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# Psychological Bonding Evaluations in Termination of Parental Rights Cases

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## Introduction

Although significant discrepancies exist between psychological and legal approaches to evaluating child protection matters, both are ultimately guided by one core focus: the best interest of the child. The most extreme form of court intervention in child protection cases is involuntary termination of the birth parent's parental rights. Such action is typically taken only after a long series of prior interventions have failed, or abuse or neglect is still occurring. Psychologists who conduct evaluations in the context of termination of parental rights (TPR) cases are asked to form an opinion regarding permanency planning for the child and whether the birth parent's parental rights should be terminated. Such evaluations do not need to prove each prong of state statutes regarding termination of parental rights, although evaluators should be aware of the statutory and case law context.

Psychological evaluations in TPR cases focus on two broad dimensions: parental fitness and the child's attachment profile (Dyer, 1998). Of course, it is not possible to completely separate these two dimensions. Parents whose fitness is impaired are those who are most likely to cause an impaired attachment bond with their children. Nonetheless, TPR psychological evaluations tend to focus more on one issue or the other in a given case. Factors that suggest a focus on parental fitness in a TPR evaluation include (modified from Dyer, 1998):

- Extended incarceration of the parent;
- Chronic parental mental illness or criminality;

- Chronic drug or alcohol addiction;
- Lengthy history of child abuse or neglect;
- Chronic lack of housing
- Intellectual limitations;
- Medical problems;
- Failure of prior interventions to remedy above issues.

In such cases, even if attachment between the parent and child is present, the parent may be so impaired as to be unfit to parent.

In other cases, issues such as the following, even in the presence of acceptable or marginal parental fitness, suggest more of a focus on the child's bonding profile:

- Lengthy foster care placement;
- Strong attachment between the child and a foster caretaker;
- Historical lack of contact between the child and a biological parent;
- Special needs or disabilities of the child that render the child particularly vulnerable to removal from an attachment figure.

The focus of these evaluations is on the child's attachment relationship(s) in conjunction with parenting quality and capabilities of the birth parent(s). As such, the purpose is to offer long-term predictions about potential effects upon a child of permanently severing parental rights, and to make recommendations that will avoid, or at least mitigate, lifelong psychological trauma for that child.

## Evaluating Parental Fitness

Four areas comprise the most salient focuses of a parental fitness examination: cognitive functioning, emotional functioning, behavioral history, and fundamental

parenting skills. If possible, these factors should be assessed through multiple sources of information (Heilbrun, 2001). Direct means include a clinical interview with and psychological testing of the parent, as well as observation of the parent's interaction with the child. Indirect means include a review of available documents. In fact, it is essential that the evaluator conduct a thorough review of records. Much can be gleaned from a consideration of the parent's history through a records review. The following records are most relevant in a TPR evaluation:

- Child protection services records;
- The child's school records;
- Previous mental health evaluations;
- Prior criminal records;
- Prior medical records;
- Substance abuse screening records.

Although some of the above records may at first seem to have little bearing on parental fitness, all bear on the issue. For example, school records may indicate not only how the child has performed, but whether the parent has been responsive to school requests and whether the child has any previously diagnosed cognitive impairments or special needs. Medical records for the parent may indicate whether a parent's disabling medical condition could impair the parent's ability to manage, for example, a child with special physical needs. Child protection services records, of course are essential, potentially providing information about the parent's prior history of neglectful or abusive

actions, as well as the success of prior remediation efforts. Records from the agency that supervises visitation should be included in the child protective services packet.

The first factor, cognitive functioning, involves "hard-wired" faculties such as judgment, insight, impulse control, forethought and planning. This area also includes intellectual functioning, which requires formal psychological testing using a measure of intelligence (e.g., Shipley Institute of Living Scale (Shipley, 1939, 1967) or Wechsler Adult Intelligence Scale-III (Psychological Corp., 1997)). However, a distinction should be made between a rudimentary screening of cognitive functioning and a formal neuropsychological evaluation. By no means should a cognitive assessment be construed as a neuropsychological assessment. Rather, a cognitive assessment is a method for gauging a select few, basic executive functions. However, during the course of a parental fitness evaluation, if there are indications of organic impairment such as brain damage, mental retardation, or gross perceptual problems, the parent can be referred to a neuropsychologist for a full assessment, if such appears relevant in making a determination regarding parental fitness.

