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# Predictors of placement duration for foster and adopted children with special needs

Patricia A. Somers
*Walden University*

# Walden University

COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCES

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Patricia Somers

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Chief Academic Officer

Denise DeZolt, Ph.D.

Walden University
2009

ABSTRACT

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by

Patricia A. Somers

M.A., Liberty University, 1994
B.A., University of Illinois, Champaign, 1972

Dissertation Submitted in Partial Fulfillment
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Doctor of Philosophy
Psychology

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# ABSTRACT

Foster and adopted children with special needs have high rates of placement instability. This has been associated with their increased risk of having special needs, particularly reactive attachment disorder which results from severe disruptions in early relationships. Child welfare agencies report inadequate knowledge of specific placement predictors and assessment measures, although research has shown that placement duration is partly a function of successful parent-child match. Using Bowlby's attachment theory as the theoretical framework, this quantitative study examined the contributions of foster and adoptive parents' own attachment characteristics, the child's type of special need, and the child's age at the time of placement in predicting placement duration. A convenience sample of 108 foster and adoptive parents completed three self-report instruments: the Parental Bonding Instrument measuring parental care and protection, the Relationship Scales Questionnaire measuring avoidance and anxiety related to relationships, and a researcher-created demographic questionnaire. Multiple regression analysis was used to examine whether parental attachment characteristics, age at placement and type of special need affect the dependent variable of placement duration. The overall model significantly predicted child placement duration in foster or adoptive homes. Reactive attachment disorder status and the child's age at the time of placement contributed significantly to the prediction model. Implications for social change include the expeditious termination of parental rights, and the need for early, well-matched permanent placement, facilitated by child welfare agency use of objective attachment measures.

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# CHAPTER 1: INTRODUCTION TO THE STUDY

## Background

### *Preliminary Issues Regarding Special Needs Foster Care and Adoption*

Foster and adopted children with special needs have higher rates of placement instability than other children in out-of-home placements. Two types of placement instability are pertinent to child welfare: (a) disruption, which involves the removal of a child from a foster home due to severe behavioral or emotional problems the family is unable manage; b) and dissolution, which is the child's removal from the family after a finalized adoption (Derdeyn & Graves, 1998; Zamostny, O'Brien, Baden, & Wiley, 2003). This study will use the term disruption to refer to either type of placement failure.

Data on disruption rates over the past 15 years indicate a rate ranging from approximately 10-25% overall, with older children at higher risk of placement changes (Briggs & Webb, 2004; Festinger, 2002; Rosenthal & Groze, 1994; Smith & Howard, 1994; Westhues & Cohen, 1990). Caution must be used in interpreting these statistics due to the variability of research approaches, and combination of data from pre and postadoption outcomes (Festinger, 2002), as well as the lack of a national "comprehensive" (Zamostny, O'Brien, Baden, & Wiley, 2003, p. 657) data gathering system. Children who have been diagnosed with Reactive Attachment Disorder represent a higher risk of disruption due to the severity of their behaviors (Chapman, 2002; Hall & Geher, 2003; Parker & Forrest, 1993). The characteristics of both children and parents which are factors in placement stability will be discussed in chapter 2.

Recent implementation of the Adoption and Safe Families Act (ASFA) (1997) has focused on accelerating children's movement through the foster care system into the permanence of adoption through use of stricter timelines on termination of biological parents' legal rights. ASFA also offers incentives for agencies to proceed with adoption planning for all children, regardless of age, who have spent 15 of the previous 22 months in foster care (McDonald, Propp, & Murphy, 2001). Despite improvements following ASFA, barriers to permanence still remain as of 2003. Both the legal delays and the lack of prospective foster and adoptive parents account for the median period of 39 months spent in foster care by children who are eventually adopted (U.S. General Accounting Office, 2003).

The challenge of matching children with special needs with prospective families is recognized at the local, state, and federal level. When the Director of Education, testified before the House Subcommittee on Human Resources Committee on Ways and Means she noted that states typically employed three approaches to recruitment of special needs adoptive parents: (a) placing a profile of the waiting children on websites maintained by the state or by local communities; (b) having children highlighted on local television spots; and (c) inviting extended family members or other adults who are already involved in the children's lives to become foster parents (U.S. General Accounting Office, 2003). The Director also noted that the state of Illinois had identified a scarcity of information on the characteristics of families most likely to adopt children with special needs (U.S. General Accounting Office, 2003).

Special needs children bring greater parenting challenges to the families that they join. Surveys during 1998-2000 examining children's movement from foster care to adoption revealed 85% of the available children have a minimum of one qualifying special need that would allow them to receive Title IV-E funding which is part of the Social Security Act providing federal funding for foster care and related child welfare casework (Courtney, 1998; U.S. General Accounting Office, 2003). Statistics from 2000 collected from 18 states indicated that an average of 32% of the children being adopted had three or more qualifying special needs (U.S. General Accounting Office, 2003). Children are designated as having special needs due to a variety of factors: being older, having prenatal exposure to drugs or alcohol, being a member of a sibling group requiring a common placement, having been physically or sexually abused, having risk factors for a genetic disorder, or having physical, mental, or psychological impairments (Brooks, James, & Barth, 2002; Rosenthal & Groze, 1994; Speirs, Duder, Grove, & Sullivan, 2003).

Although the research indicates that children who are in permanent adoptive placements fare better than those who remain in foster care, maintaining the stability of special needs placements often requires post-placement support that is more considerate of both the needs of the child and those of the parents, with particular attention to problems that may have originated during the time spent in the child welfare system (Groze & Gruenewald, 1991). Often special needs children have serious developmental, cognitive, medical, educational, and/or emotional needs that foster or adoptive parents either did not anticipate prior to placement, or which did not become evident until after

placement. Those factors, along with other stress specific to the parents, for example, resolving infertility, giving up the fantasy of the hoped-for child, coping with the social stigma associated with adoption, the lack of acceptance of the child by extended family, and marital strain, may be sources of additional stress that the foster and adoptive parents manage better with support (Kramer & Houston, 1998).

Some researchers have expressed concern that the incentives for permanence created by AFSA guidelines, particularly with regard to children with multiple special needs, may result in "urgency of placement, rather than [on] maintenance of children in their new families" (McDonald et al., 2001, p. 72) which merely changes the locus of the problem from the child welfare agency to the juvenile justice or mental health systems. Thus, with more previously unadoptable children becoming available to families, the use of standardized instruments to insure accurate matching has been recommended (Valdez & McNamara, 1994; Ward, 1997).

## Attachment Theory Applied to Foster Care and Adoption

Bowlby (1979) recognized the critical nature of the relationship between children and their caregivers. Much of Bowlby's (1973, 1980) professional attention focused on the problems that develop as a result of inadequate or faulty attachment. Bowlby maintained that the quality of attachment during childhood has significance throughout the individual's life span, an assertion that has been supported by an abundance of research evidence (Allan & Land, 1999; Cassidy, 1999; Feeney, 1999; Hazan & Zeifman, 1999; Rholes & Simpson, 2004).

Children who come into the child welfare system have frequently experienced a severe lack of care or protection by their original attachment figures (Dozier, Albus, Fisher, & Sepulveda, 2002). In their survey of 700 children in their first year in foster care being served by public child welfare agencies in 92 areas across the United States, the National Survey of Child and Adolescent Well-Being Research Team (NSCAW) (2003) found that 73% of the children, the largest single category, had experienced poor care. Thirty-six per cent had experienced neglect due to failure to provide care, and 37% had been neglected by failure to supervise. In addition, 10% had been physically mistreated, and 8% had been sexually mistreated. These early adverse experiences affect subsequent attachment relationships, which in turn increase the child's risk of placement failure and his risk of physical, social, emotional, and behavioral distress (Bowlby, 1979; Cassidy, 2000; Dozier, Stovall, & Albus, 1999).

Bowlby (1952) warned that when children are deprived of maternal love their development across life domains is affected, leaving the child more likely to develop clinically significant physical and mental illnesses. For example, Enns, Cox, and Larsen (2000) found evidence of a relationship between parental attachment style and depression in adult children.

Bowlby (1979) further indicated the possible influence of attachment security for couple relationships and explained that "there is a strong causal relationship between an individual's experience with his parents and his later capacity to make affectional bonds" (p. 135). This was explored by Hazan and Shaver (1987), who found a correlation

between attachment style in childhood and later adult romantic attachment, as well as by others who have devised treatment approaches to couple therapy derived from attachment theory (Goldberg & Johnson, 1988; Wampler, Shi, Nelson, & Kimball, 2003).

The developmental research on biological families supports the view that attachment patterns are intergenerational in that the style of attachment that a parent had to her own mother is subsequently duplicated in her relationship with her child (Steele, Hodges, Kaniuk, Hillman, & Henderson, 2003, p. 187). When examining the effect that maternal attachment representations had upon adopted children, Steele et al. (2003) found that there was a significant correlation between adoptive mothers' mental representation regarding their own attachment experiences, and the attachment security of their adopted children. Support for the intergenerational transmission of attachment patterns has also been noted by Hesse (1999); however, researchers vary in their views of the most valid ways of measuring attachment, which has given rise to a variety of measurement instruments. While a more detailed discussion of attachment measurement will be offered in chapters 2 and 3, the following will provide the initial rationale for using the Parental Bonding Instrument and the Relationship Scales Questionnaire in this study.

## Rationale for Using the Parental Bonding Instrument and the Relationship Scales Questionnaire

The rationale for using retrospective measures of adult attachment to predict the security of subsequent parent-child bonds is based upon evidence that these measures elicit responses which describe the adult's mental representations of their own childhood attachment relationships which are in turn a determinant of the type of attachment

between themselves and their own children (van IJzendoorn, 1995 p. 387). Internal working models or mental representations, sometimes called states of mind with regard to attachment, are considered critical constructs by attachment theorists (Furman & Simon, 2004; Rholes & Simpson, 2004). These models develop as a result of the daily interactions between parent and child which create expectations about the way that attachment figures will respond across various circumstances (Furman & Simon, 2004; Rholes & Simpson, 2004). Believed to have both conscious and unconscious components, to direct attention, cognitions about self and others, behavior toward or away from others, and affective responses (Rholes & Simpson, 2004), working models are believed to be influenced by the degree of parental responsiveness and emotional availability to the child's signals of distress, which consequently direct the child's emotional development and self-construct (Collins, 1996; Stams, Juffer, van IJzendoorn, & Hoksbergen, 2001; van IJzendoorn, 1995).

Parker et al. (1979) asserted that the Parental Bonding Instrument (PBI) provides a measure of respondents' experiences with regard to their own attachment relationships with their parents. It provides a useful means of estimating the enduring contribution these early experiences make to subsequent bonding with their own children. Lieberman (2003) likewise identified parental care as a factor that is capable of improving an adopted child's emotional well being.

The Relationship Scales Questionnaire similarly proposes a model of adult attachment based upon internal working models. Internal models of self and others are divided into positive and negative scales with four attachment styles resulting

(Bartholomew & Horowitz, 1991). These issues will be discussed in more detail in chapter 2.

## Core Concepts

This research is based upon certain core assumptions about the nature of parent child attachment as articulated by Bowlby (1969/1982, 1973). The first theoretical assumption is that the quality of the parent child bond is a function of the caregiver's availability and responsiveness to the offspring. A central feature of Bowlby's (1982) attachment theory is the concept of proximity seeking as the means of insuring survival. Separation distress is designed to solicit care from the person with whom the child uses as a secure base/safe haven.

A second core assumption is that the attachment style characterizing the parent-child dyad remains relatively stable over time. This has implications for adult romantic and peer relationship attachment later in life, as established by Hazan and Shaver (1987). Fraley and Brumbaugh (2004) have questioned the validity of conceptualizing attachment stability over the life span. In support of this view, Rholes and Simpson (2004) noted that the term *working model* by which Bowlby (1969/1982, 1973, 1980) described the child's mental representations, implies fluidity and a responsiveness to change based upon new experience. The potential for change in attachment stability over time would be a significant finding for children whose early attachment experiences were insufficient or damaging. Such changes in attachment stability would be indicative of alterations in the internal representations, or working models of attachment that some researchers believe

to be the most important construct in attachment theory (Rholes & Simpson, 2004). The issue of stability and change of attachment style over time will be developed in chapter 2.

The third core assumption regarding parent child attachment is that the style of attachment between the parent and offspring should predict other behavioral, social, and emotional factors of the child's development. Various investigators have found correlations between adult psychopathology and retrospective accounts of parent-child attachment (Bowlby, 1979; Cassidy, 2000; Dozier, Stovall, & Albus, 2000). Hazan, Gur-Yaish, and Campa (2004) have also discussed the markers of attachment at various individual levels including: behavior, cognition, physiology, and emotion.

The fourth core assumption that follows from Bowlby's (1982) formulation is that attachment behavior is part of a biologically directed regulatory system that is universal in nature. This system is specific within species, and shares equal importance with the sexual mating regulatory system, the exploratory system, and the caregiving system (Bowlby, 1982).

The parental motivation to provide for the care and protection of offspring is necessary for survival (Ainsworth, Blehar, Waters, & Wall, 1978). The Parental Bonding Instrument measures the respondent's perception of these two factors (Parker, 1989; Parker, Tupling, & Brown, 1979). The care and protection constructs were derived from factor analytic studies which consistently pointed to the developmental importance of these two elements in interpersonal relationships, both in childhood and adulthood, as well as evidence that parental lack of care and overprotection have been associated with later psychopathology (Parker, 1990). In a similar manner, the Relationship Scales

Questionnaire measures internal models of self and others, presumably based upon the degree to which ones needs for care and protection were met during childhood.

## Definitions

*A child with special needs:* is defined as an individual having at least one of the following characteristics: being older than 5 years, having had two or more previous foster or adoptive placements, having had prenatal exposure to drugs or alcohol, being non-white, being a member of a sibling group requiring a common placement, having risk factors for a genetic disorder, or having psychological disability (Brooks, James, & Barth, 2002; Speirs, Duder, Grove, & Sullivan, 2003).

*Reactive Attachment Disorder (RAD):* is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision) (DSM IV-TR) (APA, 2000) as the presence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 years," (p. 217) presumed to be related to early pathogenic care.

*Placement stability or duration:* is defined as the uninterrupted period of time that the child has remained in a foster or adoptive placement. It will be measured in months.

## Statement of the Problem

A review of the literature has revealed (a) that children with special needs have higher rates of placement disruption than other children in substitute care; (b) that both the characteristics of the children and the foster or adoptive parents influence placement

outcome; and (c) that knowledge of placement predictors used by child welfare agencies is inadequate. If this study can demonstrate an association between parental characteristics and placement outcome for special needs children, procedural changes in foster and adoptive parent selection for special needs children may result.

## Purpose of the Study

The purpose of this quantitative study is to examine whether certain parental characteristics, the child's type of special need (RAD), and the child's age at the time of placement, are variables which can be used to predict placement duration. Parental factors will be assessed by two self-report instruments. The Parental Bonding Instrument (PBI) measured the factors of care and overprotection (Parker, 1989; Parker, Tupling & Brown, 1979), and the Relationship Scales Questionnaire (RSQ) used to measure models of self and others, as related to anxiety and avoidance in personal relationships (Bartholomew & Horowitz, 1991; Bartholomew & Moretti, 2002). The scores on the Parental Bonding Instrument will also be compared with normative data.

## Research Question and Hypothesis

1. Do attachment characteristics of foster and adoptive parents, as assessed by the PBI and the RSQ, the child's type of special need (RAD) and the child's age at the time of placement influence placement duration of children with special needs?

Null hypothesis: There will be no association between PBI scores, RSQ scores, the child's type of special need (RAD) or the child's age at the time of placement and placement duration.

Research hypothesis: Higher scores on the PBI for care and low scores of overprotection, lower scores on the RSQ for anxiety and avoidance, no diagnosis of RAD, and younger age at time of placement will predict longer placement duration.

## Research Design

This quantitative investigation employed a convenience sample of 108 foster and adoptive parents of children with special needs drawn from private and state child welfare agencies, parent support groups, conference attendees, and the Internet. The participants were various ages, came from a range of socioeconomic strata, and represent diverse ethnic backgrounds. Confidentiality will be assured to all participants and the results of the PBI and RSQ will not affect the participants' current placements or prospects of future placements.

PBI is a self-administered 25-item questionnaire designed to measure parental factors of care and overprotection (Parker, 1989; Parker et al., 1979). It yields interval data; respondents can also be designated as falling into one of four categories. The PBI has been the subject of extensive psychometric interest and has been used in a variety of applications assessing adult parent-child attachment as a single measure and in combination with other measures, with both clinical and non-clinical samples and normative data is available (Cox, Enns, & Clara, 2003 Kazarian, Baker, & Helmes, 1987;

MacKinnon, Henderson, Scott, & Duncan-Jones, 1989; Parker, 1989; Parker, Roussos, Hadzi-Pavlovic, Mitchell, Wilhelm, & Austin, 1997; Smith, Lam, Bifulco, & Checkley, 2002; Wilhelm & Parker, 1990).

Like the PBI, the RSQ is dimensional rather than categorical. However, respondents can be categorized into one of the attachment categories defined by Hazan and Shaver's (1987) Adult Attachment Questionnaire. Comparable scaled scores on other attachment instruments (Adult Attachment Scale, Relationship Questionnaire) can also be derived from RSQ scores because it uses items drawn from these other measures. Normative data for the RSQ has not been established.

## Assumptions and Limitations of this Study

There is considerable debate regarding the various ways in which adult attachment is measured (Fraley, Waller, & Brennan, 2000; Shaver & Mikulincer, 2002; Shemmings, 2004; Sperling, Foelsch, & Grace, 1996). The use of self-report measures of adult attachment has been criticized by some who claim that they do not assess the unconscious aspects of individuals' working models of attachment. Shaver and Mikulincer (2004) however found that the empirical data indicates that self-report measures are accurate measures of the unconscious aspects of attachment representations and have accepted construct validity. Compared to interview instruments, self-report measures are short, economical, and are easy to administer and score, making them much more likely to be adopted for use by child welfare agencies.

The sample was not randomly selected or matched. Variables other than those examined by this study may confound the independent variables. These may include the

number of children in the home, previous biological parenting experience, the age of the parent, socioeconomic status, ethnicity, ethnic match between parent and child, and the number of previous placements the child has experienced. These results will only be generalizable to the population of special needs foster and adoptive parents, not to all foster or adoptive parents.

## Significance of the Study

Attachment theory has become an area of intense research interest. The barriers to long-term placement stability of foster and adoptive children are multiple and include: child and parent characteristics, the juvenile court and child welfare systems, family systems, and personal psychological problems. The first goal of this study is to contribute to the knowledge base concerning which parental factors facilitate placement durability and allow the child to develop new attachments. A second goal of the study is to suggest empirically based tools that are easily scored and interpreted (Cohon & Cooper, 1993). Objective measures may help inform placement decisions, thereby decreasing the rate of placement failure and the risk of emotional trauma to children and foster or adoptive families.

In summary, chapter 2 discusses special needs adoption and foster care, the characteristics of children in need of placement, the characteristics of prospective foster and adoptive parents, factors that influence placement outcome, the application of attachment theory to adoption and foster care, and the debate among researchers regarding the measurement of attachment. Chapter 3 discusses the characteristics of the sample, the research design, the instruments used, the demographic questionnaire, the

method used to collect the data, the type of analysis used and the way participants' rights were protected. A multiple regression analysis described in chapter 3 was conducted on the data. The results reported in chapter 4 indicate that both a diagnosis of RAD and the child's age at the time of placement were predictors of placement duration, but RSQ and PBI scores were not. Chapter 5 provides and interpretation of the results, the limitations of the study and offers recommendations for child welfare agencies use of age and RAD status as criteria for expediting child permanency policies. Although the PBI and RSQ were not predictive of placement outcome further research on the use of such measures is indicated.

# CHAPTER 2: LITERATURE REVIEW

## Introduction

The purpose of this literature review is to provide a brief history and current status of foster care and adoption, the theoretical perspectives that inform those practices, and the attitudes toward adoption and foster care, primarily as it is carried out in the United States. This information serves as background for examining the issues related to maintaining long-term foster and adoptive placements of children with special needs. This review presents a discussion of the methodological challenges of measuring adult attachment characteristics and ways to use attachment measures in making placement decisions.

The research studies used in this review were obtained through a comprehensive electronic search limited to peer-reviewed articles drawn from the following databases: Academic Search Premier (1975-present), PsycARTICLES (1985-present), PsycINFO (1887-present), MEDLINE (1976-present), and Social Science Citation Index (1956-July 2005). The terms and phrases used in conducting this search included *adoption*, *foster care, special needs,* and *attachment,* paired with a variety of key words and phrases such as *children, parents, parental, maternal sensitivity, family, measurement, resilience, stigma, disorders, disruption, placement, separation, trauma, child welfare, and stability*. From references listed in the primary studies additional sources were identified. A total of 248 journal articles have been cited. A limited number of additional contributions from

recognized attachment researchers published in nonjournal sources have also been included.

## Overview of Adoption and Foster Care

### *Brief History of Adoption*

The history of providing alternative care for children, whose parents were either unable or unwilling to care for them, dates to the 18th century B.C.E. when the Babylonian code of Hammurabi established the first guidelines for adoption (Brodzinsky & Schechter, 1990). Adoption is mentioned in the Hebrew Bible, and as early as 3 centuries B.C.E. adoption laws were established among the Hindus and Romans; by the 18th century the French and English had established similar legal codes (Brodinsky & Schechter, 1990; Brodzinsky, Smith, & Brodzinsky, 1998; Freundlich, 2001a; Moe, 1998; Wegar, 1997). The theme of adoption can also be found myths ranging from Oedipus to Superman (Brinich, 1990).

The early practice of adoption was used to insure alliances between nations, to provide for an adequate labor force, to insure inheritance rights, or to fulfill religious directives; in many cases adoption involved adult males rather than children or females (Brodzinsky, Smith, & Brodzinsky, 1998). Thus, the early practice of adoption was carried out to serve the needs of adults rather than dependent children (Valdez & McNamara, 1994). In the United States adoption history is traced to colonial times when settlers needed ways of managing homeless and orphaned children. This gave rise to

systems of indentured servitude, apprenticeship, and almshouses (Brodzinsky et al., 1998; Hacsi, 1995; Wegar, 1997; Zamostny, O'Brien, Baden, & Wiley, 2003).

Beginning in the 19th century formal laws began to shape adoption practice which has continued to respond to changing sociohistorical factors such as the increased need for homes for children orphaned after the world wars, and those left in need as a result of widespread epidemics. Those early laws continue to form the basis of most state statutes to the present day (Zamostny et al., 2003).

The advent of contraception, and the Civil Rights and Women's Movements affected the availability of both the most sought after children–healthy, Caucasian, infants, as well as decisions about transracial foster and adoptive placements. This has resulted in a rise of international and special needs adoptions (Brodzinsky et al., 1998; Zamostny et al., 2003). The Adoption Assistance and Child Welfare Act (Public Law 104-542) took a step toward permanency for children awaiting adoption by establishing timelines for reunification or placement into an adoptive home, rather than allowing them to linger in foster care (Brodzinsky et al., 1998). Most recently the passage of the Adoption and Safe Families Act (ASFA) (1997), described as "the most significant overhaul of the American foster care system since 1980" (Curtis, Dale, & Kendall, 1999). Despite its idealistic intent ASFA has not proven to be as successful as anticipated in facilitating family reunification freeing children from lengthy stays in the foster care system or expediting their adoption. Its shortcomings will be discussed in a following the section.

*Brief History of Foster Care*

Foster care has developed in parallel to the evolution of adoption practice and is a principle means by which child welfare agencies intervene in the lives of children and families in need (Holland & Gorey, 2004). Historically, according to Barth and Berry (1988), it was the child's economic destitution, rather than the need for protection, that brought children into care. Hacsi (1995) provided a historical summary of foster care and noted that during American colonial times children from various economic strata who were in need of care were sometimes indentured in households where they could learn a trade, work, and contribute to the family income. During the first half of the 19th century, indenture became more common for children from the poorest backgrounds while those less needy from urban families were sent to rural homes. The cholera epidemic of 1832 and the rise of urban poverty created a need for larger facilities to house the growing number of children; orphan asylums, often run by religious or benevolence groups, then came into existence. The practice of placing children in substitute homes became more common with the foundation of the Children's Aid Society (CAS) in 1853 where older children were expected to work while the younger ones were accepted as family members. The CAS and other similar organizations frequently had strong religious values in their zeal to rescue children often placed them into new homes that had been inadequately screened. As agencies became more careful in selecting homes, fewer homes met with their approval. By the 1880s and 1890s welfare agencies began contracting with foster families to care for children too young to work or those who had physical handicaps or challenging behaviors. This system became increasingly

formalized with the government's growing involvement in removing and placing children in care with the provision of a board payment to parents. This led to more scrutiny in the selection of boarding homes and evaluation of the children's welfare during the placement. Thus, boarding out became the immediate predecessor of today's foster care system.

In tracing the evolution of the foster care system Hacsi (1995) noted that growing state and federal government oversight of dependent children resulted in the 1935 creation of Aid to Dependent Children (ADC, later Aid for Dependent Children, AFDC) as Title IV of the Social Security Act. It provided funds needed to help biological families care for their children and prevent their removal. This act was viewed as a critical factor in stemming the entrance of children into public care. However, by the 1970s the AFDC funds had begun to shrink and correspondingly over the next two decades, the tide of children entering the foster care system began to swell. Today, although a significant number of children who are currently removed from their parents' care are placed into the homes of relatives, those children who do come into public care are often younger, come from more economically depressed families, have more serious problems than in the past, and stay in the foster care system longer (Hacsi, 1995). A more complete discussion of the problems of the foster care system will follow, but the developing picture is unfortunately one which Courtney (1999) described as being inadequately understood and under studied.

## Need for Research on Adoption and Foster Care

### *Scope of the Adoption Issue*

Although adoption is a relatively uncommon statistically, for the children, biological, foster, and adoptive parents whose lives are affected by it, the influence is significant (Bachrach, 1986). Adoption directly or indirectly affects the lives of about two-thirds of people in the U.S., either through having an adopted family member or friend, knowing someone who has adopted a child, or knowing a birth parent who has placed a child for adoption (National Adoption Attitudes Survey, 2002; Smith & Howard, 1999). Pertman (2000) has called attention to the current culture of adoption because it affects the lives of so many people. In 2000 the U.S. Census Bureau reported that there were 2,058,915 adopted children living in the nation's households (U.S. Census Bureau, 2000).

### *Research Bias and Deficits*

Given these statistics, Fisher (2003) expressed surprise that adoption, and by inference foster care, has not received adequate research attention by sociologists because it provides a unique window for examining the cultural definition of family created through the purposeful joining of individuals who are not biologically related. Berebitsky (2000) observed that:

> Adoptive parents continually struggle to create families that reflect their beliefs about the real meaning of "family." Adoption continues to function as a site on which the culture at large works out its understanding about 'family' including the issues of who should be in a family, what roles family members [including birth parents and adoptive parents] should play, and what functions (both public and private) the family should fulfill. (p. 168)

Lee (2003), Miall (1996), O'Brien & Zamostny (2003), and Zamostny et al. (2003) have indicated that clinical and counseling psychologists may be ill-prepared to serve the adoptive families, adult adoptees, and birth parents who seek their services, or may simply overlook the significance of adoption issues; they warn that those involved in transracial adoptions may be at even greater risk of inadequate or ineffective treatment. In describing the way adoption is ignored as an area of study Carp (2004) suggested that the influence of adoption is more pervasive and significant than most people realize.

The paucity of information on the foster care system was noted by Whiting and Lee (2003) who urged researchers to gather data that could inform both the public and policy makers with the need to reform outdated systems of care and provide potential foster and adoptive parents with sources to make informed decisions. Similarly, Orme and Buehler (2001) concluded that the current research effort to understand factors associated with best both outcomes and placement risks often lack funding and methodological soundness.

Fisher (2003) argued that adoption deserves vigorous research attention for a number of reasons. First, the primacy of the traditional family is being challenged by growing diversity in the form of single parent families, stepfamilies, gay and lesbian families, and families formed through reproductive technologies. Adoptive and foster families add to that diversity could provide validating evidence that they can offer children optimal environments in which to grow. Fisher (2003) also urged social scientists to continue their efforts to understand what fundamental elements besides shared biology are necessary to create a family. Miall (1996) similarly observed that the

study of adoption is well suited to that purpose of understanding nonbiological factors associated with successful families. Fisher (2003) suggested that because the barriers of race and ethnicity are often breached in adoptive and foster families, the study of adoptive families may lead to understanding the mechanisms by which families cope with racial and ethnic diversity.

Adoption and foster affect the lives of millions of individuals, although exact statistics on U.S. adoptions are difficult to obtain (Zamostny et al., 2003), in part due to the number of adoptions by individuals who become related to children through marriage and step-parenthood. These are estimated to account for 42% of all adoptions (Flango & Flango, 1995). An estimated 4% of Americans are adopted (Freundlich, 1998), and 39% of Americans polled during the National Adoption Attitudes Survey (2002) described themselves as having been interested in adoption at some point in their lives. Increased availability of research on the realistic challenges and positive outcomes of adoption and foster care may encourage potential parents to make more informed decisions. Powers (1995) argued for more vigorous empirical research into adoption and adoptive families in order to direct public policy, promote placement stability, and to insure the well-being of the affected children.

Although there is evidence that foster and adopted children are overrepresented as consumers of mental health services (Viner & Taylor, 2005), the bias of research in focusing on deficits and psychopathology may increase the stigma experienced by this population (Fisher, 2003). The trend in social work practice toward using psychodynamic theory may have served to foster a view of adopted children as being less emotionally

stable than their nonadopted peers (Wegar, 1997). Miall (1996) noted that the absence of control comparison groups in many studies make the existing research suspect and may create a false overrepresentation of the level of pathology among adoptive families, particularly in light of data to the contrary. Research on the positive outcomes of adoption and foster care are needed to balance this bias. Wegar (2000) cited concern over the effect that stigma has had in pathologizing foster care and adoption, leading to a view of adoption as being a second-best alternative (Fisher, 2003; Freundlich, 1998). The issue of stigma in adoption will be discussed in the following pages.

Unger, Denier, and Wilson (1988) observed gaps in the adoption research. They observed that research about the differences between outcomes for those adopting children they have previously fostered, known as foster care conversion, and those who adopt children whom they have not previously fostered known as outright adoption is an area that has been ignored. Unger, Denier, and Wilson (1988) also noted that little is known about the reasons why parents choose to adopt or not adopt a child who has been with them as a foster child who becomes legally available for adoption. Geen, Malm, and Katz (2004) suggested that research focusing on finding ways to increase the number of willing families and examining why those who make initial inquiries into adoption drop out of adoption-seeking are areas of important study due to the number of children needing homes and the lack of available families.

Zamostny et al. (2003) found that despite the recognition that adoption is a process that affects individuals across the lifespan the research on adoption has been limited to childhood and adolescence, although issues related to adoption such as loss,

abandonment, rejection, and dual identity may surface with varying intensity during significant developmental periods. The need for longitudinal studies to assess the changes in family functioning and adaptation to special needs adoption over the life span has been discussed by numerous authors. Specifically, Brodzinsky, Schecter, and Henig (1992) have addressed the lack of longitudinal research on the impact of adoption across the stages of developmental. Similarly, in a review of existing adoption research Rushton (2004) found that issues such as marriage, the birth of a first child, or the death of an adoptive parent have not been answered by longitudinal research. Rushton (2004) urged researchers to undertake studies of services needed by adoptive families which might result in policy recommendations.

The pressing need for research on the factors that predict placement stability or dissolution (Cautley & Aldridge, 1975; Festinger, 2002) have particular relevance to this present study. Festinger (2005) cited the sever lack of information on areas most critical to adoption workers such as how attachment is measured in older children, and what assessments can be used to identify the key dynamics of attachment in parent-child relationships. Festinger (2005) also called for more accurate and empirical ways of assessing adoption success which may mean more that simply placement stability. Edens and Cavell (1999) also noted the lack of research on the effect of adoptive parents' attachment styles on adoption outcome, or of the attachment status of adult adopted persons.

Rushton (2004) observed that research on placement decisions and disruption has not provided clear direction for changes in practice guidelines. Perhaps one reason for the

research deficiency is that foster children in particular and minors in general are a protected population, making direct research difficult. Berrick, Frasch, and Fox (2000) argued that despite the legal, administrative, and political barriers to such studies the absence of the children's input regarding their experiences of instability, separation, the formation of new attachments, and permanence is a significant deficit in the child welfare literature.

The scope of adoption continues to broaden leading to March and Miall (2000) calling it an "institution in transition" (p. 359). It increasingly includes: domestic adoptions through public or private agencies, international adoptions, private adoptions facilitated by attorneys, transracial adoptions, single parent adoptions, adoptions by gay and lesbian parents, and special needs adoptions. The growing trend toward openness in adoption is a relatively recent change and has been found to be related to levels of maladjustment (Derdeyn & Graves, 1998), whether single or two parent adoptions (Shireman, 1995), and interest or motivation to foster or adopt (Tyebjee, 2003). Adoption also varies in its degree of openness, that is, the initial and sometimes ongoing post-placement contact between the birth family and the adoptive family which has been discussed by Fisher (2003) and Grove (1996). The diversity of foster and adoptive families has prompted researchers to question which comparison groups may be most appropriate for them (Caballo, Lansford, Abbey, & Stewart, 2001). This growing diversity requires child-specific approaches to recruiting adoptive families for children with special needs (Brown, 1988).

*Statistical Limitations of the Existing Research*

In their review of 38 studies focusing on adoptive families, O'Brien and Zamostny (2003) raised several concerns. In general they noted that the majority of studies relied upon descriptive designs resulting in limited generalizability and concerns abut internal validity. Of the 22 empirical articles in their review, only three focused on children with special needs; eight studies did not specify whether the children of interest had special needs or not. Only about half of the total number of studies (16) used comparison groups of nonadoptive families. Some of studies were affected by failure to use measures with psychometric vigor and lacked standardized procedures when collecting data from multiple locations. Many of the studies reviewed by O'Brien and Zamostny performed multiple comparisons between variables and neglected to consider the affect this could have on increasing the risk of Type I error. The overrepresentation of Caucasian respondents and use of subsets of data from the same dataset further compromised the integrity of the studies. O'Brien and Zamostnet noted that generalizability could be improved by controlling sampling bias both in terms of the sources of data and the use of representative samples. For example, using data from adoptive parent support groups might result in healthy families being overrepresented. Drawing respondents from general agency rolls as well as from families in treatment might create a more representative sample and allow for greater generalizability. Finally, O'Brien and Zamostny suggested that the results of the studies they reviewed should be interpreted cautiously and in need of replication with the inclusion of children adopted at older ages and children with special needs.

Barth (2001) similarly cautioned that the data gathered from foster families may not be typical of this population, but rather typical of those who are functioning better than the norm and may not reflect the socioemotional environments in which most foster children live. Barth warned that the extensive use of self-report data, with the potential for social desirability bias, may also contribute to a more positive representation than is warranted.

Orme and Buehler (2001) conducted a literature review of research on foster parent characteristics and their influence on the emotional and behavioral problems of the children in their care. Of the 34 studies most were limited by small, nonspecific samples with questionable representativeness. They examined a range of foster parent characteristics that enhanced the child's socioemotional functioning including: the quality of the home environment, family functioning, marital health, certain demographic features, the mental health of the parents, the parents' ability to adjust to the child's temperament, and access to social support. Many of the studies examined by Orme and Buehler were 10-25 years old and deficient in four important areas: the exclusion of foster fathers or lack of distinction between the responses of foster fathers and mothers, lack of data from kinship foster homes, missing information about families that were not approved as foster parents, and overrepresentation of crossectional rather than longitudinal data which would not account for improvements in outcome due to foster parents' increased experience. They also noted the absence of comparison groups making it difficult to determine whether or how foster families differed from nonfoster families. In defense of the data currently available Orme and Buehler found that a considerable

variety of foster family characteristics have been studied and many studies have used at least one standardized measure with normative data available for comparison, but few have used the same measures making it impossible to combine and compare results. Orme and Buehler concluded that 15-20% of foster families have some difficulties in their home environments, the functioning of their families, or their style of parenting. The extent to which those factors, and others not examined affect the emotional and behavioral health of the children they foster remains unclear and in need of further research. Brodzinsky et al. (1998) addressed the need for theory driven research to explain how adoptive families function. The following section will consider which theoretical perspectives provide the best fit for adoptive families.

*Theoretical Perspectives to Explain Adoption*

There are recognizable gaps in the adoption research, both methodologically and topically. The early attempts to interpret data on adoptive outcomes have been hindered by the absence of well articulated theories (Brodzinsky & Schechter, 1990). Brodzinsky et al. (1998) cited the need to move from descriptive research to empirical research guided by strong theoretical models. Zamostny, Wiley, O'Brien, Lee, and Baden (2003) discussed a number of theoretical models by which adoption research may be directed including the psychodynamic and family systems perspectives, social role theory, the stress and copying theory, and attachment theory.

*Psychodynamic Perspective*

Despite the absence of empirical support, the psychodynamic perspective, which places considerable importance on the influence of early childhood experiences on the

subsequent development of psychopathology, has had a formative role in the clinical understanding of adoption (Brodzinsky & Schechter, 1990; Brodzinsky et al., 1998). Of note is the fact that one of Freud's most compelling examples of how personality development can go askew is the impact that adoption had on Oedipus, resulting in the tragedy of patricide and incest (Schechter, 2000). The psychoanalytic model also gained the interest of the social work profession which has dominated child welfare practice since the 1940s. Because of its association with the medical profession, social workers drew upon this model to help legitimize their profession and to enhance its standing in the scientific community (Wegar, 1997).

According to the psychoanalytic view unconscious conflicts arise for members of the adoption triad due to various factors: loss of birth parents by the adoptee; the adoptive parents' loss of the longed for biological child, the loss of the extension of one's biological endowment to future generations and the ego insult associated with infertility, the complication of the adopted person's dual identity in both the biological family and adoptive family; reliance on ego defense mechanisms to explain anger toward adoptive parents for taking the child from birth parents, or anger toward birth parents who abandoned the child to be rescued by adoptive parents; the failure to trust due to rejection and separation from birth family; and feelings of ambivalence or lack of entitlement by the adoptive parents (Brodzinsky et al., 1998; Zamostny , O'Brien, Baden & Wiley, 2003).

In writing about the implication of the psychoanalytic construct of the Oedipus complex for foster and adoptive children, Canham (2003) examined the effects that

caseworker's or foster or adoptive parents providing misrepresentations of the child's early history might have on the adopted person's sense of self or their construction of family and the larger social world. In psychoanalytic theory parents must manage impulses that may be stirred by the child's insistent needs if they are a reminder of their own unmet childhood needs. In the worst of circumstances this may place the child at risk of neglect or abuse. If the foster or adoptive child's early history included abuse or neglect, he may seek to recreate those earlier circumstances in order to work through the unresolved trauma. The parent's ability to provide the child with an understanding other with whom to identify, is one of the key elements in successful resolution of the Oedipal crisis (Canham, 2003). Wegar (2000) noted that the psychoanalytic emphasis on instinct positions mothers as the source of misdirected unconscious forces which may be further complicated if the child is an ongoing reminder of her infertility. Resolution of the incestuous pull may be more complex to negotiate in nonbiological families; as the adopted child achieves sexual maturity, unresolved issues about infertility may become an unconscious source of conflict within the family.

*Goodness of Fit Theory*

The theory that adoption success can be enhanced by attempting to simulate the biological family through accurately matching adoptive parents and children on the basis of physical resemblance, shared racial and ethnic characteristics, personality traits, and intelligence level has been a common practice among child welfare workers. Efforts to achieve a good fit however, may have resulted in sending contradictory messages to the family by inadvertently conveying the notion that differences between the parents and the

child are somehow less desirable and to be avoided (Wegar, 2000). This may be particularly true when adoptive parents are offered a child who differs significantly from the child who was hoped for or promised and result in rejection of the child.

Although the goodness of fit model attempts to enhance family functioning by controlling for personality and temperamental differences, the data indicating the higher rates of adoptees, compared to non-adoptees in residential treatment facilities, would question the success of the matching practice (Noble, 1994). Leon (2002) noted that data from non-clinical samples has indicated adopted adolescents perceive their parents as more nurturing and supportive than the ratings of biological children, findings which would indicate considerable compatibility between the matched parent-child dyads.

*Social Role Theory*

Kirk's (1964) sociological investigation of adoptive family dynamics articulated the social implications for the adoption triad, recognizing the critical role that loss plays in the formation of the adoptive family. Because of the stigmatization of adoptive parenting as being less desirable than biological parenting, and the confusion of roles that may result due to comparison to biological families, Kirk suggested that adoptive families fare better when their differences from biological families are openly recognized and accepted, rather than minimized or ignored. Brodzinsky (1987) indicated that both overemphasis on differences as well as failure to recognize the differences in adoptive families result in poorer adjustment. Despite the influence that the social role theory has had in adoption policy, it has not been the subject of empirically sound research. The

origins of stigma in adoption, whether inherent or socially derived, will be discussed later in this chapter.

*Social Constructionist Theory*

Somewhat aligned to the social role theory is the social constructionist orientation suggested by Miall (1996) who claimed that the contribution made by the community to the ways that adoptive families are formed has not been systematically investigated. Social role theory proposed that social problems are constructed by *claimsmakers* who are esteemed members of the community. They offer opinions and explanations of the problems which reflect the culture's beliefs and values. In the case of adoption and foster care the claimsmakers might be child welfare caseworkers, lawyers, clinicians, physicians. Thus the meanings given to social institutions such as family, adoptive versus biological parenthood, transracial adoption, and kinship are derived from the way that communities construct those institutions.

*Family Systems Theory*

The adoptive family system has an increased level of complexity because it is formed through the creation of a lifelong kinship alliance composed of the birth family, the child, and the adoptive family, and therefore has different developmental challenges than families formed through biological reproduction (Reitz & Watson, 1992). This perspective may be a better fit for adoptions involving children who have come through the foster care systems and have established social relationships with members of their biological families, for example, with parents and siblings, or previous foster parents.

Brodzinsky et al. (1998) suggested that a number of family variables make the ongoing development of adoptive families more demanding. These may include: expectations about adoption, rules about the child's contact with the birth family, the degree of secrecy or openness with which adoption related information is handled, loyalty to the birth family, and the ability of the extended adoptive family to offer support through infertility and adoption.

