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ADOLESCENT MOTHERS: THE SPACE BETWEEN WHAT THEY KNOW AND

WHAT THEY DO

By

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Dissertation

presented in partial fulfillment of the requirements  
for the degree of

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in Psychology, Developmental emphasis

The University of Montana  
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Adolescent Mothers: The Space Between What They Know and What They Do

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Although the current rate of teen pregnancy in the United States is at a historic low (Martin et al., 2007), there are a number of risk factors associated with early parenthood. Adolescent parenthood is often embedded in a larger context of risk such as poverty, single parenthood, low educational attainment, a history of physical and emotional abuse, and engagement in risky behavior (Hans & Wakschlag, 2000). As parents, adolescent mothers tend to be less knowledgeable about child development, less stimulating in interactions with infants, less tolerant, and more punitive with punishment (Brooks-Gunn & Furstenberg, 1986). The children of adolescent mothers are at a greater risk for health problems, cognitive deficits, behavior problems, and insecure attachment styles (Broussard, 1995; Hans & Wakschlag, 2000). This study examined the effectiveness of an intervention designed to promote positive parenting skills in a group of homeless adolescent mothers residing in a group home. The intervention lasted 8 weeks and included weekly group and individual sessions. The goals of the intervention were to increase maternal knowledge of child development, improve maternal beliefs and expectations of infants, and increase maternal responsiveness. The effectiveness of the intervention was assessed by examining differences in pre and post intervention measures within the targeted group of homeless adolescent mothers. Results are presented in a case study format. This research adds to the literature on teen parenting and has implications for relationship-based interventions targeting teen mothers. The intervention may become a component of the services offered to teen mothers by a local transitional housing program for adolescent mothers.

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## Adolescent Mothers: The Space between What They Know and What They Do

Though the last several decades have witnessed a decline in births to teenage mothers, adolescent parenthood still represents a significant social problem in the United States. The teen birth rate fell to a historic low in 2005 with 41.1 births to women ages 15-19 per 1000 women, or 10.2% of all births (Martin et al. 2007). In Montana, the teen birth rate was below the national average with 35.3 births to women ages 15-19 per 1000 women, or 10.2% of all births in the state (March of Dimes, 2005). In contrast to earlier periods in history in which the majority of young mothers relinquished their parental rights, in more recent times, 90% of teen mothers chose to parent their infants themselves rather than pursuing adoption as an option (National Survey of Family Growth, 1997). Although there is some degree of variability in outcomes for adolescent mothers and their infants, a large body of research suggests that both adolescent parents and their children are a group at high risk for a variety of poor outcomes. Adolescent parenthood is often embedded in a larger context of risk such as poverty, single parenthood, low educational attainment, history of physical and emotional abuse, and engagement in risky behavior (Hans & Wakschlag, 2000). This study explored the efficacy of an intervention designed to improve parent-infant relationships in a group of homeless teen mothers living in transitional housing.

### *The Effects of Early Parenthood on Adolescents*

Early parenthood and the life changes associated with it can have a tremendous impact on the lives of young women. A constellation of risk factors emerges from the literature reviewing the plight of young mothers and their children. First, early childrearing has been found to interfere greatly with mothers' educational attainment.

About 30% of adolescent mothers fail to complete high school and many others do not graduate on time. Among graduates and GED recipients, many adolescent mothers lack the functional reading and math skills or work and motivational habits necessary to attain a job. Thus it is not surprising that 25% of teenage mothers do not become economically self-sufficient and instead must depend on public assistance to survive (Whitman, Borkowski, Keogh, & Weed, 2001). Other adverse long-term consequences associated with teen parenting include higher fertility rates, increased probability of single parenthood and increased dependence on welfare assistance (Sommer, Whitman, Borkowski, Schellenbach, Maxwell & Keogh, 1993).

#### *Parenting Behaviors of Adolescents*

In studies examining the parenting characteristics of adolescent mothers, several problematic behaviors have emerged. One particular area in which adolescent mothers tend to exhibit deficits is in their knowledge and expectations of infant development. Several studies have found that adolescent mothers tend to have less knowledge of child development than adult mothers (Culp, Culp, Blankemeyer, & Passmark, 1998; Whitman et al., 2001). First, young parents tend to either overestimate or underestimate children's developmental levels. Overestimating the rate of development might lead mothers to be impatient and intolerant of their child's behavior and to overestimate their child's recognition of wrong doing (Culp et al., 1998). On the other hand, underestimating the rate of development might lead young mothers to provide infants with less stimulation than necessary. For example, in daily interactions with their infants, adolescent mothers tend to vocalize much less than adult mothers (Brooks-Gunn & Furstenberg, 1986). Such a lack of verbal stimulation and encouragement has been associated with developmental

delays including language deficits, unskilled use of objects, internalizing problems, and poor communication in early childhood (Sommer et al., 1993). In play, exchanges between teen mothers and their infants are often less interactive, with mothers tending to offer less stimulation in play and to be more passive play partners (Hans & Wakschlag, 2000). Similarly, adolescent mothers tend to be less verbal and more physical in play interactions. They also tend to be less responsive, less involved, more negative, and more intrusive in play with their infants (Osofsky, Hann, & Peebles, 1993).

Adolescent mothers also tend to misperceive the emotional qualities of their children. Specifically, they often perceive their infants as having difficult rather than easy temperaments. Brooks-Gunn and Furstenberg (1986) found that adolescent mothers were likely to rate their 4-month-olds as high in distractibility and not adaptable, potentially reflecting inappropriate developmental expectations. It has been suggested that such misperceptions might mask mothers' understanding of how their own actions affect interactions with their child (Osofsky et al., 1993). For example, mothers may attribute difficult interactions to temperamental qualities of the child, ignoring the role their response plays in such situations.

Another concern with adolescent mother-infant interactions is emotional expression, which may impact the development of regulatory abilities in young children. Groups at high risk for psychosocial problems in development, such as adolescent mothers and their infants, sometimes have difficulty sharing affective experiences, which may in turn, result in a breakdown in emotional communication (Osofsky, Eberhart-Wright, Ware, & Hann, 1992).

Specifically, adolescent mothers are more likely to engage in dysregulated patterns of affective interactions with their children, emphasizing negative affects of infants or misreading cues. Such difficulties in affect regulation may be a result of less emotional availability on the part of the caregiver (Osofsky et al., 1993). Of particular concern is that infants born to young mothers at high psychosocial risk are more likely to experience inappropriate affective exchanges, which may make it difficult for them to experience appropriate emotions in response to others as they grow older (Osofsky et al., 1992).

Although there is a large body of evidence detailing the negative qualities associated with adolescent parents, several factors have been identified as determinants of individual differences in parental competence. First, social support and other relationship factors have been found to contribute to parenting success. In particular, it has been found that social isolation increases the risk of maltreatment in adolescent parent-child dyads (Hans & Wakschlag, 2000). One factor that seems to affect parental competence is the quality of the relationship between adolescent mother and her mother. Crockenberg, (1987) found a link between adolescent mothers' histories of parental rejection or problematic attachments and higher levels of depression and harsh, punitive parenting. In contrast, young mothers who received social support from their mothers tended to be more responsive parents (Crockenberg, 1987). Interestingly, several studies have found differences in the role of grandmother support. For example, East and Felice (1996) found that living with one's mother can have a negative effect on parental competence as young mothers may experience role confusion. Thus it seems that the best outcomes for children and young mothers occur when the mother receives support from her mother, but

resides separately. In addition to the presence of a supportive grandmother, the presence of a supportive parenting partner has been associated with better outcomes for the children of adolescent mothers (Hans & Wakschlag, 2000).

### *Cognitive Readiness to Parent*

In addition to social support, the personal resources and adjustment of adolescent mothers have been found to play a role in their effectiveness as parents. Specifically, cognitive readiness to parent has emerged as an important predictor of parental competence. Cognitive readiness to parent describes a mother's knowledge and expectations about child development, attitudes and commitment toward child rearing, and the ability to understand appropriate parenting practices and apply them flexibly (Sommer et al., 1993). Cognitive readiness to parent has been associated with better maternal coping skills, positive perceptions of infants, and more responsive parenting (East & Felice, 1996). In a comparison of adolescent mothers and adult mothers, Sommer et al., (1993) found that adolescent mothers were less prepared for parenting prior to the birth of their children than adult mothers. After the birth of their infants, adolescent mothers experienced greater parenting stress and were less responsive to their children. These authors also found that adolescent mothers had difficulty taking the child's perspective, held unreasonable developmental expectations, tended to use more harsh punishments, and were often disappointed when their children failed to meet their expectations.

Cognitive readiness to parent has also been associated with a variety of outcomes for children. In a sample of adolescent mothers, cognitive readiness to parent measured during pregnancy predicted children's attachment status at 12 months of age, as well as

the quality of mother-child interactions when children were 3 years of age (Whitman et al., 2001). These authors concluded that young mothers' knowledge of child development, expectations for children, and commitment toward child rearing have a direct effect on the parent-child relationship, which in turn has important implications for outcomes among children. Similarly, Hans and Wakschlag (2000) found that if mothers' expectations of parenting are realistic, children tend to show more adaptive coping strategies, better intellectual development, and fewer internalizing and externalizing behavior problems at 3 years.

#### *Maternal Mental Health*

Maternal mental health has also been associated with parental competence. Specifically, higher social competence, self-confidence, and self-efficacy have been associated with increased parental responsiveness, lower abuse potential, and higher quality parenting. In contrast, maternal depression and a history of sexual abuse have been associated with less responsive parenting, difficulties maintaining stable relationships, and greater potential for abuse (Hans & Wakschlag, 2000). Several studies have found that adolescent mothers tend to experience a higher rate of depression than adult mothers (Whitman et al., 2001). Depressed mothers are often erratic in their behaviors toward their children, sometimes showing sadness, helplessness, and low affect and at other times irritability and anger. They also tend to be less emotionally available and responsive parents, again contributing to difficulties with affect regulation (Osofsky et al., 1993). Children of depressed mothers are themselves at higher risk for problems in affect regulation and inappropriate aggression (Osofsky et al., 1992).

*Developmental Status of Adolescents*

When examining factors that contribute to adolescents' success as parents, it is also important to consider the developmental status of adolescents. Many researchers have suggested that adolescent parenthood is particularly problematic because it represents an "off-time" event (Hans & Wakschlag, 2000; Whitman et al., 2001). Such an off-time, unplanned event forces young mothers to make huge adjustments in daily activities and to accept many new demands. Early pregnancy also tends to be disruptive because it forces young mothers to change their expectations and future goals. The theories of both Jean Piaget and Eric Erikson shed light on the ways in which the unique developmental stage of adolescence might complicate the emergence of positive parenting practices.

In terms of cognitive development, Piaget believed that between the ages of 15 and 20, formal operational thought emerges. Thus many teen parents in Western societies are in a stage of "not quite adult" thought that is characterized by both idealistic thinking and egocentrism (Piaget, 1972). The idealistic thinking of adolescents leads them to an optimistic view of themselves as a source of change in a world they view as unfair. The byproduct of such thought is a cynical view of adults and authority figures combined with an oversimplified view of the world. In addition to idealized views of their own power, young mothers may have very unrealistic expectations about their children and the role they play in the mothers' life. For example, adolescents sometimes become pregnant to fill a void in their lives or to make a young man fall in love with them. The baby becomes a means through which she can achieve some status and the mother often fails to realize the sacrifices she will have to make to raise a child (Rellinger, 2001).

Egocentrism is another characteristic of adolescent thought, according to Piaget. Adolescents tend to feel unique and immortal, and to believe that their own feelings and experiences are more intense and meaningful than those of others. Such thinking is often a contributing factor to unplanned pregnancy in the first place as adolescents are aware of the risk of becoming pregnant, but fail to take precautions because they believe that they are not vulnerable to such risk. Once they become parents, adolescents may fail to take necessary precautions, such as using a car seat, to keep their children safe, believing that no harm will come to them (Sommer et al. 1993). Thus it seems that, “ Young mothers are entering a complex and demanding new world with inadequate problem-solving skills, an idealized view of the world, and unrealistic expectations about what to expect from her child” (Rellinger, 2001, p. 30).

Erikson’s theory of personality development can also be used to understand the particular challenges faced by adolescent parents. According to Erikson, the rapid bodily growth and sexual maturity that come with puberty force adolescents to struggle to resolve conflicts regarding their personal identity. With the resolution of these conflicts, adolescents are able to establish intimacy and commitments to others, which is necessary for effective parenting (Erikson, 1960). Fulfilling typical adolescent tasks such as completing school or socializing with peers can mean a neglect of parental duties for young moms. In contrast, the social stigma and responsibilities involved in being a parent might isolate young mothers from their peers, making the completion of age appropriate tasks difficult (Rellinger, 2001).

Another major task of adolescence is shifting attachments from parents to peers and moving from relationships in which they primarily receive care to those in which

they are expected to give care. Therefore, the dependency upon others such as social services or family members inherent in young parenthood often directly conflicts with the emerging independence adolescents are seeking (Schwartz, McRoy, & Downs, 2004).

Another issue is that young parents might get stuck in a particular role, that of parent, too early and without the benefit of trying new roles and discarding those that do not fit. With their opportunities limited due to familial responsibilities and potentially a lack of education or social skills, teen mothers may come to believe that her child should fulfill her needs (Spieker & Bensley, 1994).

#### *Outcomes for Children of Adolescent Parents*

Given such risk factors, it is not surprising that early motherhood has been associated with a variety of negative outcomes for children. Although many studies suggest that young motherhood alone does not cause adverse outcomes in infants, several issues associated with adolescent parenting have been found to contribute to poor outcomes for children. First, the children of adolescent parents are often at a greater risk for developing health problems. Adolescent mothers are at a greater risk for malnutrition than adult mothers and often receive less prenatal care, which often has long-lasting consequences for their infants. There are several reasons why young mothers might receive less than optimal prenatal care. First, they tend to have lower SES and often lack awareness of free or reduced cost services for prenatal care. In addition, adolescents may not realize that they are pregnant until several months have passed. Once aware, they might be afraid to tell their parents or partners, further delaying care (Osofsky et al., 1993).

Researchers have also been interested in whether the biological immaturity of teen mothers may have adverse effects on the health of their offspring. Given the number of confounding variables, researchers have found it difficult to tease apart the effects of biological immaturity from the effects of other sociodemographic variables. One large, population based study examined whether teenage pregnancy was associated with increased risks of adverse birth outcomes such as pre-term delivery, infants born small for their gestational age, neonatal mortality and low APGAR scores independently of known confounding sociodemographic variables (Chen, Wen, Fleming, Demisse, Rhoads, & Walker, 2007). Through an examination of national birth data from 1995-2000, these researchers found that compared with 20-24 year old mothers, teenage mothers were more likely to be unmarried, to have smoked while pregnant, and to have had inadequate prenatal care. They also found that rates of pre-term and very pre-term delivery, low and very low birth weight, low and very low APGAR, and neo-natal mortality were higher for young mothers than for adult mothers. The highest rates were observed in the youngest mothers, those who were less than 15 years old when they became pregnant. This higher risk of adverse perinatal outcomes remained stable even when researchers controlled for ethnicity, marital status, education, prenatal care, and smoking or alcohol use while pregnant (Chen et al., 2007).

In addition to health-related risks, the children of adolescent parents often display deficits in cognitive abilities. Early cognitive deficits may be subtle, but tend to become more obvious as children age. Cognitive deficits first appear in preschool, with children of adolescent mothers showing slightly below average intelligence. In particular, their receptive language scores are well below average (Lefever, Nicholson, & Noria, 2007).

As these children enter elementary school, such deficits become magnified, with intelligence test scores in the low average or mildly impaired range (Lefever, Nicholson, & Noria, 2007). By high school the children of adolescents are doing poorly in terms of incidences of delinquency, low scholastic achievement, and greater early child bearing (Brooks-Gunn & Furstenberg, 1986; Hans & Wakschlag, 2000).

Children of teen mothers also show higher levels of behavior problems such as low impulse control and aggression and personality problems (Jaffee, Caspi, Moffitt, Belsky, & Silva, 2001; Osofsky et al., 1993). As the children of adolescents become adolescents themselves, a different set of adverse outcomes emerges. Adolescents born to teen mothers are at risk for several negative outcomes including: teen pregnancy, low academic achievement and school drop out, and antisocial outcomes such as delinquency, substance abuse, and incarceration (Jaffee et al., 2001; Pogarsky, Thornberry, & Lizotte, 2006).

### *Attachment*

One area in which the children of adolescent mothers are believed to be particularly at risk is in the formation of secure attachments. Several studies have found an over-representation of insecure attachments when examining adolescent mother-infant dyads. For example, Spieker and Bensley (1994) in a study of 197 adolescent mother-infant dyads, found significantly more insecurely attached infants, 50% of their sample, a figure much larger than would be expected from normative data (25-30%). Similarly, Ward and Carlson (1995) found that 51% of the infants born to adolescent mothers in their sample were classified as insecurely attached, with 18% rated as disorganized. A study by Broussard (1995) found a strikingly low rate of securely attached infants in a

sample of 37 adolescent mother-infant dyads. Only 23% of the infants in this study were classified as securely attached, a finding that contrasts sharply with the 65% rate of secure attachment expected from previous studies. In addition, the number of children classified as disorganized, 31.6% of this sample, was higher than the expected rate of 12% in white middle class samples (Broussard, 1995).

In a study examining prenatal parenting attitudes and parenting behaviors during infancy and early childhood as predictors of attachment in children of adolescent mothers, Lounds, Borkowski, Whitman, Maxwell, and Weed (2005) found that maternal interactions during infancy, but not early childhood, predicted 5-year attachment security. These authors also found that quality of maternal interactions and cognitive readiness to parent predicted attachment stability. As in previous studies, these authors found a high rate of insecure attachments among infants of teen mothers, with only 31% of their sample rated as securely attached. An interesting finding from this study was that there seemed to be a connection between maternal verbal stimulation and attachment security. Specifically, these authors found that children whose attachment status changed from insecure at 12 months to secure at 5 years, tended to have mothers who were more verbally stimulating than mothers of children who maintained their insecure attachment status. Lounds and colleagues (2005) concluded that verbal stimulation is a key component of parenting and an important predictor of attachment security.

When attempting to explain such a high rate of insecure attachments among adolescent mothers and their infants, it is important to consider the foundations of parent-infant attachment. Attachment theory represents a joint effort on the part of John Bowlby and Mary Ainsworth to explain infant behaviors of proximity seeking and exploration

(Bretherton, 1992). From observations of the behavior of young children separated from their parents, Bowlby concluded that human infants are equipped with an attachment system. The goal of this system is security, which can be observed in the regulation of behaviors designed to maintain proximity to an attachment figure. Such attachment behaviors are most obvious when the child is frightened, fatigued, or ill and less obvious when the child feels protected, helped, or soothed (Bretherton, 1985).

One of Mary Ainsworth's contributions to attachment theory was the addition of the concept of a secure base for exploration. According to Ainsworth, as infants develop, they tend to seek less proximity to parents and instead to use parents as a secure base from which to explore the world around them. In the course of exploration, if children become frightened, they seek proximity to caregivers, allowing for exploration under safe conditions (Bretherton, 1985).

Through continual experiences of proximity seeking and exploration with the help of caregivers, infants develop an internal working model of the world, people in it, and the self. The development of such a model depends greatly upon early interactions with caregivers. For example, if caregivers frequently reject or ridicule the child's attempts to gain comfort, the child may develop a model of the parent as rejecting and of the self as unworthy of comfort. On the other hand, if caregivers give help or comfort when needed, the child might develop a model of the parent as loving and of the self as worthy of support. Internal working models are formed early in life and operate outside of conscious awareness, but are revised frequently in early childhood when development is rapid (Bretherton, 1985).

Several longitudinal studies have examined the relationship between early attachments and subsequent adult relationships. These studies have found that unresolved attachment issues from early childhood might have an effect on adult romantic relationships and on parenting relationships (Main, Kaplan, & Cassidy, 1985). Thus, given the sometimes traumatic childhood of adolescent parents combined with their current developmental stage, the children of adolescent parents might be at a greater risk for attachment insecurity than the children of adult parents.

*Maternal Responsiveness.* In searching for factors that contribute to attachment security in infants, maternal responsiveness has emerged as a major determinant of relationship quality (Juffer, Bakermans-Kranenburg & van Ijzendoorn, 2007; Lounds et al., 2005). Parental responsiveness involves the parent's ability to provide contingent, consistent, and appropriate responses to his or her infant's cues (Ainsworth, Blehar, Waters, & Wall, 1978). Responsive parents are aware of their infant's signals, respond promptly, display flexibility in behavior and thought, exert an appropriate level of control, and are able to negotiate between the sometimes conflicting goals of their infants (Lounds et al., 2005). Similarly, responsiveness represents the degree to which parents' actions are sensitive and child focused, and is evident in both daily care-taking tasks and social interactions between parents and children. Findings from Ainsworth's Baltimore study showed that maternal sensitivity to infants' signals during feeding, play, physical contact, and distress episodes in the first 3 months was predictive of the quality of the relationship at 8 months. Maternal sensitivity was also correlated with infant behavior at 12 months in the Strange Situation (Ainsworth et al., 1978). Thus, attachment theory

suggests that early responsiveness provides a foundation that allows children to feel secure and to develop basic trust of their caregivers.

A major component of parental responsiveness is an understanding of the child's developmental abilities. Without such an understanding, parents may over or underestimate their children's skills, and thus not provide children with the appropriate early experiences (Hans & Wakschlag, 2000). Several factors influence parental responsiveness including parental characteristics such as personality type and feelings of effectiveness in interactions with infants, as well as situational factors like perceived social support from partners and life stress. In addition to parental factors, factors within the infant have been associated with the level of parental responsiveness. Specifically, infant temperament, readability, and predictability have been found to have an impact on parental responsiveness (Bornstein & Lamb, 1992). Interventions targeting parental sensitivity have found that parental sensitivity can be affected by alleviating stress, improving social support, increasing knowledge of child development, enhancing maternal self esteem and perceived effectiveness, and providing practical assistance in solving everyday problems (Culp et al., 1998).

### *Reflective Functioning*

Another parenting capacity that may contribute to the formation of secure attachments is reflective functioning. Reflective functioning involves the parent's capacity to reflect upon her own and her child's mental experience and to understand behavior in light of underlying mental states and intentions (Slade, 2005). Reflective functioning has been described as "a crucial human capacity that is intrinsic to affect regulation and productive social relationships" (Slade, 2005, p. 269). According to

Fonagy and colleagues, the creators of the concept of reflective functioning, it is the parent's ability to reflect upon the child's internal experience that allows for the development of a secure attachment as well as a variety of other developmental outcomes (Fonagy, Steele, & Steele, 1991). The first step in responsive parenting, a key contributor to attachment security, is to recognize and make sense of infant cues; thus reflective functioning is also key to the developing attachment between parent and child.

Reflective functioning is also important for children's emotional development. A child's ability to recognize his or her internal states is built upon observations of such mental states mirrored by sensitive caregivers (Slade, 2005). Parents are essentially bringing attention to children's emotional states by responding appropriately to children's cues. Over time, the child develops the ability to self regulate based upon early interactions with sensitive caregivers. In addition to marking and mirroring children's affective states, mothers high in reflective functioning also grasp the interplay between her own mental state and that of her child. Such mothers understand the relationship between internal state and observable behavior, for both herself and her child. Highly reflective parents are able to embrace and identify their own internal state and to conceive of how their own feelings affect their parenting interactions (Slade, 2005).

Given the egocentrism characteristic of adolescents in this developmental stage, and risk factors such as a lack of knowledge of appropriate developmental expectations, reflective functioning might be relatively low amongst adolescent mothers. There are many manifestations of low reflective functioning in parent-infant interactions, such as having no concept of a baby's internal experience or misunderstanding the meaning of behavior. For example, mothers might consider an infant's cries to be manipulative rather

than an indicator of an internal state, and respond by ignoring them. In this case, mothers are correctly marking a particular affective state in an infant, but misattributing the infant's emotion (Slade, 2005). Another example might occur when a mother is asked about her child's reaction to separation: if the mother replies "She clings to me and cries, but she's fine," this is an indication that she is noticing a behavior, but not connecting it with an internal state. Parents might also deny their own internal experience in relation to parenting, thus having no response to questions about the most common feelings of parenting, specifically, guilt, anger, and joy (Slade, 2005). Finally, mothers low in reflective functioning might have very negative characterizations of their child, such as "He's a devil and makes my life miserable." If reflective functioning plays such a central role in parents' ability to respond sensitively to their children's cues, interventions seeking to increase responsiveness must also target reflective capacities in order to improve relationships.

