CULTURE & CONTEXT: A COMPARISON OF THE ROMANIAN AND CALIFORNIAN CHILD PROTECTION AND MENTAL HEALTH SYTEMS AND THEIR PERCEIVED EFFICACY

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A Thesis

Presented

to the Faculty of

California State University, Chico

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In Partial Fulfillment

of the Requirements for the Degree

Master

in

Social Work

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by

Marc William Clanton

Spring 2017

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DEDICATION

To every child who feels forgotten and to those who spend their lives loving them.

ACKNOWLEDGEMENTS

To Dr. Sue Steiner: I am incredibly grateful for your continued guidance and support throughout this process. Thank you for teaching me that any change for the better, no matter how small it feels, is worth it in the end. Your patience, guidance, and flexibility has been so helpful through the evolution of this thesis. Thank you for teaching me to remain hopeful even when I am discouraged with everything that has gone awry in this world.

To John Penrose: Thank you so much for your mentorship both in this project and in life. You have been so helpful with this whole process. Thank you for getting me started on this journey, and walking with me along the way.

To Bogdan, Florina, Nelu, Daniel, Ana, Simona, Costel, Nela, Iona and all the CTL staff, past and future, who work so hard to improve the lives of children in Romania. Thank you to every single one of you. Being a part of this team is ultimately what lead me to do this thesis. Your perseverance and compassion are immeasurable. A part of my heart will always be with you and the kids in Romania. Thank you so much for your insight into the lives of these kids, for helping translate, and for your help with my research. Above all else, however, thank you for the work you do every day to care for children that others have forgotten. The work you do is difficult and draining, and incredibly important. I am proud to count you among my friends and colleagues.

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ABSTRACT

CULTURE & CONTEXT: A COMPARISON OF THE ROMANIAN AND CALIFORNIAN CHILD PROTECTION AND MENTAL HEALTH SYTEMS AND THEIR PERCEIVED EFFICACY

by

Marc W. Clanton 2017

Master of Social Work

California State University, Chico

Spring 2017

This study attempts to elucidate some of the complexity of the Romanian and California Child Welfare systems and provide insight that will enhance the outcomes of the children within them. This is done by synthesizing 1) the history of these agencies, 2) literature on the effects of these systems on children and effective treatments for traumatized children, and 3) the efficacy of the systems as perceived by the social service workers in close proximity to these systems. Six participants were recruited, three from Romania and three from California. They were interviewed to determine their views on their respective system. Relevant themes were gleaned from the data, such as the prevalence of stigma toward children in these systems, the role of attachment in the development and treatment of trauma, and the overall desire for change within these systems. These, along with other themes, were analyzed in relation to existing literature and several key concepts were identified. These concepts included the need for a shift in cultural perspective in order to reduce stigma toward foster youth, especially LGBTQ

foster youth, as well as the need for systemic change. Consistency, permanency, early intervention, and trauma informed care were identified as crucial elements of successful interventions, and steps should be taken in order to incorporate them into these systems of care.

CHAPTER I

INTRODUCTION

Background

The summer of 2007 was the first time I held a baby Romanian Orphan in my arms. His name was Petru, and I sang to him as he fell asleep. I was told that this was probably the most attention he and the other infants in the center would receive in a long time. This experience started me down a unique path that ultimately lead to this project. Several years after meeting Petru, I chose to live in Romania for a time. While there, I worked for a small organization with partnerships in various orphanages and families throughout the capital city. The relationships I built during that time had a profound effect on me. The situations many of the children faced were heartbreaking, but I was constantly moved by the glimpses of joy and hope I saw in the children and the staff that worked with them. I was inspired by the work being done and I longed to learn more about the circumstances that lead to Romania's condition, and what could be done to improve it. My time over there changed my world view forever and as I began the MSW program at Chico State, my passion for helping these children continued. As I learned more about systems and policies and the way they shape and influence the lives of children, I decided to bridge the gap between the two systems. I hoped to bring the knowledge and expertise I was learning in the United States to a country that I loved in a way that respected the history and culture that makes it unique.

Purpose of the Study

Providing for the welfare of children seems to be a significant challenge in many societies throughout the world. The method and quality of caregiving has a profound impact on a child's development and future performance in mainstream culture (Child-care, 2002), and support from adults during childhood is one of the most important factors in determining a child's emotional well-being (Oberle, Schonert-Reichl, Guhn, Zumbo, & Hertzman, 2014). When the quality of a child's care falls below the determined cultural standard due to abuse, neglect, or parental inability, many societies develop systems and agencies to intervene, and provide care. Often this responsibility falls within the realm of the government. This project will be looking at two such systems and how they go about providing care for children, specifically mental health services, in their respective cultures. The two systems being studied are the Romanian Child Protection Department, and the California Child Welfare and Mental Health system.

The original purpose for this project was to compile resources and interventions designed specifically to help children in child protection systems who have experienced traumatic upbringings. The idea was to interview workers from both countries and see which tools or methods could help fill gaps in the other country's agency. After examining existing research and literature, however, I discovered that several groups have compiled resources and interventions related to this topic. Indeed, early into the research I discovered that the tools and skills for working with individuals (micro-level) were readily available to workers in both systems. There was still, however, disparity in both systems between the expectations and goals of the agencies, and reality. There

seemed to be a need for broader systemic change (macro-level), and new conceptual frameworks (meso-level) in both countries.

Government systems are daunting entities; complex bureaucratic structures comprised of countless individuals and managed by various policies and mandates. Because of their complexity, it can be difficult to fully understand what lead to the current state of affairs. Often child protection systems are perplexing, even to those who work within them. Without a full understanding of the structure, and the circumstances leading to its present state, one cannot effectively identify its shortcomings or make meaningful recommendations for reform.

