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Social Support Is Related to the Use of Adaptive Emotional Regulation Strategies in Ecuadorian Adolescents in Foster Care

Ana F. Trueba [1,2,3],* and Graham Pluck [1,4]

[1] Instituto de Neurociencias, Universidad San Francisco de Quito, Quito 170901, Ecuador; graham.pluck@nu.edu.kz
[2] McLean Hospital, Belmont, MA 02478, USA
[3] Harvard Medical School, Cambridge, MA 02115, USA
[4] Chulalongkorn University, Bangkok 10330, Thailand
* Correspondence: atruebayepez@mclean.harvard.edu

Abstract: Adolescents in foster care are exposed to maltreatment and inadequate social support which can have lasting repercussions on their emotional development. The aim of this study was to examine the effect of social support on the use of emotional regulation strategies in Ecuadorian adolescents in foster care and non-foster peers. This study recruited 181 adolescents, 56 in foster care and 123 non-foster peers, from various locations in Quito, Ecuador. Participants completed the Cognitive Emotion Regulation Questionnaire (CERQ) and the Multidimensional Scale of Perceived Social Support (MSPSS). Using linear regression, we found that being in foster care was related to lower perceived social support. The non-foster care control group reported using more emotion regulation strategies, both adaptive and maladaptive (acceptance, rumination, refocusing to planning, and self-blaming), than the foster care group. Greater social support was associated with the use of more positive strategies (reappraisal, positive refocusing, and refocusing to planning) and less maladaptive strategies (catastrophizing). Youth in foster care have less social support than their non-foster peers. This puts them at risk, as social support has an important role in the use of healthy emotion regulation skills in adolescents.

Keywords: foster care; adolescents; emotion regulation; social support; Ecuador

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1. Introduction

Most youth in foster care have been subjected to some form of hardship and have had disturbances in their attachment relationships [1]. This can negatively impact their psychological and emotional development [2]. Indeed, studies have shown that children in foster care in Australia have poor mental health outcomes and socialization difficulties [3]. Children and adolescents in foster care struggle with more depression, anxiety, and impulsivity than their non-foster peers [4]. One study found that 61% of the children and adolescents in foster care in their sample displayed behavior problems, and 7% of adolescents in foster care had attempted suicide and had required medical attention as a result [5]. Indeed, research indicates that adolescents in foster care are more likely to commit repeated self-harm [6] and are four times more likely to have attempted suicide [4]. Research indicates that among adolescents in foster care, 45% reported using substances in the last six months, 49% reported lifetime drug use, and 35% have a substance use disorder [7]. The mental health disparities that foster care youth face directly impact their ability to perform academically and adjust socially, leading to school failure and antisocial behaviors [8,9].

There is research to suggest that difficulties with emotion regulation might be an underlying cause of the mental health struggles and dysfunctional behaviors commonly

displayed in foster youth [10,11]. Emotion regulation is a complex process that involves initiating, inhibiting, or modulating one's response or behavior in emotionally charged situations. There are adaptive and maladaptive ways of regulating emotions. Internalizing behaviors such as rumination and catastrophizing are maladaptive, while acceptance, putting in perspective, and positive refocusing are considered adaptive coping [12]. Generally, foster care youth display difficulties in regulating their behaviors and emotions compared to their peers [13] and display more maladaptive coping [14]. Indeed, one study found that maltreated foster children had more difficulty regulating their anger, less positive emotions, and displayed more internalizing behaviors [14]. In addition, research findings suggest that foster care children have generally lower inhibitory control, and this was directly associated with lower social–emotional and academic adjustment in school [9].

Lack of social support and insecure attachment might be some of the core reasons why foster care youth experience difficulties with emotion regulation [15]. Foster care youth have disruptions in their attachment process and often lack the supportive relationships that are important for healthy emotion regulation [16]. Indeed, one study found that adolescents that had lower social support, and whose parents were not emotionally available, had more difficulty regulating, identifying, and expressing their emotions [17]. This is because caregivers have a critical role in a child's capacity to cultivate emotion regulation skills [18]. Indeed, attachment figures act as co-regulators by modeling adaptive behaviors, and giving supportive responses to their children's emotions [19]. Without the appropriate emotional and social support, foster care youth are at an increased risk of mental health difficulties [1].