#### *Child Abuse and Neglect*

In addition to parental responsiveness and reflective functioning, child abuse and neglect have also been identified as factors affecting attachment security. Child maltreatment, which can be conceptualized as the direct opposite of responsive parenting, significantly reduces the likelihood of a secure attachment developing between mother and child. Adolescent mothers have been found to be particularly at risk for the development of abusive behavior, and are often over-represented as perpetrators in child maltreatment cases, thus interventions must be directed at reducing the likelihood of maltreatment (Culp, et al., 1998). When examining risk factors for child maltreatment, several emerge as characteristics of young parents: being abused as a child, stressful life

events, low self efficacy, and a lack of understanding of children's developmental needs (Egeland and Erickson, 2004). These authors point out however, that most mothers who are abused as children do not in turn abuse their own children.

#### Rationale

A large body of research supports the idea that adolescent parenting is often characterized by a variety of risk factors that can result in negative outcomes for both young parents and children. Most of these studies have selected teen mothers living with their families or partners as participants. However, a growing number of teen mothers, those living in transitional housing, have not been considered in studies examining the characteristics of teen parents. In a study that was part of a larger process and outcome evaluation of the effectiveness of ten transitional living programs for teen mothers, Schwartz, McRoy, and Downs (2004) found that services directed at strengthening relationships were severely lacking. These authors found that attachment issues were of critical importance for the young families they studied, and strongly recommended that such issues be addressed in the intervention process. Although there are a great deal of parenting interventions available, some of these interventions fall short with a "one size fits all" approach that fails to consider the unique personal qualities of mother and infant (Berlin, 2005). In particular, it is likely that interventions with teen mothers and their infants will need to have a high level of flexibility to meet the needs of mothers in such a unique stage of development. In addition to the need for more flexible parenting interventions for teen mothers, there is a lack of information in the research literature concerning adolescent mothers who are residing in transitional living arrangements. It seems that given the variety of risk factors that may lead these mothers to homelessness,

combined with a lack of familial support, this growing population of teen mothers and infants might be of particular concern for the development of insecure attachments and other maladaptive behaviors. The current study was therefore designed to examine the effectiveness of a relationship-based intervention targeting adolescent mothers in transitional living arrangements.

### Hypotheses

Three general hypotheses were explored in the course of this study. First, it was thought that adolescent mothers participating in the 8-week, relationship-based parenting intervention would show improvements in their knowledge of child development. Several previous studies have identified deficits in knowledge of child development as a predictor of poor parenting (Whitman et al., 2001). Such deficits are thought to contribute to the inappropriate expectations adolescent mothers tend to have of their children (Culp et al., 1998). Although it was hoped that the intervention would increase mothers' overall knowledge of child development, it seemed more appropriate to focus most of the developmental education mothers received on the current developmental stage of their child. The parenting intervention implemented in this intervention targeted knowledge of child development in both group and individual sessions in a variety of ways to be described in greater detail in both the methods and results sections.

Next, it was thought that mothers participating in a parenting intervention would show increases in their level of maternal responsiveness as assessed by a video-recorded and coded free play interaction. Previous studies have found that adolescent mothers tend to be less responsive in interactions with their infants (Osofsky, et al., 1993). Similarly, several studies have found that the children of adolescent mothers are at a greater risk for

the development of insecure attachments (Spieker & Bensley, 1994). Given the relationship between maternal responsiveness and the formation of secure attachments, a major goal of this intervention was to increase teen mothers' sensitivity and responsiveness in interactions with their infants. Maternal responsiveness was targeted in several ways throughout the intervention. For example, one major implication of a relationship-based intervention is that the responsive, caring relationship provided by the interventionist serves as a model for young mothers who may not have experienced responsive care themselves. Young mothers may then apply this model to their relationships with their infants. Responsiveness was also targeted more directly through teaching young mothers to pick up on their infants' cues and encouraging them to respond consistently and appropriately.

Finally, a third hypothesis of this study was that adolescent mothers participating in a parenting intervention would show changes in their expectations and attitudes regarding their children and parenting. Previous longitudinal studies have identified cognitive readiness to parent as a major contributor to outcomes for the children of adolescent mothers (Whitman et al., 2001). One major component of cognitive readiness to parent is the mother's expectations and attitudes about parenting and about her child. Such expectations are partly influenced by knowledge of child development, as well as by mothers' own experiences as children. These representations of parenting can affect mothers' ability to respond consistently and appropriately to their child's cues, which may have important implications for the formation of a secure attachment between mother and infant. Mothers' expectations and attitudes were addressed in a variety of ways throughout the intervention. Throughout the course of the intervention, participating

mothers were frequently asked to reflect upon their own childhoods and the lessons they learned from their own relationships.

## Method

### *Participants*

The participants in this study were adolescent mothers residing at a transitional home for homeless pregnant or parenting teens and their children. The goal of this home is "to provide a safe, loving home where teen mothers can discover their strengths and their children can experience the joys of childhood" (Mission Statement). This transitional home is a voluntary program that provides shelter and a variety of services for up to 6 mothers and infants. Young women enter this program with a variety of issues and for a variety of reasons. All of the mothers are homeless and most have no relationship with or support from their families. Many of the mothers have suffered physical and/or sexual abuse, have chemical dependency issues, suffer from mental illness, have cases open with Child and Family Services, and some have a criminal record. Mothers are limited to parenting one child while residing in this transitional home, and most often the child is an infant or toddler. Residents between the ages of 14 and 19 may stay for up to 2 years and receive a variety of services tailored to their individual needs. Program staff provides 24 hour supervision and addresses such issues as: parenting, problem solving, communication skills, relationships, health issues, nutrition, time and money management, employment skills, housing, housekeeping, chemical dependency issues, and transportation. Each young mother completes a personal development plan with an on-site social worker and engages in continuous assessment of her progress in attaining her goals. Adolescent mothers participating in this program also

receive a variety of need-based services including WIC, Early Head Start, the Child Development Center, etc. on an individual basis.

This residential program for teen mothers engages in continuous strategic planning to improve the services offered to young women. As a result of such planning, program staff and board members recently developed the goal of implementing an intervention to improve the relationships between the resident adolescent mothers and their infants. Adolescents residing at the transitional home were required to participate in the intervention provided by the experimenter (see Procedures section for details) as a component of their treatment plan. Mothers participating in this component were compensated by the home. Participation in the assessment portions of this study was optional. Mothers participating in this aspect of the study were compensated with a \$25 gift card upon completion of both pre- and post-intervention assessments. Infants received a small toy for participation in this study.

IRB approval was granted for this project on Feb. 7, 2008. Before granting full approval, the IRB required more information regarding the demographic information provided by participants. The IRB also expressed concern about the experimenter's access to participants' records. The IRB committee was assured that demographic information would be used only to characterize the sample and that the experimenter would not have access to participants' medical records.

During the months of the intervention, the transitional home for teens experienced below average levels of enrollment as well as a high level of attrition. Five adolescent mothers completed pre-intervention assessments. One of these mothers ran away from the home and subsequently lost custody of her child and was thus unable to complete the

intervention. Another mother was under investigation by Child and Family Services and was mandated to work with a variety of other service providers. Her cognitive abilities were well below average and it was thought that introducing an additional intervention might be overwhelming for her and so she was excluded from the intervention. Three adolescent mothers completed the intervention as well as the pre and post assessments.

### *Measures*

A series of pre-intervention measures were administered to participants prior to the start of the intervention. Assessments were conducted over the course of a single 2-hour long session. Mothers and infants were given breaks to minimize fatigue and also given the option to complete the assessments over the course of 2 days. All of the pre-assessments took place at the transitional home, in a room free from distraction. Mothers who were no longer residing at the home at the time of the post-assessments completed these assessments at their current residence or at the Parent-Infant Lab in Corbin Hall at The University of Montana. The pre-intervention assessments included a demographic questionnaire, a basic child development quiz, form A of the Adult-Adolescent Parenting Inventory, a semi-structured parenting interview, and a free play interaction. The post-intervention assessments included a basic child development quiz, form B of the Adult-Adolescent Parenting Inventory, a semi-structured parenting interview, and a free play interaction.

The demographic questionnaire (see Appendix A) asked mothers to provide information regarding their current age, age at first pregnancy, number of times pregnant, age of child or due date, presence of birth complications, health issues of child, ethnicity, highest level of education completed, marital status, relationship with the father of the

baby, length of time in transitional housing, services received (Early Head Start, WIC, CDC, etc.), and employment status.

Maternal knowledge and expectations about child development were examined via a 16-item quiz designed to assess knowledge of basic child development. Mothers were asked to agree or disagree with a variety of statements concerning developmental norms. The experimenter created this quiz from the material covered in a popular parenting book (Sears & Sears, 1992). Questions reflect maternal knowledge of basic child development in social, emotional, motor, and cognitive domains. Mothers completed the quiz with an experimenter present to provide clarification as needed. This quiz is included in Appendix B. Researchers in the Notre Dame Adolescent Parenting Project used a similar quiz to assess knowledge of child development in a sample of adolescent mothers. These researchers created a multiple choice quiz based on material covered in an introductory child development text book (Whitman et al., 2001). Given the cognitive abilities of the participants of this study, the experimenter chose to use a commonly available parenting book, *The Baby Book*, by Sears and Sears, as a source for the questions. Potential answers were also reduced to agree/disagree to suit the cognitive abilities of the mothers participating in this study.

Maternal attitudes about children and parenting, feelings of parental competency, and perceptions of social support were assessed in a semi-structured interview. This interview was a modified version of Zeanah, Benoit, and Barton's Working Model of the Child Interview (Zeanah & Benoit, 1995). The Working Model of the Child Interview (see Appendix C) is a structured interview to assess parents' internal representations of their relationship to a particular child. The interview was modified to suit the cognitive

abilities of the participants in this study. Interviews took approximately 1 hour to complete. Interviews were tape-recorded with the mother's consent.

Parenting and childrearing attitudes were assessed via the Adult-Adolescent Parenting Inventory (AAPI-2; Bavolek & Keene, 2001), the revised and re-normed version of the original AAPI developed in 1979. This inventory is based on the known parenting and child rearing behaviors of abusive and neglecting parents, and responses to the inventory can be used as an index of risk (high, medium, or low) for child abuse and neglect. Several other studies of teen mothers have used the AAPI as an indicator of Cognitive Readiness to Parent (Sommer, et al., 1993; Whitman et al., 2001). The AAPI-2 includes 5 subscales:

- inappropriate expectations of children ("Children should do what they're told to do, when they're told to do it. It's that simple.")
- parental lack of empathy towards children's needs ("Children who express their opinions usually make things worse.")
- strong belief in the use of corporal punishment as a means of discipline ("Spanking teaches children right from wrong.")
- reversing parent-child role responsibilities ("Children should offer comfort when their parents are sad.")
- oppressing children's power and independence ("Children who receive praise will think too much of themselves.").

The AAPI-2 consists of 2 forms with 40 different items presented in a five-point Likert scale. The AAPI-2 takes only 20 minutes to administer and has been assessed as requiring a fifth grade reading level. The AAPI-2 is a validated and reliable inventory

that has shown significant diagnostic and discriminatory validity (Bavolek & Keene, 2001).

Parental responsiveness was assessed via a video-recorded free play interaction. The 10 minute free play interaction was video-recorded at the transitional home, the mother's current residence, or in the Parent-Infant Lab in Corbin Hall, with a variety of age-appropriate toys provided by the experimenter. Mothers were asked to play with their infants just as they would if they had a few extra minutes in the day. The experimenter did not intervene and attempted to minimize her involvement in the interactions.

Parental responsiveness in play interactions was measured using the Infant-Caregiver Interaction Scale, or ICIS, (Munson & Odom, 1995). The ICIS is a numerical rating scale developed to assess overall parent and infant behaviors in playful interactions. Behaviors included in the ICIS are those that have been associated with infants' current or later competence in previous research. Two subscales of ICIS, infant and caregiver, were used to code the free play interactions in this study. Both the infant and caregiver scales contain items to rate interactive behaviors, including: participation, predictability/consistency, sensitivity/responsiveness, turn taking, communicative intent, playful routines, imitation, and affect. Items are rated on a five-point Likert scale, with higher scores representing a higher degree of positive interaction (Munson, 1996). Internal consistency of the ICIS was established in a study with 60 infants (3-25 months) and their mothers (Munson & Odom, 1994, 1995). Cronbach's alpha was used by those authors to calculate internal consistency, with alphas for play of .85 for caregivers and .87 for infants.

The ICIS was primarily used as a guide for assessing pre and post play interactions in this study. Given the qualitative nature of the data, ratings of individual play interactions are given in narrative rather than numerical form in the results section of this paper. Coded scores for each mother in the various domains assessed by ICIS are provided in Table 1.

Table 1

*Participant Pre- and Post- Intervention Assessment Scores*

Measure	Miss M. Pre	Miss M. Post	Participant		Miss J. Pre	Miss J. Post
			Miss O. Pre	Miss O. Post		
AAPI	7	8	7	9	8	10
Expectations AAPI	10	6	5	8	10	7
Empathy AAPI	7	9	5	9	7	8
Punishment AAPI	9	10	6	7	10	10
Role Reversal AAPI	9	9	5	3	9	5
Independence ICIS	2.7	4	4	4.7	4.7	4.3
Participation ICIS	4	4	5	5	5	5
Predictability ICIS	1.3	4	3.7	3.7	5	5
Turn-taking ICIS	2	3.5	5	5	5	5
Communication ICIS	2.5	4	3.5	4.5	4	5
Play Routines ICIS	1	4	1	3	4	4
Imitation ICIS	2.3	4	4.3	5	4.5	4.5
Affect CD Quiz	14	13	12	11	12	15

Note. Infant-Caregiver Interaction Scale (ICIS) is a measure of responsiveness in play interactions with scores ranging from 1-5. Higher scores indicate greater responsiveness. Adult Adolescent Parenting Inventory (AAPI-2) provides an index of risk for child abuse with scores ranging from 1-10. Scores of 1-3 indicate a high risk of abuse, scores of 4-6 indicate a normal risk of abuse, and scores from 7-10 indicate positive parenting. Scores on the Child Development quiz range from 0-16.

*Procedure*

The parenting intervention implemented in this study was modeled after Egeland and Erickson's Steps Toward Effective Enjoyable Parenting (STEEP) intervention (2004). The STEEP intervention is a preventative home visitation program that offers both group and individual support and education from pregnancy until the child is 3 years old. STEEP was formed based on findings regarding the precursors of child maltreatment and factors associated with breaking the intergenerational cycle of abuse. This intervention addresses parental responsiveness and the variety of other factors that might influence parents' ability to provide sensitive care (Egeland & Erickson, 2004).

In addition to targeting specific parenting behaviors, the STEEP intervention focuses on parental representations of parenting. Specifically, the intervention focuses on what parents learned about themselves and about relationships in their own childhood, how they defend themselves against the painful parts of those lessons, and how the transition to parenthood provides a chance to move toward new models of the self and other (Egeland & Erickson, 2004). The STEEP intervention ideally begins in pregnancy, so that services can be in place before the parent begins to experience relationship difficulties with their child, but can be implemented after birth. The intervention is highly individualized to address the unique strengths of each dyad and includes bi-weekly home visits and bi-weekly group sessions. The STEEP intervention handbook was used as a source of guidance and for ideas for activities in both group and individual sessions. The experimenter also obtained basic STEEP intervention training.

A major component of both the STEEP intervention and a number of other parenting interventions is videotaping interactions in a variety of settings, and using

subsequent video feedback to improve parenting (Egeland & Erickson, 2004; Juffer, et al., 2007; Marvin, Cooper, Hoffman, & Powell, 2002; Slade, et al., 2005). There are several reasons for using videotaping in parenting interventions. First, the use of videotaping allows the interventionist to keep the parent-child relationship at the center of the intervention (Egeland & Erickson, 2004). Video feedback provides parents with a mirror of their own interactions with their children, subjects with whom they can identify, and thus can facilitate behavioral changes (Juffer et al., 2007). Specifically, observing themselves interacting with their children helps parents to develop observational skills that they can then apply to reading and responding to their children's cues (Juffer, et al., 2007; Marvin, et al., 2002). Several intervention programs have found that observing their behavior in interactions with their children can have a tremendous impact on maternal behavior (Juffer, et al., 2007). Videotaping can also serve as a record for monitoring the progress of young mothers and their children. In terms of training, videotaping interactions can provide examples for other interventionists and allow for input from others (Egeland & Erickson, 2004).

For some mothers, the process of filming was somewhat uncomfortable. While most of the mothers were comfortable being filmed, they were rather anxious about watching themselves on video. Therefore, the experimenter started by filming a brief segment of child behavior, such as the child playing with a new toy brought by the experimenter. The experimenter talked with the mothers about how almost all parents feel awkward when they are video recorded for the first time. The experimenter also reassured the mothers that only she and the experimenter would have access to the tape (Juffer, et al., 2007). Use of video-feedback varied with intervention participants. One

mother, who suffered from social anxiety, refused to watch herself on video, which made video-feedback completely ineffective for her. Other participants were video-recorded during several interactions with their children including diapering, feeding, and play. Prior to viewing the videotape with mothers, the experimenter watched the tape alone and prepared comments. Such advance preparation allowed the experimenter to focus the mothers' attention on positive elements of the interaction, specific infant cues, and on areas for improvement in the interaction.

For this intervention, the "Seeing is Believing" (Erickson, Endersbe, & Simon, 1999) approach to videotaping parent-infant interaction and engaging parents in the process of self-observation and reflection was used. This approach consists of a series of open-ended questions that intervention facilitators use to guide parents in focusing on what their baby is telling them and to recognize their own skill in adapting to their baby's needs (Egeland & Erickson, 2004).

*Parenting Intervention.* The intervention implemented in this study consisted of two major components: one-on-one interventions with each adolescent mother and group sessions with all residents. The experimenter consulted with program staff and administrators at the transitional home throughout the intervention and provided recommendations to the Executive Director as well as staff training at the conclusion of the intervention. Staff training focused on sharing the techniques used by the experimenter to promote positive parenting among the participating adolescent mothers. Although the experimenter shared intervention goals and techniques with the staff, participant assessment results were kept confidential. The intervention was designed to meet the unique needs of this particular program for teen mothers, with input from both

staff and residents. The experimenter had been observing and interacting with residents on a weekly basis at the transitional home since August of 2007 as part of a Field Placement requirement at The University of Montana. The group component of the intervention began in late February 2008, and lasted 8 weeks. Two mothers also began individual sessions at this time. An additional mother began the intervention during the fifth week. Over the course of the 8-week intervention phase, adolescent mothers met individually with the experimenter on a weekly basis for 1 hour. In addition, mothers also attended a weekly group session that lasted between 1 and 2 hours.

The first component of the intervention was weekly one-on-one sessions with each adolescent mother and her infant. At the beginning of the individual sessions with each mother, the experimenter met with the mother to set individual goals for the intervention, answer any questions about the intervention, and determine which topics might be of particular interest to the mother. With this information and the results of the pre-intervention assessments, the experimenter created an intervention plan based on each mother's strengths, interests, areas for improvement and cognitive abilities. Individual sessions were broadly focused on increasing maternal knowledge of child development, increasing maternal responsiveness, and shifting maternal beliefs and expectations. The methods of achieving these goals varied with each mother and are presented in more detail in the results section.

These individual sessions most frequently took place at the transitional home. The experimenter brought a variety of age-appropriate toys to entertain the children, who attended most sessions. Individual sessions included a 15-minute introduction in which the mother was free to discuss any issues from the week or other such topics of interest.

The remainder of the visit focused on individual parenting goals. Examples of individual goals and methods for intervention are included in the results section of this report. The last few minutes of the session were spent reflecting on the session and planning for future sessions. Mothers were also asked to give suggestions for group topics at the end of their individual sessions.

The second major component of this parenting intervention was weekly group sessions. The benefits of group sessions have been documented in several other studies (Egeland & Erickson, 2004; Juffer et al., 2007; Marvin, et al., 2002). Through group sessions, adolescent mothers were able to share their parenting experiences, offer advice, and receive feedback from other group members. One benefit of the group is that it can be empowering for a young mother struggling with parenting to be able to offer advice to another mother. In addition, the adolescent mothers living in transitional housing often face similar issues in raising their children and attempting to become independent. Thus, these mothers can greatly benefit from the experiences shared by one another and may be more likely to accept advice from someone who understands their experiences first hand. Finally, given that most of the adolescent mothers living in transitional housing have no contact with their families, other residents may serve as a source of support. One goal of the group sessions was to facilitate the development of such relationships.

Group sessions lasted between 1 and 2 hours depending on the topic and interest level of the mothers. The first group focused on introductions and creating rules for group behavior. Mothers were given a list of potential group topics and asked to indicate topics they would be interested in discussing with the group. The activity for this first group was

to "make a collage to reflect yourself and your baby." The mothers really seemed to like this activity and most displayed the collages later in their rooms.

Future group sessions covered a variety of topics and included several activities to help achieve the goals of the intervention. Topics included attachment, language development, play, limit setting, punishment, discipline, and temper tantrums. At the beginning of each group meeting, mothers were asked whether they had any parenting questions they would like to discuss with the group. Most questions involved dealing with their children's challenging behaviors. These discussions and presentations directly addressed the intervention goal of increasing participants' knowledge of child development. In the course of discussing most topics, mothers frequently talked about their childhood experiences and their feelings about these experiences. In particular, many mothers shared their own experiences of limit setting, punishment, and discipline. Through discussion of their own childhood experiences, it was hoped that mothers would gain perspective on their own representations of parenting, which in turn, may have a positive effect on their expectations and beliefs about their children and parenting.

Most groups included activities or demonstrations to illustrate the concepts. One example is "Babysitter from Mars." For this illustration, the experimenter behaved like a clueless, but harmless babysitter who had no idea how to play with a baby. Group members were asked to critique the babysitter and give directions for more appropriate play. As mothers provided feedback, the experimenter immediately changed her behavior. At the end of the demonstration, the group talked about the changes they observed in the baby's behavior as the babysitter became a better play partner.

A demonstration was also used to help mothers understand the feelings behind their children's temper tantrums. For this demonstration, mothers were asked to sit on their hands for 5 minutes. The experimenter then placed a plate of brownies (the group's favorite snack) in the middle of the table. The mothers were confused and asked when they would be able to have a brownie. The experimenter said that they needed to wait, and began the group discussion. After 5 minutes, the experimenter asked the moms how they were feeling. They said they felt, "frustrated," "confused," and "hungry for a brownie." The experimenter asked what the mothers would do if they continued to be denied a brownie. They said they would, "take one anyway," "yell," and "throw a fit." This activity provided a great introduction to the topic of temper tantrums and gave the mothers insight into how their children feel when they cannot have what they want.

Three adolescent mothers completed the parenting intervention and participated in each of the pre-and post-intervention assessment procedures. In the following sections, case studies of each of these young mothers are presented first; these include background information (demographics and family histories), assessment results, case-specific intervention goals and strategies, and conclusions related to each individual mother-infant dyad. These case descriptions are followed by a more general discussion of the effectiveness of the interventions and conclusions that can be drawn based on this intensive work with these homeless, adolescent mothers.

## Results

### Case I Background: Miss M.

Miss M. began services with the transitional home for teen mothers when she was 17 years old and her baby was 3 months old. Mother and baby arrived at the home after

being kicked out of her adoptive parents' home and having spent a few weeks staying with various friends. Miss M. spent most of her childhood in foster care and has no memory of her biological parents. She reported that her biological parents were drug users and that they were frequently abusive towards their children. She reported having a poor relationship with her adoptive parents as well and currently does not have contact with them. Program staff was concerned about Baby M.'s development, Miss M.'s parenting abilities, and the bond between mother and baby.

Initially, Miss M. was not well liked by the other residents of the transitional home. She had difficulty picking up on the social cues of others and was often ostracized by the other residents. Given such rejection by her peers, Miss M. spent large amounts of time with program staff.

Miss M. seemed at times to be very subdued, with rather flat affect. Other times, her energy level was quite high and she was incredibly talkative. She often seemed to misperceive the intentions of others and was very easily angered when she felt threatened. Miss M. was also very open about her personal life. For example, Miss M. disclosed a great deal of very personal information upon first meeting the experimenter. After a brief introduction and conversation about her baby, without prompting, Miss M. talked about her childbirth experience and her own rather traumatic childhood. Although the experimenter was almost a complete stranger to her, she disclosed that she was abused both physically and sexually as a child. She also talked about how she used drugs, drank alcohol, and smoked cigarettes while she was pregnant.

