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“I Want to be There When He Graduates:” Foster Parents Show Higher Levels of Commitment than Group Care Providers

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Abstract

Group care is a frequent placement for adolescents placed in out of home care when their birth parents' care is deemed unsafe. In the present study, we assessed whether foster parents show greater commitment to children than group care providers. Given that group care represents a number of living arrangements, we considered both shift care (where staff work shifts and do not live with the children) and cottage care (where staff live for extended periods of time with the children in a group living context). Commitment was assessed using the This Is My Child Interview (adapted for adolescents). Thirty-one foster parents, 18 shift workers, and 28 cottage care providers were interviewed. As predicted, foster parents showed higher levels of commitment than both shift care workers and cottage care providers, and the associations held when children's externalizing behaviors and the number of children the caregivers had cared for were controlled. The results suggest that foster care promotes greater commitment among caregivers than other out of home placements, and add to other findings that favor foster care as the out of home placement of choice for adolescents.

Keywords

Foster care; group care; commitment

Approximately 400,000 children in the United States have been removed from the care of their birth parents and placed into out of home care (DHHS, 2013), with about 46% of these in traditional foster homes, 6% in group care, 9% in institutional care, and the remainder in kin care and other living arrangements. The percentage of adolescents in group care is substantially larger than other age groups. Whereas the total number of children in out of home care has decreased over the last decade, the percentage of children in group care has increased (Child Welfare Information Gateway, 2013).

Among infants and young children, there is consensus in the field that placement with foster parents is considered optimal for healthy development (Barth, 2002; Dozier et al., 2014;

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Dozier, Zeanah, Wallin, & Shaffer, 2012). Living with parental figures is typically considered preferable for older children and adolescents as well for a variety of reasons, including its representing a family-like and least restrictive environment (Barth, 2002), and its association with less problematic outcomes (Dishion & Dodge, 2005; Ryan, Marshall, Herz, & Hernandez, 2008), and lower expense relative to group care (Barth, 2005), among other things. Some have argued, however, that a group context may be useful and/or necessary for the out of home care of older children (Lee & Thompson, 2008).

One additional possible benefit of foster care is a greater level of commitment among foster parents than among group care providers to the children in their care. Foster care is set up as an extension of the foster parents' families, with foster parents assuming many of the roles of parents. Children live in foster parents' homes, and foster parents function as parental figures all of the time. In group care, staff members typically work at the facility rather than live with the children, and do not see themselves as parental figures, although there is some variability in the types of group care (shift care versus cottage care, as described below). Given the different roles caregivers play, we expected that foster parents would express higher levels of commitment to their children than group care providers.

Commitment

Commitment has been defined as the parent's investment in the child and the motivation to continue a relationship with the child into the future (Bates & Dozier, 2002). Dozier and colleagues have argued that commitment is essential for young children because having an invested caregiver has been critical to evolutionary success. A highly committed caregiver is likely to place his or her child's welfare above the caregiver's own safety (Bates & Dozier, 2002; Dozier & Lindhiem, 2006). Foster parents with higher levels of commitment have been shown to express more delight in their young children than foster parents with lower levels of commitment (Bernard & Dozier, 2011). Children whose foster parents express higher levels of commitment show more positive representations of attachment figures than children whose foster parents express lower levels of commitment (Ackerman & Dozier, 2005). Higher commitment has been related to greater likelihood of adoption or long-term placement, and is inversely related to disruption of placements (Dozier & Lindhiem, 2006).

As would be expected, the level of foster parent commitment is associated with child behavior problems. Commitment and problem behaviors are not only inversely related contemporaneously, but also predict one another at subsequent time-points (Lindhiem & Dozier, 2007). More specifically, greater commitment at time 1 predicts fewer problem behaviors at time 2, controlling for problem behaviors at time 1; more problem behaviors at time 1 predicts less commitment at time 2, controlling for commitment at time 1. However, although caregiver commitment has been studied among young children, to this point, it has not been studied among older children. This study assesses whether commitment differs between foster parents and group care providers of adolescents, taking into account differences in adolescent problem behaviors.

