WHEN BALANCING FEELS LIKE JUGGLING: SUPPORTING INFANTS AND YOUNG CHILDREN IN FOSTER CARE THROUGH THE LENS OF ATTACHMENT

Michigan Association for Infant Mental Health
Learning and growing together.

Faith Eidson, LMSW, IECMH-E®
June 27 & 28, July 25 & 26, 2022

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- Attachment and Working Models
- Cultural Humility and Reflective Practice
- Special Considerations in the Work
- Best Practices in Assessment

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The developing capacity of the child from birth to age three to…

- Experience, regulate, and express emotions
- Form close and secure interpersonal relationships
- Explore the environment and learn

…all in the context of family, community and cultural expectations….*Zero to Three IMH Task Force*

www.zerotothree.org

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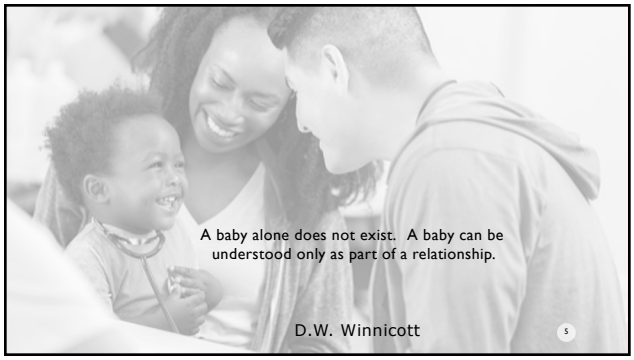

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- Infants are the largest group entering foster care – they are 4x more likely to be placed in foster care than children over 1
- After reunification, 1 in 3 infants return to care, unless they were placed with relatives, then only 1 in 7 return (big difference!!)
- Brains are the most malleable in infancy – most vulnerable to effects of maltreatment, also most responsive to intervention and healing
- The experiences in the first 2 months of life have a disproportionately important impact on your long-term health and well-being

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- An enduring emotional connection between the child and a specific individual ("attachment figure") characterized by a tendency to seek and maintain closeness to that figure, especially under conditions of stress (i.e. fear, fatigue, illness…)
- Attachment Relationships are central and may be "protective" or "risk" factor depending up on the relationship
- Attachment is based on pattern of care
- Attachment is revealed by organization of babies' behavior
- "An evolutionary basis for love."

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- The ability of the parent or caretaker to make an emotional commitment to meet the infant's needs
- The affiliative tie of the caregiver to the infant, "which can be thought of as the caregiver's affectionate, warm and loving commitment to the infant."
- Another way to think about this: Parental behaviors in response to infant's expression of attachment

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ATTACHMENT BEHAVIORS

Any form of behavior that results in the child attaining or retaining physical closeness to a preferred or specific individual for the purpose of feeling secure, achieving protection, or organizing feelings.

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- Attachment is designed to help child to deal with threats and anxieties
- **Activator:** a stimulus or condition that turns the system on or turns the system up.
- **Terminator:** a stimulus that turns the system off or down.

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- Definition of sensitivity – caregiver's ability to interpret accurately the signals and communications implicit in infant's behavior, and given this understanding, to respond to them appropriately and promptly. From Ainsworth, quoted by Stern, et. al.
- Attachment theory holds that maternal sensitivity predicts children's secure attachment (i.e. confidence in availability of secure base when needed) and substantial data support this link across cultures.
  - Stern, et. al.

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AINSWORTH'S ATTACHMENT CLASSIFICATIONS

Secure

Insecure/Anxious

- Anxious - Avoidant
- Anxious - Ambivalent

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Infant is confident in the sensitive and responsive availability of caregiver, so is therefore confident in his/her safety in exploration. These babies DO feel fear and anxiety, but experience has taught them that they can rely on their caregivers to alleviate the stress.