In interactions with her baby, Miss M. was almost completely uninvolved. She rarely paid attention to her baby unless prompted. Miss M. rarely held her baby, choosing

instead to utilize an infant seat or swing. When program staff limited the amount of time she could use the swing or seat, Miss M. responded by handing her baby to staff, other residents, and visitors to the home. Miss M. rarely vocalized to her daughter. When she did vocalize, she did not use infant-directed speech. She needed to be prompted to take care of her daughter's basic needs and would frequently allow Baby M. to go without a diaper change for an extended period of time. Miss M. did not engage in face-to-face interactions with her baby and rarely offered her baby any toys. Miss M. stated that since her baby could not play with toys yet, there was no point in giving her any.

Program staff were very concerned about Baby M.'s development. At 3 months, the baby appeared to be somewhat delayed or to potentially have some neurological issues. She had received an evaluation from a child development specialist, but Miss M. was reluctant to work with them. Miss M. reported that her baby had not smiled at her, that she could not grasp a small rattle, and that she did not have control of her head. It also seemed that Baby M. had a visual impairment. She did not seem to make any eye contact, even at close distances. She was also unable to track a moving object. Other than her weight, which was high for her age, the baby seemed like a case of failure to thrive.

Miss M. seemed to be struggling with interacting with her baby. She provided very little stimulation in interactions with her child and seemed to take little pleasure in such interactions. The baby, who was relatively unresponsive to social initiations, may not have provided her young mother with the feedback she needed to enjoy interactions with her child and feel confident as a mother. Miss M. mentioned several times that, "she won't even smile at me, most babies do that, especially with their mothers." Miss M. in

turn, did not seem to offer her baby much stimulation to which she might respond. She rarely mentioned her baby in conversation unless directly asked to.

Since moving to the transitional home, Miss M. and her baby had improved in several ways. Though still somewhat behind other babies her age, Baby M.'s behavior seemed to be more age-appropriate. She received much more stimulation from her mother, program staff, other residents, and the daycare she was attending 5 days per week. As her baby changed, Miss M. seemed to become more interested in interactions with her.

#### Case I Pre-Assessment Results: Miss M.

##### *Demographics*

Prior to beginning the intervention, Miss M. completed a variety of assessments including a demographic questionnaire. These were completed during one 2-hour visit to the transitional home. During the assessments, she was in a positive mood and seemed to enjoy talking with the experimenter. At the time of the assessment, Miss M. was 17 years old, had been pregnant just once, and was now parenting a 7-month-old baby girl. She had been residing at the transitional home for almost 5 months. At this time, she reported having no relationship with the father of the baby or with her adoptive parents. She reported experiencing abuse both within and outside her family. Miss M. identified herself as Caucasian and the highest level of education she had completed was the 10<sup>th</sup> grade. She planned to obtain her GED in the future and was attending some classes at an alternative school. Miss M. was employed for a few hours a week. Miss M. reported that her daughter was born 3 weeks before her due date and that there were no birth complications. In terms of health-related problems, Miss M. reported that her daughter is

lactose intolerant and that she had an abdominal hernia, which healed recently on its own. At the time of these assessments, the infant was attending daycare 5 days per week. Beyond the services offered by the transitional home, Miss M. was working with a variety of service providers. She was also seeing a therapist. She admitted, however, that her participation in these services was rather inconsistent. Baby M. had been referred and qualified for services with a child development specialist, but Miss M. chose to decline such services.

#### *AAPI*

On the AAPI, Miss M's scores on all subscales were high, indicating a positive, nurturing parent. Specifically, she scored a 7 on inappropriate expectations, which indicated a realistic understanding of the developmental capabilities and limitations of children. She scored a 10 on lack of empathy, which indicated that she was sensitive to the needs of children and viewed such needs as important. On physical punishment, Miss M. scored a 7, which indicated a positive attitude toward non-violent ways of providing discipline for children. She scored a 9 on role reversal, which indicated an understanding and acceptance of the needs of self and children. Finally, Miss M. scored a 9 on power and independence, which indicated a strong emphasis on children feeling empowered. Miss M. requested that the items be read to her because she did not feel confident in her reading abilities.

#### *Child Development Quiz*

On the child development quiz, Miss M. missed only 2 questions. She answered incorrectly that a 2 year old should know how to share and that 1 year olds understand when their mothers are sad and can comfort them. Both questions reflect maternal

expectations for their children's behavior. Otherwise, her responses reflected adequate knowledge of basic child development and developmentally appropriate expectations. Again, test items were read to Miss M. as requested.

### *Free Play*

Miss M. was observed and video recorded in a 10 minute free play interaction with her infant. This interaction took place in the playroom at the transitional home, which is an area that is relatively free from distractions. The experimenter brought a variety of age appropriate toys and asked Miss M. to play with her daughter as she normally would. Both caregiver and infant behaviors were coded to examine individual contributions to the play interaction.

Miss M. spent the first 6 minutes sitting on the couch while her baby was seated on the floor, eventually moving to the floor for the last 4 minutes of the interaction. Miss M. almost always participated in the play interaction. She offered her baby a variety of toys, but didn't give the baby an opportunity to fully explore a toy before offering her another toy. Rather than expanding on her play with a particular toy, Miss M. continued to offer new toys even when her daughter was appropriately engaged. Miss M. attempted to create playful routines with the toys but had difficulty doing this appropriately. For example, she hit her daughter with a toy in the face repeatedly. Although the infant didn't cry, she didn't appear to be enjoying this activity and she looked away several times. Miss M. spoke quietly and infrequently during the interaction. There was minimal physical affection such as hugging, kissing, holding, or touch between mother and infant during the interaction and Miss M. smiled very infrequently. Towards the end of the interaction, Miss M. moved to the floor, sat behind her daughter, and began reading a

picture book. In this brief interaction, Miss M. pointed to pictures and named them for her daughter.

The infant almost always participated in interactions as well. She accepted the toys that her mother offered and explored them with her mouth. She had recently learned to sit up, which made play with objects much easier. The infant's play repertoire was somewhat limited given her age and developmental level. She mostly grabbed and mouthed toys. The infant didn't cry during the interaction and her vocalizations were minimal. She only subtly protested by averting her gaze when her mother was a little rough with a toy. She was easily engaged with the toys, smiled a little, reached toward toys, and watched her mom.

#### *Interview*

Finally, Miss M. completed a parenting interview to assess her beliefs about herself as a parent and her beliefs about her child. Miss M. seemed comfortable throughout the hour-long interview and readily answered questions about her experience as a parent. Several themes emerged from this interview: 1) inconsistencies and contradictions in her reporting; 2) projecting her own feelings and characteristics onto her infant; and 3) inability to describe her child or her own parenting style.

*Pregnancy.* First, Miss M. discussed her pregnancy. She reported that the pregnancy was unplanned and that she did not know she was pregnant until she was 4-5 months along because she was not showing and had not missed a period. She learned that she was pregnant when she was in the emergency room for another medical issue. She reported that the doctors told her and her parents of the pregnancy at the same time. When asked about her feelings upon learning of the pregnancy, she said her parents

“didn’t like it” that she was pregnant, but that she was excited. When asked when the pregnancy felt real to her, Miss M. replied, “When I was pushing. When I was in pain.” She also reported having some back pain during the pregnancy and post-partum depression soon after the birth.

*Inconsistencies.* Overall, Miss M.’s narrative was marked by a number of contradictions. One major area in which she gave inconsistent responses was in her narrative of her childbirth experience. Miss M. described being on bed rest due to her baby’s heart condition for the last 2 weeks of her pregnancy. She later described going into labor while on a road trip to a wedding, several hours away, which conflicted with her account of being on bed rest at the time.

Other inconsistencies emerged from Miss M.’s description of the events following the birth. She stated that her daughter was healthy at birth and that there were no birth complications. However, when asked about the first time she held her baby she said, “...they took her away to the nursery because we told them she had a heart issue. They didn’t even let me hold her.”

Miss M. blamed this lack of early contact for her inability to breastfeed. She said, “They wouldn’t let me breastfeed her. They knew that I wanted to. So she wouldn’t correctly latch onto my nipples. I had to bottle feed her because I got thrush and my nipples would be flat.” Later when describing her first few days at home with her baby, Miss M. said, “The first couple days were bad because she wasn’t eating. Well, my milk came in and my nipples were flat, so she wasn’t eating.” She reported that her baby wouldn’t stop screaming on the trip home from the hospital, and that Baby M. had lost a

pound due to her inability to be breastfed. Miss M mentioned her inability to breastfeed on several occasions when describing her birth experience.

Miss M.'s remarks concerning the father of her baby were also inconsistent. Miss M. mentioned the father of the baby several times during the interview when discussing unrelated topics. Before learning that she was pregnant, Miss M. said that she and the father of the baby lived together. Upon learning that she was pregnant, Miss M. said that the father of the baby kicked her out of his home. She described how he rejected both her and the baby once she learned she was pregnant. She said that he had visited the baby only twice in 7 months and that, "he wanted nothing to do with me and now he wants nothing to do with us." In the next sentence Miss M. said that the father of the baby has threatened to take the baby away from her. When asked why he has threatened to take her child away, Miss M. replied that he is trying to scare her. She seemed reassured that he wouldn't be successful and said, "Yeah, the court won't let him have her. He is doing meth. He is smoking pot. He drinks a lot and he has knives and weapons in the house." She also said that the father of the baby has denied that the baby is his and that she had been trying to convince him to take a DNA test.

Miss M.'s description of her relationship with her adoptive family was also inconsistent throughout the interview. She reported that she lived with her adoptive parents prior to giving birth to her daughter. When asked about how she felt when she learned she was pregnant, Miss M. replied, "Excited. My parents didn't like it. I don't have a relationship with them anymore." Later, when she described the birth, she said that her mother and sister were with her because they were all traveling to a wedding

together. She described how her father drove to meet them and to bring the car seat they had purchased for the baby.

When asked about her current relationship with her adoptive parents, Miss M. said that she never sees them and that they do not have a relationship. When asked who supported her, Miss M. did not mention her parents. When she talked about her fear of her daughter becoming pregnant as a teenager, Miss M. said that she would handle such an event differently than her own parents. She said, "If she does, I'm not going to be like my parents. I'm going to help her out. I'm going to give her money. I'm going to help her raise her kid. I'm not going to kick her out so that she has to go to (transitional housing). You know what's really sad is that my parents don't even care, they don't even know I was raped." Miss M. did not seem to see her family in a positive way. She also clearly felt that they did not support her when she was pregnant or as she was raising her daughter.

Throughout the interview, Miss M. did not seem to be aware that she was contradicting herself. She did not seem to have a consistent narrative of her childbirth experience or of the relationships in her life. It is difficult to determine whether Miss M. was being dishonest or if her perception of events and people is somewhat inaccurate. Her description of her relationship with the father of the baby in particular might represent wishful thinking on her part. Her description suggested that the father of the baby wanted nothing to do with her or her baby. It is possible that her description of his attempts to take away her child reflected her desire for a relationship with the father of the baby.

*Projections.* Another theme that emerged during the interview was that Miss M. seemed to view her daughter as very similar to herself. When asked whether her daughter's personality reminded her of anyone else's, Miss M. said that her daughter's personality was like her own. When asked to be more specific, she said, "...just her actions. She's such a brat sometimes, she's so hyper, that's me, and she won't go to bed when she's told, that's me. Just her, her actions." These statements do not make much sense for a 7-month-old baby. Miss M. also reported that her daughter looked like her, but that she did not know what she had looked like as a baby because she had no baby pictures of herself.

When asked about a time in her daughter's life that she thought would be the most difficult, Miss M. said, "when she turns into a teenager and realizes that she doesn't have a dad." When asked to clarify, Miss M. replied, "cause for me, I was adopted but I was too young to realize that I was being adopted. My parents didn't tell me that I had other parents until I was a teenager, thirteen. I freaked out cause a little kid needs to realize that they have different parents but it just didn't work out." Miss M. was describing her own experience rather than imagining what might be difficult for her daughter as she grows up. Miss M. went on to describe when and how she will tell her daughter about her absent father, "What I'm going to tell her is that she has a dad, but I gave him so many chances and he didn't care. I tried so hard to keep her dad. At least I tried, you know. I hope she understands that and I hope she can't go over to her dad's house at all, cause if I find out she goes to her dad's house, I will call the cops."

When the experimenter asked Miss M. about her plans to tell her daughter about her absent father, she contradicted her previous statement about wanting to be honest

with her daughter at an early age. She said that she will tell her daughter about her father when she is a teenager, "because at a young age, I want her to know life. I don't want her to know my dad didn't care, especially if I'm with someone else. I want her to call him daddy. He will adopt her, so he will be her dad. She may never find out, I may never tell her, 'cause I just don't know how to tell her." Miss M. seemed to have difficulty deciding whether to be completely honest with her daughter, or to spare her the pain of learning about her father. On the other hand, she was also concerned about letting her daughter know that her father did not care and preventing her from seeing him.

When asked what her daughter would be like as a teenager, Miss M. again saw herself in her daughter and replied, "a brat, because I was a brat. I was a runaway." Miss M. was unable to discuss why she thought her daughter would be a brat and a runaway. She also seemed to describe her own wishes when asked about the life she hopes her daughter will have one day: "I want her to have her own kids. I want her to be married before she has her own kids. At least have kids with a guy that she won't get left. I want her to have lots of money." Similarly, when asked to describe her fears for her daughter, Miss M. replied, "Rape. Because I was raped three times." Miss M. seemed to understand that her daughter might be a bit young for such a fear. She said, "She's kind of young, but I really keep an eye on who holds her, what they are doing to her, what's going on." When asked about other fears, Miss M. replied, "getting pregnant at the age of 16." Miss M. tended to describe her own experience and her own personality when asked about her daughter.

Rather than viewing her daughter as a unique individual, Miss M. seemed to see her daughter as a smaller version of herself. She seemed to use these questions as an

opportunity to describe herself and her experiences rather than think about her daughter. On the other hand, it seems that many parents might base their hopes and fears for their children on their own lives. Although Miss M.'s inability to separate her daughter's personality and life experiences from her own might be problematic over time, it is also possible that seeing her daughter as very similar to herself might help her to identify with her.

*Lack of Verbal Descriptors.* A final theme from the interview was that Miss M. sometimes had difficulty accurately describing her baby and her parenting. When she was asked to give 5 words to describe her baby, Miss M. initially could only generate one, saying that her baby was "cute." When the experimenter prompted her and asked about new skills that her baby had recently acquired, Miss M. accurately replied that her baby had just learned to sit up and that she was teething and making some new sounds. She then said that her baby was also rolling over and beginning to crawl, which were skills that the infant had not yet developed. Miss M. also described her baby as "very active and crazy" and said that, "I always have to keep on top of her, literally."

In reality, Baby M. seemed to be a relatively inactive baby. She was content to sit for long periods of time and explore toys offered to her. She was not yet mobile at this time, and thus unlikely to require her mother to "keep on top of her." Miss M. seemed proud of her baby though, and delighted in talking about her developing skills. Eventually, she was able to describe her daughter as, "cute, active, crazy, chubby, ticklish, and gassy." When asked about what was unique about her baby, Miss M. said that her belly laugh was special and tried to get her daughter to laugh by tickling her.

Miss M. also seemed to idealize her role as a parent as well as her efficacy as a parent. When asked what was good about being a parent, Miss M. replied, "everything is great." On the other hand, when asked if anything about parenting was tough to deal with, Miss M. appropriately responded: "Teething. She is usually pretty good at it. There are some days that she won't stop crying. I don't take her to daycare on those days." Miss M. was also asked to give herself a rating as a parent from 1 to 10, with 1 being the worst parent ever and 10 being the best. Miss M. gave herself a 9.5. When asked to explain her rating she said, "Because I do everything for her. You can just tell by looking at her. See, she thinks I'm the best parent alive."

*Interview Summary.* Miss M.'s parenting interview provided several important insights into her thoughts about herself as a parent and her thoughts about her child. Although Miss M. seemed to have difficulty viewing her daughter as an individual, she seemed to have a positive view of her. At one point she said, "She's always happy. She is a very good child." She was able to talk about skills her baby had acquired or challenging behaviors, but could not describe her daughter's personality. Miss M. also seemed to be rather confident in her parenting abilities and reported enjoying parenting.

On the other hand, Miss M.'s interview was characterized by numerous inconsistencies, which makes it difficult to determine the accuracy of her reporting. Her reports about her relationships with others, such as her parents and the father of the baby, although inconsistent, seem to indicate that these relationships are not positive for her. When asked whether she feels supported, Miss M. said that she did not feel like she had enough support. However, when asked about who supported her, Miss M. said that Mountain Home and the Futures program were sources of support for her.

### Case I Intervention: Miss M.

The individual session component of Miss M.'s parenting intervention focused on 3 major goals. These goals were chosen based on Miss M.'s pre-intervention assessments, input from program staff, and input from Miss M. The first goal was to increase her awareness of her daughter's cues in both play and daily interactions. It was also hoped that increasing her ability to pick up on her daughter's cues might, in turn, increase her ability to respond consistently and appropriately. Another major goal was to teach Miss M. how to play appropriately with her daughter. It was thought that increasing Miss M.'s skill as a play partner might make play more enjoyable for both partners and might also increase the frequency of playful interactions. Finally, Miss M. requested help with introducing solid foods to her daughter and ensuring that her food intake was age appropriate. Each of the three major goals was addressed throughout the intervention along with some smaller issues that arose along the way.

Both prior to and throughout the intervention, Miss M. reported feeling very confident in her parenting abilities. When asked about parenting goals to work on during individual sessions, she stated that she knew all she needed to know about parenting. She credits herself with raising her foster siblings and considers herself to be well versed in child development. She also made it clear that she did not appreciate having others give her parenting advice. It appeared that Miss M. interpreted suggestions given by the staff as a threat and frequently responded defensively. Given her response to feedback regarding her parenting, it seemed that the best approach for intervention with Miss M. would be an indirect one in which the focus would be mostly on the baby. Another important element of this intervention was to let Miss M. know that she was the expert

where her child was concerned and that the experimenter was there to help clarify any developmental questions that she might have. This approach allowed Miss M. to receive information in a less threatening way.

Another approach utilized for all three goals was to make positive parenting seem beneficial to Miss M. In other words, it was important to make sure that there was something concrete in it for her if she tried something new with her baby. Rather than encouraging her to change a behavior for her baby's sake, framing the change as something that would make her own life easier or make her look better as a parent seemed to be more likely to result in a change in behavior.

Goal one, increasing Miss M.'s awareness of her infant's cues, was addressed via several methods. During each home visit, the experimenter modeled paying attention to the baby while engaged in other tasks with Miss M. The goal of such modeling was to show Miss M. that she can multi-task and meet her own needs while giving her baby some much-needed attention. Baby M. is an extremely tolerant and laid back baby who rarely fusses, making her signals somewhat difficult to detect. In situations where most infants would cry, Baby M. might simply turn her head away. On the other hand, it is quite easy to tell when Baby M. likes a particular activity. During home visits, the experimenter created situations in which Baby M.'s cues were relatively obvious. For example, the experimenter placed a toy just beyond her reach. When the baby signaled, the experimenter would draw Miss M.'s attention to the baby: "Look at baby, what is she doing?" The experimenter would then name the signal if mom couldn't/wouldn't, i.e., "she's reaching with her mouth open and making some grunting sounds" and ask Miss M. what she thought it meant, e.g., "I'm not sure what she wants here, do you have any

idea?" This approach drew Miss M.'s attention to her baby's signals and also allowed her to feel like an authority on her daughter.

Another method for increasing Miss M.'s awareness of her baby's cues was talking for the baby. The experimenter used this method in a variety of parent-child interactions. For example, Miss M. and her baby enjoyed rough and tumble play. However, Miss M. frequently played a little too roughly. The baby rarely cried, but it was evident that she was no longer enjoying herself long before Miss M. stopped the play. During such interactions, the experimenter might verbalize, "Oh, mom this is so fun. I really love playing like this with you" while the baby is laughing and clearly enjoying the play. When the play became too much, the experimenter might say, "Mom, I think I need a little break." When mom responded appropriately, the experimenter might say, "Thanks mom, you knew just what I needed." Miss M. responded really well to this type of cue. It was humorous to her that the experimenter was talking in a funny voice for her baby and she was able to take the suggestions offered without offense.

A third technique used to increase Miss M.'s awareness of her infant's cues as well as her sensitivity in parenting was video feedback. Miss M. was very open to being filmed during interactions with her baby; however, her inability to reflect on her behavior rendered the feedback ineffective. The first filmed interaction was a diapering situation. During this interaction, Miss M. swore at her baby, made no eye contact or positive vocalizations, displayed obvious disgust while diapering, and handled her baby roughly. After diapering the baby, Miss M. tickled the baby and began to have a nice play interaction. The baby appeared very excited, vocalizing to her mother and waving her hands and feet. Unfortunately, Miss M. then pulled the baby to a stand on the bed and

dropped her on the bed. The baby did not cry, but she stopped smiling and looked distressed.

The experimenter and Miss M. watched the video together. After giving her time to respond without prompting, the experimenter asked Miss M. what she thought about the interaction. Miss M. replied, "I'm just changing a diaper." The experimenter drew Miss M.'s attention to her baby's face during the diaper change and during the playful interaction afterwards. When asked what she thought her baby might be thinking or feeling at this point, Miss M. responded, "How would I know?" The experimenter tried talking for the baby so that Miss M. might gain some perspective when Miss M. continued to be unable to identify her child's feelings during the interaction. Video feedback is designed as an opportunity for parents to observe their parenting as well as their child's cues and to gain insight into both of their behaviors. It is not intended to be a time for an interventionist to point out positive and negative parenting. This first video feedback session was not an overwhelming success because of Miss M.'s inability to take her daughter's perspective or to have insight into either of their behaviors.

Goal two, teaching Miss M. how to play appropriately with her child was also addressed in several ways. During each home visit, the experimenter sat on the floor with the baby, regardless of where Miss M. was seated. Initially, Miss M. avoided sitting on the floor, preferring instead to interact more passively with her child and the experimenter. The experimenter never directly asked Miss M. to move to the floor, rather she tried to lure her down with interesting activities. For example, during one visit the experimenter asked Miss M. what she thought might happen if they covered the toy Baby M. was interested in with a blanket. The experimenter asked Miss M. if she thought Baby

M. would try to look for the toy or if she would think it was gone forever. Miss M. was very intrigued by the concept of object permanence. The experimenter asked her to help cover the toy with the blanket, which made her move down to the floor. She stayed on the floor throughout the remainder of that visit. When Baby M. failed to search for the toy that was hidden, Miss M. was thrilled. She called in staff to watch. In future visits, Miss M. and the experimenter monitored Baby M.'s development of object permanence. Each time, such mini experiments got Miss M.'s attention and engaged her in the visit, even if for a brief time.

Another method used to encourage Miss M. to play with her daughter was to frame interactions as practicing developing skills. Miss M. was much more willing to interact with her daughter if she thought she was facilitating an emerging skill like talking, crawling, or rolling over. Each of these "lessons" was set up so that baby and mom could succeed. For example, propping baby's chest up with a rolled up towel and allowing her to push off her mother's hands almost always resulted in a little forward movement. Miss M. got really excited by this progress and usually showed that excitement by physical contact with the baby and positive vocalizations. Baby M. in turn, delighted in her mother's positive attention.

Talking for the baby was also used to shift Miss M.'s play to a more appropriate style. This method seemed to work when Miss M. was engaged in play and needed to make some adjustments to keep the play interesting or to lessen the level of stimulation. On the other hand, this method was a complete failure when used to encourage Miss M. to play at times when she wasn't interested in interacting with her daughter. Saying, "Hey mom, I really want you to play with me," on such days was often completely ineffective.

A final method used to encourage play was to introduce play into daily caretaking tasks such as feeding, diapering, and bathing. Initially Miss M. seemed to view such caretaking tasks as jobs to be completed as quickly as possible, rather than opportunities to play with her infant. She often completed such tasks in a silent and mechanical manner as her baby passively experienced care taking. The experimenter introduced the idea during a diaper change by asking Miss M. if she ever considered giving her daughter a toy during diapering. It was suggested that giving the baby something to occupy her might make her less likely to wiggle and squirm during diapering, which would make the experience easier for Miss M. Miss M. was concerned that the toy might become soiled, so the experimenter suggested that Miss M. try being the distracter herself. Miss M. was skeptical, but accepted the challenge of trying to make her daughter laugh during a diaper change. The diapering that followed was one of the best observed. The experimenter praised Miss M. heavily for her ability to entertain and encouraged her to try this technique during other caretaking tasks.

