

- **ATTACHMENT AND FOSTER CARE**

*Yesterday was my first day of school. I'm in the 2<sup>nd</sup> grade. My teacher's name is Mrs. Felber and my teacher is very nice. I had a hot dog for lunch today. Today I was a very good boy. I wonder if my mom had a good mom. I would like to know a lot about my mom. I really love my mom. I hope we can find my mom. I sorta remember my mom but I barely remember what she looks like. I miss my mom very much and I wish she was here. I would tell her I love her very much. I would ask her to never leave me again. If she did I would be very sad. My foster dad, John, bought me a new book and three pair of long pants. My best friend Kyle from last year is in my class. I love my mom very much but my mom smoked too much and she did drugs too much. Today I had a fun day and then I went home. I guess that's all.*

—Billy, 7, Foster child

Over the last 50 years we have accomplished amazing things. We have cured diseases, landed men on the moon, figured out DNA, split the atom, and invented the computer and the internet. There have been great strides in technology, medicine, space exploration, and other realms due to the priority placed on those endeavors and the vast human and financial resources applied. Sadly, we have not placed such a priority on children and families, as evidenced by the increases in child maltreatment and out-of-home placements.

As long as there are parents who do not nurture, love, and protect their children, there will be a need for foster care. As long as there are chronic social problems that lead to high-risk children and families, we will need foster homes as temporary and/or longer-term placements. These family and social problems include the increasing number of children who are victims of abuse and neglect, the growing number of high-stress single-parent households, poverty and homelessness, the cycle of violence in families, and the reactionary way in which child welfare is funded.

### **FOSTER CARE SYSTEM: A BRIEF HISTORY**

In order to understand the current state of our foster care system it is helpful to appreciate how it began and changed over time. Initially, there was no organized approach for dealing with child welfare in the United States. Beginning in the early 19<sup>th</sup> century, public concern and policy for maltreated and dependent children came from private and secular agencies. Only the state of Indiana had a governmental body concerning child welfare. Abandoned and unwanted babies were placed in foundling hospitals and large orphanages, where many were neglected and even died from lack of nurturing and human contact.

Our current foster care system originated with two contrasting models. The New York City Children's Aid Society, started in 1853, was created to protect the community from children whose behavior was viewed as threatening. Violent and antisocial children from the City were placed with rural Western families; 100,000 of these children were placed between 1854 and 1921. The ties to their families and communities were completely severed.

A new and different approach to foster care began in 1886 with the Boston Children's Aid Society, which focused on the needs of the child and the importance of maintaining ties with the biological family. The foster home was meant to be a temporary placement with the goal of reunification. They were also the first to emphasize prevention in order to avoid the need for out-of-house placement. This approach to foster care was endorsed by the first White House Conference on Children in 1909, and family foster care became favored as an alternative to institutional care.

The Child Welfare League of America (CWLA) was founded in 1920. They helped to standardize child welfare programs, stressing the need for temporary out-of-home placements, family preservation, and reunification. The Social Security Act of 1935 marked the federal government's first attempt to fund child welfare services. Grant money was provided to states for children lacking parental support, to pay for foster care, but not for services involving biological families. From the 1930's, child welfare services moved from a punitive, law enforcement model to a rehabilitation approach.

There was a huge increase in foster care placements, as well as federal funding for social service programs, in the 1960's and 1970's (177,000 in 1961 to 500,000 by 1977). This was a result of the increased public awareness of child abuse and neglect, and the new laws requiring child care professionals to report maltreatment. Additional factors also lead to the vast increase in foster care: poverty, increased minority population, single-mother households, alcohol and drug abuse, homelessness, and how child welfare was funded by the federal government.

The foster care system has been *reactionary* on the federal level in its efforts to respond to the needs of at-risk children and families. The Child Abuse Prevention and

Treatment Act in 1974 was passed as a reaction to the growing awareness of child maltreatment. The result was an enormous increase in foster care placements, more time spent in foster care, and more moves from home-to-home. In 1980, Congress passed the Adoption Assistance and Child Welfare Act, a reaction to the ballooning foster care population. The goal now was “permanency planning,” an effort to prevent removal, place children in adoptive homes quickly, and reunify families. The term “special needs” was introduced, and agencies tried to find homes for hard-to-adopt children (e.g., older, sibling groups, physically and mentally disabled, varying racial backgrounds).

