Enhancing Parent-Child Interaction During Foster Care Visits: 
Experimental Assessment of an Intervention

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Abstract

Mothers of young children recently placed in foster care participated in an intervention intended to enhance parent-child interaction during visits or a standard visit. Immediately prior to their visits, mothers in the intervention group received coaching focused on strategies for separating from their children at the end of the visit. All mothers participated in semi-structured clinical interviews after their visits, and all reported substantial histories of loss and trauma. Mothers in the intervention group displayed more behavioral strategies for supporting their children when the visit was over than mothers in the comparison group. Contrary to expectations, however, intervention mothers were less engaged with their children during the leave-taking sequence than they had been earlier in the visit, and than the comparison mothers were during leave taking; and they displayed fewer ways of maintaining the child’s involvement in mother-child interaction during leave-taking than the comparison mothers. Although mothers in the intervention group easily learned specific behavioral strategies, the intervention may also have sensitized them to the pain of separation and complicated their affective responses to leave taking. Parents’ trauma history is discussed as an important aspect of context to consider in designing interventions to enhance parent-child interaction.
Enhancing Parent-Child Interaction during Foster Care Visits:
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Family reunification is a permanency goal for the majority of the more than one-half million children in foster care in the United States (e.g., Downs, Costin, & McFadden, 1996; Hess & Proch, 1993). In order for family reunification to be successful, parent-child relationships must develop adequately while children are in foster care. Parent visitation, the scheduled, face-to-face contact between parents and their children in foster care, is considered the primary child welfare intervention for maintaining the development of adequate parent-child relationships (Hess & Proch, 1993; Mallon & Leashore, 2002). Organized visits are considered so critical to the effort to reunite families that PL 96-272 (The Adoption Assistance and Child Welfare Act of 1980) explicitly requires their inclusion in family preservation efforts. Yet, existing research suggests that visits are psychologically and interpersonally complex, and often problematic. Direct observations (Haight, Black, Workman & Tata, 2001), as well as reports by social workers, parents and foster mothers (Fanshel, 1982; Haight, Black, Mangelsdorf, Giorgio, Tata, Schoppe & Szewczyk, 2002), indicate considerable variation in the quality of mother-child interaction during visits, including the extent of mutually engaging and developmentally appropriate interactions important to the development of adequate parent-child relationships.

In this study, we examine an intervention designed to enhance mother child interaction during visits focusing on leave-taking. Presumably the ways in which a mother and child negotiate separation at the end of the visit influence how stressful or traumatic leave-taking is experienced by the child and parent, as well as the child’s strategies for coping with the separation. Existing empirical research (Haight et al, 2001. Haight et al., 2002), however, suggests that leave-taking is an especially problematic aspect of visiting for many young children and their mothers. Mothers describe their own and their children’s grief and anger when required to separate at the
end of each visit (Haight et al, 2001, 2002). Consistent with their mothers’
descriptions of leave-taking as problematic, behavioral observations reveal that many
young children display overt signs of distress (e.g., crying) or anxiety (e.g., clinging to
the mother) at the end of their visits (Haight et al., 2001).

Developing strategies to conclude visits can be very challenging for parents for a
number of reasons. First, parents’ experience of stress and trauma due to their forced
separation from their children may affect their energy level, emotional availability to
the child, and ability to collaborate with other adults during the visits. Parents have
reported emotional suffering, grief, depression, trauma (Jenkins & Norman, 1975;
Haight, et al., 2002), rage, fear, and powerlessness (Diorio, 1992; Haight et al 2002) as
a result of their families’ involvement with public child welfare systems. They also
report that such feelings affect the quality of visits (Haight et al., 2002). Second,
young children show very serious short- and long-term reactions to the experience of
separating from a primary caregiver including depressive withdrawal, resistance to
care, inability to be soothed, and excessive clinging behavior (see Stovall & Dozier,
2002). The forced separation from their primary caregiver by police or child welfare
workers experienced by many young children in foster care may further complicate
the normal developmental process of coming to tolerate separation from the caregivers
during the preschool years. Intense child reactions to separation may affect parents’
abilities to negotiate the emotionally complex issue of leave-taking with their children.

