Clinical Work with Young Children in Foster Care

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Topics/Learning objectives

- Characteristics of young children in foster care, characteristics of caregivers, and characteristics of the child welfare system
- Complex clinical issues posed for the therapist
- Where we, as therapists, can make a difference
- Therapeutic resources
- Therapists' reflections on the work
- The legal context for clinical work

Young children are disproportionately represented in foster care

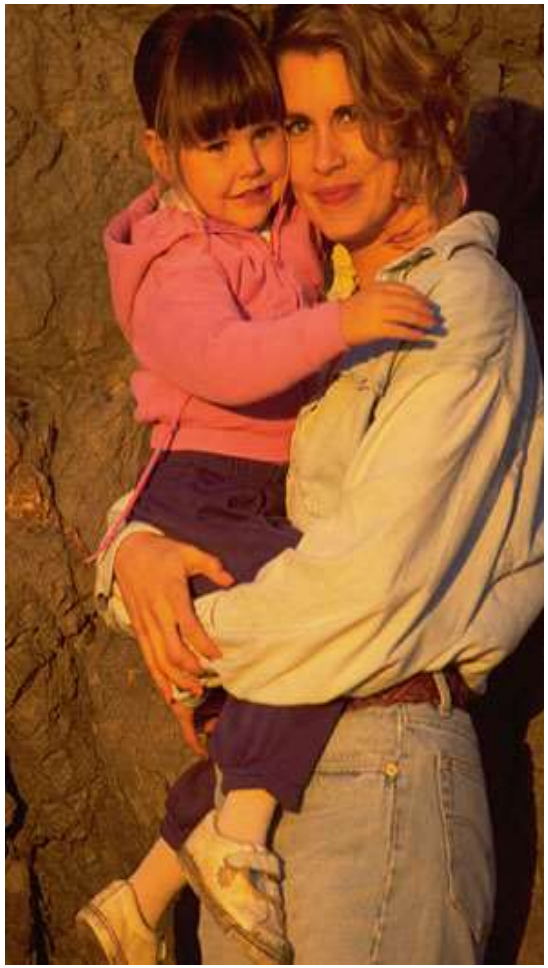
- Infants and toddlers are the largest cohort of children who enter foster care, nationally and locally
- They are the most vulnerable with respect to their child welfare system and developmental trajectories
- Infants stay in foster care longer than older children
- They are more vulnerable to repeat maltreatment whether they are in foster care or home with their parents
- 20-25% of infants who are reunited with their parents return to foster care
- Multiple (2) foster care placements is typical

Multiple Levels of Risk and Adversity

- Prenatal exposure to drugs and alcohol
- Limited or no prenatal care
- High rates of prematurity and low birth weight
- Genetic predispositions
- Poverty
- Housing insecurity/homelessness
- Multiple caregivers and/or multiple changes in caregivers
- Intergenerational patterns of insecure attachment
- Unmet needs (safety, shelter medical, hunger, physical and emotional comfort)
- Chaotic lifestyle/no routines to support regulation
- Neglect, physical and/or sexual abuse, exposure to violence and other forms of trauma (adult criminal, substance abuse, sexual activity)

Attachment Disruptions

- Parental abandonment
- Parental incapacitation
- Parental death
- Parental incarceration
- Removal from parents
- Multiple moves in foster care