Goal three reflected Miss M.'s interest in introducing solid foods into her daughter's diet and addressing the infant's weight issue. A more subtle goal was to increase Miss M.'s sensitivity in feeding interactions so that her daughter received appropriate amounts of food as well as an enjoyable interaction with her mother. Baby M.'s weight was a concern to her mother and her pediatrician. At 7 months, Baby M. was still obtaining all of her calories from formula, though she appeared ready to begin eating solid foods. Miss M. was also ready for her daughter to start eating solids and prior to beginning the intervention had given Baby M. apple sauce, fruit snacks, and cereal puffs. Although Miss M. made an effort to try to introduce solids on her own, her choices for

first foods were not appropriate and Baby M. choked on several occasions. These experiences led Miss M. to believe that her daughter could not eat solid foods. During the second home visit, the experimenter brought rice cereal and pureed bananas, common first foods, as well as a written plan for introducing solids. The plan included a list of appropriate foods to introduce, directions for introducing new foods, a list of foods that were not appropriate, and a list of things to look for when introducing new foods such as food allergies. The experimenter suggested that Miss M. post the lists in the kitchen so that the rest of the mothers, who might also be unsure of how to introduce solid foods, could benefit. Miss M. initially resisted giving her baby rice cereal, saying that it was disgusting and voicing her own dislike of bananas. When the experimenter explained the rationale for first introducing foods that are as similar to formula as possible, Miss M. agreed to let the experimenter try, but predicted that her baby wouldn't eat. Baby M. enjoyed the rice cereal and the experimenter gave Miss M. the box of cereal as well as a few jars of fruit.

In order to increase Miss M.'s sensitivity in feeding interactions, the experimenter asked to video record a feeding interaction to be used for a second attempt at video feedback. Miss M. fed her daughter 2 jars of baby food in this interaction in under 5 minutes. She fed her baby rather mechanically, with no facial expressions, vocalizations or playful routines. The baby is a voracious eater and seemed very excited about the food. When Miss M. watched the video she was able to comment on how excited the baby was to be eating. Miss M. was concerned that her baby ate so quickly and such a large quantity at a time. The experimenter asked Miss M. what she thought might happen if she tried to deliver the food at a slower pace. Miss M. was willing to try it, but skeptical. The

experimenter suggested that Miss M. introduce some playful routines or conversation into mealtimes to distract Baby M. from the slower delivery of her food.

Throughout the course of the intervention, the success of each individual visit was largely dependent on Miss M.'s mood and what was going on in her life. Miss M.'s life was frequently very chaotic. Sometimes she was able to put aside whatever stress she was dealing with and focus on her child for an hour, other times it was very difficult to shift her focus. On such occasions, the experimenter would offer to come back at another time when she was feeling less stressed. Miss M. never accepted this suggestion. The experimenter would agree to stay with the understanding that they needed to focus on parenting. Miss M. also frequently seemed out of touch with reality. It was often difficult to tell whether Miss M. was intentionally being untruthful or whether she was simply misperceiving events. She frequently felt persecuted by the staff and other residents. She expressed on several occasions a fear that Child Protective Services would take away her baby.

A major component of this intervention was to provide a consistent, predictable, responsive model for both mother and baby. Miss M. in particular really seemed to need such a model. She often pushed the limits of the intervention, attempting to get the experimenter to stay for longer periods of time or to talk about issues outside the realm of parenting. At the end of most visits, Miss M. would become quite agitated. She would playfully hit the experimenter, follow her to the door, and then hold onto her bag as she tried to leave. Although it was sometimes difficult, for the most part, the experimenter was able to follow the parameters of the intervention.

One exception occurred when after 5 weeks of meeting with Miss M., she ran away from the transitional home. Miss M. gave a variety of reasons for leaving. At times, she claimed that she had been kicked out. At other times, she said that she left because staff would not allow her to see the father of the baby. Miss M. also told the experimenter that she was concerned that if she stayed at the transitional home, Child Protective Services might take her daughter away, as she had seen other residents lose custody of their children. Regardless of the reason, Miss M. and her baby were again homeless, staying at shelters and with various friends for 2 weeks. During this time, Miss M. was in contact with the transitional home, which provided her with baby formula and other supplies when she ran out. Miss M. asked the home to give the experimenter her contact information so that they could continue to meet.

Initially, staff at the transitional home felt that Miss M. should no longer receive the intervention because she had chosen to leave and should not be entitled to choose which of their services she received. On the other hand, Miss M. was not receiving any other services at a time when she most needed support. The fact that she had chosen to continue the intervention seemed like a good sign. Meeting with Miss M. also provided an opportunity to ensure that her baby was not in danger. Program staff agreed that the experimenter should continue the intervention with Miss M. with two additional visits.

After 2 weeks of moving from place to place, Miss M. was able to obtain a hotel room for 48 days. The experimenter met Miss M. twice in the hotel room. Although her living conditions were less than ideal, Miss M. and her baby seemed to be happy. Both spent most of their time on the large bed in the room because the floor was too cluttered and dirty for baby to play on. At the beginning of the first visit, the experimenter gave

Miss M. a few minutes to talk about what was happening in her life. Without prompting, Miss M. switched her focus and asked the experimenter if they could work on crawling and rolling over with the baby. Miss M. also proudly showed the experimenter that her baby was babbling and engaged in a "conversation" with her to show her new skills. Miss M.'s life was incredibly chaotic at this time. Although she had a temporary home, she did not have any income other than Welfare, and she had no transportation. She was also attempting to have a relationship with the father of her baby. This relationship was often very volatile, with both parties making reports to Child Protective Services regarding the other's parenting. In spite of all of this chaos, Miss M. was able to focus some of her attention on her baby during the visit. Given the close quarters, Miss M. was forced to be in close proximity with the baby and seemed to be inadvertently interacting more with her. She was also excited about her baby's developing skills.

#### Case I Post-Assessment Results: Miss M.

##### *Demographics*

Miss M. completed post-intervention assessments in the hotel room in which she was residing. Miss M.'s mood was rather negative during this visit. She expressed many negative feelings toward the transitional home, her current life circumstances, and the father of the baby. Miss M. also reported feeling stressed because she didn't have any money or a job. She was also concerned about where she would be living when her time in the hotel was up. The experimenter offered to come back at another date, but Miss M. insisted on completing the assessments immediately.

Since the pre-assessments, Miss M. had turned 18. Her baby was now 10 months old. They were no longer residing at the transitional home or receiving any other services.

Miss M. was no longer working toward completion of her GED and she was unemployed. Her relationship with the father of the baby was inconsistent, but on this date she reported that they were friends. Baby M. was still attending daycare 5 days per week.

#### *AAPI*

On form B of the AAPI-2, all of Miss M.'s scores reflected positive nurturing parenting. Her score on inappropriate expectations was a 7, which reflected a realistic understanding of the developmental capabilities of children. She scored a 10 on lack of empathy, which indicated sensitivity to the needs of children. Her score on physical punishment was a 7, which indicated a positive attitude toward non-violent ways of providing discipline for children. Her score on role reversal was a 9, which indicated an understanding and acceptance of the needs of self and children. Finally, her score on power and independence was a 9, which indicated a strong value on children feeling empowered.

#### *Child Development Quiz*

Miss M.'s score on the Child Development quiz was one point lower than her pre-assessment score. She answered 3 questions incorrectly (most babies usually say their first words between 9 and 12 months, young children should be able to use a fork, knife, and spoon to feed themselves by the time they are 2 years old, and 1-year-olds understand when their moms are sad and can comfort them).

#### *Free Play*

Miss M. and her infant were again recorded in a 10 minute free play observation. Miss M. and baby were both seated on the bed for the entire interaction. Miss M. began the interaction by silently offering the baby a toy and sitting behind her while she played.

After about 2 minutes, Miss M. seemed to warm up and become interested in the interaction. She offered her baby a toy and delighted in her play with it. Miss M. was still somewhat intrusive when she offered her baby a toy when the baby was already appropriately engaged. Miss M. vocalized, smiled, laughed, and used physical contact in play with her infant. She engaged in a great deal of face-to-face and vocal play with her infant, imitating her baby's vocalizations. She displayed much more physical affection than that shown in previous interactions, holding her daughter close, hugging, and kissing her. Miss M. did not rely much on objects during this interaction, choosing instead to engage in physical play with her daughter. Miss M. was able to use physical play appropriately and did not become too rough with her infant at any point during the interaction.

Baby M. was very active during the play interaction. Although she was not yet crawling, she was vocalizing much more. She was smiling, laughing, and touching her mother throughout the interaction. She readily explored toys offered to her and delighted in her play. She responded positively to her mother's social initiations, especially physical play. Although Baby M. was at an age where play with objects has become much more salient, she seemed to genuinely prefer close playful contact with her mother to the variety of objects provided in the play environment.

### *Interview*

Miss M. completed a briefer version of the original parenting interview as a post intervention assessment of her beliefs and expectations about her child and about parenting. This interview also included questions regarding Miss M.'s experience with the 8-week parenting intervention. Miss M. was somewhat guarded during the interview,

although she occasionally relaxed and laughed with the experimenter. Several themes emerged during this interview including: 1) assertion of self-sufficiency; 2) projections; 3) inconsistencies; and 4) thoughts on the intervention.

*Assertion of Self-Sufficiency.* One major theme that was prevalent throughout the interview was Miss M.'s assertion that she did not need support from anyone. One component of this self-expression of independence was negativity regarding the transitional home. When asked about how her life had changed since the beginning of the intervention, Miss M. replied, "I'm on my own." When asked what her life was like since leaving the transitional home she said, "Great. I do what I want, when I want." When asked about whether she felt like she had enough support she said, "I don't need any help. I don't trust people." Since leaving the transitional home, Miss M. discontinued her meetings with other service providers. She had made some friends in the hotel where she was residing, but it seemed like these relationships were transitory. Miss M. reported that she and the baby's dad were talking again, but it seemed that this relationship was rather unhealthy. Throughout the interview, Miss M. continued to assert that she did not need anyone. It seemed though that she was desperately in need of support, but unable to admit it. She was presenting herself as completely self-sufficient, but in all likelihood, given her current situation, she really needed support. It is possible that Miss M.'s assertion of self-sufficiency and her inability to ask for help when she clearly needs it is a manifestation of a dismissive adult attachment style.

*Projections.* As in the first interview, Miss M. continued to have difficulty viewing her daughter as separate from herself. When asked about how her parenting had changed as her daughter grew, Miss M. said, "She needs more attention. I have to help

her in lots of ways. I have to show her how to walk, talk, what things are, crawl, and how to meet boys. I have to teach her not to smoke, not to swear." Although walking, talking, and crawling are skills that Baby M. would be learning, Miss M. was herself trying to find a boy friend and quit smoking. Later, when asked about how her baby has changed in the last few weeks, Miss M. said, "She is sitting up, talking more, eating solid food, sleeping all night. She has 10 teeth. Flirting with boys. She says my mommy is single." Baby M. was currently only babbling. When asked to clarify, Miss M. said, "Oh, she says it in her grin. I swear to god she winks. She's going to get mommy a boy friend. Boys like her." When asked whether parenting had gotten easier as her baby grew, Miss M. said that, "I have to watch her more. I have to watch where I put things, watch what she eats. Watch everything. I have to change her diaper. I have to buy everything for her. She needs to get a job."

In these examples, Miss M. began to accurately describe her daughter and then switched to talking about her own needs. Miss M. was able to accurately describe a major challenge of parenting, keeping a close eye on an active and exploring baby; however, she again seemed to be projecting her own needs for a boyfriend or a job onto her baby. She was able to give an appropriate response about her method for teaching her daughter by modeling appropriate behaviors. She was also able to give a good solution for keeping her daughter away from unsafe objects, "I put a blanket down and set her down, put all the toys around her. She can't move yet." Miss M. laughingly joked that this solution will not work for long as Baby M. is almost crawling.

Miss M.'s knowledge of her daughter's abilities was more accurate during this interview; however, she continued to struggle to describe her daughter's personality. She

reported that her baby was sitting up, talking more, eating solid food, and growing. She also said that her baby was paying more attention to her when she talks and putting everything in her mouth. She talked with the experimenter about her daughter's developing ability to crawl. In contrast, when asked to describe her baby using three words, Miss M. was again only able to come up with one. She said she was "wonderful," and when asked to explain her word choice, Miss M. replied, "I think wonderful, the word, explains it all." Miss M. was also asked how she would like others to describe her daughter when she was a grown up. Miss M. could not initially answer this question, so the experimenter asked what kinds of things she would not want to hear about her daughter. Miss M. readily answered, "All the rude words. Like she's a whore, or a slut, or a bitch, or whatever." When asked again about things she would like to hear about her daughter she said, "For me, my parents said I was a hard worker. So that's how I'm training her." When asked about this training, Miss M. said, "Make her clean her messes up and I was one of those kids that always helped in the kitchen, so have her help in the kitchen." She also wanted others to describe her daughter as "cute" and "attractive." Finally, Miss M. wanted her to ride horses.

*Inconsistencies.* As in the first interview, there were also numerous inconsistencies in this interview. When Miss M. was asked whether parenting has gotten any easier as her daughter grew, she replied, "I don't have to breast feed." In the previous interview, Miss M. went into great detail when describing the reasons she was unable to breastfeed. Miss M. also said that she rode horses, "while I was pregnant with her and when she came out." In the previous interview, there was no mention of horseback riding.

There were also several inconsistencies in her description of her experience in the parenting intervention. When asked about the parenting intervention, Miss M. reported that she hadn't learned anything from group or individual sessions. She said, "I already knew everything." When asked how she knew so much about parenting, she replied, "from babysitting and taking care of my brother." In reality, Miss M.'s parenting was lacking in many ways. When asked about the group component, Miss M. said, "I fell asleep" or "I just shut up. I didn't talk." When the experimenter challenged her and reminded her that she usually shared a lot during group and that she never fell asleep, Miss M. said, "I don't usually do that." When asked what about the group made it easy for her to talk, Miss M. said, "Because it was just you and another resident. Because then I would know who spread it if it did spread." Miss M. seemed to indicate that she felt comfortable with the small group because she would be able to identify a source of gossip if necessary. Although she frequently shared her opinions and experiences during group, Miss M. denied giving advice to others. She said that she felt overwhelmed by everyone's opinion, "especially when they think they know what they are doing, but I don't think that's right." It seems that while Miss M. felt good about giving advice to others, she was somewhat threatened by it herself.

*Thoughts on the intervention.* When asked whether the transitional home should implement such a parenting intervention, Miss M. answered that it depended upon the residents. When asked to elaborate, she said, "For me, I didn't mind it. I can't remember who it was that told me it was just annoying. Somebody told me it made her feel like she doesn't know what she is doing, so that they had to have someone come in and tell her what to do." When asked if she felt like she had been told what to do, she denied such

feelings and insisted that it was another resident who felt that way. Miss M. also felt that it should be the resident's choice to participate in the intervention, rather than a program requirement. She said, "You can't force someone to do something they don't want to do, or they won't do it." When asked about things she liked about the intervention, Miss M. said that she liked the snacks and some of the activities. She mentioned enjoying playing "Child Development Jeopardy" and the "Babysitter from Mars activity."

Miss M.'s negativity about the intervention might stem from her overall negativity towards the transitional home. She made an appropriate comment that she did not like having to attend group even if she was having a bad day. When reminded that attending groups was the transitional home's policy, she said, "I don't like the education sessions, I don't like the fact that you have to be in a meeting for an hour. I don't like the fact that I had to put my kid to bed at 8, no matter what, even if she was sick. No, I don't like signing out. I don't like them telling me that her dad can't see her at his place. I don't like them. I just don't." She then explained that the only reason she agreed to continue the intervention after leaving the transitional home was that the experimenter was not an employee of the home.

*Interview Summary.* At the time of this interview, Miss M.'s life was very stressful. Such instability and stress in her life are likely to have contributed to her responses during the interview. In particular, Miss M.'s assertion that she does not need any support is likely to be a product of her feeling that she currently has no support. Given her experience with close relationships, it may be easier for Miss M. to push people away than to seem vulnerable. Although Miss M. again tended to project her own experiences and needs when asked about her daughter, her thoughts about her daughter

seemed to be positive. She seemed most happy during the interview when talking about her daughter. On the other hand, her expectations that her daughter "get a job" or "get mommy a boyfriend" were inappropriate.

The inconsistencies that emerged in this interview were somewhat bizarre. At times, Miss M. directly contradicted her responses from the previous interview, in particular, her responses concerning breastfeeding. Her responses to questions about the intervention directly contradicted her behaviors during the intervention. Miss M. seemed very reluctant to admit that she had actively participated in group sessions, instead she claimed to have said nothing and that she had fallen asleep. Such negativity about the intervention was surprising since Miss M. had requested that the intervention continue beyond the scheduled 8 sessions. When the experimenter explained to her that it would not be possible to continue, Miss M. became upset. It is possible that Miss M. was dealing with her feelings about the completion of the intervention by denying that she actively participated in it.

#### Case I Discussion: Miss M.

Miss M. is a young mother who has experienced and continues to experience a variety of stressful events in her life. Such experiences are likely to contribute in important ways to her approach to parenting her daughter. In spite of her defensive attitude and apparent indifference, Miss M. was excited about the parenting intervention. Initially she seemed to see the intervention as a chance to socialize and to have someone else play with her baby. Over time though, Miss M. seemed to become more interested in her baby's development. It is possible that this improvement reflected changes in the baby's development rather than the effects of intervention itself. When Miss M. first

came to the transitional home, her baby was almost completely inactive. More recently, Baby M.'s developing skills have allowed her to be much more interactive and to give her mother more obvious cues and feedback. Miss M., in turn, seemed to begin to enjoy interactions with her baby more frequently.

In terms of the intervention, Miss M. did not miss a single individual session while living at the transitional home; in fact, when the experimenter needed to cancel a weekly visit, she insisted upon making it up. Even after running away from the transitional home, Miss M. persistently made efforts to continue the intervention in spite of rather adverse life circumstances. During home visits, Miss M.'s parenting seemed to improve. However, it is not possible to tell whether such behavior was situation specific. Her interest level in her daughter's development also seemed to increase and she appeared to be more sensitive to her daughter's needs. During group sessions, Miss M. actively participated. She was very open about her experiences as a child and frequently sought the opinions of the group when she had a question about parenting.

At the end of the intervention, Miss M.'s life circumstances were less than ideal. She was homeless, unemployed, and without transportation. She had few sources of reliable emotional support and had discontinued services with a variety of providers. In spite of such stress, Miss M. was able to delight in a play interaction with her daughter, which was one of the most positive interactions observed between mother and daughter to date. Such an interaction defied expectations and is difficult to explain. It could be that at this point in Miss M.'s life, parenting her daughter represents one of the few elements that she can control and that give her joy. Baby M. provides her mother with unconditional love and acceptance, which is something that seems to be lacking from the

other relationships in her life. She is an incredibly easy-going and tolerant baby that gives her mother the opportunity to be a success as a parent, even when the rest of her life is chaotic. It may be that parenting is one aspect of her life that regardless of whether it is appropriate, Miss M. feels confident about.

Miss M. would benefit from continued one-on-one support and parenting education. In particular, as Baby M. gets older and begins to assert her own will in interactions, Miss M. might struggle with parenting a more independent and less forgiving toddler. In addition to parenting support, Miss M. would also benefit from having an ongoing, consistent, and predictable relationship with another adult. Such a relationship might provide Miss M. with a positive model of relationships from which she can build her own with her daughter.

#### Case II Background: Miss O.

Miss O. began services with the transitional home when she was 16 years old and her baby was 13 months old. Miss O. arrived at the home with her older sister, who was pregnant with her third baby and had previously lived at the transitional home. Miss O. had a strong relationship with her family of origin. Her parents are divorced, and prior to moving to the transitional home, Miss O. lived with her mother. She had several full and half siblings as well as a large extended family. Miss O. grew up on a Native American Reservation and had lived there until moving to the transitional home. Although she was close with her family, Miss O. described her family life as chaotic and life on the Reservation as filled with negative influences. She felt that living at the transitional home would provide her and her baby with better opportunities.

Miss O. and her sister were both well liked by staff and residents of the transitional home. They were both viewed as positive examples for other residents to follow. The sisters seemed close and appeared to be a source of support for each other. However, Miss O.'s sister was struggling with a variety of serious issues such as methamphetamine addiction, domestic violence, and Child and Family Services involvement. After only a short time at the transitional home, Miss O.'s sister decided to return to her abusive partner, leaving Miss O. alone at the home.

Miss O. was an incredibly upbeat young woman. Although her life was at times, very stressful, she consistently presented herself in a positive way. She was very willing to help both staff and other residents as needed. She accepted and was kind to other residents and their babies. Miss O. also had a great sense of humor and used her humor to reduce tensions within the home. Initially, Miss O. was very friendly with the experimenter, but somewhat guarded with her personal information. Over time, she became more comfortable discussing her experience as a mother.

In interactions with her baby, Miss O. was generally responsive and caring. She was attentive to his needs and made attempts to meet them. She also seemed to genuinely enjoy being with him. A strong bond between mother and child was very evident and Miss O. was very affectionate with her child. Miss O. was eager to learn more about parenting and to be the best mother she could be.

Baby O. was a very active little boy. He was extremely mobile and interested in exploring his environment, which required constant supervision by his mother. At 14 months, Baby O. had not yet said his first words and was not making speech sounds other than grunts and screams. His lack of speech was a concern for his mother. Baby O. was

easily frustrated when restricted, bored, or when his needs were unmet. He expressed this frustration with temper tantrums that included hitting others.

Overall, Miss O. and her son seemed to have a relatively positive relationship. However, Baby O.'s lack of communication abilities at times, made it difficult for Miss O. to detect his cues. Baby O.'s resulting tantrums were frustrating for Miss O. to deal with and seemed to be undermining her feelings of parental competence.

#### Case II Pre-Assessment Results: Miss O.

Prior to beginning the intervention, Miss O. completed a variety of assessments. These were completed during one 2-hour visit to the transitional home. Miss O. was in a positive mood throughout the assessments. Baby O. had some difficulty with the length of the assessments and became somewhat fussy. After taking a short break, Baby O. was calm enough to continue the assessments.

#### *Demographics*

At the time of the assessment, Miss O. was 16 years old, had been pregnant just once, and was now parenting a 14-month-old baby boy. She had been residing at the transitional home for 1 month. At this time, she was not married, but was in a committed relationship with the father of the baby. She and the father of the baby had been a couple for 2 years. She reported having a strong relationship with her mother and a somewhat distant relationship with her father. She did not report a history of abuse of any kind. Miss O. identified herself as Native American. The highest level of education she had completed was 10<sup>th</sup> grade, but she was currently enrolled in high school full time and planned to attend college. She was unemployed. Miss O. did not report any health problems or birth complications for her son and her son was not born prematurely. At the

time of these assessments, Baby O. was attending daycare full time at his mother's school. Beyond the services offered by the transitional home, Miss O. received nutritional services and parenting classes from her school.

#### *AAPI*

On the AAPI, Miss O.'s scores on lack of empathy, physical punishment, role reversal, and power and independence were in the moderate range, indicating a normal or moderate risk for abuse. Her score on inappropriate expectations was in the high range, indicating positive, nurturing parenting and an understanding of the capabilities of children. Miss O. did not appear to have difficulty completing the questionnaire, although she expressed that she was unsure of her answers.

#### *Child Development Quiz*

On the child development quiz, Miss O. missed 4 questions. She answered the following items reflecting maternal expectations incorrectly: a 2-year-old should know how to share, 2-year-olds can be expected to behave in a store while their mother is shopping, and 1-year-olds understand when their mother is sad and can comfort them. In addition, she was unsure of whether a baby's temperament is when he misbehaves, and did not answer this question.

#### *Free Play*

Miss O. was observed and video recorded in a 10-minute free play interaction with her son. This interaction took place in the playroom at the transitional home, which is an area that is relatively free from distractions. The experimenter brought a variety of age-appropriate toys and asked Miss O. to play with her son as she normally would. Both

caregiver and infant behaviors were coded to examine individual contributions to the play interaction.

