AMERICAN ACADEMY OF PEDIATRICS

Committee on Early Childhood, Adoption and Dependent Care

Developmental Issues for Young Children in Foster Care

ABSTRACT. Greater numbers of young children with complicated, serious physical health, mental health, or developmental problems are entering foster care during the early years when brain growth is most active. Every effort should be made to make foster care a positive experience and a healing process for the child. Threats to a child's development from abuse and neglect should be understood by all participants in the child welfare system. Pediatricians have an important role in assessing the child's needs, providing comprehensive services, and advocating on the child's behalf.

The developmental issues important for young children in foster care are reviewed, including: 1) the implications and consequences of abuse, neglect, and placement in foster care on early brain development; 2) the importance and challenges of establishing a child's attachment to caregivers; 3) the importance of considering a child's changing sense of time in all aspects of the foster care experience; and 4) the child's response to stress. Additional topics addressed relate to parental roles and kinship care, parent-child contact, permanency decision-making, and the components of comprehensive assessment and treatment of a child's development and mental health needs.

More than 500 000 children are in foster care in the United States.[1,2] Most of these children have been the victims of repeated abuse and prolonged neglect and have not experienced a nurturing, stable environment during the early years of life. Such experiences are critical in the short- and long-term development of a child's brain and the ability to subsequently participate fully in society.[3–8] Children in foster care have disproportionately high rates of physical, developmental, and mental health problems[1,9] and often have many unmet medical and mental health care needs.[10] Pediatricians, as advocates for children and their families, have a special responsibility to evaluate and help address these needs.

Legal responsibility for establishing where foster children live and which adults have custody rests jointly with the child welfare and judiciary systems. Decisions about assessment, care, and planning should be made with sufficient information about the particular strengths and challenges of each child. Pediatricians have an important role in helping to develop an accurate, comprehensive profile of the child. To create a useful assessment, it is imperative that complete health and developmental histories are available to the pediatrician at the time of these evaluations. Pediatricians and other professionals with expertise in child development should be proactive advisors to child protection workers and judges regarding the child's needs and best interests, particularly regarding issues of placement, permanency planning, and medical, developmental, and mental health treatment plans. For example, maintaining contact between children and their birth families is generally in the best interest of the child, and such efforts require adequate support services to improve the integrity of distressed families. However, when keeping a family together may not be in the best interest of the child, alternative placement should be based on social, medical, psychological, and developmental assessments of each child and the capabilities of the caregivers to meet those needs.

Health care systems, social services systems, and judicial systems are frequently overwhelmed by their responsibilities and caseloads. Pediatricians can serve as advocates to ensure each child's conditions and needs are evaluated and treated properly and to improve the overall operation of these systems. Availability and full utilization of resources ensure comprehensive assessment, planning, and provision of health care. Adequate knowledge about each child's development supports better placement, custody, and treatment decisions. Improved programs for all children enhance the therapeutic effects of government-sponsored protective services (eg, foster care, family maintenance).

The following issues should be considered when social agencies intervene and when physicians participate in caring for children in protective services.

EARLY BRAIN AND CHILD DEVELOPMENT

More children are entering foster care in the early years of life when brain growth and development are most active.[11–14] During the first 3 to 4 years of life, the anatomic brain structures that govern personality traits, learning processes, and coping with stress and emotions are established, strengthened, and made permanent.[15,16] If unused, these structures atrophy.[17] The nerve connections and neurotransmitter networks that are forming during these critical years are influenced by negative environmental conditions, including lack of stimulation, child abuse, or violence within the family.[18] It is known that emotional and cognitive disruptions in the early lives of children have the potential to impair brain development.[18]

Paramount in the lives of these children is their need for continuity with their primary attachment figures and a sense of permanence that is enhanced

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

when placement is stable.[10] There are critical periods of interaction among physical, psychological, social, and environmental factors. Basic stimulation techniques and stable, predictable nurturance are necessary during these periods to enable optimal cognitive, language, and personal socialization skills. Because these children have suffered significant emotional stress during critical periods of early brain development and personality formation, the support they require is reparative as well as preventive. The pediatrician, with knowledge of the child's medical and family history, may assist the social service and judicial systems in determining the best setting to help the child feel safe and heal.