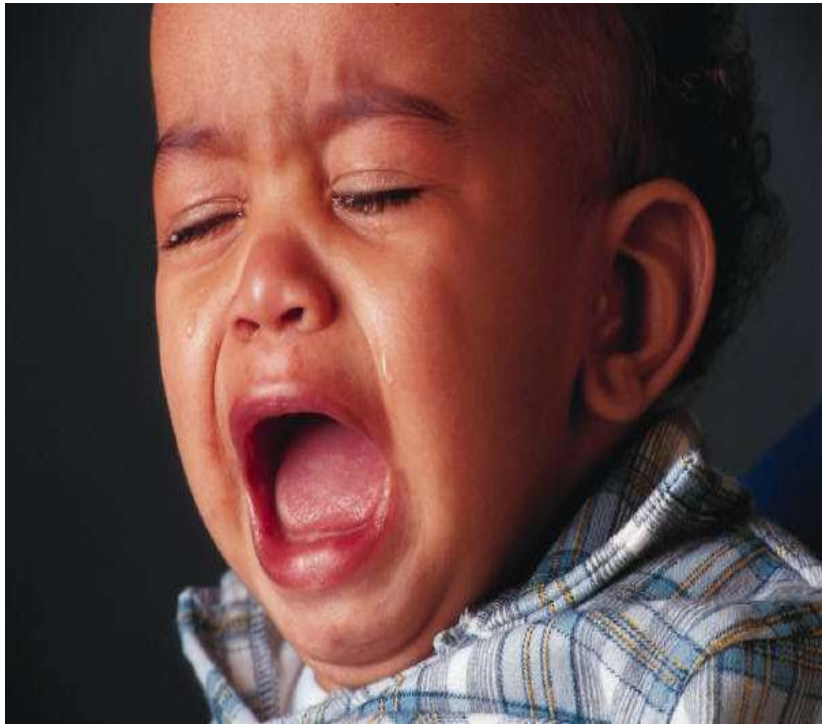
TOXIC STRESS

"Strong, frequent, and/or prolonged activation to the body's stress-response system *in the absence of adult support"*

(Shonkoff, 2010, p. 360)

Adverse Childhood Experiences

In a study of children followed by the National Survey of Child and Adolescent Well Being, 38% of children had experienced 4 or more adverse childhood events by the time they were 2 years old.



Complex Needs of Parents

- Many were in foster care as children
- High number of adverse childhood experiences
- Few, if any, social supports
- Mental health problems
- Substance abuse problems
- Victims of violence/violence exposure in the past and present
- Cognitive limitations/learning difficulties
- Homelessness, or housing insecurity
- Low level of educational achievement
- Criminal charges
- Financial Stress/Poverty
- High levels of conflict, stress in family

Problems imposed by the child welfare system

- Multiple professionals and limited communication between them; systems fragmentation
- Frequent turnover of casework staff and of attorneys
- Little preparation of foster parents (child's specific history; psycho-education about trauma; positive behavior management)
- Over-crowded foster homes
- Working foster parents dependent on child care (questionable quality)
- Multiple moves due to sibling reunification, child behavior problems, emerging relatives
- Poor visit practices
- Confusion about confidentiality
- Confusion about/problems with consent and decision making
- Loss of services each time child moves
- Long delays in court process and permanency planning
- Lack of, or limited knowledge, in infant and early childhood development including critical areas such as attachment theory and research and developmental neuroscience

History of Poor Outcomes

CHILDREN

- Health and medical problems
- Developmental problems
- Emotional/behavioral problems
- Placement breakdowns
- Long periods of instability
- Poor access (or not timely access) to corrective/therapeutic services)
- Poor/no access to high quality early education services

PARENTS

- High levels of conflict with child welfare staff
- High levels of conflict with children's foster parents
- Missed visits with children
- Poor compliance with services
- High levels of recidivism of mental health problems and substance use disorders
- Maltreatment recurrence

Behavioral characteristics of young children in foster care

- Dysregulation (sleep, frequent and easily provoked tantrums)
- Heightened arousal, anxiety, startle
- Negative mood (irritability, depression)
- Affect disorders (flat or constricted)
- Over-activity, impulsivity
- Aggression
- Sexual behaviors
- Hyperphagia; food hoarding
- Indiscriminate social behavior
- Fears (diaper changes, bathtubs, men, being alone)
- Limited play or exploration
- Self-injurious behaviors
- Developmental regressions

Common clinical disorders

- Developmental delays and disabilities
- Relationship disorders
- Post-traumatic Stress Disorder
- Eating Disorder - Hyperphagia
- Complicated Grief Disorder of Infancy/Early Childhood
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder

Complex Trauma

- Complex trauma refers to early-life onset exposure to multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature.

- These exposures occur within the child's early caregiving system – the social environment that is supposed to be the source of safety and stability in the child's life - and include physical and emotional neglect, physical, emotional and sexual abuse, and exposure to domestic violence

- Complex trauma describes the dual problem of children's exposure to traumatic events and the impact of this exposure on immediate and long-term outcomes

- Domains of Impairment: Attachment, Biology, Affect Regulation, Dissociation, Behavioral Control, Cognition, Self-Concept

- Children who are shown to have complex trauma are eligible for health home services

Typical Child Welfare Interventions/ Service Plan Requirements

- Parenting classes (usually group based)
- Anger management
- Substance use disorder treatment
- Mental health services for parents (generic)
- Sometimes, referral to EI but not usually effective
- No interventions that specifically address parenting problems that resulted in maltreatment or that target parent-infant interactional difficulties
- Few trauma focused interventions