Types of Settings

We are limiting our consideration to children who are placed into out of home care based on a determination that they are not safe in the care of their birth parents. In these cases, out of home care includes foster care and group care. Children are also sometimes removed from their parents' care because of behavioral or emotional problems, and at such times, may be placed into treatment group care, institutional settings, or more rarely, treatment foster care facilities. We will not include consideration of children in treatment care, that is, care that is defined as therapeutic to address noted behavior or emotional problems. We instead limit our consideration to the former group of children who have been removed from birth parent care because of birth parents' inability to care for them safely. Because this does not remove the possibility of behavior or emotional problems, however, we include caregiver ratings of such problems in our analyses.

Foster care—Foster care refers to placement of children with foster parents who care for a limited number of children in their own homes. Foster care is intended to be “home-like,” with parents having a limited number of children in their care. Foster parents do not have hours or shifts as do group care providers, but rather function as parents all the time.

Although historically foster parents have been cautioned against becoming too committed to children in their care to protect themselves and children from becoming too invested in what could possibly be a temporary relationship, many develop high levels of commitment to children (Dozier & Lindhiem, 2006), and many go on to adopt children, and/or to have relationships with children that extend beyond the time the child leaves the placement or is “emancipated” (Dozier & Lindhiem, 2006). There are greater challenges to foster parents feeling commitment to older children than younger children, including more significant problem behaviors among older children than younger children (Stovall-McClough & Dozier, 2004). Despite the challenges, having an adult committed to a relationship with the child enduring through difficult times, and committed to a future relationship (e.g., when the child is him or herself a parent) are likely key to an adolescent's sense of security, as they are for younger children (Ackerman & Dozier, 2005).

Group care—Group care is defined as any large or small institution, or group home facility (Dozier et al., in press; Dozier et al., 2012). We further break down group care into shift and cottage care in this paper. In shift care, staff members work shifts (e.g., 8 or 12 hours for a number of shifts across the week), with children typically experiencing many caregivers over time. In cottage care, “house parents” work and live in the facility with a group of adolescents. The two types of care are quite different in many respects, but both involve the housing of youth together. The environment is necessarily less home-like than a foster home, and more like a dorm or boarding school, or even a treatment facility. Group care providers may also have had worked with more children over time than foster parents, with unknown implications to group differences in commitment. Because caregiver commitment has been found to be associated with the number of foster children cared for by foster parents (Dozier & Lindhiem, 2006), the number of children providers have worked with is included as a covariate in this study. To our knowledge, commitment has not been studied in group care environments.

Group Care and Delinquency

Even among adolescents, foster care is typically seen as the preferred care arrangement for a host of reasons. Adolescents in group care have been found to be at higher risk for subsequent delinquency (Ryan et al., 2008), and to show higher rates of problem behaviors than children in foster homes (Heflinger, Simpkins, & Combs Orme, 2000). Dishion and colleagues (Dishion & Dodge, 2005; Dishion, McCord, & Poulin, 1999; Dishion, Nelson, & Bullock, 2004; Dishion & Tipsord, 2011) have warned that housing vulnerable youth together leads to contagion of problem behaviors – adults lose influence, and deviant peers gain influence in such settings. Foster care represents the least restrictive environment for out of home placement as well. Foster parents are better able than group care providers to function as parents who are involved with and monitor adolescents' activities (Allen, Moore, Kupermine, & Bell, 1998; Kobak, Herres, Gaskins, & Laurenceau, 2012; Smetana, 2008). Fewer restrictions are typically needed in such settings. In addition, group care is substantially more expensive than foster care (Barth, 2002).

