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Dissociative symptoms in family foster children

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Introduction

Children in the foster care system have typically undergone significant early adversity, including neglect, physical and sexual abuse, or frequent placement changes. Besides general externalizing and internalizing adjustment problems, a sizable minority of children in foster care may present more complex problems that have been less studied, among which is dissociation.

Clinically significant dissociation in childhood occur frequently as a response to overwhelming traumatic events, such as physical or sexual abuse, that are not processed and consequently disrupt the normal integration and coherence of memory, consciousness and perception. It can manifest as behavioral and emotional fluctuations, trance-like states, or uncommon forgetfulness and amnesia (Silberg & Dallam, 2009).

The scarce previous research with foster children has found high levels of dissociative symptoms and around 20 % of foster children with clinical dissociation levels (Hulette, Freyd, & Fisher, 2011).

High levels of dissociation entail significant risk for developing other psychological problems and a maladaptive developmental pathway (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997), and, therefore, the need for further analysis of this phenomena in foster children is relevant.

This study aims to analyze the presence of dissociative symptoms in a sample of Spanish children in non-kin foster care, as a preliminary exploration. As dissociation is a continuum from normal or age-appropriate to clinical symptoms, we focus on comparing children with and without clinical dissociation scores. We also explore the role of adversity variables like physical and sexual abuse or number of placements, as well as the presence of adjustment problems.

Method

Participants

37 children in non-kin foster care between 50 and 108 months (*M* = 86.84, *SD* = 17.85; 18 boys, 48.6 %). Inclusion criteria: age 4-8 years old, living in a non-kin foster placement for at least 6 months in the provinces of Seville and Cadiz, and no physical or psychological disability.

Instruments

➡ ***Child Dissociative Checklist*** (CDC; Putnam, Helmers, & Trickett, 1993): Caregiver-reported scale of 20 items, asses dissociative symptoms in children and adolescents. 3-point Likert scale, provides a total score. Scores higher than 12 are considered indicative of clinical dissociation. Cronbach's α = 0.85

➡ ***Strenghts and Difficulties Questionnaire*** (SDQ; Goodman, 1997): Caregiver-reported scale of 25 items, assess adjustment problems and prosocial behavior in children and adolescents. 3-point Likert scale, 5-items subscales of *emotional symptoms*, *conduct problems*, *hyperactivity*, *peer problems*, *prosocial behavior*, and a *total difficulties* score. Total difficulties Cronbach's α = 0.79

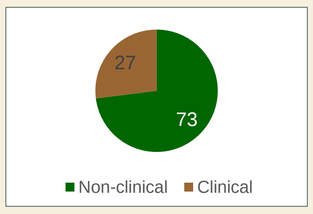
➡ ***Adversity variables***: Information on maltreatment history and number of previous placements were provided by foster care caseworkers. Severity of physical maltreatment and sexual abuse (0-5) were coded following the Maltreatment Classification System (Barnett, Manly, & Cicchetti, 1993), and combined to form *severity of active maltreatment*. Preplacement information was only available for 23 participants.

Procedure and data analyses

Data were collected in home visits and through contact with caseworkers for preplacement information. Group comparison (non-parametric Mann Whitney U) with calculation of Pearson's *r* as effect size between groups were conducted with SPSS 24.

Results

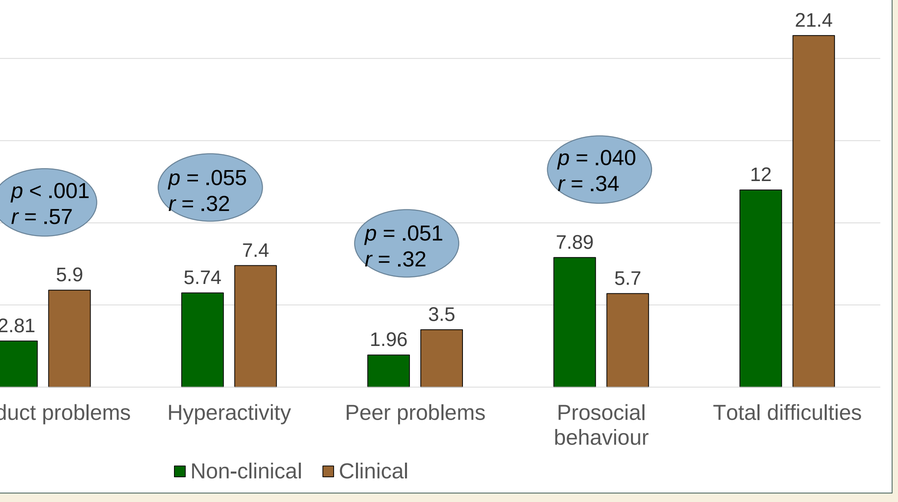
Figure 1. Percentage of foster children with clinical dissociation scores



CDC Total Score *M* = 7.59 (6.58)

