Will I Ever See You Again?

Attachment challenges for foster children

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“It is now clear that human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise.”

*John Bowlby, 1973.*

Who did you trust?
Attachment is defined as a/an...

✓ “...evolutionary adaptive emotional tie...(Darwin)
✓ “...reciprocal process by which an emotional connection develops...(Erikson)
✓ “...intense affectional bond...(Harlow)
✓ “...instinctual process...as basic as seeking food and always results in some form of attachment...(Freud)

...between the child and his primary caregiver.
The Cycle of Attachment

Infant/child feels threatened, needs help, has a need and elicits the help of the caregiver displaying an “attachment behavior to get his/her attention.

Caregiver correctly reads needs of child and tends to the need.

Child is satisfied, returns to activity confident that help is there if needed.
A broken attachment cycle can result in two serious problems:

- *Children* have difficulty forming attachments to their caregivers (bio or foster.)
- Bio or foster *parents* have difficulty responding correctly to their children.

...so a new cycle is created...

The child learns not to become attached...
The Study of Attachment

History….
- Sigmund Freud (1920’s)
- Rene Spitz (1940)
- Harry Harlow (1958)
- Erik Erikson (1968)

Recent research…
- Measured by behavior.
- WWII children in hospitals, institutions, or nurseries (John Bowlby) (1940’s)
  - Protest, despair, detachment
- “Strange Situation” (Mary Ainsworth) (1979)
All children attach to caregivers in one of two ways:

- Securely
- Or
- Insecurely
Secure Attachment

The emotional bond is positive and care is consistent. A sense of trust develops. Child may move away and explore knowing that the caregiver is available for help in case of adversity or fear.
Insecurely Attached

Either:

- Insecure-**Resistant**: child is uncertain. Vacillate between seeking and resisting contact with caregiver.

- Or:

- Insecure-**Avoidant**: child expects rejection from caregiver. Actively avoid caregiver.

...or so they thought...
Until: A mid-1980’s Discovery

Researchers slowed down Ainsworth tapes and discovered an additional Insecure Attachment type in maltreated children:

**Disorganized/Disoriented**
– child is confused, dazed, may subtly try to hit caregiver….

Common to children who had been abused…
...which describes foster care children who have a background of...

- neglect, abuse, parental drug abuse, and family instability all of which make the occurrence of Disorganized/Disoriented attachment disorder more likely.
- Some children are resilient... why?
- More specifically, foster children have backgrounds which include
- Sudden or traumatic separation from primary caregiver.
- Inconsistent or inadequate care at home.
- Chronic depression of primary caregiver.
- Physical, sexual, or emotional abuse
- Illness or pain which cannot be alleviated by caregiver.

**All factors that interfere with healthy attachment to mother/caregiver**

“Joseph”
Neurological Response to Maltreatment

New information comes in through here first

THEN gets matched to PRIOR information

If unknown or threat body will protect itself

Neural response strengthens with repetition

PTSD?

Look! A Rattlesnake!

Brain is still forming in children

Cortex

Limbic system

Hindbrain
But that’s not the end of trauma for them:

Problems also occur AFTER children come into care…
AFTER they come into care, foster children...

- display unusual neurologically strong attachment behaviors which are misunderstood.
- suffer from neurological problems.
- experience the turnover of case managers, CASAs, judges, GALs, therapists, foster homes...(NO ONE stays!)
- experience frequent moves and/or placements.


**Links to Psychopathology/criminality:**

- “Insecure attachment patterns in infancy and early childhood are strong predictors of psychopathology and maladaptive behavior in adolescence and adulthood.” (Genuis, 1995).

- Foster children are almost 9 times more likely than home reared children to evidence psychological disturbance. (McIntyre & Kessler, 1986).

- Within the first year, 68% of children who age out of foster care system are in jail or dead. (Dr. Bruce Perry 2006)

- 80% of homeless in NY were foster children in late 1990’s. (Dave Thomas Foundation)

- In 1997, 60% of inmates in Folsom prison were foster children. (Dave Thomas Foundation)
Now a word about…

Reactive Attachment Disorder --

- Before 5 years old
- “grossly pathological care” -- disregard of both emotional and basic physical needs.
- “fails to initiate and to respond to most social interactions in a developmentally appropriate way.” (either extreme)
- Repeated changes in primary caregiver.
- An extreme form of attachment disorder, “very uncommon” (DSM-IV)
A more likely reality…

We each fall somewhere along a continuum

Healthy Attachment

Reactive attachment disorder

DSM-IV

Unhealthy begins here

Shouldn’t wait for here
**Attachment disorder symptoms may include the following behaviors...**

*(checklist approach)*

- Superficially charming
- Lack of eye contact
- Overly affectionate
- Not cuddly
- Control problems*
- Destructive
- Cruel to animals*
- Chronic lying*
- No impulse control*

- Learning deficits
- Lacks cause/effect thinking*
- Lack of conscience*
- Abnormal eating patterns
- Poor peer relationships*
- Preoccupied with fire, blood, gore*
- Nonsense questions/chatter
- Demanding
- Abnormal speech patterns

*may also be symptoms of ODD and Conduct Disorder

“David”
The questions is always: To whom & how is child attached?

- Checklist doesn’t tell us about child/caregiver relationships.
- Modern diagnosis of attachment disorders is not focused on whether foster children attach to their caregivers but how…
Clinical Assessment of Attachment Disorders

“Bonding Assessment”

A smorgasbord of evaluation procedures utilized to consider the relationship between a child and an actual or potential caretaker.” (Stokes & Strothman, 1996)

Consists of records, interviews, observations, tests to determine best placement – which may be “least detrimental alternative.”