Certain cognitive propensities, such as the degree to which we learn from experience or the process by which we make decisions, are dictated by the frontal lobe region of the brain. As such, these cognitions are part of our genetic/biological makeup and are thought of as being fixed and unchangeable. Needless to say, one's capacity to use good judgment and control impulses is imperative in parenting. A useful place to start in evaluating a parent's cognitive processes is to look for patterns of behavior across numerous contexts (e.g., in relationships, at work, while parenting, etc.). For instance,

does the parent have a tendency to react impulsively, without thought? Is there a history of repetitive problematic behavior despite looming consequences?

By way of example, in a recent parental fitness assessment, I (NB) evaluated a 30 year-old mother of five children, all of whom were repeatedly removed from her care over the years. Throughout her adolescent and adult life, this mother demonstrated a pattern of poor judgment, impaired impulse control, and a lack of insight into her problematic behavior. She had a substance abuse history, yet continued to engage in intimate relationships with men who were drug users, eventually leading to her own relapses. When faced with emotionally provoking situations, this mother reacted with impulsive hostility toward peers, resulting in numerous arrests for assault. She also continued to have children, even after the older children were removed from her care. The pervasive and repetitive nature of this woman's self-defeating behavior despite the assistance of social services and treatment strongly suggests the presence of certain cognitive, "hard-wired" impairments, which is a prognostic concern.

Intellectual functioning plays a significant role in one's ability to parent. For instance, an individual whose level of intelligence falls within a mentally retarded or borderline range may be unable to benefit from parent training or instruction. As a result of that individual's limited ability to learn, his ability to recognize a harmful situation or intervene appropriately in an emergency situation may be compromised. Moreover, intellectual limitations may preclude a parent from fully grasping the needs of his child, or advocating for the child. An individual whose thinking is concrete and literal may not be able to relate to a child at various ages, problem-solve new situations that arise with ever changing developmental stages, or interpret a nonverbal child's behavior. Healthy

parenting requires the ability for abstract thought, intellectual flexibility, and creativity. However, intellectual impairment in and of itself does not preclude the ability to parent. Other considerations come into play, such as the degree of intellectual impairment, the level of social adaptation, and the extent of social support.

The second focus of a parental fitness evaluation is behavioral history, which examines the manner in which one functions in society. This takes into consideration the parent's level of self-sufficiency. Whereas cognitive functioning speaks to an individual's ability to understand the need for change and to improve one's lifestyle circumstances, that individual's past behavior reflects how well the individual has implemented plans for change. Areas of assessment in this category include, but are not limited to, criminal history, substance abuse history, aggressive tendencies, relationship dynamics, employment history, and one's own experiences being parented. Much of this information can be gathered from a review of records.

The third factor is emotional functioning, which concentrates on the presence of any Axis I acute psychopathology (e.g., schizophrenia, major depression) or Axis II personality disorders. A parent's psychiatric status is derived not only from the clinical interview but also from psychological testing and a review of the parent's history. A segment of the clinical interview should be allotted for a mental status exam as well as questions aimed at collecting information about a parent's psychiatric history. For instance, has the parent ever been hospitalized for psychiatric reasons, prescribed psychotropic medications, attempted suicide in the past, or engaged in self-injurious behaviors? Has the parent ever engaged in psychotherapy, and if so, for what purpose? Much of emotional functioning is inferred from other areas, such as behavioral history.

For instance, if a parent has a significant and diverse criminal history involving crimes against person and property that began in early adolescence, then one might reasonably infer the presence of antisocial personality traits (emotional functioning) as well as impaired conscience development and poor judgment (cognitive functioning).