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- Infant is not confident in the caregiver's availability, and fear the caregiver will be unresponsive or ineffectively responsive.
- They may be angry with their caregivers for this.
- When there is no apparent danger, may still direct attachment behaviors towards caregiver.
- These infants are not as free to explore without worry, so cannot achieve the same confidence in themselves and mastery as securely attached infants can.
- These classifications can be viewed as adaptive (in evolutionary terms) - promoting proximity to caregivers, and therefore survival past vulnerable period of infancy.

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Secure Attachment – Under stress, infant seeks out proximity to caregiver, is able to be calmed (it works), and is able to return to play

Avoidant Attachment – Under stress, infant continues to play (play is usually impoverished) and shows no outward signs of need for caregiver

Resistant/Ambivalent Attachment – Under stress, infant can seem clingy and inconsolable. However, the proximity and efforts of caregiver do not work and the child continues to be distressed and unable to return to play. May also show signs of anger at caregiver

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[redacted]

Direct Apprehension regarding parent:

- Running away
- Show fear in facial expression
- Vigilance in looking away

•Holds arm away, not touching body

•Holds toy out but keeps body back

•Holds hand to mouth, pulls head back

•Walk up to parent then fall to floor (incomplete, interrupted movement)

•Two contradictory behaviors at once – reaching for parent but holds head down. Approach and then move away while crying (if quiet, could be avoidance). *

•Disoriented behaviors – Stilling, staring, freezing, slowed movements

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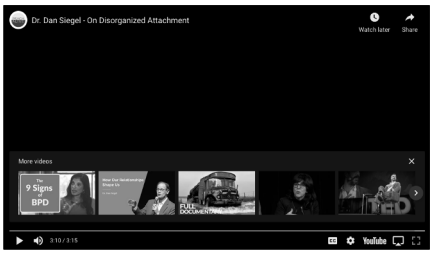

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- These terms describe the **infant's apparent perception of the availability of the caregiver** should the need arise, and **the organization of the infant's responses to caregiver in light of these perceptions** - how the infant organizes attachment behaviors to balance the need for protection and comfort with the desire to explore the environment.
- So, it is not simply behaviors.

(Weinfeld, Sroufe, Egeland, & Carlson, 1999)

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[redacted]

- Stage 1 – Indiscriminate responsiveness (birth to 2 months)
- Stage 2 – Focusing on Familiar People (see at about 2 months, social smile)
- Stage 3 – Focused Attachment (between 7 and 12 months)
- Stage 4 – Secure Base Behavior (toddlerhood)
- Stage 5 – Goal Directed Partnership (preschool)

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[redacted]

Attachment moves from Recognition/Familiarity → Familiarity/Comfort→ Comfort/Pleasure → Pleasure/Reliance → Reliance/Preference

"Only at the level of reliance/preference do we say that infants have fully formed attachments to caregivers."