*Stress and Coping Theory*

Similar to the core tenet of the social role perspective regarding loss and stigma, the stress and coping theory assumed that adoption carries with it stressors not associated with biological family life. Brodzinsky et al. (1998) offered that adoption results in negative affect and requires more diligent cognitive appraisal of the circumstances and of one's relation to the stress, as well as the development of coping strategies, such as help-seeking or avoidance. Multidimensional models recognize that adoptive families must manage additional parenting, developmental, and life span tasks involving individual, social-environmental, and biological factors (Leon, 2002). Individual variables may include cognitive abilities, attachment style and personality factors. The child's social history prior to placement, similarities or differences in race or ethnicity between the child's biological and adoptive families, the functioning of the family systems at the time of placement, and post-placement supportive services are social-environmental factors that may affect the families' and the child's disposition. Finally, biological factors such as prenatal exposure to drugs or alcohol, genetically transmitted disorders, the child's physical health, and the experiences the adoptive parents may have had during infertility

treatment or pregnancy loss have a determining influence on family outcome. Coping attempts may include cognitive or behavioral avoidance such as loosing birth family photos, as well as attending adoptive parent support groups. Wegar (2000) contended that in contrast to the other theories which take a deficiency or pathology perspective, the social role and the stress and coping theories are the only two which consider the influence of social and cultural variables in adoption adjustment. The stress and coping model and attachment theory provide the focus of current research interest and may be particularly useful in understanding the adoption experiences of older children and those with special needs.

*Attachment Theory*

Attachment theory has helped illuminate factors that contribute to both successful and disrupted adoptive and foster placements and it may be the most common perspective among adoption workers (Wegar, 2000). Much of Bowlby's (1973, 1980) attention centered on the problems arising from inadequate or faulty attachment. Although he never considered himself far from his original training as a psychoanalyst, the durability of Bowlby's theory sprang from roots in a variety of disciplines including: general systems theory, communication and control theories, evolution, biological developmental theories, and ethology and primate studies (Marvin & Brittner, 1999).

Bowlby (1979) recognized the critical and lasting nature of the relationship between children and their caregivers when he observed that, "Whilst especially evident during early childhood, attachment behavior is held to characterize human beings from the cradle to the grave," (p. 129). The importance of attachment across the life span has

been supported by an abundance of research evidence. Allan and Land (1999) examined attachment during adolescence. Cassidy (1999) considered the biological bases of attachment behavior in children, the mechanisms involved in various behavioral regulatory systems including the attachment and caregiving regulatory systems. Feeney (1999) studied attachment in adult couple relationships. Hazan and Zeifman (1999) examined the transition from parent-child attachment binds to adult pair bonds. Rholes and Simpson (2004) applied the fundamental concepts of attachment theory across the life span with particular attention to biological regulation, internal working models, intergenerational passage of attachment styles and the influence of childhood attachment on psychological adjustment in adulthood. Bowlby (1969/1982) described attachment as a species-specific set of four related yet discrete types of behaviors which resulted in: establishing and maintain *proximity* with the attachment figure, experiencing the attachment figure as a *safe haven* in times of distress, experiencing and expressing *separation distress* at the unavailability of the attachment figure, and using the attachment figure as a *secure base* from which to explore the surrounding environment. These regulatory behaviors afford immature offspring a greater likelihood of surviving to reproductive age because they are designed to keep a parent or caregiver near enough to protect the young one from danger. Bowlby (1969/1982) believed that the biologically based attachment regulatory systems evolved to aid in species survival. West and Sheldon-Keller (1994) likewise described the function of attachment behavior as that which insures the organism's safety and protection in order to increase the likelihood of survival.

When children are deprived of what Bowlby (1952) described as *mother-love* their development across the life span is likely to leave them at greater risk of clinically significant physical and mental illnesses. To counter this Waterman (2001) posited that the substitute mother must express a unique preoccupation with the child which allows the child to relinquish his fear of abandonment and also helps the new mother to give up unrealistic expectations that the substitute child will replace the biological child she may never have.

While the study of attachment between biologically related dyads has been the focus of research interest (Bowlby, 1952; Rholes & Simpson, 2004), the implication of attachment theory on adoption and foster care has been less defined. The child's ability to form new attachments following attachment failure has important implications for adoption and foster care, particularly with older and special needs children (Gauthier, Fortin, & Jeliu, 2004). Attachment theory may provide a broad understanding of the ways in which the biologically directed attachment regulatory system, interacting with social-behavioral systems, can explain the resilience of children in seeking emotional ties with new parents. Attachment theory, family systems theory and social role theory which focus on resilience may help to explain the healthy functioning of the majority of families created through adoption (O'Brien & Zamostny, 2003). Rushton (2004) suggested that adoption presents an unmatched opportunity to study the effects of early adversity on subsequent attachments. This may be particularly significant since the majority of adoptive families do well despite the child's early adversity, parental infertility, or societal discrimination (Leon, 2002). As Wegar (1997) observed the adoptive relationship

stands as a testament to the human capacity to generate kinship and emotionally secure bonds from personal desire rather than from biological forces.

Although the perspectives discussed above provide unique views into the adoption experience they may be inadequate. The multidimensionality of adoption may require incorporating cross-cultural, family development, and life span theories to explain the differences between adoptive and biological families (O'Brien & Zamostny, 2003).

## Stigma in Adoption

Caballo et al. (2001) argued that social stigmatization of adoptive parents and their children is a problem in our society. By ignoring the social impact that stigma has on members of the adoption triad, birth parents, adoptive parents, and the adopted child, researchers have inadvertently condoned the pathologizing of adoption (Wegar, 1997). The social perception of children available for adoption demonstrates evidence of concern about the problems that adopted children are likely to have. For example, 69% of the respondents to the National Adoption Attitudes Survey (2002) believed that children adopted from foster care would be more likely to have behavior problems than their nonadopted peers. The dominant culture's family ideology that blood bonds form the basis of kinship has been suggested as a source of stigma for members of the adoption triad, as well as for children in foster care (Wegar, 1997). An additional source of stigma may be based in the system responsible for children's welfare by categorizing children based upon the severity of their physical and behavioral needs. In addition, Wegar (1997) observed that those children who are designated as having special needs due to

membership in a racial minority group are also harder to place. Ward (1997) found that children with special needs also experience greater stigma and have higher rates of placement disruption.

The language of adoption is replete with stigma, making distinctions between the real parent and the adoptive, that is, unreal or artificial parent. Biological parenthood is described as being natural and by implication adoptive parenthood is unnatural (Leon, 2002). Nickman et al. (2005) called for research examining the effect that open adoption might have in relieving the stigma experienced by relinquishing birthparents.

Both March (1995) and Wegar (1997) noted that the secrecy and lack of information about one's biological origins and the circumstances surrounding relinquishment are a source of stigma for adopted persons. March suggested that searching for one's biological parents may establish a generational link and a more adaptive way of coping with socially constructed stigma, allowing adoptees to counteract stigma by placing their search within a socially acceptable context.

## Summary of Issues Related to Foster Care and Adoption

The preceding discussion is indicative of why Etezady et al. (2000) referred to adoption as a psychosocial process with multiple factors stretching across the life span. Adoption and foster care have developed in tandem. Adoption practice has grown into a means of providing for the best interests of children in need, departing from its primary historical purposes of providing children to infertile couples, or the even earlier practice of guaranteeing heirs to insure the continuation of property inheritance, forging political

alliances, and providing labor for the family enterprises (Brodzinsky & Schechter, 1990). The following section will clarify the scope of special needs foster care and adoption and examine the need for permanency plans for these children.

## Special Needs Foster Care and Adoption

### *The Nature of Substitute Care*

Foster care may be considered a means of providing substitute families for children (National Clearinghouse on Child Abuse and Neglect Information, 1994, Foster care). Although originally seen as a form of temporary, short-term assistance to families in need, a number of children only leave the foster care system when they reach the age of majority, and not to return to their original families (Bass, Shields, & Behrman, 2004; Courtney, 1999). Alternatively some children spend their childhoods moving from one foster home to another, putting down tenuous roots only to have them brusquely pulled up. Despite its problems foster care remains a primary intervention of the child welfare system (Holland & Gorey, 2004).

The Adoption and Foster Care Analysis and Reporting System (AFCARS) (U.S. Department of Health and Human Services, 2004a) found that 532,000 children were in foster care during 2002. Of those, 46% resided in nonrelative homes, 23% in the homes of relatives, and 5% resided in preadoptive homes. AFCARS further reported that the average length of time children remained in foster care was 32 months. During the same period, 281,000 children left foster care to return to their original families, about 49,000 children were adopted, and 27,750 moved to another relative home. Of those children

who do return to their biological families about 33% are eventually taken back into foster care (Avery, 2000).

According to the U.S. Department of Health and Human Services (USDHHS) (2000) the length of time children remain in foster care varies considerably by state, with the average length of time across the U.S. being 33.26 months. In Illinois, the average number of months children remain in foster care is 45.26 months, the longest in the nation, compared, for example, to New Mexico, which has the shortest length of stay at 7.62 months (U.S. Department of Health and Human Services, 2000). When families cannot be reunified after considerable effort to assist the biological parents in rehabilitation, the Adoption and Safe Families Act (1997) recommended that adoption provide the permanent exit from the foster care system (Brooks, James, & Barth, 2002). Of the 532,000 children in foster care in 2002, 24% or 126,000 of them had a case goal of adoption and were able to proceed toward that goal because their biological parents' rights had been terminated (U.S. Department of Health and Human Services, 2004b).

There are many reasons that children come to the attention of child protection services including: neglect and abuse (Curtis, 1999; Roberts, 2002); living in impoverished conditions (Chipungu & Bent-Goodley, 2004); exposure to domestic and other violence (Babb & Laws, 1997); parental substance abuse or incarceration (Hacsi, 1995); parents who are unwilling or unable to care for them due to their own or their child's mental retardation, physical disability or mental illness (Niel, 2000); and the child's or youth's status as a delinquent or an offender (Holland & Gorey, 2004). Some of these factors result in children developing emotional and behavioral problems, as well

as physical and mental illnesses which create additional challenges in parenting (Holland & Gorey, 2004). According to Davidson-Arad (2005) most investigations of child endangerment involve evaluating ambiguous reports where there is no immediate risk of physical harm to the child, and therefore the decision to remove a child from his biological parents' care is one that is exceptionally difficult and has such potentially long-term effect on the children, their families, and the communities in which they live. However, Davidson-Arad did find that when children are truly at risk and are removed from their original homes to foster care, their quality of life does improve. Hacsi (1995), cited, Folks of nearly a century ago, who suggested that the removal of a child from his parents' care should only be considered when there is irrefutable evidence that the child is more at risk by remaining in his home, an understanding of what resources the child and family require to solve the crisis, and evidence that the plan to remove the child is more cost effective than using the same amount of financial resources to maintain the family intact.

Curtis, Dale, and Kendall (1999) contended that the foster care system is troubled by a variety of financial, administrative, and policy woes. Although the federal government is responsible for legislation that directly affects state funding and obligations related to foster care, Courtney (1999) held that it also allows for too little regulation in the direct administration of child welfare programs. During the 1960s and 1970s states began creating laws mandating professionals to report suspected cases of child abuse and neglect. By 1974 the institution of the Child Abuse Prevention and Treatment Act (CAPTA, Public Law 93-247), the most significant piece of federal

legislation to address child abuse and neglect, provided funding to states that would create programs to help prevent, identify, and treat the problem (Courtney, 1999; National Clearinghouse on Child Abuse and Neglect, 2004). The effect of this act and others was to flood the child welfare system with reports of abuse which had to be investigated, and which frequently resulted in children being taken into the system. For example, the 3 million reports of child abuse or neglect made in 1994 was an increase of 63% over 1985, and a dramatic rise from the 670,000 reports in 1976 (Courtney, 1999). Freundlich (1998) marked a similar progression initiated by welfare reform acts that had the effect of expanding the number of children living at the poverty level which in turn resulted in socioeconomic stressors which are associated with higher rates of child abuse and neglect. These factors have directly affected the intake of children into protective foster custody and necessitated the development of permanency planning for growing numbers of children.

A summary of the data from 2003 gathered by the AFCARS (USDHHS, 2004a) on the foster care system appears in Table 1. Of the children who remained in the foster care system, 55% (64,740) were residing in nonrelative foster homes, begging the question of what factors prevent these children from moving into permanent adoptive placements.

The data also suggested that the largest single age group at risk of entering foster care is that of very young children. Based upon a sample of 690,000 children from 11 states, covering the period from 1990-1997, Wulczyn, Hislop, and Harden (2002) found that 1% of the children less than one year of age and 2.5% of those under four months

entered foster care. Perhaps most significant is that these young children also remain in care longer than children who enter care at older ages.

Table 1

*U.S. Foster Care Statistics 2003*

| | |
|---|---|
| Children in foster care in 2003 | 523,000 |
| Average time in care | 31 months |
| In care 5 years or more | 83,920 |
| White non-Hispanic | 46% |
| Black non-Hispanic | 27% |
| Hispanic | 17% |
| Entered foster care | 297,000 |
| Exited foster care | 281,000 |
| Returned to their families | 151,770 |
| Adopted | 49,340 |
| Went to live with relatives | 30,570 |
| Awaiting adoption | 119,000 |
| Black non-Hispanic | 40% |
| White non-Hispanic | 37% |
| Hispanic | 14% |
| Average time in foster care | 43.9 months |
| 36-59 months | 23% |
| 5 years or more | 24% |
| In a non-relative home | 55% |

*Kinship foster care.* Courtney (1999) identified an additional aspect of the foster care crisis as being the rising rates of kinship foster care resulting from the continuing decline in non-kinship homes by about one-third during 1984-1990 (Courtney, 1999). Since most children eventually do return to their parents' care, kinship placement is theoretically less traumatizing and the availability of such placements has also seemed to make removing the child from his home an easier decision. Some have questioned the wisdom of this trend since the outcome data indicates that children in kinship placements remain in foster care longer and have lower adoption rates than children in non-relative care (Courtney, 1999; Thornton, 1991). There is also concern that kinship placements are

perceived as requiring and receiving less case management because of the family's presumed increased investment in the child's well-being (Barth, 2001). This may place children at greater risk because younger children entering care have higher rates of developmental delays and may receive interventions based upon whether they are in non-relative or kinship foster homes (Leslie, Gordon, Ganger, & Gist, 2002; Vig, Chinitz, & Shulman, 2005). Because lack of preparation for parenting a special needs child has been associated with placement instability (Barth, 2001) the National Clearinghouse on Child Abuse and Neglect Information (1994) has cautioned that kinship care is complex and has both advantages and risks.

*The intention to adopt.* The question of what personal factors distinguish those who consider adopting but never do from those who actually take steps toward that end is one that researchers might examine. The results of the National Surveys of Family Growth (NSFG) for women between the ages of 18-44 years were analyzed by Chandra, Abma, Maza, and Bachrach (1999). They found that of the data gathered from 1973, 1982, 1988, and 1995 there was a decrease of 2.1 and 2.2 percent in 1973 and 1982 respectively in the number of women who identified themselves as having "ever adopted," to 1.6 and 1.3 in 1988 and 1995. Regarding the 1995 data, of the 1,856 (representative of 9,893,000 women in the U.S. population) "ever-married women who had ever considered adoption" only 15.9% (290 women) had taken some steps toward realizing that intention, and of those only 31% (89 women) had adopted.

Although Chandra et al. (1999) examined characteristics of women who have considered adoption their study did not investigate prospective adopters' willingness to

adopt foster children in particular, nor did it suggest ways to recruit parents for older children or children of color. Brooks, James, and Barth. (2002) called for research on the ways that parental characteristics might be a factor influencing of the types of children they would prefer to adopt. In a further analysis of the Brooks et al. (2002) data, Brooks and James (2003) found that despite respondents' report of willingness to adopt African American foster children, only 5% of them actually did. As Brooks et al. (2002) concluded, the child welfare system must find ways to identify more adoptive families to match the types of children who are available to be placed. The need for this type of research is particularly urgent since younger age has been identified as a preferred characteristic by prospective adoptive parents and the longer children remain in foster care the less likely they will be candidates for adoptive placements (Chandra et al., 1999).

In the state of Illinois, even when children are placed in kinship substitute care the relative is licensed as a foster parent. Recruiting appropriate foster parents, whether relatives or non-relatives, for non-specialized children is difficult, but finding appropriate homes for children with special needs presents unique challenges to child welfare agencies. Recruiting foster families for African American children has been particularly difficult. Because African American children are over-represented in the foster care system, they tend to remain in care longer than other children, and have historically been unlikely to be placed with non-African American families (Hamm, 1997). With regard to single parent foster and adoptive placements Shireman (1995) has voiced the concern that because such placements have traditionally been viewed as less advantageous for children such placements have been considered as a last resort, resulting in children being

placed in such homes when they are older, have more severe behavioral or emotional problems and have a history of placement failure.

*Recommendations for Reform*

In writing for the National Center for Policy Analysis, Craig and Herbert (1997) made a number of recommendations designed to encourage the adoption of children in foster care which included: reimbursement incentives and stricter guidelines for states to limit children's term in foster care to under 2 months; limiting the definition of special needs to conditions that might require continuing medical or other costs to the adopting families; and requiring states to provide annual statistics on the number of children entering, leaving, and being adopted from foster care. They also recommended that states tighten their guidelines and timelines in setting limits on birth parents regaining custody of their children by demonstrating their fitness, 30-day limit for non-custodial birth parents to prove their parental rights or to forego efforts to contest the child's adoption, and parental termination of rights for children abandoned longer than 30 days, followed by a 30 day mandate to identify an appropriate adoptive placement for such children, and the prohibition of placement decisions base upon race.

Following a year-long intense review of the foster care system the Pew Commission on Children in Foster Care (2004) issued a number of recommendations for improving care including federal funding to facilitate children moving from foster care to adoptive status, as well as funding for programs to reduce the number of children needing care. The Commission also made suggestions of changes the courts' management of child welfare decisions that could promote the "safety, permanence, and well-being" of

children in care (p. 8). Finally, recommendations that the federal government improve its data gathering efforts, including longitudinal tracking, in order to assess the outcomes of its child welfare services, and to provide funds for "research, evaluation, and sharing of best practices" (p.17).

In their review of the state of children and families involved in foster care Bass, Shields, and Behrman (2004) made numerous recommendations including: access to health assessments and screenings at intake and during placement; ongoing quantitative measurement of their educational and health needs and developmental specific services for all children and youth in care; ongoing training and support for foster families, as well as policies to identify and respond to their needs; continuing supportive services following permanent placements; revision of eligibility requirements to allow for greater flexibility of federal funding for foster care; and improvement in coordination of all agencies providing services to children and families.

## Importance of Permanence in Childhood Development

Placement stability, permanence, or duration is frequently used as the measure of successful foster placement outcome although numerous other factors might be assessed such as overall family functioning, sibling interaction, and the child's level of satisfaction with the placement (Redding, Fried, & Brittner, 2000). Placement stability has the advantage of being readily measured both objectively and quantitatively (Redding et al., 2000; Ward, 1997). Most moves within the foster care system are intended to improve the child's condition, that is, to facilitate educational opportunities, aid in reunification with

the child's original family, increase proximity to siblings to allow for more regular visitation, provide emergency intervention, or with the hope that the new placement may become a suitable permanent home. Unfortunately children are often moved for reasons unrelated to their well-being. Investigators recognize placement change as a significant issue in child welfare practice because of data indicating that with each successive move children's feeling of rejection may increase and their ability to form new attachments may be impaired (Webster, Barth, & Needell, 2000).

The earliest attachment researchers noted that the deprivation of continuity in their care, either by the biological mother or a substitute results in short term distress often followed by lasting incapacity to form enduring social relationships (Bowlby, Ainsworth, Boston, & Rosenbluth, 1956). Henry (1999) noted that when the child's relationship with his primary caregiver is interrupted or severed it may result in developmental impairment across psychological, emotional and intellectual functioning. The very system which exists to insure the safety of children who cannot remain with their original families is often the target of widely publicized media contempt exposing cases of children being lost or abused while in the state's guardianship. Although the vast majority of children living in foster homes are well cared for, Bass et al. (2004) criticized the system as being "fraught with uncertainty, instability, and impermanence" (p.6), leaving children feeling confused and unstable.

Bowlby (1973) used the terms *mother*, *attachment figure, support figure, and mother substitute* to mean the person who "mothers the child and to whom he [the child] becomes attached" (p. 3). He and other researchers including Ainsworth, Blehar, Waters,

and Wall (1978) found a predictable response pattern when a child is separated from his mother. It begins with intense protest, followed by despair, and finally detachment. Bowlby (1973) observed that temporary separation or permanent loss of the attachment figure can be due to the parent's physical inaccessibility or emotional unavailability because of physical illness, depression, rejection of the child, unresponsiveness, or distraction by other concerns. Bowlby (1973) further noted that impact of the child's separation distress can be mitigated by a number of factors such as the presence of a familiar companion or sibling, the availability of a reasonably attentive substitute mother, being older at the time of separation, and being separated for a shorter duration.

Bowlby's (1944b) original investigation of juvenile thieves led him to propose that "prolonged separation of a child from his mother (or mother-substitute) during the first five years of life stands foremost among the causes of delinquent character development and persistent misbehavior" (p. 113). Of the 44 delinquent youths in his study 14 were classified as being "affectionless" incapable of neither "attachment, affection nor loyalty" (Bowlby, 1944b, p.39). Furthermore, of these 14 children, all had been separated from their mothers for some period of time and half of them had lived for a time in foster homes (Bowlby, 1944b). So convincing was the effect of separation and loss on the individual's emotional condition that Bowlby (1973) believed that the individual's level of anxiety or distress was a direct function of the attachment figure's availability and responsiveness.

More recent researchers have confirmed that the loss of multiple attachment figures has important developmental consequences (Hamm, 1997; Wulczyn, Kogan, &

Harden, 2003). Newton, Litrownik, and Landsverk (2000) observed that a history of multiple foster placements was associated with increased levels of externalizing and internalizing behaviors, and that there was a reciprocal interaction between placement instability and disruptive behavior, that is, challenging behavior resulted in placement disruption and placement change resulted in worsening behavior.

Previous research findings of a relationship between foster placement instability and increased medical problems, developmental delays and mental health problems prompted Rubin, Alessandrini, Feidtner, Mandell, Localio, and Hadley (2004) to look for a link between placement instability and mental health costs for children in foster care. In their sample of 1,635 children studied over a single year in foster care 41% of the children experienced three or more different placements during the year following their initial placement and these children had a probability of 0.78 (95% CI) of using mental health services. In addition, the use of such services was correlated with the use of general medical services. Consistent with the findings of Newton et al. (2000), Rubin et al. observed an association between children having multiple risk factors and their movement through multiple placements.

Wulczyn et al. (2003) also noted that the children with the most consistent histories of placement moves often had the most severe behavioral problems. In a longitudinal study examining the effect of caretaker and residence transitions on five measures of adolescent deviant behavior, Herrenkohl, Herrenkohl, and Egolf (2003) found that changes in caretakers accounted for more of the variance related to alcohol use, drug use, and status offenses than maltreatment variables. Further evidence of the

potential harm resulting from the child's separation from his mother will be discussed in the following pages.

*Lack of available families.* Perhaps the most basic issue facing the child welfare system is the lack of foster and adoptive homes. Freundlich (1998) observed that families were more reluctant to take children with more specialized needs; Rhodes, Orme, and Buehler (2001) cited lack of agency support, their lack of input in the child's future and the severity of the children's behavior problems as reasons why foster parents stop fostering. A report by the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services (2005) noted that, "Child welfare agencies are continually challenged to provide adequate numbers of foster homes that are stable, can accommodate sibling groups, and are located in proximity to family members" (p. 1). The further finding by this report noted that "research on foster parent retention is surprisingly slender, with little known about the length of time served by foster parents and the characteristics associated with varying length of service" (p. 1).

The Adoption and Safe Families Act (ASFA) (1997) has contributed to a significant increase in the number of children annually adopted from foster care from 28,000 in 1999 to 50,000 in 2001. However, fewer than 10% of adoptions are by those not already foster parents or relatives, and ASFA made no provision for the recruitment of parents from the general population (Geen, Malm, & Katz, 2004). Rhodes, Orme, and Buehler (2001) suggested that child welfare agencies focus increased attention on strategies to retain existing foster parents to provide children with greater stability, and potentially decrease overcrowding in fewer homes as well as helping to keep children

from being sent to more restrictive settings. Characteristics of parents who persevere in foster or adoptive care will be discussed more fully in subsequent sections, however, Redding et al, (2000) has suggested that placement stability is partly a function of accurately matching the characteristics of the foster or adoptive parents with those of the child, which is the premise of the current study.

Considering the seriousness of placement instability Wulczyn et al. (2003) noted the significant gap in the research on the factors that induce placement breakdown or facilitate stable placements. Similarly, Holland and Gorey (2004) called for more research on factors that predict placement instability. The current study seeks to identify the attachment characteristics of foster and adoptive parents which may be a factor in placement success.

## Preparation for Fostering and Adoption

Although some argue that there is no appreciable difference between biological and adoptive parenting, others contend that adoption and foster care challenge beliefs that are central to the meaning of family (Kirk, 1964; Prochaska, Paiva, Padula, Prochaska, Montgomery, Hageman, & Bergart, 2005). Preparation for non-biological parenting presents a challenge to normal family development (Farber, Timberlake, Mudd, & Cullen, 2003) and may activate issues tied to kinship, loyalty, entitlement, trust, and the hope of extending one's genetic influence into the future (Brodinsky, 1987; Noy-Sharav, 2002). Brodinsky, Schecter, and Henig (1992) examined the effect of adoption across the lifespan, both the adoptee's and the adoptive family. Whereas the creation of a new

nuclear biological family involves the joining of two individuals and their respective parents and extended families of origin, the creation of a foster or adoptive family also includes the child, the birth parents and the birth parents' extended families (Farber et al., 2003). For these reason the preparation to become a foster or adoptive parent requires not only additional knowledge, but also screening by child welfare agencies to insure that the child is placed with parent(s) who are most capable of successfully meeting his physical, social, and emotional needs.

Orme and Buehler (2001) suggested that research is needed to develop more effective screening and selection criteria, as well as investigating the ways that the family's overall functioning including marital stability affect placement outcome. The necessity of a collaborative approach to family identification and preparation was stressed by the Field Guide to Child Welfare offered by the Child Welfare League of America (Rycus, Hughes, & Goodman, 1998). This process is designed to help family members clarify ideas about adoption, assess both strengths and vulnerabilities and examine the life experiences which brought them to this choice.

The extensive and intrusive screening process for foster and adoptive parents may create an illusion that an ideal standard exists and discourage individuals from applying (Freundlich, 2001b). Freundlich (2001b) has noted that, "neither practice nor literature provides a well-articulated set of criteria that agencies use or should use in determining whether an individual will be a "good" adoptive parent" (p. 140). The high dropout rate among foster parents shortly after a child is placed in the home would also attest to the lack of research based methods for screening, matching, and predicting successful

outcomes (Redding, Fried, & Britner, 2000). This has led some practitioners to doubt the value of the extensive screening processes and question whether the screening process may be somewhat useful in screening *out* applicants, but may be of little use in identifying characteristics considered desirable in adoptive parents.

While there are obvious factors that contraindicate foster licensure, such as history of conviction for sexual abuse or evidence or credible suspicion of sexual control problems, current substance abuse or dependence, and severe mental illness (Rycus, Hughes, & Goodman,1998), other, less obvious issues, may also affect parenting ability. These may include a personal history of child abuse or neglect, prior arrest or felony conviction, history of domestic violence, resolved substance abuse or psychiatric problems, behavior problems with one's biological children, or other serious interpersonal issues (Rycus et al., 1998).

Freundlich (2001b) has noted that emphasizing the prospective adopters' self-assessment may be valuable in determining their suitability for parenting foster or adopted children, particularly those with a history of previous trauma. Rycus et al. (1998) suggested that a number of assessment areas be explored in collaboratively determining whether a family would make a suitable adoptive home. The current study hopes to offer some additional decision making tools.

## Factors Related to Placement Outcome

As noted above, the implementation of the Adoption Assistance and Child Welfare Act (Public Law 96-272) (1980) and the Adoption and Safe Families Act (Public

Law 105-89) (1997) have resulted in child welfare agencies being mandated to shorten the time spent in out-of-home care, monitor the number of placements that children experience while in foster care, and carry out permanency planning for all children, even those who would have previously been considered unlikely to be adopted. Unfortunately, expediting the adoptions of special needs children has concurrently been linked with increased risk of disruptions in some studies (Barth & Berry, 1988; Hollingsworth, 2003).

Some have suggested that as adoptive placements have increased since 1980 the number of placement failures has declined and the seeming increase found in some studies is attributable to a blurring of the distinction between disruption (the termination of a placement intended to result in adoption) and displacement (the child's return to public custody following a legalized adoption) (George, Howard, Yu, & Radomsky, 1995). Displacement may or may not end in adoption dissolution, that is, the legal setting aside of the adoption. Permanency planning is designed to insure that children either have a speedier resolution of the issues that resulted in their removal from the biological parents' custody and are thereby able to return to their original family, or that they are placed into a permanent adoptive home as quickly as possible (Deiner, Wilson, & Unger, 1988). While in foster care each child is assured a bi-annual administrative case review and an annual permanency hearing to insure that they do not languish in the system (Courtney, 1999; U.S. General Accounting Office, 2003). In addition, concurrent planning has become more the norm for children in care so that while efforts are being directed toward reunification, simultaneous planning is undertaken which anticipates the

possibility that the child will require a permanent long-term foster or adoptive home (Katz, 1999; Martin, Barbee, Antle, & Sar, 2002).

Despite governmental mandates the task of reunification or permanent placement in a substitute home remains an elusive goal. According to the Child Welfare League's (2002) National Data Analysis System the mean number of placements that foster children experience nationwide is 3.26, with Nevada having the fewest at 1.2 and Maine the most at 5.2, followed closely by Vermont and North Carolina at 5.1 moves. The overall percentage of placement breakdowns in long-term foster care 2-5 years following the original placement is estimated at 43% (Triseliotis, 2002) with even higher rates estimated between 38-57% among children who require more intense placement in what are designated as treatment foster homes (Smith et al., 2001). One study found a disruption rate of 19% among special needs adopted children 2-8 years after the original placement (Triseliotis, 2002). The National Adoption Information Clearinghouse (2000), an office of the USDHHS, estimated that 10-25% of adoptive placements disrupt.

Although Smith and Sherwen (1983) noted that "For a child, adoption is an unparalleled opportunity to move from a life of neglect and poverty to a situation where parents want to nurture" (p. 45), the task of providing a permanent home to a child who has suffered multiple traumatic experiences and losses sometimes requires exceptional fortitude. As Brodzinsky et al. (1998) observed, families who adopt or foster children with special needs have multiple challenges and stressors to face before successfully creating a reciprocally satisfying relationship with the child.

*Overview of Risk Factors*

The data continues to indicate that placement success or failure is the result of a combination of multiple factors contributed by the child, parent(s), family, and community. Barth and Berry's (1988) comments remain relevant: "no checklists of factors standing alone or together should ever rule out an adoptive placement" (p. 78), but that failed attachment efforts between the child and parents are a predictor of subsequent attachment and placement difficulties.

Various other researchers have examined the factors affecting placement outcome which generally fall into one of the following four categories: (a) those related to the child, such as previous experiences and characteristics, e.g. age at placement, ethnicity, abuse, previous failed attachments, mental illness (Barth & Berry, 1988; Brodzinsky et al., 1998; Holland & Gorey, 2004; Moffatt & Thoburn, 2001; Rosenthal, 1993; Smith et al., 1998; Smith, Stormshak, Chamberlain, & Whaley, 2001; Webster, Barth, & Needell, 2000); (b) factors related to the foster or adoptive parents, e.g. previous parenting experiences, parenting style, marital stability, availability of social support, changes in life circumstances such as moving, employment and illness (Doelling & Johnson, 1990; Freundlich, 1998; Reilly & Platz, 2003; Westhues & Cohen, 1990); (c) factors related to the system of care, e.g. pre-placement training and preparation, lack of post-placement support, poor casework management (George, Howard, Yu, & Radomsky, 1995; Rhodes, Orme, & Buehler, 2001; Rosenthal & Groze, 1994); and (d) factors related to the biological parents, e.g. substance abuse, mental illness, homelessness, criminal involvement (Frame, 2002). The majority of the investigations in which the child's age

was considered as a variable in placement stability found that younger age at placement predicted placement stability. Specific prenatal risk factors were noted by Schneider, Roughton, Koehler, and Lubach (1999) such as maternal exposure to severe anxiety and stress were associated with the lower adaptability, increased distractibility, and more negative mood in offspring.

Children who come into care from biological families with significant problems and multiple risk factors are at greater risk of remaining in care (Martin et al., 2002) and may also experience foster care drift, the interminable wait experienced by children in care as they await either their parents' successful rehabilitation, or court action to terminate parental rights (Lee & Lynch, 1998). Greater numbers of risk factors have been associated with higher levels of behavioral dysregulation which can lead to placement failure. Holland and Gorey (2004) observed that the risk factors in the original family that resulted in the child's removal account for about two-thirds of the variance in foster placement breakdown leading to more frequent moves which further traumatize the children and magnify their problem behaviors. Maynard (2005) has suggested permanency mediation as a means of expediting voluntary surrender and providing the child with long term stability.

The Webster et al. (2000) eight-year longitudinal study of a cohort of 5,557 children entering foster care examined the risks to placement stability. They found that children placed in kinship care remained in care longer; a trend that continued across the eight years of the study when about 71% of the children originally placed in kinship care remained in their first or second placement compared to only 48% of the children in non-

relative care. The child's age at placement, gender, and physical or sexual abuse were also factors that predicted placement stability. Male children were about 33% more prone to have multiple moves; children who entered care as toddlers were 1.75 times more likely to be moved three or more times if they were moved during their first year in foster care. Children who entered the system following physical or sexual abuse were 25% more apt to experience multiple moves than children who entered care as a result of neglect. Finally, African American children were one-fourth as likely to experience placement changes compared to Caucasian children. Their most compelling finding was that children moved more than once during their first year in care were more likely to experience subsequent future instability. Smith, Howard, and Monroe (1998) argued for more longitudinal research to identify whether there are developmental patterns or other factors that affect the development of problem behaviors that increase the risk of placement disruption (p. 82).

Moffatt and Thoburn's (2001) study of 254 British children did not find that previous placement dissolution predicted future placement instability, but their findings confirmed that age at time of placement and an early traumatic history of mistreatment were predictive of placement failure. Matching the ethnicity of the child and the adoptive parent(s) was a more critical factor for girls than for boys who were more stable in transracial placements. Similar to the findings of Reilly and Platz (2003), Moffat and Thoburn found that placement with siblings did not predict greater placement stability.

Reilly and Platz (2003) looked at the characteristics of the child, the parents, and the agencies for factors that predict positive placement outcome. In their study of 249

adoptive families (379 children) 66% of the respondents reported that their families had been positively affected by the adoption; 77% said that they had "good to excellent" relationships with their adopted child or children. The impact of adoption on marriage was less positive with (49%) reporting "mostly positive" and 10% reporting that it had been "mostly negative" (p. 795). There was a positive correlation between the number of years the child was in the home and the number of behavior problems reported; there was also a positive correlation between the number of years in the home and the number of disabilities (behavioral, emotional, learning, and developmental), indicating that the children's problems not always evident at the time of placement, but they may increase over time and developmental stage. Sibling group placements also demonstrated more problem behaviors than single child placements. With regard to parent characteristics, the adoption of sibling groups was associated with lower levels of nurturing and more "high risk parenting practices" but may be masking a more basic issue of the number of children in the home (p. 793). Reilly and Platz also found an increased level of questionable parenting behaviors among African American parents, and also among those who described themselves as being very involved in their religious activities. With regard to agency policy and practice, 58% of the adoptive parents said that they had not received adequate information about the child they had adopted and 37% thought that the agency underrepresented the severity of the children's problems prior to placement. In this study the children's behavior problems were the primary predictor of parental satisfaction, followed by the parents' expectation of the children. The data also supported a finding that appropriate parental expectations were associated with higher levels of parent-child

relationship quality and positive impact of the adoption on the family and the marital relationship. These findings are consistent with Brodzinsky et al. (1998) who contended that the key to successful special needs placements is a combination of adequate pre-placement preparation of the foster or adoptive parents, helping the prospective parents cultivate realistic expectations, and providing vigorous post-placement support.

As the preponderance of the literature on special needs placements has indicated the increase of failed foster placements is followed by increased rates of post-adoption difficulties and placement breakdown, either adoption disruption or dissolution (Brodzinsky et al., 1998; Hollingsworth, 2003). More pre-adoption training and information about the children before placement, as well as post-adoption services to meet the demands of special needs children may be warranted (Freundlich, 1998; Reilly & Platz, 2003).

The majority of the research interest has focused upon the child's trauma due to separation from his biological mother, however, Gauthier, Fortin, and Jeliu (2004) examined trauma in children who felt pulled in their loyalties between their biological and their long-term foster families when they were later considered ready for reunification. This writer has been involved in numerous such cases in which the legal rights of the parents have been given preference over the attachment and emotional needs of the child.

## The Challenge of Creating Families through Foster Care and Adoption

Considerable attention is given to the preferences of prospective foster and adoptive parents for specific child characteristics (Brooks et al., 2002). During pre-placement screening, prospective parents are asked to describe the types of children they believe themselves most capable and least capable of parenting. Because of the scarcity of children with the most sought-after qualities prospective parents are often asked to consider taking a child who is a poor fit for the profile they have identified (Ward, 1997). When parents take a child who is very different from the one they had hoped to parent, the resulting match may be strained to the breaking point, or the prospective parents may simply withdraw their interest in fostering or adopting (Brooks et al., 2002).

### *Characteristics of the Children*

*Special needs.* Despite the efforts of ASFA (1997) to shorten the length of time that children remain in foster care Barth (2001) contended that they will remain a difficult population due to having a range of special needs. In addition to the definitions provided by the Adoption Assistance and Child Welfare Act (1980), various other authors have examined the use of the label of having special needs: being older (Babb & Laws, 1997; Speirs, Duder, Grove, & Sullivan, 2003); belonging to a particular ethnic or minority group, having prenatal exposure to drugs or alcohol (Rosenthal, 1993; Rosenthal, Groze, & Aguilar, 1991); exposure to early environmental adversity (Valdez & McNamara, 1994), being a member of a sibling group requiring a common placement, having been physically or sexually abused (Reilly & Platz, 2003), having risk factors for a genetic disorder, being HIV positive, or having physical, mental, or psychological impairments

(Babb & Laws, 1997; Rycus, Hughes, & Goodman, 1998, and indication of need for dependence upon public support or resources. The term is frequently associated with being more difficult to place and some believe it to have a discouraging effect on prospective foster or adoptive parents (Freundlich, 1998). The availability of special needs children is predicted to rise, along with a decrease in the number of adoptable infants due to the accessibility of contraceptives and abortion (Freundlich, 1998; Reilly & Platz, 2003). As the availability of adoptable infants no longer matches the demand by childless couples it may in turn boost interest in international and special needs adoption (Freundlich, 1998).

Describing children in foster care dos Reis, Zito, Safer, and Soeken (2001) noted that slightly more than 50% of the children had experienced abuse and neglect. As a result children have higher rates of chronic medical conditions and psychiatric disorders than children in intact families (Dale, Kendall, & Schultz, 1999). Viner and Taylor (2005) attributed the children's early adversity and poor physical and mental health to socioeconomic disadvantage prior to entering care, conditions which then continued during their years in foster care. Citing a review of earlier research, Zima, Bussing, Crecelius, Kaufman, and Belin (1999) concluded that children diagnosed with mental illnesses have higher rates of placement instability than those who do not. Unfortunately this places them at even greater disadvantage in not having a consistent caregiver to help insure that they receive appropriate treatment or the benefit of a parent willing to participate in treatment with them. The effects of early deprivation and mistreatment are not confined to childhood. Viner and Taylor's 30-year longitudinal study comparing

former foster children in the United Kingdom with a community cohort found that in adulthood those formerly in foster care were more apt to have been homeless, have a criminal conviction, have psychological problems, and have lower levels of general health.

Data summarized from AFCARS reported to the Subcommittee on Human Resources Committee on Ways and Means of the U.S. House of Representatives noted that 85% of the children who were adopted during the years 1998-2000 qualified as having at least one special need, and 32% who were adopted from foster care in 2000 had at least three special needs (USDHHS, 2004b). Barth and Berry's (1988) study of 120 special needs children found that the children had experienced high rates of previous trauma including: neglect (82%), physical abuse (60%), and sexual abuse (32%), and 83% were identified as having emotional and behavioral problems. They remained in foster care longer than other children even after being legal freed for adoption. They also exhibited other problems including learning disabilities (59%) and developmental (40%), and physical (33%) disabilities. In a longitudinal study of 71 children Grove (1996) found significant mental and physical disabilities including mental retardation (20%), medical and orthopedic disabilities (21% and 13%), vision and hearing disabilities (5%), and learning problems (35%), with the largest category being behavioral and emotional difficulties (51%). About two-thirds had been victims of physical abuse or neglect and over 50% had been exposed or suspected of having been exposed to sexual abuse. Unfortunately the problems that children have when they enter foster care are often exacerbated by the foster care system due to inadequate budgets, overextended caseloads,

and lack of permanency planning resulting in multiple moves (Rosenfeld, Pilowsky, Fine, Thorpe, Fein, Simms, Halfon, Irwin, Alfaro, Saletsky, & Nickman, 1997).

In the state of Illinois, even when children are placed in substitute care in the home of a biological relative, the relative is licensed as a foster parent. Recruiting appropriate foster parents for children with special needs presents unique challenges to child welfare agencies. Shireman (1995) voiced concern that because single parent placements have been viewed as less advantageous for children such placements have been considered as a last resort, resulting in children being placed in such homes when they are older, have more severe behavioral or emotional problems and have a history of placement failure.

According to Kramer and Houston (1999) efforts to sustain special needs adoptive placements have been shown to call for more planning and post-placement support. McGlone, Santos, Kazama, Fong, and Mueller (2002) found elevated post-placement parental stress levels among special needs adoptive parents, indicating the need for greater pre-placement attention to identifying parental strengths, stress management skills, and parenting characteristics that may predict outcome.

*Race.* Brooks et al. (2002) found a number of factors that predicted a child's adoptability including age and race. African American children are over-represented in the foster care system, tend to remain in care longer than other children, and have historically not found placements with non-African American families (Hamm, 1997). Although 42% of the adoptable children are African American (2004a) they are only one-fifth as likely as Caucasian children to be adopted and half as likely to be adopted as

Latino children (Barth, 1997). Barth attributed this disparity to a combination of inadequate numbers of prospective African American adoptive homes and a lack of responsiveness on the part of child welfare agencies to the needs of African American children and families.

