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DISSERTATION

BOUNDARY AMBIGUITY AND BORDERLINE PERSONALITY TRAITS:  
IMPLICATIONS FOR TREATMENT FOR ADOLESCENT GIRLS IN FOSTER CARE

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Submitted in partial fulfillment of the  
Degree of Doctor of Philosophy

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Accepted Without Revision

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## CHAPTER I

### INTRODUCTION

Foster care is defined in the Code of Federal Regulations as “24-hour substitute care for children outside their own homes” (Child Welfare Information Gateway, 2005, p. 1).

This is a somewhat benign statement; it almost sounds like plans made by parents before they go away for the weekend. However, this “substitute care” occurs in the context of abuse and neglect by the familial caregiver—abuse and neglect so significant that the child is separated from “everything familiar, including places (home, neighborhood, school) and people (primary caregivers, birth family, other family members, friends)” (AACAP/CWLA, 2003, p. 2). It is the horrific combination of the trauma that has occurred before the removal from home (abuse and neglect) with the trauma of the removal itself that leads to the questions regarding the effects that these traumas have on these children, and more specifically in this study on adolescent girls (Kim, Cicchetti, Rogosch, & Manly, 2009; Fonagy & Luyten, 2009). This study will seek to make links between trauma, attachment patterns, and borderline personality traits that connect with the boundary ambiguity that is characteristic of those in foster care.

As of September 30, 2006, it was estimated that 510,000 children were in foster care in the United States, with a 15.5 month median length of stay. Of that number, 49% had a goal of reunification with their parents or primary caregivers. Forty-eight percent of these children were female. The median age of the children in foster care was 10.2 years (U.S. Department of Health and Human Services, 2008). Table 1 below provides additional statistics for 2005 for the four New England states from which the sample for this study will be drawn.

During FFY 2006, an estimated 905,000 children were victims of maltreatment, while 3.6 million children were the subject of a Child Protective Services (CPS) investigation or assessment. Of that 905,000, it was found that 64.1% were victims of neglect, 16.0% were physically abused, 8.8% were sexually abused, 6.6% were victims of psychological maltreatment,

Table 1  
*Foster Care Statistics*

	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Child population for the state	835,375	286,746	1,487,118	306,231	244,049	137,446
Number of children in out-of-home care on 9/30	6,742	2,760	12,608	1,217	2,357	1,409
Median length of stay in months	20.0	25.8	18.7	24.0	13.9	17.5
Mean number of Placements	2.8	4.2	3.8	2.9	4.3	4.9
Number of children exiting out-of-home care	2,143	933	6,139	613	1,347	760
Discharge reason: reunification	66.5%	40.1%	59.2%	43.6%	61.2%	54.7%
Discharge reason: live with other relatives	7.2%	6.0%	5.9%	7.0%	2.7%	6.8%
Discharge reason: adoption	15.5%	30.1%	12.5%	20.4%	16.6%	20.4%
Discharge reason: emancipation	2.1%	22.4%	12.4%	11.6%	6.3%	15.7%
Discharge reason: guardianship	5.4%	0.3%	8.0%	4.9%	2.5%	1.1%
Discharge reason: transfer to another agency	1.5%	0.6%	1.8%	5.9%	5.2%	0.7%
Discharge reason: runaway						
Children with one or more recurrences of maltreatment within 6 months	10.1%	8.4%	11.0%	4.6%	11.1%	5.5%
Children entering foster care for the first time	83.6%	89.7%	75.8%	74.0%	60.3%	81.5%
Children re-entering within 12 months of a prior episode	7.0%	3.1%	11.7%	16.6%	20.3%	9.5%



	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Children living apart from their families in out-of-home care ages 0-5 years	24.6%	25.6%	21.9%	23.2%	22.4%	19.7%
Children living apart from their families in out-of-home care ages 6-15	63.5%	51.5%	52.9%	66.2%	46.0%	51.6%
Children living apart from their families in out-of-home care 16 years or older	21.9%	22.9%	25.2%	20.6%	31.6%	28.7%

*Note.* From Child Welfare League of America (n.d.) National Data Analysis System: State data trends, 2008. Retrieved November 29, 2009 from [http://ndas.cwla.org/data\\_stats/states/data\\_trends.asp](http://ndas.cwla.org/data_stats/states/data_trends.asp).

and 2.2% were medically neglected. The percentage of victims who were abused by a parent acting alone or with another person was 82.4. Child victims maltreated by their mothers acting alone were 39.9%. Child victims maltreated by their fathers acting alone was 17.6%, and 17.8% were abused by both parents. (U.S. Department of Health and Human Services, 2008). There is no data stating how many of these children then entered foster care, but using the figures from 2005, it can be estimated that it is about one-half. Table 2 below provides further statistics from 2006 for the four New England states the sample for this study will be drawn from.

Harden (2004) states that “child development can be understood as the physical, cognitive, social, and emotional maturation of human beings from conception to adulthood, a process that is influenced by interacting biological and environmental processes. Of the environmental influences, the family arguably has the most profound impact on child development” (p. 33). It is well understood that maltreated children are likely to have been exposed to inadequate and inconsistent parenting, which can result in difficulty forming attachments, explored further below. Studies suggest that at least 75% of maltreated children

have disordered attachments (Harden, 2004) and that the minimal studies that have been done of attachment and foster children suggest that these children are more likely to experience disorganized and insecure attachments (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Cole, 2005; Dozier, Higley, Albus, & Nutter, 2002).

In addition to attachment problems, it is known that children in foster care are more likely to have mental health problems and more likely to require intervention by mental health professionals (Knopf, Park, & Paul Mulye, 2008; Clausen, Landsverk, Ganger, Chadwick, & Litrownik, 1998). Children who have suffered multiple forms of maltreatment logically demonstrate “disproportionately high rates of emotional and behavioral disorders” (Pecora, Jensen, Romanelli, Jackson, & Ortiz, 2009, p. 7). The work of dosReis, Zito, Safer, and Soeken (2001) note that between 40% and 60% of children in foster care have at least one psychiatric disorder and about 33% have three or more diagnosable psychiatric disorders. Burns et al.

Table 2  
*Child Abuse*

	Total 50 states	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
Child population	51,987,025	818,286	280,994	1,448,884	297,625	237,451	133,389
Total referrals	2,271,160	44,298	18,434	65,192	15,999	12,739	12,231
Substantiated referrals	480,332	7,175	2,231	22,111	622	2,761	700
Victims of maltreatment	885,245	10,174	3,548	36,151	822	4,400	861
Maltreatment type: Neglect <sup>a</sup>	64.1%	91.3%	68.4%	91.5%	68.7%	85.7%	4.9%
Maltreatment type: physical abuse	16.0%	6.2%	17.8%	12.9%	16.8%	12.5%	51.3%
Maltreatment type: medical neglect	2.2%	3.8%			2.8%	1.5%	2.3%
Maltreatment type: sexual abuse	8.8%	4.4%	10.6%	2.7%	19.6%	5.7%	43.2%
Maltreatment type: psychological	6.6%	3.0%	38.9%	0.2%	1.8%	0.1%	0.9%

	Total 50 states	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
	51,987,025	818,286	280,994	1,448,884	297,625	237,451	133,389
Child population							
Percentage of victims who are girls	51.5%	51.1%	50.1%	49.4%	53.6%	51.2%	59.2%
Age of victims: under 1 year	11.4%	11.7%	13.4%	10.0%	12.6%	12.0%	6.2%
Age of victims: 1-3 years	19.6%	18.8%	21.0%	18.1%	16.4%	20.0%	15.0%
Age of victims: 4-7 years	24.2%	24.1%	23.6%	23.4%	20.3%	23.7%	24.8%
Age of victims: 8-11 years	19.4%	19.3%	20.3%	20.6%	19.4%	19.8%	19.3%
Age of victims: 12-15 years	19.3%	20.9%	17.5%	22.5%	24.2%	13.9%	6.4%
Age of victims: 16-17 years	6.1%	5.2%	4.3%	6.9%	7.2%	6.5%	10.3%
Percentage of perpetrators who were parents	79.9%	83.7%	74.8%	84.8%		85.7%	61.1%
Maltreatment types of victims removed from home: physical abuse	12,939 (8.6%)	30 (2.3%)	11 (1.5%)	260 (4.9%)	13 (5.8%)	95 (7.5%)	105 (64.8%)
Maltreatment types of victims removed from home: sexual abuse	4,754 (3.2%)	6 (0.5%)	14 (1.9%)	95 (1.8%)	4 (1.8%)	12 (0.9%)	23 (14.2%)
Maltreatment types of victims removed from home: neglect	95,696 (63.6%)	1,107 (84.8%)	330 (43.8%)	4,392 (82.1%)	183 (81.7%)	1,067 (83.8%)	24 (14.8%)
Maltreatment types of victims removed from home: psychological, other or unknown	11,722 (7.8%)	1 (0.1%)	66 (8.8%)	5 (0.1%)			
Maltreatment types of victims removed from home: multiple types	25,316 (16.8%)	162 (12.4%)	333 (44.2%)	598 (11.2%)	24 (10.7%)	100 (7.8%)	10 (6.2%)
Number of victims removed from home	150,427	1,306 (12.8%)	743 (21.3%)	5,350 (14.8%)	224 (27.3%)	1,274 (29.0%)	162 (18.8%)
Number of nonvictims	90,504	222 (0.7%)	329	2,457 (5.6%)	47 (0.5%)	377	61

	Total 50 states	Connecticut	Maine	Massachusetts	New Hampshire	Rhode Island	Vermont
	51,987,025	818,286	280,994	1,448,884	297,625	237,451	133,389
Child population							
removed from home			(5.3%)			(4.4%)	(3.1%)
Percentage of victims who received reunification services within the previous 5 years	8.1%			6.0%	2.3%	14.8%	2.1%

<sup>a</sup>The total percentage may add up to more than 100% because the child may be victim of more than one form of maltreatment.

*Note.* From U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (n.d.). *Child Maltreatment 2006*. Retrieved November 29, 2009 from <http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf>

(2004) assert that up to 80% of children in foster care suffer from developmental delays, emotional disorders, behavioral disorders, or other symptoms that indicate the need for mental health interventions, while these diagnosed mental health disorders occur in the general child population at a rate of 20%.

My professional experience as a clinician in a residential program for adolescent girls strongly informed my experience that the most intransigent and damaging mental health disorder found in those girls in foster care was borderline personality disorder. Bandelow et al. (2005) discuss studies in which borderline patients reported childhood physical, emotional, and supervision neglect as well as childhood sexual abuse, physical abuse, and witnessing of domestic violence. Paris (2000) concurs with these findings when he discusses the psychosocial risk factors that lead to childhood borderline personality disorder, including families “characterized by trauma, neglect, and separation” as well as children whose parents have “histories of substance abuse and criminality” (pp. 81-82). Trull (2001) concurs that “although childhood abuse is not the primary etiological factor in BPD [borderline personality disorder], it remains an important

factor to include in models of BPD” (p. 479). Zelkowitz, Paris, Guzder, and Feldman (2001) found that childhood victims of sexual abuse were four times more likely to “exhibit borderline pathology than those who had not been victims of sexual abuse” (p. 6). As compelling as these statements are, it is important to note that there is no data on the frequency of borderline personality disorder in adolescent girls in foster care.

Many girls in foster care develop borderline personality disorder as early as adolescence. Staggeringly, adolescents make up 15% of the population diagnosed with borderline personality disorder, with the age of onset being 13-17 years (Gunderson & Links 2008). Adolescents in foster care diagnosed with borderline personality disorder are emotionally overwhelmed, unable to self-soothe, and often resort to self-destructive behaviors in order to cope with their world. An abused girl, removed from her biological family, has at latency most likely already begun to demonstrate difficult behaviors that the agency responsible for her removal hopes will be quelled by a stable environment. Agency workers, themselves overwhelmed by the numbers of children in need of a stable home setting, often do not have the theoretical knowledge and theoretically informed interventions that would help prepare foster parents for the difficulties they may very well face in maintaining a supportive environment. The frustration, disruption, and chaos that ensue often lead everyone in the child’s life (school, pediatrician, caseworker) on a search for help. Without a guide the adolescent and her new custodians may be buffeted from doctors to therapists to psychiatrists to inpatient hospitalizations. The adolescent faces potential further losses by separation—to a different foster home, to a residential facility—all with the questions length of time removed from them, the visitation schedule, and possible reunification with her biological family remaining out of her hands and constantly in question.

In this study, I explore the relationship between boundary ambiguity in the biological family system and borderline personality traits in adolescent girls in foster care. Boundary ambiguity, as defined by family systems researcher Pauline Boss, is a theoretical construct in which family members are uncertain about who is in or out of the family—in either psychological

or physical presence or absence. Boss states that “a major consequence of an ambiguous system, that is, a system that is not sure of its components, is that systemic communication, feedback and subsequent adjustment over time are curtailed” (Boss, 1977, p. 142). In my research boundary ambiguity pertains to how the adolescent girls in foster care understand their role in their biological family. The variables identified by Boss: time, systemic communication, and adjustment are identified as the variables intrinsic to this study. For this research time is understood as time away from the biological family. Systemic communication is understood as the concept of physical presence of the mother. Adjustment is viewed in this study as the clarity of reality regarding reunification—without which adjustment cannot occur. The ambiguity of feeling the psychological presence of their family while experiencing their physical absence over time without a clear honest statement of reality regarding the outcome of their removal is what I hypothesize has an influence on the borderline traits of these adolescent girls. Despite all the constancy and care that a foster family can provide, it is my clinical experience that in this population those borderline traits bloom and thrive nonetheless. I hope to provide a deeper understanding of how the quality of the initial attachment between infant and mother, no matter how disrupted, becomes the determining factor in the child’s development. Despite the best of intentions, the attempted interruption of the negative attachment by placement in foster care replete with uncertainty (how much time away from family, will there be physical contact, will the child and family reunify) most often provides no solution for the innocent child and the people who want to help her. Clausen et al. (1998) discuss the effect of separation from the family, acknowledging that “when an abused child, who has likely experienced difficulty developing appropriate attachment to his abusing caretakers, is removed from home and placed in foster care, he/she suffers further due to an inability to separate in a healthy way” (p. 284). They go on to discuss the “feelings of rejection, guilt, hostility, anger, abandonment, shame, and dissociation reactions in response to the loss of a familiar environment and the separation from family and community” (1998, p. 284). Experiences like these underscore how boundary

ambiguity begins for the child removed from her biological home and may be compounded by multiple placements, behavior of the family members, and, perhaps most especially, the treatment plan of CPS.

In formulating my research questions, it is necessary first to conduct a close analysis of the psychological theories of attachment, boundary ambiguity, and borderline dynamics. From a psychological theory perspective, I explore attachment theory as set forth by Bowlby and Ainsworth, and show how their ground-breaking work has influenced the more recent attachment theory of Fonagy. Boundary ambiguity and its relation to ambiguous loss are explored through the work of Boss. Building on Gunderson's understanding of borderline dynamics, I demonstrate the potential connection between insecure attachment and borderline personality in adolescents. With this theoretical foundation firmly established, I then ask whether these ruptured attachments can in some way be repaired—a question that leads directly to the arena of clinical practice.

Treatment of borderline personality disorder is controversial within the psychological community and navigating a way through the welter of treatment modalities for borderline adolescents is crucial for this study. Before addressing treatment, the differences between borderline personality disorder and posttraumatic stress disorder (PTSD) must be illuminated. Fonagy's mentalization-based treatment of psychotherapy, Boss's treatment for ambiguous loss, and the importance of family and attachment therapies are each considered.

From the consideration of the array of clinical treatment approaches for adolescent girls with borderline personality disorder, there is a natural segue to the question how the adolescents and those involved in their lives make sense of family boundaries as well as the potential influence of these boundaries on their diagnosis. I shift the focus of this study to these broader questions of social theory by considering the social construction of the family and its boundaries as well as the social construction of borderline personality disorder.

From social theory, there is a logical transition to social policy—how our society organizes the meaning that is made of borderline personality disorder and embodies that meaning

in enacting laws and allocating public funds. There is no social policy specific to this diagnosis, but the policy issue most pertinent to this study is the Adoption and Safe Families Act of 1997 (ASFA) (42 U.S.C. 1305 (1997)). As informed by the exploration of the social construction of borderline personality disorder, I assess how policymakers fail to understand the limitations of permanency in solving the developmental issues of an adolescent female in foster care, especially by their ignoring the impact of the implications of boundary ambiguity on the disorder. Taussig, Clyman, and Landsverk (2001) caution against the overly simplistic goal of seeking the outcome of reunification, for example, and the dangers inherent in setting this goal without research bearing out its favorability as a goal, stating that “too often legislation goes into effect based on ideology, without a strong research basis, and without necessary resources for implementation and evaluation” (p. 6). To ensure that policymakers understand the needs of these adolescent girls requires first that those treating and overseeing the care of these girls (therapists and CPS caseworkers) recognize the extent of the problems facing these adolescents in foster care, including both borderline personality disorder and the influence of boundary ambiguity.

I have yet to find any literature pertaining directly to this topic. Hence, my review focuses on areas of empirical research that are most pertinent to my interest. In this exploration, the empirical research connects the question of the borderline diagnosis in adolescence with the clinical treatment of attachment disorders, most especially treatment including the concepts of boundary ambiguity and ambiguous loss.

Borderline personality disorder, as defined in the DSM-IV (American Psychiatric Association, 1994), includes the following diagnostic criteria: desperate efforts to avoid abandonment, a pattern of intense and difficult relationships with others, an uncertain sense of self, impulsivity that may be self-damaging, chronic suicidal behavior or self-harm, an unstable mood that is markedly intense, feelings of emptiness, recurrent and intense demonstrations of anger, and paranoia or dissociation during times of stress. The DSM-IV also states that borderline personality disorder can be diagnosed in adolescents whose symptoms are persistent



and pervasive and not assessed as an adaptation to a new stage of development (Gratz et al., 2009; Meijer, Goedhart, & Treffers, 1998).

The controversy regarding applying the borderline personality disorder diagnosis to adolescents has diminished somewhat during the past decade as clinicians identify more and more of the symptoms in more and more adolescents (Carlson, Egeland, & Sroufe, 2009; Cole, Llera, & Pemberton, 2009; Shiner, 2009). In 1983 Pine reported that the number of adolescents diagnosed with borderline personality disorder who were receiving treatment in a clinical setting had reached “flood proportions” (Bleiberg, 2000, p. 39), and Bleiberg acknowledged that “twenty five years later the ‘flood’ has not receded” (p. 39). In the past the issues most commonly raised concerned the applicability of the diagnosis, the amount of empirical data to support the shift, and the ongoing quandary about how valid it is to assert the existence of a personality disorder among a cohort of children and adolescents who have yet to complete their personality formation (Carlson, Egeland, & Sroufe, 2009; Cole, Llera, & Pemberton, 2009; Shiner, 2009; Bleiberg, 2000). It is universally acknowledged that as children mature they have “ever-changing tools” to make sense of their experiences and their relationships. Over the past 10 years, however, empirical studies have shown that the diagnosis of borderline personality disorder in adolescents is justified and has gained increased acceptance among mental health professionals (Carlson, Egeland, & Sroufe, 2009; Cole, Llera, & Pemberton, 2009; Shiner, 2009; Becker, Grilo, Edell, & McGlashan, 2002; Pinto, Grapentine, Francis, & Picariello, 1996). Becker et al., for example, found that in the comparison of borderline symptoms between hospitalized adolescents and hospitalized adults, the symptoms that were thought to be “characteristic of adolescence” (dysregulated affect, identity, and behavior) were found equally in both groups (Becker, Grilo, Edell, & McGlashan, 2002, p. 2046). Becker et al. concluded that there was no difference in appearance of borderline personality disorder symptoms in hospitalized adolescents and adults. Research findings such as these, as well as the practical experiences of clinicians who work with

these troubled adolescents, adds to the increasing evidence that borderline personality disorder in adolescents is not to be ignored

In the world of mental health care over the last decade, individuals who meet borderline personality disorder criteria have seemingly been in every waiting room and on every inpatient unit. Borderline patients are estimated to constitute about 20% of psychiatric inpatients and outpatients (Gunderson & Links, 2008). They are in addition “high consumers of emergency room services, crisis lines, and psychiatric liaisons to other medical services” as well as 9-33% of suicides (p. 9). It is recognized that the disorder has become “one of the common psychopathologies of our era” (Sable, 2000, p. 250). In addition to the challenges posed by their numbers, the difficulty of successfully treating these individuals can be overwhelming to treatment providers, prompting feelings of inadequacy on the part of practitioners who may long wistfully for a more successful treatment modality. It is well understood in the mental health field that workers view the treatment of those with borderline personality disorder with “considerable ambivalence” (Gunderson, 1999, p. 308) because of the difficulties presented by the diagnosis and the futility of treatment. As a result of these difficulties, the term “borderline” has taken on a pejorative connotation, which has in turn led some clinicians to protest the label (Hodges, 2003).

In the light of the acknowledgment that “borderline patients are so numerous that most practitioners must treat at least one” (Linehan, 1993, p. 3), it is clear that a study of the etiology of borderline personality disorder is worthwhile. This study is especially relevant having previously acknowledged the complexity and controversy of the differentiation between borderline personality disorder and posttraumatic stress disorder. The implicit value of such a study concerns the seriousness of the diagnosis, since borderline personality disorder is linked to increased suicide and suicidal behavior in adolescents (Crawford, Cohen, & Brook, 2001b). A better understanding of the developmental course of borderline personality disorder can only lead

to earlier and more effective interventions, which would in turn reduce the problems this disorder can present (Bornovalova, Hicks, Iacono, & McGue, 2009; Crawford, Cohen, & Brook, 2001a).

### *Statement of the Study Issue*

The issue explored in this study is the relation between boundary ambiguity, as defined by Pauline Boss, and borderline personality traits in adolescent girls in foster care. This relationship will be explored through the analysis of measures of boundary ambiguity and of personality prototypes completed by the social service caseworkers and by the psychotherapists who treat them. The underpinnings of boundary ambiguity—time away from the biological family, physical presence of the mother, and the clarity of the reality regarding reunification will be studied simultaneously in an attempt to enrich the understanding of the primary hypothesis.

### *Rationale*

This study has significant clinical relevance. Adolescent girls in foster care are in the custody of the state. Many of these girls struggle with borderline personality traits, for the myriad of reasons explained in the following literature review. Social service caseworkers, with the aid of assessments by the therapists who treat these girls, make decisions every day regarding treatment plans, visitation, and ultimate goals. These decisions are heavily influenced also by the understanding of the state CPS department of the appropriate placement and treatment of these girls. I contend that the lack of specificity of these goals (e.g., “we hope for reunification [with biological mother], but we just don’t know if it will work”) adds to the anxiety and depression that these girls experience as they live in limbo, helpless in the decisionmaking surrounding them and painfully ambivalent about their mothers and what their role should/could be in their lives. This exploration of the relationship of boundary ambiguity and borderline personality disorder should result in evidence-based recommendations affecting clinical treatment and social policy that, if heeded, could significantly impact the lives of these vulnerable adolescents.

CHAPTER II  
REVIEW OF THE LITERATURE

*Introduction*

When young children are abused or neglected and their biological parents deemed unable to parent them effectively, they are removed from the home by social services and placed in foster care. These children, often victims of sexual and/or physical abuse, then become part of the foster care system. On the basis of my clinical observation, even in the best of circumstances—with a solid foster home, an informed therapist, a savvy caseworker, and biological parents willing to do the work in order to reunify—these children will likely develop—if they do not already display—difficult behaviors, often uncontrollable. As discussed previously, had these children been exposed to trauma and then immediately cared for by a loving family, they may or may not have developed posttraumatic stress disorder with no impact on personality development. It is the combination of the abuse and neglect occurring in the midst of the family home, enough to warrant their removal, that puts these children at risk for borderline personality disorder. Any comfort or support that they may experience after the trauma is not coming from their immediate family—at least not without child welfare standing firmly between that family and the child.

The focus of this study is on the relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. Because there is no reported empirical research exploring this area, this literature review focuses on the areas of knowledge that together provide the groundwork for my study.

It begins with a discussion of borderline personality disorder in adolescence and the definition of boundary ambiguity and how these concepts fit together. The section on psychological theory includes exploration of the salience of attachment theory, focusing on the work of Bowlby, Ainsworth, and Fonagy. The theories of boundary ambiguity and borderline personality disorder are elucidated and their connections with attachment theory are explained.

The review goes on to discuss the social theory pertinent to this topic, especially the social construction of psychological diagnosis, of borderline personality disorder, of the family as pertains to boundary ambiguity, and finally of the diagnosis of borderline personality disorder in adolescent girls. The section on social policy discusses foster care and the limitations of our social service system to help the children and families that are the focus of this study. From that discussion, this review turns to the clinical implications of borderline personality disorder in adolescents by examining mentalization therapy, family therapy, attachment therapy, and the theory of boundary ambiguity treatment. Finally, the section on current research focuses on empirical research salient to this study: the relationship between attachment development and adopted maltreated children; between attachment development and older adopted children; between attachment styles and borderline personality disorder; and between ambiguous loss and foster children.

#### *Borderline Personality Disorder and Posttraumatic Stress Disorder*

It is important at this juncture to highlight the differences between borderline personality disorder and posttraumatic stress disorder, and important as well in that context to explain this study's focus on BPD. Gunderson (2008) raises the pertinent issue directly when he asks if they are really separate disorders, stating that the “interface” between the disorders is a complex one, as abusive experiences “predispose children to a variety of serious psychiatric illnesses” and one of those is borderline personality disorder (2008, p. 45). Gunderson carefully traces the differences between the two diagnoses according to the way in which social conditions come into play. He states that the development of borderline personality disorder requires that there be an “emotional estrangement from parents” (p. 45). He goes on to state that it is this estrangement that lends the abuse more impact and becomes far more traumatic and therefore able to shape personality development than if that same abuse found a child able to heal through the interventions of a supportive, loving family.

Hodges (2003) states that there are many vantage points from which to view the relationship between borderline personality disorder and PTSD. One of those vantage points is a developmentally based theory, stating that personality disorders result from early, prolonged experiences of trauma along a continuum that in turn causes the individual to be predisposed to develop PTSD symptoms in reaction to stressors occurring later in life. Golier et al. (2003) theorize that due to the high rate of early trauma in those with borderline personality disorder and its often occurring overlap with PTSD symptoms, borderline personality disorder should be relabeled as either a trauma-related disorder or a variant of PTSD.

Davis and Siegel (2000) acknowledge the proposed new category of complex PTSD for “victims of prolonged abuse, particularly of an interpersonal nature” (p. 136). They go on to state that complex PTSD is “based on the premise that victims develop personality changes, including deformations of relatedness and identity, dissociation, somaticization, and profound depression” (p. 136).

In this study, the distinction drawn between PTSD and borderline personality reflects the work of Gunderson (2008) and Davis and Siegel’s description of complex PTSD, along with my own clinical observations. The adolescent girls in foster care in my study have been placed out of their biological homes for reasons involving abuse and neglect, which is to say that they have potentially experienced physical, sexual, or emotional maltreatment, been exposed to this maltreatment inflicted on a member of her family, or lived with incompetent and inconsistent parenting deemed neglectful. It is likely that a combination of these traumas have occurred. From what we know of attachment theory coupled with our assumptions that these girls have never had a secure home life, we can say that from an early age they were insecurely attached to their primary caregiver, which in turn led to their forming maladaptive coping styles that develop over time into borderline personality disorder. “PTSD,” while sounding less pejorative perhaps than “borderline personality disorder,” fails to adequately describe the emotional brutality that those with borderline personality disorder relentlessly inflict on themselves in the desperate attempt to

solidify the ground beneath their feet. A further examination of psychological theory will better illuminate this diagnosis and why it is most salient for this study.

### *Borderline Personality Disorder in Adolescence*

Many clinicians have argued that because personality is not completely formed by adolescence, the diagnosis of a personality disorder is improper (Kernberg, Weiner, & Bardenstein, 2000). Other clinicians have contended that, though adolescence may be too early to conclusively diagnose borderline personality disorder, the disorder does not “arise *de novo* in adulthood” (James, Berelowitz, & Vereker, 1996, p. 12). In the past decade the concept of an adolescent with borderline personality disorder has become increasingly accepted in the psychiatric community (Gratz et al., 2009; Kernberg, Weiner, & Bardenstein, 2000; Shiner, 2009). Carlson, Egeland, and Sroufe (2009) through a developmental psychopathology lens state that “adult borderline personality symptoms reflect a lengthy, multidetermined developmental process, beginning in the earliest years of life” (p. 1329). Cole, Llera, and Pemberton (2009) also consider the “developmental links between the emotional sequelae of young children’s exposure to risk environments, particularly parental maltreatment” and how this is understood to “play a role in the development of the emotional dysregulation associated with borderline personality disorder” (pp. 1293-1294). The developmental understandings of the beginnings of borderline personality disorder are grounded in attachment theory and how the environment surrounding the child can have a negative impact enough to adversely effect the evolution of personality (Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009).). On this basis, to fail to diagnose borderline personality disorder in an adolescent is to put the child’s future at great risk since treatment would be delayed significantly (Bornovalova, Hicks, Iacono, & McGue, 2009).

### *Boundary Ambiguity*

Family boundary ambiguity, derived from family systems theory, is a “theoretical construct that applies to a wide variety of family stress events” (Berry, 1990, p. 393). Boss originally defined boundary ambiguity in 1975 as “uncertainty about who is in the family system,

when they are there, or what their roles are” (Berry, 1990, p. 393). Family members become “uncertain in their perception about who is in or out of the family and who is performing what roles and tasks within the family system” (Carroll, Olson, & Buchmiller, 2007, p. 211). Boss suggested that boundaries “include both physical and psychological phenomena that serve to foster a sense of group and individual identity that differentiates the members of a family from one another and from other groups” (Carroll, Olson, & Buchmiller, 2007, p. 211). According to Boss a higher level of boundary ambiguity occurs when a family member is physically present but psychologically absent (e.g., with Alzheimer’s disease) or when a family member is psychologically present but physically absent (e.g., family member missing in military action). Boss also suggests that a higher level of boundary ambiguity occurs when the absence persists over time and is “incongruent with reality” (1997, p. 141). For the purposes of this study, this incongruence may be interpreted as the adolescent’s having a mother, but not being able to be with her. This boundary ambiguity “becomes a risk factor, which predicts depression, somatic symptoms, and family conflict” (Boss, 2006, p. 12). The “not knowing who is in our out of your family” is tied to ambiguous loss that Boss defines as “a situation of unclear loss in which it is not known if a loved one is dead or alive, absent or present” (Boss, 2006, p. 12). Ambiguous loss is by definition a “relational phenomenon and thus cannot be an individual condition” (Boss, 2007, p. 106). How family members understand their ambiguous loss is the construct of boundary ambiguity. For the uses of this study, it is necessary to see boundary ambiguity as the struggle within a child between the “mix of ambiguity and ambivalence . . . a complicated interplay between the conscious and unconscious processes of stress reduction and self-protection” (Boss, 2006, p. 150).

Berge and Holm (2007) examine boundary ambiguity found in the parents of chronically ill children, proposing that “boundary ambiguity is a risk factor for psychological distress in parents of children with chronic health conditions” (p. 123). They discuss that it is the “ambiguity rather than the event itself that predicts the familial level of stress” (p. 125). They



conclude that the ability to think dialectically, “holding two opposing ideas at the same time regarding the ambiguous situation” (p. 128), is one solution to lowering the degree of boundary ambiguity. This situational construct was found to alleviate stress associated with its opposite, absolute thinking. The finding is important to this study. It is well known that those with borderline personality disorder struggle mightily from the inability to use dialectical thinking, their thinking often referred to as “black or white.” The possibility of improving dialectical thinking as an intervention geared to helping those who experience boundary ambiguity parallels the efforts of clinicians doing much the same thing with those afflicted with borderline personality disorder. This link—the deficit of dialectical thinking in both boundary ambiguity and borderline personality disorder— is one construct that guides my research question regarding how boundary ambiguity relates to borderline personality traits in adolescent girls in foster care.

#### *Psychological Theory*

The wide-ranging and irregular organic growth of the population recognized to have borderline personality disorder has prompted numerous etiological theories meant to organize the pertinent conceptualization (Kernberg & Michels, 2009). Over the past 40 years, psychological theory has varied greatly in its understanding of the etiology of borderline personality disorder. Psychological theory has been buffeted about. Kernberg’s definition of borderline personality organization in the late 1960s relied on a psychoanalytic construct. In the 1980s, theory was heavily influenced by the disorder’s perceived relationship with trauma and PTSD. The influence of new clinical treatments moving away from the psychoanalytic to the more manualized treatment with focus on the here and now in the 1990s was very influential. In the present research is exploring issues of heritability and the potential for borderline personality disorder to be a “brain disease” with research through “newly available neurobiological and genetic technologies” (Gunderson, 2009).

Yet, amidst these etiological alternatives, to illuminate my exploration of the relationship between boundary ambiguity and borderline traits in adolescent girls in foster care the

developmentalists are the most cogent. I here discuss attachment theory as set forth by Bowlby and Ainsworth, and consider how their ground-breaking work has influenced the more recent attachment theory of Fonagy, particularly his concept of “mentalization.” This leads to a discussion of the psychology of borderline personality dynamics, especially as elucidated by Gunderson. Building on this understanding, I seek to shed some light on the potential connection between insecure attachment and borderline personality in adolescents. With this theoretical foundation firmly established, the question may then be raised whether insecure attachments can in some way be made secure—a question that leads to the arena of clinical practice, which is featured later in this review.

### *Attachment Theory*

The development of attachment theory is the joint work of John Bowlby and Mary Ainsworth and is the foundation underlying all current attachment research (Bretherton, 1992). Bowlby and Ainsworth declare that the “distinguishing characteristic of the theory of attachment . . . is an ethological approach to personality development” (1991, p. 333). They characterize their theory as “open-ended” and “eclectic,” one that draws from “a number of scientific disciplines, including developmental, cognitive, social and personality psychology, systems theory, and various branches of biological science” (1991, p. 340).

Bowlby’s theory of attachment emphasizes the “primary status and biological function of intimate emotional bonds between individuals,” bonds that are controlled by a biological system that focuses on the relationship between the attachment figure and the working model of the self (Bowlby, 1988, p. 120). Intrinsic in this theory is that this primary relationship takes place in the midst of other relationships and therefore the culture in which this primary relationship exists cannot be ignored. He replaces the psychoanalytic development theory with his theory of “developmental pathways,” in which the infant progresses along one of many potential courses of development that is determined every moment by the intersection of the individual and her environment (Bowlby, 1988).

Bowlby asserts the importance of how the child is treated by her parents, “especially ...[her]mother figure,” and its impact on her development (Bowlby, 1988, p. 120). From the perspective of the object, the caregiving system is the part of parental behavior that encourages proximity when the parent perceives that the child is in danger. In an ideal world, the parent and child reflect a balanced reciprocity between “accessibility” and “responsiveness” (Fonagy, 2001, p. 11; Bowlby, 1969/1982), a balance that is sustained by the central nervous system much as blood pressure is kept within set limits by physiological measures (Bowlby, 1988).

The concerns that emerge from the internal working model and those that relate to the attachment figure are “built in the mind during childhood” and are thought to be “central features of personality functioning throughout life” (Bowlby, 1988, p. 123). Bowlby acknowledges that the interaction of the working models of child and parent “tend to persist” and “come to operate on an unconscious level” (Bowlby, 1988, p. 130). He hypothesizes that by observing the behavior of her mother, the child gains insight as to how the mother achieves her goals. Mother and child develop an increasingly complex relationship that he labels a “partnership” (Bowlby, 1969/1982, p. 267).

Bowlby concludes that the pattern of attachment developed by an infant and continued through maturity is “profoundly influenced” by how her parent treats her (Bowlby, 1988, pp. 123-124). In addition, the complexity of the parent–child relationship is made more intricate by the fact that the parent was once a child herself, “profoundly influenced” by her own parents. Included in this intergenerational nexus are the influence of other adults and their attachment patterns, as well as the influence of the parent’s culture (Bowlby, 1969/1982). Bowlby’s understanding of intergenerational attachment patterns derived its evidence from the prospective studies of socio-emotional development pioneered by Ainsworth discussed below. The attachment theory, as Bowlby draws it, is exquisitely complex and at the same time profoundly simple.

Mary Ainsworth's research methodology both tested and expanded Bowlby's theory. Her contributions include identifying the attachment figure as a "secure base" from which the infant explores the world. This notion of a secure base stems from her observations of children and mothers in which the secure child is more likely to explore away from her attachment figure. Any sign of *dis-ease*, however—feeling sick, tired, anxious—is accompanied by an "urge toward proximity" (Bowlby, 1988, pp. 121-122). This concern with the child's feeling of security, as well as the mother's sensitivity to the signals of the infant, plays a role in the development of mother–infant attachment patterns.

A further expansion of Bowlby's theory is Ainsworth's description of the three principal patterns of attachment and the family and cultural conditions that underlie them: secure attachment, anxious resistant attachment, and anxious avoidant attachment (Bowlby, 1988). The first of these, secure attachment, is characterized by the child's confidence that the parent will be available, responsive, and helpful in a frightening or dangerous situation. This pattern begins at birth, though some research would suggest it begins in utero. The parent ensures that she is accessible and sensitive to the child's prompts. The anxious resistant attachment finds the child uncertain about the parent's availability, responsiveness, and ability to help. It is a reaction to the unpredictable parent—helpful sometimes and unavailable on other occasions. The anxious avoidant pattern applies to a child who has no confidence that the parent will respond in a helpful manner and in truth expects to be rejected. This pattern is a response to a parent who consistently turns away from her child when the child approaches.

Ainsworth's contributions to attachment theory, particularly her identification of attachment patterns, center around the outcome of her famous study called the "Strange Situation" (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth realized that it is not the separation of mother and child that is the key to understanding the response of the child, but the child's account of the separation in the context of the child's expectation of the mother's behavior

(Fonagy, 2001). The Strange Situation concluded that the child's demonstration of distress on being separated from the mother is an indication that the child is attached to the mother.

Ainsworth has also clarified what she perceives to be a misreading of Bowlby by stating that he did not declare that an infant can only be attached to the mother. She proposes her own conception of multiple attachments, stating that infants are "very selective" about who they pick as their attachment figure, that no infant was observed as having "many" attachment figures, and that although an infant may have more than one attachment figure, they are not of equal importance to the infant (Ainsworth, 1979). A salient facet of her understanding of infant-parent attachment is the way in which the infant's attachment to her mother "affects the way in which [the infant] organizes behavior toward other aspects of the environment, both animate and inanimate" (Ainsworth, 1979, p. 935). Once more, Ainsworth explores the mystery of the attachment figure when she speaks of an attachment as "an affectional bond, and hence an attachment figure is never wholly interchangeable with or replaceable by another" (Ainsworth, 1989, p. 6). This figures to be especially important when considering the child in foster care.

Bowlby speaks directly to this point when reminding his readers that the self and the attachment figure are "complementary and mutually confirming." He goes on to say that an "unwanted child is likely not only to feel unwanted by his parents but to believe that he is essentially unwanted, namely unwanted by anyone" (Bowlby, 1973, p. 204). As part of his commentary on neglect, Bowlby asks "how long . . . can a child during his second year retain in recoverable form a model of his absent mother, either for recognition or recall? For how long does he continue to yearn for her?" (1980, p. 415). From this description of neglect, it is easy to see Bowlby's influence on attachment research that finds the insecure and disorganized child-mother attachment patterns to be connected to children who live in difficult life situations (Howes & Richie, 1999). Fonagy also references Bowlby's "suggestion" that early caregiving experience "serves to organize later attachment relationships," which he uses in his explanation of

psychopathology in borderline personality disorder (Fonagy, Target, Gergeley, Allen, & Bateman, 2003, p. 414).

A thorough understanding of attachment theory requires going beyond the work of Bowlby and Ainsworth, although together they provide the cohesive foundation that later attachment theoreticians have built on. Peter Fonagy is a current researcher who has reshaped aspects of Bowlby and Ainsworth while retaining most of their work in attachment theory. His work attempts to connect attachment theory with the etiology of borderline personality disorder and is therefore salient to this discussion.

