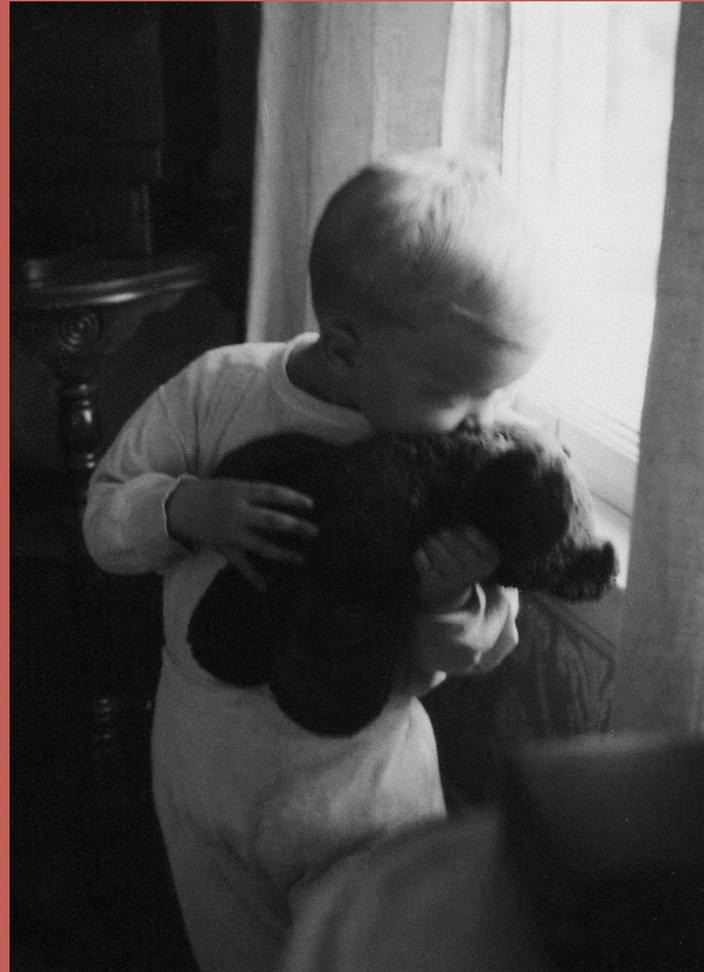


Will I Ever See You Again?

*Attachment
challenges for
foster children*

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Prepared for the
First Things First
Early Childhood Summit 2015

Arizona Foster Care Facts

- Children in foster care: 16,990¹
- Number of placements:
 - Average per child: 2.3
 - Ranging from: 1-43
- Ages 0-5 = 41.7%
- Ages 0-3 = longest time in foster care²
- Ages 0-3 = highest reentry rate³
- Ages 0-3 less likely to be reunified⁴

¹CASA of AZ, 2015

²AFCARS Report, 2014

³Dicker and Gordon, 2004

⁴Jacobs, 2015

“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)
- ✓ “...biologically propelled love song...” (Stamm)

*...between the child and his primary caregiver
occurs between 6 and 12 months.*

The Cycle of Attachment

Infant/child feels has a need: hunger, fear, frustration & 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.

Will repeat this successful attachment behavior



Then brings these behaviors
into foster care so...

- Children have difficulty forming attachments to their foster parents because their needs are not met.
- Bio or foster parents have difficulty responding correctly to the children because the behaviors seem odd..

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

The child learns not to become attached...



A Short History of the Attachment Research

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)
 - “Secure Base”
 - Protest, despair, detachment
- “Strange Situation” →



Research results were pretty simple...

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. Children learn from caregiver how to handle stress. Becomes a **secure base**.
(*Protective factor.*)



Insecurely Attached

Makes future secure attachments less likely
(Risk factor)

Either:

- Insecure-Resistant: child is uncertain.
Vacillates 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 :

Disorganized/Disoriented

- child is confused, dazed, may subtly try to hit caregiver....

Common to children who had been **abused**...



...just like Arizona's 16,990 foster children who come into care after experiencing...