ATTACHMENT

To develop into a psychologically healthy human being, a child must have a relationship with an adult who is nurturing, protective, and fosters trust and security.[19] Attachment refers to this relationship between 2 people and forms the basis for long-term relationships or bonds with other persons. Attachment is an active process—it can be secure or insecure, maladapative or productive. Attachment to a primary caregiver is essential to the development of emotional security and social conscience.[20]

Optimal child development occurs when a spectrum of needs are consistently met over an extended period. Successful parenting is based on a healthy, respectful, and long-lasting relationship with the child. This process of parenting, especially in the psychological rather than the biologic sense, leads a child to perceive a given adult as his or her "parent." That perception is essential for the child's development of self-esteem and self-worth.[21] A child develops attachments and recognizes as parents adults who provide ". . . day-to-day attention to his needs for physical care, nourishment, comfort, affection, and stimulation."[21] Abused and neglected children (in or out of foster care) are at great risk for not forming healthy attachments to anyone.[9,10] Having at least 1 adult who is devoted to and loves a child unconditionally, who is prepared to accept and value that child for a long time, is key to helping a child overcome the stress and trauma of abuse and neglect.

The psychosocial context and the quality of the relationship from which a child is removed, as well as the quality of alternative care that is being offered during the separation, must be carefully evaluated. This information should be used to decide which placement is in the child's best interest. The longer a child and parent have had to form a strong attachment with each other (ie, the older the child) the less crucial the physical proximity will be to maintain that relationship. Separation during the first year of life—especially during the first 6 months—if followed by good quality of care thereafter, may not have a deleterious effect on social or emotional functioning. Separations occurring between 6 months and about 3 years of age, especially if prompted by family discord and disruption, are more likely to result in subsequent emotional disturbances. This partly results from the typical anxiety a child this age has around strangers and the normal limitations of language abilities at this age. Children older than 3 or 4 years placed for the first time with a new family are more likely to be able to use language to help them cope with loss and adjust to change. These preschool-aged children are able to develop strong attachments and, depending on the circumstances from which they are removed, may benefit psychologically from the new setting.

The emotional consequences of multiple placements or disruptions are likely to be harmful at any age, and the premature return of a child to the biologic parents often results in return to foster care or ongoing emotional trauma to the child.[22] Children with attachment disorders and an inability to trust and love often grow up to vent their rage and pain on society.[19]

CHILDREN'S SENSE OF TIME

Children are placed in foster care because of society's concern for their well-being. Any time spent by a child in temporary care should be therapeutic but may be harmful to the child's growth, development, and well-being. Interruptions in the continuity of a child's caregiver are often detrimental. Repeated moves from home to home compound the adverse consequences that stress and inadequate parenting have on the child's development and ability to cope. Adults cope with impermanence by building on an accrued sense of self-reliance and by anticipating and planning for a time of greater constancy. Children, however, especially when young, have limited life experience on which to establish their sense of self. In addition, their sense of time focuses exclusively on the present and precludes meaningful understanding of "temporary" versus "permanent" or anticipation of the future. For young children, periods of weeks or months are not comprehensible. Disruption in either place or with a caregiver for even 1 day may be stressful. The younger the child and the more extended the period of uncertainty or separation, the more detrimental it will be to the child's well-being.[21]

Any intervention that separates a child from the primary caregiver who provides psychological support should be cautiously considered and treated as a matter of urgency and profound importance. Pediatricians should advocate that evaluation, planning, placement, and treatment decisions be made as quickly as possible, especially for very young children.

RESPONSE TO PSYCHOLOGICAL STRESS

The body's physiologic responses to stress are based on involuntary actions of the brain. Physical and mental abuse during the first few years of life tends to fix the brain in an acute stress response mode that makes the child respond in a hypervigilant, fearful manner.[18,22] Research demonstrates chemical and electrical evidence for this type of brain response pattern.[18,23] The age of the child dictates the developmental response and manifestations to stress. When an infant is under chronic stress, the response may be apathy, poor feeding, withdrawal, and failure to thrive. When the infant is under acute

threat, the typical "fight" response to stress may change from crying (because crying did not elicit a response) to temper tantrums, aggressive behaviors, or inattention and withdrawal.[24] The child, rather than running away (the "flight" response), may learn to become psychologically disengaged, leading to detachment, apathy, and excessive daydreaming. Some abused and neglected children learn to react to alarm or stresses in their environment reflexively with immediate cessation of motor activity (freeze response). Older children who have been repeatedly traumatized often suffer from posttraumatic stress disorder and automatically freeze when they feel anxious, and therefore are considered oppositional or defiant by those who interact with them.