- Charles Zeanah, Handbook of IMH 3rd Edition, pg 422

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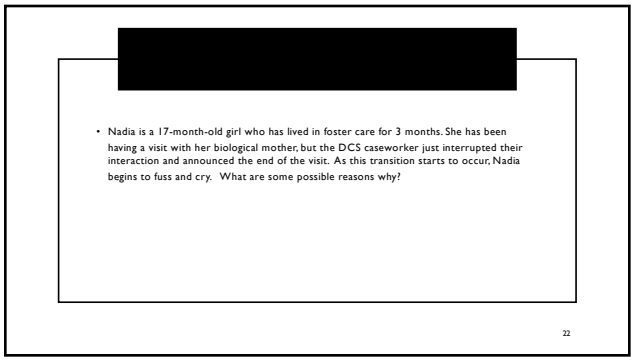
• Nadia is a 17-month-old girl who has lived in foster care for 3 months. She has been having a visit with her biological mother, but the DCS caseworker just interrupted their interaction and announced the end of the visit. As this transition starts to occur, Nadia begins to fuss and cry. What are some possible reasons why?
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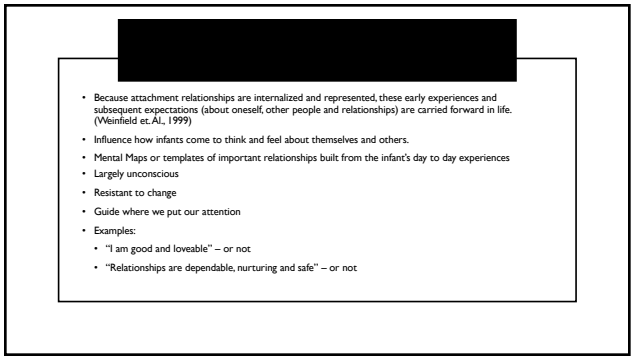
• Because attachment relationships are internalized and represented, these early experiences and subsequent expectations (about oneself, other people and relationships) are carried forward in life. (Weinfield et. Al., 1999)
• Influence how infants come to think and feel about themselves and others.
• Mental Maps or templates of important relationships built from the infant's day to day experiences
• Largely unconscious
• Resistant to change
• Guide where we put our attention
• Examples:
• "I am good and loveable" – or not
• "Relationships are dependable, nurturing and safe" – or not

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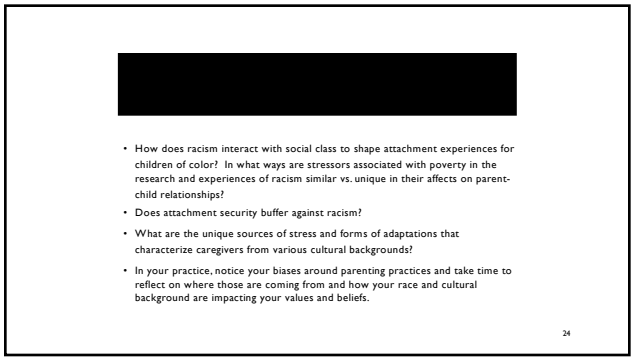
• How does racism interact with social class to shape attachment experiences for children of color? In what ways are stressors associated with poverty in the research and experiences of racism similar vs. unique in their affects on parent-child relationships?
• Does attachment security buffer against racism?
• What are the unique sources of stress and forms of adaptations that characterize caregivers from various cultural backgrounds?
• In your practice, notice your biases around parenting practices and take time to reflect on where those are coming from and how your race and cultural background are impacting your values and beliefs.
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- Significant amount of research documents over-representation of certain racial and ethnic groups, including African Americans and Native Americans,, in the child welfare system when compared to their representation in the general population - the degree of this disparity varies but it is virtually everywhere at some level
- At the same time, the first three National Incidence Studies of Child Abuse and Neglect found no relationship between race and child maltreatment when controlling for poverty and other risk factors and instead associated child abuse and neglect with poverty, single parenthood and other risk factors (SES being the strongest risk factor). A more recent NIS study found Black children experience maltreatment at higher rates than White children, and authors believe this is due to the enlarged gap in SES among the the races.

Source: https://www.childwelfare.gov/pubpdfs/racial_disproportionality.pdf

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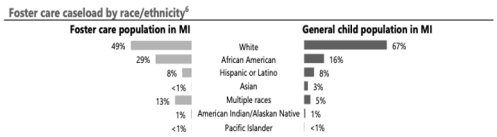

Source: https://www.childtrends.org/wp-content/uploads/2017/01/Michigan-Foster-Care-Factsheet_2015.pdf

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INCREASED DISPROPORTIONALITY AND DISPARITIES FOR BLACK FAMILIES

Black children remain over-represented in foster care at a rate of more than 1.6 times their proportion of the child population

2020 KIDS count data: Black children represent 14 percent of the population and 23 percent of children in foster care

Black children are more likely to be reported for suspected maltreatment than White children

Once reported, allegations are more likely to be substantiated

More likely to be removed from homes and placed in foster care

Less likely to be reunified and spend a longer time in care

Dettlaff & Boyd, 2020

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[redacted]

