

Perennial Factors Impacting Foster Care Placement Stability: Perspectives of Alumni of Foster Care Who Worked Directly with Children and Youth in Foster Care

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Abstract

Many of the hundreds of thousands of children and youth in the foster care system in the United States face uncertainty about the stability of their foster homes, making foster care placement instability one of the dire challenges perennially faced by many children and youth in foster care. A trove of studies has and continues to utilize perspectives of children or youth in foster care, foster parents, alumni of the foster care system, and child welfare professionals to investigate factors that influence foster care placement stability. However, studies have yet to gain insight into the foster care disruption quandary through the lenses of alumni of foster care who have also worked directly with children and youth in foster care. This phenomenological study employed purposive and snowball sampling techniques to recruit 12 alumni of foster care who had professional experience working directly with children and youth in foster care in Delaware and Pennsylvania. One major theme (child or youth characteristics) and five sub-themes (age, problem behaviors, medical/mental health needs, larger sibling group, and attachment or bonding difficulties) emerged from participant interview responses. The findings provide a further understanding of factors that have recurrently impacted foster care placement stability, especially as they are based on perspectives of individuals who have lived that experience and have also worked professionally with children and youth with similar experience. Research and practice recommendations have been offered.

Background

In the United States, foster care placement instability has remained a major setback for children and youth in the foster care system for years, and the adverse outcomes associated with the phenomenon have been well documented by child welfare researchers (e.g., Cross et al., 2013; Koh et al., 2014; Oosterman et al., 2007; Pecora et al., 2003). Each year, thousands of children and youth enter the foster care system for various reasons (U.S. Department of Health and Human Services, [HHS], 2016). Though the overall number of children and youth in foster care declined by 9.8% between 2007 and 2017, the number of children and youth entering foster care steadily climbed between 2012 and 2017 (Child Welfare Information Gateway, 2019). The high number of children and youth entering foster care is accompanied by increased foster care placement needs (Cross et al., 2013), which ultimately causes placement disruptions.

Various factors have been linked to foster care placement instability. Systems or agency-related factors, foster family characteristics, and child or youth factors have all been found to contribute to foster care disruptions (Cross et al., 2013; Fisher et al., 2014). Oosterman et al. (2007), for example, concluded that the removal of a child or youth from a foster home to a treatment facility or other more restrictive care settings is a systems-related factor that disrupts foster care placement. Cross et al. (2013) found two-thirds (70.2%) of all foster care disruptions attributable to system- or policy-related factors, while foster parent and child or youth factors accounted for 8.1% and 19.7% of all disruptions respectively.

Cross et al. (2013) found geographic moves, employment changes, health problems and other family emergencies, problems in licensing, maltreatment reports against caregivers, and caregivers' failure to meet children's treatment needs as some of the major foster family factors that negatively impact placement stability. Regarding child- or youth-related factors, research has established that the child or youth in foster care's problem behaviors is the most common child or youth characteristic that precipitate placement disruptions (e.g., Cross et al., 2013; Koh et al., 2014; Oosterman et al., 2007). Research has also found that other child or youth characteristics such as the child's or youth's demographics (particularly age, gender, and race),

resilience, and mental health status (e.g., Anctil et al., 2007; McMahon, 2005; Steen & Harlow 2012) as influential factors for or against placement stability. For instance, a child or youth in foster care's longer stay in foster care is almost synonymous with placement instability (HHS, 2016; McMahon, 2005). The HHS (2016) found that 73% of children and youth in the U.S. who were in care longer than four years experienced three or more placements, while 65.2% of those who had been in foster care for 24 months or longer experienced more than two placements (HHS, 2016).

In conclusion, existing studies on placement instability show compelling evidence of the causes and impacts of foster care placement disruptions, as well as ways to curb the phenomenon. However, these studies have generally relied on perspectives of foster parents, youth in foster care, alumni of foster care, and child welfare professionals and administrators. As a result, studies on foster care placement instability that incorporate the perspectives of alumni of foster care with professional experience working with children and youth in foster care are missing. More specifically, existing research on foster care placement instability that involved alumni of foster care did not capture the any of the alumni's professional experience working with children and youth in foster care. Including perspectives of alumni of foster care creates an opportunity to understand foster care instability from experiential, intergenerational standpoints. To that end, the central question for this study was framed: *"How do foster care alumni who work(ed) directly with children and youth in the foster care system describe the factors that contribute to foster care placement instability?"*

Methodology

To gain the perspectives of the study participants on foster care placement disruptions through their lived and professional experiences, this study employed a phenomenological qualitative approach. A major goal of phenomenological research is to allow the researcher to capture a participant's lived experiences, usually through interviews, in an accurate fashion, and to depict these lived experiences in a meaningful and factual context. Phenomenological research requires that the researcher makes all efforts to understand the sociological and psychological perspectives of the participant, as they pertain to the phenomenon under study (Welman & Kruger, 1999). This researcher conducted interviews that captured participants' lived and professional experiences in relation to foster care placement disruptions.

