American Orthopsychiatric Association

Consensus Statement on Group Care for Children and Adolescents

---

Adoption: February 2014

Every child has a basic right and need to grow up in a safe home with a stable continuous relationship with at least one adult who is a trusted, committed parent figure. Group settings should not be used as living arrangements, because of their inherently detrimental effects on the healthy development of children, regardless of age. Group care should be used for children only when it is the least detrimental alternative. That standard is met only when there is no less restrictive setting available to meet a child's need for therapeutic mental health services. Even in that instance, group care should end when it ceases to be the least detrimental alternative for that child.

It is estimated that more than 2 million children are being raised in institutions around the world, with more than 800,000 of them in Central and Eastern Europe and the Commonwealth of Independent States (UNGA, 2010). As systematic records of the number of children living in institutions are not kept in many countries, this likely represents a gross underestimate of the actual number of children living in institutions worldwide (UNGA, 2010). In the United States, approximately 58,000 children are living in congregate care settings, approximately 34,000 in institutions, and 24,000 in group home settings (DHHS, 2013). This represents 15% of the foster care population in the United States (DHHS, 2013), with the majority of children placed in congregate care settings having mental health problems and a history of abuse or neglect serious enough to warrant out of home placement. In this document, the term *group care* is used to denote any congregate care arrangement: large- and small-scale institutions and group home settings.

The United Nations Convention on the Rights of the Child, ratified in 1989, asserts that the family is the fundamental group of society and the natural environment for the growth and well-being of children. It contends that the family should be afforded the necessary protection and assistance so that it can fully assume its responsibilities, and if a child is temporarily or permanently deprived of his or her family, or in whose own best interests cannot be allowed to remain in that environment, the child is entitled to special protection and assistance by the State, which includes assurance of alternative care (UNGA, 1989). In 2009, in celebrating the 20th anniversary of the Convention of the Rights of the Child, the United Nations adopted a resolution delineating guidelines for alternative care for children deprived of parental care (UNGA, 2010). The resolution states that alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. It proposes that residential care facilities and family-based care can complement each other in meeting the needs of children, although it encourages a deinstitutionalization strategy be developed to eliminate the use of large residential care facilities (UNGA, 2010). We assert a stronger position by contending that institutional care

is nonoptimal for children of all ages, including teenagers, and that even smaller group care settings can be detrimental to the growth and well-being of youth.

1. **Healthy attachments with a parent figure are necessary for children of all ages and help to reduce problem behaviors and interpersonal difficulties.**

The availability of positive, stable supports has been identified as one of the most important factors in promoting resilience in traumatized individuals studied across the life cycle (Kaufman, 2007). Researchers have long been aware of the importance to infants and young children of a healthy, secure attachment to at least one adult (Bowlby, 1969/1982). Attachment is also critical to healthy development as children enter middle childhood and adolescence (Allen, Moore, Kupermine, & Bell, 1998; Bowlby, 1969/1982). Furthermore, benefits of secure attachments extend into adulthood, including how adults care for their children.

Attachment to an adult requires the adult to be consistently available to the child over an extended period of time. Shift care, whether the shifts last hours or days, interferes with accessibility to a parent figure (Hawkins-Rodgers, 2007). Rules that protect against liability by prohibiting activities that would encourage a relationship between staff and youth are a further barrier. In these situations, children and youth may turn to peers, with whom they have their only consistent, emotionally close relationships (Kobak, Herres, Gaskins, & Laurenceau, 2012). These relationships may in themselves be unhealthy and even abusive (Dishion, McCord, & Poulin, 1999). Iatrogenic effects of housing with peers who have behavioral and emotional problems can increase an adolescent's susceptibility to deviant peer influence (Dishion, Nelson, & Bullock, 2004).

A relationship with a parent figure can reduce the adolescent's susceptibility to deviant peer influence (Allen et al., 1998; Dishion et al., 2004). An adult who is committed and invested in the adolescent's well-being can provide resources and supports that are not available from peers (Allen et al., 1998). These supports include monitoring the adolescent's activities, providing structure and supervision, negotiating increased adolescent autonomy, encouraging engagement in school, and planning for the future. An adolescent's bond with a parent figure provides a context for the adolescent to develop competencies that prepare him or her to successfully transition into adult roles. The adolescent who fails to develop a bond with a committed caregiver is likely to rely on peers for guidance and protection and to engage in risky behaviors (Dishion et al., 2004).

