



The attitudes of medical professionals toward children and children at risk of separation from parents in Eastern Europe

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ARTICLE INFO

Keywords:

Children
Attitudes
Affect
Eastern Europe
Institutional care
Medical professionals
Disability

ABSTRACT

This article reports the findings of a multi-country study of medical professionals' perceptions and evaluations of children. The primary aim of the study was to establish the perceptions medical professionals working in three Eastern European countries (Romania, Bulgaria, Moldova) hold toward children identified as “typical”, “at-risk” and “with disability”. A second aim was to explore the existence of country-level differences in medical professionals' perceptions of children. The third aim was to examine the pattern of associations between attitudes toward children and a change in use of institutional care to family and community-based alternatives. Over 800 respondents provided survey responses using paper-based and online returns. Findings indicated that positive affect toward children was associated with the favourability of attributes generated about “typical” children. In contrast, positive affect toward children was associated with less favourability toward at-risk children. Attribute favourability ratings generated for at-risk children were positively associated with attributes generated for children with disability. Differences were identified between respondents working across the three countries. No association was identified between attitudes toward children and endorsement of a statement supportive of de-institutionalisation as part of child protection reforms. These findings illuminate how children are conceptualised and understood by a group of medical professionals who hold considerable sway over decisions and recommendations about their relative risk and vulnerability.

1. Introduction

Globally, up to eight million children are growing up in institutional care (Csaky, 2009; Dozier, Zeanah, Wallin, & Shauffer, 2012). Institutional care infringes a child's right to a family life, as set out in the United Nations Convention on the Rights of the Child (UNCRC). The United Nations General Assembly endorsed the [United Nations General Assembly \(2010a\)](#), which set the overall objective to gradually eliminate institutional care and recommend governments to develop de-institutionalisation strategies and national action plans. There was a particular focus within the Guidelines on ceasing the use of large institutional settings for all children and young people, and that all children under 3 years should be cared for in family-based settings. Despite tremendous progress achieved in deinstitutionalisation over the past 15 years, especially in Central and Eastern Europe, the challenges remain significant. Disabled children remain over-represented in institutions, as do those whose families struggle to care for their children because of factors associated with poverty and social exclusion (Browne & Hamilton-Giachritsis, 2005).

It is well documented that children's emotional, social, physical, and cognitive development is adversely affected within large institutions, particularly when exposure occurs early in the life course and extends beyond six months (e.g. Sonuga-Barke et al., 2017). Children struggle to form secure attachments in institutions, particularly in the context of high staff-child ratios (Dobrova-Krol, Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2010), and there is a higher rate of disorganised attachment present than in other vulnerable populations (O'Connor, Bredenkamp, & Rutter, 1999; Zeanah, Smyke, Koga, & Carlson, 2005). Children's physical development has also been shown to be profoundly affected by institutional living, with considerable gains reported in height and weight for children moving to foster or adoptive families (Johnson et al., 2010; Van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2007). Similarly, cognitive development is adversely affected by institutionalisation, particularly in relation to IQ score, executive functioning and attention (Gunnar & Quevedo, 2007; McDermott et al., 2013; Nelson et al., 2007; Van IJzendoorn & Sagi-Schwartz, 2008). The developmental impact of institutional care on cognitive functioning can continue despite moving to alternative forms of care such as fostering

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and adoption. Although there is evidence of developmental ‘catch-up’, some difficulties have been shown to persist (Rutter, 1998; Sonuga-Barke et al., 2017; Zeanah et al., 2003). Children are also at risk of abuse within institutions (e.g. Rus et al., 2013). Yet many countries continue to place children in large institutions as a matter of preference, despite considerable evidence regarding the damaging effects on their development and welfare.

The United Nations General Assembly (2010b) emphasise that in order for deinstitutionalisation to be practically possible, a range of appropriate community-based alternatives should be developed, resourced and supported. These include children being supported to remain with their birth families, kinship care, foster care, small group homes and adoption. However, alongside the practical provision of these resources, a shift in the mindset of governments, donors to institutions and those in direct practice has been highlighted as being necessary (Dozier et al., 2012). Until the value of supporting children to remain with their families (especially those living in poverty and those with disabilities), and the appropriateness of and preference for community-based alternatives in promoting healthy child development is present, it has been argued that investment in and use of institutions will persist (Dozier et al., 2012; Williamson & Greenberg, 2010).