Fonagy's theory of "mentalization" is best approached by first understanding how his theory varies from classical attachment theory. Bowlby focuses on the internal working model and how the perception of an attachment figure's behavior is transmuted to become the child's representation of that behavior—in other words, the child expects the attachment figure to perform in a certain way based on past performances. Bowlby asserts that this "switch" is due to an "attachment system propelled by cognitive development" (Fonagy, Target, Gergeley, Allen, & Bateman, 2003, p. 416). Fonagy and his colleagues contend the opposite, however, and argue that "attachment actually propels cognitive development," which he refers to as a "major selective advantage conferred by attachment to humans . . . for the development of social intelligence and meaning making" (Fonagy et al., 2003, p. 416, italics removed). This significant alteration in classical attachment theory paves the way for mentalization.

As defined by Fonagy and Bateman, mentalization is "fundamentally the capacity to understand and interpret human behavior in terms of underlying mental states" (Bateman & Fonagy, 2003, p. 191). This capacity develops through "a process of having experiences of oneself in the mind of another during childhood within an attachment context," a process that can be developed fully only through a secure attachment (Bateman & Fonagy, 2003, p. 191). During the development of the capacity to mentalize, the parent's affective mirroring allows the infant's self-representations as reflected by the parent to be mapped "onto the primary, procedural self-

states of the constitutional self” of the infant and internalized (Bateman & Fonagy, 2003, p. 193). A successful development of mentalization requires meeting the conditions of “contingency” and “markedness.” In this context, contingency means that the parent’s response to the infant accurately matches the internal state of the infant. Markedness means that through her expression the parent is able to clearly indicate that she is expressing the feeling of the infant and not her own feelings (Bateman & Fonagy, 2003). In a dyad demonstrating adequate mentalization, mother takes her cues from baby—and from her knowledge of her baby over time. Her face is just the right distance away, her tone of voice gives the baby pleasure, eye contact is for the right amount of time. The baby “feels” understood by the way in which mother is “with” the baby.

*Boundary ambiguity and attachment theory.* Boss references Bowlby and his theory of loss and the role ambivalence plays in motivating “despair and letting go in order to lower stress and anxiety” (Boss, 2006, p. 167). Boss also refers to Freud’s *Mourning and Melancholia* where he “suggested that the goal of recovery after loss is to relinquish one’s ties to the absent person and eventually invest in a new relationship” (Boss, 2006, p. 167). However, Boss uses the concepts of attachment and loss differently than Bowlby and Freud as she connects them to their role in boundary ambiguity. She asserts that with ambivalent loss, there is no moving on because “the old attachment still has possibilities” (Boss, 2006, p. 163). This has salience in this study as the adolescent girls hold tight to their hopes that their mother will change for the better, making reunification possible. Seeing attachment as a drive toward survival, Boss asserts that “people go to great lengths to preserve the relationships they need in order to survive” (Boss, 2006, p. 186) and therefore “without information to clarify their loss, family members have no choice but to live with the paradox of absence and presence” (Boss, 2007, p. 105). Living with this paradox, the adolescent girl in this study struggles with this dialectic while wondering how long she will be physically absent, when she will have visitation with her mother (presence), and whether reunification will be possible.

### *Borderline Personality Disorder Theory*

The following discussion of the psychology of borderline personality dynamics clarifies the link between attachment theory and borderline personality disorder, including how the thread of boundary ambiguity strengthens the connection. Over the past 40 years, clinicians and researchers have relied on a variety of theories in order to understand the development and maintenance of borderline personality disorder. Just as Bowlby and Ainsworth have provided the firmer foundation enabling later attachment researchers to refine the theory in light of current findings, the classic work of John Gunderson has been insightful in explicating the psychology of the borderline personality dynamic.

Gunderson's contribution to a better understanding of the borderline personality diagnosis can be traced back to the 1960s. Gunderson's formulation "represents more of a reshuffling or reordering of the same set of observations drawn on by others rather than a radical departure" (1984, p. 39). Gunderson's formulation reflects the then-current research findings reported in the literature. Thus, he believes, his criteria are the "best possible available means" for identifying borderline patients: intense, unstable interpersonal relationships; manipulative suicide attempts; unstable sense of self; negative affects; ego-dystonic-psychotic experiences; impulsivity; and low achievements (1984, p. 4). He states that unlike the previous psychoanalytic theories regarding borderline personality, his begins with "empirical efforts to define an adult syndrome" and that such a syndrome requires a "broader developmental base" (1984, p. 45)—one that includes how "constitutional factors" interact with early parenting and how the patterns of family interaction has an impact throughout development (1984, p. 45). Gunderson believes the ego to be active and responsive in the attempt to help the individual stay connected with and have control over the objects it deems necessary. He admits, however, that the ego is deformed and its actions are maladaptive, resorting to such defenses as the regressive use of grandiose and omnipotent fantasy, loss of reality testing, and impulsive actions (Gunderson, 1984).



Gunderson's three levels of function constitute his dynamics of borderline personality disorder that fall within the framework of ego psychology and object relations. The individual with borderline personality moves from one level to another depending on her ability to function, high to low. Level I is characterized by the tension between wanting more from the object and fearing that less will be given. There is a conscious longing for attachment but a significant lack of initiation due to fear of rejection. Level II is characterized by a frustrating object, so that anger and devaluation are predominant. The anger lessens the fear of losing the object while maintaining the wish to stay connected. Devaluation is an alternative to the anger, where denial of fear of loss of the object is present. At Level III the borderline individual experiences the absence or lack of a significant object. During such times, she may experience a brief psychotic episode, panic, or impulsive efforts to avoid panic. All efforts are made to avoid the feeling of aloneness and "total badness" (Gunderson, 1984, p. 34). This overview of the theory enunciated by Gunderson makes it clear that attachment theory and attachment experiences have significant implications in the etiology of borderline personality disorder. It is also clear that in all the circumstances involving the presence or absence of the significant object, the theory of boundary ambiguity plays a salient role. Boss (2006) speaks of anticipation of loss when "we both cling to our loved ones and push them away" (p. 63), and states that from a "psychoanalytic perspective, ambiguous loss is indeed an uncanny situation of traumatic anxiety produced by the combination of the known and the unknown" (p. 5). Boss goes on to assert that the most significant predictor of mental health in the face of boundary ambiguity resulting from ambiguous loss is the "individual's ability to learn how to hold onto two opposing ideas in their minds at the same time" (p. 16), a high-level defense well known to be lacking in those with borderline traits. As Sroufe et al. have suggested, "From its inception, attachment theory was a theory of psychopathology as well as a theory of normal development" (Sroufe, Carlson, Levy, & Egeland, 1999, p. 1).

### *Attachment Theory and Borderline Personality Theory*

Fonagy (2001) connects his theory of mentalization with borderline pathology by way of his understanding how trauma and maltreatment are connected to the disorganized/disoriented attachment pattern. The abused child closes down her mind to other minds, known as the “inhibition of mentalization,” due to the pain involved in acknowledging her attachment figure’s desire to harm her. That lack of safety triggers the child’s attachment system thus causing the child to seek closeness to the abuser while closing her mind to the abuser’s mind. This closing of her mind stems from the unconscious concern that if she were to see the hatred in the attachment figure’s mind, she would be compelled to experience herself as hateful and unlovable, and if she allows the attachment figure to know what she experiences, she would be humiliated with the risk of ridicule. Any sense of stability for the child then is “maintained through mental isolation,” through the inhibition of mentalization (Bateman & Fonagy, 2003, p. 191).

In light of Fonagy’s attachment theory, an abusive parent is implicated in the child’s development of a cluster of affective, identity, and impulsive symptoms. For Fonagy, it is the “intrinsic instability of the self, the protection of the self-structure, and the mechanisms required to shield it that form the core pathology” of borderline personality disorder (Bateman & Fonagy, 2003, p. 193).

Interweaving the three strands of early abuse and neglect, attachment theory, and the development of borderline personality disorder provides context for my further exploration of the influence of boundary ambiguity on borderline traits among adolescent girls in foster care. If a child is in foster care during latency, one can assume that there already has been significant difficulty in previous years, especially with primary caretakers, to the degree that parental rights have been suspended. A review of studies regarding attachment in borderline patients finds that disorganized attachment is present in family environs with increased parental risk factors and, in turn, that disorganized attachment was most consistently connected to child and adolescent psychopathology. In fact, in 13 studies relating attachment styles to borderline personality

disorder a significant connection between insecure attachment styles and borderline personality disorder was found (Agrawal et al., 2004).

Fonagy and his colleagues strengthen this connection by incorporating his theory of mentalization with that of attachment theory and its relationship with borderline personality disorder. He states that for “normal development the child needs to experience a mind that is concerned with *his* mind” and that this capacity for mentalization is a “developmental achievement greatly facilitated by secure attachment” (Fonagy, Target, Gergeley, Allen, & Bateman, 2003, pp. 427, 429). Fonagy relies in part on the work of Schore, stating that “secure attachment is essential for optimal development of cerebral structures supporting mentalization” (Fonagy et al., 2003, p. 432).

There is growing evidence that the “child’s manner of engaging the environment in subsequent developmental periods will be predictable from patterns of attachment in infancy” (Sroufe, Carlson, Levy, & Egeland, 1999, p. 6). In addition there are certain “arenas of functioning—those tapping anxiety about the availability of others or apprehension regarding emotional closeness”—that are likely to show the “legacy of early attachment” (Sroufe et al., 1999, p. 6). Thus, for example, if that early attachment is disorganized due to abuse and neglect, and the toddler is put into foster care, certain predictions concerning her future mental health may be made on the basis of this discussion of attachment theory and the dynamics of borderline personality disorder.

### *Social Theory*

#### *Social Construction of Borderline Personality in Adolescence*

To answer the question concerning how these adolescents, and those who both love and work with them, understand the diagnosis, I here shift my focus to the broader questions of social theory and consider the social construction, first, of psychiatric diagnosis, and consequently of borderline personality disorder. Included as well is the impact of the social construction of the

family with its intrinsic cultural variability of membership and boundary ambiguity on borderline traits.

This exploration best begins with the general concepts of social construction. Cushman's (1995) view of social constructionist theory starts with the explanation that humans do not have a "basic, fundamental, pure human nature that is transhistorical and transcultural" (p. 17). We are ineluctably part of a "specific cultural matrix" (p. 17) that includes language, ritual, rules, hierarchy, and systems of power, as well as moral expectations. Cushman asserts that this cultural matrix " 'completes' humans by explaining and interpreting the world . . . instructing and forbidding them to think and act in certain ways" (p. 17).

Humans create ideas and concepts, as well as material objects. These acts of creativity are shaped by the social context in which people were raised (Cushman, 1995). It is important to remember that these "cultural artifacts" are not merely the "expression of an era" but also include the mundanity of everyday living, often generalized into our communities and often "subtle and unseen" (Cushman, 1995, p. 18). Cushman speaks of the "dual nature of cultural artifacts," (p. 19) in which cultural reciprocity is manifest in the social context that both reflects the culture and is in turn influenced by it. As a result, these cultural artifacts "also reinforce and reproduce the constellations of power, wealth, and influence that dominate in that society" (Cushman, 1995, p. 19).

The social construction of psychiatry can be understood by tracing even the most skeletal progression of psychiatry's modern history. In the decades that followed World War II, the pendulum has swung back and forth between favoring social construction or a biological basis for psychiatry.

In order to overcome the dilemma of having to choose between organic and inorganic causes of psychiatric disorders, Eisenberg (1995) asserts that "the human brain is constructed socially" (p. 1563). This statement can be read in two ways: first, that any given era's understanding of the mind and brain reflects the particular worldview—political, scientific, etc.—

of that day; and second, that “the cytoarchitectonics of the cerebral cortex are sculpted by input from the social environment because socialization shapes the essential human attributes of our species” (Eisenberg, 1995, p. 1563).

A psychiatric diagnosis should describe a person’s clinical condition in such a way that it accurately represents her psychiatric disorder. In so doing, it optimizes the clinician’s ability to provide an appropriate treatment plan that connects the person’s condition with the clinician’s intervention for that condition. The diagnosis in this context is intended to facilitate communication between mental health professionals (Fabrega, 2002). From a different perspective, the individual who seeks care is also seeking legitimacy for her disordered condition that can only be attained through diagnosis (Linder, 2004). In this sense, diagnosis serves as a “labeling process” that is, in essence, an “agreement between society and the profession of psychiatry” (Linder, 2004, p. 6). In the final analysis, then, diagnosis is a “mechanism of social control” (Linder, 2004, p. 4). As much as this may seem to fly in the face of the Hippocratic oath, diagnosis has a beneficial function: to comfort those who suffer by holding out hope for the possibility of successful treatment and ease of pain.

Constructionists know that psychiatric diagnostic categories are not set in stone, but rather represent ways that the clinician can construct the client (Gergen, Lightfoot, & Sydow, 2004). Yet, even if diagnoses are thought of as “impersonalized . . . objectified . . . [with no] ties to social values, spiritual concerns, [or] existential implications” (Fabrega, 2001, p. 398), there is still the fact that despite what label the suffering is given, the suffering still exists. Different constructions will shape the experience of suffering including how the suffering is accepted, how it is tolerated, and how it is understood in the context of the culture.

The development of the borderline personality disorder diagnosis is the culmination of what we have come to understand about the social construction of gender and of psychiatric diagnosis. The term “borderline” was first used in 1938 by Adolf Stern to describe patients who appeared more disturbed than those labeled “neurotic” but not as disturbed as those labeled

“psychotic” (Shaw & Proctor, 2005). In 1980 borderline personality disorder was for the first time included in the DSM as a diagnosable disorder. By 2005 it had become the most commonly diagnosed personality disorder (Shaw & Proctor, 2005). Despite its rapid ascendancy, the diagnosis has always been controversial due to its “inconsistent and unclear meaning, and its uneven, stigmatizing and punitive application” (Shaw & Proctor, 2005, p. 484). It is fair to say, however, that the history of borderline personality disorder is inextricably intertwined with the history of mental health in women and their treatment, especially in view of the social construction of the diagnosis.

In modern times, theorists such as Masterson, Adler, Kernberg, and Buie provided first-generation studies of the etiology of borderline personality disorder that focused on “parental separation or loss and disturbed parental involvement” (Bjorklund, 2006, p. 8). The second-generation researchers built on the earlier work to find that childhood physical and sexual abuse was common in those diagnosed with borderline personality disorder (Bjorklund, 2006; Nehls, 1998). Third-generation research broadened the findings to include any difficult childhood experiences, not solely abuse, to be common among those carrying the diagnosis (Bjorklund, 2006). Since the majority of sexual abuse survivors are female, the “gendered nature” of borderline personality disorder may be explained in part by this research (Bjorklund, 2006, p. 9).

Understanding the social construction of a psychiatric disorder requires examining how society both shapes the disorder and in turn is shaped by it. Shaw and Proctor (2005) recognize the diagnosis of borderline personality disorder as the “latest manifestation of historical attempts to explain away the strategies which some women use to survive and resist oppression and abuse, by describing these strategies as symptomatic of a disturbed personality pathology” (p. 484). The borderline diagnosis can therefore be a matter of “silencing and disempowering” the patient who is dependent on a mental health professional charged with judging the appropriateness of the patient’s emotions in relation to the “norm” (p. 485).

Shaw and Proctor (2005) suggest that, from a social construction vantage point, borderline personality disorder may be diagnosed both in women who do not live up to their gender role (by expressing aggression and anger) and in women who do live up to their gender role (by internalizing that same anger and self-injuring). The survivor is now deemed “difficult” because she has borderline personality disorder, not because she has survived a serious trauma. The “dysfunction” is no longer in the society where this trauma is allowed to occur, but in the individual who has experienced the trauma (Shaw & Proctor, 2005).

To those diagnosed with borderline personality disorder, it matters a great deal how their mental health providers “see them”—“in terms of frontal lobe dysfunction, skills deficits, sex bias in diagnostic criteria and/or research, or in terms of a certain gendered mode of being sick in early 21st century industrialized societies—or all of the above” (Bjorklund, 2006, p. 20). This is so because all interventions are invariably influenced by some or all of these social constructions.

Raising the question of the role of mental health professionals in this context leads to the issue of stigma as it relates to the borderline personality disorder diagnosis. Penn et al. (2005) state that stigmatizing takes place when “a person or group is labeled in a pejoratively categorized way that sets them apart from the majority and, as a result, is treated in ways that mark the person as socially unacceptable” (p. 532). Women with borderline personality disorder are likely to experience stigma because their psychiatric disorder begins in early adulthood, is chronic, involves multiple modalities of treatment including psychiatric hospitalizations, and often leaves self-inflicted scars (Rüsch, Lieb, Bohus, & Corrigan, 2006). These women, utilizing as much of the psychiatric system available to them, often to little avail, have been tagged as “systems misfits” and labeled “treatment resistant” (Nehls, 1998, p. 103).

In reality, the clinical challenge these clients present to their mental health professionals often leaves those professionals with “feelings of fear and impotence” leading to a “hateful avoidance” due to the strength of the evoked countertransference (Lequesne & Hersh, 2004, p. 173). This has resulted in a professional looseness with which the term “borderline” is used, often

being used to describe any client who provokes frustration and anger in a clinician. In fact, “the borderline has become the most pejorative of all personality labels, and it is now little more than shorthand for a difficult, angry female client certain to give the therapist countertransferential headaches” (Becker, 2000, p. 423). Indeed, for many it is the one diagnosis for which the inability to make progress in treatment and the ability to evoke strong negative reactions in the clinician is a “proof of validity” of diagnosis (Becker, 2000, p. 424).

All that has been said thus far about the social construction of the borderline personality disorder diagnosis can be focused even further in order to explore that diagnosis in adolescent girls. This is also the appropriate locus for how the social construction of the family as seen in boundary ambiguity has its influence on the diagnosis. It is obvious that the motivation for the psychiatric treatment of children does not come from the children themselves, but from adults in their lives—parents or teachers—who see symptoms and behaviors that cause the adults concern (Maschi, Schwalbe, Morgen, Gibson, & Violette, 2009). Boss (1999) states that the “secret to coping with the pain of an uncertain loss, regardless of culture or personal beliefs, is to avoid feeling helpless” (p. 116).

Boss discusses the social construction of loss when she states that “the last and most difficult step in resolving any loss is to make sense of it . . . [and that in] the case of ambiguous loss, gaining meaning is even more difficult than in ordinary loss, because the grief itself remains unresolved” (p. 118). She goes on to state that the “meaning one attributes to the ambiguous loss also determines whether there is hope or hopelessness” (Boss, 2006, p. 74). We are able to connect Boss’s social construction of the family with that of psychiatric diagnosis when she states that “the psychological family is an active and affective bond that helps people live with loss and trauma in the present. Cut off from loved ones physically or psychologically, people cope by holding on to some private perception of home and family. This psychological construction of family may coincide or conflict with official records and the physical family one lives with, but who is viewed as being in the family is of therapeutic importance” (Boss, 2006, p. 26).



As acknowledged by Dr. E. Jane Costello, professor of psychiatry at Duke University, over the past two decades the frequency of psychiatric diagnoses in children has increased insofar as doctors are more willing to connect behavior problems with psychiatric disorders; but, it is argued, that willingness springs from society's greater belief that these disorders exist, as a reality and not just as a social construction (Carey, 2006). Even as some complain about a lack of systemic support, others point to a new conception of diagnosis for children, one that is more conducive for those who work directly with children and adolescents each day in their practices (Jensen, Knapp, & Mrazek, 2006). This new approach acknowledges that diagnoses of children will change as the brain develops because psychiatric disorders are the result of both biological as well as environmental factors. As of this writing, the call has been made that the DSM V include developmental context in the psychiatric diagnostic system (Jensen, Knapp, & Mrazek, 2006), illustrating an aspect of the social constructionist shift in diagnosing children.

Prior to adolescence, girls in western culture ordinarily exhibit the norms and expectations of strong initiative and an eagerness about life. Then, for many girls, the developmental process of differentiating causes "ruptures in the core sense of self—ruptures of coherence and agency" (Becker, 1997, pp. 93-94). Carol Gilligan's research on girls' development shows "early adolescence to be a time when girls' resilience is at risk and that what is at risk is the possibility of a confiding relationship" (Gilligan & Machoian, 2002, p. 323) which highlights Gilligan's view of the "importance of considering girls' development within a societal and cultural framework" (p. 325).

If integration does not follow differentiation, the self may stay in a "state of pathological fragmentation that can result from an assault on the sense of coherence of the core self" (Becker, 1997, p. 94). Freud noted that a girl's adolescence is a time of "contraction rather than expansion" due to a sense that she is one who must defer to the "needs and desires of others" (Becker, 1997, p. 100). Gilligan and Machoian recognize that "girls' awareness, their knowledge, and their outspokenness, especially as they become young women, often arouse fears and concerns leading

to attempts at silencing on the part of even well-meaning adults and peers. Consequently, girls quickly discover where, when, and with whom it is safe for them to speak” (Gilligan & Machoian, 2002, p. 325). They note that “in middle and later adolescence, girls will often protect a bruised and fragile sense of self-worth by ‘not caring’ or appearing not to care. ‘Not caring,’ in our terms, means giving up hope for connection” (2002, p. 323).

It is possible to discern a relationship between the rise in psychiatric difficulties among adolescent girls and a decline in self-esteem over the course of their development (Becker, 1997). It is also apparent how the western cultural construction of the self and ideals of development contribute to this erosion. Autonomy, or care for self, is often unmanageable by adolescent girls who have not been taught the appropriate skills. The anger, aggression, and self-blame that result from an invalidating family environment in which emotional needs are minimized or punished are realized in the traits of borderline personality disorder in adolescent girls. Just as society dictated the role of women in the nineteenth century, it now attempts to understand why there are young girls who cut themselves, are sexually promiscuous, substance abusing, suicidal, and assaultive. Gilligan and Machoian assert that “girls learning to speak a language of violence at adolescence...are discovering that this language is taken seriously in our society” (2002, p. 322). This “language of violence” is what Gilligan and Machoian recognize as the adaptive skills that these girls utilize to make relationship, make connection, and to be taken seriously. Yet in our society “if girls threaten to kill themselves, they will be taken seriously; if they do not actually kill themselves, they will be dismissed as manipulative and will not be taken seriously” (Gilligan & Machoian, 2002, p. 332). Therefore, these girls will “lose relationship in the attempt to gain relationship” and the borderline cycle begins (Gilligan & Machoian, 2002, p. 332). In this way, psychiatry and society collude once again, so that neither has to bear the responsibility for the struggles of these young women.

## *Social Policy*

### *Borderline Personality Disorder and Foster Care*

How our society organizes the meaning of psychiatric diagnosis and how we embody that meaning by enacting laws and allocating public funds regularly present a familiar social policy dilemma. Governmental and budgetary resources are almost always stretched to the limit. Inevitably, some promising areas for clinical research are neglected. Such is the case for borderline personality disorder in adolescent girls in foster care. There is to date no social policy directed toward the specific social problem that is the subject of this study: that the boundary ambiguity experienced by an abused or neglected girl without adequate services can contribute to the development of borderline personality disorder. As Boss (2006) asks, in regard to boundary ambiguity and social policy, “what happens when a person is faced with an ambiguous loss . . . and it is the external situation, not the person’s psyche, that makes letting go of the lost object impossible” (p. 4). She goes on to recognize that “people in poverty or without language skills . . . experience less power and control over their lives. Perceptions of powerlessness also may stem from family of origin issues or from past traumas that keep a person in a victimized state rather than an empowered mode” (Boss, 2006, p. 107). Can these powerless children trust adults outside their home? Can they trust adults in their home? Where can they turn?

In tracing the ramifications of this specific problem for social policymakers, it is most fruitful to begin with the legislation most pertinent to this study, the Adoption and Safe Families Act of 1997 (ASFA) (42 U.S.C. 1305 (1997)). Public policy must often deal in broad generalizations that tend to simplify complex situations. I conclude that, in this study at least, such an approach to policymaking fails to do justice to the lives of troubled families and children who are not all alike and must not be treated as if they were.

There is a strong likelihood that a child in foster care at latency has been exposed to some sort of trauma (abuse or neglect) in her biological family. Relying on the analysis of psychological theory outlined above, we can also predict a strong likelihood that a female who as

a young child was exposed to trauma, especially that resulting in her removal from her family of origin, would by adolescence show symptoms of borderline personality traits. Policymakers' recent focus on the push to permanency for foster children through adoption without significant, clinically based pre-adoption services fails to appreciate the etiology of borderline personality disorder in young girls in foster care and the role played by boundary ambiguity.

Over the course of four decades there has developed a national policy framework for the protection, care, and placement of children in foster care with the goal that these children find stable and safe homes (Allen & Bissell, 2004). Foster care provides a necessary service to children living in biological families that cannot keep them safe (Kernan & Lansford, 2004). These children have often experienced some combination of maltreatment, poverty, parental psychopathology, exposure to substance abuse, and domestic violence. As a result, the children enter "the system" often with significant emotional, behavioral, educational, and health problems of their own. Indeed, "merely entering foster care and experiencing its concomitant requirements of forming new relationships and attachments and separating from biological parents may lead to additional problems" for these already vulnerable children (Kernan & Lansford, 2004, p. 524). The concerns about children languishing in foster care while waiting for their biological families to heal, with little funding for either the children in care or the families in need, have led policymakers to equivocate on the question concerning what is in the best interest of the child, as noted in the consideration of ideological and historical contexts below.

It is known that "older children [in] foster care may have been exposed to more maltreatment than younger children, have stronger ties to their birth parents, and have more ingrained learning and behavioral styles, making it more difficult for them to adjust" (Christian, 2002).

The total annual cost to administer the foster care system as of 2002 was over \$7 billion (Moye & Rinker, 2002). Of the children in foster care, about 33% were diagnosed with three or more psychiatric disorders (Moye & Rinken, 2002). Of special pertinence to this study is that, in

1999, 46% of the children in foster care were 11 years or older (USGAO, 2002). Older children (interestingly, “older” is not defined in any of the literature), children of color, and children with disabilities of any sort have longer lengths of stay in foster care (Smith, 2003). Studies have shown that the chance of leaving foster care “decreases sharply” after the child has been in care for more than a year (Smith, 2003, p. 968).

Milan and Pinderhughes (2000) rely on attachment theory to explore how maltreated children make the adjustment to foster care. They discuss the “impaired working models of self and interpersonal relationships” that children with “early experiences of erratic or insensitive parenting” may have (2000, p. 64). These children therefore enter foster care with both impaired representations of themselves and impaired views of relationships with others. They “face an immediate crisis—separation from the familiar” (Milan & Pinderhughes, 2000, p. 76), which may lead to glorifying their biological family, denying negative feelings about their biological mothers, and making only positive reports of their parental relationships in an effort to influence where they will be placed (Leathers, 2003; Mitchell & Kuczynski, 2010). That seemingly secure attachment to a “dysfunctional mother” and family and the “denial of negative information about one’s parents is associated with maladjustment” and “may pose great risk for later symptomatology” (Milan & Pinderhughes, 2000, p. 76).

With the social problem thus defined, we can move on to the ideological perspective that has a bearing on the social policy analysis. Child welfare professionals have attempted to achieve permanence for foster children since the first documentation of children “stuck” in foster care in 1959 (Testa, 2004). In the 1970s the evidence of the negative effects of long-term foster care placement on the child’s well-being resulted in a consensus in support of permanence (Testa, 2004). Often, however, tension surrounded the ideal goal of permanent placement as it was not always clear with whom the child should permanently reside. Conflicts also erupted over such issues as the importance of the biological family and the importance of stability and who would

decide what was in the child's best interest. Such tension was reflected in the various objectives of federal policy.

A different framework for foster care was created by the enactment of the Adoption Assistance and Child Welfare Act (AACWA) in 1980. While this Act did ensure continued federal funding for foster care, it introduced at the same time several policy initiatives: finding the least restrictive settings for the child's needs, setting up a periodic review of the child's care, and emphasizing reunification (Allen & Bissell, 2004). It also led to an initial decline in the number of children in foster care, the rate at which they entered, and the length of time they remained. But by the mid-1980s the numbers began to rise once more, due in large measure to an increase in unwed teenaged mothers and an increase in substance-abusing mothers (Kernan & Lansford, 2004).

The Adoption and Safe Families Act of 1997 was part of the political reform agenda that began in 1996 when Congress passed the Personal Responsibility and Work Opportunity Act (PRWOA). The ASFA was enacted in November 1997 with bipartisan support as an amendment to the 1980 Adoption Assistance and Child Welfare Act (AACWA). Although the Act stressed the importance of permanence for children, it nevertheless made clear that foster care could provide a temporary alternative for those who have been abused or neglected (ASFA, 1997; Allen & Bissell, 2004). This marked the first time that federal law explicitly made the child's "health and safety" the most important factor in deciding whether she should be removed from the biological home and, later, returned to that home, assigned to foster care, or placed permanently in another home. The Act further promoted both safety concerns and the interest in permanent placement for abused and neglected children by providing incentives for states to "change policies and practices to better promote children's safety and adoption or other permanency options" (Children's Defense Fund, 2000; ASFA, 1997). Most salient to the challenge to social policy considered here, ASFA required states to use their bonus funds from federal payouts for child welfare services, which included postadoption services. Supporters of the legislation saw it

as the “cure for years of poor child welfare system administration and represented a philosophical shift from reunifying broken homes to putting the health and safety of children first” (Moye & Rinker, 2002, p. 3). They believed that ASFA would “dramatically change the pattern of the child welfare system” by moving children to permanency more quickly and providing services more effectively (Moye & Rinker, 2002, p. 5).

Both ASFA and PRWOA rest on the conviction that social policy should not reward women who have children out of wedlock only to raise them while on welfare, and that social policy should not provide the means or support for parents who use illicit drugs by caring for their children (Stein, 2003). The main goals of ASFA were to keep children safe and to place them in permanent homes as soon as possible (Stein, 2000). To that end, ASFA expedited the timelines of decisionmaking concerning whether children in foster care can be moved to permanent homes, put increased attention on the safety of children in foster care, eliminated long-term foster care as a permanent placement, recognized kinship care as a permanency option, provided payment incentives to states that increased their adoptions over an established base rate for a year, expanded services to include both reunification and adoption promotion activities, and required tracking of outcome measures, thus increasing accountability (ASFA, 1997; Allen & Bissell, 2004).

Under the provisions of ASFA, the termination of parental rights was closely linked to adoption and required the state agency to concurrently pursue both. The most significant change to adoption law and foster care was the requirement that a “permanency hearing” be held within 12 months of a child’s entering foster care; this measure caused more difficulties for the child welfare system than any other ASFA provision (Moye & Rinker, 2002). Another significant change wrought by the Act was that the state must file a petition to terminate parental rights in the case of a child who has been in foster care for 15 of the preceding 22 months (ASFA, 1997; Moye & Rinker, 2002). With the passage of ASFA, state and local agencies were given the primary responsibility for the welfare of their state’s children.

ASFA's major provision was adoption incentive payments made directly to the states. These encouraged the states to turn their focus away from reunification of the biological family and toward permanency through adoption (Moye & Rinker, 2002). Two seemingly opposing emphases emerged: the development of permanency plans were expedited by reducing the amount of time required before terminating parental rights and thereby encouraging adoption, while at the same time the Act emphasizes "the importance of preserving biological families if doing so is feasible," thus "providing the stable and continuous care for children that scientific research shows to be important" (Kernan & Lansford, 2004, p. 534). This conflict confuses all involved: biological parents, adoptive parents, professionals trying to help, and the already tormented children.

The social problem underlying this study concerns the lack of awareness and understanding by state agency providers of the potential relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care with a history of trauma. The causal analysis of this problem begins with the lack of support for families in trouble. By understanding how trauma is handed down through generations, how poverty affects the ability of family members to live healthy lives, and how "blaming the victim" continues to dominate our understanding of those in need in our society, we can better appreciate the causes of this social problem. Moreover, working to solve the problems of poverty, substance abuse, domestic violence, sexual abuse, physical abuse, and emotional abuse, as well as providing a sense of hope for the adults who bear those children who end up abused and neglected, represent major steps toward resolving or at least ameliorating the problem.

The lack of continuity between the various supports and agencies that make up the child welfare system is a paradigm for the way the system is unable to root out its shortcomings and provide a much needed corrective. The care it offers troubled children must be "sufficiently flexible to address the individual needs of the child; . . . comprehensive so that the needs of the 'whole' child can be met; places a priority on responding immediately to the vulnerable families



of foster children; and ultimately avoids duplication of effort and funds” (Harden, 2004, p. 43). All those involved in child welfare—social workers, supervisors, judges, attorneys, guardians ad litem, therapists, psychiatrists, case managers, legislators, and probation officers—need their roles clearly defined in light of a plan for advocacy that begins with the high-risk family (Martin, Barbee, Antle, & Sar, 2002).

In terms of policy analysis, distinguishing between “gainers” and “losers” is difficult in the context of this social problem because it appears that all involved are “losers.” The pertinent attachment issues and their affect on children and families have already been noted. Because there is a lack of consensus “on what outcomes demonstrate achievement of the goal of promoting child well-being” and on the degree to which the child welfare system should take responsibility for this goal, the children continue to lose out—or at the very least they become recipients of what others think they need (Harden, 2004, p. 43). In the rush to secure permanent placement, the biological family’s rights may actually be terminated before an adoptive placement for the child is found, leaving the child with no legal ties at all (Kernan & Lansford, 2004). As difficult as all of this is for any child, it is even worse for children of color, who are less likely to receive services to prevent disruption of the biological family or to reunite with the family of origin, and who once removed stay in the foster care system longer than Caucasian children (Curtis & Denby, 2004).

The biological families of these children are also “losers.” ASFA established new timelines that have had a significant impact on biological families. Where there had been no law connecting termination of parental rights with time spent by children in foster care, ASFA required states to file the petition and approve a “qualified adoptive family” for any child who had been in foster care for 15 of the “most recent” 22 months (Child Welfare League of America, 1997, p. 3). In addition, where dispositional hearings had been required within 18 months of the child’s removal from the home, ASFA mandated a permanency hearing within 12 months. The 12-month time frame of ASFA is often too short for biological parents to locate the services they

may require for substance abuse or mental illness. Public housing timelines also do not dovetail with the time frame of ASFA, often preventing biological families from acquiring adequate housing for reunification (Moye & Rinker, 2002). The overriding goal of ASFA appears to be to facilitate the termination of the biological parents' rights rather than to support their needs, as the increased focus on adoption has "unintended consequences for reunification" (Hollingsworth, 2000; Wulczyn & Hislop, 2002, p. 3). A 1999 field study by the General Accounting Office found that states had concluded that termination of parents' rights would not be in the best interest of the child in 60% of the children in foster care (Stein, 2003). This data points to a lack of congruence between Temporary Assistance for Needy Families (TANF) and ASFA. TANF has its own time frame within which the family can receive welfare benefits, but as it expires the child is often forced into foster care because the family lacks financial support (Moye & Rinker, 2002).

ASFA provides financial incentives to increase adoptions (Sec. 473A), but there are notably no incentives to agencies for strengthening and supporting biological families. This is likely due in part to the concern of child care providers that the funding for reunifying and for adoption come from the same pool of money and therefore present dilemmas for services providers, who might feel they can adequately fund only one interest (Kernan & Lansford, 2004). This lack of incentives to support the family is significant to this study. It is clear that the physical and psychological health of the mother is imperative for the return of her daughter in foster care. As a likely survivor of abuse and neglect herself, and very possibly living in generational poverty, where will she receive the guidance and support she requires for her improved mental health, improved parenting skills, and the ability to build a safe existence with food and shelter so that she can reunite with her child? And if the mother is not supported in these efforts, how will her adolescent daughter believe that her mother can change?

The judicial context of the social problem examined here has always been an important arena: the courts review the child's status in foster care, hold dispositional hearings, and promote

permanency placements. It is notable that ASFA leaves to the court the final decision regarding the best interest of the child: preventive and reunification services or termination of parental rights. There are significant obstacles to the realization of ASFA's timeframe that involve the court system. Poorly trained judges and social workers with heavy caseloads causing high turnover rates often result in a particular case having inadequate direction from the bench and multiple social workers—and no continuity of care. Building the case for termination of parental rights is a complicated job and driven by legal considerations that not all social workers are trained to recognize and handle effectively. Because the phrase “best interest” is not precise, judges must balance many competing interests: biological parents, extended family, social worker, foster parent with a desire to adopt, and the state. In some jurisdictions there is no family or juvenile judge and the presiding judge may have no expertise in these matters (Stein, 2000).

Through this policy analysis, it is easy to identify how the questions that my research addresses are salient to the issues intrinsic to foster care and could be invaluable to those who make policy decisions “in the best interest” of these children.

#### *Clinical Implications*

The psychological community has become increasingly sophisticated in its theoretical understanding of borderline personality disorder and the treatment of this disorder has shifted both *because* of the changes in the theoretical understanding as much as being the inspiration for those changes. Kernberg and Michels state that research of evidence-based treatment focuses on the DSM symptoms and “much less on the subtle and permanent features of their difficulties in work, love, social life, and creativity (2009, p. 507). They go on to state that the current “prevalent instruments for evaluating degrees of psychopathology and symptomatic change have not yet been geared to those fundamental aspects of personality functioning that determine the long-term satisfaction and effectiveness of a person's life project (2009, p. 508). In considering here the various clinical treatments, the question nevertheless persists whether how and if they apply to borderline adolescents.

The focus for treatment comes primarily from psychodynamic and cognitive-behavioral theories as well as pharmacotherapy, with the aim of “reducing anxiety, promoting ego development, and helping the child develop healthy interpersonal relationships,” but significantly, for this study, with no mention of the role of boundary ambiguity (Haugaard, 2004, p. 140).

Generalizing from a psychodynamic theoretical perspective, the goal of treatment in borderline adolescents is “the resolution of primitive defense patterns by establishing integrated and stable self- and object-representations that facilitate separation (autonomy) and individuation (individuality)” (Kernberg, Weiner, & Bardenstein, 2000, p. 166). This treatment approach centers on the adolescent’s perceptions of reality, including an understanding of the “expectations of unpredictability or rejection,” the fact of “the parents’ limitations as separate from themselves,” and a realization that they are not the “cause or victim” of their chaotic home environment (Kernberg, Weiner, & Bardenstein, 2000, p. 172). Each form of treatment considered here is meant as an intervention seeking to aid in the process of affective regulation, healthy defensive development, and positive internalization rather than projection (Haugaard, 2004).

The Practice Guidelines for the treatment of borderline personality disorder compiled by the American Psychiatric Association (2001) recognizes that in clinical practice with borderline patients a combination of treatment theories and modalities are an appropriate approach to treating this diagnosis. Choosing from the theoretical bases of ego psychology, object relations theory, and self psychology, psychodynamic psychotherapy with borderline patients depends on the therapeutic alliance for interpretation of the transference and resistance. Simply put, the functions of this “therapy as usual” are support, containment, involvement, structure, and validation (Gunderson, 2008). The goals of psychodynamic psychotherapy with borderline patients are to increase affect tolerance, decrease impulsivity, provide insight into relationship difficulties, make the unconscious patterns consciously available, and help the patient develop an understanding of the internal motivation of self and others. It should be noted that children who

experience symptoms of posttraumatic stress disorder in addition to symptoms of borderline personality disorder provide an added challenge to the treater. Work on controlling the PTSD symptoms must be addressed first or at least in close combination with the work on the borderline symptomology.

From the perspective of object relations, the integration of the good and bad in others and self is a major treatment goal. Self psychology, on the other hand, seeks to strengthen and empower the self in order to allow for greater cohesion and less fragmentation in the patient's experience. Support for each of the theoretical bases for treatment include increasing self-esteem, validating feelings, strengthening defenses, internalizing the therapeutic relationship, and helping the patient to learn to cope with difficult feelings (Oldham et al., 2001). This understanding of supportive therapy applies whether the clinician is working with adolescents or with adults. It has been acknowledged, however, that part of the hesitation in diagnosing adolescents with borderline personality disorder is that there are so few specialized treatments for adolescents with the disorder (Santisteban, Muir, Mena, & Mitrani, 2003).