The current study—In the current study, we examined the levels of commitment in caregivers of adolescents in foster parent, shift care, and cottage care settings. We hypothesized that caregivers in foster parent settings would display higher amounts of commitment than caregivers in the two residential group home settings. Given that previous studies found problem behaviors differentially related to both care-type (Heflinger et al., 2000; Ryan et al., 2008) and caregiver commitment (Lindhiem & Dozier, 2007), we also accounted for differences in problem behaviors between youth in foster and group care. Given the known associations between number of children cared for and commitment (Dozier and Lindhiem, 2006), we also account for differences in the number of children caregivers have cared for between youth in foster and group care.

Method

The study was reviewed and approved by the university's Institutional Review Board and by the supporting foundation's Human Subjects Review Board.

Participants

Participants included 31 foster parents, 18 shift care workers, and 28 cottage care workers in a large southern state. All of the caregivers cared for children between the ages of 13 and 17 who were placed in out of home care because it was determined that their parents were unable to care for them safely. Although specific reasons for placement were unknown, children may be placed into group-care settings if it is deemed appropriate (e.g. in order to keep a group of siblings together) (OPPAGA, 2014). Children in treatment facilities such as those intended for therapeutic treatment of children with mental health issues and serious behavioral problems were not included. Children were selected from a list of children in out of home care supplied by the state child welfare system. Of the 18,152 children placed into out-of-home care during the 2013-2014 fiscal year, approximately 828 were 11-17 years of age and placed in foster care and approximately 1,208 were 11-17 years of age and placed in group care (OPPAGA, 2014). Approximately equal numbers of children were sampled from foster care, shift care, and cottage care. Attempts were made to make the groups roughly

comparable in terms of child age and gender. To the extent possible, we avoided sampling more than one child from a facility.

Recruitment was performed in two stages. In the first stage, interviewers received contact information from foster care agencies and contacted the caregivers to schedule interviews. During this stage, 22 foster parents, 11 shift care workers, and 13 cottage care workers were interviewed. Three foster parents and 2 cottage care workers were scheduled for interviews but did not complete the interview. Six foster parents and 2 cottage care workers declined to be interviewed. In the second stage, caregivers were directly contacted by the foster care agencies to schedule the interviews. During both stages, foster care agencies were instrumental in the selection of caregivers to be interviewed. We requested that foster care parents be the primary caregivers of the children whereas shift care and cottage care workers be caregivers who had regular contact with the children and worked the afternoon/evening shifts.

Data were missing for the following reasons. Marital status data were missing for 2 caregivers because the caregivers were not asked during the interview. Caregiver age data were missing for 2 caregivers because they declined to answer. One caregiver did not provide a clear answer regarding the number of months she had cared for her child. Income data were missing for 13 caregivers because caregivers declined to answer, did not know the answer, or gave unclear answers. Two caregivers did not provide clear answers about the number of biological children they had. Data for number of hours a caregiver worked a week were missing for 11 caregivers because caregivers were unclear or not specific enough in their answer, were not specifically asked, were unintelligible on the audio recording, or did not follow a weekly schedule. Data for the number of children the caregivers previously cared for were missing for 10 caregivers because caregivers were not asked, were unintelligible in the interview, or gave answers that were unclear or not specific enough. Finally, reported externalizing behavior data were missing for 14 caregivers because the caregivers did not answer according to protocol, did not know, or were unintelligible due to low audio quality.

As can be seen in Table 1, the three groups differed significantly in caregiver gender, $X^2(2, N = 77) = 10.43, p < .01$, with more male shift care workers than foster parents or cottage care providers ($z = 2.3$). The three groups also differed significantly in caregiver ethnicity, $X^2(8, N = 77) = 15.84, p < .05$, although post-hoc analyses were not significant. As can be seen in Table 2, the three groups differed in caregiver age, $F(2, 72) = 7.93, p < .01$, with foster caregivers significantly older than cottage caregivers, $t(50.51) = 3.40, p < .01$, and shift caregivers, $t(45) = 3.57, p < .01$.