- External to child welfare system
  - Historical laws and policies that perpetuate racism that result in disproportionate and disparate experiences of adverse conditions associated with child maltreatment for children and families of color, particularly due to higher rates of poverty
  - Geographic context, such as the region, state, or neighborhood; health disparities; public education; housing policies
- Internal to child welfare system
  - Origins of child welfare as an institution (public assistance removal of Black families
  - Racial bias and discrimination exhibited by individuals and decision makers (e.g., caseworkers, mandated and other reporters, judges, etc)
  - Child welfare system factors (e.g., lack of resources for families of color, caseworker characteristics)

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SOLUTIONS

Individual

System

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[redacted]

"How you are is as important as what you do in making a positive difference for infants, toddlers and families."

-Jeree Pawl

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1. Self Awareness leads to better service for families

Working with infants, children, and families requires all individuals, organizations, and systems of care to reflect on our own culture, values and beliefs, and on the impact that racism, classism, sexism, able-ism, homophobia, xenophobia, and other systems of oppression have had on our lives in order to provide diversity-informed, culturally responsive services.

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- What are your internalized values and beliefs about parenting?
- What are your cultural identities and lenses?
- How do they show up in your work with very young children and families? With colleagues and community partners?
- Where do you get triggered? Stuck?

If time:

- How do you find your way back to clarity?

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- Remaining open and curious about what is contributing to our experiences and those around us is crucial for combating individual and systemic discrimination and bias
- The work is evocative and can lead us to respond reflexively
- The work is often deeply troubling and our experiences of the work live within us
- Emotions are data – not directive
- What else?

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[redacted]

- We know that relationships are crucial for babies, for all humans…
- We know that reflective functioning is correlated strongly with secure attachment relationships for babies and caregivers…
- We know that learning only happens in the context of relationships…
- Therefore we must be working within and through our relationships, which requires strong reflective skills

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[redacted]

- Listen generously
- Be curious
- Observe carefully
- Wonder with curiosity
- Pay attention to your own thoughts, feelings, beliefs and attitudes
- Wonder about the thoughts, feelings beliefs and attitudes about the other
- Do these things regularly and consistently with a trusted mentor

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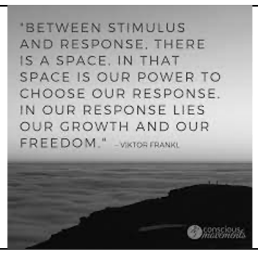

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Tony – 6 months old, Hispanic

Foster Parents – White, one other biological child

Father – Hispanic, in jail indefinitely, would like Tony to go to his aunt

Mother – White, actively using substances and unable to safely attend visits with Tony

Great Aunt (and Uncle in home as well) – Hispanic, in mid-60's, Requests placement when Tony was 4 months old, after initially not wanting placement, licensed foster parent, has previously adopted 2 of Tony's mom's children and also has custody of 2 other younger children, states she is seeking custody of tony because God came to her in a dream and told her to.

Initial visit – Foster mom left room and waited outside the door, Tony cried the entire 45 minutes, great aunt did not respond to suggestions by IMH clinician, Tony was able to be calmed when foster mother returned. Great aunt left the visit angry and stated "When can I take him home, he just needs to be home with me, he won't do that when we get home."

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[redacted]

You are…the baby, the foster parent, the aunt, the child welfare worker, the clinician:

What are you thinking?

What are you feeling? What is coming up for you?

What reactions do you notice in your body when you step into this role?

How are you making sense of this? What is your narrative or story about what is happening?

What do you hope will happen?

What are you still curious about?