Moreover, foster care youth are often exposed to maltreatment instead of support [16]. Maltreatment is one of the leading causes of poor mental health outcomes and aberrant emotional development [20]. Accordingly, childhood maltreatment is related to difficulties with emotional regulation [21,22]. Caregivers that maltreat do not provide the supportive environment to manage their children's' emotional needs. They tend to be indifferent or punitive in response to their children's emotions [22]. In addition, they are more emotionally reactive, express more negative emotions, and model maladaptive responses to emotions [23]. The effects of maltreatment on emotion regulation are evident in brain imaging studies that show more emotional reactivity to negative cues in maltreated youth, demonstrated by heightened amygdala, putamen, and insula activity [24].

Most of the current research on mental health outcomes of adolescents and children in foster care has been conducted in developed countries. Adolescents in the foster care system in Ecuador face unique challenges as they are placed in group homes instead of new family homes. Children and adolescents get little individual attention from adult caregivers at group homes, and their relationships are unstable as many of the caregivers and volunteers rotate in and out. Furthermore, adolescents often take care of younger children [25]. In total, there are 58 group homes located around Ecuador, and approximately 3000 children and adolescents (0–18 years old) in the Ecuadorian foster care system [26]. Children and adolescents usually enter the foster care system when they are abandoned, refugees, and/or family, friends, or other caregivers relinquish them to the system. Children and adolescents usually remain in foster care until they are adopted, or a family member comes to retrieve them. However, in these instances, minors are not immediately returned to their families, and they must submit to an extensive vetting process that can take months. Adolescents and children can be adopted after 6 months of being admitted into foster care, but the process, once initiated, can take up to 3 years. Children and adolescents are given food, education, and access to medical and psychological care when admitted into the system. In Ecuador, group homes are funded by the government and charity organizations. For this reason, some group homes have more resources than others [25]. Overall, research findings indicate that youth exposed to maltreatment and with inadequate social support have more difficulty with emotion regulation [20,21]. However,

few studies have examined the direct role of social support in the use of emotional regulation strategies in adolescents in foster care. In addition, many studies that have examined the effects of social support and foster care on general emotion regulation do not assess specific maladaptive and adaptive emotion regulation skills. Furthermore, much of the research has focused on foster care youth from developed countries. Few studies have examined foster care outcomes in developing countries such as Ecuador, where foster children are not placed into new homes but rather in group homes where they face unique difficulties. The first aim of this study was to examine the association of foster care status and social support in Ecuadorian adolescents. Our hypothesis was that adolescents in foster care would report less social support than their non-foster peers. The second aim was to evaluate the use of emotion regulation skills in foster care adolescents in Ecuador. Our hypothesis was that foster care adolescents will use less positive emotion regulation skills and engage in more maladaptive coping. The third aim was to test the relationship between social support and the use of emotion regulation skills independent of foster care status. Our related hypothesis was that social support would be positively associated with the use of positive emotion regulation skills and negatively related with the use of negative emotion regulation strategies, regardless of foster care status. A final supplementary aim was to test the mediating role of social support in the relationship between foster care status and emotion regulation skills and the moderating role of foster care status in the relationship between social support and emotion regulation skills.

2. Materials and Methods

2.1. Procedures

Adolescents were recruited from two different state-run schools and five different foster care sites located in Quito, Ecuador. Written informed consent to recruit each adolescent was obtained from a parent or legal guardian, and the adolescents themselves provided written informed assent to participate. The protocol was approved by a recognized research ethics committee and the research was conducted in accordance with regulations set down in the Declaration of Helsinki and by the American Psychological Association. Those that consented to be part of the study completed the self-report measures. Exclusion criteria included age (only adolescents participated in the study), missing data, or misreporting. The inclusion criterion was age, namely, youth that were 13–17 years old.

Recruitment and data collection were conducted at each of the foster care sites and schools. We did not advertise the study outside of the sites that we selected for recruitment. We identified the larger foster care sites in the city of Quito and presented an overview of the aims of our research study. Similarly, we approached two large public schools to recruit non-foster care adolescents.

Before recruitment and data collection started, we arrived at each foster care site or school and talked to the proper authorities. We presented them with an overview of our study (aims, procedures, etc.). They gave us guidelines of which days and times were best to recruit participants and start data collection. This was done to ensure that we had approval to recruit participants and collect data at each site. In addition, we wanted to make certain that we would not disrupt any scheduled activities. Once we were given approval to start data collection, we arrived at each site at a designated time and presented the study to large groups of adolescents, and verbally described the study to them and answered any questions. This allowed us to identify adolescents interested in participating so that we could review the informed consent document with them and their parents or legal guardians in detail. We then obtained written informed consent from parents or legal guardians as well as from the adolescents.