2. **Especially during adolescence, it is critical to balance children's need for parental control and regulation with their developing needs for autonomy.**

The relationship between parent and child involves a continuous readjustment of the balance between the parent's role as protector and the child's increasing need for autonomy (Bowlby, 1969/1982; Carrilio & Walter, 1984). As the child matures, this balance gradually shifts toward autonomy, whether manifested as increased exploration by a toddler or the capacity to be self-regulating and make independent decisions as an adolescent (Ainsworth, 1989; Matas, Arend, & Sroufe, 1978).

In older children, an appropriate balance is critical to achieving the key tasks of childhood and adolescence, learning the rules and values of the cultures, maintaining close relationships with others, and developing the skills to work productively and become self-reliant and able to function (Kobak et al., 2012; Sroufe, 2005).

Successfully balancing the need for parental control and regulation with the developing need for autonomy involves two, often unrecognized, processes. First, because children's ability to manage autonomy varies, not only from one child to another, but also within an individual child from one realm to another, it is necessary to tailor rules and consequences to the individual needs of the child. Second, the system needs to be reciprocally responsive. That is, parental rules should be modified as the child matures and becomes capable of making responsible decisions (Smetana, 2011). This interaction depends on the parent's knowing the child (e.g., recognizing patterns of the child's behavior) and having the corresponding flexibility to adjust rules to meet the child's unique needs. In this way, the child experiences the natural consequences of good and bad decisions (expansion and limitation of autonomy). In addition, this system allows the child to gradually assume ever more control of his or her life with a safety net for errors in decision making. An institutional setting with fixed rules and procedures that are not adapted to the individual is not conducive to the healthy development of autonomy.

3. Child-sensitive exercise of adult authority is critical to healthy development.

Children and adolescents differentiate between areas in which their parents or adult authority figures have legitimate authority to regulate and those in which they are entitled to self regulate (Smetana, 2011). Specifically, adolescents view parents as having the legitimate authority to regulate *moral issues* (issues that have consequences for others' rights and welfare, such as hitting, teasing, bullying, and stealing), *conventional issues* (such as etiquette and manners, which provide norms for appropriate behavior in different contexts), and *prudential issues* (which involve the child's health, safety, and comfort, and include risky issues like alcohol and drug use; Smetana, 2011). However, adolescents do not view parents as having the legitimate authority to regulate *personal issues*, which involve control over the body, privacy, and certain preferences and personal choices (such as choice of recreational or leisure activities or friends; Smetana, 2008; Tilton-Weaver, in press). As children get older, they view an increasing set of issues as personal and beyond parents' legitimate authority (Smetana, 2011).

Furthermore, the extent to which parents are willing to negotiate with adolescents and cede decision-making authority to them varies for different types of issues and follows different timetables than earlier in development (Smetana, 2011). Because of a need for standardization in a living arrangement, institutional placements often rigidly regulate many areas of adolescents' lives in which adolescents might play a constructive role in planning and decision-making. Institutions that over-regulate children's lives and undermine moves towards autonomy may incite defiance, because these rules are seen as regulating areas that should be within the child's purview.

Recent research has shown that parents' knowledge of their children's away-from-home activities (whom they are with, what they are doing, etc.) comes primarily from teenagers' willingness to disclose to parents, not from parental surveillance, control, or monitoring (Kerr, Stattin, & Burk, 2010; Smetana, 2008; Stattin & Kerr, 2000). In other words, it is a child-driven process, not a parenting issue. Disclosure is more likely when parents are responsive to children and adolescents and parents have a close, trusting relationship with them. In other words, parents or caregivers can help to establish the conditions that facilitate child disclosure, but then it is up to the child to keep parents informed. That kind of responsive, trusting relationship is much less likely in group care.

4. Group care is not an appropriate living arrangement, and it can never substitute for a home environment.

It is important to distinguish between group care used for a limited time as a respite, "cooling off" period or a time-limited therapeutic intervention with specific goals and the use of group care as a place to live. One key distinction is that children and youth in group treatment arrangements like wilderness camps (Russell & Phillips-Miller, 2002) or psychiatric facilities (Persi & Sisson, 2008) retain an ongoing highly involved relationship with adults who serve as or attachment figures. Youth *living* in group care, in contrast, must rely on a constantly rotating staff to provide guidance and support.