In order to remain within a defined, specific area of inquiry, this study's investigation into foster care placement instability was guided by Fisher et al.'s (2014) definition of foster care placement instability: "any change of household and caregiver that does not result in a permanent placement with a child's biological family or an adoptive family" (p. 10). Fisher et al. (2014) also described foster care instability as including foster care re-entry, moves between foster homes, failed reunifications with biological parents, and failed adoptive placements. These descriptions were considered when interviewing study participants.

As a study that involved human subjects, an approval of this study's methodology was obtained from Widener University's Institutional Review Board (IRB).

Participants

Purposive and snowball sampling techniques were employed to recruit 12, all-female participants. The reason for using a purposive sampling technique was to enhance the identification and selection of participants who could provide rich information on foster care placement stability or instability (Patton, 2015). Purposive sampling also ensured that participants who had profound experience with the phenomenon of interest were included in the study (Creswell & Plano Clark, 2011). Bernard (2002) discussed the significance of employing purposeful sampling technique, noting among other reasons that the ability of a defined population to communicate experiences and opinions in an articulate, expressive, and reflective manner bodes well for any qualitative study.

Recruiting participants through a snowball technique in this study was equally compelling. For instance, Patton (2015) noted that the use of a snowball sampling technique becomes necessary when it is hard to access study participants. Finding participants that met all the eligibility criteria for this study was difficult, due in part to well documented barriers confronting the foster care alumni population, especially their bleak chances of attaining a higher level of education (e.g., Casey Family Programs, 2010; Randolph & Thompson, 2017; Watt et al., 2013), which is usually the minimum educational qualification required to work in the child welfare or foster care field. With the snowball sampling technique, participants were asked to refer other potentially eligible participants to consider participating in the study.

Potential participants were asked the following screening questions, which were directly based on the inclusion and exclusion criteria of the study: a) did you live in a foster care home for at least one year as a child or youth?, b) did you ever experience a disruption in your foster care placement?, c) are you able to recall your foster care experiences?, d) do you currently or have you ever worked professionally with children

or youth in foster care?, e) are you between 23 and 65 years of age?, and f) do you live or work in Delaware (DE) or Pennsylvania (PA).

The criteria that participants had a minimum of one year lived foster care experience, lived foster care placement disruption experience, and professional experience working with children and youth in foster care were to assure that participants could speak to the phenomenon being investigated. The 23-year minimum age criterion was arrived at by taking into consideration the time needed for a foster care alumnus to acquire the requisite education and/or training to work with a foster care agency, while the maximum age criterion of 65 was used because of it being the conventional retirement age for most workers in the United States. The criterion that participants had the ability to recollect their foster care experiences was to ensure that participants could provide an accurate account of the events that transpired during their foster care episode(s). Participants were required to live or work in DE or PA so that the researcher could travel to meet with them for the in-person interviews.

All participants (n=12) met all the inclusion criteria of this study. Nine (75%) and three (25%) participants worked and/or lived in DE and PA respectively. Eleven (91.7%) were still working professionally with children and youth in foster children during the studies, with only one participant having retired. Participants' age varied significantly; the youngest being 23 and the oldest 54 (M = 35). Racially, there were seven (58%) were Black (non-Hispanic), four (33%) were non-Hispanic White, with one non-Hispanic biracial participant. All participants reported having lived in at least three foster homes during their time in foster care. With six as the average number of foster care placements experienced by participants, four (33.3%) of participants reported being in only three foster homes (the fewest number of foster homes reported), while 66.7% of the participants reported having lived in between five and 16 foster homes. Participants had significantly different number of years of experience, with an average of seven years, when it came to their professional experience of working with children and youth in foster care. While only three participants (25%) had between two and three years of professional experience working with children and youth in foster care, 75% of them had between five and 12 years of experience. It is noteworthy to point out that more than half (58%) of the participants had a minimum of eight years of professional experience working with children and youth in foster care.