The same areas of the brain that are involved in the acute stress response also mediate motor behavior and such functions as state regulation and anxiety control.[23] Repeated experiencing of traumatic events can lead to dysregulation in these various functions resulting in behaviors such as motor hyperactivity, anxiety, mood swings, impulsiveness, and sleep problems.[18]

EFFECTS OF NEGLECT

An increasing number of young children are being placed in foster care because of parental neglect.[1] Neglect has very profound and long-lasting consequences on all aspects of child development—poor attachment formation, understimulation, development delay, poor physical development, and antisocial behavior.[8,17,25–27] Being in an environment in which child-directed support and communication is limited makes it more difficult for a child to develop the brain connections that facilitate language and vocabulary development, and therefore may impair communication skills.[28] Recent findings in infant mental health show how development can be facilitated, how treatment can enhance brain development and psychological health, and how prevention strategies can lessen the ill effects of neglect.[29]

COMPREHENSIVE ASSESSMENT OF THE AT-RISK CHILD—BEFORE PLACEMENT

Knowledge of normal child development and family functioning helps identify children receiving insufficient and inappropriate care as well as children who are victims of, or at risk for, abuse or neglect. Comprehensive pediatric assessments can complement programs that prevent abuse and neglect, decrease the likelihood of placement in foster care, identify whether a child's current needs are being met, and allow placements to be customized to meet each child's needs.

COMPREHENSIVE ASSESSMENT OF CHILDREN IN FOSTER CARE—AFTER PLACEMENT

A pediatric assessment should be done within 30 days of placement.[30] This evaluation must be:

1. *Comprehensive:* Appropriate in breadth and depth, assessing physical, behavioral, emotional, cognitive, relational, and environmental domains.
2. *Integrative:* Address the effect any 1 domain of function has on another domain of function (eg, impact of motor deficits on speech).
3. *Developmental:* Age-appropriate using validated instruments that are sensitive to changes in development over time.
4. *Preventive:* Anticipatory, focusing on early identification and interventions.
5. *Longitudinal:* Based on data collected over time to determine problems, each child's abilities, and future course.
6. *Summative:* Able to synthesize and compile results for the purpose of prioritization.
7. *Culturally Sensitive:* Sensitive to different values, meanings, and perceptions of importance.
8. *Child-Sensitive:* Conducted in settings and in a manner that protects the child's comfort and that controls and limits the stress of the evaluation.
9. *Standardized:* Sensitive, specific, valid, and reliable.
10. *Child Welfare-Sensitive:* Consistent with norms, standards, and goals of child welfare.
11. *Parsimonious:* Compact, efficient, and able to be completed in a reasonable amount of time.

At a minimum, the following areas should be assessed:

- Gross motor skills
- Fine motor skills
- Cognition
- Speech and language function
- Self-help abilities
- Emotional well-being
- Coping skills
- Relationship to persons
- Adequacy of caregiver's parenting skills
- Behaviors

TREATMENT

The comprehensive assessment should lead to an individualized court-approved treatment plan and ongoing monitoring by a multidisciplinary team skilled in working with this population in the context of a medical home.[31] In-home monitoring, placement with a relative ("kinship care"), or out-of-home placement should support each child's psychological and developmental needs. Parents and foster parents must be well-informed about the importance of the environment in the development of normal brain function and the specifics needed for the child under care. Children can often be helped by providing predictability, nurturance, support, and cognitive or insight-oriented interventions to make them feel safe, comfortable, and loved. Specific mental health plans must be developed to meet the functional needs of each child.

Early interventions are key to minimizing the long-term and permanent effects of traumatic events on the child's brain.[14,17,32–36] After the first several years of a child's life, patterns of interaction with the world are formed, both psychologically and in the brain structure, making it more difficult, though still possible, to improve a child's physical, cognitive,

and emotional abilities.[17] Several studies have shown how favorable and stimulating environments for infants and young children can lessen the adverse effects of prior negative environments.[27] Pediatricians have an important role in recognizing problem situations in the home and for children already in foster care. Prompt referrals should be made for early intervention services to secure full developmental assessments and treatments under the Individuals With Disabilities Act.

PLACEMENT ISSUES

Courts with jurisdiction over families and children have been charged by Congress and the states to ensure that "reasonable efforts" are made to preserve and repair families or to place children in foster care when necessary. The courts also have the responsibility to make foster care a healing process. Given limited social, economical, educational, and health care resources, the judiciary has a responsibility to try to make needed resources available in the community and to decide whether application of available resources has been reasonable and appropriate. An array of supportive services should be available to assist families in child rearing and to offer alternative and therapeutic parenting (ie, foster care) when temporary removal of the child from the home is required.

