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FOSTER CAREGIVERS' VALUES AND JUDGMENTS
ABOUT POTENTIAL RESIDENTS

By

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ABSTRACT

FOSTER CAREGIVERS' VALUES AND JUDGMENTS ABOUT POTENTIAL RESIDENTS

By

Carol G. Ellstein

The past two decades have brought enormous changes to the lives of people who have developmental disabilities. In response to federal deinstitutionalization mandates, thousands of previously-institutionalized residents are now living in various community settings. Although the movement has been accompanied by research dealing with predictions of community success, few studies have examined the people who provide, specifically, foster care for severely disabled residents.

This study explored foster caregivers' values and acceptance judgments. Three questions were investigated: (a) Could foster caregivers' values be described by Rokeach's (1973) values theory? (b) Could the judgments that foster caregivers make about the acceptability of potential residents be studied within a "policy-capturing" methodological framework? (c) Could a values-oriented approach be applied to foster caregivers' acceptance judgments?

Seventy-seven foster caregivers, grouped by experience, participated in the study. Subjects' values were measured by the Value Survey. An original vignettes instrument was used to measure subjects' weighted judgments about the acceptability of four dichotomous resident characteristics. Analysis of variance tests were performed on subjects' values and weights to determine group differences. Correlational statistics were used to examine the relationship between specific values and weights.

Although none of the specific hypotheses about foster caregivers' values, weights, and value-weight correlations were supported, the general questions were affirmatively answered. Foster caregivers placed greatest importance on values having to do with caregiving and personal morality. Residents who had unpredictable behaviors were least preferred by caregivers. A resident's medical condition, degree of responsiveness, and ambulatory status were not particularly important to caregivers. Respite and dropout foster caregivers were least willing to accept potential residents. Six value-weight matches were significant.

The study provided a foundation for a "goodness of fit" model of foster caregivers' values and acceptance judgments. That significant results were obtained despite the fact that specific hypotheses were not supported underscores the need for further research on foster caregivers.

To Chuck and Missy: Todah Rabah

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Research is typically not conducted in isolation. This research was no exception. I have been blessed with an abundance of support and tangible assistance every step along the way.

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TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

INTRODUCTION

A child born with a severe developmental disability often presents to family members an overwhelming array of physical care demands. Almost immediately, many parents are faced with the dilemma of determining whether they can adequately manage their child's intensive care needs. If the parents decide that they can, they must then tackle the specifics of home care. If they decide that their child will receive better care in an out-of-home environment, then they must choose the alternative setting that best fits their family's and child's needs.

Using Rokeach's (1973) value theory as a theoretical backdrop in conjunction with a policy-capturing methodology, the current study examined the characteristics of people who provide alternative services in foster care homes. Rather than focusing on biological parents, who are usually thrust into involvements with developmentally disabled people by a twist of nature, the research sought to uncover information about foster caregivers, who willingly seek to have involvements with developmentally disabled individuals. In order to understand contributions from both personal and social factors, caregivers' values and foster care experiences were explored. In addition, the research examined criteria that foster parents use when judging whether or not to accept a potential resident into their values and foster care experience influence their judgments about their willingness to accept a given individual into their homes.[1]

The Rise of Deinstitutionalization

Historically, parents have often chosen to place their "defective" children elsewhere. Care-oriented residential centers first became available in the United States during the mid-nineteenth century. Social reformers, led by Dr. Samuel Gridley Howe (Switzky, Dudzinski, Acker & Gambro, 1988), succeeded in promoting the establishment of new-concept government- or private-supported residential "training schools." The schools, which embraced Seguin's (1812-1840) humanitarian educational principles for the teaching of retardates, were modeled after Guggenbühl's (1816-1883) renowned Abendberg "colony," Europe's first segregated educational/residential facility for mentally deprived individuals. Parents were persuaded to enroll their children amid promises of excellent care, education, habilitation and economic savings.

The motivating belief behind social reformers' actions during that time was that all children could be habilitated and returned to their communities. Their assumption was eventually proven incorrect when it was found that many children lacked sufficient improvement and/or family support to enable societal re-entry. Disillusionment soured

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[1] This dissertation was part of a larger research project that explored social and developmental correlates of foster caregiving. The larger study included three additional measures (Life Experiences Survey, Hassles and Uplifts Scale, a "decision questionnaire") and a structured interview. Further information may be obtained from the author.

reform; training schools became permanent homes; and educational goals dissolved into custodial practices.

By the late 1800s through the mid-1900s, negative social attitudes and a sense of hopelessness toward handicapped people again prevailed (Switzky et al., 1988). Taking counsel from the newest belief that disabled children could not differentiate between one setting or another, well-meaning physicians and other supports routinely encouraged "institutional placements" in the now-warehoused former training schools to relieve parents of the enormous emotional and financial drains that home care required. Most parents followed their advice (Bruininks, Hill, & Thorsheim, 1982).

Within the past half-century, however, concurrent pressures from various sources have enlightened both social perceptions and government policies regarding people who have developmental disabilities. Continuing research has demonstrated educability and non-criminal social development among retardates (e.g., Fernald, 1919, 1924; Martin, 1988). Two presidents (one handicapped, the other having a retarded sister) and new advocacy groups (such as the National Association for Retarded Citizens, founded in 1950) have challenged the public concept of disability. Finally, there has been increasing recognition that it costs less to support people who live in non-institutional living environments than it does to provide care for their institutionalized peers. Professionals now agree that even a profoundly retarded individual can differentiate between environments and will likely benefit more from living in a community environment than in an institution that is separated from the mainstream of society.

A political movement - deinstitutionalization - has blossomed out of this newest reform period (Switzky et al., 1988).

The Development of Deinstitutionalization

In practice, deinstitutionalization - the transfer of institutionalized residents to the community - is not new. Supervised institutional discharge plans were introduced as early as 1922, with paid family care programs following in 1930 (Switzky et al., 1988). Deinstitutionalization as a federal mandate, however, is fairly recent. Its origins may be traced to John F. Kennedy's President's Panel on Mental Retardation (1962). Assembled for the purpose of forging a national plan to fight mental retardation, the Panel's efforts culminated in the enactment of Public Law 88-164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963. Out of that legislation emerged a nationwide network of community mental health centers (CMHs) to serve the needs of mentally disabled people. The designated purpose of CMHs was to develop community programs that would "house, treat, train, educate and rehabilitate" mentally ill and/or retarded people who could potentially function outside an institutional setting. An additional responsibility involved "improving conditions, care, and treatment for those who need institutional care" (Government Accounting Office [GAO], 1977, p.1). The approach was called "deinstitutionalization" in recognition of its primary goal in preventing long-term and unnecessary institutional admissions (GAO, 1977).

Federal objectives that separated the needs of mentally retarded people from those of their mentally ill counterparts were developed in

1970. The objectives specified the creation of developmental disabilites programs "to (1) identify needs and develop comprehensive plans to meet them, (2) stimulate and coordinate agencies to take specific actions to provide services to the retarded, and (3) fill gaps in services and facilities" (GAO, 1977, p.9). In congruence with legislative imperatives, a primary goal was to facilitate deinstitutionalization. CMH boards were commonly called upon to implement the objectives under the direction of designated state agencies. Their success at doing so has varied from state to state.

The Creation of the "Developmental Disabilities" Designation

So far, the key words "mental retardation" and "developmental disabilities" have been used interchangeably. Yet, technically, they are not the same. The newer term "developmental disability" evolved out of the same legislative process that generated deinstitutionalization.

Testimony that preceded the enactment of PL 88-164 emphasized four major points about individuals whom the Panel studied: (a) many had common needs, yet were separated into different diagnostic categories; (b) many retarded individuals also had other disabilities that were not included under the "retarded" designation; (c) those other disabilities also needed attention; and (d) there were some people who were not mentally retarded, but whose needs were similar to those of people who were (Thompson, 1986). In accordance with attempts to incorporate those points into an umbrella concept, the term "developmental disability" was chosen to reflect both the congenital origins of many disabilities and the common needs that are shared by people who have them.

While CMHs and other government agencies were struggling to meet the needs of developmentally disabled people, the legislature was laboring to create a definition of "developmental disability" that would encompass all the people whose particular needs required similar services. The current definition grew out of years of intergroup disagreements, task force clarifications and legislative debate. An initial category-based classification system (e.g., "mental retardation," "cerebral palsy") gave way to an emphasis on functional limitations caused by mental and/or physical disabilities. This approach ultimately allowed additional relevant categories (e.g., "autism") to be included under the central umbrella (Thompson, 1986). The resulting federal definition of "developmental disability," legally adopted in 1978, is:

> . . . a severe, chronic disability of a person that:
> (1) is attributable to a mental or physical impairment or constellation of mental or physical impairments
> (2) is manifested before age twenty-two
> (3) is likely to continue indefinitely
> (4) results in substantial functional limitations in three or more of the following areas of major life activities
>   (a) self-care
>   (b) receptive and expressive language
>   (c) learning
>   (d) mobility
>   (e) self-direction
>   (f) capacity for independent living or
>   (g) economic self-sufficiency and
> (5) reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are
>   (a) of lifelong or extended duration
>   (b) individually planned and coordinated.
>
> (Thompson & O'Quinn, 1979, p. 14)

This broadened reconceptualization has enabled the government to institute employment directives and social welfare policies that guarantee humane treatment and equal opportunities for people who have a multitude of disabilities.

Social Correlates of Deinstitutionalization

A major social consequence of deinstitutionalization has been a forced national reconceptualization of the concept of disability. The movement has spawned laws and objectives that mandate the high quality of care and attention to which developmentally disabled people are entitled. Among the most widely known mandates are "normalization," which specifies an existence "as close to the norm as possible" (Switzky et al., 1988); and "least restrictive environment," which specifies an individual's right to live in an environment that promotes the highest possible attainment of functional independence. Government agencies and protection and advocacy groups regularly monitor the quality of care that developmentally disabled people receive to ensure that the mandates are being met.

Deinsitutionalization has also facilitated a gradual shift in philosophical perspective. From the late-1800s to the mid-1900s, most disabled residents were described according to the "medical model;" i.e., they were commonly characterized as "diseased patients" who lived in "hospitals" and received various "treatments" or "therapies." Institutions were typically administered by physicians and operated according to normal hospital routines. With the advent of normalization (which, by its nature, opposes the medical model), an alternative "developmental model" has been advanced. The model assumes that the same principles of learning, development, education and basic humanity that apply to able-bodied people also describe people who have mental or physical disabilities (Switzky et al., 1988). Although the developmental model is still evolving and vestiges of the medical model remain, professional viewpoints have progressed far from the disease-oriented perspective that was once embraced.

The Deinstitutionalization Process

The rate with which people are deinstitutionalized depends in large part on the type and availability of community arrangements. States, as well as individual communities within states, vary by both the number and type of community offerings that are available to deinstitutionalized clients and by the percentage of personal income dollars that are spent on community vs. institutional programs (Braddock, Haney, Hemp, & Fujiura, 1988). Some communities have placed primary emphases on opening group homes; others have concentrated on expanding their foster care network; still others have focused on improving conditions within institutions (Hill, Lakin & Bruininks, 1988).

Twenty-year estimates from 1962-1982 indicated a fairly stable national population of 240,000-250,000 mentally retarded residents in state-licensed facilities (both community and institutional). Between 1967 and 1985, the number of people who were housed in institutions decreased from 195,000 in 1967 (Lakin, 1979) to 103,000 in 1985 (Scheerenberger, 1986). By June, 1985, community residents surpassed institutionalized residents by 37% (Hill et al., 1988).

Current community placement settings include semi-independent apartment-like arrangements, board-and-supervision facilities, "personal care" facilities, nursing homes, foster care homes, and large and small group residences. More adults currently live in group residences than in any other type of facility. Single-family foster homes or small group homes are generally the residences of choice for children (Hill et al., 1988).

"Higher-functioning" (mild or moderately retarded) institutionalized residents typically benefit first when new community placements become available. Residents who are in frail health, who have extensive maladaptive behaviors and/or who function at severely or profoundly impaired levels of development are likely to remain institutionalized for much longer periods of time (Hill et al., 1988; Haney, 1988). An individual's placement into one setting does not necessarily ensure permanency; transfers (e.g., to other settings; back to the institution) often occur as the result of a given client's adjustment or a given system's needs.

The Future of Deinstitutionalization

Deinstitutionalization is booming. A growing number of community residences are opening each year to house an increasing number of deinstitutionalized residents. In addition, incentives and support services are becoming increasingly available for families who wish to keep their developmentally disabled children at home (Hill et al., 1988). Some institutions have closed in response to a shrinking population base; others have been transformed into "regional centers" that provide needed support (e.g., clinical services; medical care;

permanent and respite housing) for their associated community agencies. Given both the ongoing growth in community development and the fact that deinstitutionalization is the law of the land, one must conclude that deinstitutionalization will continue in the forseeable future across the United States. Although the separation of developmentally disabled people from their families and communities may not be completely eliminated, alterations in the institutional landscape will ensure that residents receive more humane care than their predecessors did.

Foster Care Placements for Developmentally Disabled Individuals

Despite the increased availability of in-home supportive services, many parents still seek alternative living arrangements for their severely disabled offspring. They may do so for a variety of reasons. For some parents, prolonged grief and other adjustment difficulties interfere with their ability to raise their developmentally disabled child in a beneficial manner (Cummings, 1976; Waisbren, 1980). For others, the high level of stress that many families normally experience with a child's birth may be exacerbated to intolerable levels by the presence of a developmentally disabled infant (Adams, 1970; Browder, Ellis, & Neal, 1974). In still other homes, parental divorce, death, or health difficulties may interfere with the family's continuing ability to care for a developmentally disabled child (Browder et al., 1974). In some cases, professionals still advise parents to seek an out-of-home placement so that they may be relieved of an extreme caregiving burden (Adams, 1970). Finally, some parents choose to release their infant temporarily in order to ensure adequate respite care while they alleviate marital difficulties, adjust to their new family demands, or decide whether they feel they can permanently care for the child on their own.

As a result of these and myriad other factors, many developmentally disabled infants, children and adults come eventually to reside in settings away from their families. The placements may be temporary, depending on the parents' home situation or caregiving capabilities; or they may be permanent, resulting either in adoption, a few stable placements over a lifetime, or a number of relatively short-term placements.

Foster care is being increasingly hailed as appropriate for all types and degrees of disability. As Hill et al. (1988) have noted: "The pace of transition to 'family-scale' programs and their favorable cost imply that they have become the placements of choice for severely handicapped individuals." (p.123). This is a relatively new development; at one time, individuals who had severe deficits seldom left the institutional environment. A given individual's placement into a foster care home currently depends on both the level of progress that a particular state has made in the area of deinstitutionalization and the number of foster homes that are available to accept placements. Unfortunately, the demand for foster homes usually exceeds the supply (Tavormina, Hampson, Grieger, & Tedesco,1977; N. Rosenau, personal communication, December, 1986).

Research on Foster Care for Developmentally Disabled People

Relatively little has been written about foster care issues as they relate specifically to placements for people who have developmental disabilities. One group of articles, which mirrored initial deinstitutionalization efforts in the late 1960s and early 1970s, questioned whether foster care is a viable alternative for mentally retarded or developmentally disabled clientele (e.g., Adams, 1970; Browder et al., 1974; Freeman, 1978; Tavormina et al., 1977). The answer, a resounding "yes!," paved the way for a second group of studies, which have attempted to specify qualities of successful foster parents (Willer & Intagliata, 1981; Sanderson & Crawley, 1982), placements (Sternlicht, 1978), and programs (Barsh, Moore, & Hamerlynck, 1983; Coyne, 1978; DeVizia, 1974). The quest to find individual and systemic correlates of "success" has dominated recent research efforts in both "generic" and "developmentally disabled" foster parent literatures.

Successful Foster Placements for Developmentally Disabled People

In an effort to identify variables that impact on a given placement's success, Sternlicht (1978) combined a literature review of foster placements for mentally retarded individuals with insights from his own and others' field experiences. Ten factors from three sources were identified as contraindicated for success: (a) foster resident factors: maladaptive behavior, poor health, young adult age; (b) foster caregiver factors: poor health, immature or young age, emotional instability; and (c) community factors: lack of support services, public misconceptions about mental retardation, interferences from natural parents, adverse environmental conditions. Ten other factors from two sources were found to require further investigation due to conflicting results within the literature: (a) foster resident factors: sex, intellectual level, length of prior institutionalization, and degree of independence in self-care skills; (b) foster caregiver factors: socioeconomic status, education, degree of religiosity or religious involvement, and available social support.

Willer & Intagliata (1981) studied the relationship between various caregiver characteristics and foster care placement success by analyzing responses to mailed questionnaires returned by the foster families of 229 foster care recipients in New York. The foster residents, who represented 58% of the target group, had been in the community for 2-4 years when their caregivers were contacted. Prior to their community placement, all residents had been institutionalized for at least one year; each had been at least 13 years old at the time of his or her institutional release. Success was defined in terms of four resident outcome variables: self-care, adaptive behavior, community living skills and community use (pre-release comparison scores were available only on the first three variables). Caregiver variables included age, education, marital status, mental health and overprotectiveness. The results indicated a negative relationship between caregivers' level of overprotectiveness and residents' self-care skills. Younger caregiver age and psychological well-being were positively related to frequency of community use.

Sanderson & Crawley (1982) studied the agency records of 55 foster caregivers in 32 upstate New York family-care homes (32 women and 23 men) in order to determine the relationship between various foster caregiver characteristics and placement success. Twenty-one homes that had been in operation for at least one year were labeled "successful;" they were compared with 11 "unsuccessful" homes that had been closed either by an inability to meet government requirements for care or by caregiver request. Five caregiver variables were examined: home locale (rural v. urban), age, education, religious involvement, and vocational orientation of both male and female caregivers. The results indicated that successful placements were associated with caregivers who were older, less educated, and more active Protestants (vs. less active Protestants or Catholics of any activity level). Successful female caregivers generally fit Holland's (1978) Conventional vocational orientation; successful male caregivers had a Realistic orientation.

In conjunction with an extensive literature review concerning correlates of success across community settings, Haney (1988) concluded that residents' maladaptive behavior was the only factor to pose a clear contraindication for success. Good personal appearance, adequate adjustment, vocational ability, and social skills were related somewhat positively to success; race/ethnicity, length of institutionalization, and diagnostic category had no relationship with success; and conclusions about sex, age, intellectual level, adaptive behavior, academic ability, physical handicap and health problems could not be made. In her summation, Haney (1988) cautioned that:

> . . . the findings on individual characteristics may be taken more as a depiction of the present status of community residential offerings than as indicators of the effect of individual variables on success. For example, the fact that maladaptive behavior is such a good predictor of failure suggests that community residential settings presently do not offer sufficient support for individuals exhibiting such behaviors. Again, the thesis is put forth that any individual can succeed in a community residential placement given appropriate circumstances at the small-group,

> organizational, and community or institutional levels. Empirical support for this viewpoint is mounting." (p.131).

A glimpse at the literature specifically regarding foster care placement systems may underscore Haney's (1988) contention. Inadequate or incomplete training procedures (Browder et al., 1974; Tavormina et al., 1977) and a lack of supportive networks or interventions for the foster family (Barsh et al., 1983) have been cited as interfering with the success of specialized foster care placements.

Overall, the sketchy literature regarding correlates of successful foster care placements must be interpreted conservatively due to methodological flaws (e.g, contradictory definitions of success, questionable selection methods, use of subject reports to determine residents' success) and possible interferences from external sources (e.g., deficiencies in community supports). More information is needed about the foster care process in general and foster caregivers and residents in particular before an accurate assessment of the system's impact on developmentally disabled individuals can be made.

The Literature on Successful "Generic" Foster Care Placements

The broader literature on "generic" foster care (i.e., includes all types of foster care) provides a further window into foster placement concerns. There have been two major reviews of the generic system. Taylor and Starr (1967) bemoaned the serious lack of information that was available up to that time. Carbino (1980) reported that research efforts since Taylor and Starr's review offered sketchy information about parent education and training methods, payments, foster parent adoption, foster parenting for special-needs children, and, particularly, predictions of foster placement success. Both reviews concluded that little was (still) actually known about the foster care system.