Procedure

After orally consenting over the phone, caregivers completed a recorded 15-30 minute phone interview. The interview began with an assessment of the caregiver's commitment levels to the child. Caregivers then completed a symptom checklist concerning the child and a demographics questionnaire. Caregivers were compensated with a 10-dollar gift card for completing the interview.

Measures

Commitment—The current study used the This Is My Child (TIMC) interview as a measure of the caregiver's commitment to the child. The This Is My Child Interview is a modified version of the "This Is My Baby" Interview (TIMB; Bates & Dozier, 1998). The This Is My Baby Interview is a semi-structure interview that was developed to assess caregivers of infants whereas the This Is My Child Interview was modified to assess the caregivers of adolescents in foster care. Although the TIMB was developed to assess three variables, caregiver commitment, acceptance, and belief in influence, commitment emerged as the key variable related to foster care outcomes (Dozier & Lindhiem, 2006). For this reason, the TIMC was created with the specific intention of measuring commitment in caregivers of adolescents and questions related to acceptance and belief in influence were not asked of the caregivers. Commitment on the adapted TIMC was defined as the degree to which the caregiver thought of the foster child as his or her own child, as well as the caregiver's desire to continue the relationship with the adolescent into the future. During the interview, caregivers answered 9 open-ended questions that asked them to describe the child as well as answer questions regarding the child's future and the caregiver's role in the child's future. Trained raters scored commitment on a 5-point Likert scale. Higher scores indicated higher levels of commitment. Interviews were coded by one of two raters who had an inter-rater agreement of .96. Coders were trained to 90% reliability with a master coder. Seventeen per cent of cases were double coded.

Adolescents' externalizing behaviors—Children's behavioral problems were assessed with the Brief Problem Monitor. The Brief Problem Monitor was designed to rate externalizing, internalizing, and attention problems and includes items from the Child Behavior Checklist for Ages 6-18, the Teacher's Report Form, and the Youth Self-Report. The Brief Problem Monitor has shown strong test-retest reliability and criterion-related validity (Achenbach, McConaughy, Ivanova, & Rescorla, 2011). Caregivers were asked to rate each item by replying with *no or not true* (0), *sometimes, or somewhat true* (1), and *very true* (2). This study used the externalizing subscale because previous studies had found that externalizing behaviors were differentially related to group versus foster care (Heflinger et al., 2000; Ryan et al., 2008), and to caregiver commitment (Lindhiem & Dozier, 2007).

Number of children—In an open-ended format, caregivers were also asked how many children they had worked with in their caregiving experience. Some caregivers gave a precise number, whereas others provided a range (e.g., "hundreds"). The answers were thus coded to represent the variability but also allow for analysis. They were coded as follows: 0-9 children were coded as a 0, 10-49 children were coded as a 1, 50-99 children were coded as a 2, 100-999 children were coded as a 3, and more than 1000 children were coded as a 4. The resulting variable was normally distributed. Means and standard deviations are reported in Table 2.

Results

Preliminary Analyses

Preliminary analyses were first conducted to assess associations of secondary interest that could be important for primary analyses. Differences between foster, cottage care, and shift care are reported for variables of secondary interest. These differences were examined as analyses of variance, followed by post-hoc comparisons when initial group differences were statistically significant. In addition, correlations between caregiver commitment and other variables were examined.

As seen in Table 2, caregivers differed in how many hours they indicated working, $F(2, 63) = 88.29, p < .01$, with foster parents reporting that they worked more hours than cottage caregivers, $t(18.00) = 3.21, p < .01$, and shift caregivers, $t(15.00) = 12.69, p < .01$, and cottage care workers reported more hours than shift care workers, $t(33) = 6.41, p < .01$. Caregivers differed in the number of children they indicated that they had cared for previously, $F(2, 64) = 13.66, p < .01$, with foster parents reporting fewer children than cottage care caregivers $t(38.69) = -3.73, p < .01$, and shift care caregivers, $t(42) = -5.39, p < .01$.