### *Cognitive Behavioral Therapy*

Dialectical Behavior Therapy (DBT) is a popular cognitive-behavior approach developed by Marsha Linehan for outpatient parasuicidal and self-harming adults (1993). Linehan utilizes a theory of development of borderline behaviors that “incorporates both biological and social-environmental influences” (Robins & Chapman, 2004, p. 74). The biological influence includes a possible dysfunction of the emotional regulating system due to trauma or genetics; the environmental influence has to do with the “invalidating environment” where “erratic and inappropriate responses are given during childhood by insensitive and thoughtless caregivers” (Bateman & Fonagy, 2004, p. 121).

Dialectical behavior therapy has been modified for use by a number of groups in various therapeutic settings—by substance abusers, for example, and inpatients, but salient to this discussion is the modifications for adolescents. The primary modifications include a shortening of

the treatment to 12 weeks, reducing the number of skills taught, and simplifying the language in the skills training paperwork. Further modifications are including caregivers/parents in the skills training group and including family members in the individual therapy sessions when the family issues are most troubling. The individual therapy sessions are twice weekly. The therapist's consultation team and the telephone consultation between sessions remains the same as in adult DBT treatment (Robins & Chapman, 2004).

### *Mentalization and Adolescence*

There is a treatment model for adolescents with severe personality disorders called “reflective function,” which is often connected with mentalization treatment for adults (Bleiberg, 2001). Like Bateman and Fonagy, Bleiberg (2001) believes that reflective function both comes from and can be restored by secure attachments and involves a corrective experience as a psychodynamic principle. He affirms that forming secure attachments in treatment is accomplished by paralleling the course of normal development. Therefore these attachments are made secure when the therapy focuses on both locating and providing support services for the family “that lessen anxiety and hyperarousal, and promote a safe and secure environment for everyone” (Bleiberg, 2001, p. 157). The treatment is a systematic program to help these adolescents “regain reflective function in the face of the internal and/or external cues that trigger its inhibition” (Bleiberg, 2001, p. 153). Bleiberg states that changing the “mutually reinforcing patterns of maladjustment” in children and their families requires long-term therapy because “short-term programs fail to achieve sustainable functional changes” (Bleiberg, 2001, p. 157). Interventions that follow include those to enhance reflective functioning, to enhance the adolescent's impulse control and self-regulation, and to help the adolescent become aware of the mental states of others—to mentalize (Bleiberg, 2001).

### *Family Therapy*

It should be obvious that the treatment of borderline adolescents is not possible without the participation of the family in the treatment process. The consideration of affect regulation and the

invalidating environment, separation/individuation, or “deteriorated personality structures, social customs, and family networks” makes clear that family treatment that explores both “core family processes unique to the borderline syndrome and to the complex adolescent developmental stage” is paramount (Santisteban, Muir, Mena, & Mitrani, 2003, p. 252). The success and limitations of family therapy are especially crucial, for it is within the context of that treatment modality that the value of attachment theory for this area of clinical practice may best be appreciated (Main, 1995; Rutter, 1995).

There are multiple treatment models for families of borderline patients, though assessment of them makes it apparent that there are common precepts and components that are salient to success in this modality. Primary is the goal of psychoeducation, seen as a social treatment that can lessen the stress in a borderline family environment. This education removes the focus on parents/caregivers as the cause of the disorder, and instead validates for them that they have a very difficult child to raise. They need support and a safe place to express their feelings so that they in turn can provide the same for their borderline adolescent (Fruzzetti & Boulanger, 2005).

This psychoeducation of the family, however, does not alleviate responsibility on the family’s part but allows it to be addressed in a different aspect of treatment. It is imperative that the family learn to provide a predictable and validating family structure. As the adolescent works on regulating affect, maintaining positive relationships, and setting developmentally appropriate goals, aiding parents in leadership and communication skills to support and guide their vulnerable adolescent cannot be ignored. Maladaptive family interactions—some of which may have arisen from living with the troubled adolescent while others precede any difficult child behaviors—must be addressed.

It is easy for a family to “bypass” their significant family dynamics and instead “organize themselves around the presenting problems of the borderline member” (Kreisman & Kreisman, 2004, p. 122). One advantage of family therapy with a borderline adolescent is that the primary

transference figures may be in the room and can be addressed directly in the treatment.

Minimization from patient and family can be attended to directly in the room with all parties present. As a result, it is apparent that family therapy with borderline families “should not be passive [for] without active intervention, patterns of blame, anger, frustration, projection, guilt, rigidity, and lack of conflict resolution may persist” (Kreisman & Kreisman, 2004, p. 125). DBT family therapy has become increasingly popular and other skill-based family treatments continue to emerge in the arena of family therapy for borderline adolescents (Fruzzetti & Boulanger, 2005).

The intensity of family therapy with a borderline family raises the question regarding who does the treating and in what sequence. Since family intervention is part of a “treatment package,” it is left to the therapist’s discretion whether family therapy occurs simultaneously with individual therapy or whether individual treatment begins first so that a therapeutic alliance can be more solidified. Borderline families have the tendency to split, often demonstrate the “extreme and persistent reversal of parent-child roles,” and accept violent behavior, “strongly held projections” and “family myths which are incongruent with reality” (James & Vereker, 1996, p. 271). To treat with any hope of success a borderline patient, full knowledge of the social context of the patient—her family, past and present, and its environment—is imperative. Insecure and “oscillating” attachments are the primary problem in these families, suggesting a “natural link” between family therapy and attachment theory (James & Vereker, 1996, p. 279).

#### *Attachment Therapy*

Therapy for attachment or trauma-related problems is a long and arduous process due to the complexity and severity of the difficulties. James (1994) speaks of “The Blueprint for Attachment Therapy,” which outlines the specific areas that require attention in this treatment. These areas include much of what has already been discussed regarding treatment for borderline patients: affect tolerance and regulation, relationship building, lowering impulsivity and mastering behavior, and developing a self-identity (James, 1994). She specifies that attachment therapy is



not traditional adolescent individual therapy or traditional family therapy and that it attends to the attachment relationship, the adolescent, and the parents/caregivers. James (1994) asserts that the establishment of a safe and protective environment must come first. She also recognizes that the exploration of losses and past trauma will be woven throughout treatment, but most likely not until some progress has been made in affective regulation and behavior control. James (1994) acknowledges that this treatment may possibly occur as a combination of outpatient therapy and therapeutic parenting in the home and school, or it may require a residential setting for the child with a transitional program that provides support as the child moves home.

James divides attachment relationships into five categories based on the quality of the relationship: “good enough, maladaptive with potential for change, maladaptive without potential for change, new primary caregiver, and nonprimary supplemental attachment” (1994, p. 50). James states that using these “relationship-based categories of treatment” can help the clinician stay focused on the principal issue of treatment: the attachment relationship (1994, p. 50). These treatment foci as they relate to goals are as follows: for good enough the goal is to reestablish attachment. The goal for maladaptive with potential is trauma work and modification of attachment. The goal for maladaptive without potential is resolution of loss, trauma work, and to prepare the child for a new or restructured relationship. For the new primary attachment the goal is to facilitate mourning and then relationship building. And for the nonprimary supplemental attachment the goal is to support the primary relationship, clarify the roles, and then build relationships (James, 1994).

A question that emerges from these considerations is how families—and in the case of this study, families in crisis with ambiguous boundaries—cope with adolescents with severe symptoms when there is no obvious treatment approach that produces positive results consistently. The primary factors that correlate to the severity of the attachment disorder are the age of the child when removed from the family of origin, history of abuse and neglect in the first two years of life, and the number of prior placements (Levy & Orlans, 1998). Moreover, it is also

salient that “recent advances in prenatal psychology have shown that . . . at birth, the newborn ‘knows’ who his or her mother is and is not,” which contributes to the importance of this study (Levy & Orlans, 1998, p. 217).

There are five family situations that Levy and Orlans (2000) identify as disrupting family security: the loss of an attachment figure, the child’s turning to an inappropriate attachment figure due to the unavailability of the appropriate attachment figure, the ongoing and destructive conflict between caregivers or between children and caregivers, one family member forming an exclusive connection with the attachment figure that results in the prevention of a connection with the child, and finally the caregiver’s unresolved attachment conflicts. It is easy to understand how any one of these situations can compromise a child’s attachment prior to or after being placed in foster care. It is also thereby easy to conclude that children who are in foster care during adolescence have had at the very least a disrupted attachment to their birth parents, putting them again at risk for an attachment disorder. When the history of some form of trauma—which unfortunately may be likely, for why else would a child remain in foster care at adolescence—adds to the already difficult situation, it should be no surprise that upon reaching adolescence that child will show a heightened likelihood for developing borderline personality disorder.

If all involved in the care of the child has been guided in the right direction, attachment therapy would have begun prior to removal from the home. As part of the pertinent treatment program, the child must address prior psychosocial trauma and the disrupted attachment and begin to improve the “internal working model” and appropriate coping skills (Levy & Orlans, 2000, p. 250). The caregivers must address their own family-of-origin issues that may be in the way of optimal interpersonal functioning. Concurrent couples or individual therapy for the caregivers is important in this treatment program, depending upon the psychopathology of the caregivers, so that the advancement of the child in therapy does not surpass that of the adults (Levy & Orlans, 2000; Brisch, 2002).

In the parent–child relationship there must be a facilitation of a secure attachment that includes trust and emotional closeness. The “secure base” that is provided by therapy can make possible “an affective ‘new beginning,’ or a ‘corrective emotional experience’ [and] is a fundamental prerequisite for the processing of old maladaptive attachment patterns” (Brisch, 2002, p. 85). In family dynamics there must be a modification of negative patterns of relating that results in enhanced stability, support, and positive environment. Finally, regarding parenting skills, the caregivers must learn the skills of Corrective Attachment Parenting, which include knowing their own attachment history, taking responsibility for creating a secure attachment framework, showing willingness to use new parenting skills and ideas, and providing a balance of nurturance and structure for the parent, her co-parent, the child, and the family (Levy & Orlans, 2000).

#### *Theory of Boundary Ambiguity and Treatment*

Although there is no specific protocol of treatment regarding boundary ambiguity, Boss does outline areas that should be addressed. She states that the “major theoretical premise underlying therapy is this: the greater the ambiguity surrounding one’s loss, the more difficult it is to master it and the greater one’s depression, anxiety, and family conflict” (Boss, 1999, p. 7). Boss (1999) explains that the only way that grieving can begin is by moving from “denial to a reluctant acceptance” thereby lessening the ambiguity (p. 83). Then the process of merging two opposing ideas, for example for a girl to keep “her mother both absent and present,” is the goal of treatment (Boss, 1999, p. 105). There is a redefinition of the relationship to the missing person and a realization that “the confusion we are experiencing is attributable to the ambiguity rather than to something we did—or neglected to do” (Boss, 1999, p. 107). She goes on to state that at “the root of the ambiguous loss model is the contextual stress perspective discussed . . . with an emphasis on resilience. What this means is that when there is a situation that cannot be fixed or an illness that cannot be cured, our therapeutic goal is to help clients live with the inherent stress and anxiety by increasing their resilience. We cannot get rid of the ambiguity, but we can

increase tolerance of ambiguity” (Boss, 2006, p. 11). It is important to this study to note that this acceptance of the dialectic of ambiguity is not different from the treatment for black-and-white thinking so commonly found in borderline personality disorder making treatment for both boundary ambiguity and for borderline personality disorder ideal companions.

Boss asserts that individual therapy alone is not enough when dealing with ambiguous loss, recommending both family and community interventions. However, when the “players in the therapy process . . . remain ambiguous” (for example, when social services cannot be sure if reunification of an adolescent girl and her mother will occur) treatment is very difficult, as the boundary ambiguity is continued by the not knowing (Boss, 2006, p. 32). Boss recommends that therapists require, in these circumstances, specific strategies to find meaning amid ambiguous loss. These strategies include the process of “searching for new options about who to be and what to do now,” “trusting that the stress of change will be less painful than maintaining the status quo,” reconstructing their “psychological family,” and ultimately learning to live with “the tensions of contradictory feelings and emotions” (Boss, 2006, pp. 128, 130, & 160).

As we have seen in this chapter, there are multiple models of treatment and multiple modalities within each model that attempt to ease the pain both of those with borderline personality disorder and of those who treat them. The more we come to know about the role of attachment in the etiology of this disorder, the more we can expect the treatment for those afflicted to begin at an earlier age.

#### *Current Research*

The culmination of this study is a review of the research literature pertinent to my specific area of interest: the relationship between boundary ambiguity and borderline traits in adolescent girls in foster care. I have yet to find any literature bearing directly on this topic. While, on the one hand, this may provide the opportunity to help close a significant gap in the research literature, it does, on the other hand, pose challenges when trying to give an account of what is at present the most significant empirical research for this study. Because of the dearth of

research to even come close to the topic of the relationship of boundary ambiguity and borderline traits, the empirical research discussed here is geared toward illuminating the process by which this study question emerged.

I begin with a discussion of articles concerning the influence of abuse on borderline personality disorder. The rationale governing the selection of articles is that this study involves foster children who do not become foster children unless some abuse or neglect has occurred to them in their home of origin. This discussion is followed by an exploration of the literature on attachment's influence on borderline personality disorder. The pertinent research at this juncture deals with the theoretical understanding of the powerful influence insecure attachment has on the development borderline personality traits. I then turn to research regarding the question of how abused children make meaning of the concept of "family," which leads to an assessment of the research on boundary ambiguity, which more fully explores the concept of family and one's role in family, most especially in the two articles regarding foster children and ambiguous loss. Therefore the influence of abuse on attachment styles leads to the influence of attachment styles on borderline personality disorder, and the influence of abuse on the conception of family leads to how boundary ambiguity encompasses that family conception. Since these linkages begin with "abuse," the context of foster care is salient throughout and connects to form the question regarding the relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care.

*Research on the Influence of Abuse on Borderline Personality Disorder*

Bradley, Jenei, and Westen (2005) acknowledge that for the past 20 years research has "identified several factors likely to contribute to the development of BPD, including history of childhood abuse, unstable or otherwise toxic family environment, and family history of psychopathology" (p. 24). In highlighting these factors, the authors make the point that no one has heretofore attempted to "disentangle" both physical and sexual abuse from the "broader family and parental dysfunction" (p. 24). Their sample of 524 psychologists and psychiatrists were asked to provide

the solicited data from only one client each. Data were collected using measures of personality disorder, including Shedler and Westen's SWAP-200, measures of child abuse, family environment, and family history of psychopathology. Through the data analysis of multiple regressions the study concludes that both physical and sexual abuses are "important etiological contributors to borderline symptoms," but they also find that this abuse occurs in the "context of a disturbed family environment, whose effects can be difficult to distinguish from the effects of abuse" (p. 30). This study, like mine, focuses on abuse's influence on borderline personality disorder, as well as its use of the SWAP-200 as a measure, and the utilization of the clinician as the sample member. It does not, however, discuss adolescents and it uses the term "development" when speaking of borderline personality disorder. No clinician has seen borderline personality traits just disappear after their development; indeed, it is their intractability that results in all the research done on the topic of borderline personality disorder. This study is not an exploration of borderline personality disorder's etiology as much as an understanding of how boundary ambiguity exacerbates the traits that already exist. (There is the distinct possibility that boundary ambiguity will after future research be found to be part of the etiology constellation, but that is not the goal of this study.)

*Research on the Influence of Attachment Styles on Borderline Personality Disorder*

Liotti and Pasquini (2000) examine the predictive factors for borderline personality disorder through their exploration of the experience of, and losses suffered by, the attachment figure. They reiterate the research findings concerning the predictive value of childhood abuse on borderline personality disorder. They also note that "there is an interesting similarity between the borderline personality disorder and the path of personality growth laid open by disorganized attachment" (p. 283). These two issues are combined to form their hypothesis: if both early trauma on the part of the child and losses by the attachment figure at the time of the child's birth are risk factors for borderline personality disorder, then "we should expect a higher prevalence of exposure to such events among cases of BPD compared to controls" (p. 283). Using a case-

control approach, Liotti and Pasquini gathered a sample of 66 cases of borderline personality disorder and 146 controls. Sample inclusion criteria required members to be over 18 years of age and to have a living mother with whom they were still in contact. Conclusions noted that the probability of developing borderline personality disorder in the future for a child who experienced early childhood trauma was 5.3 times greater than the control, while the probability of developing borderline personality disorder in the future for a child with a mother with a perinatal serious loss was 2.5 times greater than the control. They note that a limitation of their study is that, although abuse and loss appeared to be independent predictors of borderline personality disorder, due to the small size of their sample they were prevented from studying the interaction of both.

This study is included as salient empirical research because of its focus on both abuse and the emotional state of the biological mother and because the influence of both are predictors of the development of borderline personality disorder. The influence of the biological mother on her child is of utmost importance for my study in regard both to attachment styles and boundary ambiguity, and how they relate to borderline personality traits.

Nickell, Waudby, and Trull (2002) explore the predictive possibilities of attachment and parental bonding on the development of borderline personality disorder. They discuss the influence that childhood abuse would have on the relationship between the child and her caregiver, and note that significant strain on their bond could lead to maladaptive attachment styles and therefore to symptoms of borderline personality disorder. In their study, Nickell et al. assess whether parental bonding patterns and attachment styles were “significantly related to BPD features above and beyond what can be accounted for by negative childhood events” (p. 148). The sample was 398 18-year-olds selected through a screening process at the University of Missouri-Columbia. Each sample member was administered structured interviews assessing borderline features (SIDP-IV and DIB-R) as well as self-reported assessments on attachment and parental bonding. By controlling for “the full range of non-BPD Axis II symptoms, comorbid

Axis I disorders, and adverse childhood experiences” (p. 148) through regression analysis, the results of the study show that attachment patterns and parental bonding are significantly related to borderline personality disorder features. Although the research of Nickell et al. does not include adolescents and is drawn from a nonclinical sample, it does help clarify my research question. Since it is known that foster children are almost always exposed to significant trauma (or would not have been removed from their home), this study’s results of the predictive qualities of attachment and parental bonding are directly related to how the foster children in my study will feel about their mothers, who either did the abusing or “allowed” it to happen. This is likely to have a significant impact by increasing the degree of boundary ambiguity.

Nakash-Eisikmovees, Dutra, and Westen (2002) also explore the relationship between attachment patterns and personality pathology, and do so in adolescents, acknowledging how recent is the inclusion of adolescents in research concerning attachment and psychopathology. This study uses practice network methodology, relying on clinicians to make up the sample, as in Bradley, Jenei, and Westen (2005) above. The sample was a compilation of 294 psychologists and psychiatrists who were administered four measures of Axis II symptoms using adult Axis II criteria as well as the Shedler-Westen Assessment Procedure Q-sort for Adolescents (SWAP-200-A), which I use in my study. They were also administered a measure of attachment, the Child Behavior Checklist, and the Clinical Data Form. Findings include that “secure attachment was negatively correlated” with every personality disorder (p. 1117) and more salient to my study, that the “associations between disorganized/unresolved attachment style . . . [were correlated to] (a) history of lengthy separations from primary caretaker and (b) history of physical and sexual abuse” (p. 1119). Although this study does not name borderline personality disorder explicitly, it does indicate a relationship between the “disorganized/unresolved status” of the participant and the “empirically derived emotionally dysregulated prototype, which describes a type of adolescent who is overwhelmed by emotion and uses desperate measures to try to escape it” (p. 1120). These prototypes are directly derived from a “large sample of adolescent patients with



personality pathology rather than assumed to match categories and criteria developed through research and clinical observation with adults” (p. 1118). These findings are important for my research again because of the predictive ability of attachment, and because of the inclusion of adolescents, the use of the SWAP-200-A, and the particular finding about separation from primary caretaker (since each foster child in my study is removed from her primary caretaker).

#### *Research on Abused Children’s Understanding of Family*

Sherrill and Pinderhughes (1999) report on their relational study examining the differences in the understanding of family and adoption between children adopted after age 8 and their nonadopted peers. The study sought to resolve questions concerning the scope of the understanding on the part of older adoptees regarding what it means to be adopted, and to gauge as well their ability to elaborate their conception of "family."

The sample was 30 children, ages 8-11. Fifteen had lived with new adoptive two-parent families for less than 1 year when interviewed and 15 had lived with both biological parents since birth. The adoptees had first been removed from their birth parents at an average age of 3.8 years and had experienced an average of 2.87 prior placements. None of the adoptees was still in contact with a birth parent. This fact is an important variation to the possibly intermittent connection between foster child and biological mother in my study.

Data collection included acquiring demographic information, measuring cognitive functioning (WISC III), semi-structured interview about family and adoption, and the Structured Family Constellation Task. It was concluded that “overall, there were no differences between older adoptees and nonadopted children in their level of understanding of family or of adoption” and that therefore “the relatively limited exposure that older adoptees have had to a stable intact family does not jeopardize their basic understanding of family” (p. 38). This study is included here because of the finding that both children in an intact family and children adopted at latency (and removed from their biological families at an older age, as well as having been moved about) have the same understanding of what a family is. This is relevant to my study because the

adolescent foster children who are the subjects of my research have also been removed from biological families, with the difference that the children in the Sherrill and Pinderhughes have also been adopted—so their boundary ambiguity might in fact be thought to be less than those in my study, who remain in limbo.

Milan and Pinderhughes (2000) use the theoretical framework of attachment theory to expand on the concepts underlying the research just described by tracing the relationships among maltreatment, internal representations, and emotional adjustment with children entering foster care for the first time. This study focuses on the maltreated child's internal representations of her biological mother and how that representation influences the new relationship with a foster mother and the adjustment to a foster home.

The sample was 32 children, aged 9-13, who entered foster care during a 3-month period for the first time, and had experienced at least one episode of abuse by their biological mother. The children had been removed from their biological homes and placed in a residential facility for 4 weeks prior to placement in a foster home. The first measurements were administered between the second and third weeks of the stay in the residential placement. The children were administered the measurements again between the ninth and eleventh weeks in custody, after approximately 1 month with foster placement.

The most interesting finding in this study is the children's evaluations of their biological mothers, with whom the majority of the children reported having a positive relationship "characterized by love, warmth, and happiness," despite any maltreatment (p. 75). The authors remark that "this finding suggests a possible cognitive bias in the way abused or neglected youth process relational information" and that "these children's positive evaluations of their mothers may have unfavorable developmental implications. Specifically, there is evidence to suggest that the denial of negative information about one's parent is associated with maladjustment and that being securely attached to a dysfunctional mother may pose great risk for later symptomatology" (pp. 75-76). This study, like the Nickell, Waudby, and Trull (2002) above, is pertinent to my

work due to its finding that the children felt warmly toward a biological mother who had abused them and whom, we must assume, remained unfit so that adoption by another family was sought. This conclusion has a direct correlation to the findings I expect on the Boundary Ambiguity Scale #A, in which the child remains fixated on the positive aspects of her mother. Milan and Pinderhughes' remark concerning the potential for "unfavorable developmental implications" directly parallels my expected findings concerning borderline personality traits.

#### *Research on Boundary Ambiguity*

I have yet to find in the literature any research examining the relationship of boundary ambiguity and borderline personality traits. There are, however, studies that explore the relationship of boundary ambiguity to other situations, most significantly the connection between ambiguous loss with children in foster care. Fravel, McRoy, and Groterant's (2000) qualitative study explores the relationship between boundary ambiguity and adoption openness, which was operationalized as "contact and information-sharing between birth- and adoptive parents after an adoption plan is implemented" (p. 425). The sample was data gathered from 163 birthmothers who had participated in the Minnesota/Texas Adoption Research Project. The birthmothers had been gathered from 35 private adoption agencies where the levels of openness were varied. The birthmothers were administered an interview consisting of 300 open-ended questions addressing the mother's feelings about the adoption and about the level of openness involved. The interviews were audiotaped and transcribed. From the transcriptions a list of 10 categories of "markers" or "indicators of psychological presence" (pp. 427-428), which had been discerned from the previous pilot study, guided the coders in "assigning ratings on the variables of ultimate interest, degree and valence of psychological presence" (p. 428).

Data analysis showed "clear evidence that adopted children are psychologically present to their birthmothers, not only on special occasions but also as the birthmother goes about her routine, day-to-day life" (p. 428). This is to say that the psychological presence of the adopted child in the birthmother's heart and mind occurs most commonly in the mother's thoughts and

feelings, her concept of roles and boundaries, and connections made through genetic links. Although the results regarding boundaries and roles are consistent with those of other studies of boundary ambiguity, this is the first to demonstrate how differences occur when the physical presence is varied depending on the extent of adoption openness. This may be predictive in regard to my study, where the adolescents in foster care may also see their biological mothers in varying degrees of time. What is different, however, is that in this study there is no opportunity for ambivalence regarding the question of adoption, while in my study the ambivalence regarding how the story will end remains strong and unknown. The authors conclude that although these mothers may “get on with their lives,” they do not forget the child they gave up for adoption. This example of dialectical thinking--holding two opposing ideas in mind at the same time--is a skill known to assist with managing ambiguity. This study, therefore, is especially significant for mine since the capacity to engage in dialectical thinking is lacking in those with borderline personality disorder. This clinical understanding helps solidify my intent to demonstrate an important relation between boundary ambiguity and borderline personality traits, hypothetically the less able one is to manage ambiguity, the more likely to have high boundary ambiguity. It is significant however that the biological mothers in this study had a choice, where the foster children and their biological mothers in my study are mandated clients.

One of the first studies done by Pauline Boss (1977) involves the MIA families whose Vietnam military fathers are missing in action and are the source of the Boundary Ambiguity Scale #1 that I have varied (BAS-A) for my own study. This study’s purpose is to “establish a relationship between the sociological ambivalence of psychological presence with physical absence and dysfunction within the family system” (p. 141). Boss spoke about the father’s physical absence and psychological presence, just like the biological mother in my study, and how that situation causes the boundary ambiguity for the family system. In my study, I alter the perspective as one in which it is the adolescent who is ambivalent about both her boundary and

that of her mother, not knowing who is in or out. In the Boss study, it is the father who is missing and the family that suffers with the ambiguity.

Boss's hypothesis is that "psychological father presence with physical absence, if incongruent with reality and persistent over a long period of time, will be related to a high degree of dysfunction in the family system" (p. 142, italics removed). Boss defines "family dysfunction" as "the manifestation of emotional dysfunction in one or more members of a family system according to literature from family therapy" (p. 143).

The method of this study involved a pretest of 10 MIA families in the San Diego area. Each family was assigned two tasks: to plan something that they might do together (vacation trip, birthday party) and to discuss family closeness and what it meant to them. Raters viewed the family interactions live and determined variables that were factor analyzed for further clarification. From this pretest, 11 dimensions "were chosen as specific indicators of the independent variable," psychological father presence (p. 145). The representative sample was then drawn, consisting of 47 MIA families with fathers from all branches of military service. The mean number of years of father absence was 6.26.

Boss discusses how the MIA family is helpless in knowing whether the father is in or out of the system, much as the adolescent in foster care in my study is unable to gain clarity about what will happen to her and her mother, no matter who and how often she asks. The need for control, organization, and inflexibility were factors related to family dysfunction in this study and can be easily correlated to the simplistic black-or-white thinking of those with borderline personality disorder and to the inability to "go with the flow" thus leading to their further dysfunction.

My study differs most significantly from Boss in that her findings reflect the measure of boundary ambiguity in the context of the family as a whole, whereas my study measures that of the adolescent. Further, in Boss's study, the father cannot be reached, whereas in my study there

may be intermittent contact between mother and daughter and there may be a hint that if “only mother would improve” then reunification could occur.

The final two studies involve ambiguous loss—the losses which according to Boss’s definition actually cause the boundary ambiguity that I explore. Lee and Whiting (2007) acknowledge that foster care is “rife with circumstances wherein the losses are not clear-cut and final” (p. 417). Their concern is that the foster care system may not be aware of the significance of ambiguous loss for the children whom they hope to protect and that the children’s “attendant feelings of confusion, hopelessness, and ambivalence typically impede progress identifying and fulfilling case goals” (p. 418).

The sample for this qualitative study is divided into two parts. A group of 23 foster children aged 7-12 years old describe their foster care experience in semi-structured interviews. A second group was 182 foster children aged 2-10 years old respond to *Blacky Pictures*, which show a puppy in relation to its family. A limitation of this study is that no additional information about the sample or the interview is provided. Of the 11 *Blacky* pictures, the sample sees only the four that appear to the authors to be most illustrative of ambiguous loss.

The authors’ find through open coding of all responses that the children’s stories in both parts of the sample contain many of the symptoms characteristic of ambiguous loss. These symptoms include: frozen grief; confusion, distress, and ambivalence; experience of helplessness; uncertainty leading to immobilization; guilt, denial, and refusal to speak about situation.

Although the children are not the same age as my study’s sample, there is still significance in this study for my own. The connection between foster care and ambiguous loss symptoms is apparent, leading the way to my own question regarding the relationship between boundary ambiguity and adolescent girls in foster care. Just as in the following study, Lee and Whiting make specific recommendations to the foster care system. They recommend adding the concept of ambiguous loss to foster care treatment planning. They also underscore the importance of telling the truth to these children—because withholding potentially painful

information may “elicit, maintain, or exacerbate ambiguous loss” (p. 427). This connects directly to my boundary ambiguity questionnaire (BAS-A) and my hypothesis that the “not knowing” has an impact on borderline personality traits.

In the final study Samuels (2009) extends the “theoretical framework of ambiguous loss...to foster care” and therefore understands foster care as “an experience embedded in chronic and repeated loss events around one’s identity and sense of belonging within a permanent family system—an ambiguous loss of home” (p. 1229). Through interpretive qualitative research she uses Boss’s lens of ambiguous loss to “theorize (im)permanence” and examines the concept of “family” from the vantage point of young adults who have recently aged out of foster care (p. 1230).

The sample of convenience for the study is 29 young adults recruited in collaboration with the Jim Casey Youth Opportunities Initiative. Criteria for participation to be in foster care no longer and must have gone through the aging out of foster care process. The sample is approximate two-thirds female, 51% African American, 34% White, and 10% Latino, and over half the participants are high school graduates. Data collection comprises of an audiotaped 90-minute interview. The interview asks the participant about definitions of family, permanency, support, and closeness. It also includes questions regarding the participant’s feelings about adoption (especially for older foster children) as well as their involvement in their case plans. They also discuss their relationships with biological families, foster families, and surrogate parental figures.

Findings in this study are rich with qualitative descriptions of the participants’ definition of permanence as the “ideals of the authentic (i.e., ‘real’) family” (p. 1236). This loss of a “real family” in childhood was conceptualized as an “ambiguous loss of home” (p. 1236). The findings illuminate the methods the participants use to manage the ambiguity of the loss by making their own plans for permanence, rejecting adoption, and “attempting to build their own familial permanence as adults” (p. 1236).

The significance of this study to my own is apparent. Samuels states that her study joins a growing body of work finding the significance of “relational permanence” in the lives of children in foster care. She also acknowledges the relational complexities and the fact that these complexities must be a part of treatment planning for these children. The act of removing a child from his or her biological family is “institutionally caused ambiguous loss” (p. 1237), which in turn will result in the boundary ambiguity addressed in my study.

Samuels’s study has a significant influence on my own hypothesis insofar as it fits with my clinical observations of girls in foster care with borderline traits. In my own practice, I have seen girls psychologically cling to their biological mothers, no matter what those mothers have done or how they are currently participating in the lives of their daughters. It is the insecure attachment to this psychological presence that fascinates and has drawn me to my current study.

#### *Conclusion of Literature Review*

Through this review of psychological theory, clinical practice, social construction, implications for policy, and salient empirical research, it should be clear why this topic is relevant to clinical social work. Indeed, it was my own clinical experience working with adolescent girls diagnosed with borderline personality disorder that initially sparked my interest in this topic. These girls were primarily survivors of abuse—most of them in the custody of the state, and in irregular and conflicted contact with their families of origin, with no clear plan for what would happen next. They had been removed from abusive biological families with ambiguous plans for reunification set out by caseworkers, continually yearning for those tantalizing, clinically speaking, bad objects who are their parents.

The literature review raises many issues salient to this study. Boss discusses the relationship between attachment theory and boundary ambiguity. Intrinsic in her definitions is the role that time, presence, and clarity of reality play in the maintenance of or recovery from boundary ambiguity, which have led directly to the choice of variables of time away from family, physical presence of mother, and clarity of reality regarding reunification to be studied in this



research. The progression from attachment disturbance to borderline personality disorder connects the theoretical and the clinical understanding regarding boundary ambiguity and borderline personality disorder, which leads to this study's primary question. The clinical implication of this primary question leads one to wonder if clinicians working with attachment disorders are aware of the possible importance of boundary ambiguity as a source of conflict for their clients. In addition, do policymakers understand the construct of boundary ambiguity in the social construction of the family and does that understanding put the appropriate pressure on policymakers to enable families and children to receive the most effective support. The empirical research explored here brings to light questions surrounding all of these issues, but none that focuses specifically on the research questions I consider.

I am committed to further exploring the relationship between the borderline adolescent girl's attachment to the neglecting/abusive object, as understood through the concept of boundary ambiguity and how that relates to the lack of resolution of borderline traits. In so doing, I hope to improve our understanding of the scope and nature of clinical treatment that should be available to these adolescents. This understanding should prompt changes in the approach and policies of child protective services relating directly to those who may be predisposed to such a stigmatizing and insidious disorder. New policies might change the effect of the trauma inflicted by the children's families and unfortunately perpetuated by a federal system uninformed of the latest theory and research.

### CHAPTER III

#### METHODOLOGY

Relational research is a “deductive method of inquiry because it begins with a logical hypothesis, or provisional theory, about a specific relationship among phenomena, and the study methodology is also predetermined in advance based on the phenomena to be examined” (Anastas, 1999, p. 149). My own relational research falls within the arc of Anastas’s definition. I have carefully distilled my hypothesis from the literature review. Each variable was explored there and carefully linked together in a series of relationships: psychological theory to social policy to clinical treatment to current research. The relationship in my hypothesis, previously unexplored in the literature, completes the chain: that there is a relationship between boundary ambiguity of adolescent girls in foster care regarding their biological mothers and the girls' borderline personality traits. I apply two well-reviewed measures specifically chosen to gauge boundary ambiguity and borderline personality traits, explained in this chapter, meeting Anastas’s requirement for a predetermined methodology.

#### *Research Questions and Hypotheses*

The overarching question of this study is whether there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. The boundary ambiguity referred to is that between these adolescent girls and their biological mother. Three major questions can be discerned: (A) is there a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her biological mother; (B) is there a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care; and (C) is there a relationship between boundary ambiguity and the clarity of reality regarding the goal for reunification with biological mother. The tertiary questions embedded in secondary questions are displayed in Table 4 as well as their corresponding hypotheses.

## *Measures*

### *SWAP-200-A*

The dependent variable is borderline personality traits, as defined by the Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200-A) (Westen, Shedler, Currett, Glass, & Martens, 2003; Westen, Dutra, & Shedler, 2005). The SWAP-200-A (see Appendix R) has 200 items. The caseworkers and therapists completing the questionnaire were asked to provide the data based on a selected female adolescent patient (operationalized as ‘a client whom you have worked with for the past three months and seen in the past month who was the last patient you saw before completing this form who meets study criteria’) currently in treatment. It was decided not to include the criteria “ ‘enduring maladaptive patterns of thought, feeling, motivation, or behaviour—that is, personality’ ”(Westen, Dutra, & Shedler, 2005, p. 227) in order to compare the relationships between boundary ambiguity and the clients with borderline personality disorder and the clients without borderline personality disorder. As described by its creators, the SWAP-200-A is a “Q-sort instrument for assessing adolescent personality pathology designed for use by skilled clinical observer based on either longitudinal knowledge of the patient over the course of treatment or a systematic clinical interview of the patient and parents” (Westen, Dutra, & Shedler, 2005, p. 227). A Q-sort is a group of statements that “provides a ‘standard vocabulary’ for clinicians to use to describe their clinical observations” (Westen, Dutra, & Shedler, 2005, p. 227). The clinician filling out the SWAP-200-A sorted the statements into categories based on how the statements apply to the patient, from nondescriptive to highly descriptive. The measure “correlates with a range of variables such as attachment status, and history of suicide attempts, psychiatric hospitalizations, arrests, and family and developmental history variables” (Westen, Dutra, & Shedler, 2005, p. 227). The SWAP-200-A was adapted from the SWAP-200, which is the measurement for adults. Both the SWAP-200 and the SWAP-200-A have shown evidence of validity and reliability (Westen, Dutra, & Shedler, 2005). The personality disorder prototypes that the SWAP-200-A can distinguish are antisocial-psychopathic, emotionally dysregulated,

avoidant-constricted, narcissistic, histrionic, inhibited self-critical, and the psychological health index. The two sorts of clients that are “conceptually related to the DSM-IV borderline construct” belong to the emotionally dysregulated and histrionic personality prototypes (Westen, Shedler, Durrett, Glass, & Martens, 2003, p. 961).

#### *BAS-A*

Boundary ambiguity is an independent variable. Boss, Greenberg, and Pearce-McCall (1990) define boundary ambiguity as “not knowing who is in and who is out of the [family] system” (p. 1). They elaborate on this definition by stating that the “family may perceive a physically absent member as psychologically present *or* may perceive a physically present member as psychologically absent. . . . In either case, the family boundary is ambiguous” (Boss, Greenberg, & Pearce-McCall, 1990, p. 1). The construct of boundary ambiguity and the Boundary Ambiguity Scale (BAS) were “developed inductively out of the clinical observation . . . tested deductively with a population of military families experiencing extreme ambiguity in their loss” (Boss, Greenberg, & Pearce-McCall, 1990, p. 2), referring to male family members missing in action during the Vietnam War.

Boundary ambiguity scales measure boundary ambiguity “through self-reports of family members’ perceptions of psychological presence with physical absence . . . or physical presence with psychological absence” (Boss, Greenberg, & Pearce-McCall, 1990, p. 2). “Psychological presence” is defined as “the symbolic existence of an individual in the perceptions of family members, in a way that, or to a degree that, influences the thoughts, emotions, behavior, identity or unity of the remaining family members” (Fravel, McRoy, & Groterant, 2000, p. 425). Scales are adapted from the original Psychological Presence Scale depending on which perception is pertinent for the situation. The degree of boundary variability “refers to both real uncertainty about the loss of a family member as well as the failure of the family to alter its perception to fit reality after a loss has occurred” (Boss, Greenberg, & Pearce-McCall, 1990, p. 3).

What is especially salient to this study is how boundary ambiguity can “result from the outside world not giving the family enough information about the event of loss, or it can arise inside the family based on their perceptions of the loss” (Boss, Greenberg, & Pearce-McCall, 1990, p. 5). This fits with the concern of the adolescent girls and their biological mothers not knowing what the actual outcome of their separation will be. Equally important is the theoretical proposition of Boss et al. that “over the short term, family boundary ambiguity may not be dysfunctional” (1990, p. 5). In addition, “the higher the boundary ambiguity in the family system, the higher the family stress and the greater the individual and family dysfunction” (Boss, Greenberg, & Pearce-McCall, 1990, p. 5). This factor is salient to this study as well insofar as I am seeking the possible relationship between boundary ambiguity and borderline personality traits, which at the very least could be thought of as individual dysfunction.

For this study, the boundary ambiguity being measured involves perceptions of psychological presence with physical absence. As a result, the variations that I made were to the BAS #1, which was given to wives of men declared missing in action—also a situation of psychological presence and physical absence. The 18 statements of the BAS #1—originally written to be answered by the wife about her husband--were altered to reflect answers by the clinician or caseworker about the client and her mother. The thrust of each statement, however, is the same (see Appendix K).

### *Design*

This study’s design appears simple and straightforward. Email was sent to CPS caseworkers and therapists working with adolescent girls in foster care in residential programs in New England with the request that they complete a demographic questionnaire, the Boundary Ambiguity Scale (BAS-A ) specifically designed for this study, and the Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200-A), which is a Q-sort instrument for assessing adolescent personality pathology. As I discuss, however, the design was complicated

by administrative details and as a result the data collection took far longer to complete than anticipated.