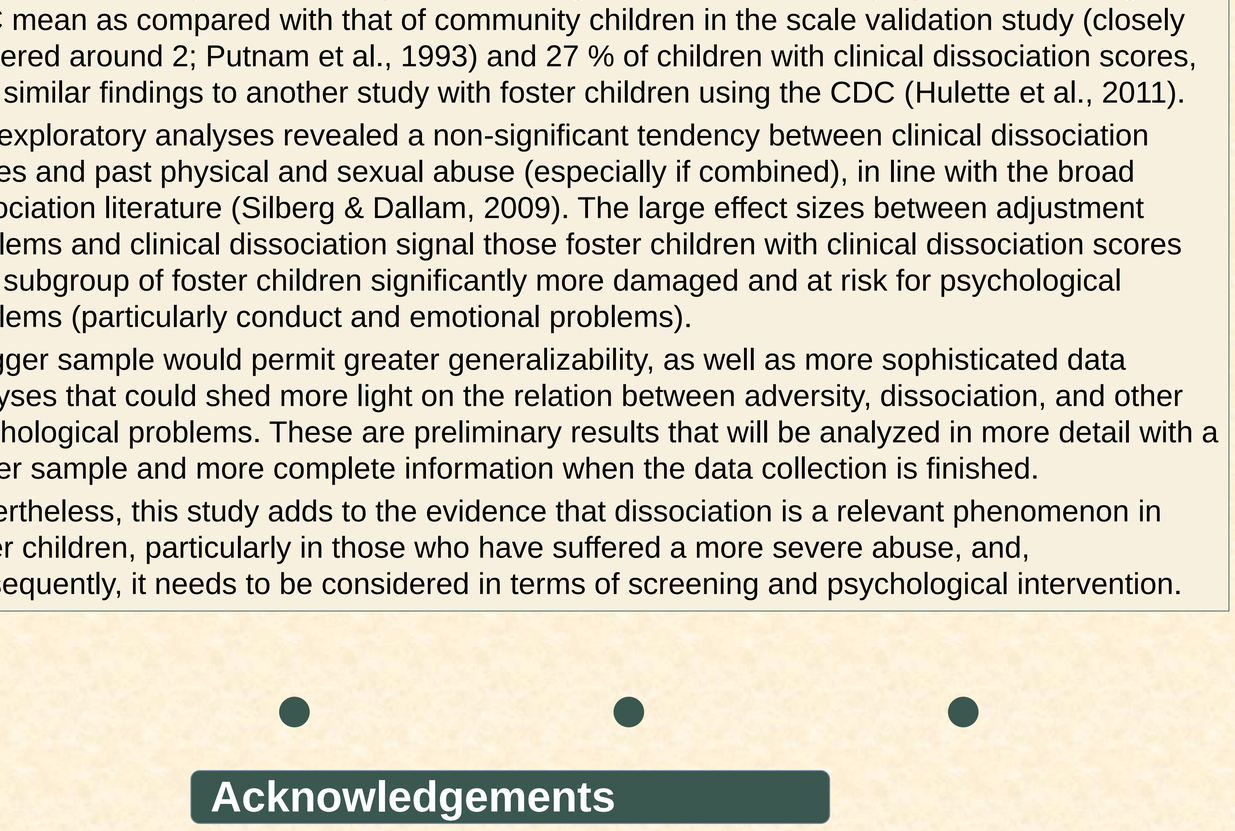
Graphs with means of foster children with clinical and non-clinical dissociation scores in variables of interest are presented. Non-parametric Mann Whitney U signification and Pearson's *r* as effect size are reported when the effect is non-negligible.

Figure 2. Comparison between foster children with clinical and non-clinical dissociation scores on adversity variables



r > .10 ⟶ Small effect, *r* > .30 ⟶ Medium effect, *r* > .70 ⟶ Large effect

Figure 3. Comparison between foster children with clinical and non-clinical dissociation scores on adjustment variables



Conclusions

- We found a minority but relevant presence of significant dissociative symptoms, with a high CDC mean as compared with that of community children in the scale validation study (closely clustered around 2; Putnam et al., 1993) and 27 % of children with clinical dissociation scores, very similar findings to another study with foster children using the CDC (Hulette et al., 2011).
- Our exploratory analyses revealed a non-significant tendency between clinical dissociation scores and past physical and sexual abuse (especially if combined), in line with the broad dissociation literature (Silberg & Dallam, 2009). The large effect sizes between adjustment problems and clinical dissociation signal those foster children with clinical dissociation scores as a subgroup of foster children significantly more damaged and at risk for psychological problems (particularly conduct and emotional problems).
- A bigger sample would permit greater generalizability, as well as more sophisticated data analyses that could shed more light on the relation between adversity, dissociation, and other psychological problems. These are preliminary results that will be analyzed in more detail with a bigger sample and more complete information when the data collection is finished.
- Nevertheless, this study adds to the evidence that dissociation is a relevant phenomenon in foster children, particularly in those who have suffered a more severe abuse, and, consequently, it needs to be considered in terms of screening and psychological intervention.

References

Barnett, D., Manly, J. T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. Toth (Eds.), *Advances in applied developmental psychology: Child abuse, child development and social policy* (pp. 7–73). Norwood, NJ: Ablex.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of Child Psychology and Psychiatry*, *38*(5), 581–6. doi: 10.1111/j.1469-7610.1997.tb01545.x

Hulette, A. C., Freyd, J. J., & Fisher, P. A. (2011). Dissociation in middle childhood among foster children with early maltreatment experiences. *Child Abuse and Neglect*, *35*(2), 123–126. doi: 10.1016/j.chiabu.2010.10.002

Ogawa, J. R., Sroufe, L. A., Weinfield, N. S., Carlson, E., & Egeland, B. (1997). Development and the fragmented self: longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, *9*(4), 855–879. doi: 10.1017/S0954579497001478

Putnam, F. W., Helmers, K., & Trickett, P. K. (1993). Development, reliability, and validity of a child dissociation scale. *Child Abuse & Neglect*, *17*(6), 731–741. doi: 10.1016/S0145-2134(08)80004-X

Silberg, J. L., & Dallam, S. (2009). Dissociation in children and adolescents: at the crossroads. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders. DSM-V and beyond* (pp. 67–81). New York: Taylor & Francis Group.

Acknowledgements

This research project was conducted in collaboration with the Office for Childhood and Families of the regional government of Andalucia (Spain) and the foster care associations Fundación Márgenes y Vínculos and APRONI. We thank all the families and professionals who have participated, as well as the undergraduate students who have collaborated in the data management.