Return to parent not always a given because –
- Parents not prepared to parent
- Child is bonded with foster parents
- Separation from foster parents may be another trauma for child
- The longer the placement, the more likely the trauma of separation
### Recent FCRB Cases:

<table>
<thead>
<tr>
<th>Child/age</th>
<th>CP</th>
<th>TIC</th>
<th>CMs</th>
<th>PLs</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>F, 13 m.</td>
<td>RTP</td>
<td>12 m.</td>
<td>1</td>
<td>1</td>
<td>7 m. to begin Compliance</td>
</tr>
<tr>
<td>M, 10 m.</td>
<td>C: S&amp;A</td>
<td>10 m.</td>
<td>2</td>
<td>2</td>
<td>11th hour comp. - No CM@ Review</td>
</tr>
<tr>
<td>M, 17</td>
<td>LTFC</td>
<td>9.75y</td>
<td>9</td>
<td>22</td>
<td>&quot;Looking for relatives“ (from early PR)</td>
</tr>
<tr>
<td>F, 12 y (1)</td>
<td>Adp/G-ma</td>
<td>3.4 y</td>
<td>3</td>
<td>2</td>
<td>Child vacillates re adopt (OK now)</td>
</tr>
<tr>
<td>F, 2 y (2)</td>
<td>Adp/Place</td>
<td>18 m.</td>
<td>2</td>
<td>1</td>
<td>Concerns about safety in Adopt. Pl.</td>
</tr>
<tr>
<td>M, 11 m.</td>
<td>Adp/Rel</td>
<td>11 m.</td>
<td>1</td>
<td>2</td>
<td>&quot;S/not linger in system&quot;</td>
</tr>
<tr>
<td>M, 10 m.</td>
<td>Ad/Rel</td>
<td>10 m.</td>
<td>1</td>
<td>2</td>
<td>Mother SMR - w/ aunt (concerns)</td>
</tr>
<tr>
<td>M, 16 m.</td>
<td>RTP</td>
<td>11 m.</td>
<td>2</td>
<td>1</td>
<td>CPS will rec. S&amp;A (Adoption time)</td>
</tr>
<tr>
<td>M, 16 y.</td>
<td>LTFC</td>
<td>8.5 y.</td>
<td>3</td>
<td>5</td>
<td>No PR, No CP, No CM *</td>
</tr>
<tr>
<td>M, 15 y</td>
<td>LTFC</td>
<td>6.25 y</td>
<td>11</td>
<td>7</td>
<td>Loves GH, will run if placed (doing well)</td>
</tr>
<tr>
<td>M, 12 m (1)</td>
<td>RTP</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td>Initial: &quot;Grave Risk&quot; - charges pending. 4 &amp; 2 yo to be</td>
</tr>
<tr>
<td>F, 4 y (2)</td>
<td>RTP</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td>moved because of sexual acting out.</td>
</tr>
<tr>
<td>F, 7 y (3)</td>
<td>RTP</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>F, 10 y (4)</td>
<td>RTP</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>F, 15 m (1)</td>
<td>G/G-ma</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td>Initial: Bio Mom's 9th &amp; 10th child. G-ma has all.</td>
</tr>
<tr>
<td>M, 28 m (2)</td>
<td>G/G-ma</td>
<td>5 m</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>M, 17.5 y</td>
<td>LTFC</td>
<td>10 m.</td>
<td>1</td>
<td>4</td>
<td>&quot;incorrigible“ No CM *</td>
</tr>
</tbody>
</table>
How can we improve the future for foster children?

Rule #1:

Best interests of the child = Primum non nocere
We can change the status quo...

“For various reasons, biological families fail to demonstrate rapidly enough sufficient progress to allow their child to return to their care; as a result, their children stay in their foster family much longer than intended. The caseworker is then confronted with a major dilemma: Should a child who has developed a significant attachment to his or her foster parents return to the biological parents who have not progressed enough in their parental competencies or stay in the foster family on a long-term basis? In such situations, we have come to recommend permanence in the foster family.”

Gauthier, Fortin, and Jeliu, 2004
Circumstances affecting healthy attachment:

- Age of child.
  - ...0-3 – critical neurological development
- Child’s sense of time,
  - ...e.g., 6 mo. to a 2 year old...
- Ability of child to express him/her self.
- Number/length/severity of traumatic experiences
  - ...from the reports.
  - ...possibilities but not in reports.
  - ...from number of previous placements.
- Is this child healthily attached to placement
  - ...confidence in parents to risk another placement?
- ...Attachment to parents
  - ...were visitations adequate.

*How do we know about ANY of these relationships? (“by report”?)
Circumstances affecting healthy attachment: (Continued)

- ...parent/kin/foster training to handle unique problems this child brings into care
- ...Child’s physical and emotional development
- ...Is there Concurrent case plan?
Reducing the odds...

- **Use the experts:**
  - State Psychological Associations—
  - Early Intervention programs

- **If doubt about FR, include concurrent of S&A**

- **Place in Foster/Adopt home to provide continuity if FR fails.**

- **Provide therapeutic foster training**

- **Provide intermittent training as problems arise**

- **Move children reluctantly**

- **Find/Be a consistent person/situations for child**
  - Foster parent, CASA, family members, therapist, schools, GS troops, church, etc.
  - Adoption communities like Hope Meadows
Recommended Reading


Recommended Reading (2)


Recommended Reading (3)


Thank you for your interest in watching this video!

If you wish to receive CASA of Arizona training credit you are welcome to take a quiz. Passing scores will receive a certificate of completion.

Go to: