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Understanding Caregiver Perceptions of Attachment with Drug Exposed Foster Children

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Walden University, 2014

BS, University of Nevada – Las Vegas, 2010

Dissertation Submitted in Full Fulfillment

of the Requirements for the Degree of

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Human Services

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Abstract

Lacking a healthy attachment to a caregiver and having in-utero methamphetamine exposure have been linked to a variety of cognitive delays, developmental delays, and mental health issues throughout a person's lifespan. It is unknown if there is a relationship between in-utero methamphetamine exposure and the ability to build a healthy attachment to a caregiver. The purpose of this generic qualitative study was to improve understanding of the perceptions of caregivers about attachment efforts for foster children under the age of 3, who have had in-utero methamphetamine exposure. This study was guided by attachment theory. Purposeful sampling was used to select 7 participants who had provided care to foster children with in-utero methamphetamine exposure within the last year. Data were collected through the use of semistructured interviews, which were conducted in-person, audiotaped, and then transcribed. Data was analyzed through text searches of themes, axial coding, and repetitive words. Trustworthiness was obtained through member checking and generating a rich description of the participants' experiences. The findings revealed that many of the participants feel that these children do not respond to their efforts to build a healthy attachment to them. They also felt that the foster children did not process stimuli, such as touch, in the same way as other children; that the foster children found such interactions to be aversive. The findings of this study have the potential to impact social change by assisting therapists, caseworkers, and foster parents better understand the needs of foster children and to create a foundation for interventions to better serve foster children with in-utero methamphetamine exposure.

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Dedication

I dedicate this work to all of those that have taken to the path to work with children within the foster care system. I thank each of you for the daily work you do to make the lives of children who are surviving abuse and neglect a better place to live in.

Acknowledgments

There are not enough words to describe my appreciation to the people in my life who have supported me through this arduous process. Dr. Tracey Phillips, I could not have completed this process without your encouragement and forward focused interactions. I also would like to thank Dr. Andrew Carpenter, my second committee member, for continuing to be a guide and aid in the processes of qualitative methodology. I would also like to thank my mother, Rachel Barr, who has not only been an inspiration to me, but has also been a constant support and source of encouragement for whatever endeavor I thought I wanted to complete. I would also like to thank Kelli Callaway and Lisa Walker, who have helped keep me grounded throughout this process. Without the five of you, I would never have been able to accomplish this. THANK YOU!

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Chapter 1: Introduction to the Study

Introduction

This research focused on exploring the social and emotional milestones associated with attachment, as reported by the primary caregivers of foster children under the age of three. By exploring this concept, an opportunity arose to gain an understanding of the attachment process in children under the age of three who are part of the foster care system, based on the caregiver's perceptions of the caregiver-child relationship. There was then the potential to better understand attachment in drug-exposed infants and increase the ability to respond and intervene in these cases of attachment deficit. This created an prospect to better understand both the caregiver and the child's behaviors associated with difficulties in the parent-child relationship, and how these difficulties impact society, There also becomes an circumstance to expand the existing body of literature related to attachment.

Background

The human condition is often researched by understanding the relationships that revolve around a person, and how these relationships have impacted one's life. These relationships are now understood to be an expansion of the first relationships a child has (Carlson, Hostinar, Mliner, & Gunnar, 2014; Meyer, Wood, & Stanley; 2013; Zeanah, Berlin, & Boris, 2011). John Bowlby (1947) began exploring human relationships, particularly the parent-child relationship, in the early 1940s. Bowlby (1947) explored improving family functioning through an exploration of familial relationships, which eventually challenged the status quo of childhood mental health. Prior to his research, the

first few years of a child's life were not considered an important factor in social-emotional development and family functioning (Bowlby, 1947). His expansion of the family relationship and his idea that relationships were established from birth culminated in his theory of attachment (Bowlby, 1947: Bowlby, 1951). His theory of attachment focuses on a child's need to seek out an emotional connection with a selected individual to meet his or her physical and emotional needs, particularly when scared, sick, or tired, to ensure survival (Bowlby, 1947; Bowlby, 1951; Zeanah, Berlin, & Boris; 2011). In meeting these physical and emotional needs, a child is then able to feel safe and secure in the caregiver-child relationship, which in turn results in self-awareness, self-assurances, and independence (Zeanah, Berlin, & Boris; 2011). The foundation of a healthy attachment, though instigated by the infant, is not based on the needs and wants of the infant, but on the parent's responsiveness to his needs (Bowlby, 1951).

Much of the current research on attachment theory focuses on exploring and understanding the issue from the perspective of the caregiver in response to a child's delays and struggles (Bovenschen et al., 2016; Cihan et al., 2014; Lang et al., 2016). Some children are at an increased risk of behavioral and emotional delays and difficulties, such as anxiety, hyperactivity, defiance, aggression, and an inability to relate to appropriate peers due to in-utero drug exposure (Altshuler & Cleverly-Thomas, 2011; Madide et al., 2012; Ross et al., 2015). Most children over the age of three, without known in-utero drug exposure, do not exhibit these difficulties in their ability to respond to healthy caregivers who attempt to establish healthy attachments (Bovenschen et al., 2016). It is important to note that children over the age of three have had time to form

attachments even if? to unhealthy caregivers or to various foster care providers, or they experience various traumas that eventually result in their removal from their families of origin (Bovenschen et al., 2016). These predictors and outcomes have not been generalizable to children under the age of three, which is the focus of this study.

Problem Statement

Parental drug use during pregnancy can be a predictor of a wide array of negative consequences experienced by both the parent and the child (Madide et al., 2012). Researchers have found that early exposure to illegal drugs (e.g., cannabis, heroin, methamphetamine) can result in a variety of delays that can negatively affect infants and young children, particularly relating to physical and emotional developmental delays (Altshuler & Cleverly-Thomas, 2011; Children's Bureau, 2014; Madide et al., 2012; Ross, Graham, Money, & Stanwood, 2015). While there are approximately 30 years of research on the implications of illegal drug exposure on infants, I was unable to find research that explored how this drug exposure interacts with the infant attachment process; whether the interaction enhances, is neutral, or impedes the attachment process (Altshuler & Cleverly-Thomas, 2011; Madide et al., 2012; Ross et al.,2015). Furthermore, children who are exposed to neglect, abuse, or illicit substance in-utero who are not immediately removed from their natural parents' care are at a higher risk of experiencing neglect or abuse by the drug-using parent, or other traumatic events, such as domestic violence or parental illegal activities (Altshuler & Cleverly-Thomas, 2011). These exposures can also decrease a child's ability to create secure attachments to an existing parent or caregiver (Zeanah, Berlin, & Boris, 2011).

Children who are not provided an adequate opportunity to create healthy attachments with a caregiver are at risk for a variety of behavioral and mental health challenges later in life (Elovainio, Raaska, Sinkkonen, Mäkipää, & Lapinleimu, 2015; van Rosmalen, van der Horst, & van der Veer, 2016; Zeanah et al., 2011). These children are more likely than the general population to display aggression, hyperactivity, impulsivity, an inability to appropriately relate to peers, cognitive and developmental delays, and a higher rate of diagnosed mental health disorders that persist into adolescence and adulthood (Elovainio et al., 2015; van Rosmalen et al., 2016; Zeanah et al., 2011).

Current research indicates that despite the implementation of interventions, 55% of drug-exposed children in foster care are unable to develop or maintain a healthy and secure attachment to a safe caregiver within the first 2 years of placement (Bovenschen et al., 2016). The etiology of this statistic relates to a lack of attachment that has not yet been explored. Children exposed to drugs experience a variety of barriers to healthy attachments, such as feelings of fear and anxiety. These barriers can be overcome when a new, secure caregiver is introduced into a child's life and therapeutic interventions addressing attachment are implemented (Bovenschen et al., 2016; Bruskas, 2010; Cihan, Winstead, Laulis, & Feit, 2014; Lang et al., 2016). Although research on drug exposure and childhood attachment revealed important findings, I found no research that examined caregiver perceptions of in-utero drug exposure on a child's ability to respond to a caregiver's efforts to create healthy attachments.

Purpose of the Study

The purpose of this generic qualitative study was to improve understanding of the perceptions of caregivers about their attachment efforts with foster children under the age of three, who have had in-utero methamphetamine exposure. The focus of past research has been on attachment deficits that occurred based on a caregiver's responsiveness to the child's needs and cues (Bovenschen et al., 2016; Bruskas, 2010; Cihan et al., 2014; Lang et al., 2016). I explored the issue of attachment from the perspective of the caregiver, which was done through in-person, semistructured interviews with foster parents in the Southwest United States, through the local Department of Family Service Agencies, and their various foster care subsidiaries.

Research Question

The research question that guided this qualitative study was as follows:

For children exposed to methamphetamine in utero, how do their caregivers (i.e. fictive kin, foster parents) perceive the child's responsiveness towards efforts to build a healthy attachment?

Theoretical Framework

Bowlby (1947, 1951) and Ainsworth (1969, 1979) published their ideas of attachment theory in the late 1960s (van Rosmalen et al., 2016). The focus of this theory is that infants require the attention and responsiveness of a caregiver to create the foundation for meeting a child's developmental milestones (van Rosmalen et al., 2016). When a caregiver is unable to respond in an appropriate manner, this can create insecurities within the attachment, either forcing the infant to seek out others or become

unresponsive, thus hindering the developmental processes (van Rosmalen et al., 2016). For the last 50 years, attachment theory has been the primary means to define and explore parent-child relationships and it remains a relevant foundation for the basis of mental health in all beings (van Rosmalen et al., 2016).When a caregiver is able to meet the physical and emotional needs of a child, the child must then be able to respond with "attachment behaviors," which consist of reaching for or moving towards one caregiver over other caregivers in an environment (Ainsworth, 1969; Bowlby, 1951). researchers use these responses to define and report on healthy attachments (Ainsworth, 1969; Bowlby, 1951). Bowlby (1947, 1951) and Ainsworth (1969, 1979) assumed that all children have the capacity to engage in these "attachment behaviors," such as object permanency, constancy, sustained eye contact, etc. Thus, when barriers exist that may impede this ability, such as methamphetamine exposure, further evaluation is required to understand how to better help this population meet standardized developmental milestones.

Bowlby's (1947) theory of attachment focuses on a child's need to seek out an emotional connection with a selected individual to meet his or her physical and emotional needs as a means to ensure survival (Zeanah et al., 2011). In meeting these physical and emotional needs, a child is then able to feel safe and secure in this caregiver-child relationship, which in turn results in self-awareness, self-assurance, and independence (Zeanah et al., 2011).

In Chapter 2, I provide an in-depth background on information concerning attachment theory, the connection between healthy attachments and social-emotional

development, and the role of parental methamphetamine use during pregnancy on the development process of the child after birth. I examine the need to expand the literature to include current research regarding parental methamphetamine use, child social-emotional development, and the role of attachment in this development process.

Nature of the Study

This study was a qualitative study utilizing a generic qualitative approach. Through the use of semistructured interviews, I met with foster parents in Southern Nevada regarding foster children that they have provided care for, who are aged 3 and under, and have documented methamphetamine exposure. During these meetings, I conducted a guided interview to ascertain their perspectives on their foster child's responsiveness to their efforts to build a healthy and secure attachment. Each interview was then coded according to their responses to the preformulated questions.

Definitions

The following terminology was used throughout this study:

Attachment: The child's efforts to build and seek a connection with a caregiver who will be able to meet their emotional and physical needs through the child's development (Bowlby, 1947; Bowlby, 1951; Zeanah, Berlin, & Boris; 2011). These connections are the foundation for the future development of self-awareness, self-assurance, and independence (Bowlby, 1947; Bowlby, 1951; Zeanah, Berlin, & Boris; 2011). Attachment is further defined into four sub-categories; avoidant, disorganized, ambivalent, and secure (Bowlby, 1947; Bowlby, 1951; Ainsworth 1969; Ainsworth, 1979).

Secure attachment: Children who are in the process of developing a secure attachment are able to maintain a healthy balance of independence and reliance within their caregiver-child relation (Lang et al., 2016). They are able to explore their environment, while being able seek out their caregiver when in need of assurance or reassurance (Lang, et al., 2016). Furthermore, children with a secure attachment are able to display trust and connectedness with their caregivers, for they are easily able to be consoled when upset and seek out assistance to meet their physical and emotional needs (Lang, et al., 2016).

Ambivalent attachment: Children who have developed an ambivalent attachment style, display behaviors congruent with quickly identifying and establishing an attachment in a short period of time, and within the foundations of this relationship, become overly attached to this caregiver (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011). The establishment of these attachments often occur with caregivers with whom the child has had minimal interactions, and thus has no knowledge relating to trustworthiness or safety; which is then later tested through complex behavior displays (Zeanah, Berlin, & Boris; 2011). In forming these quick attachments to caregivers, the child is utilizing this intense expression of emotion as a means to connect to a caregiver so that a caregiver does not again reject them, as in the past (Zilberstein, 2014). These children are easily distressed, particularly if the caregiver leaves and they are often difficult to comfort in times of distress. They may even become increasingly distressed when a caregiver makes efforts to meet a child's physical or emotional needs, for the lack of this occurring in the

past has created an uncertainty as to why a caregiver is attempting to meet such needs (Lang et al., 2016; Zeanah, Berlin, & Boris; 2011).