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TRAUMA AND TOXIC STRESS

- A reality for the children and families who are involved with the child welfare system
- Not well understood by all professionals
- Can feel all-encompassing

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[redacted]

- Threatens the life or physical integrity of a child or someone important to the child.
- Potential resulting feelings include overwhelming terror, horror and helplessness
- Overwhelms a child's capacity to cope and may produce intense "physical" reactions

-The National Child Traumatic Stress Network

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[redacted]

- Event – What happened, the harm or threat of physical or psychological harm to self or other
- Experience – How did the individual experience the threat? Development stage of person, cultural beliefs, and access to social supports impact one's experience. The same experience may be traumatic for one person and not for another.
- Effects – How is individual affected by the event? Anxiety, difficult eating, difficulty trusting others, hypervigilance, numbing, memory and attention, etc are all examples.

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TRAUMA AND TOXIC STRESS

Examples of events that can be traumatic or chronically stressful-

- Physical abuse
- Sexual abuse
- Domestic violence
- **Neglect**
- Substance exposure
- Natural Disasters
- Community violence
- Primary caregivers being unavailable
- Being separated from primary caregivers
- Medical concerns
- Limited resource

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[redacted]

- Acute Trauma
  - A singe events that is limited in time (e.g., a car accident)
- Chronic Trauma
  - The experience of multiple traumatic events (e.g., domestic violence)
- **Complex Trauma**
  - The experience of chronic trauma, typically caused by caregivers and occurring in the primary caregiving system, often starting early on in the child's life
- Historical Trauma
  - Personal or historical events or prolonged experiences that continue to impact over multiple generations (e.g., slavery)

The National Child Traumatic Stress Network

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- Re-experiencing of traumatic events (e.g., nightmares, play that reenacts the event, etc.)
- Avoiding stimuli that remind the child of the event (e.g., child saying he/she doesn't remember, stating an event didn't happen, trying to stop other people from talking about an event, etc.)
- Decreased positive emotional responsiveness (e.g., social withdrawal, increased sadness, etc.)
- Increased arousal (e.g., irritability, fussiness, difficulty sleeping, etc.)

Zero to Three (2016). *Diagnostic Classifications of Mental Health and Developmental Disorders of Infancy and Early Childhood* Revised Edition (DC: 0-5). Washington, D.C.: Zero to Three Press.

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[redacted]

Other symptoms to look for-

- Regression of skills
- Child acting younger or older than his or her age
- Disruption in biological rhythms (e.g., sleeping, eating, toileting)
- Developmental delays (e.g., lack of developmentally appropriate play)
- Reckless behavior (e.g., jumping off tall furniture)
- Difficulty focusing
- Restricted range of emotions or activities
- Increased tantrums or aggression
- High level of activity
- More fearful or more friendly with strangers

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[redacted]

When children develop in environments characterized by stress that overwhelms their ability to cope, the impact broad and far reaching.

- Areas impacted-
  - **Attachment**
  - Biology
  - Affect Regulation
  - Dissociation
  - Behavioral Control
  - Cognition
  - Self-Concept

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. A. (Eds.) (2003). *Complex trauma in children and adolescents*. National Child Traumatic Stress Network. Retrieved from http://www.NCTSNet.org

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HEALING REQUIRES RELATIONSHIPS

"If young children are to be restored to positive and hopeful developmental trajectories after trauma, then it is essential that the ruptures in their relationships with those who care for them are mended."

- Joy Osofsky, 2011

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[redacted]

- What is important to the work? Does the parent want to work on the infant/parent relationship even if he or she does not yet understand the impact that the use/abuse of substance has on ability to parent?
- When might it not work?
  - Parent is unable to attend IMH sessions
  - Parent shows up under the influence
  - Parent poses a safety risk to the infant

***Unrecognized beliefs and feelings about addiction (on behalf of the clinician) are the single biggest obstacle to effective work**
Weatherston and Tableman (2015)

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What is earliest experience with substance abuse/addiction? How do you think that affects your values, beliefs and perceptions around SA and addiction?

