

2007

Comparing kin and non-kin foster parents' emotional investment in their young children

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COMPARING KIN AND NON-KIN FOSTER
PARENTS' EMOTIONAL INVESTMENT
IN THEIR YOUNG CHILDREN

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The School of Social Work

by
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August 2007

DEDICATION

This work is dedicated to the memory of my parents, Ronnie Guy and Patricia (Guy) Rathbun. Although they each influenced me in different ways, it is because of them that I learned the value of hard work and persistence. They instilled in me the belief that one should not “go with the flow” and encouraged me to challenge and change things that I do not find acceptable. It is that belief that prompted me to return to school and work toward this degree. My mom would laugh and deny that she had anything to do with my successes in any of my endeavors, but she was my “secure base” and therefore I could not have achieved any of this without her love, acceptance, comfort, and support throughout my years.

ACKNOWLEDGEMENTS

I am forever indebted to many different people for their help, guidance, and support during the last few years.

Five years ago, I had the honor of meeting Dr. Charley Zeanah, who opened my eyes and heart to the wonder and the possibilities of Infant Mental Health. It was not until after our initial work together was completed did I truly realize what an amazing clinician, researcher, and visionary he truly is. It was his passion and genuine belief in our ability to intervene and change young children's lives that inspired me to return to school just one year after meeting him. He remained excited and encouraging about this project despite the delays, frustrations, and natural disasters that we experienced along the way, provided me with all of the data and resources that I needed, and was always responsive and helpful, no matter how late or frequent the emails or phone calls were. Even though this process was harrowing at times, this opportunity to work with Dr. Zeanah has been the greatest thing to happen to my career. I would also like to thank Dr. Zeanah's colleague, Dr. Anna Smyke, for her contribution to this project. Dr. Smyke served as a human database answering each and every question regarding the subjects in this sample, often times putting aside her own work to help further this project.

I cannot thank each and every one of my committee members enough for their unique contributions to this project. Dr. Daphne Cain was always so encouraging and available for any questions, and through working with her as a research assistant I discovered how enjoyable research could actually be. Dr. Catherine Lemieux was also very encouraging and quick with a joke about the misery that is writing a dissertation, while at the same time challenging me to "push the envelope" while always remaining grounded in the field of social work. Dr. Juan Barthelemy patiently took on my anxiety about statistics and never once laughed at the

ridiculousness of my questions! He worked with me quite a bit until all of the data were analyzed; if it were not for him, I would still be frozen and incapacitated in front of the SPSS screen. Dr. Thompson Davis was a fantastic Graduate School Representative. He was always quick to respond to concerns and meetings and fit right in with the other committee members. Most of all, you all worked together seamlessly and I benefited greatly from working with you. I cannot thank you enough for the time and effort you put into this project.

There are not enough words to describe the immense gratitude that I have for my committee chairperson, Dr. Timothy Page. I entered this program believing that I knew all there was to know about attachment and infant mental health, but Dr. Page gently helped me to discover that there were higher levels of knowledge in this field that I did not even know existed. Dr. Page has this unique ability to encourage and support my work while always pushing me to seek more and to do better. Each time I found myself satisfied with my work, he opened my eyes to how much better it could be, and now I can see the tremendous influence he has had on me as a researcher and scholar. Dr. Page has always been there for me with guidance and support academically and professionally, while teaching me tolerance and patience along the way! I have been so fortunate to find such a distinguished academician in my field who also has the same compassion and desire to improve the lives of young children; I entered this program with excellent clinical training, but Dr. Page was the one who helped me to set my sight on greater possibilities that may truly allow me to make a difference in this field. Tim, you have been the greatest mentor that I could have ever hoped for. Thank you.

I also have to thank the two other survivors of my cohort, Hee Young Kim and Martha Novoa. The last four years would not have been the same without you there to experience it with

me. Thanks for the lunches/de-briefing sessions, I could not have survived the program without them!

And finally I have to thank my family. Grant and Drew, you have been such troopers having a mom who is a professional student. You have been my sanctuary from the work; your little smiles and hugs can instantly and completely wash away any frustrations for me. Shane, I could not have done any of this without you. You supported me in every way possible, and I will forever be so thankful. I love you all with all my heart.

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ABSTRACT

In 2003, there were reports of child maltreatment affecting over 5.5 million children in the United States. As a result of this epidemic, over 500,000 children are in foster care with an estimated additional 300,000 in voluntary kin placements. Because of a shortage of foster families and resources, Child Protective Services (CPS) agencies routinely seek and give priority to family members to serve as foster families to maltreated children. There is a large body of research that demonstrates that children in kinship care are often at greater risk than those children placed in non-kin foster homes, particularly in terms of poverty, sub-standard housing, and receiving less support from CPS. Studies of foster care dyads have demonstrated that the degree to which a foster mother is emotionally invested in her foster child is an important predictor in the success of the placement. This study examined differences in emotional investment in foster children between kin and non-kin foster parents. Its primary hypothesis was that kin foster parents would express less emotional investment in their foster children compared to non-kin foster parents. Multiple regression analyses confirmed this expectation.

CHAPTER 1.
INTRODUCTION

Rationale

The Child Welfare System was born out of society's desire to alleviate the suffering of children whose parents were not able to adequately take care of them. At that time, in the latter half of the 19th century, the goals of the system were to mitigate the effects that poverty and other harmful environmental and parental characteristics had on vulnerable children, in effect to provide treatment to victims and families. As the number of children identified and the severity of their maltreatment and neglect increased, however, roughly in the last quarter of the twentieth century, the system began to refocus its efforts on the investigation and punishment of severe abuse rather than the prevention and treatment of child abuse and childhood poverty (Lindsey, 2004). This change in the system's approach to the problem of child maltreatment has led to an increase in children being removed from their homes and has been criticized by many researchers as being inadequate or ineffective, as evidenced by the increased numbers of reports of maltreatment and recidivism rates (Hetherington, 1998), the agencies' inability to cope with these large numbers of reports (Tomison, 1996), ineffective responses to children in real danger (Besharov, 1987), and an ineffective reliance on investigative approaches as opposed to treatment and prevention (Gibbons, Conroy & Bell, 1995).

The present state of the Child Protection Services (CPS) agencies and the statistics of child abuse and neglect indicate that these current approaches have been unsuccessful at reducing the incidents of child maltreatment. Hetherington (1998) suggests that CPS agencies use a more "integrated approach" to the problem of child

maltreatment, ensuring that there is a “focus on safety and risk issues as well as children’s needs, and the incorporation of formal assessment instruments” (p.121) when determining best practices and decisions concerning maltreated children. Bullock, Little and Mount (1995) argue that more attention should be given to the children who experience cumulative harm from highly critical and low-warmth environments in addition to those children who experience specific incidents of maltreatment.

These are a very few of the problems that are associated with many CPS agencies today. Even if agencies are able to resolve many of the problems in the investigation, treatment, and prevention of maltreatment in the future, there will likely always be children whose parents are unable to care for them appropriately. The safety and well-being of these children often necessitate their removal from their parents’ care and subsequent placement into foster care. Upon entering the foster care system, children often experience more challenges as they adjust to new caregivers and environments, sometimes experiencing multiple placements and attachment disruptions. Furthermore, foster mothers are often ill prepared to effectively respond to the emotional needs of a maltreated child (Dozier & Sepulveda, 2004). Without a caregiver who is able to effectively provide a sense of acceptance and security, a child faces elevated risk for stress-related problems and impaired capacities for self-regulation (Dozier, Higley, Albus & Nutter, 2002). In such circumstances, the hoped-for therapeutic effect of foster placement cannot be provided (Tyrell & Dozier, 1999).

Just as it is important for CPS agencies to become more effective in their approach to child maltreatment, it is equally important that their foster care systems offer effective, research based interventions and assessments. Foster mothers’ abilities and

desires to provide appropriate and enduring care for their foster children should be assessed before, or soon after, placement. One such assessment tool, the This is My Baby Interview (TIMBI) (Bates & Dozier, 2002), has demonstrated promise in identifying foster parents who are accepting of their foster children and committed to providing enduring care to them. These qualities, acceptance and commitment, together with the foster mother's belief in her ability to influence the child's development, have been conceptualized as emotional investment. The emotional investment expressed by foster mothers toward their foster children has been found to be significantly associated with children's representations of self (Ackerman & Dozier, 2005), the level of support offered by foster mothers during a problem solving task (Bates & Dozier, 2002), and the stability of the placement (Dozier & Lindheim, in press).

Since emotional investment has proven so important to the welfare of foster children, this should be a quality that is routinely assessed in foster care dyads. The TIMB interview may therefore be an efficient, evidence-based tool that can assess the appropriateness of a foster care placement in terms of the emotional investment that a foster mother is able to provide to her foster child.

The Problem of Child Maltreatment

In 2004, CPS agencies received 3 million reports of maltreatment of 5.5 million children, and there were 1,490 child fatalities due to child maltreatment (U.S. Department of Health and Human Services [DHHS], 2006). Furthermore, researchers believe that these statistics are far below actual occurrences, by as much as 50-60%, due to underreporting practices and inconsistencies in investigations and validations of abuse and deaths (Crume, DiGuseppi, Byers, Sirotnak, & Garrett, 2002). Infants and toddlers

are the most vulnerable to abuse and neglect. In fact, 81% of all maltreatment related deaths in 2004 occurred to children under the age of three years (U.S. DHHS, 2006).

There are many risk factors that are highly correlated with child abuse. Studies demonstrate, however, that it is the additive effect of multiple risk factors that increase the likelihood of child abuse, rather than any one risk factor in particular (Sameroff, Seifer, Baldwin & Baldwin, 1993; Beckwith, 2000). It has also been postulated that 30-40% of maltreatment is transmitted from generation to generation (Egeland, 1993; Kaufman & Ziegler, 1993). It is, thus, understandable that maltreating parents are often struggling with their own trauma and resulting dysfunction that was never treated, and that this struggle may impede their ability to parent appropriately.

Studies have consistently demonstrated the detrimental effects of abuse on children's development. In general, a child's physical, cognitive, and social-emotional developmental processes are greatly affected. Maltreated children typically exhibit depression, aggression, relationship problems with caregivers and peers, rigid and restricted affect, problems with self-regulation, cognitive and language delays and poor development of the autonomous self and self-esteem (Briere, Berliner, Bulkley, Jenny & Reid, 1996; Cicchetti & Toth, 1995; Pearce & Pezzot-Pearce, 2001).

Foster Care

Foster care is the system that provides alternate care for children whose homes are either inadequate or unsafe. Foster care homes may be homes of relatives, non-relatives, or various types of group or institutionalized homes (National Clearinghouse on Child Abuse and Neglect Information; [NCCANH], 2003). In 2001, there were an estimated 542,000 children in foster care, 48% of whom were in non-kin homes, 24% in kin homes,

and the remainder in a variety of institutional and alternate placements (NCCANH, 2003).

Foster Care Policy and Placement Stability

There have been many changes in legislation and policies in the United States over the years in an attempt to improve the foster care system. In 1962, Kempe and colleagues released their influential report on the Battered Child Syndrome, which described symptoms, behaviors, and specific injuries typically associated with repeated abuse (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). As researchers and physicians became more knowledgeable about the ill effects of abuse and neglect on the development of children, states began to adopt mandatory reporting laws, with 44 states having such laws in 1967. In 1974, the Child Abuse Prevention and Treatment Act was passed which provided funds for the investigation and treatment of abuse to states that had mandatory reporting laws (National Association of Counsel for Children [NACC], 2005). This led to an increase in removal of children from their homes, especially for non-white, poor children (Adler, 2001). At this point the nation was faced with an increased need for substitute care for these children.

As a result, the first legislation attempting to change the foster care system was created: the Indian Child Welfare Act of 1978. This act attempted to decrease the disproportionate number of American Indian children who were being removed from their families of origin because of, as many believed, cultural differences in child rearing practices. This act gave more control to the tribes in deciding the fate of Indian children perceived to be maltreated and required higher standards of proof for the state to gain custody (Adler, 2001).

The Adoption Assistance and Child Welfare Act of 1980 (AACWA; P.L. 96-272) was the next federal legislation enacted to decrease the number of children who entered the foster care system. The AACWA created Title IV-E of the Social Security Act, to allow for reimbursement of state foster care costs (Adler, 2001). The AACWA intended to accomplish its goal by providing financial incentives to states for providing family preservation programs and requiring that “reasonable efforts” be made to prevent the removal of children from their biological parents. The AACWA also required that “reasonable effort” be made to reunify foster children with their biological parents, and it required that permanency hearings be held within 18 months of the child’s removal. Adoption subsidies were also established to further reduce the number of children in the foster care system.

In the years following the adoption of the AACWA, the term “reasonable efforts” came to be perceived as interfering with the appropriate care of children. Anecdotal reports revealed that the lack of defining criteria for “reasonable efforts” was resulting in children being left in or returned to unsafe homes and families, or remaining in foster care for years while every conceivable effort was made for reunification (Herring, 1992). Even though the explicit goal of this act was to decrease the number of children and the time spent in the foster care system, the national average length of stay under this act was three years (Adler, 2001).

Placement stability and permanency for children are extremely important for the well-being of foster children. Instability in foster placements has been shown to affect children negatively by putting them at increased risk for emotional and behavioral disorders (Fisher, Burraston, & Pears, 2005; Budde et al., 2004), greater academic

difficulties (Aldgate, Colton, Ghate & Heath, 1992), increased likelihood of running away and future incarceration (Courtney, Skyles, Miranda, Zinn, Howard, & George, 2005), and decreased likelihood of a permanent placement (Noonan & Burke, 2005). In an effort to provide more stability to foster children, the Adoption and Safe Families Act (ASFA), Public Law 105-89, was signed into law on November 19, 1997. ASFA's global goals are to ensure the safety, permanency and well-being of the children in the child welfare system. The act was designed to accomplish these goals by increasing the collaboration between the child welfare system, family support services, and the courts, as well as remove barriers to achieving permanent placements for foster children (DHHS, 1998). ASFA attempted to achieve greater permanency for children by requiring that a permanent plan for the child's care, reunification or termination of parental rights, be established within 12 months of the child entering into care. In practice, reunification or termination are sometimes not achieved within the 12 month period, however there are now new systematic pressures in place with the arrival of ASFA to achieve one of these outcomes.

Although ASFA was created with the goal of permanency and well-being for the children, there is not much evidence available that it has been successful at achieving its goal. In opposition to the criticism that the AACWA was promoting permanency planning by favoring reunification at the expense of the child's welfare, ASFA is often seen as promoting permanency by preferring the termination of parental rights (Adler, 2001). While there are many reports of egregious child abuse that certainly warrant expedited termination of rights, many cases are much more difficult to classify into the termination or reunification categories allowed by ASFA. With the exception of the

exemptions from the reasonable efforts clause, that is those cases of abuse or neglect which are deemed so egregious that reunification is not possible, the decision to seek termination must be made if the parents are not making “sufficient progress” within the twelve month period allowed by the act (DHHS, 1998). Twelve months can be a very short time for families who have a lifetime of struggles and issues to overcome. For the cases where termination or reunification are not easily determined, judges are often pressured to terminate parental rights because of the time limits required by ASFA (Adler, 2001).

Noonan and Burke (2005) evaluated the ways in which termination decisions are fulfilling ASFA’s goal of permanency. This study used a competing risks hazard model to examine the reasons for the child coming into care, and child and family characteristics related to the decision to terminate or reunify. Results, which are limited to foster care children in New Jersey, demonstrated very different outcomes regarding termination and reunification. Every child characteristic, except for gender, was associated with the decision to terminate rights, however the child’s characteristics did not significantly predict reunification. Some children, specifically, African American, Hispanic children and children who were older or had multiple foster care placements were less likely to have their parental rights terminated but were also less likely to be reunified with their parents. On the other hand, while children with a disability also had a lower likelihood of reunification, they were more likely to experience termination of parental rights. Children were more likely to be reunified if they came into care initially because of neglect, parental alcohol abuse or because their parents could not cope with them, and less likely to be reunified if they were initially referred for physical abuse. There was no

significant relationship between any of the reasons for coming into care and termination of rights however, unless it was a child characteristic. In other words, if a child came into care because of some problem, such as an emotional or behavioral disorder, then they were much less likely to experience termination of rights.

Noonan and Burke (2005) interpret these findings in terms of the “adoptability” of the children. Thus, if the child’s characteristics are more likely to appeal to a potential adoptive family, then parental rights are more likely to be terminated. If the child is not likely to be adopted, then parental rights are less likely to be terminated, and reunification rates are higher. In the case of children with disabilities, however, these children are also less likely to be reunified, perhaps because of their greater need for specialized care. These children are therefore remaining in limbo in the system much longer. Thus, while expedited termination of parental rights is achieving permanency for the more adoptable children, children who are African American, Hispanic, older, have had multiple placements, or have some sort of disability still remain in the system for long periods, experiencing more termination of parental rights and less reunification.

The Growth of Kinship Foster Care

Historically, maltreated children were taken into state’s custody and then placed with non-kin foster families. Because of shrinking financial and foster family resources with a simultaneous increase in the number of children requiring foster homes, CPS agencies have been increasingly, over the last decade, placing children into the care of their relatives, with or without taking the children into state’s custody (Leos-Urbel, Bess & Geen, 2002). There have been several justifications for this preference, including that kin placement offers a continuity and familiarity to the child to lessen the effects of the

trauma experienced (Ehrle & Geen, 2002) and the concern for culturally appropriate placements (Wilhelmus, 1998).

In recent years, the use of kin foster placements has leveled off, however studies show that this is likely due to changes in placement practice and reporting practices of states and therefore not reflective of how many children are actually in the care of their relatives. After substantiating abuse, almost all states report that they first seek relatives to care for the child; if such relatives are found, the children are then placed with those relatives without the state taking custody. This type of placement is typically referred to as voluntary kinship placements. These children are therefore not considered by most states in their foster care data (Leos-Urbel, Bess & Geen, 2000; Geen & Berrick, 2002). Ehrle and Geen (2002) estimate that there are likely an additional 300,000 children in such voluntary kin foster placements at any given time.

In addition to shrinking resources, changes in policy support and encourage this increased use of kinship care. In 1979, the Supreme Court ruled in *Miller V. Youakim* that kin foster parents were entitled to the same payments as non-kin foster parents. This ruling led to kinship care becoming the fastest growing segment of the foster care system (Testa, Shook, Woods & Cohen, cited in Testa & Slack, 2002). In 1996, The Personal Responsibility and Work Opportunity Reconciliation Act dictated that preference should be given to a relative over a non-related caregiver in placement determinations. Likewise, The Adoption and Safe Families Act (ASFA) of 1997 also encouraged preference of kinship placements as it waived certain restrictions and standards to family providers that are still required of non-relative foster parents. ASFA also allows for

exceptions to timelines that require permanency planning and termination of parental rights in cases where the children are placed with relative foster parents.

The advantages and disadvantages of utilizing relatives for foster care have been studied (See Cuddeback, 2004, for a review). These studies, to be discussed in greater detail below, are largely cross-sectional and descriptive in nature, comparing specific outcome measures between the two groups of foster care children. These measures include rates of abuse while in foster care, supervision status by CPS workers, environment and risk factors, and physical and emotional outcomes of the children. While most of the findings of these studies report conflicting or equivocal results, many of these studies demonstrate that children placed with relatives are exposed to greater risk factors than children placed with non-kin foster parents (e.g., Barth, Courtney, Berrick & Albert (1994); Berrick, Barth & Needle, (1994); Chipungu, Everett, Verduik, & Jones (1998); Ehrle & Geen (2002).

Furthermore, the clinical experience of experts in the field suggests that kin foster parents tend to be less emotionally invested in their foster children than non-kin foster parents (Charles Zeanah, personal communication, April 26, 2005). Emotional investment in the care of a child is typically a naturally- occurring phenomenon in biologically intact dyads, however foster parents have been found to differ greatly in their level of emotional investment, or degree of psychological adoption, in their foster children for a variety of reasons (Bates & Dozier, 2002). The level of emotional investment in a foster child may predict the success of that placement and future development of the relationship between the foster parent and foster child (Bates &

Dozier, 2002), and is likely, therefore, to be an important variable to assess when determining appropriate foster placements.

Summary

The foundation of the social work profession is to enhance the lives of its clients. It is a fundamental right of every child to develop and grow without fear of abuse or neglect, but finding appropriate foster homes for children whose parents cannot provide adequate care is very difficult. Because of the dearth of foster homes available, placement decisions are often made based on the availability of placements rather than in the best interests of the child. The typically limited resources of social service agencies, particularly CPS agencies (Lindsey, 2004), should not be justification for decisions that so greatly affect the well being of children. It is imperative that all placements for children who cannot be cared for by their biological parents are assessed, chosen, and given continual support on the basis of the needs of the children. In light of the evidenced- based knowledge, to be described below (e.g., Lindhiem & Dozier, 2006; Ackerman & Dozier, 2005; Bates & Dozier, 2002), that the success of a foster care placement depends, among other factors, on the emotional investment of the foster caregiver, this attribute should be considered when determining the suitability of placements for foster children. Given the complexities involved in adequate caregiving to children, especially children who have experienced trauma and are exhibiting symptoms from that trauma, a placement decision based on relative status alone is likely to be insufficient.

This study will compare the emotional investment between kin and non-kin foster caregivers. If there are significant differences between the two groups, this information

may better inform placement decisions for young children, particularly in terms of the preferential placement with kin caregivers.

CHAPTER 2.

REVIEW OF RELATED LITERATURE

This section will review and summarize the literature pertinent to this area of research, foster parents' emotional investment in their young children. A summary of attachment theory will first be presented, followed by a discussion of internal working models, and a review of the current state of knowledge regarding kin and non-kin placements.

Attachment Theory

A discussion of attachment theory is imperative when discussing the well-being of children, as it serves as the framework for caregivers' understanding of and responses to the socio-emotional needs of their children (Cooper, Hoffman, Powell & Marvin, 2005) and the ways in which children attempt, or fail to attempt, to elicit care from their caregivers (Dozier, Lindheim & Ackerman, 2005; Dozier & Sepulveda, 2004). This is particularly true of children affected by abuse or neglect, as these experiences often negatively affect attachment strategies.