Problems

- Typical child welfare interventions for parents are generic, and don't emanate from a thorough assessment of the child, parent, or social context in order to specifically target those problems that resulted in maltreatment and removal
- Typical child welfare interventions do not work with child and parent together, thus obscuring the interactional problems that occur between them, and leaving them unavailable for intervention

Problems

- Courts do not order relational work (i.e., CPP), as they are usually unaware of such interventions and/or have no access to resources for infant parent work
- Court personnel typically do not have access to information related to psychotherapeutic treatment progress due to issues of confidentiality and perceived liability, thus limiting their ability to use such information to inform permanency planning

Problems

- Prolonged court processes impede the development of attachment between child and parent which is a critical foundation for successful reunification, or they contribute to attachment disruption by working toward reunification when an infant/toddler has already consolidated attachment with an alternate caregiver (i.e., foster parent)

Complex Clinical Issues

- Multiple parents/caregivers/families
- Multiple perspectives to hold
- Multiple systems involved –

Caregivers

- One or two parents: (respondent parent(s), non-respondent parent)
- Foster parent(s): kinship or non-related (get along, or don’t get along with parents)
- Other members of the extended family who may come forth immediately, or later; who may want visits with child; who support or don’t support parents’ efforts to reunify with child; who may have prior history with child welfare system
- System leans toward family as preferred resource

Others involved: Legal and child welfare team

- Child's attorney (Legal Aid Society)
- Parent's attorney (each respondent parent has his/her own attorney)
- ACS attorney (FCLS)
- Foster agency caseworker
- ACS caseworker
- Family Court Judge (Child Protection)

Service providers

- Pediatrician
- Early intervention providers
- Child care providers
- Preschool teachers
- Power of Two
- Dyadic therapists
- Parent's individual therapists, substance use disorder counselor

Multiple Perspectives to Hold: Parents' Experience

- Anger
- Sadness
- Grief
- Shame
- Judged
- Not safe to ask for help
- Dysregulation of affect, behavior
- Overwhelmed by service requirements
- Jealousy, rivalry with foster parent
- Confusion (system complexity)
- No voice; no choice; helpless; powerless

Multiple Perspectives: Foster parents

- Over-extended
- Lacking information
- Conflicts in role
- Attached to child, but may not stay in relation to child
- Responsible, but not authorized to make decisions
- Fearful of parent
- Anger at parent
- For kinship providers – history with parent
- Uncertain of, unpredictability of outcome

Therapeutic alliance: How does case come to clinical attention?

- Foster parent initiates
- Foster agency initiates
- Foster parent agrees/doesn't agree with referral
- Foster parent makes herself accessible to the therapy? (doesn't see herself as relevant to child's problems)
- Who do we have access to?
- Tendency to judge, protect child from, parent especially when not known

Multiple Perspectives: the child

Bowlby – On knowing what you are not supposed to know, and feeling what you are not supposed to feel

- Fear
- Adrift, disoriented – unfamiliar people, bed, foods, routines, language, culture
- Sadness
- Secrets
- Conflicted loyalties
- Rejection
- Unworthy of love
- Helpless
- Lacking the exuberance of early childhood

Points of stress for young children

- Chronic neglect
- The event(s) that resulted in remand
- Removal from parent
- Children's Center or Sheltering Arms Reception Center
- Visits with parents
- Transitions between caregivers/homes
- Parent/foster parent conflict
- Moves in care
- Loss of foster parents; loss of other children in the home
- Reunification adjustments

Visits

- Usually very necessary and very important
- Highly correlated with reunification
- Often stressful for child and parent
- Supervised, unsupervised
- Therapeutic visits; visit coaching
- Often occur in small, crowded spaces with no/few/broken toys
- No opportunity for parents' caregiving (feeding, bathing, putting to sleep)
- Highly triggering for parents and children
- Cause severe dysregulation in children after visits

Rise Visiting Video

Goals

Child Welfare Goals

- Safety
- Permanancy
- Well Being

Infant Mental Health Goals

- Secure attachments
- Protection from trauma and adversity
- Recovery from trauma

Where do they converge?
Where do they digress?

Issues for Clinicians

- Limited/incomplete information on child's history
- Child has limited information (may or may not have ever lived with parent; may not know that foster parent is not parent; does not know why not living with parent or where parent is; does not know/is not told why he is moving)
- Child likely knows more than others think
- Child's emotional safety is not considered – caseworker transports child to appointments or visits; parental exchanges at police precincts

Issues for Clinicians

- SADNESS
- Anger
- Frustration
- Vicarious trauma
- Clinical and therapeutic alliances

Where can we make a big difference?