A brief mental status exam can reveal signs of psychosis or organic brain damage, serving as a screening tool for more severe psychiatric or neurological disturbances. Additionally, formal psychological testing should be used as part of any comprehensive parental fitness evaluation, assuming the parent has a reading level that would allow completion of standardized testing. An objective and well-standardized personality measure, such as the Millon Multiphasic Personality Inventory (Millon, 1997) or Personality Assessment Inventory (Morey, 1991), is a necessary component of a psychological testing battery, particularly for evaluating personality style. Severe mental illness or characterological impairment may undermine one's ability to safely and effectively parent. Moreover, it may render a parent unamenable to intervention. For instance, an individual with a severe Narcissistic Personality Disorder whose way of functioning in the world is marked by a well-ingrained and pervasive sense of entitlement may find it difficult to benefit from treatment. Such a personality disorder may preclude a parent from placing his child's needs before his own and from offering the ingredients necessary to form a secure attachment. In fact, one authority has gone so far as to state that Axis II personality disorders—such as Antisocial Personality Disorder or Narcissistic Personality Disorder—are far more frequent as the cause of parental unfitness than are Axis I disorders—such as Schizophrenia or Major Depressive Disorder (Dyer, 1998).

Although a mental disorder may compromise or disrupt parenting behaviors, the evaluator must not assume that the level of disruption will be so great as to necessarily result in parental unfitness. The evaluator must consider the impact of the mental disorder on parenting, that is, conduct a functional-contextual analysis of parenting competencies (Benjet, Azar, & Kuersten-Hogan, 2003; Grisso, 2003). Factors that mitigate against the risk posed by a psychiatrically diagnosed parent to his child include insight into one's illness, compliance with pharmacological treatment, and social support. It is imperative that such information be elicited through an archival review or clinical interview with the parent.

The final factor is parenting ability. This, after all, is the key factor. The three preceding factors are relevant only insofar as they influence the parent's ability to effectively raise a child. Children are not born with instruction manuals, and parenting is a challenging endeavor. As such, there are no clear guidelines regarding the correct way to parent. However, there are certain fundamental parenting skills that are essential in raising secure and well-adjusted children. A logical starting point in evaluating an individual's parenting skills is to examine that individual's own experiences being parented. Typically, individuals will either mimic the parenting approach that was utilized with them or will do the exact opposite, depending on one's opinion as to the parenting one received. For instance, was corporal punishment extensively used during the parent's childhood as a form of discipline? If so, does the parent see this form of punishment as having been abusive or does he view it as an acceptable and standard method of child rearing? Another area of inquiry involves whether the respondent was neglected as a child, particularly if the reason for the parent's involvement with child

protective services is child neglect. Some questions that may tap into this territory include, “Were you responsible for taking care of your younger siblings (or, “Were you taken care of by older siblings”), “Who cooked the meals in your home?, or “Were there ever times that your parent(s) didn’t come home at night” and if so, “How often would this occur?”

Disciplinary tactics that the parent would employ depending on his child’s age are important to assess. Are such tactics inappropriately punitive or indiscriminant given the child’s age? For instance, does the parent report using ‘time-outs’ with his three year-old as well as his ten month-old? At the opposite extreme are parents who do not understand the need for limit setting and structure or have difficulties recognizing inappropriate behavior in their children, a parenting style that the research literature indicates leads to the development of antisocial behavior (Patterson, Reid, & Dishion, 1992). These parents may demonstrate either an overall neglectful disposition or a proclivity to relate to their child more as a friend or sibling rather than as a parent.

A general ability to keep one’s child safe and protected from harm is a vital parenting skill. To provide a safe environment for a child, a parent needs to be able to recognize high-risk situations. Such situations can range from potentially dangerous items in one’s home (e.g., unprotected electrical outlets, easily accessible knifes, scissors, and other sharp objects) to leaving one’s child in the company of individuals who might place the child at risk through negligent or criminal behavior, such as sexual abuse or exposure to drug use. Potential questions include, ‘Does the parent understand the importance of child supervision’? ‘How would the amount of supervision differ depending on the child’s age’? ‘What type of situations would warrant more supervision

than others'? The confluence of responses to such questions would provide a sense of the parent's capacity to safeguard his child from injury.