*Age.* Age has also been identified as a factor in adoptability. Brooks et al. (2002) noted that younger age increases the child's likelihood of adoption. The average age of the adoptable children in 2002 was 8.5 years and their mean age upon removal from their biological parents' care was 4.9 years (U.S. Department of Health and Human Services, 2004b). Although Barth (1997) found that prospective adoptive parents would prefer to adopt infants and younger children, according to U.S. Department of Health and Human Services (2004b) statistics as of September 2002 only 3% (4,224) of the adoptable children were under 1 year of age and 32% (40,204) were between the ages of 1 and 5 years; of the remaining 64% of the children, 30% (37, 740) were between 6 and 10 years, 29% (36,310) were between 11 and 15 years, and 5% (6,393) of the adoptable children were 16 to 18 years old.

*Mental illness*. Over a half century ago, upon observing the conditions of children who had experienced maternal deprivation, Bowlby (1952) observed that:

> Among the most significant developments in psychiatry has been the steady growth of evidence that the quality of parental care which a child receives in his earliest years is of vital importance for his future mental health…what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent other-substitute) in which both find satisfaction and enjoyment...It is this complex, rich, and rewarding relationship with the mother in the early years, varied in countless ways by relations with father and the siblings, that child psychiatrists, and many others now believe underlie the development of mental health. (p. 11)

Unfortunately, foster children or those adopted from that care system have often been deprived of such opportunities. Subsequent data collected over the past 50 years on the rates of mental illness among children in foster care have borne out Bowlby's (1952) comments. Simms, Dubowitz, and Szilagyi (2000) found that children frequently enter foster care with multiple physical and psychological needs and fail to receive the care necessary to ameliorate those conditions. Perhaps more worrisome is their observation that the children's mental health problems may be exacerbated while in care. Data over the last two decades has indicated three to seven times the rate of acute and chronic health problems among foster children as compared to their nonfoster peers (Rosenfeld et al., 1997). Studies comparing the rates of mental health problems among children living in foster care with normative and community samples have consistently found that foster children exhibit elevated rates of psychiatric illnesses. For example, in a sample of 2419 children entering foster care Chernoff, Combs-Orme, Risley-Curtiss, and Heisler (1994) ) found that over 90% had some medical condition, 75% had a family history of mental illness, drug or alcohol abuse, 36% had a history of behavior problems, 18% had been sexually abused, 15% admitted to suicidal ideation, and 7% admitted homicidal ideation. Similarly, in a sample of 267 foster children Clausen, Landsverk, Ganger, Chadwick, and Litrownik (1998) found that approximately 40% score in the clinical range for behavioral problems and found that in a sample of nearly 300 foster children ages 0-17 years, scores were 2.5 times higher on measures of behavioral problems than the projected community sample. Goodman, Ford, Corbin, and Meltzer (2004) noted that about 45% of children in foster care in England had at least one psychiatric disorder. Harmon, Childs, and Kelleher

(2000) found that children in foster care were 3-10 times more likely to be diagnosed with a psychiatric illness, had 6.5 times more claims for mental health benefits, were 7.5 times more likely to be psychiatrically hospitalized, and had almost 12 times the mental health expenses of other disabled children who were qualified to receive Aid for Dependent Children. Others have reported that 40-60% of children in foster care have at least one psychiatric disorder, with 33% having three or more diagnosable conditions (dos Reis, Zito, Safer, & Soeken, 2001).

Adverse events in childhood can set a course for continuing problems in adulthood. Bernier, Ackerman, and Stovall-McClough (2004) observed that even children placed into foster care as infants face considerable risk including mistreatment and parental loss, which place them at higher risk for later psychopathology. Similarly, Viner and Taylor (2005) found that children in public care were more likely to have poorer physical and mental health and lower levels of academic achievement. Despite the clinical presentation of special needs children which can sometimes include sociopathic behaviors, such as fire setting, lying, stealing, violence toward others, and defiance of authority, Smith (2001) has argued against the notion of an adopted child syndrome contending that it has insufficient theoretical basis and its existence as a diagnostic category lacks empirical and methodological support.

Simms and Halfon (1994) noted the complex and overlapping physical, emotional, and developmental problems of children entering the foster care system, but which are often not the focus of child welfare programs, despite many of the children's conditions being amenable to treatment and able to significantly improve the quality of

the children's lives. They noted that the children who are most disturbed and in need of consistent parenting and support are frequently the ones whose placements disrupt because of their externalizing behaviors.

*Attachment problems.* In addition to the trauma of abuse or neglect many special needs children, many also suffer from loosing a home or family that was at least familiar, if not nurturing. If the child's move through the foster care system has included multiple placements he may have difficulty forming healthy attachments to adult caregivers (Redding et al., 2000). Fortunately there is no evidence that attachment must occur within a critical period (Boris, Zeanah, & Work Group on Quality Issues, 2005).

The American Psychiatric Association's (APA) (2002) position statement on reactive attachment disorder (RAD) describes it as a "complex psychiatric condition" that is caused by "severe disruptions" in the child's early caregiving relationships and is often accompanied by abuse or neglect (p. 1). The diagnosis of RAD is given when there is "markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 years" and may be evidenced by failure to initiate or respond to social cues, characterized by excessive inhibition or hypervigilance, or severely ambivalent or contradictory types of response (APA, 2000, p. 130). Conversely, the child may exhibit excessive friendliness towards strangers and lack of discrimination in attachment cues and behaviors. These symptoms must not be related to mental retardation or pervasive developmental disorder. RAD is believed to directly result from the child having previously received pathogenic care, including disregard for her basic physical and/or emotional needs, or multiple changes in caregivers. The disorder is

believed to occur infrequently in the general population (APA, 2000), but the course of RAD has not been well documented (Boris et al., 2005).

Boris et al. (2005) described a range of behavioral indicators of disturbed attachment in young children including: lack of affectionate interaction with identified attachment figure or indiscriminate affection toward unfamiliar adults; failure to seek comfort when hurt; excessive independence from or dependence upon the caregiver; extreme lack of compliance, or fearful overcompliance; lack of exploratory behavior; failure to use caregiver as a secure base; excessive caregiving behavior toward the caregiver or manipulation of the caregiver; caregiver avoidance following separation; inappropriate physical contact with a non-caregiver, or willingness to leave or be taken from the attachment figure without protest or distress.

In a sample of 94 maltreated foster children, Zeanah, Scheeringa, Boris, Heller, Smyke, and Trapani (2004) found that 38-40% met the diagnostic criteria for RAD with higher rates among those whose own mothers had a history of psychiatric illness. Although clinicians may be tempted to stretch the criteria to include older children whose attachment history prior to age five years may be unknown, Zeanah et al. warn that this could lead to diagnostic imprecision. Also some have suggested that older children who present with Oppositional Defiant Disorder or Conduct Disorder may also have RAD (Levy & Orlans, 1998). Hoksbergen and Utrecht (2000) found higher rates of RAD and other health problems among foreign born adoptees that were later placed into residential treatment facilities. Similarly, Chisholm (1998) found that children who had spent at least eight months in Romanian orphanages before being adopted had behaviors that were

indicative of insecure attachment as compared to earlier adopted Romanian orphans. Singer, Brodzinsky, Ramsay, Steir, and Waters (1985) also reported that interracially adopted children were significantly more likely to be insecurely attached.

The original categories of attachment described by the Strange Situation Procedure (SSP) (Ainsworth, Blehar, Waters, & Wall, 1978) included secure, insecure avoidant and insecure ambivalent. However, some infants were unclassifiable because of their behaviors were contradictory and inconsistent (Green & Goldwyn, 2002). Main (1999) later described these unclassifiable children as having disorganized or disoriented attachment associated with the child experiencing chronic conflict between needing to rely upon a parent for relief from distress while simultaneously perceiving the parent as a source of distress. These children exhibited a lack of organized attachment strategies, demonstrated both approach and avoidance, and showed evidence of distress when in attachment situations such as becoming still, freezing, dissociating or acting being fearful when in the presence of the caregivers (Green & Goldwyn, 2002). This style of attachment disorganization has been found at rates of up to 80% in groups of at-risk children who have been exposed to parental drug abuse or mistreatment typical of many special needs children (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Howe (2003) noted the prevalence of disorganized and controlling attachment strategies among children whose earlier attachment experiences had been with abusive caregivers who may have frightened the children or who had been afraid themselves. These children subsequently displayed a variety of aggressive and hostile behaviors including stealing, lying about things of no consequence, struggles to be in control, fascination with violence

and bloody imagery, poor consequential thinking skills, and poor eye contact. These behaviors may precipitate frustration and anger in parents which may be more difficult to manage when the bonds between the child and parents are not secure (Silverman, 2000).

As noted above parent-child attachment has long-term implications. In examining the etiological factors of criminal behavior van IJzendoorn (1997) noted the role played by the parent and child relationship. He has proposed that disordered attachment may be the cause of subsequent aggressive, delinquent or antisocial behavior throughout the lifespan. However, attempts to find links between specific attachment categories and psychopathology are only in the beginning stages. Rosenstein and Horowitz (1996) examined the types of psychiatric categories and attachment classifications of mother-child pairs among hospitalized adolescents finding a high degree of concordance between the mothers and their adolescent children's attachment categories, with higher incidence of conduct disorder, substance abuse disorder, and antisocial or narcissistic, histrionic, obsessive-compulsive, borderline, and schizotypal personality disorder. West, Adam, Spreng, and Rose (2001) described other types of pathology and problem behaviors in children with attachment problems including dissociative symptomatology and Lungu (1999) found evidence that children with insecure attachment showed higher levels of cruelty to animals and to other children, fire-setting, self-harm, destruction of property, and lying.

*Parent, Family, and Other Characteristics.*

The child's special needs are only part of the placement equation. Parent and family characteristics and post-placement services have also been associated with

placement outcome (Doelling & Johnson, 1990; Hudson & Levasseur, 2002; McDonald et al., 2001). Examining the characteristics of successful foster and adoptive parents may assist agencies in selecting families with the greatest probability of succeeding, or helping prospective families develop the skills needed to succeed. Selection of foster and adoptive parents is a time-consuming and costly task for child welfare agencies (Geen et al. (2004). Dando and Minty (1987) found that childless couples and foster mothers who were able to identify with the distress experienced by the children. Deiner et al. (1988) found that successful adoptive families were flexible, emotionally close and adaptable. Geen et al. (2004) found that the current methods of assessing foster or adoptive parent readiness have not been as effective in matching children and families, findings that were complimented by the findings of Briggs and Webb (2004), Festinger (2002) and others.

Examining the types of families who adopt children with special needs, Unger, Denier, and Wilson's (1988) study of 56 adoptive parents of children with special needs found the following. First, consistent with other studies, those most likely to adopt a special needs child were those who had developed an emotional attachment to the child through personal knowledge and they viewed the child as someone in need of love and care, rather than as someone with special needs. Usually these were the child's foster parents. Second, special needs adopters exhibited a sense of social obligation and had confidence to cope with the child's special needs. Third, they had optimism about the impact that they could make in the child's life through adoption. Fourth, they were typically involved in community and church groups. Fifth, as a group they were older than those adopting non-special needs children and they had the financial resources to

meet the needs of their households. Unger et al. noted that although the research indicates that foster parents are more likely to adopt the special needs children who are placed with them and that those adoptions have lower disruption rates, they also warned that it is difficult to obtain data on disruptions involving outright adoptive families because they frequently exit the child welfare system following the disappointment of the disruption.

Speirs, Duder, Grove, and Sullivan (2003) examined the demographics of prospective adoptive parents and the barriers to adoption in Canada. They found that 84% of the applicants were married and were distributed equally across urban, suburban, and rural settings. Reasons for considering adoption were often due to infertility (37.0%), but as frequently motivated by wanting a larger family (37.8%) or wanting to help children who needed a family (19.3%). About half (45.4%) had no children. Of the sample of 119 respondents 33.6% had an adopted extended family member and 5.0% were adopted themselves. The rest had already been foster parents or had already adopted. Contrary to the belief that prospective adoptive parents are interested only in healthy infants 63.9% expressed an interest in adopting a child 3-7 years old and 20.2% would adopt a child 8-16 years old. Those who had already adopted special needs children and those who had been foster parents were also "significantly more open to a wider range of special needs children and those with more severe handicaps" (p. 82).

Deiner et al. (1988) used the Family Adaptability and Cohesion Evaluation Scales (FACES III) to measure two dimensions of family functioning, cohesion and adaptability, to provide a description of 56 families who had adopted children with special needs. FACES III is based upon the Circumplex model of family systems which asks

respondents to indicate both a perceived and an ideal rating of their family functioning (Goldenberg & Goldenberg, 2000; Gorall & Olsen, 1995). Typical of most special needs placements, the majority (70%) of the families in Deiner et al.'s study had adopted children they had previously fostered. The predominant family type revealed by the FACES III and other demographic measures collected were families who rated themselves in the mid- to extreme range of being close, flexibly connected with one another, and adaptable and flexible.

The guidelines for caseworkers placing children who are state wards have been created by the Child Welfare League of America (Rycus, Hughes, & Goodman, 1998). Foster and adoption agencies look for prospective parents who possess the following characteristics: realistic expectations; personal maturity (able to delay gratification, accept help, put the child's needs before their own, maintain a sense of humor, maintain commitments); evidence of stable interpersonal relationships; time management skills; ability to cope with stress, and recover from adversity; an open, flexible family system; parenting skill across a range of child behaviors; empathy; feeling entitled to be the child's parent; a hands-on parenting style; and the willingness to make and maintain a lifelong commitment.

## Research Studies on Placement Outcomes

An early attempt was made by Cautley and Aldridge (1975) to add to the scant body of research on foster applicant screening and practice guidelines for matching specific children and families. In their study of 145 approved foster parent applicants

there were no single characteristics predictive of success. The number of siblings in the foster mother's own family, combined with her place in the family birth order, had value as predictors of parenting success, with being first born or among the oldest in the family being more predictive of success than being an only child or the youngest. A second variable correlated with placement outcome was the length of time the foster mother had previously had a child not her own stay overnight in her home, with more nights being associated with increased success. For foster fathers, the number of his siblings and his place in the birth order were likewise predictive of success, with being the only or oldest child predictive of less success. The foster fathers' report of their own parents' strict religious beliefs and practice was a predictor of outcome with high degrees of religiosity being predictive of less successful outcome. Interestingly, and of particular salience for the current study was the finding that the foster fathers' report of their own father's affection and warmth toward them were significant predictors of success.

Although the majority of the data referred to in these pages is specific to special needs foster care and adoption in the United States, similarly high rates of placement failure have been noted in the United Kingdom. Kay (1966) indicated that successful foster parenting was associated with two types of motivation: the desire to parent by couples who had been unable to achieve biological parenthood and the experience of empathy for a deprived child borne out of the parents' own childhood experiences. Kay contended that the applicants' own successful resolution of early trauma is necessary in order for them to have the resilience to parent a child with a history of abuse or neglect.

Dando and Minty (1987) examined the motivation, personal backgrounds, and characteristics of a sample of 80 foster mothers from a range of urban, suburban, and semi-rural areas. The authors described the approach of the committee members who made the final selections to approve or disapprove prospective foster parent applicants as a combination of reliance upon professional experience of social workers with the selection process influenced more by loosely identifiable hunches and intuition than by empirical research. Their findings indicated that 57% of the foster mothers in the home with the best placement outcomes reported unhappiness in their own childhoods and 43% of the foster mothers in the homes with a moderately good placement outcome reported the same. Dando and Minty concluded that successful foster parenting was associated with childlessness and being able to empathize with an abused or neglected child based upon the foster mother's own personal childhood experiences. The question of what factors contribute to the parents' ability to overcome adversity may be the focus of future studies as this would also have application for special needs foster children.

Using the Sixteen Personality Factor Questionnaire (16PF), a measure of 16 bipolar personality traits, Ray and Horner (1990) examined the personality characteristics of foster parents caring for children with severe emotional disturbances and a history of sexual abuse. They found that personality profiles differed from population norms, and that there were differences between the more successful parents and less successful parents, as measured by objective variables such as length of placement. Parenting success for foster mothers was correlated with being more mature, self-disciplined, reality focused, enthusiastic, and able to make logical decisions, while successful foster

fathers exhibited more skepticism, were more difficult to deceive, used reason rather than force to get children to comply, and were generally more conservative.

In their analysis of data from the 1993 National Survey of Current and Former Foster Parents conducted by the USDHHS, Cuddeback and Orme (2002) compared the demographic characteristics of kin and nonkin foster parents. There were no statistically significant differences between the groups with regard to age, marital status, family income or employment status. Most parents were married (83.3% kin, 77.8% nonkin), most of the mothers were not employed (49.4% kin, 43.2% nonkin), and over 80% of both kin and nonkin foster fathers were employed full time. The average age for both foster mothers and foster fathers was about 45 years. The average family income for kin foster parents was less, but not significantly so, with 21.5% of kin foster families earning $40,000 or above compared to 27.3% of the nonkin families. Nonkin Caucasian foster parents (77.1%) outnumbered kin foster parents (61.9%), but kin African American foster parents (26.95%) outnumbered nonkin African American parents. Nonkin foster mothers had significantly more education than kinship foster mothers, but there was no significant difference in educational levels between kin and nonkin fathers.

With regard to the characteristics of those foster and adoptive parents who cared for multiple children with severe special needs, Goetting and Goetting (1993) examined the demographic, social traits, life satisfaction, and motivations among a group of 18 parents caring for children who were completely dependent upon them due to severe mental retardation, inability to use language and inability to do any self-care. Of note was the finding that when compared to a sample from the general population, this group

demonstrated greater life satisfaction in all domains except health and work. Demographically the group was older, with a mean age of 49.4 years; 66% were Caucasian, 27.8% African American, 5.6% were Hispanic. Two-thirds were currently married and had been for a mean of 26.8 years, 22.2% were widowed, and 22.2% were divorced. Similar to other findings, religious affiliation was a characteristics of this sample with 66% reporting that they were Protestant and 55.6% claimed to be higher than average in their religious observance. The primary motivations identified by the parents included: feelings of warmth for the child, a desire to help the child progress, wanting to accept a challenging task, living out their religious beliefs, and having had some life experience in which they had grown to love a child with special needs. Although these parents expressed a high degree of satisfaction with their roles as foster or adoptive parents, they may not be typical of the population of special needs foster or adoptive, or of those parenting children with severe behavioral or psychological disorders.

In a similar study of foster parents of medically complex, drug-exposed, and HIV positive infants Cohon and Cooper (1993) found that those foster mothers who were successful at parenting these special needs children exhibited the following characteristics: being idiosyncratic rather than reflective; having realized more of their potential; being less conventional, but desiring to be positively viewed by others; being able to withstand social pressure; a willingness be cooperative which sometimes resulted in wavering when making decisions. Again, whether these results can be generalized to the population of foster parents including non-medically compromised children is questionable.

Placing older children into adoptive homes is particularly challenging. Katz (1986) suggested that successful adoptive outcomes of older children are more likely when parents have the following characteristics: tolerance for their own and the child's ambivalent or negative feelings, refusal to accept rejection from the child, measuring improvement in small increments, having a healthy sense of humor, ability to delay gratification, a flexible parenting style, feels of entitlement to the child, being caringly intrusive, valuing self-care, and viewing the family as a system with members who have individual needs.

In summarizing their review of the scant literature on the characteristics of successful foster parents Redding et al. (2000) observed that as a group they are emotionally mature, able to respond to the needs of the child, have realistic expectations, become foster parents out of a desire to parent a child, and had early experiences that have prepared them to feel empathy for children in need of care. They are authoritative parents able to provide children with adequate amounts of social and emotional stimulation and they tend to have sufficient social support from personal or agency sources. However, Powers (1995) recognized the challenges that special needs children bring into their new families. Their entrance into the family may alter the relationship dynamics between the parents and also among other biological or adopted children. Powers also noted that research into adoption and adoptive families is urgently needed in order to direct public policy, promote placement stability, and to insure the well-being of the affected children.

Parental sensitivity. Parental (maternal) sensitivity to the child's signals was one of the key elements of care that predicted the organization of a secure base identified by Ainsworth et al. (1978). Bugental (2003) also highlighted the importance of parental sensitivity to the child's unique temperament style as a factor influencing adoptive outcome. In its practice guidelines for children diagnosed with reactive attachment disorder, the American Academy of Child and Adolescent Psychiatry (Boris, Zeanah & The Work Group on Quality Issues, 2005) recommended that "the most important intervention for young children diagnosed with RAD…is providing the child with an emotionally available attachment figure" (p. 1215).

The research literature has identified maternal sensitivity as a characteristic associated with successful parenting of children at-risk. Van den Boom (1994) found that children born to mothers of lower socioeconomic class and were identified as having irritable temperaments at six months of age were found to be significantly different from the control groups at nine months of age. Following experimental intervention, the mothers demonstrated greater responsiveness and visual attending to the infants and were able to control their infants' behavior than the mothers in the control groups. The infants who were in the experimental groups were also more sociable, better able to self-sooth, cried less, and spent more time in exploration than control group infants, and their exploration was indicative of higher levels of cognitive complexity. At one year of age there were significantly more experimental group members classified as securely attached compared to control group dyads.

In their study of 30 at-risk mother-child pairs in which 83% were classified as anxious and 17% as autonomous (secure) in their attachment style, Oyen, Landy, and Hilburn-Cobb (2000) found that the mothers with insecure attachment also demonstrated the least sensitivity to their children, and those classified as either autonomous or those who were not able to be classified due to multiple classifications, one of which was autonomous, showed the greatest sensitivity in response to their children. Similarly, in their sample of adoptive mothers and 146 children adopted internationally before age six months Stams, Juffer, and van IJzendoorn (2002) found a positive correlation between maternal-child attachment security and the child's cognitive and social development which were not related to the child's temperament or gender. Laucht, Esser, and Schmidt (2001) also found that in a sample of 347 children born with both biological risk factors (low birth weight, physical disability, complications of delivery, and difficult temperament) and psychosocial risk factors such as chronic family problems, that maternal responsiveness was not only found to decrease the child's level of hyperactivity associated with low birth weight, but for families faced with ongoing adverse psychosocial factors, maternal responsiveness was effective in reducing the level of maladaptive internalizing and externalizing behaviors.

The effect of maternal depression and sensitivity on attachment security was investigated by Campbell, Brownell, Hungerford, Spieker, Mohan, and Blessing (2004) who found that mothers with depression during the first 36 months of their children's lives were more likely to have children with insecure attachment, whereas the children of women whose depression was only evident during their first 15 months did not

demonstrate higher levels of insecurity. However, maternal sensitivity was a confounding variable in this study, with the preschool children of women who were depressed and also low in sensitivity being more apt to have insecure attachment than depressed women who were high in sensitivity.

Finally, in their meta-analysis of attachment and sensitivity interventions during early childhood, Bakermans-Kranenburg, van IJzendoorn, and Juffer (2003) found that attachment classification was more durable and difficult to change than maternal insensitivity, but in studies reporting an improvement in maternal sensitivity there was generally an accompanying improvement in attachment security. Of interest also was the finding that in the 70 studies that they considered, those which included interventions involving fathers resulted in significantly better outcomes than those with mothers only. Similarly, Cautley, and Aldridge (1975) highlighted the significance of the father's characteristics in predicting successful foster placement outcomes.

## Matching

The practice parameters of the American Academy of Child and Adolescent Psychiatry recognized that the goodness of match between the child and the caregiver is an important factor in treatment with children who have attachment problems (Boris, Zeanah, & Work Group on Quality Issues, 2005). In addition, the research literature clearly ties the concept of matching with placement success or disruption (Doelling & Johnson, 1990; Redding et al., 2000; Valdez & McNamara, 1994; Ward, 1997). However, Redding et al. (2000) also observed that research based guidelines on how to

match families and children are absent from the literature perhaps due to a more general lack of a comprehensive theoretical framework by which to assess placement outcome, though they warned that even if there were clearer evaluation procedures it would not make up for the lack of available families relative to the number of children in need of placements.

Ward (1997) referred to matching as the task of finding parents with the right strengths to meet the needs of the children needing homes in a manner that is similar to the goodness of fit model of biological parenting. Modell and Dambacher (1997) refer to matching as an assumption that the more the child is like the foster or adoptive parent the more successful the outcome of the placement will be. Presumably, the temperament of the parents is reflected in the temperament of their progeny and makes for an unproblematic initial bond between them. However, as Orme and Buehler (2001) noted, there is little research on the goodness of fit model as it applies to the parenting style of foster parents and child temperament, but it may be a valuable component of family screening and selection. The obvious complication in adoption is that the parents and children do not begin with those initial predisposing conditions, and matching is an after-the-fact attempt to simulate the biological model (Lindsey, 2001). When factors such as the child's previous life history and their current special need conditions are added, the matching process may become less precise.

Historically, matching was based upon the religious affiliation of the child's birth family (Polier, 1955). Later, according to Nickman et al. (2005) matching efforts were directed at insuring that the child and family not only had the same religious beliefs, but

even more critically, bore a strong physical resemblance, providing a greater likelihood that the family would simulate a biological family and allow them to escape the stigma associated with adoptive kinship. Melosh (2002) referred to matching as an attempt to socially manipulate impressions in order to ease the ambivalence between the need to obscure the differences between biological and adoptive parenting and the recognition that they exist. More recently with regard to placing children within or across racial lines, matching has perplexed child welfare professionals and spurred heated debates (Freundlich, 2000). In fact, the concept of matching may actually have perpetuated a myth that adoptive parenting is less desirable and better concealed. Some groups such as the National Association of Black Social Workers have taken a strong position regarding the placement of African American children with any but African American foster or adoptive families, viewing transracial adoption as a form of racial and cultural genocide (Simon & Roorda, 2000). The placement of children across borders of race, color, and national origin is now supported and guaranteed by the InterEthnic Placement Act of 1996 (USDHHS, 1997).

Other issues that are becoming increasingly part of the matching controversy include the placement of children into single parent families or into families with same-sex partnerships. In observing the research finding that minority families, that is those belonging to an ethnic minority, with lower educational and income levels, older age parents, and single parent status, generally have lower disruption rates, as well as high rates of parental satisfaction, Rosenthal (1993) noted that these findings for non-traditional families highlight the need for more aggressive recruitment to families and

individuals who in the past may not have been considered potential adopters. A thorough discussion of this issue is beyond the scope of this work, however, Perrin (2002) writing on behalf of the American Academy of Pediatrics noted that adopted children who are raised by gay or lesbian parents had the same level of social, emotional, sexual, and cognitive functioning as children raised by heterosexual couples. In addition, Groze (1991) found that single-parent families were able to provide for special needs children as well as two-parent families and may be an under utilized source of families for such children. Shireman's (1995) review of the literature on single-parent adoptive placements similarly found that not only do children do as well as in two-parent families, but in some cases single-parent homes may be more advantageous.

As the characteristics used to match children and families began to focus less on physical traits and more on other factors such as personality traits, expectations of the family, and developmental or other special needs of the child, the selection of families for specific children became a more "thoughtful decision-making process, requiring considerable insight and foresight by both adoption professionals and adoptive families" (Rycus et al., 1998, p. 935). Babb and Laws (1997) referred to matching as a task that should be undertaken only by experienced caseworkers and even then it must be handled cautiously and with the understanding that despite the best efforts some placements cannot be maintained.

The use of temperament as a matching variable was also proposed by Valdez and McNamara (1994). They suggested the use of a combination of quantitative and qualitative information about the child's developmental history and current level of

functioning, as might be gained from instruments such as the Child Behavior Checklist (CBCL) or the Behavior Assessment System for Children (BASC). In addition, data on the child's and the prospective adoptive parents' temperaments, from the Dimensions of Temperament Survey Revised (DOTS-R), as well as information from structured interviews would be valuable tools to insure more accurate matching. Valdez and McNamara argued that improving the matching process might also reduce the need for children being placed into more restrictive residential settings and decrease the high rates of mental health usage among this population. This approach to matching has gathered some additional research support. Green, Braley, and Kisor (1996) found preliminary evidence for the use of DOTS-R in matching foster parents and adolescents. Doelling and Johnson (1990) also found evidence supporting a goodness-of-fit model matching parent-child temperament variables. They found that a rigid foster mother matched with a child who had a predominantly negative mood and a child with negative mood with a foster mother who expected a more mood-positive child, were both conditions predictive of less successful outcome. Finally, Orme and Bueler (2001) suggested that congruence between the child's temperament and the caretakers' parenting style is a critical variable in insuring a lasting match between foster children and parents.

Ward (1997) suggested that mismatching may result from a number of causes: the parent's expectations of the child are disappointed; once placed, the child may display behaviors or deficiencies that were previously unnoted and not factored into the match; and the prospective adoptive parents were stretched to accept a child with characteristics that they had originally rejected. Matching has been viewed as a means of insuring

placement longevity, with poorer fit being associated with the higher the risk of disruption (Barth & Berry, 1988; Valdez & McNamara, 1994). The problem of disruption will be considered in a following section.

In the past, matching has relied almost exclusively on the request of the adoptive parents for a child with specific characteristics: age, gender, race, health, and cognitive ability. However, Barth, Berry, Yoshikami, Goodfield, and Carson (1988) found that only 1% of the variance in adoption disruption is accounted for by the matching of those demographic characteristics, with the suggestion that the remaining factors accounting for disruption might include pre- and post-placement services and the characteristics of the parents and the child. Accordingly, rather than using demographic data to sort children into adoptive families, some of the research on the process of matching in foster placements may be applicable, with the skills and interpersonal characteristics of the parents being matched with the severity of the child's needs. In discussing the differences between foster placements that remain intact and those that disrupt, Hampson (1988) found that even after parent training, those parents who were initially less skillful continued to have higher disruptions than the initially more skillful parents who showed higher levels of confidence, optimism, and were competent using consequences for shaping behavior. The range of behaviors among children in care testifies to the need of corresponding levels of training, expertise, and personal parental characteristics, and accounts for the variety of foster placements available including: relative, non-relative, specialized, treatment, group home, and residential care.

A poor fit between adoptive parent and child may result in the parents' inability to experience and express empathy for the child and the child's subsequent failure to use the parents as a resource of support and self-organization (Etezady et al., 2000). However, Etezady and his colleagues also noted that even in the unfortunate case of a poor match, parents who have the ability to experience and express empathy may be better able to overcome the risk of attachment failure that accompanies adoption. They contended that while genetic familiarity primes new biological parents for emotional connection with their newborns, adoptive parents lack the hormonal and genetic similarity that eases the initial stages of bonding. This absence of familiarity is even more dramatic when adoption occurs later in the child's life or across racial lines.

There is considerable disparity between the characteristics most desired by potential adopters and the characteristics of the actual children who are available. This further complicates matching. According to AFCARS 2004, the children in foster care who are awaiting adoptive homes have the following characteristics: they are members of a minority (43% African American, 13% Hispanic); their mean age is 8.1 years, and 64% were over age five; they are more likely to be male (52%); they have been in care for an average of 3.75 years; and they have some special needs. As noted above in the section on "Intention to Adopt" the National Survey of Family Growth found that while most prospective adoptive parents reported that they would prefer to adopt a child who is young and without medical or psychological disabilities, they are also willing to accept a child who is more like the majority of those who wait in the foster care system (Chandra et al., 1999; Geen et al., 2004). For example, of the NSFG sample of Caucasian women,

1.8% reported that they would prefer to adopt an African American child, and 51.0% a Caucasian child, but 79.1% would accept an African American child. Although 57.5% would prefer to adopt a child of less than 2 years, 85.5% would accept a child 2-5 years old, 56.4% would accept a child who was 6-12 years old, and 36.6% would accept a child 13 or over (Chandra et al., 1999). Thus, although prospective parents may begin the adoption process with notions about the types of children they would prefer, those preferences clearly do not determine actual placements made. And if general applicants can become more informed about the potential benefits of fostering as a first step toward adopting, they would probably have the opportunity to more quickly receive placement of a child closer to the desired age, and increase the likelihood of adopting that child sooner than if they choose to wait several years for the child to make his way through the foster care system. Whether the mismatch between the preferred child and the accepted child is a factor in placement stability is a research question that has yet to be answered.

There may be different tasks involved in matching prospective foster or adoptive parents with infants than matching with an older child or an adolescent. Bernier, Ackerman, and Stovall-McClough (2004) found a correspondence between the foster infant's attachment behavior shortly after joining the family and the child's later attachment behavior. Approaching matching from a combined psychoanalytic and attachment theory perspective Briggs and Webb (2004) discussed the factors that facilitated adolescent placement. They suggested that an analysis of the foster or adoptive parents own attachment patterns might be a suitable approach to parents for older children.

Even when care has been taken to match parents and children, placements may break down because of unrealistic expectations on the part of the parents or the child. New parents may be disappointed at a foster child's lack of gratitude for the material benefits they are able to provide, or become frustrated that their new family is not as happy as they had hoped; the foster child may be unwilling to accept new caregivers after experiencing several previous placement failures, and remain emotionally distant from his new parents (Reilly & Platz, 2003; Ward, 1997).

Another variable identified in the research as an outcome predictor is the quality of the attachment between the child and the foster or adoptive parents. Levy and Orlans (1998) noted that because all adopted children have at least one significant loss, and that unresolved loss of previous attachment relationships can impair attachment to adoptive parents, these relationships begin at a disadvantage and can increase the risk of placement failure. Placement disruption may be lowered through accurately matching the needs of the child and the parental attachment style (Westhues & Cohen, 1990). Briggs and Webb (2004) suggested that attachment theory provides a valuable context in which to make placement decisions and predict outcomes. A considerable body of literature has accumulated from adult attachment measures that examine the attachment adults had to *their own* parents as predictive of future attachment relationships with their children (Benoit & Parker, 1994; van IJzendoorn, 1995), in marital and romantic relationships (Cassidy, 2000; Hazan & Shaver, 1987; Kobak & Hazan, 1991; Mikulincer, Florian, Cowan, & Cowan, 2002) and with friends (Feeney, 1990; Feeney & Noller, 1990).

Today, adoption professionals recognize that matching requires the collaboration of numerous parties who have a stake in the child's wellbeing including the caseworker, the child's biological family, the current caregivers, teachers, and mental health professionals who may be working with the child (Rycus et al, 1998). Their combined input provides a broader view of the child's needs and strengths. The process of matching only becomes more complex with sibling groups, and families in which there are already children with special needs.

## Disruption

Wulczyn et al. (2003) have described the negative impact of placement instability for children in substitute care and have noted its historic and ongoing importance for child welfare policy programs. However, the earliest records of adoption do not mention disruption; adoption was considered as permanent and irrevocable as a bond between a biological parent and child (Barth & Berry, 1988). Perhaps disruption can best be understood in terms of the change in the population of children needing substitute care. Whereas historically children entered care because their families were economically incapable of caring for them (Valdez & McNamara, 1994), today children come into care for protection from their biological families, arrive in care at younger ages and stay in care longer (Wulczyn, Hislop, and Harden (2002).They also bring with them a range of behaviors, and emotional and physical disorders that make it difficult, and sometimes impossible, for them to blend into a new family (USDHHS, 2000). These factors may

account for the frequent breakdown of non-relative and relative foster placements (Proch & Taber, 1985; Rittner, 1995).

As the placement of children with multiple risk factors has increased, rates of placement disruption have correspondingly risen (Brodzinsky et al., 1998). Although the research literature distinguishes between disruption (the untimely and unplanned termination of a placement prior to legal adoption), and dissolution (the legal reversal of an adoption) Hollingsworth (2003) pointed out that both involve a placement change with attendant losses for the child. Various stages in the disruption process for parents have been identified by Partridge, Hornby, & McDonald (1986): finding decreased pleasure in the parent-child relationship, identifying the child as the source of the problems, admitting publicly that the problems is serious, reaching a crisis that results in irreparable damage to the relationship, establishing a deadline or ultimatum, and finally the decision that the placement must end.

Ward (1997) argued that there were two ways that adoption success could be measured: placement stability and relationship quality. Rushton (2004) suggested that although multiple indicators might be a better method of determining placement outcome than disruption, which provides little specific information about what lead to the placement ending, finding ways to decrease placement instability must remain a research goal. Similarly, Cautley and Aldridge (1975) suggested that the best measure of the success of a foster placement would be the growth and development of the child; this however this is a difficult variable to measure. Using case worker qualitative ratings does not necessarily provide reliable measures, particularly with high rates of worker turnover.

The foster parents' rating might be more accurate, but lack objectivity. So, because placement continuation is a readily measured, quantifiable variable, and because it is of significance in the child's overall well-being, placement success defined as stability, or its bipolar complement, disruption, is frequently used in research. Disruption carries an emotional toll for both the child and foster or adoptive family; approaches to prevention have centered upon providing effective pre-placement screening better post-placement support and training (Derdeyn & Graves, 1998).

*Rates of Disruption*

A range of disruption rates from 7-47% were reported in the literature reviewed by Barth and Berry (1988) with rates affected by the age of the child, the sample size, the length of the study, and the demographic characteristics of the sample. In their summary review Westhues and Cohen (1990) found the highest reported rate was 21.4%, with the majority of studies showing rates from 11% to 15%. Festinger's (1990) study found a disruption rate of 8.2% within 12 months of finalizing adoption; her more recent review of the adoption literature resulted in an estimate of between 10 and 25% (Festinger, 2002). In a study of thousands of adoptions placed through the Illinois Department of Child and Family Services between 1976 and 1994, George, Howard, Yu, and Radomsky (1995) found a disruption rate of just over 12%. Extremely high rates of 43% (Triseliotis, 2002) and 57% (Smith et al., 2001) were found among children in long-term foster placements.

A recent summary of adoption disruption from various empirical sources found that approximately 10-16% of all special needs adoptions end in disruption (Barth, Gibbs,

& Siebenaler, 2001). Smith et al. (2001) found a disruption rate of 17.8% within the first six months of treatment placement; boys placed between the ages of 5-12 years had a disruption rate of 19% after eight years in care (Rushton, Treseder, & Quinton, 1995). In a Finnish sample a similar rate of 11% disruption among foster placements was found (Kalland & Sinkonnen, 2001). The National Adoption Information Clearinghouse (2000) reported disruption or dissolution rates of between 10 and 20% for special needs placements.

The rates of placement disruption are difficult to interpret (Barth & Berry, 1988; Smith, Howard, & Monroe, 1998). James (2004) and Smith et al. (2001) criticized the lack of a standard operational definition of placement disruption. The literature refers to disruption by a variety of terms: placement change, placement breakdown, placement instability, or placement failure. By whatever the definition, however, when adoption disruption results it carries emotional and financial tolls for the child, the adoptive family, and the child welfare agency (Valdez & McNamara, 1994) which is adequate justification for an intensification of research effort.

*Reasons for disruption*. Rycus, Hughes, and Goodman (1998) observed that disruption is the result of multiple factors. Their survey of the research, as well as this writer's review of the causes of placement disruption identified the following contributing factors: inadequate preparation of the child or the parents; lack of postplacement or postadoption services (Partridge, Hornby, & McDonald, 1986; Rosenthal, Schmidt, & Conner, 1986; Smith & Howard, 1999); poor child-family match (Holland & Gorey, 2004; Smith & Howard, 1994; Smith & Sherwen, 1983); the severity

of the child's behavioral problems, particularly behaviors that violate the family norms (Barth, Berry, Carson, Goodfield, & Feinberg, 1986; Smith et al., 1998); previous psychiatric hospitalizations (Brodzinsky et al., 1998); degree of externalizing behaviors (Barth, Berry, Yoshikami, Goodfield, & Carson, 1988; Smith et al., 1998; Wulczyn, Kogan, & Harden, 2003); the age of the child at the time of placement (Barth & Berry, 1988; Holland & Gorey, 2004; Rosenthal, Schmidt, & Conner, 1986); child's history of abuse or neglect, particularly multiple types of abuse (Brodzinsky et al., 1998; Partridge, Hornby, & McDonald, 1986); the child's problems with forming attachments, or having a particularly strong bond with the birth mother (Barth & Berry, 1988); parents' lack of social support from family and friends (Rosenthal, 1993); parents' inability to meet the needs of the child (Partridge, Hornby, & McDonald, 1986); previous placement failures (Barth, Berry, Carson, Goodfield, & Feinberg, 1986; Wulczyn, Kogan, & Harden, 2003); placement with siblings (Barth, Berry, Carson, Goodfield, & Feinberg, 1986; Wulczyn, Kogan, & Harden, 2003); male gender (Holland & Gorey, 2004; Rosenthal, Schmidt, & Conner, 1986).

Barth and Berry (1988) found an association between higher family income and increased risk of disruption which they believed might be due to more realistic expectations of working-class as compared to professional adoptive couples. The foster or adoptive father's involvement and support of his wife's parenting has also been associated with lower disruption risk (Westhues & Cohen, 1990).

Barth et al. (1986) offered a number of recommendations to decrease placement disruption rates but particularly the following: careful monitoring of the number of

children placed into families, even if it means separating sibling groups; ongoing parent training; continuing postadoption subsidy assistance; the provision of counseling and other special services. Contrary to Barth and colleagues' (1986) findings Rosenthal, Schmidt, and Conner (1986) did not find that sibling group placement increased disruption rate but they did identify older age at placement, male gender and adoption by a non-previous foster family to be factors increasing risk. In descending order of importance Barth and Berry (1988) found significant associations between a number of characteristics: a previous failed adoptive placement, a foster parent adoption, higher educational level of the adoptive mother, age of the child at the time of placement, male gender, the number of problems that the child had. McDonald, Propp, and Murphy (2001) found that the number of special needs and the age of the child at the time of placement were most salient and accounted for 39.6% of the variance in outcome. Rushton et al. (1995) also linked male gender, older age and adverse pre-placement experiences with higher rates of disruption. Howe (1997) and Kalland and Sinkkonen's (2001) Finnish sample both found that the presence of nonadopted siblings increased disruption risk.

Investigating the rates and the reasons for placement failure is marked by considerable complexity. George et al. (1995) found that gathering data on placement failure or change is difficult for a number of reasons. First, the period between initial placement and the placement failure may be years and occur long after the data has been collected. In addition, relative to the number of adoptive placements made, the number of placement failures is small, making it challenging to collect samples large enough to provide statistically significant results. It is difficult to track a child whose adoption

disrupts after finalization and a change in surname if he returns to the system years later. Finally, because of the relatively small potential sample of participants, many studies have grouped together children with a range of characteristics making it more difficult to separate incidence and predictors of placement failure. Festinger (1990) similarly pointed out that accurately identifying the factors responsible for placement disruption is made more difficult when: data is combined from different sampling methods, different operational definitions of disruption are used, the sample sizes are small, and sibling groups are compared with single placements. Both Festinger (1990) and George et al. (1995) confirmed numerous previous investigations indicating that the child's age at placement, a history of abuse or neglect, previous placement disruptions, especially disruptions of lengthy placements, and the number of problems that the child had were consistently associated with higher subsequent disruptions.

