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The Importance of Access to Benefits under the Family Medical Leave Act
for Low-Income Families for Bonding and Attachment Facilitation with a Fragile Infant
and the Role of the Social Worker

Theresa Stewart Moran

Abstract

Lack of universal family leave discriminates against low-income families with infants who require care in the Neonatal Intensive Care Unit. Birth complications tend to occur more frequently in families living with low socioeconomic status, placing a disproportionate burden on an already vulnerable population. Parents in this group tend to be employed in jobs that do not include the benefit of parental leave. Considering that attachment relationships form as the result of bonding transactions during a critical time in development, limiting contact curtails secure attachment. This, combined with other risk factors, increase the odds of lifelong negative outcomes. Family leave policy on the national level warrants reexamination. Lessening restrictions on eligibility criteria will ultimately lead to better family outcomes. The social worker is uniquely positioned in the interdisciplinary team to advocate for the infant and parents and can facilitate creative alternatives to minimize deleterious sequelae resulting from lack of bonding opportunities.

Lack of universal access to family leave time discriminates against low-income families with infants who require care in the Neonatal Intensive Care Unit (NICU). Parents in this group tend to be employed in low wage, temporary, seasonal, or per diem jobs and do not qualify for parental leave. Infants born to this group of parents are more at risk for complications requiring extended hospital stays (Jenkins, McCall, Gardner, Casson, & Dolk, 2009). Opportunities for forming attachment bonds are curtailed when parents are not able to take leave from work to visit the infant in the NICU. The strength and frequency of infant attachment behaviors may be increased or decreased by the environment (Ainsworth & Bell, 1970). Sociodemographic risk factors stemming from low socioeconomic status already increase the likelihood of future difficulties. Children with secure attachment, which originates in newborn bonding, tend to have better outcomes in multiple domains. Those most at risk are also those who can least afford to jeopardize their employment and least able to afford unpaid time off.

Low-income parents of NICU infants who are unable to take leave from work have limited opportunities to participate in care, and form attachment, which can cause later behavioral dysfunctions. Birth complications tend to occur more frequently in families in low socioeconomic status, placing a disproportionate burden on an already vulnerable population. Indicators of education, income, and level of poverty are associated with adverse birth outcomes (Cantor, Waldfogel, Kerwin, McKinley-Wright, Levin, Rauch, Hagerty, & Stapleton, 2001, as cited in Candelaria, Teti, & Black, 2011). This is not only true in the United States. Studies in the United Kingdom, Ireland, and Denmark also have yielded similar trends; higher incidences of fragile infants are born to low-income families (Hvas Mortensen, Helweg-Larsen, & Nybo Andersen, 2011; Jenkins et al. , 2009; Smith, Draper, Manktelow, Dorling, & Field, 2007). Fragile infants born to disadvantaged families are additionally burdened if their chances for

success are curtailed by lack of parental attachment. Those who start with a disadvantage of poor infant health will suffer a greater accumulation of risk factors not experienced by infants born to parents who can access leave time (Ferraro, Shippe, & Schafer, 2008). Social justice demands that these NICU infants be given the same opportunities for attachment, in order to increase their coping skills for later life challenges. In the United States, 4 million babies are born each year, with almost 12% born prematurely, prior to 37 weeks gestational age and 8% born with low birth weight. This means that 480,000 infants are born every year with low birth weight, prematurity, or other medical conditions that require placement in a special needs nursery (National Center for Health Statistics, 2011). These infants can spend as long as several months in the NICU.

Families of fragile infants are at risk for poor attachment formation due to time spent in the NICU for management of medical complications. Infant attachment behaviors, including rooting, sucking, crying, and smiling, seem to be intrinsic behaviors for bonding with a primary caregiver in that the behaviors promote proximity. These behaviors of the very young infant are necessary for infant-parent bonding, the basis for the formation of attachment (Ainsworth & Bell, 1970). While infant attachment behaviors seem to be intuitive, parental bonding is not thought to be an automatic process, and needs investment from the parent in order to be successful. Bonding is a specific purpose of FMLA, but is discouraged by the lack of equitable access for the families of the sickest and most disadvantaged infants. In affluent areas, where more time and resources are available to parents, bonding with preterm infants may be heightened as the parents are able to spend time in the NICU (Hoffenkamp, Tooten, Hall, Croon, Braeken, Winkel, Vingerhoets, & van Bakel, H. J., 2012).