Instrument

Using a semi-structured interview guide, open-ended were asked to elicit responses on participants' foster care placement stability and instability experiences, and participants' professional perspectives on factors impacting foster care placement stability and instability for the children and youth with whom they have worked. These questions were included on the interview guide:

- What was being in foster care like for you?
- How was it like to move from one foster home to another?
- What would you describe as factors or reasons that led to you leaving one foster home for another?
- What would you describe as factors or reasons that helped you to stay in one foster home much longer than the other(s)?
- When did you start working with children in foster care?
- Why do you work with children involved with the foster care system?
- What factors have contributed to placement disruptions for foster children with whom you worked?
- On average, how long have the children with whom you worked been able to maintain a longer foster home?
- What factors have helped the children with whom you worked to stay longer in foster homes longer?
- Are there any similarities between the factors that contributed to your own experience of placement stability or disruptions and those of the children or youth with whom you worked?

The interview guide was designed such that the interview could be facilitated in a formal, interactive approach. The use of formal, interactive interview approach was critical for this phenomenological study in that the approach helped evoke comprehensive accounts of participants' experiences of the phenomenon (Moustakas, 1994).

Procedures

The researcher recruited participants from foster care agencies in DE and PA. The researcher contacted the agencies about the study and shared with them the IRB approval letter, flyers, and recruitment letters. The recruitment letter encouraged potential participants to contact the researcher through phone or email. Following a potential participant's interest, the researcher followed up by emailing a participant eligibility screening questions (described under 2.1.) with them. The researcher then encouraged the potential

participant to share information about the study with other individuals who could qualify to participate in the study.

After a potential participant met all the inclusion criteria, the researcher arranged with the participant for an approximately 60-minute initial interview and a 30-minute follow-up interview (whenever necessary) at a location, date, and time chosen by the participant. Before the initial interview, the participant was given copies of the informed consent form to read, ask any questions pertaining to the study, and consent to participate in the study by signing the informed consent form. All interviews were audio-taped on a digital recorder, and participants were aware of the recording as it was noted in the informed consent. The researcher used the same digital recorder to record any oral reflections following each interview. To protect the contents on the digital recorder and assure confidentiality of the interviewees, audio files were transferred from the digital recorder to a private, password-protected computer owned by and accessible only to the researcher. To prevent loss of data, the researcher also used a removable, portable hard drive that was password-protected to store backup data of the audio files.

Data Analysis

Data analysis for this study was an ongoing process, which started right after the first interview and continued until data saturation was reached. As typical of phenomenological inquiries, data analysis for this study aimed at reviewing and making sense of significant statements by participants, while generating and finding the interconnectedness among those statements (Corbin & Strauss, 2008). MAX Qualitative Data Analysis (MAXQDA, Version 2018.1), a computer-assisted qualitative data analysis tool, was utilized throughout the data analysis process, which facilitated the search for meaningful themes and sub-themes to shed more light on the phenomenon under study. The researcher followed a seven-step qualitative research data analysis approach (Morrissette, 1999) that increases a deeper understanding of participant responses.

First, the researcher listened and relistened to the audio recordings of the interviews, followed by transcription of each interview. Second, the researcher highlighted key words and significant statements. As a third step, coded the highlighted the key words and statements, which led to emergence of the main theme and sub-themes of this study (see Table 1 below). The fourth and fifth steps entailed clustering of identified theme and sub-themes and conducting a within person analysis respectively, leading to a synthesis of participants' interview responses. This process helped in identifying participant quotes that supported the main theme and sub-themes. The sixth step included reflecting upon the main theme from a participant's individual foster care experience, as well as upon the shared foster care and professional experiences between that participant and the other participants. The final step involved the presentation of the clustered themes for all participants in a grid form to enhance a quick visual reference.

Starting with the first interview, the researcher ensured that each interview recording was transcribed immediately following the interview, and the generated data analyzed promptly. This process helped the researcher to ensure that subsequent interview recordings followed the same procedure so that the analysis of those data was done alongside the existing data, thereby allowing the researcher to synthesize the interview data as they became available. In the absence of triangulation in this study, the researcher used audit trail and member checking to help increase scientific rigor. For audit trail, the researcher kept an extensive observation and reflexive journal that served two respective purposes: to track the pre-interview, interview, and post-interview process, and to record the interactions and field observations. For member checking, the researcher shared the theme and sub-themes from the interviews with participants and asked for their responses in relation to the correctness of the theme and subthemes. The member checking did not lead to any new perspectives or changes to the theme or subthemes.