Parents of children with special needs (e.g., physical handicaps, medical conditions, psychiatric disorders, learning disabilities) require a unique knowledge base regarding their child's particular disability. Not only should the parent have a general understanding of the disability, but also of the management and treatment of the disability. Essentially, prerequisites of competent parenting of such special needs children are commitment, self-sacrifice, and a willingness to put the child's needs before one's own.

One gauge for measuring a parent's level of commitment is the amount of effort exerted in attempts at being reunified with his child, assuming that the child has already been placed in foster care (as is typically the case). For instance, is the parent complying with rehabilitative services as per court order or child protective services' recommendation? Is the parent consistently attending visits with the child? Has the parent gained employment and appropriate housing?

One source of information regarding parenting ability is psychological testing. In recent decades, some psychological tests have been constructed that focus directly on parenting behaviors (as opposed to general personality characteristics). One such test in wide use is the Child Abuse Potential Inventory (CAP) (Milner, 1986). In addition to three validity scales, the CAP has scales upon which abusing parents tend to score higher than non-abusing parents. These scales include distress, rigidity of expectations for children, unhappiness, problems with family, and others.

## Bonding and Attachment

As noted above, the other crucial component in many TPR evaluations is an assessment of attachment and bonding between the parent and the child. One must have an understanding of the underlying theory of parent-child bonding to proceed in this area.

### Bonding/Attachment theory

The concept of attachment serves as a core element in most contemporary theories of child development and child psychopathology. It would be clinically irresponsible to conduct a psychological evaluation involving termination of parental rights issues without examining the child's attachment profile. Why is attachment such a critical factor in evaluating permanency needs of children? Human development depends on a child's ability to care for, relate to, and learn from others. Attachment sets the stage for an individual's capacity to function in a healthy, prosocial manner. Moreover, it dictates the way in which a child will function in all future relationships; the perspective from which that child will come to view himself; and the process by which that child will develop a code of ideals, values, and standards used to govern the child's quality of life.

The terms "attachment" and "bonding" are used to define two separate phenomena by some and used interchangeably by others. Attachment is a strong emotional connectedness between children and their primary caretaker(s) that endures over space and time, and is necessary for physical survival and emotional well being. Bonding, on the other hand, has historically been portrayed as an almost mystical experience for mothers with their newborn baby that is thought to lead to stronger, long-term attachment. For the purpose of this article, I will use the terms 'attachment' and 'bonding' interchangeably.

Attachment is a reciprocal, two-way process that develops over time, in which both the child and caretaker are active participants. John Bowlby, a pioneering theorist in this area, developed the original attachment theory in the 1950's by observing infants who had been separated from their parents for long periods in nurseries and hospitals (see Witt, Adams, & Weitz, 1988, p. 179). According to Bowlby, attachment describes the way in which an individual will relate to the world around him and become a social being throughout his lifespan (Bowlby, 1973, 1978). Attachment occurs when there is a "warm, intimate, and continuous relationship with the mother in which both [mother and child] find satisfaction and enjoyment (Kaplan, Sadock, & Grebb, 1994, p. 161)." Although Bowlby originally focused on interaction and bonding between mother and child, recent work has demonstrated that it is the quality of the interaction between caretaker and child, not sex of the caretaker, that determines attachment (see Witt, Adams, & Weitz, 1988, p. 179).

Bowlby's theory proposes that children need a close and continuous relationship with a primary caregiver in order to thrive emotionally. Bowlby hypothesized that attachment behavior is adaptive, having evolved through a process of natural selection, and serves as a mechanism through which infants protect themselves from danger by staying in close proximity to their primary caretaker. Aside from the evolutionary dimension of attachment theory, Bowlby also identified other interrelated functions of attachment. Attachment figures serve as a secure base from which the child feels safe to explore and master the environment (Feeney & Noller, 1996). When the child perceives a threat in his surroundings during exploratory activity, he will retreat to the attachment figure for reassurance and comfort. Thus, the attachment figure also serves as the child's

safe haven. In summary, attachment theory proposes that when children feel secure with, and confident in, their primary caretaker, they are likely to be more social and less inhibited. However, when children feel insecure and lack confidence in their primary caretaker, they will likely respond with fear, anxiety, and/or defensiveness.