The measure of *reasonable and appropriate* should always be what is in the best interests of the child. Lack of agreement exists about what constitutes such reasonable efforts. Principles of child development and expert consultation can provide guidance to assist in determining what is in the best interest of the child and whether these interests can be best met within the biologic family or another family. The lack of available resources to ensure a reasonable effort should not be used by the protective services agencies as an excuse to delay a permanent placement plan for a child.

PARENTAL ROLES AND KINSHIP CARE

The increasing number of children entering foster care, the insufficient number of suitable foster homes, and the increased interest by extended families to care for their kin have led social service agencies to place children with their extended families. Placement with a relative has psychological advantages for a child in terms of knowing his or her biologic roots and family identity. It may offer a better chance for stability and continuity of caregiving. However, little is known about the outcomes of kinship placement, and it should not be assumed to offer a superior home environment.[37] Supervision by social workers of relatives providing foster care is often less intense and family support services are less available than when a child is placed in nonkinship foster care. Placement with a relative may lead to a circuitous and unintended return of the child to his or her parents.

The report by the National Commission on Family Foster Care states: "The use of kinship care has expanded so rapidly that child welfare agencies are making policy, program, and practice decisions that lack uniformity and/or a substantive knowledge base. Kinship care provides an opportunity to affirm the value of families. But the assessment process and support should include unique family strengths and needs, cultural and ethnic identification, necessary financial and service supports, continuity of care, and permanency goals."[38] Studies suggest that a range of parenting arrangements can provide the feelings of permanency, security, and emotional constancy necessary for normal development.[39]

VISITING (PARENT-CHILD CONTACT)

Children in out-of-home dependent care are usually accorded a schedule of visits with their parents. The intent is to maintain or improve the child-parent relationship, to give the social service agency an opportunity to observe and improve the parent-child interaction, and to monitor the parents' progress. The visits are frequently brief encounters occurring on a weekly basis, in a neutral setting if possible, often under the supervision of a caseworker. For younger children, this type of visit is not conducive to optimal parent-child interaction and may minimally serve the parents' needs for ongoing contact with the child or may even be harmful for the child. A young child's trust, love, and identification are based on uninterrupted, day-to-day relationships. Weekly or other sporadic "visits" stretch the bounds of a young child's sense of time and do not allow for a psychologically meaningful relationship with estranged biologic parents. For older children, such sporadic and brief visits may be sufficient to maintain a meaningful parent-child relationship.

For parent-child visits to be beneficial, they should be frequent and long enough to enhance the parent-child relationship and to effectively document the parent's ongoing interest and involvement with the child. Sporadic visits are appropriate if an older child has established a strong attachment to the parent before entering foster care or if the visits are sufficient in frequency, length, and content to contribute to the child's continuing normal development and enhanced parent-child relationship.

STABLE PLACEMENT VERSUS LEGAL CUSTODY VERSUS PERMANENCE

Children who have experienced abuse or neglect have a heightened need for permanency, security, and emotional constancy and are, therefore, at great risk because of the inconsistencies in their lives and the foster care system. Every effort should be made to rapidly establish a permanent placement for the child. Tangible continuity in relationships with family and friends is essential for a child's healthy development. Stability in child care and the school environment is important. Multiple moves while in foster care (with the attendant disruption and uncertainty) can be deleterious to the young child's brain growth, mental development, and psychological adjustment.

All children, regardless of their type of placement, must receive individual attention from their caregivers. Foster parents and extended family members can play a significant role when the child's mother or

father cannot. Impersonal placement settings do not effectively support young children who have been abused and neglected. Bureaucratic proceedings, including conferring legal status, are usually of little or no consequence to children, whose needs are much more fundamental. Generally, assignment of custody should reinforce a child's perception of belonging and should not disrupt established psychological ties except when safety or emotional well-being are in jeopardy.