Unfortunately, like its specialized foster care cousin, most research dealing with predictions of success has been methodologically shortchanged by selection biases, contradictory definitions or ratings of success, lack of comparison groups, and a reliance on quasi-experimental designs. In addition, results from studies on personality correlates of success have typically been at odds with each other (Carbino, 1980). The literature concurs that foster parent and resident characteristics may affect placement success (e.g., Cautley & Aldridge, 1975; Cautley, 1981; Haney, 1988; Jordan & Rodway, 1984; Wiehe, 1982); but there is little agreement on what those characteristics are (Carbino, 1980).

Only one study of foster parent characteristics relates directly to the developmental disabilities literature. Using Holland's (1978) Vocational Preference Inventory to assess vocational orientation, Wiehe (1982) reported that "Conventional" foster mothers and "Realistic" foster fathers were associated with successful placements. These results support Sanderson & Crawley's (1982) findings on specialized foster caregivers. However, given that both studies had selection biases (e.g., Wiehe's results came entirely from responses to mailed questionnaires; Sanderson & Crawley used agency records) and other flaws, caution must be exercised when generalizing to foster parents as a whole.

The topics of recruitment and selection of generic foster parents have also received attention. Past recruitment techniques were generally unsuccessful (Stone & Stone, 1969). More recently, there is no agreement on which methods are considered most effective (Carbino, 1980). In order to keep up with the demand for foster parents, some agencies engage in selection processes that stipulate only minimal requirements for foster care applicants (Kraus, 1971; Tavormina et al., 1977; N. Rosenau, personal communication, 1986). Considering the quality-of-care implications that could arise from hurried or haphazard selections, this condition may affect both a resident's well-being and a placement's success. Unfortunately, little attention has been given to rigorous explorations of selection methods (Carbino, 1980).

Attrition and foster parent turnovers are ongoing problems as well (Carbino, 1980). Cautley and Aldridge (1973) estimated that as many as 1/3 of foster parents drop out within 18 months of their involvement in the foster care placement system. Carbino (1980) has noted that few studies address attrition directly and none have analyzed it systematically.

About the only information that has been reliably obtained concerns demographics. The majority of foster parents are white, middle-class, high-schooled, middle-aged, married, and come from larger families of origin than the general population (Carbino, 1980). While this information is interesting, it primarily serves to demonstrate that foster parents are virtually indistinguishable from the population-at-large.

Summary. The generic literature has illuminated some problems, but it has not generated sufficient information to facilitate recruitment and placement successes in the field. In order to reach for success, agencies must have more information about the people who participate in the foster care process (Carbino, 1980). Specifically, knowledge about the "goodness-of-fit" between a potential resident's needs and a foster family's skills would help agencies to make more informed placement decisions (Tavormina et al., 1977) .

The current study was created from a desire to learn about the criteria that foster caregivers employ when deciding whether or not to provide shelter and supervision for a given developmentally disabled individual. It was felt that research in this direction would begin to address both Tavormina et al.'s (1977) and Carbino's (1980) suggestions. Specifically, this study sought to determine whether caregivers' values and foster care experiences are related to their judgments about the placement acceptability of potential foster care recipients. The study utilized a policy-capturing methodological approach.

Conceptual Framework

Four tasks had to be completed before the study could be conducted. First, an appropriate theory had to be applied to foster caregivers. Second, a grouping variable had to be developed. Third, a dependent variable had to be specified. Fourth, a methodology had to be created. The first three tasks are described below. The methodological framework will be discussed in the next section.

Motivations to Provide Foster Care

It was assumed that all caregivers had a motivation for providing foster care. Thus, it was felt that a theoretical approach should address some aspect of motivation. The opportunity to earn money while staying at home seemed to be a factor, since foster caregivers are paid for their efforts. It was also speculated that part of the impetus came from a person's core system of beliefs, attitudes, or values, coupled with some sort of exposure or sensitivity to people who have developmental disabilities.

The foster care literature has indicated that money is not the major motivator; in most cases, foster caregiver wages barely cover the day-to-day expenses of caring for a developmentally disabled resident (Haney, 1988; Sanderson & Crawley, 1982). However, because the literature has not tackled other motivational issues, they remain open to speculation. The current study adopted a values approach to the study of foster caregivers. Three primary reasons guided the decision: (a) values are assumed to have motivational components (e.g., Rokeach, 1973); (b) information about foster caregivers' values could provide insight into fundamental aspects of their personalities; (c) a large literature was available for reference.

The Nature of Values

Perhaps the two most prolific sources for the psychological study of values are Gordon Allport, who, in collaboration with Vernon and Lindzey, developed the Study of Values inventory (Allport, Vernon, & Lindzey, 1960) and Milton Rokeach, who created the Value Survey (Rokeach, 1973). Both measures have spawned many research efforts; the Value Survey alone has been used in at least 250 studies since its inception in the late 1960s (see Buros,1978; Mitchell, 1985; Mueller, 1984; Rokeach, 1973). Rokeach's theory was adopted for two major reasons: (a) the theory assumes that values, attitudes, and behavior are dynamic and interconnected; (b) the Value Survey measures a wide array of values with satisfactory reliability.

According to Rokeach's (1973) conceptualization, values are enduring beliefs that specify an individual's preference concerning a "mode of conduct" or an "end state of existence" (p.5). They are fused together to form a value system that specifies, "along a continuum of relative importance," the individual's personal beliefs "wherein some means or end of action is judged to be personally or socially desirable in relation to its opposite or converse" (Feather, 1980). Although values are relatively stable, they can be altered in response to an individual's life experiences. The following extended definition of "value" has been offered by Rokeach (1973):

> To say that a person has a value is to say that he has an enduring prescriptive or proscriptive belief that a specific mode of behavior or end-state of existence is preferred to an oppositive mode of behavior or end-state. This belief transcends attitudes toward objects and toward situations; it is a standard that guides and determines action, attitudes toward objects and situations, ideology, presentation of self to others, evaluations, judgments, justifications, comparisons of self with others, and attempts to influence others. Values serve adjustive, ego-defensive, knowledge, and self-actualizing functions. Instrumental and terminal values are related yet are separately organized into relatively enduring hierarchical organizations along a continuum of importance. (p. 25)

Rokeach (1973) has proposed two distinct types of values: terminal values, which are "desirable end states of existence" (p.7); and instrumental values, which guide an individual's day-to-day behavior as he or she strives toward the desirable end state. The two types of values may be further analyzed into two subtypes each: personal or social terminal values and competence or moral instrumental values. Personal values are self-centered, such as A comfortable life or Inner harmony. Their social value siblings are interpersonal and world-centered, such as National security or Equality. Competence values have a self-centered and personal component; Imaginative and Ambitious may be considered in this group. In contrast, moral values are interpersonal and carry a strong "ought" imperative; Polite and Honest typify this group.

The Literature on Rokeach's Conceptualization of Values

Values research involving Rokeach's (1973) theory has focused primarily on three core areas: validating the Rokeach Value Survey, examining the relationship between values, attitudes and behavior, and exploring the values of specific groups of interest. Selected results are reviewed below.

Normative aspects. In 1968, the National Opinion Research Center (NORC) administered the Value Survey to a large sample of adult subjects (N=1409) representing a cross section of demographic groups in the United States (Rokeach, 1973). Data from a second NORC sample (N=1430) were collected in 1971 (Rokeach, 1979). Value medians and composite rank orders were calculated for both samples and compared among groups that varied by sex, education, race, age, political ideation, income and/or religion. Within each sample, there were both remarkable similarities and significant differences when value patterns of specific groups were compared with each other. A synopsis of results for both sets of NORC data is as follows:

1. The Value Survey described differential value patterns for subjects who varied according to demographic factors.

2. Certain values had equivalent ranks across groups.

3. The top three and bottom four terminal values, and the top four and bottom four instrumental values were the same for both the 1968 and 1971 samples.

4. Between-group differences were in expected directions.

5. Comparisons involving the entire 1968 and 1971 samples indicated significant changes on 11 of 36 values. Fewer value changes occurred when subgroups' value patterns were compared.

Given an overall impression of value stability within a three-year period, Rokeach (1979) concluded that: "(1) the value measure employed is sufficiently sensitive to register short-term changes, (2) certain values had in fact undergone changes in American society between 1968 and 1971, and (3) more clear-cut trends are likely to become discernible with measurements over longer time intervals." (p. 143).

Although these results are intriguing, they were obtained almost 20 years ago; it is uncertain whether they provide appropriate normative comparisons for the current research. To minimize interpretive errors, the results were used conservatively in the current study; i.e., they were used to aid interpretations of the current data rather than to provide direct comparisons.

Values, attitudes and behavior. Another cluster of studies has examined the impact that values have on attitudes and behavior. Rokeach (1973) has hypothesized the existence of a "total belief system" whose contents - values, attitudes, self-cognitions - are "functionally interconnected" (p.216). Belief system changes may be induced when a given individual is exposed to information about his or her own beliefs that is contradictory to his or her self-cognitions. The individual's attempt to reduce the contradictions results in a state of self-dissatisfaction, which eventually fuels value changes that affect the entire belief system. Overt expressions of the values-mediated belief-system change process may be reflected in the person's behavior.

In conjunction with his ideas, Rokeach (1973) conducted three self-confrontation experiments involving Michigan State University freshman subjects that targeted belief system changes in the values Equality and Freedom. The experiment, which involved a values-oriented self-confrontation approach with attitudinal and behavioral components, produced significant results in all domains. Rokeach (1973) interpreted the results as being highly supportive of his theory of values-mediated cognitive and behavioral change processes.

Rokeach's (1973) experiments produced two reactions. First, self-confrontation techniques were found to produce significant value and behavior changes in other situations (e.g., Conroy,1979; Greenstein,1976; Sherrid & Beech,1976) which, in turn, raised concerns that values could be manipulated arbitrarily (Rokeach & Grube, 1979). Second, critics contended that Rokeach's (1973) experiment did not provide an adequate test of the value-mediation hypothesis (Grube, Greenstein, Rankin, and Kearney, 1977).

Subsequent studies (Grube, 1982; Rokeach & Grube, 1979) sought to diffuse both reactions. Supportive results were interpreted as both a theoretical reaffirmation of the value-mediation hypothesis and an ethical reassurance that values can not be arbitrarily manipulated.

Research efforts involving Rokeach's theory have continued (e.g., Grube, Weir, Getzlaf & Rokeach, 1984; J. M. Wardwell, personal communication, June 10, 1987).

Other values research. Explorations of an individual's values are an integral part of vocational assessments (Anastasi, 1976; Hansen, 1984). Attention has also been given to explorations of possible links between values and specific occupations (e.g., Brown, 1976; Chong, 1976; Holland, 1973; Jansen, 1973; Rokeach, 1973) and values and age (e.g., Feather, 1980; Ryff & Baltes, 1976). Results have tended to be in expected directions.

Although most of the values literature has lacked specific relevance for the current research, there is an overall sense that values are linked to personal characteristics, occupations, attitudes and behavior. The application of a values approach to a study involving foster caregivers seems appropriate.

A Values Model of Foster Caregiving

In order to construct a values model of foster caregiving based on Rokeach's theory, one might first try to visualize the caregiver. From anecdotal accounts, she (most primary foster caregivers are women) appears to engage in foster care not merely because it is paid employment that enables her to work at home, but also because she has an internal drive that pulls her toward it. Chances are her predilection for foster care is not easily understood or encouraged by others around her. Therefore, she might have an independent streak that motivates her to act in accordance with her own wishes, regardless of what other people think or say. Perhaps, too, foster caregivers who house developmentally disabled individuals place a higher premium on certain values that intuitively correspond to specialized foster care (e.g., Helpful, Loving, Broadminded, Equality) than do other caregivers.

The model may be extended to the foster care system through an experience variable. A woman whose values identify her as a prospective foster caregiver somehow learns about the foster care system. She works her way through the development process and eventually becomes licensed to accept residents. A placement occurs, and she begins her paid caregiving duties. Barring unforeseen environmental, health or intrafamilial factors, if the demands of the placement are congruent with the person's value system, then the placement and/or the individual's involvement with the foster care system should be expected to continue in a manner that is ultimately deemed self-satisfactory. If the placement arouses feelings of self-dissatisfaction in the foster caregiver, or if the placement unmasks self-contradictions within the foster parent's belief system, then the foster caregiver should predictably seek to terminate the placement or to leave the foster care system altogether.

A "test" of the model. One might attempt to test this model according to Rokeach's (1973) self-confrontation paradigm. Unfortunately, an investigation of this sort would likely be very difficult to implement, given limitations with subject resources, economic constraints, and, particularly, resistance at an agency level to a methodology that risks possible dropout behavior among foster caregivers.

Alternatively, other aspects of Rokeach's (1973) theory could be explored. Rokeach has noted that "since the total belief system is a functionally interconnected system, a change in any part of it should affect other parts and should moreover affect behavior" (p. 216). Given this interconnected state, it is reasonable to predict that a foster caregiver's values will be related both to her behavior and to her cognitions. A study of this nature would not be a threat to a foster care agency because any risks involving potential dropouts would be irrelevant to the focus.

Caregivers' Experience

Nancy Rosenau, Director of Admissions and Placement Services, Macomb-Oakland Regional Center, and Laurel Berger, Coordinator of Community Training: Home Development and Placement, Wayne Community Living Services (ongoing personal communications, 1986-1987) suggested that caregivers who have had previous placements might draw on their experience when engaging in caregiving activities. Since one of the few things that all foster caregivers have in common is experience with the foster care system, it made sense to group subjects by their foster care experience for intergroup comparisons on independent variables.

One problem with the foster care literature is that experience variables have been created only in conjunction with explorations of success. Although success has been typically defined in terms of some time frame (with related implications of some sort of experience), a consistent definition has not been used. For Sanderson & Crawley (1982), "successful homes" were those that had been operating for at least one year and continued to meet state and local care requirements. DeVizia (1974) used a placement of about one year's duration as the criteria for a "successful placement." For Stone & Stone (1983), success in "generic" foster care was defined in terms of a continuous placement lasting no less than sixty days. Wiehe (1982) did not use a time frame at all; he noted only that the average caregiver in his sample had six years' experience.

A decision was made to define experience along a "quasi-developmental" dimension that incorporated four mutually exclusive experience levels: pre-foster (prospective) caregivers-in-training, new caregivers, experienced caregivers, and post-foster (dropout) caregivers. From the literature, a standard of at least one year continuous caregiving experience with at least one resident was set for the "experienced" group. By extension, prospective caregivers who had no prior foster care experience would be placed into a "prospective" group; caregivers who were currently engaged in a first placement that had been in effect for less than one year would be considered "new" caregivers; and subjects who had stopped providing foster care before the one-year criterion was met would be placed in a "dropout" group.

Other Caregiver Characteristics

It was realized that caregivers' values and experience are only two characteristics that could influence caregivers' cognitions and behaviors; other variables are also likely to be important. However, given the dearth of research about caregiver variables in general, a decision was made to obtain more information about caregivers' backgrounds, specific foster and non-foster care experiences, and social concerns before identifying other characteristics that may influence caregivers' activities. Additional data were gathered through a structured interview. They were referenced in the current study only when needed to interpret the results.

Caregivers' Judgments About the Acceptability of Potential Care Recipients

The decision to use caregivers' judgments as a dependent variable was made in response to a practical concern. Rosenau and Berger suggested that successful placements often hinge on whether a potential resident's characteristics are acceptable to a caregiver. Unfortunately, because many caregivers are unable to articulate what they are looking for in a potential resident, it is difficult - if not nearly impossible - to predict which placements will "take." A request for information about caregivers' preferences was made by Rosenau and Berger and encouraged by other placement specialists (personal communications: N. Rosenau, March 25, 1986; N. Rosenau and L. Berger, April 16, 1986; K. Slater, November 4, 1986; P. Syers, March 20,1987).

Methodological Framework

Any exploration of preferences or other social judgments requires a methodology that can describe mental processes connected with real-life situations. From a review of methods associated with behavioral decision theory (Slovic, Fischhoff, & Lichtenstein,1977), the "policy capturing" methodology, which uses regression approaches to describe how individuals weight and combine information, was deemed particularly applicable for the current research because of its primary use in applied settings. The policy-capturing methodology and its use are described below.

Brunswik's Lens Model

The origin of policy capturing studies may be traced to Egon Brunswik's (1956) perceptual psychology. Brunswik perceived the task of psychology to be "the analysis of the interrelation between two systems, the environment and the behaving subject" (Hammond, 1966, p. 23). The relationship was thought to be uncertain and changing; "an uncertainty that requires an organism to employ probabilistic means in order to adapt and thus to survive" (Hammond, 1966, p. 21). His viewpoint was termed "probabilistic functionalism" in recognition of both the functionalistic emphasis on the environment-organism interrelationship and the uncertain character of the organism's responses to the probabilistic cues from the environment.

Brunswik developed a lens model to represent his theory pictorially. The model, which mimics the functioning of a lens, depicts a single perceptual task. The task consists of two end points ("focal variables") that are connected by a wide-spreading array of cues. The initial focal variable is an object that is about to be perceived by an organism. It radiates cues that are subject to probabilistic influences from the environment (e.g., light, distance). The terminal focal variable is the environmentally-mediated object that is perceived by the organism.

Brunswik used his model to develop many avenues of experimental inquiry. One approach, which is of historical interest for the current research, involved a series of experiments dealing with "social perception" (Tolman, 1966). Using schematic faces of individuals as initial focal variables, subjects were asked to make judgments about select characteristics (such as beauty, age, intelligence and mood) of each individual. Correlational statistics were used to measure the degree to which different facial cues (e.g., distance of eyes) were related to the subjects' judgments. A linear model was developed to describe the relation between each cue and subjects' judgments.

Paramorphic Representation of Clinical Judgment

Hoffman (1960) applied Brunswik's ideas to cognitive phenomena by suggesting that mathematical models could be used to describe mental processes involved in clinical judgment tasks. According to Hoffman, "The term mental process refers simply to a functional relationship which accounts for consistencies in response to divergent stimulus (information) patterns. It is thus a set of intervening variables, nothing more." (p. 117). Hoffman postulated that cognitive input (information) and output (a clinical judgment) comprise a functionally related mental process that can be described by linear or configurational mathematical models.

Borrowing from mineralogy, Hoffman (1960) employed the term "paramorphic" to describe mathematical models' abilities and limitations as descriptive, predictive, and explanatory devices for clinical judgments. A paramorph is a change from one mineral species to another by a change in physical characteristics without an accompanying change in chemical composition. Applied to judgment tasks, a paramorphic representation "helps to account for or 'explain' what is observed concerning certain properties or characteristics of the judge" (p. 125), but it lacks clues about underlying meanings.

Hoffman cautioned that although paramorphic representations help to explain observable mental processes, "the mathematical description of judgment is inevitably incomplete, for there are other properties of judgment still undescribed, and it is not known how completely or how accurately the underlying process has been represented" (p. 125). Given its incomplete nature, it would be possible for two or more models to offer different, though equivalent, explanations for judgment variances.

The Policy Capturing Methodology

The methodology that is associated with Hoffman's (1960) ideas has been termed "policy capturing" because it attempts to "capture," through paramorphic representation, an individual's judgment "policy" (Dawes & Corrigan, 1974). The term "policy" refers here to an individual's set of beliefs and values that lead to specific judgments that the individual makes about a particular event. Policy capturing studies seek to determine how much weight a given person places on certain variables of interest when making judgments about a related event. Subjects' "policies" are reported as individual variables' "weights" in a linear regression equation.

Experiments based on the methodology enable researchers to explore interrelationships between a criterion, its cues, and the subject's judgment about the criterion. Comparisons between subjects' judgments about their own behavior and subjects' actual behaviors are possible, as long as appropriate behavioral measures are available. Group comparisons involving policy similarities, cue-weightings, and other properties can also be made.

Research Using Policy Capturing Approaches

Although linear models were originally used to capture individuals' policies in the laboratory (e.g., Slovic & Lichtenstein, 1971), favorable results have facilitated their wider use in a variety of real and analog situations. In their review of the methodology, Slovic et al. (1977) have noted that "linear equations have accounted for most of the predictable variance in these complex judgments. The coefficients of these equations have provided useful descriptions of the judges' cue-weighting policies and have pinpointed the sources of interjudge disagreement and nonoptimal cue use." (p.12).