This study uses a fixed method design that is relational. The benefit of using a relational design is that it allows for the examination of influences of one variable on another without experimentation (Anastas, 1999). This study, as a two-tailed research hypothesis, is nondirectional and states only that there is a relationship between the variables, but is not predictive. Because the work is deeply embedded in theory, it follows that “emphasizing understanding and explanation rather than notions of causation and proof” (Anastas, 1999, p. 154) will aid the study’s concentration on theory building. Experimental designs with subjects suffering from traumatic relationships would be neither possible nor ethical, as Anastas stated (1999).

#### *The Recruitment Process*

Request for permission to grant me email access to the CPS caseworkers working with adolescent girls in each New England state was made by email to the directors of the CPS departments in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont (see Appendix D). In the same manner, directors of the residential programs in the six New England states (New England Residential School Directory, 2008) who treat adolescent girls were emailed requesting permission for email access to the therapists working with the adolescent girls at these programs (see Appendix C). The term “adolescent girls” referred to girls between the ages of 14-18 who are in foster care after being removed from their biological families due to abuse or neglect.

Connecticut and Vermont and one residential program (Justice Resource Institute) had Institutional Review Board (IRB) requirements. Applications were made and approvals were granted. Due to the concerns of the Connecticut CPS Department and their experience with their staff finding the phrase “Survey Monkey” to be a racial slur, all references to this site were

changed to [www.survey.mk.com](http://www.survey.mk.com). The state of Vermont required that the ethnicity of the clients not be part of the data collection.

Inclusion criteria required that the participant have professional knowledge of an adolescent female client on his or her caseload who is in the custody of the state and whom they had seen in the past month and worked with for the past three months. The exclusion criteria required that they have no knowledge of such an adolescent currently on their caseload. To allow data analysis to examine both the relationship between the clients *with* borderline personality traits and boundary ambiguity and the clients *without* borderline personality traits and boundary ambiguity, the inclusion criteria did not require that the chosen client be diagnosed with borderline personality traits. That diagnostic data was garnered from the SWAP-200-A through data collection and therefore clients were not diagnosed by the participants.

#### *Sample*

The sample was drawn from a population of CPS caseworkers and therapists working in residential programs in the six New England states. There are 57 residential programs in New England with adolescents who fit the criteria and a CPS department in each state. The sample was one of convenience based upon the relative ease of accessibility to this population by email. I limited the population to the six New England states hoping this would provide a large enough sample without having to manage an unwieldy population. The goal of a sample of a minimum of 40 respondents was set to reach significant statistical power. As will be seen in the data collection section below, this study was not able to attract more than the goal sample size. At the conclusion of the recruitment process, directors of a total of four states' CPS departments and 13 residential programs agreed to their staffs' participation. The state of Maine refused to have their CPS caseworkers participate because the director believed the caseworkers to be too busy. Massachusetts CPS agreed to participation but could never ascertain how to provide me with the individual email addresses. Therefore, the state of Massachusetts also did not participate. In Connecticut, due to the inability of CPS to sort their caseworkers by type of client they serve,

CPS administrators requested that an introductory email be supplied to them (see Appendix H), which in turn they sent to approximately 3,000 CPS caseworkers. If the caseworkers chose to participate, Connecticut requested that the caseworkers then email me directly for further instructions.

The sample was drawn from a population of 463 email addresses (see Table 3). This number includes the ten responses that I received from Connecticut CPS caseworkers. Of this total, 40 respondents (8.6% of the population) completed all of the instruments that made up the protocol. All data analysis was done using this *N* of 40. There are an additional 28 respondents who completed only the surveymk (“Demographic Information About You,” “Considerations About Care of Your Client,” and the BAS-A).

Table 3  
*Participation*

Complete ( <i>N</i> = 40)	<i>N</i>	Percentage of population
Total number of email packets sent (the population)	463	100.0%
Nonresponders	<u>395</u>	<u>85.3</u>
Respondents who did BOTH surveymk AND SWAP-200-A	<b>40</b>	<b>8.6%</b>

There will be some exploratory analyses using the *N* of 68 (40 completers plus the 28 partial completers). This sample will be referred to as “Combined,” as it combines those subjects who completed all the instruments and those who completed everything except the SWAP-200-A (the “Partial” sample). Additional information will be provided separately for the “Partial” group also.



### *Methods and Procedures for Data Collection*

Once permission by the directors was granted and email addresses obtained, the population received an email “package.” This package contained a letter (see Appendix F) which served as informed consent and contained the participant’s unique user number, the link to the surveymk questionnaire, and explicit step-by-step instructions about how to participate. The two attachments to this email were the SWAP-200-A and a “gift” of a list of annotated web-based resources (see Appendix L).

Participation involved two steps: (1) completing the first questionnaire on [www.surveymk.com](http://www.surveymk.com) (a secure external website intended to collect data through surveys and designed with firewalls to ensure confidentiality), and (2) completing the SWAP-200-A. The surveymk questionnaire contained three parts: “Demographic Information About You,” a questionnaire requesting nonspecific information about the participant’s understanding of the client entitled “Considerations About Care of Your Client,” and the BAS-A. To be a participant, the caseworker or therapist completed both the surveymk questionnaire and the SWAP-200-A. Complete participation took from 60 to 90 minutes, but could be completed over several sessions. Given how busy all of the participants were, and how much paperwork was already a part of their work life, it was decided to provide a method of participation that could be done at one’s leisure.

The email letter explained the project, issues of confidentiality, and the anonymity of participation. By clicking on the questionnaire link or opening the SWAP-200-A, the participant indicated that he or she has read the email, understood the content, and consented to participate. Subjects were informed of their right to refuse to participate, their right to skip questions, and their right to withdraw from the survey if only partially completed. Participants, however, were not able to withdraw from the study once they submitted their survey. They were also informed how to contact the researcher with any questions. Each participant was assigned a user ID number in the email letter, which was used to link the data from the surveymk questionnaire and the SWAP-200-A for data analysis.

The participant was told in the email letter that compensation would come in two ways. By completing both the surveymk questionnaire and the SWAP-200-A, a \$1 contribution to either the Child Welfare League of America (<http://www.cwla.org>) or Mental Health America (<http://www.mentalhealthamerica.net>) would be made in thanks for their participation. This choice was provided as a question at the end of the surveymk questionnaire. Additional compensation came in the form of a list of helpful web-based resources to aid the participant in his or her work.

Participants were informed that the responses to both the surveymk questionnaire and the SWAP-200-A would be downloaded and analyzed. It was explained that responses would be combined and examined in groups, not individually, and that the data would be available to this researcher and the data analyst. They were informed that the survey data will be kept securely for three years, which is consistent with federal regulations, at which time all data will be destroyed.

#### *Completing the Surveymk Questionnaire*

To complete the surveymk questionnaire (including demographic information about the participant, nonspecific information about the participant's understanding of the client, and the BAS-A), participants clicked on the URL link provided at the end of the email letter, which connected them directly to the questionnaire. When the questionnaire was complete, they clicked "Done" and the data was sent to the secured database at [www.surveymk.com](http://www.surveymk.com).

#### *Completing the SWAP-200-A*

To complete the SWAP-200-A, the participant opened the SWAP-200-A attachment, making it possible to read "Overview" and "Score Distribution" for additional instructions. The participant then clicked on "data entry." The questionnaire was displayed as well as the instructions, restated. After completing the SWAP-200-A, the participant opened the Dartmouth URL provided in the email and uploaded the SWAP-200-A datafile to a secure server maintained by the BioInformatics Service Center at Dartmouth Medical School. The stated time frame for response was four weeks from the participant's receipt of the email. The original plan was to

send a reminder email to all participants two weeks after receipt of the original email package (See Appendix G-1). Due to difficulty with acquiring respondents, the data collection plan was adapted several times.

### *Data Collection*

The initial response from the emailing was inadequate. It became clear that the one reminder email would not be sufficient. One week after the first reminder email, I sent an additional reminder email (Appendix G-2). The response to this reminder also proved insufficient. After consulting my dissertation committee, I sent a reminder email that included an offer to upload the SWAP for the participant by their sending it to me as an email attachment (Appendix G-3). The next email reminded the participants that there were ten days left to participate (Appendix G-4). At this point the response rate remained low enough to warrant yet another strategy: a lottery was created in which participants were eligible to win a \$100 VISA gift card by completing the surveymk questionnaire and the SWAP-200-A (Appendix G-5). Permission was granted by the Smith College IRB to proceed. Emails were sent to participating agencies asking for any concerns regarding the lottery change; CPS in Connecticut asked that this offer not be made to their caseworkers.

At this juncture, reminder emails were sent weekly until I acquired 14 more participants, after which reminders were sent biweekly. These reminder emails are reproduced in Appendices G-6 through G-16.

### *Data Analysis Procedures*

Data analysis for this research involved descriptive statistics, correlations, simple analyses of variance (ANOVA), and *t* tests for independent samples. In addition, the primary instruments required their individual statistical computation. The SWAP-200-A “allows both dimensional and categorical diagnosis” (Westen, Shedler, Durrett, et al., 2003, p. 955). The dimensional diagnosis reflected the size of the correlation between the patient’s profile and a diagnostic prototype. According to Westen, Shedler, Durrett, et al., these correlations can be

converted to T scores to make interpretation easier (2003) and are then referred to as personality disorder scores. A Q-factor analysis was applied to the SWAP-200-A data in order to identify the “naturally occurring groupings” based on the personality profiles of the patients (Westen, Shedler, Durrett, et al., 2003, p. 955).

The BAS-A contains 18 statements that are rated on a five-item Likert scale ranging from "strongly disagree" to "strongly agree." The boundary ambiguity score is the summation of responses across items after the numerical answers to specific items have been reversed (Boss, Greenberg, & Pearce-McCall, 1990). For BAS-A, statements 1, 2, 6, 8, 11, 13, and 15 must have their answers recoded (1=5, 2=4, 3=3, 4=2, 5=1) before adding all sums of the individual answers for the total boundary ambiguity score. The higher the total sum, the more ambiguous is the boundary. According to Boss, Greenberg, and Pearce-McCall, the “best interpretation of scores is to examine within-sample comparisons, using central tendencies and measure of variation as well as correlations with other variables” (1999, p. 23). The BAS-A scores were classified based on upper and lower percentages. For example, the BAS-A was correlated with the results of the SWAP-200-A to address the primary research question regarding the relationship between boundary ambiguity and borderline personality traits.

### *Hypotheses*

This study’s primary hypothesis is that there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. The three secondary hypotheses embody variables that are proposed to have an influence on the primary hypothesis: time away from the biological family, presence of the biological mother, and the clarity of the goal for reunification with the biological mother. Based on previous research and clinical observation, the nine tertiary hypotheses which nest within the secondary hypotheses, provide an opportunity to drill more deeply into the core concepts that make up the secondary hypotheses and attempting to provide more explicit possible contributors to understanding the results of the study.

Using the scores from the SWAP-200-A and the BAS-A the following hypotheses, emergent from the research questions noted at the beginning of this chapter, were tested using the statistical methods indicated. These test results are explored in the following chapters.

*Hypothesis I*

A correlation analysis was conducted to test whether there is a relationship between boundary ambiguity and borderline personality traits. A significant correlation was expected.

The remaining secondary and tertiary hypotheses (see Table 4) were tested through different statistical analyses as outlined below.

Table 4  
*Research Questions and Hypotheses*

Research questions	Secondary research questions	Tertiary research questions	Hypotheses
<u>I.</u> Is there a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care?			There is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care.
	<u>A.</u> Is there a relationship between boundary ambiguity and the amount of time the adolescent girl in foster care spends away from her biological family?		There is a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her family.
		<u>A-1.</u> Is there a relationship between boundary ambiguity and the number of foster care placements?	There is a relationship between boundary ambiguity and the number of foster placements.
		<u>A-2.</u> Is there a relationship between boundary ambiguity and the age of the adolescent when removed from biological home?	There is a relationship between boundary ambiguity and the age of the child when removed from the home.
		<u>A-3.</u> Is there a	There is a relationship between boundary

Research questions	Secondary research questions	Tertiary research questions	Hypotheses
		relationship between boundary ambiguity and how many times the adolescent was reunified with biological mother in the past?	ambiguity and the number of times an adolescent was reunited with her biological mother.
	<b>B.</b> Is there a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care?		There is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care.
		<b>B-1.</b> Is there a relationship between boundary ambiguity and how often the biological mother visits her?	There is a relationship between boundary ambiguity and the number of times a mother visits her adolescent daughter in foster care.
		<b>B-2.</b> Is there a relationship between boundary ambiguity and whether the visits are planned, supervised, and/or a part of the daughter's treatment?	There is a relationship between boundary ambiguity and visitation by the biological mother as part of the treatment plan.
		<b>B.3.</b> Is there a relationship between boundary ambiguity and the behavior of the adolescent following the visit?	There is a relationship between boundary ambiguity and behaviors by the adolescent representative of traits of borderline personality disorder which occur after a visit with biological mother.
	<b>C.</b> Is there a relationship between boundary ambiguity and the clarity of reality regarding the goal for reunification with biological mother?		There is a relationship between boundary ambiguity and the clarity of reality of regarding the goal of reunification with biological mother.
		<b>C-1.</b> Is there a relationship between boundary ambiguity and the clinician/worker's clinical opinion about the possibility of reunification?	There is a relationship between boundary ambiguity and whether the clinician/worker thinks that reunification is possible.
		<b>C-2.</b> Is there a relationship between	There is a relationship between boundary ambiguity and whether the biological

Research questions	Secondary research questions	Tertiary research questions	Hypotheses
		boundary ambiguity and whether the biological mother's individual therapy is part of the treatment plan?	mother's individual therapy is part of the treatment plan.
		<b>C-3.</b> Is there a relationship between boundary ambiguity and whether parenting skills training is part of the treatment plan?	There is a relationship between boundary ambiguity and whether parenting training is part of the treatment plan.

*Hypothesis A*

A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her biological family. A significant relationship was expected.

*Hypothesis A-1.* A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the number of foster placements had by an adolescent girl in foster care. A significant relationship was expected.

*Hypothesis A-2.* A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the age of the adolescent when first removed from her biological home. A significant relationship was expected.

*Hypothesis A-3.* A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the number of times the adolescent was reunited with her biological mother. A significant relationship was expected.

*Hypothesis B*

A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care. . A significant relationship was expected.

*Hypothesis B-1.* A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the number of times a mother visits her adolescent daughter in foster care. A significant relationship was expected.

*Hypothesis B-2.* A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and visitation by the biological mother as part of the CPS treatment plan. A significant relationship was expected.

*Hypothesis B-3.* A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and behaviors by the adolescent representative of borderline personality traits that occur after a visit with biological mother. A significant relationship was expected.

#### *Hypothesis C*

A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and the clarity of reality regarding the goal of reunification between adolescent girl in foster care and her biological mother. A significant relationship was expected.

*Hypothesis C-1.* A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and if the clinician/worker thinks that reunification is possible. A significant relationship was expected.

*Hypothesis C-2.* A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and if the biological mother's individual therapy is part of the CPS treatment plan. A significant relationship was expected.

*Hypothesis C-3.* A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and if parenting training is part of the CPS treatment plan. A significant relationship was expected.

#### *Rigor and Limitations*

This study, seen in light of Anastas (1999), harbored multiple sources of potential bias. These biases fall under the general categories of sexism, racism, and heterosexism. Sample



members, however, are not excluded by race or by sexual preference. The fact that borderline personality traits are also found in male adolescents does not feature in this study. This should not compromise the findings in view of the predominance of females among those diagnosed with the disorder.

Strengths of the SWAP-200-A include that its “factors are theoretically and clinically coherent, internally consistent, and show convergent and discriminant validity in predicting a range of variables” (Westen, Dutra, & Shedler, 2005, p. 233). Its creators note that its “personality descriptions and ratings of adaptive functioning show high interrater reliability and validity and strongly predict relevant criterion variables as assessed by independent information” (Westen, Dutra, & Shedler, 2005, p. 236). Limitations of the SWAP-200-A include its “exclusive reliance on a single informant” (Westen, Dutra, & Shedler, 2005, p. 236), opening it up to observer bias. However, the fact that the clinician completing it is unfamiliar with its factor structure minimizes “the likelihood of systematic sources of error stemming from rater biases” (Westen, Dutra, & Shedler, 2005, p. 236).

Another limitation was the ongoing controversy concerning the “durability of personality pathology in adolescents” as well as its appropriateness, issues that continue to be argued in the world of mental health. It could also be stated that the high validity coefficients reported by the constructors of the SWAP-200 are “artificial, because the . . . descriptions of actual patients may have been based on the clinicians’ implicit prototypes or theories about their patients’ personality disorders, not on the actual characteristics of their patients” (Weston & Shedler, 1999, p. 271).

In the BAS, the validity of the construct is “based on the verification of a positive relationship between degree of boundary ambiguity and level of individual and family dysfunction across many different samples” (Boss, Greenberg, & Pearce-McCall, 1990, p. 7). Boss et al. note that since “boundary ambiguity is expected to change over time, we need to establish internal consistency reliability (Cronbach’s alpha) for each scale rather than rely on test-retest measures of reliability” (1990, p. 7). In BAS #1, Boss’s study of MIA families, Boss

(1977) "empirically established the *construct validation* of the Psychological Presence Scale (now titled the Boundary Ambiguity Scale)" (Boss, Greenberg, & Pearce-McCall, 1990, p. 7).

According to Boss's prediction, the psychological presence of the father was significantly related to the functioning of his wife and his family, where the low degree of psychological father presence was related to a high degree of "functionality for the MIA wife ( $r=.35, p<.05$ )" (Boss, Greenberg, & Pearce-McCall, 1990, p. 7). In a follow-up MIA study, Boss reported that the wives' BAS scores were "significant predictors of their functioning ( $R^2=.14, p<.025$ )" (Boss, Greenberg, & Pearce-McCall, 1990, p. 7).

Another version of the BAS (#3, regarding mid-life couples with an adolescent leaving home), is a variation of the BAS #1, with some statements changed based on "adolescent literature and on clinical judgment" just as in the case of the variation of BAS #1 used in this study (Boss, Greenberg, & Pearce-McCall, 1990, p. 9). The reliability of BAS #3 was calculated using the SPSS reliability subprogram. Its content validity was determined by a panel of 20 psychiatrists who examined the scale and deemed that the items "'made sense' and were relevant to the population under study" (Boss, Greenberg, & Pearce-McCall, 1990, p. 9). The results of the study utilizing BAS #3 provided "general support for the reliability and validity" of the Boundary Ambiguity Scale (Boss, Greenberg, & Pearce-McCall, 1990, p. 10).

The BAS-A will lack reliability or validity because it is a variation of BAS #1. Without a panel of experts to examine the scale as in the BAS #3 above, it will only have my "general support" if the relationships as laid out in my hypotheses are found to be significant and "make sense."

#### *Ethical Concerns*

Anastas (1999) states that there are "three ethical principles that should underlie research activities": beneficence, respect, and justice (p. 250). I earlier mentioned that my choice to question caseworkers and therapists rested on a concern for the fragile mental health of the adolescent girls and their mothers, and what damage questioning them directly might produce.

However, minimizing the harm to the caseworkers and therapists was of utmost importance and was an ethical concern. To lessen any risk, each person receiving the questionnaire had the right to delete it from their computers and never respond—in other words, all participation was voluntary. For those who chose to respond, I provided my name, address, phone number, and email address in case they required support for any difficult issues this questionnaire might have produced—either for them personally or professionally as well as a resource list for anonymous consultation. Treating young women with borderline personality traits is not for the weak of heart. It is often gut-wrenching work that might be stirred up by a questionnaire, work that one is able to keep in check through strong defenses while in the throes of the treatment.

Some of the ethical issues in this study centered on data collection. The use of email to distribute a questionnaire may result both in significant cost reduction as well as improved compliance; it does, however, raise concerns about the confidentiality of the data. It has already been stated that, although I knew the email addresses to which questionnaires were sent, I could not identify the responders as the questionnaires are returned. However, as I attempted to simplify the process (by offering to help by phone, by offering to upload the SWAPs for the participants) the concept of confidentiality all but disappeared, if the participant chose to take advantage of my offers. It is significant that no participant taking advantage of these offers stated concerned about a breach of confidentiality.

## CHAPTER IV

### FINDINGS

#### *Introduction*

The findings of this study can be divided into the following categories: demographic findings about the sample, descriptive statistics garnered from “Considerations About Care of Your Client,” findings from the BAS-A and the SWAP-200-A, and the findings of the hypothesis testing. The descriptive statistics analyzed with the two validated instruments (BAS-A and SWAP-200-A) provide the results of the hypotheses set forth in Chapter III.

#### *Demographic Findings*

As reported in Chapter III, the sample for this study is the 40 respondents who completed both the surveymk and the SWAP-200-A. In my discussion I refer only to the 40 completers, but the results for the 28 respondents who completed only the surveymk and the *N* of 68 (40 completers plus 28 partial completers) can be found in the referenced tables.

#### *The Sample*

The respondents are nearly all female and Caucasian (92 and 95% respectively) (see Table 5). They are equally divided among the four New England states. Over 65% of the sample is equally divided between 21-30 and 31-40 years old. Over 70% of the sample is equally divided between those who have either a BA/BS or a MSW degree. Approximately 67% of the respondents are CPS caseworkers, and of that cohort 42% have worked in child protection for 1-5 years. Twenty-five percent of the therapists are equally divided between 1-5 and 6-10 years as clinicians.

#### *Descriptive Statistics*

“*Considerations About Care of Your Client.*” Over half the respondents (53%) have two to four clients on their caseloads who met criteria for the study (see Table 6). Regarding the client the respondents chose to think of while completing the instruments, 60% have had the client on their caseload for more than a year. The client has been in custody of the state from 7 months to 3 years for 60% of the respondents. For 68%, the client was removed from her

biological parents when she was 11 years old or older. The client has never been reunited with her biological family for over half (57%) of the respondents, and been reunited once but subsequently removed for just under one-fourth (23%). Thirty percent of the respondents report that their client has had six or more out-of-home placements. The answers regarding improvement of the

**Table 5**  
*Demographic Information About You*  
*Frequency Data*

		<b>Complete</b> (N=40) n(%)	Combined (N=68) n(%)	Partial (N=28) n(%)
Gender	Female	<b>36 (92.3%)</b>	63 (94.0%)	27 (96.4%)
	Male	<b>3 (7.7%)</b>	4 (6.0%)	1 (3.6%)
Age	21-30 years	<b>12(30.0%)</b>	23(33.8%)	11(39.3%)
	31-40	<b>14(35.0%)</b>	24(35.3%)	10(35.7%)
	41-50	<b>4 (10.0%)</b>	10(14.7%)	6 (21.4%)
	51-60	<b>9 (22.5%)</b>	10(14.7%)	1 (3.6%)
	over 60	<b>1 (2.5%)</b>	1(1.5%)	
State	Connecticut	<b>1 (2.5%)</b>	1 (1.5%)	
	Maine		1 (1.5%)	1 (3.6%)
	Massachusetts	<b>10(25.0%)</b>	17(25.0%)	7 (25.0%)
	New Hampshire	<b>12(30.0%)</b>	21(30.9%)	9 (32.1%)
	Rhode Island Vermont	<b>9 (22.5%)</b> <b>8 (20.0%)</b>	15(22.1 %) 13(19.1%)	6 (21.4 %) 5 (17.9%)
Ethnicity	Caucasian	<b>38(95.0%)</b>	64(94.1%)	26(92.9%)
	Black	<b>1 (2.5%)</b>	1 (1.5%)	
	Hispanic	<b>1 (2.5%)</b>	3 (4.4%)	2 (7.1%)
	Asian			
How long worked for CPS	less than one year		1 (1.6%)	1 (3.8%)
	1-5 years	<b>16(42.1%)</b>	26(40.6%)	10(38.5%)
	6-10	<b>6(15.8%)</b>	10 (15.6 %)	4 (15.4%)
	11-15	<b>3 (7.9%)</b>	5 (7.8%)	2 (7.7%)
	16-20	<b>2 (5.3%)</b>	3 (4.7%)	1 (3.8%)
	Over 20	<b>1 (2.6%)</b>	2 (3.1%)	1 (3.8%)
	n/a	<b>10 (26.3%)</b>	17(26.6%)	7 (26.9%)

		<b>Complete (N=40) n(%)</b>	Combined (N=68) n(%)	Partial (N=28) n(%)
How long been therapist	less than one year			
	1-5 years	<b>4 (11.1%)</b>	10 (15.9 %)	6 (22.2%)
	6-10	<b>5 (13.9%)</b>	6 (9.5%)	1 (3.7%)
	11-15	<b>1 (2.8%)</b>	1 (1.6%)	
	16-20	<b>1 (2.8%)</b>	3 (4.8%)	2 (7.4%)
	Over 20			
	n/a	<b>25(69.4%)</b>	43(68.3%)	18(66.7%)
Highest degree	High school diploma	<b>1 (2.5%)</b>	1 (1.5%)	
	BA/BS	<b>14(35.0%)</b>	27(39.7%)	13(46.4%)
	MSW	<b>14(35.0%)</b>	25(36.8%)	11(39.3%)
	MA/MS/MEd	<b>10(25.0%)</b>	13(19.1%)	3 (10.7%)
	PhD			
	PsyD		1 (1.5%)	1 (3.6%)
	EdD			
	Other	<b>1 (2.5%)</b>	1 (1.5%)	

Table 6  
*Considerations About Care of Your Client*  
*Frequency Data*

		<b>Complete</b> (N=40) n(%)	Combined (N=68) n(%)	Partial (N=28) n(%)
Clients currently on caseload who fit criteria	Just this one	<b>13(32.5%)</b>	20(32.8%)	7 (33.3%)
	2-4	<b>21(52.5%)</b>	33(54.1%)	12(57.1%)
	5-10	<b>6(15.0%)</b>	8(13.1%)	2 (9.5%)
	Over 10			
How long has this client been in treatment with you?	3-6 months	<b>6 (15.0%)</b>	11(18.0%)	5 (23.8%)
	6-12 months	<b>10(25.0%)</b>	16(26.2%)	6 (28.6%)
	Over 1 year	<b>24(60.0%)</b>	34 (55.7%)	10(47.6%)
If you are her CPS caseworker, how long has she been on your caseload?				
Age of client	14 years old	<b>10(25.0%)</b>	16(26.2%)	6 (28.6%)
	15	<b>6 (15.0%)</b>	8(13.1%)	2 (9.5%)
	16	<b>8 (20.0%)</b>	11(18.0%)	3 (14.3%)
	17	<b>10(25.0%)</b>	17(27.9%)	7 (33.3%)
	18	<b>6 (15.0%)</b>	9 (14.8%)	3 (14.3%)
Length of time client in the custody of the state	under 3 months		1 (1.6%)	1 (4.8%)
	3-6 months	<b>2 (5.0%)</b>	5 (8.2%)	3 (14.3%)
	7 months – 1 year	<b>10(25.0%)</b>	14(23.0%)	4(19.0%)
	2-3 years	<b>14(35.0%)</b>	21(34.4%)	7(33.3%)
	4-5 years	<b>7(17.5%)</b>	10(16.4%)	3 (14.3%)
	6-8 years	<b>1 (2.5%)</b>	1 (1.6%)	
	Over 8 years	<b>6 (15.0%)</b>	9 (14.8%)	3 (14.3%)
I don't know				
Age when removed from her biological parent(s)	Under 1 month	<b>1 (2.5%)</b>	1 (1.6%)	
	1-3 months		1 (1.6%)	1 (4.8%)
	4-6 months			
	7 months-1 year		1 (1.6%)	1 (4.8%)
	2-3 years	<b>3 (7.5%)</b>	5 (8.2%)	2 (9.5%)
	4-6 years	<b>2 (5.0%)</b>	2 (3.3%)	
	7-10 years	<b>5 (12.5%)</b>	7 (11.5%)	2 (9.5%)
	11 years or older	<b>27 (67.5%)</b>	41(67.2%)	14(66.7%)
I don't know	<b>2 (5.0%)</b>	3 (4.9%)	1 (4.8%)	
Number of times reunited previously with her biological parents(s) and subsequently removed	She has never been reunited	<b>23(57.5%)</b>	35(57.4%)	12(57.1%)
	Reunited once before	<b>9(22.5%)</b>	12(19.7%)	3(14.3%)
	Twice before	<b>2(5.0%)</b>	3(4.9%)	1 (4.8%)
	Three times	<b>1(2.5%)</b>	1(1.6%)	
	Four or more times	<b>2(5.0%)</b>	2(3.3%)	
	I don't know	<b>3 (7.5%)</b>	8(13.1%)	5(23.8%)
Number of placements since initially removed from her home	1	<b>2 (5.0%)</b>	8 (13.1%)	6 (28.6%)
	2	<b>7 (17.5%)</b>	11(18.0%)	4 (19.0%)
	3	<b>8 (20.0%)</b>	8 (13.1%)	
	4	<b>6 (15.0%)</b>	8 (13.1%)	2 (9.5%)
	5	<b>4 (10%)</b>	6 (9.8%)	2 (9.5%)

		<b>Complete (N=40) n(%)</b>	<b>Combined (N=68) n(%)</b>	<b>Partial (N=28) n(%)</b>
	6 or more	<b>12(30.0%)</b>	17(27.9%)	5 (23.8%)
	I don't know	<b>1 (2.5%)</b>	3 (4.9%)	2 (9.5%)
Have you met the biological mother of the client?	Yes	<b>25(62.5%)</b>	39(63.9%)	14(66.7%)
	No	<b>15(37.5%)</b>	22(36.1%)	7 (33.3%)
Frequency client sees her biological mother	Weekly	<b>7 (17.5%)</b>	15(24.6%)	8 (38.1%)
	Bimonthly	<b>2 (5.0%)</b>	3 (4.9%)	1 (4.8%)
	Monthly	<b>4 (10.0%)</b>	6 (9.8%)	2(9.5%)
	No set schedule	<b>14(35.0%)</b>	17(27.9%)	3 (14.3%)
	Never	<b>13(32.5%)</b>	20(32.8%)	7 (33.3%)
Are these visits planned/predictable or intermittent?	Planned/predictable	<b>13 (41.9%)</b>	22(48.9%)	9 (64.3%)
	Intermittent	<b>9 (29.0%)</b>	12(26.7%)	3 (21.4%)
	Very rare	<b>9 (29.0%)</b>	11(24.4%)	2 (14.3%)
	No response			
Are visits with biological mother scheduled and supervised by CPS or up to biological mother?	Scheduled/supervised	<b>14(43.8%)</b>	15(32.6%)	1 (7.1%)
	Up to mother	<b>18(56.3%)</b>	31(67.4%)	13(92.9%)
	No response			
Are visits with biological mother part of the CPS treatment plan?	Yes	<b>24(63.2%)</b>	36(64.3%)	12(66.7%)
	No	<b>14(36.8%)</b>	20(35.7%)	6 (33.3%)
	No response			
Is family therapy with the biological mother part of the CPS treatment plan?	Yes	<b>16(41.0%)</b>	25(43.1%)	9 (47.4 %)
	No	<b>23(59.0%)</b>	33(56.9%)	10(52.6 %)
	No response			
How would you describe the client prior to these visits?	Excited	<b>14(35.0%)</b>	24(35.3%)	10(35.7%)
	Subdued	<b>6(15.0%)</b>	7(10.3%)	1 (3.6%)
	Engaged in self-destructive behavior	<b>2(5.0%)</b>	3 (4.4%)	1 (3.6%)
	She sabotages the visits	<b>2(5.0%)</b>	3 (4.4%)	1(3.6%)
	Anxious	<b>11(27.5%)</b>	16(23.5%)	5 (17.9%)
	Grandiose	<b>1 (2.5%)</b>	1(1.5%)	0
	Anxious mother won't come	<b>14(35.0%)</b>	17(25.0%)	3 (10.7%)
	Anxious about mother's behavior	<b>11(27.5%)</b>	15(22.1%)	4 (14.3%)
	Angry	<b>7(17.5%)</b>	7(10.3%)	0
	Sad	<b>3(7.5%)</b>	4(5.9%)	1(3.6%)
	No response			



		<b>Complete (N=40) n(%)</b>	<b>Combined (N=68) n(%)</b>	<b>Partial (N=28) n(%)</b>
How would you describe the client after these visits?	Excited	<b>7(17.5%)</b>	9(13.2%)	2(7.1%)
	Subdued	<b>5(12.5%)</b>	6(8.8%)	1 (3.6%)
	Engaged in self-destructive behavior	<b>4(10.0%)</b>	7(10.3%)	3(10.7%)
	Anxious	<b>8(20.0%)</b>	12(17.6%)	4(14.3%)
	Grandiose		1 (1.5%)	1 (3.6%)
	Angry at self	<b>6(15.0%)</b>	10(14.7%)	4(14.3%)
	Sad	<b>9(22.5%)</b>	16(23.5%)	7(25.0%)
	Angry at mother	<b>14 (35.0%)</b>	20(29.4%)	6(21.4%)
	Angry at CPS	<b>6(15.0%)</b>	13(19.1%)	7(25.0%)
	Angry at therapist	<b>1 (2.5%)</b>	4(5.9%)	3(10.7%)
No response				
Ultimate goal of the CPS treatment plan is reunification with biological mother	Yes	<b>8 (20.0%)</b>	15(24.6%)	7 (33.3%)
	No	<b>32(80.0%)</b>	46(75.4%)	14(66.7%)
The client knows that reunification is the plan	Yes	<b>25(100.0%)</b>	39(97.5%)	14(93.3%)
	No		1 (2.5%)	1 (6.7%)
	No response			
The mother knows that reunification is the plan	Yes	<b>22(95.7%)</b>	35(92.1%)	13(86.7%)
	No	<b>1 (4.3%)</b>	3 (7.9%)	2 (13.3%)
	No response			
The plan for reunification includes family therapy with the mother and others who live in the home	Yes	<b>16(57.1%)</b>	23(54.8%)	7 (50.0%)
	No	<b>12(42.9%)</b>	19(45.2%)	7 (50.0%)
	No response			
The plan for reunification includes individual therapy for mother	Yes	<b>12(44.4%)</b>	19(47.5%)	7 (53.8%)
	No	<b>15(55.6%)</b>	21(52.%)	6 (46.2%)
	No response			
The plan for reunification includes parenting skills training	Yes	<b>9(33.3%)</b>	15(37.5%)	6(46.2%)
	No	<b>18(66.7%)</b>	25(62.5%)	7(58.8%)
	No response			
Has there been a change in the CPS treatment plan regarding reunification?	Yes, toward reunification	<b>2(5.1%)</b>	3 (5.1%)	1 (5.0%)
	Yes, against reunification	<b>20(51.3%)</b>	25(42.4%)	5(25.0%)
	No change	<b>17(43.6%)</b>	31(52.5%)	14(70.0%)
	No response			

		<b>Complete (N=40) n(%)</b>	Combined (N=68) n(%)	Partial (N=28) n(%)
Have you seen improvement in adolescent's mental health during the time you have known her?	Definitely	<b>11(27.5%)</b>	21(34.4%)	10(47.6%)
	Intermittent	<b>12(30.0%)</b>	19(31.1%)	7(33.3%)
	Much the same	<b>11(27.5%)</b>	14(23.0%)	3(14.3%)
	No, regression	<b>6(15.0%)</b>	7(11.5%)	1(4.8%)
Was any improvement or lack of improvement connected with any decision regarding her biological mother in the context of treatment?	Yes	<b>15(38.5%)</b>	24(40.7%)	9(45.0%)
	No	<b>13(33.3%)</b>	20(33.9%)	7(35.0%)
	Hard to say	<b>11(28.2%)</b>	15(25.4%)	4(20.0%)
	No response			
From your clinical viewpoint, do you think that reunification of this client with her biological mother is possible?	Yes	<b>9(22.5%)</b>	17(27.9%)	8(38.1%)
	No	<b>31(77.5%)</b>	44(72.1%)	13(61.9%)

client's mental health were equally divided between the four choices: definitely, intermittent, much the same, and regression.

*The client's mother and visitation.* Over 60% of the respondents have met the client's biological mother. For almost two-thirds (63%) of the respondents, it is part of the treatment plan for the mother to visit the client. The visits are divided equally between planned and intermittent or very rare. About 44% of the visits are scheduled and supervised by CPS. There is no set schedule for visits between biological mother and the client for about one-third (35%) of the

respondents and one-third (33%) of the clients never see their biological mother. *The treatment plan and reunification.* For 80% of the respondents there is no goal of reunification for the client and her mother. Of the total sample, over half the respondents reported a change in the CPS treatment plan from favoring reunification to opposing it. Over 77% of the respondents think that reunification of their client with her biological mother is not clinically possible. If there is a plan for reunification, for 43% of the respondents the plan does not include family therapy, for 56% it does not include individual therapy for the mother, and for 67% it does not include parenting skills training for the family.

*BAS-A and SWAP-200-A*

The BAS-A was scored by summation (see Tables 7 and 8). For all three samples ( $N=40$ ,  $N=68$ ,  $N=28$ ) one standard deviation above the mean—or the highest scores representing the highest degree of boundary ambiguity—was 20% of each sample.

Table 7  
*BAS-A Scores*

<b>Complete (<math>N=40</math>)</b>	
<b>Scores</b>	<b>Percentages</b>
34.00–43.00	17.5% low
44.00–61.00	
62.00–70.00	20% high
<b>Combined (<math>N=68</math>)</b>	
33.00–40.00	11.8% low
42.00–62.00	
63.00–77.00	20% high
<b>Partial (<math>N=28</math>)</b>	
33.00–43.00	20% low
44.00–60.00	
64.00–77.00	25% high

Table 8  
*BAS-A Means and Standard Deviations*

Sample	<i>M</i>	<i>SD</i>
<b>Complete (N=40)</b>	<b>52.65</b>	<b>9.27</b>
Combined (N=68)	52.83	10.05
Partial (N=28)	53.20	11.70

Boss et al. acknowledge that one of the best ways to interpret the scores is to correlate them with other variables, which the following hypothesis testing demonstrates. The SWAP-200-A used SPSS syntax to calculate factor scores. It is significant to note that of the five personality disorder prototypes that the SWAP sorts, the BAS-A only correlated significantly with the emotionally dysregulated personality disorder prototype.

#### *Hypothesis Testing*

The primary hypothesis of this study is that there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. There are three secondary hypotheses regarding the variables that are asserted to have an influence on the primary hypothesis: time away from the biological family, physical presence of the biological mother, and the clarity of reality regarding the goal of reunification with the biological mother. The nine tertiary hypotheses are composed of variables proposed to have an influence on the secondary hypotheses and provide the opportunity to explore the concepts more fully.

#### *Hypothesis I. Primary Research Hypothesis*

The primary research hypothesis of this study, that there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care, is found to be significant using a Pearson correlation. A correlational analysis to examine the interrelationship between boundary ambiguity and borderline personality traits used the scores of the BAS-A and the Q factors from the SWAP-200-A (see Table 9). The higher the degree of boundary

ambiguity, the more likely is the adolescent to display borderline personality traits, a conclusion drawn from the significant positive relationship between the BAS-A and the emotionally dysregulated personality prototype,  $r(38)=.347, p=.028$ . The higher the degree of boundary ambiguity, the less likely is the adolescent to display mental health, a conclusion that follows from the significant negative relationship between the BAS-A and the psychological health index from the SWAP-200-A,  $r(38)=-.451, p=.003$ .

Table 9  
*Correlations Between SWAP-200-A and BAS-A*  
 (N=40)

SWAP-200-A Personality Disorder Prototype	Pearson correlation	Significance (2-tailed)	SWAP-200-A	
			<i>M</i>	<i>SD</i>
Emotionally Dysregulated PD	.347*	.028	1.85	.58
Psychological Health	-.451**	.003	2.30	1.18
Antisocial Psycho- pathic PD	.269	.094	2.52	.78
Avoidant Con- stricted PD	-.037	.819	1.70	.72
Narcissistic PD	-.004	.983	1.89	.65
Histrionic PD	.021	.896	2.07	.80
Inhibited Self- Critical Style	-.275	.086	1.95	.71

\*Correlation is significant at the 0.05 level (2-tailed).

\*\*Correlation is significant at the 0.01 level (2-tailed).