Miss O. began the interaction sitting on the couch, but moved to the floor after 2 minutes had passed. Miss O. almost always participated in the play interaction. She tried to get her son's attention by offering him a variety of toys. However, Miss O. continued to offer new toys even though her son was appropriately engaged in play, thus interrupting his play. Miss O. tried to take turns with her son in play. For example, she demonstrated how to blow bubbles and then offered him the opportunity to try. Miss O. talked to her son throughout the interaction, mostly in an attempt to get him interested in the toys. For the most part, Miss O. used the toys as they were intended and rarely modified activities to encourage playful routines. She did not imitate her son at any point in the interaction. Finally, Miss O.'s affect throughout the interaction was very positive. She used mostly positive words and smiled frequently. She did not touch her son in an affectionate manner, but there was little opportunity to do so in this interaction.

Baby O. was very interested in the video camera during the interaction, which made it somewhat difficult for his mother to engage him in play. Baby O.'s play behaviors, like many children his age, were somewhat unpredictable. At times he seemed to enjoy a particular activity and at others the activity was rejected. He responded to some of his mother's social initiations, and other times she could not get his attention. Although he was not yet talking, Baby O. communicated his pleasure or displeasure in activities with smiles, laughter, eye contact, or physical movement toward or away from an object. Baby O. explored all of the toys offered to him, sometimes very briefly. Baby

O's affect was mostly positive throughout the interaction. He laughed and smiled frequently.

### *Interview*

Miss O also completed a parenting interview to assess her beliefs about herself as a parent and her beliefs about her child. Miss O. seemed comfortable throughout the hour-long interview and readily answered questions about her experience as a parent. Several themes emerged from this interview: 1) a strong bond with her child; 2) sensitive and realistic parenting; 3) a lack of confidence in her parenting abilities; and 4) a perception of support.

*Pregnancy.* First, Miss O. discussed her pregnancy. She reported that she became pregnant when she was 14 years old and that the pregnancy was unplanned. Upon learning that she was pregnant, Miss O. reported feeling scared. She learned that she was pregnant while in the emergency room for an unrelated medical issue. She reported that her mother was very upset when she was told that Miss O. was pregnant, but did not mention her father's reaction. The pregnancy felt real to her when she began to show and had to buy maternity clothes.

Miss O. was asked to describe how she felt physically during her pregnancy. She said, "I felt huge. It was hard to get used to. I wasn't sick, but I slept a lot." When asked to describe her emotions during her pregnancy, she said, "I didn't really think about it too much. I was scared. It was weird. I was ok after (when the pregnancy became real). I knew I could probably handle it and deal with it." When asked to discuss what was scary about her pregnancy, Miss O. replied, "Having your own kid. (laughter) I had to take care

of another person and buy him diapers and everything like that. Not being able to go to school.” She described her labor as being incredibly painful and taking a long time.

*Bond with child.* Miss O’s strong bond with her child and positive perceptions of her son are evident throughout the interview. Although she was understandably afraid while pregnant, Miss O. described being excited upon learning that she was having a boy. She and the father of the baby chose a family name for their son. After a normal delivery and a brief hospital stay, mother and baby went home together. When asked to describe the first few days at home, Miss O. said it was, “Kind of weird having him there and everything. But he was ok. He slept a lot. We slept a lot. He did good.” When asked whether her son cried a lot during the first few weeks at home, Miss O. said, “Not really, until after he was 2 months old. Then he started crying a lot because I carried him all the time. We could barely put him down and if we did, he knew we weren’t there and he would just start to cry. It was kind of hard. He is still like that, very attached to me, even now.”

Miss O. was also asked to talk about her child’s developmental milestones. Although she could not remember when he was first able to sit without support, Miss O. readily described other milestones such as smiling, crawling, and walking. She showed delight in describing these milestones and laughed while telling stories of her son learning to crawl and walk. She was unsure of whether he had actually said a first word or was merely babbling at this point.

Miss O.’s strong bond with her son was also evident when she was asked to describe separations from him. When asked about her baby’s reaction to separations from her she said, “He’s crazy. He freaks out. He starts crying and screaming. He doesn’t want

toys or anything. He is very attached. Whenever I leave him, I get worried because I know he is going to cry." Miss O. and her son had never been apart prior to living at the transitional home. Upon moving to the home, Baby O. began attending daycare while Miss O. attended high school, which was difficult for both mother and baby. When asked how she felt when separated from her child, Miss O. replied, "It is getting easier, kind of. I cried that first week. It's kind of weird because he is always with me, but then at school we have to be apart."

Miss O. had some difficulty describing her son's personality. When asked to give 5 words to describe her baby, she could only generate 3, "playful, happy, and active." However, she was able to explain why she chose these words to describe her son. She was able to tell a favorite story she had about her son and seemed to enjoy telling it. When asked if she could pick one age for her son to stay for a while, she responded, "I liked it when he was tiny. Like when he was one month old. I loved that." When asked what she loved about that particular age, Miss O. said, "Just being able to hold him, and him being so tiny and cuddly. He was so cute."

Miss O. was also able to talk about her son's challenging behaviors in a positive way, which suggests that her expectations for her son are appropriate. She described how the newly walking Baby O. had been getting into everything. Baby O's need to explore his environment often resulted in Miss O. needing to set limits. Like most children of his age, Baby O. responded to these limits with temper tantrums. Although the tantrums were frustrating for her, Miss O. showed appropriate insight when she explained his behavior by saying that he tantrums, "because he wants something he can't have." Rather than attributing his behavior to internal characteristics, Miss O. attributed his behavior to

situational factors. When asked what she thought might happen with this behavior as he gets older, Miss M. replied, "I think he might grow out of it when he starts to talk and learns that there are some things he can't have." She seemed to view his behavior as age appropriate and transient.

Her future expectations and hopes for her son were appropriate and positive as well. When asked about what she thought would be the most challenging time in her son's life, Miss O. responded, "Maybe when he is a teenager. Because there are a bunch of decisions that you have to make and you have to do well in school to get out of high school. There is pressure to do different things like drugs and alcohol and stuff like that." When asked what she thought her son would be like as an adult, she said that she hoped he, "would go to college, do something he really likes, get a good job, have a good life, and maybe have kids of his own – but only when he is old enough."

Her beliefs and expectations about parenting were also positive and appropriate. When asked to give three words to describe parenting she said that parenting is, "loving and caring." She felt that her strength as a parent was "Always being there for him and giving him what I know he needs. And caring for him." When asked what she liked about being a parent, she said, "Being able to see him grow up and get older. Like when I saw him start crawling and then suddenly he was walking too."

*Sensitive and Realistic Parenting.* In addition to having a strong bond with her baby, Miss O.'s parenting seems to be rather sensitive and her view of parenting seems to be realistic rather than idealistic. When asked about what she does when her child is upset, Miss O. was able to describe several different types of upset; i.e. angry, sad, sick, and hurt, as well as the different responses that these types of upset require. For example,

Miss O. described the following response to her son when he was angry or sad; "Try to let him know that it wasn't on purpose. Let him know that he will be fine. Comfort him and let him know its ok."

Miss O. was very candid throughout the interview. She seemed to be answering the interviewer's questions honestly without concern for answering in socially desirable ways. For example, when she talked about breastfeeding, Miss O. was very honest about her discomfort and subsequent decision to bottle-feed. She was also very forthcoming in discussing her confusion about dealing with her son's challenging behaviors. She admitted to trying spanking as a form of punishment and often not knowing what to do with her son's behavior.

*Lack of confidence.* Although Miss O.'s parenting seemed to be sensitive and her beliefs about parenting seemed to be appropriate, Miss O. frequently reported feeling unsure of her parenting abilities. When asked about what she would like to do when her son has a temper tantrum, Miss O. responded, "Leave him in the room by himself. (laughs) I don't know, it's hard because I don't know what to do." Although the responses she described having when her son was upset were appropriate, Miss O. also described feeling unsure of herself in such situations. She said, "People have told me that I should spank him. I've tried it before. He would get mad and try to hit me back. I don't want to do that anymore. I don't know what to do though." When asked to provide a rating of herself as a parent on a scale of 1 to 10, with 1 being the worst parent ever and 10 being the best, Miss O. gave herself a 6. When asked why she gave herself this rating she said, "Because I don't know if I'm actually doing everything right. Maybe there is something I am doing wrong and I don't know. I know I'm not doing everything right,

but I know I'm not doing everything wrong either." While her beliefs about parenting seemed appropriate, Miss O. seemed to have slightly unrealistic expectations for herself as a parent.

*Sense of support.* Miss O. reported that she felt supported by a variety of people including her mother, father, boyfriend, brother, and staff at the transitional home. Although Miss O.'s mother was angry with her for becoming pregnant at such an early age, she eventually accepted the pregnancy. She was present at the birth and continued to help her daughter raise her son until her move to the transitional home. Miss O. and her mother frequently spoke on the phone and Miss O. frequently returned home for visits. When asked how her mother supports her, Miss O. said, "My mom is always there and willing to help me with taking care of Baby O. And if I don't know how to do something, she would do it or tell me how. If I have to go somewhere and need someone to watch him, she can always take care of him."

Miss O.'s relationship with her father was not as close as her relationship with her mother. However, Miss O. felt that she could rely on her father for financial support if she needed it. At the time of this interview, Miss O. had been in a monogamous relationship with the father of the baby for 2 years. The father of the baby, although far away at the time, seemed to take an active role in his son's life. He was present during the birth and helped to name the baby. Miss O. reported that although she was uncomfortable with breastfeeding, the father of the baby encouraged her to try it for the baby's sake.

*Interview Summary.* Based on this interview, Miss O. appeared to have a positive relationship with her son. Unlike most residents of the transitional home, she felt supported and had a seemingly healthy relationship with her parents and the father of the

baby. Miss O. seemed to be a relatively sensitive mother who sometimes struggled with handling her son's challenging behaviors. Miss O. also seemed to have very high expectations for herself as a mother, which may contribute to her lack of confidence in parenting her son.

#### Case II Intervention: Miss O.

The individual session component of Miss O.'s parenting intervention focused on 3 major goals. These goals were chosen based on Miss O.'s pre-intervention assessments, input from program staff, and input from Miss O. The first goal was to help mother and baby cope more effectively with separations. It was thought that helping Miss O. understand her baby's reaction to separation and giving her strategies to help reduce stress upon separation might make separations less traumatic for both. The second goal was to improve Baby O.'s communication skills. It was thought that increasing Baby O.'s ability to communicate his needs in an effective way might, in turn, decrease the frequency of his temper tantrums. A final goal was to increase Miss O.'s confidence as a parent. While Miss O.'s instincts regarding parenting were often correct, she frequently second guessed herself and relied on the advice of others in parenting her son. Each of these three goals was addressed throughout the intervention in both group and individual sessions along with other smaller issues that arose.

Miss O. was very open to directly receiving advice regarding her parenting. She asked questions throughout the intervention and was willing to try most suggestions at least once. Miss O. seemed determined to be a good mother and was eager to learn about child development. She was particularly interested in research and the methods for studying child development. The experimenter frequently used research examples to

illustrate concepts for Miss O. Other techniques used in the intervention with Miss O. were modeling and reinforcement of positive parenting behavior.

Although Miss O. was open to receiving advice, she occasionally found it difficult to follow through with some of the advice. For example, early in the intervention she was interested in weaning her son from the bottle because she was concerned about the health of his teeth. Baby O. had been drinking a variety of beverages including milk, juice, and soda in his bottle and had not yet learned to use a cup. The experimenter created a plan with her to slowly wean her son from the bottle and introduce a cup. Miss O. found it difficult to deal with her son's initial resistance to weaning and subsequently decided to continue to give him the bottle. It seemed that various factors often came between what Miss O. knew to be the correct parenting behavior and her actual response.

Goal one, helping mother and baby cope more effectively with separation, was addressed in several ways. First, the experimenter asked Miss O. to talk about what separations were like for her and her son. Miss O. described being very upset by separations, mostly due to Baby O.'s extreme reaction to being apart. Although Baby O.'s reaction to separations had improved since beginning daycare, he still cried for an extended period of time when left at daycare. Miss O. said that her baby cried for at least an hour or more but eventually recovered. When Miss O. visited Baby O. during her lunch hour, which was a requirement of the daycare, Baby O. became upset all over again. Miss O. was concerned that Baby O.'s reaction was abnormal and that he would grow up to be clingy and dependent. She had been given a variety of advice on how to handle separations, but was unsure of the best method. When asked what methods she had tried this far, Miss O. described her initial reaction of staying with him until he was

calm and trying to distract him with a toy before slipping away. She reported that she was told by daycare staff that she was making the transition worse and that she should just leave him quickly. Miss O. had been using this method prior to beginning the intervention. She said she felt awful just leaving him, but wasn't sure what to do instead.

To help Miss O. understand her baby's behavior, the experimenter asked her to put herself in his position and imagine what he was thinking. She was able to talk about how they had never been separated prior to moving here and how being away from his mother for the first time might be scary. However, she still thought that there was something wrong with him for continuing to be upset with separations. The experimenter then introduced the concepts of attachment and separation anxiety to Miss O. Given Miss O.'s cognitive abilities and interest in research, the experimenter described, in a very basic way, how attachment is measured based on a baby's reaction to separations and reunions with caregivers in the Strange Situation. The experimenter explained that separation anxiety peaked between 12-18 months and that her baby's reaction to separations might be an indicator of something positive, a secure attachment, rather than a character flaw. Miss O. reported feeling relieved to know that her son's behavior was age appropriate rather than deviant.

Miss O. was very interested in the concept of attachment. She had many questions about how attachments formed and what they meant for babies and parents. Learning about attachment seemed to help Miss O. see her parenting behaviors in a new light. She reported being criticized by her family and various professionals for spoiling her son by paying too much attention to him. The experimenter praised Miss O. for being such a responsive mother and encouraged her to continue with this style of parenting. The

experimenter then introduced the other goal of the attachment system, exploration, and the concept of parents providing a safe base from which their baby can explore. The experimenter and Miss O. talked about how allowing her baby to explore might be difficult for Miss O., but that she needed to be prepared for her son's need to explore to increase as he grows older and develops new skills. Miss O. reported being excited about his increasing autonomy, but also sad to lose her baby.

With this new understanding of attachment, the next task involved minimizing her son's distress upon separation. The experimenter praised Miss O. for her efforts to make transitions more gradual and to get her son interested in an activity before leaving. Miss O. was encouraged to try this method again rather than follow the advice she had been given to simply leave him and exit quickly, leaving him to deal with his distress alone. Miss O. and the experimenter discussed how leaving her son abruptly might actually make the transition to daycare worse as he might come to anticipate a traumatic separation and become upset before she even tried to leave him. The experimenter also suggested that Miss O. be sure to greet the daycare staff and interact cheerfully with them because Baby O. might be considering her reaction to this new situation when forming his own reaction. The experimenter also suggested that Miss O. include the daycare staff in an engaging activity with her and Baby O. to make the transition less difficult. Miss O. seemed happy with this solution and agreed to try it.

Over the course of the intervention, the experimenter and Miss O. continued to revisit the separation issue. Baby O.'s distress at daycare gradually decreased as he became accustomed to the staff and the separation from his mother. As Baby O.'s reaction to separations improved, Miss O. became more comfortable leaving him. Several

weeks into the intervention, Baby O.'s distress during separation returned when he encountered a substitute daycare worker. Miss O. handled his distress appropriately, by again making her exit more gradual. More importantly, Miss O. felt confident enough to handle her son's distress on her own, rather than relying on others. Eventually, Baby O. adjusted to his new caregiver.

Goal two, improving Baby O.'s communication skills, was also addressed in several ways. First, the experimenter asked Miss O. about her son's current language abilities. Miss O. had initially thought that Baby O. had said a first word, "mama" several months ago, but now that that he had just been babbling. She was concerned that he was no longer saying "mama" or anything else that approximated speech. Baby O.'s communication skills at 14 months consisted mostly of grunts, whines, and screams. He became easily frustrated when his needs were not met, sometimes having a tantrum, hitting his mother, or crying.

The experimenter reassured Miss O. that some babies take longer to say their first words than others, but suggested that there may be ways to help Baby O.'s emerging language skills. Given the relevance of the topic to both children in the intervention, language development was addressed in a group session with both moms present. The experimenter briefly described the stages of language development and the ways in which babies learn to talk. In particular, the experimenter stressed the importance of talking to babies. Neither Miss O. nor Miss M. seemed to talk much to their babies. When they did talk to them, they often did not use infant-directed speech. The experimenter talked about the importance of infant-directed speech for language development and encouraged the mothers to talk to their babies as much as possible. The group discussed ways to integrate

“speech lessons” into a variety of daily activities such as diapering, feeding, play, etc.

The mothers were also encouraged to have “conversations” with their babies by imitating the sounds they make and expanding upon them with new sounds. Finally, mothers were encouraged to label interesting things in their environment and to try to spend a few minutes each day reading to their children.

In individual sessions with Miss O., the experimenter introduced the idea of teaching Baby O. basic baby signs to help him communicate his needs more effectively. Initially, Miss O. was very resistant to this idea. She was concerned that learning signs might confuse Baby O. and make it more difficult for him to learn to talk. She was also concerned about other’s reactions, in particular her family’s reaction, to her son using signs. The experimenter reassured Miss O. that using signs would not be a substitution for speech; rather using sign would allow Baby O. to communicate his needs effectively before his speech abilities fully emerge. The experimenter described how using signs might actually help spoken language emerge as babies learn that they can get their needs met by communicating. Miss O. was also told that the signs would be used in combination with spoken language.

Miss O. needed some time to think about incorporating signs into Baby O.’s daily routines and to talk to her family about the use of signs. During the following week’s session, the experimenter revisited the idea of using signs. Miss O. was still hesitant, but willing to try introducing one sign. The experimenter suggested that they teach Baby O. to sign, “more” as this is a relatively easy sign to learn and is useful for the baby. Baby O. quickly picked up on using the sign to get more cookies and Miss O. was excited by his

progress. The experimenter praised Miss O. for trying something new and encouraged her to keep using this sign with her son throughout the week.

During the next visit, Miss O. reported that Baby O. was consistently signing for "more". They had made a trip home to visit family and her family did not approve of Baby O.'s signing, which made Miss O. uncomfortable. Although it was difficult for her to go against her family's wishes, Miss O. decided to continue to use a few basic signs with her son until he learned to speak. In later visits, the experimenter introduced the signs for milk, play, all done, and help.

A final technique for facilitating Baby O.'s language development involved modeling communication with the baby during visits. Although Miss O. was a very caring mother, she rarely directed conversation at her son, and rarely used infant-directed speech. During individual sessions, the experimenter directed conversation in infant-directed speech at the baby, imitated his sounds, and used signs. When talking with Miss O. the experimenter included the baby in the conversation and responded immediately to his communicative bids. The experimenter also discussed the technique of giving baby a "running commentary" of Miss O.'s activities and modeled this technique. The goal of such modeling was to show Miss O. that she could multi-task by talking to her baby while she was engaged in other activities. With this approach, Miss O. could meet her own needs while providing her baby with much needed verbal stimulation.

By the end of the intervention, Miss O. seemed to be talking more with her son. He was occasionally signing "more", but had not incorporated any of the other signs into his daily routines. Baby O. was saying a few words like "ball, uh oh, bird, and bottle."

Miss O. was imitating his words and trying to get him to repeat them. She was very pleased with his emerging skills.

Goal 3, increasing Miss O.'s confidence as a parent, was addressed indirectly throughout the intervention. For the most part, Miss O.'s natural inclinations as a mother were appropriate, sensitive, and caring. Unfortunately, Miss O. tended to doubt herself and instead to rely on others such as her family or other professionals for parenting advice. Although seeking the opinions of others can be incredibly helpful for many parents, Miss O. often received advice that was inappropriate or insensitive.

Miss O. tended to follow the advice of others even when it made her uncomfortable. For example, like many toddlers, Baby O. had begun hitting others. Miss O. was frustrated with this behavior and unsure how to change it. She reported that her family and friends suggested that she try spanking her son to reduce his aggressive behavior. When asked if this method was successful, Miss O. said that it was not. She felt uncomfortable hitting her son and questioned whether she was actually teaching him that hitting was ok by spanking him. The experimenter and Miss O. talked about how mildly aggressive behavior is relatively normal for toddlers who are easily frustrated and have limited means to communicate such frustration. Miss O. was eager to try the experimenter's suggestions of being preventative, removing Baby O. from the situation that provoked the aggressive response, and using distraction. She reported being relieved to learn that spanking was not necessary to change her son's behavior.

Miss O. was also somewhat distressed by her inability to always know what her son wanted. The experimenter and Miss O. talked about how difficult it can be to determine what her son wants sometimes, especially because what he wants changes so

frequently. The experimenter used video feedback to help Miss O. take a closer look at her son's cues during a play interaction. Mother and baby were playing at the playground. Miss O. tried throughout the interaction to interest her son in an activity, throwing the ball to her. In previous interactions mother and baby enjoyed this game together. However, on this day, Baby O. was much more interested in playing with bubbles and was completely ignoring his mother's bids to play ball with him. Eventually, Miss O. joined her son in play with bubbles. Unfortunately, Baby O. then moved onto another toy. When Miss O. tried to join him in play, he pushed her away, but then later brought her a toy.

When Miss O. watched the video, she was able to reflect on her play experience. She commented on Baby O.'s mixed signals and how difficult it can be to know what he wants. She was also able to more clearly see his cues on the video than she had been in real time. Miss O. and the experimenter discussed how toddlers' interests could change quickly and that many parents struggle to decipher their child's needs and wants. The experimenter praised her for being persistent and for trying to play with her son. The experimenter also suggested that rather than trying to engage her son in play, Miss O. might try playing "follow the leader" for part of their playtime, imitating what her son does. It was thought that this method might improve Miss O.'s ability to follow her son's lead in play, which might make the play experience more enjoyable for both.

Throughout the intervention, Miss O. had many parenting questions. She was curious about healthy eating, language, discipline, managing temper tantrums, potty training, introducing a cup, motor development, cognitive development, attachment, and dealing with un-solicited parenting advice. Prior to answering her questions, the

experimenter asked Miss O. what she thought about a particular issue and praised her when she generated good ideas. The experimenter told Miss O. that often times there were many correct answers to dealing with a particular parenting issues and reminded Miss O. that she was the expert on her child. The experimenter also reminded Miss O. that even the best parents make mistakes with their children and that it was important to repair such mistakes rather than worry so much about making them.

Over the course of the intervention, Miss O. seemed to become more comfortable sharing her ideas on parenting with the experimenter. Initially, she tended to defer to others much more readily and doubt her own instincts. By the end of the intervention she appeared more confident and seemed to question herself less.

#### Case II Post-Assessment Results: Miss O.

##### *Demographics*

Miss O. completed post-intervention assessments in the playroom at the transitional home. Miss O.'s mood was quite positive during the assessments; however, Baby O. was rather fussy. Since the pre-assessments, Miss O. had turned 17. Her baby was now 17 months old. Miss O. was still residing at the transitional home, but was planning to return home for the summer, and perhaps permanently. Miss O. was almost finished with her sophomore year of high school and still planned to continue her education. She was still unemployed. One major change since the pre-assessments was that Miss O. and the father of the baby were no longer together. Two weeks prior to these assessments, Miss O. had learned that the father of the baby had been unfaithful and she decided to end their relationship. Baby O. was still attending daycare 5 days per week while his mother attended high school.

*AAPI*

On form B of the AAPI-2, all but one of Miss O.'s scores reflected positive, nurturing parenting and all but one of her scores improved. Miss O. scored a 9 on inappropriate expectations, which indicated a realistic understanding of the developmental capabilities and limitations of children. She scored an 8 on lack of empathy, which indicated that she was sensitive to the needs of her child and thought such needs were important. Her score on physical punishment was a 9, which indicated a tendency to use methods other than physical punishment. Her score on role reversal was a 7, which indicated an understanding and acceptance of the needs of self and children. Finally, her score on power and independence was a 3, which indicated that Miss O. placed a strong emphasis on obedience at the expense of autonomy.

*Child Development Quiz*

Miss O.'s score on the Child Development quiz was one point lower than her pre-assessment score. She answered the following 5 questions incorrectly: most babies usually say their first words between 9-12 months, a 2-year-old should know how to share, babies usually first start eating solid foods when they are 1 year old, young children should be able to use a fork, knife, and spoon to feed themselves by the time they are 2-years-old, and 1-year-olds understand when their moms are sad and can comfort them. While completing the quiz, Miss O. gave examples of other children living at the transitional home who supported her answers, such as the 2-year-old who can properly use his utensils at meal times.