Adoption agencies and social service programs were not prepared to deal with the extensive needs of children and families. In 1989, a government report entitled *No Place to Call Home: Discarded Children in America*, exposed the nation’s failure to really help high-risk children and families. The report concluded, “...children bounce from one overwhelmed system to another, and fail to receive the counseling and safeguards necessary to enable them to find permanent families and essential services” (U.S. Select Committee on C.Y.F 1989, p. 3.).

Congress responded once again in 1993 with funding for intensive family preservation and reunification services. However, child welfare services continued to be overwhelmed by large caseloads, high burnout and turnover of staff and foster parents, and increasing numbers of disturbed children remaining in long-term placement. The Adoption and Safe Families Act of 1997 was designed to improve the safety of children and move them more quickly from foster care to adoptive homes. Placing needy children in permanent adoptive homes was, of course, a worthwhile goal, but several problems resulted: lack of necessary pre-placement services (assessment, effective transitioning of

children, training and support of parents); lack of crucial post-placement services (treatment and support for children and families), which left many adoptive parents unable to manage their special needs children. Meanwhile, the foster care population continued to increase (Levy & Orlans 1998).

To date, not much has changed. The federal government is currently conducting Child and Family Service Reviews, designed to evaluate the safety, permanency, and well-being of vulnerable children in our foster care system. Affected are nearly 550,000 children in foster care and approximately a half million others living at home under state supervision. These reviews are looking at such things as whether children continue to bounce from foster home to foster home, are siblings kept together or separated, are children being abused after entering the system, how long is it taking states to finalize adoptions or send children back home, and are parents receiving promised services? The reviews so far indicate that not a single state has passed the test in its ability to protect children from child abuse and to find permanent homes. It is the same old story; Human Services Departments are not providing the case management, assessment and treatment, and other services that these children and families desperately need.

This is not meant to be an indictment of the many dedicated and hardworking people in the foster care system – foster parents, case workers, administrators, mental health professionals. These people have their hands tied. Children and families continue to be a low priority among those who make funding decisions.

Our society is being “penny wise and pound foolish.” We fail to realize that by providing real help to high-risk children and families today, we are likely to prevent more serious problems and the need for considerably more services tomorrow. On an

economic level, it does not make much sense. By not allocating the appropriate funding, we are creating a much larger financial burden on society when these children become adults.

## **FOSTER CARE SYSTEM**



Now what?

On any given day, half a million children are in foster care in the United States. During the 1980's, about 260,000 children were in out-of-home care. By 1999, that figure increased to 568,000 (U.S. Department of Health & Human Services 2002). Not only did the numbers of high-risk children and families increase, but the severity of their problems increased as well. Around 75% of children entering foster care have a family history of mental illness and/or drug and alcohol abuse (Chernoff et al. 1994). Children in foster care are 10 times more likely to have mental health problems than other Medicaid eligible children (Harmon et al. 2000). These children have high rates of

emotional and behavioral problems due to early maltreatment, attachment disruptions, and the instability of the foster care system itself (McIntyre & Keesler 1986).

Foster care is a term for children living in out-of-home care, mostly as a result of abuse and/or neglect. There are four types of foster care: family foster care (non-relative), kinship care (relative), therapeutic foster care (treatment or specialized), and residential group care (not actually foster care, but these children are considered in national statistics as living in foster care). Most children live in family foster care (50%) or kinship care (42%), while less are in therapeutic foster care (2%) (Curtis et al. 1999).

Therapeutic foster care, also called treatment or specialized foster care, is designed to have the following characteristics: 1) foster parents are considered professionals; 2) small number of children under the foster parents' care (one or two preferably); 3) case managers also have small caseloads; 4) special training and skills for foster parents; 5) child has specific treatment plan implemented by foster parents; 6) emotional and professional support given to foster parents; 7) crisis intervention services are available to parent 24 hours a day; 8) emphasis on assessment and fulfillment of the child's educational needs; and 9) a coordinated system of care for each child. These are ideals which are not often followed in many foster care programs (Curtis et al. 1999).

Although thousands of foster parents provide conscientious and heart-felt care, the *system* often fails the very children it's supposed to protect. Foster care was originally set up to furnish safe and temporary homes for children. The reality is that many children stay in foster care for years, often until they "age out" as young adults. Stability and safety are also often lacking, as children are commonly moved from one home to another. A state-wide study in Wisconsin found that children had an average of

4.6 different placements, and stayed in the system for an average of 5.5 years. Children raised in multiple homes are more likely to have severe emotional, behavioral, and academic problems. Children in long-term foster care are more likely to become adults who are homeless, unemployed, and suffer from debilitating psychological problems (Newton et al. 2000).