Two studies demonstrate how the policy capturing methodology works. Dawes (1971) constructed a policy capturing study to examine how admissions committees make judgments about which students to accept into graduate school. Using applicants' admissions information (e.g., GRE scores, transcript, letters of recommendation) as multiple criteria, members of a psychology admissions committee individually rated the acceptability of each graduate applicant. An overall single rating for each applicant was then obtained from the average of the four members' scores. The ratings were used by the committee to determine which applicants would be accepted (highest-rated applicants were accepted first) and by Dawes to represent the committee's judgment of each applicant's potential achievement in graduate school. The procedure was repeated for a few years; eventually, the ratings data set was evaluated in terms of its ability to predict graduate performance and its adequacy as a paramorphic representative in a linear model of admissions decision processes.

Floden, Porter, Schmidt, Freeman, & Schwille (1981) constructed an analog study to examine the effects that curriculum pressures have on teachers' judgments about content. Fourth-grade mathematics teachers were asked to imagine that they had found a new job with a fourth-grade class in a new school district. Characteristics of the district, the mathematics curriculum, and the school were described in a set of 63 vignettes that contained unique combinations of up to six pressures. For each vignette, teachers made judgments about their willingness to follow the curriculum (which included five "new" topics in place of familiar ones), given each vignette's pressures and certain conditions within the judgment tasks. Multiple-regression analysis was used to determine the weighted effects of each pressure on teachers' judgments about their willingness to teach the content, given various situations.

Foster Caregivers' Acceptance Judgments

It was felt that an analog-based policy-capturing methodology could be used to determine how foster caregivers weight various resident characteristics when making judgments about their willingness to accept individuals with those characteristics into their homes. The results of the study would enable a glimpse into caregivers' judgment processes and provide directions and predictions for further studies.

A policy capturing analog study of foster caregivers' acceptance judgments would require the construction of a set of vignettes through which to represent prototypic foster care recipients. The vignettes would be composed of unique combinations of a number of independent dichotomous variables. Each variable would be represented in every vignette. Half the vignettes would have one level of the variable; the other half, the other level. The number of vignettes required would be 2^k, where k = the number of independent variables that would be selected for representation.

Characteristics of Developmentally Disabled Foster Residents

In order to construct useful vignettes, three selection criteria were established: (a) the variables had to capture essential characteristics; (b) they had to lend themselves to precise descriptions in simple language for adequate emphasis and understanding by subjects; (c) the number of vignettes had to be limited in order to counteract tendencies toward random responding. It was felt that subjects could tolerate reading no more than 16 repetitive vignettes; thus, a target of 4 variables was selected.

According to descriptions from Rosenau and Berger, the foremost common characteristic of developmentally disabled foster care residents is a chronic mental impairment of congenital origin. Some individuals lack coherent speech; others may have no speech at all. Their abilities to walk, talk, see, and/or hear may be impaired. Attention, memory, and general learning deficits are likely to exist.

Emotional make-up and social skills may be damaged, so that the individual behaves in a manner that could be perceived as bizarre. Self-abusive, self-stimulatory, aggressive and/or other maladaptive behaviors may be present. All told, their capabilities are likely to extend to levels no higher than the skills associated with middle-childhood; in many cases, their abilities are much lower.

Rosenau and Berger noted that their most difficult placements involve individuals who require extensive behavioral, physical and/or medical care. Their impressions complemented those of Sternlicht (1978), who has affirmed that unacceptable behavior and poor health are contraindicated for placement success, and, in part, Haney (1988), who has emphasized that unsuccessful placements are associated primarily with maladaptive behavior. Given their apparent influence on placement success, it was felt that dichotomous variables dealing with behavioral, physical, and medical concerns should receive primary attention in the vignettes.

Physical, behavioral, and medical needs. Rosenau and Berger mentioned that many developmentally disabled individuals are wheelchair-bound. They also noted, from clinical experience, that wheelchairs sometimes provoke in caregivers strong reactions that are unattributable to environmental barriers (e.g., steps). Given that wheelchair-bound foster residents usually have physical conditions that require intensive assistance with daily living tasks (e.g., feeding, toileting), it was felt that physical care needs could be described through a wheelchair variable. Furthermore, given that wheelchairs *per se´* seem to elicit affective reactions, it was concluded that the presence or absence of a wheelchair might influence a caregiver's judgment about the acceptability of a potential foster resident.

The creation of behavioral and medical variables was not as simple. It was realized that both behavioral and medical factors have categorical (i.e., specific behavior or condition) and qualitative (e.g., predictability or intensity) dimensions. Furthermore, it was assumed that perceptions of "difficult" behaviors or medical conditions vary widely among caregivers. Suspecting that judgments about the acceptability of individuals who have "maladaptive behaviors" or "poor health" are influenced more by qualitative aspects of care than by specific diagnoses, a decision was made to emphasize qualitative correlates of behavior and health rather than particular conditions.

With regard to behavioral needs, Rosenau and Berger noted that questions about a potential foster resident's ability to behave in fairly predictable ways (e.g., "What does she do if I take my eye off her for a minute?") often arise during placement discussions with caregivers. They also observed that, during the decision process, many caregivers become "hooked" when potential foster residents smile, reach out, touch, and/or gaze directly at them. Although the foster care literature has not mentioned either of these variables to date, descriptions of behavioral predictability and social responsiveness (represented as "visual responsiveness") were included in the study because they represented two avenues through which severely developmentally disabled people can communicate.

Medical care was conceptualized as a multi-dimensional concept. Rosenau and Berger suggested that intensity of care, stability of condition, and prognosis (i.e., whether the condition is terminal) appear to be of foremost concern to foster caregivers. It thus became a goal to identify a chronic, unstable medical condition that requires special monitoring and has a small but nevertheless real risk of death. Two conditions that are commonly associated with severe developmental disabilities were rejected: seizure disorder, because it seldom requires special monitoring procedures, rarely presents a significant risk, and is usually well-controlled with medication (Wiener, Bresnan, & Levitt, 1982), and esophogeal reflux, which primarily occurs in conjunction with neuromuscular disorders and is rarely experienced by ambulatory people (Batshaw & Perret, 1981). Disorders involving pulmonary and heart conditions were also rejected because it was felt that accurate but content-controlled and understandable representations would not be possible to achieve. A decision was finally made to represent medical care needs through a description of diabetes mellitus. Although diabetes occurs less frequently within the developmentally disabled population than do either seizure disorder or esophogeal reflux (Brunner & Suddarth, 1986), it was chosen because it is a chronic, highly unstable condition that (a) requires close daily monitoring (i.e., medication and diet) to prevent metabolic imbalances, (b) can result in death in severe cases, and (c) is not associated with a specific developmental disability (Batshaw & Perret, 1981).

The four independent variables - ambulatory status, responsiveness, behavioral predictability, and medical condition - were represented in either a problem or no-problem condition. The four variables were crossed with each other to provide 16 unique descriptions, each having various combinations of the vignettes' conditions.

Age, sex, intellectual functioning, independence with self care. Obviously, more than four variables can describe individuals who have developmental disabilities. However, given the methodology and its associated limitations in the number of variables that could reasonably be manipulated, some variables were controlled or eliminated from consideration. Age, sex, intellectual functioning, and extent of independence with self-care were included but controlled in the vignettes.

With regard to age, Sternlicht (1978) has reported that developmentally disabled infants and young children are easiest to place, and that individuals of young adult and adult ages fall into age categories that are contraindicated for success. Rosenau and Berger concurred, noting that adolescent placements in particular provide constant challenges for them. In contrast to younger children, who often enjoy stable home lives for many years, Rosenau and Berger noted that placement instability sharply increases during adolescence. They were curious to know how subjects would respond if every description involved an adolescent. To accommodate their interest, a constant age of 14 was set to reflect a midpoint of their agencies' adolescent population. It was assumed that if adolescent age was a deterrent, then subjects would be inclined to indicate greater rejection of all individuals in the vignettes.

With regard to sex, Rosenau and Berger indicated that their residential clientele consists of slightly more boys than girls and that they had no specific perceptions about foster caregivers' gender concerns. Sternlicht (1978) and Haney (1988) have indicated that results concerning the relationships between gender and placement success were equivocal. Because there were no clear guidelines and it was felt that other variables were more important, a flip of the coin indicated that all descriptions would involve male subjects.

In order to ensure that subjects understood that the individuals in the vignettes were severely retarded and needed extensive supervision, the following statement was inserted into each vignette: "_____ is a 14-year old severely retarded male. He needs a lot of help in order to learn how to care for himself." Although the statement was eventually perceived by subjects in a pilot study as nebulous but acceptable (one complained that "it doesn't tell me anything"), results from a manipulation check of the variables revealed the sentence to be an important discriminator for people unfamiliar with the developmentally disabled population.

<u>Other characteristics</u>. The characteristics of race, prognosis, size, weight, involvement of biological parents, ability to communicate with words, and potential for adoption were ultimately excluded from the descriptions of developmentally disabled youngsters.

One might suspect that race could have an impact on foster caregivers' decisions, given the history of difficulties that race has engendered in the American society. However, racial factors do not appear to affect the success of foster care placements (Haney, 1988). Rosenau and Berger indicated that they try to match an individual with foster caregivers of the same racial/ cultural background whenever such matches are possible. Using this informal guideline as a model, it was originally decided that two analogous forms (white and black) of the descriptive measure would be developed and administered in accordance with subjects' race. However, discussions with foster caregivers who assisted with the development of the measure indicated that they would (and had) accept(ed) individual(s) of any race. Consequently, race was deleted from the measure.

Prognosis is often a difficult issue for agencies and caregivers to tackle; it is not easy to articulate what "prognosis" means. If prognosis involves the individual's capacity to live a self-sufficient or independent life, then the prognosis for this group of severely impaired individuals is very poor. On the other hand, if the prognosis concerns the individual's ability to experience and contribute to a successful placement, given the individual's personality and special needs, then prognosis can be viably assessed. Originally, each descriptive vignette included a statement that indicated a "good" prognosis. However, "consulting" foster caregivers thought that the prognosis statement was rather meaningless because it appeared in every description and was written in an ambiguous manner. Prognosis was subsequently deleted from the vignettes.

The literature lacks specific mention of residents' size and weight. However, it makes intuitive sense to assume that both variables impact significantly on caregivers' acceptance decisions, particularly if the potential resident needs a wheelchair or exhibits severe maladaptive behaviors. Indeed, Rosenau and Berger have noted from their experience that tall, large and/or husky individuals are more difficult to place than their smaller, lighter peers. Ultimately, size and weight were excluded from the vignettes for two reasons: (a) their impact seemed obvious; and (b) it was uncertain whether they should be paired together as one variable (which would render separate comparisons impossible) or treated as two separate variables (which would necessitate quadrupling the number of vignettes). Although their exclusion may have added "noise" to the wheelchair and predictability variables, it was felt that information about size and weight could be obtained through a different type of measure.

Finally, ability to communicate with words, potential for adoption, and involvement of biological parents were deemed to be of secondary importance. They were explored through another measure that was not included in the current study.

Combining the Conceptual and Methodological Frameworks

Overall, this study was conceived as an exploratory attempt to gain information about foster caregivers' values and judgment processes. According to Rokeach's (1973) values theory, relationships should be expected to occur between subjects' values, cognitions (i.e., judgments), and behaviors (loosely represented by the experience variable). Thus, the main intent of the study was to determine whether the three subject variables - subjects' values, experience, and judgments about the acceptability of potential residents with certain characteristics - were related in any way.

Three basic questions were examined: (1) Do foster caregivers who have different levels of foster care experience also have differential value patterns? (2) Do foster caregivers who have different levels of foster care experience also make differential judgments about the characteristics of individuals whom they are willing to accept for placement into their homes? (3) Can information about foster caregivers' values provide any clues about the judgments regarding the placement acceptability of various foster care residents?

Hypotheses

Due to the exploratory nature of the study, the three major hypotheses were necessarily broad-based and non-directional. The intent of the main hypotheses was to test for basic group differences. The purpose the secondary hypotheses, which were based more on intuition than on a detailed literature, was to add texture to the hypotheses.

The following hypotheses guided this study:

(1) Subjects' values will differ according to their foster care experience.

(a) The following terminal values will be rated higher by drop-out foster caregivers than by experienced foster caregivers:

(1) A comfortable life
(2) An exciting life
(3) Freedom

Rationale: The basic day-to-day care and time demands that developmentally disabled individuals require are enormous. While the promises of extra money and intrinsic satisfaction may initially propel people to consider work as foster parents, some caregivers may find that the benefits ultimately do not justify the caregiving costs. People who come to realize that the above values are important to them may leave foster care when they learn that the expression of those values is inconsistent with the demands of the care. This hypothesis assumes that the demands of foster care induce a state of self-dissatisfaction that can only be abated when the demands are removed. In contrast, experienced foster caregivers, who may have originally sought foster caregiving for the same economic reasons that other foster caregivers did, somehow may have come to learn that their values are congruent with the demands that foster care requires. Perhaps the values A comfortable life, An exciting life, and Freedom are not as relevant for them in the long run as those values are for foster caregivers who ultimately leave the system.

(b) The following instrumental values will by rated higher by experienced foster caregivers than by foster caregivers in any other group.

(1) Loving
(2) Helpful
(3) Broadminded

Rationale: Among the information obtained in a large-sample (N=2,025) interview study of married women under age 40 and their husbands, Hoffman & Manis (1979) reported that women valued parenthood because it provided them with opportunities to experience usefulness, love and companionship via their children. In congruence with those results, several foster caregivers have expressed motivations along the lines of "wanting to help someone" and "wanting to provide love to someone who might otherwise not have it" (based on informal conversations with foster caregivers during the process of developing this study). Of the instrumental values in the Value Survey, Loving and Helpful correspond most closely with these sentiments. The experience of foster caregiving may facilitate the emergence of Loving and Helpful as major motivators behind foster caring behaviors because these two values, as reflections of parenthood sentiments, are intuitively congruent with the demands of foster care. It was expected that experienced foster caregivers would place a higher premium on the motivating aspects of those two values than would, specifically, drop-out foster caregivers or, less specifically, foster caregivers with less fostering experience.

With regard to Broadminded, informal conversations with foster caregiver consultants revealed that many feel anger and dismay over the lack of acceptance and understanding that they perceive society shows to their foster residents. One may expect that a foster parent's experience with the public might result in a heightened sensitivity toward others' prejudices; the awareness might, in turn, create a reactive response via increased personal salience of the value Broadminded.

(2) Subjects' judgments about the acceptability of potential foster residents will differ according to their foster care experience.

> Subjects who have more experience with foster care will be more willing to accept a wider range of individuals into their homes than will subjects who have less experience.

Rationale: With greater experience, it is assumed that foster caregivers come to realize that a person is a whole, regardless of any disability that the person might have. Anecdotally, many foster caregivers referred to their love for individuals and the joy that they receive from people, regardless of the specific problems that a given individual might have. This hypothesis is based on the assumption that experienced foster caregivers learn to see an individual as a whole person, rather than as an individual with a specific presentation. It was hypothesized that with time, experienced foster caregivers tend to minimize the disabilities, and may tend to accept individuals with a wider range of disabilities than would a foster parent with less experience.

(3) Subjects' preferences and weights on various foster resident characteristics will differ in accordance with their values.

(a) Subjects who indicate a willingness to accept the widest range of residents will rate the following terminal values higher than will other subjects:

(1) Equality
(2) Health

Rationale: It was hypothesized that subjects who rate these items high would tend to conceive of individuals as whole beings who are entitled to good health care, regardless of their deficits. If these subjects believe that everybody, regardless of deficit, deserves an equal chance for comfort, health, and an acceptable quality of life, then perhaps they would be willing to accept individuals with a larger array of deficits than would foster caregivers who do not place as high a priority on the above values.

(b) Subjects who indicate a willingness to accept the smallest range of residents will rate the following terminal values higher than will other subjects:

(1) A comfortable life
(2) Pleasure
(3) An exciting life

Rationale: It was assumed that subjects who rate these values high do so because personal comforts and leisure pursuits are important to them. Some residents' needs are more demanding than are those of other residents; an individual who has tremendously time-consuming needs may not be as desirable to caregivers who value Pleasure, A comfortable life, or An exciting life as a resident who has fewer or less demanding needs might be. It was hypothesized that subjects who place a high value on the above items would be more discriminating about their choices for individuals than would subjects who do not place as much value on them.

METHODOLOGY

Design

This analog study was part of a larger research project that explored various social and developmental characteristics of foster caregivers. The current study examined how caregivers' values and foster care experience impacted on their judgments regarding the placement acceptability of 16 individuals who needed foster homes. Four resident characteristics were systematically manipulated to form a set of 16 original vignettes, each describing one resident. Subjects rated their willingness to accept each of the individuals into their home. The Value Survey (Rokeach, 1973) was used to measure subjects' values. Before analysis, subjects were grouped according to their current involvement with foster care.

The following variables were examined:

1. Caregivers' foster care experience: 5 levels (prospective, new, experienced, dropout, respite)
2. Caregivers' values: 2 sets (terminal, instrumental) of 18 levels each
3. Residents' characteristics: 4 dichotomous variables (predictability of behavior, visual responsiveness, medical condition, ambulatory status)

Subjects

Adult representatives from seventy-seven households in metropolitan Detroit, metropolitan Grand Rapids and the Mt. Pleasant-Clare area participated in the study. Subjects ranged in age from 25-71 years; the mean age was 43.5 years. Seventy-four subjects were female; three were male. The majority of subjects were white, married, had at least a high school education, and lived in urban or suburban areas. Complete demographic information may be found in Appendix A.

The chosen subject was that person who assumed primary caregiving responsibilities for the household. All subjects were prospectively, currently, or formerly employed as foster caregivers for the developmental disabilities regional center in their area. Subjects were classified into one of five "experience" groups according to their responses during data collection.

Subjects' Experience Groups

Prospective Foster Caregivers (PRO) (N=16). These subjects were in the process of applying to become foster caregivers for developmentally disabled individuals. At the time of their interviews, they were in various stages of training. None had received licensure as foster caregivers yet.

New Foster Caregivers (NEW) (N=6). Subjects in this group were licensed foster caregivers who had successfully completed the development process and had received their first placement within one year prior to their involvement in the study.

Experienced Foster Caregivers (EXP) (N=34). These subjects currently held licenses to provide foster care. Each subject in this group had had at least one developmentally disabled placement in his/her home that had lasted at least one continuous year. Although most of the subjects in this group had at least one ongoing placement at the time of their involvement with the study, some were "between placements;" i.e., they were finished with a given placement and awaiting another one.

Drop-out Foster Caregivers (DO) (N=10). Original conceptualizations of subjects who would fit into the dropout group (i.e., subjects would have terminated their involvement with the foster care system within the first year of a placement) were too rigid; only one of five people who met the criteria participated in the study. The definition was expanded to include all former foster caregivers, regardless of the length of their previous involvement with foster care. Although it was still difficult to secure the participation of drop-out caregivers,10 former caregivers with varying degrees of previous foster care experience finally participated in the study.

Respite Only Foster Caregivers (RES) (N=11). During the course of data collection, it was found that eleven subjects provided around-the-clock weekend or vacation care (called "respite care"), but did not otherwise have year-round 24-hour foster care responsibilities. Because it was felt that the experience of those caregivers was sufficiently different from that of other groups, a new category was created late in the study to include subjects who provided only respite care at the time that the interviews were conducted.

Recruitment of Subjects

Subjects were recruited from foster caregiver lists that were given to the experimenter by administrative personnel from each of four state-run developmental disabilities agencies. Initial contacts with subjects were made through an introductory letter that was written on the appropriate agency's stationery and co-signed by an agency employee who was known to each potential subject (Appendix B). Follow-up telephone contacts were made by the experimenter to secure subjects' participation and set up interview appointments.

Random selection procedures were used with the experienced group. However, due to the smaller number of potential subjects in the other groups, it was impossible to maintain random selection for the other four groups.

Instruments

In conjunction with a larger research project, from which the current study has been taken, a battery of instruments was administered to subjects. The ones described here have relevance for the current study.

Rokeach Value Survey (Form G)

Description.The Rokeach Value Survey is a widely researched and popular instrument that purports to measure an individual's ranked system of values. The current instrument consists of "two lists of 18 alphabetically arranged instrumental and terminal values. . . Each value is presented along with a brief definition in parentheses. The instruction to the respondent is to 'arrange them in order of importance to YOU, as guiding principles in YOUR life'." (Rokeach, 1973, p.27).