5. Group care itself may be related to an increased likelihood of problem behavior.

Although children may be placed in group care because of serious behavioral problems, it is reasonable to ask if group care itself leads to increased involvement with the juvenile and criminal justice systems (Dishion & Dodge, 2005). To address this question, Ryan and colleagues (Ryan, Marshall, Herz, & Hernandez, 2008) conducted a large-scale study comparing youth in group care settings to a propensity matched sample of youth living in foster care. The samples were matched on race, sex, abuse and placement history, presence of behavior problems, and history of running away. After controlling for all these factors, youth placed in group care settings were 2.4 times more likely to be arrested (Ryan et al., 2008). Thus, group care per se may increase the likelihood of delinquency and criminal activity. Modeling, contagion effects, and lack of adequate regulation all may contribute (Dishion & Dodge, 2005). In addition, group care prevents children having access to peers who are coping well with everyday life, who do not have behavioral or emotional problems, and who can provide positive peer support.

6. Group care may cause psychological harm even in typically developing children.

The critical importance of parental availability, particularly for young children, is demonstrated by the results of a longitudinal study of children in the kibbutz. The kibbutz practice of collective upbringing of children was a unique "experiment in nature" that took place for over 70 years in Israeli kibbutzim (Aviezer, van IJzendooon, Sagi, & Schuengel, 1994), which demonstrated the negative impact of group care on otherwise normally developing children who had no exposure to trauma. Its most distinctive characteristic was the practice of children's sleeping at night in infant/children's houses, away from their parents.

In a typical kibbutz, at bedtime, parents brought their children back to the children's house and put them to bed. Children then remained in the children's house for the night under the care of two watchwomen whose assignment was based on weekly rotations that included all the kibbutz women, and who supervised the sleep of all kibbutz children under age 12.

Over the past three decades, researchers followed the development of these children. They observed substantially higher rates of attachment insecurity among communally sleeping children as compared to family sleeping kibbutz children as well as to normative city samples in Israel and worldwide (Aviezer, Sagi, & van IJzendoorn, 2002). They concluded that the responsibility for the higher rate of insecurity rested in the practice of communal sleeping because of the inconsistent responsiveness that was inherent to the day-to-day reality of communally sleeping children. A night-time experience characterized by parental inaccessibility and nonavailability, combined with exposure to numerous unfamiliar adults, was associated with increased risk of insecure attachments. In fact, some adults who had experienced such a setting

in their childhood reported that they had no significant memory of their parents (Tikotzky, Sharabany, Hirsch, & Sadeh, 2010). Because the kibbutz made the group of children a family unit, some may have felt that the natural protection expected by the family was lacking.

This result among normally developing children raises serious questions about how much more damaging the experience can be for children who have already experienced the trauma of abuse, neglect, or abandonment. At the same time, it should be noted that despite the semi-institutional nature of such a kibbutz setting, children were protected by other rearing experiences such as normal daily surroundings, and available and accessible parents who had no known serious deficiencies. Parents also used bedtime rituals, for example, placing candy under the child's pillow, promising that they would come and visit during the night, and placing "loving and caring letters" on the walls. Moreover, some sick children slept at home, and some kibbutz parents were sufficiently assertive to violate the kibbutz rules. Potentially, all these practices might have served as protective factors (Oppenheim, 1998), although these are rarely present for most children placed in group care.

7. Group care for abused and maltreated children also may be physically dangerous.

There are several highly publicized cases of the physical and sexual abuse of children in residential care settings in various countries, leading some governments to appoint national committees to investigate the rate of child (sexual) abuse in residential settings (e.g., Commissie Samson, 2012), or to examine institutional responses to sexual abuse in residential care (e.g., Royal Commission, 2013). Systematic research also suggests that children in congregate care settings are at increased risk for maltreatment compared to children placed with families (Euser, Alink, Tharner, van IJzendoorn, & Bakermans-Kranenburg, 2013, 2014). A recent study comparing the prevalence of maltreatment in foster and residential care with the prevalence in the foster care and general population found that sexual and physical abuse occur more frequently in residential care than in the general population (Euser et al., 2013, 2014). Sexual abuse was higher in residential care than in either foster care or the general population (Euser et al., 2013). There was no difference in the incidence of sexual abuse between foster care and the general population. The rate of self-reported physical abuse in residential care was almost double that of foster care and triple that of the general population of same age adolescents (Euser et al., 2014). A large majority of group care workers in residential settings (81%) also suffered from violence (Alink, Euser, Bakermans-Kranenburg, & van IJzendoorn, in press).