Workers within child welfare systems have a unique position. Often their proximity to the structure prevents a broader understanding of the whole system, however they see first-hand the shortcomings and pitfalls that come at its behest. This study seeks to bridge that gap by incorporating 3 crucial facets into one document: 1) an abridged history of child welfare systems in California and Romania 2) review of the existing literature on the effects of trauma, institutionalization, and foster care on children and 3) the efficacy of the systems and their methods as perceived by social services workers in each country. Informed by this synthesis, I hope to make meaningful recommendations for future research and reform in the macro and meso levels of these systems and the agencies that support them.

Limitations of the Study

One of the most significant issues with this study is its small sample size. This is, in large part, due to the shifting purpose of the study and logistical constraints. Because of the small sample size, the results of the study cannot be generalized broadly. In addition

the sampling of the participants took place in two limited geographical locations, Northern California and Bucharest, Romania. Therefore the results of the study are not representative of the country or state as a whole.

CHAPTER II

LITERATURE REVIEW

Historical Context

In order to fully understand these systems, one must consider the context in which they were shaped. Each system is unique to its culture and must be viewed with its history in mind.

Romania

Romania's recent history and time under communist rule has created a set of unique circumstances that have drastically shaped the lives of children in the Child Protection system. From 1965 to 1989, Nicolae Ceaușescu was the leader of Romania (Britannica, 2016). Soon into his tenure as dictator, Ceaușescu enacted a decree banning abortion throughout the nation (Levitt & Dubner, 2005). Later, he included regulations banning all forms of contraception (Britannica, 2016). These regulations were coupled with a so-called "celibacy tax," imposed on women who did not bear children for long periods of time. These policies were designed to bolster Romania's population and increase its military power and work force. The regulations had the desired effect, and the Romanian population exploded. However, due to the economic and political structure of the country, many of the families bearing children either did not have the desire to raise children, or were financially unable to support their entire family (Levitt & Dubner, 2005). This created a culture in which children were readily given to the state for care in hopes that the government would provide better care than families could (Powell, 2010).

After the fall of communism and the execution of Nicolae Ceaușescu in 1989, the horrendous conditions these institutionalized children experienced were exposed to the global community. While conditions in orphanages have improved since then, the effects of institutionalization and abandonment still plague Romania and its people. Children in these systems face myriad obstacles including traumatic backgrounds, mental health problems, (Powell, 2010), and social stigma.

Meaningful reform in Romania's child welfare system came more than a decade after the revolution. According to the National Authority for the Protection of Child's Rights (NAPCR, 2006), in 2005 the child protection department created policies that catalyzed significant shifts away from institutionalization toward reunification with families, and more "family-like" care. While this is a positive move, the implementation of the policy has been significantly hindered by the culture of abandonment created by Romania's history (Leon, 2011). Parents in Romania are not obligated to forfeit their parental rights in order to place their children in an orphanage, and children are not eligible for adoption until at least one year has passed without a relationship with their parent. This often places children in a sort of limbo because they are not eligible for permanent adoption, and their parent(s) maintains only a perfunctory relationship with the child in order to retain their rights (Sullivan, 2014). In doing so, the parents provide neither the stability nor the attachment needed for adequate development. While many parents have the best of intentions, this system, nonetheless, often prevents children from permanent placement.

Welfare policies in Romania also play a major role in shaping the dynamics surrounding a child's entrance into the Romanian foster care system. There are financial

benefits given to families with children in Romania. These benefits include tax breaks, entitlement payments based on financial need, and a one time "birth grant" paid to every child that is born. One of the most significant benefits families receive is a, sum paid to any family with a minor. The same sum is paid regardless of the family's demographics, but is significantly higher for children under the age of two (Avram, & Militaru, 2016). While the intention of these policies is to provide a safety net for low-income families, it could be argued that they ultimately provide incentives for impoverished families to continue to bear children.

Romania's mental health system is also lacking. Compared to other European countries with comparable history (i.e. former communist dictatorships), Romania spends less on healthcare than any other nation, and an even lower percentage of these funds on mental health. This suggests that as a country, Romania places little value in mental health services. This leads to inadequate compensation and low motivation for many mental health workers in the country (Dlouhy, 2014).

California

The California Child Welfare system is a complex amalgam of agencies designed to ensure that children are living above society's minimum standard of safety and care. From the federal level, the United States Department of Health and Human Services regulates state systems for foster care and child protection and distributes federal money to finance the systems. The California Department of Social Services (CDSS) oversees county agencies and distributes funds throughout the state. Each county, in turn, has its own child protection department and mental health department (Foster, 2001).

In its earliest years, the child welfare system fulfilled its mandate to protect children by simply removing them from abusive homes. This resulted in the housing of abused children in institutions and orphanages. In the beginning of the 20th century, the shift was made to foster care. Despite its faults, the foster care system remains in place today in order to provide homes for children removed from their families (Myers, 2008).

The child welfare system has evolved rapidly since the 19th century. Its modern incarnation came into existence in the 1960s. During this time, awareness about child abuse became widespread, and there was a public outcry to address the problem. In response to this outcry, laws were developed to protect children against abuse. These laws started by addressing physical abuse, and eventually expanded to encompass sexual abuse, emotional abuse, and neglect. With the foundation of the child protection system, the enforcement of these statutes, and the implementation of mandated reporting, cases of suspected abuse came in droves. While many agencies struggle to keep up with incoming cases, one cannot deny the progress that has been made (Myers, 2008).

The buzzword in the current child welfare system is "permanency." Ideally, the foster care system is meant to be a waystation for children in the process of reunification or adoption; a safe haven while their family receives services and becomes a nurturing environment, or a permanent family is found. While reunification seems to be the most common reason for exiting foster care, it only accounts for about half the children who exit, with a quarter of children remaining in foster care or leaving the system without a permanent family (Akin, 2011). According to the University of California at Berkeley California Child Welfare Indicators Project, 57% of children who entered foster care

between July 2014 and June 2015 were still in foster care over a year later (Webster et al 2016b).

