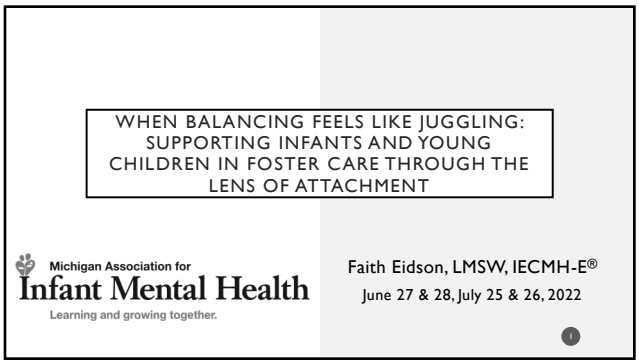
WHEN BALANCING FEELS LIKE JUGGLING: SUPPORTING INFANTS AND YOUNG CHILDREN IN FOSTER CARE THROUGH THE LENS OF ATTACHMENT
Michigan Association for
Infant Mental Health
Learning and growing together.
Faith Eidson, LMSW, IECMH-E®
June 27 & 28, July 25 & 26, 2022
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WELCOME BACK!
IT'S SO GOOD TO SEE YOU
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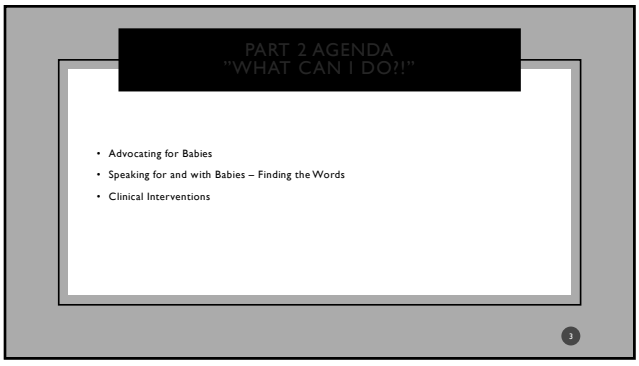
PART 2 AGENDA
"WHAT CAN I DO?!"
• Advocating for Babies
• Speaking for and with Babies – Finding the Words
• Clinical Interventions
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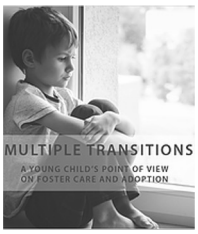
WHAT IS IT LIKE FOR THE BABY?



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FIVE FACTORS TO PROMOTE RESILIENCE

1. Parental resilience
2. Social connections
3. Knowledge of parenting and child development
4. Concrete support in times of need
5. Social and emotional competence of children

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ADVOCATING FOR BABIES: HOW CAN YOU HELP?

- Always remember and remind – RELATIONSHIPS are key to everything
- Recommendations about visits – Who, what, when, where, how and for how long?
- Transitions – How are they happening? How should they be happening? What can we change?
- Routine – Is the team respecting the baby's routine?
- Visits/sessions – Are they consistent, predictable and developmentally appropriate?

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VISITATION CONSIDERATIONS

Visits should be frequent

There needs to be a routine that includes:

- Family or childcare routines
- Developmental stimulation
- Play and exploration

How can we work with parents to set up the visits in a way that meets these needs?

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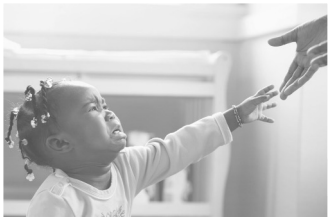
MINIMIZING THE TRAUMA OF MOVES

"The trauma of parental separation or losses may be lessened if the child is prepared for the transition, if all participants in the moving process are, in a sensitive manner, open and honest with the child, and if careful attention is given to the child's reactions to to the separation."

- V. Fahlberg, 1991, page 175



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TRANSITION CONSIDERATIONS

- Maintain connections for children whenever it is safe and possible.
- Transitional objects as critical developmental need.
- PLAN for transitions, and be flexible.
  - Schedule Transition Planning Meeting
  - Invite the right people
  - Talk with team members prior to the meeting
  - Develop a calendar
- Focus discussion on baby's emotional states and needs rather than only behavior (fussiness, clinginess, crying, aggression, etc.)
- Step outside of the box and ask, "Why are we doing it this way?" and "Do we have to do it this way?" and most importantly:

How is this affecting the baby? What does the baby need?