Attachment theory was born as Bowlby (1969) attempted to make sense of the behaviors exhibited by infants and young children who were institutionalized or hospitalized away from their mothers. Bowlby (1969) begins his outline of the attachment system from an ethological perspective, by describing instinctual animal behaviors that increase young animals' chances of survival. Specifically, these varied behaviors are instrumental in maintaining or regaining proximity to a preferred, protective adult animal. Typically, the adult animals are instinctually responsive to these protection- eliciting behaviors, thereby increasing the young animals' chances of

survival. Although he acknowledges the course of development is quite different, Bowlby believed that infant attachment to parents/caregivers is similar to and serves the same survival-goal as these behaviors observed in mammals and birds. Specific attachment behaviors of human infants include crying, smiling, following, clinging, sucking, and calling. The goals of these behaviors are to either maintain or achieve physical proximity to the caregiver, which will likely increase the child's safety and felt security. Thus, separations from the caregiver, the introduction of a frightening stimulus or event, such as the approach of a stranger, or other forms of distress like hunger or fatigue tend to elicit such responses from a child. Generally, infants begin to demonstrate these behaviors in response to such events after 6 months of age, particularly in the 7 to 10 month period (Bowlby, 1969, 1980).

The attachment behavioral system is inversely related to the exploratory behavioral system. Ainsworth (1973) describes the mother as a "secure base" from which a securely attached infant can explore his surroundings. If the mother is a consistently responsive caregiver, the infant will have developed confidence in himself and a trust that the mother will be available when needed, or a secure base to which he can return at any time. It is this confidence and trust that allows an infant to venture out into his environment. Once an infant becomes mobile, he will become interested enough in his surroundings to crawl away from his mother to discover new things. During this exploration, the infant will occasionally "check in" with mother, by either looking at her or returning to her, perhaps to reassure himself that mother is still there should he need her.

Bowlby describes two situations which may disrupt this exploration: the infant becoming hurt, frightened or otherwise distressed (e.g., tired, hungry, sick) or the mother leaving. Should either of these events occur, the child will naturally seek after her mother or display signs of distress, such as crying. Thus, when the environment is deemed to be safe, and the attachment system is not activated, the exploration system can be activated. But as soon as a threat, real or perceived, enters the environment or affects the child, that attachment system is activated and exploration must stop while the child seeks comfort or protection from the mother.

Classifying Attachment Strategies

The Strange Situation Procedure (SSP) (Ainsworth et al., 1978) examines the child's balance and negotiation of exploratory and secure base behaviors and is the most commonly used observational procedure for the assessment of attachment relationships for children up to 24 months. The SSP is designed to induce stress in and elicit attachment behaviors from young children. During this laboratory procedure, a mother (*note: "mother" is conventionally used for expedience to refer to any attachment figure*) and child dyad participates in a series of episodes consisting of play, separations, introductions of a stranger, and reunions. This 20- minute procedure allows researchers to observe the level of maternal sensitivity and responsiveness to the child as well as the ways in which the child reacts to separations from the mother, and then, more importantly, how the child reacts to reunions with the mother. According to attachment theory, stressful situations elicit attachment behaviors from the child, the goal of which is to maintain or regain proximity with a primary caregiver. The SSP typically elicits

attachment behaviors from the child due to the stress of being left alone or with a stranger in an unfamiliar room.

After observing many of these procedures, Ainsworth and colleagues (1978) detected certain patterns of behavior exhibited by the children and created three categories of attachment qualities based on these behaviors. The first category of behaviors was deemed to represent those of a “Secure” attachment strategy. Behaviors commonly seen in this group include the exploration of the room and toys while using the mother for a secure base, becoming distressed or inhibited in exploration upon separation, approaching mother for comfort or with positive affect to welcome her into play upon reunion, and then returning to exploration and play after calming or checking in with mother.

The next two categories, Avoidant and Resistant/Ambivalent, are considered to be “Insecure” strategies. Avoidant strategies are believed to develop because of the mother’s rejection or discouragement of attachment behaviors. Because of this rejection, these children learn to not signal, or to minimize their signals, in times of stress. In the SSP, these children explore away from the mother a great deal, although their exploration is generally superficial. These children display little affect or distress during separation and often ignore the mother during reunion. Resistant strategies, in contrast, are believed to develop in response to inconsistent caregiving, which results in exaggerated behaviors to increase the chance of obtaining the caregiver’s attention. Resistant children seem preoccupied with their mothers and are unable to explore the room and toys, become extremely distressed during separation, and are not comforted by the mother upon reunion, oftentimes seeking and rejecting comfort at the same time.

The strategies discussed above are considered to be “organized” strategies because of the consistency with which they are used in circumstances that elicit attachment-related behaviors. Even though the insecure strategies are maladaptive in a broad sense, they are still coherent and have the goal of maintaining/achieving security from a caregiver. The behaviors of a small number of children in Ainsworth’s sample, however, did not follow an organized strategy, but instead appeared incoherent, conflicted, and odd, and were therefore very difficult to classify according to Ainsworth’s system. Main and Solomon (1986) developed the “Disorganized” category to encompass many of the children who could not be classified by Ainsworth’s system. The behaviors exhibited by disorganized children are characterized by their *lack* of an obvious goal and bizarreness. Examples of such behaviors include freezing, stereotypies, being frightened by the parent and acting confused and disoriented, especially in reunions with the caregiver following brief separations (Solomon & George, 1999). Sequences of behavior such as these seem to involve normal proximity-seeking actions that are then interrupted by fear or confusion (Main & Hesse, 1990). The conflicting behaviors that are often observed in disorganized infants seem to reflect a conundrum experienced by the infant. Specifically, when the child experiences stress or fear he instinctually desires proximity to his caregiver, however, this caregiver is also a *source* of stress and fear. The parent may be experienced as a source of fear for different reasons, including scaring or abusing the child or by acting frightened by the infant (Lyons-Ruth & Jacobvitz, 1999). Thus, the child is left with intense emotions and no practical or coherent way to alleviate them. This theory is supported by findings that maltreated children are highly likely to be classified as disorganized. Carlson, Cicchetti, Barnett and Braunwald (1989) found that

in a sample of maltreated infants, over 80% demonstrated disorganized attachment strategies. Similarly, Zeanah, Smyke, Koga and Carlson (2003) found that 65% of children in Romanian institutions had developed disorganized attachments to their caregivers.

Children who experience severe deprivation, as is commonly experienced with institutional care, are at great risk for forming attachment disorders. Attachment disorders are distinguished from disorganized strategies by the severity of the deviant attachment behaviors and are believed to result from severely impaired or deficient caregiving. There has been much debate as to how to define an attachment disorder. The DSM-IV describes Reactive Attachment Disorder (RAD) as primarily a disorder of social relatedness. According to the DSM-IV, there are two sub-types of RAD: inhibited and disinhibited. The DSM-IV's criteria for attachment disorders have been criticized, however, as they are not supported by empirical or clinical data and focus on non-attachment only, rather than including seriously impaired attachment relationships. (Zeanah, Mammen, & Lieberman, 1993). Relying on developmental research, Lieberman and Zeanah (1995) proposed alternate criteria for the identification of attachment disorders, and included disorders of nonattachment, secure- base distortions, and disrupted attachment disorder.

Attachment and Foster Care

Research has demonstrated that attachment patterns in infancy are highly correlated with behavioral and social competencies in later childhood. Of particular note is the disorganized attachment strategy. Infants who are classified as disorganized typically become controlling, aggressive and hostile children (Solomon, George &

DeJong, 1995). Because relationships are the foundation for attachment strategies, it seems reasonable to believe that a child's removal from an aversive environment and subsequent placement into a loving and responsive environment would be enough of an intervention to correct the common maladaptive behaviors found in maltreated children. It is often the case, however, that maltreated children continue these maladaptive behaviors even when placed in the care of a foster or adoptive mother who is able and willing to interpret and respond to the child's needs appropriately. Thus, a child who has learned to not signal her needs to her dismissing biological mother may likely continue to fail to signal her needs even after being placed with a responsive caregiver. This behavior may alienate the new caregiver who expects typical signals of need, such as crying, and may therefore elicit dismissive caregiving from the new foster mother (Stovall & Dozier, 2000). Although there are many foster mothers who do respond sensitively in these circumstances, other foster mothers require interventions aimed at helping them to reinterpret and respond appropriately to the child's signals and mis-signals as expressions of need for the attachment figure (Dozier, Higley, Albus & Nutter, 2002).

There is some evidence that a foster or adoptive placement with a caregiver who consistently offers sensitive and responsive care may be instrumental in changing maladaptive attachment behaviors in young children (Dozier & Sepulveda, 2004; Dozier et al., 2002). The severity of the behavioral, emotional, and social problems associated with disorganized attachment classifications suggests that a child's potential for the formation of healthy attachment strategies should be considered when assessing new homes and caregiving relationships for maltreated children.

Internal Working Models

Internal working models of self and others are organized memories of the experiences and interactions the infant has with caregivers in the context of the attachment relationship. The function of internal working models is to enable the child to make predictions about his or her caregiving environment, which is especially helpful in situations when the caregiver is not immediately available. Bowlby departed from the then common concept of *cognitive maps* and referred to these organized memories as *working models*, to capture the dynamic nature of representations. Once these models are established, however, they are relatively enduring and typically operate outside of consciousness (Bowlby, 1980).

Internal working models are seen as tools that allow efficient interpretation and responses to social situations, without having to consider each individual situation anew. Information organized into working models reflects experiences, thoughts and emotions regarding the environment, others, and self. The quality of the attachment relationship determines the degree of balance or distortion that will characterize internal working models and, hence, perception of and behavior toward others. For example, if a child feels certain that her mother is usually available for comfort when needed, then that child's internal working model will be organized and consistent, which will result in coherent behavior, thoughts, and verbalizations with respect to attachment relationships. On the other hand, the internal working model of a child who does not know whether his mother will respond to his cries with a hug or a slap will likely be confused, inconsistent, and disorganized, resulting in incoherent behavior, thoughts, and verbalizations with respect to attachment relationships.

A working model will be organized and consistent with respect to these expectations, and will be able to accurately evaluate and predict novel situations. This function of the working model will develop to the extent that the data that the child internalizes are consistent and reliable. In situations where a child's needs and desires are consistently met by the mother, it is likely that this child's internal working model will be one that views others as kind and responsive and views self as loveable. With enough consistency, the infant's working model becomes relatively stable, and her attachment and social behaviors will reflect that model (Bretherton, 1985). Problems for the child arise when caregivers are not consistently sensitive or responsive to attachment needs; in such cases, the child's working model will likely reflect a mistrust of others and view self as being unlovable.

Further complications can arise if the child's internal working model must incorporate opposing views of self and others (Bowlby, 1980). For example, if a child perceives her mother as harsh and insensitive to her needs but the mother portrays herself to be a loving, good mother, then that child is left to struggle with which perception is reality or the need to incorporate both perceptions into her internal working model. To deal with the incompatibility of these two working models and the knowledge of a threatening parent, which is generally intolerable to a young child because of the pervasive sense of danger that accompanies a frightening parent, the child may form defenses that will exclude her own interpretations and resulting working model from consciousness, and develop instead an illusory model of a good parent and a corresponding self-model that is bad (Bowlby, 1980). Despite the formation of these defenses, however, the data from her own interpretations will still likely influence her

behavior (Bretherton, 1990). For example, while the child may repress her perceptions of her mother as harsh and insensitive to allow room for the mother's portrayals of herself as loving, much of the child's behavior, particularly attachment related behaviors, will still be influenced by the unconscious working model of the mother as frightening.

Once internalized, these mental representations are fairly stable. This trait can be both beneficial and harmful, depending on the circumstances. For example, if an otherwise sensitive, responsive mother becomes suddenly unavailable for a short period of time, her child will likely be able to rely on his mental representation of her availability to maintain his "felt security" until she is once again available. On the other hand, if a child who has experienced maltreatment, and thus developed a mistrusting representation of others, is placed into a new setting with responsive caregivers, his mistrustful internal working model will likely persist, at least for some time, even when the quality of caregiving behaviors has changed.

The enduring quality of internal working models can thus cause problems for maltreated children and foster caregivers. While the development of the mistrusting/unlovable mental representation may serve the child well in the context of an insensitive or maltreating caregiving relationship, the application of this working model to other situations may cause significant problems. This is particularly true if the representations include defensive strategies as discussed above, such as shutting out anxiety provoking information or feelings and dissociative processes (Bretherton, 2005). These defenses can develop when a young child is told that his perceptions of experiences are not accurate or when realities are ego-dystonic. This is likely to occur in situations where the child relies on a parent for care and protection, but that parent is also

a source of fear for that child. Thus, the child is left with the challenge of reconciling his view of self as someone who needs and deserves comfort and protection, and instinctively seeks this from the parent, with the reality of his mother's behavior towards him. Fraiberg (1994) discussed how these defended representations, particularly those with suppression of affect, have a negative effect on adults as they try to parent their own children. Although repressed from consciousness, the defended internal working model still influences behaviors, particularly parenting behaviors, and is often seen as a "ghost in the nursery" (Fraiberg, Adelson, & Shapiro, 1975).

Likewise, the internal working models of caregivers with respect to attachment and to their children are influential in how the caregivers view their children and their relationships. This directly affects the way in which the caregiver will react and respond to her child, which, in turn, directly affects the development of that child (Zeanah & Benoit, 1995). Caregivers who are struggling with past negative personal experiences and emotions, especially past trauma, may, unknowingly, be transferring or projecting those feelings and attributes onto their children. The resulting frightened or frightening behavior that these parents exhibit toward their children then incorporates those children into the trauma/struggles of the parents. It then follows that these parents cannot become secure bases for these children as the parents also become a source of fear (Main & Hesse, 1990). If children do not have a secure base providing sensitive and empathic responses to their needs, then insecure and disorganized attachments are likely to be formed.

Measuring Internal Working Models

Main, Kaplan and Cassidy (1985) proposed that internal working models should be directly investigated instead of inferred from behavior. Since mental representations guide interactions and behaviors, Main et al., (1985) reasoned that it is these representations that differentiate classifications of attachment. This paper also describes a longitudinal study of attachment, which demonstrated associations between parental classifications of state of mind with respect to attachment to their infants' attachment classifications obtained from the Strange Situation. Up to this point, attachment research focused on associations between caregiver behaviors and infant attachment classifications. The concordances of parental representations and child behaviors found in this study, however, suggested that the focus of research should be on the representations themselves, as they shape the behaviors.

Children's Internal Working Models

Main et al. (1985) attempted to directly measure children's representations of attachment relationships by using a revised version of the Separation Anxiety Test (SAT). Six year-old children were shown pictures illustrating varying degrees of child-parent separations and then asked what the child in the picture is feeling and what the child would do upon separation. Assuming that children would project their own attachment representations onto the drawings, the children's responses to the pictures were categorized and compared to their attachment classifications obtained from Strange Situations when the children were 12 months old, resulting in concordances between the children's representations and attachment classifications. For example, children who were previously classified as secure in the Strange Situation as an infant provided more

openly emotional and constructive responses to the SAT, whereas children previously classified as insecure-avoidant tended to ignore the parents in the photographs or provide minimal responses (Main et al., 1985).

Narrative Story Stem Techniques (NSST), particularly the Attachment Story Completion Task (ASCT) (Bretherton & Ridgeway, 1990), are similar to the SAT in their projective natures, but add play props to facilitate the child's narrations and increase the interpretability of the child's representations. Many studies have correlated the narrative responses with attachment classifications and various other domains of child functioning, supporting the tenet that they do measure the child's attachment representations. Studies using an NSST have found concordances between children's representations and attachment classifications, maltreatment status, social and peer relations and a variety of other variables (e.g., Solomon, George & De Jong, 1995; Bretherton & Ridgeway, 1990; Cassidy, 1998; Page, 2001; Page & Bretherton, 2001).

Adults' State of Mind with Respect to Attachment

The Adult Attachment Interview (AAI) (George, Kaplan & Main, 1985) was created to measure an adult's current state of mind with respect to his or her attachment experiences (Hesse, 1999). The AAI is a semi-structured interview that elicits stories/memories of relationships and interactions with parents, including losses experienced. The organization of these experiences reflected in the communicative style of the narratives is of particular interest, more so than the actual content of the narratives. For example, an adult who has experienced a loss or other trauma, presently or earlier in childhood, will likely experience some degree of disorientation with respect to perceptions of safety, and consequently the availability of safety in attachment

relationships. As a result, a breakdown in cognitive processes may occur, particularly in terms of the storage and retrieval of traumatic memories, which are then reflected in his or her internal representations and consequent behaviors, including narrative processes. Successful resolution of this type of disorientation with respect to safety and security occurs when the individual is able to reorganize the loss or trauma internally, to reestablish a sense of equilibrium and emotional security, and change his or her behavior, particularly attachment behavior (Bowlby, 1980). The responses of adults on the AAI who have successfully resolved previous loss and who value attachment relationships typically contain rich details and structural coherence, whereas adults who have failed to resolve these issues are often incoherent in their narratives.

Based on their responses, adults are classified as autonomous, dismissing, preoccupied, or unresolved, which correspond to the infant classifications of secure, avoidant, resistant, and disorganized/disoriented, respectively (Hesse, 1999). Autonomous adults recount memories coherently, regardless of the positive or negative nature of the content. Narratives that minimize attachment experiences are classified as dismissing, and are typically characterized by responses such as “I don’t remember”, poverty of detail, and contradictory responses. Preoccupied responses are characterized by an inability to maintain focus on the question as asked, with their memories guiding their discourse to irrelevant topics. Unresolved classifications are assigned to those narratives that are incoherent and disorganized, either pervasively or specifically when the respondent is discussing a traumatic loss or event. These narratives are frequently characterized by lapses in thought processes and reasoning capabilities as a result of a difficulty with storing and retrieving memories associated with the trauma (Hesse, 1999).

Initial studies (e.g., Main et al., 1985) linked the classifications of parents' state of mind with respect to their own attachment histories to their infants' attachment classifications in the Strange Situation. These results, which have been replicated many times, imply that parents' representations of their own attachment experiences mediate their interactions with their infants, which, in turn, influence the development of their infants' internal working models and their resulting attachment classifications. For example, autonomous adults are coherent in their narratives about their attachment experiences, valuing the influence these experiences had on their own development. Autonomous mothers are typically sensitive to their own infants' needs, and their infants are therefore likely to be securely attached to them.

Main and Hesse (1990) linked the frightening/frightened parental behavior common in dyads with children with disorganized attachment strategies to unresolved experiences of trauma or loss in the parent's past. Main and colleagues found that 60% (9 out of 15) of mothers classified as unresolved on the AAI also had infants classified as disorganized, while only 21% of mothers not classified as unresolved had disorganized infants. Main and Hesse (1990) review subsequent studies that also demonstrated strong associations between the adult unresolved and infant disorganized classifications (Ainsworth & Eichberg, 1990; Levine, Ward, & Carlson, 1989 cited in Main & Hesse, 1990).

In the field of attachment with foster children, studies have found that the adoptive or foster parents' state of mind with respect to attachment is related to whether or not the foster home can be a corrective environment for a maltreated child. Studies have demonstrated that a foster child's disorganized or insecure attachment strategy is

more likely to change to secure after being placed with an autonomous foster mother than foster mothers with other classifications (Dozier, Higley, Albus, & Nutter, 2002; Dozier, Stoval, Albus & Bates, 2001). Foster mothers with an autonomous state of mind with regard to attachment are typically better able to negotiate the challenging behaviors of their maltreated foster children and can promote the development of a secure attachment. This change in attachment has not been seen with non-autonomous mothers.

Maternal Insightfulness

Maternal insightfulness is a concept that is closely related to, and influenced by, a mother's state of mind with respect to her own attachment discussed above. Oppenheim and Koren-Karie (2002) define maternal insightfulness as the mother's ability to see things from the child's point of view in a complete, open, and accepting way (Oppenheim, Goldsmith, & Koren-Karie 2004). The ability to empathize with her baby directly influences the level of sensitivity with which the mother respond to the child's needs. For example, an insightful mother who understands that her infant is crying because she believes that it is appropriate for infants to want to be held and comforted when tired or scared, for example, will likely respond appropriately and sensitively to her baby's needs. In contrast, a non-insightful mother may interpret her baby's continued cries as a "spoiled" or manipulative attempt to be held constantly, and the mother may therefore allow the baby to cry for extended periods of time without offering comfort.

As can be seen in the literature on attachment strategies described above, the way in which the mother responds to her child will influence the child's view of self as well as his or her attachment related behaviors. Thus, a mother's level of insightfulness into her child's behavior, which will influence that mother's responses to the child, will likely

elicit responses from the child that will reinforce the mother's perception of the child (Silverman & Lieberman, 1999). To illustrate this phenomenon, consider the differing responses of the mothers above. The first mother empathizes with her infant and therefore holds and soothes her baby, who is likely to calm, reinforcing to the mother that the baby was indeed crying because of a legitimate need. Babies who consistently receive such care typically have balanced attachment strategies and are therefore relatively easily soothed and emotionally regulated, characteristics which will likely reinforce the mother's positive attributions of the child. The second mother, on the other hand, perceives her baby's crying as a manipulative attempt, and this negative attribution prevents her from understanding the baby's needs accurately. She therefore may either dismiss the baby's pleas or may even react punitively to the baby. The baby may then respond with even louder, more persistent crying, which confirms for the mother that the baby is indeed spoiled. Children who consistently receive such insensitive care typically develop insecure attachment strategies and maladaptive behavioral patterns and are more often emotionally dysregulated, further confirming the mother's negative perception of the child (Silverman & Lieberman, 1999).

Maternal insightfulness is therefore an important influence on caregiving behavior, setting the stage for child development, particularly in terms of attachment strategies, emotional development, self-knowledge and esteem, and sense of competence and efficacy (Oppenheim & Koren-Karie, 2002). The Insightfulness Assessment (IA) (Oppenheim, Goldsmith, & Koren-Karie, 2001) was developed to measure the level of a mother's insightfulness into her child's behavior. During this assessment, the mother is shown video vignettes of herself interacting with her child and is then asked about her

and her child's thoughts and feelings during the vignettes. The mother's responses are then analyzed and rated as either Insightful or one of three Non-insightful possibilities.