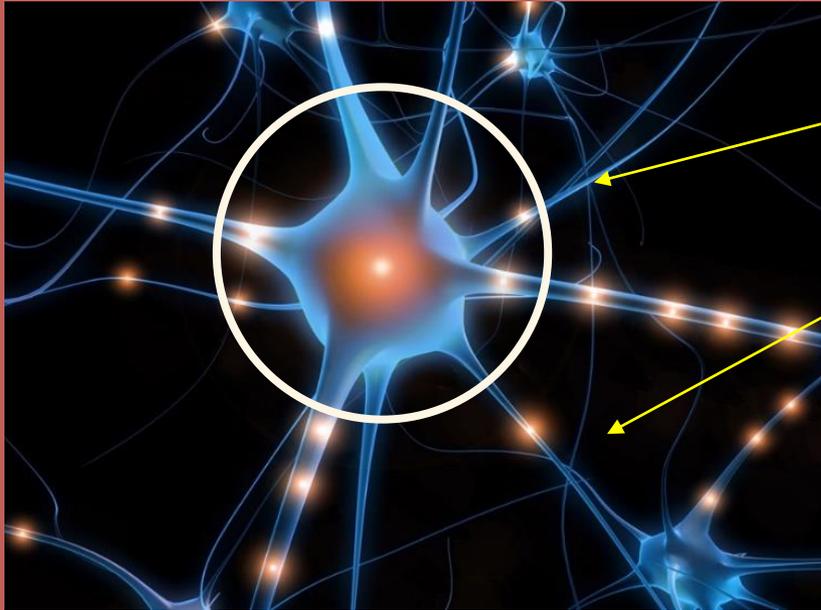
- Neglect; abuse; parental drug abuse; inconsistent care at home; chronic depression of primary caregiver; physical, sexual, or emotional abuse; illness or pain which can not be alleviated by caregiver; family instability; ***all of which make the occurrence of Disorganized/Disoriented attachment disorder more likely.***



But wait, there's more...

Neurological development also affects a child's ability to attach to caregivers.....





