



Published in final edited form as:

Infant Ment Health J. 2011 ; 32(2): 251–262. doi:10.1002/imhj.20293.

THIS IS MY BABY: FOSTER PARENTS' FEELINGS OF COMMITMENT AND DISPLAYS OF DELIGHT

KRISTIN BERNARD and MARY DOZIER

University of Delaware

Abstract

This study examined the association between foster parents' commitment to their young foster children and the delight they showed in their interactions with children. Seventy foster parent–child dyads were included as participants. The dyads were videotaped during a play interaction when children were between 9 and 28 months, with delight coded on the basis of foster parents' responses to children. Caregivers were interviewed with the “This Is My Baby” Interview (B. Bates & M. Dozier, 1998), with commitment coded as the extent to which parents expressed interest in enduring relationships with their foster children and the extent to which they thought of them as their own. Regression analyses revealed that commitment was a significant predictor of foster parent delight. Foster parents who were more highly committed to their foster children showed greater delight in their children than did foster parents who were less highly committed. These results suggest an important way in which caregiver commitment is transmitted to foster children.

When mothers give birth, they are biologically “prepared” to care for and protect their young infants. The production of oxytocin during pregnancy, childbirth, and nursing is among the biological mechanisms that promote a sense of maternal commitment (Carter & Altemus, 1999; Maestripieri, 2001; Pederson, 1999). Humans are a species in which alloparenting is seen, however, such that nonbiologically related adults are capable of providing parental care to unrelated children. Whereas biological parents are usually highly committed to their children, foster parents express a range of levels of commitment, with some considering foster children as “their own” and others expressing relative indifference about the relationship (Dozier & Lindhiem, 2006). Therefore, although commitment may not be a key variable under more typical circumstances, it may be critical under conditions of surrogate care. In this study, we examined how caregiver commitment is communicated to children. More specifically, we expected that foster parents who were more highly committed to their children would convey greater delight in their children than would foster parents who were less committed.

WHAT IS COMMITMENT?

Commitment is defined as the caregiver's investment in an enduring relationship with the child (Bates & Dozier, 1998; Dozier & Lindhiem, 2006). A highly committed caregiver would be expected to encourage the formation of a mother–child bond and accept the child as her own. Evidence of high levels of commitment may include expressions of a desire to adopt the child, investment of emotional and physical resources, and integration of the child into the family. Low commitment is conceptualized as relative indifference regarding the child and the relationship.

Due to the nature of foster care as temporary, we acknowledge that committing to a child who will likely leave may be emotionally challenging for a foster parent. As a result, it is reasonable to expect that many foster parents will maintain some degree of distance in the relationship. Although such efforts to limit commitment may protect the foster parent, we argue that high levels of commitment are optimal for children in care, regardless of placement goals. Thus, even when reunification with a biological parent is the placement goal for a child, we expect high levels of foster caregiver commitment to be more advantageous for the child than low levels of commitment. Foster parents can invest in important and significant ways in both temporary and long-term arrangements, accepting foster children as their own while in their care.

Commitment and responsiveness are considered orthogonal at the conceptual level. A parent who is highly committed to a child may or may not be responsive when the child is distressed. Conversely, a parent who is responsive to a child's distress may or may not be highly committed to a long-term relationship with the child. Although responsiveness has been the focus of thousands of studies in the last 3 decades, the concept of commitment has received little empirical attention.¹ Ainsworth, Blehar, Waters, and Wall's (1978) development of a methodology for categorizing children's quality of attachment has almost exclusively reflected the importance of maternal responsiveness. This may well be because commitment does not vary in important ways among normative populations whereas responsiveness does. Examining atypical populations, however, can highlight aspects of normative development that would otherwise remain obscured (Luthar, Burack, Cicchetti, & Weisz, 1997). In his early writings, Bowlby (1969/1982) emphasized the importance of parental commitment as well as responsiveness. He described his observations of children in orphanages (Bowlby, 1951) and young "affectionless thieves" living in the community (Bowlby, 1944), both groups fundamentally distinguished by their lack of committed caregivers. In these cases, extreme and prolonged maternal deprivation put children at risk for severe outcomes, including an inability to form close relationships (Bowlby, 1944, 1951). Recent studies of children raised in Romanian orphanages have shown fundamental disturbances of attachment behavior among some children (O'Connor et al., 2003; Zeanah, Smyke, Koga, & Carlson, 2005).