Linked to the use of community-based alternatives for children unable to remain with their birth parents, is the increased emphasis that has been placed on children having the capacity to able to participate meaningfully in decisions being made about them. As Cashmore (2002; 838) notes, for children in care, “participation has the potential to accord children recognition as well as protection”. Article 12 of the United Nations Convention of the Rights of the Child states that children have the right to express their views, ‘freely in all matters affecting the child [with] the view of the child being given due weight in accordance with the age and maturity of the child’. The United Nations Convention on the Rights of People with Disabilities (2009) also emphasises the rights of disabled children to meaningful participation in discussions about their lives. As Stalker and McArthur (2012: 173) note, ‘disabled children are children first and foremost’. How children and childhood are conceptualised by professionals is therefore important for gaining insight into the psychological processes that underlie and contribute to decision-making about children’s residential arrangements.

The present study focuses on medical professionals’ conceptualisation of children in three Eastern European countries: Bulgaria, Moldova and Romania. In rural and urban areas of all three countries, mother and child care, as well as reproductive health, are reported to be tasks for family doctors or primary care physicians (including routine antenatal care, immunization and paediatric surveillance; WHO Regional Office for Europe, 2012a, 2012b). The WHO reports that challenges remain in ensuring access for some groups to high quality children care services, including those living in rural areas, the Roma population and children with disabilities (Rechel, Blackburn, Spencer, & Rechel, 2009). Many countries in Eastern Europe continue to have a medicalised care system and the engagement of the medical professional in deinstitutionalisation and child protection reform remains problematic. Some authors have discussed their findings in relation to a ‘defectology tradition’, whereby families are regarded as unable to meet the complex needs of disabled children with institutions regarded as the preferred option (Tobis, 2000; Tomescu-Dubrow, 2005). A pervading ‘rescue mentality’, coupled with a focus on ‘inadequate’ parenting, has meant that paternalistic policies ensure a continued reliance on institutional care for children (Bilson & Markova, 2007). Furthermore, medical professionals in some countries have been seen to have a vested political and financial incentive to support institutional care for vulnerable and at-risk children (Dozier et al., 2012).

Medical professionals involved in supporting children in care and at risk of separation are at the forefront of the effects of a challenging set of economic and social circumstances that currently characterise a number of Eastern European countries. This is evidenced, in part, by

Romanian data revealing that the majority of instances whereby children are apparently abandoned by their caregiver take place in maternity wards, closely followed by hospitals and paediatric wards (Dickens & Serghi, 2000). The underlying decision making processes that occur within healthcare systems in relation to such cases are not clear and nor are the likely complex views of professionals who undertake assessments of children and make recommendations for care arrangements in hospitals and clinics. Stativa, Anghelescu, Mitulescu, Nanu, and Stanciu (2005) described a fear among professionals engaged in child protection that child-focused reform may have turned parents into dependents of their children, with parents’ access to certain benefits dependent on the presence of their children. More recently, Bilson and Larkins (2013) reported that parents of disabled children in Bulgaria were advised by medical staff in hospitals to give up their children into out-of-home care facilities. Parents complained that they were given no offers of support for children when making the decision whether to keep their child. State care for disabled children in Romania and Bulgaria is reported to be underfunded and inadequate, adding to the pressure on medical professionals and medical facilities in caring for children both in care and at risk of separation and apparent abandonment (Bilson & Larkins, 2013).

The overarching aim of this study was to evaluate the knowledge, attitudes and professional experiences of a group of medical professionals toward children identified as at risk of separation or those in care in Romania, Moldova and Bulgaria. Identifying the attributes that health professionals working in Eastern Europe associate with children, particularly vulnerable children, will highlight how children are conceptualised and understood by this professional group, and some of the possible influences present when medical professionals make decisions and recommendations about children’s risk and vulnerability. The findings could, in turn, assist with the formulation and implementation of alternative models of family-based care, and could contribute toward the development of necessary policy and legislation that moves toward deinstitutionalisation.

Our approach regarding how to study medical professionals’ perceptions of children was informed by the social psychological literature on the topic of attitudes. An attitude refers to an individual’s overall evaluation (e.g. like-dislike) of an object. Predominant theories conceptualize attitudes as having affective and cognitive components. The affective component refers to feelings or emotions an individual associates with the attitude object, whereas the cognitive component refers to beliefs or attributes that an individual associates with an attitude object (see Maio & Haddock, 2015). Attitudes are important because they influence how people process information and how they behave. A large amount of research has considered how individuals evaluate social groups in their environment. However, most of this literature has assessed evaluations of groups that can be differentiated on the basis of race, ethnicity, gender, or sexual orientation. As it stands, the literature assessing attitudes toward children is sparse, and the research that has been conducted has addressed issues such as whether outgroup children are perceived more negatively than outgroup adults (e.g. Wolf, Maio, Karremans, & Leygue, 2016) and whether adults, children and teachers show preferences for White versus Black children (e.g. Baron & Banaji, 2006; Downey & Pribesh, 2004; Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014). To the best of our knowledge, no empirical research has addressed how medical professionals evaluate children, whether they evaluate typical, at-risk, and children with disabilities with differing levels of favorability, and whether their evaluations impact the decisions they make about children’s medical care. The current study addresses this gap.