Smith and Howard (1994) also found that sexually abused children had more externalizing behaviors, attachment difficulties and higher risk of adoption disruption. James (2004) confirmed the role that externalizing behaviors, older age at placement and a history of emotional abuse have in placement disruption, particularly within the first 100 days of the placement. Smith et al. (2001) similarly found that 70% of disruptions took place within the first six months of placement with older children and females being at higher risk. Although many studies cite age at time of placement as a critical factor in placement stability Nickman et al. (2005) have suggested that age is actually confounded by the degree of trauma that the child has experienced prior to placement, that is the longer the child remained in the adverse environment the more damage and the higher

risk of disruption. They also noted that whether the adoption is intra- or inter-racial, domestic, or foreign, are variables that must be examined by future researchers.

Contrasting the high disruption rates of many other studies Festinger (2002) found a low 3.3% disruption rate, leading her to conclude that formal, legal adoption dissolution is infrequent and predictions of dissolution rates are overstated. One explanation might be found in the significantly lower disruption rates among children with mental retardation, serious medical illnesses, or vision, hearing, or physical impairments when compared with children who have behavioral and emotional problems (Rosenthal, Groze, & Aguilar, 1991). George et al. (1995) concluded that with appropriate treatment and service interventions as well as indicated policy changes disruption rates can be lowered. They also emphasized the urgency of more research into the risk factors associated with disruption. Table 2 provides a summary of the research findings on disruption.

Table 2

*Risk Factors in Placement Disruption*

| | Older age at placement | Behavioral/ emotional problems | Multiple placements | History of abuse/neglect | Other |
|---|---|---|---|---|---|
| Barth et al. (1986) | X | X | X | | Less flexible family<br>Foster/adoptive parents overwhelmed<br>Poor match between child and family<br>Excessive stressors and inadequate resources |
| Barth et al. (1988) | X | X | X | X | Placement with siblings group |
| Doelling and Johnson (1990) | | | | | Poor parent-child match |
| Festinger (1990) | X | | X | X | Parent inflexibility |
| Frame (2002) | | | | | Poor quality marital relationship<br>Prenatal drug or alcohol exposure |
| George et al. (1995) | X | | | | Male gender<br>Caucasian<br>Longer time in foster care |
| Holland and Gorey (2004) | | | | | History of child or familial trauma |
| James (2004) | X | X | | X | |
| Moffatt and Thoburn (2001) | X | X | | | |
| Redding et al. (2000) | X | X | X | | |
| Reilly and Platz (2003) | X | X | X | X | Placement with sibling group |
| Rhodes et al. (2001) | | X | | | Lack of agency post-placement training<br>Foster parents' lack of influence in decisions about the child |

| | Older age at placement | Behavioral/ emotional problems | Multiple placements | History of abuse/neglect | Other |
|---|---|---|---|---|---|
| | | | | | (*table continues*) |
| Rosenthal et al. (1986) | X | X | | X | Male gender |
| Rosenthal (1993) | X | X | | X | New adoptive placement rather than foster-to-adoption placement<br>Placement with sibling group<br>Social worker-reported lower parenting skills<br>New adoptive placement rather than foster-to-adoption placement<br>Lack of disclosure of background |
| Rosenthal and Groze (1994) | X | X | | X | New adoptive placement rather than foster-to-adoption placement<br>Lack of background information<br>Unrealistic parental expectations<br>Rigid family functioning<br>Uninvolved father<br>Unsupportive family and social network<br>Previous psychiatric hospitalization |
| Smith et al. (2001) | X | | | | |
| Webster et al. (2000) | X | | | X | Male gender<br>African American<br>Non-relative foster care |
| Wulczyn et al. (2003) | X | X | | | Poor quality parent-child relationship<br>Length of time in foster care |

## Facilitating Factors in Placement Outcome

### *Parent and Family Characteristics*

Finding more effective ways of matching those parents with children who have special needs is the purpose of the present study. However there is little research to date on the characteristics, motivation, personality types, available support, and family dynamics that are associated with placement stability (Redding et al., 2000). The majority of research on special needs placements has focused on the characteristics of the children. Hollingsworth (2003) and Brodzinsky et al. (1998) have both noted that individuals with specific characteristics might be more competent than others to parent children with particular needs.

McDonald, Propp, and Murphy (2001) found that the most significant parent characteristic significantly correlated with placement outcome was marital status, accounting for 15.5% of the variance in overall adjustment; and when other parent characteristics were controlled, race was also a significant predictor, with African American families showing higher levels of placement adjustment than Caucasian families. Finally, three general characteristics of the family accounted for 14.5% of the total adjustment variance: the ages of the youngest and the oldest children in the home and the size of the community in which the family resided. Families living in more densely populated areas showed better adjustment, as did families with younger children.

As noted in the section on "Factor Related to Placement Outcome," children with a history of trauma show evidence of elevated rates of psychopathology. Cohen et al. (1993) found that the contribution of the adoptive family to the child's problems was less significant than the contribution of child's original family. They concluded that adoptive

families have the necessary psychological and social strength that can be valuable assets in the child's treatment, and they have closer ties with their own families of origin and access to social support from friends.

The research has also uncovered the importance of the father's role in successful placement outcomes. Westhues and Cohen (1990) found that fathers who were active in parenting and supportive to their wives added significantly to successful placements. Noy-Sharav (2002) considered the ability of the partners to reciprocally contain each others childhood pain and narcissistic wounds, as well as being able to form a stable parental dyad to be valuable factors in successful parenting.

As Kirk's (1984) seminal work on adoption indicated, the parent's ability to recognize and accept their own differences from the adopted child is predictive of better outcome. Those parents able to value the diversity the child adds to the family may be more able to address the child's unique needs and create an environment which fosters respect for individual uniqueness and identity formation (Farber et al., 2003).

Festinger (1990) found that being married, single, or divorced were unrelated to disruption. Having been the child's foster parent decreased risk of disruption whereas having more rigid expectations and a child who is a poor match with the parents' preferences were associated with greater risk.

*Characteristics of the Child: Resilience*

Half a century ago Bowlby (1952) questioned what factors in the child made him more or less resilient to the effects of maternal deprivation. Today, resilience continues to capture the interest of child development investigators despite questions raised by researchers regarding the validity of resilience as a theoretical construct (Luthar,

Cicchetti, & Becker, 2000). Despite theoretical and research problems, resilience has emerged as a factor predictive of positive development (Walsh, 2002). Masten (2001) has suggested that rather than being indicative of extraordinary invulnerability resilience is a common product of human adaptation explaining the observed ability that children have in surviving and thriving in the face of considerable risk.

Resilience is the ability to successfully adapt, and function positively and competently, despite adversity and risk of maladaptation due to chronic stress or severe or recurrent trauma; it grows through responsive interplay between the individual and environmental challenge (Egeland, Carlson, & Sroufe, 1993). In their study of high-risk children and their families, Egeland and his colleagues found that for children burdened by poverty, maltreatment, and family dysfunction, the presence of caregivers who were emotionally responsive ameliorated the adverse life events. Masten and Coatsworth (1998) defined resilience as competence in the face of challenge. Rutter (1999) claims that resilience is demonstrated in healthy responses despite psychosocial threat. Rather than a single trait resilience may be conceptualized as a set of skills, both learned and dispositional, that are available for use as required by the specific adversity (Alvord & Grados, 2005).

In discussing positive adaptation, Fraser and Terzian (2005) attributed it to the interaction between adverse experiences and the individual's ability to draw upon their own resources and to identify and drawn upon resources in the environment. For foster or adopted children adverse life events or risk factors may include adversities such as abuse, neglect, or removal from one's family (Fraser & Terzian, 2005). In contrast Fraser and Terzian identified protective factors which offer individuals a safe haven and support in

the face of adversity, thereby reducing its impact. In the context of foster and adoptive children, parents who are responsive and nurturing may function as protective factors.

Bugental (2003) noted that early exposure to adversity holds the potential for both maladaptive and highly adaptive consequences. When children are exposed to chronic and unrelieved stress, the potential for long-term changes in the brain's response to subsequent stress may be affected due to changes that have taken place in the hypothalamic-pituitary-adrenal (HPA) axis (fight or flight stress response pattern). Nachmias, Gunnar, Mangelsdorf, Parritz, and Buss (1996) examined the role of mother-child attachment as a protective factor in HPA regulation and found that only the children assessed as having insecure attachment, as measured by Ainsworth's Strange Situation, had elevated cortisol levels and higher levels of inhibition in exploring novel environments. The implication for children in out-of-home placements becomes apparent. Even after removal from abusive circumstances neurological response patterns may have been established and may be difficult to reprogram.

In their study of 505 individuals, one-third of whom possessed risk factors such as perinatal stress, poverty, parents' lack of education, living in chaotic environments, and parental deficiency, Werner and Smith (1992) found that one-third of this high risk group showed evidence of healthy adjustment by age 18 years. These resilient children possessed a number of protective factors that existed in dynamic counterpart with other familial and societal factors which allowed them to draw out positive responses from their environments despite the existence of multiple risk factors. Werner and Smith identified three groups of protective factors: minimum of average intelligence and constitutional factors, attachments to parent substitutes such as siblings or extended

family members, and involvement in a support network such as school or church which afforded opportunities to demonstrate competence and to experience consistency. Of interest to the current study is that the majority of those in the high risk group with lower adaptive responses early in life experienced critical events in adulthood which changed their life course in a more pro-social direction. These critical events included: the birth of a first child, marriage or commitment to a long-term relationship, entering the work force and establishing a career, going to college, joining the military or becoming actively involved in a spiritually oriented group.

Rushton (2004) has observed that adoption research provides a unique opportunity to study the effects of early childhood adversity on the individual's ability to form subsequent attachments, and thus it may add to our current understanding of resilience. O'Brien and Zamostny (2003) have suggested that the research findings of Wegar (2000), Leon (2002), Masten (2001), and Brodzinsky et al. (1998) discussed earlier in this work might provide the basis of a comprehensive adoptive family functioning model based on resiliency. Thus, foster and adoptive children and their families may provide a window through which to observe recovery from adversity.

Holland and Gorey (2004) observed that foster children and their parents who do better than the research might predict them to based upon their risk factors, were considered to have particular strengths. Holland and Gorey found that 74% of the foster children who had an early childhood of abuse and neglect had school problems, 70% had difficulties interacting with peers, 61% had problems involving delinquency, and 30% had threatened or had attempted suicide. However, it was the resilience of the children that most impressed these investigators in that only about one-third of the children and

their foster families reported that they were experiencing significant problems such as placement disruption, conflicts with foster siblings, physical aggression, or need for in-home support.

In Henry's (1999) qualitative study of maltreated adolescents in foster care or independent living programs five major resilience themes surfaced. First, maintaining loyalty to their biological parents allowed the resilient children to believe that they had been and were still loved by their parents, and gave them increased capacity to see themselves as lovable and able to form new attachments. Next, resilient children attempt to make sense of their abusive or chaotic environments through believing their experiences were part of normal family life and gave them a sense of predictability and control. Third, resilient children became skilled at being invisible to their abusers though escaping into dissociative states, or getting involved in outside activities that helped them feel competent to protect themselves. Next, resilience in children was associated with feelings of self-value sometimes fostered through identification with independent and self-confident characters in fiction or the media. Finally, the resilient children were able to maintain a future orientation in which they viewed themselves as able to accomplish their goals and were able to reconcile their positions in both their biological and foster or adoptive families.

Similar to several of Henry's (1999) themes and Werner and Smith's (1992) findings, Alvord and Grados (2005) found a number of protective factors that facilitate the development of resilience in children. First, resilient children tend to have a proactive orientation, see themselves as able to impact their circumstances and view adversity as an opportunity to acquire new learning and skills. Second, they have better developed self-

regulatory skills are able to self-sooth and elicit positive attention from others. Third, resilient children have at least one proactive biological parent, or surrogate or substitute parent who provides warmth and authoritative limits. Fourth, emotional attachments and connections were also shown to facilitate a range of positive life benefits and are able to engage in mutually reinforcing reciprocal interactions. Finally, Alvord and Grados noted that the literature has found resilience to be associated with cognitive ability and access to pro-social role models of individuals in the community such as coaches, club leaders, employers, and teachers who were available during times of adversity.

Further examples of resilience were evident in the findings of the children in foster care in Illinois, one of few states which gather data directly from the children served through the Illinois Department of Child and Family Services. Findings indicated that the children's experience in foster care was highly satisfactory, and that the quality of their lives had improved while in out-of-home care (Wilson & Conroy, 2001). Approximately 85% reported that they always felt loved and 87% reported that they always felt safe.

## Attachment Theory

As noted in an earlier section, attachment theory has provided a useful framework to understand both the importance of biological parent-child relationships and the effects that disturbances in those relationships have upon later functioning. Barth, Crea, John, Thoburn, and Quinton (2005) have called it the "most popular theory for explaining parent-child behavior by professionals involved in child welfare services" (p. 257). In tracing the development of the current recognition of the importance of the mother-child

relationship, Crockenberg and Leerkes (2000) highlighted the early emphasis that Freud placed upon the mother-child relationship as foundational to all future relationships. So significant is it in setting the child's future course that Zeanah, Larrieu, Heller, and Valliere (2000) argued that the infant's development hinges upon the relationship with the mother.

Although particularly critical during the earliest stages of development, due to the child's inability to insure his own physical or emotional survival, attachment continues to be important throughout life. Echoing Bowlby's (1969/1982) earlier claims of life long significance of attachment, Carlson, Sampson, and Sroufe (2003) have noted that "the need for human contact, reassurance, comforting in the face of illness, injury, and threat is a normal response throughout the life span" (p. 364). In addition, the parent-child relationship has been found to have intergenerational contiguity as demonstrated by Benoit and Parker (1994) who found significant correspondence between attachment characteristics across three generations. Thus, the internal models which take shape in the earliest interactions with caregivers are carried forward into subsequent relationships. Ongoing research on infant mental health has also unveiled the critical role played by the infant in the social construction of the mother-child relationship, which in turn is the principal framework upon which later emotional regulation is constructed (Crockenberg & Leerkes, 2000). Because of its central role across the developmental lifespan, research on multiple losses and separations from caregivers such as those experienced by foster or adopted children has captured the interest of attachment investigators (Carlson, Sampson, & Sroufe, 2003; Kretchmar, Worsham, & Swenson, 2005).

Beginning with his earliest observations that children who experienced maternal deprivation were at risk of developing adolescent and adult pathology, Bowlby's (1969/1982) work has shaped the direction of attachment theory and research. From his early training in psychoanalysis, Bowlby departed from Freud's view of the child's mother-seeking behavior as the means of regulating id directed drives, and adopted control systems theory for its more scientific explanation of the child's behavior (Waters & Beauchaine, 2003). The attachment regulatory system is one of several primary motivational regulatory systems which interact with and build upon each other; the others identified by Bowlby and other attachment theorists are: the exploratory system, the affiliative system, the fear/wariness system, and the caretaking system (Colin, 1996).

Bowlby (1969/1982) held that the attachment system was responsible for the child's efforts to seek and maintain proximity to an adult caregiver. Proximity insures protection from predators and other threats in the environment, insures provision of nourishment, affords socializing interaction and brings the child into a setting where he can acquire necessary survival skills (Bowlby, 1969/1982). The caregiver also functions as a secure base from which the youngster launches his exploration of an expanding physical and social world while enjoying the assurance of support. Several decades after the initial formulation of his theory, with the advancement of more sophisticated technology, Schore (2000) offered confirming evidence from neuroscience of the attachment system's instinctual function.

Although Bowlby used the term *mother-figure* or *mother* throughout his work, he did not hold the view that mothering could not be shared by multiple figures or that mothering could only be effective when provided by the child's biological mother. In fact

Bowlby (1969/1982) and others (Carlson et al., 2003) have noted that while infants do form a principle attachment to a single primary caregiver, they establish a hierarchy of attachment figures when they are cared for by multiple adults, such as father, grandparent, and daycare provider, although the quality of the child's relationship with each of the adult caregivers continues to show specificity. During periods of extreme arousal the child typically demonstrates a preference for the primary caregiver; once established the principle relationship typically remains stable, thereby making it difficult for the child to substitute a new adult into that role (Carlson et al., 2003).

Attachment is not an immediate instinctual reflex; rather it is a relationship that grows over a period of time and through the course of innumerable interactions between the child and the caregiver (Carlson et al., 2003). Colin (1996) warned that rather than just being a behavior, attachment is a bond built through emotional engagement, which when tested through separation may be associated with the child's crying, clinging, or protests.

Bowlby (1969/1982) traced the development of attachment through four distinct phases that occur over the course of the child's first few years of life. The beginning phase, spanning the child's first two months of life, is characterized by relatively little discrimination and the beginning efforts to orient and signal to others. During the second phase the baby's increasing ability to discriminate between adults leads him to display greater orientation and interest in specific others. This phase lasts until the child is about six months of age. The third phase begins as the child becomes more mobile and able to signal and to follow the identified discriminated figure(s); this persists into the second and third years of the child's life. Boris, Aoki, and Zeanah (1999) have called this the

*secure base and safe haven phase* because children are able to navigate away from their secure base with the assurance that they are emotionally tethered and can return at will to its safety. Bowlby's final phase was the establishment of what he called a *goal directed partnership* in which the mother-figure comes to be acknowledged as a separate, distinct other, though behaving in a way that follows a predictable pattern. It is at this point Bowlby believed that the child became capable of entering into a relationship possessing a degree of understanding of his mother's goals and feelings.

Consistent with Bowlby's developmental outline of attachment Schore (2000) and others have demonstrated that the limbic areas and orbital prefrontal cortex, particularly in the right hemisphere from which inhibitory control emanates, undergo significant myelination in response to synchronous interactions between the infant and the caregiver. This process occurs during the same time frame Bowlby (1969/1982) indicated that the stages of attachment formation took place.

Polan and Hofer (1999), Belsky (1999) and Suomi (1999) have investigated the psychobiological underpinnings of attachment behavior and infant responses to separation using data from animal and human research. Barton and Robbins (2000) have similarly noted that the origins of regulatory disorders such as sensory processing problems and sensory-motor processing difficulties can be traced to the 0-3 year period in the child's development. Thus, the importance of attachment in the development of the child's ability to regulate his emotions, such as offering empathy, and engaging in prosocial behavior, have links to his earliest attachment experiences, and may have implications for later adolescent and adult behavior, a point that has salience for the current study.

From Bowlby's (1969/1982) original formulation, and decades of subsequent research indicate that attachment behavior arose in response to evolutionary survival pressures. Thus, even children who experience pathological care during their earliest years still form attachments to their caregivers, but it is the characteristic quality, rather than the durability of the attachments that is at risk from such mistreatment (Carlson et al., 2003). In addition, the regulatory patterns that are set in place during the child's earliest development have effects reaching into adulthood and into the next generation (Benoit & Parker, 1994). Interest in how variables such as the caregiver's sensitivity and responsiveness, and how the specific characteristics of the child and the caregiver(s) combine to influence attachment quality has given rise to a range of attachment measures as a means to assess and create interventions to enhance the quality of the parent-child bond.

*Internal Working Models as Mental Representations of Attachment*

Belsky (2002) has noted that there are essentially two core theoretical issues with regard to the differences in individual attachment patterns. The first is that internal working models shape the way that individuals view themselves and others and the way relationships develop between the self and others. The second core concept is that these mental representations develop as a result of lived experiences which take place during the earliest interactions between the child and his caregivers (Bowlby, 1968/1982; Collins, 1996; Noller & Feeney, 1994). Internal working models have also been described as *states of mind* with regard to attachment (Main, 1999).

In their key theoretical proposal and investigation of the individual differences in attachment relationships Main, Kaplan, and Cassidy (1985) defined internal working

models as “a set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information” (p. 67). Their work was significant in that it moved the assessment of attachment from the behavioral observation of the interaction between parent-infant dyads to the level of internal processes. They demonstrated that interview methods, which rely upon verbal self-report, accessed language patterns and *structures of mind* that described inner representations or states of mind with regard to attachment. They also found that the description of mental representations were significantly associated with the Strange Situation classification of the subjects’ children six years earlier. They proposed that the move from explaining attachment in terms of observable behavior to the explanation of attachment based upon internal representations makes clear a number of factors. First, it explains how early lived experiences shape later development and behavior. Secondly, it explains the person-specific nature of attachment patterns and the reasons that the patterns can undergo revision. Third, mental representations explain why attachment bonds can remain intact across time and geographic separation.

Zeanah et al. (2000) posited that the relationship between infants and their parents is specific to that dyad and able to be examined through a model which identifies the internal representational worlds of both the child and the parent as well as the interactive behavior that each displays toward the other. This also helps explain the variable characteristics seen in the relationships between parents and each of their children. As the number of interactions between parent and child accumulate they form the basis of the child’s beliefs and expectations regarding the caregiver’s trustworthiness and of the child’s own worthiness to be cared for (Collins, 1996). Based upon ethological research

conducted in naturalistic settings as well as laboratory settings which employed the Strange Situation, the patterns of attachment identified as secure, avoidant, and anxious-ambivalent, and disorganized/disordered are believed to be associated with corresponding characteristics such as responsiveness and emotional availability in the child's caregivers. In turn, the organization of attachment styles directs the child's behavior in relationship to the caregiver, and forms the basis of the child's expectations about others and about the self. For example, Collins and Read (1990) found secure attachment style to be related to working models of the self and others as measured by self-esteem, expressiveness, ability to trust others, self-efficacy, basic beliefs about what it means to be human, and styles of loving. The measurement of the behaviors, cognitions, and affect, through the use of various behavioral, narrative, and self-report instruments, are viewed as a means of indirectly assessing the individual's working models of attachment (Collins, 1996; Bretherton, Oppenheim, Buchsbaum, & Emde, 2003).

In describing the significance of the child's internal working models Main, Kaplan, and Cassidy (1985) have noted that they direct the child's attention, memory formation and cognitive processes related to relationships. The representation of the self and others not only shape the interactions with the caregiver, but form the foundation of relationships with others as the child moves out of his nuclear cluster and into his expanding social world (Collins & Read, 1990). Collins (1996) commented that "Every situation we meet in life is constructed in terms of the representational models we have of the world about us and of ourselves" (p. 810). However, as Bowlby (1968/1982) and others (Belsky, 2002; Collins, 1996; Collins & Read, 1990) have made clear, the models

are *working,* that is, they are in progress, shaped and remodeled through the interactions with significant others throughout the lifespan.

It becomes evident then that the internal working models of children exposed to years of unresponsive or even abusive interactions with their original parents continue to be activated in relationships with new caregivers (Howe, 2003). Hypothesizing that the established internal working models were transplanted from the children's original relational experiences to their adoptive placements, Howe (2003) found that the child's age at placement was correlated with the amount of their contact in adulthood with both their biological and their adoptive mothers. That is, older placed children felt a lack of belonging in their adoptive families, felt unloved by their adoptive mothers, and were least apt to remain in contact with either their adoptive or biological mothers.

These findings are clearly relevant to the current study. As Stovall and Dozier (2000) observed existing models from abusive or emotionally unavailable caregivers may sabotage relationships with new caregivers. However, as noted above (O'Connor et al., 2000; Rutter, 1999) there is also some evidence that early adversity can be mediated by subsequent sensitive, responsive parenting. Interestingly, the younger placed children in Howe's study had the highest rates of adult contact with both their adoptive and their biological mothers; secure adoptees, it would seem, had the greatest ability to engage in complex relationships, experience empathy, and enjoy open reciprocal bonds. In addition, the research has found that the foster or adoptive parents' attachment history also affects the formation of the relationship with the child (Dozier, Stovall, Albus, & Bates, 2001; van IJzendoorn, 1995).

*The role of the caregiver's state of mind with regard to attachment.* Just as older children placed into foster and adoptive homes bring with them mental representations based upon previous caregiving experiences which affect their relationships with their new parents, the research has found that the caregiver's state of mind with regard to attachment also affects the quality of the new foster or adoptive relationship. Bates and Dozier (2003) have noted the the mother's attachment state of mind is believed to direct the mother's interpretation of the child's needs and their subsequent to the need, particularly when the child is in distress. Dozier et al. (2001) found that there was a correspondence between the foster mother's attachment state of mind as measured by the Adult Attachment Interview (AAI), and the attachment quality of the infants placed with them as measured by the Strange Situation (SS), conducted at least 3 months post-placement.

The AAI was designed as a predictive instrument of the parent-infant attachment as observed in the SS. The AAI designates three primary categories: autonomous, dismissing, preoccupied, and a fourth unresolved state of mind with regard to attachment. These are assessed through an extensive narrative provided by the adult with regard to her/his own attachment relationships with parents which are believed to provide a picture of the adult's attachment representations. The narratives are audio taped, transcribed, and rated by trained coders. The AAI has demonstrated both high inter-rater and test-retest reliability. In his metaanalysis of the predictive validity found in 18 studies using the AAI, van IJzendoorn (1995) found that autonomous mothers are most likely to have securely attached infants, dismissing mothers most likely to have infants who are avoidantly attached, preoccupied mothers more likely to have children with resistant

attachment patterns and unresolved mothers were prone to have infants exhibiting disorganized attachment. In Dozier et al.'s (2001) study there was a 72% concordance rate between the foster mother's attachment state of mind (autonomous or nonautonomous) and the infant's attachment classification (secure or insecure). These rates are consistent with biologically related mother-infant pairs. They did not find age at placement to be a significant factor in outcome, but the age range of the infants in their sample was only birth-20 months.

In a similar study Bates and Dozier (2003) explored the possibility of interactions between the foster mother's state of mind with regard to attachment measured by the AAI, the age of the infant at the time of placement, either before 12 months or older than 12 months of age, and the foster mother's acceptance, commitment and belief in their ability to influence the child's development as assessed by This is My Baby Interview (TIMB). They found an interaction between foster mother state of mind with regard to attachment and the age of the infants at the time of placement which was predictive of their acceptance of the infant and belief that they would be able to have a positive influence on the child's development. That is, autonomous mothers of younger infants were more accepting of their babies and believed they would positively affect the children's development. Nonautonomous mothers were not as accepting of their infants whether they had been placed earlier or later, that is, prior to 12 months of age or older than 12 months. Similarly, Stovall and Dozier (2000) found that even when older infants were placed with foster mothers with autonomous states of mind with regard to attachment, their behavior when distressed evidenced an avoidant or resistant pattern and their foster mothers made fewer or less vigorous attempts to soothe them. Dozier et al.

(2001) noted that over time these insecure patterns of attachment between foster infants and their autonomous mothers moved toward more secure attachment, whereas this was not observed among the older infants who had been placed with mothers who had nonautonomous attachment states of mind.

In examining the effects that maternal attachment representations have upon older placed children Steele, Hodges, Kaniuk, Hillman, and Henderson (2003) found an association between adoptive mothers categorized as being nonautonomous or insecure with regard to attachment, that is, dismissing or preoccupied as measured by the AAI, with a higher level of aggressive imagery in the story completions of their adopted children only three months post-placement. The stories of children whose adoptive mothers were classified as unresolved with regard to loss or trauma also had more emotional themes than the stories of children whose mothers were more resolved regarding loss and trauma.

In a study of the ways that mothers and their foster infants form attachments within the first two months following the placement, Stovall-McClough and Dozier (2004) used the AAI to assess parental state of mind with regard to attachment, the Parent Attachment Diary to measure the characteristics of the dyad's daily interactions, and the SS to assess the child's attachment categorization. Their sample of 38 parents and their foster infants demonstrated that earlier placed infants and those who were placed with autonomous foster parents exhibited more secure attachment behaviors, less avoidance, and more coherent strategies with regard to attachment during the first week of placement compared with those children placed with parents who were nonautonomous as assessed by the AAI. However, the attachment behaviors of children who entered the foster

placement with more risk factors, for example, abuse, drug exposure, and multiple placement changes, became less coherent over time, and showed decreasing levels of attachment security with a more disorganized pattern of attachment during the SS.

Although they hypothesized such a relationship Edens and Cavell (1999) noted that there existed no direct empirical data demonstrating a correspondence between adoptive parents' attachment styles and its influence on the parent-child bond. They speculated that individuals low in avoidance on attachment scales would be more likely to adopt, as compared with individuals higher on scales of ambivalent attachment. Santona and Zavantinni (2005) offered a partial answer in finding that the majority of the 50 couples in the process of adoption screening were found to be classified as secure on the AAI and only a few couples were comprised of two individuals classified as insecure.

The implications of these studies are evident with respect to the placement of children in substitute care. First, they support a non-biological mechanism of attachment organization and provide evidence of the possibility of successful secure attachment formation following early disruption in care. Secondly, they point to the importance of the child's age at the time of placement as a critical factor in the child's outcome (Bates & Dozier, 2003; Dozier et al., 2001; Stovall & Dozier, 2000). However, even older placed children are affected by the attachment representations of their foster and adoptive mothers (Dozier et al., 2001; Steele et al., 2003). Third, as van IJzendoorn (1995) noted, the internal representations of parents' own attachment experiences, as measured by their narrative reports, has been found to be significantly associated with the quality of their children's attachment to them. It is notable that children with nonautonomous-dismissing caregivers have higher rates of disorganized/disoriented attachment with corresponding

emotional and behavioral dysregulation which can test the durability of their placements (Bates & Dozier, 2003; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005; Steele et al., 2003).

The application of these findings for children who are significantly older at the time of placement and have experienced numerous attachment disruptions must be guarded. Nevertheless, the research indicates the usefulness of qualitative and quantitative measures of parental states of mind with regard to attachment in helping to guide placement decisions, particularly for children who have already experienced numerous attachment disruptions. Bates and Dozier (2003) suggested that questions regarding whether the initial responses of autonomous foster mothers toward older placed children remaining responsive and nurturing despite the child's initial avoidance or resistance, as well as whether interventions designed to aid foster and adoptive mothers understand the insecure patterns of their later placed children need answers which must be provided by additional longitudinal research and practice. Also, the extent to which the severity of trauma previously experienced by the child effects her attachment representations, and how this is associated with the ability of parents to persevere despite severe frustration is open to additional research investigation. The role of parental attachment characteristics on adoption or foster placement outcome forms the basis of the present study.

## Disorders of Attachment

Almost all children, under ordinary circumstances, succeed in forming a secure bond with at least one caregiver and are able to establish a competent strategy for

managing the stress accompanying separation, illness, and other distressing events (Juffer et al., 2005). Steele et al. (2003) observed that although humans are born with a predisposition to affiliate a history of early deprivation, abuse, and multiple relationship disappointments affect both the child's internal representations of caregivers and their own self-representations. However, even children exposed to pathological care show evidence of some consistent pattern of attachment to their caregivers (Carlson et al., 2003). Thus, differences in the quality of the care provided to the child will result in measurable differences in the quality of the attachment between the child and caregiver; these differences will be expressed later in the life through individual variability in the child's self-regulatory competence (Carlson et al., 2003).

Not only is attachment theory used by developmental psychologists to explain the child's growth in social aptitude, but it has clinical value in assessing the presence of reactive attachment disorder (RAD) and other attachment disturbances (Barth et al., 2005). Despite its inclusion in the DSM-IV (APA, 2000), the International Classification of Diseases (World Health Organization, 2003), and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Zero-to-Three National Center for Infant Clinical Programs, 2005), acceptance of RAD as a diagnostic category is controversial (Carlson et al., 2003). There remains a lack of consensus on the definition of attachment disturbances as well as techniques for assessing attachment. In addition, despite the proliferation of attachment therapies there are no empirically validated clinical treatment guidelines for the disorder (O'Connor & Zeanah, 2003).

Although the DSM-IV-TR (APA, 2000) currently requires the presence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts beginning before age 5 years," presumed to be related to early pathogenic care, children and adolescents are often given a diagnosis of RAD inferentially, especially when little reliable information is available about the child's early functioning or care, as is often the case with children in foster care or those who are late adopted (p. 130). Kaufman and Henrich (2000) explained that data do not exist that estimate the number of children with insecure attachment as measured by the SS or who meet the criteria for a diagnosis for RAD. They suggested that difference between the children who meet and those who do not meet the criteria for RAD is that RAD manifests across a larger range of social relationships whereas insecure attachment classifications are relationship-specific. Other distinctions between children with attachment disturbances and those who exhibit secure attachment were observed by van IJzendoorn (1997) who found that children who have secure relationships with their parents have characteristics such as: the internalization of the parents' social norms, feelings of empathy for others and the ability to make attempts to relieve others' distress, and greater self-regulatory ability especially with regard to negative affect.

An alternate approach to conceptualizing the link between attachment and psychopathology within a developmental framework was offered by Carlson et al. (2003). They proposed that although the prevalence of RAD is extremely low, many parent-child attachment relationships may contribute to developmental impairments. Having a secure relationship with a parent does not offer assurance of optimal adult adjustment, but rather may cultivate resilience in the face of adversity and stress.

Similarly, patterns of insecure attachment, and corresponding behavioral strategies used by the child to maximize available caregiving resources, develop in response to inadequate or inappropriate responsiveness from the caregiver. Although these strategies may not be the most advantageous in terms of normative attachment, even insecure attachment strategies maximize the child's opportunity for proximity to the caregiver, despite the caregiver's irregular availability. In other words, the child's attachment behavior is specific and complementary to the behavior of the attachment figure and is adaptive within the relational context (Crowell & Treboux, 1995). Given this compromise, children with anxious-avoidant attachment patterns take advantage of the most that their caregivers can offer by curtailing their distress signals. This is designed to lower the caregiver's strain and increase the child's probability of a response from her/him. Children with anxious-resistant attachment attempt to gain the most attention possible from their occasionally available caregivers by amplifying their distress behavior. Carlson et al. (2003) warned that the strategies used by children with insecure attachment may have limited adaptive or generalizeable value beyond infancy and may in fact hinder the child's ability to use the resources provided in future relationships.

Of concern in the clinical arena is the likelihood that these early patterns of interaction may incline children toward a variety of maladaptive behavioral and psychological disorders later in life. For example, avoidant children who have relied upon minimizing their attachment signals may develop tendencies to see others as unavailable and undependable, which may in turn lead to angry, hostile alienation, and the inability to experience empathy. These are characteristic criteria for oppositional defiant and conduct disorder in youth and adolescents which often grow into adult antisocial personality

disorder. Children with a history of resistant attachment who have used exaggerated attachment efforts to secure the attention of their caregivers may grow into adolescents and adults with little tolerance for frustration, high levels of anxiety about their ability to obtain support, poor self-esteem, and the use of magnified emotionality, all to the detriment of exploratory and other life-enhancing behaviors. Both avoidant and resistant patterns are likely to increase vulnerability to depression and anxiety about abandonment. For those children who have developed a disorganized approach to maintaining attachment relationships an increased rate of adolescent psychopathology and vulnerability to the use of dissociative coping may be increased (Carlson, 1998). In addition, children with a history of disorganized attachment and co-occurring trauma, as is the case with the majority of special needs foster and adoptive children, are at higher risk of developing dissociative symptomatology (Carlson, 1998; Main & Hesse, 1990). Steele et al. (2003) similarly observed that caregiving which is at times responsive and at other times frightening to the child may result in the development of multiple internal models of attachment representation. These are more difficult for the child to maintain in a coherent fashion and may lead to hyper-vigilance about the caregiver's attachment state of mind (Steele et al., 2003)). The child's uncertainly about the intentions of the caregiver may result in the development of attachment strategies which alienate rather than engage the parent. For example, a child with a history of dismissive caregivers may develop patterns of distress signally such as aggression, lying, incessant questioning, and other maladaptive attention-seeking behaviors which elicit avoidance or anger from the parent, thereby reinforcing the child's caregiver representations as insecure and untrustworthy.

## Methodological Challenges in Measuring Adult Attachment

As Simpson and Rholes (1998) indicated, attachment theory has two aspects, the one dealing with the normative species-specific development of attachment behaviors, and the other, which has been the focus of much greater research interest, which has sought to account for *individual differences* in patterns of attachment behavior. The success of Ainsworth et al.'s (1978) Strange Situation assessment, as well as the ability of the AAI, developed to predict infant behavior on the SS, may have set a research course which has not significantly varied over the last three decades. Additionally, Fraley (2002) has observed that two different research traditions have been represented among attachment investigators. First are those who approach the study of attachment from a developmental perspective whose interest has focused upon the manner in which adult parents' internal representations of attachment influence the organization of attachment behaviors in their children. Secondly are those coming from social and personality psychology who tend to examine ways that attachment theory can be applied in the area of interpersonal relationships and personality development. As a result attachment measurement has developed along two distinct lines, employing either the use of interview or self-report instruments. Stein, Jacobs, Ferguson, Allen, and Fonagy (1998) identified three different research traditions that have produced various attachment measurement instruments: the attachment research tradition stemming from the work of Bowlby (1969/1982, 1973, 1980), Ainsworth, Blehar, Waters, and Wall (1978), and Main, Kaplan, and Cassidy (1985); the personality and social psychology tradition from the original work of Hazan and Shaver (1987); and the social cognition tradition represented by Bartholomew and Horowitz (1991).

*Interview Versus Self-Report Measures*

Crowell and Treboux (1995) have declared that a theory's strength depends upon the researcher's ability to measure theoretical constructs. As a result, the question of measuring attachment in both childhood and adulthood, in the context of parent-child, peer, adult romantic relationships, and other life domains such as the therapeutic relationship, has been a central concern among attachment researchers since the 1980s.

In addition to the difficulty of achieving consensus regarding what behavioral symptoms constitute disturbances of attachment, the measurement of attachment as a construct has been burdened by two areas of controversy. The first controversy involves the use of interview versus self-report measures (Feeney, 1999; Hesse, 1999; Shaver & Mikulincer, 2002; Simpson & Rholes, 1998). Although both of the disparate camps are based upon Bowlby's theory, they arose from different traditions. Following Ainsworth et al.'s (1978) observations of mother-infant behavioral interactions, developmental and clinical researchers created interview formats to assess parents' internal working model, or state of mind with regard to attachment. These instruments include the Current Relationships Interview (CRI) developed by Crowell and Owens (1996), the Peer Attachment Interview and the Family Attachment Interview created by Bartholomew and Horowitz (1991), as well as the Adult Attachment Interview (AAI) which was the first attempt to measure adult attachment created by Main, Kaplan, and Cassidy (1985) and considered by many to be the preeminent attachment measure. The interviews rely upon lengthy narrative formats and require interviewers to undergo extensive training and certification. In contrast, researchers coming from the social psychology tradition have created shorter, easily scored self-report forms such as the Relationship Scales

Questionnaire (RSQ) by Bartholomew and Horowitz (1991), the Relationship Questionnaire (RQ) designed by Bartholomew and Shaver (1998) and Hazan and Shaver (1987), and the Parental Bonding Instrument (PBI) created by Parker (1990) and Parker, Tupling, and Brown (1979). Thus, the two traditions have had different focal points. The interview approach has typically examined relationships within the nuclear family and the self-report tradition has looked at attachments to peers and romantic partners. However, this may not be the major point of disagreement.

Perhaps the principle tension between the interview vs. self-report camps is that those using interview assessments contend that they tap into unconscious psychodynamic defensive processes that cannot be fathomed by self-report instruments, which they assume are only able to measure conscious mental states. While this may be an intuitive impression, it can also be misleading (Shaver & Mikulincer, 2002). Simpson and Rholes (1998) posited that certain advantages lie in using interview measures such as the AAI. First, because it poses questions that respondents may have never considered it may be able to gently tap into the unconscious, thereby circumventing ego defense systems. Second, the progressively more emotionally arousing questions on the AAI, such as those asking about abuse and loss, may successfully activate the attachment system and yield more accurate attachment-relevant data. Despite these advantages Simpson and Rholes conceded that self-report measures have some benefit in being both easy to administer and score as well as being able to capture the respondents' perception of current working models of attachment which direct peer and romantic attachment behavior. They proposed that in fact the two types of assessments measures different aspects of the working models. Brennan, Clark, and Shaver (1998) agreed that for most purposes the

use of interview measures, although often very informative are unfortunately not practical. Having used and developed both types of assessments, Bartholomew and Moretti (2002) suggested that rather than criticizing self-report formats for their inability to assess the underlying psychological processes related to attachment, their strength may lie in using diagnostic questions about attachment style that do not trigger ego defense mechanisms. In this way act self-report measures may act as "convenient surface indicators of differences in attachment-related cognitions, emotions, and behavioral tendencies which are partly unconscious, indicators that can be examined *in relation to more direct measures of unconscious processes*" [authors' italics] (Shaver & Mikulincer, 2002, p. 137).

Some studies have found that self-report tools did not yield information about parental internal working models and showed few significant correlations between the AAI and various self-report measures of adult attachment (Crowell, Treboux, & Waters, 2000; De Haas, Bakermans-Kranenburg, & van IJzendoorn, 1994). Kobak and Hazan (1991) and Simpson, Rholes, and Nelligman (1992) have found that certain aspects of the two types of measures are associated, such as the availability of comfort from parental attachment figures as measured by the AAI and the ability to comfort others in adult romantic relationships as measured by self-report. Crowell et al. (2000) also reported an 81% correspondence between individuals who were *secure* in the AAI classification and *secure* on the RQ, but only 42% of those classified as *insecure* on the AAI were also *insecure* on the RQ.

Based upon their review of the pertinent research Shaver and Mikulincer (2002) found that individual self-report scores describe distinct patterns of distress response and

emotional self-regulation. For example, secure individuals are found to manage stressful information, appropriately express emotions, seek support when needed and use adaptive coping methods. Individuals who score in the avoidant range of attachment security on self-report measures tend to truncate their distressing thoughts and memories and employ dissociative strategies to defend against their intrusion into conscious awareness; they also deny hostility and anxiety. Finally, individuals who score in the anxious category are hyperactivated by distressing memories and affect, resulting in a flood of autonomic dysregulation. Shaver and Mikulincer concluded that although the research does indicate that the AAI and self-report scales provide somewhat different information about attachment representations, the measures are related in that they are both based upon core attachment theory concepts. Thus, Shaver and Mukulincer defended the use of self-report measures as a source of data that extends, broadens, and is coherent with data gathered from interview measures.