WHY DOES COMMITMENT MATTER?

Humans have likely evolved such that infants "expect" committed caregivers, with failures of commitment presenting challenges to development. Evolutionarily, an infant's biological preparedness to depend on a parent fits with a parent's biological preparedness to provide care (Numan & Insel, 2003). From birth, infants rely on adults to regulate their biology (Hofer, 1984) and emotions (Tronick, 1989). An infant's repertoire of innate attachment behaviors (e.g., crying, reaching) functions to maintain proximity to a caregiver. Whereas parental sensitivity to these cues promotes feelings of security for an infant, we expect parental commitment to fulfill an even more critical need. Although practices today (e.g., institutional care, foster care) allow for survival without a committed caregiver, the lack of one may still be devastating.

Early disruptions in care are associated with a number of difficulties in healthy development, including deficits in inhibitory control (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007), delinquency (e.g., Ryan & Testa, 2005), internalizing and

¹Socioemotional investment, a concept similar to commitment, has been measured in biological dyads with the Parental Investment in the Child Questionnaire (PIC; Bradley, Whiteside-Mansell, Brisby, & Caldwell, 1997). However, commitment is conceptually distinct in that it taps a caregiver's willingness to have an enduring relationship with the child, an intention assumed in most biological parents.

externalizing behavioral problems (e.g., Newton, Litrownik, & Landsverk, 2000; Pardeck, 1984), and academic difficulties (e.g., Aldgate, Colton, Ghate, & Heath, 1992). At a concrete level, parental commitment is associated with the likelihood that the relationship will endure (Dozier & Lindhiem, 2006). When compared with highly committed parents, foster parents who are less committed to children have relationships that are more likely to disrupt. Therefore, commitment allows for a supportive relationship within a stable environment, which has implications for later adjustment.

Children in foster care also are at risk for developing negative self-representations (Ackerman & Dozier, 2005; Toth, Cicchetti, Macfie, Maughan, & Vanmeenen, 2000). These “internal working models” that reflect early caregiving experiences are associated with children’s beliefs about self and others later on (Bowlby, 1969/82; Bretherton & Munholland, 1999). Ackerman and Dozier (2005) found that foster parent investment in and acceptance of their toddlers predicted children’s positive self-appraisals at age 5 years. Committed caregivers appear to serve as protective factors in the development of negative self-evaluations typical of children who have lost attachment figures. Thus, having a committed caregiver who values the parent–child bond is associated with a developing model of the self as loveable and worthy of care.

HOW IS COMMITMENT COMMUNICATED TO CHILDREN?

Given evidence that commitment varies significantly among foster caregivers and seems to be important to young children in a number of ways, we were interested in examining how it is communicated to children. Our conceptualization of commitment involves the caregiver’s willingness to continue to care for the child; thus, we might expect variation in caregiver behavior at times of placement disruption. However, we also expect commitment to be observable during close interactions while the relationship is still intact. Bowlby (1988) described a “state of ecstasy” apparent in mothers upon childbirth, followed by the mother’s acceptance of her baby as “her very own” (p. 6). Ainsworth (1967) similarly described the intensity of mothers’ expressions of delight in their infants in her cross-cultural observations. Although “delight” is not frequently examined as a predictor of relationship quality in biological dyads, Britner, Marvin, and Pianta (2005) argued that it represents an integral dimension in describing the attachment relationship, in addition to more commonly studied dimensions such as sensitivity, rejection, and support of exploration. Despite high intercorrelations among these variables of caregiving behavior (Britner et al., 2005), we chose to examine parental delight exclusively as we expected it to vary in important ways among surrogate caregivers. In the case of a highly committed foster parent, we expected delight to evidence an emotional and psychological investment in the relationship. Displays of delight during interactions communicate to children their worth and importance in their world. We hypothesized that foster parents who were more committed to having enduring relationships with their foster children, as assessed using the “This is My Baby” Interview (TIMB; Bates & Dozier, 1998), would show higher levels of delight when interacting with their infants.