We had three research aims:

1. Establish the perceptions medical professionals working in three Eastern European countries hold toward children identified as “typical”, “at-risk” and ‘with disability’.
2. Explore the existence of country-level differences in medical

professionals' perceptions about children.

3. Examine the pattern of associations between attitudes toward children and a change in use of institutional care to family and community-based alternatives.

2. Method

We conducted an online anonymous survey of all medical professionals working in Bulgaria and Romania via County Health Agencies using Qualtrics software. It was not possible to distribute the survey in Moldova via the internet because of intermittent/unreliable access. The Ministry of Health issued and sent letters with paper copies of the questionnaire to the heads of Family Medical Centres across the country. In addition, medical professionals were also invited to participate as part of announcements at general meetings of specialists in maternal and child health in the country and via word of mouth. Questionnaires were distributed with paid postal return. Instructions explained that the focus of the survey was medical professionals' role, experiences and perspectives on working with at risk and disabled children and their families. Participation was highlighted as *entirely voluntary and anonymous* and participants were able to withdraw from the study at any time without explanation. The survey was designed to take approximately 15 min to complete. When answering questions about children, participants were asked to think about children aged under 18 years old. Ethical approval for the study was granted by the School of Psychology ethics committee at Cardiff University. The survey was presented in English, Romanian, Moldovan and Bulgarian with respondents able to select the language of choice for question completion. The survey was translated and back-translated by native speakers.

Over 800 medical professionals working across the three countries returned questionnaires. The majority of responses were received from general practitioners ($n = 588$) and paediatricians ($n = 116$) with responses also received from family medics, neonatologists, and nurses ($n = 110$). Over 80% of respondents had been working in their current role for over a decade. The majority of responses were received from women (87%), which may be reflect the greater interest among women in the survey, that more women were engaged in professional practice with children compared to men and also that the respondents were surveyed in countries with large numbers of women physicians (e.g. Romania and Bulgaria both have over 50% women physicians; [http://ec.europa.eu/eurostat/statisticsexplained/index.php/File:Physicians,_by_sex,_2014_\(%25\).png](http://ec.europa.eu/eurostat/statisticsexplained/index.php/File:Physicians,_by_sex,_2014_(%25).png)) (downloaded 05/01/17).

Other participant characteristics are summarised in Table 1. Some differences were identified between respondents who moved through

Table 1
Participant characteristics.

		N	%
Citizenship	Romania	123	15.2
	Moldova	520	64.2
	Bulgaria	164	20.3
Gender	Male	105	13.0
	Female	701	87.0
Age	25–35	71	8.7
	36–45	168	20.7
	46–55	303	37.3
	56–65	246	30.1
	Prefer not to state	26	3.2
Place of work	Rural area	164	20.6
	Urban area	634	79.4
Primary place of work	Outpatient clinic/polyclinic	469	53.7
	Private practice	145	16.6
	Hospital	94	10.8
	Hospital children's ward	34	3.9
	Institution for children	14	1.6
	Other (general practice/health centre)	105	12.0

all questions as part of the survey and those who terminated/ended survey completion before reaching the final questions. Specifically, there was an association between completing the survey and whether or not the respondent was working in a rural or urban area (complete surveys were received from 96% of urban respondents and 89% of rural respondents; $X^2(1, N = 787) = 12.805, p < .01$), the gender of the respondent (complete surveys were received from 95.4% of women and 90.3% of men; $X^2(1, N = 796) = 6.318, p < .05$) and the citizenship of the respondent (complete surveys were received from 99.8% of Moldovans, 97.6% of Bulgarians versus 69.1% of Romanians; $X^2(2, N = 807) = 189.279, p < .01$). There was no association between completing the survey and the age range of the respondent ($X^2(4, N = 803) = 2.876, p = .579$).

Little's MCAR test (Little, 1988) indicated that it was unlikely that the demographic data and study variables were systematically missing, and could be treated as if missing completely at random, $\chi^2(8356, N = 814) = 7700.56, p = 1.000$.

3. Measures

The survey included questions that assessed respondents' roles and responsibilities, the professional groups they routinely liaised with regarding children in their care, their evaluations of 'typical children', 'at-risk children', and "children with disability" as well as the type of problems (physical, psychological, social) they came across among the children in their care. We also asked respondents about their attitudes toward general principles of medical professionalism in relation to working with vulnerable children, including the primacy of child welfare, child protection, and the role of the family in decision making. Finally, respondents were asked about their knowledge of community-based alternatives and continuing care within the family (compared to institutionalisation), and their willingness to consider alternative ways of working. The research aims are primarily addressed using quantitative approaches to data analysis with supplemental information obtained by scrutinising word frequency occurring as part of free responses questions included in the survey.