Avoidant attachment: Children who have developed an avoidant attachment style do not seek out their caregivers to meet their emotional or physical needs, as they attempt to hide their expressed need for both physical and emotional attention. This is done as a means to attempt to meet a caregiver's emotional and attachment needs based on the child's perspective, which has been based on a bias created from past caregivers who did not make an attachment with them (Zilberstein, 2014). In the process of blunting their emotional and physical needs, they then begin to display more focus on exploring their environment as a means of hiding their emotional responses from their caregiver, thus creating a barrier to assist in protecting themselves from emotional pain, disappointment, and further rejection (Lang, et al., 2016; Zilberstein, 2014).

Disorganized attachment: Children who have developed a disorganized attachment style display a combination of ambivalent and avoidant attachment styles (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011). These children oscillate between avoiding attachments with caregivers and being clingy to the same caregiver within small timeframes, displaying the juxtaposition of both wanting to form an attachment while also fearing the rejection that they have become accustomed to (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011; Zilberstein, 2014).

Child welfare: Child welfare is a descriptive term used across the country to describe the foster care system and the associated departments that evaluate allegations of

child abuse and neglect (Children's Welfare Gateway, 2013; Children's Bureau, 2014a; Children's Bureau, 2014b

In-utero drug exposure: the exposure of a fetus to a chemical substance (i.e. opioids, amphetamines, alcohol, marijuana) that is documented to have potential impacts on the fetus's development (Abar, et al., 2014; Kiblawi, et al., 2014; Madide et al., 2012; Minnes, Lang, & Singer, 2011).

Assumptions

The first assumption was that all participants were foster parents who were providing care for children with methamphetamine exposure. This assumption was necessary, as the focus of the study is the relationship between a methamphetamine exposed child and their foster parent. The second assumption was that all the responses from the participants were honest. This assumption was necessary, as the honest response of the caregiver was what allowed for an accurate and in-depth understanding of their experiences and perceptions. The third assumption was that the use of semistructured interviews with the participants yielded accurate and in-depth data of their experiences and perceptions. This assumption was necessary, as a semistructured interview was utilized to ensure consistency amongst all participants, and thus gain the knowledge of said experiences.

Scope and Delimitations

The scope of this study was foster parents in Southern Nevada, who were currently providing care for children under the age of 3 with methamphetamine exposure, as reported by the caregiver. With such a specific scope and geographical region, it was

understood that the overall outcomes of this study would not be generalizable to the general public. However, it is likely that this research has future implications for foster parents who are currently providing care to children under the age of 3 with methamphetamine exposure. This research has the potential to better support the mental health needs of foster children, thus allowing for the creation of new early intervention strategies that will better address the role of attachment with children who have in-utero drug exposure.

Delimitations existed in this study. Using purposeful sampling, I focused only on those foster parents who were working with children under the age of three and with reported methamphetamine exposure, within Southern Nevada. The interviews conducted in this study consisted of 10 foster parents across Southern Nevada to maintain congruence with validity established by studies working with a similar population.

Limitations

Within this study, there were two limitations: that of the sample size and that of the lack of geographical variance amongst the sample (all participants were from Southern Nevada). With regards to the specific sample size, though small with the use of seven participants, the focus of the study was to gain an in-depth understanding of the participant's perceptions and experiences. Thus, a smaller sample size limits the ability to of the findings to be generalized.

Significance

This research study is important because it explored attachment, from the caregiver's perspective, of the foster child's responsiveness when it was known that the

child had experienced methamphetamine exposure. Specifically, this study focused on data from foster parents who cared for methamphetamine-exposed children aged 3 and under. Current researchers demonstrated that these children are more likely than the general population to display aggression, hyperactivity, impulsivity, an inability to appropriately relate with peers, cognitive and developmental delays, and a higher rate of being diagnosed with a mental health disorder (Bruskus, 2010; Elovainio et al., 2015; van Rosmalen et al., 2016; Zeanah et al., 2011). However, the current research has displayed a consistent focus on the caregiver's role in the development of a healthy attachment. Research has shown that, through the replication of Ainsworth's (1969, 1979) strange situation, only 45% of children with drug exposure were able to appropriately respond to these efforts; that they made eye contact and engaged in developmentally appropriate responses to bonding stimuli. Thus, it can be inferred that the majority of drug-exposed children display some form of individual deficit in their ability to create and maintain healthy attachments with a new caregiver (Bovenschen et al., 2016). However, these statistics are focused on the use of the strange situation, and not on associated attachment behaviors, such as constancy, object permanence, appropriate eye contact, and mirroring. (Pallini & Barcaccia, 2014). By exploring this concept, I sought to increase both the understanding of the attachment process and the therapeutic interventions used when deficits in caregiver-child attachment are present. The yielded the potential to increase the rate of attachment in drug-exposed infants and decrease the negative effect on society of behaviors associated with drug-exposed children.

Summary

This chapter has provided a generalized overview of the study as a whole, providing a glimpse into the background of the topic of attachment, a history of research, and why further research is needed. Furthermore, this chapter identified where a gap exists within the current literature and the societal changes that impact the development of healthy attachments.

Chapter 2 provides an in-depth look at related peer-reviewed literature. Chapter 3 defines the methodology. Chapter 4 focuses on the data that was gathered through the semistructured interviews. Chapter 5 summarizes that collected data.

Chapter 2: Literature Review

Introduction

The research explored the social and emotional milestones associated with attachment, as reported by the primary caregivers of foster? children. This literature review created a framework to understand the perceptions and experiences of caregivers on a foster child's responsiveness to efforts of healthy attachments when these children were exposed to methamphetamine during pregnancy. By exploring this concept, an opportunity arose to gain an understanding of the attachment process in children under the age of three who are part of the foster care system, based on the caregiver's perceptions of the caregiver-child relationship. There then exists the potential to better understand attachment in drug-exposed infants and increase the ability to respond and intervene in these deficits, and thus creating a prospect to minimize the negative impact that the behaviors associated with parent-child attachment difficulties have on society.

Research Strategies

An exhaustive search of the literature was conducted on the issue of methamphetamine exposure during pregnancy and attachment theory. This literature search encompassed a variety of databases for literature published in the English language from 1950 to 2017. The databases I searched included the following: EBSCOhost, Academic Search Complete, PsycINFO, PsycARTICLES, ProQuest Central, SAGE Journals, Thoreau Multi-Database Search, and SocINDEX. Internet sources included web pages from established organizations, such as (a) (b) (c) . The keywords and phrases used alone or in combination included the following: *attachment*

theory, prenatal drug exposure, foster care, in-utero drug exposure, childhood development, childhood mental health, and infant social-emotional development. Reference sources compiled for the literature review were predominantly peer-reviewed journal articles published within the last 5 years on the topics of methamphetamine exposure during pregnancy and attachment theory.

Conceptual Framework

John Bowlby (1947) began exploring human relationships, particularly the parent-child relationship, in the early 1940's. Bowlby (1947) explored improving family functioning through an exploration of familial relationships, which eventually challenged the status quo of childhood mental health. Prior to his research, the first few years of a child's life were not considered an important factor in social-emotional development and family functioning (Bowlby, 1947). His expansion of the family relationship and his idea that the relationships established from birth culminated in Bowlby's theory of attachment (Bowlby, 1947; Bowlby, 1951). His theory of attachment focuses on a child's need to seek out an emotional connection with a selected individual to meet his or her physical and emotional needs—particularly when scared, sick, or tired—to ensure survival (Bowlby, 1947; Bowlby, 1951; Zeanah, Berlin, & Boris; 2011). In meeting these physical and emotional needs, a child is then able to feel safe and secure in this caregiver-child relationship, which in turn results in self-awareness, self-assurance, and independence (Zeanah, Berlin, & Boris; 2011). The foundation of a healthy attachment, though instigated by the infant, is not based on the needs and wants of the infant, but on the parent's responsiveness to his needs (Bowlby, 1951).

Since originally developed by Bowlby (1947, 1951) and expanded by Ainsworth (1969, 1979), attachment theory has been accepted as a survival mechanism in infants; a mechanism that allows for an infant to create a bond with a caregiver that is able to meet their physical, physiological, and emotional needs (Carlson, Hostinar, Mliner, & Gunnar, 2014). Research in this topic has explored both healthy and unhealthy attachments, as well as the outcomes associated with each (Bovenschen, et al., 2016; Elovainio, Raaska, Sinkkonen, Mäkipää, and Lapinleimu. 2015 and Zeanah, Berlin, and Boris, 2011). These outcomes have particularly focused on the relation of unhealthy relationships and the increased risk for behavioral and mental health issues in children who develop unhealthy attachments (Bovenschen, et al., 2016; Elovainio, Raaska, Sinkkonen, Mäkipää, and Lapinleimu. 2015 and Zeanah, Berlin, and Boris, 2011).

Types of Attachment

Bowlby (1988) postulated four different types of attachment; secure, ambivalent, avoidant, and disorganized, each of the four is described below.

Secure. Children who are in the process of developing a secure attachment are able to maintain a healthy balance of independence and reliance within their caregiver-child relation (Lang et al., 2016). They are able to explore their environment, while being able seek out their caregiver when in need of assurance or reassurance (Lang, et al., 2016). Furthermore, children with a secure attachment are able to display trust and connectedness with their caregivers, for they are easily able to be consoled when upset and seek out assistance to meet their physical and emotional needs (Lang, et al., 2016). This emotional responsiveness creates a dyadic responsiveness between the child and the

caregiver which helps the brain appropriately develop coping strategies, the ability to successfully regulate emotions, and the foundation for social relationships throughout a lifespan (Zilberstein, 2014).

Ambivalent. Children who have developed an ambivalent attachment style, display behaviors congruent with quickly identifying and establishing an attachment in a short period of time, and within the foundations of this relationship, become overly attached to this caregiver (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011). They establishments of these attachments often occur with caregivers with whom the child has had minimal interactions, and thus has not knowledge relating to trustworthiness or safety; which is then later tested through complex behaviors dispalys (Zeanah, Berlin, & Boris; 2011). In forming these quick attachments to caregivers, the child is utilizing this intense expression of emotion as a means to connect to a caregiver so that a caregiver does not again reject them, as in the past (Zilberstein, 2014). These children are easily distressed, particularly if the caregiver leaves and they are often difficult to comfort in times of distress. They may even become increasingly distressed when a caregiver makes efforts to meet a child's physical or emotional needs, for the lack of this occurring in the past has created an uncertainty as to why a caregiver is attempting to meet such needs (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011).

Avoidant. Children who have developed an avoidant attachment style do not seek out their caregivers to meet their emotional or physical needs, as they attempt to hide their expressed need for both physical and emotional attention. This is done as a means to attempt to meet a caregiver's emotional and attachment needs based on the child's

perspective, which has been based on a bias created from past caregiver's who did not make an attachment with them (Zilberstein, 2014). In the process of blunting their emotional and physical needs, they then begin to display more focus on exploring their environment as a means of hiding their emotional responses from their caregiver, thus creating a barrier to assist in protecting themselves from emotional pain, disappointment, and further rejection (Lang, et al., 2016; Zilberstein, 2014). These behaviors are congruent with children avoiding the attachment efforts of their caregiver. (Lang, et al., 2016).

Disorganized. Children who have developed a disorganized attachment style display a combination of ambivalent and avoidant attachment styles (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011). These children oscillate between avoiding attachments with caregivers and being clingy to the same caregiver within small timeframes, displaying the juxtaposition of both wanting to form an attachment while also fearing the rejection that they have become accustomed to (Lang, et al., 2016; Zeanah, Berlin, & Boris; 2011; Zilberstein, 2014). Furthermore, these changes in attachment do not occur on a consistent timeframe, and are unique from individual to individual, as a means of self-preservation or as a means of self-defense in order to prevent themselves from feeling the emotional pain that they have become accustomed to when others have not formed healthy attachments to them (Lang, et al., 2016; Zilberstein, 2014).

The study of attachment has mainly focused on the long-term implications of unhealthy attachments in children due to inadequate parent-child relationships and environments (Zeanah & Gleason, 2015). This negative impact on the social-emotional

and behavioral development of the child can be seen and diagnosed before the age of six, which is congruent with Bowlby's theory that healthy attachments become the foundation of functional mental health in human beings (Bowlby, 1947; Bowlby, 1951; Zeanah, Berlin, & Boris, 2011; Elovainio, et al., 2015). This research suggests that without the ability of a child to develop a healthy attachment to a caregiver, they will experience emotional instability and behavioral problems from childhood into adulthood.

Expansion of Attachment Theory over Time

Over the last 50 years, there have been many researchers who have contributed to the expansion of attachment theory, such as Ainsworth (1969, 1979), Slade (2014), Lieberman (2014). Most notably, Ainsworth (1969, 1979) expanded the definitions of attachment types, as well as – the specific characteristics that helped define a healthy attachment based on observations seen when strangers are introduced and caregivers leave a child in what is known as the "Strange Situation Procedure." The "Strange Situation Procedure" created the primary means to assess and measure a caregiver-child attachment based on the child's responses to changes in the environment (Ainsworht, 1969; Ainsworth, 1979). Ainsworth (1969, 1979) developed a procedure in which a caregiver, a young child, and a stranger were witnessed to have structured, short-term interactions within a room as a means to understand whether the child was able to explore and define their caregiver as a secure base, if they chose to attach to a stranger to meet their immediate needs, or if they became unresponsive (Ainsworth, 1969; Ainsworth, 1979). Thus, by introducing external stimuli of a stranger to children in the form of a new person, the stability of a child's attachment was able to be rated and defined. Ainsworth

maintained consistency in the existing terms created by Bowlby in the early 1950's, though she expanded on his existing definitions to include the responsiveness of young children within the pattern of parental attachment (Ainsworth, 1969; Ainsworth, 1979).