RECOMMENDATIONS

All placement, custody, and long-term planning decisions should be individualized for the child's best interest and should maximize the healing aspects of government-sponsored protective services. These decisions should be based in part on a comprehensive assessment and periodic reassessment of the child and family by professionals who are experts in pediatrics and child development (eg, pediatrician, psychiatrist, or psychologist).[22] An ongoing relationship between the pediatrician and the child and family can provide valuable insights about a child's needs and the ability of a family to meet them. Pediatricians should actively participate in prevention services for at-risk families and placement, custody, and long-term planning decisions for children for whom they provide care, taking into account the following considerations.[40]

The following important concepts should guide pediatricians' activities as they advocate for the child:

1. Biologic parenthood does not necessarily confer the desire or ability to care for a child adequately.
2. Supportive nurturing by primary caregivers is crucial to early brain growth and to the physical, emotional, and developmental needs of children.
3. Children need continuity, consistency, and predictability from their caregiver. Multiple placements are injurious.
4. Attachment, sense of time, and developmental level of the child are key factors in their adjustment to environmental and internal stresses.
5. Pediatricians can play a constructive role in the referral, assessment, and treatment of children who are at risk for being abused, neglected, or abandoned or who are involved in the protective services system.
6. Pediatricians need to encourage caregivers to:
   - give the child plenty of love and attention.
   - be consistent with love, stimulation, and discipline.
   - stimulate the child through exposure to developmentally appropriate holding, conversation, reading, music, and toys.
   - expose the child to opportunities to improve language via direct voice and face-to-face contact.
   - match the environment to the child's disposition.
7. Parents should be given reasonable assistance and opportunity to maintain their family, while the present and future best interests of the child should determine what is appropriate.
8. A child's attachment history and sense of time should guide the pace of decision-making.
9. Foster care placements should always maximize the healing aspects of foster care and be based on the needs of the child.
10. Foster care placement with relatives should be based on a careful assessment of the needs of the child and of the ability of the kinship care to meet those needs. As with all foster care placements, kinship care must be supported and supervised adequately.

REFERENCES

1. Sedlak AJ, Boadhurst DD. *The Third National Incidence Study of Child Abuse and Neglect.* Washington, DC: US Department of Health and Human Services, Administration for Children, Youth, and Families; 1996
2. Sedlak A. *Study Findings: Study of the National Incidence and Prevalence of Child Abuse and Neglect: 1986*. Washington, DC: US Department of Health and Human Services; 1988
3. Garbarino J, Guttmann, Seeley JW. *The Psychologically Battered Child: Strategies for Identification, Assessment, and Intervention*. San Francisco, CA: Jossey-Bass; 1986
4. O'Hagan KP. Emotional and psychological abuse: problems of definition. *Child Abuse Negl.* 1995;19:449–461
5. Brassard MR, Germain R, Hart SM. The challenge to better understand and combat psychological maltreatment of children and youth. In: Goldstein AP, Krasner L, eds. *The Psychological Maltreatment of Children and Youth.* New York, NY: Pergamon Press; 1987:3–24
6. Silverman A, Reinherz HZ, Glaclonia RM. The long-term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse Negl.* 1996;20:709–723