3.1. Assessment of attributes ascribed to typical children, at-risk children, and the child with disability

To assess the cognitions respondents associated with children, the study used a psychometrically validated open-ended approach in which participants were asked to consider the attributes they associated with each of the three target categories (see Esses & Maio, 2002; Haddock & Zanna, 1998). For example, with respect to the category typical children, participants were asked to 'Think about the typical child. Try to visualize him or her and fill in the following statements with what comes to mind (a maximum of three rows were presented to populate with an adjective, 'The typical child is ___)'. Having completed this task, participants were asked to decide for each characteristic whether it was positive, negative or neutral. Specifically, they indicated using a radial dial (if completing online) or else by circling the appropriate response, whether the characteristic was slightly positive (assigned a score of 1), quite positive (2), extremely positive (3; for positive characteristics), slightly negative (-1), quite negative (-2), extremely negative (-3; for negative characteristics), or else neutral (0). Scores were averaged across the listed attributes to provide an overall score of attribute favorability for each of the three groups of children. Thus, for each group of children scores could range from extremely positive (3) through neutral (0) to extremely negative (-3). This type of measure has been used in many lines of research (for reviews see Esses & Maio, 2002; Haddock & Zanna, 1998; see Maio & Haddock, 2015, for a summary).

3.2. Assessment of affective responses to children

To assess the affective responses individuals associated with

children, respondents were asked, ‘We are interested in how children make you feel. Please list only the emotions that are relevant, that is, feelings that you experience when you see, meet or think about children’. Respondents were asked to list only the emotions that were relevant, that is, feelings they experienced when they met, saw or thought about children. Respondents could generate up to three feelings. Having completed this task, they were asked to decide for each feeling whether it was positive, negative or neutral and indicate whether it was slightly positive (assigned a score of 1), quite positive (2), extremely positive (3; for positive characteristics), slightly negative (–1), quite negative (–2), extremely negative (–3; for negative characteristics), or else neutral (0). Scores were averaged so that the affective response to children could range from extremely positive (3) through neutral (0) to extremely negative (–3).

3.3. Assessment of attitudes to de-institutionalisation

We asked respondents free response questions that asked them to comment on up to three advantages and up to three disadvantages of institutional care for children. A final question asked respondents to use a sliding scale anchored by 1 (low agreement) and 10 (strong agreement) to show the extent to which they agreed with the statement ‘I believe we should transition from institutional care to family and community-based alternatives.’

4. Results

4.1. Working practices

The responses revealed that medical professionals regularly liaised with a range of other professionals as part of their work with children. Almost three quarters of medics regularly liaised with social workers or child protection professionals (72%). Over half (57%) reported regularly liaising with psychologists, 54% with speech therapists, 55% with physiotherapists, 43% with teachers, and 52% with other educators. A smaller percentage of respondents regularly liaised with non-government organisations (NGOs; 28%). Respondents also liaised with others within the medical profession including general practitioners (57%), paediatricians (80%), obstetricians (49%), nurses (71%) and psychiatrists (57%).

Respondents were divided regarding whether or not children themselves were *currently* involved in making decisions about placement away from their family in out-of-home care and whether children *should* be involved in making such decisions. Seventeen percent of professionals reported in relation to current practice that they often or always consulted children, compared with 62% who never or rarely involved children in decision making (22% reported that children were sometimes consulted). These percentages were almost inverted for the question of who *should* be consulted about placing a child away from their family: 13% percent stated the child should never or rarely be consulted while 51% stated a child should be often or always consulted (36% endorsed ‘sometimes’).

Turning to the consideration of who medical professionals used to establish whether a child is at risk, respondents again endorsed a range of different organisations and sources of expertise. The results revealed that medics most frequently reported consulting family members i.e. 75% consulted other relatives (besides parents), 50% consulted parents and 67% used information provided by the child. Respondents also obtained information from teachers (73%), social workers (72%), paediatricians (54%), nurses (61%), general practitioners (51%), other medics (37%), the police (58%), child protection services (61%), school services (44%) and psychologists (45%). The percentages of respondents consulting other professionals were lower (e.g. judiciary, 15%; NGOs, 15%; physiotherapists, 11%).

Table 2
Frequency of generation of first positive and negative attributes for each group and descriptive statistics for the typical child, at-risk child and child with disability.