Noller and Feeney (1994) raised important questions regarding overreliance on self-report measures to assess adult attachment. Both Bowlby's (1968/1982), and Ainsworth et al's. (1978) conclusions were based upon ethological methods and naturalistic observations. Ainsworth's SS was designed to elicit attachment relevant behavior from children facing a stressful separation. In Bowlby's view attachment behaviors were activated by three stressful conditions: caregiver actions such as departure, absence, or efforts to prevent proximity; fatigue, sickness, or pain in the child; and environmental conditions that engender fear or threat. Various difficulties arise in creating equivalent conditions of stress under which to measure adult attachment behaviors; additionally such efforts are limited both by adult inhibition and ethical issues

regarding the observation of adult attachment behavior (Noller & Feeney, 1994). Furthermore, though applauding the utility and straightforwardness of the categorical model Noller and Feeney warned that using such a model based upon infant behavior may have unintentionally fostered reluctance to question important aspects of existing attachment theory and an unwarranted adherence to a limited categorical model to the detriment of developing more accurate dimensional models, such as those proposed by Bartholomew and Horowitz (1991). Finally, Crowell, Fraley, and Shaver (1999) have maintained that self-report measures are valuable means of assessing individual differences in general, arguing that most adults are able to access memories of their experiences in close relationships and that even if self-report measures are not as precise in taping unconscious attachment processes, both conscious and unconscious modes tend toward correspondence.

Bartholomew and Shaver (1998) discussed the problems inherent in comparing the results of self-report and interview measures and determining whether the two types of assessments converge. As noted by Shaver and Mikulincer (2002) researchers from each of these traditions have become mired in two problem areas. First, coming from different backgrounds, interviewers primarily from clinical and developmental psychology and self-report researchers come from social and personality psychology. Thus they have engaged in little collaborative exchange. Secondly, because both lines of research are based upon the Bolwby's and Ainsworth's theories there has been an assumption that the two ways of classifying attachment significantly overlapped, that is, the AAI categories of autonomous, preoccupied, dismissing, and unresolved would correspond to the self-report categories of secure, avoidant, and anxious attachment in

Hazan and Shaver's (1987) scale, for example. However, as Bartholomew (1990) observed, the AAI dismissing-avoidant individuals do not admit to experiencing distress and minimized the salience of their attachment needs, in contrast to those classified as avoidant on the Hazan and Shaver (1987) scale who reported high levels of subjective distress and feared closeness with others (Bartholomew & Shaver, 1998). In addition, Bartholomew (1990) argued that because the two measures were attending to two different spheres of attachment, one parental and the other romantic, believing that they were measuring equivalent factors would be presumptuous. A final problem in assuming that the measures would converge was that they were relying upon two different types of information, one derived from unconscious, defensive dynamics from childhood working models and the other from directly reported behaviors and feelings related to close adult relationships. Bartholomew's solution to this dilemma was to expand the category of avoidance into two separate types, avoidant dismissing and avoidant fearful, and to assess attachment using both self-report and interview instruments based upon four attachment patterns (secure, preoccupied, dismissing, and fearful) defined by two-dimensions: positive/negative model of self and positive/negative model of others. Given the differences in the focus of the assessments (conscious and unconscious) and the domains (parent/child, adult/adult) that they attempt to measure it would seem improbable that the two types of measures would converge. However, studies which have combined the use of self-report and interview measures (Bartholomew & Horowitz, 1991) have found a moderate convergence between the types of measures. Bartholomew and Moretti (2002) have suggested using both interview and self-report tools to provide a larger and more complete view of attachment, as well as fertilizing the ground in which more

comprehensive and empirically sound theories of personality and development could flourish.

*Categories Versus Dimensions*

The second area of measurement controversy is whether attachment is better conceptualized categorically or dimensionally (Feeney, 1999; Garbarino, 1998; Hesse, 1999; Shaver & Mikulincer, 2002). As discussed above, the Ainsworth et al. (1978) observations which resulted in the creation of the SS described three principle styles or categories of child attachment: secure, anxious-ambivalent, and avoidant-resistant; a fourth category disorganized/disoriented was later identified by Main and Solomon (1990). The AAI, also a categorical measure, has been used extensively by attachment researchers and has demonstrated excellent validity (see Bakermans-Kranenburg , van IJzendoorn & Juffer, 2003 metaanalysis). Simpson and Rholes (1998) have noted some challenges with models based upon *categorical* rather than *continuous* or *dimensional* attachment. First, conceptually, there has been little support for the existence of a baseline of attachment which would allow individuals to be reliably classified. Secondly, the use of categorical data restricts the type of statistical testing to the analysis of variance. And finally, categorization provides only qualitative description, that is, it fails to indicate the degree to which a particular attachment category describes a certain individual. Other investigators have cautioned the use of categorical measures that force respondents to make a choice between short statements or descriptions because they may assess only a limited dimension of the individual's self-concept (Buelow, McClain, & McIntosh, 1996; Garbarino, 1998). Additionally, responses may be sensitive to factors such as mood or immediate circumstances rather than true indications of underlying

constructs (Garbarino, 1998). The use of category instruments may offer useful measures of attachment patterns for non-clinical populations, but clinical populations may present added challenge in discriminating accurately between categorical styles (Buelow et al., 1996). Finally, (Hardt & Rutter, 2004) have cautioned against unreserved use of retrospective measures, of which the AAI is one, due to the risk of false negative reports and measurement error that may particularly infect the recollection of early adverse experiences.

To address some of these concerns various researchers (Bartholomew & Horowitz, 1991; Main, Kaplan, & Cassidy, 1985) have developed interview assessments based upon three and four category conceptualization (secure, anxious, and avoidant and secure, anxious-preoccupied, avoidant fearful, and avoidant-dismissing) and three and four category measures using self-report forms such as those created by Bartholomew and Horowitz (1991) and Hazan and Shaver (1987). There are also longer self-report measures that are based upon two factors (support/closeness seeking and anxiety/fear) developed by Simpson, Rholes, and Nelligan (1992), and three factors (dependence, anxiety, and closeness) created by Collins and Read (1990). In addition Brennan, Clark, and Shaver (1998) posited a two-dimensional model consisting of attachment-related avoidance and attachment-related anxiety. Using this schema, for example, the classification of *secure* on the SS and *autonomous* on the AAI would be located in the low anxiety and low avoidance region; the classification of *anxious/ambivalent or anxious/resistant* on the SS, and *preoccupied* on the AAI would fall in the low avoidance and high anxiety region (Brennan et al., 1998; Shaver & Mikulincer, 2002). The *avoidant* category on the SS corresponding to the *dismissing* AAI classification proved more

difficult to locate. However, Bartholomew and Horowitz (1991) described a distinction between *dismissing avoidants* who were located in the area conceptualized as being in the high avoidance and low anxiety area and the *fearful avoidants* who were located in the high anxiety and high avoidance area.

In defense of the use of categorical or typological models used to support attachment measures, Fraley and Waller (1998) have noted that there is a broad misconception that categorical distinctions are derived from arbitrary convenience or labeling, or merely from statistical cut-points, rather than being indicators of true types that occur in nature. They offer the example of recursive systems, of which the attachment regulatory system is one, as a means of describing the qualitative differences in attachment behavior between parent-child dyads as a factor of both parental responsiveness and the goal-corrected partnership of the pair. Thus, parental responsiveness or unresponsiveness would be the factors that might describe the child's categorical designation. In addition, they noted that certain attachment behaviors tend to be group together for some individuals and not for others, creating a yes/no dichotomy. However, Fraley and Waller also suggested that there is support for a dimensional approach. For example, Griffin and Bartholomew (1994a) found that there were significant within-category covariances which would not be predicted from a strict categorical model. Also, attachment is not reducible to a single dimension of interaction between parent and child or between peers, but rather varies with temperament, sensitivity of responsiveness, and previous attachment relationships. Finally, the finding of subcategories within the SS categories, 11 in all, supports the notion of a dimensional aspect even within that categorical instrument component. Fraley and Waller's analysis

of data from a sample of 639 young adults, using two statistical techniques (MAMBAC and MAXCOV) led them to conclude that the typological/categorical model is inadequate to explain the naturally occurring structure of attachment patterns, but that the organization of adult attachment is a variable that is distributed is qualitatively and one on which individual differences can be measured by degree rather than by category.

Closely aligned to the category vs. dimension debate is the issue of blurring the distinctions between attachment as a *status* in a specific relationship and viewing it as a general *trait* (secure, anxious, avoidant) that characterizes all relationships (Waters et al., 2002). This has led to thinking that a certain attachment trait causes specific behavior, rather than the trait being a label that names the consistencies of a person's attachment behavior (Waters, Crowell, Elliot, Corcoran, & Treboux, 2002)

Coming from a different perspective, in answer to the question of why attachment continues to be described categorically rather than through the use of multidimensional scaling Sroufe (2003) has suggested that the complexity of defining the dimensions has proved to be daunting. For example, in the SS underlying dimensions of search and greeting behavior, wariness, the quality of the child's exploration, passivity, affective exchange, and child-caregiver distance could all be relevant dimensions, but present insurmountable scoring difficulties. Sroufe contended that a more pressing research need than conducting large scale studies which might or might not demonstrate the validity of dimensional models, is the need for measures analogous to the SS for older children and for adults.

Griffin and Bartholomew (1994a) provided a summary of the issue of conceptualizing adult attachment as dimensional, typological, or prototypical and in

defining the assumptions, advantages, and disadvantages of each approach. The dimensional approach assumes that individual differences can be quantitatively described in that there exist no qualitative cut-offs between one category or type and another.. Second, the dimensions are assumed to be independent. Dimensional measures are indirect measures of attachment and are used less frequently than categorical measures though they have the advantage of preserving information that may be lost when individuals are grouped arbitrarily by mean or median cut-offs. A further advantage of dimensional data is the type of statistical analysis that may be used such as correlations, multiple regression analysis, or structural equation modeling. Additionally, dimensional data derived from multi-item instruments can be highly reliable as well as providing a simple pattern of responses, for example, on two dimensions. However, there are also disadvantages in a dimensional approach in that it examines the relationships among variables across individuals rather than creating an individual profile or pattern.

According to Griffin and Bartholomew (1994a) the categorical or grouping approach has a convincing research tradition stemming from Ainsworth et al.'s (1978) SS and the Hazan and Shaver (1987) adult attachment measure. This approach operates under the assumption that people who are classified within a discrete type are interchangeable as far as dimensions of a variable may be concerned, making the variance within the group or category a result of random error, and placing prominence on the between-group differences. Of course the advantage to this approach lies in the ease, parsimony, and convenience of measurement and use of analysis of variance to examine the data. Those researchers relying upon category measures contend that the existence of the actual phenomenon of the variable of interest, such as a secure or other

attachment type, can actually be observed through this measurement approach. Griffin and Bartholomew however argue that the categorical method fails to provide a means of testing the assumptions of the model, that is, that individuals are by nature divisible into certain identifiable groups, rather than having characteristics that might best be measured along some dimensional scale, an exclusive either/or rather than an inclusive both/and view. A further disadvantage of the categorical model is that investigators may be tempted to see the group variables, that is, secure, anxious, avoidant attachment, as independent variables which *cause* particular outcomes, rather than as the *result* of underlying dimensional factors such as anxiety and avoidance. Finally, what the categorical method of assessment offers in simplification may be offset by the hazard of stereotyping group members, exaggerating group member similarities, and ignoring disconfirming information.

The prototype method of measuring adult attachment is a hybrid approach, integrating elements of both categorical and dimensional measures. Griffin and Bartholomew (1994a) argued that this approach is best suited to the measurement of adult attachment because they view attachment as a function of various early experiences and current relationship dynamics. From this perspective attachment is subject to modification over time and across circumstances thereby limiting the usefulness of attempts at rigid categorization. The prototype method assumes a prototypical category member by defining the most frequently occurring features of all members of the category, without defining a single feature or combination of features necessary for membership in that category. In this schema the members of a group vary in the extent to which they possess the prototypical characteristics. For example, the prototypical homo

sapien has two eyes, two ears and one mouth, walks upright, breaths oxygen, and bears live young, however, an individual with congenital deformities may only approximate those characteristics, conforming to the defining features in some measurable degree. In the prototype model the categories such as attachment types, have more fluid and indistinct borders and may share some features. The four-category, two dimensional model developed by Bartholomew (1990) and Bartholomew and Horowitz (1991) is one such integrated approach to the measurement of adult attachment and is the basis for several measurement tools including the Relationship Scales Questionnaire (RSQ). It incorporates both the internal model of self and other, as well as a dimensional measure of dependence and avoidance. However, Feeney, Noller, and Hanrahan (1994) caution that even this approach is sensitive to the characteristics of the sample group, as well as the wording used in the instrument to describe the prototypical attachment styles. Another measure, the Parental Bonding Instrument (PBI) (Parker, 1990; Parker, Tupling, & Brown, 1979) offers similar advantages to Bartholomew and Horowitz's prototype approach. Both will be discussed in greater detail in the following pages.

## Rationale for the Use of the Relationship Scale Questionnaire (RSQ)

The RSQ (Bartholomew & Horowitz, 1991) is based upon a four-category model developed by Bartholomew (1990). Two intersecting dimensions, the model of self and the model of others are dichotomized as positive or negative which yields the four prototype or ideal attachment patterns; these correspond to differences in individual attachment behavior. The four prototypes can be seen in Figure 1: the positive model of self is associated with low anxiety and the negative self model with high anxiety; the positive model of other is associated with low avoidance and the negative model of other

with high avoidance. Viewed in this way a positive self and negative other model would be characterized by low anxiety and high avoidance (insecure/dismissing attachment pattern), positive self and positive other model would correspond to low anxiety and low avoidance (secure attachment pattern), negative self and positive other model would yield high anxiety and low avoidance (insecure/preoccupied attachment pattern), and negative self and negative other model would be characterized by high anxiety and high avoidance (insecure/fearful attachment pattern) (Griffin & Bartholomew, 1994b).

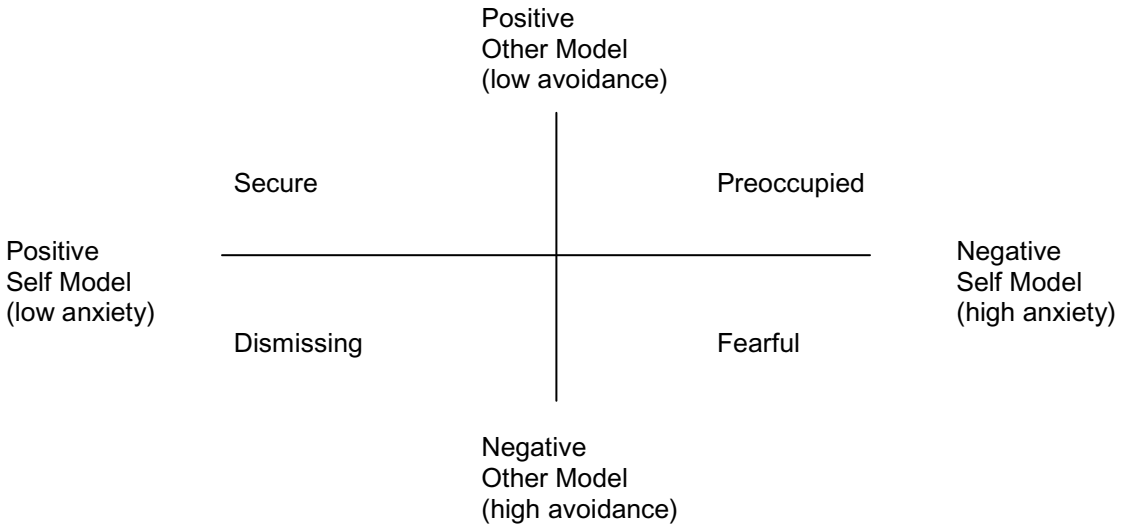


*Figure 1.* The model of adult attachment as described by the Relationship Scales Questionnaire (Griffin & Bartholomew, 1994b).

The self and other model is consistent with Bowlby's (1973, 1969/1982, 1980) earlier formulation of the child's development of the working model of the self as being worthy of care and the model of other as being willing to provide care and support. The self model corresponds to the degree to which individuals experience *anxiety* in close relationships, and the model of others corresponds to the degree to which individuals

engage in *avoiding* intimacy in relationships. (Bartholomew & Horowitz, 1991; Kurdek, 2002). Brennan, Clark, and Shaver (1998) have suggested that two principle dimensions, anxiety and avoidance, may underlie the categories described by many attachment measures.

Bartholomew and Horowitz (1991) suggested that their four prototypes corresponded to the categories identified by Main et al. (1985) and Hazan and Shaver (1987): low anxiety and low avoidance prototype corresponds to the secure category in both Main et al. and Hazan and Shaver's models; the high anxiety and low avoidance prototype corresponds to the preoccupied category of Main et al. and the ambivalent category of Hazan and Shaver; the low anxiety and high avoidance prototype corresponds to Main et al.'s dismissing category while the high anxiety and high avoidance prototype corresponds to the Hazan and Shaver avoidant category.

Griffin and Bartholomew (1994a) described the process of constructing dimensional models. Starting with a large collection of relevant items, which might be gathered from various existing instruments, there follows a factor analysis which reduces the sample items so that their essential structure is revealed. However, they warn against the hazard of misrepresenting the *structure* of a set of test *items* to be the "structure of the human psyche" (p. 29). In the case of attachment research, for example, an orthogonal or oblique statistical analysis of the phrases from Hazan and Shaver's (1987) attachment measure yielded a two-dimensional model highlighting avoidance of intimacy and anxiety about relationships (Simpson et al., 1992; Feeney, 1994; Feeney, Noller, & Callan, 1994). A thorough description of the RSQ appears in chapter 3.

## Rationale for the Use of the Parental Bonding Instrument (PBI)

The PBI (Parker et al., 1979; Parker, 1989) is designed to assess the respondent's perceptions of mother and father along the dimensions of care and overprotection. The PBI provides separate maternal and paternal scores for the respondent's experiences of parenting during their first 16 years. The originators also intended it to be used as a means of quantifying the degree to which parental characteristics play a role in the development of the child's subsequent psychopathology; a sizeable body of research has examined these effects. The parental characteristics of care and protection have been supported by theory and by research using other instruments, as being central to the parent-child relationship. In addition to work of Bowlby (1973) and Ainsworth et al. (1978), which articulated the importance of the child's early experience of parenting, Hinde (1974) added to the knowledge of parent-child interaction by providing evidence of the biological bases of human social interaction. He noted that care and protection were the foundation of all important close relationships.

The developers of the PBI indicated that four types of parental bonding could be designated: high care/low overprotection (indicative of secure bonding), low care/low overprotection (indicative of weak or absent bonding), high care/high overprotection (restriction with affection) and low care/high overprotection (restriction without affection), but that the scores could also be used dimensionally (Parker, 1989; Parker, Tupling, & Brown, 1979). See Figure 2. Parker et al. (1979) further suggested that comparing the maternal and paternal scores on the PBI could yield a discrepancy score which might be related to other dependent variables, for example, placement stability,

degree of parent-child conflict. The PBI has been translated for use with diverse samples (Arrindell & Engebretsen, 2000; Favaretto, Torresani, & Zimmerman, 2001) and used to investigate the effect of parental relationships on subsequent adult relationships (Mallinckrodt, 1991). It has also been modified for use with specific clinical populations.

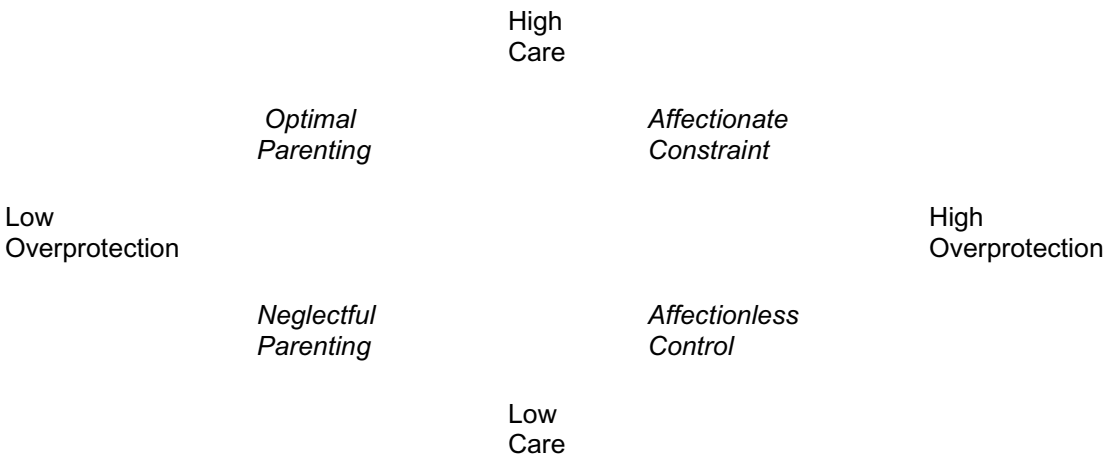


*Figure 2.* The attachment model described by the Parental Bonding Instrument (Parker et al., 1979).

Some research has pointed out the PBI's independence from personality traits or current affective states (MacKinnon et al., 1989; Parker, 1983). However, Enns, Cox, and Larsen (2000) found a significant correlation between overprotective fathers and depression in males, and low care by mothers and depression in females. They proposed that personality variables may be a factor in the observed relationship between parenting style and depression in children. Heisse, Berman, and Sperling (1996) found similar correlations between measures on various attachment scales and personality variables.

The AAI is considered by some attachment researchers to be the foremost adult attachment measure. However, Manassas et al. (1999) noted that the *care* factor of the

PBI ostensibly resembles the *loving/unloving* AAI scale and the PBI *overprotection* factor is similar to the AAI *involving/reversing* scale. In their sample of 130 emotionally disturbed adolescents they found that respondents with the most advantageous attachment histories exhibited comparable results on the AAI and the PBI. However, results obtained by the two measures had lower correlations for those with less optimal parental attachment histories. They suggested that the PBI be used with caution in assessing attachment in clinical samples. In contrast Smith, Lam, Bifulco, and Checkley (2002) found significant correlations between the *antipathy and neglect* scale on the interview instrument Childhood Experience of Care and Abuse (CECA) and a questionnaire version of the CECA (CECA-Q), and the PBI. The maternal antipathy scale on the CECA was strongly correlated with the PBI maternal care scale (-0.832) and positively correlated with the PBI maternal protection scale (0.413). The CECA paternal antipathy scale was likewise significantly correlated with the PBI paternal care (-0.793) and paternal protection scales (0.483). In addition they found a high degree of test-retest reliability over a period of three years. The issue of convergent validity between different types of measures, that is between interview and self-report measures has been ongoing since the 1980s and has been discussed above in the section entitled "Interview versus self-report measures."

Kazarian, Baker, and Helmes (1987) found support for the internal structure of care and overprotection on the PBI in their study of individuals diagnosed with schizophrenia who were being seen in an outpatient clinic. They also suggested that those parents designated as being low in care and high in overprotection were correlated with the expressed emotionality of the relatives of the patients. Similarly, in a large

community sample of 386 respondents, MacKinnon, Henderson, Scott, and Duncan-Jones (1989) found support for the two-factor structure of the PBI. Using a Goodness of Fit Index they found between-items correlations of 0.726 and 0.782 for mothers and fathers respectively. They also found that the scales showed high test-retest reliability. In another study of 26 individuals with schizophrenia and their parents Favaretto, Torresani, and Zimmerman (2001) found test-retest reliability ranged from .65 to .67 for the parents and .32 (paternal protection scale) to .67 (maternal care scale). They explained the low paternal protection score as being a function of intra- rather than inter-category rating variability. Wilhelm and Parker (1990) found impressive test-retest reliability in the PBI over a ten-year period: maternal care (0.63), maternal protection (0.68), paternal care (0.72), and paternal protection (0.56). When these levels of reliability were compared to scores on a number of personality measures over the same period the results were impressive: neuroticism (0.50), self-esteem (0.48), dependency (0.55), and trait depression (0.46). The relationship between satisfaction with parenting and self-criticism, considered a risk factor for depression, was investigated by Brewin, Firth-Cozens, Furnham, and McManus (1992) with results indicating that individuals with higher levels of trait self-criticism and depression reported higher levels of dissatisfaction as measured by their retrospective report of relationships with parents on the PBI.

Recently, a 16-item version of the PBI with modification to three-factors was adopted for inclusion in the U.S. National Comorbidity Survey because it demonstrated ease of replicability when comparing clinical and community samples (Cox, Enns, & Clara, 2003). In response to the need expressed by foster care agencies for empirical research and tools to support placement decisions (Edens & Cavell, 1999; Fisher, 2003;

Orme & Buehler, 2001; Whiting & Lee, 2003) the Casey Home Assessment Protocol (CHAP) was developed. It consists of a battery of 20 standardized tools, including the PBI, used to help prospective foster parents clarify their readiness for fostering and also assist foster care agencies in selecting applicants (Rhodes et al., 2003).

The PBI has been used with diverse populations, for various applications, and with both clinical and non-clinical populations (Parker, 1998, 1990, 1989). It is short, inexpensive to administer, and easily scored and interpreted. With its demonstrated statistical strength its may be a valuable predictive measure in screening foster and adoptive parents considering placement of special needs children. More specific psychometric properties of the PBI will be discussed in Chapter 3.

# CHAPTER 3: RESEARCH METHOD

## Introduction

This study attempted to demonstrate that the use of empirically sound assessments may help guide child welfare professionals making placement decisions for children with special needs. The lack of research on foster care and adoption in general, as well as the lack of quantitative assessments to identify the most competent parents for these children, has been cited in the literature (Edens & Cavell, 1999; Fisher, 2003; Orme & Buehler, 2001; Whiting & Lee, 2003). The following pages describe the rationale for using scores on two retrospective parental self-report attachment measures, and two child demographic variables as possible predictors the duration of special needs foster and adoptive placements; the psychometric strengths of the tools will be discussed. A researcher-developed demographic questionnaire will also be described. Eligibility for participation and the sampling method used will be explained and defended.

## Research Design

### *Research Problem*

The research has identified a lack of empirical data as it relates to the influence of foster and adoptive parent characteristics on the stability of special needs placements. Child welfare agencies have expressed the need for more accurate ways of identifying parents most capable of successfully maintaining such placements.

## Research Approach

Consistent with the research problem, the current study used a quantitative approach to measuring the combined effect of ten independent variables that may have predictive value in placement stability: (a) maternal and paternal care and overprotection as assessed by the PBI (Parker, 1989; Parker et al., 1979); (b) anxiety/model of self and avoidance/model of other as assessed by the RSQ (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994b); (c) the child's age at the time of placement, and (d) designation of RAD as a special need assessed by a researcher-created demographic questionnaire.

The rationale for using retrospective measures of adult attachment to predict the security of subsequent parent-child bonds is based upon evidence that adult mental representations of their own childhood attachment relationships are a determinant of their children's attachment to them (van IJzendoorn, 1995). These mental representations are believed to influence the degree of parental responsiveness to the child's signals of distress, which consequently direct the child's emotional development and self-construct (Stams, Juffer, van IJzendoorn, & Hoksbergen, 2001; van IJzendoorn, 1995). Lieberman (2003) identified parental care as a factor that benefits the child's emotional well-being. Waterman (2001) similarly noted that primary maternal attentiveness is essential in forging a secure attachment bond. Parker et al. (1979) asserted that the PBI provides a measure of the parent's contribution to either optimal or disturbed parental bonding.

The RSQ similarly proposes a model of adult attachment based upon internal working models. Internal models of self and others can be measures as positive and negative scales with four attachment styles resulting: secure, dismissing, preoccupied, or

fearful attachment (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994b), although the authors warn against using the RSQ categorically. These scales are believed to be associated with two factors: anxiety related to the evaluation of others in close relationships, and the inclination to either avoid or seek closeness with others (Bartholomew & Horowitz, 1991; Kurdek, 2002).

*The Sample*

*The population of interest.* The population of interest for this study was current or former foster and adoptive parents of children with special needs. The population to which these results will be generalized will be considered heterogeneous by age, gender, ethnicity, educational level, socioeconomic level, and religious affiliation.

*Eligibility.* A convenience sample was drawn from the population of licensed or formerly licensed foster or adoptive parents. Participants had to be 25 years or older, able to read English, and respond to written statements, either in a pencil-and-paper or computer format. The participants were of various ages, came from a range of socioeconomic strata, and represented diverse ethnic backgrounds.

*Sample size.* The size of the sample was originally 108 but reduced to 105 to eliminate outliers. The calculator at http://www.danielsoper.com/statcalc/calc01.aspx was used to calculate the necessary sample size (Soper, 2009). For alpha = .05, power = .80, ten proposed predictors, and medium expected effect size $f^2 = .15$ (equivalent to $R^2 = .13$), the required sample size for multiple R is 118. To examine the effect sizes of the individual predictor variables a sample of 268 would be required.

*Instrumentation and Materials*

*Instrument format.* All three questionnaires follow a self-report format. The advantage of using self-report instruments includes the ease with which they are administered, and the assurance of anonymity, which improves the level of honesty in the responses, and their inexpensiveness (Mitchell & Jolley, 2004). For the sample used in this study it was essential that foster and adoptive parents were confident that their answers would not compromise the status of their current or prospective placements. Because it was hoped that this study would provide useful tools for child welfare agencies in screening and matching prospective families and children, using inexpensive, easily administered, and scored self-report instruments was preferred. Finally, because there is no interaction between the researcher and the respondent, researcher bias was minimized.

However, there were several weaknesses in using self-report tools. There was a much lower rate of return which may have added bias to the sample and fail to be representative of the population of interest (Mitchell & Jolley, 2004). To counter this problem the sample was collected through several methods. The questionnaires were available on the internet, distributed through adoptive and foster parent support groups, and through the mail. A second potential drawback of self-report instruments is that they did not provide the researcher the opportunity to correct questions which may be ambiguous or to answer questions that the respondents might have as they complete the forms. Both the PBI and the RSQ have been used widely and refined and normative data is available for the PBI. However, both the PBI and RSQ ask for retrospective information based upon internal working models of attachment. They depend upon

respondents' accurate recall of experiences that originated decades earlier and thus may be subject to imprecision. In addition, because of the nature of the study, and despite assurance of anonymity, respondents may have demonstrated social desirability bias (Mitchell & Jolley, 2004).

*The Relationship Scales Questionnaire.* The RSQ consists of 30 short phrases that were taken from existing measures: the Hazan and Shaver (1987) attachment measure, the Relationship Questionnaire (RQ) (Bartholomew & Horowitz, 1991), and the Adult Attachment Scale (Collins & Read, 1990). Only 25 of the items are used to create the four scales. The remaining items are sometimes used to create subscales to measure dimensions of attachment that have been described by Simpson, Rholes, & Nelligan (1992) and Collins & Read (1990), developers of other self-report attachment measures. .

The Bartholomew and Horowitz (1991) model accounts for the majority of individuals showing evidence of more than one attachment style making it necessary to measure their behaviors, affect and expectations, across four typical attachment patterns (Griffin & Bartholomew, 1994a). Scores for each of the four attachment patterns were derived by computing the means of the four or five items corresponding to each of the prototypes (Bartholomew, n.d.). Combining the two orthogonal dimensions (self and other models with shared underlying dimensions of anxiety and avoidance) is what Griffin and Bartholomew (1994a) contend accounts for the low internal consistencies of the RSQ scales. Correlations between interview prototype ratings (PAI and FAI) and self-report on the RQ and the RSQ indicated good convergent validity, with correlations being higher between the same prototypes among all of the measures (Griffin & Bartholomew, 1994a). The correlations between the interview ratings and the RQ ratings ranged from

.22 (secure scales), .33 (preoccupied), .40 (dismissing), to .50 (fearful); for the interview and RSQ scales the correlations were slightly higher with .25 (secure), .32 (fearful), .34 (preoccupied), and .47 (dismissing) (Griffin & Bartholomew, 1994a). The investigators suggested that the lower correlations for the secure prototype may indicate greater self-report bias for this prototype and that the modest convergent correlations provide evidence that using interview and self-report measures are not one and the same. The correlations between the dimensions (self and other) on the RQ and the RSQ showed evidence of reasonable convergent validity with .58 for the model of self component and .57 for the model of other component.

Backstrom and Holmes (2001) found moderate to high correlation between the four scales on the RQ and RSQ (secure, dismissing, preoccupied, and fearful) ranging from 0.595 to 0.668. They similarly found that the two-factor model provided a better fit for the data with secure and fearful variables loaded on one factor and preoccupied and dismissing on another, as well as reducing the Chi-square value from 749.1 ($df$=20, $p<0.001$) on the one-factor model to 504.7 using the two-factor model (p. 82). With regard to the reliability of the RSQ scales, although the secure and preoccupied scales demonstrated very low reliability with $\alpha= 0.32$ and $\alpha=0.46$ respectively, the fearful and dismissing scales had much higher Chronbach's Alpha coefficients with $\alpha=0.79$ and $\alpha=0.64$ respectively. The reliability of the model of self and others was found to be $\alpha=0.50$ and $\alpha=0.68$ respectively. In addition, Siegert, Ward, and Hudson (1995) found supporting evidence for the two-factor structure of anxiety and avoidance on the RSQ.

Regarding the discriminant validity of the attachment dimensions, when RSQ and RQ scales were correlated with scores on the NEO-PI (Costa & McCrae, 1995) a big-five

personality inventory, the RSQ had higher correlations with the related big-five scales (neuroticism, extroversion, agreeableness, and conscientiousness) than the RQ (Griffin & Bartholomew, 1994a). Similarly Backstrom and Holmes (2001) examined the construct validity of the Swedish translation of the RSQ with the NEO-PI (Costa & McCrae, 1995) and found a pattern matching the findings of Griffin and Bartholomew (1994a) and concluded that the Swedish translation measures fundamentally the same construct as the English version.

The validity of the RSQ was established using multidimensional scaling derived from family, peer, and self ratings taken from interviews, friend-report, and self-report instruments (Bartholomew & Horowitz, 1991). The RSQ was validated using young adults in romantic relationships; it has recently been used to study attachment relationships in couples (Bartholomew & Horowitz, 1991; Kurdek, 2002). Normative data has not been established for the RSQ.

Using a 5-point scale each question is assigned a score of 1 = "not at all like me," 2 = "barely like me," 3 = "somewhat like me," 4 = "mostly like me," and 5 = "very like me." A few of the items are reverse scored. Participants indicate how closely each phrase describes their characteristic style in close relationships. Examples of the phrases from the scales are: "I find it easy to get emotionally close to others" (secure scale); "I find it difficult to depend on other people" (fearful scale); "It is very important to me to feel independent" (dismissive scale); "I worry that I will be hurt if I allow myself to become too close to others" (preoccupied scale). The respondent's score for each of the prototype scales is obtained by calculating the sum of the items associated with each of the prototype scales. There are five phrases for each of the secure and dismissing

prototype patterns and four phrases for each of the preoccupied and fearful prototype patterns. Respondents receive a numeric score on each of the four scales ranging from 1-25 or 1-20 depending upon whether the scale has four or five items (phrases). The scores on the four scales represent four of the independent variables being examined for their ability to predict the dependent variable, placement duration. A copy of the RSQ can be found in Appendix A.

*The Parental Bonding Instrument.* The Parental Bonding Instrument (Parker et al., 1979; Parker, 1989, 1998) is a self-administered 25-item questionnaire designed to assess the respondents' perceptions of mother and father along two dimensions, care and overprotection for the respondents' experiences of the parenting they received during their first 16 years.

Parker and his colleagues (1979) used factor analysis of items generated from clinical practice and the theoretical literature to derive the two dimensions of care and overprotection. The care dimension was found to account for 28% of the total variance and the overprotection factor for 17%. The two dimensions were considered bipolar with the limits of the care dimension extending from "affection, emotional warmth, empathy, and reciprocity to [one of] coldness, indifference, and neglect" (Parker, 1983, p. 112). The care dimension was also conceived of as being a homogeneous factor, as confirmed by split-half reliability and concurrent validity. The overprotection scale was not as obviously homogeneous, however, the dimension was similarly bipolar and spanned "parental control, overprotection, intrusion, and infantilization to parental allowance of independence, and the development of autonomy" (Parker, 1983, p. 112). The overprotection scale was subsequently renamed the *protection* scale (Parker, 1983).

Although the PBI yields interval data, respondents can also be designated as belonging in one of four attachment categories as illustrated in Figure 2: high care and low protection designated as *optimal parenting*, high care and high protection designated as *affectionate constraint,* high protection and low care designated as *affectionless control*, and low care and low protection designated as *neglectful parenting* (Parker et al., 1979). The authors suggested that the intercorrelations between scores on the care and overprotection scales be calculated to determine the independence of the scales. If correlations exist the scores should be corrected in order to partial out the contribution of overprotection made, for example, to the care score, or the contribution of care to the overprotection score. Parker et al. suggested that in studies seeking to discover a relationship between one of the factors (care or overprotection), and another variable, that these independent scores be used.

In their original study Parker et al. (1979) found an inter-item correlation of 0.704. In addition, the initial sample revealed test-retest reliability for the care scale of 0.761 and the overprotection scale of 0.628; the split-half reliability of 0.879 was found for the care scale and 0.739 for the overprotection scale. Using interviews, raters demonstrated inter-rater reliability of 0.851 and 0.688 on the care and overprotection scales respectively; concurrent validity between the raters' assessment and the self-report scales of 0.775 and 0.492 for the care and overprotection dimensions respectively. Following the initial investigation population norms were derived from a representative sample of 500 respondents in Sydney, Australia. A subsequent sample of 132 was collected in Oxford, England, which when compared with original Sydney normative sample showed evidence of significant similarities (Parker, 1983).

The PBI has been the subject of extensive psychometric interest and has been used in a variety of applications with both clinical and non-clinical samples assessing adult parent-child attachment both singly and in combination with other measures. Smith, Lam, Bifulco, and Checkley (2002) examined the construct validity of the PBI finding a correlation between PBI scores and CECA scores. In an Italian study of schizophrenic patients and their parents Favaretto, Torresani, and Zimmerman (2001) found evidence of weak parental bonding and scores on the PBI. Cox, Enns, and Clara (2003) provided confirmation of a three factor model of a revised PBI using a psychiatric sample. Manassas et al. (1999) found support for convergent validity between the AAI and the PBI. Parker et al. (1997) found predictive validity for the PBI with a sample of patients with affective disorders. Wilhelm and Parker (1990) found support for construct validity of the PBI. MacKinnon et al. (1989) confirmed two factor structure of PBI. Parker (1989) found confirmation for the two factor structure of the PBI as well as confirming its predictive validity. Kazarian, Baker, and Helmes (1987) provided support for the PBI two factor model. Heisse et al. (1996) examined the convergent and construct validity of five self-report scales of parental attachment including the PBI. They found that parental care emerged as an unambiguous dimension among five measures they examined. The PBI has demonstrated good psychometric stability (Parker, 1989).

The maternal and paternal care and overprotection scales represent four of the independent variables being examined for their ability to predict the dependent variable, placement duration. The care scale is comprised of 12 items and the overprotection scale 13 items. All of the items use a four point scale with a score of 0 = “very unlike,” 1 = “moderately unlike,” 2 = “moderately like,” and 3 = “very like.” Some of the items are

reverse scored. Examples of items from the care scale are: “Spoke to me in a warm and friendly voice” and “Did not help me as much as I needed.” Examples of items from the overprotection scale are: “Let me do those things I liked doing” and “Did not want me to grow up.” Each respondent receives two care scores (maternal and paternal) and two overprotection scores (maternal and paternal) derived by summing the scores for items associated with each scale. The scores can range from 0-36 on the care scales and 0-39 on the overprotection scales. Parker, Tupling and Brown (1979) also established cut-off points for each scale based upon large sample sizes, but those cut-offs were not used in this study. A copy of the PBI can be found in Appendix B.

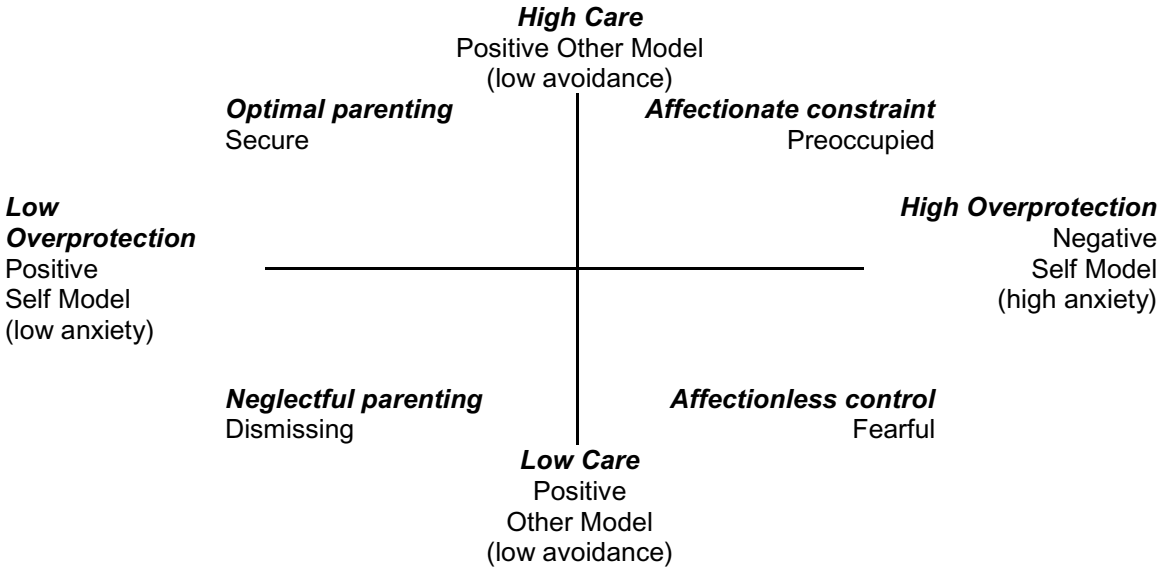


*Figure 3.* The Relationship Scales Questionnaire and the Parental Bonding Instrument (italics) attachment categories (Griffin & Bartholomew, 1994b; Parker et al., 1979).

*The demographic questionnaire.* In addition to completing the PBI and the RSQ, participants completed a demographic form to gather information on a number of variables including age, age of child at the time of placement, length of time the child

was in the home, reasons, the child's RAD status, ethnicity of the parent and the child, and socioeconomic status. RAD status and age at time of placement represent two of the independent variables being examined as possible predictors of placement duration, the dependent variable. The RAD status was scored as a dichotomous variable, either present or absent. Age at time of placement was measured in years, as was placement duration. Both are interval measures. The demographic form consisted of 24 items and a copy appears in Appendix C. Confidentiality was assured to all participants and the results of the PBI and RSQ did not affect the participants' current placements or prospects of future placements.