*Free Play*

Miss O. and her infant were again recorded in a 10-minute free play interaction. Miss O. began the play interaction on the floor and stayed there for most of the interaction. Miss O. almost always participated in social interactions. She tried to engage her son in a variety of activities, sometimes when he was already appropriately engaged. Although Miss O. occasionally interfered with her son's play, she did not persist in activities that he was not interested in. Miss O. demonstrated activities, like blowing bubbles, and attempted to get him to imitate her. She did not imitate his actions though. Miss O. communicated with her son throughout the interaction and interpreted his behavior as having communicative intent. She mostly played with the toys as they were intended and did not really modify activities to create playful routines.

Throughout the interaction, Miss O.'s affect was very positive. She spoke to her son throughout in a positive tone and frequently smiled. She seemed to be enjoying the interaction and delighted in her son's play. Toward the end of the interaction, Miss O. and her son snuggled together in a rocking chair. She hugged and kissed him and he accepted this affection.

As mentioned previously, Baby O. was somewhat fussy throughout the post-assessments, which may have made him difficult to engage in play. Baby O. rarely initiated interactions with his mother; however, he frequently responded to her social initiations, even if for a brief amount of time. Baby O.'s behavior during the interaction was somewhat inconsistent. He seemed to move from one activity to the next without really becoming engaged in any activity for a sustained amount of time. Baby O. attempted to communicate with his mother through pointing, vocalizations, and

proximity. He attempted to participate in his mother's playful routines, but only for short periods of time. Baby O. tried to imitate his mother and blow bubbles. Given filming limitations, it was difficult to determine whether Baby O. was smiling throughout the interaction. His vocalizations were both positive and negative, depending on his interest in a particular activity. Toward the end of the interaction, Baby O. was physically affectionate with his mother.

### *Interview*

Miss O. completed a briefer version of the original parenting interview as a post-intervention assessment of her beliefs and expectations about her child and about parenting. This interview also included questions regarding Miss O.'s experience with the 8-week parenting interventions. Miss O. was in a positive mood during the interview, but Baby O. was rather fussy, which required several breaks throughout the interview. Three themes emerged from this interview: 1) a lack of verbal descriptors; 2) feelings of competence; and 3) thoughts on the intervention.

*A lack of verbal descriptors.* In this interview, Miss O. was again asked to answer questions about her son and about parenting. She seemed to have difficulty describing her thoughts on such topics when asked directly. For example, when Miss O. was asked whether she had made any changes in her parenting over the last several weeks, she could not think of any. She was also unable to describe any changes in her son over the last few weeks even though major changes had occurred with his language abilities. When the experimenter reminded Miss O. that her son was talking now, she was able to talk about the new words he was saying. Miss O. again had difficulty using three words to describe her son. During this interview, she described him as, "happy and crazy and that's it."

Miss O. was also asked what it was like being Baby O.'s mother. She was unable to generate a response to this question.

Miss O. was able, however, to talk about her son's challenging behaviors and the strategies she was using to deal with them. When asked whether her child was doing any thing challenging at that point, Miss O. laughed and replied, "Everything!" She reported that his most challenging behavior was hitting others. When asked how she handled this behavior she said, "When he hits people, I can't do much about it. I can't give him time out or talk to him about it and it will stop. He is going to keep doing it for a while. I just take him away from the situation." Miss O. seemed to realize that hitting was a normal part of toddler development. She also seemed to understand her son's limited ability to control such behavior at his age, making traditional responses like reasoning with him or giving him a time out ineffective.

*Feelings of competence.* Several of Miss O.'s responses in this interview suggested that her feelings of competence as a mother had increased. First, Miss O. did not answer, "I don't know" to any of the questions about handling her son's difficult behavior. Instead, she was able to talk about her responses to such behaviors with confidence. Miss O. was asked again to give herself a rating as a parent from 1 to 10 with 1 being the worst parent ever and 10 being the best. Prior to the intervention, Miss O. gave herself a 6 and said that she was not sure she was doing everything right as a parent. At this time, Miss O. gave herself a 9. When asked to explain this rating, Miss O. said, "Because I think I'm doing a pretty good job." This change suggested that Miss O. was feeling more competent as a mother and that her expectations of herself were more realistic.

*Thoughts on the intervention.* Miss O. was also asked to provide feedback on her experience with the 8-week parenting intervention. When asked whether she thought that the transitional home should implement such an intervention, Miss O. replied, "They already kind of tell us what to do. I mean it is helpful though. Some things they don't know. I mean sometimes they tell us that we're doing something wrong, when we're really not." When asked about the individual sessions, Miss O. said, "I learned stuff I didn't know and found out I was doing the right thing even though people told me I wasn't." Miss O. did not have any suggestions to improve the individual sessions. She expressed that she thought that program staff should not provide the intervention; instead, someone separate from the transitional home should implement the intervention.

Miss O. was also asked about the group component of the intervention. She reported that the best part of group was that, "we got snacks." When asked what would have made the group better, Miss O. said, "If it were longer. One hour wasn't long enough for us to talk about everything. And we needed to cover more stuff." When asked what other topics she would have liked to discuss, Miss O. replied, "Everything about parenting; potty training, feeding, discipline, everything."

*Interview Summary.* Although Miss O. had some difficulty verbally describing her thoughts on parenting and her son, such difficulty is unlikely to reflect negative representations. It is likely that Miss O. was distracted by Baby O.'s behavior during the interview and found it difficult to gather her thoughts. Her expectations for herself as a parent seemed to be more realistic and she seemed to be much more confident as a parent. Miss O. reported that the intervention was helpful for her and offered suggestions for future interventions.

## Case II Discussion: Miss O.

Although she was very young when she became pregnant, Miss O. was a very responsive and caring young mother. Her desire to give her son a good life, along with their close emotional bond was evident throughout the course of the intervention. Miss O. willingly participated in the parenting intervention and seemed to enjoy the individual sessions in particular. She was eager to learn about child development and willing to apply what she learned to interactions with her son. Miss O. attended all group and individual sessions over the course of the 8 weeks. She requested that the intervention continue beyond the scheduled 8 sessions and explained that she still had a lot she wanted to learn about parenting.

The changes observed in Miss O. throughout the parenting intervention were not terribly drastic. For the most part, Miss O. was a responsive mother who seemed to enjoy parenting her son. Her expectations for her son were mostly appropriate and she seemed to have a very positive view of her child. She felt that she had adequate emotional support and a loving relationship with her family. The biggest change in Miss O. was in her increased confidence as a mother. At the beginning of the intervention, she seemed unsure of herself as a mother and was not confident in her parenting choices. Over time, her expectations for herself as a mother became more realistic and she became more comfortable with her parenting decisions. Miss O. also improved in play interactions with her son. She was less intrusive, more vocal, and more likely to follow his lead in play in the post-assessment play interaction.

In contrast, some of Miss O.'s scores on the post assessments were worse than her pre-assessment scores. Specifically, one of her scores on the AAPI-2 form B, fell in the

range of a high risk of abuse. She received a low score on Construct E, oppressing children's power and independence. Such a score is thought to indicate that parents place a strong emphasis on obedience: having children do what they are told to do, when they are told to do it. Such parents discourage their children from expressing their opinions, expressing feelings of discomfort, and seeking comfort from their parents. They are also likely to use physical punishment (AAPI manual). Given Miss O.'s answers during the parenting interview as well as the experimenter's experience with her throughout the intervention, this score does not seem to be an accurate reflection of Miss O.

Miss O.'s scores on the Child Development quiz were also a bit low at both pre and post assessments. Although Miss O. had received parenting education through her school, her knowledge of child development may have been limited. When answering the questions on the quiz, Miss O. frequently used her child or the other children at the transitional home as a model, which may have been why she did not think that children said their first words as early as 9 months.

Miss O. seemed to thrive at the transitional home. She was well liked by both staff and other residents throughout her time there. At the end of the intervention, Miss O. decided to return to her home on the Reservation. Although her family serves as a source of support for her, Miss O. described life at home as chaotic and stressful. Such an environment is likely to challenge Miss O. in a variety of ways and may have some effects on her parenting. Miss O. seems to be headed in an appropriate direction with her parenting, but may need some support as she deals with the challenges of parenting a toddler, especially if her environment is stressful. Although an intense intervention would not be warranted, Miss O. might benefit from having a consistent relationship with a

professional who could continue to advise her as new challenges arise and reinforce her efforts to parent her son in a positive way.

#### Case III Background: Miss J.

Miss J. began services with the transitional home when she was 16 years old and pregnant with her first baby. She reported that her parents told her that she either needed to have an abortion or move into a group home when she told them she was pregnant. Miss J. lived at the transitional home for 7 months during this first pregnancy, and returned home shortly before the birth of her son. She returned to the transitional home when she was 19 years old and parenting her 2 year old son.

Miss J. also gave birth to a second son, who was 1 year old at the time of the intervention. However, Miss J. was not raising this son and had given him to her mother when he was an infant. Miss J. expressed having conflicted feelings about giving her youngest son away. She explained that she gave him to her mother because she did not feel like she could handle two children and she was concerned about her oldest son harming his younger brother. Miss J.'s youngest son was being raised to think his grandmother was his mother and Miss J. his sister. Miss J. reported that she would like to parent her younger son, but she was concerned that it would be traumatic for him to have a different mother at such a young age. She was also concerned that no longer parenting her grandson would hurt her mother. She reported that she did not feel comfortable addressing this issue with her mother.

Miss J. was a very sociable young woman. She quickly formed friendships with the other residents of the transitional home and became a source of support for the other mothers. Miss J. was very concerned with the affairs of others, which was at times,

frustrating for the staff of the transitional home. Such a preoccupation also occasionally resulted in minor conflicts with the other residents. Miss J. reported that she had been diagnosed with a number of mental health issues, including a personality disorder, bipolar disorder, and an anxiety disorder. She was seeking further evaluation and treatment for these disorders. Miss J. also reported that several members of her immediate family also suffer from psychological disorders.

Baby J. was an incredibly active, intelligent, and temperamental 2-year-old. Staff at daycare and staff at the transitional home were very concerned about Baby J.'s aggressive behavior. Baby J. was reported to be intentionally aggressive toward infants in both settings. One potential contributor to Baby J.'s aggression was the rather stressful transition he experienced upon moving to the transitional home. Prior to the move, he had been living with his younger brother and grandmother and had been in frequent contact with his father. Upon moving to the transitional home, the frequency of this contact was dramatically reduced because his mother was without transportation and his grandmother lived out of town. Baby J. frequently talked about his brother and father in interactions and often asked where they were. In addition, Baby J. encountered a variety of new people in his new environment, including both staff and residents.

In interactions with his mother, Baby J. was difficult to engage in activities and easily frustrated, which often resulted in temper tantrums. Baby J.'s verbal skills were quite advanced for his age, but he often had difficulty communicating his needs. Miss J. was very patient with Baby J. She made efforts to meet his needs and keep him entertained in play. For the most part, she was able to stay calm during his frequent and intense temper tantrums. Baby J. required a great deal of his mother's attention and had

difficulty playing independently. When Miss J. was occupied with other tasks or other residents of the transitional home, Baby J. became very upset. At times, given the activity level in the home, Miss J. struggled to give her son the attention he needed.

#### Case III Pre-Assessment Results: Miss J.

##### *Demographics*

Prior to beginning the intervention, Miss J. completed a variety of assessments, including a demographic questionnaire. She completed these assessments during one 2-hour visit to the transitional home. Miss J. was in a positive mood during the assessments and seemed to enjoy talking with the experimenter. At the time of the pre-assessments, Miss J. was 19 years old. She had given birth to 2 sons and was currently parenting the oldest son. Miss J. was in a committed relationship with the father of her children and had been with her current partner for 3 years. She identified herself as Caucasian. Miss J. had obtained a GED and was hoping to attend college in the future. She was unemployed, but looking for work. She had lived at the transitional home for 7 months two years ago when pregnant with her first son. At the time of these assessments, she had lived at the transitional home for 1 week.

Baby J. was 28 months old at the time of these assessments. His mother reported that he had no birth complications or any current health problems. Baby J. attended daycare 5 days per week. In addition to the services provided by the transitional home, Miss J. and her son received nutritional services. Miss J. was also in the process of obtaining mental health counseling.

*AAPI*

On the AAPI, Miss J's scores on all subscales were high, indicating a positive, nurturing parent. Specifically, she scored an 8 on inappropriate expectations, which indicated a realistic understanding of the developmental capabilities and limitations of children. She scored a 10 on lack of empathy, which indicated that she was sensitive to the needs of children and viewed such needs as important. On physical punishment, Miss J. scored a 7, which indicated a positive attitude toward non-violent ways of providing discipline for children. She scored a 10 on role reversal, which indicated an understanding and acceptance of the needs of self and children. Finally, Miss M. scored a 9 on power and independence, which indicated a strong emphasis on children feeling empowered.

*Child Development Quiz*

Miss J. missed 4 questions on the child development quiz. She answered the following questions incorrectly: most babies usually say their first words between 9 and 12 months, a two year old should know how to share, babies usually first start eating solid foods when they are 1 year old, and babies usually first crawl between 6 and 9 months. Miss J. provided examples of her son's behavior as she completed the quiz.

*Free Play*

Miss J. and her son were also recorded during a 10-minute free play interaction. The interaction took place in the playroom at the transitional home. Miss J. expressed some apprehension about being video recorded, but was willing to complete this portion of the assessments. Miss J. almost always participated in social interactions with her son and she spent most of the interaction on the floor playing with her son. When he moved

away, she either followed him or continued to speak to him. She followed her son's lead in play and allowed him to choose all activities, rather than initiating play activities herself. Miss J. did not interrupt or interfere with her son while he was engaged in play. Miss J.'s behavior was consistent throughout the interaction. She recognized her son's signals that he was becoming frustrated or bored with an activity and quickly modified the activity. She attempted to take turns with her son when he was blowing bubbles and playing with a ball. Miss J. spoke to her son throughout the interaction in a positive tone and interpreted his behavior as having communicative intent, even though it was often difficult to determine his wants.

Although Miss J. mostly followed her son's lead in play, she did expand on his play to keep him interested in activities. Miss J.'s affect throughout the interaction was positive. She smiled at her son and spoke to him in a positive way. There was no opportunity for affection during this interaction as both were engaged in play.

Baby J. almost always participated in the play interaction with his mother. He initiated almost all of the interactions by vocalizing, bringing items to his mother, or pointing to items of interest. Baby J.'s behavior during the interaction was rather unpredictable. He gained and lost interest in activities very quickly. Baby J. was very easily frustrated when his needs were not immediately met. He expressed this frustration with whining, crying, and tantrums. He had 2 tantrums during the 10-minute interaction. Baby J. paid attention to his mother throughout the interaction. He has strong communication skills and talked with his mother while he played. Baby J. directed the play interaction, but also participated in his mother's playful routines. During the 10-minute interaction Baby J. played with just 2 toys, bubbles and a ball. However, he and

his mother invented a variety of games to play with these objects to keep Baby J. entertained. Baby J.'s affect was variable throughout the interaction. At times, he laughed and smiled, at others he cried and had a tantrum.

### *Interview*

Miss J. also completed a parenting interview to assess her beliefs about herself as a parent and her beliefs about her child. Miss J. seemed comfortable throughout the hour-long interview and readily answered questions about her experience as a parent. Several themes emerged from this interview: 1) a realistic view of parenting; 2) shifting beliefs about her child; and 3) role reversal.

*Pregnancy.* First, Miss J. described her pregnancy. When asked about whether her pregnancy was planned, Miss J. said, "I was trying to get pregnant when I was younger, but it was unplanned." She explained that she had stopped wanting a baby just before she became pregnant. Miss J. reported feeling scared when she learned that she was pregnant and said that she cried because she didn't want to tell her mother. When asked about her parents' reaction to her pregnancy, Miss J. said that initially they did not want to talk about it. She told them she was pregnant just before they went to bed and they waited to talk to her until the morning. Miss J. left for school before her parents were awake in an effort to postpone the conversation. When they did finally talk, her father reportedly said, "you either need to get rid of it or move into a group home." Miss J. described her reaction to his statement by saying, "I freaked out. I didn't come home and I moved in with my boyfriend at the time. And then, I didn't talk to my mom forever and ended up moving in with my godmother. And then here."

Miss J. reported that she remained estranged from her parents until she was 8 months pregnant. At this time she said that her parents wanted her to come home and that they wanted to help her with the baby so she left the transitional home 1 month before her son was born. When asked about how she felt during her pregnancy, Miss J. said, "I was really happy, excited. I had a lot of friends helping me through it." When asked when her pregnancy felt real to her, Miss J. said, "Never really. When I would think about it, I was like, 'wow, how is this really possible? How am I pregnant?' It was never really real. I never really hit reality that I was a parent until I actually had to take him into surgery. I then was just like, 'wow, I'm really a parent.'" Miss J. said that her son was 14 months old at the time of the surgery.

Miss J. also talked about her birth experience. She said that she went 2 weeks past her due date and had to be induced. When the birth did not progress as planned, Miss J. had a Caesarean section. Her mother was with her when she gave birth. Miss J. said that she wasn't able to see her son for a long time after the birth because he had jaundice and was also having trouble breathing. She said, "I didn't get to see him until 2 in the morning and I had him at 8:05pm. Finally, I freaked out on the nurses." When asked about the first time she saw her son, Miss J. said, "It was kind of exciting. He was cute. It was so weird. He just kind of looked at me with his little eyes. I was like, 'oh, he is so cute,' and I cried. I was like, 'mom, he is so cute and he came out of my tummy.'"

*Realistic view of parenting.* Throughout the interview, Miss J. was able to talk honestly about the joys and challenges of parenting. When asked to describe parenting, Miss J. said it was, "fun, complicated, and exhausting." She said that she really liked, "having someone look up to me and rely on me." Miss J. was asked to give herself a

rating as a parent from 1 to 10 with 1 being the worst parent ever and 10 being the best. She gave herself an 8 and explained, "I'm good at staying calm and everything. Every once in a while I'll have a setback or raise my voice." When asked to talk about what she thought she was doing well as a parent, Miss J. said, "Teaching him and always being there, using a calm manner." When asked what she would like to change about her parenting, Miss J. said, "I want more of an imagination, kind of like guys would." She explained that she wished she were more creative with activities with her son. Miss J. seemed to have appropriate and realistic beliefs about herself as a parent. She was able to talk about her strengths, while also acknowledging that there is room for improvement.

Miss J. also spoke freely about the challenges involved in parenting a toddler. When asked what about her son's behavior was difficult for her to handle, Miss J. said, "The independent, I get into everything, do everything myself and screams and whines if it doesn't happen snap, snap, snap. And potty training." When asked what she felt like doing when her son was misbehaving, Miss J. said, "Screaming, because I can't figure out what he wants. I try everything and it doesn't stop. I just want to scream and have someone figure out what he wants."

*Shifting beliefs about her child.* It was evident throughout the interview that Miss J. and her son have a strong bond. She seemed to enjoy talking about her son and had many stories to share. When asked how she would describe her relationship with her son, Miss J. said, "very bonded." In spite of this strong bond, Miss J.'s beliefs about her child seemed to vary depending on what age she was asked to discuss. When asked to talk about what she thought about her son while she was pregnant, Miss J. said, "I thought he was going to be a nocturnal, wound up, very hyperactive kid because I swear he never

slept in my stomach, especially at night. He was always up kicking, squirming, everything. He purposely would shove his head into my rib. He was like, 'hey look at me, pay attention to me.'" When her son was born however, Miss J. described him as, "...the perfect baby. I was like, 'how do people have problems with parenting. This is so easy. I could have seven more babies.' Until he turned 2."

Miss J.'s description of her son in the present time was also both positive and negative. On several occasions during the interview, Miss J. talked about how smart her son was. She seemed very proud of his intelligence. She used the words, "temperamental, loving, energetic, sweet, and demanding" to describe her son and she was able to give examples of his behavior to explain her word choice. Miss J. was also asked to choose an age that she would like her son to be for an extended period of time. She replied, "I don't want him to get older yet. I don't want him the age he is. I'd prefer him to be like, 6 months. He was cute, he was cuddly, and he didn't cry unless he was hungry."

When asked whether she thought her son's personality was anything like her own, Miss J. said, "I get told that it is, but I don't see it. I think his demanding and knowing exactly what he wants maybe." When asked how she thought her son was different from her, she said, "His looks, his anger issues, his hyperactiveness, he's not shy, he's very outgoing, and I'm the complete opposite." At this time in Baby J.'s life, it seemed like his mother was able to talk honestly about both the positive and negative aspects of his personality. Baby J. was in the midst of a developmental stage that can be somewhat challenging for parents and Miss J. seemed to be struggling with her son's difficult behaviors. Although her description of her son seemed accurate given Baby J.'s

observed behavior, Miss J. seemed to attribute his negative behavior to internal characteristics rather than seeing it as age-appropriate and transient.

Miss J. also talked about her expectations, hopes, and fears for her son when he is a teenager and an adult. When asked what she worries about for her son she said, "...mental health. I have bi-polar issues and other people in the family do too. I know that he is going to have like, massive....crazy." She reported that she thought the most difficult time in her son's life would be the teenage years. Miss J. explained, "because there are temptations, there is pressure, mommy is the bad guy all the time.....I'm going to have to bail him out of jail." When asked what she thought her son would be like as a teenager, Miss J. said, "From the way he is now so much like his dad, he's probably going to be a little rebel.....I know he will never be a perfect student." Miss J. said that she hopes that as an adult her son will, "go to college, play football, become a head surgeon, get married, have kids, have a career, and make good money." It seemed that Miss J.'s hopes for her son were positive and potentially unrealistic, while her expectations for him were somewhat negative.

*Role Reversal.* At times it seemed that Miss J. relied on her son for emotional support. When Miss J. was asked to talk about her son's intelligence, she said, "He is way too smart. He knows everything." She explained this statement by saying, "One day I lost my cigarettes and I was kind of cranky. He grabbed one of my cigarettes, put it in my mouth, and goes, 'mama go smoke.' He looked at me and was like, 'lighter, mama go.' I was like, 'you're 2 years old, what are you doing?'" Miss J. used this example to illustrate her son's intelligence, but it also seemed like he was very perceptive of her state of mind and her needs.

Another possible indicator of role reversal occurred when Miss J. was asked to describe her son. One word she used was "loving." When asked to explain her word choice, Miss J. said, "If he notices that I'm sad, he will cuddle up to me and give me a kiss and go, 'mama sad.' I'll be like, 'yeah' and he will give me a kiss on the other cheek and go, 'you sweetheart.'" Miss J. seemed to view her son as a source of comfort when she is distressed, but it is unclear whether she expected such behavior of him.

Miss J. may also have viewed her son as more mature than he really is. When asked what she thought was special or unique about her son, Miss J. said that she thought his vocabulary and his ability to do a lot of things was special. She also said, "He kind of reminds me of a 2-year-old that acts like he is 13." Although Miss J. may have been saying that her son is very intelligent for his age, it is also possible that she views him as more of an adolescent than a toddler.

*Interview Summary.* Based on this interview, Miss J. and her son seemed to have a strong bond. Miss J. said that she wanted to be pregnant and that she was excited to be a mother. She shared many stories about her son and seemed to be genuinely proud of him in many ways. Throughout the interview, Miss J. interacted positively with her son and responded immediately to his signals. She seemed to be very honest during the interview and openly admitted to having difficulties as a parent at times. Although Miss J.'s love of her son was evident in this interview, she may have had some inappropriate expectations for him and may have viewed him in a slightly negative light at times.

#### Case III Intervention: Miss J.

The individual session component of Miss J.'s parenting intervention consisted of 3 major goals. These goals were chosen based on Miss J.'s pre-intervention assessment

results, input from program staff, and input from Miss J. The first goal, which was chosen by Miss J., was to work on potty training. Miss J. was very interested in beginning to potty train her son and it was thought that helping her achieve this goal in a sensitive way might in turn affect other interactions between her and her son. The second goal was to help Miss J. deal with her son's aggressive behavior. Baby J. had been aggressive at daycare and at the transitional home and Miss J. was struggling to handle his behavior in an appropriate way. Finally, the third goal was to increase the amounts of positive attention Miss J. gave to her son. It was thought that increasing positive attention might reduce the number and intensity of Baby J.'s temper tantrums and increase his mother's enjoyment in interacting with him.