An understanding of these definitions, that of secure, ambivalent, disorganized, and anxious, and responses established the way in which attachment would later be utilized to evaluate how children's behaviors and emotional responses to change in caregivers and when attachment- based interventions would be needed. For each different type of attachment is identified by specific traits and characteristics, which are in need of unique interventions to help assist the caregiver-child dyad to create a healthy and secure attachment (Ainsworth, 1969; Ainsworth, 1979). Through this experimentation and the establishment of attachment categories and definitions, it then became possible to identify areas of concern and need within the attachment process, thus allowing for attachment interventions to be identified and disseminated to a community of mental health professionals.

Biology and Attachment

As science progressed and a better understanding of neurology and neuropsychology became more readily available, so too did the understanding of attachment issues and child development. The human brain is not fully formed and attachment to a caregiver does not exist at the time of birth, thus allowing for growth, adaptation, and manipulation as the child begins to experience new environments and interactions (Carlson, Hostinar, Mliner, & Gunnar, 2014; Meyer, Wood, & Stanley; 2013; Zeanah, Berlin, & Boris, 2011). It is within that first year of life, based on their

experiences with a caregiver, that a child's attachment pattern is fostered and determined (Carlson, Hostinar, Mliner, & Gunnar, 2014; Meyer, Wood, & Stanley; 2013; Zeanah, Berlin, & Boris, 2011). These experiences that guide attachment development are based on touch interactions, how a caregiver meets the child's physical needs, and how the caregiver responds to the child's emotional needs (Carlson, Hostinar, Mliner, & Gunnar, 2014; Jakubiak & Feeney, 2016; Meyer, Wood, & Stanley; 2013; Zeanah, Berlin, & Boris, 2011). With the understanding that the foundation of attachment is not an inherent developmental process, there was a shift in the research focus from the biological parent creating these experiences of attachment to any available caregiver, such as grandparents or foster parents (Carlson, Hostinar, Mliner, & Gunnar, 2014; Meyer, Wood, & Stanley; 2013; Zeanah, Berlin, & Boris, 2011). Furthermore, as research in this area continued, it became apparent that the need for a child to create a healthy attachment was not just a process of bonding, but was, in fact, an instinctual biological drive (van Rosmalen, van der Horst, & van der Veer, 2016). Through caregiver-child touch, there is a release of the chemical oxytocin, which allows for the caregiver to bond with a child and increase feelings of sensitivity, compassion, and a relational bond between them (Bhandari et al., 2014; Jakubiak & Feeney, 2016). Through this experience, not only does the caregiver become more sensitive to the child's needs, but the child also begins to establish feelings of safety and security within the caregiver-child relationship (Jakubiak & Feeney, 2016). Thus, without this biological process, caregivers do not respond to the children, and the children never establish a sense of safety and security in their own life (Bhandari et al., 2014; Jakubiak & Feeney, 2016). It is through this research that it became apparent that,

while attachment is imperative for continued life in children, it is also engrained in human biology as an innate and fundamental skill.

Effects of the Absence of Healthy Attachment

As expressed above, the development of a healthy attachment to a caregiver is the basis for functional development in human beings. When this attachment is not achieved, various concerns arise for those individuals. From a developmental perspective, children who do not form healthy attachments not only exhibit indiscriminate social and emotional behaviors towards anyone who may be able to meet their needs, but Researchers found that they were also unable to meet childhood milestones on time and were at a greater need for special education services (Zeanah & Gleason, 2015). Throughout adolescence, these children also displayed notable challenges in their ability to engage in age appropriate social interactions and prosocial behaviors, had higher rates of aggression and hyperactivity, and displayed a higher need for intensive mental health services (Christian, Sellbom, & Wilkinson, 2017; Zeanah & Gleason, 2015). From a long-term perspective, adults who did not form healthy attachments in early childhood were at a higher rate of diagnosed mental health disorders that persisted into adolescence and adulthood, and were often involved in unhealthy and unstable romantic relationships (Elovainio et al., 2015; Hillen, Gafson, Drage, & Conlan, 2012; Jakubiak & Feeney, 2016; van Rosmalen et al., 2016; Zeanah et al., 2011). Children who experience insecure attachments have lower rates of empathy and compassion, may lack appropriate peer relationships, may lack appropriate relationships with authority figures, may lack a sense of loyalty and connectedness to their interpersonal relationships, and may be more aggressive than the

general population (Christian, Sellbom, & Wilkinson, 2017). There also exists a higher prevalence of lying, stealing, hoarding, manipulation, cruelty towards animals, sexual misconduct, and patterns of pyromania that extend into adolescence and adulthood (Christian, Sellbom, & Wilkinson, 2017; Zilberstein, 2014). All of these concerns are generally noted as conduct disorders, which in turn results in an increased rate of interaction with the criminal justice system as juveniles (Christian, Sellbom, & Wilkinson, 2017; Zilberstein, 2014). Furthermore, there are higher rates of anxiety, depression, attention deficit hyperactivity disorder, somatic symptoms, and externalizing behaviors related to the depression and anxiety noted above (Elovainio et al., 2015; Wilkerson, 2017). These personality traits, as adolescents transition into adulthood, are more congruent with personality disorders, as well as increased behavioral and emotional problems, that can result in long-term consequences, such as incarceration and institutionalization (Christian, Sellbom, & Wilkinson, 2017; Elovainio et al., 2015; Wilkerson, 2017). This in turn has the potential to result in long-term criminal behaviors that require society to be financially responsible for them either through the criminal justice system, long-term incarceration, half-way houses, and short-term incarcerations (Elovainio et al., 2015; Wilkerson, 2017). Thus, it appears that without healthy attachments in infancy and early childhood, individuals may not only fall behind in expected development, but they are also more likely to struggle with overall functioning and have the potential to become a burden on society.

In understanding outcomes of insecure attachments, there are many present risk factors that increase a child's likelihood to lack a healthy attachment to a caregiver.

Children who are not presented with an opportunity to form healthy attachments to a caregiver are disproportionally found within specific populations; homes with parental substance abuse, parental mental illness, and domestic violence (Raman & Sahu, 2014). Within these family systems, the children are also at a higher risk of exposure to some form of abuse or traumatic event, which are patterns congruent with early social deprivation and removal from natural parents into the child welfare system (Carlson, Hostinar, Mliner, & Gunnar, 2014; Raman & Sahu, 2014).

Caregiver Perceptions

Children within the foster care system, in addition to lacking opportunities to create secure attachments, they must also attempt to build a relationship with a new caregiver, and these caregiver's have perceptions and past experiences that may also impact the establishment of this relationship. In general, I have been unable to find specific research found regarding the caregivers perceptions of attachment within their relationships with foster children or the their views on the a young child's responsiveness to their attempts at creating a bond. Though, research does exist regarding caregiver responsiveness to problem behaviors, which are often related to attachment difficulties, and to treatment interventions (Bick, Dozier, & Moore, 2012; Gabler, et al., 2014; Jacobsen, Ivarsson, Wentzel-Larson, Smith, & Moe, 2014; Roosa, Webb, Sadler, & Slade; 2015). It is noted throughout the research, that those that choose to become foster parents are making a conscious choice to alter their lives, thus there is a presumption that the caregiver's perspectives on attachment and potential difficulties are well informed, thus creating a foundation to address any potential issues (Bick, Dozier, & Moore, 2012;

Gabler, et al., 2014; Jacobson, et al., 2014). However, this foundation does not adequately prepare all families for the challenges associated with the foster care system. As difficulties arise, particularly in relation to behavioral problems displayed by the child, research shows that caregiver's who report increases in levels of stress and frustration related to said behaviors also displayed less empathy and sensitivity to the child's behaviors, which in turn can lead to barriers in the caregiver-child relationship and the potential disruption of the placement (Bick, Dozier, & Moore, 2012; Gabler, et al., 2014). These behaviors appear to be consistently categorized into groups such as aggression or risk-taking behaviors, such as impulsivity or a lack of awareness of danger or harm; which in turn creates the above-described barriers within the caregiver-child relationship (Taylory & McQuillan, 2014). It should also be noted that these issues of attachment and concerning behaviors are often related to developmental traumas that have compounded in these children's short lives; which then test the strength of their minimally-existent attachment through the lack of caregiver knowledge or sensitivity to this topic (Gabler et al., 2014). Furthermore, researchers have found that it took approximately six-months for the caregiver and child to build an adequate relationship; yet, when the majority of placement disruptions occurred within four months of a child being placed within the home (Bick, Dozier, & Moore, 2012; Gabler, et al., 2014; Jacobson, et al., 2014; Taylor & McQuillan, 2014). It is within this timeframe that the caregivers own attachment experiences, trauma's and understanding of their role within the caregiver-child relationship, thus defining caregiver sensitivity, play a substantial role in the success of the development of this attachment, and the overall compatibility of a

foster child in their life (Bick, Dozier, & Moore, 2012; Gabler, et al., 2014; Jacobson, et al., 2014; Taylor & McQuillan, 2014). Thus, while there is not direct research on a caregiver's perspective of attachment, the current research does show that when a caregiver has increased levels of stress and distress within the caregiver-child relationship due to the child's behaviors, the ability to establish, build, and solidify the needed attachment becomes hindered.

Child Welfare

The Child Welfare System was formally established in the United States in 1974 with the passing of the Child Abuse Prevention and Treatment Act. This Act was designed to better prevent, address, and respond to child abuse issues (Children's Welfare Gateway, 2013). The federal government created a way to assist states and local governments in more consistent and concise responses to allegations of abuse. This, in turn allowed for children to be better protected (Children's Welfare Gateway, 2013). The act established federal guidelines that provided legal rights for children who have been abused, as well as established how caseworkers within the Child Welfare System were to engage with the family (Children's Welfare Gateway, 2013). As of the end of the federal fiscal year 2014, approximately 415,129 children resided in the Foster Care System (Children's Bureau, 2014a; Children's Bureau, 2014b). Of this population, 28% were aged 3 years and under, and of those children, approximately 31% were removed from their natural parent's due to parental drug use (Children's Bureau, 2014a; Children's Bureau, 2014b). Children often enter the foster care system through abuse or neglect by their primary caregiver (Children's Welfare Gateway, 2013). There are six specific forms

of abuse; physical abuse, neglect, sexual abuse and exploitation, emotional abuse, parental substance abuse, and abandonment (Children's Welfare Gateway, 2016). Though each state defines the specifics of child abuse and child neglect, there exist common definitions that help guide this process (Children's Welfare Gateway, 2016).

Children within the child welfare system have unique early childhood experiences that have been linked to long-term medical and social-emotional challenges (Raman & Sahu, 2014). Raman and Sahu (2014) evaluated the risk and rate of medical and social-emotional delays of children, primarily under the age of five, in the child welfare system. Their research showed that over 50% of their participants displayed symptoms of mental illness and that approximately 45% had some other form of developmental delay (Raman & Sahu, 2014).

Within these statistics of mental illness in the child welfare system, one set of behaviors is particularly prevalent; those associated with attachment (Bovenschen, et al., 2016; Oliveira, et al., 2012; Zilberstein, 2014). Within the child welfare system, approximately 42% of children under the age of nine show an indiscriminate pattern of attachment, thus indicating that while material and physical needs are being met by the variously encountered caregivers, the inconsistent presence of one caregiver for a period time leaves a lasting impact on how relationships are established and maintained (Bovenschen, et al., 2016; Oliveira, et al., 2012; Zilberstein, 2014).

The use and abuse of illicit substances has posed social, medical, legal, and economic problems within every society and socioeconomic level. However, it has only been within recent years that studies have been conducted to explore the impact of this

drug exposure on pregnant women and their fetuses (Abar, et al., 2013; Behnke & Smith, 2013; Ross, Graham, Money, & Stanwood, 2014). It is estimated that 4.4% of pregnant women engage in illicit drug use, and 0.01 of pregnant women use methamphetamines (Behnke & Smith, 2013; Smith et al., 2015). Though, it should be noted that these statistics are based on self-report, and that the actual rates of illicit drug use, including that of methamphetamine are believed to be underreported (Behnke & Smith, 2013).

In children who have experienced in-utero exposure to methamphetamines, there are documented concerns relating to developmental delays (Abar, et al., 2014; Kiblawi, et al., 2014; Madide, Smith, & Odendall, 2012; Minnes, Lang, & Singer, 2011). In infancy, for example, there is consistent documentation that methamphetamine exposed children display higher states of arousal and asymmetrical reflexes, which are also congruent with a higher state of stress at birth (Kiblawi, et al., 2014). These children also have abnormal sleep patterns, difficulties with feeding, and poor muscle tone (Madide, Smith, & Odendall, 2012; Minnes, Lang, & Singer, 2011). Furthermore, there are acknowledged physical defects, such as low birth weights and smaller head circumferences (Abar, et al., 2014; Madide, Smith, & Odendall, 2012; Minnes, Lang, & Singer, 2011).

As a child grows into toddlerhood, the effects of methamphetamine exposure continue to remain. Children over two-years of age often struggle to engage in appropriate visual motor coordination, have poor attention spans, and struggle to engage in complex tasks associated with school attendance (Ross, Graham, Money, & Stanwood, 2014). These children are also more likely than the general population to display aggression, hyperactivity, impulsivity, an inability to appropriately relate with peers,

cognitive and developmental delays, and a higher rate of diagnosed mental health disorders that persist into adolescence and adulthood (Abar, et al., 2013; Elovainio et al., 2015; van Rosmalen et al., 2016; Zeanah et al., 2011).