It is the proximity of the caregiver and the ability to respond the infant's needs that promote the feelings of security given to the infant by the parent. These feelings of security are the basis for attachment, an emotional bond between infant and parent, whereby the infant is confident about the parent's predictable and appropriate responsiveness (Ainsworth & Bell, 1970; Bowlby, 1988). If only the infants born to parents with better jobs are allowed to form bonds, then the disadvantages of being born into a family with fewer opportunities for social mobility will be even further exacerbated.

The effects of secure attachment in infant development has important sequelae predicated on the initial attachment bonds. Bonding occurs through parental interaction with the infant (Bowlby, 1982, 1988) and the level of attachment can be rated as secure or insecure (Ainsworth & Bell, 1970). Preterm infants from low-income parents showed more adverse attachment behavior than full term infants when measured at 6 and 12 months (Wille, 1991).

Secure attachment is thought to enhance self-efficacy in children and enable healthy socialization as adults. Poor attachment is a predictor of adolescent and adult dysfunction (Siegel, Gardner, & Merenstein, 1993). The interaction of complex medical needs with socioeconomic disadvantage results in more infants with poor developmental outcomes than infants with prematurity alone (Candeliera, O'Connell, & Teti, 2006; Laucht, Esser, & Schmidt, 1997 as cited in Candeliera, Teti, & Black, 2011) and the effects of the neighborhood factors on prematurity and poor outcome have been persistent over time (Auger, Gamache, Adam-Smith, & Harper, 2011). Medical interventions, including the need for the infant's prolonged stay in an isolette for temperature control and monitoring of vital signs, limit initial contact of parents with the infant and can lead to deficiencies in attachment with results evident years later (Klaus, Kennel, Ringler as cited in Siegel, et al., 1993). If parents have fewer opportunities to form

secure attachment, this adds another risk factor for the infant who may struggle with long-term medical problems (Berggren, 2007). Long term adverse sequelae have been noted for these families, as high medical risks are associated with insecure attachment (Udry-Jorgensen, Pierrehumbert, Borghini, Habersaat, Forcada-Guex, Ansermet, & Muller-Nix, 2011.) and increased incidence of psychiatric and emotional symptoms among adolescents and adults (Heider, Matschinger, Bernert, Alonso, & Angermeyer, 2006; Tallandini & Scalembra, 2006).

Parents of infants who need NICU care have obstacles to overcome in order to form the bonds that facilitate secure attachment (Tallandini & Scalembra, 2006). The transactional nature of the attachment development through infant bonding supports close contact between parents and infant (Fegran, Helseth, & Fagermoen, 2008). A number of strategies for fostering bonding and attachment have been suggested including the involvement of parents in the care of the infant whenever possible, as physical proximity, and visual and tactile stimulation are primary interactions in the infant-parent dyad. Parents are encouraged to hold and cuddle the infant when medically feasible (Fegran, et al., 2008; Siegel, et al., 1993). One of the more successful attachment strategies has been kangaroo mother care (KMC), where the infant is placed skin to skin on the parent's chest, allowing for warmth and physical contact to be shared. Parents who participate in KMC also demonstrate behaviors consistent with fostering later social and cognitive growth (Furman & Kennell, 2000; Tallandini & Scalembra, 2006).

Other forms of skin to skin contact promote infant development in the NICU. Skin is the largest organ in the body, with many nerve endings. Stroking the skin stimulates the infant to breath more regularly, which is medically beneficial (Giustardi, Stablum, & De Martino, 2011). Infants who received massage from a parent had higher increases in weight gain at age 2 months than those infants who did not receive massage (Karbasi, Golestan, Fallah, Golshan, & Dehghan,

2013). The amount of skin to skin contact given to the infants was dependent on the amount of time that mothers spent in the NICU (Gonya, & Nelin, 2013). Additionally, infants whose mothers spoke or sang to them while in the NICU, had higher oxygen saturation levels and heart rates with fewer negative critical events when the mother was speaking or singing (Filippa, Imberty, Gratier, Devouche, & Arioni, 2013). Utilizing these methods of connecting to the infant communicate the parent's presence and care (Fegran, et al., 2008). In order for the parent to participate in care, they must be able to obtain leave from their jobs, something that is not possible for all families.