The current policies place strict time limits and expectations on families working toward reunification (California, Department of Human Services 1993). Despite these policies, however, studies indicate that the recidivism rate can be from 13 to 31% among families that have undergone the reunification process (Wells & Correia, 2012). The child welfare system attempts to balance the complicated relationship between a child's safety, and finding them a permanent home.

Often, induction into the child welfare system is only the beginning. Approximately one third of cases in which abuse or neglect is confirmed result in the child being removed from the home (Danielson, 2010). Over 60,000 children in California currently reside in foster care (Webster et al 2016a). For those that are not removed, parenting classes, mental health services, and other resources are provided to the family in order to increase stability and quality of life for the child and family (Foster, 2001).

Mental Health and Foster Care

The far reaching effects of institutionalization and foster care must be understood within the context of trauma. Trauma is generally defined as an atypical event in which an individual is exposed to, or perceives intense danger and is unable to regulate their physical and/or emotional reaction to the experience (Fratto, 2016). There are varying forms of trauma that can include singular, catastrophic events, but the form most relevant to this paper is prolonged, complex traumatization. The most insidious category of trauma for the developing child is childhood maltreatment. This is defined by the Center for Disease Control (CDC) as "any act or series of acts of commission or omission by a

parent or other caregiver that results in harm, potential for harm, or threat of harm to a child." (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008, p.11).

There are four categories of childhood maltreatment. They are: physical abuse, sexual abuse, emotional abuse, and neglect. Trauma of this nature is particularly harmful to a child's development because it takes place at the hands of someone with whom the child has a relationship (Fratto, 2016). The United Nations has developed a global standard regarding the treatment of children, however culture still has a significant effect on perceptions of the nuances surrounding this topic (i.e. where the line between physical abuse and corporal punishment is). Despite these differences, however, there is consensus across culture regarding these broader categories of maltreatment (Fakunmoju et al, 2013).

The very nature of the child welfare systems in Romania and California are such that the children who enter the systems are already at increased risk for mental health problems. Because the child welfare systems were designed to protect children from maltreatment, the children, by default, have undergone any number of traumatic experiences before entering. Being removed from an abusive home can, itself, be a traumatic event. The correlation between out-of-home placement and increased mental health problems is well documented, with some studies indicating up to 60% of foster children have been diagnosed with a mental illness. These early mental health problems often extend into adulthood despite efforts from mental health systems (Scozzaro & Janikowski, 2015; Swanke, Yampolskaya, Strozier, & Armstrong, 2016). These complications during development can also be compounded if the child is placed in an institution.

One of the most renowned longitudinal studies on the effects of institutionalization was the Bucharest Early Intervention Project (BEIP). This intervention and accompanying study were designed by Zeanah (2003) and his colleagues, and sought to determine just how drastic the effects of foster care and institutionalization can be on a child's mental health. This study was conducted on 136 Romanian children, 68 of whom were placed at random into a foster care program, while the remaining half continued to live under typical care in their respective orphanages. A number of tests were conducted on each group and compared to a group of children who remained with their original families. In all categories, the children who remained in their institutions performed worse. On average, the institutionalized children scored 10 points lower in IQ tests than those in foster care, and 30 points lower than the control group. Of the 68 institutionalized children, over half were diagnosed with a mental disorder before the age of five, compared to just 20% in the control group. While foster care seemed to reduce the occurrence of mood disorders such as anxiety and depression, it had no effect on behavioral disorders such as ADHD or conduct disorder. This study also determined that the earlier a child is placed in foster care, the higher the likelihood of positive outcomes (Nelson, Fox, & Zeanah, 2013).

In a follow up study, the same cohort of children was studied when they were approximately 12 years old to determine the prevalence of maladaptive mental health symptoms. Both the institutionalized group and the foster care group showed increased levels of internalized symptoms such as mood disturbances or anxiety, however the foster care program seemed to mitigate externalized symptoms such behavioral problems and high risk behavior. The results were also moderated by the consistency of the foster care

placement, meaning permanent placement is more likely to result in fewer symptoms (Humphreys et al 2015).

One line of research has provided interesting insight into the possible explanations for the variance in behavioral and mental health problems among children in the child welfare system. One of the first studies done on children in institutionalized care was done in England, comparing institutionalized and adopted children. This study suggested relationships to a caregiver played a significant role in the child's development, regardless of whether the child was in an institution or a family setting (Tizard & Rees, 1975).

This has spurred other researchers to analyze the data gathered in the BEIP to look for signs of reactive attachment disorder (RAD). Researchers like Zeanah, & Gleason, (2015) have characterized RAD by a number of symptoms including difficulty regulating feelings and emotions, below average social awareness and reciprocal relationships, and an absence of desire for, and response to, comfort when the child is agitated or upset. They have also differentiated RAD from disinhibited social engagement disorder (DSED), which is characterized by inappropriate and often intrusive social behavior due to the inability of the child to recognize and develop social boundaries. Zeanah & Gleason explain that while the DSM V has designated these as two separate disorders, past iterations of the DSM refer to Inhibited and Disinhibited subtypes. Smyke et al (2012) found that among the BEIP cohort, foster care played a role in abating occurrences of inhibited RAD, but made little to no difference in disinhibited type.

