POSITIVE HEALTH IN ADOPTED, FOSTERED, INSTITUTIONALIZED AND COMMUNITY ADOLESCENTS: A COMPARATIVE ANALYSIS

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INTRODUCTION

Studies of children and adolescents in the child welfare system have traditionally focused on the mental health problems of this at-risk population. However, we know little about their health in terms not merely of the absence or presence of mental health problems, but in terms of a wider and integrated view of health as physical, mental and social wellbeing, as the WHO already stated in 1948. This trend towards a more holistic approach or positive outcomes is already present in child welfare research (Jones, LaLiberte & Piesche, 2015).

Regarding foster care, it is important to note that Spain's legislation establishes kinship care as the preferred option for out-of-home placements. In fact, approximately 75% of all family foster care takes place within the kinship network, compared to 25% in non-kinship families (Del Valle, López, Montserrat, & Bravo, 2009; Palacios & Amorós, 2006; Palacios & Jiménez, 2009).

Furthermore, adolescents in the child welfare system should be of special concern: the adverse past of these youth can have negative effects on their health during this crucial developmental period. Accordingly, the **aim** of this study is to analyse the health of a sample of adolescents in adoptive families, kinship care families and residential care, in comparison with community adolescents and amongst each other. For this purpose, the research is approached from an integrated and positive perspective of health that includes subjective measures of life satisfaction, health-related quality of life, psychosomatic complaints and sense of coherence (SOC).

METHOD

Participants:

The sample was comprised of 28,998 Spanish adolescents between 11 and 18 years old. Of them, 394 were adopted, 195 were living with theirs grandparents in kinship foster care, and 35 adolescents were living in welfare centres. The remaining 28,374 participants formed the control group of community adolescents. All of them took part in the 2014 Spanish edition of the WHO collaborative study *Health Behaviour in School-aged Children* (HBSC).

Instruments:

The instruments used were Cantril's Scale for Life Satisfaction, Kidscreen-10 Index for Health-Related Quality of Life, Self-Reported Health, the HBSC-Symptom Checklist for Psychosomatic Complaints and the SOC-13 scale for sense of coherence (a construct related to the capacity of coping in a positive and meaningful way (Antonovsky, 1987; García-Moya & Morgan, 2016)).

Procedure and statistical analyses:

Data was collected through anonymous, self-completed questionnaires according to guidelines from the international coordination protocol of the HBSC study. Descriptive analysis with mean comparisons (ANOVAs) controlling for gender and age were used in all analyses. Cohen's *d* was used to measure the effect size.

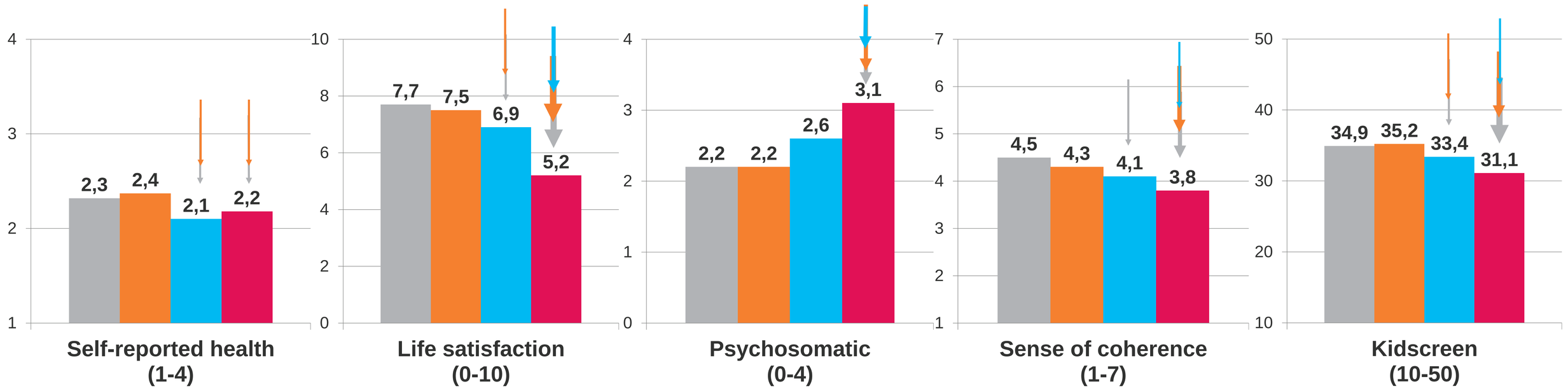
RESULTS

	F	*p* values
SELF-REPORTED HEALTH (1-4)	7.115	≤ .001
LIFE SATISFACTION (0-10)	32.598	≤ .001
PSYCHOSOMATIC COMPLAINTS (0-4)	5.890	= .001
SENSE OF COHERENCE (1-7)	9.348	≤ .001
KIDSCREEN (10-50)	12.007	≤ .001

Cohen's d was used to calculate the effect size and is represented by arrows. Arrow's thickness shows the type of effect size and colour indicates the group in which a difference is shown.

→ Small effect (0.20 – 0.49)
→ Moderate effect (0.50 – 0.79)
→ Large effect (≥ 0.80)

Control
Adoption
Kinship
Centre



DISCUSSION

Our results showed a clear trend in the subjective well-being of the adolescents according to the child's status inside the protection system, a trend in line with the majority of scientific literature (Jiménez-Morago, León & Román, 2015). In first place, adopted adolescents presented a profile similar to the community group in all dimensions of positive health. At the same time, they showed more positive health than kinship-care and especially more than institutionalized adolescents. These results point to the known general success of adoption as intervention for children with early adversity (van IJzendoorn & Juffer, 2006).

Adolescents in kinship-care, on the other hand, showed a less positive health profile in comparison with community and adopted adolescents, particularly in self-reported health, health-related quality of life and life satisfaction. This is an undesirable result, but expectable if we take into account some of the difficulties of kinship carers related to their social and personal situation (Palacios & Jiménez, 2010; Montserrat, 2014). However, other research has found that the subjective well-being (a dimension similar to those of our study) of adolescents in kinship care was similar to that of the general population (Montserrat & Casas, 2006).

Lastly, institutionalized adolescents presented lower positive health in comparison with all the other groups. This result is in consonance with the academic literature that points to the deficits of institutional care as a context for psychological development (Palacios, 2003), and with research specifically on well-being that found worse levels of subjective well-being in Spanish institutionalized adolescents in comparison with community adolescents (Llorada-Gistau, Montserrat & Casas, 2015). This study remarks the importance of analysing well-being and health dimensions as outcomes in child welfare research, and the convenience of family alternatives to institutional care.

In order to contrast these results on lifestyles with this same sample, see another poster of our team entitled "Lifestyles: a comparison between adopted, fostered, institutionalized and community adolescents" in this poster exhibition session.

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