	Positive			Negative		
	n	Mean	SD	n	Mean	SD
1. Typical child	429	2.18	0.81	28	–1.39	0.69
2. At-risk child	74	1.47	0.71	364	–1.76	0.80
3. Child with disability	95	1.77	0.88	299	–1.77	0.81

4.2. Attributes generated about children

The most frequently mentioned attributes respondents used to describe children provided an initial insight into how medical professionals conceptualised children and childhood. The typical child was most frequently characterised as healthy, active, happy, developed, curious, cheerful, joyful, well and educated. At-risk children were most frequently characterised as scared, sad, anxious, aggressive, vulnerable, untidy, restless, neglected and abandoned. Children with disability were most frequently described as helpless, limited, dependent, passive, sad and shy.

Table 2 shows the number of *first* responses generated as characteristics for each of the three target groups of children. For example, 436 respondents self-categorised the first trait they generated for the typical child as positive. The average score for this first characteristic was 2.24 ($SD = 0.93$). In contrast, just 28 respondents generated a trait they categorised as negative for the typical child with the average score being –1.39 ($SD = 0.69$). This pattern of generativity was reversed for the at-risk child and the child with disability. The first characteristic generated for the at-risk child was characterised as positive for 74 respondents ($M = 1.47$, $SD = 0.71$) contrasted with 364 responses self-categorised as negative ($M = –1.76$, $SD = 0.80$). Likewise, respondents generated 95 positive responses as the first characteristic for the child with disability ($M = 1.77$, $SD = 0.88$) compared with 299 responses characterised as negative ($M = –1.77$, $SD = 0.81$). The ten most frequently mentioned words respondents used to describe their feelings about children were that children made them feel, ‘happy’, made them ‘smile’, feel ‘positive’, ‘responsible’, ‘joyful’, ‘good’, ‘better’, ‘optimistic’, ‘careful’ and ‘young’. Table 3 presents descriptive statistics and the Pearson product-moment correlations between the scores provided for the averaged scores for affect experienced toward children, the averaged scores for attribute favourability toward *typical children*, *at-risk children*, and *the child with disability* and agreement with the attitudinal statement about deinstitutionalisation. The mean attribute favourability score for typical children was higher (i.e. more positive) compared to scores for at-risk children (mean difference = 3.20, $SD = 1.63$; 95% CI = 3.04, 3.36, $t(415) = 39.82$, $p < .001$) and children with disability (mean difference = 2.84, $SD = 1.81$; 95% CI = 2.65, 3.01, $t(387) = 30.71$, $p < .001$). The mean attribute favourability score for at-risk children was lower compared to the score

Table 3
Pairwise intercorrelations among selected study variables (n = 314–421).

	1	2	3	4	5
1. Valence of affect toward children	–				
2. Typical child attributes	.21**	–			
3. At-risk child attributes	–.15**	–.08	–		
4. Child with disability attributes	–.05	–.08	.46**	–	
5. In favour of a transition to alternative forms of out-of-home care	–.01	.01	.03	.01	–
Mean	1.91	1.90	–1.25	–0.91	8.15
Standard deviation	1.25	1.03	1.19	1.40	2.52

** $p < .01$.

for children with disability (mean difference = -0.28, SD = 1.34; 95% CI = -0.42, -0.15, $t(390) = -4.16, p < .001$).

The pattern of relationships revealed positive associations between affective responses toward children and attribute favorability about the typical child ($r(330) = 0.21, p < .001$). More positive affect toward children was associated with attributing more positive attributes to the typical child. Interestingly, a negative association was identified between affective responses toward children and attribute favourability for at-risk children ($r(325) = -0.15, p < .01$) and a non-significant association with attribute favourability for children with disability ($r(311) = -0.05, p > .10$). Attribute favorability responses for at-risk children and children with disability were positively associated ($r(391) = 0.46, p < .001$) but attribute favourability about typical children was not associated with scores derived in response to at-risk children ($r(416) = -0.08, p > .10$) and children with disability ($r(388) = 0.08, p > .10$).

Significant differences in affect about children and attribute favourability were identified based on country of citizenship. A one-way ANOVA with a Bonferroni correction indicated that Bulgarian respondents had more positive affective responses toward children compared to Moldovan and Romanian respondents ($F(2, 385) = 7.162, p < .01$). Moldovan and Bulgarian respondents had higher scores on attribute favourability for typical children compared to Romanian respondents ($F(2, 447) = 7.595, p < .01$). Romanian respondents had higher scores on attribute favourability to children with disability compared to Moldovan respondents ($F(2, 412) = 4.111, p < .05$). No other differences were found between countries (Table 4 shows mean values by country of citizenship). There was a difference between respondents in their attitude toward a transition from institutional care to family and community based alternatives based on country of citizenship ($F(2, 661) = 3.73, p < .01$). Romanian respondents were more favourable in attitude compared to Moldovan and Bulgarian respondents.