Table 10  
*SWAP-200-A (N=40) Means and Standard Deviations*

SWAP-200-A Personality Disorder Prototype	SWAP-200-A	
	<i>M</i>	<i>SD</i>
Emotionally Dysregulated PD	1.85	.58
Psychological Health	2.30	1.18
Antisocial Psycho- pathic PD	2.52	.78
Avoidant Con- stricted PD	1.70	.72
Narcissistic PD	1.89	.65
Histrionic PD	2.07	.80
Inhibited Self- Critical Style	1.95	.71

*Hypothesis A. Time in Foster Care*

A simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her biological family. A significant relationship was not found when  $N=40$ ,  $F(26, 13)=.83$ ,  $p=.67$  (see Table 11).

The three additional hypotheses (A-1—A-3) that fit within the construct of time in foster care were also not found to be significant. A simple analysis of variance (ANOVA) was used for hypothesis A-1 to test whether there is a relationship between boundary ambiguity and the number of foster placements had by an adolescent girl in foster care. The relationship was not significant,  $F(26, 13)=.88$ ,  $p=.63$ . For hypothesis A-2 a simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the age of the adolescent when first removed from her biological home. Again, the relationship was not significant,  $F(26, 13)=.91$ ,  $p=.60$ . Finally, for hypothesis A-3 a simple analysis of variance

(ANOVA) was used to test whether there is a relationship between boundary ambiguity and the number of times the adolescent was reunited with her biological mother. No significant relationship was found,  $F(26, 13)=.82, p=.68$ .

*Hypothesis B. Visitation with Biological Mother*

A  $t$  test for independent samples was used to test whether there is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care. The relationship for  $N=40$  was not significant,  $t(38)=1.33, p=.20$ .

Table 11  
*Secondary Hypothesis A: ANOVA*

	<b>Complete (N=40)</b>						Combined (N=68)						Partial (N=28)					
	<i>F</i>	<i>p</i>	<b>BAS-A</b>		<b>CAC*</b>		<i>F</i>	<i>p</i>	<b>BAS-A</b>		<b>CAC</b>		<i>F</i>	<i>p</i>	<b>BAS-A</b>		<b>CAC</b>	
			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
A:Time in Custody	<b>.83</b>	<b>.67</b>	<b>52.65</b>	<b>9.27</b>	<b>4.33</b>	<b>1.42</b>	1.04	.46	52.83	10.05	4.20	1.50	16.15	.001	53.20	11.70	3.95	1.66

\*CAC=Considerations About Care of Your Client



Table 12  
*Secondary Hypotheses B and C: t Tests*

	Complete (N=40)						Combined (N=68)				Partial (N=28)							
	<i>T</i>	<i>p</i>	BAS-A		CAC*		<i>t</i>	<i>P</i>	BAS-A		CAC		<i>t</i>	<i>p</i>	BAS-A		CAC	
			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
B: Visits planned and predictable	<b>1.33</b>	<b>.20</b>	<b>52.65</b>	<b>9.27</b>	<b>1.87</b>	<b>.85</b>	2.44	.02	52.83	10.05	1.76	.83	2.11	.07	53.20	11.70	1.50	.76
C: Goal of CPS treatment plan is reunification	<b>2.38</b>	<b>.02</b>	<b>52.65</b>	<b>9.27</b>	<b>1.80</b>	<b>.41</b>	3.69	.02	52.83	10.05	1.75	.43	2.75	.01	53.20	11.70	1.67	.48

\*CAC=Considerations About Care of Your Client

Table 13  
*Tertiary Hypotheses A-1—A-3: ANOVA*

	Complete (N=40)						Combined (N=68)						Partial (N=28)					
			BAS-A		CAC*				BAS-A		CAC				BAS-A		CAC	
	<i>F</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>F</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
A-1: Number of placements	<b>.88</b>	<b>.63</b>	<b>52.65</b>	<b>9.27</b>	<b>4.08</b>	<b>1.72</b>	.86	.65	52.83	10.05	3.92	1.94	1.59	.30	53.20	11.70	3.62	2.31
A-2: Age of client when removed	<b>.91</b>	<b>.60</b>	<b>52.65</b>	<b>9.27</b>	<b>7.43</b>	<b>1.41</b>	.96	.58	52.83	10.05	7.34	1.52	.96	.56	53.20	11.70	7.19	1.72
A-3: Times Reunited	<b>.82</b>	<b>.68</b>	<b>52.65</b>	<b>9.27</b>	<b>1.98</b>	<b>1.56</b>	1.33	.22	52.83	10.05			2.70	.12	53.20	11.70	2.43	2.11

\*CAC=Considerations About Care of Your Client

Table 14  
*Tertiary Hypotheses B-2: t Tests*

		<b>Complete (N=40)</b>				Combined (N=68)				Partial (N=28)								
		<b>BAS-A</b>		<b>CAC*</b>		BAS-A		CAC		BAS-A		CAC						
<i>T</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>T</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
B-2: Visits part of the treatment plan	<b>3.99</b>	<b>.000</b>	<b>52.65</b>	<b>9.27</b>	<b>1.37</b>	<b>.49</b>	4.82	.000	52.83	10.05	1.36	.48	2.64	.02	53.20	11.70	1.33	.49

\*CAC=Considerations About Care of Your Client

Hypotheses B-1 through B-3 are the subsets of hypothesis B that round out the construct of the physical presence of the biological mother of the adolescent girl in foster care and its relationship with boundary ambiguity. For hypothesis B-1 a simple analysis of variance (ANOVA) was used to test whether there is a relationship between boundary ambiguity and the number of times a mother visits her adolescent daughter in foster care. The relationship was not found to be significant,  $F(26, 13)=.88, p=.63$ . A  $t$  test for independent samples was used for hypothesis B-2 to test whether there is a relationship between boundary ambiguity and visitation by the biological mother as part of the CPS treatment plan. This relationship was found to be significant,  $t(36)=3.99, p=.000$ .

Hypothesis B-3 asserts there is a relationship between boundary ambiguity and behaviors by the adolescent representative of traits of borderline personality disorder that occur after a visit with biological mother. A  $t$  test for independent samples was used to find relationships between the traits named in the “Considerations About Care of Your Client” questionnaire and both the BAS-A as well as the SWAP-200-A’s personality prototypes of emotional dysregulation and psychological health (see Tables 15 and 16). The relationship between boundary ambiguity and being sad after the visit was significant,  $t(58)=-2.14, p=.04$ . There was also a significant relationship between being sad after the visit and the emotional dysregulation personality disorder prototype,  $t(38)=-2.45, p=.019$  and with the psychological health prototype  $t(38)=3.69, p=.001$ .

Table 15  
*Tertiary Hypothesis B-3: After the Visit—Sad*

	Complete (N=40)				Combined (N=68)				Partial (N=28)			
	<i>t</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>M</i>	<i>SD</i>
BAS-A	<b>-2.14</b>	<b>.039</b>	<b>51.03</b>	<b>9.56</b>	-3.48	.001	50.44	10.16	-2.75	.013	49.14	11.64
Emo- tional Dys- Regulation	<b>-2.45</b>	<b>.019</b>	<b>1.74</b>	<b>.53</b>	-2.45	.019	1.74	.53				
Psycho- logical Health	<b>3.69</b>	<b>.001</b>	<b>2.62</b>	<b>1.12</b>	3.70	.001	2.62	1.12				

Table 16  
*Tertiary Hypothesis B-3: After the Visit—Angry at CPS*

	Complete (N=40)				Combined (N=68)				Partial (N=28)			
	<i>t</i>	<i>p</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>P</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	<i>M</i>	<i>SD</i>
BAS-A	<b>-1.77</b>	<b>.09</b>	<b>51.59</b>	<b>9.21</b>	-3.01	.004	51.00	9.13	-2.36	.03	49.57	9.10
Emotional Dysregulation	<b>.036</b>	<b>.97</b>	<b>1.85</b>	<b>.60</b>	.04	.97	1.85	.60				
Psychological Health	<b>1.46</b>	<b>.15</b>	<b>2.41</b>	<b>1.20</b>	1.46	.15	2.41	1.20				

*Hypothesis C. Goal of Reunification with Biological Mother*

The final secondary hypothesis involves the clarity of the reality regarding the goal of reunification with the biological mother. A *t* test for independent samples was used to test whether there is a relationship between boundary ambiguity and clarity of reality regarding the goal of reunification between the adolescent girl in foster care and her biological mother (See Table 12). A significant relationship was found,  $t(38)=2.38, p=.02$ .

For the final three tertiary hypotheses (C-1—C-3), there was a plan to use *t* tests for independent samples. The responses, however, were too few to complete any analysis. Therefore there are no findings for whether there is a relationship between boundary ambiguity and if the

clinician/worker thinks that reunification is possible (Hypothesis C-1), no findings for whether there is a relationship between boundary ambiguity and if the biological mother's individual therapy is part of the CPS treatment plan (Hypothesis C-2), and no findings for whether there is a relationship between boundary ambiguity and if parenting training is part of the CPS treatment plan (Hypothesis C-3).

#### *Exploratory Data*

As mentioned in the beginning of this chapter, the sample is the 40 respondents who completed the protocol for this study. However, as noted, there were 28 additional respondents who completed a subset of the instrument: "Demographic Information About You," "Considerations About Care of Your Client," and the BAS-A. They did not do the SWAP-200-A. This is why the tables include data in addition to the  $N$  of 40: the  $N$  of 28 (the partial completers) and the  $N$  of 68 (the 40 completers plus the 28 partial completers).

With this "extra data" it was thought that there could be some further evaluation because there is greater statistical power with a higher  $N$  for the secondary and tertiary questions. Exploratory data can be used to enhance insight into the data set. It can also identify anomalies and therefore areas where further research is needed for full explanation.

Hypothesis A did not find a significant relationship for the  $N$  of 40: whether there is a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her biological family (see Table 11 above). However, for the  $N$  of 28, this hypothesis was significant,  $F(13, 6)=.16.15, p=.001$ . This data is understood as an anomaly that will require further investigation.

Hypothesis B for the  $N$  of 40 was not found significant,  $t(38)=1.33, p=.20$  as discussed above: that there is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care (see Table 12). With the larger  $N$  of 68 the exploration of this hypothesis found a significant result,  $t(31)=2.44, p=.02$ . In addition the  $N$  of

28 approached significance,  $t(9)=2.11, p=.07$ . These additional findings raise more questions and require further study.

Hypothesis B-2, that there is a significant relationship between boundary ambiguity and visitation by biological mother being part of the CPS treatment plan, was found significant for the  $N$  of 40 and was additionally found significant for the  $N$  of 28,  $t(15)=2.64, p=.02$  and the  $N$  of 68,  $t(53)=4.82, p=.000$  (see Table 14 above). For Hypothesis B-3 there was found a significant relationship between boundary ambiguity and being sad after the mother's visit for the  $N$  of 40 in  $t$  tests using the BAS-A and the SWAP-200-A personality prototypes of emotional dysregulation and the psychological health index as discussed above (see Table 15). Significant relationships were also found for the  $N$  of 68 in these same categories:  $t(58)=-3.48, p=.001$ ;  $t(38)=-2.45, p=.02$ ; and  $t(38)=3.70, p=.001$ . A significant relationship was also found for the  $N$  of 28 in the  $t$  test using the BAS-A,  $t(18)=-2.75, p=.01$ .

In the other Hypothesis B-3 relationship mentioned, a significant relationship between boundary ambiguity and being angry with CPS caseworker after the visit was found for the  $N$  of 68,  $t(58)=-3.01, p=.004$  and  $N$  of 28  $t(18)=-2.36, p=.03$ , while the  $N$  of 40 approaching significance,  $t(58)=-1.77, p=.09$  (see Table 16).

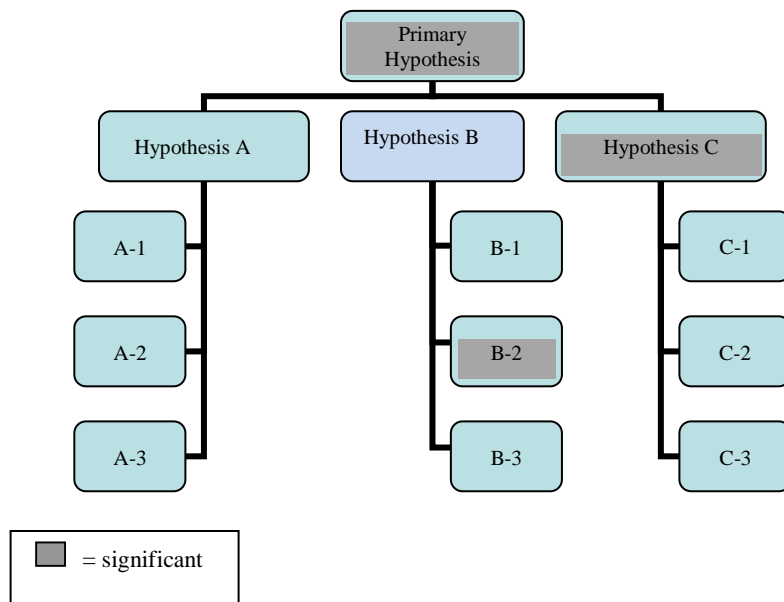
Hypothesis C, that there is a relationship between boundary ambiguity and the clarity of reality regarding the goal of reunification as part of the CPS treatment plan, was found significant for the  $N$  of 40 as discussed above (see Table 12). However it was also found significant for the  $N$  of 68,  $t(58)=3.69, p=.02$  and the  $N$  of 28,  $t(18)=2.75, p=.01$  (see Table 12 above).

### *Conclusion*

Statistical significance for the primary hypothesis of this study was found there is a relationship between boundary ambiguity and borderline personality traits in adolescents in foster care. In addition, one of the three secondary hypotheses is also found to be significant: there is a relationship between boundary ambiguity and the clarity of reality regarding the goal for reunification with biological mother (see Figure 1). Only one of the tertiary hypotheses is found

significant: there is a relationship between boundary ambiguity and visitation by biological mother being part of the CPS treatment plan. The meaning behind this significance is discussed in the following chapter, as well as a discussion of the exploratory data in the context of the psychological theory, clinical treatment, social theory, social policy, and the need for further research.

Figure 1  
*Hypothesis Significance*





## CHAPTER V

### DISCUSSION

#### *Introduction*

There is strong evidence determined by a review of the literature that children suffering from abuse and neglect experience significant attachment instability. Since this instability is found prior to their removal from their home for foster care placement, it is understood that the etiology of the attachment disturbance is in their early relationships with primary caregivers. Research demonstrates the connections between disturbed attachment and the possible development of borderline personality traits in adolescents (Bateman & Fonagy, 2003). Removal from the family by CPS points directly to the constructs of boundary ambiguity and ambiguous loss. Removing children from their biological home, even “for their own good,” causes a rupture in that family system. The family members’ reality is one of uncertainty. The removed child suffers with the physical absence of her mother alongside her mother’s psychological presence. Coping with that ambiguity is psychologically difficult and negative behaviors result, perhaps resembling the same borderline personality traits that developed from the disturbed attachment that came before the removal from home. Therefore the primary goal of this study is to discover whether there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care.

The literature review identified the three most important concepts underlying boundary ambiguity that were translated to the world of foster care: time away from the biological family, the physical presence of mother, and the clarity of the reality regarding reunification. As supporting players to the primary hypothesis regarding the relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care, these issues were explored in secondary and tertiary hypotheses: time in foster care, visitation of the biological mother, and the goal of reunification, the limitation of not being able to directly question those adolescents who were the subjects of this study required creating a study design built around the

CPS caseworkers and therapists who worked directly with the girls. They answered an altered boundary ambiguity scale specific to this research almost as if they were the adolescent, in a mentalizing position of keeping the minds of the adolescent in their own minds to plumb the construct of boundary ambiguity for these girls and their biological families. They also used a new diagnostic tool, the SWAP-200-A, to arrive at personality prototypes without the subjective use of the DSM-IV. What follows is a discussion of the findings regarding these questions and hypotheses set forth in the previous chapter.

### *Discussion of Demographic Findings*

#### *“Demographic Information About You”*

Given their occupations and the states where they worked, it is not surprising to discover that almost all the participants were white and female, despite the desire for gender and ethnic diversity. Had CPS caseworkers from Connecticut and Massachusetts participated as planned, I think that there would have been more ethnic diversity. The fact that almost half of the CPS workers had only been working in their present jobs for only one to five years was not surprising given how difficult their job is—and how often and quickly caseworkers positions turnover. However, I do not believe that this lack of experience had an impact on the findings due to the objectivity of the questions in both instruments.

#### *“Considerations About Care of Your Client”*

From the answers to this questionnaire I prepared, a composite sketch of the “typical” client can be drawn: She has been in custody of the state for between 7 months to 3 years. She was removed from her biological family when she was more than 11 years old. She has had two to six placements during that time. The caseworker/therapist has met the mother. Her caseworker/therapist does not think that reunification would be possible. The ultimate goal of her treatment plan is not to be reunified with her family and she is aware of that goal. This composite can be seen in the context of two defining issues of boundary ambiguity as identified in this study: time away from the biological family and the clarity of the reality regarding reunification.

The findings regarding the third defining issue, presence—defined here as visitation by the mother—are less clear. Although a composite was easy enough to compile from the available data, the frequencies of visitation are more ambiguous. Almost 70% of the girls see their mother on no set schedule or not at all. When there are visits, almost 60% are intermittent or very rare. Over half the visits are “up to the mother,” and yet over 60% of the visits are part of the treatment plan. What is not teased out from answers to the questionnaire is whether visits are part of the treatment plan even if the treatment goal is not reunification. Nonetheless, from the descriptive statistics, it is difficult to get a clear picture regarding visitation. It will be important to remember this while discussing the statistical findings regarding visitation.

*BAS-A and SWAP-200-A*

The instruments were carefully chosen for this study. It was strategically decided not to request that the participants complete the instruments with a “borderline adolescent” in mind. It was thought that this decision could strengthen the correlation between boundary ambiguity and borderline traits if boundary ambiguity was found to only correlate with borderline personality disorder and not with any other personality prototypes for which the SWAP-200-A sorts. This is indeed the scenario that ensued. In addition, the negative correlation between the BAS-A and psychological health is the only significant correlation for that personality prototype as well. The psychological health index prototype is one of the subfactors (the other is inhibited self-critical) that was “composed of patients characterized by general healthy functioning; these patients differed in type of pathology within a generally adaptive personality structure” (Westen, Shedler, Durrett, Glass, & Martens, 2003, p. 960). In light of this study, therefore, the negative correlation means that the higher the boundary ambiguity, the less psychological health demonstrated by the client.

## *Discussion of Statistical Findings*

### *Primary Hypothesis*

The primary hypothesis, that there is a relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care, was found to be significant. The significant positive relationship between the BAS-A and the emotionally dysregulated personality prototype leads to the conclusion that the higher the boundary ambiguity of these adolescent girls, the more likely they are to have the emotionally dysregulated personality prototype. Westen and Shedler et al. view the emotionally dysregulated personality prototype as “conceptually related to the DSM-IV borderline construct” and characterizes this prototype as “intense, dysphoric emotions and desperate efforts to escape them” (Westen, Shedler, Durrett, Glass, & Martens, 2003, p. 961). All aspects of attachment theory, borderline personality theory, and boundary ambiguity theory discussed in the literature review of this study point in the direction of this hypothesis and the research bears this out. The negative correlation between boundary ambiguity and the psychological health index supports the premise of the primary hypothesis, concluding that the higher the boundary ambiguity, the less psychological health the adolescent will experience. It is a limitation of the study (to be discussed below) that all instruments and questionnaires were completed by clinicians and caseworkers but not the adolescents themselves. Although the SWAP-200-A was created for this objective measurement of personality prototypes by clinicians, Boundary Ambiguity Scales are usually completed by the family members experiencing the ambiguity directly. Yet given the fact that the majority of clinicians and caseworkers completing the survey had known the client for more than a year (60%) and that they are trained in psychological and psychosocial assessment, it appears safe to say that this is but a minor limitation.

Why did this correlation occur? The BAS-A is made up of 18 statements that can be roughly divided into categories of ambivalence, certainty of the desire to move on, and concerns about being judged by the extended family. By utilizing the likert scale, it is easy to see that the

clinician, rating the ambivalent statements with “strongly agree,” the certainty statements about moving on with “strongly disagree”, and the family pressure statements with “strongly agree” would be answering as would an adolescent with borderline traits. That adolescent girl would be ambivalent—and unable to cope with that ambivalence. She would remain securely attached to her mother in a disorganized fashion which would make moving on impossible. And if the adolescent girl is unable to move on, then in her own mind she remains a member of the family and remains strongly influenced by the family’s image of her. Our understanding of the borderline personality disorder provides the ability to see how that construct fits hand in glove with that of boundary ambiguity.

*Hypothesis A and Tertiary Hypotheses A-1—A-3*

The secondary and tertiary hypotheses were divided into three categories in an attempt to isolate the factors that would have an influence on the significance of the primary hypothesis: the relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. Hypothesis A, that there is a relationship between boundary ambiguity and the amount of time an adolescent spends away from her biological family was not found to be significant.

This hypothesis was made due to the important role that time plays in boundary ambiguity and the important role that time away from the biological family plays for children in foster care. To make sense of this lack of relationship it is important to remember that the type of boundary ambiguity used in this study is psychological presence and physical absence. With that in mind, although 25% of the adolescents had been in foster care for 7 months to 1 year and an additional 35% had been in foster care for two to three years, it is reasonable to think that for much of that time—if not all—memory of the biological family would be fresh. The physical absence may be painful but may also not feel absolute to these girls—especially since over one-third of them see their mother at least monthly. As a result perhaps the boundary between being in

or out of the family is not as ambiguous as would have been thought and these girls continue to feel that they belong to their biological family.

Hypothesis A-1, that there is a relationship between boundary ambiguity and the number of foster care placements, was not found significant. This hypothesis was based on the assumption that an increased number of moves by the adolescent would diminish her hope for reunification—because each move is not a move home, but to another placement. Thirty percent of the adolescents had had six or more foster placements. It is possible that the turmoil accompanying multiple placements only solidifies the original sense of belonging to her family of origin and not to placements that don't work out for one reason or another. Multiple moves may just raise the hope that the next move will be back home.

Hypothesis A-2, that there is a relationship between boundary ambiguity and the age when the child was removed from the biological home, is also not significant. When this hypothesis was asserted, it was assumed that these girls would have been removed from their biological mothers at a much earlier age. However, almost 70% of the children identified in this study were removed from the home when they were 11 years old or older. I think it clear that this advanced age and the amount of time the adolescents had to experience membership in their families of origin is pertinent to the finding that there is no significant relationship found here. Again, it is salient to think that with visitation these girls are not questioning if they are in or out of the family—just that they are “removed.” Knowing with certainty that their biological family exists would have an impact on the lack of significant relationship found here.

Hypothesis A-3, that there is a relationship between boundary ambiguity and the number of times the adolescent had been reunited with her biological mother, was not significant. Underlying this hypothesis is the presumption that a failed reunification would increase the adolescent's confusion regarding where she belongs. It was also thought that a failed reunification would help increase the adolescent's certainty that her mother was not going to change enough to provide a safe environment for her and contribute to her clarity of her reality

regarding reunification. It is pertinent to this insignificance that 58% of the adolescents have never been reunited—so that failure has not occurred. This hypothesis, in agreement with the previous hypotheses regarding time in foster care, gives credence to the proposal that the intermittent reinforcement the adolescent has that her family is “out there”—reinforced by visit, by phone call, by the laws that require the state to facilitate connection between the child in custody and her biological family—may have much to do with the fact that this group of hypotheses was not found significant. Instead it may be crucial to recognize the importance of not knowing about the existence of the family—much like the families not knowing whether MIAs are alive or not—that would solidify the relationship between boundary ambiguity and time away from the biological family.

*Hypothesis B and Tertiary Hypotheses B-1—B-3*

This cluster of hypotheses concerns the notion of boundary ambiguity and its relationship with the physical presence of the biological mother—exploring the role of presence as it contributes to the construct of boundary ambiguity. Hypothesis B, that there is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care was not found significant. This finding is confounding because presence of the family member is part of the definition of boundary ambiguity. Therefore it was thought that there would be a relationship between these two variables: either a lack of visitation or ongoing visitation would have an impact upon boundary ambiguity. The results of the tertiary hypotheses may help to explain this result.

Hypothesis B-1, that there is a relationship between boundary ambiguity and how often the biological mother visits her daughter, is not significant. Nearly one-third of the adolescent girls in this study never see their mother. It makes sense that if there is no relationship between visitation and boundary ambiguity, then the frequency of visitation would have no bearing. However, Hypothesis B-2, that there is a relationship between boundary ambiguity and visitation being part of the CPS treatment plan, is significant. It is interesting that the authoritative

expectation of the visit is significant while the visiting itself is not. This makes sense in the context of the clarity of reality regarding reunification and its relationship to boundary ambiguity: that it is part of child protection's expectation that the mother's visit is able to be counted upon by the adolescent. Visiting—not stipulated as part of the CPS plan—is inherently ambiguous. The relationship between boundary ambiguity and an ambiguous dependent variable (visiting representing the concept of the physical presence of the mother) results in an insignificant finding.

Hypothesis B-3 states that there is a relationship between boundary ambiguity and behaviors by the adolescent representative of traits of borderline personality disorder that occur after a visit with the biological mother. Of the 10 descriptors only the relationship between boundary ambiguity and being sad after the visit was found significant. There was also a significant relationship between being sad after the visit and both the emotional dysregulation personality disorder prototype and the psychological health prototype. The significance of the adolescent being sad after the visit and its relationship to boundary ambiguity is too vague to be useful, which points out flaws in the hypothesis. In retrospect, Hypothesis B-3 was set up incorrectly. It currently contains 10 descriptive options offered to the clinician/caseworker to describe the client after the visit with her mother. It is noted that all but one of these descriptors is a negative feeling state, demonstrating bias. The options should be more balanced. The question previous has 10 descriptors about the client prior to the visit—and unfortunately not all of the descriptors are the same as those for post visit. The descriptors for this hypothesis should have been taken from the SWAP-200-A items that best describe the emotionally dysregulated personality disorder prototype to make any found significance relate to both boundary ambiguity and its inherent relationship to borderline personality traits.

#### *Hypothesis C and Tertiary Hypotheses C-1—C-3*

This group of hypotheses center on the possibilities of reunification for adolescent girls in foster care with their biological mothers. Hypothesis C, that there is a relationship between boundary



ambiguity and the clarity of reality regarding the goal of reunification with the biological mother, was found significant. Reunification in the context of this study means that the child returns to her family of origin. The hypothesis was included because it seems logical that a goal of reunification would negate any boundary ambiguity. Since the plan is for the child to return to her family, how can there be ambiguity? However, it is significant to know that when children are removed from their families of origin by CPS, reunification with that family is always the goal—by default. Therefore, ironically, what appears to be certainty is anything but. However, in this study 80% of the treatment plans did not have reunification as the ultimate goal and 78% of the therapists/caseworkers did not clinically believe that reunification was possible. With this data it is conclusive then that whether there is a goal of reunification or not, the fact that there is a decision about this particular goal makes the relationship significant. Again, it is found that when ambiguity is eliminated, the relationship between boundary ambiguity and the dependent variable is significant.

Unfortunately there was not enough data to determine the significance/insignificance of Hypotheses C-1—C-3. These hypotheses concerned predicting relationships between boundary ambiguity and the therapist/caseworker's clinical opinion about reunification, between boundary ambiguity and if the CPS treatment plan included individual therapy for the mother, and between boundary ambiguity and if the CPS treatment plan included parenting skills training. These hypotheses were formulated to tease out how kernels of hope—that child protection was insisting on individual treatment for the mother and insisting on the family learning how to parent correctly—had an impact both on understanding who is in and out of the family as well as reflecting the role that authority plays in the underlying certainty: if CPS expects treatment there is a better chance of the parent participating and therefore a better chance to decrease ambiguity. Unfortunately the descriptive data regarding reunification (see Table 6) is difficult to decipher. If 80% of the adolescent girls do not have a treatment plan with the ultimate goal of reunification, then are the questions regarding reunification (including those research questions that became

hypotheses C-1—C-3) about the 20% who *do* have reunification plans? Perhaps this confusion is responsible for the dearth of analyzable data. A clearer line of questioning in further research is imperative.

### *Exploratory Data*

As explained in the previous chapter, exploratory data often can enhance the existing data set or point out anomalies. In this study, there was a cohort of 28 partial participants who completed all questionnaires but the SWAP-200-A. The additional data that these participants provided was viewed individually (*N* of 28) and in combination with the *N* of 40 (*N* of 68).

There are three instances when the additional data raises more questions than it answers. For Hypothesis A, that there is a relationship between boundary ambiguity and the amount of time an adolescent girl in foster care spends away from her biological family, the *N* of 28 found this to be significant while the other two cohorts (40 and 68) did not. For Hypothesis B, that there is a relationship between boundary ambiguity and the physical presence of the biological mother of the adolescent girl in foster care, the *N* of 68 found this significant while the other two cohorts (28 and 40) did not. Finally in Hypothesis B-3, that there is a relationship between boundary ambiguity and the adolescent's being angry with the CPS caseworker after her mother's visit, both the *N*s of 28 and 68 found this significant, while the *N* of 40 did not. These three findings may be seen as anomalies. However, they also say something about the *N* of 28 and the fact that their data found significance when the *N* of 40 did not. This requires further explanation beyond this study.

There are three times these additional cohorts both found significance when the *N* of 40 also did so—emphasizing the finding. These hypotheses which the *N*s of 28, 40, and 68 found significant were B-2 (that there is a relationship between boundary ambiguity and visitation being part of the CPS treatment plan), B-3 (that there is a relationship between boundary ambiguity and being sad after the mother's visit), and C (that there is a relationship between boundary ambiguity

and the goal of reunification. In these three instances the additional findings can be seen as an exclamation point following the significance found by the *N* of 40.

### *Limitations of Study*

This study was designed with broad brush strokes, despite its efforts to drill down from the primary hypothesis to the three secondary areas of influence and then further to the tertiary influences. From the discussion above it is clear that the questionnaire containing “Considerations About Care of Your Client” could have been more carefully thought through. The questions regarding the descriptors of the client before and after the visit with her mother could have replicated the descriptors in Shedler and Westen’s emotionally dysregulated personality disorder prototype. The questions regarding the goal of reunification could helpfully have been divided into two categories: namely, if the goal remains reunification, the participant would answer a set of different questions than if the goal was not reunification.

The broad brush strokes of nondirectional relationships can leave us wanting more information and demonstrates the difficulty of making policy and treatment recommendations based upon this study’s findings. For example, knowing there is a relationship between boundary ambiguity and biological mother’s visitation being part of the CPS treatment plan does not tell anything about the degree of boundary ambiguity. So although the research question was answered, it leaves us wanting more information regarding a direction. However, it is known that boundary ambiguity remains “a construct that is more developed at the theoretical level than it is at the research level” (Carroll, Olson, & Buckmiller, 2007, p. 225). As a result, those most actively involved in the study of boundary ambiguity admit that “the state of measurement and analysis in [boundary ambiguity]...research remains quite rudimentary in contrast to the more elegant adaptation of the theory to various areas of study” (Carroll, Olson, & Buckmiller, 2007, p. 225). Ideas about how to address this are suggested in directions for future research below.

Perhaps the most significant limitation of this study is the relative smallness of the sample size. The SWAP-200-A can be daunting when first encountered, and I overestimated the

technological savvy of the population with whom I was communicating. Asking for more than an hour of their own time, especially for CPS caseworkers, apparently was asking for too much. The directors of some CPS and residential programs decided not to allow their workers and therapists to participate lest they be further stressed by the addition of yet another drain on their time. In addition to its small size, the sample is limited by the lack of ethnic diversity, primarily due to the very limited participation of Connecticut and Massachusetts.

Some of these problems can be avoided by the researcher's receiving permission to spend time in a CPS office or with residential therapists to provide them onsite technological support. It can also heighten the sense of collegiality between researcher and sample population. Further, such an approach could also provide an opportunity to add a qualitative slant to the study. The use of interviews of caseworkers and therapists would add texture to the numeric approach of this purely quantitative study.

Finally, the BAS-A ideally would have been completed by the adolescent girls themselves. Asking clinicians and caseworkers to judge how these girls understand their place in their biological families is not the preferred approach. But where the ideal is not possible, research can continue: if anyone knows how these girls think and feel about their families, it is their caseworkers and therapists.

#### *Summary of Findings*

This study demonstrates a positive relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. A significant relationship was found between boundary ambiguity and the clarity of reality regarding the goal of reunification with the biological mother. A significant relationship was also found between boundary ambiguity and visitation with the biological mother as part of the CPS treatment plan—one of the three tertiary hypotheses representing the physical presence of the biological mother.

Despite the nondirectional relationships that the data provides for these subordinate hypotheses, their statistical significance provides a solid foundation in support of the significant

positive relationship between boundary ambiguity and borderline personality traits in adolescents in foster care. This primary hypothesis is supported by two subordinate hypotheses that have one thing in common: the involvement of child protective services. When the CPS goal of reunification is clear, its relationship with boundary ambiguity is significant. When the expectation of the CPS treatment plan is presence of the biological mother (through visitation), its relationship with boundary ambiguity is significant. It may be presumed that authority of CPS is the common factor in these two hypotheses. It may also be presumed that with that authority comes the potential for the clarity of reality. Therefore although these relationships are nondirectional, because it is understood that certainty diminishes boundary ambiguity, these significant results can guide the directional hypotheses for future research.

The significant relationship between boundary ambiguity and the clarity of reality regarding the goal of reunification with the biological mother means that the authority of CPS to set reunification as a goal—whether it is carried out or not—has an impact on boundary ambiguity. The significant relationship between boundary ambiguity and visitation with the biological mother being part of the CPS treatment plan can be seen in the same manner. CPS has the authority to hold the mother accountable. How the mother responds to that expectation is not as important as the setting of the standard. Clarity of reality can dissolve ambiguity just as not knowing maintains it. With clarity of reality the adolescent does not have to cope with the dialectic of where she fits in her family—in or out. It can be seen that the decrease of ambiguity can only help diminish the intense symptomatology from which these borderline adolescents suffer.

#### *Directions for Future Research*

The process of any research study always --has moments of “what if”—and it is in my suggestions for future research that these possibilities are expressed. The significant relationship found between boundary ambiguity and borderline personality traits in adolescent girls in foster care provides a solid foundation from which future research can extend.

### *Boundary Ambiguity and Borderline Personality Traits*

Qualitative research may be a preferred method for further exploration of boundary ambiguity and borderline personality traits in adolescent girls in foster care, given the emotional intensity involved. The core psychopathology of borderline personality disorder is attributed to both temperamental—or genetic—origins and “environmentally induced character failures” ( Gunderson & Links, 2008, p. 318). Either way, “these theories have all emphasized failures in early preborderline children’s experience with their primary caregivers” (p. 318). This knowledge combined with the fact that boundary ambiguity remains a relatively new concept provides a fertile arena for research.

The BAS-A is made up of 18 statements that are clinically evocative. Future research might look at the BAS-A purely from a qualitative standpoint, using some of the statements in a semi-structured interview. For example, although having no specific significance for this current study, a significant relationship was found between boundary ambiguity and the fact that the caseworker/therapist had met the biological mother in this study ( $t(38)=3.15, p=.003$ ). This finding in combination with the significance of the relationship between boundary ambiguity and the goal for reunification and the fact that over 77% of the caseworkers/therapists did not clinically think that reunification was a possibility deserves further examination. There may be something significant about how the biological mother demonstrates her understanding of the psychological presence of her physically absent child, as well as her role in that absence, that can have a direct impact on how CPS understands whether that child can be safe physically present in that family again. The richness of the data that could be acquired by asking this mother to comment on the BAS-A statements is something to anticipate.

Future research should also involve the adolescent girls directly, if at all possible. For example, knowing that boundary ambiguity has a relationship to borderline traits in this population, a research study where the CPS caseworker gives a girl with borderline personality traits the BAS-A when she is first removed from her biological family and then at yearly intervals

thereafter may provide important information regarding therapeutic interventions—what is working, what needs to be attended to. Research where the BAS-A is given both to the adolescent girl and to her biological mother at designated intervals may provide data about how each member of the family considers the adolescents current role and may have significant implications for clinical decisions regarding disposition.

Directions for future research regarding the theories of boundary ambiguity and borderline personality disorder appear limitless. With the knowledge of their positive relationship, the world of child protection has boundless opportunity to make a significant mark in this area.

#### *Implications for Social Work Practice*

The concept of boundary ambiguity is not new but, as the literature review bears out, is not utilized in social work practice. Pauline Boss's work with families directly involved with loss during 9/11, Hurricane Katrina, and the latest earthquakes in Haiti and Chile continue to signal the importance of boundary ambiguity in the effort to help devastated families cope. Clarity that results from further research in the theory of boundary ambiguity and its relationship to borderline personality disorder in adolescent girls in foster care will have a direct impact on intervention. In addition, this study has shown the similarities between therapy for attachment disturbances, boundary ambiguity, and borderline personality disorder. Attachment therapy focuses on relationships—past and present—and the resolution of loss, as well as a clarification of roles. Treatment for boundary ambiguity issues involves a redefinition of relationships, the ability to move from denial to acceptance and an increased resiliency to help tolerate the ambiguity. Finally and simplistically, treatment for borderline personality disorder involves affective regulation and healthy defense development to aid with accurate perceptions of reality and positive internalization rather than projection. This brief summary shows where these theories of treatment overlap.

Families involved in foster care, where a child is removed (physically absent, psychologically present), struggle with loss, inclusion, and intrusion. The long-term goal of intervention might be to help the family find meaning in the “family boundary change” and the loss of the child, even if it is temporary. Interventions are needed to make sense of the question whether that child is still included in the family. In addition, the intrusion of the child protection system in the life of the family is another boundary crossing to be understood. Social workers would do well to understand how to include this ambiguity in their family treatment. As this research has shown, these interventions may be just as valuable for the individual adolescent as she attempts to make sense of this same loss, inclusion, and intrusion. If her family does not change, she is the member who will need to go forward with her family continuing to be physically absent and psychologically present. The more social work can aid in her coming to terms with this ambiguity, the sooner the adolescent will heal.

In the world of foster care, the goal of reunification is ever present, with conditions upon conditions attached—either by the court system or by CPS itself. The conditional aspect of the goal provides another arena where social workers need to define a situation of boundary ambiguity and the fact that “families may need to learn to adapt to a situation where certainty is not possible” (Carroll, Olson, & Buckmiller, 2007, p. 228). As far as the adolescent girls in these families are concerned, this research has shown the significance between boundary ambiguity and borderline personality traits, making it very clear that helping these girls cope with the uncertainty is imperative.

This study shows the relationship between boundary ambiguity and the goal of reunification. It may therefore be assumed that therapists and caseworkers must understand the importance of clarity to assist these adolescents, and it is imperative that their therapists accrue clarity from CPS whenever possible. Any interventions that would assist in clarifying the possibility of reunification must be aggressively pursued, especially family therapy. CPS treatment plans must include family therapy and the caseworker and therapist must communicate



often regarding their ongoing assessments of the realism of reunification. Certainty regarding the possibility of reunification can provide these struggling adolescents with a clearer understanding of their future, thereby potentially reducing their borderline symptoms.

#### *Implications for Social Work Policy*

When I first sought permission to email CPS caseworkers, I was gratified by the number of CPS directors who were interested in learning the outcomes of this study. The area of social work policy for which the study has implications is that of child welfare. The same argument can be framed here as in the literature review—starting with psychological theory and building to social policy, except now we have the results of the research to sustain us.

As those in child protection know, the power behind decisionmaking regarding children in foster care rests in the hands of legislators and the court system. The impact of attachment theory on children must be made clear to CPS staff and those who can lobby our legislators so that they understand the context in which they make their decisions. They must be taught that attachment begins in the womb. In a chaotic family, the removal of a child by CPS is insult added to injury—the disordered attachment has long ago occurred. As an agency of state government, CPS is bound in each case by the pertinent statutory scheme enacted over time. Therefore our legislators must be educated about the impact of goals of reunification that are strung along for years, the impact that the goal of reunification has on a child watching her mother continue to deal drugs or be beaten by the man in her life, and the impact of boundary ambiguity on these families attempting to manage the confusion of loss, inclusion, and intrusion.