Results of NICU bonding and attachment interventions seem promising. Secure attachment seems to be associated with number of visits to the NICU (Gloppestad, 1995, as cited in Fegran, et al., 2008; Sullivan, 1998 as cited in Fegran, et al., 2008). Participating in these types of interventions takes time. The parents of NICU infants who qualify for the Family Medical Leave Act (FMLA) and who can afford to take time off without pay are able to spend time at the nursery and take advantage of strategies for attachment.

The FMLA benefit is accessible to working parents, guardians or other adults acting in loco parentis who need to take time off from work to receive health care or to care for a family member with a "serious health condition". One of the qualifying conditions for FMLA eligibility is for the birth of a son or daughter in order to promote bonding (U. S. Department of Labor (DOL), 2013). The benefit is one of job security after an unpaid leave. In order to qualify, "[a]n employee must (1) work for a covered employer, (2) work 1,250 hours during the 12 months prior to the start of leave, (3) work at a location where 50 or more employees work at that location or within 75 miles of it, and (4) have worked for the employer for 12 months" (DOL, 2013). The most vulnerable families have the least access to FMLA and then have the fewest

opportunities to interact with their infant in the NICU to form attachments. This, combined with the other sociodemographic risk factors, increases the odds of lifelong negative outcomes (Phillips, 2004; Wille, 1991).

According to the 2002 National Survey of America's Families, only 60% of U.S. families are eligible for FMLA (Phillips, 2004). The Bureau of Labor Statistics reports that low-income workers have the least access to leave because they work in firms where there are a small number of employees. Those workers who earn less than 200% of the federal poverty level have the least access to leave (Phillips, 2004).

Gender and age influence a worker's access to leave, with women having less eligibility than men and younger workers having less eligibility than older workers due to less accrued time in employment. Although the goal of FMLA was to establish gender neutrality for leave, women are at a disadvantage because they are less likely to work in jobs that qualify for paid leave and FMLA (Berggren, 2007). Workers with highest probability of needing leave time, younger workers with the youngest children, are least likely to be eligible (Phillips, 2004). Low-income families must choose between losing jobs and losing opportunities to form attachments. This seems like an unfair burden to the families with non-traditional employment.

According to Rawls's (2001) Theory of Justice as Fairness, those with the most need should get care first, which would bring them up to the level of other members of society (Rawls, 2001). Also called the Equal Liberty Principle (Rawls, 2001), this viewpoint states that all society members should be able to participate equally in society. If they are at a disadvantage due to health, then they should be restored, so that they may be productive citizens. Children born with a sociodemographic disadvantage as well as a health disadvantage should get extra care according to Rawls. In fact, they are further deprived of parental attachment opportunities

when parents cannot take FMLA leave time, which only adds to their risk factors. If we value the contribution of individuals, we should then provide the opportunities for them to grow and flourish. Depriving premature infants of the necessary bonding and attachment opportunities because their parents need to work will only further contribute to their marginalized status (Hester, 2001).

What is proposed?

Family leave policy needs to change to include low-income, seasonal, and part-time workers. In the current economy, giving up a job when there is no leave available is a risk that many cannot afford. Without the security of a waiting job, working parents may lose their place in the labor market. Acknowledging the needs of these working parents and lessening restrictions on eligibility criteria will ultimately lead to better family outcomes (Phillips, 2004). Workers who feel supported by their employer tend to be more loyal and productive. Employers report that accommodating their employees who take leave does not create undue hardship for the company (Phillips, 2004). All families should be able to take the necessary time to form secure attachments with their infants (Brisch, Bechinger, Betzler, & Heinemann, 2003). Those at higher risk for negative long-term outcomes due to structural disparities should not be excluded from this intervention strategy. The difference in access to these opportunities implies that some parents and their infants are less deserving of optimal care. Social justice demands that low-income parents be given the same chances for infant attachment as higher income parents.