Miss J. was very open to directly receiving parenting advice throughout the intervention. She had many questions about parenting and child development and frequently asked the experimenter for suggestions on how to handle her son's behaviors. Miss J. was also very honest about her feelings of frustration and the techniques she had been using to handle her son's difficult behaviors. She was willing to try most of the experimenter's suggestions at least one time.

Miss J. seemed to learn most easily when given vivid examples of children's behavior and adult responses to that behavior. For example, the experimenter often gave Miss J. examples of other children she had worked with and techniques that were successful for those children. Miss J. also responded very well to modeling, positive reinforcement of her parenting behavior, and positive reinforcement of her son's behavior. In contrast, Miss J. completely refused to try using video-feedback as a technique for improving her parenting. She felt very uncomfortable being video-recorded

and was unwilling to watch herself on tape. The experimenter tried on several occasions to encourage Miss J. to try the video-feedback, but she was adamant in her refusal. The experimenter chose to use other methods rather than alienate Miss J.

Goal one, sensitive potty training was addressed in several ways. Miss J. was very excited about working on toilet training and had approached the experimenter for help with this issue immediately upon meeting. First, the experimenter and Miss J. talked about her goals for potty training. Miss J. said that she had been working on potty training Baby J. and that things were going well until they moved to the transitional home. Miss J. was confused by her son's apparent loss of potty training abilities. The experimenter and Miss J. talked about how transitions, especially transitions that are somewhat stressful, could have an effect on children's developing skills.

After talking with Miss J., it seemed that some components of her approach to potty training were appropriate. For example, she rewarded her son for successes and did not punish him for failures. However, it also seemed that she might have needed more information, so the experimenter brought Miss J. a handout on potty training. The handout included signs of readiness for toilet training, skills children need to be toilet trained, and techniques for sensitively introducing toilet training. The experimenter suspected that Baby J. might not be quite ready to begin toilet training, but wanted Miss J. to come to that conclusion herself. As Miss J. and the experimenter went over the handout together, Miss J. seemed to realize that it might be a little early for toilet training. She agreed keep working on toilet training, but at her son's pace and with the expectation that it might take a long time before he is fully potty trained.

This discussion about toilet training became a larger discussion about following her son's lead in a variety of situations. Miss J. and the experimenter talked about how children give a variety of signs that they are ready to progress to a different developmental task. They talked about how it was important to follow the child's lead rather than rush them into something before they are ready. They also talked about how it can be frustrating for both children and parents if parents try to push children to develop new skills before they are ready. Miss J. described being very excited when her son learned new things and proud of him for his intelligence. The experimenter recognized that it can be difficult for parents to be patient as new abilities slowly emerge and praised Miss J.'s interest in her son's development.

Goal 2, helping Miss J. manage her son's aggressive behaviors was addressed in a variety of ways throughout the intervention. Although Miss J. had been very forthcoming with a great deal of information, she was reluctant to talk about her son's aggression and did not bring up this issue herself with the experimenter. Rather, the staff at the transitional home reported that Baby J. had been aggressive towards other children at daycare and at the transitional home. Daycare staff reported that Baby J. was intentionally aggressive toward infants in particular. Staff said that when Baby J. was unattended, he would bite, kick, hit, pull ears or hair, or lie on infants until the other infant cried. Baby J. was given a brief time out as punishment at daycare and staff talked to him about why his behavior was inappropriate. Staff at the transitional home observed similar behaviors and reported that Miss J. would either get very mad and yell at her son or not address the behavior at all.

The experimenter was able to address Baby J.'s aggressive behavior on the third home visit. Miss J. was rather unfocused during the session and told the experimenter that she and her son had had a rough weekend. When asked to explain, Miss J. said that her son's godmother had been attacked by a roommate while babysitting Baby J. The police were involved and Miss J. had to pick up her son at the police station where his godmother was filing a complaint. Miss J. was very angry about the situation and very focused on getting even with the assailant. The experimenter asked Miss J. how Baby J. reacted to his experience. Miss J. said that her son had seen several similarly traumatizing events and she did not seem to view such events as damaging to her son. The experimenter asked Miss J. what she thought her son might be thinking or feeling as he witnessed such events. Miss J. laughed and said that her son called the woman who attacked his godmother a bitch, but did not talk about his thoughts or feelings.

Since Miss J. was unable to talk about how her son might feel about his experience, the experimenter asked Miss J. to talk about how other children, who had never seen violence before, might feel the first time they witnessed someone being attacked. Miss J. was able to talk about how these kids might feel scared or confused. She said they might not understand what was happening. The experimenter then brought up the concept of modeling and told Miss J. that children who observe the aggressive behavior of others are sometimes more likely to behave aggressively themselves. The experimenter then asked Miss J. whether Baby J. had been aggressive at daycare or at the transitional home.

Miss J. finally told the experimenter about her son's aggressive behavior. She said that she was not sure why Baby J. was so aggressive with infants and that she did not

know how to handle his behavior. Miss J. said that she felt the staff at daycare thought that she was a bad mother and that her son was a bad kid. The experimenter told Miss J. that some aggressive behavior is common in toddlers and reassured her that Baby J. was not a bad kid. They talked about reasons why children behave aggressively such as frustration and attention seeking. Miss J. thought that Baby J. might be behaving aggressively to get attention since most of his attacks occurred when daycare staff was not paying attention to him. Miss J. also worried that Baby J.'s aggression might be an early sign of mental illness given her family history of mental illness.

After talking about potential causes of Baby J.'s aggression, the experimenter and Miss J. talked about ways to handle Baby J.'s aggressive behavior. Miss J. reported that when Baby J. was aggressive, she responded by raising her voice so that he knows she is serious and then lightly smacking his bottom. The experimenter asked Miss J. whether she thought this method was effective and Miss J. said that it was because he seemed to pay more attention to her when she raised her voice. Miss J. said that she felt that this method was more effective than time out or reasoning with him. The experimenter challenged Miss J. and asked her whether she thought either method was very effective if Baby J.'s aggressive behavior had not decreased. Miss J. then admitted to knowing that spanking was not the best method for handling her son's aggressive behavior. She was able to tell the experimenter many of the reasons that spanking is inappropriate, but she did not think that other methods would work either.

The experimenter and Miss J. tried a variety of methods for decreasing Baby J.'s aggressive behavior over the course of the intervention. One effective technique was to be preventative. For example, Miss J. was encouraged to engage Baby J. in an activity,

before becoming engaged in activity herself. When Baby J. was occupied in an interesting activity, he was much less likely to seek attention through aggressive behavior, which allowed Miss J. to focus her attention on other tasks. Although difficult for Miss J., she reported that Baby J. was much less aggressive when occupied with an activity. The experimenter also suggested that staff at daycare might involve Baby J. in daily tasks as a helper to reduce the amount of time he was left unoccupied. The experimenter and Miss J. also talked about ways to respond when Baby J. was aggressive. Miss J. agreed to temporarily eliminate spanking as a response while trying the other methods. One effective response was comforting the victim. It was thought that if Baby J. was being aggressive to get attention, taking attention away from him and giving attention to the victim might decrease his aggressive behavior. Miss J. really liked this approach and was able to relate to the idea of acting out to get attention.

Over the course of the intervention, Miss J. and the experimenter continued to talk about Baby J.'s aggressive behavior. His aggressive behavior at the transitional home decreased over time, but his aggression at daycare remained stable. Interestingly, Baby J. was aware of his aggressive behavior and able to talk about it afterwards. For example, when prompted by Miss J., Baby J. would often tell the experimenter about a particular act of aggression that he had committed on a particular day; i.e. "I bit Baby Stella today." Baby J. was able to talk about his behavior as well as his punishment, "I did time out," but could not talk about why he had been aggressive. The experimenter encouraged Miss J. to talk with the daycare staff and to share ideas with them on how to handle Baby J.'s behavior. Miss J. said that she did not think the daycare would listen to her and that she did not feel comfortable talking with them. At the daycare staff's request, Miss J. signed

a release so that they could talk to the experimenter about Baby J.'s aggressive behavior; however, the daycare staff never contacted the experimenter.

Limit setting, discipline, and punishment were also topics covered over 2 group sessions. During these sessions, the mothers discussed the difference between setting limits, punishment, and discipline. They talked with each other about their children's difficult behaviors and how they were handling such behaviors. Miss J. really seemed to enjoy these sessions. She had a lot of examples of problem behaviors to share with the group. The mothers were also given scenarios of children's difficult behaviors and were asked to come up with a variety of responses. Miss J. contributed a great deal to this discussion and responded positively to advice given by her peers.

Goal 3, encouraging Miss J. to give her son positive attention was addressed throughout the intervention in a variety of ways. Although Miss J. gave her son a great deal of attention, much of it was negative and in response to Baby J.'s tantrums or aggressive behavior. There seemed to be several reasons that Baby J. was not receiving much positive attention. First, there were many distractions in Miss J.'s life that competed for attention with Baby J. As mentioned previously, there were a number of stressors in Miss J.'s life that may have made it difficult for her to give Baby J. the attention he needed. Another possibility was that at the transitional home, other residents, staff, and activities frequently occupied Miss J. Baby J. spent a great deal of time with his mother, but her attention was often elsewhere unless he misbehaved.

Another possible reason that Miss J. was not giving Baby J. the positive attention that he needed was that Baby J. was rather difficult to engage in play for extended amounts of time. He frequently became bored with an activity after only a few minutes

and then whined or had a tantrum until he could be engaged again. Miss J. was very good at trying to engage Baby J. in play and at modifying activities to make them more interesting; however, play with Baby J. appeared to be rather frustrating for her. Although Miss J. was able to stay calm in the face of her son's tantrums, neither seemed to be enjoying the interaction, and Miss J. would eventually turn her attentions to more rewarding tasks.

One simple solution to the problem of engaging Baby J. was to bring fun activities that mother and baby could enjoy together. For example, the experimenter brought materials to make kool-aid play dough during an individual session. Miss J. was very excited about this activity and tried to engage her son in making play dough. Baby J. briefly helped stir the ingredients before moving on to play with another toy. Miss J. appropriately took a break from play dough making and tried to join her son in play. He ignored her attempts to join him, so she tried to interest him in the play dough. After a few minutes of play with the play dough, Baby J. began to whine. Miss J. tried to get him interested in another activity and he began to cry and throw toys at her. Miss J. remained calm, but turned her attention to another resident. Once Baby J. calmed down, the experimenter was able to engage him in play with the play dough. Although Miss J. stayed in the room with her son, she did not return to the interaction until it was time for the experimenter to leave and Baby J. had another tantrum.

The experimenter continued to bring toys or activities to try to engage Baby J. in play with his mother. Eventually, the experimenter and Miss J. discovered that Baby J. liked very simple activities like stacking blocks, playing ball, or having a tea party. At times, Baby J. accepted his mother's bids to join him in play, at other times he wanted to

play independently or only with the experimenter. Miss J. was obviously hurt by his rejection. She reported that Baby J. had been pushing her away lately and that he wouldn't let her do anything for him. Miss J. said that she knew his behavior was normal, but that it still hurt her feelings.

The experimenter and Miss J. talked about how even though Baby J. was more independent in many ways, he still needed his mother even though he seemed to be pushing her away. Miss J.'s tendency when rejected by her son was to leave him to his own devices until he acted out and required punishment. The experimenter suggested that maybe Baby J.'s acting out was his way of getting Miss J.'s attention since she always reacted to such behaviors. Miss J. and the experimenter talked about ways to give Baby J. autonomy, while also staying involved in the interaction. Miss J. seemed to understand that Baby J.'s rejection of her was not personal. She also acknowledged that when he was tired or upset, he went to her to be comforted.

Another technique used to increase the amount of positive attention Miss J. gave Baby J. was modeling. Baby J. frequently wanted to play with the experimenter during individual sessions, which gave the experimenter the opportunity to model such behaviors as following baby's lead in play and dividing attention between adult conversations and play with Baby J. Dividing her attention was a skill that Miss J. really needed to work on as she was incredibly sociable and frequently engaged in conversations with other residents. Miss J. was able to admit that most of Baby J.'s aggressive behaviors or tantrums occurred when she was not paying attention to him. Although she was concerned that it might be rude to take attention away from an adult conversation to interact with her child, the experimenter reassured her that such behavior

was part of being a good parent. The experimenter also encouraged Miss J. to serve as a model to other residents, who also needed to learn this skill.

A final technique used to increase the amount of positive attention Miss J. gave to Baby J. was positive reinforcement of both Miss J.'s parenting behavior and her son's behavior. Miss J., like many mothers responded well to compliments of her parenting abilities. When complimented, Miss J. would often be incredibly attentive to her son for a short time following the compliment. Miss J. was also proud of Baby J. and enjoyed hearing compliments about her son. When engaged in play with Baby J., the experimenter would often get Miss J.'s attention by commenting upon her son's behavior. (For example, "Oh, my goodness, he just counted to 5. I can't believe he can do that already.") Miss J. would respond to these compliments by giving her son attention and encouraging him to repeat the act for which he had been praised.

#### Case III Post-Assessment Results: Miss J.

##### *Demographics*

Miss J. completed a variety of post-assessments, including a demographic questionnaire, at the end of the 8-week intervention. Miss J. completed these assessments at the Parent/Infant Lab in Corbin Hall at the University of Montana since she was no longer residing at the transitional home. Miss J. and Baby J. were in a positive mood during the assessments. At the time of these assessments, Miss J. was 19 years old and her son was 31 months old. She had recently ended her relationship with her son's father and was currently looking for new housing. She reported that she would be attending college in the fall and that she was currently looking for employment. Baby J. was still attending daycare 5 days per week.

*AAPI*

All but one of Miss J.'s scores on form B of the AAPI-2 reflected positive nurturing parenting. Her scores increased on 2 of the subscales, decreased on 2 of the subscales, and stayed the same on 1 subscale. She scored a 10 on inappropriate expectations, which indicated a realistic understanding of the capacities and limitations of children. She scored a 7 on lack of empathy, which indicated that she was sensitive to the needs of children. Her score on physical punishment was an 8, which indicated that she valued positive discipline practices. Her score on role reversal was a 10, which indicated an understanding and acceptance of the needs of children. Finally, she scored a 5 on power and independence, which suggested that she might struggle with balancing children's feelings of empowerment with obedience.

*Child Development Quiz*

Miss J. missed only one question on the child development quiz. She incorrectly answered the following question: most babies usually say their first words between 9 and 12 months. Miss J. also missed this question on the pre-assessment quiz. Her score on the post-assessment quiz was 3 points higher than her previous score.

*Free Play*

Miss J. and her son were recorded during a 10-minute free play interaction. Miss J. almost always participated in play with her son. She allowed her son to direct the play and for the most part did not interfere or interrupt his play when he was appropriately engaged. She introduced toys or activities appropriately when he began losing interest. Miss J.'s behavior was predictable and sensitive throughout the interaction and she was able to recognize her son's signals and modify her behavior appropriately. Miss J.

directed intentional communication to her son throughout the play interaction. She talked about what they were doing and asked him questions about colors and numbers to help him learn these concepts. Miss J. interpreted her son's behavior as having communicative intent.

Miss J. did a great job providing playful routines for her son during the interaction. She suggested that they build a tower of blocks for him to knock down with his truck and he seemed to really enjoy this activity. Miss J. was also able to modify activities to keep Baby J.'s interest. Miss J. took turns in play with her son throughout the interaction and imitated what he said. Her affect was positive throughout and she smiled frequently during the interaction.

Baby J. almost always participated in social interactions with his mother. He initiated most activities by telling his mother what he would like or by bringing her a toy. His behaviors during the interaction were consistent and predictable. Baby J. paid attention to his mother throughout the interaction and frequently responded to her social initiations. He verbally communicated with his mother throughout the interaction, most often to express his wants. Baby J. played with a variety of toys during the interaction and often participated in his mother's playful routines. He verbally imitated his mother when she identified objects for him. Baby J.'s affect was positive throughout and he laughed and smiled at his mother. He did not whine or have any tantrums during the interaction, even when his mother set limits on his behavior.

#### *Interview*

Miss J. completed a briefer version of the original parenting interview as a post-intervention assessment of her beliefs and expectations about her child and about

parenting. This interview also included questions regarding Miss J.'s experience with the 8-week parenting intervention. Several themes emerged from this interview: 1) stressful life circumstances 2) changes in her son; 3) changes in parenting; and 4) thoughts on the intervention.

*Stressful life circumstances.* At the beginning of the interview, Miss J. was asked to comment upon recent changes in her life. One significant change since the beginning of the intervention was that Miss J. was no longer residing at the transitional home. When asked why she left the home, Miss J. gave several reasons. First, she said that she had come to the transitional home because, "I needed help getting stuff ready to go to college. I knew they would help. It kind of felt like home." After receiving help with college, Miss J. felt that she no longer needed to live at the home. Miss J. also said that she left because program staff, "...tried to tell me who I could and couldn't see, who was allowed around my kid and who was not."

Miss J. described the differences in her life by saying, "It's much more crazy." When asked to elaborate, Miss J. said that she was taking care of her little sister, who is pregnant with her first baby. She also reported that she had recently broken up with Baby J.'s father, who had been her boyfriend for 3 years. Because of the breakup, Miss J. needed to find somewhere else to live. She said that she was hoping to obtain student housing because she did not know where else she could live. She also said that she was welcome to live with her mother, but since her mother lives out of town, the commute would be too expensive. Miss J. talked about feeling stressed by her lack of employment. She had been trying to get a job, without success for several months and reported being concerned about her ability to pay her bills. One positive change was that Miss J. was

enrolled in college for the fall semester. Although she was excited, Miss J. also reported that she was, "nervous nauseous" about beginning school.

*Changes in her son.* In addition to changes in her life circumstances, Miss J. also reported that her son had changed over the last few months. Miss J. mentioned several times that her son has become more independent. She also said that his vocabulary has increased dramatically. One major change was that Miss J. reported that her son, "...doesn't throw tantrums too much lately." When asked what she thought contributed to this decrease in tantrums, Miss J. said, "I have no idea. I think I'm handling it much better." She explained that she usually ignored the tantrums or mimicked her son as he was having them, rather than getting upset with him. She said that when she mimicked him, both often ended up laughing. Miss J. also reported that Baby J. was much less aggressive at daycare. She said that the frequency and intensity of his aggression toward infants has decreased. When asked why she thought this behavior had changed, Miss J. was again unsure.

*Changes in parenting.* When asked whether her parenting has changed over the last few months, Miss J. said, "Yeah, because my kid has calmed down a lot." When asked to elaborate, Miss J. explained, "He's not so mama demanding, so it's not as stressful. It is easier for me to be calm about things." When asked about the changes she has made as a parent, Miss J. talked instead about changes in her son. She said, "Yeah, he doesn't want to be held. He is more independent. I can't do everything for him. I miss it." It seemed that while her son's independence has made him less demanding and parenting less stressful, Miss J. might miss his dependence upon her. When asked whether she thought parenting was easier or more difficult at this time, Miss J. replied, "Far more

difficult." When asked to explain, she said, "You can't just feed him, change his diaper, hold him, and put him to bed. He kicks and screams, 'no, no, no, mama, no.' They get into everything. You can't just plop them in a swing and say goodnight."

As in the first interview, Miss J. provided a rating of herself as a parent on a scale of 1 to 10. She gave herself a 7 this time and explained, "Because I do ok, as good as I can. I guess he's happy, so I do a pretty good job. But I think there are some things I can improve on." Miss J. seemed to have a realistic perception of her parenting skills, and an understanding of her strengths and weaknesses as a mother. When asked to talk about what it is like to be Baby J.'s mom, Miss J. said, "Sometimes I find it very hard.....Sometimes it may be frustrating and hard, but I would be lost without him." Miss J. seemed to answer questions about parenting honestly, rather than idealistically.

*Thoughts on the intervention.* Finally, Miss J. was asked several questions about the parenting intervention she had participated in. When asked whether she thought the intervention was helpful, she said, "It was pretty helpful. It helped me learn all kinds of stuff." Miss J. said that she learned about, "...potty training, discipline, setting limits, letting him tell me what he wants and needs....you didn't judge me or make me feel like I didn't know what I was talking about. You didn't make me feel like a bad mom." Miss J. thought that both the individual and group components of the intervention were helpful. When asked what she liked about the group, Miss J. said, "The good sense of humor. I also liked the mix of activities and time to just talk to you and the other moms. And the snacks." Miss J. did not have any suggestions for improving the group or individual sessions. In addition, she felt strongly that the intervention should not be implemented by program staff, instead the interventionist should be someone neutral, such as a student.

She said, "(the transitional home) should do it (the intervention), but not the staff."

Overall, it seemed that Miss J.'s experience with the intervention was a positive one.

*Interview summary.* Although Miss J.'s life seemed to be rather stressful and chaotic at the time of the interview, she seemed to have a positive view of herself as a parent and of her son. She expressed that parenting her son was less stressful given the changes in his behavior, but that parenting a toddler was much more difficult than parenting an infant. Miss J. was able to talk honestly about the changes in her son's behavior and the challenges such changes may present for her parenting. Miss J. seemed to view the intervention as helpful and her experience with the intervention seemed to be positive.

#### Case III Discussion: Miss J.

In many ways, Miss J.'s life had become more chaotic since the beginning of the intervention. However, in spite of this chaos, Miss J. continued to participate in the intervention and continued working to improve her parenting. Miss J. attended all individual sessions and 3 of the 8 group sessions. She requested that the experimenter keep working with her after the completion of the intervention.

Miss J.'s parenting seemed to change in small ways throughout the course of the intervention. Initially, she was struggling to effectively parent a very intelligent and volatile toddler. Her most frequent response to her son's challenging behaviors was to raise her voice, spank him, or disengage. Miss J. learned many new, more developmentally appropriate techniques over the course of the intervention. Although it is unlikely that she will never spank her son again, at the very least, Miss J. has more options for handling her son's behavior.

Throughout the course of the intervention, Baby J.'s behavior changed in important ways. The frequency and intensity of his temper tantrums dramatically decreased. He was easier to engage in activities and able to play somewhat independently for longer periods of time. His aggression at daycare also decreased in both frequency and severity. Miss J. was unable to explain these changes in her son. Given the multiple transitions he has experienced in the last few weeks, such positive behavior changes are unexpected. However, Miss J. did say that she was able to be calmer around her son, which might be contributing to the changes observed in Baby J.

Miss J. and Baby J. would benefit from continued intervention. The intensity of Baby J.'s behaviors would be difficult for many parents to handle and Miss J. is likely to need support in parenting her son, especially when her own life is rather chaotic. It is possible that given such stress, Miss J. might revert to using physical punishment to discipline her son. In spite of their difficulties, Miss J. and her son seem to have a close, affectionate relationship. Miss J. is very proud of her son and seems to genuinely enjoy his company. Future interventions might be directed at helping Miss J. find alternative sources of emotional support so that she does not need to rely on Baby J. to comfort her when she is upset.

### General Discussion

#### *Implications*

There are several important implications of this study. First and foremost, this study provides implications for effective intervention strategies with teen mothers. Although it is not possible to determine whether the intervention alone was responsible, all mothers participating in the intervention showed improvements in some of the areas

assessed. For most mothers, the area of greatest improvement was in their free play interactions. Video-recorded free play interactions were used as a measure of maternal responsiveness in playful interactions. Scores on this measure support hypothesis 2 of this study, that mothers participating in a parenting intervention will show improvements in maternal responsiveness. In contrast, mothers' knowledge of child development as assessed by a basic child development quiz, decreased for some participants. Such a decrease may have occurred due to the intervention focus on individual rather than overall child development. Finally, expectations and beliefs as assessed by the AAPI-2, both worsened and improved depending both on the construct assessed and on the individual participant. Thus, it seems that Hypotheses 1 and 3 were not uniformly supported.

Although the participants in this study did not improve in all domains assessed, their participation and interest in the intervention should also be considered when evaluating the success of the intervention. All of the mothers participating in this study consistently and enthusiastically attended most of the individual sessions. When sessions were missed, all of the mothers readily re-scheduled their appointments with the experimenter. Most importantly, all of the mothers wanted the intervention to continue beyond the 8 weeks and all felt that the transitional home should implement such a program, which suggests that they felt that the intervention was beneficial.