Table 1. Overview of the main theme, sub-themes and codes.

| <i>Theme</i> | <i>Sub-themes</i> | <i>Codes</i> |
|-----------------------------|-------------------|---|
| Child/Youth Characteristics | Age | Older children and youth vs. younger ones in foster care Foster parents' preference for younger children and youth Older age in foster care synonymous with problem behaviors |
| | Problem behaviors | Externalizing problem behaviors as a major barrier Foster parents' unwillingness to keep children and youth with problem behaviors |

| | |
|---------------------------------|---|
| Medical/mental health needs | Having medical/mental health need(s) limited placement options Foster parents' unwillingness to attend therapies or other interventions for child/youth Mental health issues associated with some problem behaviors |
| Larger sibling group | Siblings of three or more harder to place together Fewer foster homes willing to/capable of taking larger sibling group Separating siblings cause some behavior issues |
| Attachment/bonding difficulties | Child/youth's mistrust of foster parent Child/youth's detachment from foster parent/family |

Results

Child/Youth Characteristics

All 12 participants described personal attributes of a child or youth in foster care as one major factor that caused placement disruptions for them (when they were in foster care) and for the children and youth in foster care with whom they have directly worked. As seen in Table 1, the Child/Youth characteristics theme generated five sub-themes. Each sub-theme was shared by at least three-fourths of the participants. Following are descriptions of each sub-theme supported by poignant and representative participant quotes from the interview responses. To protect the identities of participants, all participant names herein are pseudonyms.

Age

Of the 12 participants, 10 shared that their age contributed to the foster care placement disruptions that they personally experienced. Being relatively older, from 12 years of age until aging out of the foster care system, was discussed by participants as a major cause of placement instability. Participants looked at age as a risk factor for placement disruptions from two angles: age as an independent risk factor for placement disruptions and age as a confounding factor between problem behaviors and placement disruptions. Shakira, a participant, shared that *"one foster parent moved me out because of my age so age was a factor [of me moving from one placement to another]."* Speaking specifically about placement disruptions being more common for relatively older children and youth in foster care, Amber, another participant, noted:

In the foster care system, based on my own experience, a lot of people want babies from families who are not able to conceive with their own. They just want a baby that they can start with and they can mold it into their own culture.

Amber went on to add that *"A lot of them [foster parents] do not like teenagers. That is a very tough group because some of them [teenagers] are already set in their ways. Some of them have a jaded sense of caregivers, whether they [foster parents] say they care or not."* Similarly, other participants concurred that placement stability is less attainable for children and youth in foster care who are relatively older. Olivia, a participant, offered a detailed perspective:

I've never seen a person [foster parent] give back an infant because they couldn't handle them... many foster parents that only take infants are looking to be adoptive parents. So, they're in it for the long haul. If it takes two, three years for the process to be completed, they'll stick it out for that time because they're committed to that child...Whereas if they get a child at the age of 15 and they [the youth] have no interest in being adopted, they [foster parents] are not interested in keeping them.

On the relationship between being an older child or youth in foster care, problem behaviors, and placement instability, Tamika put it succinctly: *"I think the older you are, the more you hold onto that anger, you mad at everybody, mad at the world."* Participants' descriptions of older age as a cause of foster care placement instability showed that foster parents were more likely to stop fostering a child or youth with problem whom they saw as too old to change. Age as an agent of foster care placement instability presented a similarity between participants' own experience of the phenomenon and that of the children and youth in foster care with whom they worked.

Problem Behaviors

All 12 participants described problem behaviors as a single most influential factor that caused most of the placement disruptions. Participants' description of problem behaviors was three-fold: a) if a foster parent felt that she or he was unable to handle a particular behavior from the child or youth in foster care; b) if the child

welfare caseworker saw a behavior from a child or youth in foster care as inhibitive of placing the child or youth with a particular caregiver; or c) if the child or youth knew that the behavior he or she displayed was not desirable and would not sit well with others.

Explaining how her own problem behaviors hampered the stability of her foster care placement, Monica noted that *“So I was in trouble in school, got suspended, and almost expelled in my 10th grade year, and I guess that became overwhelming for some of the parents and it led to me to leave.”* Participants’ descriptions of problem behaviors and their resultant placement disruptions revealed some striking similarities between participants’ own experiences and those of the children and youth in foster care with whom they worked. Alisha stated that, *“So like a lot of times it’ll be like either an arrest or some type of interaction [of the child/youth] with police where foster parent feels frustrated and they’re like, I can’t do this anymore.”* Striking a similar tone, Kerri added:

...the child’s behaviors interrupt their placement because the foster families are like, I didn’t sign up for this... Sometimes the children attack other children in the home, not that they’re trying to be violent, but they’re acting out because they can’t process everything that they’re going through.