METHOD

Participants

Participants included 70 foster caregiver–infant dyads involved in an ongoing longitudinal study assessing the effectiveness of an attachment-based intervention program. Sixty-five of the foster parents in this study were female, and 5 were male. Thirty-five were White (50%), 30 were African American (42.9%), 4 were Biracial (5.7%), and 1 was Hispanic (1.4%). Foster caregivers ranged in age from 23 to 66 years ($M = 44.7$, $SD = 10.5$). Family income ranged from the lowest (<\$10,000, $n = 7$) to the highest (>\$100,000, $n = 8$) income category,

with a median family income between \$30,000 and \$39,000. Level of education ranged from less than high school ($n = 7$) to a college degree ($n = 10$), with the median level of education a high-school degree. Foster caregivers ranged in years as a foster caregiver from less than 1 year to 31 years ($M = 4.9$, $SD = 6.3$), and ranged in number of foster children cared for from 1 to 100 ($M = 11.6$, $SD = 20.2$). Given the positively skewed distribution in number of foster children cared for, this variable was standardized by log-transformation. The transformed variable, which ranged from 0.0 to 2.0 ($M = .62$, $SD = .58$), was used in analyses.

Of the foster children included in the study, 36 were males, and 34 were females. Forty-five were African American (64.3%), 22 were Caucasian (31.4%), 2 were Biracial (5.7%), and 1 was Hispanic (1.4%). Foster children ranged in age from 9.4 to 28.3 months ($M = 17.4$, $SD = 5.6$). The length of time foster children had been in the current placement ranged from 2.5 to 26.9 months ($M = 11.1$, $SD = 5.2$). For 55 children, this was the first placement (78.6%); for 14 children, it was the second placement (20%); and for 1 child, it was the third placement (1.4%).

Procedure

Child and caregiver demographic data and foster-placement information were collected with a questionnaire at a consent visit at the time of enrollment in the longitudinal study. Foster parents also completed the Brief Symptoms Inventory (BSI; Derogatis, 1975/2004) at the time of enrollment. Foster parents and infants were randomly assigned to participate in one of two 10-session intervention programs completed in the parents' homes. The Attachment and Biobehavioral Catch-up intervention (Dozier & the Infant Caregiver Laboratory, 2002a) focused on helping foster parents respond to their children in sensitive and responsive ways whereas the Developmental Education for Families intervention (Dozier & the Infant Caregiver Laboratory, 2002b) focused on helping foster parents enhance cognitive and language development in their children. Neither intervention was expected to affect caregiver commitment to or delight in the child.

The assessments of primary interest for the present study were conducted at home and lab follow-up visits after the completion of the intervention programs. Foster parents received \$25 for their participation in each visit, lasting approximately 1 hr. The TIMB Interview (Bates & Dozier, 1998) was conducted at a lab visit following several other procedures. The child was removed from the room for this portion of the visit. The interview was conducted by the experimenter and audiotaped for later coding.

Different play-assessment procedures were used based on child age to provide developmentally appropriate contexts for interaction. For children younger than 20 months, this involved a 9-min procedure during which the child first was placed in a high chair and given a set of three toys (i.e., a rattle, stacking cups, a squeaky toy). Foster parents were instructed to sit approximately 3 ft from the child and interact with the child as usual, without moving closer or touching the toys. After 2 min of distance interaction, caregivers were instructed to move as close to the child as they liked and play with the child as they normally would. This portion was videotaped for 7 min. For children older than 20 months, dyads were given a set of blocks to play with. Foster parents were instructed to play with the child as they normally would. After 7 min of play, the foster parents were instructed to ask the child to clean up the blocks. This was videotaped for a total of 10 min.

Measures

Commitment—Caregiver commitment was measured with the TIMB Interview (Bates & Dozier, 1998). This semistructured interview takes between 5 and 15 min to administer. The foster parents were asked eight open-ended questions about their feelings concerning: the