2.2. Participant Characteristics

Two hundred and two participants consented to the study, but 21 were excluded because of inconsistent reporting, missing data, or because of they were older than 18. Our final participant number was 181 adolescents, 56 were in foster care and 123 participants lived with their families (non-foster peers). The age range was 12–18 and the average age was 15.59 (SD = 1.4), and there was no significant age difference between groups (p > 0.240).

There was a significant difference in the distribution of gender between groups X^2 (1, N = 181) = 7.30, p < 0.010. In the foster care group, there were 21 females and 37 males, and in the non-foster group there were 71 females and 52 males (total sample: females n = 92, and males n = 89). For this reason, we included gender as a covariate in all analyses.

Most participants were students (n = 141), 22 adolescents were students and working at the same time, and 19 did not respond to this question (no significant group differences). Foster youth had significantly lower grades (M = 7.20, SD = 2.66) when compared to non-foster peers (M = 8.20, SD = 0.80), $t(86) = -2.76$, p < 0.010. Most of the participants were from Ecuador (n = 156), other nationalities included Colombia (n = 6), Spain (n = 2), and Cuba (n = 2), and 15 participants did not report their nationality.

Reasons for individuals being in foster care were provided by the care staff in the group homes. These were: abandonment (n = 10), negligence (n = 13), physical abuse (n = 9), parents with substance abuse issues or mental health difficulties (n = 2), war refugee (n = 1), and orphans (n = 3). For the remaining 18 participants, information on events preceding foster care were not provided to us. The average amount of time in foster care was 6.4 years (SD = 3.48), ranging from less than a year to 13 years.

2.3. Measures

The Cognitive Emotion Regulation Questionnaire (CERQ) [27] is a 36-item questionnaire developed to assess the use of cognitive emotion regulation strategies when people are confronting adverse situations. It uses a 5-point Likert scale (0 = never, 5 = always). In this study, we used the validated Spanish version [28]. The CERQ has been validated to be used in normal populations, and adolescents ages 12 years and over, including Spanish-speaking adolescents [29]. There are 9 subscales divided into positive and negative: self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and refocus to planning [28]. The current sample had a Cronbach's α of 0.88.

The Multidimensional Scale of Perceived Social Support (MSPSS) [30] is a 12-item questionnaire designed to assess perceived social support from family, friends, and significant others. It uses a 5-point Likert scale (0 = strongly disagree, 5 = strongly agree). We used a Spanish version of this questionnaire. Although originally validated in a college student sample, it has been validated for use with younger adolescent samples [31]. In the current sample, the Cronbach's α was 0.89.

2.4. Statistical Models

All the analyses were carried out using IBM SPSS Statistics 21.0 (IBM Corp., Armonk, NY, US). We excluded participants that were older than 18 years old so that we only included adolescent participants in our analyses. "Control" participants that indicated that they had been in foster care in the past were also included. For all analyses, we had gender as a covariate, because there were differences in gender between the two groups.

Linear regression was used to test the first aim, examining whether being in foster care was related to perceived social support. The dependent variable was social support and the independent variable entered in the regression model was group (foster care/control).

Regression models were used to test the second and third aim of testing whether foster/control group membership and social support were associated with emotion regulation skills. We had 9 models for each emotion regulation skill subscale of self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and refocus to planning.

Finally, we conducted supplementary analysis examining if social support mediated the relationship between foster care status and emotion regulation skills, or if foster care status moderated the relationship of social support and emotion regulation skills.

3. Results

3.1. Foster Care and Emotion Regulation Skills

Using linear regression, we found that controls reported significantly higher social support ($\beta = -0.92$, $t(181) = 4.47$, $p < 0.001$). Foster care status also explained a significant portion of the variance ($R^2 = 0.10$, $F(2178) = 9.97$, $p < 0.001$).

We also used linear regression models to test if the foster group and social support were associated with the use of each of the emotion regulation skills of self-blame, other-blame, rumination, catastrophizing, putting into perspective, positive refocusing, positive reappraisal, acceptance, and refocus to planning. Due to the number of analyses, we implemented a Bonferroni correction and set the p value at 0.005.