However, while research has continued to explore various physical and behavioral experiences, as well as long-term mental health outcomes of children with methamphetamine exposure, there continues to be a lack of research exploring the caregiver's understanding and personal perspective within the attachment process in foster children with methamphetamine exposure.

Summary

Attachment theory provides a foundation for explaining the importance of interpersonal relationships within the process of human development, and how faults within these relationships can cause various long-term delays and implications for overall functioning. Bowlby's (1947, 1951, 1988) theory focused on the parent's ability to appropriately respond to the needs of his or her child. However, at the time in which Attachment Theory was hypothesized and researched, the use of illicit drugs such as methamphetamine, by the birth mother was not as prevalent, and thus not represented in the original research. This issue has resulted in an increase in children entering the child welfare system, which in turn has resulted in an increase in the population at risk for unhealthy attachments to caregivers. Thus, I have been unable to find research that addresses and explores the perceptions of attachment from caregivers who have children with in-utero methamphetamine exposure. These perceptions are based on their observations regarding the child's ability to respond to a healthy caregiver and create the

healthy attachment that is so important to long-term development and the stability of mental health.

Conclusion

Research continues to expand the understanding of the importance of healthy attachments and the negative consequences of in-utero drug exposure. These two paths of research continue to exist in parallel; however, it appears that there is interrelatedness within these two topics, particularly within the child welfare system. More research seeks to explore these facets in conjunction with each other, not as separate problems.

Chapter 3 will address the methodology of the present research study including a brief review of research design, population and sampling procedures, instrumentation, statistical analysis, threats to validity, and ethical considerations.

Chapter 3: Research Method

Introduction

Much of the current research in attachment theory focuses on exploring and understanding the issue from the perspective that delays ‘in attachment and struggles are based on a lack of appropriate responsiveness from the caregiver (Bovenschen et al., 2016; Bruskas, 2010; Cihan et al., 2014; Lang et al., 2016). After an exhaustive review of the literature, I was unable to find research that explored perceptions of attachment from caregivers who were fostering children with in-utero drug exposure. There are about 128,000 children in the United States who are at an increased risk of behavioral and emotional delays and difficulties, such as anxiety, hyperactivity, defiance, aggression, and an inability to relate to appropriate peers, due to in-utero drug exposure (Altshuler & Cleverly-Thomas, 2011; Children’s Bureau, 2014a; Madide et al., 2012; Ross et al., 2015). Approximately 40% of children over the age of 3, without known in-utero methamphetamine exposure, can exhibit difficulties in their ability to respond to healthy caregivers attempting to establish healthy attachments (Bovenschen et al., 2016). However, Bovenschen et al.’s (2016) focus was on children over the age of 3, in which there was a period of time in which these children had an opportunity to form attachments to unhealthy caregivers or various foster care placements; they also had the chance to experience various traumas that eventually resulted in their removal from their families of origin. These predictors and outcomes of Bovenschen et al. (2016) have not been generalized to children under the age of 3. Thus, the focus of my study was to gain a

better understanding of attachment to healthy caregivers for children with in-utero drug exposure under the age of 3.

The purpose of this generic qualitative study was to gain an understanding of the perceptions of attachment from caregivers who were fostering children with in-utero drug exposure. I explored this issue of attachment from the perspective of the caregiver through semistructured interviews with foster parents in Southern Nevada. This chapter provides an explanation of the methodology of this research study. I review the generic qualitative study design as well as the arrangement and implementation of the research procedures utilized to gather and analyze the thematic results.

Research Design and Rationale

The research question that guided this qualitative study was as follows:

For children under the age of 3 with in-utero drug exposure, how do their caregivers perceive the child's responsiveness towards efforts to build a healthy caregiver-child attachment?

This question was explored by seeking observations from the caregiver as to the child's responsiveness to affection, direct eye contact, physical touch, and interactions in games.

In this research I aimed to answer the research question relating to attachment efforts between foster children and their caregivers, from the perspective of the caregivers, using a case study approach. Qualitative methodology guided the use of a semistructured interview strategy to obtain the necessary data. I interviewed the foster parents of children, under the age of 3, within the foster care system. These interviews

provided data that allowed me to understand the nuances of the attachment present within this dyad from various caregivers' point of view. Data were also collected through a thorough literature review with a focus on attachment and child development.

By utilizing a generic qualitative approach, I was able to engage with the participants in a manner that facilitated open communication to better understand their experiences related to fostering children exposed to methamphetamine (Moustakas,1994). The use of the generic qualitative study approach allowed me to focus on gaining an in depth understanding of attachment experiences in children with in-utero drug exposure, for the use of illicit substances was not as prevalent within the timeframe of Bowlby's (1947, 1951, 1988) original research (Moustakas,1994). The use of this generic qualitative approach allowed me to gain perspective on the caregiver-child dyad that is attempting to exist under the strain of external stimuli (Moustakas,1994).

In addition to the key points addressed above, a foundational piece to generic qualitative research is the understanding of the theory that is guiding the research process (Moustakas,1994). These research processes then established a guided direction for data collection (Moustakas,1994). The theory that guided this proposition is that of Bowlby's attachment theory (1947, 1951, 1988). As described above, the interactions between the participants and myself occurred as semistructured interviews as this allowed for a natural flow of conversation between myself as the interviewer and the participant, which in turn allowed for a more fluid and comprehensive exchange of information (Moustakas,1994). Due to the fluid nature of information gathering, the order of the questions identified in the interview may be altered to remain in context with the

experiences described by the participant, particularly when seeking further clarification from the participant (Moustakas,1994). Furthermore, some of the language utilized in asking specific questions was altered slightly with each participant as a means to minimize bias and to provide clarification regarding the established interview questions (Moustakas,1994).

Qualitative research, particularly that of generic qualitative studies, lacks a specific outline to analyze gathered data. (Moustakas, 1994). One way to address this is to rely on already identified theoretical propositions (Moustakas, 1994). Moustakas (1994) also expressed that the use of software can assist in the organization of data, to ensure comprehensive analysis occurs once data collection is completed.

Role of the Researcher

In this study, I was responsible for collecting data from the sample participants and maintaining appropriate ethical behaviors during this process, thus identifying myself as the instrument utilized for this research process. The data were gathered from the participants by utilizing semistructured interviews with foster parents who care for foster children under the age of three. These interviews were audio taped for later transcribing.

I began my career in the late 2000's as a substance abuse counselor at a facility that allowed mothers to seek drug treatment while having their children reside with them. The program included parenting classes as part of the treatment program. As my education and career advanced, I became a Licensed Clinical Professional Counselor. I am currently employed as a child therapist in Southern Nevada, where I provide mental health therapy services to children under the age of six. Thus, the biases that could impact

this research exist not from my personal experiences, but from my professional experiences.

Amongst research, though efforts to control for issues of bias and prejudice, it is generally understood that the researcher is not fully aware of areas in which these occur until confronted by unique and specific situations (Huberman & Miles, 2011). To ensure that these unique situations do not negatively impact my research, I utilized reflective journaling and the peer review process to account and counteract any potential personal beliefs and biases regarding the research outcomes as well as foster children (Rubin & Rubin, 2012; Huberman & Miles, 2011; Moustakas,1994). Such beliefs and biases related to the education of foster parents regarding the children they are caring for, the belief that the effects of methamphetamine exposure and negative life experiences in children can lead to behaviors that create strain within the caregiver-child relationship, and that these two factors have the potential to negatively impact the development of a healthy attachment. I maintained a conscious awareness of these biases, through reflective journaling, member checking, and peer review, to avoid the potential misinterpretations of data. In the peer review process, I utilized two of my colleagues, both of whom hold Masters' Degrees in Mental Health Counseling and are licensed therapists in the state of Nevada (Rubin & Rubin, 2012; Huberman & Miles, 2011., 2012; Moustakas,1994). One peer, Lisa Walker, has been working with children in foster care for approximately 30 years, and conducted her Master's Thesis on Attachment. The second peer reviewer, Kelli Callaway, has been working with children in foster care for approximately seven years and has multiple Masters' degree that focus on family interactions and social work.

These are peers whom I consult with regarding ethical decision making within my profession, thus they are aware of potential areas for bias and how that could impact my interpretation of data. Through this awareness and guidance, I have able to prevent the addition of themes due to potential bias, that are not truly present in the collected data (Huberman & Miles, 2011; Moustakas,1994). Any potential bias was also be managed by communication and supervision from my Committee Chair. Furthermore, I will not select any participants with whom I have any prior or current professional or personal affiliation (Moustakas,1994).

Methodology

Population and Sample Selection

The overall target population I have addressed in this study are foster parents who are currently providing care for children under the age of three with methamphetamine exposure, as reported by the caregiver. National research indicated that in 2014, there were 400,129 children within the child welfare system, 28% of whom were 3 years of age and under. Of those children, approximately 31% were removed from their natural parent's due to parental drug use (Children's Bureau, 2014a; Children's Bureau, 2014b). Due to the expansiveness of this population, only foster parents located in Southern Nevada will be utilized. These foster parents were not all from the same foster care agency, as Nevada has both public and private foster care providers. Purposeful sampling was used due to the intentional need for the participants to be composed of foster parents who are providing care for a specific population; that of children exposed to methamphetamine. The process of purposeful sampling focuses on gathering information

from a population that is known to have a vast knowledge regarding a specific event or phenomenon (Palinkas, et. al., 2013). In doing this, not only does the research sample allow for the data to become saturated, but it also allows for participant selection to focus on the similarities within the groups' experiences (Palinkas, et al., 2013). Moustakas (1994) recommends that in the use of a generic qualitative study, there can exist between three and fifteen participants, to provide an adequate amount of thematic information without the opportunity for unnecessary information to be given and saturation to be achieved. In the goal of achieving saturation, the focus is not on how much information is gathered, but at what point new data is no longer being provided within the interviews (Dworkin, 2012). It should also be noted that similar research studies exploring attachment consistently utilize between six and seven participants to achieve this saturation, thus creating a standard of sample size that will be followed in this study (Oke, Rostill-Brookes, & Larkin, 2013). For this study, I interviewed seven participants, which was between the six and ten recommended participants, thus allowing for saturation to be achieved, with extra participants, to ensure that an accurate number is represented (Moustakas,1994). This allowed me to focus more on in-depth data gathering, as opposed to less data from multiple sources (Moustakas,1994). These participants were selected based on being the primary caregiver for the foster child. Participants have been a foster parent for at least one year, and the child in question will have to have resided with them for at least 90-days.

Procedures for Recruitment, Participation, and Data Collection

Participants were recruited through contact made at various support group meetings for foster parents in Southern Nevada. Flyers were handed out at these meetings. These meetings were held independently of the various care agencies and were established by members, to support foster parents navigate the child welfare system.

Flyers were distributed with two ways to contact me for participation; my Walden University Email or a phone number generated from Google Voice. Once potential participants contacted me, a demographic questionnaire was sent to each to ensure that they meet the criteria required for this study. Once the demographic questionnaire was returned, I scheduled a day and time to meet with the participant.

Upon meeting with the participants, I first ensured each participant had comfort within the setting, by being aware of where restrooms within the building and where the exists are located, should they have been needed at any time during the interview (Jacobs & Schimmel, 2013). I formally reviewed the informed consent, which included the risks and benefits of participating, the confidentiality procedures, the data collection procedures and what will be done with the data gathered. In addition to discussing the risks and benefits, I also explained that participation was fully voluntary, and that they could cease participation at any time during the interview. It should be noted that as I reviewed this information, the corresponding documents were also provided to the participant in duplicate, one copy signed and included in the documentation of this research and one copy for the participant to retain. I explained the purpose and procedure of the interview, and how the gathered information would used. At that time, I also

sought permission from the participant to audio record the interview for more accurate data collection (Namageyo-Funa, et al, 2014). Upon receiving a response from the participant regarding audio recording; I reviewed how the gathered information would be stored, how the information would be used within the study, how their information would be kept confidential through the use of numerical identifiers, and how the data would be disposed of upon completion of the study (Moustakas,1994; Namageyo-Funa, et al, 2014). Permission was granted by all of the participants, and the recordings were gathered through the use of an audio recorder that was specific only to this research study and has no Internet connection. It was expected that each interview will take between 90-120 minutes, and at the end of each interview, each participant was gifted with a $15 Starbucks gift card as a thank you for his or her participation and time.

Data were formally collected through the use of semistructured interviews (Jacobs & Ferguerson, 2012). These semistructured interviews were peer reviewed by Kelli Callaway, who was also be the peer reviewer for bias. Through the course of these interviews, I used a variety of behavioral skills to build a sense of trust and rapport with each of the participants, such as maintaining appropriate boundaries and personal space, having a welcoming and open body posture, maintaining eye contact, and having an empathetic response to the life experiences each participant provides (Jacobs & Fergerson, 2012). The semistructured interview (Appendix C) focused on answering the above described research question by using a preset question guide, so that consistency could be established amongst each of the completed interviews (Jacobs & Schimmel, 2013). In addition to this, areas that need further clarification were followed up eith open-

ended probing questions, such as asking for examples or asking directly for clarification (Jacobs & Schimmel, 2013).

After the data collection had been completed, I had the interviews transcribed with the assistance of Rev.com, a third party transcription company. Rev.com only had access to the recordings, and the audio file label, which only consisted of the numerical identifiers, thus allowing for continued confidentiality of the participant (Namageyo-Funa, et al, 2014). Once the audio data were transcribed, the storage of the audio recording and the transcribed data are being kept in a locked filing cabinet within the private home of this researcher. I will retain the raw data for five years. Once the five years has passed, the transcriptions will be shredded and the audio files will be deleted.