child (e.g., “What is [child]’s personality like?”), their role in continuing to care for the child (e.g., “How much would you miss [child] if he/she ever had to leave your care?”), and the effects of their relationship with the child (e.g., “How do you think your relationship with [child] is affecting him/her right now?”). Caregivers were asked to elaborate on brief responses. Interviews were each coded using both the transcripts and audiotapes on 5-point Likert scales (see Appendix). Foster parents rated as high on commitment showed evidence of a strong emotional investment in the child, psychological adoption of the child, and consideration of the child as their own (Bates & Dozier, 1998). To receive a high rating of commitment, it is not required that the caregiver expresses the intent to adopt the child. The construct being assessed is “psychological adoption,” as opposed to actual physical adoption (Bates & Dozier, 1998). A caregiver who demonstrates “psychological adoption” describes the child as her own and part of her family while the child is in her care whether legal adoption is a goal or an option. Foster parents rated as low on commitment did not demonstrate a strong emotional investment in the child, possibly reporting indifference about whether the child stayed in their care or even active efforts to limit the formation of an affectional bond (Bates & Dozier, 1998). Two raters who had established acceptable levels of interrater reliability on practice transcripts coded the interviews. Twenty percent of the interviews were coded by both raters as a reliability measure. The Spearman correlation for interrater reliability was .89. Ratings of caregiver commitment ranged from 1 to 5 ($M = 3.8$, $SD = 1.2$).

Delight—Caregiver delight in the child was coded from the videotaped play interactions. Delight was rated from caregivers’ facial expressions, vocalizations, and behavior on a Likert scale of 1 (*No delight in child*) to 7 (*Very much delight in child*). This scale was adapted from the Maternal Delight Scale used by Ainsworth et al. (1978) for coding maternal behavior during the Strange Situation. Foster parents who received high ratings of delight demonstrated a genuine affection and joy in playing with or being with the child, through displays of strong positive affect, smiling, praising, and active encouragement of mutual interaction. Low ratings of delight were made for foster parents who interacted with the child without affective involvement or who seemed uninterested in interacting with the child at all. The play-assessment videotapes were coded by one rater, and 20% were coded by a second rater as a reliability check. The Spearman correlation for interrater agreement was .84. Ratings of caregiver delight ranged from 1 to 7 ($M = 4.4$, $SD = 1.4$). Coders for delight were blind to ratings of caregiver commitment, and vice versa.

Possible Covariates

Placement variables—Caregiver and child demographic data were collected using a questionnaire at the consent visit. Variables included in the analyses were caregiver and child age, race, and gender. Child’s time with the caregiver at the time of the postvisit assessments was calculated from initial placement records.

Depression—Caregiver depression was measured as a possible covariate to rule out the possibility that it could drive associations between commitment and delight. Depression was measured using the Depression subscale of the BSI (Derogatis, 1975/2004). The BSI is a 53-item self-report measure, for which foster parents rated how much they were distressed by symptoms from 0 (*not at all*) to 4 (*extremely*) during the past 7 days. The Depression subscale includes six items (e.g., “Feeling blue”). The Depression subscale of the BSI has demonstrated good internal consistency, test-retest reliability, and validity (Derogatis, 1993). T scores of caregiver depression ranged from 42 to 74 ($M = 47.5$, $SD = 8.1$).

RESULTS

Preliminary Analyses

Descriptive statistics for the variables in the sample are presented in Table 1. Bivariate correlations among the variables are presented in Table 2. Caregiver commitment was associated with child time with caregiver, $r = .26, p < .05$, but not with caregiver age, child age, caregiver depression, caregiver years as a foster parent, number of children previously cared for, or children's number of previous foster care placements. Spearman correlations between caregiver education level and income level and caregiver commitment and delight were not significant ($p > .05$). *T* tests revealed no significant differences in caregiver commitment or delight predicted by caregiver or child gender, caregiver or child race, play-assessment type, or intervention group. Furthermore, *t* tests did not indicate a significant association between the match between caregiver and child race (a dummy variable coded 1 when a caregiver and his or her child were of the same race) and caregiver commitment or delight. Variables that were not associated with commitment or delight were excluded from primary analyses.

Primary Analyses

Multiple linear regression analyses were conducted to examine the association between caregiver commitment and caregiver displays of delight. Child time with caregiver was included as a control variable, given its association with caregiver commitment. Child time with caregiver was entered into Step 1 of the model, and caregiver commitment was added into Step 2, with caregiver delight as the dependent variable. The results are presented in Table 3. Step 1 accounted for 0.1% of the variance in caregiver delight ($R^2 = .001$) and was not statistically significant. Step 2 accounted for 12.1% of the variance, $F(1, 67) = 9.192, p = .003$. These results indicate that caregiver commitment was associated with caregiver delight, after taking into consideration the effects of child time with caregiver. More specifically, higher levels of commitment were associated with higher ratings of delight.