The responses of insightful mothers are ones that convey an accurate understanding and acceptance of the child's motives, including both positive and negative motives, and an openness to new discoveries about her child or herself. The non-insightful mothers typically display negative emotions regarding their children, express excessive worries about their children, and/or are not accepting of their children. These negative emotions and worries influence the mother's perceptions of her child and therefore interfere with the mother's ability to accurately interpret the child's motives.

The IA has been used in several studies that support its validity. Two studies have shown that mothers who were classified as positively insightful were more likely to have children with secure attachments compared to the non-insightful mothers (Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Oppenheim et al., 2001). Koren-Karie et al. (2002) also demonstrated that mothers classified as insightful were more sensitive in their interactions with their infants than mothers classified as non-insightful. In another study, the level of maternal insightfulness was used as an outcome measure for a clinical treatment program for preschoolers, and they found that maternal insightfulness increased after six months of treatment and was associated with improvements in internalizing and externalizing problems in the children (Oppenheim et al., 2001). In a follow-up study of this preschool group, the behavior of the children of mothers whose insightfulness did not increase worsened, despite the improvement in social skills of all children in the study (Oppenheim et al., 2004).

Parents' Internal Working Models of Their Children

Closely related to maternal insightfulness is the parent's perception of the child. The Working Model of the Child Interview (WMCI) (Zeanah & Anders, 1987; Zeanah & Benoit, 1995) assesses the parent's internal representations of her young child, applying the term "internal working model" to the cognitive and affective processes involved in the relationship from the parent's point of view. Similar in structure and coding procedures to the AAI, the WMCI assesses parents' perceptions and *subjective* experiences of their infants and their relationships with their infants (Zeanah & Benoit, 1995). Research has demonstrated that parents' reports of their children's characteristics and behavior are greatly influenced by parental characteristics and experiences (Zeanah, Benoit, Hirshberg, Barton & Regan, 1994). An example of this can often be seen in adults who have detailed expectations and perceptions of their unborn children (Zeanah & Anders, 1987). In other words, parents' states of mind with respect to attachment, that are based on their own experiences and relationships prior to becoming parents, influence their unique perceptions and interpretations of their children's actual characteristics and their relationships, which are then organized into a working model of a particular child.

The WMCI allows for the direct measurement of a parent's perceptions of her child, which has proven to be an important area for clinical intervention and the basis for most infant-parent psychotherapeutic interventions (Stern-Brushweiler & Stern, 1989). There are three classifications of parents' responses to the WMCI, to be discussed in greater detail below: balanced, disengaged, and distorted. Because the WMCI was used in this study to collect the data on emotional investment, and it also provides one of the

major dependent variables of this study, a detailed review of published studies in which it has been used will follow.

Validity and Reliability of the WMCI

The WMCI classifications have been found to be concordant with Ainsworth et al.'s (1978) classifications of attachment. In one study, the working model classifications of 45 middle-class mothers were associated with the attachment classifications of their 12 month-old infants as follows: 74% of mothers classified as balanced had infants classified as secure, 73% of mothers classified as disengaged had infants classified as avoidant, and 55% of mothers classified as distorted had infants classified as resistant (Zeanah et al., 1994). A second study of 85 Canadian mothers similarly found a high concordance between the balanced/secure categories (88%), but the disengaged/avoidant (50%) and distorted/resistant (40%) correlations were not significant (Benoit, Parker, & Zeanah, 1997).

The WMCI classifications have shown predictive validity and stability in studies of pregnant women and unborn children and their children's attachment classifications. In one investigation of 85 women, there was an 80% concordance between the WMCI classifications obtained during the third trimester of pregnancy and WMCI classifications obtained when the infants were 11 months old. The results of this study also demonstrated concordances between the mothers' representations of their unborn children their *children's* attachment classifications at 11 months of age (73%), particularly with the balanced/secure group (91%) (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997)

An investigation of three groups of mothers and their infants with clinical disorders provides further evidence for the validity of the WMCI classifications (Benoit et al., 1997). In the first sample, the WMCI was administered to 24 mothers of infants with Failure to Thrive (FTT) and to 25 mothers matched for comparison. All of the mothers in this study were from an impoverished, inner-city area; there were no differences demographically between the clinical and comparison subjects. In this sample, only 13% percent of mothers with the FTT infants were classified as balanced as opposed to 40% of the comparison mothers. The second sample consisted of 16 mothers of toddlers with sleep disorders and 21 mothers of toddlers without sleep disorders. All of these mothers were middle and upper-middle class Canadians, and there was no significant difference between the groups demographically. In this sample, none of the mothers of the children with sleep disorders were classified as balanced, whereas 35% of the comparison mothers received balanced classifications. The final sample consisted of 13 low SES Canadian mothers of infants who had been referred for clinical services for maltreatment, disturbed relationships, or feeding difficulties. In this sample, 15 % of the mother's representations were classified as balanced, 31% as disengaged, and 54% as distorted. Taken together, 91% of these clinical samples received disengaged or distorted classifications as opposed to 58% of the comparison mothers (Benoit, Zeanah, et al., 1997).

Inter-rater reliability of the WMCI classifications has been reported in several studies. In Zeanah et al. (1994), inter-rater agreement was reported to be 83%. Similarly, inter-rater agreement was reported to be 87% ($k=.67$) in the prenatal stability study (Benoit, Parker et al., 1997). In the study of infants with clinical disorders, inter-rater

reliability was calculated in each of the three groups of infants studied (i.e., FTT, Sleep Disorders, and Clinically Referred) and found to be 89% ($k=.80$), 54% ($k=.34$), and 100% respectively. The unacceptable inter-rater reliability in the sleep disorders sample was explained by a newly trained rater, and acceptable rates were reported for subsequent samples after further training, although the authors did not specify that rate (Benoit, Zeanah et al., 1997).

Emotional Investment in Foster Children

Emotional investment in a foster child has been conceptualized as the degree of psychological adoption by the foster mother, particularly consisting of: acceptance of the child, commitment to parenting the child, and belief in her ability to influence the child's development (Ackerman & Dozier, 2005).

Acceptance of the child has been defined as the degree to which a foster mother expresses positive feelings about the child, enjoying and delighting in the child, and respecting the child's individuality. Commitment to child has been defined as the degree to which the foster mother views the baby as her own, permits herself to become emotionally invested, provides physical and emotional resources to promote the child's growth and development, and demonstrates that parenting this child is important to her (Ackerman & Dozier, 2005). Commitment has also been more narrowly defined as the extent to which a caregiver is motivated to maintain an enduring relationship with her child (Bates & Dozier, 1998).

Most biological parents are naturally invested in providing long-term care for their children, providing any emotional or physical resources necessary to ensure the safety and well being of their children. Although there is certainly a biological and

evolutionary component to this investment, the fact that substitute caregivers can be invested in unrelated children suggests that there are other factors influencing a caregiver's commitment. While attachment quality assessed longitudinally in childhood among biologically related dyads, typically with the Strange Situation, has been proven to predict developmental outcomes of children, these associations have not been as clear cut among foster children/dyads (Lindhiem & Dozier, 2006). The emotional investment expressed by foster parents has been found to better predict foster children's developmental outcomes, including attachment quality (Bates & Dozier, 2002). Emotional investment may be so important for foster children's developmental outcomes because of its relationship to sensitive and empathic caregiving (Ackerman & Dozier, 2005), which have been shown to be necessary parenting qualities for the healthy development of a child, and are likely to be especially potent influences in the lives of foster children.

Research has demonstrated the developmental benefits of emotional investment, particularly acceptance and commitment, in foster parents. In one study of 39 foster mother/ infant dyads, foster children of mothers who expressed higher levels of acceptance of their foster children at age 2 demonstrated more positive self-representations in a projective puppet interview at age 5 than the foster children of mothers who expressed lower levels of acceptance. These same children also demonstrated more constructive coping solutions to deal with hypothetical separations from caregivers (Ackerman & Dozier, 2005). Highly invested foster mothers were also found to interact with their children in a problem solving task with more quality support than non-invested foster mothers (Bates & Dozier, 2001, cited in Ackerman & Dozier,

2005). Commitment to the child has been found to predict the stability of foster placements, which positively affects the child in various ways discussed above (Dozier & Lindhiem, 2006). In one study of 84 foster dyads, placement stability, defined as the placement lasting for at least two years, increased with each degree of commitment expressed by the foster mother, as measured on the commitment scale of the This Is My Baby (TIMB) interview (Bates & Dozier, 2002). For example, a foster mother who was scored as a 4, on a 5 point scale of commitment, was approximately twice as likely to continue to care for her foster child for two years or longer than a mother who was scored as a 3 on commitment (Dozier & Lindhiem, 2006).

Several variables have been found to predict caregiver commitment to child in foster dyads. Although specific numbers were not reported, Dozier and Lindhiem (2006) reported that, in one study of 84 foster dyads, foster mothers who had fostered fewer children ($M = 0.9$) in the past, prior to having this foster child, expressed higher levels of commitment than those foster mothers who had previously cared for more (range 1 to 200) children. These mothers also expressed more commitment to children who were placed at a younger age ($M = 8.5$ months) than mothers who received older infants (Dozier & Lindhiem, 2006). Child behavior, as measured by the Child Behavior Checklist (CBCL) (Achenbach, 1991), was also investigated with regards to caregiver commitment. In a study of 102 foster dyads, caregivers of children with lower levels of externalizing behavior problems, as reported on the CBCL, expressed more commitment to those children than the caregivers of children with higher levels of behavior problems. This association was examined at two time points, and child behavior was only associated with caregiver commitment at the initial assessment. Because initial assessments were

completed an average of 16 months into the placements, no directional effects of this association could be established (Lindhiem & Dozier, under review).

Empirical Literature Related to Kin versus Non-Kin Foster Parents

There have been several theoretical justifications for the preference for kin foster care placements in child welfare policy. Kin placements are thought to offer a continuity and familiarity to the child, which is believed to lessen the effects of the trauma experienced from the maltreatment and disruption of formal care (Ehrle & Geen, 2002). Kinship care also addresses the concern for culturally and racially appropriate placements (Wilhelmus, 1998) and is often argued to be a way of life for many cultures, particularly African American and other cultures who routinely experience economic and social hardships, and is therefore a natural and culturally appropriate response when child welfare services are involved (Brown, Cohon & Wheeler, 2001). Likewise, a child placed in kinship care usually continues to be involved with other family members, which further increases the supports available to that child (Hegar, 1999).

The literature supporting the value of kin placements is largely qualitative and theoretical (e.g., Ehrle & Geen, 2002; Wilhelmus, 1998). As will be discussed below, it relies heavily on subjective reports of small numbers of respondents who express their preferences for their own kin placements.

Many argue that non-kin placements are superior to kin placements. One of the predominant arguments is that the “apple doesn’t fall far from the tree”. In other words, if a biological parent is abusive, neglectful, or mentally ill, for example, there may be an increased likelihood that the relative of that parent, with whom the child is being placed,

will also be similarly ill-equipped to provide adequate care for the child. The empirical findings of studies that support an intergenerational transmission of child abuse (Kaufman & Zigler, 1989) can be argued to support this side of the debate. Proponents of the superiority of non-kin placements often base their arguments on reports and findings of studies addressing the outcomes of children in each placement. These studies, discussed in detail below, are largely cross-sectional and descriptive in nature, comparing specific outcome measures between the two groups of foster care children at a single point of time, demonstrate conflicting results, and are wrought with methodological problems.

There have been two studies that have examined the rates of abuse that occur to the children while in foster homes. Zuravin, Benedict and Somerfield, (1993) found that children in non-kin foster homes experienced more abuse, whereas Dubowitz, Feigelman, and Zuravin's (1993) child subjects in kinship care experienced more abuse than those in non-kinship care. Many studies have demonstrated that CPS workers tend to supervise children less closely in kinship care than they do in non-kin foster families (Beeman, Wattenberg, Boisen & Bullderick, 1996; Berrick, Barth & Needell, 1999; Gebel, 1996). Additionally, the birth parents from whose custody the children have been removed typically have more frequent and unsupervised visitation with children in kinship care in comparison to non-kin placed children (Berrick et al., 1994; Chipungu, Everett, Verduik & Jones, 1998).

One longitudinal study examined the outcomes of children who have left foster care. Benedict, Zuravin and Stallings (1996) found that children placed with kin fared just as well as adults as children who were placed with non-kin foster care. This study,

however, examined only kin families who were licensed and met the same standards as required by non-kin foster families, so these results may not be representative of all children in kin placements. A cross-sectional study of the long-term effects of kinship care revealed no differences in physical health status between women who were raised in kin placements versus those raised by adoptive or biological parents, but did find that the women living in kinship care were more likely, as adults, to be unhappy with life and experience prolonged anxiety (Carpenter & Clyman, 2004). Although this study utilized a large sample ($n = 8760$), its comparison group did not include women who lived in non-kin foster care, but rather who were adopted or raised by their biological parents.

There have been studies examining the well-being of the children in kin and non-kin foster homes. In examining the differences in child internalizing and externalizing behavior, most studies report that the two groups are comparable (Dubowitz, Feigelman, Harrington, Starr, Zuravin & Sawyer, 1994; Sawyer & Dubowitz, 1994; Shore, Sim, Le Prohn, & Keller, 2002). With the exception of Shore et al. (2002), however, these studies use foster parent reports of behavior and therefore may not be entirely reliable or accurate. These studies also have not examined behaviors longitudinally to determine if there are changes in behavior following extended time periods in the foster care setting. Furthermore, these studies examined children living in different foster care conditions (eg., kin not in state custody, licensed versus unlicensed). Thus, it is difficult to ascertain true differences between “kin versus non-kin” placements, as there is little consistency in this literature regarding the populations studied.

Other studies measure environmental aspects of foster children’s well-being. Research findings consistently demonstrate that children in kinship care experience

greater poverty, substandard housing, have older, single, less educated foster parents, and are offered less support from CPS agencies (Barth, Courtney, Berrick, & Albert, 1994; Berrick et al., 1994; Chipungu et. al, 1998; Ehrle & Geen, 2002; Gebel, 1996; Zimmerman, Daykin, Moore, Wu, & Li, 1998). The long list of these and other risk factors to the well-being of foster children merit close examination, especially their additive effects, since these are associated with the highest risk levels (Sameroff, Seifer, Baldwin & Baldwin, 1993; Beckwith, 2000).

As discussed above, one of the major arguments of proponents of kinship care is that it offers more stability and continuity for the children. In a qualitative study, Brown et. al (2001) interviewed 30 youth who were living in kinship care placements. These youth generally reported that they were very familiar with, and often living with, their kin prior to their official placement. Many of the youth therefore reported that their placement with relatives was not disruptive to their lives. Likewise, in a survey of administrative data and 1,200 CPS workers in Illinois, children who were placed with relatives were 45% less likely to experience multiple moves than those children placed with non-relatives, and that stability increased to 60% if the child was placed in a relative home with at least one sibling and within the same local area network, or geographical area, as the child's home of origin (Zinn, DeCoursey, Goerge, & Courtney, 2006).

Testa and Slack (2002) also studied placement stability by examining reunification and replacement rates for 983 foster children in kinship placements over a 5- year period. Replacement was defined as a child being removed from one foster home for any reason and then placed directly into another foster home. The study demonstrated that relatives' motives for caring for their relative foster children were influenced by both

altruism/obligation and reciprocity. The authors defined the kin foster parents' typical reciprocal interests as including expectations for improvement and involvement by the biological parents and subsidy payments from the state. Findings demonstrated a much higher rate of reunification (407%) and lower (64%) replacement rate when kin foster parents perceived that the biological parents were cooperating with their case plans. Following a change in the distribution of financial incentives during the course of the study, there was a 150% increase in the rate of replacement and a 142% increase in reunification among kin placements receiving a reduced incentive compared to conditions before the financial reduction occurred. There was no change in replacement and reunification rates among kin who continued to receive the same subsidy. Relative foster parents' reports of poor relationships with either the child or the biological parents also increased replacement and reunification rates. Children living with relatives who regularly attended church and who were born in the South were less likely to be replaced, which the authors attributed to the increased sense of duty felt by the foster parents in this region. The findings of this study indicate that kin caregivers cannot be considered more stable based on kinship status alone, but that many variables influence their commitment to care for their relatives' children. The authors also point out that non-kin foster care replacement and reunification rates generally are not affected by the biological parents' compliance with service plans.

As can be seen with the conflicting results in the studies discussed above, the literature on the outcomes of children in various foster care placements is inconsistent. Cuddeback (2004) provides an extensive review of the outcome literature attempting to address the numerous issues in the kin versus non-kin debate. Cuddeback reviewed over

100 multi-disciplinary, empirical articles that have examined some aspect of this debate, and summarizes what can be gleaned from the literature after considering the methodological limitations of the studies. Studies do consistently and reliably demonstrate that kinship caregivers have fewer resources, training, and support services compared to non-kin caregivers, although he warns that the state of the knowledge still does not know why this is so, nor what impact, if any, it has on their relative foster children. Cuddeback concludes by recommending future research be more rigorous and attempt to sort out the confounds that are so plentiful in this research.

Summary

This review of the literature has elucidated the importance of the quality of caregiving on the young child. The caregiving relationships in which a child is embedded significantly impact his or her development and future success in life. The child who has a securely attached relationship with a caregiver who can fulfill his or her physical and emotional needs and shape the child's view of self as lovable and worthy will likely have many advantages in life over a child who does not experience such a relationship.

The children whose parents are not able to adequately take care of them are typically placed into foster care in hopes that they can be cared for effectively by surrogate caregivers while CPS agencies can provide services to the biological families and make determinations about their abilities to offer appropriate care to their children in the future. Once in the foster care system, the children's negative experiences may be repeated several times as children often have multiple foster placements. Thus, the very system whose intent is to provide a safe and nurturing environment for maltreated

children often becomes yet another source of disruption for the children. To minimize disruption to children, CPS agencies often rely on kin caregivers in hopes that this will offer greater stability and continuity (Brown *et al.*, 2002), but studies have shown that kin stability is also influenced by various factors, including financial incentives and biological parent involvement (Testa & Slack, 2002).

There has been a large amount of research conducted to investigate the differences in kin and non-kin placements (See Cuddeback, 2004, for a review), but the results are often conflicting or equivocal. Nevertheless, studies have demonstrated that children in kin homes are often less supervised by CPS (Beeman *et.al*, 1996; Berrick, *et al.*, 1999; Gebel, 1996), have more anxiety and depression as adults (Carpenter & Clyman, 2004), have behavior disorders at rates comparable to children in non-kin care (Dubowitz *et. al*, 2004; Sawyer & Dubowitz, 1994; Shore *et al.* 2002), and experience greater rates of poverty, substandard housing, and have older, single, less educated foster parents (Barth *et.al*, 1994; Berrick *et.al*, 1994; Chipingu, *et.al*, 1998; Ehrle & Geen, 2002; Gebel, 1996; Zimmerman *et.al*, 1998) when compared to children placed in non-kin homes.

At the same time, studies investigating factors related to successful foster placements have revealed that emotional investment in child is one of the most significant predictors of successful foster care placements (Ackerman & Dozier, 2005; Bates & Dozier, 2002; Zeanah & Smyke, 2005). A foster mother's level of emotional investment in her foster child has been shown to significantly impact the stability of placement, the quality of the dyad's interactions, and the child's representations of self and others (Lindhiem & Dozier, 2006; Ackerman & Dozier, 2005; Bates & Dozier,

2002). Screening foster mothers for their investment in caring for their foster children would offer a reasonable and evidence-based approach to assess the suitability of a placement in regards to its potential impact on the foster children.

Since a foster mother's emotional investment in her foster child has been established to be an influencing factor on foster child and placement outcome, it should also be a factor to consider in the kin versus non-kin debate. To date, there have been no studies that have compared kin and non-kin foster parents' investment in their children. Such a study may produce information that can contribute to the growing body of knowledge concerning the best placements for maltreated children. The present study, the first of its kind, may thus produce information that can contribute to the growing body of knowledge concerning the best placement for maltreated children. Differences found in the levels of emotional investment in children between kin and non-kin foster caregivers would be of importance to the shaping of future foster care policies, particularly those that support preferential placement with kin caregivers.

CHAPTER 3.

METHODOLOGY

The purpose of this cross-sectional study is to compare the emotional investment of kin and non-kin foster parents in their young foster children. Emotional investment has been found to be a significant predictor of child and placement outcomes. Despite the great amount of studies examining the merits of kin and non-kin foster care placements, no studies to date have examined the two groups in terms of this very important variable.

Sample

This study used secondary data obtained from foster mothers who were involved in an intensive intervention program for maltreated children and their parents (Zeanah & Larrieu, 1998). “The Infant Team” of the Tulane Institute of Infant and Early Childhood Mental Health program provides clinical services to all children under the age of five years in Jefferson Parish, Louisiana, who were removed from their parents’ care due to maltreatment and placed into foster care. These foster parents are invited to participate in multiple assessments and treatment, including support services, case management, and intensive clinical interventions, as indicated, to ensure that the foster placement is appropriate for the child.

This study used a non-probability sample from the above foster parent population. All of the foster mothers who completed most of the measurements of interest ($N = 63$) were included in the study. Foster mothers who had multiple children were included in the sample only once, with the particular interview included being randomly chosen from

those available. For example, if one foster mother had completed four interviews on four separate children, then one of those interviews was randomly chosen for inclusion.

Likewise, siblings with different foster parents were randomly chosen so that only one child per family was included in the sample. Although it is certainly possible that a foster mother can demonstrate differing levels of investment with different children, it was felt that to include multiple interviews by the same mother may reduce the variability within the sample.