- Trauma narrative
- Narrative around separations
- Explanations in general (child doesn't know foster parent is not birth parent); adoption – colluding with avoidance
- Supporting children's relationships – picture albums
- Developmentally appropriate transitions
- Parent/foster parent relationship (book reading, face time)
- Psychoeducation to foster parents about trauma, neglect, attachment disruptions; prevent placement breakdown
- Psychoeducation to parents (calling foster parent mommy; wariness about entering visit without foster parent)
- Developmental monitoring
- Importance of touch, language rich environment
- Post reunification or post adoption support/ previewing
- Diagnostic clarification

Therapeutic Modalities

- Child Parent Psychotherapy
- Attachment and Bio-Behavioral Catch Up

  Power of Two
- FILM: Filming Interactions to Nurture Development, (video-coaching) Phil Fisher, University of Oregon

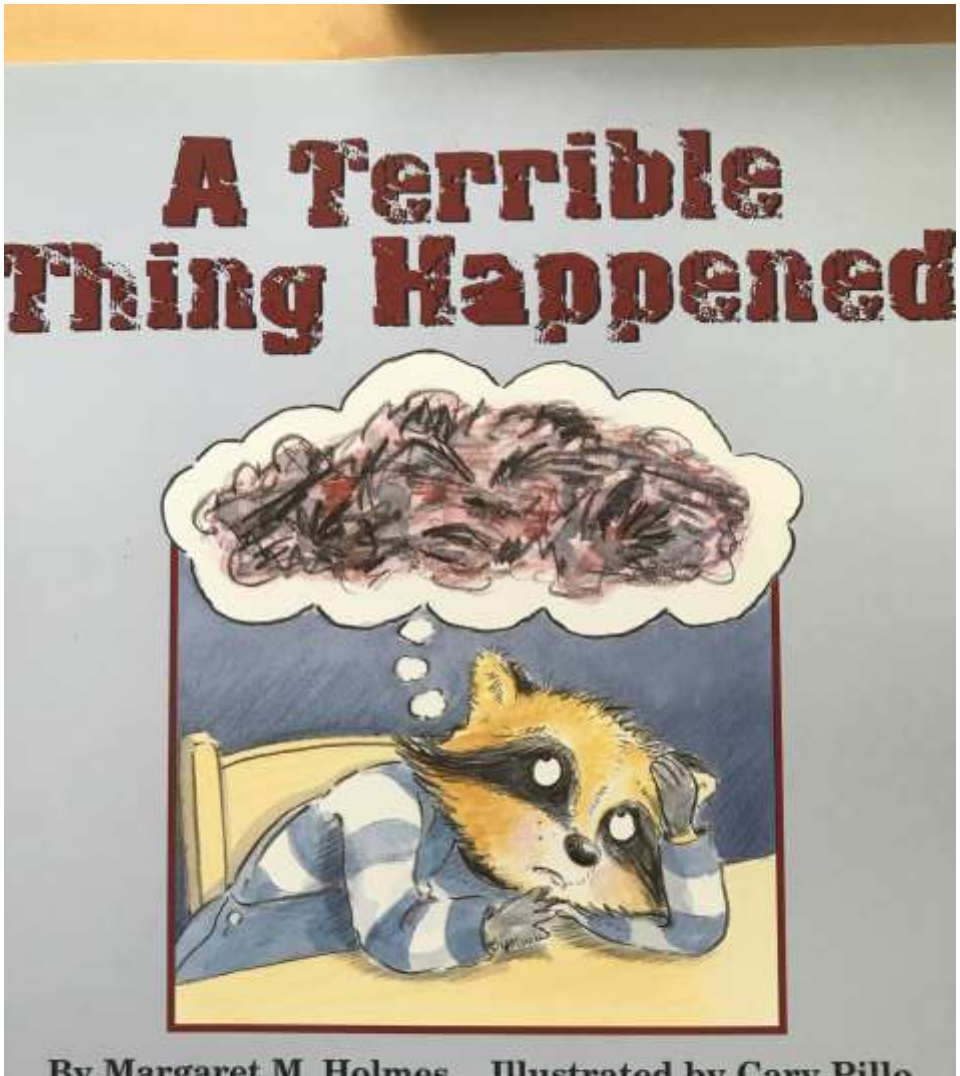
Parenting Journey

Circles of Security

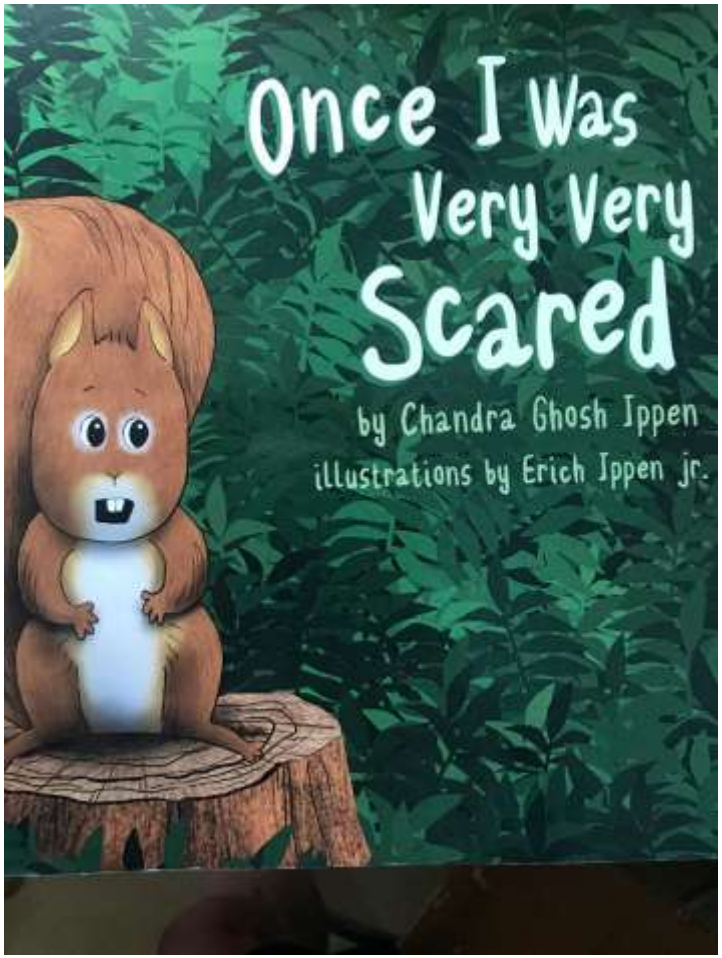
Resources

- Ippen Ghosh books
- I am here for you now
- Rise Magazine
- Rise tip sheets
- For children of incarcerated parents
  Sesame Street tool kit
  Televisiting
  Visiting picture book
- Picture albums for pictures of family
- Rise Magazine video – visits, others
- ACS Visit Policy
- Child Safety Alert 14

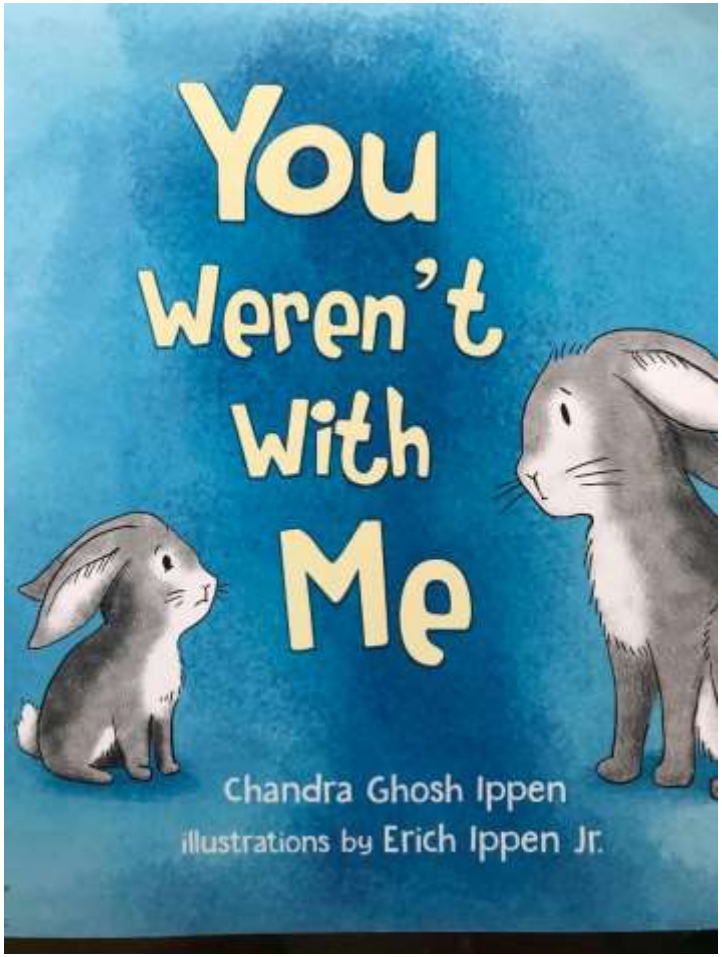
Therapeutic Resources for Working with Young Children and Families