*Data Collection and Analysis*

*Sampling method.* In an effort to avoid problems of sampling bias and generalizability noted by Barth (2001), O'Brien and Zamostny (2003), and Orme and Buehler (2001) this sample was obtained through various methods. Participation was voluntary. Ads were placed in parenting and foster/adoptive parenting newsletters, a public service announcement was made on the Chicago National Public Radio Station, and various foster/adoptive parent websites agreed to link to the study website. Local state and private child welfare agencies were invited to cooperate in obtaining data from their licensees during their continuing education classes. Agencies have an interest in improving placement stability, and cooperation with this research was expected. The National Adoption Information Clearinghouse (NAIC) maintains lists of foster and adoptive parent support groups by state (NAIC, 2006). Approximately 50 support groups were contacted and invited to participate. Support group were offered reimbursement for

the cost of returning surveys through the mail. The questionnaires will also be available online. The results of the research will be available to study participants.

*Analysis and Potential Confounding Variables*

This study involved ten independent variables: maternal and paternal care and overprotection scores on the PBI, and scores on the RSQ related to secure, dismissive, fearful and preoccupied attachment characteristics, the age of the child at the time of placement, and special need status of RAD. Normative data have been gathered with cut-off scores designating four distinct categories: high care and low overprotection, high care and high overprotection, low care and high overprotection, and low care and low overprotection. Mean RSQ subscales scores using a four-category model of secure, fearful, preoccupied, and dismissing attachment styles were derived. The dependent variable, length of time in placement, is quantitative, and has interval characteristics. The independent variables scores on the PBI and the RSQ are also quantitative and have interval characteristics. RAD status was treated as a continuous or dummy variable.

This research was exploratory in that it tested whether the ten independent variables were able to predict placement duration. The sample size was too small to examine the relative contributions of the individual variables. A multiple regression analysis was used. A small to medium effect size was expected. A sample size analysis was conducted using the G*Power statistical program assuming three possible effect sizes: small ($f^2$=0.02), medium ($f^2$=0.15), and small/medium ($f^2$=0.085) (Erdfelder, Faul, & Buchner, 1996). The statistical power was set at 0.80 meaning that a real effect would be detected 80% of the time (Jaccard & Becker, 2002). The alpha value was set at .05

meaning that 95% of the time the null hypothesis would be correctly rejected. The corresponding sample sizes for the three possible effect sizes were determined to be 602 for a small effect, 85 for a medium, and 146 for a small/medium effect size. With over 17,000 licensed foster homes in the state of Illinois alone, meeting the requirement for even a small effect size was expected to be within reason (N=602).

The sample size was too small to allow for the effects of the variables to be individually examined, that is, the amount of change in the dependent variable brought about by one of the independent variables while controlling for the effects of the other three. The multiple regression analysis only examined the way in which the predictor variables operated together.

Possible confounding variables such as the number of special needs, the child's previous trauma, the number of children in the home, previous biological parenting experience, the age of the parent, socioeconomic status, ethnicity, ethnic match between parent and child, and the number of previous placements the child has experienced were expected. Parents of children diagnosed with severe psychiatric disorders tend to seek resources for their children. Because of this, responses from parents of children with RAD could have been overrepresented in this sample.

Participants completed the instruments either in the paper-and-pencil format or electronically on the Internet. The raw data is available by request from the researcher. A summary of the data appears in Chapter 4.

## Hypothesis

The following research question and hypothesis was examined.

1. Do attachment characteristics of foster and adoptive parents, as assessed by the PBI, and the RSQ, the child's special need of RAD, and the child's age at the time of placement influence placement duration?

   Null hypothesis: PBI and RSQ scores, RAD status, and the child's age at placement do not predict placement duration.

   Research hypothesis: PBI and RSQ scores, RAD status, and the child's age at placement predict placement duration.

## Protection of Participants' Rights

No identifying information is requested on the demographic form, on the PBI or RSQ. Participants who came through the stakeholders' cooperation were assured that their participation was completely voluntary and would not affect their standing with the agency, that is, neither increase nor decrease their chance of licensure as foster parents, or affect the status of their current placements. Participants were advised of a disclaimer of the stakeholdres' responsibility for conducting the research or the findings obtained, thereby protecting the rights of the stakeholders.

Several vulnerable groups may have been included in the sample, but were not targetted in this research: pregnant women, mentally or emotionally disabled individuals, traumatized individuals, economically disadvantaged individuals, clients, or potential clients. It was not be possible to screen individuals belonging to such groups. Pregnant

women, mentally and emotionally disabled, and/or traumatized individuals were advised that participation in the research was not expected to exceed that level of stress which would ordinarily be associated with recalling events or circumstances related to their relationships with parents and other significant others. Economically disadvantaged individuals were not exposed to any events which might further increase their degree of disadvantage. It was not be possible to identify individuals who may have been former clients, or who are current clients of this researcher, unless the researcher was present at the time the information about the research was disseminated, such as at a foster parent support group meeting or a training session. No such instances arose. With regard to future clients, prospective participants were assured that participation in the research neither provided them an advantage nor a disadvantage since their responses were anonymous and were available to the researcher/clinician should a therapeutic relationship ever be initiated.

Only summarized data were used in the analysis. Once the raw data was entered into the statistical program it was stored in triplicate. One copy is kept in the researcher's office stored on an external memory stick, the other is stored in a locked file in the researcher's home, and the data is stored temporarily on the researcher's computer. All data will be kept for a period of at least five years. The hard copies of the responses will be shredded at the completion of this research.

# CHAPTER 4: RESULTS

## Introduction

This study involves ten independent variables: maternal and paternal care and overprotection scores on the PBI; secure, dismissive, fearful and preoccupied scores on the RSQ; age of the child at the time of placement; and RAD status. The dependent variable is the length of placement. A multiple linear regression analysis was selected to determine whether a linear relationship exists between the independent variables and the dependent variable.

The first section of this chapter will include a description of sources from which the data were gathered and a description of the sample. The second section will present the inferential statistical analysis of the data.

Demographic and survey data was gathered from a convenience sample of 108 foster and adoptive parents over the course of one year. The data was collected in either a paper-and-pencil (11%) or an online format. The assent form and instruments were identical in both formats. The paper-and-pencil versions were collected primarily from attendees at a foster and adoptive parent conference that took place in the Chicago, and thru local child welfare agencies (Catholic Charities, Metropolitan Family Services DuPage) which serve foster and adoptive families. Several other agencies, including one in Canada, agreed to help gather data, and were sent both paper-and-pencil forms, as well as flyers to distribute which described the research and the Internet address of the research website. Only one form was returned. At least 50 other organizations around the country were contacted at least once, and in some cases several times, via phone and/or

email, but they did not respond. The low rate of response was attributed to the voluntary nature of the organizations.

Respondents were linked or directed to the research website, www.parentshelp.us, through a variety of means. The website is no longer active. There was an article in the Illinois Department of Children and Family Services January 2008 online and print newsletter briefly describing the research and directing prospective respondents to the research website. Links were also established from numerous other websites frequented by foster and adoptive parents:

1. Attachment.org (http://www.attachment.org/),
2. Attachment and Trauma Network (http://www.radzebra.org/),
3. Focus Adolescent Services (http://www.focusas.com/ ),
4. Wednesday's Child (http://adopt.org/servlet/page?_pageid=289&_dad=portal30&_schema=PORTAL30 ),
5. Adoptive Families Today (http://adoptivefamiliestoday.com/),
6. Hands Around the World (www.handsaroundtheworld.com),
7. Children of Easter European Regions (www.cheerchicago.org),
8. Chicago Area Families for Adoption (www.caffa.org), and
9. Stars of David (http://www.starsofdavid.org/ )

Chicago Public Radio (WBEZ) also aired a 30-second public service announcement several times which described the research and gave the Internet address.

After the data collection was complete it was entered by the researcher into SPSS Graduate Pack 12.0 for Windows (Kinnear & Gray, 2006). Approximately 12% of the data entries were checked by an assistant.

## Description of the Sample

The relationship status of the foster or adoptive parents from this sample in comparison to national statistics is seen in Table 3.

Table 3

*Relationship Status Comparison (USDHHS Adoptive Family Structure,2006 )*

| | Percent in this sample | Percent 2006 USDHHS |
|---|---|---|
| Married | 81.5 | 69 |
| Single | 9.3 | |
| Female | 92.6 | 26 |
| Male | 7.4 | 3 |
| Divorced | 6.5 | |
| Unmarried, but in a committed relationship | 1.9 | 1 |

U.S. Department of Health and Human Services (2006) also provided comparison information on the number of married couples adopting versus single females. Over the years of data collection from 1996-2003 the percentage of married couples to single female adopters was 66.89% versus 29.51% respectively (Hansen, 2006). USDHHS data was not available for divorced adopters.

The sample was composed of 100 females and 8 male respondents and does not match the U.S. population statistics for gender of which 51% is female (U.S. Census Bureau, 2006). The ages of the parents can be seen in Table 4. According to U.S. Census Bureau data (2006) only 40% of the U.S. population falls within the age range of 35-64

years compared to 98% in this sample. No AFCARS data were found for the age of adoptive or foster parents.

Table 4

*Age of Parents*

| Age | Frequency | Percent |
|---|---|---|
| 26-35 | 9 | 8.3 |
| 36-45 | 47 | 43.5 |
| 46-55 | 41 | 43.5 |
| 56-65 | 10 | 9.3 |
| 66 and over | 1 | .9 |
| Total | 108 | 100.0 |

Of the age categories provided, most of the children in this sample were between 5 and 10 years at the time of placement (24.1%), although 62.9% were 5 years old or younger at the time of placement. The children's ages at the time of placement are shown in Table 5. In comparison, the most recent data on the 303,000 children who entered foster care in 2006, 16% were under 1 year, 18% were between 3-5 years, 24% were between 5-10 years, and 35% were over 10 years of age (U.S. Department of Health and Human Services, 2007). Of the children who were awaiting adoption, 25% were under 1 year, 24% were 1-3 years, 14% 4-5 years, 26% were 6-10 years, and 11% were over 10 years of age (U.S. Department of Health and Human Services, 2007).

Table 5

*Placement Age of Child*

| Valid | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| at birth | 3 | 2.8 | 2.8 | 2.8 |
| under 6 months | 15 | 13.9 | 13.9 | 16.7 |
| 6 months - 1 year | 21 | 19.4 | 19.4 | 36.1 |
| 1 year - 3 years | 17 | 15.7 | 15.7 | 51.9 |
| 3 years - 5 years | 12 | 11.1 | 11.1 | 63.0 |
| 5 years - 10 years | 26 | 24.1 | 24.1 | 87.0 |
| over 10 years | 14 | 13.0 | 13.0 | 100.0 |
| Total | 108 | 100.0 | 100.0 | |

Respondents were provided with an option of five specific ethnic categories or the option of indicating *other.* According to U.S. population statistics only 80% of the population is white, whereas the sample was 97% Caucasian (U.S. Census Bureau, 2006). The sample was not representative of the U.S. population which is 13% black or African American and only 4% Asian, and 2% biracial (U.S. Census Bureau, 2006). The ethnicity of the foster or adoptive children that they parented was more diverse as seen in Table 6. Population statistics for children who entered foster care in 2006 indicated that 45% were Caucasian, 26% Black, 19% Hispanic, 1% Asian, 4% biracial, and the remaining 5% were Native American or unknown (U.S. Department of Health and Human Services, 2007). Similarly, population statistics for children who were awaiting adoption indicated that 38% were Caucasian, 32% Black, 20% Hispanic, 1% Asian, 4% biracial, and the remaining 5% were Native American or unknown (U.S. Department of Health and Human Services, 2007).

Table 6

*Child's Ethnicity*

| Valid | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| African American | 14 | 13.0 | 13.0 | 13.0 |
| Asian American | 11 | 10.2 | 10.2 | 23.1 |
| Caucasian | 55 | 50.9 | 50.9 | 74.1 |
| Hispanic | 11 | 10.2 | 10.2 | 84.3 |
| Biracial | 10 | 9.3 | 9.3 | 93.5 |
| Other | 7 | 6.5 | 6.5 | 100.0 |
| Total | 108 | 100.0 | 100.0 | |

At the time of placement, 68.5% of the parents had indicated an intention to adopt the child placed with them, 13.9% were only interested in providing foster care, and 17.6% were uncertain, but open to the possibility of adoption. Children had lived in the home from less than 6 months to 24 years, with an average placement length of 7.2 years. At the time the data was gathered 85.2% of the children were still living in the home, 4.6% were living in a different placement, and 10.2% were living as independent adults. Of all of the children who had been placed, 85.2% had been adopted, another 3.7% were planning to be adopted, and 11.1% were not adopted. In this sample, 13% were still in foster care, and 76.9% of the adoptions had remained intact.

Of those parents who had adopted 36.1% had adopted one child. 31.5% had adopted two children, 10.2% had adopted three children, and 8.3 had adopted four or more children.

Table 7 provides information about the types of adoptions with most of the adoptions having been foster conversions or international placements.

Table 7

*Adoption Type*

| | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Child was a relative | 3 | 2.8 | 2.8 | 2.8 |
| Foster—adopt conversion | 33 | 30.6 | 30.6 | 33.3 |
| Domestic—state agency | 11 | 10.2 | 10.2 | 43.5 |
| Domestic—private agency | 12 | 11.1 | 11.1 | 54.6 |
| Identified by birth parents | 2 | 1.9 | 1.9 | 56.5 |
| International | 32 | 29.6 | 29.6 | 86.1 |
| Other (private arrangement) | 4 | 3.7 | 3.7 | 89.8 |
| Not applicable (not adopted only foster care) | 11 | 10.2 | 10.2 | 100.0 |
| Total | 108 | 100.0 | 100.0 | |

With regard to whether the child was diagnosed with Reactive Attachment Disorder (APA, 2002), 41.7% had been diagnosed, and 8.3% had not been formally diagnosed, but their parents believed them to have RAD. Whether the child was formally diagnosed or suspected by parents to have RAD the child was considered in the RAD category for the purpose of this analysis. The sample included children with a wide range of special needs besides RAD. The distribution of those needs by category is shown in Table 8 with 73.1% of the children having multiple complex needs which might be a combination of developmental/physical disabilities, emotional/psychological disabilities, being a member of a sibling group, being older, having had multiple placements, prenatal drug exposure, institutionalization during infancy or childhood. Only 8% of the respondents reported a single category of special need, such as being a member of an ethnic minority group, prenatal exposure to a substance, or multiple placements.

Table 8

*Type of Special Need*

| Valid | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| Developmental/physical disability | 10 | 9.3 | 9.3 | 9.3 |
| Emotional/psychological disability | 3 | 2.8 | 2.8 | 12.0 |
| Member of a sibling group | 1 | .9 | .9 | 13.0 |
| Member of ethnic minority | 3 | 2.8 | 2.8 | 15.7 |
| Older than 5 years | 3 | 2.8 | 2.8 | 18.5 |
| Two or more previous placements | 2 | 1.9 | 1.9 | 20.4 |
| Prenatal exposure to drugs or alcohol | 3 | 2.8 | 2.8 | 23.1 |
| Institutionalized during infancy or childhood | 3 | 2.8 | 2.8 | 25.9 |
| Other | 1 | .9 | .9 | 26.9 |
| Multiple complex special needs | 79 | 73.1 | | |
| Reactive Attachment Disorder suspected | (9) | (8.3) | | 100.0 |
| Reactive Attachment Disorder diagnosed | (45) | (41.7) | | |
| Total | 108 | 100.0 | 100.0 | |

Questions regarding family income and participation in religious activities were asked as an additional way to assess the match between the sample and the population. The family income is shown in Table 9, although 44.4% chose not to respond to that question.

Table 9

*Family Income*

| Valid | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| $10,000-24,999 | 5 | 4.6 | 4.6 | 4.6 |
| $25,000-39,999 | 2 | 1.9 | 1.9 | 6.5 |
| $40,000-54,999 | 31 | 28.7 | 28.7 | 35.2 |
| $55,000-69,999 | 3 | 2.8 | 2.8 | 38.0 |
| above $70,000 | 19 | 17.6 | 17.6 | 55.6 |
| data missing | 48 | 44.4 | 44.4 | 100.0 |
| Total | 108 | 100.0 | 55.6 | |

The majority of respondents indicated that they either very active or inactive in religious or spiritual activities as shown in Table 10.

Table 10

*Participation in Religious Activity*

| Valid | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|
| very active 1-2x/week | 52 | 48.1 | 48.1 | 48.1 |
| moderately active 3-4x/month | 13 | 12.0 | 12.0 | 60.2 |
| moderately inactive 1-2x/month | 16 | 14.8 | 14.8 | 75.0 |
| Inactive 0-2x/year | 27 | 25.0 | 25.0 | 100.0 |
| Total | 108 | 100.0 | 100.0 | |

## Analysis of the Data

There are several assumptions that must be met in order to test hypotheses using the multiple linear regression model (Norusis, 2003). First, there must be two or more interval, ratio, or dichotomous independent variables and a dependent variable which is either an interval or ratio measure. Second, the data must satisfy the requirements for collinearity, multicollinearity, independence, linearity, normality, and homoscedacicity. Finally, the data must be examined for outliers which may exert undue influence over the regression line.

### *Collinearity*

Simple collinearity was assessed using SPSS with the resulting evidence of significant correlations among all of the RSQ scales but particularly among RSQFearful, RSQDismiss, and RSQPreocc as seen in Table 11. Berry and Feldman (1985) note that the multicollinearity is usually assessed by examining the bivariate correlations among all pairs of the independent variables and typically using a predetermined cutoff depending upon whether the purpose of the regression is for prediction or explanation, with a typical

cutoff point of .80. The correlations among the three RSQ variables all exceed .73 and these are eliminated from the final analysis. This more stringent cutoff point was selected due to the additional presence of multicollinearity among the three RSQ variables.

Table 11

*Collinearity*

| Variables | Correlations |
|---|---|
| Placement Age/Placement Duration | .475 |
| Placement Age/RAD | .275 |
| Placement Duration/RAD | .351 |
| RAD /RSQ Fear | .358 |
| RAD /RSQ Dismissive | .269 |
| RAD /RSQ Preoccupied | .261 |
| RSQ Fear/RSQ Dismissive | .797 |
| RSQ Fear/RSQ Secure | .497 |
| RSQ Fear/RSQ Preoccupied | .736 |
| RSQ Fear/PBI Maternal Care | .335 |
| RSQ Fear/PBI Maternal Overprotection | .272 |
| RSQ Dismissive/RSQ Secure | .473 |
| RSQ Dismissive/RSQ Preoccupied | .740 |
| RSQ Secure/RSQ Preoccupied | .734 |
| PBI Maternal Care/PBI Paternal Care | .343 |
| PBI Maternal Overprotection/PBI Paternal Overprotection | .383 |

*Multicollinearity*

Violations may be overlooked by examining the simple correlation matrix, and so diagnostics for multicollinearity were run with attention to the variance inflation factor (VIF) and tolerances. These can be seen in Table 12. The tolerance statistic is that portion of the variance of the independent variable that cannot be accounted for by the other independent variables (Kinnear & Gray, 2006). The lower the tolerance the less that variable contributes to the accuracy of the model to predict the outcome of the dependent variable (Kinnear & Gray, 2006). Tolerances that approach 1 indicate that the variable is not linearly related to the other independent variables and tolerances close to 0 indicate a

strong relationship among that variable and other variables (Norusis, 2005, p. 273). The reciprocal of the tolerance is the variable inflation factor and it is a measure of the increase in variances accounted for by the correlations among the independent variables (Norusis, 2005, p. 273). The presence of multicollinearity indicates that several variables are providing redundant information; their strong relationship to one another may shroud the presence of a linear relationship between the independent variables and the dependent variable. There is no definite cutoff point for determining the presence of multicollinearity in a set of data although some suggest that VIF values exceeding 10 are good indicators for concern, with values above 2.5 as being highly conservative (Braumstein, 2007;University of Kentucky Computing Center). This researcher adopted a conservative approach and elected to establish 3.0 as the cutoff point for the VIF values. This approach resulted in three of the independent variable subscales for the RSQ being removed: RSQFearful, RSQDismiss, and RSQPreocc.

Table 12

*Multicollinearity*

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Significance | Collinearity Statistics | |
|---|---|---|---|---|---|---|---|---|
| | | B | Standard Error | Beta | | | Tolerance | Variance Inflation Factor |
| 1 | (Constant) | 14.065 | 3.046 | | 4.617 | .000 | | |
| | Placement Age | -1.250 | .297 | -.382 | -4.214 | .000 | .875 | 1.143 |
| | Reactive Attachment Disorder | -2.657 | 1.105 | -.232 | -2.405 | .018 | .772 | 1.295 |
| | Relationship Scales Questionnaire Fearful Sum | -.087 | .195 | -.077 | -.447 | .656 | .245 | 4.087 |
| | Relationship Scales Questionnaire Dismiss Sum | .076 | .178 | .067 | .428 | .670 | .290 | 3.447 |
| | Relationship Scales Questionnaire Secure Sum | .172 | .176 | .134 | .977 | .331 | .383 | 2.609 |
| | Relationship Scales Questionnaire Preoccupied Sum | -.193 | .242 | -.147 | -.796 | .428 | .210 | 4.760 |
| | Parental Bonding Instrument Maternal Care Sum | -.067 | .051 | -.132 | -1.316 | .191 | .719 | 1.391 |
| | Parental Bonding Instrument Maternal Overprotection Sum | .001 | .060 | .001 | .012 | .990 | .720 | 1.388 |
| | Parental Bonding Instrument Paternal Care Sum | -.005 | .043 | -.010 | -.104 | .917 | .715 | 1.398 |
| | Parental Bonding Instrument Paternal Overprotection Sum | .035 | .045 | .085 | .781 | .437 | .613 | 1.631 |

Table 13 shows the collinearity statistics with those three variables removed and an increase in tolerance statistics and decreased VIF values for all of the remaining variables. Only PlaceAge and RAD remain significant, although the significance level of the RAD does improve in the new model**.**

Table 13

*Collinearity with Mulitcollinear Variables Removed*

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Significance | Collinearity Statistics | |
|---|---|---|---|---|---|---|---|---|
| | | B | Standard Error | Beta | | | Tolerance | Variance Inflation Factor |
| 1 | (Constant) | 15.222 | 2.573 | | 5.917 | .000 | | |
| | Placement Age | -1.274 | .292 | -.390 | -4.364 | .000 | .889 | 1.125 |
| | Reactive Attachment Disorder | -3.017 | 1.039 | -.264 | -2.904 | .005 | .859 | 1.164 |
| | Relationship Scales Questionnaire | .029 | .111 | .022 | .258 | .797 | .940 | 1.064 |
| | Secure Sum | | | | | | | |
| | Parental Bonding Instrument Maternal Care Sum | -.057 | .048 | -.111 | -1.189 | .237 | .808 | 1.237 |
| | Parental Bonding Instrument Maternal Overprotection Sum | -.007 | .057 | -.012 | -.125 | .901 | .795 | 1.258 |
| | Parental Bonding Instrument Paternal Care Sum | -.011 | .043 | -.026 | -.260 | .796 | .733 | 1.364 |
| | Parental Bonding Instrument Paternal Overprotection Sum | .023 | .042 | .057 | .551 | .583 | .672 | 1.489 |

*Normality*

The assumption of normality was evaluated by examining the histograms of each of the variables as shown below. All of the variables appear to violate the assumption of normality to some degree, but fortunately, multiple regression is not overly affected by violations of this assumption (Norusis, 2005). The histograms for all of the variables are seen below except for RADRecode because it was made into a continuous or dummy variable.

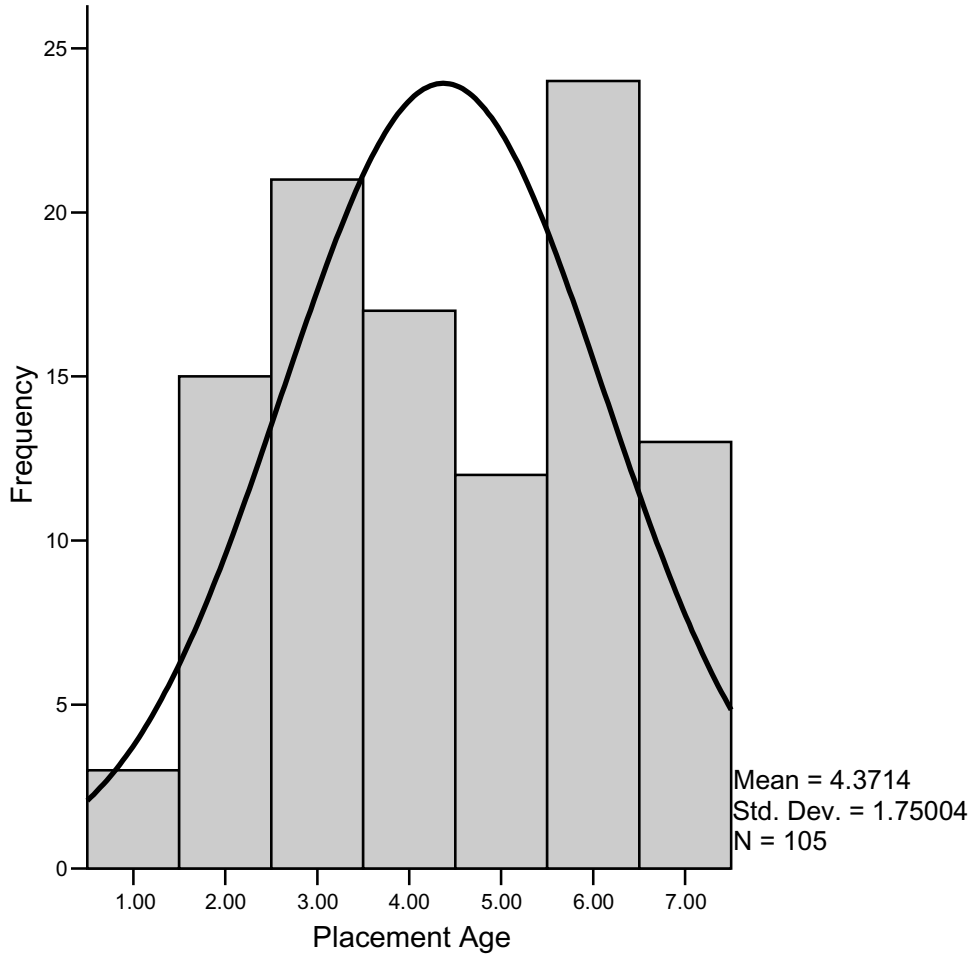


*Figure 4.* Normality Histogram for Age at Time of Placement

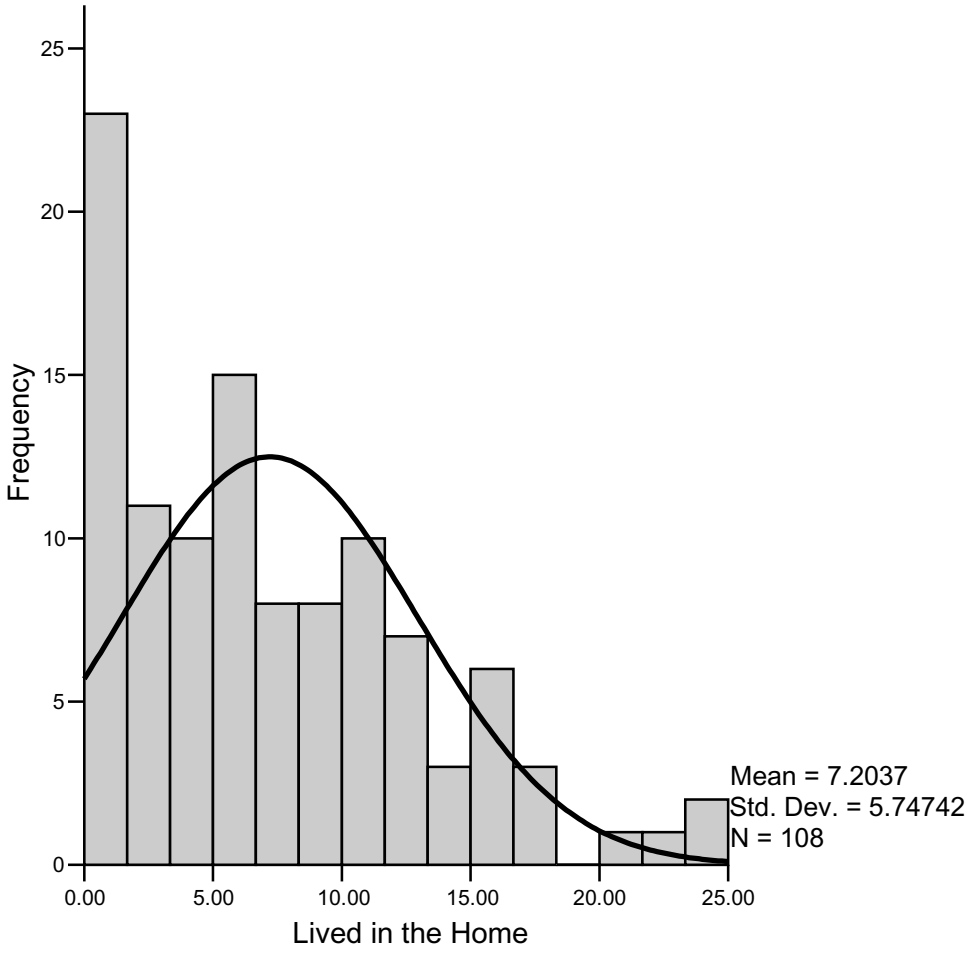


*Figure 5.* Normality Histogram for Placement Duration

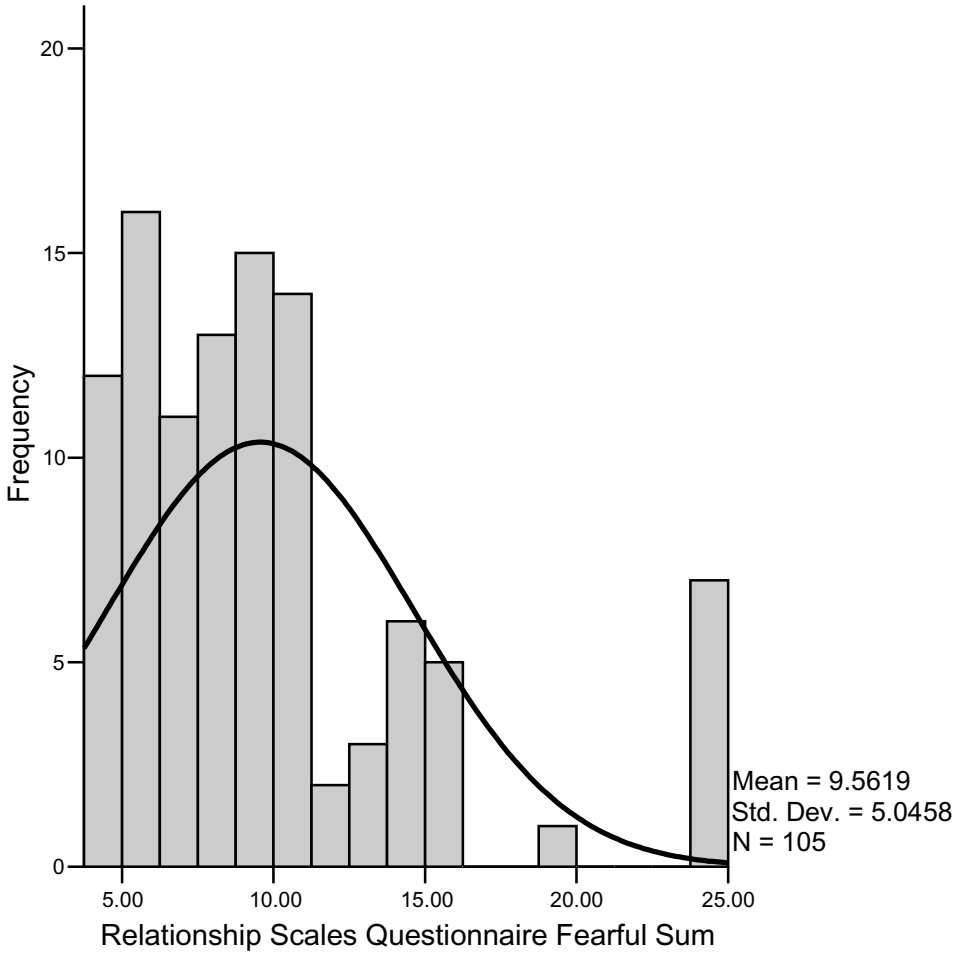


*Figure 6.* Normality Histogram for Relationship Scales Questionnaire Fearful Score

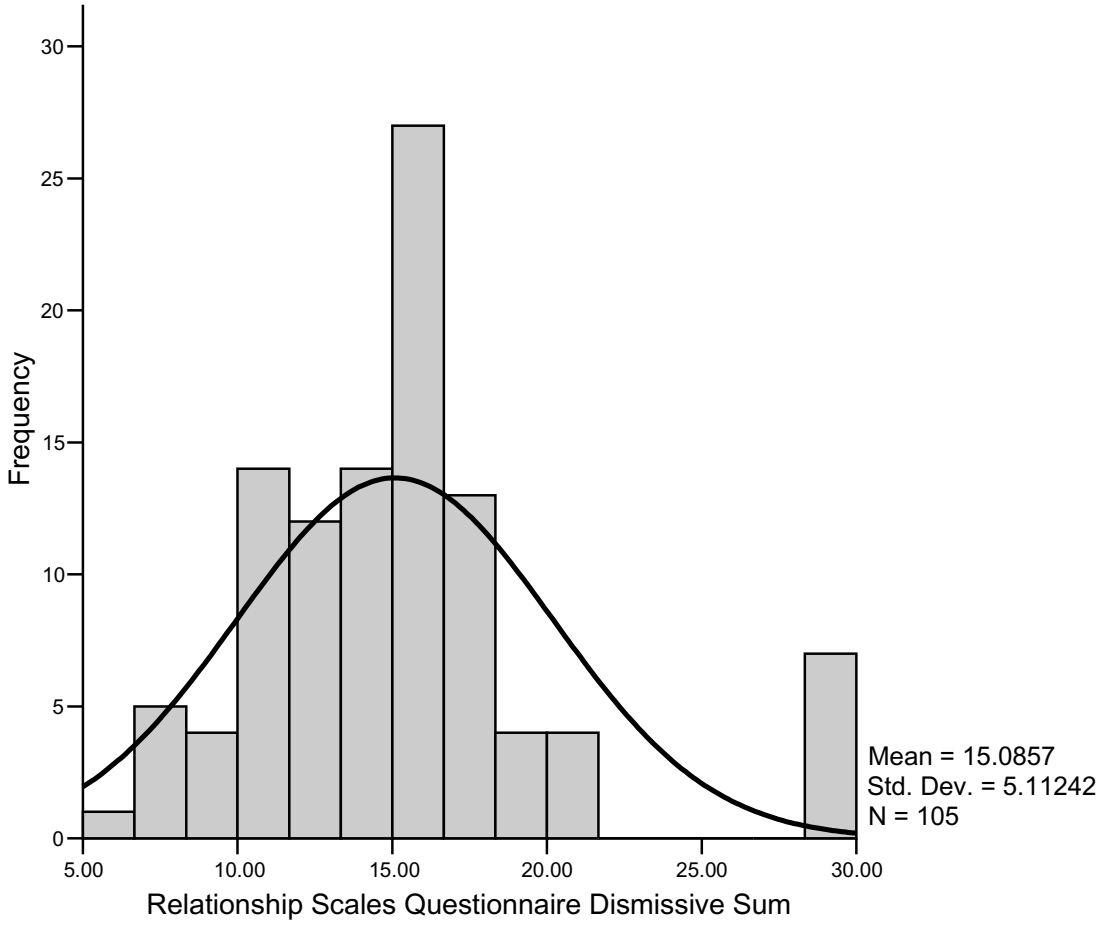


*Figure 7.* Normality Histogram for Relationship Scales Questionnaire Dismissive Score

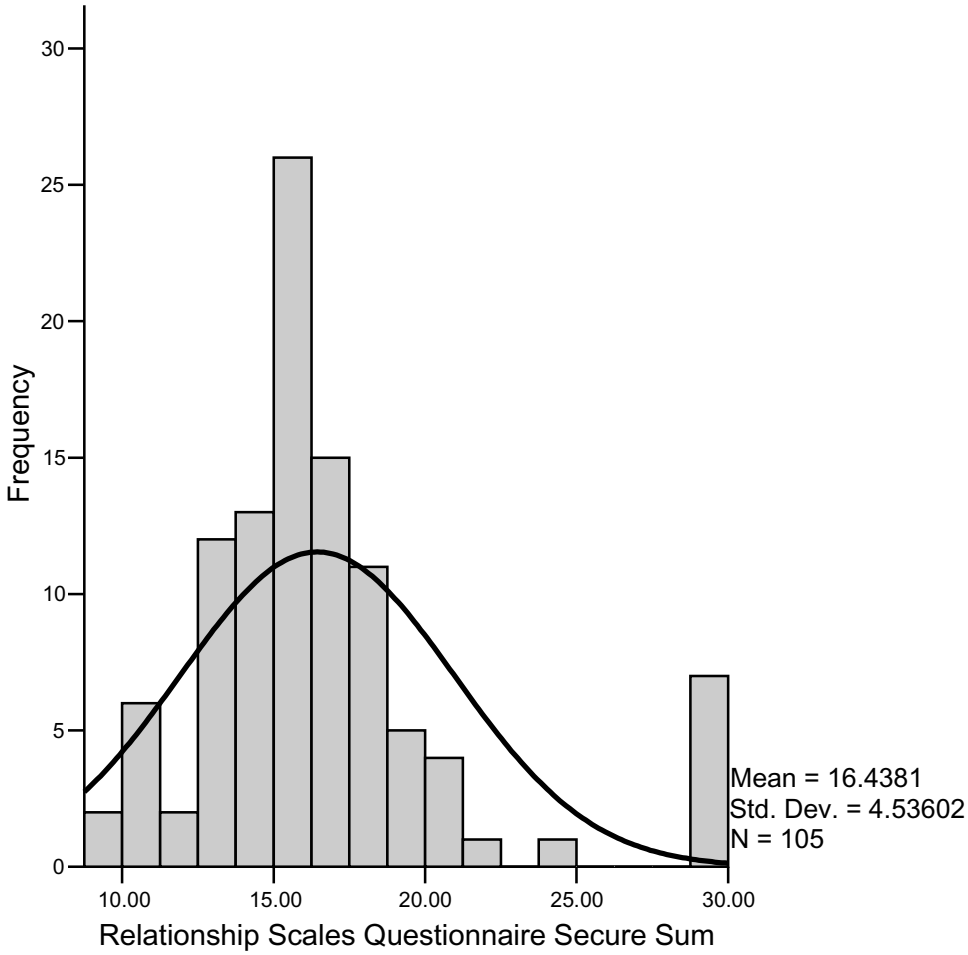


*Figure 8.* Normality Histogram for Relationship Scales Questionnaire Secure Score

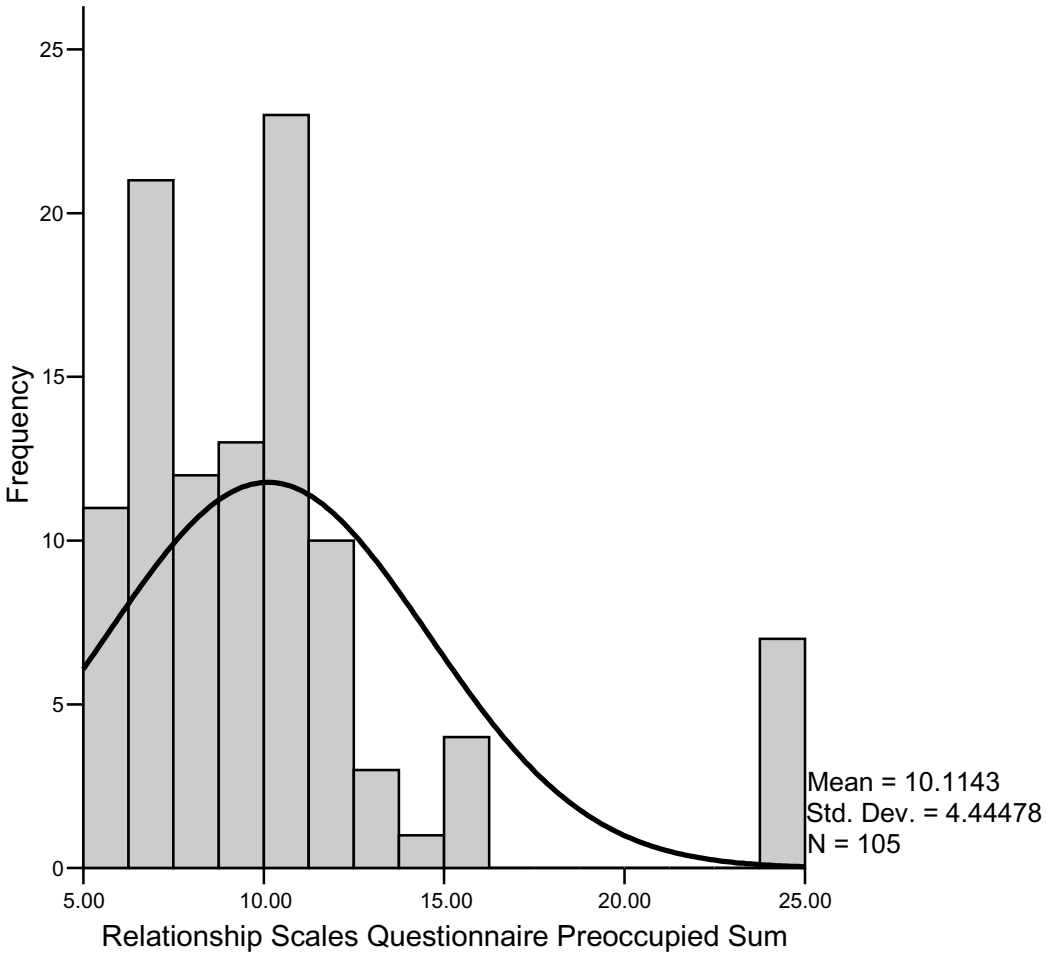


*Figure 9.* Normality Histogram for Relationship Scales Questionnaire Preoccupied Score