Throughout the process of development, seven forms (A-G) have been created. Prior to the introduction of the current Form G, Form D had been the most widely used. Form D consisted of two pages of 36 individual removable gummed labels (18 per page). Each label contained the name of one value, along with a few descriptor terms in parentheses. Subjects placed the value labels on each page in rank order according to their personal value priorities.

Form D was replaced by Form G in 1982. Form G, which utilizes the same gummed-label format, differs from D by two content modifications: Health replaced Happiness and Loyal replaced Cheerful In all other respects, Forms G and D are identical (Mueller, 1984) .

Psychometric properties. Considerable efforts have been made to establish the instrument's stability. Form D had the highest reliabilities of the first five forms (Rokeach, 1973). Median test-retest reliabilities for Form D, obtained from seven samples, ranged from .62 to .80 for terminal values, and from .53 to .72 for instrumental values. Additional median test-retest reliabilities were obtained through the method of paired comparison with comparable results (Penner, Homant & Rokeach, 1968). Product-moment test-retest reliabilities for individual values ranged from .51 to .88 for terminal values, and from .45 to .70 for instrumental values (Rokeach, 1973).

The ipsative nature of the Value Survey makes it prone to violating assumptions of independence across individuals. Rokeach (1973) addressed the issue by computing intercorrelations between the 36 values, using a data set from 1409 subjects. The average intercorrelation was -.06 for each set of values; the highest positive and negative correlations were in the .30s. Rokeach concluded that although ipsativity was not a significant problem for the Value Survey, it should be considered when interpretations are made. His assessment was supported by Mueller (1984), Cohen (1978), and Kitwood (1978).

The Value Survey measures neither the relative distance between individual rankings nor the strength that each value has for a given individual. In addition, individual values may not be completely independent of each other. Rokeach (1973) has found evidence for seven factors, each accounting for no more than 8% of the variance. Eight factors were identified by Heath & Fogel (1978) when they asked subjects to rate instead of rank the two lists of values.

Despite its limitations, Rokeach (1973) has contended that the Value Survey is a reasonably reliable instrument that can be used in a variety of research and practical situations. His conclusions have been supported by Cohen (1978), Kitwood (1978), and Mueller (1984) insofar as research is concerned. However, due to low individual scale score reliabilities, caution has been extended regarding applied uses of the Value Survey (Cohen, 1978; Mueller, 1984). Overall, there is agreement by reviewers that the instrument provides a viable vehicle for the study of values (Cohen, 1978; Kitwood, 1978; Mueller, 1984).

Vignettes

Description. The vignettes measure consists of 16 separate pages, each containing one original vignette and one reaction question. Each vignette describes characteristics of a specific adolescent who is "available" for placement. The descriptions are based on unique combinations of four dichotomous independent variables and four control variables. Subjects are asked to indicate the extent of their willingness to accept each child for placement into their homes, given the information in each vignette. The measure is located in Appendix C.

Test construction. Three rules guided the measure's construction: (a) the vignettes had to include realistic descriptions of prototypic individuals; (b) descriptions had to be precise, both to minimize the risk of misrepresentation and to ensure that subjects focused their attention on relevant concepts; (c) the vignettes had to be written in simple language so that subjects could understand them. The vignettes measure underwent a series of manipulation checks before its completion. In addition, as part of a pilot study, the measure was administered to foster caregivers in the metropolitan Lansing area prior to the actual data collection (both are described below).

Summary of the variables. The following variables were crossed to create 16 unique descriptions:

1. Behavioral predictability (2 levels):
    a. The child's behavior is predictable. He can be comfortably left out of sight for at least a few minutes during waking hours while the caregiver is in another area of the house. The caregiver can be fairly confident that the individual will stay in the same place and will not injure himself or interfere with other things in the room.
    b. The child's behavior is unpredictable. The caregiver can never be sure of what he will do next. He may hit himself or others, throw things during a temper tantrum, or act up for no apparent reason.

2. Social (visual) responsiveness (2 levels):
   a. The child is able to look directly at the caregiver and can communicate some level of understanding.
   b. The child seldom looks directly at the caregiver and often seems to lack an understanding of what the caregiver says to him. Social withdrawal from the environment is not unusual.
3. Medical condition (2 levels):
   a. The child has a medical condition (diabetes mellitus; unspecified in vignettes) that requires daily medications and a special diet. Occasionally, when the condition gets out of control on its own, additional care is needed to counteract the risk of serious consequences increases. Foster caregivers can be trained to manage the condition.
   b. The child has no special medical condition and no special medical monitoring needs.
4. Ambulatory status (2 levels):
   a. The child can walk only very short distances with assistance. He needs a wheelchair for sitting and extended ambulation.
   b. The child can walk independently. He has no need for a wheelchair.

The following variables were controlled in all vignettes:

1. Sex: boys only
2. Age: 14 years old
3. Intellectual functioning: severely retarded

4. Extent of care: each child needs a great deal of help in order to "learn how to care for himself."

Reaction to vignettes. At the bottom of every vignette page is a 7-point reaction scale with anchors of "I am virtually sure that I would accept him" (1) and "I am virtually certain that I would not accept him" (7). Subjects are asked to circle the number corresponding to the statement that best describes their degree of willingness to accept the person into their home, given only the information provided in the vignette.

Manipulation checks. During their development, the vignettes, in their various forms, were administered to subjects who had little, if any, experience with developmentally disabled people and who otherwise were not involved with the study. The variables were rated according to face validity. A variable was considered valid when 10 of 10 subjects answered descriptive questions about the vignettes with 100% accuracy. Revisions and retests continued until each variable met the criterion. The current set reflects the final revision. The manipulation check questionnaire is included in Appendix D.

Pilot study.The vignettes measure was included in a pilot study on 10 foster caregiver subjects who were otherwise not involved with the actual study. The caregivers were recruited through the Clinton-Eaton-Ingham Community Mental Health Board (Community Services for the Developmentally Disabled) via introductory letters on agency stationery that were co-signed by the experimenter and a placement specialist (Appendix A). Follow-up phone calls were made by the experimenter to secure participation. The purpose of the pilot study was two-fold: (a) to examine subjects' responses to the instruments so that necessary revisions could be made before the actual study began; (b) to collect subjective impressions from foster caregivers in a consultative role. Revisions on the vignettes measure was made as a result of the pilot study. The current measure reflected the results of the pilot study.

Experimenters

All data were collected by the author.

Procedure

Subjects were interviewed in their own homes. Although the use of the subjects' homes introduced noise into the experiment (e.g., interruptions due to other people or telephones, lack of experimental control within setting), it was felt that potential subjects would be most willing to participate if the data were collected in a setting that was convenient and comfortable for them.

At the onset of the testing session, subjects received information about the study (Appendix E) and signed a research consent form that affirmed their voluntary participation (Appendix F). Demographic information was collected next. This was followed by, in order, the vignettes measure, The Value Survey, and two other questionnaires that were not included in the current study. After all measures were completed, subjects were debriefed and thanked. The entire procedure lasted about 2 hours.

Ethical Considerations

The rationale, purpose, and design of the current study were submitted to the Michigan State University Committee for Research Involving Human Subjects (UCRIHS) for approval before any subject recruiting efforts or data collection procedures began. Subjects' data were kept confidential and anonymous; code numbers were used in place of subjects' names. The signed permission forms were stored separately from the data. Although cooperating agencies supplied names of potential subjects to the experimenter, they were informed of respondents' identities only through the participants themselves.

Data Analysis

The data collected during the study were analyzed in two basic steps. The first step involved the generation of subjects' policy statements. The second step involved comparisons between subjects' policy statements, foster care experience, and values. All analyses were performed through Systat 3.01, a statistical package for microcomputers.

Subjects' Policy Statements

Because the 16 vignettes were balanced with respect to all possible combinations of the four resident characteristics, the design enabled 5 weights (four reflecting each of the four characteristics; one reflecting subjects' mean response to the variables) to be calculated through multiple regression analysis on each subject's responses to the set of vignettes. Seventy-seven separate main effects regression analyses (one for each subject) were conducted. The resulting weights comprised the subject's "policy statement." After the weights were generated for all 77 subjects, they were treated like any other data points and used in conjunction with other analyses.

Analysis of the Hypotheses

Subjects were initially grouped into five categories on the basis of their foster care experience. Following preliminary analyses, the groups were collapsed into three larger groups.

Three-group comparisons involved a combined Prospective/New (PRO/N) group, a combined DropOut/Respite (DO/R) group, and the Experienced (EXP) group. The PRO/N group was formed on the rationale that about 95% of prospective foster parents eventually receive placements (L. Berger, personal communication, July 20, 1988). The DO/R combination assumed that both groups were more similar to each other than to other groups because their foster care involvement was limited by choice.

Comparisons involving the 3-level experience variable sought to determine whether the groups differed on individual values or policy statement weights. Correlational analysis was used to determine the relationship between individual values and policy weights.

Missing Data

Five subjects chose to ignore some values in the Value Survey. Two reasons for the omissions were offered: (a) certain values were extremely important but unquantifiable (one subject called her unselected values "gifts"); or (b) the unselected values were not at all important. Because there was no meaningful way to capture subjects' intentional deletions, missing values data were treated as piecewise deletions and left uncorrected.

RESULTS

Before actual analyses could be performed, it was necessary to calculate 77 individual policy statements to "capture" every subject's response to the 16 vignettes. Each statement consisted of 5 weights: four describing how a given subject weighted each of the four resident characteristics when making judgments about a potential resident's placement acceptability; the fifth describing the subject's overall judgment behavior. After they were calculated, the weights were able to be used like any other variable. Each weight represented an aspect of subjects' judgment in analyses with other variables.

Data Coding and the Formation of Subjects' Policy Statements

The four dichotomous resident characteristics were coded according to their orientation in the vignettes. The "no-problem" condition of a variable was coded "-1." The presence of a problem was coded "1." For each variable, 8 descriptions of the problem condition were dispersed through the vignettes; they were balanced by 8 descriptions of the no-problem condition. The coding scheme enabled each variable to have a coded value mean of 0 across the 16 vignettes.

All 16 possible combinations of the four characteristics were represented in the coding scheme. For example, one vignette described an individual whose behavior was predictable and responsive, who had no medical needs, and who used a wheelchair. That individual's characteristics were coded -1 -1 -1 1. Another vignette described an individual who had unpredictable behavior, was socially responsive, had a medical condition, and was ambulatory. His coded description was 1 -1 1 -1. Each combination had an associated judgment score of between 1 (virtually certain to accept) and 7 (virtually certain not to accept) that had been assigned by subjects to indicate the extent of their willingness to accept the individual who had that particular combination of characteristics.

A main effects model guided the generation of policy statements. Using the judgment score as the criterion, and the four characteristics as predictors, multiple regression analysis was performed on each subject's responses to the set of vignettes. The resulting coefficient on each predictor represented the weight that a given subject placed on that predictor when making his or her acceptance judgment. The smaller the weight, the less important it was to a subject. The constant's resulting coefficient, labelled here as the "mean judgment score" (MJS), represented the subject's general weighted willingness to accept the group of individuals. It was always a positive number that ranged from 0 to 7. Smaller mean judgment scores indicated greater acceptance of the total group; larger scores, greater rejection.

Directionality of judgments was indicated by each weight's sign. A positive weight represented greater acceptance of a variable's no-problem condition (e.g., predictable behaviors). Negative weights represented greater acceptance of a variable's problem condition (e.g., unpredictable behaviors).[2]

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[2] Technically, from the coding scheme, positive weights indicated greater rejection of a variable's problem condition; negative weights indicated greater rejection of the

Each subject's policy statement weights (four main effects and one MJS), and the associated multiple R^2, adjusted multiple R^2, and standard error of estimate are described in Appendix G. The adjusted multiple R^2 had a mean of .69; the mean of the adjusted multiple R^2 was .59. The fact that the main effects model accounted for, on average, almost 70% of this particular sample's variance and almost 60% of the variance after adjustment for error suggests that it was a reasonably good paramorphic representation of subjects' foster care acceptance decisions.

In order to enhance interpretation of the results, three subjects' policy statements from Appendix G will be compared. Subject 1 (S1) indicated that she was virtually certain to accept each of the 16 children, regardless of their characteristics. In contrast, Subject 24 (S24) was inclined to accept the group of children for placement into her home, but she had some reservations. A given child's behavioral predictability and ambulatory status were more important to her than the child's responsiveness or medical needs. A child who had calm behavior was more acceptable to her than one who displayed behavioral unpredictability; in contrast, a wheelchair-bound resident was preferred to someone who walked. The main effects model accounted for 72% of the variance in S24's judgments; 62% when adjusted for error. The standard error of estimate was large; i.e., there was substantial variability among S24's individual judgment scores along the 7-point scale.

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variable's no-problem condition. However, given the dichotomous nature of the variables, the obverse was also true. Because it is conceptually easier to think in terms of acceptance than rejection, interpretations focused on acceptance rather than rejection of the variable's conditions.

Subject 47 (S47) demonstrated a completely different pattern. Her policy indicated a preference for individuals who had more problematic characteristics. She gave greater weight to children who had unpredictable behaviors to those who were more predictable. A youngster who was unresponsive or who had a medical condition was likely to be found more acceptable than his responsive or healthy counterpart; however, medical condition and responsiveness were not given as much weight as predictability or ambulatory status. S47 was less willing to accept an individual if he used a wheelchair. Overall, S47 was inclined to accept the group of children. The main effects model accounted for 75% of the variance; 65% when adjusted for error. From the standard error of estimate, S47's judgments varied considerably along the 7-point scale.

Once the policy weights were established, they were treated like any other variable. During analysis, the policy weights were either grouped together into categories for tests requiring analysis of variance (ANOVA) or used in conjunction with correlational analysis.

Results from Hypothesis 1. Subjects' value patterns will differ in accordance with their foster care experience.

Preliminary ANOVA tests on the 36 value means were performed for the five experience groups to determine whether they could be collapsed into larger groups for more meaningful analysis. The objective was to combine the Prospective and NEW groups into a PRO/N group, which would have a sample size of 22, and to combine the DropOut and Respite groups into a DO/R group, with a sample size of 21. The Experienced group, with its sample size of 34, would remain intact.

Only one terminal value, Family security, and one instrumental value, Imaginative, presented potential barriers to the desired collapse. Omnibus F tests on the two values, presented in Table 1, demonstrated sufficient significance to warrant further scrutiny of each value. The results from each value's ANOVA tests on the effects for the PRO vs. NEW and RES vs. DO groups are described in Table 2.

According to Table 2, there were no differences between the PRO and NEW groups on either Family security or Imaginative; thus, those groups could be collapsed into one without further concern. However, because the RES and DO groups' mean value ranks for both Family

Table 1

Significant Value Means and Standard Deviations
For Five Groups Varying in Foster Care Experience

	Experience Groups						
Value	PRO (n=16)	NEW (n=6)	EXP (n=34)	RES (n=11)	DO (n=10)	df	F
Family security	3.19[a]	3.83	4.38	3.00	6.40	4,72	2.442*
	2.51[b]	2.23	3.19	1.79	3.66		
Imaginative	16.00	16.00	14.52	9.40	13.60	4,68	5.147**
	3.25	3.46	3.75	4.33	4.48		

[a] mean rank
[b] standard deviation
* p < .06
** p = .001

Table 2

Effects of Family Security and Imaginative on
PRO vs. NEW and RES vs. DO Value Patterns

	FAMILY SECURITY [a]		IMAGINATIVE [b]	
Comparison	df	F	df	F
PRO vs. NEW	1,72	.216	1,68	.000
RES vs. DO	1,72	7.174**	1,68	6.027*

[a] N = 77
[b] N = 73
* p < .05
** p < .01

security and Imaginative were significantly different from each other, combining the two groups into one had the potential of producing distorted results.

To reconcile the problem, the following rationale and solution were adopted. Because the Value Survey is an ipsative measure, changes in the mean rank of one terminal value (e.g., Family security) and one instrumental value (e.g., Imaginative) could potentially affect the composite rank order on all values in each value set. By extension, the same could be true for a collapsed group when the individual group members had significant differences on one terminal and one instrumental value. Although collapsing the groups might produce distortions in each value set's composite rank order, not collapsing the groups would prohibit larger-group analyses. Because the benefit of having access to larger sample sizes outweighed possible ranking difficulties produced by individual group differences on two values, the

DO and RES groups were collapsed into one DO/R group; however, interpretations involving DO/R group results considered the individual differences that the DO and RES groups each brought to the combined whole.

Table 3 describes the mean value ranks, standard deviations, composite rank orders, and omnibus ANOVA tests for the three reformulated experience groups. Among the terminal values, only the test for A world of beauty indicated significant differences between groups at the .05 level. Three instrumental values - Imaginative, Independent and Obedient - also demonstrated significant differences between groups. Interestingly, all four values were ranked within the lower half of the Value Survey for every group, with the exception of EXP subjects' ranking of Independent.

Examination of Table 3 indicates similar value patterns among groups. The top four terminal values for all groups, not necessarily in order, were Family security, Health, Self respect, and Wisdom. The bottom five values included An exciting life, A world of beauty, National security, Pleasure, and Social recognition. In all groups, Salvation, a value that is often polarized (Rokeach, 1973), had the largest standard deviation among the terminal values. Health, Family security, Social recognition, National security, and A world of beauty had the smallest standard deviations. With few exceptions, the ranks of individual terminal values varied among groups by no more than four positions.

Table 3

Value Means, Standard Deviations, Composite Rank Orders and ANOVA Tests for Groups Varying in Foster Care Experience

Values	Experience groups			df	F
	PRO/N (n=22)	EXP (n=34)	DO/R (n=21)		
Terminal Values					
A comfortable life	9.727 [a](11)[b] 4.920 [c]	12.382(13) 4.723	11.810(14) 4.468	2,74	2.196
An exciting life	14.500 (18) 3.543	12.909(14) 4.766	12.500 (15) 4.286	2,71	1.282
A sense of accomplishment	9.762(12.5) 3.659	9.618(9) 4.639	7.476(5) 4.250	2,73	2.006
A world at peace	9.619(9) 4.577	9.706(10) 4.583	11.619(13) 4.399	2,73	1.404
A world of beauty	14.238(16.5) 3.254	13.324(16.5) 3.282	11.550(12) 3.187	2,72	3.644*
Equality	9.682(10) 4.236	10.588(12) 4.912	9.900(11) 4.278	2,73	.302
Family security	3.364(1) 2.401	4.382(2) 3.191	4.619(1) 3.263	2,74	1.108
Freedom	8.357(8) 3.864	7.176(5) 4.210	7.500(6) 3.846	2,72	.567
Health	3.857(2) 2.287	4.059(1) 2.335	4.952(2) 4.129	2,73	.866
Inner harmony	8.341(7) 4.390	7.588(6.5) 6.634	7.857(7) 4.640	2,74	.185
Mature love	9.762(12.5) 4.403	9.912(11) 4.575	8.000(8) 4.735	2,72	1.214

[a] mean ranks of values

[b] composite rank orders

[c] standard deviations

* $p < .05$

Table 3 (cont'd)

Values	Experience groups			df	F
	PRO/N (n=22)	EXP (n=34)	DO/R (n=21)		
National security	12.476[a](14)[b] 3.696[c]	13.294(15) 3.881	13.600(16) 3.299	2,72	.526
Pleasure	14.238(16.5) 4.265	13.324(16.5) 3.263	13.700(17) 4.105	2,72	.378
Salvation	6.667(5) 6.053	7.588(6.5) 6.634	9.650(10) 6.945	2,72	1.120
Self respect	5.568(3) 3.755	5.706(3) 3.020	5.476(3) 4.285	2,74	.028
Social recognition	14.227(15) 4.275	14.303(18) 3.097	15.050(18) 3.017	2,72	.406
True friendship	8.091(6) 4.275	8.706(8) 2.855	8.143(9) 3.425	2,74	.276
Wisdom	6.591(4) 3.800	6.206(4) 3.914	6.650(4) 5.224	2,73	.089
<u>Instrumental Values</u>					
Ambitious	9.545(9) 4.585	8.364(6) 5.482	10.325(12) 4.531	2,72	1.023
Broadminded	8.238(7) 4.867	8.667(9) 4.878	9.350(8) 4.614	2,71	.279
Capable	9.091(8) 4.566	10.303(11) 4.334	8.595(6) 4.283	2,73	1.094
Clean	9.773(11) 5.920	12.212(15) 4.662	12.350(15) 4.464	2,72	1.924
Courageous	9.571(10) 4.545	9.727(10) 3.719	9.750(9) 4.822	2,71	.011

Note: No tests were significant at the .05 level.