Third, some parents do not accept their child’s foster care placement as
legitimate or appropriate, and consequently their support of their child’s adjustment to
care may be compromised (Haight et al., 2002). In addition, many parents have very
limited contact with their child’s foster family. Parents may not know the foster
parents or even the address where their children reside. Such limited knowledge may
restrict parents’ ability to provide bridges for their young children back into care, for
example, to verbally suggest people and activities with which the child may engage
for comfort following the visit. Finally, many parents have limited or no contact with other parents with children in foster care with whom they might share strategies for better supporting their children. Many parents report feelings of shame and secrecy surrounding their family situation which can lead to isolation (Haight et al., 2002).

The goal of the intervention examined in this report is to help mothers to support their children during leave taking. It has two components. First, mothers are offered emotional support; that is, a professional who listens to their narratives with interest, affirms the difficulty of their current situations, and notes positive aspects of their own actions and parenting. Research on intensive family preservation services (see Dawson & Barry, 2002 for review); interventions with overburdened, difficult to engage parents (McDonough, 1993); and parent-infant psychotherapy (Lieberman & Pawl, 1993) point to the importance of providing emotional support to parents. Many mothers involved with the public child welfare system lead very stressful lives. In addition to the anxieties of having a child in foster care, they may be grappling with poverty, homelessness, domestic violence, substance abuse, and unmet mental and physical health needs. Emotional support is thought to facilitate the mother’s willingness to engage in services and her ability to focus her attention on her child (McDonough, 1993). It also can provide a model of sensitivity and responsiveness that she can apply in her relationship with her child (Lieberman & Pawl, 1993). Thus, providing mothers with emotional support may allow them to engage in the visit, focus on the child and respond to their children in more sensitive and emotionally positive ways.

Second, mothers are offered education and coaching on specific strategies to support children during leave-taking. These strategies are drawn from those strategies spontaneously developed by mothers involved with visits that appear consistent with parenting behaviors supportive of parent-child relationships. For example, at the end of visits some mothers reassure children of their love, anticipate the next visit, provide
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children with a small object to take to their foster homes, and describe neutral or positive characteristics of the foster home to which the child is returning (Haight et al., 2001). Research on intensive family preservation services emphasizes the importance of skill building (see Dawson & Barry, 2002, for review). Other interventions with families under stress also provide parents with concrete coaching on how to productively handle difficult child behaviors (McDonough, 1993). This research suggests that mothers will learn behavioral strategies for leave-taking.

In this study, we focus on mothers because mothers comprise the majority of visitors in the state in which this study was conducted. We examine mothers of children aged 2-6 years because young children are entering the foster care system at increasing rates, and are staying for longer periods of time (Berrick, Needell, Barth, Jonson-Reid, 1998; Downs, Costin, & McFadden, 1996). Furthermore, because early parent-child relationships undergo considerable development during the first few years of life (e.g., Thompson, 1998), they are uniquely vulnerable to disruption through foster care placement. We focus on mothers with children in care for 12 months or less because child welfare workers increasingly recognize the significance to reunification of the establishment of regular visits early in placement. We consider mothers who have had children in care for a minimum of one month so that initial visiting patterns will be established.