Alink, Euser, Tharner, van IJzendoorn, & Bakermans-Kranenburg (2012) speculate that three factors may explain the increased incidence of peer-to-peer, staff-to-peer, and peer-to staff violence and abuse: (a) instability of care providers in residential care leading to absence of reliable attachments between staff and pupils, (b) high staff turn-over, and (c) instability of the groups which eliminates the possibility of protective peer bonds (Winters, Botzet, & Fanhorst, 2011) and provides an opportunity for contagion by deviant peers (Dishion & Tipsord, 2011) to flourish. The high rate of physical and sexual abuse among maltreated children living in residential settings is unacceptable and a fundamental violation of the principle of *primum non nocere* or "first, do no harm" (Alink et al., 2012). Exposing vulnerable children to increased risk for maltreatment in an intervention administered because of maltreatment is unjustifiable.

8. There is no demonstrable therapeutic necessity for group care to be used as a long-term living arrangement.

There is no countervailing benefit to group care as a living arrangement for children and adolescents. Rather, they can be better served in family settings than in institutions. Substance abuse, sexual acting out behavior, and delinquency are frequent reasons for placing children in residential group care settings (Dishion et al., 1999). In the majority of cases, these problems can be safely and effectively treated in the community.

Cognitive-behavioral, family-systems, and motivational enhancement therapies have emerged as evidence-based treatments for adolescent substance use disorders, with these treatments effectively administered in outpatient settings (Winters et al., 2011). Multisystemic therapy (MST) has been adapted for juvenile sexual offenders and found to be associated with significant reductions in sexual behavior problems, delinquency, substance use, externalizing problems, and out-of-home placements (Letourneau et al., 2009; Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010), with MST participants having lower recidivism rates than treatment-as-usual controls at 8.9 year follow-up for sexual (8% vs. 46%, respectively) and nonsexual (29% vs. 58%, respectively) offenses (Borduin, Schaeffer, & Heiblum, 2009). Multidimensional Treatment Foster Care (MTFC) is another model of community-based treatment for chronic, serious, juvenile offenders that has been compared to group care, with youth who received MTFC evidencing higher treatment completion rates, lower recidivism, and fewer subsequent days in detention centers than youth provided group care interventions (Joseph, O'Connor, Briskman, Maughan, & Scott, in press; Schaeffer, Swenson, Tuerk, & Henggeler, 2013).

Whereas there are indications in which psychiatric hospitalization or locked care facilities may be necessary for safety, most serious problems can be treated effectively in community based interventions. Group care should be reserved for use when it is the least detrimental alternative for children and adolescents.

9. Even children who have never experienced secure attachments can develop them in appropriate family settings.

It is not true that it is "too late" for older children to benefit from a stable parenting relationship. Foster care when supported by adequate selection training and support of caregivers can work successfully with children and adolescents. It is not too late for these young people to form and benefit from secure attachments, provided caregivers are selected, trained, and supported effectively.

Recent research evaluating attachment between foster caregivers and children who had not experienced secure attachments to their birth families found that (a) adolescents can form secure attachments to foster caregivers despite a history of abuse and neglect and despite late placement (i.e., in middle or late childhood), (b) the likelihood that the adolescent will form a secure attachment to the foster caregiver is directly associated with quality of adolescent-parent interactions, and (c) adolescents with secure attachment to foster caregivers show better behavioral and social adjustment than adolescents with insecure attachment to foster caregivers (although they still show higher rates of adjustment problems than children in typical or nonfoster families; Joseph et al., in press).

10. Group care should never be used for young children.

A large literature has documented the harmful effects of group care on young children (Dozier, Zeanah, Wallin, & Shauffer, 2012). In addition to compromises in virtually every