100 billion neurons
at birth

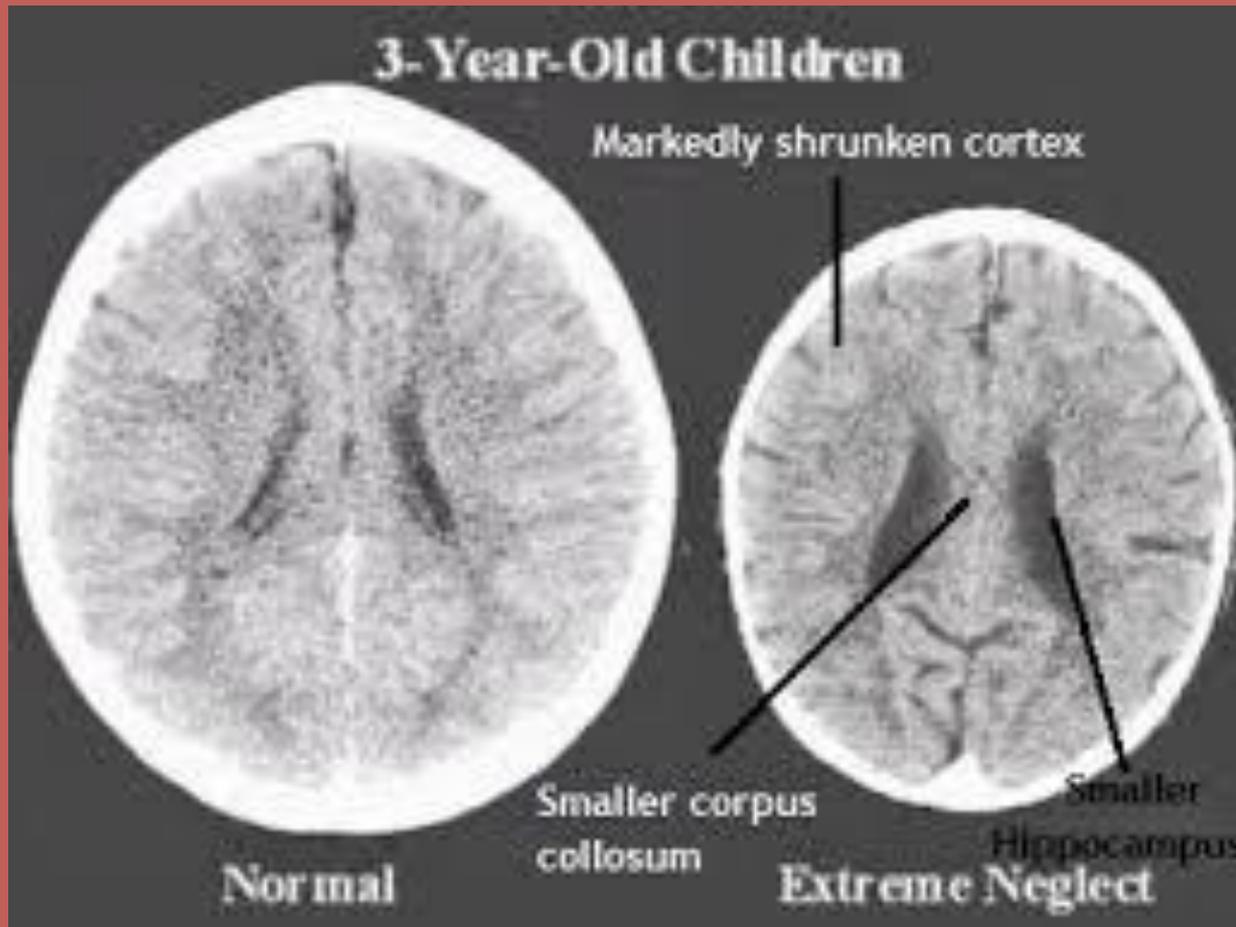
700 - 1,000
synapses per second

Repeated = strengthened
Not repeated = pruned

- Abuse/neglect cause continuous (toxic) stress
- Child's alarm system remains activated.
- Synapses for fear and stress strengthened
- Synapses for learning and self-controlled pruned
- Body and brain set permanently on high alert
- Becomes the foundation of the child's brain

Conclusion: Time is of the essence...





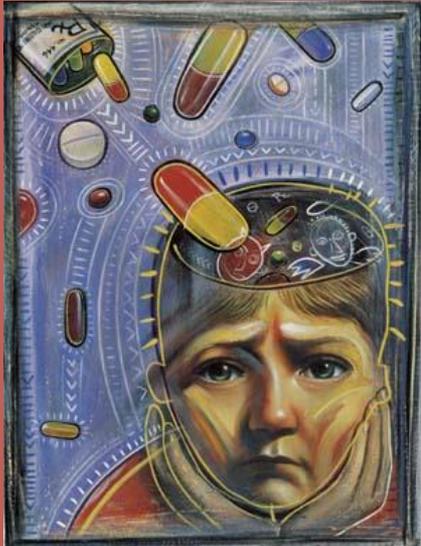
**Abuse/neglect affect brain development of young children.
The younger the child, the better chance to
recover from this consequence**

Conclusion: Time is of the essence...

As a result of their neglect/abuse foster children come into care with...

- ... unusual attachment behaviors they used to survive their abuse/neglect which may be misunderstood.
- ... and stress-related neural connections which have interfered with normal brain development.





The unusual behaviors exhibited by traumatized children often lead to **psychological diagnoses** and are often treated with Psychotropic Medication further interfering with the child's developing brain.

Classes of psychotropic medications:

Anti-psychotics, Anti-depressants,
Anti-manic, Anti-seizure and Stimulants

- 41.3% \geq 4 different classes (Zito, J., et al., 2008)
- Long-term effects of these drugs are unknown. (Littell, M., 2001)



Martin, Age 8

- **Background: DV, Parental Drug use, 2nd grade.**
- **Very aggressive, threatens to have his father kill people, sheriff called to school numerous times.**
- **Psychotropic meds:**
 1. Depakote (>10): Anti-seizure, off-label: mania
 2. Zoloft: Anti-depressant, SSRI*. 6-17: OCD
 3. Intuniv: Guanfacine, reduces BP, off-label: ADHD
 4. Risperidone: Anti-psychotic. off label: Mania

****Black box warning: "SSRI's may increase suicidal thoughts in children and adolescents."***

Side effects (partial list):

1. Breathing diff., bruising agitation, insomnia, liver damage
2. Agitation, anxiety, diarrhea, dizziness, dry mouth, gas
3. Dizziness; drowsiness; dry mouth; headache; tiredness..
4. Insomnia, rapid HR, hallucinations,, TARDIVE DYSKINESIA

Then, once in care, foster children ...

- experience multiple case managers, CASAs, judges, GALs, therapists, foster homes...
- ...experience frequent moves and/or placements.