Since FMLA was enacted in 1993, the law has undergone several interpretations and amendments. In 2008, the DOL expanded protections under the FMLA to cover military families and flight attendants (DOL, 2013). This revision included new FMLA regulations which expanded the benefit for military personnel and their family members. These new

regulations also provide new guidelines for determining the eligibility of airline flight crews due to their non-traditional work schedules (DOL, 2013). In 2010, the DOL clarified eligibility for lesbian, gay, bisexual, and transgender couples by issuing an interpretation of the definition of “son or daughter” (DOL, 2013). The new definition includes LGBT parents who have no biological or legal relationship to the child (DOL, 2013).

These provisions have expanded the law to be more inclusive. However, there are still gaps in coverage that exclude some families. This situation has not gone completely unnoticed; new bills have been introduced in recent Congressional terms. The House of Representatives had two bills introduced in 2009. H.R. 389, the Family Fairness Act, sponsored by Representative Tammy Baldwin (D-WI) would eliminate the hours of service requirement allowing part-time employees to be eligible for benefits. The second bill is H.R. 824, the Family and Medical Leave Enforcement Act, sponsored by Representative Carolyn Mahoney (D-NY). This legislation would expand access by requiring employers with 25 or more employees to participate in the benefit instead of the current requirement which only includes employers with 50 or more employees. Both bills had been referred to three House committees. Action on either would increase the availability of leave time to these parents and enable better family outcomes.

The Role of Social Work

Social workers can advocate for a more inclusive policy on several system levels. On the micro level, social workers can advocate for the individual family. It is important, then, to screen for these families when an infant is admitted to the NICU. Asking parents and other family members about their employment situation is the first step in identifying families with this difficulty. The hospital social worker cannot enable parents to obtain leave, but can work with families in order to gain maximum benefits from available time visiting the NICU. Social

workers can advocate for these families in the hospital by requesting extended visiting hours for parents, requesting that staff be available for instruction to parents during off-hours, and by providing extra support and positive reinforcement for parental interaction when it does occur.

On the mezzo level, social workers can advocate for change within an institution to allow for maximum interaction between infants and parents. Since bonding is interrupted or delayed by NICU admission, the staff should aim to involve parents in infant care whenever possible. Social workers can encourage other members of the interdisciplinary team to see parents as members of the care team, and not visitors (Haut, Peddicord, & O'Brien, 1994). Hospital staff may be able to schedule procedures that would prevent visits for times when parents are not present. Staff on all shifts can be trained to provide instruction in KMC and other strategies to enable attachment. Social workers can suggest that hospital policy reflect sensitivity to these families and to offer educational session, support groups, and continued follow-up for providing access to community resources as the child develops. Social workers can educate the institution in evidence-based practices that support these interventions for families. Communication by hospital staff also serves to lessen stress for parents, which enables a better bonding experience. Social workers can also encourage staff to keep parents informed of the infant's status and to explain medical information when necessary (Gonya, & Nelin, 2013). Hospital staff can also educate parents on how to handle their infant and provide encouragement and positive support for spending time with the infant (Giustardi, Stablum, & De Martino, 2011). It is important for the social worker to advocate for these accommodations, as these services are within the jurisdiction of the individual institution.

Social workers can intervene on the macro level by making known the needs of these families and participating in the political process to facilitate meaningful change. Social workers

can agree to participate in research and support families who agree to participate. As stated in the National Association of Social Workers [NASW] *Code of Ethics* (NASW, 1999) social workers participate in action to promote social justice. Social workers who interact with families of infants who need NICU care are urged to provide adequate support for all parents in their efforts to bond with their newborns.

Access to the FMLA benefit should be available to all parents, especially those who have infants requiring special care. As these infants are disproportionately represented in low-income families, it is especially important that the parents of these infants be allowed to spend time forming attachments in order to provide protective factors against pervasive structural inequalities. Expanding eligibility criteria through legislative provisions will enable parents to form more secure bonds and provide children with stronger foundations for optimal outcomes. Social workers can support these efforts in multiple systems of the family's environment.

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