It was apparent from participants’ responses, as evidenced by the from Alisha, that foster parents were unwilling to be involved with the law enforcement and court systems, thereby becoming dissuaded from keeping children and youth in foster care who got themselves in trouble with the law. Similarly, participants’ responses answers indicated that foster parents were less likely to continue fostering a child or youth who presented certain externalizing problem behaviors, particularly behaviors that were or appeared to be violent.

Medical/Mental Health Needs

Medical or mental health needs were described by all 12 participants as a significant determinant of whether the participants (as children and youth in foster care) or the children and youth with whom they worked could maintain stable foster care placements. Kerri, for instance, recollected:

Honestly, I think prior to being adopted, my longest placement was in the group home and that was just because they had nowhere else to put me...I don’t know if there was no particular reason [but] I feel like it may have been because I had so many things going on. I was in physical therapy until I was six. I was in speech therapy. I was dealing with [psychological] trauma...I was sexually assaulted at the same time at 18 months.

Prior to making the statement above, Kerri spoke about how coming into foster care with dire medical needs contributed to her switching foster homes. She explained:

And when I first came into foster care, it was a medical issue for me because I came in coming out of a full body cast and having to learn to walk and talk again. So maybe I was placed with families that couldn’t meet my needs and getting me to the doctors or all the physical therapy.

Similarly, participants described mental and medical needs of the children and youth in foster care as a major contributory factor of placement disruptions.

A lot of kids have medical issues that the foster parents are unwilling to deal with, because when you first come into care you don’t know every medical issue that a kid has until they get their physical and stuff...we have this one kid, he’s got severe heart problems and his doctor ... discovered other issues and the foster mom doesn’t want to deal with the other issues because they require like surgeries. (Jazmine).

Participants also drew a direct link between a foster child’s or youth’s mental health needs and a foster parent’s unwillingness to foster children and youth with such needs. Alisha, for example, explained how a child or youth in foster care placed in a mental health facility triggered some foster parents to refuse fostering that child or youth:

Placement into a mental health facility [leads to foster care placement disruptions]. So if they get like crisis intervention and let’s say they go to Terry [a mental health facility in DE] for a period or they go to Rockford [a mental health facility in DE] for a period, then the foster parents basically [will be] like I can’t deal with the aftercare. It’s just too much.

Overall, all participants shared that a child or youth in foster care with a medical or mental health need was often rejected by some foster parents. Participants' discussion also indicated that foster parents are usually unwilling or unprepared to assume medical or mental health the responsibilities presented by the child or youth. Participants further noted that some foster parents see their role as limited to only providing shelter, food, and overall safety for the child or youth, and not carrying out additional responsibilities often associated with the child's or youth's medical or mental health conditions.

Larger Sibling Group

Nine participants saw sibling group placement, where two or more siblings needed care or were already placed together, as a major hinderance to foster care placement stability. Six of the nine participants also shared that having a larger sibling group (four or more siblings) contributed significantly to placement disruptions. Jazmine said that *"At the time, it was five of us, four of us [initially] and my mom had just given birth to my other little brother, so that's all I had ever known and we all got separated,"* and Alisha added: *"And there was like a big separation between the kids because all six of us couldn't go to one home."*

These quotes signified participants' view that foster parents' inability or unwillingness to accept a group of four or more siblings into their home led to a split up among same siblings, which made it harder for some of them to remain in a stable foster home.

Focusing on the children and youth in foster care with whom they have worked, participants discussed larger sibling groups as a major cause of many placement disruptions. Olivia, for example, stated:

Somebody is moving and apparently all these people [foster parents] are not willing to have them, or don't have the openings to take all these children. So, then you have to worry about, okay, now we need to find a foster home that will take all four of them. Now they're all having placement instability.

Olivia again noted: *"It was four kids, a sibling group and we only had three foster homes for them."* Olivia and other participants who saw sibling group placement as being obstructive of placement stability noted that not only does separation of any sibling groups usually increase the chances of placement disruption, but separation of larger sibling groups exponentially increases the possibility of placement disruptions among all the siblings.

Attachment/Bonding Difficulties

Another sub-theme that emerged from participants' discussion of factors that disrupted their own foster care placements was participants' difficulty in attaching to the foster parent(s) they lived with as children. Eleven participants indicated that a child or youth in foster care's difficulty in trusting a foster parent led to capricious and unstable placements. Recounting her own trust issues while in foster care, Kimberly noted:

I would close down when I went to a new foster home and it would take them quite some time for me to trust them...I didn't want to get close to them [foster parents] because I knew the moment I got close to them I was going to be pulled away from them.

Jazmine added:

I think that [lack of trust] caused that rift between my foster mom. I didn't want to get too attached because anytime they [foster parents] can only be like, well I don't want you to be here anymore. So that was my biggest fear, so I just never got too attached to people.