Although the sample size of this study was limited to the subjects available, a power analysis was conducted with the known n (63) to provide an estimate regarding the power of this study's findings, a practice recommended when there is no option to increase sample size (Cohen, Cohen, West & Aiken, 2003). Using a statistical power table (Cohen, 1988 in Rubin & Babbie, 1997), it was verified that a medium effect size, .65, could be obtained with a sample size of 60 subjects, using a .05 significance level. Although the risk of committing a Type II error with this sample size is still higher than desired, the absence of additional subjects simply prevent increasing the sample size, and the findings should therefore be interpreted with caution. Because this is a preliminary investigation, however, the findings may still further the existing state of knowledge and provide support for future resources to be dedicated to additional studies with larger sample sizes.

Protection of Subjects

Upon entering the Infant Team program, all foster parents are given detailed explanations of the assessments administered and how the results will be used for both clinical and research purposes. Informed consents were obtained from all subjects. All

identities remained confidential and were unavailable to this author. Because this is a secondary data analysis, there was little risk to the subjects, and therefore qualified as an expedited review by the IRB. The data on investment were extracted from the foster mothers' responses to the Working Model of the Child interviews, which were videotaped when the foster mothers began to work with the Infant Team upon first receiving their foster children. These videotapes are stored in a locked storeroom to which few people have access, to protect confidentiality.

Research Design

This study is a cross-sectional, correlational design. A correlational design is appropriate for this study as it is exploratory in nature, seeking to discover if any differences in emotional investment to child exist between kin and non-kin foster mothers. Because this study is correlational, the cause of any effects seen cannot be determined.

Procedures

One type of assessment was used in this study: The Working Model of the Child Interview (WMCI; See Appendix A), a video-taped interview completed by each foster mother. The WMCI's were completed by each foster mother during the intake process upon entering the Infant Team clinic, which occurred a minimum of six weeks after the child was placed into the mother's care. The Infant Team professionals chose six weeks as a minimum time requirement believing that this was adequate time for the foster mother to get to know the child before responding to questions regarding the child. While the adequacy of this time period has not been evaluated formally, the Infant Team consensus is that it has demonstrated face validity after over a decade of use with foster

mothers. Furthermore, studies have shown that mothers and fathers are able to provide richly detailed responses to this interview before their children are even born (Benoit, Parker, & Zeanah, 1997; Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997), providing evidence that, because of the subjective and projective nature of this interview, the quality of responses are typically more reflective of the mother irrespective of the time that the child has been in her care.

Research Hypotheses

Based on clinical reports by experts in the field, kin caregivers appear to be less emotionally invested in and committed to their foster children than non-kin foster parents (Zeanah, personal communication, April 26, 2005). There may be several reasons for this, such as the relatives' unwillingness to usurp the biological parent's role, the kin caregiver's hope that the biological parent will "shape up" and be able to parent appropriately, or the unwillingness to participate in the termination of the related biological parent's rights. It was therefore hypothesized that non-kin foster care parents will demonstrate more emotional investment than kin foster parents in a structured interview that obtains the foster parents' representations of their foster children.

The independent variable in this study is the relative status of the foster parent. There were two levels of this independent variable: kin and non-kin, determined by the presence or absence of a blood relation between the child and foster parent. There was one mother in this sample who was the wife of the biological grandfather (i.e., the "step" grandmother) and she was included in the kin sample. The level of emotional investment expressed by the foster parent was the primary dependent variable.

Hypothesis 1: Foster parents who are not biologically related to their foster children will express more emotional investment in parenting their foster children as compared with foster parents who are biologically related to their foster children.

Foster parent perception of the child, as measured by the WMCI, was also included as a dependent variable.

Hypothesis 2: Foster parents who are not biologically related to their foster children will more often be classified as having *Balanced* WMCI classifications as compared with foster parents who are biologically related to their foster children.

Measures and Variables

Measuring Parent Perception of Child: The WMCI Classifications

The Working Model of the Child Interview (WMCI) is a semi-structured interview that assesses a caregiver's perceptions, beliefs, attitudes, subjective experiences and cognitive representations of her child, through questions regarding the developmental history of the infant, the child's personality, the foster parent's relationship with the child, how the child and caregiver react to different events such as the child's illnesses, and the caregiver's thoughts about the child's future, among others (Zeanah & Benoit, 1995). Each foster mother in this study completed this 1-hour, video-taped interview during her initial entry into the Infant Team program. The responses from these interviews were coded with two distinct coding systems: The TIMBI scales (See Appendix B), to determine a score for emotional investment in the child, described in detail below, and the existing coding system for the WMCI (Available from the author, Dr. Charles H. Zeanah), to classify each foster parent's perception of the child and their relationship.

The coding system of the WMCI classifies the parent's perceptions of the child into three main categories: balanced, disengaged, or distorted. A balanced classification is assigned to those narratives that coherently communicate rich details, an openness to change regarding the child's development and personality, and a valuing of the child and the relationship with the child. Representations that indicate that the parent is distant from, or has an aversion to, the infant are classified as disengaged. These narratives are characterized by lack of emotional involvement or excessive intellectualizing. A distorted classification is assigned to those narratives that are inconsistent or incoherent, overly preoccupied with one or two aspects of the child or other concerns, or self-involved and insensitive to the infant as an individual (Zeanah & Benoit, 1995). As was discussed in more detail in Chapter 2, the WMCI classifications have been found to be concordant with Ainsworth et al.'s (1978) classifications of attachment (Zeanah et al., 1994; Benoit et al., 1997), have demonstrated predictive validity and stability in studies of women in their third trimester of pregnancy (Benoit et al., 1997), and have been associated with infant clinical status (Benoit et al., 1997).

Measuring Emotional Investment to Child: This is My Baby Interview

The This is My Baby Interview (TIMBI; Bates & Dozier, 2002) was created specifically to assess the level of investment expressed by foster parents toward their foster children. The interview consists of six questions addressing the foster-mother/child relationship and a general question addressing the mother's experiences of being a foster parent (Bates & Dozier, 1997). Because the foster mothers in this sample completed the WMCI, it was decided that the coding scales of the TIMBI would be applied to their responses to the WMCI to determine their emotional investment in child.

While the majority of the questions of the TIMBI are included in the WMCI, two questions, *Do you ever wish you could raise (child)?* and *How much would you miss (child) if she/he had to leave?*, are not specifically included in the WMCI. Because the WMCI is such an in-depth interview compared to the rather brief TIMBI, however, this information was often spontaneously elicited by similar questions included in the WMCI (e.g., *How do you wish you could change your relationship with (child)*).

TIMBI Coding System

There are three scales to the TIMBI coding system: Acceptance, Commitment, and Awareness of Influence. In one study of factors associated with foster mothers' representations of their foster infants, Bates and Dozier (2002) found the three scales of the TIMB interview to be intercorrelated as follows: acceptance and commitment (.83); acceptance and awareness of influence (.65); and belief in influence and commitment (.63). Despite these moderate and high correlations, Bates and Dozier (2002) conceptualized these variables as separate constructs and therefore analyzed them as distinct variables. It may be possible for a caregiver to be highly accepting of a child while also demonstrating decreased commitment, for various reasons. For example, Bates and Dozier (2002) describe an elderly foster mother who was highly accepting of her foster child, however she expressed low commitment to the long term care of the child because of her advanced age.

The coding system of the TIMB interview consists of five- point Likert scales, with midpoint scores being acceptable. Raters apply the specific score by considering the positive and negative qualities of each of the three dimensions as described in detail in the coding manual, which will be used for this study.

The acceptance scale is conceptualized as acceptance vs. rejection. The assessment of acceptance or rejection of the foster child is based on indicators of the foster mother's perception of the child and their relationship, the valuing of the child's individuality, and the expressed enjoyment of caring for this child. These characteristics are scored based on the mother's words used to describe the child, the tone of her voice as she talks about the child and their relationship, and the congruence between the mother's thoughts and descriptions of the child and her behavior towards the child, if it is also described.

The commitment scale is conceptualized as a continuum anchored by commitment and indifference. Indicators of emotional investment and motivation to parent the child are considered evidence of commitment. A high commitment rating indicates that the foster mother considers this particular child to be important and her own, and that she has demonstrated motivation to commit the needed resources, particularly emotional resources, to raise this child. In other words, the highly committed foster mother has psychologically adopted this child. In contrast, indifference is evidenced by a lack of affective involvement and lack of interest in parenting this child. Foster mothers who are rated as indifferent may also specifically indicate that they are withholding or intentionally trying to limit their affective bonds with their foster children.

The Awareness of Influence variable assesses the degree to which the foster mother believes her relationship with the child may influence the child presently and in the future, and it examines her goals for the child. A foster mother rated with high awareness of influence will be focused on psychological, social or affective influences and goals as opposed to concrete influences and goals (Bates & Dozier, 1997).

Reliability and Validity of TIMBI

The TIMBI has been used in several studies, described in detail in the literature review (Lindhiem & Dozier, 2006; Ackerman & Dozier, 2005; Bates & Dozier, 2002), providing evidence of its predictive and convergent validity. Foster mothers' expression of emotional investment in their foster children, as measured by the TIMBI, has predicted child developmental outcomes that are typically associated with attachment quality, such as a mother's ability to support her child in a problem solving task, more successfully than direct assessments of attachment organization (Bates & Dozier, 2002). Commitment scores on the TIMBI have been found to predict foster placement stability, with approximately 2 years of increased stability for each point scored on the 5-point Commitment scale (Dozier & Lindhiem, 2006). The children of foster mothers who expressed higher levels of acceptance and commitment to their foster children at age two have demonstrated more positive self-representations during a projective puppet interview at age five than those children of foster mothers expressing lower levels of acceptance and commitment (Bates & Dozier, 2001). This same investigation found that highly invested foster mothers also provided more support and interacted with their children more than non-invested foster mothers during a problem- solving task.

Inter-rater reliability was reported to be .89 for acceptance and .90 for commitment in Ackerman and Dozier's (2005) study of the effects of foster parents' investment on children's representations of self. In the study of the effects of child behavior on foster mother commitment levels, Lindhiem and Dozier (submitted for review) reported inter-rater agreement to be .90. Dozier and Lindhiem (2006) also reported inter-rater agreement at .90 for commitment in their study of 84 foster parents.

Test- retest reliability was also investigated by measuring commitment at two points in time, 11 months apart, and caregiver commitment to child was found to be stable with a correlation of .61 (Lindheim & Dozier, submitted for review).

Coding Procedures for Current Study

Parent Perceptions

The WMCI classifications were determined after viewing the entire videotape, using the guidelines in the WMCI coding manual (Zeanah & Benoit, unpublished manual). Inter-rater reliability of 80% was established by this author with a standard set of tapes that were double coded by experts, including the author of the interview, Dr. Zeanah. Dr. Zeanah also served as a consultant to this research. All of the interviews ($N = 63$) were coded and classified by this author.

Emotional Investment

The scores for emotional investment, specifically Acceptance, Commitment, and Awareness of Influence, were derived from watching the WMCI in their entirety and applying the TIMBI scales to the foster mother's responses. Because the TIMBI scales have not been used with the WMCI in previous studies, ten WMCI that were not included in the study's final data set were chosen as a practice data set.

Preliminary Reliability Assessment

This author contacted Mary Dozier and received the unpublished coding manual that has been used in the previous literature discussed above. The research question and proposed methodology were also discussed with Dr. Dozier.

The two coders for this study, this author and a second coder who was masked to the research questions and hypotheses, then became familiar with the TIMBI coding

manual and procedures (Bates & Dozier, 1997). Following familiarization, the coders watched two videos together, scored them independently, and then discussed rationales for the results. The remaining eight interviews were then watched and scored independently, with a discussion about the results following each tape. Inter-rater reliability, calculated as a Spearman-Brown correlation, was .83 for acceptance, .39 for commitment, and .37 for influence. The unacceptable reliability scores for commitment and influence were the result of the small number of cases (n=10) and one case in which the two coders had marked disagreement; all of the other cases were scored within one point of each other, with there being exact agreement in four of the cases. Before proceeding to the reliability assessment on the final data set, this author consulted with Charles Zeanah regarding the case that resulted in such disagreement. Dr. Zeanah then reviewed that particular case and scored it, and his scores matched this coder's scores identically (November 14, 2006).

The two coders then discussed these results, and each of the cases, again to review reasons for discrepancies. The theoretical elements of each scale were discussed and studied to ensure that each coder was conceptualizing the content similarly.

Addendum to the TIMBI Coding Manual

Following the completion of the practice set, it was determined that an addendum to the TIMBI coding manual would allow for an increased level of standardization of coding when applied to the WMCI (See Appendix C).

There were two primary reasons why this addendum was believed to be necessary. First, while the TIMBI coding manual provides very rich generalized descriptions of each of the three scales, there are only three individual anchor points,

which are fairly broad. With the coding system consisting of a 5-point Likert scale, with mid-point scores being acceptable, it was felt that this allowed too much variability between the points. The addendum, therefore, operationalized points 2, and 4, to allow for more specificity. It was also agreed that mid-point scores would not be used.

Secondly, the nature of the WMCI, which lasts approximately an hour compared to the 10-minute TIMBI, often elicits discourse qualities that are typically viewed as more important than the content of the responses (see discussion regarding coherence in the AAI in literature review). For example, the TIMBI asks the foster parent to “*describe (child’s name)*” and “*What is his/her personality like?*”, whereas the corresponding question in the WMCI is “*Describe your impression of your child’s personality now*”, and then, following this general description, the mother is asked for five adjectives or phrases to describe her child’s personality, followed by a *specific* story, memory, or incident that provides further detail of *each* of the five adjectives. While most mothers are able to provide a general description of their children’s personalities, it is often the case that only “balanced” mothers can provide rich, succinct, relevant, truthful, and coherent stories to further describe their children’s personalities as is requested in the WMCI. Thus, the depth of the WMCI allows for much greater opportunity to assess the coherence of the mother’s narrative, a quality that should be considered when evaluating the mother’s responses. The addendum to the TIMBI coding scales therefore emphasizes these discourse qualities as points of consideration more so than the TIMBI coding manual does.

Following familiarization with the addendum to the TIMBI coding manual, each coder viewed and scored the tapes independently, with this author coding all 63

interviews and the independent coder coding 60 of them (95.2%). It was decided that the independent coder should do such a high percentage of the data set to avoid potential coding bias. Although this author was officially masked to the kinship status of the interviewees, the respondents often spontaneously elicited information which revealed the nature of their relationships to their foster children, and therefore may have potentially influenced this author's coding decisions. Having the independent coder, who was masked to the research question and hypotheses, increased the likelihood that the coding of the interviews remained impartial.

Following every third interview that was coded, the two coders reviewed the results and discussed discrepancies, and a consensus score was reached when the independent scores differed. Another Spearman-Brown correlation was calculated for these 60 subjects, inter-rater reliability was .81 for acceptance, .81 for commitment, and .66 for influence. The lower reliability score for influence is believed to be a result of lack of clarity in the addendum to the coding manual. Agreement continued to increase as the cases were discussed, but the small sample size did not allow for an increase in reliability level. The second coder remained masked to the research questions and hypotheses throughout this coding process.

Covariates

Child Age

Previous research (Dozier & Lindhiem, 2006) has found that there is an inverse relationship between the age of the child and the level of commitment expressed by the foster mother, with the foster mothers of younger children expressing greater commitment than the mothers of the older children. Child age was therefore included in

the analyses to determine if this effect would be seen in this sample also. The Infant Team gathered child age from the social services agency records at the time of the child's entry into the Infant Team program and provided it to this researcher.

Motivation to Foster

Previous literature has found an inverse relationship between the number of children previously fostered and the level of commitment to the current foster child (Dozier & Lindhiem, 2006), with mothers who had fostered more children expressing lower levels of commitment to the current child. Although the number of children previously fostered was not available for this sample, the motivations of the foster parents were available. At intake, the infant team obtained information from each foster mother regarding her motivation for becoming a foster mother and classified each mother into one of two motivational categories: *family building* or *professional*. Family builders are conceptualized as foster mothers whose express intentions are to foster children with the hope that they may adopt, and therefore add to their families. Professional foster mothers are conceptualized as those who did not enter foster care with the intentions of adoption, but rather had expectations of providing temporary care to children in need, and who had provided care to multiple children in the past. The incentive to foster for the mothers in this professional group varied widely, ranging from altruistic ideations to financial support. Although there were mothers in this professional group who eventually did adopt some of their foster children, they continue to foster many children without the intention to adopt and were therefore still included in the professional category. Although exact number of children previously fostered was not available for this sample, it was the Infant Team's consensus that the mothers in the professional category certainly

had cared for far greater children than those placed in the family building category, and therefore this variable may capture this same information previously found to impact commitment to child.

Data Analyses

Bivariate analyses were conducted on all of the variables to determine if there were any relationships between the independent and dependent variables to ensure a parsimonious number of variables would be entered into the multivariate analyses. Bivariate analyses were also conducted to rule out demographic differences between the two groups.

Multiple regression was then used to explain any differences in the mean scores of emotional investment between the two groups, and to determine if the other available data contributed to the difference in the means. Even though two of the covariates are categorical in nature, multiple regression is an appropriate method to use as the goal of this study is to examine mean shifts, rather than predicting the odds of the foster parents' placement into a particular threshold (Cohen *et al.*, 2003).

A chi-square analysis was conducted to determine if any differences existed between the kin and non-kin foster parents' perception of child. Another chi-square analysis was then conducted to determine if there existed the appropriate relationship between the emotional investment scores and the WMCI classifications.

CHAPTER 4.

RESULTS

The primary purpose of this study is to determine whether differences exist between kin and non-kin foster parents' emotional investment in their young children in this sample. The primary dependent variable is emotional investment, operationalized as acceptance, commitment, and awareness of influence as measured by the coding system of the TIMBI (Bates & Dozier, 1997). The second dependent variable is the foster parent perception of child, as measured by the classification system of the WMCI (Zeanah et al., 1996). The presentation of the data analyses will be organized in the following sequence:

1. Demographic information of subjects
2. Emotional investment in child and correlates
3. Foster parent perception of child and
4. Relationship between TIMBI scores and WMCI classifications.

Sample Characteristics

Following is a discussion of the demographic variables available for the subjects. Because this study is a secondary analysis, there were several demographic variables that were not available for this data- set, particularly foster mothers' ages, length of time as a foster mother, number of children previously fostered, and licensure status.

Child Characteristics

Child ethnicity, age, and gender were available for all children (63) in the sample. Fourteen (22%) of the children were Caucasian, 40 (63%) were African American, and 9 (14%) were bi-racial. There were 32 (50%) males and 31 (49%) females. Ages ranged from 6.9 months to 60.1 months, with a mean age of 24.3 months.

Because child's age was hypothesized to have an inverse relationship with emotional investment, an independent sample t-test was used to determine if there were any significant differences in the ages of children between the kin and non-kin groups. Results demonstrated that there were no significant differences in child age between the two groups, $t(61)=-.199, p=.31$.

Foster Mother Characteristics

There were 21 (33%) Caucasian foster mothers and 42 (66%) African- American foster mothers. Of the kin foster mothers, 21 (70%) were African American and 9 (30%) were Caucasian. Of the non-kin foster mothers, 21 (63%) were African American and the remaining 12 (36%) were Caucasian.

Of the 30 kin foster mothers, 20 (66%) were grandmothers, 3 (10%) were aunts, 1 (3%) was a 2nd cousin, 2 (6%) were great-grandmothers, 1 (3%) was a great-aunt, and 3 (10%) did not have exact relationship specified. No other data were available regarding the foster mothers.

Emotional Investment in Child

The major dependent variable was the emotional investment, conceptualized as the degree of acceptance of, commitment to, and belief in influence on the child, expressed by the foster parents. Differences in the foster parents' emotional investment in their foster children as expressed by each kinship group were hypothesized as follows:

Hypothesis 1: Foster parents who are not biologically related to their foster children will express more emotional investment in parenting their foster children in comparison to foster parents who are biologically related to their foster children.

Bivariate and multivariate statistics were used to examine whether or not a relationship existed between kinship status and emotional investment. A summary of the scores for each group is presented in Table 1.

Table 1
Descriptive Statistics for TIMBI Scores of Kin and Non-Kin Foster Mothers

Variable	N	Min	Max	M	SD
Acceptance:					
Total	63	2.0	5.0	3.79	1.00
Kin	30	2.0	5.0	3.10	.88
Non-Kin	33	3.0	5.0	4.42	.75
Commitment:					
Total	63	2.0	5.0	3.52	1.18
Kin	30	2.0	5.0	2.73	.98
Non-Kin	33	3.0	5.0	4.24	.83
Influence:					
Total	63	1.0	5.0	3.52	1.15
Kin	30	1.0	5.0	2.87	1.04
Non-kin	33	2.0	5.0	4.12	.89

Correlations between the TIMBI Scales

Correlations between the three scales were calculated, as previous studies have shown moderate to high correlations between them (Bates & Dozier, 2002). The scales were also highly correlated in this study as is summarized in Table 2.

Table 2
Correlations Between Acceptance, Commitment, and Influence Scales

	1	2	3
1. Acceptance		.87**	.79**
2. Commitment			.82**
3. Influence			

** $p < .01$

As is shown in Table 2, the three scales were inter-correlated as follows: acceptance and commitment (.87), acceptance and influence (.79), and commitment and influence (.82).

Bivariate Analyses

Because of the small sample size, bivariate analyses were conducted to determine which of the available variables should be included as covariates in the multivariate analyses. Child age and foster mother motivation were first chosen as covariates because of findings in previous literature that supported their relationships with emotional investment. The relationships between the remaining data that were available (i.e., child gender and foster mother ethnicity) and emotional investment were then examined using independent sample t-tests. There were no significant relationships between boys and girls on measures of acceptance, $t(61)=-.886, p=.79$, commitment $t(61)=.635, p=.86$, or influence, $t(61)=-.38, p=.31$. Likewise, there were no significant relationships between Caucasian and African- American foster mothers on measures of acceptance, $t(61)=.85, p=.27$, commitment, $t(61)=.1.14, p=.73$, or influence, $t(61)=1.65, p=.29$. Thus, kinship status, child age, and foster mother motivation were included as covariates in the multivariate analyses.

Multivariate Analyses

Separate equations were run for each of the three TIMBI scales: acceptance, commitment, and belief in influence. Kinship status, age of child at placement, and motivation to foster were entered into the equation hierarchically to determine the degree of association between these predictors and emotional investment by the foster mothers.