The results of this study suggest a gap between what participants knew and what they actually did. Most of the mothers scored well on pre- and post- assessment measures of knowledge of child development and risk for abuse (AAPI-2). However, a different picture emerged from an examination of their interview responses and free play

interactions. It is possible that some of the measures such as the child development quiz and AAPI-2 were inadequate assessments of the constructs of interest. Specifically, it may have been too easy for participants to determine the right answer, regardless of whether they actually believed the answer to be true. In other words, it is possible that they did not really have the knowledge indicated by the test scores.

Another likely explanation for the gap between participant reports and actual behavior is that the teen mothers in this study had the knowledge indicated by the test scores, but that something at a deeper, psychological level was interfering with their ability to apply this knowledge in daily interactions with their children. When attempting to determine the source of this interference, a number of possibilities emerge. First, the developmental stage of adolescence, characterized by egocentrism, might lead these mothers to be so self-focused that they cannot apply what they know to be appropriate parenting behaviors if the cost to themselves is too high. Another possibility is that the daily stresses associated with adolescent parenting such as completing school, forming and maintaining peer relationships, and becoming self sufficient interfere with young mothers' ability to apply what they know about parenting. A final potential explanation is that young mothers' representations of parenting, or their own attachment styles, might create a disconnect between what they know and what they do.

When attempting to determine which aspects of the intervention seemed to be the most effective, several possibilities emerge. It seemed that the most important component of this intervention was the relationship between the experimenter and the participants. This relationship was important for several reasons. First, it provided a model of a consistent, caring relationship for young women who may not have experienced such

relationships with other adults. It is hoped that this model relationship between the experimenter and each adolescent mother will be applied to participants' own relationships with their children.

Several factors seemed to contribute to the formation of this relationship. First, rather than simply giving parenting advice, the experimenter approached the intervention as a process of discovery in which both parties learn from each other. The experimenter viewed the participants as experts on their child and conveyed this view to them. It was also very important to provide parenting advice indirectly for some of the mothers who became quite defensive when they perceived that someone was telling them what to do with their child. Finally, given the lack of confidence of some of the participants, approaching the mothers in an accepting and non-judgmental manner may have helped them feel more comfortable sharing their experiences with the experimenter. Such a relationship also made it possible for the mothers to receive advice about their parenting in a non-threatening way.

Another important element of this intervention was an appreciation of the developmental status of the participating adolescent mothers and an understanding of how this status may contribute to observed parenting behaviors. Many of the goals of this intervention such as having appropriate expectations, providing responsive care, and focusing attention on infants seem to be directly in contrast to the developmental status of adolescents. The egocentrism described by Piaget as characteristic of adolescent thought may have made it difficult for the teen mothers in this study to put the needs of their children before their own needs. In addition, the cynical view that adolescents often hold of adults and authority figures is important to consider when interventionists hope to

promote positive parenting among this young population (Piaget, 1972). It may be that taking such an indirect approach to addressing the participants' parenting issues was successful because the adolescent mothers did not perceive such advice as a threat.

Adolescent mothers are forced into the adult role of parent, while at the same time attempting to master the challenges of adolescence. One of these challenges is shifting from relationships in which they primarily receive care to those in which they primarily give care (Erikson, 1960). Adolescent mothers must make this transition quickly if they are to be responsive parents and will likely need a great deal of support in order to achieve this goal. It is also possible that adolescent mothers are still trying to form a cohesive representation of their own childhood experiences, which may make it difficult for them to respond consistently and appropriately to the needs of their infants.

Given the developmental status of adolescents and the risk factors associated with adolescent parenting, interventions that occur at such an early stage in parent-infant relationships can have a great impact. Such interventions are thought to be particularly effective when they are initiated before maladaptive patterns are able to take hold, before parents begin to feel like failures, and before children experience truly bad parenting. Over time, such improvements could decrease the likelihood of occurrence of common negative outcomes among the children of adolescent mothers (insecure attachments, lower cognitive abilities, behavior problems, increased likelihood of becoming teen parents, etc.).

One element of this intervention that did not seem to be terribly effective was the use of video-feedback. Video-feedback was used with 2 out of the 3 adolescent mothers participating in this study. Video-feedback was somewhat useful for Miss O. who was

able to comment with some insight into her interaction with her son. However, she seemed more focused on her own appearance while watching the video and needed to be reminded that the purpose of video-feedback was to reflect upon her interaction with her son. It is possible that such a pre-occupation with one's looks, which is common among adolescent girls, might interfere with teen mothers' ability to effectively reflect upon their parenting behavior during video-feedback. Video-feedback was even less successful with Miss M., who was only able to describe the activity she was engaged in (i.e., "I'm just changing a diaper"). Even with prompting, Miss M. was unable to articulate how she or her daughter felt during the interaction. Further, Miss M. did not seem to have any insight into her behavior and the impact of such behavior on her daughter. It is possible that the reflective capacities and cognitive abilities necessary for effective video-feedback had not yet developed in some of the mothers participating in this study. Video-feedback may prove to be useful with adolescent mothers with some modifications to suit their cognitive abilities and developmental status.

In addition to implications for interventions with teen mothers, this research also had important implications for the transitional home. The goal of this project was to design and implement an intervention that could meet the unique needs of the residents of the home, and that could be implemented by program staff. At the end of the intervention, the experimenter presented the results of the intervention to the Executive Director, along with recommendations for implementing such an intervention. The experimenter recommended that the transitional home include such a relationship-based intervention as a component of the services offered, based on the results of this study and feedback provided by participants.

The experimenter also recommended that the transitional home hire someone other than staff providing direct care to implement the intervention; this recommendation was also based on the feedback provided by the mothers participating in this study. Although the experimenter provided training for direct care staff, focusing on the ways they might promote positive parenting in daily interactions with the mothers, it seemed best to have someone neutral provide the actual interventions in the future. The Executive Director was very receptive to the feedback given and expressed that the transitional home will likely implement the intervention. Such an intervention fills a gap in the services provided by this organization, and creates a model for other transitional homes across the country.

Finally, this research adds to the literature on teen parenting by examining a unique group of adolescents that are not well represented in the literature. Although the number of transitional homes for teen parents is increasing (personal communication with Executive Director of transitional home) very little is known about this group of parents and infants. It seemed that the participants in this study may have known more about child development than previous studies with adolescent mothers living with parents or partners have suggested. It is possible that given the intense needs of this population, such mothers have received more parenting education than other young mothers. It is important to increase our understanding of the particular issues this group of young families faces and to design interventions to reduce the likelihood of poor outcomes for homeless teens and their children.

#### *Limitations*

One major limitation of this study is that of a small sample size. Given the transient nature of this population of young women, it was difficult to obtain a large sample of participants. Another limitation is that the sample was not terribly diverse given the location of the home within a somewhat rural area, thus results from this study will not be able to be generalized to the larger population of homeless teen mothers. Experimenter bias may also be considered a limitation in this study. Given the experimenter's dual role of interventionist and researcher, the potential exists for bias in assessing the results. On the other hand, the experimenter's close contact with the participants allowed for a more detailed and in-depth description of the participants and the process of intervention with adolescent mothers.

In addition to bias and sampling limitations, another limitation of this study is that given the variety of other services teen mothers living at the transitional home are receiving, it is difficult to determine whether changes in parenting behavior can be attributed to the intervention. It is also difficult to determine which effects are due to the intervention itself and which are due to the social support inherent in weekly group and one-on-one sessions. A final potential limitation is that neither maternal nor infant attachment status was assessed in this study. Therefore, no conclusions can be made about whether an intervention targeting maternal responsiveness might alter attachment classifications.

#### *Future Research*

Future research should address the limitations of the current study, particularly by increasing the sample size. Such an increase might be possible if subjects were recruited from a variety of transitional homes for adolescent mothers or from a broader

geographical base. Another important direction for future research would be to assess the attachment status of both mothers and infants prior to the start of the intervention and again at the completion of the intervention. This would allow for an examination of changes in attachment status that may occur as a result of the intervention. Pre- and post-intervention assessments of attachment status are common elements in many large-scale intervention studies (Dozier, Lindhiem, & Ackerman, 2005; Egeland & Erickson, 2004; Marvin et al., 2002). In order to more clearly examine the effectiveness of the parenting intervention, it may be useful to create intervention and control groups from mothers currently living at the transitional home. Such comparisons would allow for greater control and a clearer understanding of intervention-related effects. It would also be important to reduce experimenter bias by separating the role of researcher and intervention provider. Future research might also be directed at a comparison of homeless adolescent mothers and homeless adult mothers, in an effort to determine whether age-related factors account for observed outcomes for adolescent parents and their children, or whether the stresses associated with homelessness contribute more to the variation in outcomes.

In addition to implications for future research, this study provides implications for future interventions with homeless adolescent mothers. For interventions such as this one to be successful, interventionists must help young mothers bridge the gap between what they know and what they do. The young mothers in this study violated expectations based on a large body of research on adolescent parenting, scoring higher than expected on pre-assessment measures of knowledge of child development, responsiveness, and appropriate expectations. However, such scores were often not accurate reflections of

actual behavior with their children. Future research should be directed at determining the factors that interfere with young mothers' ability to apply what they know to interactions with their children. Once these factors are identified, future interventions must be directed at helping these young mothers minimize the gap between what they know and what they do.

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Appendix A

**Background Information**

Participant ID: \_\_\_\_\_ Participant D.O.B: \_\_\_\_\_

Current Age: \_\_\_\_\_ Age at First Pregnancy: \_\_\_\_\_

Number of times pregnant: \_\_\_\_\_ Number of live births: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Child's D.O.B or Due Date: \_\_\_\_\_

Current relationship with your child's father: \_\_\_\_\_

Marital status: \_\_\_\_\_

Length of time with current partner: \_\_\_\_\_

Do you consider yourself or your child to be of a cultural heritage other than Caucasian? \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

Plans for future education: \_\_\_\_\_

Are you employed or attending school? \_\_\_\_\_

What type of work do you do? (full time or part time) \_\_\_\_\_

Length of time at transitional home: \_\_\_\_\_

Does the child have any health related problems? If yes, please describe.  
\_\_\_\_\_

Were there any complications during your child's birth? If yes, please describe.  
\_\_\_\_\_

Was your child born premature: \_\_\_\_\_  
If yes, gestational age at birth: \_\_\_\_\_

Do you and your child receive services other than those provided by Transitional Home? \_\_\_\_\_

## Appendix B

**Child Development Quiz**

*Please circle whether you agree or disagree with each statement.*

1. Most babies usually say their first words between 9 and 12 months. Agree / Disagree
2. A two-year-old should know how to share. Agree / Disagree
3. Young infants should be placed on their back to sleep. Agree / Disagree
4. Babies usually take their first steps at 6 months. Agree / Disagree
5. Babies usually first start eating solid food when they are 1 year old. Agree / Disagree
6. Babies usually first crawl between 6 and 9 months. Agree / Disagree
7. A baby's temperament is when they misbehave. Agree / Disagree
8. Babies can sit up without support when they are 2 months old. Agree / Disagree
9. Children can be expected to potty train themselves by the time they are 2.  
Agree / Disagree
10. If parents pick up a crying baby, the baby will learn to cry more. Agree / Disagree
11. Two year olds can be expected to behave in a store while their mother is shopping  
Agree / Disagree
12. It is completely normal for young children to cry when their mother leaves.  
Agree / Disagree
13. Young children should be able to use a fork, knife, and spoon to feed themselves by  
the time they are 2 years old. Agree / Disagree
14. Young children don't understand the meaning of violence or swearing on TV so it is  
OK for them to watch it. Agree / Disagree
15. 1 year olds understand when their moms are sad and can comfort them.  
Agree / Disagree
16. Young infants like to look at faces and black and white objects. Agree / Disagree

## Appendix C

## Parent Interview Questions

I am interested in learning about how parents think and feel about their young children. This interview is a way for me to ask you about \_\_\_\_\_'s development and your relationship with him/her. The interview will take us about an hour to complete.

1. First, I'd like you to tell me about \_\_\_\_\_'s development.

**Let's start with your pregnancy.** Was your pregnancy planned or unplanned? How did you feel when you found out? How did you feel physically/emotionally during the pregnancy? When did the pregnancy seem really to you? What did you think (impressions) of \_\_\_\_\_ during pregnancy? What did you think \_\_\_\_\_ might be like?

**Tell me about labor and delivery.** (give time to respond). How were you feeling? What was your reaction when you first saw \_\_\_\_\_? Did you know you were having a boy/girl? How did you feel about that? How did your family react after the birth?

**Birth Complications.** Did \_\_\_\_\_ have any problems in the first few days after birth? How soon were you discharged from the hospital? Did you get to go home together? Did you decide to breast or bottle feed.

What were the first few weeks at home like? What about his sleeping, feeding, crying, etc.?

Tell me about \_\_\_\_\_'s developmental milestones such as sitting up, crawling, walking, smiling, talking, etc. Do you have any sense of \_\_\_\_\_'s intelligence?

Does \_\_\_\_\_ seem to have a regular routine? When did this start? What happens if you don't follow it?

How does \_\_\_\_\_ react to separations from you? Were there any longer separations (more than 1 day)? How did he/she react? How was it for you? How did you feel? What did you do?

2. **Could you describe your impressions of \_\_\_\_\_'s personality now (what is he like).**

Pick 5 words to describe your child's personality. After you tell me each one, I will ask you about each one. For each, what is it about him/her that makes you say that? Then give at least one specific incident to describe what you mean.

3. At this point, who does \_\_\_\_\_ remind you of? In what ways? In what ways is \_\_\_\_\_'s personality like yours? Unlike yours?

How did you decide on \_\_\_\_\_'s name?

4. What do you feel is unique, different, or special about \_\_\_\_\_ compared to other children?

5. What about \_\_\_\_\_'s behavior now is the most difficult for you to handle? Give an example.

- a. How often does this happen? What do you feel like doing when \_\_\_\_\_ acts this way?
- b. Does he/she know you don't like it? Why do you think he/she does it?
- c. What do you think will happen with this behavior as your child gets older? How will it change?

6. How would you describe your relationship to your child now?

Pick 5 words to describe your relationship with \_\_\_\_\_. For each word, describe a memory or time that illustrates what you mean.

7. What makes you happiest about your relationship with \_\_\_\_\_? What do you wish you could change about it?

8. Does \_\_\_\_\_ get upset often? What do you do at these times? What do you feel like doing at these times?

What about when emotionally upset? Example? What did you feel/do?

What about when physically hurt a little? Example? What did you feel/do?

What about when sick? Example?

9. Could you tell me a favorite story you have about your child? What do you like about this story?

10. Do you ever worry about your child? What do you worry about?

11. If your child could be one particular age for a while, what age?

12. As you look ahead, what will be the most difficult time in \_\_\_\_\_'s development? Why do you think so?

13. What do you think \_\_\_\_\_ will be like as a teenager? What makes you think this?

14. Think for a moment of \_\_\_\_\_ as an adult. What hopes do you have for him? What fears do you have for him?

So far, we have mostly talked about \_\_\_\_\_. Now I have a few questions about your thought/feelings of being a parent.

1. What does it mean to be a parent?
  - a. Is there anything you like about being a parent?
  - b. Is there anything that makes parenting challenging for you?
2. What are 3 words that you would use to describe parenting?
  - a. Why?

*Feelings of Parental Competency:*

1. On a scale of 1 to 10, rate yourself as a parent.
  - a. Why did you give yourself this rating?
  - b. Is there anything about your parenting that you think is really great?
  - c. Are there things about your parenting that you wish you could change?

*Perceptions of Social Support:*

1. Is there anyone in your life who supports you?
  - a. Who supports you?
  - b. How does this person offer support?
  - c. Do you feel that you have enough support?
  - d. Do you feel comfortable asking for support when you need it?

What was this interview like for you?

Appendix D  
**INFANT-CAREGIVER INTERACTION SCALE**  
 (revised: 4/03)  
**CAREGIVER**

**Infant's Code Name (4 letters):** \_ \_ \_ \_

**Infant's Age** \_\_\_\_\_

**Activity (Free Play, etc.):** \_\_\_\_\_

**Length of Activity coded:** \_\_\_\_\_ mins. **Start time on video:** \_\_\_\_\_

**Coder's Initials:** \_\_\_\_\_ **Date of Coding:** \_\_\_\_\_

***Directions:** Mark 1 – 5 as appropriate. NOT APPLICABLE (NA) is to be used for not observed, not appropriate, or not applicable.*

<u><b>PARTICIPATION</b></u>												
1. Caregiver participates in social interaction.												
Caregiver never participates.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Caregiver almost always participates.
1	2	3	4	5								
NA												
2. Caregiver does not interrupt, interfere, or restrict infant when infant is appropriately engaged.												
Caregiver almost always interrupts and restricts infant.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Caregiver never interrupts or restricts infant.
1	2	3	4	5								
NA												
3. Caregiver initiates or begins interaction with infant.												
Caregiver never initiates interaction.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Caregiver almost always initiates interaction.
1	2	3	4	5								
NA												
Note if the interaction was initiated verbally, gesturally, or tactilely. _____ _____												
<u><b>PREDICTABILITY/CONSISTENCY</b></u>												
4. The caregiver's behaviors are consistent and identifiable.												
Caregiver's behaviors are never consistent.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Caregiver's behaviors are almost always consistent.
1	2	3	4	5								
NA												

<b><u>SENSITIVITY/RESPONSIVENESS/TURN-TAKING</u></b>		
5. Caregiver recognizes infant's signals and modifies behavior accordingly.		
Caregiver does not follow infant's signals or modify behavior.	1 2 3 4 5 NA	Caregiver almost always follows infant's signals and modifies behavior.
6. Caregiver responds to infant's social behavior within five seconds.		
Caregiver never responds promptly to infant's social behaviors.	1 2 3 4 5 NA	Caregiver almost always responds promptly to infant's social behaviors.
7. Caregiver takes turns with infant.		
Caregiver never takes turns.	1 2 3 4 5 NA	Caregiver almost always takes turns.
<b><u>COMMUNICATIVE INTENT</u></b>		
8. Caregiver directs intentional communication to the infant.		
Caregiver never directs intentional communication to the infant.	1 2 3 4 5 NA	Caregiver almost always directs intentional communication to the infant.
9. The caregiver interprets the infant's behavior as having communicative intent.		
Caregiver never interprets infant's behavior as communicative.	1 2 3 4 5 NA	Caregiver almost always interprets infant's behavior as communicative.
<b><u>PLAYFUL ROUTINES</u></b>		
10. Caregiver provides playful routines and opportunities for interaction.		
Caregiver never provides playful routines.	1 2 3 4 5 NA	Caregiver almost always provides playful routines.
11. Caregiver modifies activity to encourage playful routines.		
Caregiver never modifies activity.	1 2 3 4 5 NA	Caregiver almost always modifies activity.

<b><u>IMITATION</u></b>												
12. Caregiver imitates behavior of infant.												
Caregiver never imitates infant.	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 5px;">1</td> <td style="padding: 2px 5px;">2</td> <td style="padding: 2px 5px;">3</td> <td style="padding: 2px 5px;">4</td> <td style="padding: 2px 5px;">5</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 2px 5px;">NA</td> <td colspan="2"></td> </tr> </table>	1	2	3	4	5	NA					Caregiver almost always imitates infant.
1	2	3	4	5								
NA												
Note if caregiver most frequently imitates verbal or gestural behaviors: _____												
<b><u>AFFECT</u></b>												
13. Caregiver displays positive verbal affect.												
Caregiver uses mostly negative words or signals/gestures.	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 5px;">1</td> <td style="padding: 2px 5px;">2</td> <td style="padding: 2px 5px;">3</td> <td style="padding: 2px 5px;">4</td> <td style="padding: 2px 5px;">5</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 2px 5px;">NA</td> <td colspan="2"></td> </tr> </table>	1	2	3	4	5	NA					Caregiver uses mostly positive words or signals/gestures.
1	2	3	4	5								
NA												
14. Caregiver frequently smiles during the activity.												
Caregiver frowns during most of the activity.	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 5px;">1</td> <td style="padding: 2px 5px;">2</td> <td style="padding: 2px 5px;">3</td> <td style="padding: 2px 5px;">4</td> <td style="padding: 2px 5px;">5</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 2px 5px;">NA</td> <td colspan="2"></td> </tr> </table>	1	2	3	4	5	NA					Caregiver smiles during most of the activity.
1	2	3	4	5								
NA												
15. Caregiver touches infant in an affectionate manner.												
Caregiver never touches infant in affectionate manner.	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="padding: 2px 5px;">1</td> <td style="padding: 2px 5px;">2</td> <td style="padding: 2px 5px;">3</td> <td style="padding: 2px 5px;">4</td> <td style="padding: 2px 5px;">5</td> </tr> <tr> <td colspan="3" style="text-align: center; padding: 2px 5px;">NA</td> <td colspan="2"></td> </tr> </table>	1	2	3	4	5	NA					Caregiver almost always touches infant in affectionate manner.
1	2	3	4	5								
NA												

**COMMENTS:**

**INFANT-CAREGIVER INTERACTION SCALE**  
(revised: 4/03)  
**INFANT**

**Infant's Code Name (4 letters):** \_\_\_\_\_

**Infant's Age** \_\_\_\_\_

**Activity (Free Play, etc.):** \_\_\_\_\_

**Length of Activity coded:** \_\_\_\_\_ mins. **Start time on video:** \_\_\_\_\_

**Coder's Initials:** \_\_\_\_\_ **Date of Coding:** \_\_\_\_\_

***Directions:** Mark 1 – 5 as appropriate. NOT APPLICABLE (NA) is to be used for not observed, not appropriate, or not applicable.*

<u><b>PARTICIPATION</b></u>												
1. Infant participates in social interaction.												
Infant never participates.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always participates.
1	2	3	4	5								
NA												
2. Infant initiates interaction with caregiver.												
Infant never initiates	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always initiates
1	2	3	4	5								
NA												
Note how the infant initiates the interaction. _____												
_____												
<u><b>PREDICTABILITY/CONSISTENCY</b></u>												
3. The infant's behaviors are consistent and identifiable.												
Infant's behaviors are never consistent.	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant's behaviors are almost always consistent.
1	2	3	4	5								
NA												

<b><u>SENSITIVITY/RESPONSIVENESS/TURN-TAKING</u></b>												
4. Infant attends to caregiver's presence.												
Infant never attends to caregiver.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always attends to caregiver.
1	2	3	4	5								
NA												
5. Infant responds to caregiver's social initiations.												
Infant never responds to caregiver.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always responds to caregiver.
1	2	3	4	5								
NA												
6. Infant takes turns with caregiver.												
Infant never takes turns.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always takes turns.
1	2	3	4	5								
NA												
<b><u>COMMUNICATIVE INTENT</u></b>												
7. Infant attempts to communicate with the caregiver.												
Infant never attempts to communicate.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always attempts to communicate.
1	2	3	4	5								
NA												
Note how the infant communicates: _____ _____												
8. Infant persists in communicative attempts in absence of adult response.												
Infant does not persist.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant persists.
1	2	3	4	5								
NA												
<b><u>PLAYFUL ROUTINES</u></b>												
9. Infant attempts to participate in caregiver's playful routines.												
Infant never attempts to participate.	<table style="border: none; margin: 0 auto;"> <tr> <td style="border-right: 1px solid black; padding: 0 5px;">1</td> <td style="padding: 0 5px;">2</td> <td style="padding: 0 5px;">3</td> <td style="padding: 0 5px;">4</td> <td style="border-right: 1px solid black; padding: 0 5px;">5</td> </tr> <tr> <td colspan="5" style="text-align: center; padding: 0 5px;">NA</td> </tr> </table>	1	2	3	4	5	NA					Infant almost always attempts to participate.
1	2	3	4	5								
NA												
Note the play behaviors of the infant: _____												

10. Infant exhibits a variety of playful behaviors.		
Infant does not engage in a variety of Playful behaviors.	1 2 3 4 5 NA	Infant engages in a variety of playful behaviors.
<b><u>IMITATION</u></b>		
11. Infant imitates behavior of caregiver.		
Infant never imitates.	1 2 3 4 5 NA	Infant almost always imitates.
Note type of imitation that is most frequent: _____		
<b><u>AFFECT</u></b>		
12. Infant laughs or expresses positive vocalizations.		
Infant cries or fusses during most of the activity.	1 2 3 4 5 NA	Infant laughs during most of the activity.
13. Infant frequently smiles during the activity.		
Infant frowns during most of the activity.	1 2 3 4 5 NA	Infant smiles during most of the activity.
14. Infant touches caregiver in an affectionate manner.		
Infant physically rejects caregiver.	1 2 3 4 5 NA	Infant is physically involved with the caregiver.

**COMMENTS:**