Other researchers have sought to discover if additional factors might play a role in mediating RAD symptoms and similar maladaptive behaviors. One study conducted in

England researched 219 adolescents that were considered “high-risk” for being removed from their current placement in foster care or group homes. Such a population may be more readily generalized to the foster population in California due to the economic and systemic similarities surrounding each group. The factors that qualified these young adults for at risk status were inauspicious circumstances during childhood, such as neglect or abuse that resulted in poor quality of care and ultimately out-of-home placement. Data was conducted on this group through questionnaires and analysis of case history. This data was compared to a group of 71 adolescents who were considered low-risk and had never been placed in foster care or group homes due to maltreatment. The results of the study showed that the at-risk group had significantly higher rates of RAD, with 63% of the sample meeting the full criteria for the diagnosis. While the results showed a clear correlation between out-of-home placement and psychopathological symptoms, what is less clear is the cause of such symptoms. While the study concluded that abuse, and other adverse experiences in childhood have a clear effect on the prevalence of RAD and other maladaptive behaviors, it is less clear the role that out-of-home placement plays in moderating these effects (Kay & Green, 2013).

Trauma Informed Care

The relationship between out-of-home placement and trauma is a complicated one. Regardless of the circumstances that lead to a child’s removal from their family, the previous studies show that out-of-home placement puts them at higher risk for mental health complications. In addition, as stated earlier, most child welfare systems are designed specifically to address and protect children from maltreatment. In the United States, nine out of ten kids in foster care have lived through some form of trauma (Fratto,

2016). This highlights the significant and pervasive role that trauma plays within any child welfare system. It is crucial, therefore, not only to address the mental health needs of children in these situations, but to do so in a way that is sensitive to past trauma.

One study sought to reduce problematic behaviors in foster children by providing their caregivers with additional training. In this experiment, the foster parents of 97 Romanian children underwent five parenting training sessions. The trainings focused on topics such as reducing parental stress and appropriate disciplinary actions for children. The children's behaviors were analyzed before, during, and after the parental training, and compared to a group of children who were on a waitlist in order to determine its efficacy. The results showed that the program was effective in reducing the level of negative behavior in the children as well as dysfunctional parenting, though it did not prevent factors such as placement disruption (Gaviţa, David, Bujoreanu, Tiba, & Ionuţiu, 2012). This study suggests that emotionally healthy and competent foster parents are a key component in ensuring a child's wellbeing.

A number of theoretical frameworks have been developed in order to help clinicians and caregivers to address the needs of a traumatized child. The Trust-Based Relational Intervention (TBRI) was developed by Karyn Purvis (2015) after working with institutionalized and foster children. TBRI teaches caregivers an approach in which the child's physical, emotional, and social needs are met. The goal of the intervention is to help the child feel safe, develop healthy attachments, and eventually learn to regulate themselves. This is done through a holistic method that teaches caregivers to pay close attention to all the child's needs, even those that are not expressed verbally. This can include special sensory processing needs, the need for playful interactions, or a need for

reassurance when the child is showing signs of anxiety. The caregiver's emotional state is recognized as a key component in TBRI, emphasizing the importance of emotional health and wellbeing among parents in order to prevent triggers and generational trauma.

The Attachment, Self-Regulation, and Competency (ARC) model is another approach that has been developed to provide a framework for trauma informed interventions. Like TBRI, this model seeks to reframe the caregiving environment in a way that can emulate developmental attachments and therefore redeem their developmental purpose. The attachment domain is targeted through a consistent, attentive caregiver who can adequately identify and respond to the child's needs. The second domain, self-regulation, is addressed by teaching the child to identify, cope with, and express their emotions. The child's competency is addressed in part by meeting the other two domains. The ARC model recognizes that when a child is undergoing trauma, their focus is on survival and not on developmental tasks. Competency, the final domain, therefore works to help the child develop their sense of self-efficacy and identity (Fratto, 2016).

One study sought to determine the efficacy of an early intervention model based on the principal "one child, one therapist for as long as it takes." (Ruff, Aguilar, & Clausen, 2016, pp 186). This particular intervention sought to begin treating foster children before the age of five not only because abuse at this age is more likely to cause a maladaptive trajectory in the child's life, but also because intervention at a young age makes recovery more likely. The goal of the intervention was to repair unhealthy attachment constructs through the consistent, caring relationship with the therapist. Results of the study showed that the model was successful in reducing mental health symptoms in the children treated.

While the model is not particularly feasible for most current mental health structures due to its emphasis on the therapeutic relationship and clinical judgment over mandates and regulations, some principles may still be gleaned from the intervention and implemented elsewhere (Ruff, Aguilar, & Clausen, 2016).

While each of the above frameworks and interventions are unique in some aspects, they share a common focus. Each recognizes the need for reparative relationships and seeks to create an environment around the child in which they are safe to form them. Most trauma informed models can trace their roots back to attachment theory which postulates that the child's relationship with their primary caregiver provides an environment for them to learn appropriate interpersonal interaction and self-regulatory skills (Fratto, 2016). To some degree, most trauma frameworks seek to redeem or repair the damaged relationship, by allowing the traumatized child to form healthy attachments in a safe, stable environment. By allowing the child to experience consistent, safe, and warm interactions with caregivers, the child can form attachments and begin the work of restructuring their behavioral and emotional schemas.

CHAPTER III

METHODOLOGY

Procedures

Before collecting data, the study was submitted to and approved by the California State University, Chico Institutional Review Board (IRB). In order to comply with IRB policies and standards, all participants were asked to sign informed consent forms (see Appendix A) before the interview was conducted.

This is a qualitative study conducted through oral interviews, with only one exception. Due to the cross-cultural nature of the study, certain considerations had to be made. Due to distance and time constraints, one interview took place via a video phone service, and a separate interview was answered via e-mail and translation. All interviews consisted of a short demographic survey (see Appendix B), and excluding the case mentioned earlier, was followed by an oral interview conducted by one researcher. In order to maintain a higher level of reliability, the interviews adhered to a standard list of questions (see Appendix C), except when clarification or elaboration was needed.

Interviews were conducted between July 2016, and February 2017. Scheduling of the interviews was done on an individual basis and executed at the convenience of the participants and the researcher. All recorded data was stored on a locked personal device and all hard copy data was kept secure. At the conclusion of the study, a post data collection form was filed with the IRB.