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TRANSITION RECOMMENDATIONS

- Pre-placement visits – goal is to transfer attachment, decrease fear of unknown, and empower next set of caregivers
  - Outlines of daily schedules, routines, eating sleeping and play habits should be shared
- Actual move – better if current caregivers can physically hand over child to new caregivers
  - If clinging or crying, caregiver saying goodbye might say, "I'm going to miss you and you're going to miss us, but it's time to go now."
- Post-placement visits – in child's new home
- Life Books – crucial way to help child integrate her/his entire story

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WHAT WE CAN DO: SUPPORT CAREGIVERS

. "We suggest that foster children cannot develop organized attachment strategies unless they have nurturing (i.e. autonomous) caregivers. Thus, it is critical that foster parents are nurturing, or at least that they learn to respond to their foster children's bids for distress in nurturing ways." *(Dozier, Dozier, & Manni [2002]. Zero to Three Bulletin*

11

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PROFESSIONAL RELATIONSHIPS ARE KEY

- Show what is important to you. Take the time to talk, make that phone call, schedule a meeting, get to know one another.
- Prevent barriers towards communication such as release forms.
- Mutual Respect - Communicate as effectively as possible with team members. Clarify misunderstandings.
- Ask questions, explore other vantage points (wear different lenses).
- Continue educating yourself on infants and toddlers and their specialized needs.
- Finally…. hold that space for one another.

"While the team is an attempt to address this, we all feel the isolation of our clients – the babies who have had no one, the parents who have no one, no family, no support, only the services involved." P. O'Rourke (2020)

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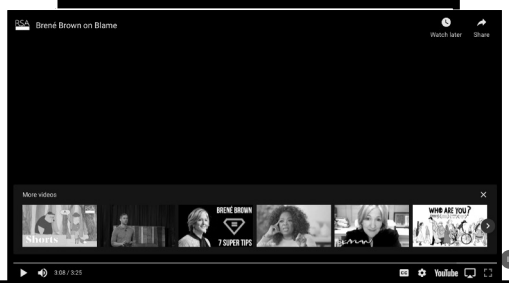
WHAT MAKES THIS HARD?



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COURT TEAMS

- For children under 4 years old
- Includes **Judge** with a commitment to this specialty court. A team of court personnel will be identified by the Judge (i.e. Guardian ad litem, Children's Advocates, key Court Administrative personnel).
- The Judge has a commitment **to increased frequency of court appearances**
- **Referral to Infant Mental Health Services**
- A **Steering Committee** of key stakeholders
- **Ongoing cross training of IMH in the Court staff and key community staff**
- The specialty court **is coordinated, and its activities monitored by a person with expertise in early childhood development.** A person is designated to coordinate the court activities.

14

14

REFLECTIVE SUPERVISION/CONSULTATION

- A relationship for learning
- A professional development strategy
- A place to explore our work; how we think about our feelings and how we feel about our thoughts
- A place to remember the baby's experience and keep it central to the work
- Difference between administrative, clinical and reflective supervision

"We cannot selectively numb emotions, when we numb the painful emotions, we also numb the positive emotions." Brené Brown

15

15

SPEAKING FOR BABIES: "USING YOUR WORDS"

What makes this so hard?

- I don't know what to say
- I will say the wrong thing (and upset the child, birth parent, etc.)
- I don't know what I'm allowed to say
- They'll find out I actually have no idea what I'm doing

16

16

WHY IT IS IMPORTANT TO USE YOUR WORDS

- You may be the only who has the full view of this baby's relationships
- You may be the only one who receives RS and is able to spend the time slowing down, reflecting and working hard see each person and relationship more clearly
- You may be the only one with IMH training and developmental knowledge to inform your assessment and recommendations
- If not you, then who?

17

17

TALKING ABOUT WHAT IS HARD

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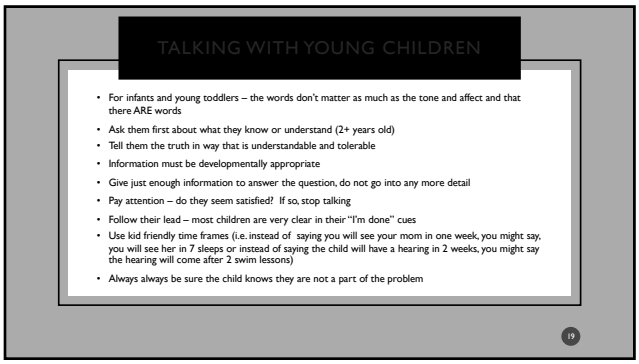
TALKING WITH YOUNG CHILDREN
• For infants and young toddlers – the words don't matter as much as the tone and affect and that there ARE words
• Ask them first about what they know or understand (2+ years old)
• Tell them the truth in way that is understandable and tolerable
• Information must be developmentally appropriate
• Give just enough information to answer the question, do not go into any more detail
• Pay attention – do they seem satisfied? If so, stop talking
• Follow their lead – most children are very clear in their "I'm done" cues
• Use kid friendly time frames (i.e. instead of saying you will see your mom in one week, you might say, you will see her in 7 sleeps or instead of saying the child will have a hearing in 2 weeks, you might say the hearing will come after 2 swim lessons)
• Always always be sure the child knows they are not a part of the problem
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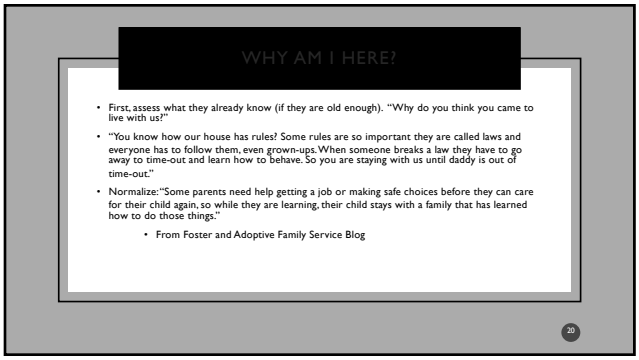
WHY AM I HERE?
• First, assess what they already know (if they are old enough). "Why do you think you came to live with us?"
• "You know how our house has rules? Some rules are so important they are called laws and everyone has to follow them, even grown-ups. When someone breaks a law they have to go away to time-out and learn how to behave. So you are staying with us until daddy is out of time-out."
• Normalize: "Some parents need help getting a job or making safe choices before they can care for their child again, so while they are learning, their child stays with a family that has learned how to do those things."
• From Foster and Adoptive Family Service Blog
20

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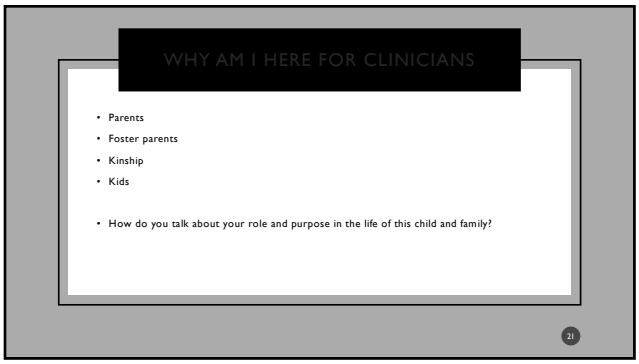
WHY AM I HERE FOR CLINICIANS
• Parents
• Foster parents
• Kinship
• Kids
• How do you talk about your role and purpose in the life of this child and family?
21

21

TALKING ABOUT ADDICTION

- Be honest, acknowledge the impact on the child and always remind the child that their parent's addiction is not their fault
- Encourage the child (when age appropriate) to talk with you about their feelings – important to combat the feelings of shame, loneliness, fear and secrecy around addiction
- The Three C's – "You didn't cause it, you can't control it and you can't cure it."
- Some recommend describing the parent as "sick," and addiction is a "disease" and parent needs help to get better, especially for very young children
- Preschoolers can be reminded of times when they want something very very bad and they can't seem to make a better choice. Then they can be told that addiction is kind of like that and their parent is dealing with that right now.
- For older preschoolers, I have said that addiction can make the brain trick people into thinking they need something that is harmful to them

22

22

MORE WORDS

- Use words of security: "You will be taken care of", "We will make sure you are safe", "You will see your mommy (enter day here) or in 3 sleeps", "You look like you feel sad. I understand why you feel sad about this".
- Be realistic: "Daddy is in jail so you can't stay with him right now."
- When an adult is unsure: "I'm sorry. I don't know what will happen yet, and I know that's scary for you".
- "Foster care can last a short time or a long time. No matter how long or short it is, kids miss their moms and dads or brothers or sisters… or pets….or school…" (From Maybe Days)
- It is ok to care about many people at the same time

23

23

TALKING ABOUT CULTURE

- How do you invite families with cross-cultural placements to think about this more deeply?
- What does the child need? What do you need? How might the child's parents feel about your role as foster parents?
- How does your identity as a service provider impact all of these relationships?
- Link families with books, mentors, resources!

24

24

TALKING ABOUT TRANSITIONS

- "You will go with Ms. Kelly to see your mom and spend some time with her. Then Ms. Kelly will bring you home right before dinner and we will have spaghetti together."
- You will go see your mom in 3 sleeps
- Be clear and give milestones they can understand

25

25

TALKING ABOUT PERMANENCY

- "The adults (use names if you can, or judge) decided that your Aunt Rhonda's home would be the best place to be your forever home. That means that when you move with her, that is where you will stay forever. Aunt Rhonda will be the one to keep you safe, read you stories at night and take care of you."
- If child is not reunified, support the team in being careful to not blame or vilify parents
- Adoption
  - Define titles with and for different parents (parents, birth parents, first mom and dad, tummy mommy, foster parents, adoptive parents – avoid the term "real parents")
  - Prepare adoptive parents that conversations about adoption typically occur informally and in places between other activities (car rides, bed time, etc)
  - **Adoption is forever**

26

26

ADOPTION LANGUAGE

Negative Language	Positive Language
Real Parent	Birth Parent
Giving Up/Away For Adoption	Placing For Adoption
Adopted Child	My Child
Handicap Child	Child With Special Needs
Available Child	Waiting Child
Illegitimate	Born to Unmarried Parents
Is Adopted	Was Adopted
Natural Parent	Biological Parent
Abandoned/Rejected	Separated from Parents

Adopt & Connect

27

27

INFANT MENTAL HEALTH WORK AND CHILD WELFARE: WHY IS THIS SO HARD?

- Working with children and families in foster is unique because:
  - Multiple relationships to consider and support
  - You don't always know which relationship will be THE relationship
  - Transitions, separations, and reunions are plentiful and constant
  - Grief and loss is always a thread
  - We are not always wanted
  - Honesty, trust and therefore progress cannot be expected in the beginning, for these parents, yet babies cannot wait
  - Lack of other necessary services (for concrete needs, severe mental illness, substance abuse, domestic violence, etc)

28

INFANT MENTAL HEALTH WORK AND CHILD WELFARE: WHY IS THIS SO HARD?

- We offer authentic empathy and compassion to a parent who has hurt their baby or allowed their baby to be hurt
- We hold ALL of the relationships in mind
- We are committed to and comfortable with not knowing
- We say the hard things, carefully (" …we treat our words and our actions not as social graces but as worthy of the same sort of delicate use as a surgeon makes of his instruments." M. Trout)
- We assume parents are doing the best they know how to do
- We allow ourselves to be students (rather than the experts)

29

29

THE CLINICAL WORK

Requires us to:

- Know the signals of threat for this child (power of association in the brain)
- Always pay attention to the meaning behind the behavior (for everyone!)
  - Example: "We tend to prefer the certainty of misery to the misery of uncertainty."

Strategies:

- Finding consistency and routine in the chaos
- Creating memory and photo books
- Putting feelings into words
- Video taping
- The power of play
- Encourage caregivers to comfort child as needed

30

THE CLINICAL WORK

Working with families in foster care requires:

- Unique skills in building a working alliance
- Balancing the pacing of building a therapeutic alliance at a pace a parent can tolerate while also holding the baby's developmental imperative front and foremost
- Courage on the part of the family when they are perhaps at their most vulnerable
- Ability to manage the many "observers" to your process

31

IMH HOME VISITING

Interventions and Strategies Include:

- Building an Alliance
- Meeting Material Needs
- Emotional Support
- Developmental Guidance
- Infant-Parent Psychotherapy
- Developing Social Support and Life Coping Skills

Weatherston & Tableman (2015)

32

PARALLEL PROCESS IN INTERVENTION

If we want a parent to listen more closely to their child's cues, he or she needs the experience of being closely listened to as well.