Data Analysis

The analysis of the data collected through the semistructured interviews was coded using the guidelines set forth by Saldana (2016) and Houghton, Casey, Shaw, & Murphy

(2013). Themes and codes were identified utilizing three separate techniques; that of text searches, coding evaluations, and the use of a matrix (Houghton, Casey, Shaw, & Murphy, 2013). Text searchers were utilized within the transcription to find key words through both the interviews and observations notes taken during said interviews, many of which will focused on language relating to attachment, child behaviors, and caregiver behaviors (Houghton, Casey, Shaw, & Murphy, 2013). This pattern of text searcher allowed for the data to be coded in a hierarchical manner, first by identifying larger themes within in the responses of each participant, which will then be classified into

smaller categories (Saldana, 2016). During this process, Saldana, (2016) also outlined a concise way to organize notes in relation to the interview transcripts, allowing for a mainstreamed coding process. This was done with specific coded colors for each large theme relating to the caregiver's perception of attachment. Once this was completed, further evaluation occurred through the use of axial coding, which explored how the larger themes were interrelated and coding evaluations were used to sort each theme within the demographics as described by the participants (Saldana, 2016; Houghton, Casey, Shaw, & Murphy, 2013). Matrixes were also utilized to identify the frequency in which each theme is found within the transcripts, thus identifying common factors (Houghton, Casey, Shaw, & Murphy, 2013). For the purpose of this study, I used NVivo Software to store transcriptions of the semistructured interviews and the coding's of these transcriptions, while still following the structure outlined by Saldana (2016).

Issues of Trustworthiness

Researcher Credibility

Within qualitative research, the issues of reliability and validity are not concisely outlined as one would find within quantitative research, for the overall goal is to gain a better understanding of a specific topic (Cope, 2014). Thus, there exists a shift from validity and reliability to the credibility of the researcher and how the researcher conducted the study (Cope, 2014). To ensure the trustworthiness of this study, I utilized the strategies suggested by Cope (2014): generating a rich, thick description, member checking, and the use of peer reviewed research to guide the study. In doing this, issues of transferability, dependability, and confirmability were addressed.

Member checking allowed for the researcher to ensure that the communicated information will be interpreted accurately (Birt, Scott, Cavers, Campbell, & Walter, F, 2016). This particular process allowed for the participant to review the data, in all of its forms, and confirm or deny its accuracy (Birtet al., 2016). For the purpose of this research study, I allowed the participant to review my handwritten notes prior to leaving the interview. I also provided them an opportunity, via email, to review the transcriptions once they are completed and converted from a Microsoft Word Document to a PDF, to ensure that data cannot be changed without additional communication. If the participant felt as though my transcription of the interview did not accurately represent their responses, I provided an opportunity to schedule a second meeting with them to review the areas of concern. Though, no participant felt that the transcription did not accurately represent their response. The generation of a rich, thick description allowed for the communication of details and nuances within the information provided to display behaviors and responses that can be transferable to other populations (Birt, Scott, Cavers, Campbell, & Walter, F, 2016).

In addition to peer review, my dissertation committee, including my chair, my second committee member, and my URR, also reviewed the findings of this research to ensure that no inherent bias is present.

Transferability was obtained by garnering a thick description of data. This process focused on not only obtaining relevant data from the participants, but also providing information on how the data were collected and analyzed (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). By including such extensive descriptions such as

the tools used, environments in which the research was conducted, and the overall population, the specificity of the outcomes are more likely to be replicated due to the ability to replicate context (Moon, et al., 2016).

Confirmability was obtained through the process of reflexivity; a process similar to reflection, but which required a more active internal evaluation and analysis of the impact of the information obtained through the interviewing process from the researcher (Goldblatt, & Band-Winterstein, 2016). This dynamic process of self-awareness incorporated the researchers' views on both the world and the research, as a means to explore and understand its effect on the actual research (Goldblatt, & Band-Winterstein, 2016). This in turn allowed the researcher to better understand my own perspective as a means to reduce bias in the data analysis and interpretation (Goldblatt, & Band-Winterstein, 2016).

Ethical Procedures for Participation Protection

The use of human participants in research required the researcher adhere to a variety of ethical standards to ensure their safety and well-being. To ensure that I followed these ethical standards, I sought formal approval from the Internal Review Board (IRB) of Walden University. The application for IRB approval included my adherence to outlined ethical standards, the benefits and risks of participation, the process to ensure the participants confidentiality, and concerns related to data collection and participant participation. The approval number was 12-07-18-0303780 and the expiration date is December 6, 2019.

Within Southern Nevada, foster parents are viewed as independent entities, and thus do not need permission from their agencies to participate in research endeavors. They were able to do so of their own volition, without concern of repercussions. Each of the participants in this study were foster parents in Southern Nevada who have cared for children, under the age of three with expressed in-utero methamphetamine exposure. All participation was voluntary, and participants were told that they are able to stop at any time, for any reason. Should a participant have wished to leave the study, they would have been able to do so at any time, even if an interview has commenced. Those that wish to leave would have been asked to call or email this researcher prior to their appointment. If a participant chooses to leave the study mid-interview, they were free to do so. However, prior to them leaving, I would first have ensured that the participant is not a danger to themself or others. Once that is established, I would have provided the participant with a list of community mental health providers, who both provide services to various types of insurance or a sliding fee scale for those without insurance, to address the potential reasons that they chose to end their participation mid-interview. No participant chose to cease participation in the study. Interviews were held in private meeting rooms located in the Clark County Library System. Each library had a similar set up of private study rooms, and I reserved each room for up to 2 hours at a time. This setup allowed for meetings to be held in a confidential setting.

Ethical concerns related to recruitment were addressed by reviewing with the participant the risks and benefits of participating, the confidentiality procedures, the data collection procedures and what will be done with the data gathered. After this occurs, I

had the participant verbally acknowledge their understanding of this, as well as sign an informed consent to voluntarily participate in the research. It should be noted that as I reviewed this information, the corresponding documents were provided to the participant in duplicate, one copy to be signed and included in the documentation of this research and one copy for the participant to retain. Also included with this was an acknowledgement regarding their Personalized Health Information (PHI) information, and how that would be used given that the study would provide confidentiality. It should be noted that while confidentiality is the standard of research to protect participants, it does not come without concern (Taylor, 2015). There exists the risk of decreasing transferability by minimizing the available context of the study, however, the participants confidentiality should be paramount, for without participants there can be no research (Taylor, 2015).

During the interview process, there was little risk of emotional distress to the participants. Participants were informed that discussing past caregiver-child relationships has the potential to bring up intense emotions, and that they were free to stop the interview at any time. Furthermore, they were provided with a list of community mental health providers, who provide services to various types of insurance or a sliding fee scale for those without insurance, to address these potential concerns.

Confidentiality of the participants was established by utilizing numerical assignments instead of the participant's name. This code was randomly generated five-digit code. Minimal demographic data were gathered regarding the participant, such as gender, age, education level, and how long they have been a foster parent. It should be

noted that while this demographic data were collected, none of said data would allow for the participant to be identified. All raw physical data, including audio recordings transcriptions, and documents correlating the participant to the numerical identifier will be kept in a locked filing cabinet within the private home of this researcher for five years. Electronic data created during the course of the research will be kept on a password protected jump drive specific only to this research, which will also be kept in the locked filing cabinet above. During the five years, I will be the only one to have access to this information, as I am the only one with keys to said filing cabinet and the room in which said filing cabinet is kept.

Summary

This chapter explored the reasoning behind the appropriateness of a qualitative case study design for this research endeavor. This chapter outlined the overall nature of the study, as well as the research procedures that will be used. Within this framework, the efforts of sampling and the efforts to ensure ethical interactions were also outlined and explained.

Chapter 4 focuses on the data that was gathered through the semistructured interviews outlined above.

Chapter 4: Results

Introduction

This research focused on exploring the social and emotional milestones associated with attachment, as reported by the primary caregivers of foster children under the age of 3 with diagnosed in-utero methamphetamine exposure. I conducted a generic qualitative study analysis using data collected from in-depth interviews with foster parents. The research question that guided this study was as follows:

> For children exposed to methamphetamine in-utero, how do their caregivers (i.e., fictive kin, foster parents) experience the child's responsiveness towards efforts to build a healthy attachment?

In this chapter, I discuss the participants' demographics, the interview settings, the process of transcribing the interviews, and the coding and analysis process for the data collected. I also explore the techniques implemented in the study to ensure trustworthiness, credibility, confidentiality, and transferability.

Research Setting

I conducted interviews in the Southwest United States, in private meeting rooms located in the Public Library System. Each library had a similar set up of private study rooms, and I reserved each room for up to 2 hours at a time. This setup allowed for meetings to be held in a confidential setting. I reserved these interview rooms under my name prior to the arrival of the participants. Upon arrival, each participant reviewed and signed the Informed Consent before beginning the interview process.

Demographics & Participant Profiles

The demographic details of the 7 participants are included in Table 1.

Table 1

Participant Demographics

Participant code	Age	Participant gender	Foster children with in-utero methamphetamine exposure	Child gender	Age when entered foster care	Length of time with foster family	Current age
C14L6	43	F	2	Male	Birth	36 months	3 years
				Male	3 years	24 months	5 years
CE582	34	F	3	Male	1 year	18 months	3 years
				Male	2 years	15 months	3 years
				Female	2 years	15 months	3 years
D83G6	20	F	1	Female	Birth	26 months	2 years
G516M	39	F	1	Female	Birth	30 months	2 years
G974E	41	M	2	Female	Birth	24 months	2 years
				Male	Birth	15 months	1 year
H38A7	36	F	1	Male	Birth	45 months	3 years
N36Q9	30	F	3	Male	3 years	6 months	3 years
				Male	2 years	9 months	2 years
				Male	3 years	9 months	3years

To be included in this study, each participant had to meet specific criteria: they needed to be a currently licensed foster parent and within the last year, have had fostered a child under the age of 3 who had documented in-utero methamphetamine exposure. Each participant was interviewed separately at the Clark County Library branch nearest to them, for their convenience, and each was provided with a $15 gift card to Starbucks at the end of the interview as a thank-you for participating. Participants also completed a short demographic questionnaire that included their age and gender. To ensure confidentiality and address any potential ethical issues, the names of the participants were not used, and a random alphanumeric code was generated as a reference.

Participant C14L6. Participant C12L6 is a 43-year old married female. She and her husband began the process of fostering children with a goal of adoption, as they were unable to expand their family naturally. She began the fostering process three years ago, when she and her husband took placement of the first of two foster children, both of whom had in-utero methamphetamine exposure, who they later adopted.

Participant CE582. Participant CE582 is a 34-year old married female. She and her family began the process of fostering children to expand their family, having already had natural children of their own. They began fostering approximately six years ago, and in that time have fostered a total of 15 children, three of which have had methamphetamine exposure in the last year. The family did adopt one of the children who had methamphetamine exposure.

Participant D83G6. Participant D83G6 is a 20-year old single female, who has been fostering children since she was 18-years old. She expressed that she was raised in a family that had been fostering since she was a child and wanted to continue to give back the community. In that time, she has fostered, or offered short-term emergency shelter, to 20 children.

Participant G516M. Participant G516M is a 39-year old married female. She and her husband began the process of fostering children approximately four years ago, but decided they wanted to adopt very early on in their marriage. She expressed that she had no intention of adopting children, as they wanted to help care for those in need for religious reasons. Overall, they have fostered 18 children, one of whom they adopted.

Participant G974E. Participant G974E is a 41-year old married male. He and his wife began fostering approximately 5 years ago, and in that time, have fostered 22 children, with one who has been adopted. He expressed that they began fostering because it was something his wife was passionate about.

Participant H38A7. Participant H38A7 is a 36-year old married female. She and her husband began fostering children approximately three years ago and have fostered three children during that time, with one child eventually being adopted. The participant stated that they began fostering as a means to give back to their community due to the high numbers of children within the foster system.

Participant N36Q9. Participant N36Q9 is a 30-year old married female. She and her husband have been fostering for approximately four years, during which time they fostered seven children. They began fostering when they accepted a job with a group

home setting for foster children with emotional and behavioral challenges. Once they left that position, they maintained their foster license.

Data Collection

Data were collected through the use of semistructured interviews. These transcriptions were peer reviewed by K. Callaway, LCPC, who evaluated the work for the presence of bias. To further reduce the presence of bias, I engaged in reflexive journaling to manage my personal responses to the interview process and to the interview. Prior to the interviews, each participant signed an informed consent, which included a review of the risks and benefits of participating, the confidentiality procedures, how the data would be secured and how long the data would be kept. Consent was also obtained for the interview to be recorded. The informed consent contained a summary of the study and Walden University's IRB contact information, IRB approval number, and the expiration date.

Each participant agreed to have his or her interview recorded, which was done through the use of a digital voice recorder. I conducted semistructured, face-to-face interviews using a preapproved interview protocol (Appendix C), that included pre-established questions, which also allowed me to ask additional probing questions to gain further insight. Field notes were also utilized, to allow for data to be collected regarding facial expressions and posture as a means of identifying questions that needed further probing or clarification. Each interview lasted between 90 and 120 minutes, and at the end of the interviews.

Upon meeting with each participant, I ensured that they were comfortable within the setting. Each participant completed the full interview without any interruptions or difficulties. The use of the semistructured interview, allowed for concise answers, as well as an opportunity to provide an in-depth explanation of their own experiences with fostering children. Many of the participants, provided deep and rich narratives of their experiences related to the question. It should be noted that the participants appeared eager to share their in-depth responses.