Sampling

A convenience sample was taken for this study with a size of six (N=6) total participants. The researcher had either a preexisting professional relationship with the participant, or a mutual professional contact. Participants in the study were included regardless of age, education level, or years of experience. The only criteria to be included was that the individual was currently employed in an agency that works in close proximity to their respective country's (or state's) child welfare and mental health system. This study includes interviews from both Romanian nationals (N=3), and California residents (N=3).

Measurements

A demographics questionnaire (See Appendix B) was developed and utilized in this study in order to determine the professional background of the participants. Due to a small sample size (N=6) the participants do not make up a generalizable population. It is nonetheless useful to know the experience and perspective of the workers, as well as their experience within the child welfare field.

The questions developed for the interviews are the second measure in this study. The participants' answers were recorded and analyzed for recurring themes and important perspectives. In order to maintain consistency, the same questions, or culturally comparable questions were utilized for all participants. Small adaptations and improvisations were made in real time during the interviews if the participant needed clarification, or a response warranted a follow up question.

CHAPTER IV

RESULTS

Demographics

A total of six participants completed the demographics survey and answered the interview questions. Of the six, half were Romanian nationals working in Bucharest, and the remaining three were American citizens working in Northern California. One participant was between the ages of 18 and 25, four were between the ages of 26 and 40, and one participant was between the ages of 41 and 50. Four participants had completed master's level degrees, and two had completed a baccalaureate degree. Four participants worked for public agencies, and the remaining two worked for non-government organizations (NGOs) or non profit agencies. Three participants had one to five years of experience, two had six to ten years, and one participant had between 11 and 15 years of experience.

Themes

Stigma

The stigmatization of children in the child protection system was a common theme among participants. This theme was most prevalent among Romanian respondents and developed at different points in the interview depending on the participant. All Romanian participants reported to some extent that the children they work with face various forms of stigma, social isolation, and discrimination; they reported that children in the system often take steps to hide the fact that they are in foster care or orphanages. Many kids in

the Romanian Child Protection system have difficulty in school for this reason. One participant described the children's interactions with their peers:

> They interact with one another, but they're different from the others, from the other kids in school. So you could see the difference. They have this social problem and they feel different. They feel disadvantaged sometimes, and because of this they like to show off, and do some things that say, "I exist," "I'm here." They would do negative things.

One participant in California listed stigma as a specific hardship that these children face. This was listed among, shame due to mental illness, and self-blame for hardships in childhood.

Stuck in the System

A theme emerged among participants of children being inducted into the system and remaining there until they age out. While the cause of this problem was not always clearly identified, one Romanian participant explicitly named inadequate policies and systemic barriers as the problem:

> The biggest problem is that they cannot find solutions for these kids to be integrated, to be adopted, to not live in the big orphanages or social apartments...Parents still have their rights, and they do not want to give permission for them to be adoptable. The legislation is horrible it does not protect the kids, it protects the parents of these kids...We have many kids who have not been in contact with their families for years, but they are still not adoptable.

This theme was only discussed by one participant in California. They described working with "non-minor dependents" who "have been in the system, most from a really young age, and on their 18th birthday they were still in the system." The existence of this particular role suggests that California faces a similar situation.

Independent Living Problems

Though not universal among participants, one theme emerged frequently in conjunction with the previous theme. Workers from Romania reported that, as a result of

their time in the system, children often exited the system unprepared to function within society. One participant put it this way, “These kids are living their entire lives in a system that doesn’t provide for them. They are not equipped, and when they turn 18, even if they finish school, they don’t know how to do anything.” This too seemed to vary depending on the culture of the respondent, however, one Californian participant stated that their goal in working with non-minor dependents was to increase their ability to care for themselves, “By the time they’re out of the system [they should] have substantial savings, have a job or to be enrolled in school, have stable housing, and be set up to have a life where they can be successful so they don’t fall back into the system.” Though the nuances seem unique to the culture, neither culture prepares children within them to thrive in society upon exiting the system.

Attachment

A consistent theme appeared throughout each interview. The idea of a lack of attachment or stable environment during development as a key factor in later behavioral problems was identified by all six participants at various points throughout the interviews. One participant described this problem, as it occurs in Romania, in depth. It should be noted that this participant is describing children cared for within an NGO, with fewer caregivers and less turnover than the government system:

> Kids when they’re young, they attach to a person that cares for them, but they have so many caregivers...and sometimes they leave their job, so they feel abandoned all the time because of people coming and going...So they don't have that constant parental figure...You're doing what you can do. They’re growing. They’re developing. They’re OK, but they’re supposed to have more.

Equally consistent among participants was reporting that not only is attachment a large contributing factor for behavioral problems, it also played a significant role in

treatment. When asked about how well they believed their interventions worked, another Romanian participant stated that, "without secure attachment, without predictability, coherence, and consistency from the adults in the child's life, change cannot be high quality." One California participant said, "Most of the kids I work with just want an adult to invest in them and to notice them."

Interventions

When asked what interventions they used when working with children in the system, the most consistent cross-culturally was Cognitive Behavioral therapy (CBT). Participants reported different approaches for different age groups. Participants reported using stories, or other forms of play therapy for younger kids, and more cognitive approaches like CBT or solution focused approaches for older populations.

One Romanian participant that works outside of a clinical setting described the agency's broader approaches. The participant reported emphasis on mentoring, support for education, socialization, encouraging spiritual practices, vocational training, and helping the children engage in the community in healthy ways.

Views of the System

Workers from both countries shared similar perspectives on the systems. All participants reported to some extent that their respective system was good in theory, but failed to meet expectations in practical application.