For children and youth in foster care with whom they have worked, participants found that the child's or youth's inability or unwillingness to develop a close bond with the foster parent was a placement-disrupting factor. Olivia noted: *"Sometimes kids push away the foster parent because they self-sabotage. They can't tolerate the love; they can't tolerate stability because they've never had that before."* Linking the child's or youth's trust issues to the child's or youth's fear of being let go by the foster parent at any point, Monica explained:

A lot of them [children and youth in foster care] are afraid to get close to people because it's like when you live a life, or your upbringing is unstable, it's hard to build connections because it is like, I'm afraid that if I get close to you, not soon I know I'm going to leave. So, I've established that relationship and for what?

The similarities between participants' experiences of placement disruptions and disruptions experienced by children and youth in foster care with whom the participants worked were striking in that not only did participants see a perennial trend of attachment, bonding, or trust issues among children and youth in foster care, but they also a perennially common outcome of the deficiency: foster care placement instability.

Discussion

It is a fact that the existing literature shows patterns of factors that negatively influence foster care placement disruptions. It is also a fact that various efforts have been implemented over the years to address those factors. Yet, it is imperative, based on the results of this research, to discuss the perennial nature of the child or youth in foster care-related factors that have contributed to foster care placement disruptions. While participants touched on some agency factors and foster parent-related factors as equally significant causes of placement disruptions, the child- or youth-related factors of placement disruptions showed a consistent, multi-era pattern. In other words, the findings of this study point to certain common experiences of placement disruptions from different eras - where participants found similarities between their own decades-old experiences of foster care placement instability and those of children and youth in foster care with whom the participants had worked. The results of this study revealed certain factors that have impeded foster care placement stability over the years. They also provide answers to the study's research question: How do foster care alumni who work(ed) directly with children and youth in the foster care system describe the factors that contribute to foster care placement instability? As seen in the discussion of the five sub-themes below, the findings of this study did not only answer the research question, but it also supported or contradicted some extant studies on foster care placement disruptions.

Age

Age proved to be a pervasive, multi-era factor that affected foster care placement disruptions. The findings of this study suggested that foster parents appeared to prefer relatively younger children and youth in foster care to those who were much older, which made older children and youth in foster care more susceptible to placement disruptions. The findings also painted a picture where participants viewed their own "older" age, and that of the children and youth with whom they worked, as dissuading to foster parents who would rather take in the "easy-to-manage," moldable babies and very young children. Age as a perennial factor that influences foster care placement stability is quite concerning, yet not all too surprising. Some earlier studies (e.g., Oosterman et al., 2007; Steen & Harlow, 2012; Weiner et al., 2011), for example, found that older children and youth in foster care were more likely to experience placement disruptions compared with their younger counterparts. Weiner et al. (2011), for instance, established that a year's increase in a child or youth in foster care's age elevated that child's or youth's risk of placement disruption by 3%; which, in part, may be due to foster parent's preference for younger children over older children and youth.

Problem Behaviors

Problem behaviors, as a determinant of foster care placement instability, showed striking similarities between the participants' own experiences and those of children and youth in foster care with whom the participants worked. The findings depicted externalizing behaviors – including anger, aggression, and insubordination – as being directly responsible for a host of placement disruption episodes for the participants themselves (as children and youth in foster care decades prior) and for the children and youth with whom the participants worked. The recurrence of problem behaviors as a militating factor against placement stability across different eras shows a troubling pattern; one that is supported by the existing literature. Newton, Litrownik, and Landsverk (2000), for instance, singled out externalizing problem behaviors as the strongest predictors of placement instability. It is also imperative to point out that, despite this study's findings showing externalizing behaviors as being the most constant problem behaviors that have disrupted foster care placements over time, the findings also indicated that all problem behaviors, whether externalizing or internalizing, have caused placement disruptions across different eras. This finds support in Oosterman et al.'s (2007) study that established that all problem behaviors, in aggregate, made up the most robust cause of placement instability among all children and youth in foster care.