While the number of children in foster care has increased, the number of foster parents has declined. There are several reasons why people do not want to become foster parents and are leaving foster care: inadequate salaries; lack of recognition, training, and support; the poor image of the foster care system; the increased needs and problems of foster children; and role confusion (CWLA 1996; Klee et al. 1997). Foster parents often say they do not feel valued, are not adequately trained to handle challenging children, and are involved in a system with a tarnished reputation. They are often unclear about the roles they play with children – are they parents, short-term guardians, attachment figures, coaches, pre-adoptive parents, or therapists? Depending on agency philosophy and personal choice, they take on some or all of these roles.

Despite the challenges and frustrations, learning to be a therapeutic and healing foster parent can be rewarding and beneficial. Studies show the benefits of mature, sensitive, and responsive parenting. Infants and young children, victims of abuse, neglect and multiple disruptions, were able to make substantial emotional, cognitive, social, and physical improvements when placed in stable and loving homes. Infants placed in foster care during the first 20 months of life were studied. These babies had a history of abuse, neglect, and up to five changes in caregivers. The results give us hope. These babies were able to develop secure attachments as long as they had “autonomous” foster moms.

Autonomous state of mind means that the mothers value attachment and are able to make sense of (“come to terms” with) their own attachment histories (Dozier et al. 2001).

Another study shows the importance of skill-based training. Low-income mothers of irritable infants were taught to be more sensitive and responsive to their babies’ needs. After nine months, these babies were significantly more likely to be securely attached than those with mothers who were not trained. At three-and-a-half years old, these mothers and children were still doing well regarding maternal sensitivity, attachment security, and mother-child cooperation. The fathers became better parents as well, even though they were not specifically trained (Van den Boom 1994, 1995).

Toddlers fostered or adopted from orphanages in Romania and other countries, where they experienced extreme neglect, have been able to change their attachment behavior over time. Many of these traumatized children learned to trust and depend on foster and adoptive parents who were sensitive, responsive, and consistently “healing” parents (Chisholm 1998; O’Conner et al. 1999).

### **Foster Youth Speak Out**



Current and former foster care youths have shared important ideas about their needs and ways to improve the system (Knipe & Warren, 1999). These young adults have had personal journeys through the foster care system and have a lot to teach us.

Here are their recommendations:

- Train foster parents and kinship care providers in how to assist youths.
- Include children and teens in decisions about their futures.
- Hire workers who have a background in child and youth development.
- Provide adopted youths with all available information about their biological family, including medical history.
- Create a program for younger youths with older and emancipated young adults as mentors.
- Establish a rental assistance fund for youths leaving foster care.
- Create a mechanism for holding social workers accountable if they do not promptly return youths' calls. Provide youths with a list of phone numbers of people to contact if the workers are unavailable.
- Inform youths about programs available to them.
- Allow youths to evaluate their social workers, placements, and foster homes.
- Assist teens and young adults with transportation to and from work.
- Help youths obtain proper clothing for job interviews.
- Be certain youths understand their medical needs, how to utilize their medical insurance, and how to access health care providers.



## **CHILDREN IN FOSTER CARE**

As a result of neglect, abuse, the absence of secure attachments, losses that led to out-of-home placements, and the trauma of removal from their homes, foster children have numerous medical, emotional, social, and behavioral problems. Studies of foster children have found that from 50% to 96% show signs of psychological problems and developmental delays, such as depression, aggression, and learning and language disorders. Children placed in foster homes after two years of age had more of these problems than children entering the homes at a younger age. Over 80% of children in foster care have at least one serious and chronic medical condition, such as asthma or infections. Infants have an average of almost three medical conditions (Harmon et al. 2000).

Even though children entering foster care are suffering from serious medical and psychological problems, they commonly do not receive the diagnostic or treatment services they need. Often, the foster care agencies and local social services departments lack the necessary financial and professional resources. So the children who need desperately to be evaluated, and are at greatest risk for developing even more problems

over time, are left without services. This same situation holds true for the foster parents; they lack sufficient information, training, and support.