[a] mean ranks of values

[b] composite rank orders

[c] standard deviations

Table 3 (cont'd)

Values	Experience groups PRO/N (n=22)	 EXP (n=34)	 DO/R (n=21)	df	F
Forgiving	6.477 [a](4)[b] 4.702[c]	6.333(4) 3.974	7.381(4) 4.738	2,73	.390
Helpful	7.190(5) 3.628	9.030(9) 4.462	7.750(5) 4.644	2,71	1.303
Honest	3.000(1) 1.604	3.545(1) 2.885	4.333(2) 3.168	2,73	1.353
Imaginative	16.000(18) 3.212	14.515(17) 3.751	11.500(14) 4.796	2,70	6.885**
Independent	11.381(15) 3.905	8.030(5) 4.246	9.762(10) 5.485	2,72	3.563*
Intellectual	13.810(17) 3.558	12.636(16) 4.300	12.850(16) 4.557	2,71	.530
Logical	12.500(16) 3.426	12.030(14) 3.869	13.095(17) 3.767	2,71	.526
Loving	5.727(2) 5.016	3.818(2) 2.888	3.476(1) 3.311	2,73	2.399
Loyal	7.905(6) 5.621	8.545(7) 5.044	8.667(7) 4.747	2,72	.139
Obedient	10.833(13) 4.334	14.727(18) 3.931	14.150(18) 4.221	2,71	6.091**
Polite	11.000(14) 4.094	11.939(13) 3.517	11.150(13) 3.760	2,72	.501
Responsible	6.318(3) 3.578	5.970(3) 3.566	5.238(3) 2.862	2,73	.571
Self-controlled	10.650(12) 4.043	10.758(12) 4.352	10.000(11) 5.452	2,71	.185

[a] mean ranks of values
[b] composite rank orders
[c] standard deviations
* $p < .05$
** $p < .01$

Instrumental values showed similar patterns. The top four values were Honest, Loving, Responsible, and Forgiving, though not necessarily in that order. Imaginative, Intellectual, Logical, and Obedient tended to hover near the bottom of the list. The smallest standard deviations occurred across groups among Honest, Loving, Responsible, and, for the PRO/N and EXP groups, Imaginative. Clean, Ambitious, and Independent had the largest standard deviations among the values for the PRO/N, EXP, and DO/R groups, respectively. With few exceptions, the ranks of individual instrumental values varied among groups by no more than four positions.

Table 4 details ANOVA tests on the effects for the four significant value differences. From Tables 3 and 4, A world of beauty was significantly less important for DO/R subjects than for PRO/N subjects. The opposite effect occurred for Imaginative. EXP subjects valued Independent significantly more than either of the other groups did. Obedient was significantly more important for PRO/N subjects than for their EXP counterparts.

There were minimal effects on the results from Family security when the five groups were collapsed into three. In combination, the lower DO group mean rank suppressed significant differences that had occurred between the PRO and DO groups before the five groups were collapsed (Tables 2 and 3). However, from Tables 3 and 4, the DO group mean rank did not affect the composite rank of 1 that Family security had in the DO/R group, nor did it cause the DO/R group's mean rank of Family security to be significantly lower than the other two groups' mean ranks.

In contrast, the differences between the RES and DO groups' mean ranks on Imaginative had reverberations in the combined DropOut/Respite group. The RES group's higher ranking on Imaginative likely affected the DO/R group's composite rank order on Imaginative, Clean, and Intellectual (ranked 14, 15, and 16, respectively, Table 3) by elevating the mean rank more than it would have been had the DO group been combined with any other group.

Table 4

Effects of A World of Beauty, Imaginative, Independent and Obedient on Value Patterns

	A World of Beauty[a]		Imaginative[b]		Independent[c]		Obedient[d]	
Comparison	df	F	df	F	df	F	df	F
PRO/N vs EXP	1,72	1.028	1,70	2.074	1,72	6.238*	1,71	10.843**
PRO/N vs DO/R	1,72	7.011**	1,70	7.241**	1,72	.040	1,71	3.114
EXP vs DO/R	1,72	3.751	1,70	2.641	1,72	4.507*	1,71	1.217

[a] N = 75
[b] N = 73
[c] N = 75
[d] N = 74
* p < .05
** p ≤ .01

Comparisons among Tables 1, 2, 3, and 4 describe the changes that occurred on Imaginative when the DO and RES groups were combined. The lower DO mean value rank lowered the combined group's mean value rank sufficiently to eliminate significant differences that occurred between the EXP and RES groups (F[1,72]=13.722, p < .001) before the groups were collapsed (Table 1). However, it did not obliterate the highly significant differences that occurred between the

PRO vs. RES (F[1,72]=17.722, $p < .001$) and NEW vs. RES (F[1,72] = 9.722, $p < .01$) groups; rather, the extent of the difference was lessened (Tables 3 and 4).

It had been hypothesized (Hypothesis 1a) that the terminal values A comfortable life, An exciting life, and Freedom would be rated higher by dropout foster caregivers than by experienced foster caregivers. As indicated by Table 3, the hypothesis was not supported. Similarly, it had been hypothesized (Hypothesis 1b) that the instrumental values Loving, Helpful, and Broadminded would be rated higher by experienced foster caregivers than by caregivers in any other group. According to Table 3, that hypothesis also was not supported.

Finally, regression analysis was performed on each value, using the ungrouped variable number of years foster care experience (defined as the total number of years that subjects were involved with foster care, regardless of their current status) as the predictor. None of the 36 regression equations were significant.

<u>Results from Hypothesis 2</u>. Subjects' judgments about the acceptability of potential foster residents will differ according to their foster care experience.

Preliminary analysis of variance tests were performed for the five experience groups to determine whether they could be collapsed for further analysis. Only one variable, medical condition, approached significance (F[4,72] = 2.362, $p < .07$). Its effects are presented in Table 5. Considering that significant effects involved only the smallest group (NEW), a decision was made to collapse the groups into

Table 5

Effects of Medical Condition on Policy Weights for Five Experience Groups

Comparison	Medical Condition df	F
PRO vs. NEW	1,72	7.245**
PRO vs. EXP	1,72	.491
PRO vs. RES	1,72	.018
PRO vs. DO	1,72	.214
NEW vs. EXP	1,72	5.906*
NEW vs. RES	1,72	5.932*
NEW vs. DO	1,72	8.159**
EXP vs. RES	1,72	.213
EXP vs. DO	1,72	1.230
RES vs. DO	1,72	.299

N = 77
* $p < .05$
** $p < .01$

the 3-group Prospective/New, Experienced, and DropOut/Respite scheme.

The means of the three groups were compared via ANOVA tests. Table 6 lists the five policy weights and mean judgment score, along with each variable's standard deviation and omnibus ANOVA tests, for the reformulated groups. Table 7 details the ANOVA tests on the effects for responsiveness (Respond) and the mean judgment score (MJS). Table 8 contains results from paired T-tests on each group's mean weights.

From Tables 6 and 8, subjects' judgments were influenced significantly more by a potential resident's behavioral predictability than by any other characteristic. The other three characteristics (not including MJS) received either small or negligible weights from subjects. The no-problem conditions were preferred whenever characteristics were weighted.

Table 6

Mean Policy Weightings, Standard Deviations, and Omnibus ANOVA Tests For Groups Varying in Foster Care Experience

Resident Characteristics	Experience Groups PRO/N (n=22)	EXP (n=34)	DO/R (n=21)	df	F
MJS	3.142 [a] 1.880 [b]	3.441 1.164	4.301 1.545	2,74	3.501*
PREDICT	.324 .605	.632 .727	.697 .566	2,74	2.111
RESPOND	- .034 .263	.195 .417	.180 .277	2,74	3.329*
HEALTHY	.261 .613	.206 .340	.097 .219	2,74	.886
WALK	.301 .689	.287 .964	.204 .751	2,74	.087

[a] mean weight
[b] standard deviation
* $p < .05$

Table 7

Effects of Responsiveness and Mean Judgment Score on Subjects' Acceptance Judgments

	RESPOND		MJS	
Comparison	df	F	df	F
PRO/N vs. EXP	1,74	5.929*	1,74	.531
PRO/N vs. DO/R	1,74	4.169*	1,74	6.403*
EXP vs. DO/R	1,74	.024	1,74	4.257*

N = 77
* $p < .05$

Table 8

Paired T-tests on the Four Resident Characteristics For Groups Varying in Foster Care Experience

Test	PRO/N[a]	EXP[b]	DO/R[c]	TOTAL[d]
	t	t	t	t
Predict vs Respond	3.083**	2.927**	3.917***	5.354***
Predict vs Healthy	.350	2.995**	4.707***	4.100***
Predict vs Walk	.104	1.465	2.006	2.116*
Respond vs Healthy	1.866	.125	1.204	1.037
Respond vs Walk	2.095*	.518	.134	1.393
Healthy vs Walk	.183	.460	.602	.698

[a] N = 22, df=21
[b] N = 34, df=33
[c] N = 21, df=20
d N = 77, df=76

* $p < .05$
** $p < .01$
*** $p \leq .001$

From Tables 6 and 8, the PRO/N group gave Predict, Walk, and Healthy almost equal weight in their acceptance judgments. In contrast, Respond was of negligible importance to PRO/N subjects. The NEW group's elevated weight on Healthy was expressed primarily through the standard deviation, which was relatively high in comparison with that of the other two groups. Although NEW's weight on Healthy did not cause the PRO/N group's weight to differ significantly from the other groups, it likely minimized any PRO/N intragroup differences that may otherwise have occurred between Predict and Healthy (Table 8). According to the MJS, PRO/N subjects were generally inclined to find the individuals acceptable for placement.

EXP subjects gave Predict more weight on acceptance judgments than Walk and significantly more weight than either Respond or Healthy. Walk and Healthy essentially had the same level of importance for the EXP group as for the PRO/N group (Table 6). Although Respond was not particularly important for any subjects, it was significantly more important for the EXP group than for PRO/N subjects (Table 7). EXP subjects were as inclined as the PRO/N subjects to accept the overall group of individuals for placement.

Finally, from Table 7, the DO/R group significantly rejected more individuals than the other two groups. Like their EXP peers, they also placed significantly greater weight on Respond than the PRO/N group. Apart from having larger intragroup differences among weights, the ordering of DO/R subjects' weights resembled that of their EXP peers (Tables 6 and 8).

Overall, PRO/N and EXP subjects were more inclined to accept the group of individuals; DO/R subjects were less inclined to do so. Although Respond was not particularly important to subjects when they made their acceptance decisions, it was significantly less important to PRO/N subjects than it was to the other groups. Apart from those differences, the three groups of subjects related to the vignette characteristics in a very similar way.

The secondary hypothesis proposed that experienced subjects would demonstrate a greater willingness to accept a wider range of individuals into their homes than their less experienced counterparts would. When the hypothesis was originally developed, "less experienced" referred to all subjects in non-EXP groups. However, during the course of the study, the definition of "Dropout" was altered and the Respite group was added; the result was that some subjects who met criteria for the EXP group were placed instead into another group. Thus, the test of this hypothesis came to involve comparisons on MJS between PRO/N and EXP groups. As presented in Table 6, the hypothesis was not supported.

Finally, regression analysis was performed on MJS, using the variable number of years foster care experience as the predictor. This analysis afforded a glimpse into the relationship between MJS and foster care experience without interferences from current foster care status. The secondary hypothesis was also unsupported by this analysis (F[1,75] = .021).

Results from Hypothesis 3. Subjects' preferences and policy weights on various resident characteristics will differ in accordance with their values.

Listwise Pearson correlations were used to test this hypothesis. All correlations involved 72 data points; the data from 5 subjects who had incomplete values information were omitted. The results are presented in Table 9.

There were six significant relationships between values and weights. Four correlations were significant at the .05 level; two were significant at the .01 level. Because ranks and weights had opposite meanings (i.e., the smaller the value rank, the greater its importance; the smaller the policy weight, the lesser its importance), negative correlations indicated that both variables had corresponding levels of relative importance; positive correlations indicated that the variables had inverse levels of relative importance.

Significant positive correlations occurred between Helpful-Predict, Courageous-Respond, Salvation-Respond, and Loving-Healthy ($p < .01$). These may be interpreted as follows: the greater the importance of the value, the lesser the weight of the characteristic.

Significant negative correlations occurred between A world of beauty - Mean judgment score ($p < .01$) and Clean-Healthy. Higher ranks on Clean were associated with larger weights on Healthy. Higher rankings on A world of beauty were associated with greater rejection of the overall set of children.

Table 9

Pearson Correlations Between Values and Vignette Weights

Terminal value	MJS	Predict	Respond	Healthy	Walk
A comfortable life	.072	.069	.122	-.104	.064
An exciting life	-.069	-.036	.032	-.018	-.080
A sense of accomplishment	.153	-.072	.072	.042	-.011
A world at peace	.119	.056	-.088	-.195	.045
A world of beauty	-.304**	.020	-.127	.137	-.222
Equality	.130	.014	-.090	.056	-.088
Family security	.004	.036	-.002	.190	.156
Freedom	.017	-.043	-.003	.071	-.007
Health	-.138	.108	-.052	-.073	.019
Inner harmony	-.087	-.108	-.171	-.051	.224
Mature love	.050	-.149	-.038	.157	.115
National security	.123	.141	.166	.008	-.155
Pleasure	-.131	-.222	-.205	-.106	-.055
Salvation	-.048	.069	.232*	-.141	.014
Self-respect	-.097	-.053	.045	-.103	-.050
Social recognition	.194	-.023	.043	.134	-.151
True friendship	.109	.111	.099	.173	-.011
Wisdom	-.092	.126	-.150	.138	.095

N = 72.

* $p < .05$.

** $p < .01$.

Table 9 (cont'd.)

Instrumental value	MJS	Predict	Respond	Healthy	Walk
Ambitious	-.078	-.119	-.210	.018	-.094
Broadminded	-.016	.010	-.033	-.089	-.081
Capable	.018	-.105	-.008	.214	-.124
Clean	-.012	.142	.130	-.234*	-.032
Courageous	-.018	-.215	.286*	.029	.014
Forgiving	.158	.134	.026	-.048	.111
Helpful	-.008	.255*	-.166	.167	.064
Honest	.151	.045	.066	-.093	.205
Imaginative	.087	-.013	-.010	.150	.049
Independent	-.063	.054	.045	-.064	-.119
Intellectual	.073	.154	-.013	.040	-.030
Logical	-.062	-.034	.003	.084	.000
Loving	.002	.003	-.005	.374**	-.033
Loyal	-.057	-.064	.147	-.034	.059
Obedient	-.128	.109	.061	-.230	.083
Polite	-.022	-.187	-.226	-.192	-.120
Responsible	.097	-.100	-.148	.114	-.036
Self-controlled	.134	-.077	.010	-.094	.147

N=72.

* $p < .05$.

** $p < .01$.

Hypotheses 3a and 3b proposed that the mean judgment score would have significant correlations with Equality, Health, A comfortable life, Pleasure, and An exciting life. From Table 9, neither of these hypotheses were supported.

According to probability estimates, nine correlations in the entire set may have been significant by chance (36 X 5 X .05 = 9). The possibility must be considered that some of the significant correlations may have reflected Type I errors.

Summary of the Results

Overall, the value patterns among the three groups were remarkably similar. For all groups, the highest ranked terminal values were Family security, Health, Self-respect and Wisdom. For all groups, the highest ranked instrumental values included Honest, Loving, Responsible, and Forgiving. Most values fell within four consecutive ranks among groups.

There were four significant value differences among groups: (a) A world of beauty was significantly less important for the DO/R group than the PRO/N group ($p < .01$); (b) Imaginative was significantly more important for the DO/R group than the PRO/N group; (c) Obedient was significantly more important for the PRO/N group than the EXP group ($p < .01$); and (d) Independent was significantly more important for the EXP group than for all other subjects.

The groups' reactions to the vignettes were also similar. As a whole, the sample gave predictability of behavior significantly more weight than any other characteristic. They also indicated greater acceptance of children who had no-problem conditions. Although responsiveness was not particularly important for any group, the Prospective/New group gave the characteristic significantly less weight than the other groups did. DropOut/ Respite subjects expressed significantly less willingness to accept the set of children than did any other group. With regard to subjects' policy statements, the main effects regression model accounted for 69% of the mean variance and 59% of the adjusted mean variance.

There were six significant correlations between the 36 values and the 5 vignette variables. Five variable pairs were significantly related in an inverse manner. They included: (a) Helpful-Predict, (b) Courageous-Respond, (c) Loving-Healthy, and (d) A world of beauty-Mean judgment score. Only Clean-Healthy were significantly related in a corresponding manner.

DISCUSSION

As expected from the exploratory nature of the research, the results raised more questions than they answered. This section will discuss several dimensions of the research. First, an elaboration of the results will occur. This will be followed by a methodological review. Finally, the entire study will be appraised from both theoretical and practical perspectives.

Foster Parents' Values

Although the specific hypotheses in Hypothesis 1 were not supported, there was some support for the general hypothesis that the groups' values would differ according to their experience. Four unpredicted significant results occurred: (a) PRO/N subjects ranked Obedient significantly higher than their EXP counterparts did, but not significantly higher than DO/R subjects; (b) EXP subjects ranked Independent significantly higher than anyone else; (c) Imaginative and (d) A world of beauty were both ranked significantly higher by DO/R subjects than by their PRO/N counterparts. This section will interpret the unpredicted results and discuss implications of the unsupported hypotheses.

Experience-based interpretations. From Appendix A, the Prospective/New group had less foster care experience (in number of years) than either the Experienced or the DropOut/Respite group. In contrast, the EXP and DO/R groups' experience were not substantially different. The PRO/N group's difference in actual years of experience, and its related implications for the caregiver-agency relationship, may be able to explain the significant results on Obedient.

Given that Prospective subjects were attempting to gain approval for foster care placements at the time of the study, and that New caregivers had recently received a first placement, it may be reasonable to describe their relationships with their foster care agencies as "probationary" (the other two groups, both more experienced, likely had other relationships with their agencies). Given their probationary status, perhaps the PRO/N subjects felt a need to "prove" their worth as caregivers; if so, then one way to prove it could be through obedient behavior with the foster care agency. From this perspective, PRO/N subjects' elevated ranking on Obedient could have reflected a situational response to their less-established agency ties.

In contrast, the results on Independent probably had nothing to do with agency relationships. Perhaps EXP subjects' greater valuing of Independent reflected their continuing ability to provide a service that is typically misunderstood by friends and family; it likely takes more than a small measure of independence for experienced caregivers to continue their foster care efforts in the face of ongoing social skepticism or downright opposition. Support for this notion comes from anecdotal information offered during the course of the data collection. Many EXP subjects expressed anger at onlookers' reactions to their residents in shopping malls or other public places. Also mentioned were the difficulties that caregivers have enlisting non-foster-involved acquaintances, friends and family to provide informal respite (i.e., a few hours of staying with the resident) when such is needed.

Perhaps the significant differences between the PRO/N and EXP groups in Obedient and Independent were themselves related. Rokeach (1973) reported a significant intercorrelation between the two values of -.25 ($p < .0001$) from his 1968 normative results; in the current sample, the intercorrelation was -.37 ($p < .001$). Methodologically, the value differences can be explained in terms of the Value Survey's ipsativity: the relationship of the two values within the two groups may have been sufficiently different to cause each value to register significant differences between the groups (note the differences in intragroup distances between the two values' mean ranks in Table 3). Developmentally, perhaps the two values represented an adaptive foster parenting progression: a high value on obedience may be more adaptive when caregivers are beginning their efforts; a high value on independence may be more suitable in the long run. That the two values are related in some way is fairly certain; however, the meaning of that relationship is unclear.

The group differences on Imaginative and A world of beauty were not as easy to explain. The only experience-based interpretation that makes sense is that the demands associated with foster caregiving are incompatible with either imaginative or aesthetic expression. Caregivers who value imaginative or aesthetic expression may choose, like RES subjects, to limit their involvement with foster care or, like DO subjects, to leave foster care altogether.