DISCUSSION

In this study, we found a positive association between foster caregiver commitment and foster caregiver delight. Specifically, foster parents who were more highly committed to their children showed greater delight in their children during a play interaction compared with foster parents who were less highly committed. The findings illustrate one way in which commitment is communicated to young foster children. Given that foster children face a host of developmental challenges, the importance of feeling that they have a committed caregiver should not be underestimated. In addition to reinforcing a sense of self-worth and of "mattering," emotional exchanges and interactions with a caregiver are expected to play an important role in a child's ability to regulate his or her emotions (Stern, 1977; see Rosenblum, Dayton, & McDonough, 2006). Future studies should examine the mediational role of delight in explaining one potential pathway between caregiver commitment and child outcome, particularly the development of self-concept. In addition to child outcome, future studies should examine changes in commitment and delight over time with longitudinal data; this will allow for an investigation of the directional association between these variables, which is a limitation of the current study.

The findings coincide with evidence in biological dyads of the elating powers of maternal love. Stern (1991) suggested that most parents show "positive distortions" regarding their children, speaking and behaving in ways that suggest that their child is the most captivating and beautiful in the world regardless of objective reality. Recent neurobiological evidence has further supported the rewarding, yet "blind," nature of maternal love (Zeki, 2007). Brain

regions rich in oxytocin and vasopressin receptors are activated when mothers view pictures of their own versus acquainted children whereas regions associated with negative emotions and critical social judgment are suppressed (Bartels & Zeki, 2004). Behavioral displays of delight may reflect this cognitive and biological bias or favoritism toward one's own baby evidenced in biological mothers. Future research should examine the cognitive and neurological underpinnings of parental feelings of commitment and displays of delight in foster dyads.

Several questions remain regarding the construct of commitment that may be addressed in future research. First, the placement goal for a child (e.g., adoption, reunification with birth parent) may influence a foster caregiver's level of commitment. We might expect foster caregivers to commit more easily to children for whom adoption is the placement goal. Although the coding scheme does not require caregivers to express the intention to legally adopt a child for a high rating of commitment, this may be an important variable to control for in future studies. Second, future research should examine additional caregiver factors that may predict level of commitment or contribute to the indifference sometimes characteristic of "professional" foster caregivers. For example, previous experience as a foster caregiver, such as number of children cared for, may influence a foster caregiver's ability to invest emotionally in relationships with subsequent children. Although the present study did not find evidence of this association, Dozier and Lindhiem (2006) found that the number of children previously cared for was negatively associated with level of commitment.

Another important direction for future research is examining what the child brings to the relationship and how this might impact foster caregivers' expressions of commitment and displays of delight. Just as caregivers have a history of fostering experiences that may contribute to how they parent subsequent children, foster children may interact differently with caregivers based on their own history of experiences with previous caregivers (e.g., maltreatment, multiple placements). For example, children vary in their level of secure attachment behaviors in the first several months of placement (Stovall-McClough & Dozier, 2004), which may affect how caregivers respond to their needs (Stovall & Dozier, 2000). Similarly, reciprocally positive interactions characterized by both caregiver and child delight might contribute to caregivers' feelings of commitment. Thus, the child should be considered an active partner in shaping the dynamics of relationships with caregivers. Future research might include child variables such as attachment security, joint attention, and positive affect to examine how child behaviors affect caregiver behaviors during close interactions.

Clinical Implications

Finally, this study provides preliminary support for the importance of commitment and delight as key dimensions in describing the foster caregiver-child relationship. Should these variables emerge as important predictors of child adjustment, developing intervention programs and child welfare policies that enhance and support caregiver commitment and delight may be warranted. Interventions might help caregivers understand the importance of being committed to children in their care, despite aspects of the situation that make that difficult. The Attachment and Biobehavioral Catch-up Intervention (Dozier & the Infant Caregiver Laboratory, 2002a) helps caregivers respond in nurturing ways even when children do not elicit nurturance and when nurturance does not come naturally to them. Foster caregivers may similarly be helped to act as committed caregivers even when the placement goals (e.g., reunification with birth parent) or their history of fostering (e.g., losing many children) make that difficult. Furthermore, if commitment proves to be a predictor of child outcome, child welfare policies should be directed at placing children with caregivers who are more likely to commit. Whereas agencies might value foster caregivers

who are willing to take in many children for short periods of time, these “professional” foster caregivers may struggle to act as committed parents. Thus, recruiting caregivers who are willing to foster a single child may prove to be most beneficial to foster children. Developing a system in which foster caregivers could remain involved with children following their removal also might support caregivers’ investment, particularly when adoption is not a possibility. Efforts to promote children’s physical safety by removing them from abusive or neglecting parents often fail to acknowledge the overwhelming psychological trauma involved with the loss of a primary attachment figure. Committed caregivers who take delight in these children and accept them as their own may offer one way in which a foster child’s trust in self and others is restored.