Bowlby's attachment theory was expanded on by Mary Ainsworth (1989), who distinguished between types of attachment relationships. Ainsworth proposed that the difference between a secure and insecure attachment lies primarily in the way mothers treat their babies in the first few months. Other theorists have suggested that the development of attachment quality depends on the mothering style directed toward the child during the first several years of that child's life (Belsky & Nezworski, 1988)). Parenting style and the manner in which one relates to one's child form the foundation of that child's attachment profile.

What are the caregiver characteristics related to secure parent-child attachment? The primary ingredients in a secure attachment relationship include sensitivity, responsiveness, and flexibility on the part of the caregiver. Sensitive responsiveness—that is, the ability to attune to the child's needs and respond to the child's signals—is a key factor for the caregiver. Insecurely attached children tend to have unresponsive, insensitive, or controlling caretakers. Vital to creating a healthy, secure relationship in which a child can thrive is a parental attachment figure who is emotionally available but not labile or overstimulating; responsive to the child's needs, but not overly intrusive; and helpful, but not controlling. For instance, at times a mother should engage a child in joint problem solving rather than directing the child's behavior. Why? Overly controlling mothers inhibit children from developing their own internal coping resources and

learning autonomous behavior. Under these circumstances, the child may never achieve a sense of self-certainty, questioning his level of competence throughout his life.

In regard to the development of one's sense of self and capacity for healthy, independent behavior, Margaret Mahler elaborated on attachment theory by focusing on separation and individuation (Mahler, Pine, & Bergmen, 1975). This theory delineates specific developmental phases by which the child's attachment to primary caretakers in its first three years of life affects the development of ego functioning and personality structure. Mahler emphasized the process of separation-individuation, which is the gradual distancing of the child from the mother. This process represents a transition from dependent to independent functioning, which Mahler viewed as the hallmark of progress and the enrichment of self, depending on the success of the transition.

A vital contribution to the attachment literature is the concept of internal working models of attachment (Rothbard & Shaver, 1994). This concept is broadly defined as a mental construction that forms the basis of the personality (Bretherton & Munholland, 1999). This theory proposes that a child's early experiences with attachment figures serve as a cognitive template or frame of reference for all future relationships in that child's life. In other words, individuals tend to form expectations about their role in relationships (e.g., lovable vs. unlovable) and others' roles in relationships (e.g., loving vs. unloving) based upon early childhood experiences with their attachment figure.

The primary window of opportunity for children to psychologically attach to a caretaker is during the first three years of life. Children who have received consistent and quality care from a caretaker in the context of a secure, reciprocal relationship will have learned, by the age of three, both how to become attached and how to manage separation

from those to whom they have become attached (Watson, 1997). If attachment is not learned during this time, it can be learned later on in life, albeit with greater difficulty. Similar to some other skills, such as language acquisition, children will not learn attachment as easily or as well as if they had learned it earlier (Watson, 1997). The further removed chronologically a child is from the developmentally opportune time, the more challenging the task becomes (Dyer, 1998). For children to learn how to attach, certain interpersonal and environmental factors need to be in place. These include residential stability, caretaker consistency, provision of security and nurturance, and the caretaker's respect for the child's task of separating and becoming an individual. Absent such ingredients, children run the risk of experiencing developmental delays in the attachment process, resulting in an attachment disorder.

When a child is deprived of the emotional connectedness that evolves from a secure attachment bond, the ability to form and maintain loving, intimate relationships is impaired. Such impairment is known as an attachment disorder. There are many reasons why such deprivation may occur including, but not limited to, abuse or neglect in the first years of life, multiple caretakers, separation from birth mother, postpartum depression in mother, hospitalizations, insensitive parenting, and in utero trauma (e.g., exposure to drugs or alcohol). Consequently, children whose early needs were not met and who lack initial attachment develop a defective ability to trust. They view the world as an unsafe place. Without this fundamental sense of trust, children acquire a hypervigilant stance, constantly questioning their own safety and presuming they must take care of themselves. As an internal protective strategy, these children become extremely demanding and controlling in reaction to events in their early life (e.g., neglect, abuse) that left them

fearful and untrusting. Psychologically, they believe that if they are not constantly in control of their world, they will cease to exist.