Medical/Mental Health Needs

Physical, behavioral, and emotional health needs of the child or youth in foster care were found as being responsible for multiple foster care placements experienced by participants and the children and youth with whom the participants worked. The findings of this study indicated that placement disruptions resulting from a foster parent's inability to meet the medical and mental health needs of a child or youth in foster care are not novel but have remained as a decades-long issue confronting child welfare. Though the child welfare field has undergone significant changes over time, this study's finding indicated a problematic, decades-long trend where foster parents have become overwhelmed when they are unable to meet the medical or mental health

needs of the child or youth in their care, which, more often than not, leads to a dissolution of the placement. The findings also suggested that not only have foster parents remained overwhelmed by their inability to handle the medical/mental health needs of the child or youth in their care, but also they have usually been more unwilling or unprepared to be involved in a child's or youth's medical or mental health treatment plan, including taking the foster child or youth to medical or therapeutic appointments, or participating in some of those appointments as a caregiver, among other appointments. The cause of this perturbing, perennial factor that has negatively influenced foster care placements finds some explanation in the existing literature. While Seltzer, Henderson and Boss (2016) argued that there is a lack of robust data on medical foster families, they found the limited available data to indicate that "foster parents often feel inadequately prepared to care for children with medical complexity" (p. 193). Also, Greiner et al. (2015), for example, explained that while children and youth in foster care are known to have unfavorable mental health outcomes, their foster parents who report feeling ill-prepared to navigate the health system and access services to address the child's or youth's medical needs are more likely to end the fostering relationship.

Larger Sibling Group

The finding that children and youth in foster care with sibling groups of three or more were more likely to experience foster care placement disruptions is concerning in that sibling relationships can create positive support and improved outcomes for children and youth in the child welfare system (Richardson & Yates, 2014). Similarly, connections among siblings in foster care can serve as a protective factor (Child Welfare Information Gateway, 2019), which can significantly contribute to placement stability. Yet, the fact that this study found larger sibling group placement to cause placement disruptions across different eras makes the issue more deserving of being tackled with precision and focus. Specifically, this study found two ways that larger sibling group placement caused foster care placement disruptions for participants and for the children and youth in foster care with whom they worked; when a single foster home was unable to take in the entire sibling group, and when the sibling group ended up splitting up after initially being placed together in one home. Larger sibling group, as a factor that negatively influences placement stability, is supported by some of the existing, including Jones and Wells (2008), who found that the size of the child's or youth's sibling group positively correlate with foster care placement disruptions experienced by children and youth in foster care. Some studies, however, did not find the size of a sibling group as the main reason behind placement disruptions. Findings by Cross et al. (2013) and Rolock et al. (2009), for example, indicated that it is the efforts by child welfare agencies to place sibling groups together or reunify them in the same foster home, in lieu of the size of the sibling group, as being more responsible for placement disruptions for sibling groups.

Attachment/Bonding Difficulties

The findings of this study indicated that struggles of children and youth in foster care to attach to or bond with their foster parents or families have been a source of many foster care placement disruptions over several decades. The findings indicated that participants (a foster care group) and the children and youth in foster care (another foster care group) with whom participants worked experienced placement disruptions due to attachment/bonding difficulties across the different eras of foster care experience between the two foster care groups. This is a worrying, yet unperplexing, phenomenon in that attachment, as a theoretical and practical framework, has long been established as an important factor that shapes relationships. Bowlby (1969), for instance, postulated that an absence of a healthy attachment often translates into a child's difficulty in relating to others and maintaining stable, healthy, and beneficial relationships. Also, Main, Kaplan, and Cassidy (1985) added that children who experienced adverse events were more likely to develop a disorganized or disoriented pattern of attachment that affects their ability to develop secure, healthy attachments with their caregivers. Of course, children and youth in foster care already experienced adverse events by being maltreated by their caregivers before child welfare agencies even stepped in. Therefore, children and youth in foster care are more unlikely to develop healthy attachment their foster parents, which, according to Kira, Somers, Lewandowski, and Chiodo (2012), culminates into foster care placement disruptions.

Strengths and Limitations

The use of interviews in this study to understand participants' lived and professional foster care placement instability experiences helped to understand the phenomenon from two distinct, yet converging perspectives. It is imperative to point out that no known study has investigated the foster care placement disruption phenomenon by incorporating the dual perspectives of alumni of foster care who have professionally worked. On that backdrop, this study's approach to investigating the phenomenon through the lenses of those who have sat on both sides of the foster care table helped in understanding the problem from the respondent as a child or youth in foster care, from the respondent as a professional working with children and youth in foster care, and from a multi-era standpoints. The findings unearthed common factors that have caused foster care placement disruptions across different eras, including the child's or youth's age, problem behaviors, physical

and mental health needs, larger sibling group, and attachment difficulties.

As a limitation, this study lacked participant heterogeneity, something that was hard to control because of the voluntary participation in this kind of study. All participants were females, which could affect the transferability of the study's findings. It is equally important, however, to point out that the all-female participant sample was not completely surprising as the child welfare (CW) workforce is predominantly female. There are no discrete statistics on the gender makeup of the CW workforce, however, Salsberg et al. (2017) found that 88.3% of the social work workforce are females. It is also unknown whether male and transgender child welfare professionals would have met all the criteria of this study.