It is common for children in foster care to have multiple diagnoses, including oppositional defiant disorder, conduct disorder, depression, anxiety disorder, posttraumatic stress disorder, ADHD, and reactive attachment disorder. These children are victims of high-risk families, characterized by abuse and neglect, poverty, substance abuse, violence, and parents with severe psychological problem and maltreatment in their own childhoods. Up to 80% of high-risk families cause severe attachment problems in their children (Lyons-Ruth 1996). The foster care system is overwhelmed with these traumatized children. Consider the following statistics regarding children in foster care (Leslie et al. 2003):

- 75% have a family history of mental illness or drug and alcohol abuse.
- Over 80% have developmental, emotional, and behavioral problems.
- Over 30% show symptoms of antisocial behaviors.
- Nearly 50% have cognitive or learning disabilities.
- Over 82% have at least one serious medical condition, such as asthma, malnutrition, infections, or failure to thrive.
- 62% were prenatally exposed to drugs or alcohol.

Foster children also have many educational challenges. Schools are generally equipped to teach and manage the “average” child. Children in foster care, however, typically have a wider range of school-related problems. They perform lower on standardized achievement tests, earn lower grades, have trouble getting along with teachers and other children, have higher rates of absenteeism and disciplinary referrals,

and are more likely to repeat a grade (Zetlin 2002). A recent study showed the educational plight of children in foster care (Meier 2003):

- Almost half (43%) were not performing at grade level.
- 38% were receiving special education services, and many others needed these services.
- 80% had lived in a different school district prior to their current foster home.
- 63% were receiving mental health services, and they had many more suspensions and expulsions than peers receiving mental health services.
- 40% of foster parents were not aware of the “parent surrogate” role in order to advocate for their children to receive special services.

### **ATTACHMENT, LOSS, AND FOSTER CARE**

When children with unresolved grief and loss enter a foster home they bring their pain with them, and their main priority is self-protection against future loss and vulnerability. They avoid intimacy, closeness, and dependence at all costs. They are fearful of ever loving again, leading to a profound sense of loneliness and mistrust; “If I get close, I’ll get hurt,” or “If I get close, you will see me for who I really am, someone unlovable and not good enough.” Wounded children can only deal with the intense fear of abandonment by armoring themselves against it. They shut down their hearts to love both physically and psychologically. Fear of abandonment is a force that runs their lives. Even though they maintain elaborate defenses against experiencing closeness, they still have a great need for it. They are also motivated by a desperate need for power and

control (“If I’m in control, I’m safe”) because they cannot trust others to be in charge. They can manipulate through helplessness, open hostility, and defiance.

Internal working models, or core beliefs, are formed early in life based on how caregivers behave toward children. Sensitive and responsive parenting results in positive core beliefs. The child feels safe, loved, learns to trust, and views himself in a positive way; “I am worthwhile, competent, and loveable.” Abusive, neglectful, and otherwise frightening parenting leads to negative core beliefs. The child is afraid of and does not trust his caregiver and views himself negatively; “I am bad, helpless, and unlovable.”

Most children are placed in foster care because of neglect, abuse, and abandonment, often associated with parental substance abuse. Maltreatment and multiple caregivers generally lead to insecure and compromised attachment styles. A recent study of children five years and younger in foster care found that 86% were avoidantly attached, regardless of the type of maltreatment they experienced in their biological families (McWey 2004). Children in foster care have negative core beliefs. They expect that caregivers will not meet their needs and develop defensive strategies for protection: *no trust, a profound need to control others, and never rely or depend on caregivers.*

These are survival strategies learned in the past in order to adapt to unhealthy caregivers and adverse conditions. When placed they view foster care in a mistrustful way and are generally resistant to accepting care, guidance, and support. They turn away from the caregivers, sending the message, “I don’t need you; I can take care of myself.” Foster parents often report that the more they attempt to offer comfort and care, the more mistrustful and angry the children become. They are protecting themselves from anticipated hurt by rejecting and alienating the foster parent. Infants show this defensive

and rejecting behavior to even the most sensitive and loving foster parent. The problem is magnified with older foster children due to long-term exposure to maltreatment, the likelihood of multiple moves and previous placement failures, and unresolved emotional issues with their birth families (e.g., loyalty conflicts) (Schofield and Beck 2005).

Many children enter foster care in their early years when brain growth and development is most active. During the first several years of life the parts of the brain that govern learning, self-control, coping with stress and emotions, and personality traits are established. The neural connections formed during those critical years are significantly influenced by abuse, neglect, and attachment disruptions (American Academy of Pediatrics 2000). Early separation and loss causes babies and young children to become behaviorally and biochemically dysregulated (Fisher et al. 2000). The absence of consistent and supportive attachment figures leaves children alone in dealing with stress. This results in children who are anxious, impulsive, lack self-control, and cannot manage their emotions and stress.