We found that the control group reported using significantly more emotion regulation skills, specifically: acceptance, rumination, refocusing to planning, and self-blaming compared to the foster care group (Table 1). Foster care status was not associated with the use of blaming others, putting into perspective, catastrophizing, positive reappraisal, or positive refocusing (ps > 0.05) as emotion regulation strategies.

Table 1. Dependent variables that were significantly associated with foster care status.

Dependent Variables	β Coefficient	t-Value	Variance Explained
Acceptance	1.89	$t(181) = 3.12$, $p = 0.002$	$R^2 = 0.06$, $F(2, 178) = 11.18$, $p < 0.001$
Rumination Subscales	3.06	$t(181) = 4.68$, $p = 0.000$	$R^2 = 0.11$, $F(2, 178) = 21.67$, $p < 0.001$
Refocusing to Planning	2.00	$t(181) = 3.28$, $p = 0.001$	$R^2 = 0.10$, $F(2, 178) = 18.65$, $p < 0.001$
Self-Blaming	2.42	$t(181) = 4.53$, $p = 0.000$	$R^2 = 0.11$, $F(2, 178) = 20.86$, $p < 0.001$

Greater social support was associated with more use of positive emotion regulation strategies, specifically: positive reappraisal, positive refocusing, and refocusing to planning, and less catastrophizing (Table 2). Social support was not associated with the use of emotion regulation skills of acceptance, blaming others, putting into perspective, self-blaming, or rumination (ps > 0.05).

Table 2. Dependent variables that were significantly associated with social support.

Dependent Variable	β Coefficient	t-Value	Variance Explained
Refocusing to Planning	0.62	$t(181) = 2.95$, $p = 0.004$	$R^2 = 0.14$, $F(2, 178) = 8.70$, $p = 0.004$
Catastrophizing	−0.55	$t(181) = -2.40$, $p = 0.017$	$R^2 = 0.02$, $F(2, 178) = 5.78$, $p = 0.017$
Positive Reappraisal	0.74	$t(181) = 3.64$, $p = 0.000$	$R^2 = 0.12$, $F(2, 178) = 13.21$, $p < 0.001$
Positive Refocusing	0.56	$t(181) = 2.31$, $p = 0.022$	$R^2 = 0.04$, $F(2, 178) = 5.33$, $p < 0.050$

3.2. Supplementary Analysis

We used linear regression analysis to determine if social support had a mediating role in the relationship between foster care and emotion regulation skills, but this was not

significant (ps > 0.05). Finally, we tested the moderating effects of foster care status on the relationship between social support and emotion regulation skills using linear regression but did not find a significant association (ps > 0.05).

4. Discussion

The purpose of this study was to evaluate the association between social support and foster care status with the use of emotion regulation skills among Ecuadorian adolescents. Consistently with the literature, we found that adolescents that were in foster care reported less perceived social support. Indeed, previous findings suggest that foster care may not provide adequate social–emotional support for adolescents [32].

The non-foster care group conversely reported using significantly more positive emotional regulation skills, specifically acceptance and refocusing to planning, than the foster care group. However, we did not anticipate that the non-foster group would also use more negative emotion regulation strategies such as rumination and self-blaming. These results are inconsistent with previous findings that foster care children engage in more internalizing behaviors [12], which would include rumination. This also contradicts previous findings that adults who were mistreated as children are more likely to engage in rumination [33] and other maladaptive coping strategies [34]. Overall, these findings indicate that the foster care group is not entirely maladjusted and has possibly developed other more adaptive coping strategies in place of ruminating and self-blaming. Indeed, research suggests that foster care youth are more independent and self-reliant, which bolsters their resilience [35].

Our results also suggest that the non-foster care group generally used more emotional regulation strategies, both adaptive and maladaptive, compared to the foster care group. One possible explanation is that the non-foster care group had more opportunities to model adaptive and maladaptive emotion regulation strategies by observing their caregivers. In contrast, the foster care adolescents might have experienced lower attachment security with their caregivers and had less opportunity to model and use emotion regulation strategies, as suggested by previous findings [1,11] This is particularly relevant for this study as the adolescents in this sample were placed in a group homes rather than family homes, so they had significantly less exposure to adult caregivers than non-foster care and even family-based foster care youths. Adolescents in group homes may rely more on peer support and may have few opportunities to acquire emotion regulation skills from adults, whether adaptive or maladaptive. Indeed, a meta-analysis of several studies revealed that children in family-based foster care had fewer internalizing behaviors, externalizing behaviors, and a better perception of care, compared to foster care children in group homes [36]. Other studies suggest that children placed in group homes have more difficulties with learning and behavioral problems than children in family-based foster care [37].