domain of development, including structural and functional brain abnormalities (Nelson, Bos, Gunnar, & Sonuga-Barke, 2011), young children raised in group settings are especially vulnerable to disturbances of attachment (Nelson, Fox, & Zeanah, 2014; Zeanah, 2000). Attachment relationships are less likely to form (Dobrova-Krol, Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2010; Zeanah, Smyke, Koga, Carlson, & BEIP Core Group, 2005), and more likely to be disorganized in institutional settings (Vorria, Papaligoura, & Dunn, 2003). Furthermore, serious clinical disorders of attachment are more likely in children raised in institutions in their earliest years, and in some, the consequences are lasting (Chisholm, 1998; Gleason et al., 2011; Hodges & Tizard, 1989; Kumsta et al., 2010; O'Connor, Marvin, Rutter, Olrick, & Britner, 2003; Rutter et al., 2007; Tizard & Rees, 1975). Placement in families is the most urgent intervention for these children and has demonstrated substantial gains in their development (Dobrova-Krol et al., 2010), including formation of secure attachments (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). Further, when children are removed from institutions and form secure attachments with their foster parents, they are less likely to experience subsequent psychopathology or problematic peer relations (Dobrova-Krol et al, 2010; McLaughlin, Zeanah, Fox, & Nelson, 2012).

Conclusions

We conclude that congregate or group care deprives children of the opportunity to form an attachment to a parent figure and is not likely to involve child sensitive exercise of adult authority. These factors substantially reduce the child's ability to navigate critical developmental tasks of childhood and adolescence and increase the likelihood of antisocial and risky behavior. In fact, antisocial behavior is prevalent in the institutions themselves, so that children and youth are frequently exposed to an excessively violent environment and are at increased risk for physical as well as emotional injury. There is evidence that not only can the needs of children and adolescents be met without group care, but also that foster care, when appropriately supported, can help resolve some of the attachment issues facing many children who enter care. Therefore, group care should be reserved for therapeutic treatment in those children in whom risk of continued placement disruptions in foster families outweighs the risks of group placement, and the goal should be return to families as soon as possible.

References

Ainsworth, M. S. (1989). Attachment beyond infancy. *American Psychologist, 44,* 709-716.

Alink, L. R. A., Euser, S., Bakermans-Kranenburg, M. J., & van IJzendoorn M. H. (2014). A challenging job: Physical and sexual violence towards group workers in youth residential care. *Child and Youth Care Forum, 43,* 243-250.

Alink, L. R. A., Euser, S., Tharner, A., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2012). Prevalentie Seksueel Misbruik in de Nederlandse Jeugdzorg. *In 2008-2010: Een Kwantitatieve Studie.* Leiden, The Netherlands: Centrum voor Gezinsstudies.

Allen, J. P., Moore, C., Kupermine, G., & Bell, K. (1998). Attachment and adolescent psychosocial functioning. *Child Development, 68,* 1406-1419.

Aviezer, O., Sagi, A., & van IJzendoorn, M. H. (2002). Balancing the family and the collective in raising Kibbutz children: Why the communal sleeping experiment was predestined to fail. *Family Process, 41,* 435-455.

Aviezer, O., van IJzendoorn, M. H., Sagi, A., & Schuengel, C. (1994). Collective child rearing: implications for socio emotional development from 70 years of experience in Israeli kibbutzim. *Psychological Bulletin, 116,* 99-116.

Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of multisystemic therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77,* 26-37.

Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment.* New York, NY: Basic Books.

Carrilio, T. E., & Walter, C. A. (1984). Mirroring and autonomy: The dual tasks of mothers. *Child and Adolescent Social Work Journal, 1,* 143-152.

Chamberlain, P., & Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology, 66,* 624-633.

Chisholm, K. (1998). A three-year follow-up of attachment and indiscriminate friendliness in children adopted from Romanian orphanages. *Child Development, 69,* 1092-1106.

Commissie Samson. (2012). *Omringd door zorg, toch niet veilig. Seksueel misbruik van door de overheid uit huis geplaatste kinderen 1945 tot heden [Surrounded by care, but not safe. Sexual abuse in out-of-home care 1945 to present]*. Amsterdam, The Netherlands: Boom.

Dishion, T. J., & Dodge, K. A. (2005). Peer contagion in interventions for children and adolescents: Moving towards an understanding of the ecology and dynamics of change. *Journal of Abnormal Child Psychology, 33,* 395-400.

Dishion, T., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist, 54,* 755-764.

Dishion, T., Nelson, S., & Bullock, B. (2004). Premature adolescent autonomy: Parent disengagement and deviant peer process in the amplification of problem behavior. *Journal of Adolescence, 27,* 515-530.

Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. *Annual Review of Psychology, 62,* 189-214.