## **Moves**

Children need consistent and predictable relationships with caregivers in order to develop properly. Due to severe emotional and behavioral problems, however, children regularly move from foster home to foster home. Children with insecure attachments have more foster care placements. This is a vicious cycle: maltreatment and loss lead to negative core beliefs; mistrust and defensiveness cause children to push parents away, refuse to be cared for, and act in angry, aggressive, and defiant ways; this causes foster parents to remove these children from their homes. With each move, children experience

more loss and abandonment, feel more worthless, inadequate, and unlovable, and are less likely to trust caregivers and form secure attachments in the future.

Adults often do not understand how traumatic it is for children to move. Although they might appear unaffected, every move children endure results in further anxiety, anger, and mistrust. As an adult, imagine how you would feel if some arbitrary person told you that tomorrow you will leave your home and live with complete strangers.

Children do best in foster care when they are placed early in life and remain in one home. When a child must be moved, the transition can be eased by appropriate preplacement planning. It is crucial that the prospective foster parents know the child, including: medical, family, and psychological history; number and results of prior moves; and emotional triggers (e.g., anniversary reactions). They need a clear understanding of therapeutic plans and goals. Knowing the child can also help determine the right match in a foster family. The better the fit, the better the chances for success. The following factors should be considered before moving a child into a foster home: match in temperaments; ages and issues of other children in the home; parent's ability to manage high-risk behavior; parent's sensitivity to cultural and ethnic background.

Foster parents must understand the child's defensive attitude and behavior when first coming into their homes. There is an adjustment period when children are grieving prior losses and trying to deal with many changes – new school, new family rules, and new relationships. It is not uncommon for children to “honeymoon” for days, weeks, or even months. During this time, they are assessing the strengths and weaknesses of the parents and family and preparing a strategy to protect themselves and cope with their new

environment. Children may be superficially close and compliant, but begin to act out in angry and defiant ways when the honeymoon is over. Table 5 describes ways to minimize the trauma of moves based on the age and developmental stage of the child.

**Table 1. Minimizing the Trauma of Moves: Developmental Considerations**

- 1. Infants:** Emphasis on transferring attachment and caregiving routines during preplacement contacts. Maintain as many routines as possible in new setting. After move, provide consistency and *meet needs on demand*.
- 2. Toddlers:** Preplacement preparation is crucial to reduce long-term anxiety and fear regarding separation, loss, and lack of safety with caregivers. Primary goal during moving process is to transfer attachment; best facilitated by cooperative contact between parents the child is leaving and new parents/caregivers. Provide support and understanding if regression occurs after move; undue pressure may have negative long-term effects. Note events surrounding the move on the child's permanent record, as this information may help caregivers and helping professionals understand the child's future actions and issues.
- 3. Preschool Years:** Explaining in "child-friendly" language what is occurring and why reduces magical thinking and helps the child attain a sense of control over events. Preplacement services aid in transferring attachment to new caregivers and initiating the process of grieving. Identifying and modifying the child's negative perceptions (e.g., "It is my fault I lost my mom") prevents future emotional problems. As child develops increased cognitive skills, around 8 or 9 years old, caregivers and/or helpers need to review the past, so that the child is not misinterpreting those events.
- 4. Grade School Age:** Despite increased cognitive and verbal skills, it remains necessary to identify and correct magical thinking and misperceptions. It is important

to help the child understand what is happening, and to provide aid in identifying and constructively expressing emotions. Adults are responsible for decision-making, but the child is encouraged to share feelings, worries, and desires regarding the transition. After the move, discussions about grief-related (or other) feelings helps the child free-up energy for social, academic, and additional activities and accomplishments.

- 5. Adolescence:** Moves during early adolescence (12 to 14) are more difficult than in later adolescence because individuation is a major developmental task of this stage. It is difficult to encourage attachment to new caregivers when the child is in the process of emotionally separating from family. Parents need to be sensitive to these development issues; children do best with a clear and concrete commitment (“contract”) to the new caregivers. Adolescents need to have input into decision-making about their lives and future, consistent with their need to have increasing control over life events in general. They should be a part of the process of deciding where to live, except in special situations (e.g., displaying poor judgment). Commitments and contracts are helpful in clarifying and attaining goals. Parents, caregivers, and helping professionals can assist the adolescent “come to terms” with prior losses and trauma, and encourage a healthy balance of dependence and independence [adapted from Fahlberg 1991].