Rural respondents had lower scores (more negative) for affect toward children compared to respondents working in urban areas (rural $M = 1.60, SD = 1.29$; urban $M = 1.95, SD = 1.25$; $t(372) = -2.02, p < .05$, 95% CI of the difference = -0.69, -0.01). No differences were observed between rural and urban respondents with respect to attribute favourability for each of the three groups of children ($t(420) = -0.59$ to $t(432) = -0.93, p > .10$; see Table 5 for mean values).

No association was found between attribute favourability and affect about children with the assessment of attitudes toward de-institutionalisation (reflecting views on a move toward alternative forms of care for children away from their family of origin; $r(408) = -0.01$ to $r(397) = 0.03, p > .10$).

4.3. Perspectives on out-of-home care

Respondents provided information about their knowledge of residential options available for children without parental care in their region and the appropriateness of these types of placement. Table 6

Table 4
Means and standard deviations for affect toward children and attribute favourability as a function of country of citizenship (n = 388–450).

	Bulgaria		Moldova		Romania	
	Mean	SD	Mean	SD	Mean	SD
1. Valence of affect	2.33	1.12	1.79	1.29	1.72	1.19
2. Typical child attributes	2.06	1.06	1.94	0.99	1.50	1.07
3. At-risk child attributes	-1.35	1.13	-1.30	1.17	-0.93	1.31
4. Child with disability attributes	-0.98	1.35	-1.01	1.39	-0.49	1.48
5. Transition from institutional care	7.96	2.58	8.11	2.55	8.88	1.89

Table 5
Means and standard deviations for affect toward children and attribute favourability as a function of location of work.

	Rural		Urban		t	df
	Mean	SD	Mean	SD		
1. Valence of affect	1.59	1.27	1.95	1.25	-2.02*	372
2. Typical child attributes	1.79	1.10	1.91	1.03	-0.93	432
3. At-risk child attributes	-1.32	1.20	-1.24	1.19	-0.53	420
4. Child with disability attributes	-1.24	1.32	-0.89	1.43	-0.72	400

* $p < .05$.

shows that respondents generally reported that a range of placement types were available, including institutional care through to adoption. Over two thirds of respondents viewed institutional care as appropriate in the short term (67%) while a smaller percentage viewed it as appropriate in the longer term (16%). Respondents ranged in their endorsement of different arrangements as appropriate in the longer term with approximately a quarter to a third of respondents viewing foster care and small group homes as appropriate. Adoption was viewed as appropriate for longer term care by 44% of respondents.

Free response questions asked respondents to remark on the advantages and then the disadvantages of institutional care for children. The most frequent advantages cited were the access to medical care and education, as well as ‘supervision’, while frequently cited disadvantages were the absence of the family environment and meeting of psychological/emotional needs, particularly the lack of parental love/affection. Most respondents (73%) agreed with the statement, ‘I believe we should transition from institutional care to family and community-base care for children’ by selecting a value of 8 or higher on the 1–10 scale. While there were no sex differences in response to the statement regarding the transition from institutional care to family and community alternatives (male $M = 8.04, SD = 2.56$, female $M = 8.19, SD = 2.50$; $t(653) = -0.526, p > .10$, 95% CI -0.74, 0.43), respondents from urban areas were more strongly in favour of a transition away from institutional care compared to respondents working in rural areas (rural mean = 7.40, SD = 2.92, urban mean = 8.37, SD = 2.32; $t(652) = -3.580, p < .001$, 95% CI = -1.51, -0.44).

5. Discussion

Our findings provide novel insights into the attitudes toward, and approaches to, professional decision-making in relation to vulnerable children. A particular focus of the study was medical professionals' practices and perspectives in relation to children at risk of separation from their family of origin, and the appropriateness of using institutional care as an alternative arrangement. From an attitudinal perspective, the results of the present study offer novel insights into how medical professionals perceive and evaluate categories of children. There was substantial variability in the attributes associated with the typical, at-risk, and disabled child. Overall, typical children were associated with more positive attributes compared to at risk and disabled children, and at risk children were associated with more negative attributes than disabled children. Further, the favourability of respondents' attributes toward the categories showed different patterns of correlations with the affect participants associated with children. Interestingly, variability in the attributes people linked with categories of children and their feelings about children differed as a function of demographic variables including country of residence and primary location of work. Bulgarian respondents reported more positive affect toward children. Rural respondents had less positive affect toward the characteristic, ‘child’, and were less favourable toward a move away from institutional care. Moldovan and Bulgarian respondents were also less favourable toward such a move compared to Romanian respondents.