Method

Overview

Twenty mother-child dyads participated in this study. All were part of a larger study of the relationships of mothers and their young children who are in foster care (Haight, et al., 2002; Mangelsdorf et al., in preparation). All mothers and children participated in a 60 minute visit. All mothers participated in clinical interviews following the visit. Ten, randomly chosen mothers also participated in an intervention immediately prior to the visit.
Participants

Participants were 20 mothers with young children in foster care through a public child welfare office (DCFS) in a medium-sized, mid-western city. Mothers of all children between 2 and 6 years of age who had been in foster care from 1 to 12 months were identified through DCFS records. Children’s caseworkers were contacted and asked to screen out any children who were not receiving visits, or for whom a permanency plan was not to “return home.” Caseworkers then obtained permission from mothers for us to contact them regarding participation in the study. We explained to each mother that we were researchers at the university interested in learning more about visits in order to develop better social work practices. Although DCFS had granted permission for our study and even designated us as “visit supervisors” for the purposes of this study, we were not employed by DCFS and would not report to DCFS employees regarding any individual mother’s or child’s participation (or lack thereof) in the study. Approximately 38% of eligible mothers referred to us by caseworkers agreed to participate. Mothers were paid $30.00 for their time. They also were given an additional visit with their children that we supervised.

Twelve mothers were Caucasian, 7 were African American, and 1 was Hispanic. The mean age of mothers was 29.10 years ($SD = 7.60$), ranging from 15 – 42 years. The mean number of years of education for mothers was 11.12 ($SD = 1.36$) with a range from 8 to 14 years. Thirteen mothers reported recent or ongoing problems with substance abuse, and 6 reported significant mental heath issues (clinical diagnoses of depression ($n = 2$), bipolar disorder ($n = 1$), anxiety disorder ($n = 2$), and PTSD/anxiety disorder ($n = 1$)). Although we did not probe systematically, incidences of domestic violence occurring around the time of their children's placement in foster care were spontaneously reported by 8 of the mothers.
All mothers reported loss or trauma in childhood or adolescence. Eleven mothers reported being maltreated as children, and 4 had been placed in the care of DCFS because of maltreatment. While children or adolescents, 7 mothers experienced the death of a parent, and 5 lost their fathers by abandonment. Four mothers reported domestic violence in their families of origin, 1 reported that her parent had a diagnosed mental illness, and 7 reported that their own parents abused substances.

Mothers had a mean of 2.65 children (SD = 1.35) ranging from 1 to 5 children. The mean age of target children was 3, ranging from 2 to 6 years. Nine children were female. All children were free of neurological disorders or major health problems. DCFS “open case” codes indicated that target children were in care primarily because of neglect (n = 15). Three children were in care because of abuse, one for abuse and neglect, and one for exposure to domestic violence. With one exception, mothers became involved with the child welfare system involuntarily. All mothers reported participating in at least one visit per week for a mean of 2.87 hours (SD = 2.48) ranging from 1 – 12 hours. 15 mothers reported that their visits were supervised, 2 that they were unsupervised, and 3 did not report on visit supervision.

Ten mothers were randomly assigned to the treatment group, and ten to the comparison group. T-tests and chi-square analyses revealed that with one exception intervention and comparison groups did not differ significantly on the characteristics described above. Mothers in the intervention group were more likely to have been placed in foster care themselves as children, $X^2 (1, N = 20) = 5.0, p < .03$.

Within the intervention group, five mothers were randomly assigned for the intervention and clinical interview to a male, community mental health psychiatrist and five were assigned to a female, PhD candidate. Because of scheduling difficulties, however, one mother from the psychiatrist’s group was reassigned to the doctoral student. Within the comparison group, five mothers were randomly assigned to the psychiatrist, and five to the PhD candidate for the clinical interview. Both
interviewers were experienced in open-ended interviewing and in the treatment of trauma survivors. (Chi-square and t-tests revealed no relationships between interviewer and maternal behaviors during the visit). Mothers were aware that the interviewers were not affiliated with DCFS, and that their conversations would remain confidential.

Setting

Interventions and clinical interviews were conducted in a small office at the University of Illinois. Visits were conducted in an approximately 12’ X 12’ parent-child interaction laboratory also at the University of Illinois. The room was furnished as a comfortable family room with adult-sized couch and chairs, carpet, and a variety of toys appropriate for preschool – aged children including puzzles, drawing materials, toy musical instruments, picture books, dolls, a doll house, and stuffed animals. Two video cameras were built into the corners of the ceiling in the visit room and operated remotely.