## **Outcomes for Foster Youths**

About 20,000 youths leave the foster care system (“age out”) each year, usually when they turn 18. They are often unprepared and unconnected. Due to the lack of support typically provided for the transition to adulthood, combined with unresolved psychological problems, these young adults have severe difficulties after exiting foster care. Douglas Nelson, president of the Annie E. Casey Foundation, wrote “...no group in the United States is more predictably headed for unhappy outcomes than young people who spend their adolescence in foster care. This litany of failure constitutes a national shame” (Advocasey 2001, p.2.).

The quality of a youngster’s life after out-of-home care is usually assessed in four realms: self-sufficiency, behavioral adjustment, family and social support, and sense of well-being. Adults formerly in care have more than their share of problems. Physical and mental health problems are severe and often untreated; homelessness and academic failure are commonplace; gainful employment is elusive. Consider the following circumstances for many former foster youths (Advocasey 2001):

- Between 25 and 41% of former foster youths spend time in prison. One study found the arrest rate 67% higher for youths previously in the child welfare system compared to those never in that system.
- 38% have severe emotional problems, with a much higher rate of serious disorders (e.g., schizophrenia, depression, personality disorders) and use of psychotropic medication.
- 50% use illegal drugs; 30% of males and 15% of females report using drugs or alcohol daily.

- 24 to 35% experience homelessness. They represent more than half of young adults using federally-funded shelters.
- Up to 46% have not completed high school within 4 years after leaving foster care. Only 48% graduate from high school compared to 85% in the general population. Only 1% goes to college compared to 42% of the general population.
- Unemployment rates of 35 to 51% two to four years after leaving the system. Those who do work earn considerably less than others, many with incomes under the poverty line; 24% report selling drugs and 11% report having sex to support themselves.
- Women who had been in care are more likely to get pregnant (and at a younger age) than comparisons; 42% of prior foster care youths become parents within 2.5 to 4 years after exiting care. Serious parenting failures were found in 51% of these young adults compared to 11% of those never in the system (McDonald et al. 1996; Annie E. Casey Foundation, 2001).

To summarize, children in the foster care system have a myriad of challenges. The aftereffects of maltreatment, losses, and compromised attachment have produced the following needs and issues:

- Experienced profound loss prior to placement.
- Unresolved loss and grief is often expressed as anger, defiance, and/or depression.

- Expect that caregivers will abuse them and/or dismiss their needs; lack trust.
- Although they avoid closeness with and dependence on caregivers, they have a pronounced need for nurturance and support.
- Afraid of abandonment and protect themselves by pushing parents away.
- Seek power and control to compensate for a lack of secure attachment.
- Many appear self-reliant, but under this façade they are insecure, needy, and fearful.
- Dysregulated behaviorally, emotionally, and biochemically; unable to cope with stress and employ self-control.
- View themselves as unlovable, inadequate, and powerless.
- Think about birth families, although may not talk about them.
- Feels loyalty conflicts; reluctant to voice feelings about birth parents and other prior caregivers.
- Birthdays and other anniversary dates often trigger painful memories and negative behaviors.
- Feel different, defective, and ashamed.
- Exhibit severe psychological and social problems as adults.

### **FOSTER PARENTS: NEEDS AND GOALS**

Many in the child welfare field refer to the *foster care crisis* as a way to describe the many difficulties of the foster care system today. What are some of these challenges? First, there has been a dramatic increase in the number of children placed in foster homes.

There were nearly 600,000 children in the foster care system in 2002, a number which doubled since 1987. Second, the children placed in foster homes are more challenging, having more serious and complex problems and needs. Third, the role of the foster parent has changed, making it more complicated and stressful. For example, foster parents are expected to be *therapeutic* parents, minus the extra training, support, and pay. Also, foster parents often have to deal with the ongoing contact between birthparents and foster children (“inclusive foster care”), which provokes unresolved grief and acting-out in the children.

Foster parents have two major frustrations regarding their role. The first is that *all foster parents are therapeutic parents*, because of the severe problems of the children they have under their care. The second is that even parents that are identified as therapeutic foster parents often are *not sufficiently trained and supported*. It is easy to understand why all foster parents must function in a therapeutic capacity when you look at the wounded children who enter the foster care system. The milieu of the foster home *must* be therapeutic. By providing a role model of healthy values and behavior, and offering a safe, nurturing, and predictable environment, foster parents can help children heal emotional wounds and achieve many positive changes.

It is becoming more difficult to keep foster parents in the current system. When asked directly, foster parents site the following reasons for leaving (Hudson & Levasseur, 2002; Jorgenson & Schooler, 2002):

- *Role ambiguity.* There is a lack of clarity about their roles and responsibilities. In exit interviews foster parents say, “We were unclear what the agency and social workers expected of us.”

- *Insufficient training.* A lack of sufficient preparation in the pre-service orientation, as well as a lack of relevant ongoing training and supervision. “My orientation training did not prepare me for the *realities* of being a foster parent;” “We were not trained to deal with the serious problems of the children in our home;” “There is no way for the agency to identify my training needs.”
- *Lack of respect and positive regard.* A central theme involves the need for more respect, recognition, and acknowledgement – recognizing and valuing the foster parents’ contribution. “We were never included in case planning;” “Records and information were kept from me;” “Our ideas were minimized and treated as unimportant.”
- *Lack of support.* Parents need a high level of support, coming from a variety of sources, to effectively deal with very challenging children and day-to-day responsibilities. “I never see my child’s social worker, only an aide who is not able to answer my questions;” “I feel isolated and alone in the agency – having more contact and support from other parents would help;” “We were told to arrange our own respite, as the agency would not provide that for us.”

Support of various kinds – practical and emotional – is necessary for successful foster parenting. Support comes in three forms. *Concrete* support involves adequate income, available respite, and proper training. *Crisis assistance* is the second type of support needed. This includes advice on how to handle difficult situations, not only someone handling the situation for them. One survey found that 90% of foster parents wanted support within 24 hours of a crisis in order to remain with the agency (CWLA

1995). The third category is *emotional* support, including the need for respect and recognition. Emotional support includes:

- Expressing gratitude for doing a difficult job.
- Returning phone calls in a timely manner and letting you know your questions and concerns matter.
- Not blaming the parent when a child acts-out or runs away.
- Debriefing after moving a child.
- Honesty in the parent/agency relationship, including honest feedback regarding strengths and weaknesses to increase the parents' competencies.
- Having a role in developing and reviewing the child's plan of care.

### **Key Principles of Success**

The foster care system needs to make a transition – from an overburdened system which does not meet the needs of its children or parents, to a place where parents and families are valued for the crucial role they play in the lives of children and society. The following are the keys to providing quality foster care and retaining experienced foster parents (Jorgenson & Schooler, 2002):

- *Recruitment:* Fully explain the application and training process and other expectations.
- *Assessment:* Parents must “look in the mirror,” an honest assessment of their own motivations, qualifications, and abilities regarding this challenging job.
- *Pre-service training:* Competency-based training that teaches the concepts and skills required to be successful with specific children in their homes.

- *Communication and support:* Mutual sharing of information between parents and agency; support, respect, and positive regard in relationships with case managers, social workers, other foster parents, respite providers, school and mental health professionals. Treated as valued members of the treatment team.
- *Clear roles:* Clear and consistent definition of their roles and responsibilities as a team member.
- *Ongoing training:* Competency-based training relevant to the challenges and requirements of therapeutic foster parenting. Includes training and supervision focusing on the emotional challenges foster parents face when dealing day-to-day with challenging children.

### **Role of Foster Parents**

Foster parents are the most influential adults in the lives of many wounded children, as they have the most direct, day-to-day contact and the greatest opportunity to impact children emotionally, socially, and morally. All interactions in the foster home have the potential to be therapeutic, an opportunity for *Corrective Attachment Parenting* and corrective emotional experiences. Foster parents are therapeutic parents, agents of healing and change. Via their actions, reactions, and the creation of a safe, consistent, and loving environment, they provide a context in which children can make numerous positive changes, including the following:

- Develop secure attachments, which will benefit children in all future relationships and endeavors.

- Improve self-image and develop positive core beliefs.
- Learn constructive coping skills, such as anger management, stress management, communication, and problem-solving.
- Achieve impulse control and emotional self-control.
- Cultivate intrinsic motivation.
- Create mastery over prior trauma and loss.
- Become responsible and accountable.
- Learn to use good judgment.
- Acquire prosocial values, ethics, and morality, including honesty, compassion, and tolerance.

## **Goals and Solutions**

Foster parents are agents of change and healing. By maintaining a positive attitude and healing environment, you provide an opportunity for children to learn and grow. The list that follows offers guidelines and practical suggestions in order to heal emotional wounds and to facilitate secure attachment in the foster home:

### *1. Understand Core Beliefs:*

Your child's early experiences with caregivers shaped his core beliefs about self, relationships, and life in general. Children with negative core beliefs perceive parents as rejecting, punitive, untrustworthy, and threatening. Therapeutic parenting can change your child's core beliefs and subsequent behavior.