Recommendations for Research and Practice

Given that there was no male or transgender voice in this study, it is recommended that future studies on a similar topic have representation from individuals who identify as male, transgender, or other gender. Since the perspectives of female alumni of foster care on placement instability have been captured in this study, it becomes even more imperative that perspectives of non-female alumni of foster care are included in future studies in a bid to enhance transferability of the findings of such studies.

Several practice recommendations are made in relation to the perennial child- or youth-related foster care disruption factors discussed in this study. First, recruitment, training, and retention of foster parents who specialize in taking in and keeping older children and youth in foster care should be prioritized by child welfare agencies. Like the now-popular therapeutic foster care subsystem, having a subset of foster parents who specialize in caring for older children and youth could lead to increased placement stability for the older children and youth group.

Second, the significance of identifying children and youth in foster care who are at risk for problem behavior-related placement disruptions cannot be overemphasized. Not only would identifying children and youth in foster care whose behaviors could potentially disrupt their placement would help ensure foster care placement stability or permanency, but it could also lead to an effectiveness of preventative interventions and reduction in financial and psychological costs associated with placement disruptions (Fisher et al., 2011). Child welfare agencies need to implement or augment new or already existing policies and practices respectively to enable them quickly identify children and youth in foster care whose behaviors could disrupt their placements.

Third, child welfare agencies must make it a priority to collaborate with physicians and foster parents, group home staff and, to the extent possible, parents and family members to accelerate medical and mental health assessments for children and youth in foster care. For instance, the American Academy of Pediatrics (AAP, 2015) recommended that an initial health assessment should be conducted ideally within 72 hours of placement for all children and youth in foster care, followed by a comprehensive assessment within 30 days. According to the AAP (2015), it is even more pertinent that children who come into foster care with identifiable health needs be seen within 24 hours, rather than 72 hours. Also, child welfare agencies should integrate health assessment results and recommendations into the child or youth's case plans to help assure that there is a focus on addressing the health needs of children and youth in foster care.

Fourth, there is ample evidence that placing siblings together increases the likelihood of achieving permanency and stability, including reunification, adoption, and guardianship (Child Welfare Information Gateway, 2019; Jones, 2016; Akin, 2011). Child welfare agencies can achieve permanency for sibling groups placed together by ensuring that families who care for sibling groups receive information and access to resources, including family support groups, respite care, and sibling camps that could help increase the foster families' ability to care for sibling groups. The agencies can also increase sibling group placement in the same foster home by providing more incentives and capacity-building opportunities to foster parents who take or plan to take three or more siblings into their care. Additionally, in the event that siblings must be separated due to an emergency, placement disruptions could be averted if the agency reviews the case quickly to prioritize reunifying the siblings in the same home.

Fifth, child welfare agencies should prioritize addressing children and youth in foster care's attachment or bonding difficulties. Both Bowlby (1982) and Atwood (2006) noted that negative attachment patterns can be discontinued with a reliably sensitive and responsive attachment figure. Therefore, the agencies could create avenues for foster parents to develop or increase their sensitivity and responsiveness to the attachment needs of the child or youth in their care through resources and training opportunities designed to specifically address this concern. Agencies could also connect the child or youth in foster care to clinicians who specialize in attachment catchup therapy to help address underlying issues affecting the child- or youth's attachment or

bonding difficulties.

Conclusion

Several factors impacting foster care placement stability have been discussed in various literature, and there is compelling evidence that disruptions in foster care are not limited to a single factor. While existing studies have utilized perspectives of current foster children or youth, youth who have aged out of the foster care system, foster care workers and administrators, and other stakeholders, to explain factors that impact foster care placement stabilities, this study sought to understand foster care placement disruptions through the eyes of those who had lived that experience and had had professional experience working with children and youth with similar experience. Responses from participants in this study led to the emergence of one main theme (child or youth characteristics) and five sub-themes that amplified certain factors that have repeatedly affected foster care placement stability, including the child or youth's age, problem behaviors, medical/mental health needs, larger sibling group, and attachment/bonding difficulties. Drawing on their own lived foster care experiences and their professional experiences working with children and youth in foster care, participants' identification and description of the main theme and five inter-generational, recurrent influencers of foster care disruptions supported or contradicted some existing studies. More importantly, the findings of this study lay bare five specific perennial factors affecting foster care placement stability that require concerted, tailored efforts to address.

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