Procedure

Intervention

The visit intervention focused on emotion support and coaching. It occurred immediately prior to the visit, lasted for approximately 45 to 60 minutes and was audio-recorded. The intervention began with an open-ended invitation for the mother to talk about her family and any other significant relationships, and her experiences with DCFS including how her family became involved, DCFS professionals and services. Mothers then talked about their current living and family situations including any significant stress such as domestic violence, substance abuse, poverty and unmet health and mental health needs. The interviewers focused on understanding the mother’s perspective. They listened, affirmed the difficulty of the mother’s current situation, and noted positive aspects of her own actions and parenting.
The second phase of the intervention focused on leave-taking. Mothers were asked to describe visits with the target child including aspects they found problematic. Nineteen mothers spontaneously identified leave-taking as difficult, and the other mother agreed, when probed, that leave-taking was problematic. Mothers were asked how they had tried to support their children during leave-taking. Then, the interviewer shared additional strategies used by other mothers (Haight et al., 2001). (These are described, below). Mothers were asked which strategies their children would respond well to, and they felt comfortable implementing. After selecting strategies, the interviewer and mother role-played their implementation.

**Visit**

All mothers and target children were observed for one, 60 minute visit. Visits involved the target child only. If the mother had other children with whom she routinely visited, they were cared for by a graduate student in another playroom during the visit procedure. This graduate student also provided child care during the intervention and clinical interview. Following the clinical interview, the mother was allowed to visit with any of her other children.

Visits were hosted by a female graduate student and supervised by a female faculty member who was available, but who interacted minimally with mother and child. Prior to participation in the study, the visit hostess had met with the mothers to establish rapport. During the actual visits, mothers were requested to visit with their children as they ordinarily would. The visit supervisors and hostess were familiar with DCFS protocol for conducting visits and followed these guidelines. They attempted to remain as unobtrusive as possible observing from an adjacent room where another investigator operated the video cameras, remotely.
After approximately 30 minutes, the visit hostess re-entered the visit room to leave cookies and juice for the mother to share with her child. After approximately 20 more minutes, she again entered the playroom to remind the mother and child that the visit would be over in 10 minutes.

Clinical Interview

Following the visit, mothers in the intervention and comparison groups participated in a clinical interview. Interviews lasted approximately 30 minutes for mothers in the intervention group, and 60 minutes for mothers in the comparison group. Interviews were audio recorded. Following the visit, all mothers discussed their histories including significant relationships; families of origin including any stresses such as domestic violence, child maltreatment, substance abuse, poverty, and loss of important relationships including through death; and education. Mothers also supplied information about the child’s history including health and mental health status. At this time, mothers in the comparison group also discussed their current family and any other significant relationships, and experiences with DCFS. Clinical interviews were transcribed verbatim.

Measures

The following codes describe mother-child interaction during the visit. The first set of codes describe the actual behavioral strategies used by mothers during the final 10-minutes of the visit, the leave-taking sequence. They also describe any distress displayed by the child. The second set of codes focuses on the quality of the mothers’ affect and interaction with the target child throughout the visit.

Leave-taking Behaviors

Codes described the actual behaviors displayed by mothers and children during the leave-taking sequence. They were constructed from those supportive strategies that we described to mothers during the intervention and that we observed the mothers employ. The categories of behavior are not exhaustive, but do include all
strategies used by three or more mothers. In addition, most mothers employed more than one strategy during the leave-taking sequence and all were coded.