The degree to which the system failed was reportedly worse in Romania. Romanian participants reported high degrees of corruption and nepotism, as well as under qualified workers. One participant described the Romanian Child protection system like this:

> It is an institution with a politically elected leadership favoring nepotism and hiring people you know. They tend to cover up serious cases. Seen from the inside

> it can be said that there is a deaf battle between those who want to focus on the interest of children and those want to maintain the status quo.

Another Romanian participant stated, "The biggest problem in my opinion is the human resources... They have people that they are not interested in investing something in the life of the kids." (Participant 5). This participant reported that government funded counseling is often perfunctory and inadequate. They described a case in which a young girl was raped, and she had a total of three meetings with a psychologist. Therapy in the Romanian Child Protection system is perceived to be more reactive, and is prescribed only when children exhibit outward problems. One participant put it this way:

> Not so many kids go to more than just one or two session with that psychologist. They don't really want to go because they're sent there when they have behavioral problems... they're not sent there to heal their wounds...I do some things for just their emotional development; not just to treat the problem, but prevent some, or just help them develop in a better way; help them go through their abandonment problems...But, a psychologist at the child protection department would not have the time and resources to do that.

Views of the system in California were generally more positive. One American participant stated:

> I think as with any system they have their issues, but overall they fulfill their purpose pretty well. Those of us that work in the system see how flawed the system can be, but as far as meeting the immediate needs in terms of resources, I think they do a pretty good job.

Participants from the US reported systemic problems like, "business, high caseloads, lack of time," and a high level of burnout among workers within the system.

Additional Resources

Though not universal among participants, the most common response to what resources would be beneficial to the kids centered around the theme of community

engagement. One participant from the U.S. reported that participation from the child's school, family, and social group in treatment would be largely beneficial.

Several respondents from Romania suggested better training for some therapists, as well as more trauma informed treatment options and interventions. This included training for NGOs and other agencies regarding approaches to trauma, as well as therapy methods that helped children process the root of their behavioral problems.

Cultural Perspectives of Mental Illness

Based on the overall responses from participants some cultural variations appeared regarding the perspective of mental illness. In Romania there seems to be a systemic and cultural perception that mental illness is synonymous with developmental disabilities. This was reflected in participants' descriptions of "rehab centers" where children with behavioral problems are housed with children with disabilities. American participants viewed mental health in a much more clinical way and placed emphasis on therapy tools that allowed children to process past trauma.

Common Interpersonal Problems

Romanian participants generally listed a plethora of problems and risks that children in the system face. One participant put it this way:

> The core difficulty of children is attachment disorder which is associated with risks like: anxiety, depression (which is underdiagnosed), oppositional and conduct disorder, antisocial tendencies, substance abuse, trafficking, homosexuality by abuse, prostitution, dropout, vagabondism, and inconsistent employment.

Many of these risk factors were not specifically mentioned by US participants. Workers in California mentioned symptoms like anxiety, worry, sadness, grief, and confusion if

they were detained from their families. Another American participant reported that children fall into one of two categories, either isolating themselves, or attach indiscriminately, in other words, “some shut down, and some have no boundaries.”

CHAPTER V

DISCUSSION & CONCLUSION

Discussion

The perspective of the participants, as well as its agreement with much of the literature, suggest several important principles that should be implemented into future interventions and policy changes. While there are significant differences between these systems, and the context in which they exist, these principles are broad enough that they can be tailored and implemented in either culture. These principles combine aspects of both systems and can hopefully allow each systems to learn from the other.

Existing literature clearly states that children within the child welfare system are more susceptible for risky behavior. This is observed by participants in children dropping out of school, increased risk for human trafficking, substance abuse, and behavioral problems like fighting. These factors are in addition to the increased risk for mental illness from trauma and institutionalization. While common in both countries, these issues seem to saturate the Romanian child protection system to a higher degree than its California counterpart. This may be in part to the way in which the systems address mental illness and problem behavior. The California child welfare system takes a slightly more preventative approach to mental health, preforming a rudimentary screening upon entrance into the system (include screening tool). If the child meets the criteria, they are then referred and interviewed by a mental health professional in order to determine if they will be seen by a county mental health clinic. Romania's approach is slightly more

reactionary. Children are referred to the child protection department for counseling only after a caretaker notices significant problem behavior.

The quality of therapy differs greatly between countries as well. Romanian workers reported that Government funded counseling is often perfunctory and inadequate. The story reported earlier of a girl who was raped, but only attended three meetings with the psychologist is a heartbreaking example of an insufficient response to trauma. A therapeutic experience like this has little hope of helping the child process the trauma they experience, let alone healing the past trauma and attachment relationships. Theoretical frameworks within the literature emphasize the importance of attachments and relationships in a child's development. The literature also reflects that permanency and consistency in a child's life is highly important. Themes from the interviews suggest that workers recognize this need and work toward it, however system problems often create barriers to permanency. In Romania, structural barriers take the form of corruption, nepotism, and under qualified workers. There is a strong sense in Romania that traumatized children need access to a better quality of care whether through private practice, or more qualified professionals within government agencies. Systemic factors in America were centered more on burnout and overworked social workers caused by insufficient staffing and a lack of support from agencies.

Stigma

While stigma was addressed more directly in responses from Romanian participants, the literature shows that it is an issue elsewhere. Even children who are not in foster care, but do not live with their biological families reported experiencing stigma and some even experienced bullying. The literature supports what was reported in

Romania, many children attempted to limit the number of people that know about their living situation (Farmer, Selwyn, & Meakings, 2013). Those who face mental health challenges in addition to living in foster care report feeling stigma for both issues and many are hesitant to seek treatment for fear of social repercussions (Jee, Conn, Toth, Szilagyi, & Chin, 2014).