"You might have to feel that another person is dependable, before you can become dependable to another."

- D. Weatherston

33

34

INFANT-PARENT PSYCHOTHERAPY

- Allows parent(s) and clinician to explore feelings about past events and present situations to identify and understand underlying conflicts that make appropriate and affectionate response difficult.
- Links present and past - remembering allows the parent to identify with the child
- Helps link parental representation to parental behavior – how are underlying conflicts motivating behavior, inhibiting the ability to read the infant's cues and the ability to understand and empathize with the infant
- Infant/Toddler is focus and tells us much
- Assist parent to:
  - Identify feelings and put them into words
  - Understand reactions, defenses and coping strategies
  - Find words to understand, grieve, forgive and heal
  - Promote new and healthier patterns of interaction and relationship with the infant/toddler

35

CHILD-PARENT PSYCHOTHERAPY (CPP)

- Encompasses "infant-parent psychotherapy," "toddler- parent psychotherapy," and "preschooler-parent" psychotherapy."
- Better describes the process of more than just one parent and/or family member involved in treatment than does "dyadic therapy."
- The basic assumption is that the most immediate and direct threat to the child's psychological well-being is an explicit or implicit message from the parent that the child is not good enough
- Treatment goal is to enhance the capacity of the child and primary caregiver(s) to create and maintain a growth-promoting partnership in the context of of the other relationships in their lives.
- Trauma-focused intervention

Lieberman & Van Horn (2008); Lieberman & Van Horn (2005)

36

COMMON PRINCIPLES OF IMH HOME VISITING AND CPP

- Compassion for what the parent endured as a child.
- Forthrightness in helping the parent recognize how the damage that the old pain caused now affects the new baby and relationship with the baby.
- Intervention begins with simple and direct strategies and moves to more complex modalities only when simpler interventions do not result in improvement.
  - In other words, figure out what they need, and then give it to them! (Greenspan idea)
  - Meet them where they are – accept them where they are and meet them there.

"If you can't remember how something felt, you are doomed to repeat it."

Lieberman and Van Horn (2008)

37

ATTACHMENT AND BIOBEHAVIORAL CATCH-UP (ABC)

ABC uses a trained coach to:

1. help a foster parent understand the child's need and unique signals for nurturance;
2. support the foster parent to respond in a sensitive and nurturing manner especially to the child's signals of distress, and;
3. target behavioral, emotional and neuroendocrine dysregulation in the child by supporting the foster parent to allow the child to express and gain mastery over emotions

Use of videotape and in the moment coaching to target 3 key desired behaviors in caregivers: **Be nurturing when the child is upset, follow the child's lead with delight, and avoid behaving in frightening ways.**

-Dozier (2005) and Asok, et. al. (2013)

38

VIGNETTE AND ACTIVITY – BABY TONY

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."

39

39

VIGNETTE AND ACTIVITY – BABY TONY

Scenario One:

Despite the many difficulties over the course of about 6 months of these visits, the judge decided to place Tony with his aunt and uncle. What kind of things would you recommend for his transition? Consider factors such as length of transition, length and location of visits, overnights, preparatory work with each family, things Tony might want/need once transition is complete, etc. If you are a clinician, what interventions would you consider?

Scenario Two:

After about 6 months of these difficult visits, the judge decided on adoption by foster parents as the permanent plan and Tony was to stay with the foster family. What kinds of things will Tony and his family need to support the adoption process and Tony's permanent place in this family? What recommendations would you make to his team? If you are a clinician, what interventions would you consider?

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QUESTIONS AND DISCUSSION

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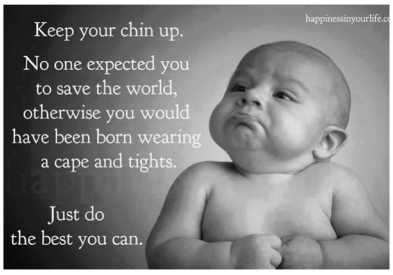

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- www.zerotothree.org
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- www.nctsn.org

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