Six maternal strategies for supporting the child during leave-taking were identified and coded: 1) Good-bye. The mother explicitly said good-bye to the child. 2) Love. The mother expressed love for the child verbally, e.g., “Mommy loves you,” or behaviorally, e.g., through hugs, kisses or pats. 3) Transition talk. The mother made positive or neutral comments about where the child was going after the visit, for example, to see her foster mother. 4) Object. The mother provided the child with a small object to take with her from the visit, for example, the mother gave the child two small juice boxes left over from the snack provided by the visit hostess to take home to enjoy with her foster mother. 5) Visit. The mother commented on the next visit, e.g., when the next visit would occur and what they would do together. 6) Clean up routine. The mother used cleaning up to signal the impending end of the visit, for example, “It’s almost time to go home now so we need to pick up these toys.” In addition, the total number of these different strategies employed were determined for each mother.

The presence or absence of overt distress by the child also was coded. Examples of distress include crying, clinging to the mother and refusing to let go, striking the visit hostess, and verbal protests.

Quality of maternal affect and interaction

Maternal affect and interaction were coded using an adaptation of scales developed by Egeland, Sroufe and colleagues (Egeland & Sroufe, 1983; Sroufe, Jacabvitz, Mangelsdorg, DeAngelo, and Ward, 1985) and scales developed by the authors. Mothers were rated on nine, seven point scales every 10 minutes from the beginning of the visit through the leave-taking sequence. These scales may be summarized as follows:
1) Supportive presence is the extent to which the mother expresses positive regard, emotional support, reassurance and confidence in the child. This scale is anchored at “1” where the mother completely fails to be supportive to the child, either being aloof and unavailable or being hostile to the child when the child shows need of some support, and “7” where the mother skillfully communicates confidence in the child and emotional support.

2) Hostility reflects the mothers’ expression of anger, discounting or rejection of the child. This scale is anchored at “1” where the mother shows no signs of rejection or blame; and “7” where the mother has frequent expressions of rejection and hostility directed at the child as well as anger accompanied by barely controlled emotions.

3) Generational boundary dissolution refers to the extent to which the mother treats the child as her contemporary rather than taking charge and setting the necessary limits. This scale is anchored at “1” where mother-child boundaries are completely clear and the mother acts as a resource for the child and provides positive and negative feedback contingent on the child’s behavior, and “7” where the mother treats the child as a contemporary, acting in ways that meet her own needs rather than those of the child, for example, playing with the toys herself, or allowing the child to dictate the situation.

4) Detachment/disengagement refers to the extent to which the parent appears emotionally uninvolved or disengaged and unaware of the child’s needs for appropriate interaction. This scale is anchored at “1” where the parent shows no signs of detachment or under involvement but is clearly emotionally involved when interacting with the child; and “7” where the parent clearly is not emotionally involved with the child and any parenting behaviors are simple, mechanical, stereotypied, repetitive and perfunctory.
5) Positive regard for the child refers to the extent to which the parent expresses positive feelings toward the child, for example, through tone of voice, physical affection, praise, and listening attentively. This scale is anchored at “1” where the parent shows little if any positive regard, for example, the parent is expressionless, flat, negative or inappropriate (e.g., smiling when the child cries); and “7” where the parent is exceptionally positive in terms of facial and vocal expressiveness and behavior.

6) Intrusiveness refers to the extent to which the parent lacks respect for the child as an individual and fails to understand and recognize the child’s efforts to gain autonomy and self awareness. This scale is anchored at “1” where there is no sign of intrusiveness and the parent does not impose directives on the child unless it is clear the child needs direction and “7” where the parent is highly intrusive and her own expectations clearly have precedence over the needs and desires of the child.

7) Engagement/interpersonal involvement refers to the interpersonal involvement of the mother with her child, and the persistence of her partner-directed behaviors. This scale is anchored at “1” where the mother appears indifferent, ignores the child, displays flat affect and very little engagement, and any contact is minimal and not very persistent; and “7” where the mother shows extensive visual regard, and communication with her child even when conflict arises.

8) Inventiveness characterizes the range of stimulation the mother is able to provide for her child in order to maintain the child’s involvement in the situation. This scale is anchored at “1” where the mother is unable to interact with her child and appears to be at a complete loss regarding what to do, and “7” where the mother consistently finds new ways to interact with and engage the child in response to the child’s changing needs and states.
9) Sadness refers to pervasive and intense depressed affect in the mother’s facial expression, posture, tone of voice and energy level. It is anchored at “1” where no sadness is present and “7” where there is pervasive and intense sense of sadness.