The interviews were transcribed using Rev.com, a third-party transcription company. Rev.com was provided access to the recordings and the randomly generated alphanumeric code associated with each participant, thus ensuring the confidentiality of each participant. Each recording did not begin until after the participant was introduced to the study, ensuring that their names and identifying characteristics were not available to Rev.com. The recordings were transcribed and returned to me within 24-hours of submission. I then checked the recordings for accuracy by relistening to the interviews while reviewing the transcripts.

The purpose of this research was to achieve an understanding of the experiences of the research participant in relation to their interactions with foster children, diagnosed with in-utero methamphetamine exposure (Dworkin, 2012). I found that saturation occurred after the completion of 7 interviews, with only the initial interview not reporting a similar experience to the following six interviews. During this interview process, I made sure to adhere to the data collection procedures that were outlined in Chapter 3.

Upon completion of the transcriptions, each participant was emailed a copy in the form of a PDF format to review for accuracy.

Data Analysis

The analysis of the data collected through the semistructured interviews was coded using the guidelines set forth by Saldana (2016) and Houghton, Casey, Shaw, & Murphy (2013). Themes and codes were identified utilizing three separate techniques; text searches, coding evaluations, and the use of a matrix (Houghton, Casey, Shaw, & Murphy, 2013). Text searchers were utilized within the transcription to find key words throughout the interview. These text searches focused on language related to attachment, child behaviors as reported by the caregivers, and caregiver feelings (Houghton, Casey, Shaw, & Murphy, 2013). This pattern of text searching allowed for the data to be coded in a hierarchical manner by identifying larger themes within the responses of each participant, which were then classified into smaller categories (Saldana, 2016). Saldana (2016) also outlined a concise way to organize notes in relation to the interview transcripts during this process, allowing for a mainstreamed coding process. The organizational process was done with specific coded colors for each theme relating to the caregiver's perception of attachment. Once completed, further evaluation occurred through the use of axial coding, which explored how the themes were interrelated. Coding evaluations were then used to sort each theme within the demographics as described by the participants (Saldana, 2016; Houghton, Casey, Shaw, & Murphy, 2013). Matrixes were also utilized to identify the frequency in which each theme is found within the transcripts, thus identifying common factors (Houghton, Casey, Shaw, & Murphy,

2013). For the purpose of this study, I utilized NVivo Software to store transcriptions of the semistructured interviews and the coding's of these transcriptions, while still following the structure outlined by Saldana (2016).

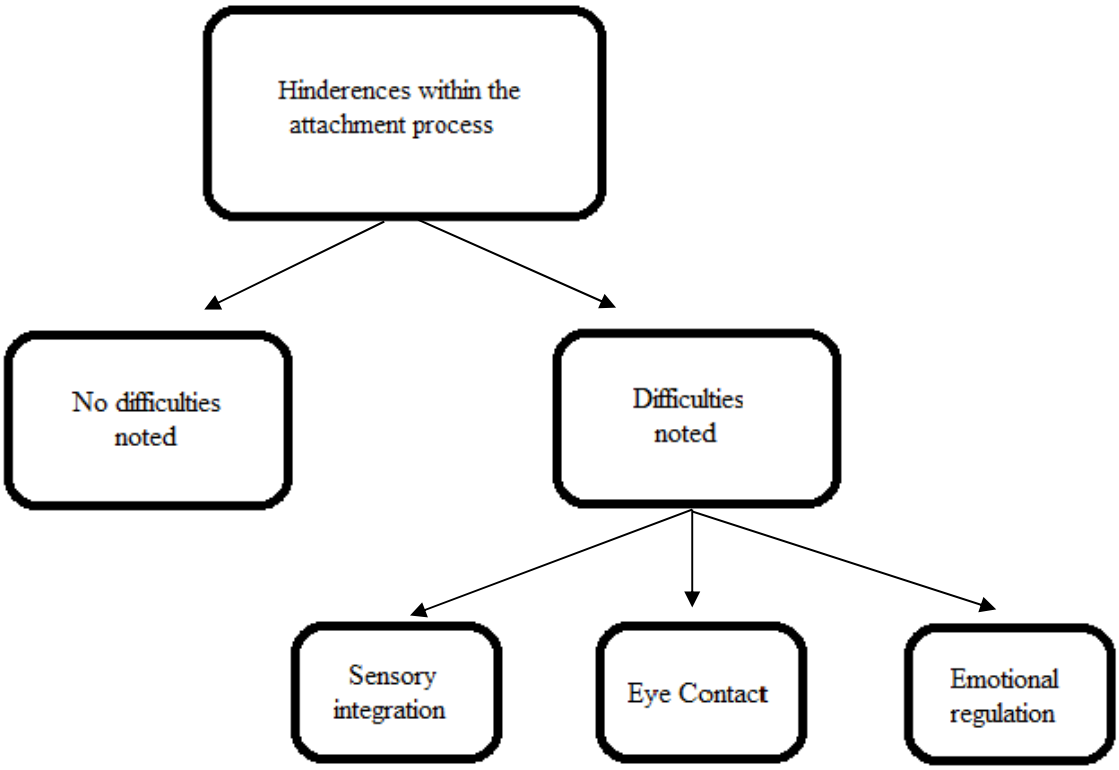

Figure 1. Data analysis flow chart. This figure illustrates the way in collected data were analyzed into themes.

Results

The analysis of the collected data utilized text searches, coding evaluations, and the use of a matrix. Through these techniques, similarities and differences were identified relating to the research question:

> For children exposed to methamphetamine in-utero, how do their caregivers (i.e. fictive kin, foster parents) witness the child's responsiveness towards efforts to build a healthy attachment?

This research question was evaluated through the use of eight formal interview questions that made up the semistructured interview and provided an in-depth and unique description of how attachment is interpreted within the foster care system. Each of the questions created three distinct themes that resulted in a better understanding of how caregivers viewed the attachment process as a whole.

Table 2

Summary of Themes

Theme	Participant	Supporting Phrases
Sensory Integration	H38A7	We went to a museum the other day 'cause I'm thinking, well they're getting a little older so we can start doing stuff and start leaving the house, ... and [he] completely ... they had to shut the place down and they had to lock the door because he ran.
	C14L6	The three-year old, he is the clumsiest little thing I have ever met in my life. Every time I turn around, he's got a new scratch from somewhere and you're like, he's always full speed. He's always just running and rushing. He's always got some type of bruise, something, and just like, "Where'd you get that? Because now I have to explain it to the case worker, like what happened?"
Eye Contact	G516M	I feel that [Foster Child 1] is terrible at eye contact. I've requested her to be tested a couple times for autism, and every time they say she's not autistic. But she does seem to get overwhelmed with making eye contact. [Foster Child 2] doesn't really make eye contact. And [Foster Child 3] also doesn't make eye contact.
	H38A7	He almost seems shy about it sometimes, you know?
Emotional Regulation	N36Q9	They had a lot of rage, a lot of temper tantrums from nowhere, and more than the typical toddler. I understand that toddlers, if you say, "No, you can't have a candy bar," they're going to get angry, but this would be giving me the Lego. Okay, give them the Lego, and they still get upset. Then I had a three-year-old break a van window one time because he was so mad.

CE582	We've got a lot of screaming going on. So he just doesn't understand things, his wail, scream. And we're trying to get him. He can't talk but try to voice through it in some kind of way and like are you mad, are you happy?

Table 2 listed selected significant statements that contributed to the three identified themes. Each theme (see subheadings) is discussed below .

Attempts to Promote Attachment with all Foster Care Children

All seven of the participants expressed very similar methods in how they attempt to attach to the foster children that they have brought into their homes, whether or not they experienced in-utero methamphetamine exposure. They expressed having a focus on spending one-on-one time with each child they have fostered, particularly in relation to play interactions. Participant G516M stated that she would engage in "holding them, rocking them, playing games with them, reading them books, stuff like that." For both children with and without in-utero methamphetamine exposure. Participant N36Q9 expressed that she and her husband would play with "whatever they want to play with, so we have Legos, blocks, we do a lot of shared experiences, so we go to the park a lot." Each participant voiced similar responses to wanting to learn about what each child, both with and without in-utero methamphetamine exposure, liked and did not like and stated that they used this knowledge as a way to help build a bond. Participant G974E stated that he would "get on their level" to work with them, making it his responsibility to get to know the child better.

All seven participants were asked if they had any assistance in learning how to build attachments with foster children they have taken care of. Only two (CE582 and

N36Q9) stated they had, and that the assistance was needed for foster children with in-utero methamphetamine exposure. They both also expressed that this assistance came in the form of family therapy. The five other participants stated that assistance in building attachments was not offered to them. All seven of the participants expressed that the process of building these attachments required hard work at first, but after time, all of the foster children in their care, both with and without in-utero methamphetamine exposure, were able to respond to their attachment efforts. Participant H38A7 expressed that initially, her foster children would be "kind of resisting it because they don't know me; but after time and remaining consistent, they would become more open to being part of the family unit." Four participants (CE582, H38A7, G974E, and N36Q9) expressed that, during this initial period, feelings of frustration with difficulty in building the attachments with the foster children. Participant H38A7 also stated that it was "it's sad, you know. And can be frustrating, not because of them, but because when I can't do anything then it's upsetting." Participant N36Q9 expressed, "At first, when they didn't respond, it was a little rough, but got over it; it's not their fault. We would just take it slowly." The other three participants expressed that they felt good about the child's responsiveness to their efforts; with participant D83G6 expressed that she "knew what to expect, since my parents fostered when I was younger" in terms of the struggle of creating attachments.

A Difference in Responsiveness

Six out of seven participants (CE582, G516M, G974E, D83G6, N36Q9, and H38A7) stated that they were able to identify differences in the way children with in-utero methamphetamine exposure attached as compared to children they have fostered

without in-utero methamphetamine exposure; with the differences being described as hindrances to the attachment process.

Lack of Eye Contact. Four of the six participants (G516M, G974E, D83G6, and H38A7) who indicated a difference in the way children with in-utero methamphetamine exposure attached in comparison to children without in-utero methamphetamine exposure stated that the foster children struggled to make or maintain eye contact with them during the process of bonding. Participant G516M, stated outright that "I feel that [Foster Child 1] is terrible at eye contact. I've requested her to be tested a couple times for autism, and every time they say she's not autistic. But she does seem to get overwhelmed with making eye contact. [Foster Child 2] doesn't really make eye contact. And [Foster Child 3] also doesn't make eye contact." She furthered explained that all three of these children have documented methamphetamine exposure. Both participant D83G6 and G974E stated that the process of making eye contact was a struggle for their foster children, and time was spent on teaching the children on how to have appropriate eye contact. Participant H38A7 stated that "If I'm looking at him, he'll immediately go ... (placed her arms over her eyes and lowered her head to look at the floor). You know what I mean? It's almost like a shy type...you know what I mean."

Lack of Emotional Regulation. Six out of seven participants (CE582, G516M, G974E, D83G6, N36Q9, and H38A7) expressed that their foster children with in-utero methamphetamine exposure also displayed difficulties in their ability to regulate their emotions in an age appropriate manner. Four of the six participants (CE582, G516M, D83G6, and H38A7) stated that the children would have excessive tantrums, which

included screaming and crying for extended periods of time. They also expressed that the children struggled to respond to efforts to be consoled or calmed by the caregiver. Participant CE582 explained that "we've got a lot of screaming going on. So, he just doesn't understand things, his wail, scream. And we're trying to get him. He can't talk but try to voice through it in some kind of way and like are you mad, are you happy?" Participant H38A7 stated:

> He'd stay in there and he'd kick his door and then in two seconds he runs right back out and throws himself on the floor and screams and kicks and all that kind of stuff. But he had the crib tent in his bed, … And that's when he's banging his head against it and making himself bleed.

Participant G974E also noted that the foster children with in-utero methamphetamine exposure that he has worked with also appeared very hypervigilant; "Noticing when we get up, when someone walks out of the room. All the other kids are out there playing with a toy or doing their own thing, it's- Yeah, they just keep on rolling. It's no big deal. But the other, they're watching every move, and where are you going? And so, yeah, it's definitely a difference. Constantly aware." Participant N36Q9 stated that with the children she has fostered with in-utero methamphetamine exposure, she has noticed a level of rage that she has not seen in any other children she has cared for. Specifically, she stated that "They had a lot of rage, a lot of temper tantrums from nowhere, and more than the typical toddler. I understand that toddlers, if you say, 'No, you can't have a candy bar,' they're going to get angry, but this would be giving me the

Lego. Okay, give them the Lego, and they still get upset. Then I had a three-year-old break a van window one time because he was so mad."

Issues with Sensory Integration. While only six of the seven participants expressed identifiable differences in the way children with in-utero methamphetamine exposure attached, all seven participants expressed that their foster children experienced issues of sensory integration. Six out of seven participants (CE582, G516M, G974E, D83G6, N36Q9, and H38A7) stated that their foster children with in-utero methamphetamine exposure had an aversion to physical touch. This aversion is expressed as though they did not like or want to be touched in any way, including hugs, being comforted, or being physically assisted with tasks. The aversion to touch also included being fed, such as holding a baby to feed them a bottle or sitting a child in one's lap to assist them in the process of eating. Participant CE582 stated:

> He just wants to be swaddled, he just wants to be left alone, he just wanted to be quiet. He didn't want lights on so it was like do I leave him upstairs in the dark? And stay downstairs? It was like, what do you do?