Acknowledgments

The project described was supported by Award Numbers R01MH052135, R01MH074374, and R01MH084135 from the National Institute of Mental Health. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Mental Health or the National Institutes of Health.

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APPENDIX

“This Is My Baby” Interview Questions and Commitment Coding Scale

TIMB Interview Questions

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

TIMB Interview Commitment Coding

High commitment (5 points)

The caregiver provides evidence of a strong emotional investment in the child and in parenting the child; multiple indices of high levels of commitment are present throughout the interview; descriptions of the child and the caregiver–child affective bond; there may be evidence of the caregiver committing resources to promote the child’s growth, or other indices of psychological adoption of the child; the child is fully integrated into the family; although the caregiver may acknowledge that the child will eventually leave her home (e.g., to return to the biological parent), she considers the child as hers while the child is in her home.

Moderate commitment (3 points)

The caregiver provides evidence of investment in the child, but this is not nearly as marked as a caregiver scoring high on commitment; although there may be some indices of high levels of commitment, there may also be evidence suggesting that the child has not been psychologically adopted by the caregiver; the caregiver may state that she would miss the child if he or she left, but this is more of a matter-of-fact statement and lacks the strong affective component seen in caregivers high in commitment; if the caregiver speaks of limiting the psychological bond with the infant, she also gives evidence of struggling with this issue; the child may be only partially integrated into the family (e.g., placed in respite

care only when the family goes on vacation); overall, the coder may conclude that the child is adequately cared for and nurtured, but not to any special degree.

Low commitment (1 point)

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

TABLE 1

Descriptive Statistics

Variable	<i>n</i>	Minimum	Maximum	<i>M</i>	<i>SD</i>
Caregiver Commitment	70	1	5	3.8	1.2
Caregiver Delight	70	1	7	4.4	1.4
Caregiver Depression	66	42	74	47.5	8.1
Caregiver Age (years)	66	23	66	44.7	10.5
Years as a Foster Caregiver	59	1	31	4.9	6.3
No. of Foster Children Cared For	61	1	100	11.6	20.2
No. of Foster Children Cared For (log-transformed)	61	0	2	.62	.58
Child Age (months)	70	9.4	28.3	17.4	5.6
Child's Time with Caregiver (months)	70	2.5	26.9	11.1	5.2
No. of Foster Care Placements	70	1	3	1.2	.46

TABLE 2

Correlations Among Variables

	1	2	3	4	5	6	7	8
1. Caregiver Commitment								
2. Caregiver Delight	.34**							
3. Caregiver Depression	.04	-.01						
4. Caregiver Age (years)	-.10	.08	.15					
5. Years as Foster Caregiver	-.06	-.05	.16	.24				
6. No. of Foster Children Cared For (log-transformed)	-.07	-.10	-.03	.12	.78**			
7. Child Age (months)	.07	-.05	.05	.02	-.06	.07		
8. Child Time with Caregiver (months)	.26*	.03	.14	.11	.09	.21	.54**	
9. No. of Foster Care Placements	-.22	-.05	.08	.16	.06	-.03	-.33**	-.08

* $p < .05$.

** $p < .01$.

TABLE 3

Linear Regression Model for Caregiver Delight

Variable	β	SE	t	p
Step 1				
Child Time with Caregiver (months)	.008	.033	.247	.805
(Constant)	4.320	.405	10.665	.000
Step 2				
Child Time with Caregiver (months)	-.017	.032	-.537	.593
Caregiver Commitment	.444	.147	3.032	.003
(Constant)	2.918	.600	4.863	.000

Note. $R^2 = .001$ for Block 1 ($p > .05$); $\Delta R^2 = .121$ for Block 2 ($p = .003$).