Copies of the complete coding scales are available from the authors upon request.

**Reliability**

**Leave-taking strategies.** Following a period of training, two raters independently coded the videotaped leave-taking sequence for two, randomly chosen mothers in the intervention group, and two randomly chosen mothers in the comparison group. Percentage agreement on leave-taking codes was 100%. Both of the raters were blind as to the group assignment of mothers.

**Quality of maternal affect and interaction.** Following a period of training, two raters independently coded the first 50 minutes of videotaped visits. The mean percent agreement for within one scale point agreement based on 18 overlapping tapes was 90% ranging from 74 to 97%. Disagreements were resolved through conference. Both of the raters were blind to the group assignment of mothers, and one was also blind to the mothers’ involvement with DCFS.

Following a period of training, a second set of raters coded the final 10-minutes of the tape (the leave-taking sequence). Because of difficulty obtaining adequate reliability (greater than 70% agreement), several scales were dropped from the leave-taking sequence: supportive presence, generational boundary dissolution, detachment/disengagement and positive regard. The mean percent agreement for within one scale point agreement based on 13 overlapping tapes for the remaining codes was 93% ranging from 78 to 100%. Both raters were blind to the mothers’ group assignment and involvement with DCFS.
**Results**

Table 1 indicates that mothers in both the comparison and intervention groups engaged in a variety of leave-taking strategies. Overall, 95% expressed their love, 75% engaged their children in clean-up routines, 65% provided their children with an object to take from the visit, 60% explicitly told their children good-bye, 55% discussed the next visit, and 45% engaged in neutral or positive talk about where the child was going from the visit. The majority of children (55%) displayed clear behavioral signs of distress during the leave-taking sequence.

Although more mothers in the intervention than the comparison group tended to use each strategy (with the exception of “express love” which all but one mother displayed), Chi-square analyses revealed no statistically significant relations between group and the specific strategies mothers used during the leave-taking sequence, or child distress. Mothers in the intervention group, however, displayed more total strategies during the leave-taking sequence than did mothers in the comparison group, $t(18) = -1.81, p < .05$, one-tailed. Mothers in the comparison group displayed a mean of 3.3 different types of strategies ($SD = 1.3$), and mothers in the intervention group displayed a mean of 4.6 different types of strategies ($SD = 1.9$).

The next set of analyses examined the quality of maternal affect and interaction during the body of the visit (first 50 minutes) and the leave taking sequence (final 10 minutes). In these and all subsequent analyses, scores pertaining to the body of the visit are averaged scale ratings based on the first five, 10 minute segments. As shown in Table 2, mothers’ mean scores on engagement, inventiveness, positive regard and supportive presence scales were above the mid points. Similarly, mothers’ mean hostility, intrusiveness, sadness, detachment and generational boundary dissolution scale scores were below the mid points.
There were differences in mothers’ scores during the leave-taking sequence and the body of the visit. Dependent t-tests revealed less intrusiveness for comparison mothers, $t(9) = 3.20, p < .01$, and less engagement for intervention mothers, $t(9) = 3.46, p < .01$, during the leave-taking sequence than the body of the visit.

There also were differences between comparison and intervention mothers during the leave-taking sequence, but not during the body of the visit. Mothers in the intervention group were less engaged, $t(18) = -2.35, p < .04$, and less inventive, $t(18) = -2.42, p < .03$, than mothers in the comparison group during leave-taking.