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- Possible substance exposure for infant
- Ongoing assessment for indications of substance abuse is necessary
  - "If you were to start using again, how would we know? Do you have a 'tell' that you could share with me? What would you hope that I would do support you and baby?"
  - See pages 298-299 of IMH Home Visiting Manual
- Training in obtaining a drug history may be helpful – very much like exploring a love relationship
- Intervention must be **present-oriented, structured and supportive**
- Expectations of parental behavior must be openly shared
- How to meet the infant's needs must be direct and clear
- Safety plan – using relapse prevention plan that may be created

Weatherston & Tableman (2015)

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When inquiring about drug use, use the frame of mind of: "Tell me about your friend, Cocaine; how does it feel to be with him?"

- Follow up questions can include "When did you meet him? Who introduced you? What did you think of him that first time? How often do you get together now?
- Once you get history: "You've given up a lot for this love, having you? It must be very important to you."

  - Taken from W. Schafer, reprinted in 2016

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[redacted]

1. Anytime drug use is mentioned, whether by self or others, do not no let it drop without showing interest (or risk sending the message that you don't want to know).

2. Do not ask "yes or no" questions

3. Be specific (do not ask about drugs, ask about alcohol, coke, crack, dope, meth, etc.)

Step one is always going to be discussing addiction and need to seek treatment.

If you find the parent unable to take any feedback or suggestions, you might wonder if you are working with someone in recovery or with someone who is actively using. If the latter, back to step one.

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[redacted]

- Keep the work "tight" with 2 main focuses
  - Help parent learn how to meet baby's special needs with increasing success
  - Help him/her maintain recovery
- Due to the developmental shift of early parenthood AND the developmental needs of early recovery, this is not generally the time for deep exploration of past traumas, unmet desires and emotional pain. This parent will need safety, stability, structure and hope.
- Successes! Focus on them and notice even the smallest of them!

- W. Schafer, 2016

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[redacted]

- "You love this relationship more than anything else, but having it really seems to mean losing everything else."
- This may not seem like the right moment for you to stop, but perhaps someday you will change your mind
- "….for in the face of an active addictive process, infant mental health work is doomed to failure."

- Taken from W. Schafer, reprinted in 2016

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[redacted]

- Relapse is inevitable, usually a part of the process
- Do not define it as a failure (and try to help the system follow you), but as an opportunity to learn (how did it happen, what caused it, what can be done next time to prevent it, etc.)

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- Be alert for indications that the parent is in need of psychiatric evaluation and possibly medication.
- Careful assessment of capacities of parent is required (see page 291 of IMH Home Visiting Manual)
- Be slow and careful, not confrontational
- Remain in the present
- Use interpretation carefully and sparingly
- Support parent in finding a personal network of in-home support, as well as external and professional resources
- Communication between you and other therapists and/or psychiatrist is key
- Essential to have a comprehensive crisis and safety plan

Weatherston & Tableman (2015)

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- Assess in context of relationships
- Multiple assessments over time – **minimum** of 3-5 sessions after initial intake (others recommend up to 8)
- Gather information from multiple sources
- Include standardized assessments and observation
- Do not challenge infant or toddler by initiating separation from familiar caregivers
- Use the DC: 0-5 in conjunction with the DSM-5

ITMHCA Position Statement 2013

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[redacted]

Understand the Culture and Community		
CHILD	RELATIONSHIP	CAREGIVER* *For each caregiver
•Full background history •Trauma history •Symptoms (including trauma) •Developmental functioning •Adaptive functioning	•Caregiver perception of the child •Child perception of the caregiver •Caregiver-child interaction	•Full background history •Trauma history •Symptoms (including trauma) •May include cognitive functioning and/or adaptive functioning

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REFRAMING THE QUESTION

"We should not be asking who this child belongs to, but who belongs to this child."

- Jim Grigger

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WHAT IS "GOOD ENOUGH?"

- What is your definition? How do you communicate this?
- Is this the same framework other professionals are working within?
- How does this change the way you are able to communicate with others?

From S. Fraiberg (1977): "Are the parents employing their capacities (however limited) to provide the reasonable minimal guarantees to a child – that he be loved, valued, protected, educated!" (Note: where do "moral fitness" and implicit bias factor in here?)

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[redacted]

"It is crucial to assess not only the abilities that a person might possess as a parent but also the likelihood that these can be realized given the internal and external forces operating upon that person."

- From MIAIMH Guidelines for Comprehensive Assessment

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Parental Capacities

The following parental capacities are minimally necessary for the healthy growth and development of the infant:

1. Capacity to **carry out parenting responsibilities**. Social skills and adaptive capabilities, not IQ, are relevant
2. Capacity to be aware of and to respond to the infant's **physical needs** and the ability to protect and provide a **safe environment**
3. Capacity to be aware of and to respond appropriately to the infant's **developmental needs**, including the sensory, motor, cognitive domains
4. Capacity **to invest emotionally** in the infant and emotional energy to invest in caregiving
5. Ability to perceive and **accurately read the infant's cues and communications** about needs and to respond appropriately and consistently
6. Ability to **delay gratification, tolerate frustration, and cope with the resulting stress**, avoiding intense anger and resentment toward the infant
7. Ability to **experience the infant as a separate person** with his or her own needs, not as an extension of the parent
8. **Capacity to meet own needs** for self-gratification and self-esteem independent of the infant
9. Ability to **recognize when assistance is needed** and to accept it when offered
10. Ability to respond appropriately to emergency situations

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[redacted]

- Conducted without the child present
- Interview multiple caregivers
- Domains:
  - Child functioning
    - Temperament, development, trauma, physical health, and strengths
  - Caregiver functioning
    - Mental health, substance use, relational, legal, physical health, educational, employment, and strengths
  - Trauma and intergenerational family dynamics
    - Ghosts in the nursery (Fraiberg, 1975)…*and* angels (Lieberman, Padron, Van Horn, & Harris, 2005)

"If you don't understand someone's behavior, you don't have enough history" (Brandt Steele)

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[redacted]

- Infants and young children cannot verbalize complex thoughts/feelings
- Communication through behavior, play, affect
- Caregiver report represents the caregiver's understanding, thoughts, and feelings about the child/child's behavior

HIGHLIGHTS THE NEED FOR OBSERVATION

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[redacted]

- One behavior can have very different meanings
  - Child throws a toy…
    - Developmentally appropriate behavior
    - Medical problem
    - Developmental delay
    - Trauma reaction
    - Relational problem

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[redacted]

- What is my initial reaction?
- What are my thoughts/feelings?
- With whom do I identify?
- Am I having especially strong feelings in this situation?
- Do I act/feel differently with this family than I generally act/feel?
- What are my expectations of myself in working with this family?
- What am I taking for granted?
- What more do I need to know?
- What is the caregiver's state of mind?
- What is the child's state of mind?
- How may your presence/the assessment impact the caregiver and the child?

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[redacted]

- Infants and young children display distress through sensory-motor disorganization and disruption of biological rhythms
- Remain curious…
  - Watch non-verbal cues
    - Gaze
    - Facial expressions
    - Motor movements
    - Proximity
    - Energy level
  - Observe how the child and caregiver co-regulate
    - Caregiver attunement
  - Notice what calms and organizes the child
  - Notice what overwhelms, irritates, or shuts down the child

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[redacted]

- What do you see?
- What do you feel?
- What do you think?
- What do you think mom and baby are experiencing? (What would they tell us?)

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[redacted]

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DISCUSSION

In pairs or small groups, please discuss:

- What is sticking with you the most after today?
- What is one thing you have learned that you have already begun thinking about implementing?

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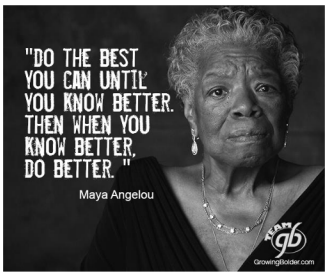

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