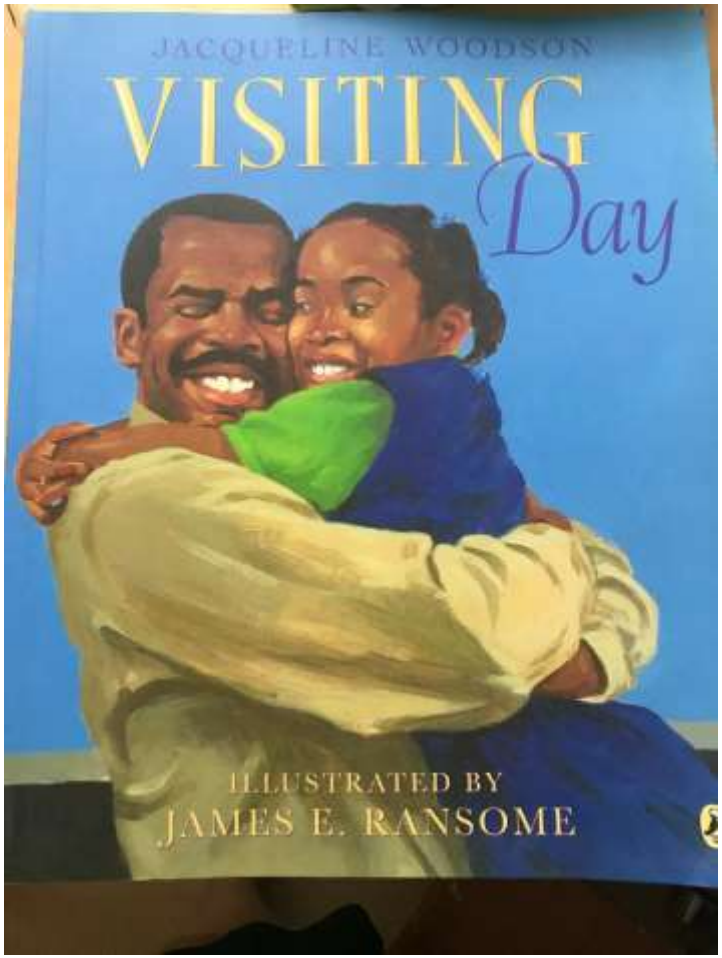
Books by Chandra Ghosh Ippen



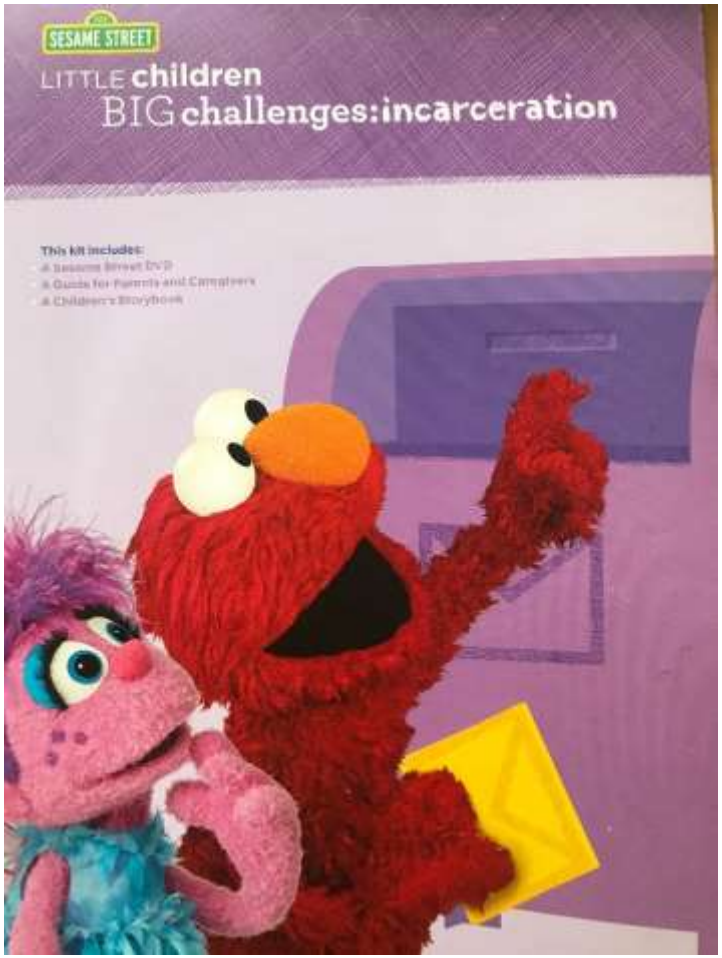
Separations

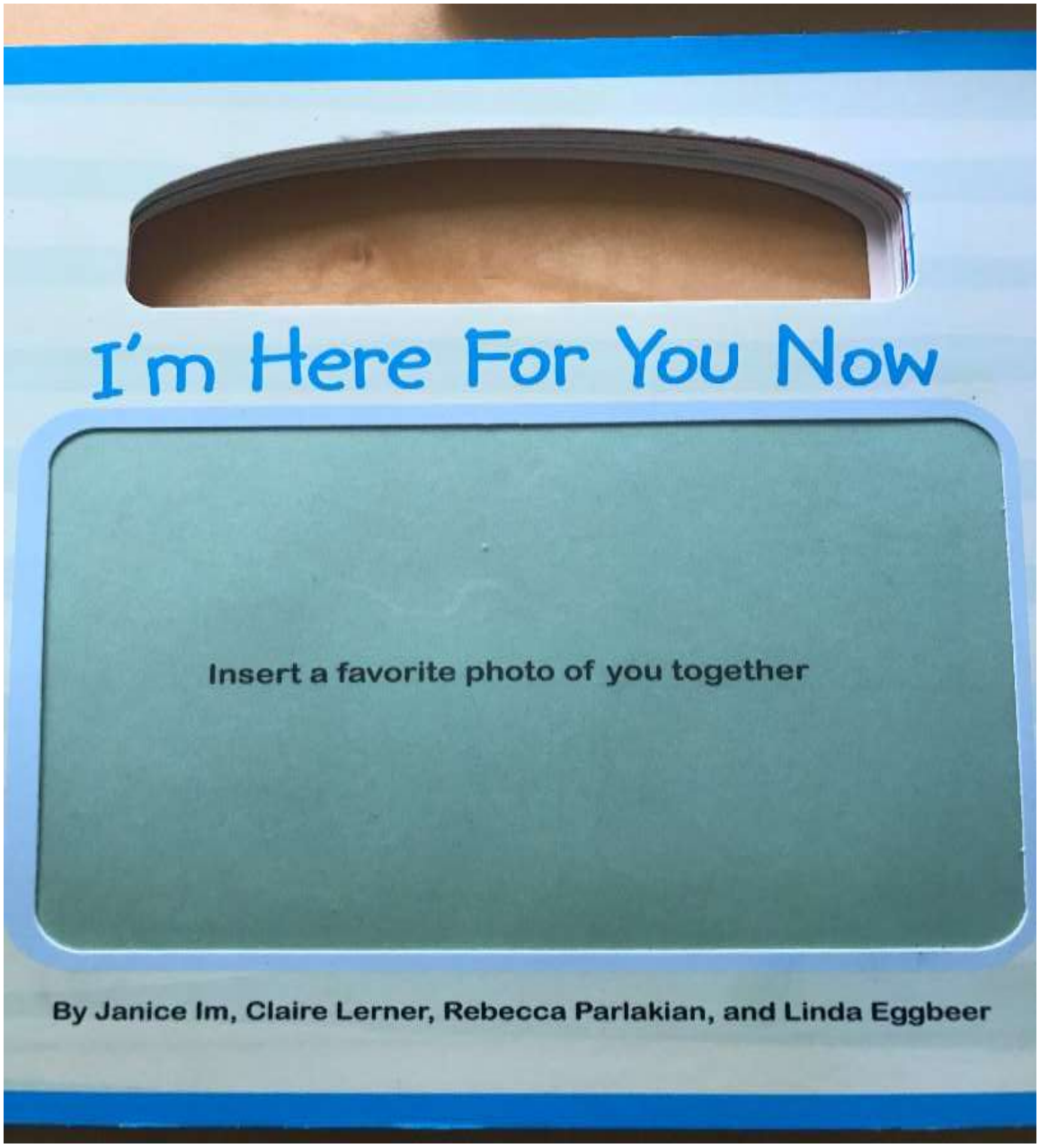


Children with Incarcerated Parents



Sesame Street Tool Kit




I'm Here For You Now
Insert a favorite photo of you together
By Janice Im, Claire Lerner, Rebecca Parlakian, and Linda Eggbeer


I see Mommy!