Alternative explanations. From Appendix A, educational status was the only demographic variable that registered differences among the groups. Thus, it makes sense to use that variable for group comparisons. From his 1968 normative sample, Rokeach (1973) found that Obedient decreased systematically, Independent and Imaginative increased systematically, and A world of beauty had no particular relationship, with educational attainment. Because the collapsed DropOut/Respite group had significantly more education than either of the other two groups, it would have been reasonable, from Rokeach's results, to have predicted that they would have valued Obedient less, Independent and Imaginative more, and A world of beauty no differently, than their peers. This was clearly not the case. Imaginative was the only value to correspond even partially with Rokeach's findings. Unless normative results are significantly different today than they were twenty years ago, it is difficult to explain the results on the basis of differences in educational attainment.

Perhaps the differences could be explained by group differences on other variables. According to other results (not detailed in this text), the groups had similar hobbies and recreational pursuits, religious feelings, and reasons for providing foster care. Thus, alternative explanations involving those sources appear to be closed.

Information from the available data does not appear to support alternative explanations. However, given the probability that two results could have been significant by chance, there is room to conclude that the results were at least partly due to sampling error. Further research is needed to determine whether the results were genuine.

Clinical significance of the results. Although PRO/N subjects ranked Obedient higher than the other groups, they ranked it lower than 12 other values. From that standpoint, the group differences on Obedient are probably not clinically significant. The result suggests only that less experienced caregivers may tend to be more obedient within the agency relationship at the beginning, and possibly less so as they obtain greater experience.

On the other hand, the results on Independent may have clinical utility. A prospective foster parent who places a high value on independence may be able to handle some of the social barriers better than one who places less value on independence. It may be useful for agency personnel to learn something about how a prospective caregiver handles personal or social issues; the degree to which a caregiver follows his or her own counsel could be an important indicator of that individual's ability to withstand the social difficulties of foster care.

Congruent with Rokeach's (1973) normative results, all subjects ranked A world of beauty and Imaginative within the bottom half of their respective scales. Within that result, the combined DropOut/Respite group ranked both values significantly higher than the combined Prospective/New group did. The results could be significant from a predictive standpoint: a caregiver who places greater value on artistic and creative expressions may find the demands of foster care inconsistent with those values. Placement specialists may wish to determine whether those values are important to a given prospective foster caregiver, and, if so, how the potential caregiver plans to satisfy their expression.

The unsupported hypotheses. It will be recalled that the Value Survey measures neither the strength of individual values nor the distance between values. In effect, those omissions caused the Value Survey ranks to act as if all values have equal meanings within their ranked order. Although this is not a problem for many subjects, it presents a difficulty for subjects whose values are not equally spaced or weighted; they are able to complete the instrument, but their profile is incomplete. If this happens in enough cases, then real differences among groups may be obscured.

This important point needs elaboration. Assume that three subjects place A comfortable life in the tenth spot among terminal values. Although their ranks were the same, the meaning of those ranks might have been considerably different for each subject. Perhaps Subject A felt that all values ranked higher than, and including, A comfortable life were more important than any value that followed. However, the higher-ranked values also differed among themselves. The first four values were equally the most important, followed by the fourth and fifth values together. The sixth, seventh, eighth, and ninth were equally third-most in importance, and so on. These nuances could not be represented on the Value Survey. An instrument that enabled both vertical and horizontal placement of values would have been better suited than the Value Survey to capture Subject A's value system.

For Subject B, perhaps the first seven values were very important, but anything below them was not. However, the directions said to rank all the values, so Subject B did. Although A comfortable life was not important to Subject B, it was slightly more important than other unimportant values; thus, Subject B placed it in the middle of the list. In this case, the Value Survey would have failed to distinguish the values' relative strengths.

For Subject C, perhaps the distance between a rank of 1 and 2 was the same as the distance between a rank of 7 and 8. In addition, all values had the same strength. The Value Survey would have accurately represented Subject C's value system.

Because similar situations could have occurred with regard to the six values that were listed in Hypothesis 1, conclusions concerning their lack of significance should be conservatively stated. It is appropriate to conclude that there were no significant differences among groups in the mean ranks on the values listed in Hypothesis 1; it is not appropriate to conclude that there were no value differences at all. Similarly, for the four values that demonstrated significant group differences, it is appropriate to conclude that the mean ranks were significant. However, statements about the values' relative strengths or distances within the Value Survey can not be made.

The pattern of results underscores the need for two types of further research. Replications involving other foster caregiver samples will help to determine whether the values of the current sample were truly representative of foster caregivers in general. Value studies that incorporate a different values instrument, such as one that measures value concepts (e.g., material versus social values; prescriptive versus proscriptive values), may help to determine further whether subjects who differ by foster care experience also have fundamental value differences.

Foster Parents' Judgments About the Acceptability of Potential Residents

Although the results did not support the specific proposal in Hypothesis 2, there was support for the general hypothesis that subjects' judgments about the acceptability of potential foster residents will differ according to foster care experience. This section will review the results and examine them in relation to the vignettes measure.

Interpretation of the results. Four main results emerged from the data: (a) Subjects were most concerned about a potential resident's behavioral predictability and least concerned about responsiveness and medical condition. (b) Although responsiveness was given less weight than other characteristics, Prospective/New subjects were significantly less concerned about it than were either of the other two groups. (c) DropOut/ Respite subjects were significantly less willing than the other two groups to accept the overall group of children. (d) Subjects' weights favored acceptance of children with the no-problem condition on all variables.

Overall, the results were quite optimistic. Subjects indicated a general willingness to accept the group of children; in addition, they were not overly concerned about any of the problem conditions that the child might have. Part of their positive responding should be attributed to social desirability; given the analog nature of this research, none of the subjects had to live with their judgments! By the same token, if the results have any semblance to reality, then the results suggest that the foster caregivers of this sample tended to be an accepting group of people.

The significant weight on behavioral predictability complements Haney's (1988) conclusion that maladaptive behaviors present the primary obstacles for success. Further studies may be able to explore qualitative aspects of the variable. For instance, what is it about unpredictability that troubles some caregivers? Are there situations in which unpredictable behaviors are actually preferred? What can agencies do to encourage caregivers to accept unpredictable residents? What types of supports can the community offer to caregivers who accept residents with unpredictable behavior?

From anecdotal information offered by subjects, it is not surprising that they placed little weight on visual responsiveness. Many subjects remarked that the characteristic was not important; as one subject noted, "Even if they don't look at you, there are lots of other ways for people to respond." In contrast to the small weight given by other groups, Prospective/New subjects placed virtually no weight on visual responsiveness. Perhaps the result can be explained by the PRO/N group's relative unfamiliarity with foster care placements; unlike their more experienced peers, they may have underestimated the relative impact that a resident's level of visual responsiveness has on a caregiver-resident relationship. Further explorations of responsiveness (visual, as well as other forms) might be useful, either to confirm the variable's lack of importance or to provide information about situations in which the variable may matter.

Similarly, it was not surprising that the combined DropOut/Respite group would reject more individuals than the other groups. However, even the level of rejection from this group was fairly mild. if DO/R subjects' mean responses were congruent at least in part with their "real" (as opposed to socially desirable) feelings, then perhaps the majority of the group has a residual interest in foster care that might be expressed in future attempts to resume or increase their foster caregiving involvement. According to responses from a structured interview (not included in the current results), this condition reflects the realm of possibility.

Three reasons may explain the lack of support for the hypothesis that experienced subjects would indicate greater willingness to accept the group of children. First, it is possible that the Prospective/New group gave more socially desirable responses than the Experienced group. If, as indicated by Hypothesis 1, the PRO/N group actually values obedience more than other groups, then perhaps they were more prone to indicating greater acceptance than other subjects. In addition, the PRO/N group may have been as willing as EXP subjects to accept the set of children because they underestimated the amount of care that was required. Finally, experienced caregivers may actually be more discriminating about their choices than others; they may know, from experience, which characteristics are most difficult, and may be less willing to accept children with those characteristics.

The last result - that subjects' weights favored the acceptance of no-problem conditions - merely reflected common sense: Why take on extra demands in an already-demanding situation? The more surprising result is that, from the negative weights in Appendix G, there were subjects who indicated a greater preference for some problem conditions. Although it seems counterintuitive to think that a problem condition would be preferred by itself, it does make sense that subjects may have a preference for some problem conditions when other conditions are present. For example, an individual who has unpredictable behaviors may be more acceptable to a caregiver if he is confined to a wheelchair than if he is ambulatory; people who lack independent use of their legs are often perceived as less able to damage their surroundings than people who can walk. Similarly, people who are medically fragile may be more acceptable if they are fairly unresponsive; responsive people have a greater capacity to communicate pain, which, in turn, may cause the caregiver to feel helpless or distressed.

Alternative models. Considering that it accounted for an average 69% of the variance of this sample, and 59% of the variance when adjusted for error, the linear main effects regression model offered a fairly good paramorphic representation of subjects' judgment behaviors. However, given the presence of several negative weights in individual policy statements, it is reasonable to wonder whether a linear interaction regression model might provide a better representation. An interaction model could help to determine, for instance, whether judgments about behavioral predictability are related to the wheelchair variable. In turn, those results could eventually lead to the development of other statistical approaches, such as path analysis, that would test causal relationships between variables.

The current data should be reanalyzed according to an interaction model in order to obtain weights for all main effects and first order interactions (second order interactions could not be examined, given the likely occurrence of high multicollinearity; third order interactions would be assumed to be negligible). Comparisons between the two models should then be made to determine which one is the best paramorphic representation and to provide directions for further research.

The Relationship Between Subjects' Judgment Policies and Values

From Hypothesis 3, six of 180 correlations were significant. This number was well within chance predictions. Thus, sampling error may explain some, if not all, of the results. Nevertheless, each significant correlation will be interpreted as if it was truly significant. In addition, further research directions will be suggested.

Interpretation of the results. Possibly the most intriguing correlations involved the two significant relationships that the values Loving and Clean had with medical condition (Healthy). The more highly valued that Loving was, the less weight that Healthy received. In contrast, the more highly valued the Clean was, the more weight that Healthy received.

People who place great importance on Loving may be more concerned about meeting the special caregiving challenges that often accompany a medical condition (e.g., to provide comfort and hope) than they are about the medical condition itself. Perhaps caregivers who place great value on love feel that if the medical condition can not be "cured," then, at the very least, large doses of nurturance will help to alleviate the resident's discomforts. The caregivers may believe that they have more than enough love to give, and that people who have chronic and/or serious medical problems are particularly situated to benefit from their love.

In contrast, perhaps caregivers who place a high value on cleanliness are finicky about the appearances and apparatus of certain medical conditions. If so, then their willingness to accept a potential resident into their home may hinge on the accompaniments of the resident's medical status; e.g., residents who drool excessively or regurgitate food may be unacceptable to caregivers for whom cleanliness is highly important. When judging the acceptability of potential residents, caregivers who place a high value on cleanliness may focus more on the child's medical needs than might a caregiver for whom cleanliness is less relevant.

Given that unpredictable behavior was least accepted by caregivers, the significant relationship between Helpful and Predict is cause for cheer! The greater the importance of Helpful, the lesser the weight on Predict. A low weight on Predict by caregivers who place higher value on Helpful may be their way of offering service not only to a resident, but to the foster care agency as well. "Helpful" caregivers may know - either through knowledge or intuition - that unpredictability is a difficult characteristic for caregivers to handle; in response, they may believe that they can provide the most service by caring for least desirable residents.

The results indicated that responsiveness, which was not highly weighted in the first place, was weighted even less by people who placed a higher value on Salvation or Courageous. The correlation between Courageous and responsiveness may be explained within the context of caregivers' relationships to the child. The correlation between Salvation and responsiveness may be interpreted within the context of the caregivers' perception of the child's relationship with God.

Courageous is described in the Value Survey as "standing up for your beliefs." Perhaps caregivers who place a higher value on courageousness choose to provide foster care partly as an expression of their personal beliefs. In addition to wanting a relationship with the care recipient, such caregivers may engage in caregiving for the societal statement that it makes. If so, then a potential resident's degree of responsiveness might be less relevant for them than it would be for those caregivers whose sole caregiving interest is to build a close relationship with their residents.

Similarly, the greater the importance of Salvation, the less the weight on Respond. This result may simply reflect the caregivers' faith. People who place a higher value on Salvation may believe that all people are children of God. As such, it is not important whether the child can respond to the caregiver; the most important communication is that which the child has with God.

A highly significant negative correlation occurred between A world of beauty and Mean judgment score. Given that both variables were scored in the same direction, a higher ranking on A world of beauty was correlated with greater rejection of the group of individuals. Considering that both variables differentiated the Dropout/Respite group from the other groups, it is likely that the result reflected the two variables' relationship with the experience category rather than a genuine relationship between the two.

Congruent with other results, the secondary hypotheses were not supported. Three factors may explain their lack of significance: (a) the Value Survey's lack of recognition for value strengths and distances would have obscured any correlations that involved those dimensions; (b) random variation may have obliterated significance; and (c) the hypotheses may have been based on faulty assumptions.

The issue of "faulty assumptions" underscores the study's exploratory nature. All of the secondary hypotheses were based on intuition because, simply, nothing else was available! The fact that incorrect assumptions may be implicated in every unsupported hypothesis emphasizes the need for continued research.

Further research directions. Correlations between values and weights may offer potential tests for a "goodness of fit" model. Perhaps caregivers who value Loving have "the right stuff" to care for residents who have medical needs; caregivers who value Helpful may find themselves better able than others to handle residents who have unpredictable behaviors; and caregivers who place higher value on Salvation or Courageous may be well-suited to care for residents who are at least visually unresponsive. In contrast, caregivers who place a higher value on Clean may be affronted by messy medical conditions, and those who value A world of beauty may be less willing to accept "just anyone."

Unfortunately, because values are not isolated entities, the current results provide only a "teaser;" i.e., a possibly meaningless glimpse into the complex area of "goodness of fit" between caregivers and residents. Some of the results may have been significant by chance; others, though significant in reality, may lack practical utility. The only way to determine whether the results are truly significant and the approach truly useful will be to conduct further research in applied and analog settings.

Methodological Implications

Given its exploratory nature, the study offered a useful start for continued research on foster caregivers. However, before further research is conducted, an evaluation of the current methodology should be made. This section will examine how the methodology influenced the results.

The experience variable. In keeping with other research (e.g., Sanderson & Crawley, 1982), the study assumed that "foster care experience" was a unidimensional concept that could be operationalized in a categorical manner. This assumption needs revision. During the study, it became obvious that the one-year-experience criterion was inadequate. The Experienced group included, for example, subjects who met the minimum definition; subjects who had cared for two or three residents for at least 10 or more years; subjects who cared for 15 or more residents for at least

20-plus years; and caregivers who had been involved with foster care for many years, had dropped out for awhile, and were again actively involved in a caregiving arrangement at the time that the study was conducted.

There was as much variability among the other groups. Dropout/Respite subjects differed among themselves in length of experience, interest in foster care, and reasons for leaving or limiting their foster care. In fact, some subjects in the combined DO/R group actually resembled EXP subjects more than they resembled their own peers. The only characteristic that distinguished the DO/R group from the EXP group was that all DO/R subjects had either limited or terminated their foster care involvement at the time of the study.

Prospective subjects also varied considerably in previous experience. The group included subjects who had no experience with developmentally disabled people, as well as subjects who were currently employed (and had been for many years) as nurses, nurse's aides, teachers, teacher's aides, or direct care workers for people who have developmental disabilities. Although they had not provided foster care yet in their own homes, most PRO subjects had many years of other experience with the population.

Other types of experience also surfaced. A few subjects in each group had developmentally disabled siblings; others had grown up with one or more disabled foster siblings. Every group contained at least one subject who had two or less years of foster care experience in their own home, but who had previously lived for many years with a developmentally disabled relative.

The inescapable conclusion is that the experience variable was too narrow to capture real differences among groups that were otherwise quite similar. Future studies should reconceptualize "foster parent experience" as a multidimensional concept that includes, at the very least, total number of years home-based foster care experience, total number of foster residents, number of years and type of work-related experience, previous life exposure to developmental disabilities (e.g., family members), respite vs. ongoing experience, and current foster care status.

The control group. It is an open question whether studies that examine one target group and exclude an equally-important group (e.g., research on men or women only) provide truly representative results. The current study is vulnerable to such criticism. All of the subjects were currently, or had been previously, involved with foster care. People who had no foster care experience were intentionally omitted from the design. The reason was straightforward: What purpose would be served if people who had no apparent interest in foster care were asked to judge their willingness to accept potential foster residents?

Although the dropout group was conceived as a type of comparison group, the results indicated that Dropout caregivers were not much different than other foster caregivers. It is unclear whether Dropout caregivers were part of a homogeneous group that is different from the general population, or whether the caregivers as a whole were actually representative of a larger population of women. The addition of a control group could provide relevant normative information about non-foster-care variables.

Because most subjects in the current study had a religious affiliation, the church offers a logical source from which to recruit control subjects. Emphasis should be given primarily to Protestant denominations, with Catholic churches represented secondarily. Control groups should be administered only those measures that have relevance for the larger population, such as the Subject Fact Sheet and the Value Survey.

Sample size. Without a doubt, all of the results could have been due to sampling error; the sample was too small to conclude otherwise. By the same token, most of the results made enough intuitive sense to argue that some were truly significant. More studies involving larger groups of caregivers and appropriate controls will help to separate the genuine results from those that occurred by chance.

Evaluation of the vignettes measure. The selection and descriptions of the variables were guided primarily by "best guess" guidelines. This was a necessary reaction to the fact that the literature contained little empirical and descriptive information about residents' characteristics. More data should be collected before conclusions are made about any one variable's relative importance. However, before the vignettes measure can be administered again, each variable's description should be refined. From impressions gathered during the study, there is ample reason to believe that the instrument was incomplete.

The results suggested that visual responsiveness does not impact on caregivers' judgments regarding the acceptability of potential residents. However, the vignettes did not provide information about other forms of responsiveness. The responsiveness variable should be altered, either to include other types of responsiveness or to replace visual responsiveness altogether.

It became increasingly apparent during the study that the description of "predictability" could have easily served "aggression," since the unpredictable behavioral condition described aggressive behaviors. Were subjects relating to the aggressive components or the predictability components, or were the two components really the same? Should the variable have been labelled "aggression" rather than "predictability"? Future attempts should be made to clarify the meaning of the variable for subjects.

Although the description of Ambulatory status may have been less troublesome from a descriptive standpoint, it was incomplete from the subjects' perspective. Subjects asked if size and weight were to be considered. Some subjects also mentioned that their rejection of people in wheelchairs occurred primarily because their homes could not accommodate a wheelchair and not because of the wheelchair *per sé*. The exclusion of those concepts enabled a "clean" measurement, but some very important pieces of information were omitted. When subjects rejected individuals in wheelchairs, was it because they did not like wheelchairs, they had possible concerns about a potential resident's size and weight, and/or their home was not barrier-free?

Medical condition was the most problematic variable. The selection of diabetes may not have satisfied the intent of the variable; it did not appear to convey the degree of risk that was desired. Subjects did not seem daunted by the unidentified condition; in fact, some subjects commented that it was trivial in comparison to what they had experienced. This could explain the insignificant weights that were given to Healthy. Perhaps the risk would have been better expressed (and more similar to the medical needs of actual residents) if there had been mention of injections and frequent monitoring of body functions.

Even though subjects were not told the name of the condition, the selection of diabetes itself may have been inappropriate. Unless the resident is a brittle diabetic, the risks may not be spontaneously acute enough to warrant caregivers' alarm. For future studies, attempts should be made to reevaluate whether other conditions are more applicable for the intent of the variable. Although attempts were unsuccessful this time, perhaps a good description of either a chronic heart disease or pulmonary condition could be developed, since either may be more characteristic of a foster resident who has medical care needs than diabetes is. Seizure disorder condition should also be reconsidered, since it is fairly common among the population, and vignettes depicting a chronically unstable seizure condition could reflect a reasonable amount of realism.

The use of vignettes offers promise, both as a methodology and as a training or placement tool. However, the current measure needs refining. For research purposes, methodological demands may conflict with attempts to maintain environmental integrity (e.g., as noted with the variable Walk); thus, revisions should attempt to satisfy both methodological and pragmatic concerns. In addition, given that the vignettes were newly-created for this research, acceptable measurement properties should be established after a satisfactory measure has been developed.