Caregivers differed in the level of externalizing behaviors reported, $F(2, 60) = 3.85, p < .05$, with foster parents reporting lower levels of externalizing behaviors than cottage care providers $t(48) = -2.74, p < .01$.

As seen in Table 3, caregiver commitment was associated with caregiver age, $r(73) = .23, p < .05$, with older caregivers reporting higher levels of commitment than younger caregivers. Commitment was also associated with child age, $r(75) = .25, p < .05$, with caregivers reporting higher levels of commitment to older adolescents than younger adolescents. Additionally, commitment was associated with number of children ever cared for, with caregivers who had cared for more children in the past reporting lower levels of commitment, $r(65) = -.31, p < .05$. Commitment was associated with hours worked, with higher commitment reported among caregivers who worked more hours, $r(64) = .29, p < .05$. Commitment was associated with caregiver-reported externalizing behaviors, $r(61) = -.39, p < .01$, with caregivers reporting lower levels of commitment to children with higher externalizing behaviors than for children with lower levels of externalizing behaviors. Finally, commitment was associated with caregiver's time with the child $r(74) = .27, p < .05$, with higher commitment reported among caregivers who cared for the child longer.

Primary Analyses

Of primary interest were differences in commitment between foster parents and group care providers. Differences were examined as analyses of variance with type of care as the independent variable and commitment as the dependent variable. Subsequent analyses were conducted to include meaningful covariates. As argued by Miller and Chapman (2001), it is not appropriate to covary the effects of variables related in meaningful ways to the independent variable (such as hours worked and age of caregiver because such variables are integral to differences between foster and group care). Including such variables would systematically remove variance associated with the variable of primary interest. On the other

hand, including child externalizing behavior and the number of children cared for as covariates is appropriate (although only in secondary analyses) because externalizing behavior and the number of children cared for have been associated with commitment in prior studies when group was held constant (Dozier & Lindhiem, 2006; Lindhiem & Dozier, 2007). Miller and Chapman (2001) recommend conducting analyses with and without such covariates, with confidence in outcomes if effects are seen in both cases.

Analyses of variance revealed that type of care was significantly related to caregiver commitment, $F(2, 74) = 7.36, p < .01$. Post-hoc planned comparisons indicated greater commitment among foster parents than cottage care providers $t(57) = 3.17, p < .01$, and shift care providers $t(47) = 3.30, p < .01$. Figure 1 presents mean levels of commitment for the three types of care. These differences represent large effect sizes (.83 and .98 standard deviations). When including child externalizing behavior and the number of children cared for as covariates, the association between type of care and commitment remained significant, $F(2, 51) = 4.37, p < .05$.

Discussion

Foster parents showed higher levels of commitment toward the children in their care than group care caregivers. These effects were seen when comparing foster parents to both shift care workers and cottage care providers. Given that shift care workers reported higher levels of externalizing behaviors than other providers, and higher levels of externalizing behaviors have been associated with lower levels of commitment (Lindhiem & Dozier, 2007), we covaried externalizing behaviors in analyses of covariance. The association between type of care and commitment remained significant when level of externalizing behaviors was controlled. In addition, given that foster parents had worked with fewer children than both shift and cottage care workers, we also covaried number of children in analyses of covariance, and the association between type of care and commitment remained significant. This study provides strong support for foster parents expressing higher levels of commitment for the children in their care than either shift care or cottage care providers.

It is easy to make a case for foster parents showing higher levels of commitment than shift care workers. Shift care workers by definition work shifts, clocking in for 8 or 12 hours and clocking out. Such staff members have responsibilities for a number of adolescents. Their roles often involve a range of activities, only some of which include caretaking. That such individuals would feel a less strong commitment to the adolescents with whom they work than those who care for adolescents more consistently does not seem surprising.