Dobrova-Krol, N. A., Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2010). The importance of quality of care: Effects of perinatal HIV infection and early institutional rearing on preschoolers' attachment and indiscriminate friendliness. *Journal of Child Psychology and Psychiatry, 51,* 1368-1376.

Dozier, M., Zeanah, C. H., Wallin, A. R., & Shauffer, C. (2012). Institutional care for young children: Review of literature and policy implications. *Social Issues and Policy Review, 6*, 1-25.

Euser, S., Alink, L. R. A., Tharner, A., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2013). The prevalence of child sexual abuse in out-of-home care: A comparison between abuse in residential and in foster care. *Child Maltreatment, 18,* 221-231.

Euser, S., Alink, L. R. A., Tharner, A., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2014). Out of home placement to promote safety? The prevalence of physical abuse in residential and foster care. *Children and Youth Services, 37,* 64-70.

Gleason, M. M., Fox, N. A., Drury, S., Smyke, A., Egger, H. L., et al. (2011). Validity of evidence-derived criteria for reactive attachment disorder: Indiscriminately social/disinhibited and emotionally withdrawn/inhibited types. *Journal of American Academy of Child and Adolescent Psychiatry, 50,* 216 –231.

Hawkins-Rodgers, Y. (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behavior and building resiliency. *Children and Youth Services, 29,* 1131-1141.

Hodges, J., & Tizard, B. (1989). Social and family relationships of ex-institutional adolescents. *Journal of Child and Adolescent Psychiatry, 30,* 77-97.

Joseph, M., O'Connor, T., Briskman, J., Maughan, B., & Scott, S. (2014). The formation of secure new attachments by children who were maltreated: An observational study of adolescents in foster care. *Development and Psychopathology, 26,* 67-80.

Kaufman, J. (2007). Child abuse. In A. Martin & F. Volkmar (Eds.), *Lewis' child and adolescent psychiatry: A comprehensive textbook* (4th Ed.). Baltimore, MD: Lippincott Williams & Wilkins.

Kerr, M., Stattin, H., & Burk, W. J. (2010). A reinterpretation of parental monitoring in longitudinal perspective. *Journal of Research on Adolescence, 20,* 39-64.

Kobak, R., Herres, J., Gaskins, C., & Laurenceau, J-P. (2012). Teacher-student interactions and attachment states of mind as predictors or early romantic involvement and risky sexual behaviors. *Attachment and Human Development, 14,* 289-303.

Kumsta, R., Kreppner, J., Rutter, M., Beckett, C., Castle, J., et al. (2010). Deprivation-specific psychological patterns. *Monographs of the Society for Research on Child Development, 75,* 48-78.

Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., et al. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology, 23*, 89-102.

McLaughlin, K. A., Zeanah, C. H., Fox, N. A., & Nelson, C. A. (2012). Attachment security as a mechanism linking foster care placement to improved mental health outcomes in previously institutionalized children. *Journal of Child and Adolescent Psychiatry, 53,* 46-55.

Matas, L., Arend, R. A., & Sroufe, L. A. (1978). Continuity of adaptation in the second year: the relationship between quality of attachment and later competence. *Child Development, 49,* 547-556.

Nelson, C. A., Bos, K., Gunnar, M. R., & Sonuga-Barke, E. (2011). The neurobiological toll of early human deprivation. In R. B. McCall, M. H. van IJzendoorn, F. Juffer, C. J. Groark, & V. K. Groza (Eds.), *Children without permanent parents: Research, practice, and policy. Monographs of the Society for Research on Child Development, 76,* 127-146.

Nelson, C A., Fox, N. A., & Zeanah, C. H. (2014). *Romania's abandoned children: Deprivation, brain development and the struggle for recovery*. Cambridge, MA: Harvard University Press.

Nickerson, A. B., & Nagle, R. J. (2004). The influence of parent and peer attachments on life satisfaction in middle childhood and early adolescence. *Social Indicators Research, 66*, 35-60.

O'Connor, T. G., Marvin, R. S., Rutter, M., Olrick, J. T., & Britner, P. A. (2003). Child-parent attachment following early institutional deprivation. *Development and Psychopathology, 15,* 19-38.

Oppenheim, D. (1998). Perspectives on infant mental health from Israel: the case of children in collective sleeping on the kibbutz. *Infant Mental Health Journal, 19,* 76-86.

Persi, J., & Sisson, M. (2008). Children in foster care: Before, during, and after psychiatric hospitalization. *Child Welfare, 87,* 79-99.