The Adoption and Safe Families Act of 1997 pushed for permanency. This study has demonstrated that clarity of reality, as understood in the context of boundary ambiguity, is important for the healing of borderline adolescent girls in foster care. Policymakers must learn about boundary ambiguity and how it exacerbates the symptoms of borderline personality disorder. Instead of focusing on permanency for the child both with the family of origin and with the possibility of a new family, why not put all focus on the biological family? Can permanency

be defined by the concept of a good enough family as opposed to a family whose rights should be terminated? Can there be a timeline by which a family must engage in all treatments prescribed? If they choose not to engage, their rights would be terminated. This sounds radical, perhaps, but this study has shown that this kind of clarity of reality would benefit adolescent girls in foster care—allowing them to either go home or move on by removing the ambiguity as much as possible.

Helping social service agencies and policymakers better understand the needs of those children who are the subject of this study, and their parents, is of utmost importance. It is only by educating policymakers about the despair that often characterizes the lives of these children and their families that those officials can begin to understand both (1) that all children are not alike and cannot be treated as if they were and yet (2) that there are similarities enough among certain constellations of the population of traumatized children that provides policymakers the opportunity to enact laws based on the most recent and adequate clinical treatments for that population.

### *Conclusion*

What is the best interest of the child? She is innocently born into a chaotic, traumatic family, develops disorganized attachment, and as she grows older this attachment style and the adaptations she utilizes to cope become borderline personality traits. The chaotic family swirls around her until something even more horrible occurs that causes CPS to wrench her away from the only life she has ever known. The caseworker might tell her that it won't be forever, that the goal is reunification. But what is the reality of that reunification—unless our legislators understand what it would really take to reunify—family therapy, individual therapy for the family members, parenting skills training, substance abuse counseling, jobs for parents, safe neighborhoods, adequate education. We are guilty of the facilitation of generational pathology

unless we embrace the knowledge of the fundamentals of attachment theory to assist in our understanding of families.

This study has demonstrated the significant positive relationship between boundary ambiguity and borderline personality traits in adolescent girls in foster care. It has also demonstrated significant relationships between boundary ambiguity and the clarity of reality regarding the goal of reunification and between boundary ambiguity and visitation with the biological mother's being a part of the CPS treatment plan—representing the construct of the physical presence of the biological mother. An adequate understanding of attachment theory, boundary ambiguity, social construction of the family and of psychiatric diagnoses, and clinical treatment that includes this information is imperative in order to stop the cycle in which the families of the adolescent girls in this study find themselves trapped. This study may signal the beginning of a process. With the wealth of significance herein, a herald cry goes out to the child protection agencies and therapists that serve these young women and their families. With this study's significant findings, the road to further research, intervention, and policymaking has been paved.

## REFERENCES

- AACAP/CWLA Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care. (2003). Retrieved on May 11, 2008 from <http://www.aacap.org/cs/root/policystatements>
- Adoption and Safe Families Act of 1997, 42 U.S.C. 1305 (1997).
- Agrawal, H. R., Gunderson, J., Holmes, B. M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A review. *Harvard Review of Psychiatry, 12*(2), 94-104.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hilldale, NJ: Lawrence Erlbaum Associates.
- Ainsworth, M. D. S. (1979). Infant-mother attachment. *American Psychologist, 34*(10), 932-937.
- Ainsworth, M. D. S. (1989). Attachments beyond infancy. *American Psychologist, 44*(4), 709-716.
- Ainsworth, M. D. S. & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333-341.
- Allen, M. & Bissell, M. (2004). Safety and stability for foster children: The policy context. *Children, Families, and Foster Care, 14*(1), 49-73.
- American Psychiatric Association. (2001). Practice guideline & resources for: **Treatment of Patients With Borderline Personality Disorder**. Retrieved on December 28, 2009 from [http://www.psychiatryonline.com/pracGuide/pracGuideTopic\\_13.aspx](http://www.psychiatryonline.com/pracGuide/pracGuideTopic_13.aspx)
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Washington, DC: American Psychiatric Association.
- Anastas, J. W. (1999). *Research design for social work and the human services* (2d ed.). New York: Columbia University Press.
- Bandelow, B., Krause, J., Wedekind, D., Broocks, A., Hajak, G., & R  ther, E. (2005). Early traumatic life events, parental attitudes, family history, and birth risk factors in patients with borderline personality disorder and healthy controls. *Psychiatry Research, 134*(2), 169-179.
- Bateman, A. W. & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. New York: Oxford University Press.

- Bateman, A. W. & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic*, 67(3), 187-211.
- Becker, D. (1997). *Through the looking glass: Women and borderline personality disorder*. New York: Westview Press.
- Becker, D. (2000). When she was bad: Borderline personality disorder in a posttraumatic age. *American Journal of Orthopsychiatry*, 70(4), 422-432.
- Becker, D. F., Grilo, C. M., Edell, W. S., & McGlashan, T. H. (2002). Diagnostic efficiency of borderline personality disorder criteria in hospitalized adolescents: Comparison with hospitalized adults. *American Journal of Psychiatry*, 159(12), 2042-2047.
- Berge, J.M. & Holm, K.E. (2007). Boundary ambiguity in parents with chronically ill children: Integrating theory and research. *Family Relations*, 56,123-134.
- Bleiberg, E. (2001). *Treating personality disorders in children and adolescents: A relational approach*. New York: Guilford Press.
- Berry, J.T. (1990). A review of the boundary ambiguity scales. *The American Journal of Family Therapy*, 18(4), 393-397.
- Bjorklund, P. (2006). No man's land: gender bias and social constructivism in the diagnosis of borderline personality disorder. *Issues in Mental Health Nursing*, 27, 3-23.
- Bornovalova, M.A., Hicks, B.M., Iacono, W.G. & McGue, M. (2009). Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. *Development and Psychopathology*, 21, 1334-1353.
- Boss, P. (1977). A clarification of the concept of psychological father presence in families experiencing ambiguity of boundary. *Journal of Marriage and the Family*, 39, 141-151.
- Boss, P. (1999). *Ambiguous loss*. Cambridge, MA: Harvard University Press.
- Boss, P. (2006). *Loss, trauma, and resilience: Therapeutic work with ambiguous loss*. New York: W. W. Norton and Company.
- Boss, P. (2007). Ambiguous loss theory: Challenges for scholars and practitioners. *Family Relations*, 56, 105-111.
- Boss, P. G., Greenberg, J.R., & Pearce-McCall, D. (1990). Measurement of boundary ambiguity in families. *Minnesota Agricultural Experiment Station Bulletin* 593-1990.

- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books, Inc.
- Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: Anxiety and anger*. New York: Basic Books.
- Bowlby, J. (1980). *Attachment and loss: Vol. 3. Loss: Sadness and depression*. New York: Basic Books.
- Bradley, R., Jenei, J., & Westen, D. (2005). Etiology of borderline personality disorder: Disentangling the contributions of intercorrelated antecedents. *The Journal of Nervous and Mental Disease*, 193(1), 24-31.
- Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28, 759-775.
- Brisch, K. H. (2002). *Treating attachment disorders: From theory to therapy*. New York: The Guilford Press.
- Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8). Retrieved May 6, 2009 from <http://www.mdconsult.com>.
- Carey, B. (2006, November 11). What's wrong with a child? Psychiatrists often disagree. *The New York Times*, pp. A1, A11.
- Carlson, E.A., Egeland, B., & Sroufe, L.A. (2009). A prospective investigation of the development of borderline personality symptoms. *Development and Psychopathology*, 21, 1311-1334.
- Carlson, V., Cicchetti, D., Barnett, D. & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology*, 25(4), 525-531.
- Carroll, J. S., Olson, C. D., & Buchmiller, N. (2007). Family boundary ambiguity: A 30-year review of theory, research, and measurement. *Family Relations*, 56, 210-230.
- Child Welfare Information Gateway. (2005). Foster care. Retrieved April 16, 2008 from [www.childwelfare.gov/pubs/factsheets/foster.cfm](http://www.childwelfare.gov/pubs/factsheets/foster.cfm)
- Child Welfare League of America. (1997). *Summary of the Adoption and Safe Families Act of 1997 (P.L. 105-89)*. Retrieved February 26, 2005 from <http://www.cwla.org/printable/printpage.asp>

- Child Welfare League of America (n.d.) National Data Analysis System: State data trends, 2008. Retrieved November 29, 2009 from [http://ndas.cwla.org/data\\_stats/states/data\\_trends.asp](http://ndas.cwla.org/data_stats/states/data_trends.asp)
- Children's Defense Fund. (2000). *Adoption and Safe Families Act (ASFA) basics*. Retrieved February 26, 2005 from [http://www.childrensdefense.org/childwelfare/adoption/asfa\\_basics.asp](http://www.childrensdefense.org/childwelfare/adoption/asfa_basics.asp).
- Christian, S. (2002). Post-adoption services: Issues for legislators. *NCSL State Legislative Report*, 27(17). Retrieved December 31, 2006 from <http://www.ncsl.org/programs/cyf/PASI.htm>.
- Clausen, J. M., Landsverk, J., Ganger, W., Chadwick, D., & Litrownik, A. (1998). Mental health problems of children in foster care. *Journal of Child and Family Studies*, 7(3), 283-296.
- Cole, P.M., Llera, S.J., & Pemberton, C.K. (2009). Emotional instability, poor emotional awareness, and the development of borderline personality. *Development and Psychopathology*, 21, 1293-1310.
- Cole, S. (2005). Infants in foster care: Relational and environmental factors affecting attachment. *Journal of Reproductive and Infant Psychology*, 23(1), 43-61.
- Crawford, T. N., Cohen, P., & Brook, J. S. (2001a). Dramatic-erratic personality disorder symptoms: I. Continuity from early adolescence into adulthood. *Journal of Personality Disorders*, 15(4), 319-335.
- Crawford, T. N., Cohen, P., & Brook, J. S. (2001b). Dramatic-erratic personality disorder symptoms: II. Developmental pathways from early adolescence to adulthood. *Journal of Personality Disorders*, 15(4), 336-350.
- Crawford, T. N., Cohen, P. R., Chen, H., Anglin, D. M., & Ehrensaft, M. (2009). Early maternal separation and the trajectory of borderline personality disorder symptoms. *Development and Psychopathology*, 21, 1013-1030.
- Curtis, C. M. & Denby, R. W. (2004). Impact of the Adoption and Safe Families Act (1997) on families of color: Workers share their thoughts. *Families in Society: The Journal of Contemporary Social Services*, 85(1), 71-79.
- Cushman, P. (1995). *Constructing the self, constructing America: A cultural history of psychotherapy*. Cambridge, MA: Perseus Publishing.
- Davis, L. & Siegel, L. J. (2000). Posttraumatic stress disorder in children and adolescents: A review and analysis. *Clinical Child and Family Psychology Review*, 3(3), 135-154.

- dosReis, S., Zito, J. M., Safer, D. J., & Soeken, K. L. (2001). Mental health services for youths in foster care and disabled youths. *American Journal of Public Health, 91*(7), 1094-1099.
- Dozier, M., Higley, E., Albus, K.E., & Nutter, A. (2002). Intervening with foster infants' caregivers: Targeting three critical needs. *Infant Mental Health Journal, 23*(5), 541-554.
- Eisenberg, L. (1995). The social construction of the human brain. *American Journal of Psychiatry, 152*(11), 1563-1575.
- Febrega, H. (2001). Culture and history in psychiatric diagnosis and practice. *Psychiatric Clinics of North America, 24*(3), 391-405.
- Fabrega, H. (2002). Evolutionary theory, culture and psychiatric diagnosis. In M. Maj & W. Gaebel (Eds.), *Psychiatric diagnosis and classification* (pp. 107-135). New York: John Wiley & Sons, Inc.
- Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis, 72*, 1-18.
- Fonagy, P. (2001). *Attachment theory and psychoanalysis*. New York: Other Press.
- Fonagy, P. & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21*, 1355-1381.
- Fonagy, P., Target, M., Gergely, G., Allen, J. G., & Bateman, A. W. (2003). The developmental roots of BPD in early attachment relationships: A theory and some evidence. *Psychoanalytic Inquiry, 23*(3), 412-460.
- Fravel, D. L., McRoy, R. G., & Groterant, H. D. (2000). Birthmother perceptions of the psychologically present adopted child: Adoption openness and boundary ambiguity. *Family Relations, 49*, 425-433.
- Fruzzetti, A. E. & Boulanger, J. L. (2005). Family involvement in treatment. In J. G. Gunderson & P. D. Hoffman (Eds.) *Understand and treating borderline personality disorder: A guide for professional and families* (pp. 151-164). Washington, DC: American Psychiatric Publishing, Inc.
- Gergen, K. J., Lightfoot, C., & Sydow, L. (2004). Social construction: Vistas in clinical child and adolescent psychology. *Journal of Clinical Child and Adolescent Psychology, 33*(2), 389-399.
- Gilligan, C. & Machoian, L. (2002). Learning to speak the language: A relational interpretation of an adolescent girl's suicidality. *Studies in Gender and Sexuality, 3*(3), 321-341.



- Golier, J. A., Yehuda, R., Bierer, L. M., Mitropoulou, V., New, A. S., Schmeidler, J., Silverman, J. M., & Siever, L. J. (2003). The relationship of borderline personality Disorder to posttraumatic stress disorder and traumatic events, *American Journal of Psychiatry*, *160*(11), 2018-2024.
- Gratz, K.L., Tull, M.T., Reynolds, E.K., Bagge, C.L., Lutzman, R.D., Daughters, S.B., & Lujuez, C.W. (2009). Extending extant models of the pathogenesis of borderline personality disorder to childhood borderline personality symptoms: The roles of affective dysfunction, disinhibition, and self- and emotion-regulation deficits. *Development and Psychopathology*, *21*, 1263-1291.
- Gunderson, J. G. (1984). *Borderline personality disorder*. Washington, DC: American Psychiatric Press, Inc.
- Gunderson, J. G. (1999). Personality disorders. In A. M. Nicholi, Jr. (Ed.), *The Harvard guide to psychiatry* (pp. 308-327). Cambridge, MA: Harvard University Press.
- Gunderson, J. G. (2009). Borderline personality disorder: Ontogeny of a diagnosis. *American Journal of Psychiatry*, *166*(5), 530-539.
- Gunderson, J. G., Berkowitz, C., & Ruiz-Sancho, A.. (1997). Families of borderline patients: A psychoeducational approach. *Bulletin of the Menninger Clinic*, *61*(4), 446-457.
- Gunderson, J. G. & Links, P.S. (2008). *Borderline personality disorder: A clinical guide*. Washington, DC: American Psychiatric Publishing, Inc.
- Harden, B. J. (2004). Safety and stability for foster children: A developmental perspective. *Children, Families, and Foster Care*, *14*(1), 31-47.
- Hartung, C. M. & Widiger, T. A. (1998). Gender differences in the diagnosis of mental disorders: Conclusions and controversies of the DSM-IV. *Psychological Bulletin*, *123*(3), 260-278.
- Haugaard, J. J. (2004). Recognizing and treating uncommon behavioral and emotional disorders in children and adolescents who have been severely maltreated: Borderline personality disorder. *Child Maltreatment*, *9*(2), 139-145.
- Hodges, S. (2003). Borderline personality disorder and posttraumatic stress disorder: Time for integration? *Journal of Counseling & Development*, *81*, 409-417.
- Hollingsworth, L.D. (2000). Adoption policy in the United States: A word of caution. *Social Work*, *45*(2), 183-186.
- Howe, D. (1997). Parent-reported problems in 211 adopted children: Some risk and protective factors. *Journal of Child Psychology and Psychiatry*, *38*(4), 401-411.

- Howes, C. & Ritchie, S. (1999). Attachment organizations in children with difficult life circumstances. *Development and Psychopathology*, *11*, 251-268.
- James, A., Berelowitz, M., & Vereker, M. (1996). Borderline personality disorder: A study in adolescence. *Journal of European Child and Adolescent Psychiatry*, *5*, 11-17.
- James, A. C. & Vereker, M. (1996). Family therapy for adolescents diagnosed as having borderline personality disorder. *Journal of Family Therapy*, *19*, 269- 283.
- James, B. (1994). *Handbook for treatment of attachment-trauma problems in children*. New York: The Free Press.
- Jensen, P.S., Knapp, P., & Mrazek, D.A. (2006). *Toward a new diagnostic system for child psychopathology: Moving beyond the DSM*. New York: The Guilford Press.
- Kernan, E. & Lansford, J. E. (2004). Providing for the best interests of the child? The Adoption and Safe Families Act of 1997. *Journal of Applied Developmental Psychology*, *25*(5), 523-539.
- Kernberg, O. F. & Michels, R. (2009). Borderline personality disorder. *American Journal of Psychiatry*, *166*(5), 505-508.
- Kernberg, P. F., Weiner, A. S., & Bardenstein, K. K. (2000). *Personality disorders in children and adolescents*. New York: Basic Books.
- Kim, J., Cicchetti, D., Rogosch, F.A., & Manly, J. T. (2009). Child maltreatment and trajectories of personality and behavioral functioning: Implications for the development of personality disorder. *Development and Psychopathology*, *21*, 889-912.
- Knopf, D., Park, M. J., & Paul Mulye, T. (2008). *The mental health of adolescents: A national profile, 2008*. San Francisco: National Adolescent Health Information Center, University of California, San Francisco.
- Kreisman, J. K. & Kreisman, J. J. (2004). Marital and family treatment of borderline personality disorder. In *Family Treatment of Personality Disorders* (pp. 117-148). Binghamton, NY: The Haworth Press.
- Leathers, S. J. (2003). Parental visiting, conflicting allegiances, and emotional and behavioral problems among foster children. *Family Relations*, *52*(1), 53-63.
- Lee, R. E. & Whiting, J. B. (2007). Foster children's expressions of ambiguous loss. *The American Journal of Family Therapy*, *35*, 417-428.
- Lequesne, E. R. & Hersh, R. G. (2004). Disclosure of a diagnosis of borderline personality disorder. *Journal of Psychiatric Practice*, *10*(3), 170-176.

- Levy, T. M. & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorder in children and families*. Washington, DC: CWLA Press.
- Levy, T. M. & Orlans, M. (2000). Attachment disorder and the adoptive family. In T. M. Levy (Ed.), *Handbook of attachment interventions* (pp. 243-259). New York: Academic Press.
- Linder, M. (2004). The construction of illness. In P.J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 3-7). New York: Jason Aronson.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Liotti, G. & Pasquini, P. (2000). Predictive factors for borderline personality disorder: Patients' early traumatic experiences and losses suffered by the attachment figure. *Acta Psychiatrica Scandinavica*, 102, 282-289.
- Livesley, W. J. (2004). Introduction to the special feature on recent progress in the treatment of personality disorders. *Journal of Personality Disorders*, 18(1), 1-2.
- Maschi, T., Schwalbe, C. S., Morgen, K., Gibson, S., & Violette, N. M. (2009). Exploring the influence of gender on adolescents' service needs and service pathways. *Children and Youth Services Review*, 31(2), 257-264.
- Main, M. (1995). Recent studies in attachment: Overview, with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 233-278). Hillsdale, NJ: The Analytic Press.
- Martin, M. H., Barbee, A. P., Antle, B. F., & Sar, B. (2002). Expedited permanency planning: Evaluation of the Kentucky adoptions opportunities project. *Child Welfare*, 81(2), 203-224.
- Masterson, J. F. (2004). Evolution of the Masterson approach. In J. F. Masterson & A. R. Lieberman (Eds.), *A therapist's guide to the personality disorders: The Masterson approach: A handbook and workbook* (pp. 1-12). Phoenix, AZ: Zeig, Tucker & Theisen, Inc.
- Meijer, M., Goedhart, A. W., & Treffers, P. D. A. (1998). The persistence of borderline personality disorder in adolescence. *Journal of Personality Disorders*, 12(1), 13-22.
- Milan, S.E. & Pinderhughes, E.E. (2000). Factors influencing maltreated children's early adjustment in foster care. *Development and Psychopathology*, 12, 63-81.
- Mitchell, M. B. & Kuczynski, L. (2010). Does anyone know what is going on?

- Examining children's lived experience of the transition into foster care. *Children & Youth Services Review*, 32, 437-444.
- Moye, J. & Rinker, R. (2002). It's a hard knock life: Does the Adoption and Safe Families Act of 1997 adequately address problems in the child welfare system? *Harvard Journal on Legislation*, 39 Harv. J. on Legis. 37.
- Nakash-Eisikovits, O., Dutra, L., & Westen, D. (2002). Relationship between attachment patterns and personality pathology in adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(9), 1111-1123.
- Nehls, N. (1998). Borderline personality disorder: Gender stereotypes, stigma, and limited system of care. *Issues in Mental Health Nursing*, 19, 97-112.
- New England Residential School Directory. (February 2008). Residential school directory, *New England Psychologist*, 16(1). Retrieved February 8, 2008, from <http://www.masspsy.com/residential/index.html>.
- Nickell, A.D., Waudby, C. J., & Trull, T. J. (2002). Attachment, parental bonding and Borderline personality features in young adults. *Journal of Personality Disorders*, 16(2), 148-159.
- Oldham, J. M., Gabbard, G. O., Goin, M. K., Gunderson, J., Soloff, P., Spiegel, D., Stone, M., & Phillips, K. A. (2001). Practice guideline for the treatment of patients with borderline disorder. *American Journal of Psychiatry [suppl]*, 158, 1-82.
- Paris, J. (2000). Childhood precursors of borderline personality disorder. *Psychiatric Clinics of North America*, 23(1), 78-87.
- Pecora, P.J., Jensen, P.S., Romanelli, L.H., Jackson, L.J., & Ortiz, A. (2009). Mental health services for children placed in foster care: An overview of current challenges. *Child Welfare*, 88(1), 6-26.
- Penn, D.L, Judge, A., Jamieson, P., Garczynski, J., Hennessy, M., & Romer, D. (2005). Stigma. In D.L. Evans, E.B. Foa, R.E. Gur, et al., (Eds.), *Treating and preventing adolescent mental health disorders: what we know and what we don't know: A research agenda for improving the mental health of our youth* (pp. 531-543). New York: Oxford University Press.
- Pinto, P., Grapentine, W. L., Francis, G., & Picariello, C. M. (1996). Borderline personality disorder in adolescents: Affective and cognitive features. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34(10), 1338-1343.
- Robins, C. J. & Chapman, A. L. (2004). Dialectical behavior therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders*, 18(1), 73-89.

- Rüsch, N., Lieb, K., Bohus, M., & Corrigan, P.W. (2006). Self-stigma, empowerment, and perceived legitimacy of discrimination among women with mental illness. *Psychiatric Services, 57*(3), 399-402.
- Rutter, M. (1995). Clinical implications of attachment concepts: Retrospect and prospect. *Journal of Child Psychology and Psychiatry, 36*(4), 549-571.
- Sable, P. (2000). *Attachment and adult psychotherapy*. Northvale, NJ: Jason Aronson Inc.
- Salzman, J.P., Salzman, C., & Wolfson, A.N. (1997). Relationship of childhood abuse and maternal attachment to the development of borderline personality disorder. In M. C. Zanarini (Ed.), *Role of Sexual Abuse in Etiology of Borderline Personality Disorder* (pp. 71-91). Washington, DC: American Psychiatric Press, Inc.
- Samuels, G.M. (2009). Ambiguous loss of home: The experience of familial (im)permanence among young adults with foster care backgrounds. *Children and Youth Services Review, 31*, 1229-1239.
- Santisteban, D. A., Muir, J. A., Mena, M. P., & Mitrani, V. B. (2003). Integrative borderline adolescent family therapy: Meeting the challenges of treating adolescents with borderline personality disorder. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 251-264.
- Shaw, C. & Proctor, G. (2005). Women at the margins: A critique of the diagnosis of borderline personality disorder. *Feminism & Psychology, 15*(4), 483-490.
- Shiner, R.L. (2009). The development of personality disorders: Perspectives from normal personality development in childhood and adolescence. *Development and Psychopathology, 21*, 715-734.
- Smith, B. D. (2003). After parental rights are terminated: Factors associated with exiting foster care. *Children and Youth Services Review, 25*(12), 965-985.
- Sroufe, L. A., Carlson, E. A., & Levy, A. K. (1999). Implications of attachment theory for development of psychopathology. *Development and Psychopathology, 11*, 1-13.
- Stein, T. J. (2000). The Adoption and Safe Families Act: Creating a false dichotomy between parents' and childrens' rights. *Families in Society: The Journal of Contemporary Human Services, 81*(6), 586-590.
- Stein, T. J. (2003). The Adoption and Safe Families Act: How congress overlooks available data and ignores systemic obstacles in its pursuit of political goals. *Children and Youth Services Review, 25*(9), 669-682.
- Taussig, H. N., Clyman, R. B., & Landsverk, J. (2001). Children who return home

- from foster care: A 6-year prospective study of behavioral health outcomes in adolescence. *Pediatrics*, 108(1). Retrieved May 6, 2008 from <http://www.pediatrics.org/cgi/content/full/108/1/e10>
- Testa, M. (2004). When children cannot return home: Adoption and guardianship. *Children, Families, and Foster Care*, 14(1), 115-129.
- Trull, T. J. (2001). Structural relations between borderline personality disorder features and putative etiological correlates. *Journal of Abnormal Psychology*, 110(3), 471-481.
- United States General Accountability Office. (2002). Foster care: Recent legislation helps states focus on finding permanent homes for children, but long-standing barriers remain. GAO-02-585. Retrieved February 26, 2005, from [www.gao.gov](http://www.gao.gov).
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2008). The AFCARS report. Retrieved November 29, 2009 from <http://www.acf.hhs.gov/programs/cb>
- U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (n.d.). *Child maltreatment 2006*. Retrieved November 29, 2009 from <http://www.acf.hhs.gov/programs/cb/pubs/cm06/cm06.pdf>
- Weinbach, R. W. & Grinnell, R. M., Jr. (2004). *Statistics for social workers* (6<sup>th</sup> ed.). Pearson: New York.
- Westen, D., Durtra, L., & Shedler, J. (2005). Assessing adolescent personality pathology. *British Journal of Psychiatry*, 186, 227-238.
- Westen, D., Shedler, J., Durrett, C., Glass, S., & Martens, A. (2003). Personality diagnoses in adolescence: DSM-IV axis II diagnoses and an empirically derived alternative. *American Journal of Psychiatry*, 160(5), 952-966.
- Westen, D. & Shedler, J. (1999). Revising and assessing axis II, part I: Developing a clinically and empirically valid assessment method. *American Journal of Psychiatry*, 156(2), 258-272.
- Wulczyn, F. & Hislop, K. B. (2002). Issue papers on foster care and adoption: Topic #3: Adoption dynamics: The impact of the Adoption and Safe Families Act. Retrieved February 26, 2005, from <http://aspe.hhs.gov/hsp/fostercare-issues02/dynamics2/>.
- Zelkowitz, P., Paris, J., Guzder, J., & Feldman, R. (2001). Diatheses and stressors in Borderline pathology of childhood: The role of neuropsychological risk and trauma. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(1). Retrieved May 6, 2008 from <http://www.mdconsult.com>.

Appendix A: Human Subjects Review Planning Form

Student Maureen A. Kaplan Date March 30, 2008

Advisor Catherine Nye, PhD Dissertation Chair

**NOTE:** If your project fits 1, 2, or 3, you will need to include letters documenting both the original Human Subjects Review and the authorization of your use of the data as appendices in your thesis. All students: please indicate below whether or not your thesis project will require a Human Subjects Review.

1. My project is based upon existing (but not publicly available) data with a Human Subjects Review completed by the party giving me access to the data. I have indicated below the name of the researcher or administrator giving me this access and the name and address of the agency which granted the Human Subjects Review approval.

a) Name of person authorizing the use of the data:

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b) The name and address of the agency that gave the Human Subjects Review approval:

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2. My project will require an agency Human Subjects Review. I have indicated below the name of the agency and the name of the Chair of its Human Subjects Review Board:

a) Name and address of agency doing the Human Subjects Review:

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b) The name of the agency Human Subjects Review Board Chair:

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3. My project will require a Smith College School for Social Work Human Subjects Review.

X  I will require a Smith College SSW Human Subjects Review.

4. My project will not involve collection of original data from human subjects. (This includes use of publicly available "canned" data sets.)

I will not require a Smith College SSW Human Subjects Review.

## Appendix B: Human Subjects Review Application

**Investigator Name: Maureen A. Kaplan, LICSW**

**Project Title: Boundary Ambiguity and Borderline Personality**

**Traits: Implications for Treatment for Adolescent Girls in Foster Care**

**Contact Address: 85 Gaskill Road, Chester, VT 05143**

**Contact Phone: (802) 463-4513**

**Email Address: makaplan@email.smith.edu**

### **Project Purpose and Design**

The issue explored in this study is the relationship between boundary ambiguity, as defined by Pauline Boss, and borderline personality traits in adolescent girls in the custody of the state. I will examine this relationship through the assessment of the perceived role of the biological mother by these girls on the parts of their Child Protective Services (CPS) caseworkers and by the psychotherapists who treat them. The research method will use an emailed survey made up of two parts: a demographic questionnaire attached to the Boundary Ambiguity Scale-A (BAS-A) ( a variation made by me of Pauline Boss's BAS #1 adjusted to be appropriate for this study) and the Shedler-Westen Assessment Procedure-200 for Adolescents (SWAP-200-A) which is a Q-sort instrument for assessing adolescent personality pathology. The demographic questionnaire and BAS-A will be collected using "Survey Monkey," an anonymous and secure web-based data collection site. However, due to the concerns of the Connecticut Department of Children and Families and their experience with their staff finding the phrase "www.surveymk.com" to be a racial slur, the references to this site have been changed to [www.survey.mk.com](http://www.survey.mk.com). The SWAP-200-A will be uploaded to a secure server maintained by the BioInformatics Service Center at Dartmouth Medical School.

This study has significant clinical relevance. Many adolescent girls in the custody of the state struggle with borderline personality traits for a myriad of reasons including insecure attachment stemming from an invalidating environment fraught with a history of sexual, physical, and emotional abuse. CPS caseworkers, with the aid of assessments by the therapists who treat these girls, make decisions every day regarding treatment plans, visitation, and ultimate goals. These decisions are heavily influenced also by the CPS understanding of the appropriate placement and treatment of these girls. I contend that the lack of specificity of these goals (e.g., "we hope for reunification [with biological mother], but we just don't know if it will work") adds to the anxiety and depression that these girls experience as they live in limbo, helpless in the decisionmaking surrounding them, and painfully ambivalent about their mothers and what their role should/could be in their lives.

The term "boundary ambiguity" derives from family systems theory. It was originally defined by Pauline Boss in 1975 as an uncertainty about who is in the family, who is out of the family, and the family members' roles. These boundaries include both physical and psychological phenomena. Boundary ambiguity can be psychological presence and physical absence (e.g., a soldier missing in action) or physical presence and psychological absence (e.g., a parent with Alzheimer's disease). For the purposes of this study, boundary ambiguity involves the construct of how the reporter (CPS caseworker or therapist) understands how their client (adolescent girl in the custody of the state) understands how she fits in her family of origin and how being in the custody of the state affects that understanding. This exploration of how these decisionmakers understand the relationship of



boundary ambiguity and borderline personality disorder should have an influence on the theory of treatment for these children as well as on the CPS department's formation of treatment goals and timelines.

This study uses a fixed method design that is relational. The benefit of using a relational design is that it allows for the examination of influences of one variable on another without experimentation. This study, as a two-tailed research hypothesis, is nondirectional and states that there is a relationship between the variables. A multivariate regression using information from the demographic questionnaire will provide predictors for boundary ambiguity and borderline personality traits. Experimental designs with subjects suffering from traumatic relationships (e.g., questioning the adolescent girls and their mothers) would be neither possible nor ethical. This study is for my dissertation and is being conducted in fulfillment of the Doctor of Philosophy degree, as well as for presentation, future research, and publication on this and related topics.

### **The Characteristics of the Participants**

The sample consists of state CPS caseworkers and therapists working in residential programs which include adolescent girls in the six New England States. The sample is to be gathered by contacting the directors of the department of CPS in Vermont, New Hampshire, Maine, Massachusetts, Connecticut, and Rhode Island. I will request permission to grant me email access to the caseworkers working with adolescent girls in each department. In the same manner, directors of the residential programs in the six New England states who treat adolescent girls will be contacted for permission that will grant me email access to the therapists working with the adolescent girls at these programs. The term "adolescent girls" refers to girls between the ages of 14-18 who are in the custody of the state after being removed from their biological families due to abuse or neglect. From this point forward, in the discussion of the specifics of this research, the caseworkers and psychotherapists will be termed "reporters" and the adolescent girls in the custody of the state will be termed "clients." The directors will first receive an introductory email, followed by a phone call one week later. It will have been determined if their agency has an IRB, and if so, how to make application, and if not, what paperwork they require for the participation of their reporters. They will be told that I have received approval from the Smith College School for Social Work's Institutional Review Board. Letters of approval from these agencies must be provided to the Smith College School of Social Work's Human Subjects Review Committee before the research commences.

The sample is a sample of convenience, chosen because the reporters are most easily available. Demographic information gathered with the rest of the data provides the age range, ethnicity, length of employment in CPS or as a clinician, and the highest degree achieved. The criteria is that the participant has professional knowledge of an adolescent female client on his or her caseload who is in the custody of the state and with whom they have seen in the past month and worked with for the past three months.. The exclusion criteria would be that they have no knowledge of such an adolescent currently on their caseload. By not including that the chosen client be diagnosed with borderline personality disorder, data analysis can look at the relationship between the clients with borderline personality disorder and the clients without (garnered from the SWAP-200-A) and each category's relationship with boundary ambiguity. The sample size is minimum of 100 and a maximum of 1000. If the maximum is reached I will terminate the data collection phase. There are 69 residential schools in New England with adolescents who fit the criteria and a CPS department in each state.

### **The Recruitment Process**

Recruitment will begin with an introductory email sent to the CPS directors in the six New England States as well as to the directors of the 69 residential programs (see Appendices C and D). This contact will introduce me and my study and request permission to access the email addresses of the reporters working with clients for the CPS department and permission to access the email addresses of the reporters working with clients at the residential programs. One week following this email, contact will be made by telephone, following up on the email request. Letters demonstrating willingness to participate from all CPS departments and from all participating residential programs must be provided to the Smith College School for Social Work's Human Subjects Review Committee prior to the commencement of the research. The diversity of the sample will most likely be set by the state in which the reporters work, since for example Vermont and Maine have very few people of color, while Connecticut and Massachusetts will have more. It should be noted that the adolescents "thought of" by these reporters will be diverse most probably by state as well.

### **The Nature of Participation**

Once permission by the directors has been granted and email addresses obtained, the reporters will receive an email which will serve as informed consent. In Connecticut, due to the inability of CPS to sort their caseworkers by type of client they serve, an introductory email will be supplied to the CPS administrators (see Appendix H). They will send the email to all CPS caseworkers in Connecticut. If they choose to participate, then they will email me directly. Participation involves two steps: 1) completing the first questionnaire on [www.surveymk.com](http://www.surveymk.com) (a secure external website intended to collect data through surveys and designed with firewalls to ensure confidentiality) and 2) completing the second questionnaire (SWAP-200-A) which is an attachment to the email. In order to participate the reporters must complete both the [www.surveymk.com](http://www.surveymk.com) questionnaire AND the SWAP-200-A. Complete participation will take from 60 to 90 minutes, but can be completed over several sessions. Given how busy all of the reporters are, and how much paperwork is a part of their work life, it was decided to provide a simple online method of participation that can be done at their leisure.

The email explains the project, issues of confidentiality, and that participation is anonymous. By clicking on either questionnaire link in this email, the reporter indicates that he or she has read the email, understands the content, and consents to participate. Subjects will be informed of their right to refuse to participate, their right to skip questions, and their right to withdraw from the survey part way completed. Reporters, however, will not be able to withdraw from the study once they have submitted their survey due to the anonymity and the fact that it is not possible to identify their particular submission. They will also be informed how to contact the researcher with any questions.

### **Addendum—9/21/09**

In the course of emailing for permission from CPS directors and residential directors I was told that I would need to make application to three additional IRBs: CPS-CT, AHS-VT and the Justice Resource Institute. All three gave permission. The Justice Resource Institute required no alterations to my application. The Vermont Agency of Human Services required the following change: the addition of a sentence indicating that "ethnicity data of adolescents will not be collected" and that this item be removed as a data element from the associated data collection tool(s). CPS in Connecticut's change involved changing the term "survey monkey" as mentioned above. In the course of arranging to email the Connecticut CPS workers, it was decided that CPS was not able to

provide me with the list of 3000 caseworkers and they requested that I send my email “package” to the IRB and they would distribute it. However, since each email had to be assigned a user ID number unique to each caseworker, it was decided that the best way to proceed was to write a “preliminary email” (Appendix H) explaining my study that the IRB would distribute to all 3000 caseworkers, asking them to be in contact with me should they want to participate.

The response from my emailing was very disappointing. It became clear that the one reminder email (Appendix G-1) was not going to be sufficient. One week after the reminder email, I sent an additional reminder email (Appendix G-2). This reminder was also not sufficient. After a discussion with my dissertation committee, I sent a reminder email that included an offer to upload the SWAP for the participant by their sending it to me as an email attachment (Appendix G-3). The following email reminded the participants that there was ten days left to participate (Appendix G-4). At this point the response rate was low enough that I again discussed a new strategy with my dissertation committee and a lottery was suggested (participants would be eligible to win a \$100 VISA gift card) and permission was granted by the Smith IRB to proceed (Appendix G-5). Emails were sent asking for any concerns regarding this change and DCYF in Connecticut asked that this offer not be made to their caseworkers. This request was granted.

After this point, reminder emails were sent weekly, until which time I required 14 more participants and then reminders were sent biweekly. These reminder emails can be viewed in Appendices G-6 through G-16.

#### [www.surveymk.com](http://www.surveymk.com) Questionnaire

To complete the [www.surveymk.com](http://www.surveymk.com) questionnaire (including demographic information about the reporter, nonspecific information about the reporter’s understanding of the client, and the BAS-A), the reporter clicks on the URL link provided at the end of the email letter, which connects them directly with the questionnaire. When completed, they will click “Done” and the data is sent to the secured database at [www.surveymk.com](http://www.surveymk.com). At the conclusion of the questionnaire is a question allowing the reporter to choose one agency that they want the researcher to donate \$1 in thanks for their participation. In order for this dollar to be sent, they must also complete the SWAP-200-A.

#### SWAP-200-A

To complete the SWAP-200-A the participant will open the SWAP-200-A attachment, and there will be a question about whether they should run the macros. In order to continue, they must click “okay.” When the document is open, the reporter will read “Overview” and “Score Distribution” for instructions. Then at bottom left, the reporter will click on “data entry.” The questionnaire will be displayed as well as the instructions, restated. After the SWAP-200-A is completed, the reporter will click “save to database.” The reporter will then open the Dartmouth URL provided in the email, and following instructions there, upload the SWAP-200-A datafile to a secure server maintained by the BioInformatics Service Center at Dartmouth Medical School.

Each reporter will receive an ID number, which will be used to link the data from the [www.surveymk.com](http://www.surveymk.com) questionnaire and the SWAP-200-A for data analysis. However the researcher will have no ability to connect the ID number with an email address after the initial email has been sent.

The time frame for response will be four weeks from the reporter's receipt of the email. A reminder email will be sent out to all reporters at two and four week intervals.

**Risks of Participation**

This is a low risk study with professionals who have knowledge of how to deal with work stress. My phone number and email address will be provided for questions and concerns.

**Benefits of Participation**

Reporters who work with clients with borderline personality traits are usually strong clinicians who care very much about the work that they do—because their work is so difficult, given this population. The benefits of participation in this study for these reporters is the satisfaction of engaging in a study that may both validate issues that they have been dealing with for a long time without support from policymakers and may also have an impact on policymaking and treatment planning in the future. They may also learn things about their client that they hadn't noticed or reflected upon before. By completing the survey and the SWAP-200-A, a \$1 contribution to either the Child Welfare League of America (<http://www.cwla.org>) or Mental Health America (<http://www.mentalhealthamerica.net>) will be made by the researcher. Additional compensation will be an additional attachment to the email in the form of a list of helpful web-based resources to aid the reporter in his or her work (see Appendix L).