Table 6
The availability and appropriateness of alternative forms of care for children (N = 403–559).

	Available in region		Not available in region		Not sure if available		Appropriate in the short term		Appropriate in the long term		Not sure if appropriate	
	N	%	N	%	N	%	N	%	N	%	N	%
1. Institutional care	355	73	64	13	65	13	245	67	59	16	60	16
2. Foster care	366	72	63	12	77	15	226	53	145	34	52	12
3. Small group homes	342	67	77	15	91	18	348	65	145	27	39	7
4. Staff-led family-type homes	273	60	97	21	85	19	252	54	166	36	45	10
5. Social parent-led family type homes	180	43	95	23	139	34	262	61	85	20	19	5
6. Placement with kin	375	72	56	11	90	17	186	46	156	39	61	15
7. Adoption	471	85	28	5	54	8	274	49	248	44	37	7

Just half of the medical professionals who responded to the survey would consult parents when assessing risk to children. This finding is perhaps less surprising when placed within the context of respondents' views about the factors in a child's life that put their well-being at risk. Most respondents cited the family as the source of risk, including living in poverty/socio-economic conditions, low educational attainment of parents, family environment and the absence of affection. Poverty and socio-economic conditions were frequently identified as key contributors toward risk for children. Understanding more of medical professionals' framing of the social contexts that they perceive as giving rise to risk for children is important, because it helps us to consider some possible reasons why institutional care may continue to be advocated. The extent to which structural factors, such as poverty, are judged as the responsibility of the parents may contribute to the idea that the parents are in some way deficient. Taken with the characterisation of disabled children as passive, helpless and dependent gives some insight into why institutions may be perceived as the best place for some children to be protected and raised. The [United Nations General Assembly \(2010b\)](#) emphasise that structural factors such as poverty and socio-economic conditions should not be the sole reason for removing children from their family. Given the findings of this study, it is important to consider how to effectively impart this message to medical professionals in policy and practice. Continuing professional development training which focuses on a more holistic view of risk (taking account of individual, social and environmental factors) alongside the importance of family support provision would be beneficial. However, for this to be effective, it must be supported by appropriate family support provision in-country.

The findings concur with the view that Eastern European countries transitioning to capitalist economies continue to assess children with disabilities in terms of their limitations and not their potential ([Bilson & Markova, 2007](#)). Future research might explore such linkages in more detail; we found no evidence of an association between attitudes toward children and a move to de-institutionalisation but did identify some country-based differences in affect and attitudes toward children. This may point to the role of the broader social, political and economic context in which decisions relating to child protection are made.

Fewer than one fifth of professionals (17%) indicated that they consulted children as part of arriving at decisions about whether a child should be placed away from their family in out-of-home care. More work is needed to identify whether some children are routinely consulted as part of medical practice (by dint of their age, socioeconomic background, verbal fluency, physical ability) while other children are not. Moreover, the division between medical professionals with respect to consulting children about their removal into out-of-home arrangements, where 62% of professionals would rarely or never involve a child in such decisions, indicates that there is considerable variation within the profession in its decision making processes and views on best practice with regard to child protection activity. It is important to recognise and work with this variation in viewpoint, given that children caught up in a process of separation from their parents and removal to

large institutions have been characterised as weak actors in such transactions ([Tomescu-Dubrow, 2005](#)). Moreover, practitioners will vary in their interpretation of what it means to liaise with or consult families, including children in particular. We do not know if consultation was regarded by respondents as a dialogue, or to what extent a child's views are sought and genuinely heard as part of decision-making processes. It may be beneficial for medical professionals to have access to training and support which emphasises both the competency of children (including children with disability) to express their views, and the importance of meaningful consultation and dialogue with parents and children in order to promote greater participation in vital decision-making. Our finding that 87% of respondents endorsed the view that children *should* be consulted sometimes, often or frequently, in relation to out-of-home care indicates that such reform would be valued.

The average score for the single item measure of attitude to de-institutionalisation reflected attitude endorsement. The broader pattern of results, however, belies complex and multifaceted views from respondents about what circumstances would lead them to recommend that a child be placed away from parents in out-of-home care. The majority of respondents regarded institutional care as appropriate in the short term (68%) while 16% of respondents regarded it as appropriate in the longer term (another 17% were unsure). Indeed, responses to longer term out-of-home placement options were more varied in general, and there was apparently less certainty about which forms of placement were appropriate. This finding may also relate to the pace of reform within countries in relation to alternative forms of care for vulnerable children ([Bilson & Larkins, 2013](#)). Further research is required to understand why institutional care is regarded as an appropriate short term response for children deemed to be unable to live with their parents and when and why alternatives to large group arrangements are more or less likely to be used.