Acceptance

The regression model for Acceptance is presented in Table 3.

Table 3
Hierarchical Multiple Regression for Acceptance with Predictors Kinship Status, Child Age, and Foster Mother Motivation ($N=63$) (Table continued)

Variable	B	SE B	β
Block 1			
Kinship Status	-1.32***	.21	-.64
Block 2			
Kinship Status	-1.31***	.19	-.63
Child Age	-.02**	.01	-.29
Block 3			
Kinship Status	-1.03***	.25	-.49
Child Age	-.02**	.01	-.25
Motivation	.20	.11	.21

Note: $R^2=.41$ for Block 1 ($p<.01$); $\Delta R^2=.08$ for Block 2 ($p<.01$); $\Delta R^2=.03$ for Block 3 ($p>.05$); ** $p<.01$ *** $p<.001$.

As Table 3 indicates, non-kinship status and younger child age were associated with higher acceptance scores. Results indicated that kinship status explained 40.3% of the variance in the acceptance scores $F(1,61)=41.2, p<.001$. Child's age was entered into the model and explained an additional 8.3% in acceptance scores, $F(1,60)=9.6, p<.01$. Foster Mother motivation did not contribute anything to the overall model for acceptance.

Commitment

A summary of the regression model for commitment is presented in Table 4.

Table 4
Hierarchical Multiple Regression for Commitment with Predictors Kinship Status, Child Age, and Foster Mother Motivation ($N=63$)

Variable	B	SE B	β
Block 1			
Kinship Status	-1.51***	.23	-.65
Block 2			
Kinship Status	-1.50***	.22	-.64
Child Age	-.02*	.01	-.24
Block 3			
Kinship Status	-1.00***	.27	-.43
Child Age	-.01*	.01	-.18
Motivation	.35*	.12	.35

Note: $R^2=.42$ for Block 1 ($p<.001$); $\Delta R^2=.057$ for Block 2 ($p<.05$); $\Delta R^2=.065$ for Block 3 ($p<.01$); * $p<.05$ ** $p<.01$ *** $p<.001$.

As Table 4 indicates, higher commitment scores were associated with non-kinship status, younger child age, and family building motivation to foster. Results indicate that kinship status explained 41.8% of the variance in the commitment scores $F(1,61)=43.7$, $p<.001$. Child's age was entered into the model and explained an additional 6% in commitment scores, $F(1,61)=6.5$, $p<.05$ and motivation explained an additional 6.5% in commitment scores, $F(1,59)=8.3$, $p<.01$.

Influence

A summary of the regression model for awareness of influence is presented in Table 5.

Table 5
Hierarchical Multiple Regression for Influence with Predictors Kinship Status, Child Age, and Foster Mother Motivation (N=63)

Variable	B	SE B	β
Block 1			
Kinship Status	-1.26***	.24	-.55
Block 2			
Kinship Status	-1.25***	.24	-.55
Child Age	-.01	.01	-.12
Block 3			
Kinship Status	-.83**	.31	-.37
Child Age	-.04	.01	-.06
Motivation	.29 *	.14	.29

Note: $R^2=.30$ for Block 1 ($p<.001$); $\Delta R^2=.01$ for Block 2 ($p>.05$); $\Delta R^2=.05$ for Block 3 ($p<.05$); * $p<.05$ ** $p<.01$ *** $p<.001$.

As Table 5 indicates, higher influence scores were associated with non-kinship status and family building as motivation to foster. Kinship status explained 30.3% of the variance in the influence scores $F(1,61)=26.5$, $p<.001$. Child's age was entered into the model and, interestingly, did not contribute anything to the model: $F(1,60)=1.2$, $p=.28$.

Foster mother motivation to foster accounted for 4.9% of the variation in influence scores, $F(1,59)=4.5, p<.05$.

Foster Parent Perception of Child

Differences between kin and non-kin foster mothers in their perceptions of their children were hypothesized. It was hypothesized that:

Foster parents who are not biologically related to their foster children will more often be classified as having *Balanced* WMCI classifications in comparison to foster parents who are biologically related to their foster children.

A chi-square test was applied to the relationship between kinship status and WMCI classification and found to be statistically significant as hypothesized, $\chi^2(2)=19.88, p<.001$. The observed frequencies can be found in Table 6.

Table 6
Contingency Table for WMCI Classification and Kinship Status

WMCI Classification	Kinship Status		Total
	Non-Kin	Kin	
Balanced	26	7	33
Disengaged	4	9	13
Distorted	3	14	17
Total	33	30	63

$P<..001$

As expected, non-kin mothers were significantly more likely to be classified as balanced (78.8%) as compared to kin foster mothers (23.3%), $p<.001$. Kin foster mothers were significantly more likely to be classified as distorted (46.7%) than non-kin foster mothers (9.1%) $p<.001$, and 30% of kin foster mothers were classified as disengaged versus 13.3% of non-kin ($p<.001$). There were no significant relationships found

between WMCI classifications and child gender, $\chi(2)=.15, p=.68$ or foster mother ethnicity, $\chi(2)=.78, p=.68$.

Relationship between TIMBI Scores and WMCI Classifications

Because this is the first study that uses the TIMBI scales with the WMCI, it was decided that an analysis of the TIMBI scores and WMCI classifications was warranted to determine if there was a relationship between the two variables. The information provided by such an analysis is limited, as the two scoring systems consider very similar content and qualities of discourse when assigning scores and classifications. Because of this dependence on similar narrative characteristics, however, the absence of a relationship between the two systems could be indicative of problems with rater reliability and validity of the combined use of these two instruments. A chi-square test was applied to the relationship between TIMBI scores and WMCI classifications and they were found to have a statistically significant relationship. The observed frequencies can be found in Table 7. As explained in Chapter 3, the higher scores (i.e. 5 and 4) are considered the desired levels of emotional investment.

Table 7.
Contingency Table for TIMBI Scores and WMCI Classifications

	TIMBI Acceptance		TIMBI Commitment		TIMBI Influence	
	2.0-3.0	4.0-5.0	2.0-3.0	4.0-5.0	1.0-3.0	4.0-5.0
WMCI						
Balanced	0	33	4	29	4	29
Disengaged	12	1	13	0	11	2
Distorted	16	1	16	1	16	1

$p<.001$

There was a statistically significant relationship between each of the three WMCI categories and TIMBI Acceptance scores, $\chi^2(6)=57.86, p<.001$, TIMBI Commitment, $\chi^2(6)=46.4, p<.001$, and TIMBI Influence $\chi^2(8)=44.3, p<.001$. Conceptually this

relationship is to be expected as the criteria for the balanced WMCI classification (e.g., acceptance of child, psychological involvement with child, belief that the relationship is important to child's development), along with narrative discourse qualities such as coherence, are nearly identical for high scores on the TIMBI, and therefore the higher TIMBI scores should be related to the balanced classification, as is demonstrated in Table 7. Similarly lower TIMBI scores are assigned to those responses that do not indicate acceptance, psychological involvement or belief in influence in the relationship, for example, just as the disengaged and distorted WMCI categories do not. As Table 7 indicates, these two categories were also significantly related to the lower TIMBI scores. These findings support the validity of the use of the TIMBI scales with the WMCI.

Summary of Findings

This study examined the emotional investment of a largely African American sample of kin and non-kin foster mothers who were involved with an urban infant mental health team. There were no significant differences in the race of the foster mothers or the ages of the children between the two groups.

As hypothesized, there were significant differences in emotional investment to child between the kin and non-kin foster mothers. Specifically, non-kin foster mothers demonstrated more acceptance of, commitment to, and awareness of influence on their young children than the kin foster mothers.

The regression model demonstrated that kinship status explained approximately 31% to 42% of the variance in emotional investment on each of the three scales. Child age explained a smaller portion of the variance for acceptance and commitment, but not influence. Foster mother motivation to foster contributed to the model for commitment

and influence, but not acceptance. The three TIMBI scales had inter-correlations ranging from .79 to .87.

The kin and non-kin foster mothers were also significantly different in their perceptions of their children as measured by the WMCI. Non-kin foster mothers had a significantly larger percentage (79%) of balanced classifications compared to the kin group, who had a significantly larger percentage (47%) of distorted classifications.

Finally, a chi-square analysis demonstrated that there was a significant relationship between the TIMBI scores and the WMCI classifications. Higher TIMBI scores (4s and 5s) were associated with balanced WMCI classifications and the lower TIMBI scores (1-3) were associated with the disengaged and distorted WMCI classifications. This finding provides support for the validity of the use of the WMCI to measure emotional investment as established with the TIMBI coding manual (Bates & Dozier, 1997).

CHAPTER 5.

DISCUSSION AND CONCLUSIONS

The central hypothesis of this dissertation was that there would be significant differences in emotional investment in foster children between kin and non-kin foster mothers. It was anticipated that the findings of this study would provide further data to inform the kinship care debate that continues to be an important and evolving field of inquiry in child welfare policy.

The findings reported in Chapter 4 provide support for the study hypotheses, in that there are significant differences in the emotional investment and perception of foster children between the kin and non-kin foster mothers in this sample. A discussion of the meanings of these findings may reveal how this information can contribute to the current foster care debate and may better inform placement policies.

Emotional Investment in Child

The findings discussed in this section will include the mothers' emotional investment in their foster children as expressed in their responses to the WMCI and measured by the TIMBI scales. Emotional investment was conceptualized as the combination of the three separate TIMBI scales: acceptance, commitment, and belief in influence. Emotional investment to child has been found to be an important measure of the quality of foster care relationships in that it significantly predicts the quality of the child's self-representations, the child's coping responses to caregiver separations, and placement stability (Ackerman & Dozier, 2005; Dozier & Lindhiem, 2006).

In support of clinical observations (Zeanah, 2005 personal communication), the findings of this study suggest that foster caregivers who are biologically related to their foster children often demonstrate less acceptance of and commitment to their relative foster children than non-kin foster mothers do. Intuitively, this observation may seem to be strange as one would think that a grandmother, for example, would be more committed to providing care for her grandchild than a stranger would. However, when a kin foster mother assumes care of a relative, there may be additional factors that interfere with her ability to focus on the child, as is needed for a caregiver to be considered highly invested in the care of the child. The following section will examine WMCI responses of kin and non-kin foster mothers in this sample selected to illustrate variation in emotional investment, as well as to elucidate some of the parenting challenges they face.

Acceptance of Child

The WMCI has many questions that elicit the tone and quality of acceptance of the child from the respondent. Some examples of such questions are *Describe the first few days with your child, describe your impression of your child's personality, describe your relationship with your child*, etc. In examining the responses to these and many other questions, the content of the responses, the associated tone and affect, and the qualities of discourse, particularly the coherence of the narrative, are all considered before assigning a score. The central question being asked for the acceptance variable is, does this parent like/accept this child as s/he is, including all of the challenges and responsibilities that come with parenting this child, or does this parent wish the child were somehow different?

Parenting children, particularly high-risk children such as are included in this

sample, is often difficult. It is therefore expected that many parents will express concern or experience some sort of strain in their relationships with their children, and doing so does not necessarily result in a lower degree of acceptance of the child. Rather, the overall perception of the child is considered, and a decision is made based on the pervasive tone of the responses. In short, does this mother accept this child, challenges included, or is there some evidence of rejection?

Following are some excerpts from interviews that may further illuminate differences in expressions of acceptance. The following response to *Tell me about when he first came to your home* came from a non-kin, professional foster mother:

The social worker said he may be retarded. It wasn't like I hadn't dealt with kids with problems before, I wasn't worried. He had a lot of physical problems, but mentally seemed normal... Something just tugged at me and we just loved him. We were very excited... He's loving, caring. I'm concerned about the future, if the aunt wants him. That's my baby.

This foster mother has provided temporary care for previous children, some with disabilities or other challenging needs. Although this particular child also came to her with many physical and other challenges, all of her responses in this interview suggest that she has integrated these difficulties into her general perception of this child so that they have not become a focus of attention when she thinks of this child. For example, in listing her personality descriptors for this child, this mother described him as being *stubborn, independent, caring, likes to do good, and affectionate*, and was able to provide, full, rich details about each descriptor. Thus, she is able to talk about the difficult behaviors (ie, stubborn/ tantrums), but the overall tone and content of her responses are clearly focused on this child's positive characteristics.

In contrast is this response to the question *what behavior is the most difficult for you to handle?*. The respondent is a non-kin foster mother, classified as family building, talking about her 58 month-old foster child:

His constant need for attention, I don't think it's normal, he can't go 5 minutes. I cannot keep my house clean because this child can't do anything. When he doesn't listen. How he handles anger. He sometimes throws stuff, spits, kicks... while smiling! Psycho kid. Jekyll and Hyde. I have to stop and hold my breath because he's being psycho... I have to walk away because I'm tired and he's psycho.

Although there were several instances where this mother did talk about some positive characteristics of the child and she did state that she loves this child, the overall tone of the interview was pervasively negative and this mother seemed overwhelmed and preoccupied by this child's difficult behaviors, and therefore received a low score for acceptance.

A repeated theme was observed in kin caregivers' responses to questions that elicited their perceptions of their children's personalities, in that the kin foster mother often compared this child to the child's mother or father. While this is often a typical response in biologically intact dyads also, and in fact is specifically probed for in the interview (ie: *Who does your child remind you of? Which parent is s/he most like?*), these types of comments seemed to be pervasive in many of the kin interviews in this sample, so much so that these interviews were judged to have some degree of incoherence as the kin caregiver could not remain focused on the child. For example, one grandmother stated, regarding her 23 month-old grand-daughter:

She's got an attitude problem just like her mother and dad. She's selfish, wants attention/whines, has mood swings... she'll bite anyone... her dad is a liar and she is too. She'll repeat what you say, that's how slick she is.

Although this grandmother also spoke of loving this child, the interview was primarily negative and often resulted in long tangents reflecting this grandmother's anger with the mother and father, forcing the interviewer to remind the grandmother of what the topic of conversation (ie: the child) actually was, and therefore received a low acceptance score.

As is seen from the above comments made by different foster caregivers, there are many different variables that exert an influence on the degree of acceptance that a foster mother may have of her child, including the mother's interpretation of what difficult behavior is, appropriateness of developmental expectations, and attributions of characteristics to the child from other people. While there were certainly examples of high and low levels of acceptance in both the kin and non-kin groups, the observation that kin caregivers were significantly lower (3.1 compared to 4.4 in non-kin), on average, in acceptance of child suggests that there may be factors that impact their abilities to accept their relative foster children that do not necessarily impact non-kin foster mothers. Although much more in-depth, qualitative analyses would have to be conducted, in looking at the responses similar to the grandmother's above, it seemed to be the case that kin foster parents were often unable to focus on the child exclusively, allowing their feelings about and perceptions of the children's biological parents to intrude upon their narratives of their foster children.

While there are many things about receiving a foster child that may be overwhelming for most foster parents, such as child behavior and navigating the child welfare system, kin foster parents may have additional difficulties, thoughts, and feelings to deal with that may be interfering with their abilities to fully accept their relative foster

children. In addition to the typical stresses of lower SES status and lack of support from CPS agencies that were discussed in Chapter 2, the mere fact that this kin foster mother is fostering a relative child, who has been removed from the care of that relative due to his or her lifestyle and behavior, would likely elicit many different feelings toward that relative, which may in turn intrude upon the foster mother's relationship with that relative's child. For example, a grandmother whose daughter loses custody of her children would likely have a variety of feelings about the entire situation, perhaps ranging from anger and resentment to disappointment and sadness, all of which may either be transferred or projected onto the child. Furthermore, inferring from the data about the intergenerational transmission of abuse and other maladaptive parenting styles discussed in Chapter 2, it may be that kin caregivers are more likely than non-kin to bring preconceived distortions and incoherence to their relationships with their relative foster children. In other words, if a biological mother is so impaired that she has been deemed unable to parent her young children, it may follow that the relative caregiver, who has often participated in the rearing of that biological mother, may likewise be impaired. Given these possible explanations, among others, for the lower levels of acceptance toward their children observed in the kin caregivers in this sample, it may be the case that some of the theoretical arguments supporting kinship care, particularly that kinship care may provide increased security and sense of belonging, may actually be more likely to occur in non-kin placements.

Commitment to child

Commitment to child has been generally defined as the degree to which the foster mother views the baby as her own, permits herself to become emotionally invested,

provides physical and emotional resources to promote the child's growth and development, and demonstrates that parenting this child is important to her (Ackerman & Dozier, 2005). It has also been more narrowly defined as the extent to which a caregiver is motivated to maintain an enduring relationship with her child (Bates & Dozier, 1998). In short, the concept being measured here is whether or not the foster mother views this child as her own while the child is in her care, or, in other words, has psychologically adopted this child.

There are many different indicators that suggest that a foster mother has psychologically adopted a child. In addition to obvious remarks about actually considering or wanting this child to be hers, a mother can express high levels of commitment by indicating that, among other things, there is a strong affective bond with the child, that she is willing to do or provide whatever is necessary for the child's well-being, that there is little or no withholding in emotional resources, and that she will miss this child if s/he were to leave her care.

As with acceptance, the scores for commitment were determined after watching the entire interview and were therefore based on the general tone and content of all of the responses. Although the WMCI does not specifically ask if the caregiver has thought about adopting the child as the TIMBI does, many mothers spontaneously offered that information in response to other questions. For example, in response to *Describe your relationship with this child*, one non-kin mother stated "He was immediately part of the family... We'll be devastated if we don't get him." The following excerpt is from a non-kin mother in response to *What do you expect your child to be like as a teenager?*:

I wonder because of his background. His grandmother told me they was all foster kids and I wonder if he'd say if my Mom was a foster child why couldn't she do

better by me? But on the other token, I would hope he know that they was all foster kids but HE would be adopted. And I think that he would have that special thing that she (foster mom) loved him enough to adopt me and give me this.

These foster mothers received high scores on commitment, not only because they directly state, in a convincing manner, that they want to adopt their children if given the chance, but also because their entire interviews supported the premise that they love their children and are willing to invest whatever resources necessary for their physical and emotional development. As with all of the scales, the narrative processes, including affect and coherence were also considered in making the final decision for scoring.

There were many foster mothers who expressly stated that they either could not or would not adopt the child yet still received high commitment scores. This excerpt is from the non-kin, professional foster mother of a 7 month old with severe medical problems, in response to *Describe your relationship with her*:

I'm her mom in the same way I'm the other kids' mom. I feed her, take care of her, comes to me when crying. I'm there as a doctor, to comfort, take care of everything. When we got B, we knew we would be adopting him, so you form a different connection with him because you know he's not going anywhere. And then we got D, and we were told she'd be here for six months and then she'd go back home, but she ended up staying. So you love them and you take care of them and want to do what's best for them. You love them unconditionally and it doesn't matter, but you keep part of yourself from being completely connected to them. Because if they go back, you don't want it to completely destroy you. What this mom has to do is so simple. If this was my kid, I'd do anything to get her back. So I love her and I do everything I do for the other kids who were adopted, but there's a part of you that holds back because you don't want it to completely destroy you when she goes home.

This mom received a 4 out of 5 for commitment. Her entire interview, including content, affect, and other narrative qualities, provided evidence that she loves this child and is providing all of the physical and emotional resources that this child needs, and will

deeply miss her if she returns home, despite her slight withholding. This mother has fostered numerous children, and appears to have been misled many times by the foster care system regarding placement decisions. The excerpt above illustrates a dilemma of many foster parents, specifically how do you care for and love a child without being personally devastated when s/he can be removed at any time with virtually no notice?

The above example illustrates a professional mother who, in practice, is a fully committed foster mother despite her efforts to defensively remain at somewhat of a distance from the child. The following example, from another non-kin foster mother classified as professional, demonstrates how some do maintain distance from the child in practice. The following is in response to *How do you feel when you're separated from your child?*:

That's a hard question. I've been a foster parent for 11 years and I had children come and go, so you can't get attached to these little children. Because it's heartbreaking. But there is a feeling there. You get to caring about this child. When I'm away, I worry about her...but I can't let my feelings go over. There have been times when I broke down when children left me. So that make you stronger when you've been there before. So there's a sense of caring, but only letting your feelings go to a certain extent.

Although this mother provided evidence that she was taking adequate care of this child, it was clear from her responses that she considered herself a temporary caregiver and this child as just one of many passing through her home. This mother often oscillated between talking specifically about this child and talking in third person or in general about other children, indicating that this specific child was not a particular focus or concern for this mother, and was therefore given a lower score for commitment than the mother in the previous example. This expression of lower commitment may be representative of the thought processes of many professional, non-kin foster mothers who

have found it necessary to maintain emotional distance from the children in their care to avoid the feelings associated with having to return a foster child. This finding was expected as previous studies have demonstrated inverse relationships between the commitment to the child and the number of children previously fostered (Dozier & Lindhiem, 2006). Intuitively, it does make sense that as a foster mother cares for more children that she would not be able to continue to experience the pain associated with having a child leave her care, and would therefore learn to defensively protect her emotions by remaining distant to the child.

There were significant differences in the commitment scores of kin and non-kin caregivers, with the kin group expressing less commitment ($M=2.7$) to their children than non-kin ($M=4.2$). While there are likely different factors that may help to explain the lower level of commitment in the kin group, one theme in particular, a reluctance to usurp the biological parent's role, was often noted in kin responses. Following are a few of such responses, all expressed by kin caregivers, in response to various questions:

My family is very important to me. Of course ultimately we would love to see her with her parents, they deserve to see as she grows, every little thing that only a mother and father will notice, their first tooth, first haircut, those things... were so important to me. The lord gave her to those parents and we don't know what happened with this particular incident, but they deserve her. (Maternal Grandmother)

I don't want him to think I'm his mom because he has a mom. And he has a grandmother. So I feel better when I'm just Auntie... I'll miss him when he's gone, but he'll still be in the family. (Aunt)

I pray that they get their lives together so they can get him. I really want them to have their child because it's their child. I don't believe in taking kids away from their family. Moms and Dads should raise their own child. (Great grandmother)

While the grandmother above showed evidence of providing sufficient care for her granddaughter, the pervasive theme of the interview was this struggle with why her daughter lost custody of her children, obviously caught up in empathic feelings for her daughter's loss more so than with the need of her grandchild to have a committed parent-figure during this difficult time. Likewise, the aunt and great grandmother were very clear that they view themselves as temporary caregivers until the children can be returned to their parents. All of these foster mothers received moderate to low commitment scores, depending on their responses to the entire interview, because of this lack of psychological adoption. These kin foster caregivers were not able to provide evidence that they have made themselves available to their young children as emotionally invested caregivers.