Evaluation of the methodology. Alone, both the Rokeach values theory and the policy capturing methodology offer promising avenues for further research. Together, their utility may be limited. One difficulty may lie in the orientation of the two approaches. Although both the Value Survey and the vignettes measure provided "paramorphic" representations of two cognitive entities, the information was elicited in opposite ways. The Value Survey sought information about singular structures; the vignettes represented a dynamic, multivariate process. Thus, interpretations of correlations between the two measures' variables could be made only within a limited context.

Better links between values and weights might be developed if Value Survey adaptations or other instruments were used to measure subjects' core values. The Value Survey might be sufficient if more empirical information on Rokeach's (1973) four value subgroups were available. Alternatively, asking subjects to rate rather than rank their values according to importance might provide information about subjects' personal value clusters. Another approach may be to use a different values measure, such as Allport, Vernon & Lindzey's (1960) Study of Values or McKinney's (1971) sentence completion test, that elicits subjects' responses to specific value constellations or orientations.

The main contribution of a values- or other caregiver characteristic-based policy-capturing methodology may be in its ability to explore "goodness-of-fit" hypotheses. Continued research is warranted to refine the approach.

Theoretical Implications

Three primary questions guided the study: (1) Could foster caregivers' values be described? (2) Could the judgments that foster caregivers make about potential care recipients be studied within a policy capturing framework? (3) Could a values-oriented approach be applied to foster caregivers' acceptance judgments? This section will examine how well the study answered the questions.

A foster caregiver "values profile." The overall impression from the study was that the subjects' values were more similar than different. From the results, foster caregivers appear well-grounded in the here-and-now. Primary value was placed on Family security, Health, Self-respect, and Wisdom. Honesty, Loving, Forgiving, and Responsibility were also highly valued. Values having to do with social welfare, material attainment, or competence did not appear to have as much importance for caregivers as did values having to do with day-to-day caregiving and personal morality. One might suspect that foster caregivers would be comfortable so long as the health and welfare of themselves and their loved ones were assured.

The profile corresponds roughly to Sanderson & Crawley's (1982) and Wiehe's (1982) characterization of foster caregivers as "Conventional." According to both the Strong-Campbell Interest Inventory (Campbell & Hansen, 1981) and Holland's (1978) Vocational Preference Inventory, conventional people describe themselves as dependable, stable, and well-controlled individuals who prefer jobs that enable them to know exactly what is expected of them. One might guess that the current group of subjects would describe themselves similarly.

Because there were no provisions for non-foster-caregiver comparisons, it is unknown whether the values profile could also describe a normative group. Even though the results are dated, Rokeach's (1973) results from the 1968 NORC sample will be used to make rough normative comparisons. Given that the majority of subjects in this study were female, the NORC sample's women's results will be used. The comparison is listed in Table 10.

Some interesting trends emerge. The bottom three terminal values and bottom four instrumental values were the same for both samples, though not necessarily in the same order. In addition, Family security, Honest, Forgiving, and Responsible were of uppermost importance for both groups. The comparison suggests that there was similarity in high and low-ranked values between the two groups and possible value stability across the years.

Women in 1968 also appeared to favor hearth-and-home values, though perhaps in a less prominent way. Both groups also gave comparably low ranks to material values. From their higher ranks on Freedom, Equality, National security and, particularly, A world at peace, women in 1968 had social preoccupations as well. The differences on those values may partly reflect social differences between the two eras; according to Rokeach (1973),

Table 10

Value Medians/Means and Composite Rank Orders for American Women, 1968 vs. Foster Caregivers, 1988

Rank	Terminal Value [a]	Median Rank	Terminal Value [b]	Mean Rank
1	A world at peace	3.0	Family security	4.2
2	Family security	3.8	Health	4.3
3	Freedom	6.1	Self-respect	5.6
4	Salvation	7.3	Wisdom	6.4
5	Happiness	7.4 *	Freedom	7.6
6	Self-respect	7.4	Inner harmony	7.9
7	Wisdom	7.7	Salvation	7.9
8	Equality	8.3	True friendship	8.4
9	True friendship	9.1	A sense of accomplishment	9.1
10	A sense of accomplishment	9.4	Mature love	9.4
11	National security	9.8	Equality	10.1
12	Inner harmony	9.8	A world at peace	10.2
13	A comfortable life	10.0	A comfortable life	11.5
14	Mature love	12.3	A world of beauty	13.1
15	A world of beauty	13.5	National security	13.1
16	Pleasure	15.0	An exciting life	13.3
17	Social recognition	15.0	Pleasure	13.6
18	An exciting life	15.8	Social recognition	14.5

[a] N=744

[b] N=77

* Replaced by Health

Table 10 (cont'd.)

Rank	Instrumental Value [a]	Median Rank	Instrumental Value [b]	Mean Rank
1	Honest	3.2	Honest	3.6
2	Forgiving	6.4	Loving	4.3
3	Responsible	6.8	Responsible	5.9
4	Ambitious	7.4	Forgiving	6.7
5	Broadminded	7.7	Helpful	8.2
6	Courageous	8.1	Loyal	8.4
7	Helpful	8.1	Broadminded	8.7
8	Clean	8.1	Ambitious	9.2
9	Loving	8.6	Independent	9.5
10	Cheerful*	9.4	Capable	9.5
11	Self-controlled	9.5	Courageous	9.7
12	Capable	10.1	Self-controlled	10.5
13	Polite	10.7	Polite	11.5
14	Independent	10.7	Clean	11.5
15	Obedient	13.1	Logical	12.5
16	Intellectual	13.2	Intellectual	13.0
17	Logical	14.7	Obedient	13.5
18	Imaginative	16.1	Imaginative	14.1

[a] N=744

[b] N=77

* Replaced by Loyal

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A world of peace was the highest-ranked terminal value among all groups in the NORC sample.

The only other notable results concerned the differential importance that the two groups gave to certain values. Inner harmony, Mature love, Loving, and Independent appeared to be more important to the 1988 foster caregiver group than to the 1968 women's sample. In contrast, Courageous, Ambitious, and Clean were more important to the 1968 women than to the 1988 foster caregivers. It would be tempting to conclude that the value differences between the groups were significant; unfortunately, such conclusions are hindered by three factors: (a) Rokeach results were medians; the current study used means; (b) standard deviations were not available for the NORC sample; and (c) the results were obtained almost 20 years apart. However, even with those difficulties, the results are compelling enough to warrant both additional comparisons with a matched non-foster control group and continued explorations of foster caregivers' values.

Paramorphic representations of clinical judgments. The policy capturing approach offered information only about the structure of foster caregivers' judgments about the acceptability of potential residents; it did not provide information about underlying factors in the judgment process. However, given the current state of foster care research, structural contributions are more than sufficient. The beauty of paramorphic representation is that it enables a description of the structure of judgments to be formed; hypotheses about the underlying mechanisms could then be developed from the information. The policy capturing approach is sufficiently flexible to be used as often as needed to gain information about various resident characteristics.

Toward a values-based model of foster caregivers' acceptance judgments. A 2-level preliminary model of factors that influence foster caregivers' judgments about the acceptability of potential foster care recipients is currently being constructed from the overall research project on which this study is based. Because the model assumes that some people have a predisposition toward becoming involved with foster care, the first level (Level 1) is comprised of predisposing factors. Those factors include, but are not limited to, prior exposure to people who have developmental disabilities or other disabling conditions (e.g., having a developmentally disabled relative, friend, etc.; working with developmentally disabled people); values that center on family-based concerns and interpersonal service; and pivotal experiences (e.g., knowing someone who provides foster care). Factors involved with the caregivers' current situation comprise the second level (Level 2). Those factors include, but are not limited to, the caregivers' current values, foster care experiential history, and other pivotal factors and experiences.

At present, Level 2 factors are thought to provide primary influences on caregivers' judgments. It is also thought that Level 1 factors primarily influence Level 2 factors and peripherally influence caregivers' judgments. However, influences in other directions or from other factors may also be involved. The current study attempted to explore the link between caregivers' current values (i.e., Level 2 values) and judgments. Research concerning all aspects of the model is needed to provide basic information about caregivers and to add substance or modifications to the model.

Practical Implications

The results from the study may be used in at least two ways. One logical avenue is to use the results to frame future research questions. Another approach is to extend the results to the practical environment.

The New group. The lack of participation by potential NEW subjects was completely unexpected. Unfortunately, because few of the new caregivers explained their refusals, one can only speculate about the reasons. Three thoughts immediately come to mind: (a) New caregivers were simply overwhelmed by their caregiving responsibilities and felt unable to give two hours for the data collection; (b) they generally felt insecure about their skills, and did not wish to open themselves to the scrutiny of an outsider, regardless of how supportive the encounter might have been; (c) they had not yet established a well-functioning working partnership with their agency, and did not trust the nature of the study.

Regardless of the reason, the NEW subjects' lack of participation is significant. Of all caregivers, they are perhaps the most vulnerable for failure. If their refusals are any indication, new caregivers could benefit from having supportive working relationships with the foster care agency.

NEW subjects were differentiated from other subjects only by their significantly greater weight on Medical condition. Inspection of the NEW subjects' policy statements (Subjects 11, 21, 39, 49, 53, 54; see Appendix G) indicated that two of the six had elevated weights on Healthy. Although it is unknown whether their results were representative of the population of new caregivers, agency personnel might be sensitive to new caregivers' possible insecurities about a potential resident's medical status. Special attempts should be made to keep in close, supportive touch with the caregivers during the early months of their foster care tenure, particularly if they are providing care to a medically fragile resident.

The Respite group. A surprising addition to the study was the inclusion of respite subjects. Respite caregivers have received scant, if any, attention in the literature. In fact, given that Michigan has a more advanced foster care system than most other states (Hill et al., 1988), it is possible that foster caregivers who provide only respite services are little known in other states. Their presence in this research may provide one of the study's larger contributions. Further information about people who offer respite care could help to increase their utility in other areas of the country.

Respite caregivers in the current sample were an educated group; all had at least one year of college experience. In addition, all 11 respite subjects had some prior connection to developmental disabilities, either through having a developmentally disabled relative or through employment in nursing or teaching situations. Nine of the 11 were currently employed in full-time work with chronically ill patients or developmentally disabled students; the other two had been experienced foster parents who were no longer interested in providing full-time care. Some subjects engaged in established respite arrangements (e.g., same child[ren] every other weekend or so); others provided respite services for their agency on an as-needed basis. Most of the group had begun to provide respite care in response to a specific ad hoc need at their place of employment.

Perhaps the most striking impression of the respite group was that the caregivers managed to extend their employment into foster care. Considering that many experienced subjects complained that their agency offered inadequate respite services, foster care agencies are well advised to encourage staff at specialized schools and nursing facilities to provide respite care services.

Conclusion

Further use of the policy capturing methodology will enable researchers and clinicians to understand how caregivers make judgments about the placement acceptability of potential residents. Additional research on caregivers' values promises to enhance understanding about one of the mechanisms that underlie and presumably influence caregivers' acceptance judgment policies. Continued efforts should be made to link values and judgments together into a model that depicts how foster caregivers come to choose which individuals will receive their care. The current research opened a new window for empirical research on foster caregivers.

APPENDICES

APPENDIX A

Subjects' Demographic Information

APPENDIX A

Subject Fact Sheet

1. Marital status:

__ Single __Divorced __Widowed __ Married __Separated

2. Respondent's age: ________

3. Spouse's age: ________

4. Respondent's sex: M F

5. Respondent's race: (check one)

__Black __White __Oriental __Hispanic
__Other (please specify): ____________________

6. Spouse's race: (check one)

__Black __White __Oriental __Hispanic
__ Other (please specify): ____________________

7. Respondent's highest level of education: (check highest level completed)

School: __ Grades1- 5 __ Grades 6 - 8 __9 __10 __11 __12
__ High School Graduate

College: ___1 yr. ___2 yrs. ___3 yrs. ___4 yrs.
___College Graduate

Advanced Degree: ____________________
Technical/Occupational School: ____________________

8. Spouse's highest level of education (check highest level completed):

School: __ Grades1- 5 __ Grades 6 - 8 __9 __10 __11 __12
__ High School Graduate

College: ___1 yr. ___2 yrs. ___3 yrs. ___4 yrs.
___College Graduate

Advanced Degree:_________________________
Technical/Occupational School: ________________________________

9. Respondent's paid employment status: (check all that apply)

Out of home: __ Full time __Part time __ Occasional __Retired
__ None

In home: ___ Full time ____Part time ___Occasional ____None

10. Respondent's occupation: (please be specific) ___________________

____

11. Spouse's paid employment status: (check all that apply)

Out of home: __ Full time __Part time __ Occasional __Retired
__ None

In home: ___ Full time ____Part time ___Occasional ____None

12. Spouse's occupation: (please be specific) ________________________

____

13. Respondent's religion: ____________________________

14. Spouse's religion: ______________________________

15. List the first names and ages of your children (biological or adopted only).

______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

16. List the first names of all people currently living in your house, their relationship to you (e.g., son, spouse, foster child), and their ages.

________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________

Table 11

Subjects' Demographic Information

	PROSPECTIVE/NEW n=22	EXPERIENCED n=34	DROPOUT/RESPITE n=21	TOTAL N=77
Marital Status				
Single	0.0%	2.9%	0.0%	1.3%
Divorced	13.7%	5.9%	9.5%	9.1%
Widowed	4.5%	5.9%	14.3%	7.8%
Married	72.8%	82.4%	76.2%	77.9%
Separated	4.5%	0.0%	0.0%	1.3%
Other	4.5%	2.9%	0.0%	2.6%
Age				
Minimum	28.00	28.00	25.00	25.00
Maximum	62.00	67.00	71.00	71.00
Mean	41.64	44.88	43.29	43.52
Standard deviation	10.01	11.06	11.62	10.88
Sex				
Male	0.0%	2.9%	9.5%	3.9%
Female	100.0%	97.11%	90.5%	96.1%
Race				
White	81.8%	79.4%	76.2%	79.2%
Black	18.2%	20.6%	23.8%	20.8%
Education				
Up to grade 8	4.5%	0.0%	4.8%	2.6%
Grade 9-12	18.2%	5.9%	0.0%	7.8%
High school graduate	50.0%	55.8%	14.2%	42.8%
Some college	22.8%	32.4%	52.4%	35.1%
College graduate	4.5%	0.0%	23.8%	7.8%
Graduate degree	0.0%	5.9%	4.8%	3.9%
Out-of-home employment				
Full time	31.8%	23.5%	38.1%	29.8%
Part time	13.6%	8.8%	38.1%	18.2%
Occasional	4.6%	14.8%	0.0%	7.8%
Retired	0.0%	2.9%	4.8%	2.6%
None	50.0%	50.0%	19.0%	41.6%

Table 11 (cont'd.)

	PROSPECTIVE/NEW n=22	EXPERIENCED n=34	DROPOUT/RESPITE n=21	TOTAL N=77
General occupation				
DD-related	50.0%	73.5%	52.0%	61.0%
Other	40.0%	23.5%	43.2%	33.8%
None	10.0%	4.0%	4.8%	5.2%
Religion				
Protestant	72.8%	73.5%	57.2%	68.8%
Catholic	22.7%	26.5%	23.8%	24.7%
Other	4.5%	0.0%	19.0%	6.5%
Number of children				
Minimum	0.00	0.00	0.00	0.00
Maximum	5.00	9.00	13.00	13.00
Mean	2.36	3.50	3.52	3.18
Standard deviation	1.40	1.91	3.01	2.19
Oldest child				
Minimum	7.00	6.00	3.00	3.00
Maximum	42.00	42.00	50.00	50.00
Mean	22.05	24.03	20.69	22.57
Standard deviation	8.83	11.03	13.61	11.20
Youngest child				
Minimum	4.00	1.00	1.50	1.00
Maximum	30.00	40.00	29.00	40.00
Mean	14.38	15.97	13.94	15.02
Standard deviation	7.39	10.51	10.06	9.58

APPENDIX B

Caregiver Letters

APPENDIX B-1

Pilot Study Letter

September 29, 1987

Dear Foster Parent:

We are writing to request your participation in a study involving foster parents of developmentally disabled children. The study will be done by Carol Ellstein for her doctoral degree in Psychology from Michigan State University. Carol is a psychologist with CSDD who works with adult clients living in group homes. She wants to study foster parents like you in order to help agencies like ours improve their foster parent programs.

The study will offer you a chance to learn more about the decisions you make about caring for foster children. You will be asked questions about children whom you might consider for foster care. You will also be asked to talk about your foster parenting experiences. Your answers will only be used in the study. Any personal information will be kept confidential.

The study should take about two hours of your time. You will be interviewed by Carol in your home.

Carol will telephone you within a few days after you receive this letter. At that time, she will answer any questions that you might have and will set up an appointment with you if you choose to participate. It is entirely up to you whether or not to participate. There will be no reward or penalty for your decision.

We hope that you will agree to participate. Thank you for your cooperation.

Sincerely,

Pam Syers	Carol Ellstein
Family Support Program	CSDD Psychologist and
Children's Foster Care Licensing Worker	Ph.D. Candidate, Psychology

APPENDIX B-2

Macomb-Oakland Regional Center Letter

January 11, 1988

«name»
«street»
«city state zip»

Dear «fullname»:

We are writing to request your participation in a study involving people who provide foster care for developmentally disabled children. The study will be done by Carol Ellstein for her doctoral degree in Psychology from Michigan State University. She is interviewing prospective, current and former foster parents in order to learn about people who get involved with the foster care system.

In the study, Carol will ask you to evaluate various children whom you might consider for placement into your home. You will also be asked to describe your values and to talk about what led you to foster care. The study should take about two hours of your time. You will be interviewed by Carol in your home.

Carol does not work for MORC. She is using our agency only to locate people who have been involved with foster care. Your answers will be used only in the study and will not be available to anyone but Carol. All information will be kept confidential.

Carol will telephone you within a few days after you receive this letter. At that time, she will answer any questions and set up an appointment with you if you decide to take part in the study. Because no one in the agency will know if you participated, your inclusion in the study will not affect on your involvement with MORC.

We hope that you will agree to participate. Thank you for your cooperation.

Sincerely,
Thomas Bauer Nancy Tancredi Carol Ellstein
Foster Care Casemanagement Supervisors Ph.D.Candidate, Psychology

APPENDIX B-3

Wayne Community Living Services Letter

(This is a prototype. WCLS conducted their own recruitment.)

March __, 1988

«name»
«street»
«city state zip»

Dear «fullname»:

We are writing to request your participation in a study involving people who provide foster care for developmentally disabled people. The study will be done by Carol Ellstein for her doctoral degree in Psychology from Michigan State University. She is interviewing prospective, current and former foster parents in order to learn about people who get involved with the foster care system.

In the study, Carol will ask you to evaluate various children whom you might consider for placement into your home. You will also be asked to describe your values and to talk about what led you to foster care. The study should take about two hours of your time. You will be interviewed by Carol in your home.

Carol does not work for WCLS. She is using our agency only to locate people who have been involved with foster care. Your answers will be used only in the study and will not be available to anyone but Carol. All information will be kept confidential.

If you are interested in participating, please call __________ and leave a message with ____________. We will then give your name to Carol, who will contact you to set up an appointment. Your decision whether or not to participate in the study will have no effect on your involvement with WCLS.

We hope that you will agree to participate. Thank you for your cooperation.

Sincerely,

_____(name and title)_______________ _____(name and title)______

APPENDIX B-4

Mt. Pleasant Regional Center Letter

July 26, 1988

«name»
«street»
«city state zip»

Dear «fullname»:

I am writing to request your participation in a study involving people who provide foster care for developmentally disabled individuals. The study will be done by Carol Ellstein for her doctoral degree in Psychology from Michigan State University. She is interviewing prospective, current and former foster parents in order to learn about people who get involved with the foster care system.

In the study, Carol will ask you to evaluate various individuals whom you might consider for placement into your home. You will also be asked to describe your values and to talk about what led you to foster care. The study should take about two hours of your time. You will be interviewed by Carol in your home.

Carol does not work for MPRCDD. She is using our agency only to locate people who have been involved with foster care. Your answers will be used only in the study and will not be available to anyone but Carol. All information will be kept confidential.