**Informed Consent Procedures**

All reporters will receive an email introductory letter serving as informed consent describing all of the risks and benefits as well as the knowledge that their participation is entirely voluntary. By clicking on the “www.surveymk.com” link provided within the letter, completing that survey and the SWAP-200-A and returning them both, they will have provided their consent.

**Precautions Taken to Safeguard Confidentiality and Identifiable Information**

Although a list of email addresses will be provided, once the subject enters the www.surveymk.com website and uploads the SWAP-200-A, all information is anonymous. The www.surveymk.com data will be collected through www.surveymk.com's secure external website intended to collect data through surveys and designed with firewalls to ensure confidentiality. The SWAP-200-A datafile will be uploaded to a secure sever maintained by the BioInformatics Service Center at Dartmouth Medical School. The data will available only to this researcher and the data collector. The email addresses as well as survey data and any communication that the reporters may have sent will be kept securely for three years in a locked file in this researcher's office, which is consistent with federal regulations. If the data is needed beyond that time, they will continue to be kept secure until no longer needed, at which time all data will be destroyed.

**Investigator's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Advisor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Appendix C: Email to Residential Program Directors

[date]

Dear [name of director]:

My name is Maureen Kaplan and I am a doctoral fellow at the Smith College School for Social Work. I am embarking on the research necessary for my dissertation and I need your assistance.

I am conducting a study to explore the relationship between boundary ambiguity and borderline personality traits in adolescent girls in the custody of the state. For the purposes of this study, boundary ambiguity involves the construct of how the reporter (CPS caseworker or therapist) understands how their client (adolescent girl in the custody of the state) understands how she fits in her family of origin and how being in the custody of the state affects that understanding and may have an impact on her mental health.

I am writing to request the email addresses of the therapists in your program who work with adolescent girls in the custody of the state. With your permission they will receive an email which will serve as informed consent. Participation involves completing two questionnaires. Complete participation will take from 60 to 90 minutes but can be done in several sittings.

The data for this study will come from the completion of these two questionnaires by Child Protective Services workers and therapists in adolescent residential programs in the six New England States. No identifying information regarding the therapist or client is requested. This study has been approved by the Smith College School for Social Work's Human Subjects Review Board.

By choosing to participate in this study, there is minimal risk to the therapist. They may choose not to participate and may stop their participation at any time during the survey. By granting permission for the therapists in your program to participate in this study, you will be contributing important information that reflects the very difficult work that your program does with very difficult children who need help.

A permission form is attached to this email. Please complete the areas in red and return to me by email as soon as possible. This form is filed with Smith College's Human Subjects Review Committee and states that you agree to allow your therapists to be a part of this study. If I have not heard from you in one week, I will follow up with a phone call. Should you have any questions, do not hesitate to call or email me.

Thank you for your consideration, time, and assistance.

Maureen Kaplan, LICSW  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
603-653-9852

## Appendix D: Email to CPS Department Directors

[date]

Dear [name of director]

My name is Maureen Kaplan and I am a doctoral fellow at the Smith College School for Social Work. I am embarking on the research necessary for my dissertation and I need your assistance.

I am conducting a study to explore the relationship between boundary ambiguity and borderline personality traits in adolescent girls in the custody of the state.

For the purposes of this study, boundary ambiguity involves the construct of how the reporter (CPS caseworker or therapist) understands how their client (adolescent girl in the custody of the state) understands how she fits in her family of origin and how being in the custody of the state affects that understanding and may have an impact on her mental health.

I am writing to request the email addresses of the caseworkers in your department who work with adolescent girls in the custody of the state. With your permission, they will receive an email which will serve as informed consent. Participation involves completing two questionnaires. Complete participation will take from 60 to 90 minutes, but can be done in several sittings.

The data for this study will come from the completion of two questionnaires by Child Protective Services workers and therapists in adolescent residential programs in the six New England States. No identifying information regarding the therapist or client is requested. This study has been approved by the Smith College School for Social Work's Human Subjects Review Board.

By choosing to participate in this study, there is minimal risk to the caseworker. They may choose not to participate and may stop their participation at any time during the survey. By granting permission for the caseworkers in your department to participate in this study, you will be contributing important information that reflects the very difficult work that your department does with very difficult children who need help very badly.

I hope to receive your positive response as soon as possible. A permission form is attached to this email. Please complete the areas in red and return to me by email as soon as possible. This form is filed with Smith College's Human Subjects Review Committee and states that you agree to allow your caseworkers to be a part of this study. If I have not heard from you in one week's time, I will follow up with a phone call. Should you have any questions, do not hesitate to call or email me.

Thank you for your consideration, time, and assistance.

Maureen Kaplan, LICSW  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
603-653-9852

**[DATE]**

**Ann Hartman, PhD  
Chair of the Human Subjects Review Committee  
Smith College School for Social Work  
Lilly Hall  
Northampton, MA 01063**

**Dear Dr. Hartman:**

**The [NAME OF YOUR AGENCY OR INSTITUTION] gives permission for Maureen Kaplan to locate her research in this institution. We understand that the Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) has performed a review of this research proposal and that Ms. Kaplan has been granted your permission to proceed. The [NAME OF YOUR AGENCY OR INSTITUTION] will abide by the standards related to the protection of all participants in the research approved by the SSW HSR Committee.**

**Sincerely,**

**[SIGNATURE]**

**[TITLE]**

**[NAME, ADDRESS, AND PHONE NUMBER OF AGENCY OR INSTITUTION]**

**Please note that your typed name on this form is considered signatory.**

## Appendix F: Informed Consent Form

Hello Colleague!

I AM Maureen Kaplan, LICSW, a doctoral student at Smith College School for Social Work. I am embarking on the research necessary for my dissertation and this is YOUR OPPORTUNITY to be an important participant. MY STUDY is an exploration of the relationship between boundary ambiguity and borderline personality traits in adolescent girls in the custody of the state. For the purposes of this study, boundary ambiguity is defined as how you understand how your client understands how she fits in her family of origin and how being in the custody of the state affects that understanding and how it may have an impact on her mental health.

- **YOU ARE BEING ASKED TO PARTICIPATE BECAUSE** you are either a therapist for adolescent girls in a residential program or are a caseworker with adolescent girls on your caseload for your state's Child Protective Services department (DCF/DCYF/DSS).
- Your participation is entirely voluntary.
- **IN ORDER TO PARTICIPATE**, you must have professional knowledge of an adolescent female client on your caseload who is in the custody of the state and whom you have seen in the past month and have worked with for the past three months.
- **YOUR PARTICIPATION** requires completion of two questionnaires and may take between 60-90 minutes. All answers are either multiple choice or rating scales.
- You may complete the questionnaires in as many sittings as you need.
- **NO IDENTIFYING INFORMATION REGARDING YOU OR YOUR CLIENT** is requested.
- **PARTICIPATION MUST BE COMPLETED BY JULY 1, 2009!**

**YOUR PARTICIPATION** in this study may be a **REWARDING EXPERIENCE**. You will be contributing important information that reflects the very difficult work that you do with very difficult children who need help very badly. **YOU MAY ALSO LEARN THINGS ABOUT YOUR CLIENTS THAT YOU HADN'T NOTICED OR REFLECTED UPON BEFORE**. Participation in the survey means minimal risk to you. You may also choose not to participate or may stop your participation at any time while taking the survey. If you complete both sections a \$1 contribution to either the Child Welfare League of America or Mental Health America will be made on your behalf. Additional compensation comes as Attachment #2 to this email: a list of helpful web-based resources to aid you in your work.

The survey is anonymous. The data will be collected by two secure external websites designed with firewalls to ensure anonymity. You will not be able to be identified or connected with your responses once this email has reached you. The data will only be available to this researcher. The email addresses as well as the data and any communication that you may have sent will be kept securely for three years in a locked file in this researcher's office, which is consistent with federal regulations. If the data is needed beyond that time, they will continue to be kept secure until no longer needed at which time all data will be destroyed. The data will be used to fulfill research necessary for completing a Ph.D. at Smith College School for Social Work. A summary of these findings may be used for future presentation and publication on this topic.



You may skip any question without penalty. You may withdraw from participation at any time by not completing the questionnaires. However, once you have submitted the questionnaires you will not be able to withdraw because there will be no way to connect you with your data. Should you have questions or want to discuss the research study, please contact me. You may also contact the chairwoman of the Smith College School for Social Work's Human Subjects Review Committee at 413-585-7974.

**BY CLICKING ON EITHER OF THE BELOW LINKS YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

**THANK YOU SO MUCH FOR YOUR CONSIDERATION, TIME, AND MOST ESPECIALLY YOUR PARTICIPATION. I truly know and appreciate how hectic and stressful your lives are. But I wouldn't be asking for your help if you did not do the very difficult work that you do. Step-by-step instructions follow.**

Yours very sincerely,  
Maureen A. Kaplan, LICSW  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
(603) 653-9852

### INSTRUCTIONS

The [www.surveymk.com](http://www.surveymk.com) questionnaire and the SWAP-200-A will prompt you to think of a female adolescent client on your caseload who is in the custody of the state and whom you have seen in the past month worked with for the past three months. You should think of the same client for both questionnaires. Your USER ID is at the end of these instructions and should be used for both questionnaires.

#### **Step One—[www.surveymk.com](http://www.surveymk.com) questionnaire**

- Click on the “surveymk” link at the bottom of these instructions and follow the directions there to complete this questionnaire.

#### **Step Two—SWAP-200-A (Attachment #1 to this email)**

1. Open the document.
2. Click “okay” on the pop-up copyright window.
3. Read “Overview” and “Score Distribution” for instructions.
4. Type your User ID as indicated in the first yellow box.
5. Enter a score from 1 to 7 (see instructions) for each statement regarding the same adolescent client you used in the “surveymk” questionnaire.
6. Note that the scoreboard (upper left) is tallying how many of each score (0-7) you use.
7. After scoring all 200 statements, click “Sort by score”.
8. Go through the statements again, adjusting the scores until you have the “desired” amount of each score. Note that when you reach the desired number, the total will turn from red to green.
9. When finished, click “save to database.”
10. Then save the file to your hard drive (click on “File,” then “Save As” and name the file by your User ID number.)
11. Upload your saved file to the secured server:

- a. Click on the link (<https://bioinformatics.dartmouth.edu//swap200/>) or paste the link in your address line.
- b. On the SWAP-200-A home page, type in your User ID and confirm.
- c. Click “browse” which will take you to the place on your computer where your saved your SWAP-200-A is located.
- d. Select the file from your documents.
- e. Click “upload.”

**YOUR PARTICIPATION IS COMPLETE!**

Thank you so much!!

Click on link below for Wwww.surveymk.com Link:

[https://www.surveymonkey.com/s.aspx?sm=Unj\\_2f8Oz7iHWXiaBqrezZfg\\_3d\\_3d](https://www.surveymonkey.com/s.aspx?sm=Unj_2f8Oz7iHWXiaBqrezZfg_3d_3d)

Click on link below to upload your SWAP-200-A:

<https://bioinformatics.dartmouth.edu//swap200/>

Your user ID is:

Please note that the SWAP-200-A is being provided solely for purposes of data collection for my dissertation project, and participants who wish to use the instrument for other purposes may obtain an authorized copy for [www.SWAPassessment.org](http://www.SWAPassessment.org).

## Appendix G-1: Reminder Email

Hello, once again, Colleague,

I am Maureen Kaplan, LICSW, writing again to remind you about the opportunity to participate anonymously in my dissertation study on boundary ambiguity and borderline traits in adolescent girls in the custody of the state. You received the original email about two weeks ago.

I am attaching the original email. Participation is voluntary and greatly appreciated. Please contact me with any questions or concerns.

Thank you for your consideration, time, and assistance.

Maureen Kaplan, LICSW  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
(603) 653-9852

## Appendix G-2

7 June 2009

Dear esteemed, overworked, potentially undervalued, colleague,

I NEED YOUR HELP BADLY!! I am the doctoral student who two weeks ago sent out a much more formal request for your participation in what I hope will be an important study for all of us who work with adolescent girls in foster care.

LET ME HELP YOU with what seems to be an arduous task for nothing. (I know, I was once sitting in your place and would not answer a survey for any reason. Sitting where I am right now, I would do a survey for Attila the Hun, knowing what it is like to look at an empty database).

If the SWAP is daunting, confusing, too technical—PLEASE EMAIL ME OR CALL ME and let me walk you through the rough spots.

I know that it is beautiful out and you are tired. But you could be a part of history (well, you know what I mean...)—and given how hard you work—you deserve it.

The formal original email, SWAP-200-A, and incentives are attached. I am so grateful for your time. Please let me hear from you.

Yours very sincerely,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
(603) 653-9852

## Appendix G-3

15 June 2009

Hello again!

In order to make things a bit easier for you, feel free to send me as an attachment your completed SWAP-200-A and I will upload it for you--to save you from some of the technical machinations.

Remember--to have your data be usable, you must complete BOTH the SWAP-200-A AND the surveymk.

I am attaching the SWAP in case you deleted the others I have sent, in disgust--or by mistake. I hope that you will take the time to be an important part of this study now.

Email or call if you don't have your USER ID number, instructions, and/or the link to the surveymk and I will get back to you immediately.

Thank you so much for participating and have a good week.

Be well,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

## Appendix G-4

20 June 2009

Hi--

There are 10 more days to the deadline for data collection for my dissertation research. I hope that you will take this opportunity to get involved!

Remember--to have your data be usable, you must complete BOTH the SWAP-200-A AND the surveymk.

I am attaching the SWAP in case you deleted the others I have sent. I hope that you decide to take the time to be an important part of this study now.

In order to make things a bit easier for you, feel free to send me as an attachment your completed SWAP-200-A and I will upload it for you--to save you from some of the technical machinations.

Email or call if you don't have your USER ID number, instructions, and/or the link to the surveymk and I will get back to you immediately.

Thank you so much for participating! I know that you are sooo busy, you play an imperative part in my completing this research. You are the best.

Be well,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

Appendix G-5 [note that the email to any CT responders did not have paragraph 2 included)

23 June 2009

Greetings!

By now you have received more-than-you'd-like invitations to participate in the data collection aspect of my dissertation research. I very much need your help and I know that I am asking a lot of precious time from you by asking you to join in and help me.

In recognition of that time (while you realize the financial constraints of a poor doctoral student) I am hoping that the **incentive of a lottery for a \$100 VISA gift card** may sway you to complete both surveys.

To be eligible for the lottery you must complete BOTH the SWAP-200-A AND the surveymk.

I am attaching the SWAP in case you deleted the others I have sent. By completing the SWAP I hope that it will trigger you to recognize some things about your client that you had not previously thought about.

In order to make things a bit easier for you, feel free to send me as an attachment your completed SWAP-200-A and I will upload it for you--to save you from some of the technical machinations.

Email or call if you don't have your USER ID number, instructions, and/or the link to the surveymk and I will get back to you immediately.

Thank you again. Social work is so dependent upon connection and it is so difficult to make that connection through email. But please know that I so appreciate everything you do every day--and hope that you will want to be an imperative part of what I hope to be important research. Don't forget to enter to win!!!

Take good care,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

PS--And if you've already completed both, you are automatically entered into the lottery!!

Appendix G-6 [Paragraph 1 did not include the lottery for CT-DCYF]

6/30

Hello again!!

It's not too late to participate in my doctoral dissertation research and be entered in the lottery to win a \$100 VISA gift card!!

All you have to do to be eligible for the lottery is complete BOTH the SWAP-200-A AND the surveymk questionnaire.

I am attaching the SWAP in case you deleted the others. Feel free to send me as an attachment your completed SWAP-200-A and I will upload it for you.

Email or call if you don't have your USER ID number, instructions, and/or the link to the surveymk and I will get back to you immediately.

Don't miss this opportunity to be a part of some important research!! As well as having the undying gratitude of a somewhat desperate graduate student! How about finishing by the 4th of July?!

Take care,  
Maureen Kaplan, LICSW  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
603.653.9852



Appendix G-7 [Paragraph 1 did not mention lottery for DCYF-CT]

Happy July!!

I am the Smith College School for Social Work doctoral student who desperately needs 20 more people to participate in my research. Below you will find the original information and instructions. REMEMBER, that by completing both the SWAP and the surveymk you will be entered into a lottery to win a \$100 VISA gift card!!

Until July 22, you can reach me at 802.463.4513 or at my email address. I desperately need your help. Please consider taking some time to be one of the additional 20 more entrants!!! I am so grateful for your help.

Sincerely yours,  
Maureen Kaplan, LICSW

**Hello Colleague!**

**I AM Maureen Kaplan, LICSW, a doctoral student at Smith College School for Social Work. I am embarking on the research necessary for my dissertation and this is YOUR OPPORTUNITY to be an important participant. MY STUDY is an exploration of the relationship between boundary ambiguity and borderline personality traits in adolescent girls in custody of the state. For the purposes of this study, "boundary ambiguity" is used to express your understanding of the client's assessment of how she fits in her family of origin and how being in custody of the state affects that understanding and how it may have an impact on her mental health.**

- **YOU ARE BEING ASKED TO PARTICIPATE BECAUSE you are either a therapist for adolescent girls in a residential program or a caseworker with adolescent girls on your caseload for your state's Child Protective Services department (DCF/DCYF/DSS).**
- **Your participation is entirely voluntary.**
- **IN ORDER TO PARTICIPATE, you must have professional knowledge of an adolescent female client on your caseload who is in the custody of the state and whom you have seen in the past month and have worked with for the past three months.**
- **YOUR PARTICIPATION requires completion of two questionnaires and may take between 60-90 minutes. All answers are either multiple choice or rating scales.**
- **You may complete the questionnaires in as many sittings as you need.**
- **NO IDENTIFYING INFORMATION REGARDING YOU OR YOUR CLIENT is requested.**
- **PARTICIPATION MUST BE COMPLETED BY JULY 1, 2009!**

**YOUR PARTICIPATION in this study may be a REWARDING EXPERIENCE. You will be contributing important information that reflects the very difficult work that you do with very difficult children who are greatly in need of care. YOU MAY ALSO LEARN THINGS ABOUT YOUR CLIENTS THAT YOU HADN'T NOTICED OR REFLECTED ON BEFORE. Participation in the survey means minimal risk to you. You may also choose not to participate or may stop your participation at any time while taking the survey. If you complete both sections a \$1 contribution to either the Child Welfare League of America or**

**Mental Health America will be made on your behalf. Additional compensation comes as Attachment #2 to this email: a list of helpful web-based resources to aid you in your work.**

**The survey is anonymous. The data will be collected by two secure external websites designed with firewalls to ensure anonymity. You will not be able to be identified or connected with your responses once this email has reached you. The data will only be available to this researcher. The email addresses as well as the data and any communication that you may have sent will be kept securely for three years in a locked file in this researcher's office, which is consistent with federal regulations. If the data is needed beyond that time, they will continue to be kept secure until no longer needed, at which time all data will be destroyed.**

**You may skip any question without penalty. You may withdraw from participation at any time by not completing the questionnaires. Once you have submitted the questionnaires, however, you will not be able to withdraw, for there would then be no way to connect you with your data. Should you have questions or want to discuss the research study, please contact me. You may also contact the chairwoman of the Smith College School for Social Work's Human Subjects Review Committee at 413-585-7974.**

**BY CLICKING ON EITHER OF THE BELOW LINKS YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

**THANK YOU SO MUCH FOR YOUR CONSIDERATION, TIME, AND MOST ESPECIALLY YOUR PARTICIPATION. I truly know and appreciate how hectic and stressful your lives are. But I wouldn't be asking for your help if you did not do the very difficult work that you do. Step-by-step instructions follow.**

**Yours very sincerely,  
*Maureen A. Kaplan, LICSW*  
[makaplan@email.smith.edu](mailto:makaplan@email.smith.edu)  
(603) 653-9852**

### **INSTRUCTIONS**

**The [www.surveymk.com](http://www.surveymk.com) questionnaire and the SWAP-200-A will prompt you to think of a female adolescent client on your caseload who is in custody of the state and whom you have seen in the past month and worked with for the past three months. You should think of the same client for both questionnaires. Your USER ID is at the end of these instructions and should be used for both questionnaires.**

#### **Step One—[www.surveymk.com](http://www.surveymk.com) questionnaire**

- Click on the “surveymk” link at the bottom of these instructions and follow the directions there to complete this questionnaire.**

#### **Step Two—SWAP-200-A (Attachment #1 to this email)**

- 12. Open the document.**
- 13. Click “okay” on the pop-up copyright window.**
- 14. Read “Overview” and “Score Distribution” for instructions.**

15. Type your User ID as indicated in the first yellow box.
16. Enter a score from 1 to 7 (see instructions) for each statement regarding the same adolescent client you used in the “surveymk” questionnaire.
17. Note that the scoreboard (upper left) is tallying how many of each score (0-7) you use.
18. After scoring all 200 statements, click “Sort by score.”
19. Go through the statements again, adjusting the scores until you have the “desired” amount of each score. Note that when you reach the desired number, the total will turn from red to green.
20. When finished, click “save to database.”
21. Then save the file to your hard drive (click on “File,” then “Save As” and name the file by your User ID number.)
22. Upload your saved file to the secured server:
  - a. Click on the link (<https://bioinformatics.dartmouth.edu/swap200/>) or paste the link in your address line.
  - b. On the SWAP-200-A home page, type in your User ID and confirm.
  - c. Click “browse” which will take you to the place on your computer where your saved SWAP-200-A is located.
  - d. Select the file from your documents.
  - e. Click “upload.”

**YOUR PARTICIPATION IS COMPLETE!**  
Thank you so much!!

Click on link below for [www.surveymk.com](http://www.surveymk.com) Link:  
[https://www.surveymk.com/s.aspx?sm=Unj\\_2f8Oz7iHWXiaBqrezZfg\\_3d\\_3d&c=0461](https://www.surveymk.com/s.aspx?sm=Unj_2f8Oz7iHWXiaBqrezZfg_3d_3d&c=0461)

Click on link below to upload your SWAP-200-A:  
<https://bioinformatics.dartmouth.edu/swap200/>

Your user ID is: 0461

Please note that the SWAP-200-A is being provided solely for purposes of data collection for my dissertation project, and participants who wish to use the instrument for other purposes may obtain an authorized copy for [www.SWAPassessment.org](http://www.SWAPassessment.org).

Appendix G-8 [Paragraph 2 was not included for DCYF-CT]

7-24-09

Hello RI [VT, NH, CT] DCYF [Residential Therapists]!!!

I know that you are weary of hearing from me (and just think--if you and 13 of your friends participated, you would never have to hear from me again!) but I really need your help by participating in my dissertation research.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I have in the past week emailed you a complete package, but I am attaching the SWAP in case you deleted it. The only other things you will need are your user number and your own link to the surveymk questionnaire. Feel free to send me as an attachment your completed SWAP-200-A and I will upload it for you--to save you from some of the technical machinations. AND email or call if you don't have your USER ID number, instructions, and/or the link to the surveymk and I will get back to you immediately.

Thanking you again for your help, time, and consideration is not adequate, but it is the best that a poor doctoral student can muster at this point. I want you to be an imperative part of what I hope to be important research. I can't wait to hear from you!!!!

Be well,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

Appendix G-9 [Paragraph 2 was not included for DCYF-CT]

7-31

I just need 13 more participants!!

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

I have been attempting to gather this data for over a year now--PLEASE help me finish this aspect of my research by being a participant.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

8-7

Happy Monday!!

Would you rather that I send this to your home computer? Just let me know.....

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

I have been attempting to gather this data for over a year now--PLEASE help me finish this aspect of my research by being a participant.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu

8-18

Yes, it's me again. Please help me (and oh, how I hate begging. I even, believe it or not, hate asking anyone to do anything. This has been a real growth experience for me).

I only need 5 more complete participants.

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

I have been attempting to gather this data for over a year now--PLEASE help me finish this aspect of my research by being a participant.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

Appendix G-12 [Paragraph 3 was not included for DCYF-CT]

8/22/09

Hello Rhode Island [Vermont, New Hampshire, Connecticut, Residential Therapists]!!

I only need 4 more complete participants and I REALLY NEED YOUR HELP!!!.

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852



8/27

Just think!! If you and a colleague participate completely in my research, I will be done with my data collection and you will never have to hear from me again!!

I only need 2 more complete participants and I REALLY NEED YOUR HELP!!!.

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

Appendix G-14 [Paragraph 3 was not included for DCYF-CT]

8/29

You could be LAST BUT NOT LEAST!!!! I REALLY need 1 more participant very badly. Others in Rhode Island [Vermont, New Hampshire, Connecticut] DCYF [residential therapists] have completed their participation and lived to tell the tale!!

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

Appendix G-15

9/3

I need your help (assistance, aid, support)!!!!

I am desperately (badly, fiercely, greatly, seriously, like crazy) asking for your participation.

I hate to beg (ask, beseech, entreat, implore, nag, plead, press, urge) but I just need ONE MORE!!!

You could be LAST BUT NOT LEAST!!!! I REALLY need 1 more participant very badly and all you have left to do is the SWAP!! I am attaching it--and would be more than happy to call you and get you started (it seems to go much easier that way). Let me know a good time and a good number--or if you want me to send it to your home email. Thank you so much for your help. You don't know what it means to me.

Maureen

Appendix G-16 [Paragraph 7 was not included for DCYF-CT]

9/8

Hello New Hampshire DCYF [Vermont, Rhode Island, Connecticut, Residential Therapists]!!!

I need your help (assistance, aid, support)!!!!

I am desperately (badly, fiercely, greatly, seriously, like crazy) asking for your participation.

I hate to beg (ask, beseech, entreat, implore, nag, plead, press, urge) but I just need ONE MORE!!!

You could be LAST BUT NOT LEAST!!!! I REALLY need 1 more participant very badly.

Others in NH DCYF [VT, RI, CT, residential therapists] have been complete participants and lived to tell the tale!!!

I have had a lot of success getting participants started by telephone on doing the SWAP-200-A, with them finding that it is much easier and quicker than they had thought. LET ME HELP YOU and you will be helping me more than you know.

Remember, that in recognition of the time you will spend completing BOTH the SWAP-200-A and the surveymk questionnaire, complete participants will be entered into a **lottery for a \$100 VISA gift card.**

I am attaching the SWAP in case you deleted it. You also need your user number and your own link to the surveymk questionnaire--just email me and you will get it as soon as I read your email.

Thanks again as always,  
Maureen Kaplan, LICSW  
makaplan@email.smith.edu  
603.653.9852

## Appendix H: Preliminary Connecticut DCF Emails

**From:** DCF NEWS  
**Sent:** Wednesday, June 17, 2009 3:34 PM  
**Subject:** Research Study  
**Importance:** High

Dear Colleague:

My name is Maureen Kaplan, LICSW, and I am a doctoral student at Smith College School for Social Work. I need your help with my dissertation research. My study is titled "Boundary Ambiguity and Borderline Personality Traits: Adolescent Girls in State's Custody." Boundary ambiguity is a state resulting from stressful events in which family members are uncertain about who is in the family and who is out. My study explores how the DCYF caseworker understands how her or his client (adolescent girl in the custody of the state) understands how she fits in her family of origin and how being in the custody of the state affects that understanding and may have an impact on her mental health.

Participation is entirely voluntary. To participate you must have professional knowledge of an adolescent female client on your caseload that you have seen in the past month and have worked with for the past three months. Your participation will require completion of two questionnaires and may take between 60-90 minutes. All answers are either multiple choice or rating scales. Completed questionnaires will be downloaded to a secure web-based data collection site. You may complete the questionnaires in as many sittings as you need. No identifying information regarding you or your client is requested.

Following completion of the data analysis, I will provide the results of this research to the Department. I hope that you share my interest in learning the results!

Thank you so much for your consideration. IF YOU CHOOSE TO PARTICIPATE, JUST FORWARD THIS EMAIL TO ME (makaplan@email.smith.edu), MAKING SURE THAT YOUR EMAIL ADDRESS IS CORRECT AND VISIBLE TO ME BY JULY 1, 2009. I will then email more instructions and the questionnaires to you.

Please don't hesitate to call or email should you have any questions. I am grateful for your time.

Maureen A. Kaplan, LICSW  
makaplan@email.smith.edu  
(603) 653-9852

## Appendix I: Demographic Information About You

Please answer the following demographic questions.

1. What is the highest degree you have achieved?  
 High school diploma    BA/BS    MSW    MA/MS/Med    PhD  
 PsyD    EdD    other
2. If you are a therapist, how many years have you been in practice?  
 less than 1 year    1-5 years    6-10 years    11-15 years  
 16-20years    over 20 years
3. If you are a Child Protective Worker (DCF/DCYF/DSS), how long have you worked for Child Protective Services (DCF/DCYF/DSS)?  
 less than 1 year    1-5 years    6-10 years    11-15 years  
 16-20years    over 20 years
4. What state do you work in?  
 Connecticut    Maine    Massachusetts    New Hampshire  
 Rhode Island    Vermont
5. How old are you?  
 21-30 years    31-40 years    41-50 years    51-60 years  
 over 60 years
6. What is your gender?  
 female    male
7. What ethnicity are you?  
 Caucasian    Black    Hispanic    Asian    Native American

## Appendix J: Considerations About Care of Your Client

Please complete the following questionnaire regarding one of your clients who fits the following criteria: an adolescent girl (between the ages of 14-18) in the custody of the state currently on your caseload, whom you have seen in the past month worked with for at least the past three months.

1. How many clients who currently fit the description in the instructions above are currently on your caseload?  
 just this one       2-4       5-10       over 10
2. How long has this client been in treatment with you? If you are her Child Protective Services worker (DCF/DCYF/DSS) , how long has she been on your caseload?  
 3-6 months       7-12 months       over 1 year
3. How old is this client?  
 14     15     16     17     18
4.  
 under 3 months     3-6 months       7 months-1year       2- 3 years  
 4-5 years       6-8 years       over 8 years     I don't know.
6. How old was she when removed from her biological parent(s)?  
 under 1 month     1-3 months     4-6 months     7 months-1 year  
 2-3 years     4-6 years     7-10 years     11 years or older  
 I don't know.
7. Has she been reunited before with her biological parents(s) and subsequently removed? If yes, how many times?  
 she has never been reunited     reunited once before     twice before  
 three times     four or more times       I don't know.
8. How many placements has she had since initially removed from her home?  
 1     2     3     4     5     6 or more     I don't know.
9. Have you met the biological mother of the client you are thinking of?  
 yes       no
10. How often does this client see her biological mother?  
 weekly       bimonthly     monthly       no set schedule       never
11. Are these visits planned/predictable or intermittent?  
 planned/predictable       intermittent       very rare
12. Are visits with biological mother scheduled and supervised by Child Protective Services (DCF/DCYF/DSS) or up to biological mother?  
 scheduled/supervised       up to mother

13. Are visits with biological mother part of the Child Protective Services (DCF/DCYF/DSS) treatment plan?  
 yes             no
14. Is family therapy with the biological mother part of the Child Protective Services (DCF/DCYF/DSS) treatment plan?  
 yes             no
15. How would you describe the adolescent prior to these visits? [Please check all answers that apply.]  
 excited             subdued             engaged in self-destructive behavior  
 she sabotages the visits             anxious             grandiose  
 anxious mother won't come    anxious about mother's behavior  
 angry             sad
16. How would you describe the adolescent after these visits? [Please check all answers that apply.]  
 excited             subdued             engaged in self-destructive behavior  
 anxious             grandiose             angry at self    sad  
 angry at mother             angry at Child Protective Services
17. Is the ultimate goal of the Child Protective Services (DCF/DCYF/DSS) treatment plan reunification with biological mother?  
 yes             no
18. If so, does the adolescent know that this is the plan?  
 yes             no
19. If so, does the mother know that this is the plan?  
 yes             no
20. Does this plan for reunification include family therapy with the mother and others who live in the home?  
 yes             no
21. Does the plan for reunification include individual therapy for mother?  
 yes             no
22. Does the plan for reunification include parenting skills training?  
 yes             no
23. Has there been a change in the Child Protective Services (DCF/DCYF/DSS) treatment plan regarding reunification?  
 yes, toward reunification             yes, against reunification             no change
24. Have you seen improvement in your client's mental health in the time that you have known her?  
 definitely             intermittent             much the same             no, regression
25. Do you think that any improvement or lack of improvement was connected with any decision regarding her biological mother in the context of treatment?



yes       no       hard to say

26. From your clinical viewpoint, do you think that reunification of this adolescent with her biological mother is possible?

yes       no

## Appendix K: BAS-A

1. My client no longer considers herself the daughter of her biological mother.
2. My client is prepared for her mother's rights to be terminated.
3. My client still wonders if her mother will return to being her full-time mother.
4. My client continues to keep alive her deepest hope that her mother will again be her full-time mother.
5. My client feels guilty when she thinks about alternative guardianship other than her mother.
6. My client feels able to plan her future without feeling guilty about not continuing to wait for her mother to change.
7. My client will never be satisfied until she has positive proof that her mother will never again be able to be her full-time mother.
8. My client hopes to get adopted.
9. My client thinks about her mother a lot.
10. My client feels that it will be difficult, if not impossible, to carve out a new life for herself without her mother.
11. My client thinks that the Child Protective Services department (DCF/DCYF) has done everything reasonable to help her mother to be an appropriate guardian.
12. My client feels incapable of establishing a meaningful relationship with another female guardian.
13. My client is able to talk about her mother without becoming emotionally upset.
14. My client still believes that she and her mother will reunify.
15. My client is aware of all "the facts" and has reconciled the loss of her mother.
16. My client and I talk about her mother seemingly quite often.
17. Conflicts with other biological family members over terminating the parental rights of her mother will present a problem for my client.
18. My client's other biological family members do not or would not approve of my client developing a life without her mother.

1—strongly disagree

2—disagree

3—neutral

4—agree

5—strongly agree

Due to my participation in your survey, please make a \$1 donation to the following organization (choose one, please):

Child Welfare League of America      [www.cwla.org](http://www.cwla.org)

Mental Health America      [www.mentalhealthamerica.net](http://www.mentalhealthamerica.net)

A leading non-profit organization dedicated to helping adults and children lead mentally healthier lives.

## Appendix L: Annotated Web-based Resources

**The following resources and links are provided to you in thanks for your participation in this survey.**

### **Borderline personality disorder**

Treatment and Research for Personality Disorder      <http://www.tara4bpd.org>

This organization, connected with the National Association for Personality Disorders, provides information on research, education, advocacy, family education programs, treatment advances, and conferences.

<http://www.bpddemystified.com>

A cite by Robert O. Friedel, MD who wrote the book *Borderline Personality Disorder Demystified*, which is a comprehensive and authoritative source for the layperson.

<http://www.mclean.harvard.edu/patient/adult/bpd>

This is John Gunderson's McLean Center for the Treatment of Borderline Personality Disorder. The site provides information on treatment, research, and family workshops.

<http://www.behavioraltech.org>

This is Marcia Linehan's organization and provides lots of information about Dialectical Behavior Therapy, including DBT trainings, products, resources, videos.

<http://www.nepda.org>

The New England Personality Disorder Association is a charitable organization connected with the McLean Hospital outpatient department. Its members are family and friends of those afflicted with borderline personality disorder and its mission is to provide educational opportunities for its members.

<http://www.bpdresourcecenter.org>

This is a site connected to New York Presbyterian where Otto Kernberg does his research. Found here is information on research, resources, and what's new with BPD.

<http://www.neabpd.org>

The site for the National Education Alliance for Borderline Personality Disorder provides information regarding conferences, reading, and resources for families and professionals.

### **Child and family resources**

<http://www.behavior.org>

The Cambridge Center for Behavioral Studies is a non-profit, charitable organization whose mission is to "advance the scientific study of behavior and its humane application to the solution of practical problems, including the prevention and relief of human suffering." This site provides information and resources about all aspects of aiding behaviors in adults and children.

<http://www.williamgladdenfoundation.org>

The mission of this organization is to understand and resolve the problems of youth and families through knowledge. This site is a library of free information about youth, parents, and family.

<http://www.childdevelopmentinfo.com>

The Child Development Institute provides information on parenting, family life, teenagers, child development, health and safety, and child psychology and mental health.

American Family Therapy Academy <http://www.afta.org>

A non-profit organization of leading family therapy clinicians, teachers, program directors, researchers, and policy makers who are dedicated to advancing treatment for families within their social context.

### **Child welfare**

<http://www.childrensdefense.org>

This is a private, non-profit organization whose mission is to be a “strong, effective voice for all the children of America who cannot vote, lobby, or speak for themselves.” This site provides information on policy initiatives, data, programs, and publications.

<http://www.aecf.org>

The Annie E. Casey Foundation

This organization’s mission is “helping the most vulnerable families achieve success.” This site includes information on child welfare, community change, education, health, and juvenile justice. There is also a link to Casey Family Services, which is an agency active in many of the New England states.

### **Site for interested clinicians**

Information for Practice: News and New Scholarship from Around the World

<http://www.nyu.edu/socialwork/ip>

This is a fascinating site with information and links to national and international news regarding all aspects of social work and the populations that social workers serve. There are links to the most recent journal articles as well as to stories, organizations, and research around the United States and the world that are pertinent to the world of social work.