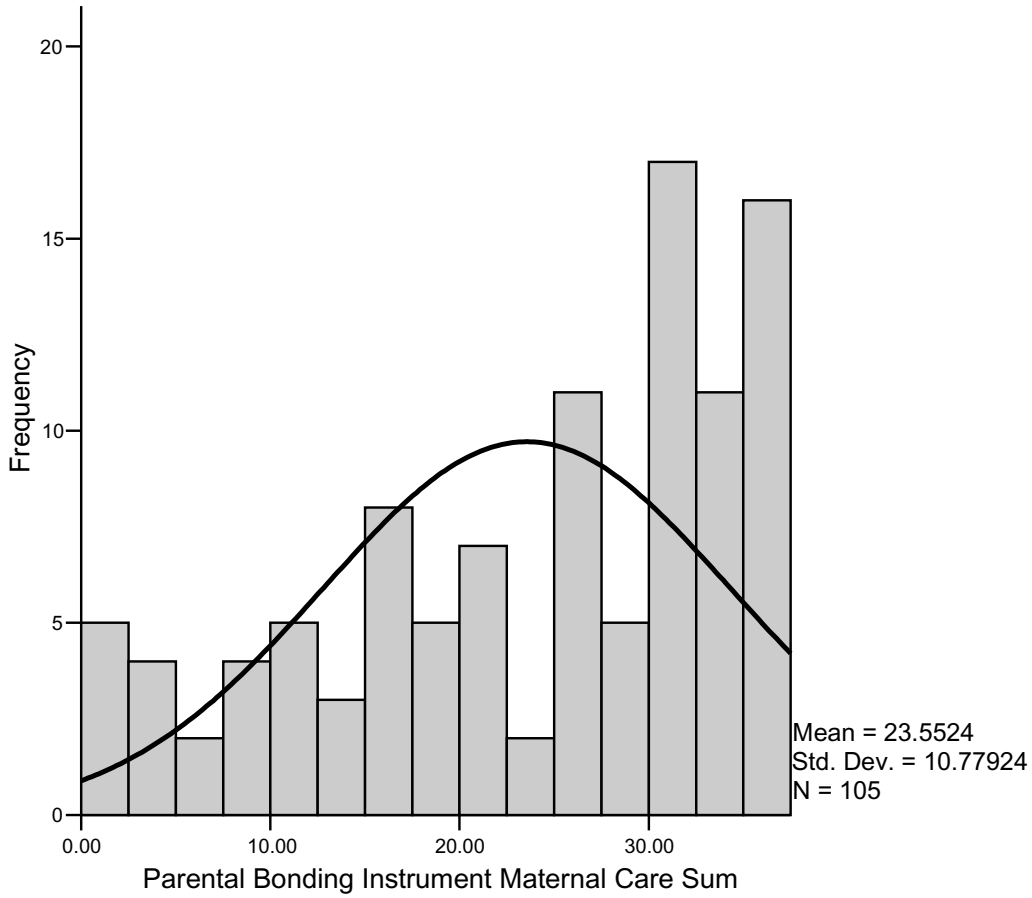


*Figure 10.* Normality Histogram for Parental Bonding Instrument Maternal Care Score

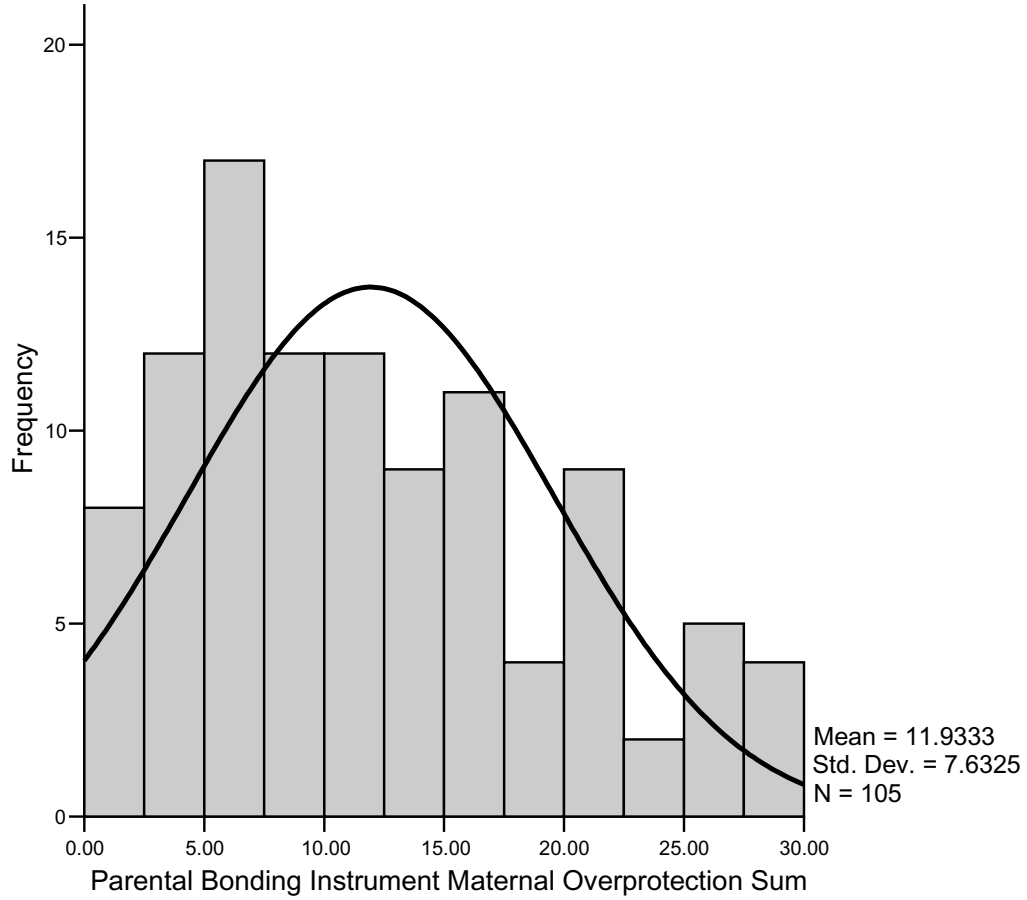


*Figure 11.* Normality Histogram for Parental Bonding Instrument Maternal Overprotection Score

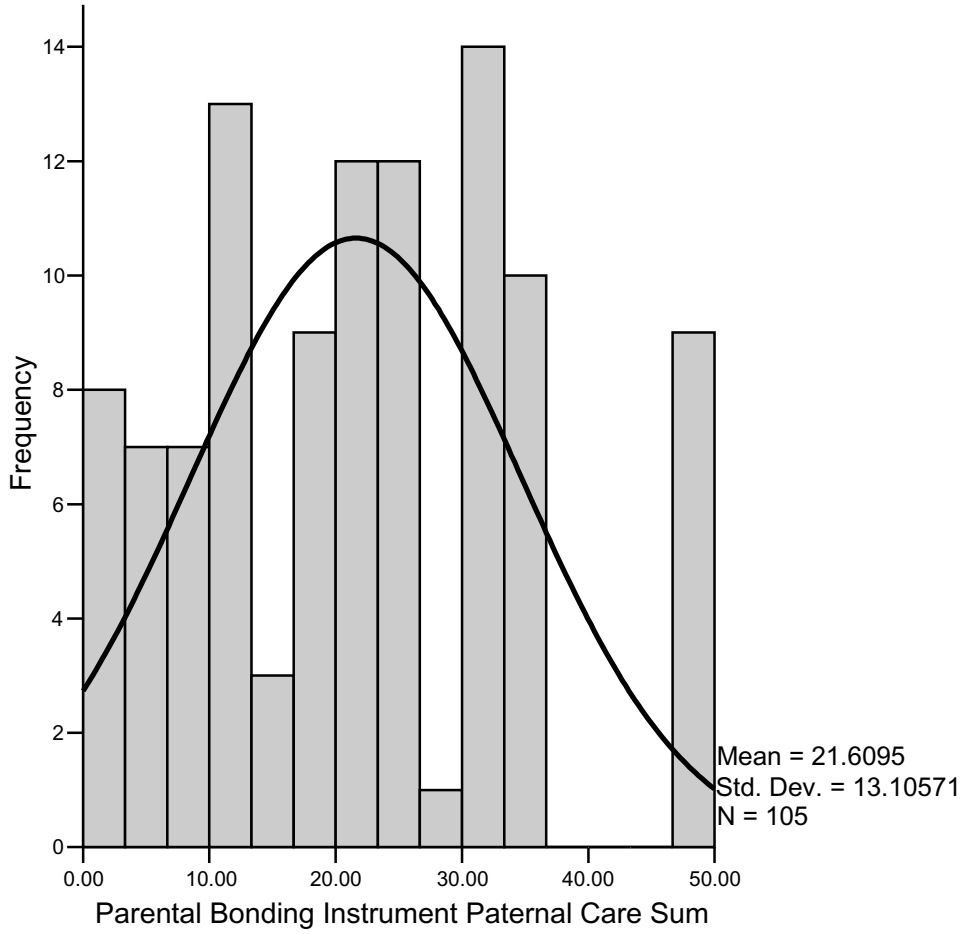


*Figure 12.* Normality Histogram for Parental Bonding Instrument Paternal Care Score

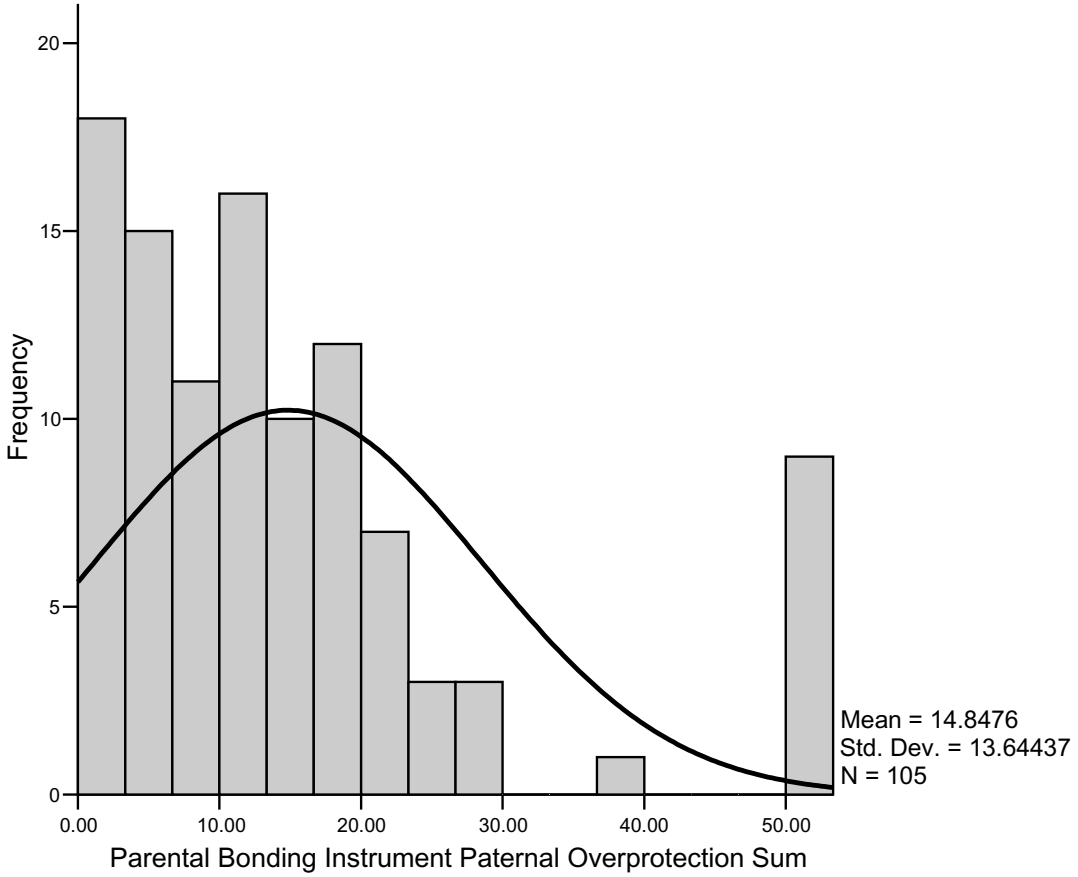


*Figure 13.* Normality Histogram for Parental Bonding Instrument Paternal Overprotection Score

*Linearity*

The assumption of linearity was evaluated examining the P-P Plot of the regression standardized residuals against the predicted values of the dependent variable as well as each of the independent variables. The Normal P-P Plot is shown in Figure 14 and the regression standardized predicted values are shown plotted against the regression standardized residuals in Figure 15. The horizontal band of residuals suggests that the assumption of linearity is met. Similar findings were evident for each of the other independent variables. Figure 16 shows the detrended normal P-P plot of the standardized residuals.

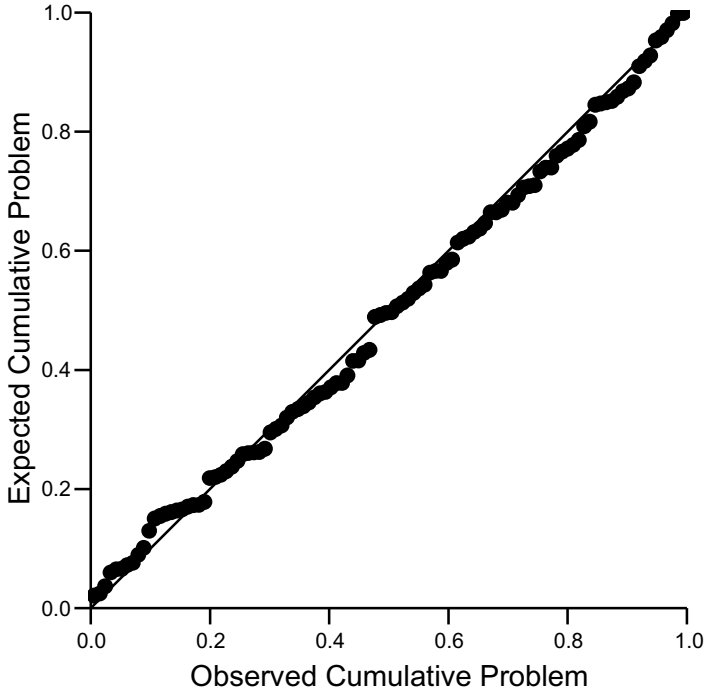


*Figure 14.* Normal P-P Plot of Regression Standardized Residual. Dependent Variable: Placement Duration.

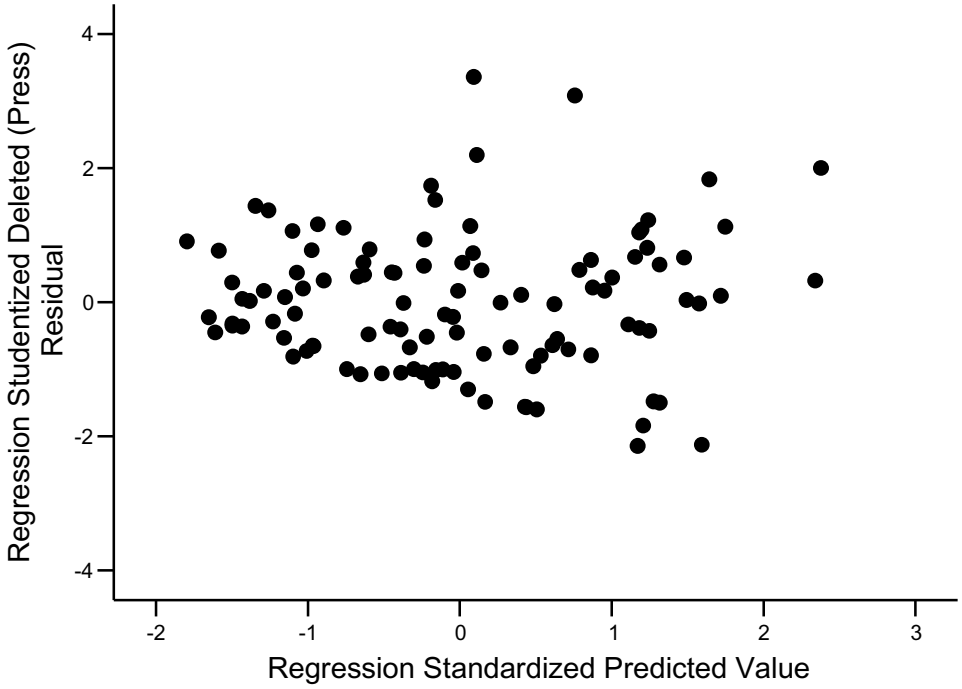


*Figure 15.* Dependent Variable: Placement Duration

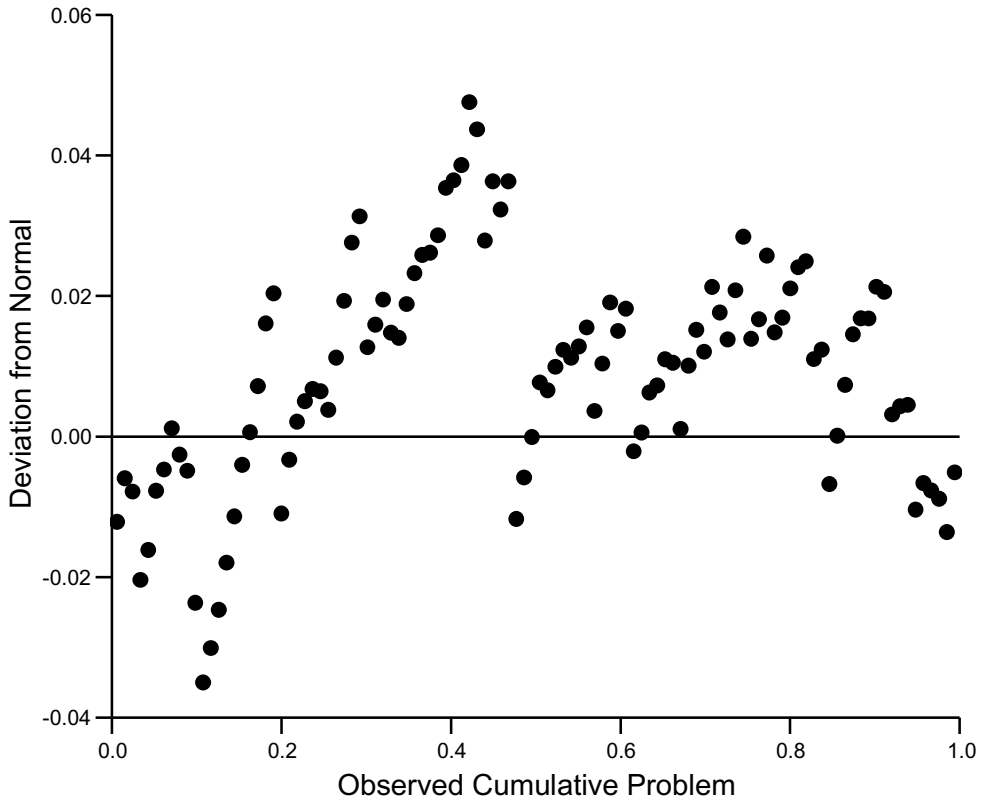


*Figure 16.* Detrended Normal P-P Plot of Standardized Residual.

*Homoscedacicity or Equality of Variance*

The next assumption tested was homoscedacicity, or equality of equal variance. This was done by examining the ratio of the standard deviations to the predicted values. If the ratio is greater than 3 there is evidence of inequality of variances (Ender, 2006). In this data the ratio is less than three. This is shown in Table 14.

Table 14

*Residuals Statistics*[a]

| | Minimum | Maximum | Mean | Standard Deviation | N |
|---|---|---|---|---|---|
| Predicted Value | 1.6968 | 14.6744 | 7.3238 | 3.08086 | 105 |
| Residual | -9.63539 | 15.81176 | .00000 | 4.87227 | 105 |
| Standard Predicted Value | -1.826 | 2.386 | .000 | 1.000 | 105 |
| Standard Residual | -1.910 | 3.134 | .000 | .966 | 105 |

[a] *Dependent Variable: Placement Duration*

However, another approach for examining equality of variances is to look at whether the residuals increase, or are more spread out as a function of the predicted value (Nau, 2005). Figure 15 above does show evidence that the residuals vary more as a function of the predicted scores. Homoscedacicity can also be affected by violations of linearity or independence (Nau, 2005); the assumptions of independence and linearity have been met.

*Independence*

To determine if the order in which the data were collected violated the assumption of independence, the Durbin-Watson statistic, a correlation of adjacent residuals, was calculated with the following results, shown in Table 15. The Durbin-Watson statistic ranges from 0-4; when the residuals are not correlated the Durbin-Watson statistic is close to 2 (Norusis, 2006). The results indicate that the residuals have met the assumption of independence.

Table 15

*Model Summary*[a]

| Model | R | R Square | Adjusted R Square | Standard Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .534[b] | .286 | .234 | 5.04501 | 2.125 |

[a] *Dependent Variable: Placement Duration*

[b] *Predictors: (Constant), Parental Bonding Instrument Paternal Overprotection Sum, Placement Age, Parental Bonding Instrument Maternal Care Sum, Relationship Scales Questionnaire Secure Sum, Reactive Attachment Disorder Recode, Parental Bonding Instrument Paternal Care Sum, Parental Bonding Instrument Maternal Overprotection Sum*

*Outliers*

The presence of outliers may increase the residual variance and thereby make it less likely to reject the null hypothesis. Outliers may result from coding errors, from the data not coming from the same population, or the data coming from non-normal populations (Jaccard & Becker, 2005). Coding accuracy was re-checked. Next, using SPSS, Mahalanobis distances were examined using df=4 and alpha=.001 which indicated a chi-square critical value of 18.47. The data from three participants, data sets 26, 41, and 74 exceeded the critical value and were excluded from the final analysis. As an additional check for outliers which may be exerting high leverage or influence on the regression line Cook's Distance was also examined and the same three data sets were revealed. The removal of the three sets of data decreased the sample size from 108 to 105.

## Research Question

Chapter 3 described a single research question: How do parent scores on the PBI and RSQ, the child's age at the time of placement, and whether the child has a diagnosis of RAD affect the length of time the child resides in the foster or adoptive home? The null hypothesis is: Scores on the PBI and RSQ, the child's age at the time of placement,

and the child's diagnosis of RAD do not affect the length of time the child resides in the foster or adoptive home.

A multiple linear regression analysis is used to create a model of the relationship between the predictor variables and a single dependent variable (Norusis, 2003). Multiple regression analysis is able to answer questions regarding whether independent variables can predict certain values of the dependent variable, whether and which independent variables have a linear relationship to the dependent variable, and whether there are certain combinations of the independent variables that are more useful in predicting the dependent variable (Norusis, 2003). However, this sample size was insufficient to examine whether there were interactions among the individual variables. It should be noted that the independent variable of RAD status was coded as a two-category variable. Also, a preliminary check for the reliability of the PBI and RSQ scales was first conducted. The results shown as Cronbach's Alpha are seen in Tables 16 and 17 indicating that the instruments have acceptable reliability.

Table 16

*Reliability Statistics for Parental Bonding Instrument Scales*

| PBI | Cronbach's Alpha |
|---|---|
| Maternal Care | .959 |
| Maternal Overprotection | .879 |
| Paternal Care | .974 |
| Paternal Overprotection | .963 |

Table 17

*Reliability Statistics for Relationship Scales Questionnaire Scales*

| RSQ | Cronbach's Alpha |
|---|---|
| Fearful | .921 |
| Dismissive | .832 |
| Secure | .736 |
| Preoccupied | .787 |

## Results of Multiple Regression Analysis

There were no missing data cases in the sample. The overall model did significantly predict the placement length for children in foster or adoptive homes, $F(7, 97) = 5.54$, $p < .01$. The $R^2$ value was .286 which indicates that approximately 29% of the variability in the length of time a child resides in a foster or adoptive home can be accounted for by this model. The adjusted $R^2$ was .234. Effects size values of .02, .13, and .26 are considered small, medium, and large effects, respectively according to Cohen and Cohen (1983). These results indicate a large effect. Both the child's age at the time of placement and the child's RAD status contributed significantly to the prediction model. The overall model significantly predicted child placement duration in foster or adoptive homes. RAD status (beta = -.27, $p < .01$) and the child's age at the time of placement (beta = -.37, $p < .01$) contributed significantly to the prediction model. Adjusted R square provides a more conservative estimate of the fit between the model and the population. The standard error of the estimate provides the standard deviation of the residuals (the difference between the observed and the predicted scores). In a good regression model there should be a significant difference between the standard error of the estimate and the standard deviation of the dependent variable, with the standard error of the estimate being

smaller. In this model the standard deviation of the dependent variable is 5.76 and the standard error of the estimate is 5.045. Without the information provided by the model, the best estimate of the length of placement would be the mean or 7.32 years with a standard deviation of 5.76 years.

The regression analysis summary is seen in Table 18 and the descriptive statistics are shown in Table 19.

Table 18

*Model Summary*

| Model | R | R Square | Adjusted R Square | Standard Error of the Estimate | Durbin-Watson |
|---|---|---|---|---|---|
| 1 | .534[a] | .286 | .234 | 5.045 | 2.125 |

[a] *Predictors: (Constant), Parental Bonding Instrument Paternal Overprotection Sum, Placement Age, Parental Bonding Instrument Maternal Care Sum, Relationship Scales Questionnaire Secure Sum, Reactive Attachment Disorder Recode, Parental Bonding Instrument Paternal Care Sum, Parental Bonding Instrument Maternal Overprotection Sum*

Table 19

*Descriptive Statistics for Regression Analysis*

| | Mean | Standard Deviation | N |
|---|---|---|---|
| Placement Duration | 7.323 | 5.764 | 105 |
| Placement Age | 4.371 | 1.750 | 105 |
| Relationship Scales Questionnaire Secure Sum | 16.438 | 4.536 | 105 |
| Parental Bonding Instrument Maternal Care Sum | 23.552 | 10.779 | 105 |
| Parental Bonding Instrument Maternal Overprotection Sum | 11.933 | 7.632 | 105 |
| Parental Bonding Instrument Paternal Care Sum | 21.609 | 13.105 | 105 |
| Parental Bonding Instrument Paternal Overprotection Sum | 14.847 | 13.644 | 105 |
| Reactive Attachment Disorder Recode | .5048 | .502 | 105 |

Table 20

*Correlations*

| | | Placement Duration | Placement Age | Reactive Attachment Disorder Recode | Relationship Scales Questionnaire Secure Sum | Parental Bonding Instrument Maternal Care Sum | Parental Bonding Instrument Maternal Overprotection Sum | Parental Bonding Instrument Paternal Care Sum | Parental Bonding Instrument Paternal Overprotection Sum |
|---|---|---|---|---|---|---|---|---|---|
| Pearson Correlation | Placement Duration | 1.000 | -.462 | -.361 | -.018* | -.108 | .099 | -.012* | .052 |
| | Placement Age | -.462 | 1.000 | .288 | .031* | .104 | -.084 | -.003** | .032* |
| | Reactive Attachment Disorder Recode | -.361 | .288 | 1.000 | .121 | -.144 | .074 | -.034* | -.048* |
| | Relationship Scales Questionnaire Secure Sum | -.018* | .031* | .121 | 1.000 | -.112 | .176 | -.065 | -.138 |
| | Parental Bonding Instrument Maternal Care Sum | -.108 | .104 | -.144 | -.112 | 1.000 | -.326 | .362 | .041* |
| | Parental Bonding Instrument Maternal Overprotection Sum | .099 | -.084 | .074 | .176 | -.326 | 1.000 | -.083 | .385 |
| | Parental Bonding Instrument Paternal Care Sum | -.012* | -.003** | -.034* | -.065 | .362 | -.083 | 1.000 | .386 |
| | Parental Bonding Instrument Paternal Overprotection Sum | .052 | .032* | -.048* | -.138 | .041* | .385 | .386 | 1.000 |
| Significance (i-tail) | | | | | | | | | |

Significance *indicates < .05, **indicates < .01.

Table 21 shows the beta weights from which the regression equation is derived. Only age at time of placement and RAD status have significance levels below 0.05, as seen in Table 21. A stepwise analysis of variance indicated the same. Therefore, using only the significant independent variables, placement age, and RAD status (Norusis, 2003): predicted placement length = 14.549 - (1.228 x placement age) – (3.097 x RAD

status). So, for example, a child placed at age 7 years with a diagnosis of RAD, the predicted placement length would be 14.549 – (1.228 x 7) – (3.097 x 1) = 2.856 years.

Table 21

*Coefficients*[*]

| Model | | Unstandardized Coefficients | | Standardized Coefficients | T | Significance |
|---|---|---|---|---|---|---|
| | | B | Standard Error | Beta | | |
| 1 | (Constant) | 14.549 | 2.731 | | 5.328 | .000 |
| | Placement Age | -1.228 | .302 | -.373 | -4.069 | .000 |
| | Reactive Attachment Disorder Recode | -3.097 | 1.056 | -.270 | -2.932 | .004 |
| | Relationship Scales Questionnaire Secure Sum | .018 | .115 | .015 | .161 | .872 |
| | Parental Bonding Instrument Maternal Care Sum | -.051 | .053 | -.096 | -.967 | .336 |
| | Parental Bonding Instrument Maternal Overprotection Sum | .029 | .079 | .038 | .364 | .717 |
| | Parental Bonding Instrument Paternal Care Sum | .000 | .045 | .000 | -.002 | .998 |
| | Parental Bonding Instrument Paternal Overprotection | .018 | .046 | .042 | .390 | .697 |

** Dependent Variable: Placement Duration*

The F- test was used to test the regression equation. It divides the variability in the dependent variable into that which is explained by the regression and that which is not. It uses the ratio between the sum of squares explained by the regression and the residual sum of squares to yield R square. The results are shown in Table 22. The significance level for the F statistic indicates how often the sample value for R of 0.534 or more would occur when the actual population value is 0. The significance level was 0.05.

Table 22

*ANOVA*[a]

| Model | | Sum of Squares | df | Mean Square | F | Significance |
|---|---|---|---|---|---|---|
| 1 | Regression | 987.138 | 7 | 141.020 | 5.541 | .000[b] |
| | Residual | 2468.853 | 97 | 25.452 | | |
| | Total | 3455.990 | 104 | | | |

[a] *Dependent Variable: Placement Duration*

[b] *Predictors: (Constant), Parental Bonding Instrument Paternal Overprotection Sum, Placement Age, Parental Bonding Instrument Maternal Care Sum, Relationship Scales Questionnaire Secure Sum, Reactive Attachment Disorder Recode, Parental Bonding Instrument Paternal Care Sum, Parental Bonding Instrument Maternal Overprotection Sum*

The significance level of the F-statistic is less than 0.05 indicating that the results are not due to chance. Although the analysis of the variance indicates a relationship, it does not describe the strength of the relationship between the independent and variables. This is found in Table 15. In this case R, the multiple correlation coefficient between the observed scores and the predicted values of the dependent variable is .534, a relatively strong correlation. An additional indicator of the strength of the model can be examined by comparing the standard error of the estimate of the model found in Table 18, with the standard deviation of the dependent variable, placement duration found in Table 19.

In summary, of the original ten independent variables: maternal and paternal care and overprotection assessed by the PBI; fearful, secure, dismissive and preoccupied attachment relationship characteristics assessed by the RSQ; the child's age at placement; and RAD status, two were found to significantly predict outcome of the dependent variable. Therefore the null hypothesis is rejected: age at placement and RAD status do predict placement duration.

# CHAPTER 5: DISCUSSION

## Introduction

The current study was exploratory in nature. It examined the relationships between foster and adoptive parents' own attachment experiences with their parents and in other close relationships and their subsequent parenting experiences with foster and adopted children who have special needs. This study provides support for existing research on factors which have been shown to affect placement duration, such as the age of the child at the time of placement and the child's particular type of special need (Barth & Berry, 1988; Barth, Gibbs, & Siebenaler, 2001; Brooks et al., 2002; Moffat & Thoburn, 2001; Redding et al., 2000; Zeanah et al., 2004). In addition, this study specifically examined whether the special need category of RAD was predictive of placement duration. Finally, this research may provide tools to child welfare agencies to use in helping to identify and pre-screen prospective foster and adoptive parents for children with special needs.

The research questions asked: How do maternal and paternal care and overprotection scores on the PBI, and fearful, secure, dismissive and preoccupied scores on the RSQ, the child's age at the time of placement, and a diagnosis of RAD affect the length of time the child resided in the foster or adoptive home? The results indicated that the child's age at the time of placement and a diagnosis of RAD were significant predictors of placement duration. There is considerable research data supporting placement age (Brooks et al., 2002; Dance & Rushton, 2005; Moffatt & Thoburn, 2001; Smith, Howard, Garnier, & Ryan, 2006; Webster et al., 2000) and RAD status as factors

that are predictive of placement outcome (Boris et al., 2005; Chisholm, 1998; Hoksbergen & Utrecht, 2000; Levy & Orlans, 1998; Redding et al., 2000; Zeanah et al., 2004).

The following sections will provide an interpretation and discussion of the results, the limitations of this study, implications for social change, and suggestions for further research.

## Interpretation and Discussion

The interpretation and discussion of the current findings will be considered within the context of the existing research. The research question was based upon the hypothesis discussed in chapter 3

The hypothesis predicted a relationship between the independent variables of PBI and RSQ scores, the child's RAD status, and the child's age at the time of placement, and placement duration for children with special needs. First, with regard to the PBI, the effect of early parental attachment experiences would have been expected to affect placement duration based upon previous findings (Bugental, 2003; Dando & Minty, 1987; Katz, 1986; Nicoletta, 2000; Oyen et al., 2000; Ray & Horner, 1990; Redding et al., 2000). However, in this sample no significant relationships were found between either maternal or paternal care or protection and placement duration for adopted or fostered children.

Second, with regard to the RSQ, previous research findings (Bengtsson & Psouni, 2008; Dance & Rushton, 2005; Dozier et al., 2001; Simpson, Winterheld, Rholes, & Oriña; 2007; Steele et al., 2003) have indicated that current relationship characteristics, such as those measured by the RSQ, might predict placement outcomes for foster and

adopted children. However, in this sample scores on the RSQ were not found to be significant predictors of placement duration, and all of the RSQ subscales except the secure scale were eliminated from the analysis due to multicollinearity.

Third, RAD status as a predictor of placement duration would have been expected to predict placement duration based upon the previous findings related to outcomes for children with psychiatric problems in general (Barth & Berry, 1988; Bernier et al., 2004; Clausen et al., 1998; dos Reis et al., 2001; Freundlich, 1998; Harman et al., 2000; Redding et al., 2000; Reilly & Platz, 2003; Rosenfeld et al., 1997; Simms et al., 2000; Smith, 2001; Viner & Taylor, 2005; Zima et al., 1999), as well as the role that a diagnosis of RAD plays in placement failure (Boris et al., 2005; Chisholm, 1998; Hoksbergen & Utrecht, 2000; Levy & Orlans, 1998; Zeanah et al., 2004;).

Comparing children with histories of early institutionalization and significant attachment insecurity with institutionalized children who were placed before 4 months of age and a control group of children who were nonadopted and never institutionalized, Chisholm (1998) found that the longer institutionalized children who were at higher risk of RAD exhibited significantly more behavior problems with their adoptive parents reporting greater parental distress. Zeanah et al. (2004) found that in a clinical sample of maltreated toddlers in foster care there were higher rates of RAD (38-40%) than in the general population. The presence of RAD was associated with withdrawn or inhibited behaviors as well as indiscriminative friendliness toward strangers. In this sample, as expected, a significant relationship between RAD status and placement duration was found. The model does provide a better estimate of placement duration predicting that children with RAD will have a shorter placement by about 3 years.

Fourth, regarding the relationship between child's age at the time of placement and placement duration, previous findings have shown the child's age at the time of placement to have a strong predictive value for placement outcome (Brooks et al., 2002; Dance & Rushton, 2005; Moffatt & Thoburn, 2001; Smith, Howard, Garnier, & Ryan, 2006). For example, Dance and Rushton (2005) found that the length of time that the child remained in a placement, as well as the number of times the child was moved within the child welfare system was significantly associated (.001 level) with age at the time of placement. Moffat and Thoburn (2001) similarly found that older placed children had higher levels of placement disruption. In their sample of 254 children, 28% experienced placement disruption. Moffat and Thoburn also found that children who had experienced significant abuse, deprivation, or institutionalization and who subsequently exhibited significant behavioral problems also had higher levels of placement disruption.

In this sample the relationship between age and placement duration was non-linear however, with the placement success decreasing precipitously from birth to age 10.24 years where it reached approximately a 50% success rate in terms of placement stability, and success rising again from age 10.3 years to reach a success rate of about 75% by late adolescence. As expected, in this sample, a significant relationship between placement age and placement duration was found with younger age at placement resulting in longer placement duration.

*Limitations and Explanation of Results*

Various explanations might be offered for these findings. Using cutoff points supplied by Parker, Tupling, and Brown (1979) scores on the PBI for high or low care and overprotection are as follows: for mothers a care score of 27.0 and an overprotection

score of 13.5; for fathers a care score of 24.0 and an overprotection score of 12.5. The results of this sample are shown in Table 23 below. In this sample the only mean score that would be considered high was paternal overprotection. All of the other scores were below the cut-off points.

Table 23

*Descriptive Statistics for PBI*

| | N Statistic | Maximum Statistic | Mean Statistic | Standard Error | Statistic |
|---|---|---|---|---|---|
| Parental Bonding Instrument Maternal Care Sum | 105 | 36.00 | 23.552 | 1.0512 | 10.779 |
| Parental Bonding Instrument Maternal Overprotection Sum | 105 | 30.00 | 11.933 | .7449 | 7.633 |
| Parental Bonding Instrument Paternal Care Sum | 105 | 48.00 | 21.610 | 1.279 | 13.106 |
| Parental Bonding Instrument Paternal Overprotection Sum | 105 | 52.00 | 14.848 | 1.332 | 13.644 |
| Valid N (listwise) | 105 | | | | |

It is also likely that the sample size (N=105), as well as the predominance of Caucasian parents (97%), and the overrepresentation of females (93%) in the sample may partially explain this outcome. Thus, this sample may not be representative of the population norms which would explain why the linear regression analysis did not find the PBI scores to be significant predictors of placement duration.

The small sample size is the most likely explanation for the lack of relationship found between the RSQ scales of fearfulness, dismissiveness, security, and preoccupation, and placement duration. In addition, Simpson et al. (1992) found evidence for a two factor model of anxiety and avoidance for the RSQ. The factor analysis done on this sample, however, found only a single factor as seen in Table 25. Table 24 shows the communalities. The initial communalities estimate the variance accounted for by all of

the factors; they always have a value of 1. When the extraction communalities are high it indicates that the factors which have been extracted are good representations of the variables (Kinnear & Gray, 2006).

Table 24

*Communalities*

| | Initial | Extraction |
|---|---|---|
| Reactive Attachment Disorder Fearful Sum | 1.000 | .778 |
| Reactive Attachment Disorder Dismissive Sum | 1.000 | .769 |
| Reactive Attachment Disorder Secure Sum | 1.000 | .589 |
| Reactive Attachment Disorder Preoccupied Sum | 1.000 | .865 |

*Note. Extraction Method: Principal Component Analysis.*

Table 25 explains the variance accounted for by the extracted and rotated factors. The total initial eigenvalues show how much of the variance in each factor or component is due to the original variables; the percentage of variance indicates the percent of the variance that is attributable to the initial variables (Kinnear & Gray, 2006). The summed scores for each of the four original RSQ categories, fearful, dismissive, secure, and preoccupied attachment were used for the factor analysis. Thus there were four original components and the total initial eigenvalues sum to 4 and always equal the total number of original components (Kinnear & Gray, 2006). When the analysis was run, only eigenvalues larger than 1 were extracted. In this sample only the first component has an eigenvalue larger than 1; it accounts for 75% of the variance in the original four variables. Because only one component was extracted the solution could not be rotated.

Table 25

*Total Variance Explained*

| Component | Initial Eigenvalues | | | Extraction Sums of Squared Loadings | | |
|---|---|---|---|---|---|---|
| | Total | Percentage of Variance | Cumulative Percentage | Total | Percentage of Variance | Cumulative Percentage |
| 1 | 3.001 | 75.025 | 75.025 | 3.001 | 75.025 | 75.025 |
| 2 | .626 | 15.644 | 90.669 | | | |
| 3 | .205 | 5.132 | 95.801 | | | |
| 4 | .168 | 4.199 | 100.000 | | | |

*Extraction Method: Principal Component Analysis.*

The scree plot, Figure 18, also depicts the presence of only a single factor in this sample which may explain why the RSQ scores were not able to predict placement duration.

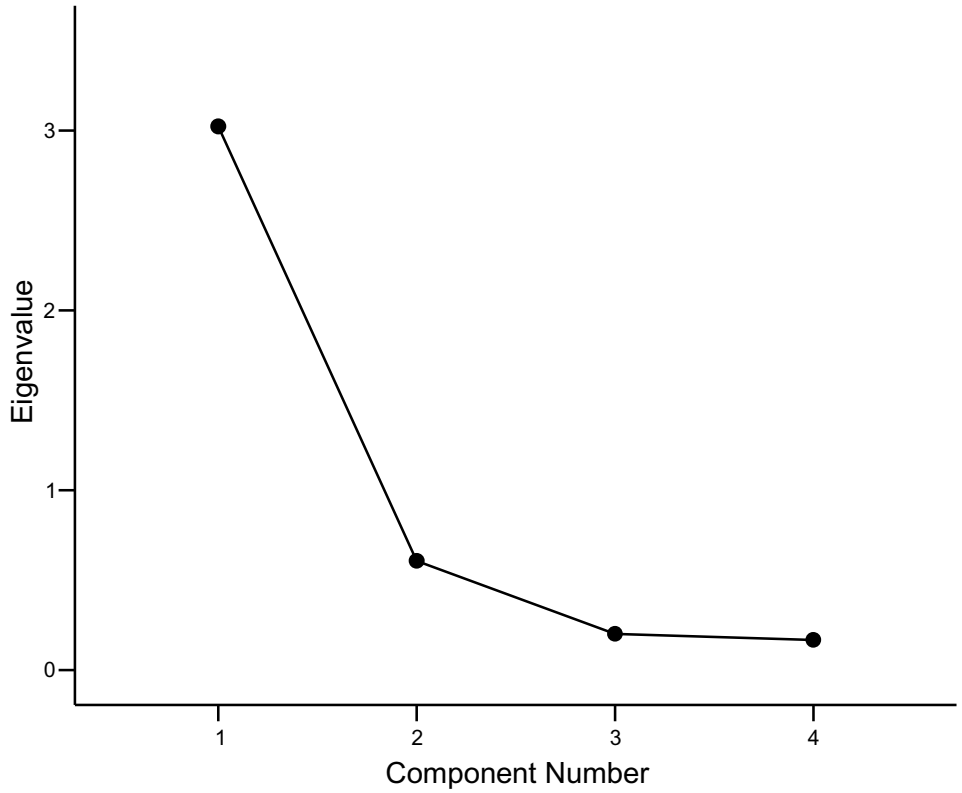


*Figure 17.* Scree Plot for Relationship Scales Questionnaire Scores

Because the existing body of research provides such convincing evidence of the relationship between placement duration and RAD status or other psychiatric conditions, as well as evidence of a relationship between placement duration and age at time of placement, the results obtained in this study were expected. However the results should be interpreted cautiously. The small size of the sample increases the risk that the model fits the particular sample better than it would fit a different sample on which the same data were collected (Norusis, 2003).