Participant N36Q9 also expressed similar concerns regarding the children she has fostered with in-utero methamphetamine exposure, stating "They don't like things touching their skin. I would have kids that don't like tight things at all." Four the seven participants (CE582, C14L6, G516M, and H38A7) also noted that their foster children with in-utero methamphetamine exposure also appeared to be easily overwhelmed by their environments; as there were sensitivities to loud sounds or bright lights. Participant H38A7 stated:

> We went to a [children's] museum the other day … The first little part with the water, all that stuff, loved that. Should have stayed there. But when we moved to the next place and its lights and sounds and all that kind of stuff, he freaked, and he shut down and he ran.

Evidence of Trustworthiness

Upon completion of the data collection, I conducted a follow up literature review to verify that a gap in the literature was still present. I was unable to find any new or conflicting literature on the topic of foster parent experiences relating to children with in-utero methamphetamine exposure. To ensure the trustworthiness of this study, I utilized strategies suggested by Cope (2014): generating a rich, thick description, member checking, and the use of peer reviewed research to guide the study. In doing so, issues of transferability, dependability, and confirmability were addressed. The credibility of the research was maintained by utilizing member checking, which allowed for the participants to see the field notes I documented before leaving the interview and providing them with a PDF of our completed interview. Each of the seven interviews lasted between 90 and 120 minutes.

Transferability was maintained by garnering a thick description of data and creating a summary of the data that could be provided both to the participants of the study, as well as other foster parents throughout the Southern Nevada community. This process focused on not only obtaining relevant data from the participants, but also providing information on how the data were collected and analyzed (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). By including extensive descriptions

such as the tools used, environments in which the research was conducted, and the overall population, the specificity of the outcomes are more likely to be replicated due to the ability to replicate context (Moon, et al., 2016).

Confirmability was obtained through the process of reflexivity, a process similar to reflection. This dynamic process of self-awareness incorporates the researchers' views on both the world and the research, as a means to explore and understand its effect on the actual research (Goldblatt, & Band-Winterstein, 2016). This allows the researcher to better understand his or her own perspective as a means to reduce bias in the data analysis and interpretation (Goldblatt, & Band-Winterstein, 2016).

Summary

This chapter explored the reasoning behind the appropriateness of generic qualitative design and analysis to gain a better understanding of caregiver perceptions of attachment with their foster children. This chapter outlined the overall nature of the study, as well as the research procedures that were used. Six of the seven participants expressed concerns about the ability of methamphetamine exposed children to attach to their caregivers, and all participants expressed a desire to create healthy attachments with all of the foster children that came into their, as well as to treat them as an existing part of their family. Chapter 5 of this study will further review the findings of this research within the parameters of attachment theory and past research.

Chapter 5 will explore the limitations of this research endeavor, as well as recommendations for future research and the implications of such research in relation to social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative study was to provide an understanding of the perceptions of caregivers about attachment efforts for foster children under the age of 3, who have been diagnosed with in-utero methamphetamine exposure. This approach allowed me to gain a better understanding of the perceptions of this caregiver-child relationship through the use of an in-depth and rich description of the participant's experiences. Past research in attachment theory focused on exploring and understanding the issue from the perspective that delays and struggles are based on a lack of appropriate responsiveness from the caregiver (Bovenschen et al., 2016; Bruskas, 2010; Cihan et al., 2014; Lang et al., 2016). After an exhaustive review of the literature, I was unable to find research that explores attachment as perceived by caregivers who are fostering children with in-utero drug exposure.

By utilizing a generic qualitative approach, I was able to engage with the participants in a manner that facilitated open communication to better understand their experiences of fostering children exposed to methamphetamine (Moustakas, 1994). The use of the generic qualitative approach allowed me to focus on gaining an in-depth understanding of attachment experiences in children with in-utero drug exposure, for the use of illicit substances was not as prevalent within the timeframe of Bowlby's (1947, 1951, 1988) original research (Moustakas, 1994). The use of this generic qualitative study approach also allowed me to gain perspective on the caregiver-child relationship forming under the strain of external stimuli (Moustakas, 1994).

In this chapter, I discuss the findings of Chapter 4 in relationship to the peer-reviewed literature explored in Chapter 2. I then discuss the limitations of this study, as well as the future research recommendations and potential implications of this research on social change. I conclude this chapter with a summary of the overall research endeavor.

Interpretation of Findings

The purpose of this generic qualitative study was to provide an understanding of the experiences of caregivers in their efforts to attach with their foster children under the age of 3, who have been diagnosed with in-utero methamphetamine exposure. The theoretical framework was attachment theory, which focuses on the importance of a child's relationship with their caregiver. Some similarities relating to the outcomes of attachment deficits were noted, despite the environments in which the attachment building efforts being different.

Attachment theory, developed by Bowlby in the 1950s, explors the foundational role of the parent-child attachment in the healthy development of children (Ainsworth, 1969, Ainsworth, 1979; Bowlby, 1947; Bowlby, 1951; van Rosmalen et al., 2016). Later research found that when a healthy attachment is not present, there is an increased risk for behavioral and emotional issues that can negatively impact functioning (Bovenschen, et al., 2016; Elovainio, Raaska, Sinkkonen, Mäkipää, and Lapinleimu. 2015 and Zeanah, Berlin, and Boris, 2011). Children who experience a lack of healthy attachment have lower rates of empathy and compassion, may lack appropriate peer relationships, may lack appropriate relationships with authority figures, may lack a sense of loyalty and

connectedness to their interpersonal relationships, and may be more aggressive than the general population (Christian, Sellbom, & Wilkinson, 2017). There also exists a higher prevalence of lying, stealing, hoarding, manipulation, cruelty towards animals, sexual misconduct, and patterns of pyromania that extend into adolescence and adulthood (Christian, Sellbom, & Wilkinson, 2017; Zilberstein, 2014).

The participants of this study indicated that they had the understanding and capacity to create healthy attachments with children and have successfully done so in the past. However, the participants expressed that when the external factor of in-utero methamphetamine exposure was present, they felt that the skills utilized with other foster children to create healthy attachments were not effective. Many participants voiced frustration with difficulty related to the child's difficulty to respond to them in a manner similar to other children. This frustration appeared to increase, as there appeared to be no ancillary services to either prepare them for the impending difficulty, or to assist them in addressing the reported deficit in the attachment building process. Not only were these caregivers navigating a relationship that was fraught with difficulties, but they reportedly lacked supports from the system that was in place to help them.

Within the study, there was one participant who expressed that she did not feel as though there were difficulties in her efforts to build attachments with her foster children. This particular participant also expressed having a different reason for fostering children than the other participants; participant C14L6 expressed that she and her husband sought out fostering as the primary means to have children. Due to this, there are potential a reasons that her responses regarding attachment have differed from the other participants.

There is the potential that participant C14L6 may have lacked awareness of what typical attachment processes look like, that she was not truthful in her responses to the questions, or that she is in denial of the potential difficulties that occurred.

In addition to the overall difficulties that were reported within the attachment process, the participants all described an unexpected similarity within the children they were fostering. They all reported that the children affected by the methamphetamine exposure were not interpreting their environment in a manner that was seen in children without the exposure. The children were displaying a heightened responsiveness to touch, sound, and light, which can also hinder the attachment process. As expressed in Chapter 2, the process of attachment begins at birth, but this process requires touch, sight, and communication to strengthen the bond. It appears as though the responses that these children have to the physical aspects of the attachment process only increase the frustrations voiced by the caregivers.

Limitations of the Study

Within this study, there were two primary limitations identified. The lack of a medical expert to provide information relating to the impact of in-utero methamphetamine exposure on neurology and the lack of geographical variance amongst the sample size are identified limitations. While this study explored attachment and in-utero methamphetamine exposure, the overall focus was to qualitatively gain a better understanding of how caregivers viewed the attachment process. Due to this perspective, a medical perspective, would have assisted in communicating the goals as it would have provided support for the participants perspectives. Having all participants derive from

Southern Nevada, there is the possibility that the homogony of the group could affect transferability to other geographical locations due to the lack of geographical variance.

To address these limitations and minimize the potential impact on the study, various means were used to ensure transferability and reliability. Transferability was obtained by garnering a thick description of data. This process focused on not only obtaining relevant data from the participants, but also providing information on how the data were collected and analyzed (Moon, Brewer, Januchowski-Hartley, Adams, & Blackman, 2016). By including such extensive descriptions, such as the tools used, environments in which the research was conducted, and the overall population, the specificity of the outcomes are more likely to be replicated due to the ability to replicate context (Moon, et al., 2016). In relation to the data sources, since the focus of this study was based on the caregiver's experiences, medical expertise was not fundamentally needed to garner a thick description of experiences.

Recommendations

There are two recommendations I would make regarding future research relating to foster children under the age of 3 who have had in-utero methamphetamine exposure. I would recommend that this study be repeated in other regions throughout the United States. This recommendation is based on the idea that perceptions of attachment may be different in other geographic and culturally diverse locations, and that the child welfare systems throughout the country may respond to fostering this population in different manners. I would also recommend that this study be repeated with natural parents who have given birth to a child with in-utero methamphetamine exposure, where the child was

not taken into the custody of the child welfare system. Future research could also be conducted with the assistance of the medical professional to explore the struggles of attachment due to the in-utero methamphetamine exposure, not just in a relational context, but also in a neurological context.

Implications and Potential Positive Social Change

This study has the potential to contribute to the existing body of literature on both childhood attachment and in-utero methamphetamine exposure. This potential expansion of the literature is based on the idea that gaining a better understanding of how foster parents interact with children who are exposed to substances in-utero can assist in the future treatment and fostering process. By doing so, there is an opportunity to not only advocate for an increase in assistance and interventions but also a path to establish evidenced based interventions that will be more beneficial to this at- risk population. There is a further need to explore this topic and gain an even better understanding of perceptions of attachment interactions so that future generations will not have to experience the same struggles in attachment. By decreasing the struggles related to attachment difficulties and the out associated negative outcomes, there would then be less likely to have a negative impact on society. There is also the potential for foster parents who are currently providing care for children under the age of three with methamphetamine exposure to increase their skills to create a more attachment friendly environment. This research has the potential to better address the mental health needs of foster children, thus allowing for the creation of new early intervention strategies that will better address the role of attachment with children who have in-utero drug exposure.

Conclusion

Childhood attachment has been a focus of research since the 1950's, though the majority of the focus has been on the relationships existing between a natural parent and a child, without the presence of in-utero methamphetamine exposure. This study provided a perspective to family systems that are not often looked from an attachment perspective and allowed for a narrative of those involved within this system an opportunity to be heard by a larger population. The foster parents expressed that they perceived there were deficits in the caregiver-child relationship when methamphetamine exposure is a factor, and the feelings of frustration that come when these deficits impact the child's functioning.

The findings from this generic qualitative study have contributed to the existing body of literature relating to childhood attachment; expanding on the ideas set forth by Bowlby and Ainsworth to include the social problems of illegal drug use, particularly methamphetamines used during pregnancy. The results of this study have the potential to create social change within human services, social work, child welfare, and the mental health communicate, as children born testing positive for methamphetamines at birth are removed from their natural parents and enter the children welfare system, where attachments are attempted with strangers. This study has the potential of creating a foundation to better address the reported frustrations from a therapeutic and systemic manner. The findings provide the narratives and viewpoints of foster parents who are working to assist children with in-utero methamphetamine exposure. These narratives may also promote the need to change the way in which child welfare caseworkers and

clinicians working with this population to better understand the difficulties their client's face and help to create new ways to address the documented deficit.

References

Abar, B., LaGasse, L. L., Derauf, C., Newman, E., Shah, R., Smith, L. M., & ... Lester, B. M. (2013). Examining the relationships between prenatal methamphetamine exposure, early adversity, and child neurobehavioral disinhibition. *Psychology of Addictive Behaviors*, *27*(3), 662-673. doi:10.1037/a0030157

Abar, B., LaGasse, L. L., Wouldes, T., Derauf, C., Newman, E., Shah, R., & ... Lester, B. M. (2014). Cross-national comparison of prenatal methamphetamine exposure on infant and early child physical growth: A natural experiment. *Prevention Science*, *15*(5), 767-776. doi:10.1007/s11121-013-0431-5

Ainsworth, M. S. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development*, *40*(4), 969.

Ainsworth, M. S. (1979). Infant–mother attachment. *American Psychologist*, *34*(10), 932-937. doi:10.1037/0003-066X.34.10.932

Altshuler, S. J., & Cleverly-Thomas, A. (2011). What do we know about drug-endangered children when they are first placed into care? *Child Welfare*, *90*(3), 45-68. Retrieved from http://www.cwla.org/

Behnke, M., & Smith, V.C. (2013). Prenatal substance abuse: short- and long-term effects on the exposed fetus. *Pediatrics 131*, e1009–e1024.

Bhandari, R., van der Veen, R., Parsons, C. E., Young, K. S., Voorthuis, A., Bakermans-Kranenburg, M. J., & ... van IJzendoorn, M. H. (2014). Effects of intranasal oxytocin administration on memory for infant cues: Moderation by childhood

emotional maltreatment. *Social Neuroscience*, *9*(5), 536-547. doi:10.1080/17470919.2014.932307

Bick, J., Dozier, M., & Moore, S. (2012). Predictors of treatment use among foster mothers in an attachment-based intervention program. *Attachment & Human Development, 14*(5), 439-452. doi:10.1080/14616734.2012.706391

Bowlby, J. (1947). The study of human relations in the child guidance clinic. *Journal of Social Issues*, *3, 2*35-41. doi:10.1111/j.1540-4560.1947.tb01489.x

Bowlby, J. (1951). *Maternal care and mental health*. New York, NY: Columbia University Press.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.*New York: Basic Books.