Finally, we found that greater perceived social support was associated with the use of more adaptive emotion regulation strategies and less use of maladaptive strategies, independent of foster care status. Specifically, we found that social support was related to greater positive reappraisal, positive refocusing, and refocusing to planning, and less catastrophizing. This is consistent with research findings suggesting that having a supportive family environment is important in the development of emotion regulation strategies [11,16]. This also contributes to research findings that suggest that a lack of social support and difficulties in emotion regulation are associated with childhood abuse and mental health symptoms [38].

Overall, these results would seem to suggest that the experience of being in foster care might not provide sufficient social support and this could hinder the use of healthy emotion regulation skills. This would be consistent with previous literature that indicates that the lack of social support mediates the relationship between childhood neglect and emotional difficulties [39]. However, in this study, we did not find that social support

significantly mediated the relationship between foster care status and emotion regulation skills. In addition, we did not find that foster care status moderated the relationship between social support and emotion regulation skills. Indeed, we found that foster care status is associated with certain emotion regulation skills independently of social support. In addition, the emotion regulation skills that were significantly associated with foster care status (acceptance, rumination, self-blaming) were different than those associated with social support (catastrophizing, positive reappraisal, positive refocusing). The only emotion regulation skill associated with both social support and foster care status was refocusing to planning. This could provide a framework to structure interventions specifically targeting certain emotion regulation strategies, such as acceptance and refocusing to planning, in foster care youth.

Overall, our findings also highlight the role that social support has in healthy coping, independent of foster care status. In this study, we used the MSPSS which assesses social support by evaluating if the adolescents have a special person (family, friends, or significant others) who is around when they are in need and with whom they can share their joys and sorrows. In a foster care system with group homes, adolescents and children may have to resort to getting support from friends. However, studies suggest that having a stable relationship with an adult is important for emotional development. Indeed, adolescents in foster care that have a significant relationship with an adult are more resilient [40]. On the other hand, children that had instability in their relationships with their caregivers had more behavioral problems [41]. This suggests that foster care youth might benefit from caregivers cultivating stable individual relationships with them. Indeed, research findings suggest that promoting nurturing, sensitive caregiving increased the use of emotion regulation skills among young children in foster care and attachment-based caregiving interventions reduce children's emotion dysregulation [13]. This study could help inform interventions that could be implemented in group homes focused on solidifying relationships between youth and caregivers in the Ecuadorian foster care system.

We also found that the foster care group had a lower grade point average than their non-foster peers, which is congruent with previous findings that indicate that foster care youth underperform academically [9]. However, we did not find that this was related to their emotion regulation abilities or social support. Therefore, it is possible that this has more to due to the education infrastructure and lack of oversight in the group homes than the adolescent's general abilities or capabilities, as other studies have found [36]

The findings in this study need to be considered in light of several limitations. This was a cross-sectional study, so we were not able to examine the relationship that social support and emotion regulation have across time. This also limited our capacity to evaluate the enduring and long-term effects of diminished social support and foster care status on emotion regulation skills. We also did not assess the impact of social support on mental health outcomes, or social adjustment. It is also important to note that although the MSPSS has been validated in various Spanish-speaking populations, including Colombian adolescents [42], Hispanic immigrants living in the US [43], and Spain [44] it has not been previously used or validated in adolescents in Ecuador. Similarly, the CERQ has been validated with Spanish adolescents [28,29,45] but not in Ecuadorian adolescents. There may be cultural variations in language that could have impacted the comprehension and response to these questionnaires in our sample.

This study contributes to a small body of literature examining the impact of foster care and social support on specific emotional regulation strategies in adolescents from developing countries. Further research is needed to fully understand all the underlying factors surrounding attachment security, early life maltreatment, and its influence on emotion regulation and, ultimately, on adjustment and functioning in these neglected populations. This research could ultimately inform interventions in foster care settings targeting social support and emotion regulation skill acquisition.

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Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available as such dissemination was not declared in the ethics committee application and was not consented to by the research participants.

Conflicts of Interest: The authors declare no conflict of interest.

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