Carol will telephone you within a few days after you receive this letter. At that time, she will answer any questions and set up an appointment with you if you decide to take part in the study. Because no one in the agency will know if you participated, your inclusion in the study will not affect your involvement with MPRCDD.

I hope that you will agree to participate. Thank you for your cooperation.

Sincerely,

Laura M. Pollaccia, ACSW	Carol Ellstein, MA
Community Placement Coordinator	Ph.D. Candidate, Psychology

APPENDIX B-5

Kent Client Services Letter

August 4, 1988

«name»
«street»
«city state zip»

Dear «fullname»:

I am writing to request your participation in a study involving people who provide foster care for developmentally disabled children. The study will be done by Carol Ellstein for her doctoral degree in Psychology from Michigan State University. She is interviewing prospective, current and former foster parents in order to learn about people who get involved with the foster care system.

In the study, Carol will ask you to evaluate various children whom you might consider for placement into your home. You will also be asked to describe your values and to talk about what led you to foster care. The study should take about two hours of your time. You will be interviewed by Carol in your home.

Carol does not work for Kent Client Services. She is using our agency only to locate people who have been involved with foster care. Your answers will be used only in the study and will not be available to anyone in the agency. All information will be kept confidential.

Carol will telephone you within a few days after you receive this letter. At that time, she will answer any questions and set up an appointment with you if you decide to take part in the study. Because no one in the agency will know if you participated, your inclusion in the study will not affect your involvement with this agency.

I hope that you will agree to participate. Thank you for your cooperation.

Sincerely,

Connie Yolles	Carol Ellstein
Children's Services Supervisor	Ph.D. Candidate, Psychology

APPENDIX C

Vignettes

APPENDIX C

Vignettes

LARRY

Larry has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Larry, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Larry occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

Larry sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

Larry can walk without assistance.

Larry does not have medical condition that requires special care.

Larry is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

JOE

Joe does not have a medical condition that requires special care.

Joe is able to respond to people. When you talk to Joe, you are pretty certain that he understands what you are trying to say. Although Joe occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

Joe sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

Joe is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Joe can walk without assistance.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

MARCUS

<u>Marcus can walk without assistance</u>.

<u>Marcus has trouble responding to people</u>. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Marcus, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Marcus occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

<u>Marcus is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.</u>

<u>Marcus does not have a medical condition that requires special care.</u>

<u>You can generally "read" Marcus' moods.</u> He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined <u>not</u> to accept him than to accept him.
6. I am fairly sure that I would <u>not</u> accept him.
7. I am virtually sure that I would <u>not</u> accept him.

PHILLIP

<u>You can generally "read" Phillip's moods</u>. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

<u>Phillip is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.</u>

<u>Phillip is able to respond to people.</u> When you talk to Phillip, you are pretty certain that he understands what you are trying to say. Although Phillip occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

<u>Phillip does not have a medical condition that requires special care.</u>

<u>Phillip can walk without assistance</u>.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined <u>not</u> to accept him than to accept him.
6. I am fairly sure that I would <u>not</u> accept him.
7. I am virtually sure that I would <u>not</u> accept him.

MICHAEL

Michael is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Michael has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Michael, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Michael occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

Michael can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

You can generally "read" Michael's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

Michael does not have a medical condition that requires special care.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

TONY

<u>Tony has trouble responding to people</u>. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Tony, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Tony occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

<u>Tony can walk without assistance</u>.

<u>Tony has a medical condition that requires special care.</u> In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Tony begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Tony from getting worse. If the flareup is left untreated for more than a day, Tony could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Tony from being placed in a foster home. Foster parents can be trained to manage Tony's condition.

<u>Tony sometimes acts up for no reason</u>. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

<u>Tony is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.</u>

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined <u>not</u> to accept him than to accept him.
6. I am fairly sure that I would <u>not</u> accept him.
7. I am virtually sure that I would <u>not</u> accept him.

DAVID

David can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

David has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, David begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop David from getting worse. If the flareup is left untreated for more than a day, David could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop David from being placed in a foster home. Foster parents can be trained to manage David's condition.

David sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

David is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

David has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to David, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. David occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

JIM

Jim has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Jim begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Jim from getting worse. If the flareup is left untreated for more than a day, Jim could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Jim from being placed in a foster home. Foster parents can be trained to manage Jim's condition.

Jim is able to respond to people. When you talk to Jim, you are pretty certain that he understands what you are trying to say. Although Jim occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

Jim can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

Jim sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

Jim is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

KEVIN

Kevin is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Kevin can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

Kevin does not have a medical condition that requires special care.

Kevin is able to respond to people. When you talk to Kevin, you are pretty certain that he understands what you are trying to say. Although Kevin occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

You can generally "read" Kevin's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

FRANKIE

Frankie is able to respond to people. When you talk to Frankie, you are pretty certain that he understands what you are trying to say. Although Frankie occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

Frankie sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

Frankie is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Frankie can walk without assistance.

Frankie has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Frankie begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Frankie from getting worse. If the flareup is left untreated for more than a day, Frankie could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Frankie from being placed in a foster home. Foster parents can be trained to manage Frankie's condition.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

STEVE

<u>Steve does not have a medical condition that requires special care.</u>

<u>Steve sometimes acts up for no reason</u>. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

<u>Steve is able to respond to people.</u> When you talk to Steve, you are pretty certain that he understands what you are trying to say. Although Steve occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

<u>Steve can walk for short distances only when supported by others</u>. He needs a wheelchair for sitting and extended ambulation.

<u>Steve is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.</u>

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined <u>not</u> to accept him than to accept him.
6. I am fairly sure that I would <u>not</u> accept him.
7. I am virtually sure that I would <u>not</u> accept him.

RON

You can generally "read" Ron's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

Ron is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Ron can walk without assistance.

Ron has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Ron begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Ron from getting worse. If the flareup is left untreated for more than a day, Ron could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Ron from being placed in a foster home. Foster parents can be trained to manage Ron's condition.

Ron has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Ron, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Ron occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

PAUL

Paul can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

You can generally "read" Paul's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

Paul has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Paul begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Paul from getting worse. If the flareup is left untreated for more than a day, Paul could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Paul from being placed in a foster home. Foster parents can be trained to manage Paul's condition.

Paul is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Paul has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Paul, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Paul occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

WILLIE

Willie sometimes acts up for no reason. He can be calm one minute, and then do something unexpected, like throwing things or repeatedly hitting himself or someone else during a temper tantrum. You can never be quite sure of what he will do at any given moment.

Willie can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

Willie is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Willie has trouble responding to people. He usually does not look directly at other people and often does not react to things that people say to him. When you talk to Willie, you sometimes get the feeling that he is not listening to you or understanding what you are trying to say. Willie occasionally withdraws from his environment, rocking back and forth, when his world is disrupted. He feels most secure when his world is quiet and routine.

Willie does not have a medical condition that requires special care.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

CARL

Carl is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Carl has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Carl begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Carl from getting worse. If the flareup is left untreated for more than a day, Carl could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Carl from being placed in a foster home. Foster parents can be trained to manage Carl's condition.

Carl can walk without assistance.

Carl is able to respond to people. When you talk to Carl, you are pretty certain that he understands what you are trying to say. Although Carl occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

You can generally "read" Carl's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

GREG

Greg can walk for short distances only when supported by others. He needs a wheelchair for sitting and extended ambulation.

Greg is a 14 year old severely retarded male. He needs a lot of help in order to learn how to care for himself.

Greg is able to respond to people. When you talk to Greg, you are pretty certain that he understands what you are trying to say. Although Greg occasionally rocks back and forth, he usually looks in your direction if you call his name while he is rocking.

You can generally "read" Greg's moods. He usually does not do unexpected things. He is able to sit quietly for at least a few minutes at a time.

Greg has a medical condition that requires special care. In order to control it, he needs to take medication twice a day and to follow a special diet. Although the condition can generally be managed, once in awhile it gets out of control on its own. When this happens, Greg begins to get lightheaded, pale and nauseous. A special medication can be given at this time to stop Greg from getting worse. If the flareup is left untreated for more than a day, Greg could lose consciousness. If it is left untreated for a week, he could die. Because it can be controlled, the condition is not considered serious enough to stop Greg from being placed in a foster home. Foster parents can be trained to manage Greg's condition.

ASSUME THAT WEEKEND VISITS ARE AVAILABLE AND THAT YOU HAVE A CHOICE OF ACCEPTING THIS CHILD FOR PLACEMENT. WOULD YOU ACCEPT HIM?

1. I am virtually sure that I would accept him.
2. I am fairly sure that I would accept him.
3. I would be more inclined to accept him than not to accept him.
4. Not sure.
5. I would be more inclined not to accept him than to accept him.
6. I am fairly sure that I would not accept him.
7. I am virtually sure that I would not accept him.

APPENDIX D

Manipulation Check Questionnaire

APPENDIX D

Manipulation Check Questionnaire

The names of the boys are listed below in alphabetical order. After you have read about one of the boys, find his name on this form and circle the answers that you think best describe him. Continue in this manner until all cases have been read.

CARL

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

DAVID

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

FRANKIE

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

GREG

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

JIM

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

JOE

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

KEVIN

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

LARRY

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

MARCUS

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

MICHAEL

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

PAUL

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

PHILLIP

1. Does he need special care for a medical condition?
    a. Yes
    b. No

2. Is he generally responsive to people?
    a. yes
    b. no

3. Is his behavior usually predictable?
    a. Yes
    b. No

4. Does he use a wheelchair?
    a. Yes
    b. No

RON

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

STEVE

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

TONY

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

WILLIE

1. Does he need special care for a medical condition?
   a. Yes
   b. No

2. Is he generally responsive to people?
   a. yes
   b. no

3. Is his behavior usually predictable?
   a. Yes
   b. No

4. Does he use a wheelchair?
   a. Yes
   b. No

APPENDIX E

Information for Research Project Participants

APPENDIX E-1

Information For Research Project Participants
(Pilot Study)

Title of research project: Foster Care Placement of Developmentally Disabled Children: The Role of Values in Foster Parent Decision Processes

Name of investigator: Carol Ellstein, M.A. Doctoral candidate, Developmental Psychology, Michigan State University; limited-license psychologist with Community Services for the Developmentally Disabled, Lansing.

Purpose of research: This pilot study will explore decisions that foster parents make regarding the types of children they want to care for in their homes. It is part of a larger research project that will examine the relationship between foster parents' values and their decisions. The purpose of the pilot study is to pretest the measures that will be used in the larger study.

Place and length of the research: The study will take place in your home. The whole process will take about two hours.

Required procedures: You will be asked to pretend that you are evaluating different case histories of children who are "available" for "placement" in your home. The histories are written as if the children are real, although they are not. These children do not really exist. You will also be asked to supply information about yourself, your background, your family and your experience with people who have developmental disabilities. All of this information will be confidential and will be used only for the pilot study.

Potential risks. The risks to you for participating in this research are minimal. The only problem may involve possible confusion as to whether the children in the vignettes are actually available for placement. Please understand that the children are fictional. If you have any questions about this, I'll be happy to answer them.

Potential benefits. (1) the chance to participate in a research project that you will probably find interesting; (2) the chance to talk confidentially about your experience with foster care; (3) the chance to learn more about your own decisions involving foster care placements.

Questions? Call me at CSDD. Telephone: (517) 394-5100 Ext. 224.

APPENDIX E-2

Information For Research Project Participants

Title of research project: Foster Care Placement of Developmentally Disabled Children: The Role of Values in Foster Parent Decision Processes

Name of investigator: Carol Ellstein, M.A. Doctoral candidate, Developmental Psychology, Michigan State University; limited-license psychologist with Community Services for the Developmentally Disabled (CSDD), Lansing.

Purpose of research: This study will explore decisions that foster parents like you make regarding the types of children they want to care for in their homes. In particular, it will examine the relationship between foster parents' values and their decisions. The study is being conducted as dissertation research.

Place and length of the research: The study will take place in your home. The whole process will take about two hours.

Required procedures: You will be asked to pretend that you are evaluating different case histories of children who are "available" for "placement" in your home. The histories are written as if they were real, although they are not. The children do not really exist. You will also be asked to supply information about yourself, your background and values, your family, and your experience with people who have developmental disabilities. All of this information will be confidential and will be used only for this study.

Potential risks. (1) There could be possible confusion as to whether the children in the case histories are actually available for placement. Please understand that the children are fictional and are NOT available for placement. (2) While discussing the case histories, one person became saddened when she realized that she now has some limitations regarding whom she can accept for care. This realization was upsetting for her, and she began to cry; she hadn't realized it before. If you have never considered your limitations with regard to foster care, then reading the case histories could possibly upset you.

Potential benefits. (1) the chance to participate in a research project that you will probably find interesting; (2) the chance to talk confidentially about your experience with the foster care system; (3) the chance to learn more about your own values and decisions involving foster care placement decisions.

Questions? Call me at CSDD. Telephone: (517) 394-5100 Ext. 224.

APPENDIX F

Consent Form

APPENDIX F

Consent Form

This research study is concerned with examining the ways that foster caregivers of developmentally disabled children make decisions about which children to accept for caregiving. Of particular concern is the exploration of the role that a foster caregiver's value system has on the decisions that he or she makes with regard to foster placements.

You will be asked to pretend that you are evaluating different case histories of children who are "available" for "placement" in your home. In addition, you will be asked to supply information about yourself, your background, your family, and your experience with people who have developmental disabilities. All information will be confidential and will be used only within the confines of this study.

Given the information above, I agree to the following:

1. I have freely volunteered to participate in a scientific study being conducted by Carol Ellstein, M.A., for her doctoral dissertation under the supervision of John Paul McKinney, Ph.D., Professor of Psychology, Michigan State University.

2. The study has been explained to me. I understand the explanation that has been given and what my participation will involve.

3. I understand that I am free to discontinue my participation in the study at any time without penalty.

4. I understand that the results of my participation will be strictly confidential and that I will remain anonymous. Within these restrictions, results of the study will be made available to me at my request.

5. I understand that my participation in the study does not guarantee any beneficial results to me.

6. I understand that my answers have nothing to do with future placements in my home.

7. I understand that my answers will not be available to anyone with whom I work in the licensing agency.

8. I understand that, at my request, I can receive additional explanations of the study after my participation is completed.

Signed: ________________________________ Date: ___________

APPENDIX G

Subjects' Policy Statements

Table 12

Policy Statements, Multiple R^2, Adjusted Multiple R^2 and Standard Error of Estimate for Each Subject

		Resident Characteristics					Adjusted	
Subject	MJS	Predict	Respond	Healthy	Walk	R^2	R^2	SEE
1	1.000	.000	.000	.000	.000	....	....	....
2	3.625	- .375	.375	.375	2.625	.825	.762	1.500
3	3.375	.500	-.750	1.125	- .250	.573	.418	1.523
4	5.188	.313	.688	.563	.188	.365	.134	1.528
5	4.000	1.000	.125	.000	.000	.903	.867	.399
6	2.875	.625	- .125	.375	.000	.745	.652	.522
7	3.125	2.000	- .125	.000	.000	.977	.979	.369
8	5.563	.188	.188	.313	- .063	.346	.109	.687
9	3.188	.188	1.063	.188	.813	.701	.592	1.074
10	1.875	.375	.375	.250	.750	.734	.638	.691
11	1.813	.313	.188	.313	.438	.543	.376	.719
12	3.688	1.938	.438	.063	.188	.868	.820	.938
13	3.438	.813	-.063	-.313	-.688	.761	.675	.750
14	3.750	.375	.625	.125	.000	.250	.000	1.545
15	3.375	.250	1.500	.125	- .125	.857	.805	.754
16	1.000	.000	.000	.000	.000	....	....	....
17	3.000	2.000	.000	.000	.000	1.000	1.000	.000
18	3.125	.625	1.250	.250	.250	.881	.837	.640
19	4.875	.125	.000	.125	2.125	.986	.982	.302
20	3.375	1.875	.000	.250	-.875	.871	.825	.965
21	2.813	.313	- .188	1.188	- .188	.830	.768	.687
22	3.188	1.438	.313	- .188	- .188	.842	.785	.780
23	4.063	.438	.188	.188	.688	.787	.709	.538
24	3.125	1.766	.154	.154	-1.346	.717	.615	1.601
25	6.938	.063	.063	.063	.063	.267	.000	.250

Table 12 (cont'd.)

		Resident Characteristics					Adjusted	
Subject	MJS	Predict	Respond	Healthy	Walk	R^2	R^2	SEE
26	1.000	.000	.000	.000	.000	....	....	....
27	4.188	.188	.063	- .188	2.813	.979	.972	.494
28	4.750	.625	.125	.250	.125	.596	.449	.691
29	3.000	1.000	.000	.750	.250	.520	.345	1.477
30	3.313	.313	.188	.188	-1.313	.808	.738	.808
31	4.125	.875	.000	.000	.125	.909	.876	.337
32	5.375	1.125	.125	1.625	-.125	.735	.638	1.438
33	3.063	- .063	- .063	.188	- .188	.253	.000	.579
34	4.375	- .125	.500	.375	.125	.284	.024	1.243
35	6.000	1.000	.000	.000	.000	1.000	1.000	.000
36	1.500	.500	.000	.000	.000	1.000	1.000	.000
37	1.563	.188	.063	.188	.063	.317	.069	.494
38	3.750	2.375	.250	.500	- .375	.848	.792	1.261
39	3.313	.688	.438	- .313	.063	.523	.349	1.008
40	3.938	.813	- .188	.188	1.313	.432	.225	2.168
41	1.000	.000	.000	.000	.000	....	....	....
42	5.000	.250	.125	.125	2.000	.963	.950	.477
43	1.500	.500	.000	.000	-.500	.286	.026	1.348
44	3.000	1.375	.250	.125	-.750	.810	.741	.929
45	3.563	.313	.063	- .063	1.938	.966	.953	.446
46	1.875	.750	.000	- .250	.000	.851	.797	.399
47	2.875	-1.000	-.625	-.625	1.250	.746	.653	1.288
48	1.563	- .188	- .063	.438	.313	.528	.357	.653
49	2.438	.438	.188	.313	.313	.424	.214	.914
50	1.000	.000	.000	.000	.000	....	....	....
51	6.063	.938	- .063	.563	- .188	.600	.453	1.095

Table 12 (cont'd.)

		Resident Characteristics					Adjusted	
Subject	MJS	Predict	Respond	Healthy	Walk	R^2	R^2	SEE
52	3.563	1.438	.438	- .063	- .063	.585	.434	1.528
53	1.500	.500	.000	.000	.000	1.000	1.000	.000
54	4.063	- .188	- .313	2.313	.188	.910	.878	.889
55	3.375	.375	- .250	.125	2.125	.950	.932	.603
56	7.000	.000	.000	.000	.000	....	....	....
57	7.000	.000	.000	.000	.000	....	....	....
58	4.750	.250	.125	.250	-.500	.481	.292	.783
59	2.688	.188	- .438	- .063	- .188	.372	.143	.808
60	5.125	.375	.250	.375	1.875	.837	.778	1.044
61	2.875	.875	.750	.000	- .125	.775	.693	.754
62	4.188	.313	.063	.188	2.313	.949	.931	.653
63	3.438	2.438	- .063	- .063	.063	.993	.990	.250
64	2.000	1.000	.000	.000	.000	1.000	1.000	.000
65	3.373	1.313	.688	.313	.188	.697	.587	1.213
66	2.438	.063	.063	.688	.313	.664	.541	.653
67	7.000	.000	.000	.000	.000	....	....	....
68	3.063	.188	- .063	.063	1.688	.908	.875	.653
69	4.813	- .188	- .313	.313	- .438	.276	.013	1.268
70	5.188	.188	- .063	-.563	.813	.446	.245	1.355
71	6.688	.063	.063	.313	.063	.509	.331	.392
72	4.188	.438	.688	.063	1.063	.476	.285	1.697
73	2.375	.375	.000	.125	- .375	.613	.472	.522
74	2.438	1.438	- .063	.188	- .188	.953	.936	.392
75	7.000	.000	.000	.000	.000	....	....	....
76	3.875	1.375	.000	.000	.250	.926	.899	.477
77	3.938	.438	.438	.313	- .063	.458	.260	.914

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