**Discussion**

Visiting presents considerable challenges to mothers and children. Despite the fact that parent visits are required by law in family preservation efforts, relatively little previous empirical research has examined mothers’ abilities to overcome these challenges and use visits to strengthen their relationships with their children. Consistent with our previous research (Haight, et al., 2001), many mothers displayed complex strategies for leave-taking that appear consistent with supportive parenting behaviors, for example, expressing love, providing information on the next visit, and helping the child to make the transition back into foster care. Furthermore, the quality of mothers’ emotional support and interaction with their children throughout the visit generally was positive. In short, many mothers demonstrated considerable strength and sophistication in their parenting upon which child welfare interventions can build. In interpreting these generally positive results, however, it is important to remember that although the mothers in our study clearly led very difficult lives, they may have been relatively high functioning compared with mothers who did not participate. Less than one-half of the eligible mothers agreed to participate in the study, and child welfare workers screened out a number of other mothers for whom they had no contact information or who did not participate in regular visits. It is
possible that some of these mothers were less successful in dealing with the challenges of visiting.

Despite mothers’ strengths, however, nearly all identified leave-taking as problematic, and the majority of their children expressed distress at the end of visits. Our intervention designed to facilitate leave-taking demonstrated that a fairly simple, short-term intervention can affect mothers’ parenting behaviors. Mothers in the intervention group easily learned specific behavioral strategies. They displayed a broader repertoire of strategies for supporting their children during leave-taking than did mothers in the comparison group. Future research should investigate any longer term effects. For example, did intervention mothers continue to display a broader repertoire of strategies, and did their children, eventually, respond with less distress?

Acquiring specific parenting behaviors, however, is only one component of leave-taking. Also critical is the mother’s ability to apply these newly learned strategies to sensitively respond to, positively engage and support her child during emotionally complex negotiations including at the end of visits. Mothers’ responses to the visit intervention in terms of quality of affect and interaction with their children was much more complex than their responses to the behavioral strategies. Mothers in the intervention and comparison group did not differ in the quality of their emotional expression and support of their children during the body of the visit. This suggests that any effect of the intervention was confined to leave-taking. Contrary to our expectations, however, during the leave-taking sequence, intervention mothers were less engaged with their children than they had been during the body of the visit, and than the comparison mothers were during leave taking. In addition, they were less inventive than the comparison mothers. In other words, the intervention seems to have had a negative effect on the quality of parent-child interaction: mothers interacted less with their children and displayed fewer ways of maintaining the child’s involvement in mother-child interaction during leave taking. In contrast, the quality
of comparison group mother’s interaction and affect showed some improvement from the body of the visit to the leave-taking segment perhaps in response to children’s distress. During leave-taking comparison group mothers were less intrusive, that is, they showed more respect for the child’s individual needs and responses independent of their own needs and desires.

There may be a number of factors contributing to the quality of affect and interaction for mothers in the intervention group. First, some intervention mothers may have been attending to the recall and mechanics of new skills/strategies, so that qualities of interaction became secondary. Second, some intervention mothers may have experienced some performance anxiety that may have interfered with the quality of the interaction. Future research should follow mothers’ strategies over time. If cognitive complexity and performance anxiety are significant factors in lowering the quality of mothers’ interactions, then quality of interaction should improve over time as mothers become more comfortable and skilled with new strategies. Future research should explore the quality of affect and interaction in intervention mothers longitudinally.

Third, the intervention necessarily drew mothers’ attention to difficult issues of separation and loss. A common response of survivors with unresolved issues of loss and trauma is withdrawal and emotional detachment during stressful situations (Wilson, Friedman & Lindy, 2001), a pattern paralleling that of the intervention mothers. Indeed, mothers in this study reported ongoing stress and trauma, as well as a history of significant loss and trauma in childhood or adolescence. Developmental theory and research indicates that a parent’s experiences of trauma and loss can negatively affect parenting (Bowlby, 1980; Main, Kaplan, Cassidy, 1985; Posada, Waters, Crowell & Lay, 1995; van IJzendoorn, 1995). Indeed, caregiver state of mind, that is the ways that adults process thoughts and feelings regarding their own attachment experiences, is a powerful predictor of the quality of young children’s
attachment relationships including with their foster mothers (Dozier, Stovall, Albus & Bates, 2001; Stovall & Dozier, 2000; Cole, 2002). Parents may express loss and trauma through affect or behavior that is frightening or disturbing to children, for example, parental helplessness, withdrawal and depression. Such expressions of loss and trauma can interfere with young children’s abilities to appropriately use their parents to obtain comfort and cope in times of stress (Carlson, 1998; Main & Hesse, 1990; van Ijzendoorn, Schuengel & Bakersman, 1999) perhaps including leave-taking during parent visits. Future research should directly assess mothers’ state of mind to examine the relationship between unresolved current and childhood trauma and loss, and responses to parenting interventions.