Other kin caregivers were focused on their negative feelings surrounding the events that led to their kin having their child(ren) removed and were therefore unable to focus on their foster children. Following is a grandmother's response to *How did you feel during your daughter's pregnancy?*: "She was having baby after baby. I said, ok, another mouth to feed. Another baby." This grandmother was deeply burdened, in many ways, by her daughter's behavior and lack of parenting. The dominant theme of this interview was that this child was another one of these burdens.

Another reason that many kin caregivers were scored lower in their commitment to child was the marked incoherence of their responses. As was discussed with acceptance, many caregivers' narratives were incoherent in terms of not being able to focus on the subject of the interview, the child. Some examples of such incoherence that decreased commitment scores were: "I was happy to get her, but I raised her mother

better than this, I can't believe she (the mother) did this to me..." or "He'll stop that crying when he's older. My mom gave my sister away and she didn't want to go..." . Each of these, and many other similar examples, was followed by long, irrelevant stories that did not concern the child or the actual question that was asked. According to the research on adult narratives discussed in detail in Chapter 2, this form of incoherence is often an indication that the parent is struggling with past painful events and associated memories that have not been reorganized internally and therefore tend to become intrusively interjected into the narratives (See Hesse, 1999 for a summary). As a result these mothers' narratives were confusing, contradictory, tangential, and sometimes bizarre. One example of an odd and tangential response can be found in a grandmother's response to *How has your relationship with your child changed over time?*:

We're closer. If you have a dog in your backyard, and you feed that dog everyday, you going to worry about that dog. If you away from that dog for 8 hours, first thing you going to do is check on her. Eventually you care for this child. I'm going to protect these children. Why they care about me because they sense it, just like a dog, sense when a person want good.

Although some examples of such incoherence were found in both kin and non-kin groups, there was a significant difference between the groups, with 47% of kin foster mothers displaying marked incoherence compared to 9% of the non-kin foster mothers. While this study was not able to examine possible causal factors or correlates for this difference in coherence, some clues may be present in the content of these kin caregivers' responses. If a mother is experiencing enough physical, economical, social, emotional, or mental/psychiatric hardships so that her children must be removed from her care, it may often be the case that the relative with whom the children are subsequently placed may also be experiencing many of the same hardships. This may be the case when the kin

foster mothers are struggling with the actions and consequences of the biological mother or consumed with confusion and sadness about the biological mother losing her children. Thus, the very events that resulted in the children being placed in her care are so confusing and overwhelming to these kin caregivers that it interferes with her ability to focus on the child.

It is also possible that another explanation for this much higher rate of incoherence in the kin foster mothers is that they have experienced much higher rates of trauma themselves, since there is a biological and likely close relation to the maltreating mother or father of the children for whom they are now caring. While studies that have examined the intergenerational transmission of abuse (eg, Kaufman & Ziegler, 1993) certainly do not demonstrate that all parents who abuse were abused, there is a significantly higher risk where abuse has occurred that it has occurred in previous generations.

Likewise, although SES information was not available for any of the foster mothers in this sample, previous studies have consistently found that kin caregivers typically experience more poverty and associated risk factors (See Cuddeback, 2004 for a review). It is therefore likely that the kin caregivers in this sample are also of lower SES than the non-kin group and are therefore more vulnerable to other risk factors, such as domestic violence or mental illness. All of these risk factors, along with the reluctance to replace the biological parent and other possibilities, may be contributing to the observed lower level of ability or willingness to commit to care for their relative foster children.

Belief in Influence

This scale examines the level of the mother's awareness regarding how her relationship with her child may affect the child both now and in the future. Higher scores were assigned to those responses that indicated that the mother believed she could influence the child's psychological development in different domains, such as the child's happiness and ability to be successful in future relationships. Lower scores were given to those responses that either focused on helping the child to achieve concrete goals, such as learning to talk, or statements that indicated the mother does not believe their relationship can affect the child's development. Belief in influence is important because it may influence the caregiver behavior towards the child; a mother that believes her interactions may significantly influence the child's future happiness may be more motivated to provide appropriate, sensitive care versus a caregiver who does not believe there is a connection between the quality of the relationship and the child's outcome. Albus and Bates (1999) found that higher belief in influence scores were associated with higher levels of sensitivity in foster mother/child interactions.

Following are excerpts of responses from *How do you feel your relationship with your child has affected his/her personality?*

It has increased his self-confidence. He's willing to try something new, he feels he can do anything he wants. (Non-kin)

A lot. She smiles, she's happy. She's not going to do like her mom. She feels secure. (Maternal Aunt)

These responses demonstrate that these mothers believe they are having a positive impact on the children in their care that will benefit the child in numerous ways. Contrast

those responses with the following, again in response to *How do you feel your relationship with your child has affected his/her personality?*

It hasn't. He has his own personality. (*Interviewer: Do you think you have influenced his personality in anyway?*) No. Just like your mom wouldn't affect yours. It's yours.

She's a different person now. Even her mom said they were clean now, that we good parents. She's getting fatter, going to the doctor, doing like my own kids. (Professional non-kin)

These responses demonstrate variations of beliefs that all resulted in lower scores for belief in influence. The first excerpt is an example of a caregiver who does not believe that the quality of her relationship will have any affect on the child's development. Similar responses were "It doesn't matter what I do, he's going to turn out the way he turns out". This belief may lessen the motivation for the caregiver to provide sensitive care if she believes that the child's personality is determined at birth and is unchangeable. In the second excerpt, this mother is focusing on hygiene and weight gain as opposed to the child's personality development, and is therefore assigned a lower score on influence. Similar responses may focus on the child now being able to recite his or her ABC's or becoming successful with toileting. A foster mother who is focusing on these more concrete goals in their responses may be focusing more on these activities in their daily interactions, therefore not providing sufficient attention to the child's emotional and social well-being.

As hypothesized, non-kin foster mothers scored higher on this scale than kin foster mothers. Although the nature of this study does not allow inferences as to the reason(s) for this difference, once again it may be the situation of the kin caregivers (i.e., having to assume the child's care because of a relative's current inability to parent

appropriately) that is impeding their ability to focus on the emotional needs of the child. This may be reflected in the marked incoherence of the kin group's narratives in comparison to those of the non-kin.

Foster Mother Motivation to Foster

The motivation of non-kin foster parents, particularly whether or not they enter the foster care system with the intention to adopt and build their families or to provide temporary care for numerous children, was examined to see if it influenced the degree of investment in child. Previous studies have shown an inverse relationship between number of children previously fostered and commitment scores (Dozier & Lindhiem, 2006). This may be a result of the mother's initial intentions for entering foster care, such as having never considered adopting any children and therefore actively limiting the affective bonds from the start, or perhaps even a defensive technique to protect herself from the pain of loving a child as large numbers of children routinely enter and leave her care.

Because lower investment can result in less optimal parenting (e.g., Albus & Bates, 1999; Bates & Dozier, 2002) it is important that factors that may contribute to lower investment, such as having previously fostered numerous children, are considered. The finding that there was no difference in acceptance between those who had fostered more children (ie, professional foster mothers) and those who wanted to build their families by adopting through the foster care system was surprising, initially. Given the findings of previous studies to the contrary, this may be the result of the small number of non-kin who comprised this sub-sample (n=33) and this will be discussed further in the limitations section below. But when the *concepts* of acceptance and commitment are

considered, these differences in their relationship with motivation may make sense.

Although it is possible to be highly accepting of a child while at the same time having a lower level of commitment to that child (e.g., “*I love him but I just have too many kids to keep him*”), it would likely be a rare circumstance where there would be markedly higher levels of commitment than acceptance. It would be difficult for a foster mother to truly be committed to providing excellent and enduring care for a child who she does not like or accept. In this regard, the findings that motivation was associated with commitment but not acceptance are not surprising. It may be that the fostering of greater numbers of children previously does not necessarily interfere with foster mothers’ ability to love and accept their children, but this study does provide further support that it does interfere with their ability or desire to provide enduring care to them.

Kin caregivers were not considered in the motivation sub-analysis because their motivation was simply that they were related to the child. In other words, their statements of intentions upon entering the Infant Team were typically that either the biological parents or CPS have asked them to care for their relative children. However, there were 3 kin caregivers who were classified as kin/family builders because they expressed an interest, immediately upon entering the program, that they would like to either start or add to their families by adopting their relatives’ child(ren). While there were not enough of these subjects to include in an analysis, it is interesting to note the differences in their mean investment scores, which were higher than the mean scores for the overall kin group. Specifically, these three kin/family builders scored an average of 4.7 for acceptance, 4.7 for commitment, and 4.3 for belief in influence, compared to 3.1, 2.7, and 2.9, respectively, for the kin group as a whole. Although this can only be

considered as anecdotal information, it may be the case that kin caregivers who have pre-conceived notions of adopting their relative children will have much higher scores of emotional investment than kin caregivers in general. In fact, the mean scores for these kin/family builders were slightly higher than that of the non-kin group as a whole, who scored 4.4, 4.2, and 4.1 respectively.

Foster Parent Perception of Child

The following section will discuss the findings regarding the differences in parent perceptions of children between the kin and non-kin groups. The WMCI was used to determine the quality of the foster parents' perceptions of and thoughts and feelings about their children. The content and, more importantly, discourse qualities of these parent narratives regarding their children have been associated with children's attachment classifications, a major developmental standard for measuring the quality of child-parent relationships (Zeanah et al., 1994), predictive of future attachment classifications when assessed during the third trimester of pregnancy (Zeanah & Anders, 1987), and associated with clinical status of infant disorders (Benoit et al., 1993) and mother and child interactive behaviors (Zeanah et al., 1998). The results of all of these studies indicate that by and large, parents who are classified as having balanced representations typically have much healthier, sensitive relationships with their children in comparison to those parents whose representations are disengaged or distorted.

The results from this study indicate that the non-kin foster parents in this sample demonstrated significantly more balanced representations compared to the kin foster parents, whose representations were significantly more disengaged and distorted. Of particular concern is the high occurrence of distorted representations (46.7%) in the kin

population. This is roughly comparable to rates of distorted representations in a clinical sample (40.7%) (Benoit, Parker, Coolbear & Zeanah, 1997) and in a sample of maltreating parents (41.2%) (Zeanah, Heller, Smyke & Aoki, 2001). A distorted representation reflects an internal inconsistency in the narrative as a result of a preoccupation or distraction with other concerns or people, a sense of confusion about the child, or being overwhelmed by the child, and the resulting narrative about the child is therefore confusing, contradictory, or bizarre. These inconsistencies result in a sense that the caregiver is unsuccessfully struggling to feel close to the child (Zeanah & Benoit, 1995). As the studies discussed above have demonstrated, this internal struggle may place the child at high risk for insecure attachments and is often associated with clinical disorders.

Because this is a cross-sectional study, it is not possible to know why there is such a higher level of distorted representations among the kin caregivers compared to the non-kin. One explanation may be shared risk factors with biological parents, such as greater degrees of poverty or single parent status, and kin parents therefore may be more overwhelmed with daily functioning than the non-kin parents. This combination of risk factors may impede their ability to focus on their foster children. While almost all studies on kinship care have shown much higher rates of these risk factors with kin caregivers compared to non-kin (See Cuddeback, 2004 for a review), and this is likely to be the case with this sample also, it seems unlikely that this can fully explain the large proportion of distorted representations found in this sample. Preoccupation with such stressors would seemingly increase the likelihood of a mother's inability to be emotionally involved with her children, which would typically result in a disengaged representation, rather than a

distorted representation. For example, if a mother is spending much of her time concerned with finances, then she may not have the emotional resources to be involved with her child, and therefore there may be an unmistakable emotional distance or disengagement in her representation about her child. A mother whose representation is classified as distorted, on the other hand, is more likely to be internally preoccupied with other issues and/or confused, rather than preoccupied with external factors. Following the research from the Adult Attachment Interview as discussed in detail in Chapter 2, this internal preoccupation and confusion is believed to be the result of experiencing trauma or losses and the failure to coherently reorganize the associated memories. In other words, the mother has yet to make sense of her own experiences and is therefore confused or overwhelmed by these experiences to the point that it is interfering with her ability to focus on her child. Although these data are not available, it may be the case that the kin foster mothers in this sample have experienced higher rates of trauma or losses than the non-kin foster mothers, and this may explain the higher rates of distortion found in the representations of the kin group. Given the research demonstrating higher rates of maltreatment between generations (e.g., Kaufman & Ziegler, 1993), the fact that a kin foster mother is related to the mother who was validated as maltreating her children would statistically place that foster mother at higher risk for having experienced her own maltreatment or trauma.

Another possibility is that the unexpected burden of having to rear a child under conditions of intense extended family crisis may uniquely contribute to distorted representations in this circumstance. Concern about the biological parent (a relative and often close relative of the kin parent) coupled with the new demands of caring for a

young child, who often has medical, emotional, and/or behavioral complications from the maltreatment experienced, may lead to the inability to focus incisively on the child, a central feature of distorted narratives.

Regardless of the reason(s) for the high rates of distorted classifications in this kin group, the literature has consistently demonstrated their associations with attachment disruptions and clinical disorders and it is therefore concerning that young children are being placed with substitute caregivers who may be too overwhelmed with their own struggles to clearly focus on the needs of their young foster children.

Why Does Emotional Investment Matter?

The data available for this study do not allow associations to be made between the levels of investment and perception of children and the quality of other aspects of the foster parent-child relationship, such as quality of behavioral interactions or attachment strategies. The research described above, however, demonstrates that foster mother emotional investment is significant in determining whether or not the placement can become a therapeutic setting for the young child, particularly in the child's development of sense of self, attributions regarding peers, ability to persist in problem-solving tasks, and the stability of the placement (Ackerman & Dozier, 2004; Bates & Dozier, 2002). Dozier describes this investment as the willingness of the parent to stand between the child and danger (Dozier, Lindhiem, & Ackerman, 2005). The fact that this child is now in foster care certainly means that his or her biological parent(s) have been unable to serve as a secure base, by failing to protect the child and/or by serving as the threat to his or her safety. Thus, it is imperative for a young child to experience the emotional involvement of a substitute caregiver who is willing and able to focus on the needs of the

child and provide for those needs, even if doing so requires sacrifice on the caregiver's part. The absence of an invested caregiver may be quite devastating for a young child (Dozier & Lindhiem, 2006). The following excerpt in response to *How has your relationship changed over time?*, from a non-kin foster mother who was classified as family building, illuminates an instinctual knowledge that children need an invested caregiver:

We were worried that they would be taken back and given to relatives, but now we just deal with it day by day. You can't deprive them of love and attention on the basis that they are taken away. First, there was no family, then all this family showed up. We considered letting them go back because we didn't want to get too attached but we realized we were already attached. So we just keep it in the back our minds. We can't let that hinder their growth and development. Children pick up on the feelings around them.

As this foster mother alludes to, children need to know that there is someone who loves them, someone who will provide them with their emotional as well as physical needs. It is not enough for a very young child to be placed with a caregiver who will provide adequate housing, clothing, and food. Foster parents of young children must be willing to risk their own emotional pain, as the mother above has, to provide the child with the necessary emotional resources for optimal development.

In addition to the benefits to the child, emotional investment can be positive for the foster mother's experience as well. Consider the following excerpt from the interview of a non-kin professional foster mother, in response to the question *How do you feel about the changes in your relationship with your child?*:

I know the definitive decision has not been made, but initially they were going to make a placement after my caseworker said there's no way they can stay here, there's too many kids. She said there's a family who has the younger brother and they'll take them. Well then it became not this week, next week. Next week. So there was a lot of uncertainty. And then I had to make the decision we can't think

short term with this, we've got to think that they're going to be with us forever, even though I know they're not. It allowed us to say well, what would we do if they're going to be with us longer, and that allowed us to look at them differently and do things differently. That was relaxing for us knowing that we were able to make long term decisions.

This mother has fostered many children in the past and elucidates so well the challenges that many foster mothers face, in that it is difficult to make decisions for and care for a child who may be removed from her care at any moment. A foster mother who views her child as a passer-by may not be able to make decisions that are in the long-term best interests of the child, since she may view her role as temporary provider for basic needs only. In addition to the obvious benefit to the child, this mother describes how relaxing it is for her to be able to parent as she instinctively knows is appropriate instead of providing less adequate care while waiting on an inconsistent foster care system to make decisions.

The above excerpts may illuminate many of the struggles that non-kin foster parents have as a result of the structure of the system. The findings of previous research that demonstrate an inverse relationship between number of children previously fostered and level of investment may be understood in this light; as a mother experiences over and over the uncertainty of the system and the unexpected removal of children from her care, it may be a protective measure to *not* become so emotionally involved with the child. While this may allow a mother to continue fostering high numbers of children without experiencing personal devastation, it is certainly not in the best interest of young children.

The circumstances of kinship care are quite different, however. These relatives enter the foster care arrangement typically because they were asked by CPS or a relative

to care for their relative's children specifically, not to serve as foster parents for an unlimited number of children. Additionally, these relatives typically have been involved in caring for these children prior to the parents losing custody and will likely continue to be involved with their relative foster children even if they are reunified with their biological parents. It seems that these circumstances would be ideal for the development of emotional investment, yet the kin foster mothers in this sample demonstrated significantly less investment than the non-kin foster mothers, some of whom who had only known their children for 6 weeks.

Although it is impossible to determine reasons for this seemingly counter-intuitive finding with this particular study, some clues may again be found in the responses of the kin mothers in this sample. Particularly, there were recurrent themes of kin mothers who did not want to replace the child's mother or general feelings that a child should be with his or her mother (e.g., "*He'll want to be around his mom mostly, but he'll still visit his grandma. That's the way it's supposed to be.*" or "*The lord gave them children to her, she deserves them.*"). Many kin caregivers also seemed to struggle with the choices and short-comings of their children or relatives as parents to such an extent that it interfered with their ability to focus on the needs of the children. One maternal aunt responded "*I just don't know what happened, I know they didn't do that to him*" and "*I don't know. It won't happen again. I can't believe she would do that. She didn't do that*" to practically every question that was asked throughout the interview. And still others seemed to be struggling or overwhelmed with other issues and concerns so that they could not even tell a reasonably coherent story about their children. Consider this response to *How do you feel about the change in your relationship with your child?:*

“I’m her parent and grandparent. I want the best for my family, my family is very important to me. Of course ultimately we would like to see her with her parents. They deserve to see her... everything that comes their way, the first tooth... Those things are so important to me. I hope so. We don’t know what happened with that incident. But they deserve her. She’s just an extension of me and her grandfather.”

This grandmother’s tone, affect, and words, which are very difficult to understand, indicate that she is confused and overwhelmed, perhaps by the current circumstances or previous issues, but her interview clearly demonstrated that she is not able to focus on her relationship with the child and is not willing to take on the role of a parent because that is not what grandmothers are supposed to do. Similar narrative processes and beliefs on not wanting to usurp the biological parents’ roles were recurring themes in many of the kin interviews.

Limitations of Study

Like the vast majority of literature studying the merits of kin and non-kin foster care, this study has many limitations that must be considered. The small sample size of this study, as discussed in Chapter 3, decreases the statistical power, and therefore may decrease the generalizability, of these findings.

Because of the cross-sectional nature of the study, it is not possible to explain causal factors for the differences in investment and parent perception of child between the two groups. Likewise, because the interview was only conducted at one time point, it remains unknown whether or not investment levels or parent perceptions may change over time. Previous studies, however, have found that both investment and parent perception of child are relatively stable over time (Lindhiem & Dozier, under review and Benoit et. al, 1997).

There are potentially other variables that may contribute to either higher or lower levels of investment that this study was not able to include in the analyses. Previous research has shown that the length of time of being a foster mother and the number of children previously fostered are inversely related to investment, although the motivation variable was conceptualized to capture this same information. Child behavior has also been found to be inversely associated with investment but was unavailable for this sample.

It is also possible that there are significant differences between the groups, such as socio-economic status, education level, marital status, and foster mother age that contribute to the differences in investment. Certification or licensing status was also unavailable for the kin caregivers in this sample, a variable that should be considered in future studies as it may influence investment.

Summary and Future Directions

Despite the limitations of this study, this initial, exploratory investigation revealed significant differences in caregiver investment between kin and non-kin groups, a quality that has been demonstrated to be vital, and likely the most important, for the success of a foster care placement.

Foster care policies discussed above prefer kin placements to non-kin placements. The literature that supports the superiority of kin placements are largely qualitative and value-based, and the quantitative research has consistently produced equivocal results. This study is the first to examine emotional investment between kin and non-kin groups. Although it also has many limitations, it is an important first step in changing the

direction of research in the kinship care debate, particularly in its focus on an evidenced-based variable that has proven to be so important in foster child outcomes.

Many more studies need to be conducted to determine if these findings will be replicated with larger, more diverse samples, and if the inclusion of the other data mentioned above would affect the results. In a prospective study, the information on emotional investment should be collected from each foster mother at a specified time after having assumed the care of the child, and then at a second time point to determine if the level of investment has changed. Behavioral and interactional data should also be collected to increase the knowledge base regarding how investment affects the child's development. Demographic data, including SES, mother age, number of children previously fostered, certification status, and relationship to the child, should also be considered in the analyses as any of these variables may contribute to the foster mothers' levels of investment. Of particular interest is the foster mother's relationship to the child; if the above hypotheses are correct in that the lower levels of commitment in kin is partially the result of the relative not wanting to usurp the parent's role, then perhaps it is the case that the more distant the relationship, such as a second cousin versus a maternal grandmother, the more the levels of investment will increase.