Bovenschen, I., Lang, K., Zimmermann, J., Forthner, J., Nowacki, K., Roland, I., & Spangler, G. (2016). Foster children's attachment behavior and representation: Influence of children's pre-placement experiences and foster caregiver's sensitivity. *Child Abuse and Neglect*, *51,* 323-335. doi:10.1016/j.chiabu.2015.08.016

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking. *Qualitative Health Research*, *26*(13), 1802-1811.doi:10.1177/1049732316654870

Bruskas, D. (2010). Developmental health of infants and children subsequent to foster care. *Journal of Child & Adolescent Psychiatric Nursing, 23*(4), 231-241. doi:10.1111/j.1744-6171.2010.00249x

Buus, N. & Agdal, R. (2013, October). "Can the use of reporting guidelines in peer-

review damage the quality and contribution of qualitative health care research?." *International Journal of Nursing Studies*, 1289-1291. *Academic Search Complete.*

Carlson, E., Hostinar, C., Mliner, S., & Gunnar, M. (2014). The emergence of attachment following early social deprivation. *Development and Psychopathology*, *26*(2), 479-489.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, *41*(5), 545-547. doi:10.1188/14.ONF.545-547

Children's Bureau. (2014a*). The AFCARS report*. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf

Children's Bureau. (2014b). Prenatal substance use and the child welfare system. *Child Welfare Information Gateway*. Retrieved from https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf

Child Welfare Information Gateway. (2016). *Definitions of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from: https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/

Child Welfare Information Gateway. (2013). *How the child welfare system works*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from: https://www.childwelfare.gov/pubs/factsheets/cpswork/

Christian, E., Sellbom, M., & Wilkinson, R. B. (2017). Clarifying the associations

between individual differences in general attachment styles and psychopathy. *Personality Disorders: Theory, Research, and Treatment, 8*(4), 329-339. doi:10.1037/per0000206

Cihan, A., Winstead, D. A., Laulis, J., & Feit, M. D. (2014). Attachment theory and substance abuse: Etiological links. *Journal of Human Behavior in the Social Environment*, *24*(5), 531-537. doi:10.1080/10911359.2014.908592

Cope, D. G. (2014). Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum*, *41*(1), 89-91. doi:10.1188/14.ONF.89-91

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of Sexual Behavior*, *41*(6), 1319-1320. doi:10.1007/s10508-012-0016-6

Elovainio, M., Raaska, H., Sinkkonen, J., Mäkipää, S., & Lapinleimu, H. (2015). Associations between attachment-related symptoms and later psychological problems among international adoptees: Results from the FinAdo study. *Scandinavian Journal of Psychology*, *56*(1), 53-61. doi:10.1111/sjop.12174

Gabler, S., Bovenschen, I., Lang, K., Zimmermann, J., Nowacki, K., Kliewer, J., & Spangler, G. (2014). Foster children's attachment security and behavior problems in the first six months of placement: Associations with foster parents' stress and sensitivity. *Attachment & Human Development, 16*(5), 479-498. doi:10.1080/14616734.2014.911757

Goldblatt, H., & Band-Winterstein, T. (2016). From understanding to insight: using

reflexivity to promote students' learning of qualitative research. *Reflective Practice*, *17*(2), 100-113. doi:10.1080/14623943.2015.1134471

Hillen, T., Gafson, L., Drage, L., & Conlan, L. (2012). Assessing the prevalence of mental health disorders and mental health needs among preschool children in care in England. *Infant Mental Health Journal, 33*(4), 411-420. doi:10.1002/imhj.21327

Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse Researcher*, *20*(4), 12-17.

Huberman, A., M., & Miles, M. B. (2011). Methodological perspectives. *The Qualitative Researcher's Companion.* Thousand Oaks, CA.: http://dx.doi.org/10.4135/9781412986274

Jacob, S. A., & Furgerson, S. P. (2012). Writing interview protocols and conducting interviews: Tips for students new the field of qualitative research. *The Qualitative Report, 17*(T&L Art, 6), 1-10. Retrieved from http://www.nova.edu/ssss/OR/QR17/jacob.pdf

Jacobs, E. & Schimmel, C. (2013). Impact therapy. The courage to counsel. Beckley, WV: Impact Therapy Associates.

Kiblawi, Z. N., Smith, L. M., Diaz, S. D., LaGasse, L. L., Derauf, C., Newman, E., & ... Lester, B. (2014). Prenatal methamphetamine exposure and neonatal and infant neurobehavioral outcome: Results from the IDEAL study. *Substance Abuse*, *35*(1), 68-73 6p. doi:10.1080/08897077.2013.814614

Jacobsen, H., Ivarsson, T., Wentzel−Larsen, T., Smith, L., & Moe, V. (2014). Foster

parents' state of mind with respect to attachment: Concordance with their foster children's attachment patterns at 2 and 3 years of age. *Infant Mental Health Journal, 35*(4), 297-308. doi:10.1002/imhj.21447

Jakubiak, B. K., & Feeney, B. C. (2016). A sense of security: Touch promotes state attachment security. *Social Psychological and Personality Science*, *7*(7), 745-753. doi:10.1177/1948550616646427

Lang, K., Bovenschen, I., Gabler, S., Zimmermann, J., Nowacki, K., Kliewer, J., & Spangler, G. (2016). Foster children's attachment security in the first year after placement: A longitudinal study of predictors. *Early Childhood Research Quarterly*, *36*269-280. doi:10.1016/j.ecresq.2015.12.019

Lieberman, A. F. (2014). Giving words to the unsayable: The healing power of describing what happened. *Psychoanalytic Dialogues*, *24*(3), 277-281. doi:10.1080/10481885.2014.911606

Madide, A., Smith, J., & Odendaal, H. (2012). Methamphetamine use by pregnant women: Impact on the neonate and challenges for the perinatal team. *Obstetrics & Gynaecology Forum*, *22*(1), 8-11.

Meyer, D., Wood, S., & Stanley, B. (2013). Nurture is nature: integrating brain development, systems theory, and attachment theory. *Family Journal. 21*(2). 162-169. doi: 10.1177/1066480712466808

Minnes, S., Lang, A., & Singer, L. (2011). Prenatal tobacco, marijuana, stimulant, and opiate exposure: outcomes and practice implications. *Addiction Science & Clinical Practice*, *6*(1), 57-70.

Moon, K., Brewer, T. D., Januchowski-Hartley, S. R., Adams, V. M., & Blackman, D. A. (2016). A guideline to improve qualitative social science publishing in ecology and conservation journal.

Moustakas, C. (1994). *Generic qualitative research methods*. Thousand Oaks, CA: Sage.

Namageyo-Funa, A., Rimando, M., Brace, A. M., Christiana, R. W., Fowles, T. L., Davis, T. L., Martinez, L. M., & Sealy, D. (2014). Recruitment in Qualitative Public Health Research: Lessons Learned During Dissertation Sample Recruitment. *The Qualitative Report*, *19*(4), 1-17. Retrieved from https://nsuworks.nova.edu/tqr/vol19/iss4/3

Oliveira, P., Soares, I., Martins, C., Silva, J., Marques, S., Baptista, J., & Lyons-Ruth, K. (2012). Indiscriminate behavior observed in the strange situation among institutionalized toddlers: relations to caregiver report and to early family risk. *Infant Mental Health Journal*, *33*(2), 187-196.

Oke, N., Rostill-Brookes, H., & Larkin, M. (2013). Against the odds: Foster carers' perceptions of family, commitment and belonging in successful placements. *Clinical Child Psychology And Psychiatry*, *18*(1), 7-24. doi:10.1177/1359104511426398

Ordway, M. R., Webb, D., Sadler, L. S., & Slade, A. (2015). Parental Reflective Functioning: An Approach to Enhancing Parent-Child Relationships in Pediatric Primary Care. *Journal Of Pediatric Health Care: Official Publication Of National Association Of Pediatric Nurse Associates & Practitioners*, *29*(4), 325-334. doi:10.1016/j.pedhc.2014.12.002

Palinkas, L., Horwitz, S., Green, C., Wisdom, J., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration & Policy In Mental Health & Mental Health Services Research*, *42*(5), 533-544. doi:10.1007/s10488-013-0528-y

Raman, S., & Sahu, S. (2014). Health, Developmental and Support Needs of Vulnerable Children - Comparing Children in Foster Care and Children in Need. Child Abuse Review, 23(6), 415-425. doi:10.1002/car.2305

Ross, E. J., Graham, D. L., Money, K. M., & Stanwood, G. D. (2015). Developmental consequences of fetal exposure to drugs: What we know and what we still must learn. *Neuropsychopharmacology*, *40*(1), 61-87. doi:10.103F8/npp.2014.147

Rubin, H. J., & Rubin, I. S. (2012). *Qualitative interviewing: The art of hearing data (3rd ed.).* Thousand Oaks, CA: Sage Publications, Inc.

Saldaña, J. (2016). *The Coding Manual for Qualitative Researchers* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Slade, A. (2014). Imagining fear: Attachment, threat, and psychic experience. *Psychoanalytic Dialogues*, *24*(3), 253-266. doi:10.1080/10481885.2014.911608

Smith, L. M., Diaz, S., LaGasse, L. L., Wouldes, T., Derauf, C., Newman, E., & ...

Lester, B. M. (2015). Developmental and behavioral consequences of prenatal methamphetamine exposure: A review of the Infant Development, Environment, and Lifestyle (IDEAL) study. *Neurotoxicology And Teratology*, 5135-44. doi:10.1016/j.ntt.2015.07.006

Taylor, R. (2015). Beyond anonymity: temporality and the production of knowledge in a

qualitative longitudinal study. *International Journal Of Social Research Methodology*, *18*(3), 281-292. doi:10.1080/13645579.2015.1017901

Taylor, B. J., & McQuillan, K. (2014). Perspectives of foster parents and social workers on foster placement disruption. *Child Care In Practice, 20*(2), 232-249. doi:10.1080/13575279.2013.859567

van Rosmalen, L., van der Horst, F. P., & van der Veer, R. (2016). From secure dependency to attachment: Mary Ainsworth's integration of Blatz's security theory into Bowlby's attachment theory. *History Of Psychology*, *19*(1), 22-39. doi:10.1037/hop0000015

Zeanah, C. H., Berlin, L. J., & Boris, N. W. (2011). Practitioner review: clinical applications of attachment theory and research for infants and young children. *Journal Of Child Psychology And Psychiatry, And Allied Disciplines*, *52*(8), 819-833. doi:10.1111/j.1469-7610.2011.02399.x

Zeanah, C. H., & Gleason, M. M. (2015). Annual research review: Attachment disorders in early childhood – clinical presentation, causes, correlates, and treatment. *Journal Of Child Psychology And Psychiatry*, *56*(3), 207-222. doi:10.1111/jcpp.12347

Zilberstein, K. (2014). The use and limitations of attachment theory in child psychotherapy. *Psychotherapy, 51*(1), 93-103. doi:10.1037/a0030930

Appendix A: Demographics Questionnaire

Project Title: Perceptions of Attachment Efforts with Foster Children Under Age 3

Name: _____Age: _____

City: _____State: _____Zip Code: _____

Phone Number: _____ Email: _____

Race/Ethnic Background: _____

Primary Language Spoken: _____

Marital Status: ☐ Single

☐ Married

☐ Divorced

☐ Widowed

Highest Education Level Completed: ☐ High School Diploma/GED

☐ College Degree

☐ Graduate Degree

☐ Advanced Graduate Degree

☐ Not Applicable

Current Occupation: _____

Number of biological Children: _____

Number of Foster Children: _____

Number of Years as a foster parent: _____

Have you fostered children under the age of 3 years old:

☐ Yes☐ No

Have you fostered children that with in-utero methamphetamine exposure:

☐ Yes☐ No

Have you fostered children of this age in the last year:

☐ Yes☐ No

Have you fostered children with in-utero methamphetamine exposure in the last year:

☐ Yes ☐ No

Have you received any specialized training relating to in-utero methamphetamine exposure on infants and toddlers:

☐ Yes☐ No

Appendix B: Interview Protocol

Interview Guide: Perceptions of Attachment Efforts with Foster Children Under Age 3

Introduction: My name is Sarah on (date) with participant (assigned #). Thank you so much for your time today., I am going to be asking you some questions about your experience with fostering children and more specifically with foster children with in-utero methamphetamine exposure. There is no right or wrong way to answer these questions, as I want to hear about your experiences and feelings; I want to better understand your insight into fostering these children.

1. What led you to deciding to be a foster parent?
2. What led you to choosing to get licensed for children 3-years old and under?
3. Describe your experience with in-utero exposed foster children?
4. Describe your experience with fostering children without in-utero exposure?
5. What do you know about childhood attachments and childhood development?
6. How do you work on creating bonds with new foster children that enter your home?
7. Tell me about the things you do to create a new bond with your foster children.
8. What kind of assistance or support do you have in establishing and creating these bonds?
9. Overall, how do you feel that children without in-utero drug exposure respond to these efforts?
10. What are some examples of how they respond to you?

11. Overall, how do you feel that children with in-utero drug exposure respond to these efforts?
12. What are some examples of how they respond to you?
13. What else would you like to tell me about your feelings regarding how attached your foster child is to you?

Thank you again for your time today.