...and their resistance/inability to attach to others becomes an expected outcome...



Now a few words about... (What we once called...)

Reactive Attachment Disorder (RAD)

DSM V now divides into two disorders...

1. Reactive Attachment Disorder:

- Withdraw/fearful of adults
- Insufficient care (at least one):
 - *Emotional needs not met
 - *Repeated changes of primary caregiver
 - *Limited opportunities to attach (e.g., institutions).

2. Disinhibited Social Engagement Disorder

Indiscriminately social toward adults
Same “insufficient care” as RAD

Extreme and rare...



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 prison inmates in Illinois have been through the foster care system (National Association of Social Workers)
- As well as dependent, histrionic, borderline, and schizoid personality disorder (Mikulincer & Shaver, 2012)



Attachment (Bonding) Assessment

Evaluates the quality of the caregiver-child relationship through:

- Single or multiple interviews.
- Video-taped caregiver-child observations
- Observations in the home
- Courts docs
- Psychological testing
- Mental Health Assessment

...of children 0-6 years old. (0-12 mo: later attachment is predicted by the mother's sensitivity to the infant.

Answers: “Who can best provide a secure base for this child by being predictable, consistent, and emotionally available?”



Attachment disorder symptoms may include the following behaviors... **(developed by clinicians)**

- ✓ 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

also symptoms of ODD* and Conduct Disorder

No current therapy for attachment disorder so use therapy for ODD/CD.



Case Study - Rosie

<u>Event</u>	<u>Case Plan</u>	<u>Age</u>	<u>Date</u>	<u>Time</u>
Birth	Sibs reunified	0	1/20/12	Home – 9 mo.
Removed (Neglect)	Family Reunification	9 mo.	10/20/12	Foster – 4 mo.
Reunified		13 mo.	2/22/13	Home – 5.5 mo.
Removed (beaten)	Family Reunification	19 mo.	8/5/13	Foster – 19.5 -- so far

Parents:

-- Mother mentally ill, both parents: drug users, missed/positive UAs, inconsistent/no show visits, not participating in services. Had CPS involvement with older children before Rosie was born.

Let's:

- Compare amount of time at home vs. in foster home.
- Emotional (attachment) consequences of moving back and forth.
- What is stressful for Rosie?
- Is the Case Plan appropriate?
- What is in the best interest of Rosie?



Miranda (As of 5/15/2015)

- 16 ½; came into care in 2004 at age 5 -- **Neglect/Abuse**
 - Sexually molested by father and mother's BFs
 - All children TPRed; Miranda's four sibs adopted
 - M. displays sexualized behaviors and aggression
 - "Denial of placement in Maricopa Co.'s TGH" (5/15)
 - All requests outside of Maricopa Co. also declined
 - 10.7 years in care; 24 placements
 - Several potential adoptions; all incomplete.
 - As adoption gets close; Miranda behaves in such a way that the adoption is cancelled or potential adoptive parents backs out after receiving her information.
 - ***FCRB reviewed notes back to 2004.***
- **Miranda has never had anyone – ever!**

In summary, then, “Best Interest” requires that we consider:

Problem

Length of abuse/neglect results in neurodevelopment problems.

Odd, unique, survival behaviors (from home or misinterpretation of events.)

Multiple people (CMs, homes, therapists, etc.)

New placement

Psych diagnosis/ Psychotropic meds (not “by report”)

Loss of bond with parents

Amelioration

Time is of the essence. Expedite case plan 0-5. Concurrent of S & A, if doubt.

Educate foster parents (& as problems arise). Involve high level therapist
(www.apa.org/practice/refer.html)

Move only reluctantly/
What does placement need?

Continuity with previous home

Re-evaluate w/ new Psych evaluation

Is visitation adequate?



“Best Interest” requires that we consider:

(Page 2)

Problem	Amelioration
No consistent person	Look for previous foster, teacher, scout leader, CASA, brother 
If any reason to doubt RTP	Concurrent of S & A and place in Foster/Adopt Home
Attachment to foster home vs. RTP	Bonding assessment will help determine best placement
Re-entry into foster care	Confidence that parents' progress will continue
Inadequate foster parent training	<u>All foster parent training should be “therapeutic.”</u>
No kinship foster parent training	Require (50% returned to parent)
Systemic problems...	New programs: Hope Meadows One therapist, one child



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Thanks!
for
coming!

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