A final important contribution, with practical implications, is the notion of a taxonomy of bonding or attachment patterns. Although authorities have devised a number of classification systems for types of attachment and bonding—some systems of daunting complexity—the clearest and most readily applied has been developed by Ainsworth (1989). Although her focus was primarily on young children, her framework can be easily generalized to older children. She proposed three types of attachment (see Witt, Adams, and Weitz, 1988, p. 179):

1. secure attachment: the child explores the environment with the mother and is distressed by separation, seeks contact when reunited;
2. insecure attachment: the child appears uncomfortable even during normal play, is distressed by separation, acts ambivalent when reunited;
3. no attachment: child rarely cries during separation, avoids mother when reunited.

We will discuss below how attachment and bonding can be assessed in children of various ages.

Bonding Evaluation

The purpose of a bonding evaluation is to assess the nature and degree of attachment between a child and his caretakers—that is, to assess what is called the attachment profile. As Dyer (1998, p. 112) states, “A bonding evaluation is a specialized type of assessment whose goal is to determine the nature of the child’s attachment to birth parents and foster parents, especially to address the question of who occupies the position of greatest centrality in the child’s emotional life.”

There are certain observable elements of the interpersonal dynamics between a caregiver and child that suggest the presence or absence of a psychological attachment or bond. To obtain such information, a bonding evaluation should be performed in which the child and caregiver are observed interacting. There are a variety of ways in which bonding evaluations can be conducted. The method used most widely, however, consists of the following elements: (1) an initial archival review for background information, (2) an interview with the caregiver to evaluate his perceptions of the relationship with the child, (3) an observation session of the child with the caretaker for approximately 45 minutes, and (4) brief interview with the child, assuming the child is beyond a preverbal stage of development. A brief individual interview of the child immediately after the joint observation session of the caretaker and child has the advantage of naturally separating the child and caretaker so that the evaluator can observe the child's reaction to separation and the caretaker's style of dealing with the child during the separation. As Dyer notes, (1998, p. 113):

> At the point when it is announced that the conjoint observation has concluded and the child is to be seen individually, the examiner should note how the parent responds to this new phase of the examination. Does the parent reassure the child that the former will be right outside? Does the parent give a parting hug or kiss? If the child reacts by attempting to follow the parent out to the waiting room, does the parent display any evidence of attunement to the child's anxiety, or does the parent mechanically command the child to remain in the room with the examiner? Does the parent bring the child back to the interview area by brute force, showing indifference to the child's protests, or does the parent employ competent strategies

to reengage the child, offering rewards, reassurances, or explanations to facilitate the child's adjustment?

The joint observation session itself is most commonly a semistructured one. Much of the session involves free play between the parent and child. Some examiners employ structured tasks, such as having the parent and child assemble blocks together, that the parent and child perform together. In fact, one authority, Whitten (1994), cites the Marschach Interaction Method (MIM), a set of structured activities, complete with an observation guide, for assessing children ranging from infancy to adolescence, with a number of the activities involving parent-child interaction. However, such a highly structured method is not necessary.

Experts have identified a variety behaviors to note when observing interaction between a parent and child in assessing bonding. For example, (see Witt, Adams, and Weitz 1988, p. 194) the examiner should consider the following:

1. comfort level of the child and the parent with each other; For example, how much touching occurs between them? Is the child animated and verbal or anxious and withdrawn?

2. comfort-seeking and guidance seeking behavior by the child; For example, how aware is the parent that the child may be frightened and what does the parent do to allay those fears?

3. degree to which that parent and child initiate interaction with each other; For example, what does the parent do to engage a reticent child?

4. nature of the parent-child interaction (i.e., distal, proximal, verbal, physical, toy play); For example, how does the parent respond to the child's verbalizations? If the child is inarticulate, how much does the parent struggle to understand?

5. amount of time the parent and child spend smiling at each other and making eye contact;

6. degree of upset by the child if a brief separation occurs and the child is asked to wait with the examiner for a brief interview (reactions will vary with age as well as type of attachment);

7. willingness of the child to explore the environment with the parent in the same room (beginning at approximately age two);

8. does the child approach the examiner for help or guidance instead of the parent, even when the parent is present?

9. ease with which the child is able to make his or her needs known to the parent; For example, how perceptive is the parent to the child's signals of hunger or thirst? Does the parent anticipate the child's needs with food and drink?

The examiner must be aware that bonding between the child and parent is reflected through a range of child behaviors, many of which depend on the child's age (see Fahlberg, 1991, pp. 41-44). For example, an infant who is well bonded may appear alert, attentive, and responsive. He will show interest in the human face and track the parent with his eyes. Although he will cry to express discomfort, he will be able to be comforted by his parent. Between the ages of one and five years, the securely bonded child will explore his environment, respond positively to his parents, show signs of reciprocity when interacting with his parents, and respond with some distress to

separation and with pleasure to the parent's return. During grade school, the child will establish eye contact with his parent, react positively when his parent is physically close, and seek physical contact with his parent. In the evaluation session, well bonded adolescents will express awareness of his parent's preferences and values and demonstrate acceptance of his parent's imposed limits.

Although child protection agencies typically require a bonding evaluation between the child and the foster parent, such agencies do not usually require an individual psychological evaluation of the foster parent (unless some specific concerns are raised in this area in the foster parent's history). Therefore, the evaluator should conduct an interview of the foster parent at least to assess discipline practices, as well as the foster parent's awareness of the child's personality and needs, strengths and weaknesses, and likes and dislikes. Bonding is reflected not only through the interaction between the caretaker and child in the evaluator's office, but also through the knowledge and interest that the caretaker shows in the child's personality and activities.

Beyond bonding, however, the examiner should consider factors that may reduce the emotional harm that the child would suffer if a bond to a parent or caretaker is broken. Such factors include (modified from Rutgers School of Social Work, 2000):

- Quality of care provided by the new caretaker; ability of the new caretaker to meet the child's needs and provide protection, nurturance, stability, and guidance;
- Acceptance of the child's pain and loss; allowing the child to grieve the loss of the relationship with the prior caretaker;
- Acceptance of the child's love for the previous caretaker;

- Continued contact or communication with the previous caretaker, if appropriate under the legal circumstances;
- Provision of therapeutic services for mourning and healing.

## Conclusion

Involuntary termination of one's parental rights is a serious and life-altering judicial process. An evaluator must be cautious when rendering a recommendation in such matters. One of the biggest challenges in these cases is identifying the threshold for recommending termination of parental rights, given the uncertainties involved in making long-term predictions of behavior and emotional consequences. The legal system deals with uncertainty by setting different standards of proof for different types of legal proceedings. The more serious the consequences of a legal proceeding, the higher the standard of proof (that is, the more certain the court must be before taking an action). Historically, the legal standard of proof for terminating parental rights was relatively low, a preponderance of the evidence (or "more likely than not"). However, the United States Supreme Court, in *Santosky v. Kramer* (1982) overturned this relatively lenient standard of proof in favor of a higher standard, clear and convincing evidence (or perhaps 75% certain); presently, most states follow this higher standard. Although the court follows a standard of clear and convincing in TPR cases, the standard for psychologists is "a reasonable degree of professional (or psychological) certainty." Although there is debate in the profession as to how to define this term, in New Jersey, the New Jersey Board of Psychological Examiners (1993) defines the term as an opinion based on substantive clinical observation, well-accepted theory, empirical research results, or an integration of these, and which is clearly not speculative.

New Jersey's statute is typical of that in many states, enumerating the elements that the court must find to involuntarily terminate parental rights. Following a N. J. Supreme Court case (*New Jersey Division of Youth and Family Services v. A.W.*, 1986), the legislature passed a bill that delineates four elements that must be present to involuntarily terminate parental rights. These elements, which must be proven at the level of clear and convincing evidence, are (see N.J.S.A. 30:4C-15: 1) the child's safety, health or development has been or will continue to be endangered by the parental relationship, 2) the parent is unwilling or unable to eliminate the harm facing the child or is unable or unwilling to provide a safe and stable home for the child and the delay of permanent placement will add to the harm, 3) the Division (the Division of Youth and Family Services) has made reasonable efforts to provide services to help the parent correct the circumstances which led to the child's placement outside the home, and the court has considered alternatives to termination of parental rights, and 4) termination of parental rights will not do more harm than good.