In conclusion, child welfare interventions to support struggling parents have become increasingly sensitive to certain aspects of family context, for example, cultural heritage and ongoing problems of living. The current emphasis on teaching parents behaviors and skills (Dawson & Berry, 2002) draws our attention away from another potentially powerful aspect of context: parents’ personal histories. Our results raise the possibility that not only do unresolved issues of loss and trauma affect parenting, they also affect parents’ responses to interventions. Parents’ resolution of the losses and traumas common to many mothers with young children in foster care (Haight et al., 2002; Petras et al., 2002) may be an important component of bringing about meaningful change in parent-child interaction. Indeed, teaching behavior strategies without attending to personal history may be harmful to the parent-child relationships we seek to support.
References


Table 1
Number of comparison and intervention mothers’ employing various leave-taking strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Comparison</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Express love</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Clean-up routine</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Give object</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Say good-bye</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Talk about next visit</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Positive or neutral transition talk about foster home</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Mean total different strategies(^1)</td>
<td>3.3 (1.3)</td>
<td>4.6 (1.9)</td>
</tr>
</tbody>
</table>

\(^1\) Significant difference between the comparison and intervention groups.
Table 2
Comparison and Intervention mothers’ emotion and interaction quality scale scores during the body of the visit and the leave-taking sequence (Means and SDs)

<table>
<thead>
<tr>
<th>Scales</th>
<th>Comparison</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Visit</td>
<td>Leave-taking</td>
</tr>
<tr>
<td>Engagement (^1,3)</td>
<td>5.7 (1.0)</td>
<td>5.3 (1.0)</td>
</tr>
<tr>
<td>Inventiveness (^3)</td>
<td>4.2 (.7)</td>
<td>4.8 (1.4)</td>
</tr>
<tr>
<td>Hostility</td>
<td>1.4 (.4)</td>
<td>1.2 (.6)</td>
</tr>
<tr>
<td>Intrusiveness (^2)</td>
<td>2.2 (.9)</td>
<td>1.2 (.4)</td>
</tr>
<tr>
<td>Sadness</td>
<td>1.6 (1.1)</td>
<td>1.2 (.4)</td>
</tr>
<tr>
<td>Detachment (^4)</td>
<td>1.6 (1.2)</td>
<td></td>
</tr>
<tr>
<td>Positive regard</td>
<td>5.1 (1.4)</td>
<td></td>
</tr>
<tr>
<td>Supportive presence</td>
<td>5.5 (1.6)</td>
<td></td>
</tr>
<tr>
<td>Generational boundary</td>
<td>1.8 (1.3)</td>
<td></td>
</tr>
<tr>
<td>dissolution</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Significant difference between body of the visit and leave-taking sequence for intervention group.
\(^2\) Significant difference between body of the visit and leave-taking sequence for comparison group.
\(^3\) Significant difference between comparison and intervention groups at leave-taking.
\(^4\) Note that reliability checks were conducted on both the body of the visit (first 50 minutes) and the leave-taking sequence (final 10 minutes). Because of the complexity of interaction during the leave-taking sequence, coders did not obtain adequate reliability, that is, greater than 70% agreement within one scale point, on several codes for the leave-taking sequence. These codes were dropped from the analysis.