## Appendix M: List of Contacted Residential Programs in New England

### Connecticut

Center of Progressive Education (COPE)  
425 Grant Street  
Bridgeport, CT 06610  
Mary Ellen Leigh  
[mbrinkmann@aptfoundation.org](mailto:mbrinkmann@aptfoundation.org)  
203.337.9943

The Children's Center of Hamden  
1400 Whitney Ave.  
Hamden, CT 06517  
Anthony Del Mastro  
[adelmastro@childrenscenterhamden.org](mailto:adelmastro@childrenscenterhamden.org)  
203.248.2116

The Children's Home of Cromwell  
Learning Center  
60 Hicksville Road  
Cromwell, CT 06416  
Gary Mullaney  
[gmullaney@childhome.org](mailto:gmullaney@childhome.org)  
860.635.6010

The CREC  
John J. Allison Jr. Polaris Center  
474 School Street  
East Hartford, CT 06108  
Bruce Douglas  
[bdouglas@crec.org](mailto:bdouglas@crec.org)  
860.289.8131

Devereux Glenholme School  
81 Sabbaday Lane  
Washington, CT 06793  
Mary Ann Campbell, Exec. Dir.  
[jsmallw2@devereux.org](mailto:jsmallw2@devereux.org)  
860.868.7377

Grove School  
[www.groveschool.org](http://www.groveschool.org)  
175 Copse Road  
Madison, CT 06443  
Richard L. Chorney  
[RLC@groveschool.org](mailto:RLC@groveschool.org)  
203.245.2778

The Learning Clinic  
Route 169  
Brooklyn, CT 06234  
Raymond W. DuCharme, PhD, Exec. Dir.  
[admissions@thelearningclinic.org](mailto:admissions@thelearningclinic.org)  
860.774.5619

Raymond Hill School  
345 Linwood Street  
New Britain, CT 06052  
Mark H. Johnson, MA  
Vice President Klingberg CFRE Family Center  
[markj@klingberg.org](mailto:markj@klingberg.org)  
860.224.9113

Stonington Institute  
75 Swantown Hill Road  
North Stonington, CT 06359  
William Aniscovich, CEP  
[william.aniscovich@uhsinc.com](mailto:william.aniscovich@uhsinc.com)  
860.535.1010

Wellspring Foundation/Arch Bridge School  
21 Arch Bridge Road  
Bethlehem, CT 06751  
Harvey Newman  
[harvey.newman@wellspring.org](mailto:harvey.newman@wellspring.org)  
203.266.8000

#### Maine

Elan School  
P.O. Box 578  
Poland, ME 04274  
Sharon Terry  
[info@elanschool.com](mailto:info@elanschool.com)  
207.998.4666  
Linda Walton (secy)

Good Will-Hinkley  
[www.gwh.org](http://www.gwh.org)  
P.O. Box 159  
Hinckley, ME 04944  
Neil Colan  
[nbcolan@gwh.org](mailto:nbcolan@gwh.org)  
207.238.4000

KidsPeace New England  
Graham Lake  
16 Kidspeace Way  
Ellsworth, ME 04605  
Jean Dickson  
[jdickson@kidspeace.org](mailto:jdickson@kidspeace.org)  
800.992.9543

NFI-North Sidney Riverbend School  
3895 West River Road  
Sidney, ME 04330  
Lisa Libby, Program Director  
[lialibby@nafi.com](mailto:lialibby@nafi.com)  
207.547.4464

The School at Sweetser  
50 Moody Street  
Saco, ME 04072  
Carlton Pendleton  
[cpendleton@sweetser.org](mailto:cpendleton@sweetser.org)  
800.434.3000

Spurwink  
[www.spurwink.org](http://www.spurwink.org)  
899 Riverside Street  
Portland, ME 04103  
Dawn Stiles  
[dstiles@spurwink.org](mailto:dstiles@spurwink.org)  
207.871.1200

#### Massachusetts

Academy at Swift River  
151 South Street  
Cummington, MA 01026  
Frank Bartolomeo  
[fbartolomeo@swiftriver.com](mailto:fbartolomeo@swiftriver.com)  
800.258.1770

The Bridge of Central Massachusetts  
School House Program  
4 Mann Street  
Worcester, MA 01602  
Barry Walsh  
[barryw@thebridgecm.org](mailto:barryw@thebridgecm.org)  
508.755.0333

Brightside  
2112 Riverdale Street  
West Springfield, MA 01089  
Karl Wiggins, Vice President  
[karl.wiggins@sphs.com](mailto:karl.wiggins@sphs.com)  
800.660.4673

Cardinal Cushing Center at Hanover  
[www.coletta.org](http://www.coletta.org)  
400 Washington Street  
Hanover, MA 02339  
Larry Sauer, Exec. Dir.  
[lsauer@coletta.org](mailto:lsauer@coletta.org)  
781.829.1202

Castle School  
298 Harvard Street  
Cambridge, MA 02139  
Linda Corwin, LICSW, Exec. Dir.  
[lcorwin@castleschool.org](mailto:lcorwin@castleschool.org)  
617.354.5410

The Children's Study Home  
Administrative Offices  
44 Sherman Street  
Springfield, MA 01109  
Steve McCafferty  
[smccafferty@studyhome.org](mailto:smccafferty@studyhome.org)  
413.739.5626

Devereux—Girls' DBT Program  
[www.devereauxma.org](http://www.devereauxma.org)  
60 Miles Road  
Rutland, MA 01543  
Steve Yeardon  
[SYEARDON@devereux.org](mailto:SYEARDON@devereux.org)  
508.886.4746

Evergreen Center, Inc.  
[www.evergreenctr.org](http://www.evergreenctr.org)  
345 Fortune Blvd.  
Milford, MA 01757  
Robert F. Littleton, Jr., Exec. Dir.  
[rlittleton@evergreenctr.org](mailto:rlittleton@evergreenctr.org)  
508.478.2631



Fall River Deaconess Home School  
603 Rock Street  
Fall River, MA 02722  
John F. Golden, Exec. Dir.  
[jgolden@deaconesshome.org](mailto:jgolden@deaconesshome.org)  
508.674.4847

Frederic L. Chamberlain School  
[www.chamberlainschool.org](http://www.chamberlainschool.org)  
1 Pleasant Street, Box 778  
Middleboro, MA 02346  
William Doherty, Exec. Dir.  
[rseifert@chamberlainschool.org](mailto:rseifert@chamberlainschool.org)  
508.947.7825

Germaine Lawrence, Inc.  
18 Claremont Avenue  
Arlington, MA 02476  
David Hirshberg, Exec. Dir.  
[dhirshberg@germainelawrence.org](mailto:dhirshberg@germainelawrence.org)  
781.648.6200

G. Stanley Hall School  
[www.gstanleyhallschool.org](http://www.gstanleyhallschool.org)  
4 Mann Street  
Worcester, MA 01602  
Jodie Rapping, School Dir.  
[jodie@thebridgecm.org](mailto:jodie@thebridgecm.org)  
508.755.3698

The Harbor Schools and Family Services  
26 Rolfes Lane  
Newbury, MA 01951  
Larry Gammon, President, Easter Seals of NH  
[lgammon@eastersealsnh.org](mailto:lgammon@eastersealsnh.org)  
978.462.3151

Hillcrest Educational Centers, Inc.  
Center Program  
P.O. Box 4699  
Pittsfield, MA 01202  
413.499.7924

Hillcrest Educational Centers, Inc.  
Intensive Treatment Unit  
P.O. Box 4699  
Pittsfield, MA 01202  
(see above)

The Home for Little Wanderers  
Knight Children's Center  
161 South Huntington Avenue  
Boston, MA 02130  
Joan Wallace-Benjamin, President and CEO  
[jwallacebenjamin@thehome.org](mailto:jwallacebenjamin@thehome.org)  
617.267.3700

Italian Home for Children  
Boston Center  
[www.italianhome.org](http://www.italianhome.org)  
1125 Centre Street  
Jamaica Plain, MA 02130  
Christopher Small, Exec. Dir.  
[chris@italianhome.org](mailto:chris@italianhome.org)  
617.645.2270

Italian Home for Children  
Community Residential Programs  
1125 Centre Street  
Jamaica Plain, MA 02130  
(see above)

Italian Home for Children  
Cranwood Programs  
5 Palmer Court Extension  
East Freetown, MA 02717  
(see above)

Judge Rotenberg Educational Center  
[www.judgerc.org](http://www.judgerc.org)  
240 Turnpike Street  
Canton, MA 02021  
Dr. Matthew Israel  
[m.ferris@judgerc.org](mailto:m.ferris@judgerc.org)  
\*82.781.828.2202

Justice Resource Institute  
Cohannet Academy  
Administrative Offices  
545 Boylston Street, Suite 700  
Boston, MA 02116  
508.977.3730  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Justice Resource Institute  
Glenhaven Academy  
Administrative Offices  
545 Boylston Street, Suite 700  
Boston, MA 02116  
56-58 Framingham Road  
Marlborough, MA 01752  
508.481.8077  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Justice Resource Institute  
The Meadowridge Behavioral Health Center/Meadowridge  
Administrative Offices  
545 Boylston Street, Suite 700  
Boston, MA 02116  
664 Stevens Road  
Swansea, MA 02777  
508.677.0304  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Justice Resource Institute  
Pelham Academy  
Administrative Offices  
380 Massachusetts Avenue  
Acton, MA 01720  
13 Pelham Road  
Lexington, MA 02421  
781.274.6800  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Justice Resource Institute  
The Swansea Wood School  
Administrative Offices  
545 Boylston Street, Suite 700  
Boston, MA 02116  
789 Stevens Road  
Swansea, MA 02777  
508.672.6560  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Justice Resource Institute  
Walden Street School  
Administrative Offices  
380 Massachusetts Avenue  
Acton, MA 01720  
978.369.7611  
Andrew Pond  
[apond@jri.org](mailto:apond@jri.org)  
Corporate office: 617.450.0500

Kolburne School Inc.  
343 New Marlborough—Southfield Road  
New Marlborough, MA 02130  
Jeane K. Weinstein, MA, Exec. Dir.  
[jweinstein@kolburne.net](mailto:jweinstein@kolburne.net)  
413.229.8787

Northampton Center for Children and Families  
Cutchins Programs for Children and Families  
78 Pomeroy Terrace  
Northampton, MA 01060  
Andrew Pollock, Exec. Dir.  
[apollock@cutchins.org](mailto:apollock@cutchins.org)  
413.584.1310

Perkins  
[www.perkinsprograms.org](http://www.perkinsprograms.org)  
971 Main Street  
Lancaster, MA 01523  
Charles P. Conroy, Ed.D., Exec. Dir.  
[jlincoln@perkinschool.org](mailto:jlincoln@perkinschool.org)  
978.365.7376

Saint Vincent's Home Corporation  
[www.stvincentshome.org](http://www.stvincentshome.org)  
2425 Highland Avenue  
Fall River, MA 02720  
John T. Weldon, MSW, LICSW, Exec. Dir.  
[jweldon@stvincentshome.org](mailto:jweldon@stvincentshome.org)  
508.679.8511

Solstice  
P.O. Box 522  
Rowley, MA 01969  
Linda Hart, Program Director  
[lhart@hes-inc.org](mailto:lhart@hes-inc.org)  
978.948.2346

St. Ann's Home, Inc.  
100A Haverhill Street  
Methuen, MA 01844  
Edward J. O'Brien, M.Ed., Director of Residential Treatment  
[eobrien@st.annshome.org](mailto:eobrien@st.annshome.org)  
978.682.5276

UMASS Transitions IRTP  
305 Belmont Street WSH 7-C  
Worcester, MA 01604  
Caroline McGrath, Exec. Dir.  
[carolineMcGrath@umassmed.edu](mailto:carolineMcGrath@umassmed.edu)  
888.296.9781

Valleyhead, Inc.  
Reservoir Road  
Lenox, MA 02140  
M. Christine Macbeth, ACSW, LICSW, Exec. Dir.  
[cmacbeth@valleyhead.org](mailto:cmacbeth@valleyhead.org)  
413.637.3635

Walker  
1968 Central Avenue  
Needham, MA 02492  
Richard Small  
[rsmall@walkerschool.org](mailto:rsmall@walkerschool.org)  
781.449.4500

Wayside Youth and Family Support Network  
31 Main Street  
Marlboro, MA 01752  
75 Fountain Street  
Framingham, MA 01702  
Toby Peterson, Program Director  
[toby\\_peterson@waysideyouth.org](mailto:toby_peterson@waysideyouth.org)  
508.879.9800

YOU, Inc.  
Cottage Hill Academy  
83 Hospital Road  
Baldwinville, MA 01436  
Maurice Boisvert, MA, LICSW, President and CEO  
[boisvertm@youinc.org](mailto:boisvertm@youinc.org)  
508.849.5600

New Hampshire

Easter Seals of NH Jolicoeur School  
1 Mommoth Road  
Manchester, NH 03109  
Larry Gammon, President, Easter Seals-NH  
[lgammon@eastersealsnh.org](mailto:lgammon@eastersealsnh.org)  
603.623.8863

Nashua Children's Home Educational Program  
125 Amherst Street  
Nashua, NH 03064  
David Villiotti, MS, Exec. Dir.  
[dvilliotti@aol.com](mailto:dvilliotti@aol.com)  
603.883.3851

Davenport School  
PO Box 209  
20 Davenport Road  
Jefferson, NH 03583  
Paul Vann  
[paulvann@nafi.com](mailto:paulvann@nafi.com)  
603.586.4328  
603.746.7550 (NFI North)

Odyssey NH: Adolescent Therapeutic Center  
30 Winnacunnet Road  
Hampton, NH 03843  
Erik Johannessen  
[ej@odysseynh.org](mailto:ej@odysseynh.org)  
603.758.1160

Shortridge Academy  
619 Governor's Road  
Milton, NH 03851  
Adam Rainer, Director  
[adamrainer@shortridgeacademy.com](mailto:adamrainer@shortridgeacademy.com)  
603.755.3096

Wediko Children's Services  
NH School & Treatment Program  
11 Bobcat Boulevard  
Windsor, NH 03244  
Elizabeth Vezina  
[vezina@wediko-nh.org](mailto:vezina@wediko-nh.org)  
603.478.5236

Rhode Island

Spurwink School  
365 River Road  
Lincoln, RI 02865  
Ray Arsenault  
[rasenault@spurwinkri.org](mailto:rasenault@spurwinkri.org)  
401.781.4380

St. Mary's Home for Children  
420 Fruit Hill Avenue  
North Providence, RI 02911  
Bernard J. Smith, Exec. Dir.  
[bsmith@smhfc.org](mailto:bsmith@smhfc.org)  
401.353.3900

Vermont

Bennington School, Inc.  
192 Fairview Street  
Bennington, VT 05201  
Jeffrey Labonte  
[hmagnusson@benningtonschoolinc.org](mailto:hmagnusson@benningtonschoolinc.org)  
800.639.3156

Easter Seals Independent School  
11 Burnham Road  
Rutland, VT 05701  
Larry Gammon, President, Easter Seals-NH  
[lgammon@eastersealsnh.org](mailto:lgammon@eastersealsnh.org)  
802.223.4744

Eckerd Youth Alternatives  
Camp E-Wen-Akee  
876 Root Pond Road  
Benson, VT 05743  
Greg Stewart  
[gstewart@eckerd.org](mailto:gstewart@eckerd.org)  
800.914.3937

The King George School  
[www.kinggeorgeschool.com](http://www.kinggeorgeschool.com)  
2684 King George Farm Road  
Sutton, VT 05867  
David Hans  
[dhans.kgs@gmail.com](mailto:dhans.kgs@gmail.com)  
800.218.5122

Brattleboro Retreat  
Adolescent Residential Program  
Anna Marsh Lane  
Brattleboro, VT 05302  
Robert E. Simpson, Jr., President and CEO  
[rsimpson@brattlebororetreat.org](mailto:rsimpson@brattlebororetreat.org)  
800.728.7328

New England Kurn Hattin Homes  
P.O. Box 127  
Westminster, VT 05158  
Christopher Barry  
[cwb@kurnhattin.org](mailto:cwb@kurnhattin.org)  
802.722.3336



Appendix N: List of Child Protective Services Departments in New England

Connecticut-DCF  
Darlene Dunbar, Commissioner  
505 Hudson Street  
Hartford, CT 06106  
[www.state.ct.us/DCF](http://www.state.ct.us/DCF)

Office of Child and Family Services  
James Beougher, Director of Office of Child and Family Services  
221 State Street  
Augusta, ME 04333  
207-287-5060  
[www.maine.gov/dhhs/bcfs/index.htm](http://www.maine.gov/dhhs/bcfs/index.htm)

Massachusetts Department of Social Services  
Angelo McClain, Commissioner  
24 Farnsworth Street  
Boston, MA 02210  
617-748-2000  
[www.state.ma.us/dss](http://www.state.ma.us/dss)

New Hampshire Department of Health and Human Services  
Division for Children, Youth and Families  
129 Pleasant Street  
Concord, NH 03301-3852  
[www.dhhs.state.nh.us/DHHS/DCYF/](http://www.dhhs.state.nh.us/DHHS/DCYF/)

Rhode Island Department of Children, Youth, and Families  
101 Friendship Street  
Providence, RI 02903-3716  
401-528-3502  
[www.dcyf.state.ri.us](http://www.dcyf.state.ri.us)

Department of Children and Families—Vermont  
Steve Dale, Commissioner  
103 South Main Street  
Waterbury, VT 05676-1201  
802-241-2100  
[www.dcf.statevt.us](http://www.dcf.statevt.us)

Appendix O: Copy of Permission Email for SWAP-200-A

Maureen,

You have our permission to use and reproduce the SWAP for purposes of your dissertation research. Copyright notices must remain on any copies that you distribute to others, along with a notice (yours) that the instrument is being provided solely for purposes of data collection for your dissertation project, and that participants who wish to use the instrument for other purposes may obtain an authorized copy from [www.SWAPassessment.org](http://www.SWAPassessment.org).

I'm attaching a copy of the Excel program that we use for data collection- this version will run on PCs and Macs both, and should in principle run on any version of Excel. Once people enter SWAP scores, you can have them email the file back to you, and then you can copy and paste their data into a master data file (e.g., in SPSS). Please keep me posted on any interesting findings that you get. Good luck with your research.

Jonathan

---

Jonathan Shedler, PhD

Visiting Associate Professor of Psychiatry  
University of Colorado Health Sciences Center

Director of Psychology, Outpatient Psychiatry Service  
University of Colorado Hospital

Direct line: 303.315.9073  
Email: jonathan@shedler.com

Appendix P: Copy of Permission Email for BAS-A

Dear Maureen: You have my permission to use the scale. I am just studying your adaptation and will get my comments back to you in a day or so. I am delighted with your interest in boundary ambiguity and taking it to a new population. If you have not already, do read the introduction I wrote to the special issue of *Family Relations*, 2007, on “Ambiguous Loss and Boundary Ambiguity” for the latest on doing research with these constructs. Good luck with your study and send me the findings so we can add you to our annotated bibliography.

Pauline Boss

--

Pauline Boss, Professor Emeritus  
Department of Family Social Science  
College of Education and Human Development  
University of Minnesota  
St. Paul, MN 55108  
[www.ambiguousloss.com](http://www.ambiguousloss.com)

Appendix Q: Approval Letter from the Human Subjects Review Committee

November 29, 2008

Maureen Kaplan  
85 Gaskill Road  
Chester, VT 05143

Dear Maureen.

Your revised materials have been reviewed and all is now in order. We are, therefore, now glad to give final approval to your study. Your deletions and simplifications do make the communication with your resources and your participants less burdensome. I do hope you get a good return.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished).

We wish you success with your project.

Sincerely,

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

cc: Catherine Nye, Advisor

Appendix R: SWAP-200-A

Score Desired		Now	<h2>SWAP-200-A Data Entry</h2> <p><b>Instructions</b></p> <ul style="list-style-type: none"> <li>• Select the <b>ID</b> cell and enter patient identifying information (e.g., patient ID number or initials).</li> <li>• Enter a score for each SWAP item (0=least descriptive, 7=most descriptive). Press the <b>Enter</b> key after each entry.</li> <li>• Click <b>Sort by score</b> to arrange the items in descending order by score (you will do this repeatedly as you work).</li> <li>• The blue table to the left shows the <b>Desired</b> score distribution and the score distribution <b>Now</b>.</li> <li>• Working from 7 to 0, adjust the scores until you have the correct distribution.</li> <li>• When the score distribution is correct, the numbers in the <b>Now</b> column turn green.</li> <li>• When finished, click <b>Save to database</b>.</li> </ul>
7	8	0	
6	10	0	
5	12	0	
4	14	0	
3	16	0	
2	18	0	
1	22	0	
0	100	0	
<b>ID ▶</b>			<p><b>To obtain an authorized copy of this software or learn more about the SWAP family of assessment instruments, visit <a href="http://www.SWAPassessment.com">www.SWAPassessment.com</a>. Clinical interpretive reports are coming soon!</b></p>
	<b>Score</b>		<div style="display: flex; justify-content: space-around;"> <input type="button" value="Clear scores"/> <input type="button" value="Sort by score"/> <input type="button" value="Sort by item no."/> <input type="button" value="Save to database"/> </div>
			Tends to feel guilty (e.g., may blame self or feel responsible for bad things that happen).
			Is able to use his/her talents, abilities, and energy effectively and productively.
			Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.).
			Has an exaggerated sense of self-importance (e.g., feels special, superior, grand; believes s/he is the object of envy; tends to boast or brag).
			Tends to be ignored, neglected, or avoided by peers.
			Is troubled by recurrent obsessional thoughts that s/he experiences as intrusive.

	Appears conflicted about his/her racial or ethnic identity (e.g., undervalues and rejects, or overvalues and is preoccupied with, own cultural heritage).
	Seems childish for his/her age (e.g., acts like a younger child or primarily chooses younger peers).
	When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).
	Is preoccupied with aggressive games, fantasies, firearms, etc.
	Tends to become attached quickly or intensely; develops feelings, expectations, etc. that are not warranted by the history or context of the relationship.
	Emotions tend to spiral out of control, leading to extremes of anxiety, sadness, rage, etc.
	Tends to use his/her psychological or medical problems to avoid school, work, or responsibility (whether consciously or unconsciously).
	Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.
	Lacks a stable sense of who s/he is (e.g., attitudes, values, goals, and feelings about self seem unstable or ever-changing).
	Tends to be angry or hostile (whether consciously or unconsciously).
	Tends to be ingratiating or submissive with peers (e.g., may consent to things s/he does not agree with or does not want to do, in the hope of getting support or approval).
	Tends to stir up conflict or animosity between other people (e.g., may portray a situation differently to different people, leading them to form contradictory views or work at cross purposes).
	Enjoys challenges; takes pleasure in accomplishing things.
	Tends to be deceitful; tends to lie or mislead.
	Tends to be hostile toward members of the opposite sex, whether consciously or unconsciously (e.g., may be disparaging or competitive).
	Tends to develop somatic symptoms in response to stress or conflict (e.g., headache, backache, abdominal pain, asthma, etc.).
	Tends to get involved in romantic or sexual "triangles" (e.g., becomes interested in people who are already attached, sought by someone else, etc.).

	Tends to be unreliable and irresponsible (e.g., may fail to meet school or work obligations).
	Has difficulty acknowledging or expressing anger.
	Tends to get drawn into relationships outside the family in which s/he is emotionally or physically abused, or needlessly puts self in dangerous situations (e.g., walking alone or meeting strangers in unsafe places).
	Has panic attacks (i.e., episodes of acute anxiety accompanied by strong physiological responses).
	Tends to be preoccupied with concerns about dirt, cleanliness, contamination, etc. (e.g., drinking from another person's glass, sitting on public toilet seats, etc.).
	Has difficulty making sense of other people's behavior; tends to misunderstand, misinterpret, or be confused by others' actions and reactions.
	Tends to feel listless, fatigued, or lacking in energy.
	Tends to show reckless disregard for the rights, property, or safety of others.
	Is capable of sustaining meaningful relationships characterized by genuine intimacy and caring.
	Is conflicted or inhibited about achievement or success (e.g., achievements may be below potential, may sabotage self just before attaining important goals, etc.).
	Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to use his/her physical attractiveness to an excessive degree to gain notice).
	Tends to feel anxious.
	Tends to feel helpless, powerless, or at the mercy of forces outside his/her control (beyond what is warranted by the situation).
	Finds meaning in belonging and contributing to a larger community (e.g., volunteer organizations, teams, neighborhood groups, church, etc.).
	Tends to feel s/he is not his/her true self with others; may feel false or fraudulent.
	Appears to gain pleasure or satisfaction by being sadistic or aggressive (whether consciously or unconsciously) or bullying others.
	Tends to engage in criminal or delinquent behavior (moderate placement of this item implies occasional or petty crimes such as shoplifting or vandalism).
	Appears unable to describe important others in a way that conveys a sense of who they are as

	people; descriptions of others come across as two-dimensional and lacking in richness.
	Tends to feel envious.
	Tends to seek power or influence with peers (whether in beneficial or destructive ways).
	When distressed, perception of reality can become grossly impaired (e.g., thinking may seem delusional).
	Is prone to idealizing people; may see admired others as perfect, larger than life, all wise, etc.
	Tends to be suggestible or easily influenced.
	Attempts to avoid or flee depressive feelings through excessive optimism, activity, energy, etc.
	Seeks to be the center of attention.
	When distressed, tends to revert to earlier, less mature ways of coping (e.g., clinging, whining, having tantrums).
	Tends to feel life has no meaning.
	Tends to be liked by other people.
	Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.
	Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.
	Tends to feel s/he is inadequate, inferior, or a failure.
	Finds meaning and fulfillment in guiding, mentoring, or nurturing others.
	Appears to find little or no pleasure, satisfaction, or enjoyment in life's activities.
	Religious or spiritual beliefs are central to his/her identity and experience.
	Has little or no interest in sexuality (e.g., does not engage in age-appropriate fantasy, exploration, or experimentation, or shows little curiosity).
	Is empathic; is sensitive and responsive to other peoples' needs and feelings.
	Tends to be shy or self-conscious in social situations.
	Tends to disparage qualities traditionally associated with own gender (e.g., a girl who disdains nurturance and overvalues power; a boy who disdains power and overvalues emotional sensitivity).
	Tends to be preoccupied with food, diet, or eating.
	Is able to assert him/herself effectively and appropriately when necessary.
	Mood tends to cycle over intervals of weeks or months between excited and depressed states (high



	placement implies bipolar mood disorder).
	Attempts to control or dominate a significant other (e.g., sibling, parent, boyfriend, girlfriend) through violence or intimidation.
	Is excessively devoted to school, work, or productivity, to the detriment of fun, pleasure, or friendships.
	Tends to be stingy and withholding (of time, money, affection, etc.).
	Has a good sense of humor.
	Decisions and actions are unduly influenced by efforts to avoid perceived dangers; is more concerned with avoiding harm than pursuing desires.
	Has uncontrolled eating binges followed by “purges” (e.g., makes self vomit, abuses laxatives, fasts, etc.); has bulimic episodes.
	Tends to seek thrills, novelty, excitement, etc.; appears to require a high level of stimulation.
	Tends to perceive things in global and impressionistic ways (e.g., misses details, glosses over inconsistencies, mispronounces names).
	Tends to “catastrophize”; is prone to see problems as disastrous, unsolvable, etc.
	Expresses emotion in exaggerated and theatrical ways.
	Tends to think in concrete terms and interpret things in overly literal ways; has limited ability to appreciate metaphor, analogy, or nuance.
	Manages to elicit in others feelings similar to those s/he is experiencing (e.g., when angry, acts in such a way as to provoke anger in others; when anxious, acts in such a way as to induce anxiety in others).
	Tends to be needy or dependent.
	Tends to express anger in passive and indirect ways (e.g., may make mistakes, procrastinate, forget, become sulky, etc.).
	Attempts to deny or “override” fear or anxiety by rushing headlong into feared situations, taking unnecessary risks, etc.
	Tends to be bullied, harassed, or teased by peers.
	Repeatedly re-experiences or re-lives a past traumatic event (e.g., has intrusive memories or recurring dreams of the event; is startled or terrified by present events that resemble or symbolize the

	past event).
	Derives satisfaction or self-esteem from being, or being seen as, “bad” or “tough.”
	Beliefs and expectations seem cliché or stereotypical, as if taken from storybooks or movies.
	Tends to be competitive with others (whether consciously or unconsciously).
	Has conscious homosexual desires (moderate placement implies bisexuality, high placement implies homosexuality).
	Tends to feel ashamed or embarrassed.
	Tends to run away from home.
	Tends to be insufficiently concerned with meeting own needs; appears not to feel entitled to get or ask for things s/he deserves.
	Is resilient in the face of stress; seems to be able to face loss, trauma, or deeply troubling events with appropriate feeling and to continue to function effectively.
	Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).
	Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.
	Is articulate; can express self well in words.
	Seems naïve or innocent; appears to know less about the ways of the world than might be expected given his/her age, intelligence, or background.
	Tends to surround him/herself with peers who are delinquent or deeply alienated.
	Appears comfortable and at ease in social situations.
	Tends to elicit dislike or animosity in others.
	Has trouble sitting still; is restless, fidgety, or hyperactive.
	Tends to fear s/he will be rejected or abandoned.
	Is unduly frightened by sexuality; appears to associate sex with danger (e.g., injury, punishment, contamination).
	Tends to think in abstract and intellectualized terms, even in matters of personal import.
	Generally finds contentment and happiness in life’s activities.
	Has a deep sense of inner badness; sees self as damaged, evil, or rotten to the core (whether consciously or unconsciously).

	Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).
	Appears to have little need for human company or contact; is emotionally detached or indifferent.
	Is suspicious; tends to assume others will harm, deceive, conspire against, or betray him/her.
	Tends to express emotion appropriate in quality and intensity to the situation at hand.
	Tends to express qualities or mannerisms traditionally associated with own gender to an exaggerated or stereotypical degree (i.e., a hyper-feminine girl; a hyper-masculine, "macho" boy).
	Tends to restrict food intake to the point of being underweight and malnourished.
	Tends to engage in self-mutilating behavior (e.g., self-cutting, self-burning, etc.).
	Tends to become attached to, or romantically interested in, people who are emotionally unavailable.
	Has the capacity to recognize alternative viewpoints, even in matters that stir up strong feelings.
	Appears impervious to consequences; seems unable or unwilling to modify behavior in response to threats or negative consequences.
	Experiences little or no remorse for harm or injury caused to others.
	Tends to be critical of others.
	Is prone to violence (e.g., may break things, provoke fights, or become physically assaultive).
	Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.
	Is unable to soothe or comfort him/herself without the help of another person (i.e., has difficulty regulating own emotions).
	Has difficulty maintaining attention and focus on tasks; is easily distracted by sights, sounds, unrelated thoughts, or other competing stimuli.
	Tends to be inhibited or constricted; has difficulty allowing self to acknowledge or express wishes and impulses.
	Has moral and ethical standards and strives to live up to them.
	Is creative; is able to see things or approach problems in novel ways.
	Attempts to avoid feeling helpless or depressed by becoming angry instead.
	Tends to adhere rigidly to daily routines and become anxious or uncomfortable when they are altered.
	Tends to avoid, or try to avoid, social situations because of fear of embarrassment or humiliation.

	Appearance or manner seems odd or peculiar (e.g., grooming, hygiene, posture, eye contact, speech rhythms, etc. seem somehow strange or “off”).
	Appears to have a limited or constricted range of emotions.
	Tends to feel misunderstood, mistreated, or victimized.
	Fantasizes about ideal, perfect love.
	Tends to be overly compliant or obedient with authority figures.
	Reasoning processes or perceptual experiences seem odd and idiosyncratic (e.g., may make seemingly arbitrary inferences; may see hidden messages or special meanings in ordinary events).
	Appears conflicted about experiencing pleasurable emotions; tends to inhibit excitement, joy, pride, etc.
	Is sexually promiscuous for a person of his/her age, background, etc.
	Tends to be dismissive, haughty, or arrogant.
	Tends to act impulsively (e.g., acts without forethought or concern for consequences).
	Is hypochondriacal; has exaggerated fears of contracting medical illness (e.g., worries excessively about normal aches and pains).
	Tends to believe in supernatural, paranormal, or superstitious phenomena or to be drawn to “alternative” belief systems (e.g., astrology, tarot, crystals, psychics, auras).
	Is confused, conflicted, or uncertain about his/her sexual orientation (e.g., may struggle to keep homosexual feelings out of awareness, have an exaggerated fear of homosexuality, etc.).
	Tends to enter altered, dissociated states when distressed (e.g., the self or world feels strange, unreal, or unfamiliar).
	Tends to hold grudges; may dwell on insults or slights for long periods.
	Sexual fantasies or activities are unusual, idiosyncratic, or rigidly scripted (e.g., dominance, submission, voyeurism, fetishes, etc.).
	Is invested in seeing and portraying self as emotionally strong, untroubled, and emotionally in control, despite clear evidence of underlying insecurity, anxiety, or distress.
	Tends to make repeated suicidal threats or gestures, either as a “cry for help” or as an effort to manipulate others.
	Tends to believe s/he can only be appreciated by, or should only associate with, people who are high-

	status, superior, or otherwise “special.”
	Tends to see self as logical and rational, uninfluenced by emotion; prefers to operate as if emotions were irrelevant or inconsequential.
	Thought processes or speech tend to be circumstantial, vague, rambling, digressive, etc. (e.g., may be unclear whether s/he is being metaphorical or whether thinking is confused or peculiar).
	Tends to elicit boredom in others (e.g., may talk incessantly, without feeling, or about inconsequential matters).
	Tends to abuse alcohol or drugs (beyond what is normative given his/her age, background, etc.).
	Has little psychological insight into own motives, behavior, etc.
	Tends to feel like an outcast or outsider.
	Tends to identify with admired others to an exaggerated degree, taking on their attitudes, mannerisms, etc., in a way that is not normative for his/her age, background, etc.
	Appears to experience the past as a series of disjointed or disconnected events; has difficulty giving a coherent account of his/her life or actions.
	Tends to repress or “forget” distressing events, or distort memories of distressing events beyond recognition.
	Relationships tend to be unstable, chaotic, and rapidly changing.
	Tends to draw others into scenarios, or “pull” them into roles, that feel alien or unfamiliar (e.g., being uncharacteristically insensitive or cruel, feeling like the only person in the world who can help, etc.).
	Tends to describe experiences in generalities; is reluctant to provide details, examples, or supporting narrative.
	Has a disturbed or distorted body-image (e.g., may see self as unattractive, grotesque, disgusting, etc.)
	Tends to become irrational when strong emotions are stirred up; may show a significant decline from customary level of functioning.
	Has areas of accomplishment or achievement other than school (e.g., sports, music, etc.) for which s/he gains considerable recognition.
	Tends to deny or disavow own need for nurturance, caring, comfort, etc. (e.g., may regard such needs as weakness, avoid depending on others or asking for help, etc.)
	Lacks close friendships and relationships.

	Tends to deny, disavow, or squelch his/her own realistic hopes, dreams, or desires to protect against anticipated disappointment (whether consciously or unconsciously).
	Expresses contradictory feelings or beliefs without being disturbed by the inconsistency; has little need to reconcile or resolve contradictory ideas.
	Appears to want to “punish” self; creates situations that lead to unhappiness, or actively avoids opportunities for pleasure and gratification.
	Tends to be self-righteous or moralistic.
	Tends to distort unacceptable wishes or feelings by transforming them into their opposite (e.g., may express excessive concern while showing signs of unacknowledged hostility, disgust about sexual matters while showing signs of unacknowledged excitement, etc.).
	Tends to alternate between undercontrol and overcontrol of needs and impulses (e.g., sometimes acts on desires impulsively while at other times denying them entirely).
	Is simultaneously needy of, and rejecting toward, others (e.g., craves intimacy and caring, but tends to reject it when offered).
	Struggles with genuine wishes to kill him/herself.
	Fears becoming like a parent (or parent figure) about whom s/he has strong negative feelings.
	Is rebellious or defiant toward authority figures; tends to be oppositional, contrary, quick to disagree, etc.
	Appears to fear being alone; may go to great lengths to avoid being alone.
	Tends to give up quickly when frustrated or challenged.
	Tends to become absorbed in details, often to the point that s/he misses what is significant.
	Expects self to be “perfect” (e.g., in appearance, achievements, performance, etc.).
	Tends to be conscientious and responsible.
	Tends to confuse own thoughts, feelings, or personality traits with those of others (e.g., may use the same words to describe him/herself and another person, believe the two share identical thoughts and feelings, etc.).
	Repeatedly convinces others of his/her commitment to change but then reverts to previous maladaptive behavior; tends to convince others that “this time is really different.”
	Tends to feel bored.

	Tends to be energetic and outgoing.
	Has trouble making decisions; tends to be indecisive or to vacillate when faced with choices.
	Tends to choose sexual or romantic partners who seem inappropriate in terms of age, status (e.g., social, economic, intellectual), etc.
	Tends to be controlling.
	Is psychologically insightful; is able to understand self and others in subtle and sophisticated ways.
	Verbal statements seem incongruous with accompanying affect, or incongruous with accompanying non-verbal messages.
	Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).
	Seems preoccupied with sex or sexuality, in a way that is not normative for his/her age (e.g., makes constant sexualized comments, masturbates compulsively, etc.).
	Tends to feel guilty or ashamed about his/her sexual interests or activities (whether consciously or unconsciously).
	Has difficulty separating from a parent (e.g., fears something terrible will happen to the parent if s/he leaves, resists going to school, cannot spend the night away from home).
	Tends to feel unhappy, depressed, or despondent.
	Appears to feel privileged and entitled; expects preferential treatment.
	Emotions tend to change rapidly and unpredictably.
	Tends to be overly concerned with rules, procedures, order, organization, schedules, etc.
	Lacks social skills; tends to be socially awkward or inappropriate.
	Tends to be manipulative.
	Tends to be preoccupied with death and dying.
	Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.
	Tends to seek out or create interpersonal relationships in which s/he is in the role of caring for, rescuing, or protecting the other.
	Has trouble acknowledging or expressing anger toward others, and instead becomes depressed, self-critical, self-punitive, etc. (i.e., turns anger against self).
	Tends to be passive and unassertive.
	Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become

		preoccupied with thoughts about what could have been, etc.
	0	

## Overview

The SWAP is a set of 200 statements that will allow you to describe a patient's psychological functioning in rich detail. Enter a score from 0 to 7 for each statement, depending on how well it describes your patient.

Assign scores of 7 to statements that describe your patient extremely well—that capture something central about his/her psychological functioning. Assign scores of 0 to statements that do not apply, or when you have no information. Use in-between scores for statements that fall in between.

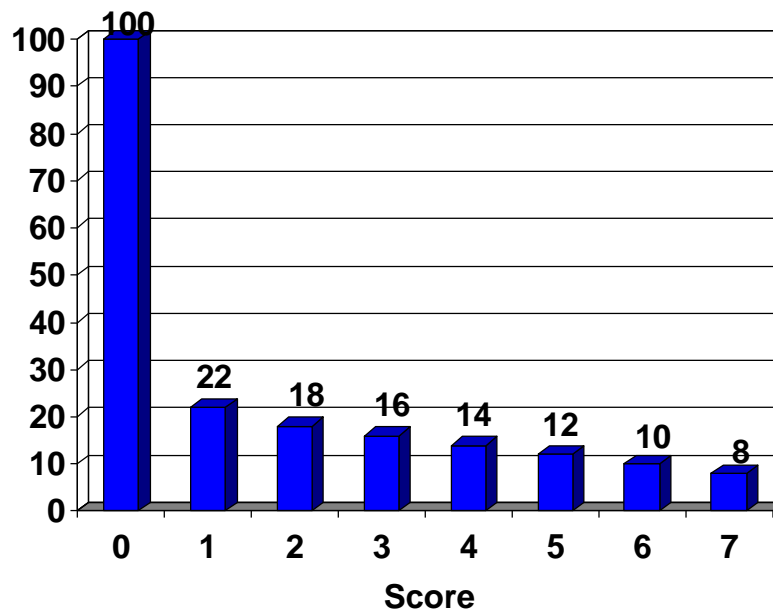
Use higher scores when the psychological characteristic is pervasive, extreme, or both. For example, you might assign a high score to the item "Tends to be needy or dependent" because the patient is often needy, or because, when s/he is needy, s/he is extremely needy.



## Score Distribution

Describing a patient with the SWAP requires multiple “passes” through the items. The first time through, simply assign a score to each item. After this, you will need to review your scores and adjust them.

The reason for the adjustments is that the SWAP relies on a “fixed” score distribution. This means that you must assign each score a specific number of times. For example, exactly 100 items will ultimately have scores of 0 (not descriptive) and exactly 8 items will ultimately have scores of 7 (most descriptive). The higher the score, the fewer times you will use it. The graph below shows the desired score distribution. The bars indicate the number of times you will assign each score



## Background and Rationale

The SWAP is based on the Q-Sort method. A “fixed” score distribution is an essential feature of this method. With standard rating scales, raters can assign any score as often as they wish. In practice, this means that some raters will gravitate toward extreme scores and some toward moderate scores. Some will gravitate toward higher scores and some toward lower scores. Thus, two raters may in principle agree with each other perfectly, but nevertheless give different ratings because they are “calibrated” differently and interpret the rating scales differently. Such differences between raters cause measurement error and decrease test reliability..

The Q-sort method eliminates this source of measurement error by ensuring that scores provided by different raters are always comparable. For example, whenever a rater assigns a score of 7, it always means the same thing: Relative to all 200 items in the item set, the item is among the top eight items that are most characteristic of the patient. The Q-Sort method is more time consuming than standard rating scales but the payoff is greater accuracy and reliability.

Before Q-sort instruments were computerized, Q-Sort items were printed on individual index cards. The rater would read through the cards and literally sort them into piles on his/her desk, according to how well they described the patient. Then the rater would review and compare the cards in each pile, and move cards from pile to pile until each pile had the correct number of cards. The computer software you are using accomplishes the same purpose. Instead of moving cards, you adjust the scores you have entered.

## **Interpreting SWAP Statements**

Many of the SWAP items assess subtle psychological processes—things that are not obvious or overt. You will need to make clinical inferences that go beyond the face value of the patient's words and actions. Trust your clinical judgment, but do not assign the very highest scores (5, 6, 7) unless you are quite certain the statements apply.

Do not worry if you find yourself giving high scores to statements that seem mutually contradictory. People often have psychological contradictions (for example, desiring intimacy but fearing dependency) and the SWAP is designed to capture this.

Your scores should reflect the patient's stable or enduring qualities, not just momentary states. When in doubt, describe the patient as s/he has been during the past year. For example, if the patient attempted suicide some years ago but no longer struggles with suicidal wishes, the statement "Struggles with genuine wishes to kill self" should receive a low score. On the other hand, if the patient continues to struggle with suicidal impulses—even if s/he is not at immediate risk of acting on them—you should assign a higher score to indicate that the suicidal impulses are enduring and have become part of the patient's "way of being."

## **Time Required**

If you have never used the SWAP before, expect to spend about 45 minutes to complete the procedure. Once you are familiar with the SWAP, you may be able to do it in as little as 20 minutes. Many clinicians tell us that by the time they finish the scoring procedure, they have learned things about their patient that they hadn't noticed or reflected on before.

## **Acknowledgments**

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