7. Wolfe DA, McGee R. Assessment of emotional status among maltreated children. In: Starr R, Wolfe D, eds. *The Effects of Child Abuse and Neglect: Issues and Research.* New York, NY: Guilford Press; 1991:257–277
8. Campbell FA, Ramey CT. Effects of early intervention on intellectual and academic achievement: a follow-up study of children from low-income families. *Child Dev.* 1994;65:684–698
9. Costello EJ, Angold A. A brief history of child psychiatric epidemiology in developmental epidemiology. In: Cicchetti D, Cohen DJ, eds. *Developmental Psychopathology. Vol 1: Theory and Methods.* New York, NY: John Wiley & Sons, Inc; 1995:23–56
10. Rosenfeld AA, Pilowsky D, Fine P, et al. Foster care: an update. *J Am Acad Child Adolesc Psychiatry.* 1997;36:448–457
11. California Center for Health Improvement. *Children and Youth Survey.* Sacramento, CA: The Field Institute; 1997
12. Dawson G, Hessl D, Frey K. Social influences on early developing biological and behavioral systems related to risk for affective disorder. *Dev Psychopathol.* 1994;6:759–779
13. Illig DC. *Birth to Kindergarten: The Importance of the Early Years*. Sacramento, CA: California Research Bureau; 1998
14. Carnegie Task Force on Meeting the Needs of Young Children. *Starting Points. Meeting the Needs of Our Youngest Children*. New York, NY: Carnegie Corporation; 1994
15. Huttenlocher PR. Synaptogenesis, synapse elimination, and neural plasticity in human cerebral cortex. In: Nelson CA, ed. *Threats to Optimal Development: Integrating Biological, Psychological, and Social Risk Factors. The Minnesota Symposia in Child Psychology, Vol 27.* Hillsdale, NJ: Lawrence Erlbaum and Associates, Publishers; 1994:35–54
16. Turner AM, Greenough WT. Differential rearing effects on rat visual cortex synapses: I. synapse and neural density and synapses per neuron. *Brain Res.* 1985;329:195–203
17. Greenough WT, Black JE, Wallace CS. Experience and brain development. *Child Dev.* 1987;58:539–559
18. Perry BD, Pollard RA, Blakley TL, Baker WL, Domenico V. Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: how "states" become "traits." *Infant Mental Health J.* 1995;16:271–291
19. Werner EE, Smith RS. *Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth*. New York, NY: Adams, Bannister, Cox; 1982
20. Lieberman AF, Zeanah CH. Disorders of attachment in infancy. *Infant Psychiatry.* 1995;4:571–587
21. Goldstein J, Freud A, Solnit AJ. *Beyond the Best Interests of the Child*. New York, NY: Macmillan Publishing Co, Inc; 1973
22. Simms MD. Foster children and the foster care system. Part II: impact on the child. *Curr Probl Pediatr.* 1991;21:345–369
23. Perry PD, Pollard R. Homeostasis, stress, trauma and adaptation: a neurodevelopmental view of childhood trauma. *Child Adolesc Psychiatr Clin North Am.* 1998;7:33–51
24. Spitz RA. Anaclitic depression. In Eissler RS, ed. *The Psychoanalytic Study of the Child.* New York, NY: International Universities Press; 1946:313–342
25. Perry B. *Neurobiological Sequelae of Childhood Trauma: Post-Traumatic Stress Disorders in Children*. Washington, DC: American Psychiatric Press, Inc; 1994
26. Frank DA, Klass PE, Earls F, Eisenberg L. Infants and young children in orphanages: one view from pediatrics and child psychiatry. *Pediatrics.* 1996;97:569–578
27. Huttenlocher J, Haight W, Bryk A, et al. Early vocabulary growth: relation to language input and gender. *Dev Psychol.* 1991;27:236–248
28. Mackner LM, Starr RH Jr, Black MM. The cumulative effect of neglect and failure to thrive on cognitive functioning. *Child Abuse Negl.* 1997; 21:691–700
29. Barnett D, Vondra JI, Shonk SM. Self-perceptions, motivation, and school functioning of low-income maltreated and comparison children. *Child Abuse Negl.* 1996;20:397–410
30. Child Welfare League of America. *Standards for Health Care for Children in Out-of-Home Care*. Washington, DC: Child Welfare League of America; 1988
31. American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. Health care of children in foster care. *Pediatrics.* 1994;93:335–338
32. Harris IB. *Children in Jeopardy: Can We Break the Cycle of Poverty?* New Haven, CT: Yale University Press; 1996
33. Ramey C, Ramey S. *At-Risk Does Not Mean Doomed*. Occasional Paper No. 4. Washington, DC: National Health/Education Consortium; 1992
34. MacMillan HL, MacMillan JH, Offord DR, Griffith L, MacMillan A. Primary prevention of child physical abuse and neglect: a critical review. *J Child Psychol Psychiatry.* 1994;35:835–856
35. Olds DL, Henderson CR Jr, Phelps C, Kitzman H, Hanks C. Effect of prenatal and infancy nurse home visitation on government spending. *Med Care.* 1993;31:155–174
36. Karoly LA, Greenwood PW, Everingham SMS, et al. *Investing in Our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*. Santa Monica, CA: Rand; 1998
37. Paul J, ed. *Infants in Day Care: Reflections, Experiences, Expectations, and Relationships: Zero to Three*. 1990;10:1–6
38. National Commission on Family Foster Care. *A Blueprint for Fostering Infants, Children, and Youths in the 1990s*. Washington, DC: Child Welfare League of America; 1991:83
39. Reiss IL. Uniformity and variation in family systems. In: Reiss IL, Lee GR, eds. *Family Systems in America*. 4th ed. New York, NY: Holt Rinehart and Winston Inc; 1988:14–41
40. Jellinek MS, Murphy JM, Bishop S, Poitrast F, Quinn D. Protecting severely abused and neglected children: an unkept promise. *N Engl J Med.* 1990;323:1628–1630