This study may have important implications for foster care placement policy also. Despite the largely equivocal results of previous studies discussed in Chapter 2, research has consistently demonstrated that kin foster parents typically have more risk factors such as higher rates of poverty, are more often single parents, and are typically offered less resources, training, and support services from CPS compared to non-kin caregivers. Add the preliminary findings of this study to these risk factors, and there seem to be many

reasons to question the preferential placement of children with their relatives. Of particular concern is the lack of services offered to kin caregivers compared to non-kin, as the findings of this study demonstrate that they may actually be in the greater need of supports and services.

Despite the theoretical arguments supporting the advantages of kin placements, the notorious shortage of foster parents is likely the major impetus behind the kinship movement. Given this shortage, it may not be the case that policy can be radically changed to support non-kin placements. Indeed, because the range of investment scores were nearly identical between the two groups, it will certainly be a loss to blindly discriminate against relatives as substitute caregivers, just as it is seemingly ill-judged to discriminate against non-kin caregivers. The focus of the debate, therefore, may no longer need to be on which *group* is superior, but rather which type of *caregiver* can provide the best placement. The above literature suggests that it is the highly invested caregiver who will provide optimal circumstances for a young child's development.

If future studies replicate these findings, then policies should enable, and require, CPS agencies to routinely assess foster parents for their investment in their children, particularly those with very young children. The first three years of life in particular are very influential in determining the developmental pathway that may affect the child throughout his or her lifetime, and the fact the child is in need of foster care necessarily means that there has already been some sort of insult to that process. It is imperative that young children are placed in optimal circumstances as soon as possible so that it can serve as a therapeutic setting. It is commonly recommended that very young children be placed with foster caregivers who are able to adopt should the parental rights be

terminated to further minimize disruptions to the child. Thus, foster parents, kin and non-kin, should be assessed of their desire and ability to adopt before assuming the care of a young child.

Foster care systems typically rely on a small number of foster parents to care for large numbers of children. Dozier and Lindhiem (2006) report that foster mothers in one sample fostered an average of 24.8 children each, with some mothers reportedly fostering between 152 to 200 children. Given the finding that commitment typically decreases as the number of children fostered increases, it is likely that these very- experienced foster mothers' ability to be fully invested in each subsequent foster child would be impaired, and such placements are therefore not appropriate for young children. To meet the need for investment in the context of the shortage of foster parents, Dozier and Lindhiem (2006) suggest that infants and young children be placed with less experienced but more committed foster parents who are specifically recruited to foster only one to several children, rather than many, as is typically the case. If parents' expectations are that they will care for one particular baby only, then perhaps that will increase the number of parents who are willing to volunteer to become foster parents as well as increase the likelihood that those parents will be more committed to that specific child. These parents should also be potential adoptive placements to minimize disruption to the child if the biological parents' rights are terminated.

The results of this study suggest that current placement policies that support preferential placement with kin caregivers fail, in many instances, to consider the best interests of young children. All foster parents, and kin foster caregivers in particular should be thoroughly assessed to determine their strengths, weaknesses, ability to invest

in the child, and the presence of other risk factors that may interfere with the foster mother's ability to focus on the child prior to or immediately after the child is placed. Depending on the degree of impairment, a decision can then be made as to whether or not the child can remain with this caregiver while providing extra support services to the caregiver and child or if the child should be moved to a more appropriate placement.

The groundbreaking work of Mary Dozier and her colleagues has provided much needed information to inform the field of foster care with young children. In addition to providing professionals with an evidence-based method for assessing the quality of foster- dyad relationships, Dozier has created a brief training program for foster mothers (see Dozier, Lindhiem, & Ackerman, 2005 for a description) that addresses each mother's individual needs in relation to her ability to parent a young foster child, and preliminary results are demonstrating significant improvements in foster mothers' responses to their young children. If future studies continue to reveal that there are significant differences in the levels of investment and perceptions of the child between kin and non-kin foster parents, then studies should then begin to focus on possible interventions, such as the training program described above, to determine if such an intervention may also be effective with kin caregivers.

With such interventions and support services, it may be the case that kinship placements in general may be able to provide young children with sufficient investment to serve as therapeutic placements. Such interventions and services should be based on attachment theory with the goal of increasing the caregivers' emotional investment to their young children and systematically studied to determine their potential impact on caregiver investment. The development, study, and widespread implementation of such

an intervention will surely take quite some time. In the meantime, the results of this study suggest that the preferential placement of young children with relative caregivers who have not been carefully scrutinized and or offered appropriate support services may be yet another way in which the foster care system fails our young children.

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APPENDIX A

THE WORKING MODEL OF THE CHILD INTERVIEW

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The Working Model of the Child Interview is a structured interview to assess parents' internal representations or working models of their relationship to a particular child. The setting of the interview should be comfortable enough to allow for attention to the questions posed and a relaxed atmosphere that permits the opportunity for reflection.

The introductory section on developmental history is optional, depending upon the setting and purposes for which the interview is used. Otherwise, the interviewer should follow the outline. The interview allows for some follow-up probes, particularly those that encourage the individual to elaborate on responses. Vital to scoring is that the interviewer not make interpretive comments, since we are interested in the degree to which individuals make these links on their own. Requests for clarification about contradictions may be made, but only for purposes of ascertaining whether the individual maintains contradictory views of the infant and only after allowing the individual an opportunity to recognize, acknowledge, and resolve the contradictions on his/her own. Essentially, the purpose of the interview is to have individuals reveal as much as possible in a narrative account of their perceptions, feelings, motives, and interpretations of a particular child and their relationship to that child.

WORKING MODEL OF THE CHILD INTERVIEW

We are interested in how parents think and feel about their young children. This interview is a way for us to ask you about child's name and your relationship to him/her. The interview will take us about an hour to complete.

1. I'd like you to begin by telling me about your child's development.

(a) Let's start with your pregnancy. I'm interested in things like whether it was planned or unplanned, how you felt physically and emotionally, and what you were doing during the pregnancy (working, etc.). In a follow-up probe, find out how much the baby was wanted or not wanted. Had you ever been pregnant before? When did the pregnancy seem real to you? What were your impressions about the baby during pregnancy? What did you sense the baby might be like? *The idea is to put the subject at ease and to begin to obtain a chronological history of the pregnancy. Additional probes may be necessary to make sure that the individual is given a reasonable opportunity to convey the history of their reactions to and feelings about the pregnancy and the baby (which may or may not be the same).*

(b) Tell me about labor and delivery. Give some time to respond before proceeding. How did you feel and react at that time? What was your first reaction when you saw the baby? What was your reaction to having a boy/girl? How did your family react? *Be sure to include husband/partner, other siblings.*

(c) Did the baby have any problems in the first few days after birth? How soon was the baby discharged from the hospital? Did you decide to breast-feed or bottle-feed? Why?

(d) How would you describe the first few weeks at home: feeding, sleeping, crying, etc.

This is often a very important time because it may set the "emotional tone" of the baby's entrance into the family, particularly if the delivery and perinatal period were routine.

(e) Tell me about your baby's developmental milestones such as sitting up, crawling, walking, smiling, and talking. Be sure to get a sense of the ways in which the baby was thought to be different, ahead, or behind in motor, social and language development. Did you have any sense of your baby's intelligence early on? What did you think?

(f) Did your baby seem to have a regular routine? What happened if you didn't stay in the routine?

(g) How has the baby reacted to separations from you? Try to get a sense of the baby's reactions at various ages. Were there any separations of more than a day in the first or second year? How did the baby react? How was it for you? How did you feel? What did you do?

(2a) Describe your impression of your child's personality now. Give the subject enough time to respond to this before proceeding to specific descriptors below.

(2b) Pick five words (adjectives) to describe your child's personality. After you have told me what they are I will ask you about each one. For each one, what is it about him/her that makes you say that?, Then, tell least one specific incident which illustrates what you mean by each word that you chose. You may tell the subject that it is fine to use any of the descriptors they used in response to the general probe above, but do not remind them what they said before you have given them time to recall themselves. Some subjects will have a hard time coming up

with five descriptors. If you feel that the cannot come up with five, then move on. The numbers are less important than the descriptions.

(3a) At this point, whom does your child remind you of? In what ways? When did you first notice similarity? If only one parent is mentioned, ask, in what ways does the child remind you of (the other parent)? The following questions should be asked whether or not the parents have been mentioned. Which of his/her parents is your child most like now? In what ways is your child's personality like or unlike each of his/her parents?

(3b) Are there any family characteristics on your side you see in your child's personality? What about (other parent's) side?

(3c) How did you decide on your child's name? *Find out about family names, etc.* How well does the name seem to fit?

(4) What do you feel is unique or different about your child compared to what you know of other children?

(5) What about your child's behavior now is the most difficult for you to handle? Give a typical example.

(a) How often does this occur? What do you feel like doing when your child reacts this way? How do you feel when your child reacts this way? What do you actually do?

(b) Does he/she know you don't like it? Why do you think he/she does it?

(c) What do you imagine will happen to this behavior as your child grows older? Why do you think so?

(6a) How would you describe your relationship to your child now? *Give time to respond.*

(6b) Pick five words (adjectives) to describe your relationship. For each word, describe an incident or memory that illustrates what you mean.

(7a) What pleases you most about your relationship with your baby? What do you wish you could change about it?

(7b) How do you feel your relationship with your child has affected your child's personality? *Give ample time to respond to this.*

(7c) Has your relationship to your child changed at all over time? In what ways? What's your own feeling about the change?

(8) Which parent is your child closest to now? How can you tell? Has it always been that way? Do you expect that to change (as the child gets older, for instance)? How do you expect it to change?

(9) Does your baby get upset often? *Give some time to respond before proceeding to specific queries.* What do you do at these times? What do you feel like doing when this happens? What do you feel like at these times?

(a) What about when he/she becomes emotionally upset? Can you recall a specific example? Indicate that you want an example by providing a reasonably long time to think of one. What did you do when that happened? What did you feel like doing? What did you feel like? *If the subject becomes extremely anxious and cannot recall an example, then proceed to part (b).*

(b) What about when he/she has been physically hurt a little bit? Can you give an example and describe what happened? *Be sure to find out what the subject felt like and did.*

(c) Has your child been sick at all? Tell an example. *Again, include what this experience was like for the parent and how they responded to the child affectively and behaviorally.*

(10) Tell a favorite story about your child, perhaps one you've told to family or friends. I'll give you a minute to think about this one. *If the subject is struggling, you may tell them that this doesn't have to be the favorite story, only a favorite.* What do you like about this story?

(11) Are there any experiences which your child has had which you feel may have been a setback for him/her? Why do you think so? *Indirectly, we're trying to determine whether the parent feels responsible in any way for the setbacks. Therefore, be sure to give time to respond before moving on to the more direct questions which follow.* Knowing what you know now, if you started all over again with your child, what would you do differently? give some time to respond.

(12) Do you ever worry about your child? What do you worry about?

(13) If your child were to be one particular age, what age would you choose? Why?

(14) As you look ahead, what will be the most difficult time in your child's development?

Why do you think so?

(15) What do you expect your child to be like as an adolescent? What makes you feel this way? What do you expect to be good and not so, good about this period in your child's life?

(16) Think for a moment of your child as an adult. What hopes and fears do you have about that time?

APPENDIX B

“THIS IS MY BABY INTERVIEW” AND CODING MANUAL

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Introduction

The TIMB interview is conducted with foster mothers who have cared for one foster child continuously for at least two months. The interview and accompanying coding system are designed to assess whether the mother thinks of the child as her own, or whether she views the child as more of a visitor or source of income.

TIMB interview

The TIMB interview is a semi-structured interview lasting approximately 5 to 15 minutes. The interview consists of six basic questions relating to the mother-child relationship, as well as a seventh question regarding the mother's experience as a foster parent. The interview should be conversational, and sound like the interviewer is reading off the page. The questions should be memorized.

For the most part, mothers answer the questions with little input or probing from the interviewer. However, if mothers struggle with the task, or if something she says needs clarification or extension, probing by the interviewer is certainly appropriate. For example, on the questions about raising to adulthood or missing the child, if they don't say much the interviewer should say something like "can you tell me a bit more about (child's name) personality?"

All interviews are to be recorded for later transcription and coding. Be sure to use an external microphone and to minimize noise in the room as much as possible. (E.g. have child go in another room to play with other staff member)

The TIMB interview questions:

1. I would like to begin by asking you to describe (child's name). What is his/her personality like?
2. Do you ever wish you could raise (child's name)?
3. How much would you miss (child's name) if she/he had to leave?
4. How do you think your relationship with (child's name) is affecting him/her right now? In the long-term?
5. What do you want for (child's name) right now? In the future?
6. Is there anything about (child's name) or your relationship that we've not touched on that you'd like to tell me?
7. I'd like to end by asking a few basic questions about your experience as a foster parent:
 - a. How long have you been a foster parent?
 - b. How many foster children have you cared for in all?
 - c. How many foster children do you currently have?
 - d. How many biological and or adopted children are currently living in your home?

TIMB coding system

The TIMB coding system consists of three scales (acceptance, commitment, and awareness of influence) reflecting how the mother thinks about the child and the mother child relationship. All three scales are rated on a five point likert scale based on a concurrent review of an audiotape and transcript of the TIMB interview. Specific scores are based on the rater's weighing of positive and negative indices of the mother's level of acceptance, commitment and awareness. Midpoint scores (e.g. 3.5) are acceptable under this system. Definitions of each scale and examples of scale items are included on the following pages.

Acceptance

This scale assesses the degree of maternal acceptance of the child as reflected in her descriptions of the child and the parent child relationship. Conceptually, acceptance anchors the opposite pole of rejection on the acceptance-rejection continuum. In general, high levels of acceptance are scored based in the presence of consistent maternal behaviors, thoughts, or feelings regarding the child. In contrast, lower levels of acceptance (i.e. higher levels of rejection) are reflected by negative maternal behaviors, thoughts, and feelings regarding the child. The central construct being scores is whether the mother has a positive perception of the child and their relationship, respects the child's individuality and expresses pleasure or delight in caring for the child. The key scoring acceptance is the degree to which positive or negative maternal perceptions of the child and the parent-child relationship characterize the interview.

The degree of maternal acceptance may be reflected in one or more ways including: (1) the words the mother uses to describe the child, (2) the tone of the mother's voice when speaking about the child or the mother-child relationship, (3) the degree of congruence between how the mother describes the child or her thoughts about the child, and if mentioned, her actual behavior towards the child, and (4) the degree to which the mother views the child as a separate respectable person with his or her own feelings, needs and goals.

Indices of high levels of maternal acceptance may include, but are not limited to:

1. Verbal affection when speaking about the child such as praise, approval, expressions of love, or positive anecdotes about the child or the mother-child relationship.
2. A tone that conveys warmth, love, or a valuing of the child or the mother-child relationship
3. Evidence of physical affection such as holding, comforting, hugging, kissing, etc.
4. Evidence of enjoyment of the child and the mother-child relationship, with little suggestion of annoyance or anger with the child's behavior or needs

In contrast, indices of lower levels of acceptance (i.e. higher rejection) may include, but are not limited to:

1. Descriptions of the child in terms, which are primarily, negative, or which consistently define the child in terms of deficits or problems.
2. Lack of evidence for verbal or physical affection directed toward the child
3. Use of a negative or hostile tone when discussing the child
4. Expressing anger, resentment, or malice towards the child
5. Sarcasm, derogation, or belittlement of the child
6. Evidence that the mother is consistently annoyed or angered by the child's expression of needs and behaviors

Recognition of the child's individuality is also an important component of acceptance. An accepting mother provides evidence that she views the child as a separate individual with his or her own wants, needs and goals. The accepting mother views the child's emotions and needs as valid and worthy of respect and does not dismiss them as unimportant simply because the child is

young. Although a mother may have her own wants and goals for the child, she also acknowledges that as the child grows he or she will develop his or her own wants and goals. In essence, the accepting mother provides age appropriate direction and guidance while showing respect and support for the child's individuality and developing autonomy. In contrast, mother's lower in acceptance may speak only of their own goals for the child, and provide little evidence that they have thought about what the child may want or need either now or in the future.

Finally, although an accepting mother may harbor some negative thoughts about the child or the parent-child relationship, overall the balance is clearly towards positive feelings about the child or their relationship. Similarly, mothers high on acceptance are happy in the parental role even though it may limit their individual activities or mean relinquishing some autonomy in order to promote the development of the child. An accepting mother is usually able to balance her own needs with the child's without overwhelming feelings of anger or resentment. In contrast, mothers lower in acceptance may express anger or resentment towards limitations on their autonomy as a result of caring for the child, or may complain about the child and his or her interference in their life.

When assigning a rating as key point to keep in mind is the degree to which the mother was convincing when expressing acceptance of the child. Points to consider include:

1. If the mother expressed love or positive feelings for the child. Was her tone warm and approving, flat, bland or perfunctory?
2. How congruent were the mother's descriptions of her thoughts and feelings about the child with how she described the infant or her behavior with the infant? (Note: not all

mothers describe their behavior towards the infant. Mothers should not be scored down for not describing their behavior, as they are not specifically asked to do so.)

3. How complete or well developed were the mother's answers? Does the mother give evidence that she is thinking actively and carefully about this particular child? Or, are her answers limited, rote, or scripted? Although accepting mothers may give short answers, their answers are not rote or scripted, and may be described as "powerful" or "moving." They also often provide other strong evidence of acceptance.

There may be many ways in which a mother can show how either high, moderate or low acceptance. Therefore, the descriptions of scales points listed below should be viewed as only limited enumeration of possible pathways to each score. It is highly unlikely that any individual mother will fulfill each of the descriptive phrases. The final score assigned should reflect a consideration of all the evidence presented in the interview, and a balancing of positive and negative indices of acceptance. Ultimately, the score assigned is based on the rater's integration of all the evidence, and his or her judgement of the mother's overall level of acceptance. Ratings are as follows:

4. High acceptance: the mother's descriptions of the child and the mother-child relationship is very positive; multiple indices of acceptance are evident throughout the interview; there is little or no evidence of annoyance or anger with the child or the mother-child relationship; if some annoyance or anger is evident, the mother is conscious of it, gives evidence that this is not an ongoing state and accepts responsibility for her own feelings rather than blaming the child; the mother shows respect for the child's individuality; the mother clearly delights in the child; the mother's responses to interview questions are well developed or thoughtful.

3. Moderate Acceptance: the mother's description of the child and the mother-child relationship is mixed; although there may be few indices of rejection, there may also be few indices of strong acceptance; or, there may be one or two indices of definite rejection but these are offset by evidence of marked acceptance; although the mother may speak positively of the child and their relationship, there may be evidence that the mother's behavior is not congruent with this positive description; overall, the mother's perception of the child and their relationship is unremarkable.

1. Low Acceptance: the mother's description of the child and the mother-child relationship is primarily negative; there may be very few to no indices of acceptance; or, there may be multiple indices of rejection; the mother may give little to no evidence of enjoying the child, and may express annoyance, dislike, or anger towards the child; the child may not be viewed as an individual with his or her own wants, needs, or goals; the mother's responses may be inordinately long and angry/complaining, or in contrast may be short or rote giving little evidence that she has thought extensively about the mother-child relationship.

Commitment

This scale assesses the degree of maternal commitment to the child and the parent-child relationship. Conceptually, commitment anchors one end of the commitment-indifferences continuum. In general, high levels of commitment are scored based on the presence of maternal behaviors, thoughts, or feelings about the child suggesting strong maternal emotional investment in the child, and a clear desire and willingness to parent the child. Lower levels of commitment (i.e. higher levels of indifference) are indexed by a lack of maternal affective involvement in the child, as well as apathy regarding being a parent to the child.

The core construct being scored is the extent to which the mother views the child as “my baby.” More specifically, it captures the degree to which the mother: (1) views the child as her own while the child is living with her, (2) has permitted the formation of a parent-child attachment without emotionally holding back or otherwise limiting the strength of nature of that bond, (3) provides evidence of a willingness to commit physical or emotional resources to promote the child’s growth and development, or (4) gives evidence that parenting this child is important to her. The key to scoring commitment is the degree to which the mother has “psychologically adopted” the child. The central question being asked is: Has the mother emotionally invested in this child and in being his or her parent? Or, has the mother limited her affective connection to the child and is indifferent to whether or not she continues to parent the child?

Indices of high level commitment may include, but are not limited to:

1. Expression of the desire or wish to adopt the child (Note: this point is elaborated on further below)
2. Expression of the desire to parent the child as long as the child remains in care or is benefiting from the mother's care
3. Evidence that the mother has allowed herself to become fully attached to the child without withholding feeling or putting up barriers to limit the extent of attachment (Note: this point is also elaborated on further below)
4. Maternal statements indicating she would deeply miss the child if he or she were removed from the home.
5. Evidence that the child is fully integrated into the family and viewed as a family member (e.g. the child is taken on family vacations if possible)
6. Evidence of a commitment of emotional resources (e.g. pride in the child's accomplishments) or physical resources (e.g. working with the child at home; advocating for services) in fostering the child's growth and development.

Lower levels of commitment are suggested by, but are not limited to, indices such as:

1. Indifference to whether the child remains in the mother's care; or expression of a hope or desire that the child will be placed elsewhere
2. Evidence of withholding feelings or putting up guards to limit the strength of the mother-child affective bond
3. Maternal statements indicating that the child would not be missed very much if he or she were removed from the home

4. Evidence that the child is not treated as a family member (e.g. is placed in respite care when the family goes out of town)

5. Failure to provide emotional or physical support of the child's growth or development;

Adoption: It is not required that the mother expresses the intent to adopt the child in order to receive a high commitment score. Again, the construct being assessed is “psychological adoption” as opposed to actual physical adoption. For example, the parent who says:

We wish we could keep her because we love her so, but we know it is impossible, so while she's here we are doing the best we know how.

would receive a very high commitment score (assuming the rest of the interview does not contradict this perspective). In contrast, the mother who responds to the question of whether she has thought about adopting the child by saying in an offhand manner:

Yeah, yeah, I've thought about it, just because we've had her since she was a day old and I've raised her the way I like.

would receive a much lower score based on the lack of convincing evidence of emotional investment in the child, and because of her offhand tone. The key here is the degree to which the mother's answer reflects an emotional investment in, and commitment to, the child and parenting the child.