Cottage care providers, however, appear to have a role more like foster parents in some regards. Many work throughout most of the week, having only the weekend off, for example. They live with the adolescents, sharing a house. Unlike shift care workers, they did not report elevated levels of externalizing behaviors relative to foster parents. Despite these similarities in some ways with foster parents, their commitment to children was lower than foster parents, and similar to shift workers. In other words, cottage care workers are less likely than foster parents to think of the children as their own or to have a desire to continue a relationship with the children in the future. This difference is not explained by the number

of children caregivers have cared for in the past. For example, although cottage care providers spend more time with the children than shift care workers, they nevertheless have designated periods of time away from the adolescents and the cottage facilities. Thus, a cottage care provider's position still resembles those of a shift care worker in that they have time on and time off, which may decrease the home-like quality of the environment, and perhaps their sense that their time with the children represents a job rather than a family. This is a contrast to foster parents who, in our study, all emphasized the never-ending nature of their responsibilities. We argue that, despite attempts to make the environment somewhat home-like, the cottage care setting is nonetheless group care and not conducive to high levels of caregivers commitment.

Examples from Interviews

Some quotations from the interviews are provided that instantiate these quantitative results. Although foster parents are sometimes cautioned not to get too close to the children in their care, when asked whether she would have a long-term relationship with her foster child, one foster mother said, "...I wanna be grandma...hopefully she'll have a baby girl!" Another said, "as long as I'm alive, he's going to go to college." A third said that she considered her foster child "...just like one of my own children... he's mine, even though I know...one day he will be leaving." Cottage care providers made comments that suggested the need for greater distance than suggested by foster parents. For example, one said, "it's for our benefit that we don't get close...she's definitely a resident (rather than my child)." Another said, "I would probably give him my phone number but I would tell him don't use it everyday...I wouldn't want him accessing my Facebook page or anything like that." Finally, some of the shift care workers' quotes suggested the greatest emotional distance. For example, when asked if he would miss the child if the child left the facility, the worker said, "I see so many kids come through here, probably not." Another said, "I've learned to not get attached to them because...they may leave one day."

Limitations and Future Directions

This study was conducted at a single point in time by interviewing caregivers. There was the possibility of shared method variance for child externalizing behaviors and commitment because caregivers provided data for both measures. In addition, samples sizes were rather small due to missing data. Future studies could examine caregiver commitment across different types of care longitudinally in order to measure change across time. Studies could also assess whether commitment levels across the different types of care predict future longer-term outcomes such as adoption, placement disruption, and child functioning. Furthermore, future studies could explore how the adolescents' experiences with caregivers in different types of care relate to commitment levels of the caregivers. The implications of commitment towards adolescents are largely unknown, and future studies could examine how caregiver commitment levels are related to behaviors shown towards the adolescents currently as well as in the future. For example, foster caregivers with higher levels of commitment may be more likely to continue as a source of support for children once they age out of the system than caregivers with lower levels of commitment. It would be interesting to examine the implications of commitment on success with transitions to independence and support from the caregiver.

We suggest that this study adds in important ways to the literature regarding foster and group care for adolescents placed in out of home care. A number of factors favor foster care over group homes, including substantially greater costs associated with group placements, the exacerbation of behavioral problems in group homes, and adolescents turning to peers rather than to adults for support negotiating autonomy (Barth, 2002; Dishion et al., 2004; Dozier et al., 2014). For vulnerable adolescents, having caregivers who are committed to the individual child for the long-run seems another critical reason to prefer foster care over group care in the out of home placement of adolescents.

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Highlights

- We assessed the level of commitment shown to children in out of home care in foster parents and group care providers
- Commitment was assessed using the This Is My Child Interview
- Foster parents showed higher levels of commitment than group care providers
- We controlled for externalizing behaviors and the number of children the caregivers had cared for

Figure 1.
Caregiver commitment levels across the three types of care.