- Look beyond behavior. See rejection and resistance as your child's strategy to cope with prior loss.

- Give approval and praise for specific behavior (e.g., “Thanks for feeding the dog”). Unconditional praise does not match your child’s self-image.
- Do not take your child’s negative attitude and actions personally.

Wounded children have negative expectations about caregivers.

## 2. *Provide a Balance of Connection and Structure:*

Therapeutic parenting is a balance of love and limits. Connecting with your child (empathy, support, nurturing) must be balanced with the necessary structure to engender respect, security, and trust. Parenting approaches that exclusively focus on control instigate power struggles and an adversarial climate.

- Be nurturing even when your child behaves in alienating ways.
- Create a positive emotional climate by being proactive, not reactive. Non-punitive responses and lots of hugs are essential.
- Model caring, nonjudgmental, sensitive, and positive emotions and behavior.
- Provide clear and consistent limits and consequences. Give choices, not commands.
- Maintain consistent and predictable routines and rituals.

## 3. *Teach Reciprocity:*

Children with histories of compromised attachment generally are self-centered, demanding, and unable to give and receive in relationships. They avoid needing others and being vulnerable, due to a lack of trust and belief that they are unworthy of love and caring.

- Encourage your child to ask for help and specific need-fulfillment.

- Your child must contribute to the family. Doing chores allows your child to be a part of the family, have a feeling of accomplishment, and receive praise and appreciation.
- Engage in reciprocal interactions via play, rituals, homework, and other activities done cooperatively.
- Negotiate conflicts; teach problem-solving, communication, and the acceptance of individual differences.

#### 4. *Meet Individual Needs:*

Understand the unique needs, core beliefs, and attachment patterns of each child.

Caregiver attunement to the needs and signals of children facilitates secure attachment.

- Know your child: history, patterns, triggers (e.g., anniversary reactions), and underlying needs.
- Fulfilling deep emotional needs promotes attachment (support, empathy, love). Look beyond negative behavior into the deeper needs and emotions.
- Build trust by successful completion of the *Attachment Cycle* (see Figure 1, page 37).

#### 5. *Look In The Mirror:*

Caregivers cannot avoid bringing their own mindsets and emotional “baggage” into relationships with their children. Healing parents must be aware of their own histories and issues. Solutions are dictated by the way you frame the problem, and your mindset is formed by prior relationship experiences.

- Do your own *Life Script*, a self-report tool which generates awareness of one’s relationship history (see pages 168-174).

- Be aware of common reactions, such as anger, fear, withdrawal, rejection, depression, and helplessness.
- Take good care of yourself. Be aware of stress levels and personal needs (physical, emotional, social, and spiritual).

#### 6. *Managing Emotions:*

Children experience and express intense anger, fear, sadness, shame, and pain due to unresolved loss and maltreatment. They had never learned to identify, regulate, and effectively communicate their emotions. They often mask fear and pain under a response of anger and avoidance in order to reduce vulnerability.

- Do not escalate. Remain emotionally neutral in response to negative behaviors, but show pleasure and excitement in response to positive behavior.
- Encourage communication about feelings. Teach your child to label and talk about her emotions in a safe and empathic context.
- Model healthy emotional management and communication.
- Promote positive emotions, such as joy, fun, love, pleasure, pride, sense of accomplishment.

#### 7. *Sense of Belonging:*

The primary experience of the foster children is loss and abandonment. They have lost connections with family, cultural background, and community, and need to feel “a part of” your family and community.

- Encourage participation as a member of your family and community via ongoing routines and rituals.

- Respect your child's cultural and ethnic background as well as prior relationships with her biological family.
- Help your child feel a sense of belonging, which has a stabilizing and reassuring effect.

### **SUMMARY**

- Over 500,000 children are in foster care in the United States.
- The number of foster parents has declined due to: inadequate pay; lack of recognition, training, and support; the poor image of the foster care system; role confusion; and the increased problems of foster children.
- Children in foster care have serious medical, psychological, and behavioral problems: 75% have a family history of mental illness and/or substance abuse; over 80% have severe developmental and emotional problems.
- Unresolved losses and disrupted attachments are common among foster children; they act-out and are moved from home to home.
- Many children enter foster care early in life when brain growth and development is most active, which affects learning, self-control, and stress-related conditions.
- Facilitating secure attachment involves: understanding core beliefs; a balance of connection and structure; teaching reciprocity; meeting individual needs; looking in the mirror; managing emotions; and enhancing a child's sense of belonging.