There are many campaigns throughout the world that focus specifically on fighting the stigma of mental illness. Despite these efforts, however, it remains a daunting task (Beldie, 2012). While some policies might be beneficial to fight stigma, what ultimately must happen is a shift in culture. Public awareness campaigns designed to educate the general population on mental illness could help reduce some of the fear surrounding mental illness. Like every cultural shift, the persistence of those affected as well as their allies is crucial. This includes individual responsibility to educate those that are in one's sphere of influence and guide them toward a place of acceptance for foster youth and those with mental illness.

LGBTQ Youth in Foster Care

An interesting theme emerged in the interviews of two Romanian participants. These respondents listed "homosexuality through abuse" as an interpersonal problem faced by many children. Sexual abuse of children is a heinous act and must be addressed, but it must be done in a responsible way. Kevin Ohi (2000) points out that molestation perpetrated by gay abusers is often amplified in media and public discourse despite its prevalence being statistically insignificant when compared to straight abusers. He points out that this is often a tool to increase homophobic and heteronormative rhetoric. The way in which this problem was framed in the interviews also reflects an antiquated

understanding of the phenomenon of homosexuality. The idea of homosexuality as a pathology, and that one becomes gay through abuse, are theories that the American Psychological Association abandoned in 1973 following increased cultural consciousness and research (Drescher, 2015).

Situations like this must be handled with delicacy, because Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ, aka queer) victims of abuse may be victimized again by the system itself. LGBTQ youth in foster care face a variety of complex issues that compound obstacles already faced by the general foster care population. The circumstances which lead queer youth into foster care, as well as their experiences once they are there, vary greatly from straight youth. LGBTQ youth are often harassed, bullied, and discriminated against specifically because of their sexual orientation or gender identity. This victimization comes not only from their peers, but often from their caretakers as well. This prejudice significantly decreases the likelihood of a permanent placement among this population and often results in additional abuse. Not only that, it also increases the rate of homelessness among LGBTQ youth because they flee their placement to avoid the abuse and discrimination (McCormick, Schmidt, & Terrazas, 2017). These issues highlight the need to take special consideration with this issue. Steps must be taken to ensure that LGBTQ victims of abuse are not further pathologized and stigmatized by the system in which they are placed.

Additional education and training on LGBTQ issues related to child welfare are desperately need, however, much like the issue of stigma, without a shift in public perspective on the queer community, these interventions will only be met with resistance. While America has made some progress toward LGBTQ acceptance and protection, both

countries would benefit from looking beyond the issue toward the people that it is affecting. People must understand the practical consequences that LGBTQ discrimination has on queer youth. Through continued education and advocacy, a shift can be made within child welfare systems that protects this vulnerable population instead of magnifying the hardships foster children already face.

Principles for Interventions

Early Intervention. Three key elements emerged regarding successful interventions, both in the literature and participant responses. Early intervention is the first element that can lead to better outcomes. As stated in the literature, intervention before the age of five can play a significant role in the trajectory of the child's life. Intervention at a young age allows the child to process trauma and learn healthy coping skills before maladaptive behaviors become ingrained in their development (Ruff, Aguilar, & Clausen, 2016). In order to provide early treatment to children, a preventative stance is needed toward mental illness. Romania's child welfare system might benefit from implementation of a screening tool like the one utilized in California. This would allow children entering into the foster care system to be screened by a psychologist to see if they would benefit from treatment.

Consistency and Permanency. This process must be coupled with systemic changes that improve the quality of therapy and caregiving that children within the child welfare system receive. This concept leads to the second key element of successful interventions, which is an emphasis on consistency and permanency. This concept must be implemented in both mental health systems and child protection protocol. Therapy as a

consistent healing process can be a tool that allows children to heal maladaptive attachment dynamics by repairing relationships with caregivers (Fratto, 2016). Ideally this is coupled with a secure, consistent home environment in which the child's physical, and emotional needs are met. While the California mental health system provides this therapeutic environment more readily, both systems would benefit from reform that places the permanent placement of the child in a home-like environment at a higher priority. In Romania, children might benefit from stricter regulations on biological parents and shorter time spans for parents to regain custody of their children. Anti-corruption legislation and stricter standards for mental health professionals may also ensure that children receiving mental health services are getting the care they need. More research is needed into the California system to determine how to address specific factors that prevent children from permanent placement.

The residential treatment program described by two Romanian participants is an example of an intervention that has attempted to integrate these principles. By starting the program when children are at a young age, and providing care at least until the children turn 18, the program exemplifies early intervention and permanency. The program described put an emphasis on a "family-like environment" with only six girls and caregivers who are willing to invest in the children's well-being. Due to its connection with a non-profit agency, this program gives the children access to community resources like private counseling and social support from agency members. Though very positive, the program is not without its faults. Despite buy-in from caregivers, they are still employed by the agency and occasionally have to leave their job caring for these girls. According to workers, this can create new feelings of abandonment. In addition, while

the number of caregivers is lower than government agencies, children are still forced to adapt to multiple caregiving styles throughout their week.

Trauma Informed Care. Because of the relationship between trauma and foster care, better training is needed at all levels of involvement in child welfare systems. In the US, there is a gradual shift toward trauma informed care, however more needs to be done to educate caregivers and even children on the effects of trauma. Even basic trainings for foster parents can help improve children's behavior (Gaviţa, David, Bujoreanu, Tiba, & Ionuţiu, 2012).

There are multiple sources for trauma informed curriculum and interventions. Resources like the National Child Traumatic Stress Network (NCTSN, n.d.), the Chadwick Trauma-Informed Systems Dissemination and Implementation Project (CTISP-DI, n.d.), and the California Evidence Based Clearinghouse (CEBC, 2017) are great places for practitioners and caregivers to find materials to help them understand trauma and its effects on child development. These organizations have compiled numerous interventions and training curriculums for the purpose of informing the social services community on trauma informed care. While face to face trainings from these organizations are more available in California, many of the resources can be accessed online creating a lower barrier for training and utilization in Romania's cultural context.