Table 1

Caregiver and Child Demographic Characteristics

Variable	Foster (<i>n</i> = 31)		Cottage (<i>n</i> = 28)		Shift (<i>n</i> = 18)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Caregiver Gender						
Male	3	9.7%	6	21.4%	9	50%
Female	28	90.3%	22	78.6%	9	50%
Caregiver Ethnicity						
White	13	41.9%	16	57.1%	2	11.1%
African American	16	51.6%	8	28.6%	12	66.7%
Hispanic	0	0.0%	2	7.1%	1	5.6%
Asian/Indian	0	0.0%	1	3.6%	0	0.0%
Other	2	6.5%	1	3.6%	3	16.7%
Caregiver Marital Status						
Single	8	25.8%	6	23.1%	7	38.9%
Married	17	54.8%	19	73.1%	9	50.0%
Divorced	3	9.7%	1	3.8%	2	11.1%
Widowed	2	6.5%	0	0.0%	0	0.0%
Separated	1	3.2%	0	0.0%	0	0.0%
Child Gender						
Male	19	61.3%	16	57.1%	10	55.6%
Female	12	38.7%	12	42.9%	8	44.4%

Table 2

Caregiver and Child Demographic Characteristics continued

Variable	Foster		Cottage		Shift	
	Mean (SD)	Min – Max	Mean (SD)	Min – Max	Mean (SD)	Min – Max
Caregiver age (years) *	54.1 (9.7)	29 – 75	43.9 (12.7)	22 – 77	43.2 (10.7)	23 – 60
Time with Child (months)	17.7 (9.5)	7 – 43	11.8 (10.5)	.75 – 48	17.7 (17.6)	6 – 66
Caregiver Income	60180 (26476)	20000 – 100000	42267 (13883)	12000 – 73000	53900 (42147)	20000 – 150000
Biological Children	2.2 (1.3)	0 – 5	1.6 (1.4)	0 – 4	1.9 (1.5)	0 – 5
Hours Worked *	168.0 (0.0)	168.0 – 168.0	138.5 (40.2)	50.0 – 168.0	55.7 (35.4)	12.5 – 168.0
Number of children *	1.0 (.9)	0 – 3	2.2 (1.3)	0 – 4	2.6 (1.0)	1 – 4
Child Age (months)	190.5 (14.9)	161 – 212	193.8 (18.2)	158 – 215	194.0 (16.1)	159 – 215
Child Behavioral Problems *	2.2 (3.2)	0 – 13	4.8 (3.5)	0 – 13	3.3 (3.2)	0 – 10

Note.

* = a significant difference among groups ($p < .05$).

Table 3

Correlations Between Variables

	1	2	3	4	5	6	7	8
1. Caregiver Commitment								
2. Caregiver Age	.23* <i>n</i> = 75							
3. Months with Child	.27* <i>n</i> = 76	.35** <i>n</i> = 74						
4. Caregiver Income	-.08 <i>n</i> = 64	-.05 <i>n</i> = 64	.07 <i>n</i> = 64					
5. Biological Children	.08 <i>n</i> = 75	.45** <i>n</i> = 73	.05 <i>n</i> = 75	.09 <i>n</i> = 63				
6. Hours Worked a Week	.29* <i>n</i> = 66	.26* <i>n</i> = 64	.04 <i>n</i> = 65	-.04 <i>n</i> = 54	-.00 <i>n</i> = 65			
7. Number of Children	-.31* <i>n</i> = 67	-.06 <i>n</i> = 66	-.03 <i>n</i> = 66	.22 <i>n</i> = 55	-.06 <i>n</i> = 65	-.59** <i>n</i> = 59		
8. Child Age	.25* <i>n</i> = 77	-.10 <i>n</i> = 75	.13 <i>n</i> = 76	.05 <i>n</i> = 64	-.03 <i>n</i> = 75	-.12 <i>n</i> = 66	-.03 <i>n</i> = 67	
9. Child Externalizing Behavior	-.39** <i>n</i> = 63	-.13 <i>n</i> = 61	-.24 <i>n</i> = 63	.04 <i>n</i> = 52	.02 <i>n</i> = 62	-.10 <i>n</i> = 54	.21 <i>n</i> = 56	-.18 <i>n</i> = 63

Note.

*
p < .05;

**
p < .01