Royal Commission into Institutional Response to Child Sexual Abuse (2013). CEO report of operations. Commissioners appointed. Downloaded from http://www.childabuseroyalcommission.gov.au/our-work/public-reports

Russell, K. C., & Phillips-Miller, D. (2002). Perspectives on the wilderness therapy process and its relation to outcome. *Child and Youth Care Forum, 31,* 415-437.

Rutter, M., Colvert, E., Kreppner, J. Croft, C., Murin, M., Colvert, E., et al. (2007). Early adolescent outcomes for institutionally-deprived and non-deprived adoptees. I: Disinhibited attachment. *Journal of Child and Adolescent Psychiatry, 48*, 17-30.

Ryan, J. P., Marshall, J., Herz, D., & Hernandez, P. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review, 30,* 1088–1099.

Schaeffer, C. M., Swenson, C. C., Tuerk, E. H., & Henggeler, S. W. (2013). Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program. *Child Abuse and Neglect, 37,* 596-607.

Smetana, J., Robinson, J., & Rote, W. (in press). Socialization in adolescence. In J. E. Grusec & P. D. Hastings (Eds.), *Handbook of socialization: Theory and research*. (2nd ed.). New York, NY: Guilford Press.

Smetana, J. G. (2011). *Adolescents, families, and social development: How adolescents construct their worlds.* West Sussex, England: Wiley-Blackwell.

Smetana, J. G. (2008). "It's 10 o'clock: do you know where you children are?" Recent advances in understanding parental monitoring and adolescents' information management. *Child Development Perspectives, 20,* 39-64.

Smyke, A. T., Zeanah, C. H., Fox, N. A., Nelson, C. A., & Guthrie, D. (2010). Placement in foster care enhances quality of attachment among young institutionalized children. *Child Development, 81*, 212-223.

Sroufe, L. A. (2005). Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attachment and Human Development, 7,* 349-367.

Stattin, H., & Kerr, M. (2000). Parental monitoring: a reinterpretation. *Child Development, 71,* 1072-1085.

Swenson, C. C., Schaeffer, C. M., Henggeler, S. W., Faldowski, R., & Mayhew, A. M. (2010). Multisystemic therapy for child abuse and neglect: A randomized effectiveness trial. *Journal of Family Psychology, 24,* 497-507.

Tikotzky, L., Sharabany, R., Hirsch, I., & Sadeh, A. (2010). “Ghosts in the nursery”: Infant sleep and sleep-related cognitions of parents raised under communal sleeping arrangements. *Infant Mental Health Journal, 31,* 312-334.

Tilton-Weaver, L. (In press). Adolescents’ information management: Comparing ideas about why adolescents disclose to or keep secrets from parents. *Journal of Youth and Adolescence.*

Tizard, B., & Rees, J. (1975). The effect of early institutional rearing on the behaviour problems and affectional relationships of 4-year-old children. *Journal of Child and Adolescent Psychiatry, 16,* 61-73.

United Nations General Assembly (UNGA). (1989). *Convention on the Rights of the Child, United Nations, Treaty Series* (Vol. 1577, p. 3). Available at: http://www.refworld.org/docid/3ae6b38f0.html

United Nations General Assembly (UNGA). (2010). *Guidelines for the Alternative Care of Children: Resolution.* Adopted by the General Assembly, A/RES/64/142, available at: http://www.refworld.org/docid/4c3acd162.htm

U.S. Department of Health and Human Services (DHHS), Administration on Children, Youth and Families. (2013). *Trends in foster care and adoption.* Washington, DC: U.S. Government Printing Office.

Vorria, P., Papaligoura, Z., & Dunn J, (2003). Early experiences and attachment relationships of Greek infants raised in residential group care. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 44,* 1208-1220.

Winters, K. C., Botzet, A. M., & Fanhorst, T. (2011). Advances in adolescent substance abuse treatment. *Current Psychiatry Reports, 13,* 416-421.

Zeanah, C. H. (2000). Disturbances of attachment in young children adopted from institutions. *Journal of Developmental and Behavioral Pediatrics, 21,* 230-236.

Zeanah, C. H., Smyke, A. T., Koga, S. F. M., Carlson, E., & BEIP Core Group. (2005). Attachment in institutionalized and community children in Romania. *Child Development, 76,* 1015-1028.