In 1996, the New Jersey Assembly passed a bill (N.J. Assembly, 1996) that elaborates on the bonding aspect of these elements by adding the following clarifying wording (see discussion in Dyer, 1998, p. 49), "Such harm may include evidence that separating the child from his foster parents would cause serious and enduring emotional or psychological harm to the child." In assessing the potential for serious and enduring harm, the examiner can consider (modified from Rutgers School of Social Work, 2000):

- The parent's ability to care for the child
- The child's physical, emotional, intellectual, and social strengths and weaknesses;
- The child's history of past traumas;

- The child's resilience as expressed through his demonstrated ability to cope with prior stress, loss, and separations;
- The attachment between the child and the parent and between the child and the foster parent;
- The resources available to the child if the attachment is broken.

The above factors need to be weighed in determining in a specific case whether the harm in breaking a foster parent-child bond is likely to be serious and lasting.

From a clinical perspective, a specific threshold for recommending termination of parental rights does not exist. However, there are some guidelines to assist in forming an opinion within a reasonable degree of psychological certainty. The foundation of these evaluations is always what is in the best interest of the child. The forest cannot be missed for the trees in that many factors must be considered beyond parental fitness and the child's attachment profiles. For instance, how long has the child been in the foster care system? How old is the child? How many failed placements have they already experienced?

Take the following case example: The birth mother of a 15-year-old female is facing possible termination of her parental rights. This family has been involved with child protective services for approximately ten years due to child neglect secondary to substance abuse. The child has been in foster care for the last two years. The mother's prognosis for meaningful change has been consistently characterized as 'fair' by numerous different evaluators. She has relapsed three times in the past, having failed previous attempts at substance abuse treatment. However, she has been compliant with treatment and has remained drug-free for the last six months, although her capacity to

parenting is questionable. The child has made it clear in no uncertain terms that she wants to be reunited with her mother and will resist forming new relationships with potential adoptive parents. Moreover, there is an attachment relationship between this child and her birth mother, albeit an insecure attachment.

The above scenario may warrant very different recommendations regarding termination of parental rights depending on the child's age. For instance, if the child was two or three years of age, it may be in her best interest to terminate the birth mother's parental rights, allowing the child permanency through adoption. However, given that this child is well into adolescence, three years from adulthood, severing her relationship to her primary love object may result in more harm than good. Although the birth mother's capacity to parent is questionable and she has a history of relapsing regarding drug abuse, the child is at an age in which she is not completely dependent on her mother as a younger child would be. Therefore, if the birth mother were to relapse yet again, the child is physically and mentally mature enough to seek help, notify authorities, or take action to ensure her own safety. In addition, this child's ability to form a new psychological attachment to a stranger at this point in her life and achieve "permanency" is debatable, and perhaps not worth the risk of psychological repercussions that may result from severing her relationship with her birth mother.

In the context of opining as to what is in the best interest of the child, it is useful to realize that *the best predictor of future behavior is past behavior*. A parent who has repeatedly failed to provide adequate care to his child despite being provided with numerous opportunities for self-improvement is unlikely to change his problematic circumstances in the near future. This is not to suggest that an individual with a self-

defeating history cannot rectify his situation. However, as the number of relapses increase, the likelihood of a positive long-term outcome decreases. As such, the question becomes, “How many chances for change should a parent be afforded while his child lingers in foster care and is denied a chance for permanency?” Moreover, “When do the psychological consequences to a child of being without permanency outweigh the parent’s right to make the necessary changes, or that child’s right to be raised by his biological parent?”

Involuntary termination of parental rights is an extreme and infrequent step (Wulach, 1998) taken by the state in intractable child abuse and neglect cases. As previously discussed, there are many factors that need to be weighed in making such decisions. In the end, the mental health expert provides guidance for the court, articulating the elements of bonding and parental fitness. It is up to the court to apply these factors within the scope of the law.

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