*Additional Limitations*

A further difference between the research sample and the population demographics is the length of the children's placements. In the current sample the

average placement length was 7.2 years, but U.S. Department of Health and Human Services (2007) data indicate that the average length of stay for children in foster care was 28.3 months. In addition, of children who were awaiting adoption, the mean age at removal from their original caregivers was 4.9 years and their mean age at adoption was 6.6 years of age (U.S. Department of Health and Human Services, 2007).

With regard to the comparison of children in the population with special needs and those in this sample the U.S. Department of Health and Human Services (2007) reported that 81% of the children who had been adopted between October 30, 2004 and September 30, 2005 were identified as having special needs. There were no data available for children diagnosed with RAD. In the current sample 73.1% of the children were reported to have multiple complex needs which might include RAD.

Questions regarding family income and participation in religious activities were asked as an additional way to assess the match between the sample and the population. The family income is shown in Table 9, although 44.4% chose not to respond to that question. Updated U.S. Census data for all races indicates that 12.8% of the population fall within the range of $10-24,999, 15% within the $25-39,999, 14% within the range of $40-54,999, 27% within the $55-69,999, and 26.4% over $70,000 (U.S. Census Bureau, 2006). The U.S. Census Bureau does not collect data on religious affiliation or participation. However, Davis and Smith (2006) reported strength of religious affiliation noting that 36.2% reported a strong affiliation, 10.8% a somewhat strong affiliation, 36.5% not a very strong affiliation, and 16.5% reported no religion.

Thus, a combination of small sample size and the specific characteristics of this sample contributed to the results obtained in this study. The small sample size may also

have resulted in an exaggerated effect from random participant error, such as misunderstanding the questions, becoming distracted, falling into a response set (Mitchell & Jolley, 2004) which could have been minimized if the sample had been larger. In addition, error may have been admitted due to the respondents' social desirability bias because they were participating in a study that was related to their experience as adoptive or foster parents (Mitchell & Jolley, 2004). It is also likely that the predominance of Caucasian parents (97%), and the overrepresentation of females (93%) in the sample may partially explain this outcome. Thus, this sample may not be representative of the population norms.

Despite the sample size and possibility that the demographic characteristics of the sample may not perfectly match the population norms in terms of gender and ethnicity, the results are consistent with much of the research on the effects of age and RAD on placement duration.

## Implications for Social Change

As described in chapter 1 there are various obstacles to long-term placement stability for children in substitute care. These include the individual characteristics of the children and foster or adoptive parents, factors related to the child welfare and juvenile court systems, personal psychological factors in the child, and the existing family system that the child joins. The current study focused on attachment characteristics of the foster and adoptive parents and two factors of the children, their age at the time of placement in the home and whether they had a diagnosis of Reactive Attachment Disorder. Various researchers have noted the lack of research on factors that facilitate placement stability or

induce placement instability (Holland & Gorey, 2004; Wulczyn, Kogan, & Harden, 2003). This study was also undertaken in response to the need of child welfare professionals for objective, empirical, easily scored and interpreted instruments to help identify, screen, and match prospective foster and adoptive parents with children who have special needs (Babb & Laws, 1997; Freundlich, 2000; Orme & Buehler, 2001; Redding et al., 2000; Rosenthal, 1993; Rycus et al., 1998). Mismatching contributes to placement breakdown and is not only emotionally detrimental to the children and the families they leave, but depletes the limited resources of child welfare agencies and the juvenile court system (Etezady et al., 2000; Hampson, 1988; Valdez & McNamara, 1994). For children with attachment difficulties the importance of matching the characteristics of the parents with the needs of the children is even more pronounced (Boris et al., 2005).

Although in this study neither the PBI nor the RSQ demonstrated utility in predicting placement duration, it did add confirmation to previous research findings that older age at placement and RAD status are predictive of placement outcome. These factors have implications for social change.

The age of the child at the time she enters the foster care system or adoptive home results from multiple factors, acting singly or in combination. Abuse, neglect, abandonment, exposure to violence, or the biological parents' inability to care for the child due to illness, substance abuse, or death are some reasons that children come into care. These are also the very elements associated with pathogenic care which, when they occur before age 5 years, are believed to result in the relational disturbances associated with RAD (APA, 2000). Thus, the older the child is when taken into protective custody

the more risk she has been exposed to the factors most likely to negatively affect her subsequent attachments thereby placing her at increased risk for placement disruption.

After entering the child welfare system the child may face years in foster care placement and numerous failed placements. If the child entered foster care already having behavioral or attachment problems they may be exacerbated by separation from the original caregivers or multiple placement disruptions (Rubin et al., 2004; Wulczyn et al., 2003). And unfortunately, even when children are returned to their original families they may be taken into protective custody again due to subsequent abuse or neglect.

The first time children enter care they are typically placed into a temporary or short-term foster home until an initial assessment determines the child's level of care, and whether relatives or friends can assume responsibility for the child. Though the child may have originally been placed in a temporary foster home in the hope that his parents would quickly complete the services necessary to have him returned, often he will need to be moved from the temporary home into a permanent foster home because his parents have not yet fulfilled the requirements for his return. Thus, a child may spend years floating from placement to placement. With each move the child experiences additional loss and possible trauma which shape the mental representations associated with future attachments. Adults may consequently be perceived as temporary, replaceable, inconsistent, and undependable figures in the child's life with future relationships being at risk for insecure, dismissive, or preoccupied attachment. From an analysis of data from the AFCARS Report of March 2000, the Administration for Children and Families reported that of the 134,000 children who are awaiting adoption or who have had their parents' rights terminated, the average length of time spent in foster care is 44 months,

and the average age of the child is 7.9 years (U.S. Department of Health and Human Services, 2006). In other words, a child taken into foster care at age 2 years is likely to remain in care for longer than he had been was with his original parents prior to removal. Thus, changes in the policies and procedures which would result in expediting the termination of parental rights, would enable the child to join a well-matched, permanent adoptive home, and is the most pressing implication for social change resulting from this study.

## Recommendations for Action

Because age at time of placement is such a credible predictor of placement outcome, two recommendations for action are proposed. The first recommendation involves approaching permanency decisions from an attachment perspective and recognizing that delays in permanence and multiple placements have profound developmental and behavioral consequences (Bowlby, 1944b; Hamm, 1997; Herrenkohl et al., 2003; Newton et al., 2000; Wulczyn et al., 2003). This may require changes in state policies which have allowed biological parents years to complete rehabilitation while their children are cared for by other. Implementing policy changes, informed by attachment theory would include accurately assessing the child's attachment to the biological parents, as well as to foster or prospective adoptive parents, before making a decision to return the child to his original family. As Dyer (2004) has argued, psychologists have come to acknowledge the issue of harm done to a child who is removed from the care of foster or prospective adoptive parents, with whom he has established a secure attachment, in order to be returned to biological parents whom he may barely know due to the length of separation or to the developmental stages that have occurred during the separation. Even in the case of older children, returning them to their original families not only severs the emotional ties to the families with whom they have been living, but to the child's school, friends, and larger community. Thus, if it has taken years, or in the case of a child taken into protective custody at birth, even a single year, for the biological parents to accomplish the goals of their service plan, it would not necessarily mean that the child would be returned to their care simply because of their biological ties. Child welfare agencies and mental health professionals who often assist in

assessing the child's attachments and serve as expert witnesses in termination of parental rights cases will need appropriate training in attachment theory and developmental psychology in order to make these difficult determinations.

A second call to action that flows from the implication for social change involves the process of termination of parental rights. Termination is a necessary step in legally freeing a child for adoption and thereby providing a stable, permanent family that will be able to meet the child's long-term needs (Child Welfare Information Gateway, 2007a). Termination can occur voluntarily or through court process. Although state statutes vary, there are several common factors involved in court termination. These include: a) evidence that the biological parents have a psychological disorder or have engaged in criminal behavior that has endangered the child and resulted in the child's removal from their care; b) reasonable efforts by the state to assist the parents in rehabilitation; c) parents' failure to benefit from the state's efforts and remaining unfit to care for the child (Dyer, 2004). In an effort to shorten the length of time children remain without the benefit of permanence, many states now adhere to the limits established by the Adoption and Safe Families Act requiring states to file a petition for termination of parental rights if a child has been in foster care for 15 of the last 22 months although some states have set shorter limits in cases involving younger children (Child Welfare Information Gateway, 2007b). However, as noted above, the ACFARS statistics indicate that the average length of time children spend in foster care prior to termination of parental rights is 44 months, indicating a significant discrepancy between policy and practice (U.S. Department of Health and Human Services, 2006). Graduated time limits, based upon the age of the child upon entering the system, with younger age having the shortest time that

the biological parents would have to complete services, as well as establishing an upper time limit for completion, would be a step toward decreasing the age at which children enter adoptive placements and thereby increase the likelihood of placement stability.

Finally, in order to provide assurance that the child who is returned to his biological parents does not return to protective care, newly re-united families would benefit from having access to supportive services during the adjustment and as needed for a period of time, depending upon the continuing needs of the child.

Case workers, child welfare advocates, including lawyers who have represented children's rights as Guardians ad Litem, court appointed special advocates (CASA), pediatricians, educators, and early child care providers, and mental health professionals who serve children in the foster care system, as well as foster and adoptive parents, the faith community and friends and relatives of affected children may be the most concerned about these issues and most inclined to become a voice for the children whose lives are impacted (Goldman, Salus, Wolcott, & Kennedy, 2003). Contacting state congresspersons and urging reform of the laws related to termination of parental rights, as well as insuring that services are made available to parents who are willing to engage in rehabilitation, are steps that could result in a more timely return home or permanent placement for children. Information about the results of this study and the recommendations for action will be reported to all of the agencies and websites which help to collect the data, and to the Illinois Department of Child and Family Services which granted IRB permission and publicized the study.

## Recommendations for Further Study

As noted above, the study was limited by the size of the sample and the under-representation of males and non-Caucasians. A replication of the study using the same instruments would be valuable if it were possible to obtain a larger and more representative sample.

If permission could be obtained it might also be valuable to examine existing child welfare records for difference in outcome related to the age at which the child was first placed in care. The current study only examined the child's age at placement in the current home as a factor in placement outcome. Further studies might examine whether the age of the child when first placed into foster care is a factor in either the total number of placements or placement disruptions, or the time frame in which the child is returned to the biological family. Foster and adoptive families often do not know the child's entire placement history so it would be more accurate to obtain this data from the child's case files.

This study also only examined the placement history for the first child placed with the respondents. A future study might examine whether previous parenting experience with children who have special needs is a predictor of future success with subsequent placements.

Another area of research is the role of the foster care agency in placement stability. The level of experience and education of the caseworkers, and whether the placing agency is private or state run, may be variables in placement stability and the rate at which termination of parental rights proceedings occur.

## Concluding Comments

There are no simple solutions to the problems faced by children whose life circumstances bring them into foster care. Just considering the financial costs in the U.S., maintaining the systems of care for children who experience abuse and neglect were $104 billion dollars in 2007, with $33 billion covering the cost of foster care, law enforcement, mental health treatment, and hospitalization for children in care (Wang & Holton, 2007). When compared to children in the general population, children in foster care are over-represented as consumers of mental health services having more psychological, emotional, and behavioral problems and they have more medical illnesses and physical conditions, and show increased rates of delays and impairments in cognitive development (Goldman et al, 2003; Hagele, 2005).

Bowlby (1944a) was perhaps the first to find a relationship between early attachment and later antisocial behavior, but Westen, Nakash, Thomas, and Bradley (2006) also found that attachment type predicted later personality pathology; Borderline Personality Disorder was particularly associated with incoherent/disorganized and preoccupied attachment. They further found evidence that incoherent/disorganized attachment was associated with childhood attachment disruptions and trauma. Others have found similar links between serous personality pathology early distorted or dysfunctional attachment (Fonagy, 2003; Sable, 1997).

Because this population of children is so vulnerable to enduring adversity there is urgent need to find ways of intervening and ameliorating the conditions which cause or exacerbated their plight. This will require a multidisciplinary approach and the integration of various systems of care operating in a collaborative effort to provide

intervention at all levels, both before children are taken into protective custody with the focus of preventing child abuse and neglect, as well after children enter the foster care system with the focus of expedient return home or timely termination of parental rights and placement into permanent adoptive families.

Despite even the most valiant efforts to address the causes which lead to a child's removal from his original family, history has provided convincing record that there will always be children in need of temporary or permanent substitute care. Those children who have lost the most basic right to be safe and protected by their own parents compel us to find ways to provide them with the best matched, most capable foster and adoptive parents, who are able to help them develop into healthy, functional adults. This study has been an attempt to contribute to the body of knowledge used to guide child welfare practice and policy. Although the study did not provide support for the use of the PBI or the RSQ as empirical tools to help match foster and adoptive parents with children who have special needs, it did add support to what previous research has shown regarding the importance of the child's age at the time of placement.

The importance of action based upon knowledge has been a continuous thread throughout history. Abu Bakr, a 5th century statesman and companion of Muhammad, warned that "Without knowledge action is useless and knowledge without action is futile" (http://en.wikiquote.org/wiki/Abu_Bakr). Centuries later, Kurt Lewin, admonished, "No research without action, and no action without research" (Franzoi, 2006). It remains the responsibility of scholar practitioners to implement not only the action component indicated by research, but to provide the public and those with

particular mandates to act on behalf of children in need, with the information and urgency to implement change to alleviate their suffering.

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APPENDIX

Appendix A: Relationship Scales Questionnaire

**Relationship Scales Questionnaire (RSQ)**

Kim Bartholomew and Leonard M. Horowitz

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about close relationships

| | | **Not at all like me** | | | | **Very much like me** |
|---|---|---|---|---|---|---|
| 1. | I find it difficult to depend on other people. | 1 | 2 | 3 | 4 | 5 |
| 2. | It is very important to me to feel independent. | 1 | 2 | 3 | 4 | 5 |
| 3. | I find it easy to get emotionally close to others. | 1 | 2 | 3 | 4 | 5 |
| 4. | I want to merge completely with another person. | 1 | 2 | 3 | 4 | 5 |
| 5. | I worry that I will be hurt if I allows myself to become too close to others. | 1 | 2 | 3 | 4 | 5 |
| 6. | I am comfortable without close emotional relationships. | 1 | 2 | 3 | 4 | 5 |
| 7. | I am not sure that I can always depend on others to be there when I need them. | 1 | 2 | 3 | 4 | 5 |
| 8. | I want to be completely emotionally intimate with others. | 1 | 2 | 3 | 4 | 5 |
| 9. | I worry about being alone. | 1 | 2 | 3 | 4 | 5 |
| 10. | I am comfortable depending on other people. | 1 | 2 | 3 | 4 | 5 |
| 11. | I often worry that romantic partners don't really love me. | 1 | 2 | 3 | 4 | 5 |
| 12. | I find it difficult to trust others completely. | 1 | 2 | 3 | 4 | 5 |
| 13. | I worry about others getting too close to me. | 1 | 2 | 3 | 4 | 5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. | I want emotionally close relationships. | 1 | 2 | 3 | 4 | 5 |
| 15. | I am comfortable having other people depend on me. | 1 | 2 | 3 | 4 | 5 |
| 16. | I worry that others don't value me as much as I value them. | 1 | 2 | 3 | 4 | 5 |
| 17. | People are never there when you need them. | 1 | 2 | 3 | 4 | 5 |
| 18. | My desire to merge completely sometimes scares people away. | 1 | 2 | 3 | 4 | 5 |
| 19. | It is very important to me to feel self-sufficient. | 1 | 2 | 3 | 4 | 5 |
| 20. | I am nervous when anyone gets too close to me. | 1 | 2 | 3 | 4 | 5 |
| 21. | I often worry that romantic partners won't want to stay with me. | 1 | 2 | 3 | 4 | 5 |
| 22. | I prefer not to have other people depend on me. | 1 | 2 | 3 | 4 | 5 |
| 23. | I worry about being abandoned. | 1 | 2 | 3 | 4 | 5 |
| 24. | I am somewhat uncomfortable being close to others. | 1 | 2 | 3 | 4 | 5 |
| 25. | I find that others are reluctant to get as close as I would like. | 1 | 2 | 3 | 4 | 5 |
| 26. | I prefer not to depend on others. | 1 | 2 | 3 | 4 | 5 |
| 27. | I know that others will be there when I need them. | 1 | 2 | 3 | 4 | 5 |
| 28. | I worry about having others not accept me. | 1 | 2 | 3 | 4 | 5 |
| 29. | Romantic partners often want me to be closer than I feel comfortable being. | 1 | 2 | 3 | 4 | 5 |
| 30. | I find it relatively easy to get close to others. | 1 | 2 | 3 | 4 | 5 |

Appendix B: Parental Bonding Instrument

**PARENTAL BONDING INSTRUMENT (PBI)**

Gordon Parker, Hilary Tupling, and L.B. Brown

**MOTHER FORM** This questionnaire lists various attitudes and behaviors of parents. As you remember your MOTHER in your first 16 years would you place a check in the most appropriate box next to each question.

| | Very like | Moderately Like | Moderately unlike | Very unlike |
|---|---|---|---|---|
| 1. Spoke to me in a warm and friendly voice | | | | |
| 2. Did not help me as much as I needed | | | | |
| 3. Let me do those things I liked doing | | | | |
| 4. Seemed emotionally cold to me | | | | |
| 5. Appeared to understand my problems and worries | | | | |
| 6. Was affectionate to me | | | | |
| 7. Liked me to make my own decisions | | | | |
| 8. Did not want me to grow up | | | | |
| 9. Tried to control everything I did | | | | |
| 10. Invaded my privacy | | | | |
| 11. Enjoyed talking things over with me | | | | |
| 12. Frequently smiled at me | | | | |
| 13. Tended to baby me | | | | |
| 14. Did not seem to understand what I needed or wanted | | | | |
| 15. Let me decide things for myself | | | | |
| 16. Made me feel I wasn't wanted | | | | |
| 17. Could make me feel better when I was upset | | | | |
| 18. Did not talk with me very much | | | | |
| 19. Tried to make me feel dependent on her/him | | | | |
| 20. Felt I could not look after myself unless she/he was around | | | | |
| 21. Gave me as much freedom as I wanted | | | | |
| 22. Let me go out as often as I wanted | | | | |
| 23. Was overprotective of me | | | | |
| 24. Did not praise me | | | | |
| 25. Let me dress in any way I pleased | | | | |

**FATHER FORM** This questionnaire lists various attitudes and behaviors of parents. As you remember your FATHER in your first 16 years would you place a check in the most appropriate box next to each question.

| | Very like | Moderately Like | Moderately unlike | Very unlike |
|---|---|---|---|---|
| 1. Spoke to me in a warm and friendly voice | | | | |
| 2. Did not help me as much as I needed | | | | |
| 3. Let me do those things I liked doing | | | | |
| 4. Seemed emotionally cold to me | | | | |
| 5. Appeared to understand my problems and worries | | | | |
| 6. Was affectionate to me | | | | |
| 7. Liked me to make my own decisions | | | | |
| 8. Did not want me to grow up | | | | |
| 9. Tried to control everything I did | | | | |
| 10. Invaded my privacy | | | | |
| 11. Enjoyed talking things over with me | | | | |
| 12. Frequently smiled at me | | | | |
| 13. Tended to baby me | | | | |
| 14. Did not seem to understand what I needed or wanted | | | | |
| 15. Let me decide things for myself | | | | |
| 16. Made me feel I wasn't wanted | | | | |
| 17. Could make me feel better when I was upset | | | | |
| 18. Did not talk with me very much | | | | |
| 19. Tried to make me feel dependent of her/him | | | | |
| 20. Felt I could not look after myself unless she/he was around | | | | |
| 21. Gave me as much freedom as I wanted | | | | |
| 22. Let me go out as often as I wanted | | | | |
| 23. Was overprotective of me | | | | |
| 24. Did not praise me | | | | |
| 25. Let me dress in any way I pleased | | | | |

Appendix C: Demographic Questionnaire

This questionnaire draws upon your experience as a foster or adoptive parent of a child with special needs. Your responses will provide valuable information designed to improve the lives of children entering their first foster placement. Thank you for taking the time to help.

If you are the parent of several foster or adopted children, please answer the following questions based upon your **first** foster or adoptive parenting experience only. If your first placement was a sibling group please report on the oldest child in the group.

Please check those answers that provide the best descriptions.

1. Your gender: □ female □ male

2. Your marital status:
   □ married
   □ unmarried, but co-parenting in a committed relationship
   □ single
   □ divorced
   □ widowed

3. Your age:
   □ 25 and under
   □ 26-35
   □ 36-45
   □ 46-55
   □ 56-65
   □ 66 and over

4. Your ethnicity:
   □ African American
   □ Asian American
   □ Caucasian
   □ Hispanic
   □ Other _____

5. Child's ethnicity:
   □ African American
   □ Asian American
   □ Caucasian
   □ Hispanic
   □ Other _____

6. Was the **first** child who was placed with you a relative?
   □ yes □ no

7. Age of the **first** child at the time s/he was placed in your home:
   Birth-11months old: □
   Years old: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9
   □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16 □ 17 □ 18

8. When the **first** child was placed with you what was your original intention?
   □ only to provide foster care
   □ only to adopt
   □ uncertain, but open to adoption

9. Was the child *ever* diagnosed with Reactive Attachment Disorder?
   □ yes □ no
   If "yes," was the diagnosis given by a social worker, counselor, psychologist, therapist, or doctor? □ yes □ no

10. Did you adopt this child?
    □ <u>If you did not,</u> what was the length of time the child resided in your home?
    _____ years and _____months
    Now proceed to question #11.
    □ <u>If you adopted</u> the child, please answer the following:
    Type of adoption (check **any** that apply):
    □ the child was a relative
    □ foster-adopt conversion (the placement began as foster care and then converted to a pre-adoptive or adoptive placement)
    □ domestic – through a state agency
    □ domestic – through a private agency
    □ identified – the birth parents specifically chose you
    □ international – from a country outside of the U.S.
    Please specify the country_____
    □ other
    Please specify _____
    Is this child still living in your home?
    □ yes □ no
    Is the adopted person an adult living independently?
    □ yes □ no
    What is the adopted person's current age? _____

11. Whether or not you adopted the child, if the child is now independent (over 18 and/or living on his/her own), is s/he still in regular contact with you?
    □ yes, at least once each year
    □ yes, several times each year
    □ no
    □ other _____

12. Did the foster or adoptive placement end, disrupt, or go through legal dissolution?
□ yes □ no

13. The reason the placement ended:
□ the child returned to his/her biological parents
□ the child moved to another type of placement for the following reason(s):
□ to be with siblings
□ to be in the home of a relative
□ because she/he was too difficult to manage in your home and needed a more restrictive setting (group home, residential placement, hospital)
Please specify_____
□ the child needed a home that was better able to meet his/her needs (fewer children, more children, closer to biological family, more appropriate school, or other)
Please specify: _____
□ other reason
Please specify: _____

14. Please specify the **first** child's special need(s) by indicating **all** that apply:
□ Developmental/physical disability
Please list: _____
□ Emotional/psychological disability
Please list: _____
□ Member of a sibling group requiring a common placement
□ Older than 5 years at the time of placement
□ Two or more previous foster or adoptive placements
□ Prenatal exposure to drugs or alcohol
□ At risk of a genetic disorder
□ Institutionalized during infancy or childhood (orphanage or residential care)
□ Other _____

15. Your family income:
□ under 10,000
□ 10,000-24,999
□ 25,000-39,999
□ 40,000-54,999
□ 55,000-74,999
□ Above 75,000

16. Please indicate how active you are in a church, temple, synagogue, or other religious or spiritual group:
□ Very active (1-2 times per week)
□ Moderately active (1-2 times per month)
□ Inactive (0-2 times per year)

17. Please indicate the highest educational level you have completed:
    - □ Grammar school
    - □ Some high school
    - □ High school graduate
    - □ Some college
    - □ College graduate
    - □ Graduate school
    - □ Professional school

18. Are you still a licensed foster parent?
    □ yes □ no

19. How long were you or have you been a foster parent?
    _____ years and _____months

20. How many children have you fostered? _____

21. How many children have you adopted? _____

22. Have all of the adoptions remained intact?
    □ yes □ no
    If "no" how many disrupted/dissolved? _____

Appendix D: Assent Statement for Foster or Adoptive Parents

The Use of Adult Attachment Measures to Predict Placement Duration for Foster and Adopted Children with Special Needs

Walden University

You are invited to participate in a research study about adoption/foster care of special needs children because of your prior knowledge and experience as a foster or adoptive parent or because you have previously ha an interest in becoming a foster or adoptive parent. Please read this entire Assent Statement prior to completing the questionnaires. It addresses various questions you may have about your participation in this research.

This study is being conducted by Patricia A. Somers, MA, LCPC. She is a PhD candidate at Walden University.

**Background Information:**

The purpose of the study is to examine whether certain characteristics of foster/adoptive parents are related to the placement stability of children with special needs.

**Procedures:**

If you agree to participate in this study you will be asked to complete three short forms: a 10 question demographic form, The Relationship Scales Questionnaire with 30 short descriptions, and two forms of The Parental Bonding Instrument related to each of your parents. There are no correct or incorrect answers. All information is based upon your own personal experiences. Completion of all forms should take no longer than 15 minutes.

**Voluntary Nature of the Study:**

Your participation in this study is completely voluntary. Your decision to participate or not participate in this study will not affect your future relations with any agency that licensed your foster home. No incentives either monetary or in-kind apply to your participation.

**Risks and Benefits of Participating in the Study:**

The questions you will be asked are related to your previous close relationships with your parents. Depending upon the nature of those relationships recalling them *may* result in some distress.

It is hoped that the information gained from this study will assist child welfare agencies in more accurately matching special needs children with prospective foster and adoptive

families, thereby minimizing children's trauma resulting from multiple moves, as well as maximizing the resources of prospective foster / adoptive families.

In the event that you experience stress or anxiety during your participation in the study, you are free to end your participation at any time. You may refuse to answer any question you consider stressful or invasive.

**Confidentiality:**

The records of this study will be kept private. Your name will not appear on any of the documents. In the event that this research is published the researcher will not include any information that could identify a participant. The research data will be kept in a locked file maintained on the premises of Centennial Counseling Center, 1120 E. Main St. St. Charles, IL 60174, and only the researcher will have access to the records. No child welfare or other agency will have access to any of your demographic or questionnaire information.

**Conflicts of Interest**

Because the researcher conducting this study is also a mental health professional, and is on the faculty of several colleges in the Chicago suburban area, it is possible that you may have met her in one of those other professional capacities. You will not be asked for any identifying information during the course of your participation in this research and there will be no way for a link to be established between your answers and your interaction with Ms. Somers in one of her other roles.

**Contacts and Questions**:

The researcher conducting this study is Patricia Somers. Her advisor is Dr. Stephanie Cawthon. You may ask any questions about the nature or the results of this study by contacting the principal researcher, Patricia Somers, at Centennial Counseling Center, 1120 E. Main St. St. Charles, IL 60174, by telephone at 630-377-6613, or by email at psomers@waldenu.edu. The research Participant Advocate at Walden University is Dale Good. He can be reached at 1-800-925-3368, x 1210 with questions regarding your participation in this study. The final results will be available at http://www.parentshelp.us

You may keep a copy of the consent form if you completed the paper-and-pencil format or you may print the consent form if you have completed the online version.

**Statement of Assent**:

Your completion of the demographic and research questionnaires indicates your implicit assent to participate in this research.

Thank you for your participation and your interest in improving the lives of children.

# Appendix E: Sample Invitation Letter to Parent Support Groups

**Patricia A. Somers, MA, LCPC**
**550 Madison St.**
**Winfield, IL 60190**
**Email: psomers@waldenu.edu**
**Cell: 630-842-0797**

September 3, 2006

Adoptive Parent Support Group
1492 Columbus Drive.
Bollingbrook, Il 60177

Dear Support Group Leader:

I am currently conducting research on the way that foster/adoptive parent characteristics affect the outcome of special needs placements. This study is part of my doctoral work at Walden University (www.waldenu.edu). In addition to being a counselor who treats special needs children and their families, I am also an adoptive mother of two adult sons, so my interest in this topic is both professional and personal.

I am writing to ask for your help in inviting your parent members to participate in the study. It involves completing three short questionnaires. The questionnaires have to do with the relationships that they had with their own parents. The questionnaires include the Parental Bonding Instrument (one form regarding their relationship with their mothers and one for their relationship with their fathers), and the Relationship Scales Questionnaire (only one form). In addition there is a short demographic form. I have included copies of the questionnaires and a brief abstract of the study.

All of the information is confidential and anonymous. Respondents are not asked for their names. I am the only person who will have access to the responses. It should take about 10 minutes to complete the forms.

There are two ways to participate. First, I can send you the forms and include return postage paid envelopes. You simply ask the members to complete the forms and mail them to me. Or I can send you fliers with a website address for people to visit and submit their responses online.

If you would be willing to help in this research please contact me either my email or by telephone. If you would like more information about me you may visit our practice website at: http://www.centennialcounseling.com/ and find my name under "Meet the Staff." I hope to have all of the data gathered by January 31, 2007.

Thank you in advance for your time and consideration,

Pat Somers, MA, LCPC

# Appendix F: Sample Invitation Letter to Attachment Clinicians

**Patricia A. Somers, MA, LCPC**
**550 Madison St.**
**Winfield, IL 60190**
**Email: psomers@waldenu.edu**
**Cell: 630-842-0797**

September 3, 2006

Henry Alexander, MA, LCSW
Crossroads Counseling Center
1128 E. Main St.
St. Paul, IL 60174

Dear Mr. Alexander:

I obtained your name on a website as a clinician having experience treating children with attachment problems. I am currently conducting research on the way that foster/adoptive parent characteristics affect the outcome of special needs placements. This study is part of my doctoral work at Walden University (www.waldenu.edu). I am also a clinician myself who treats children with special needs and their families.

I am writing to ask for your help in inviting your foster/adoptive client parents to participate in the study. It involves completing three short questionnaires. The questionnaires have to do with the relationships that they had with their own parents: the Parental Bonding Instrument (one form regarding their relationship with their mothers and one for their relationship with their fathers), and the Relationship Scales Questionnaire (only one form). In addition there is a short demographic form.

All of the information is confidential and anonymous. It should take about 10 minutes to complete the forms. Respondents are not asked for their names. I am the only person who will have access to the responses.

There are two ways to participate. First, I can send you the forms and include return postage paid envelopes. You simply ask the clients if they would like to participate, give them the forms and envelopes, and they mail them directly to me. Or I can send you fliers with a website address for people to visit and submit their responses online.

If you would be willing to help in this research please contact me either at the email or telephone number above. I hope to have the data collected by early December. If you would like more information about me you may visit our practice website at: http://www.centennialcounseling.com/ and find my name under "Meet the Staff."

Thank you in advance for your time and consideration,

Pat Somers, MA. LCPC

# Appendix G: Sample Letter to Community Stakeholder/DCFS

**Patricia A. Somers, MA, LCPC**
**550 Madison St.**
**Winfield, IL 60190**
**Email: psomers@waldenu.edu**
**Cell: 630-842-0797**

October 26, 2006

Bryan Samuels
Director
Illinois Department of Children and Family Services
100 West Randolph Street 6-200
Chicago IL 60601

Director Samuels:

Last June I had the pleasure of attending the Chapin Hall panel, "Beyond Common Sense: Integrating Child Well-Being into Child Welfare Policy," at which you were a discussant. As a licensed clinical professional counselor who has worked with many foster and adoptive children and their families over the last decade, and as an adoptive parent myself, I have both a professional and a personal interest in the welfare of children who spend parts of their lives in our foster care system.

One of my frustrations as a clinician has been the placement instability of special needs children that is so detrimental to their emotional well-being. That is why, when I decided upon a dissertation topic as part of my program at Walden University, I chose to examine the use of two quantitative instruments which might help guide agencies in making difficult placement choices.

I am writing to ask for your help in gathering data from foster and adoptive parents in Illinois who provide homes to children with special needs children. I have included a brief abstract of the research plan as well as copies of the instruments that will be used to gather the data. No identifying information will be collected and participants' responses will remain anonymous.

I would like your permission to provide foster and adoptive parents the opportunity to participate in this research when they attend foster parent training sessions, either by completing the three short questionnaires as part of the meeting, or by providing them with a flyer which will direct them to an internet website where they can complete and submit the questionnaires electronically. Would it also be possible to notify the various regional newsletters such as the Cook County Advocate, Central Connections, Northern News, and Our Kids of the study website? I hope to have the data collection complete by early January, 2007.

Thank you for your consideration and the opportunity to work with the Department in serving the children in its care. If you would like more information about me you may visit our practice website at http://www.centennialcounseling.com/. You may also wish to visit the Walden University website at http://www.waldenu.edu .

Pat Somers, MA, LCPC

Enclosures

# Appendix H: Sample Letter to Community Stakeholder/LCFS

**Patricia A. Somers, MA, LCPC**
**550 Madison St.**
**Winfield, IL 60190**
**Email: psomers@waldenu.edu**
**Cell: 630-842-0797**

October 26, 2006

Ann Lading-Ferguson, MSW, MA, LCSW, ACSW
Lutheran Child and Family Services
PO Box 5078
River Forest, IL 60305

Dear Ms. Lading-Ferguson:
You may remember me from my years as a part-time counselor from 1994 to 1999 who worked out of the LCFS Oak Park office providing services to foster children and their families. I have continued to work with foster and adoptive families and have been a clinician at Centennial Counseling Center for the past 11 years (http://www.centennialcounseling.com/). Because I am also an adoptive parent of two adult sons I have both a professional and a personal interest in the well-being of children in the child welfare system. I am completing my doctoral dissertation requirements at Walden University (www.waldenu.edu) and have chosen to examine the use of two quantitative instruments which might help guide agencies in making difficult placement choices for special needs children.

I am writing to ask for your help in gathering data from foster and adoptive parents who provide homes to special needs children. I have included a brief abstract of the research plan as well as copies of the instruments that will be used to gather the data. Participation would be completely voluntary. No identifying information will be collected and participants' responses will remain anonymous. I am the only person who will have access to the data. Foster and adoptive parents could participate in this research by having the questionnaires distributed at foster parent training sessions, and returning them to me by mail, or by providing them with a flyer which would direct them to an internet website where they could complete and submit the questionnaires electronically. I hope to have the data collected by early January, 2007.

Thank you for your time and consideration. If you would like to discuss this research further you may contact me at the telephone number or email address above.

I look forward to working with you in serving the needs of the children in your care.

Pat Somers, MA, LCPC

Enclosures

# Appendix I: Sample Letter to Community Stakeholder/ECFA

**Patricia A. Somers, MA, LCPC**
**550 Madison St.**
**Winfield, IL 60190**
**Email: psomers@waldenu.edu**
**Cell: 630-842-0797**

October 26, 2006

Ken Withrow, Director
Evangelical Child and Family Agency
1530 N. Main St.
Wheaton, IL 60187

Dear Mr. Withrow:

Last winter Joyce Moffitt, one of ECFA's counselors, invited me to give a presentation on parent-child attachment to a group of ECFA foster/adoptive parents. I am a licensed clinical professional counselor and have worked with many foster and adoptive children families over the last decade. I am also an adoptive parent, and therefore have both a professional and a personal interest in the welfare of children who spend parts of their lives in our foster care system.

I mentioned to Joyce that I was engaged in completing my doctoral work through Walden University (www.waldenu.edu) and would be looking at the use of two quantitative instruments which might help guide agencies in making difficult placement choices for special needs children.

I am writing to ask for your help in gathering data from foster and adoptive parents who provide homes to special needs children. I have included a brief abstract of the research plan as well as copies of the instruments that will be used to gather the data. Participation would be completely voluntary. No identifying information will be collected and participants' responses will remain anonymous. I am the only person who will have access to the data. Foster and adoptive parents could participate in this research by having the questionnaires distributed at parent training sessions and returning them to me by mail, or by providing them with a flyer which would direct them to an internet website where they could complete and submit the questionnaires electronically. I hope to have the data collected by early December.

Thank you for your time and consideration. If you would like to discuss this research further you may contact me at the telephone number or email address above. If you would like more information about me you may visit our practice website at http://www.centennialcounseling.com/ and click on "Meet the Staff."

I look forward to the opportunity of discussing this study with you further and working with you in serving the needs of the children in your care. You may contact me at either the telephone or the email address above.

Pat Somers, MA, LCPC

Enclosures

Appendix J: Invitation to Participate in Research

As a foster or adoptive parent of a child with special needs your insight and experience is valuable. This is an invitation to participate in research which may provide valuable information about how placement stability could be increased for children with special needs.

My interest in the welfare of children with special needs is both personal and professional. I am an adoptive parent of two adult sons; I am also a counselor who has worked with foster and adopted children for the past 12 years. As part of my doctoral dissertation I am examining ways in which the child's age at the time of placement, the type of special need s/he has, and the parent's own prior attachment experiences may be related to placement duration.

Your participation in this study is completely voluntary and anonymous. Your responses will not be made available to any agency or entity, and will not affect your current or any future placements.

Participation involves completing four short questionnaires: the Parental Bonding Questionnaire (one form related to each of your parents), the Relationship Scales Questionnaire, and a demographic questionnaire. The forms may be completed in a paper-and-pencil format or online at: http://www.parentshelp.us

Thank you for your willingness to contribute to this research effort. If you would like to know the results of the study you may contact me at psomers@waldenu.edu. The results will also be posted at http://www.parentshelp.us by June 2007.

Pat Somers, M.A.
Licensed Clinical Professional Counselor

# CURRICULUM VITAE

Patricia A. Somers, MA, LCPC

Centennial Counseling Center
1120 E. Main St.
Suite 201
St. Charles, IL 60190
(630) 377-6613
(630) 842-0797 cell

## EDUCATION

PhD.
Walden University
Minneapolis, MN
August, 2009

M.A. Counseling
Liberty University
Lynchburg, VA
September, 1994

B.A. Psychology
University of Illinois
Urbana - Champaign, IL
June, 1972

## COUNSELING EXPERIENCE

Centennial Counseling Center
St. Charles, IL
June 1995-present

Provide assessment and counseling to individuals and families, children, adolescents, and adults presenting with a wide range of psychiatric diagnoses.

Provide in-home counseling to families with severely disturbed children.

Extensive training and experience treating Posttraumatic Stress Disorder and Reactive Attachment Disorder.

Experience testifying in child welfare cases involving termination of parental rights and determination of the best interest of minor children.
Experience assisting parents obtain appropriate educational resources including designation of eligibility for IEP and WRAP around services.

The Family Resource Center of Mt. Prospect
Mt. Prospect, IL
September 1994-May 1995

Provided counseling services to adoptive and foster families.

Facilitated therapy groups for children, adolescents, parents, and multiple families related to adoption issues.

Conducted parenting skills classes for parents court mandated to attend due to findings of abuse or neglect.

Conducted Dialectical Behavior Therapy groups for individuals with Borderline Personality Disorder.

## TEACHING EXPERIENCE

Instructor, Department of Psychology
College of DuPage, Glen Ellyn, IL 60187
September 2001-present
General Psychology, Social Psychology, Lifespan Development, Abnormal Psychology, Adolescent Development

Lecturer, Department of Psychology and Sociology
Benedictine University, Lisle, IL 60153
September 2006 - present
General Psychology, Social Psychology, Introduction to Sociology, Group Dynamics Lab, Race, and Ethnicity

Instructor, Department of Psychology
Waubonsee Community College, Sugar Grove IL 60543
January 2006-September 2007
Abnormal Psychology, Lifespan Development

CONSULTANT

Adoption Department
Evangelical Child and Family Agency
Wheaton, IL
2006-present

LICENSE

Licensed Clinical Professional Counselor
State of Illinois
1998-present

RESEARCH EXPERIENCE

Assisting Martha Welch, M.D., Columbia University, Department of Child Psychiatry, New York, collect data on the application of Direct Synchronous Bonding Therapy on long-term outcome of families with children suffering from behavior regulatory disorders.
November 1999-2005

Conducted survey of faculty at the College of Du Page, large Midwestern community college to determine frequency of student-initiated help from faculty and faculty referral to the school counseling and advising office.
Summer 2002

Undergraduate assistant to Peter Shaw, PhD., Department of Psychology, University of Illinois, Urbana-Champaign, Illinois. Created research materials, conducted subjects through visual perception experiments, and tabulated research data.
September 1971-May 1972

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

| | |
|---|---|
| Member | American Association of Women at Community Colleges |
| Student Affiliate Member | American Psychological Association |

PROFESSIONAL ACTIVITIES

Mentored by Martha Welch, M.D., psychiatrist and internationally recognized expert on child and adult attachment behavior and the treatment of reactive attachment disorder.

Since 1999 has participated in Dr. Welch's two-day treatment intensives held six times each year to treat families in crisis due to children's extreme behavioral dysregulation.

Past secretary of Adoptive Families Today, educational support group, legislative advocate for adoptive families in Illinois.

PRESENTATIONS

| | |
|---|---|
| 2009 | Attachment, Development and Identity in Adopted Individuals<br>sponsored by Evangelical Child and Family Agency |
| 2006 | Facilitating Parent-Child Attachment in Children with Special Needs<br>sponsored by Evangelical Child and Family Agency |
| 2004 | Supporting Friendship in Marriage<br>sponsored by Delnor Community Hospital, Centennial Counseling Center, and St. John Neumann Catholic Church |
| 2003 | When the Nest is Empty<br>sponsored by Delnor Community Hospital, Centennial Counseling Center, and St. John Neumann Catholic Church |
| 1995 | Search and Reunion<br>sponsored by Adoptive Families Today |