Withholding: Although not seen in every transcript, some mothers mention withholding emotions, putting up guards to limit what they feel, or participating in physical activities designed to limit what they feel, or participating in physical activities designed to limit the

development of an attachment with the child (e.g. not hold the baby very much). When present, maternal withholding behaviors are an important component in deriving the commitment scores. These maternal or physical activities suggest a reluctance or unwillingness to fully emotionally engage the child or to emotionally invest in the child. Therefore, they are a reflection of limited maternal commitment. There are at least four possible degrees of withholding:

1. The mother provides no evidence of holding back; she does not say she wants to hold back and provides no evidence of the interview that she does; this is the most optimal circumstance (i.e. is one indice of high levels of commitment)

2. The mother says she tries to hold back but cannot help but “fall in love” with the child and give the child her all; although the mother’s words say she tries to hold back- her description of her behavior with the child suggests she does not.

3. The mother feels torn between wanting to giver her all to the child yet being afraid to do so; the mother provides some evidence that she struggles with the issue of holding back and sometimes may hold back, yet she still may provide a “good enough” level of emotional care for the child (but not necessarily the best she is capable of providing); the mother may be able to speak about concerns she has that her holding back may affect the child’s development; in essence, the mother says she holds back, provides some evidence that at times she may hold back, yet struggles with the issue.

4. The mother clearly states that she does not hold back and acknowledges that she does not think it is harmful; or the mother fails to acknowledge that she holds back while concurrently providing evidence the she does; this the least optimal circumstance.

Again, the key issue in withholding is the degree to which the mother is willing to allow the development of a full mother-child attachment with no limiting or exclusion of related feelings or behaviors.

Similar to the Acceptance scale, it is important to keep in mind the degree to which the mother was convincing when speaking of her level of commitment to the child. Points to consider include:

1. When expressing commitment to the child and investment in parenting the child, was the mother's voice confident, assertive or empathic? Or was her tone monotone, perfunctory, or bland? In essence, was the affective component that is normally a part of the high levels of commitment present?
2. Are maternal descriptions of her level of investment in the child and in parenting the child congruent with how the mother describes her behavior with the infant? (Note" not all mother's describe their behavior with the infant. Mother's should not be scored down for not describing their behavior as they are not specifically asked to do so.)
3. How complete and well thought out were the mother's answers? Does she give evidence that she is thinking actively and carefully about what it means to raise this particular child? Or, are her answers limited, rote, or scripted?

There are many ways in which a mother can show either a high, moderate or low commitment. Therefore, the descriptions of scale points listed below should be viewed as only a limited enumeration of possible pathways to each score. It is highly unlikely that any individual mother will fulfill each of the descriptive phrases. The final score assigned should reflect a consideration of all the evidence presented in the interview, and a balancing of positive and

negative indices of commitment. Similar, to the Acceptance scale, the final score is assigned based on the rater's integration of all the evidence, and his or her judgement of the mother's overall level of commitment. Ratings are as follows:

5. High commitment: the mother provides evidence of a strong emotional investment in the child and in parenting the child; multiple indices of high levels of commitment are present throughout the interview; descriptions of the child and the mother-child relationship clearly reflect a strong attachment to the child with no evidence of mental or physical activities designed to limit the strength of the mother-child affective bond; there may be evidence of the mother committing resources to promote the child's growth, or other indices of psychological adoption of the child; the child is fully integrated into the family; although the mother may acknowledge that the child will eventually leave her home (e.g. to return to the biological parent) she considers the child as hers while the child is in her home;

3. Moderate commitment: the mother provides evidence of the investment in the child, but this is not nearly as marked as a mother scoring high on commitment; although there may be some indices of high levels of commitment, there may also be evidence suggesting that the child has not been psychologically adopted by the mother; the mother may state she would miss the child if her or she left, but this is more of a matter of fact statement and lacks the strong affective component seen in mothers high in commitment; if the mother speaks of limiting the psychological bond with the infant, she also gives evidence of struggling with this issue; the child may be only partially integrated into the family (i.e. is placed in respite care only when the family goes on vacation); overall, the coder may conclude that the child is adequately cared for and nurtured, but not to any special degree;

1. Low commitment: the mother provides virtually no evidence of a strong and active emotional investment in the child or in parenting the child; there are few if any indices of high levels of commitment; the mother may be indifferent to whether the child remains in her care, or may actually state she hopes/desires that the child will be removed; there may be little evidence that the mother would miss the child if he or she leaves; the mother may provide evidence of participating in physical or mental activities designed to limit the strength of the mother-child bond; the child has not been psychologically adopted by the mother, and may not be fully integrated into the family (e. g. is routinely placed in respite care); the child may seem to be more of an unwelcomed guest than a member of the family, or may be viewed as only one of a series of children passing through the mother's home.

Maternal Awareness of Her Influence on the Child

This scale assesses the mother's level of awareness regarding how her relationship with the child may affect the child both now and in the future, as well as the focus of her immediate and long-term goals for the child. The central questions being answered are:

- Does the mother give evidence that she has thought about how her relationship with the child may influence him or her either now or in the future?
- Is the mother aware that her relationship with the child may influence his or her psychological or emotional development? Or, does she frame her influence in terms of concrete goals or accomplishments?
- Are the mother's immediate and long-term goals primarily focused on fostering the child's psychological, emotional, or relational development? Or, are her goals more focused on helping the child obtain concrete goals such as good education, good health, etc.?

The key to scoring this construct is the degree to which the mother predominately focuses on psychological, social or affective influences and goals, or whether her main emphasis is on concrete influences or the achievement of physical goals.

Information relevant to this scale may primarily be gathered from maternal responses to interview questions four and five:

- How do you think your relationship with the child will affect him or her right now? In the long-term?
- What do you want for the child right now? In the future?

Higher scores on this scale are assigned when the mother gives evidence that she has thought seriously about this questions, and her focus is primarily psychological or interpersonal, as opposed to being concrete in nature. There are many ways in which mothers can obtain high scores. As a result, an exhaustive list of ways in which mothers may score high is not possible. However, some indices of higher scores include, but are not limited to:

1. General maternal acknowledgement that her relationship with the child has an important psychological or affective component.

Examples: Well my relationship with her, I think it is positive and will affect her in a way that, if she were to be taken away from me, it would bother her, it would stunt her growth I think, I really think so, because we have bonded.

2. Maternal influence that is characterized as promoting the child's sense of being loved or feeling secure.

Example: ... some children look past their faults and their parents' faults and you see their needs. This child is a child that needs love, and I want to give her what she needs. That's what I think.

Example: I think our relationship will affect her in a positive way. She's feeling more secure, and that's what children need, security. I want her to grow up to be the child she's supposed to be, and that's what we are trying to get her at now.

3. Maternal focus on promoting the development of age appropriate psychological autonomy in the child.

Example: I treat her like my own and try to make her a disciplined person to try and help her be strong for whatever she wants. Not so much as what everyone says she should be or what she should do, but what would make her happy.

4. Maternal realization that her relationship with the child may influence the child's ability later in life to form stable relationships.

Example: I want her to develop both education wise and sociable. I want her to learn that people can be trusted, despite what has happened to her. I don't want her to go around not trusting nobody. I want her to be able to have a normal life,

to have a husband she loves and trusts, and kids she adores and wants.

In contrast, lower scores on this scale are obtained by mothers whose primary focus is more concrete. Again, an exhaustive list is not possible. However, indices of lower scores may include, but are not limited to:

1. Primary focus on helping a child catch up in terms of developmental milestones or the maintenance of good health.

Example: How's the relationship affect her right now? Well, it's been positive for her. When they evaluated her they said, because she was two months premature, that she was on target on everything. I mean, what do I want do her? Nothing, I mean she's progressing real well, so actually, nothing.

2. Maternal emphasis on the child obtaining a good education, job or house.

Example: What would I want for him? Good education. Yeah, a good education. Healthy too.

3. Mothers who give limited rote answers such as wanting the child to be happy, successful, or well adjusted.

Example: I would want for her to be happy and continue to do well and to have the things she wants and needs.

Note: However, if the mother states that she wants the child to be happy, and then provides a particularly thoughtful response for why she wants this for the child, this suggests that a score at the upper end of the scale may be appropriate.

Example: What I would want for that little girl right now is just to be happy, be happy. I know that she is not completely happy. Whatever has happened to her it still haunts her, it is haunting her each and every day. Just by her behavior, the way she talks, the way she walks,

everything she does I know that it is still affecting her. So, all I want for her right now is to be happy. Happy and secure. To know that it's all right. It's okay.

4. Mothers who do not believe the mother-child relationship will have a long-term influence on the child.

Example: Well, I don't know how it will affect her because she's a little baby. I don't think she will remember. But I think that the loving care and the way I've cared for her will stick with her for maybe a couple of weeks after she's gone.

Note: Some mothers state that they do not know how the relationship will affect the child. An "I don't know" answer could lead to either a high or low score. The key to scoring these responses is the degree to which the mother gives evidence of having thought seriously about this question. A mother who says she does not know what her influence will be yet gives evidence she has thought about or struggled with the question could receive a high score. In contrast, a mother who provides no evidence of wrestling with this issue would receive a low score. Again, the key is the degree to which the mother gives evidence of approaching the question in a thoughtful and reflective manner.

There are many ways in which a mother can show either a high, moderate or low commitment. Therefore, the descriptions of scale points listed below should be viewed as only a limited enumeration of possible pathways to each score. It is highly unlikely that any individual mother will fulfill each of the descriptive phrases. The final score assigned should reflect a consideration of all the evidence presented in the interview, and a balancing of positive and negative indices of awareness. Similar to the Acceptance and Commitment scales, the final score

is assigned based on the rater's integration of all the evidence, and his or her judgement of the mother's overall level of awareness. Ratings are as follows:

5. High: The mother frames the discussion primarily in psychological, relational or social terms. She provides evidence of having carefully considered the question, and her answers may be particularly insightful or reflective. This mother may give clear evidence of believing that her relationship with the child will have long-term implications for the child's development. Or this mother may state she does not know what her influence will be but gives evidence of having carefully considered the issue.

3. Moderate: The mother frames the discussion with a mixture of psychological and concrete goals and influences, although the balance may be tipped more towards the concrete end of the continuum. Unlike a mother receiving a high score, this mother's responses are less insightful and reflective, any may have somewhat of a rote or scripted quality to them. Mother's receiving this score may give evidence that the question is somewhat foreign or strange to them.

1. Low: The mother frames the discussion in concrete terms. If she does mention psychological influences, her ideas are not well developed and may appear perfunctory or rote. In addition, a mother who states that she will have little to no influence on the child would receive a low score.

APPENDIX C
ADDENDUM TO THE TIMBI

Addendum to the TIMBI

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Addendum to the “This is My Baby Interview” Coding Manual

Following is an addendum to the This is my Baby Interview (TIMBI; Bates & Dozier, 1997) coding manual, to be applied to the Working Model of the Child Interview (WMCI). This addendum is meant to serve only as a supplement to the TIMBI coding manual. This addendum further specifies the rating scale indices to accommodate the information obtained in the WMCI. The TIMBI coding manual must still be used when applying these scales to an interview. For further examples and clarifications of information below, see the TIMBI coding manual.

Acceptance

For an in-depth conceptualization of the Acceptance variable, see the TIMBI coding manual.

General Indices of Acceptance

	<u>Higher</u>	<u>Lower</u>
Tone	Warm, approving	Flat, bland, perfunctory
	Comfortable with interview questions	Uncomfortable, annoyed with questions
Content/	Rich, detailed descriptions, Words corroborating affect	Impoverished detail and descriptions, indifferent affect
	Coherent, succinct, focused on child and relationship	Incoherent, inability to stay focused on child, often distracted by other concerns or people
	Well thought out and developed, actively thinking about this child	Limited, rote/scripted answers, little evidence of active thought or discovery about this child
Congruence	Congruent thoughts, feelings, and behaviors (if mentioned)	Incongruent thoughts, feelings or behaviors (if mentioned)

Acceptance Rating Scale

5. Very High Acceptance

The mother's descriptions of the child and the mother-child relationship are very positive; multiple indices of acceptance are evident throughout the interview. There is little or no evidence of annoyance or anger with the child or the mother-child relationship. If negative descriptors are used, the mother tends to attribute this to the situation ("She's fussy when she's tired") or a normal developmental characteristic ("All 2 year olds have tantrums, she'll grow out of it") rather than to the child's character or disposition. The mother shows respect for the child's individuality. The mother clearly delights in the child. The mother's responses to interview questions are well developed, thoughtful, coherent, and richly detailed.

4. High Acceptance

The mother's descriptions of the child and the mother-child relationship are generally positive. The mother is conscious of any annoyance or anger with the child, gives evidence that this is not an ongoing state, and accepts responsibility for her own feelings rather than blaming the child (e.g. "I'm frustrated when I can't get the house cleaned because he wants me to hold him all the time, but I know he needs the extra security now, so I just have to learn to be ok with things not being as neat as they were before he came"). Even though a few negative descriptors may be used, the mother does not appear to be bothered by them or believe they are concerning (e.g. may describe the child as "demanding, just like her mother" but is laughing and may even provide evidence that she thinks this behavior is kind of cute). Overall, multiple indices of acceptance are evident throughout the interview, the mother delights in the child, and views the child and her relationship with the child in generally positive terms.

3. Moderate Acceptance

The mother's description of the child and the mother-child relationship is mixed. Although there may be a few indices of rejection, there are also a few indices of strong acceptance. While the mother may speak of the child positively, there may be evidence that the mother's behavior is not congruent with this positive description. Flat, matter-of-fact responses and impoverished details (e.g. "She's just a normal 3 year old"; "Our relationship is fine") would score no higher than a 3 on this scale. Also, if there is one or two indices of strong rejection, despite evidence of marked acceptance, the interview should not be scored any higher than a 3. Overall, the mother's perception of the child and their relationship is unremarkable.

2. Low Acceptance

The mother's description of the child and the mother-child relationship is generally negative. Any positive descriptions of the child or their relationship seem rote or scripted and are without any supporting affect. There is little evidence that the mother is thinking actively about this child and their relationship. The mother provides little evidence of enjoying

the child, and may express annoyance, dislike, or anger towards the child. The child is not viewed as an individual with his or her own wants, needs, or goals.

1. Very Low Acceptance

The mother’s description of the child and the mother-child relationship is primarily negative with little or no positive descriptions about the child or their relationship. There is clear evidence that the mother is annoyed or angered by this child or that the mother dislikes the child. Anger or annoyance may be directed at the interviewer or the interview. There is clear evidence of rejection.

Commitment

For an in-depth conceptualization of the Commitment variable, see the TIMBI coding manual.

	High	Low
Tone	Confident, assertive, empathic Congruent with content	Monotone, perfunctory Incongruent with content Indifferent affect/tone
Content/ Words	Complete and well thought out Actively thinking about this child and parenting this child Coherent, focused on child and Relationship	Rote/scripted Little evidence of much thought Indifferent, impoverished details Incoherent, inability to focus on child/topic. Easily distracted by other concerns or people.
Congruency	Descriptions congruent with with behavior if mentioned	Descriptions incongruent with behavior mentioned

Commitment Rating Scale

5. Very High Commitment

The mother provides evidence of a strong emotional investment in the child and in parenting the child. Multiple indices of high levels of commitment are present throughout the entire interview; descriptions of the child and the mother-child relationship clearly reflect a strong attachment to the child with no evidence of mental or physical activities designed to limit the strength of the mother-child affective bond. There is evidence of the mother committing resources to promote the child's growth, or other indices of psychological adoption of this child. The child is fully integrated into the family. Although the mother may acknowledge that the child will eventually leave her home (e.g. to return to the biological parent) she considers the child as hers while in the home.

4. High Commitment

The mother provides evidence of a strong emotional investment in the child and in parenting this child. Multiple indices of high levels of commitment are present throughout the interview, as described above, but there may be some evidence of mental or physical activities that are designed to limit the strength of the mother-child affective bond. This does not seem to actually lessen the attachment- feelings or change the mother's behavior to the child, however (e.g. "I know she's going back to her mom so I keep telling myself not to get used to her being here, but I just can't help it. I will miss her terribly"). Despite statements that the mother is trying to limit the affective bond, the mother's affect and behavior, if described, suggest that there is little or no holding back.

3. Moderate Commitment

The mother provides investment in this child, but this is not nearly as marked as a mother scoring high on commitment. Although there may be some indices of high levels of commitment, there may also be evidence that the child has not been psychologically adopted by the mother. The mother may state she would miss the child if he or she left, but this is more of a matter of fact statement and lacks the strong affective component seen in mothers high in commitment. If the mother speaks of limiting the psychological bond with the infant, she also gives evidence that she is struggling with this issue. The mother may express a strong commitment to take care of this child, but it is because of a sense of duty and not affectively related to this child (e.g. "I thought about returning him, but I said I was going to do this and I always do what I say"). The child may only be partially integrated into the family (e.g. is placed in respite care only when the family is going on vacation). Overall, the coder may conclude that the child is adequately cared for and nurtured, but not to any special degree.

2. Low Commitment

The mother provides little evidence of a strong and active emotional investment in this child or in parenting this child. There are few indices of high levels of commitment and the mother may be indifferent to whether the child remains in her care. Despite possible statements to the contrary, the mother's affect and tone provide evidence that the child will not be missed if

he or she leaves. The mother may provide evidence that she is participating in physical or mental activities that are designed to limit the strength of the mother-child bond and is not struggling with this issue. The child may not be fully integrated into the family (e.g. is routinely placed in respite care). The child may be seen as more of an unwelcome guest than a member of the family, or may be viewed as only one of a series of children passing through the mother's home.

1. Very Low Commitment

The mother provides virtually no evidence of a strong or active emotional investment in this child or in parenting this child. There are virtually no indices of high levels of commitment. The mother may be indifferent to whether the child remains in her care, or she may actually state that she hopes/desires that the child will be removed. There is no evidence provided that she will miss this child if he or she leaves.

Maternal Awareness of Her Influence on the Child

This scale assesses the mother's level of awareness regarding how her relationship with the child may affect the child both now and in the future, as well as the focus of her immediate and long-term goals for the child. While it is important to integrate all responses from the entire interview, the mother's responses to the questions "How has your relationship affected your child (*See note below)?", "What will your child be like as an adolescent?" and, "Think of your child as an adult, what are your hopes and fears for that time?" may be particularly informative.

*Some mothers interpret "affected" as a negative term and therefore state that their relationship has *not* affected the child. In these cases, the mothers often say something like "It hasn't affected him, I've been good for him". It is important to gather evidence from the entire interview to determine whether or not the mother may have misinterpreted the question or whether she truly believes that her relationship will have no impact on the child.

General Indices for Belief in Influence Scores

	High	Low
Tone/Affect	Confident, assertive, empathic Congruent with content	Monotone, perfunctory Incongruent with content Indifferent affect/tone
Congruency	Congruent thoughts, feelings, and behaviors (if mentioned)	Incongruent thoughts, feelings or behaviors (if mentioned)
Content/		

Words	States that the relationship will influence the child now or in future	States that the relationship will have little or no influence on the child
	Provides thoughtful, well-developed ideas of the effect of the relationship	Little evidence of much thought or consideration of the effect of the relationship on the child; Rote/ scripted responses; lack of details
	Focuses on psychological and emotional development	Focuses on concrete goals and accomplishments

Belief in Influence Rating Scale

5. Very High Belief in Influence

The mother frames the discussion primarily in psychological, relational, or social terms. She provides evidence of having carefully considered the question, and her answers may be particularly insightful or reflective. This mother may give clear evidence of believing that her relationship with the child will have long-term implications for the child’s development.

4. High Belief in Influence

The mother may discuss a few concrete goals and influences but the discussion is still primarily focused on psychological, relational, or social terms. If the mother states that she does not know what her influence will be, she gives evidence that she is carefully considering the issue and may offer some speculations or hopes. Some descriptors may seem concrete but a psychological, relational, or social goal may be evident in the elaboration (e.g. “I want him to get a high school degree. With a degree he can get a better job and be secure financially. Feel proud of himself and his accomplishments”).

3. Moderate Belief in Influence

The mother frames the discussion with a mixture of psychological and concrete goals and influences, although the balance may be tipped more towards the concrete end of the continuum. Unlike a mother receiving a high score, this mother’s responses are less insightful and reflective, and may have somewhat of a rote or scripted quality to them. Mother’s receiving this score may give evidence that the question is somewhat foreign or strange to them.

2. Low Belief in Influence

The mother frames the discussion in concrete terms. If she does mention psychological influences, her ideas are not well developed and may appear perfunctory or rote (e.g. “Now she knows all her colors and her ABC’s. And she’s happy”).

1. Very Low Belief in Influence

The mother states that she has little to no influence on the child. Additionally, there may be statements such as “It doesn’t matter what I do, she’s going to turn out the way she turns out”.

VITA

Rhonda G. Norwood was born in Zachary, Louisiana, on March 9, 1972, to the late Ronnie and Patricia Guy. She graduated from Episcopal School of Acadiana in Cade, Louisiana, in 1990, and then attended Allegheny College in Meadville, Pennsylvania. She received a Bachelor of Science degree from Louisiana State University in general studies, with minors in psychology, sociology, and philosophy, in 1999. Ms. Norwood then entered the School of Social Work at Louisiana State University and received her Master of Social Work degree in 2001.

Ms. Norwood began her career in social work in September of 2001 as a mental health counselor on the children's unit of Capital Area Human Services District. In 2002, Ms. Norwood accepted a position with the Office of Mental Health as an Infant Mental Health Clinician. Ms. Norwood then spent one year with the Tulane University Department of Child Psychiatry completing a fellowship in infant mental health.

In 2003 Ms. Norwood entered the doctoral program of Louisiana State University's School of Social Work. Ms. Norwood became a research assistant with the School of Social Work and joined a private practice specializing in the treatment of young children. She left the Office of Mental Health in 2005. Ms. Norwood has recently accepted a position with Capital Area Human Services District in Baton Rouge, Louisiana, to provide clinical and research services to young children and their families who are involved with child protective services. Ms. Norwood is also currently serving as an infant mental health consultant to the Baton Rouge regional Early Head Start centers. She and her husband, Shane Norwood, have two children, Grant and Drew.