asp.)

1) Principal Investigator: _Dr. Timothy Page_ **Rank:** _Associate Professor_ **Student*? Y/N** _N_

Dept.: _Social Work_ **Ph:** _578-1358_ **E-mail:** _tpage2@lsu.edu_

2) Co Investigator(s): please include department, rank and e-mail for each
*If student, please identify and name supervising professor in this space
Kena L. Ourso, MSW Thesis Student

3) Project Title: _Family Related Risk Factors and It's influences on Behaviors of Children in Foster Care._

4) LSU Proposal?(yes or no) _N_ **If Yes, LSU Proposal Number** _____
　　Also, if YES, either ○ This application **completely** matches the scope of work in the grant
　　　　OR
　　　　○ More IRB Applications will be filed later

5) Subject pool (e.g. Psychology Students) _children <18_
　　•Circle any **"vulnerable populations"** to be used: (children <18; the mentally impaired, pregnant women, the aged, other). Projects with incarcerated persons cannot be exempted.

6) PI Signature _____ **** Date** _____ (no per signatures)
　　I certify my responses are accurate and complete. If the project scope or design is later changed I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted. I also understand that it is my responsibility to maintain copies of all consent forms at LSU for three years after completion of the study. If I leave LSU before that time the consent forms should be preserved in the Departmental Office.

　　Effective August 1, 2007, all Exemptions will expire three years from date of approval, unless a continuation report, found on our website, is filed prior to expiration date

Study Exempted By:
Dr. Robert C. Mathews, Chairman
Institutional Review Board
Louisiana State University
203 B-1 David Boyd Hall
225-578-8692 | www.lsu.edu/irb
Exemption Expires: 3/21/2016

IRB# E9221 LSU Proposal#_____
☑ Complete Application
☑ Human Subjects Training

| Screening Committee Action: Exempted _✓_ Not Exempted ____ Category/Paragraph _4_ |
| Reviewer _Mathews_ Signature _Bill Collins_ Date _3/22/13_ |

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VITA

Jena Ourso was born and raised in Donaldsonville, Louisiana, and attended Donaldsonville Elementary School and Ascension Catholic Elementary, Junior, and High School. Jena graduated from Nicholls State University with a Bachelor of Arts degree in psychology with a minor in criminal justice in May 2010. She continued her studies at Louisiana State University and obtained a Master of Social Work degree in August 2013.

Jena currently lives in Addis, Louisiana with her partner, Michelle. Jena plans to continue her research in early childhood mental health as well as gerontology.