It is important to note that this research used explicit (i.e., direct) measures to assess evaluations of children. That is, participants were required to *directly* reflect on their views of children in responding to the questions. Contemporary attitude research has seen the development of various implicit (i.e., indirect) measures of attitudes, which were partially designed to try to circumvent concerns related to socially desirable responding. Given the procedural conditions of this research (e.g., some participants could only complete paper and pencil measures), we limited ourselves to the use of explicit measures of attitude. Future research should investigate respondents' perceptions using implicit measures, especially as explicit and implicit measures often predict different types of behaviour.

Our findings can be integrated with research that has studied the prevalence and implications of biases among medical professionals. A number of studies have revealed that doctors and nurses sometimes hold implicit negative stereotypes and attitudes toward particular groups. For example, [Moskowitz, Stone, and Childs \(2012\)](#) found that negative implicit attitudes and stereotypes about African Africans were prevalent among a sample of American doctors. More recent research has demonstrated that these implicit biases can impact doctors'

treatment decisions (see Hall et al., 2015; Zestcott, Blair, & Stone, 2016). As applied to the present context, future research can directly investigate how explicit and implicit evaluations made by medical professionals influence decisions about out-of-home placements, including the use of institutions, for children. In the context of research in Eastern European countries, it would also be important to consider attitudes to the Roma population, who are disproportionately represented in figures for children living in poverty and/or residing in state care (e.g. Rechel et al., 2009).

Some limitations of this study are noted. First, the survey asked questions about children in general. The rationale for this decision was that we wanted to minimise the possibility that respondents would consider a single exemplar, conceivably more likely if the category had been constrained. Of course, one implication of this process is that we do not know what age of child respondents visualised when generating attitudes and affect for children. The characteristics generated may vary quite considerably depending upon whether an infant, child or adolescent is visualised or whether more than one visualisation is generated to inform responses as part of completing the survey. Future research with medical professionals might explore the potential attitudinal differences that exist between child age groups and the implications for working practices. We also confined our assessment of affective responses to children to one question rather than assessing affective response to “typical”, ‘at-risk’ or ‘children with disability’ separately. Future research should consider using experimental paradigms to assess medical professionals’ perceptions and affective responses to children with a view to increased construct validity.

A second limitation of the study was that we did not have comparison data to ascertain whether the professionals who responded to our survey were representative of medics working across the three countries where data collection took place. In addition, a large proportion of survey responses were incomplete. We received a disproportionate number of responses, as well as complete responses, from medics working in urban areas (where internet connection is likely more reliable) and from women. The higher proportion of responses from women may reflect greater interest among women in the survey, that more women were engaged in professional practice with children compared to men and/or also that the respondents were surveyed in countries with large numbers of women physicians (e.g. Romania and Bulgaria both have over 50% women physicians; [http://ec.europa.eu/eurostat/statisticsexplained/index.php/File:Physicians,_by_sex,_2014_\(%25\).png](http://ec.europa.eu/eurostat/statisticsexplained/index.php/File:Physicians,_by_sex,_2014_(%25).png)) (downloaded 05/01/17). Both gender and geography may have influenced the pattern of responding and future research could aim to recruit a more diverse panel of participants. Likewise, fewer Romanian respondents completed all of the survey questions in relation to Bulgarian and Moldovan respondents. This may reflect motivational differences between participants living in different countries or issues relating to unreliable internet connection. Indeed, the highest level of responses was received from Moldova where data collection occurred using paper and pencil questionnaires. This is point to consider for future work.

The ways in which medical professionals characterise children based on their circumstances and disabilities has implications for how services are developed and deployed that affect children and their families, insofar as such characteristics are deemed to be problematic or intractable. Our findings suggest that an increased understanding of current attitudes and working practices in relation to child protection may contribute to the development of strategies for removing barriers to the use of alternative forms of care to institutionalisation, and facilitate positive engagement with different professional groups working directly with children.

Acknowledgements

This research was supported by an Economic Social Research Council (ESRC) Impact Acceleration Award to the first author. Dr.

Carolyn Sampeys (Designated Doctor, National Safeguarding Team; NHS Wales) and Dr. Delia Pop (Hope and Homes for Children) were central to discussions regarding the rationale for this research and co-lead a workshop event in Romania that considered how medical professionals in Eastern Europe engage with families living in poverty. The authors thank Audra Smith and Sarah-Jane Jones for research assistance. Sincere thanks also go to the staff at Hope and Homes for Children for their support with survey development, participant recruitment and translation.

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