Conclusion

The Romanian Child Protection Department, and the California Child Welfare and Mental Health System were put in place to protect children from abuse and provide them with treatment to ensure successful development. In many ways, these structures fulfill their purpose, however, as with any system, they are not without fault. Each system is

unique and complex in so many ways; specialized study and research should be done individually into each system in order to provide more specific suggestions for reform. My hope is that this study provides a starting point for those interested in advocating for children in child welfare systems. This comparison of two culturally different systems provides insight into the common problems child welfare systems, and the individuals within them face. By addressing the broader principles identified in this study, such as destigmatization, trauma informed care, and early intervention, individuals within child welfare and mental health systems can begin to make changes in their practice and advocate for systemic changes as well. Change takes time, but children who have had their lives disrupted by abuse deserve the best care available. Providing better care should always be a priority no matter what barriers are in the way.

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APPENDIX A

INFORMED CONSENT & LIMITS OF CONDIFIDENTIALITY

This study is researching cultural differences and similarities between American and Romanian Culture, as well as their respective approaches to child welfare and mental health. By signing this document you are acknowledging your consent to allow us to use the information provided in the interview for the purpose of this research project. This study has been submitted to the California State University, Chico Institutional Review Board.

Your participation is valuable, however some of the topics discussed may cause psychological distress due to the nature of the topic. If at any time during the study, you wish to discontinue your participation, you may do so without penalization.

By initialing here you agree to allow the interview to be recorded (audio) for the use of the study. Any recorded data will be stored on locked devices and your name and personal info will not be connected to your answers.
Initial: _____

Thank you very much for your participation in our study, we greatly appreciate your time and feedback. Everything we discuss within this meeting will be kept confidential with the exception of: disclosing intent to harm yourself, or someone else, and disclosure of child or elder abuse. Any identifying information pertaining to yourself, or the clients discussed will not be discussed with any third party. If you are interested, we would be happy to share the results of our study with you.

Should you have questions regarding your participation or this study, please contact the Principal Investigator, Marc Clanton at mclanton1@mail.csuchico.edu, or Professor Sue Steiner, MSW, PhD at sjsteiner@csuchico.edu.

Print Name

_____

Participant's Signature

_____ Date _____

APPENDIX B

DEMOGRAPHIC SURVEY

What is your Gender?

- ❑ Male
- ❑ Female
- ❑ Other:_____

What is your age?

- ❑ 18-25
- ❑ 26-40
- ❑ 41-55
- ❑ 56 or older

What is the highest level of education you have completed?

- ❑ Associate's Degree
- ❑ Bachelor's Degree
- ❑ Master's Degree
- ❑ Doctoral Degree
- ❑ Professional Degree
- ❑ Other:_____

Which best describes the agency where you are employed?

- ❑ Private (Private Practice, etc.)
- ❑ Public (Gov't Agency)
- ❑ Non-Profit (NGO, Religious Organization, etc)
- ❑ Other:_____

How long have you worked in the social services field?

- ❑ 1-5 years
- ❑ 6-10 years
- ❑ 11-15 years
- ❑ 16-20 years
- ❑ 20+ years

APPENDIX C

INTERVIEW QUESTIONS FOR ROMANIAN PROFESSIONALS

Please briefly explain your job.
Please describe the Romanian Child Welfare System in your own words.
What are common interpersonal problems that children in this system experience?
What systems are in place to provide these children with resources (Mental health, social assistance, etc)?
How well do you think these systems fulfill their purpose?

What is the process for identifying, diagnosing, and treating children with mental health problems in Romania?
What techniques do you use when working with children with mental health problems?
How well do you feel these techniques work?
What additional resources would be helpful in identifying, diagnosing, or treating traumatized children in Romania?

What would you say are the most important aspects of Romanian Culture?
How would you describe Romania's communication style?
Do you consider most Romanians to be individualistic or collectivistic?
What are the most significant differences between US and Romanian Culture?
What potential barriers do you see to utilizing American therapy styles in Romania?

INTERVIEW QUESTIONS FOR US PROFESSONALS

Please briefly explain your job
Please describe the child welfare system, and its interaction with the mental health system, in your own words.
What are common interpersonal problems that children in this system experience?
What systems are in place to provide these children with resources?
How well do you think these systems fulfill their purpose?

What is the process for identifying, diagnosing, and treating children with mental health problems?
What techniques do you use when working with children with mental health problems?
How well do you feel these techniques work?
What additional resources would be helpful in identifying, diagnosing, or treating traumatized children?

What would you say are the most important aspects of American Culture?
How would you describe the communication style of the general population you work with?
Do you consider most Americans to be individualistic or collectivistic?
What potential barriers do you see to utilizing American therapy styles in in another culture?

APPENDIX D

HUMAN SUBJECTS APPROVAL LETTER

California State University, Chico
Chico, California 95929-0875

Office of Graduate Studies
530-898-5850
Fax: 530-898-3342
www.csuchico.edu/graduatestudies

May 24, 2016

Marc W. Clanton
12119 Red Rose Way
Bakersfield, CA 93312

Dear Marc W. Clanton,

As the Chair of the Campus Institutional Review Board, I have determined that your research proposal entitled "Cross-Cultural Child Welfare: Filling Gaps in Mental Health Services in Romania With Cultural Sensativity"is exempt from full committee review. This clearance allows you to proceed with your study.

I do ask that you notify our office should there be any further modifications to, or complications arising from or within, the study. In addition, should this project continue longer than the authorized date, you will need to apply for an extension from our office. When your data collection is complete, you will need to turn in the attached Post Data Collection Report for final approval. Students should be aware that failure to comply with any HSRC requirements will delay graduation. If you should have any questions regarding this clearance, please do not hesitate to contact me.

Sincerely,

John Mahoney, Ph.D., Chair
Human Subjects in Research Committee

Attachment: Post Data Collection Report

cc: Sue Steiner (550)