Rise Magazine

Regular Editions

Special Topics

Tip Sheets

Rise

WRITTEN BY PARENTS IN THE CHILD WELFARE SYSTEM

ADOPTION: BROKEN BONDS

ISSUE #32 | SPRING 2017

Heartbroken

At 9, my daughter was allowed to choose adoption

BY SHARKKARAH HARRISON

IN 2013, I PLACED my oldest daughter in foster care because I didn't know how to help her. She was 6 when she started to say that she hated me and her siblings and didn't want to live with us anymore. One day, after I told her that she could have a piece of cake only after she did her homework, she said, "I hate you, Mommy," and "I want to kill myself," over and over.

I had an open child protective case at the time and was afraid of my agency knowing that something was wrong with my family. But I was so shocked and scared that I called my caseworker. She told me to take my daughter to the hospital.

Six days later, the hospital discharged her saying she was the best behaved child there. But at home she pushed her siblings and hit them with a broom. When I tried to stop her, she hit me and tried to run out the door. I felt heartbroken. I wanted to help her but I didn't know why she was hurting.

Shakkarah and her youngest child

GOOD AND BAD MOTHER

I'd spent much of my childhood in foster care, and my own children had already spent six months in care because I'd used excessive corporal punishment.

At the time, I was a good mother and a bad mother. I loved my children, who were 2, 3 and 6 when they came home from care the first time. I hugged and kissed them. I took them to the movies and the pool. We had water balloon fights and played in the park.

But other times I'd be mad at the world because I didn't have enough money, mad at my kids for messing up their room, and I would curse and beat them if they got me really mad. After, I'd hug and kiss them and tell them I was sorry. Somehow they'd still love me. That's what surprised me.

When they came home from foster care, I promised them they wouldn't go in again. But when my daughter started acting up, I was afraid that child protective would take all my children. Three days after she came home from the hospital, I felt like I had no choice but to place her in foster care.

HEARTBROKEN

A month later, my daughter told her new worker that she'd been molested and that I knew and did nothing to stop it. In truth, I was completely unaware.

After I found out, my heart felt like it was broken, literally. I felt like I'd had a stroke. I'd been molested and not protected when I was a child. I felt horrible that I'd been unable to protect my own child. I felt unworthy to be my children's mother even though I loved them so much.

When I visited, I wanted to hug my daughter and say, "I'm sorry that this horrible thing happened to you but I'm here for you and I will help you get help." But the agency said that if I talked to my daughter about it, I would only upset her. They kept me from her like I was the one who violated her.

For several weeks after that, I stopped going to visits because it was too painful to face my daughter. Eventually I became so overwhelmed—I was also homeless—that I placed my other two children.

I reassured them that I would be back. But I felt so bad for telling them that I did not go to the planning conference at the agency and I was off track with services for the next two months.

GAMES AND TALK

What helped me start working to bring my children home was remembering being in foster care myself. I never wanted my children to feel as lonely as I'd felt. So I began talking to a therapist about my past and present problems. I found support groups, and anger management and parenting classes. Eventually, I began to have the space and the skills to be a calm and loving parent.

After six months, I gained unsupervised visits. The first half hour was supervised. But after that, my children and I had time together without anyone watching or judging. We'd play board games like Tic Tac Toe and Jumping

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Rise TIPS

WHAT YOU NEED TO KNOW ABOUT VISITS

BY AND FOR PARENTS IN THE CHILD WELFARE SYSTEM

Visiting Do's & Don'ts

Below are general guidelines about visits. However, every case is different. Ask your caseworker and your attorney about your case.

1. VISITS WITH YOUR CHILDREN SHOULD:

- Start within a week of your child entering foster care
- Take place for at least 2 hours each week and more often for infants and toddlers
- Be unsupervised as much as possible

2. BEYOND VISITS, YOU CAN:

- Ask for contact by phone or email (If you have a positive relationship with the foster parent)
- Exchange photos and letters
- Participate in children's medical visits, school conferences and activities

3. VISITING TIME SHOULD INCREASE IF YOU'RE:

- Attending consistently and on time
- Paying attention to your child for the whole visit
- Showing progress on the goals in your case — not just attending programs, but
- Called in advance if you were going to be late or had to reschedule
- Gave your attention to your child the whole time
- Disciplined your child appropriately
- Kept anger and frustration out of time with your child

5. YOUR VISITS MAY BE SUPERVISED, OR BE SET BACK TO SUPERVISED, IF:

- There's a concern that your child will be unsafe with you
- You are not showing a change in being able to keep yourself and your child safe
- You are not taking steps to address mental health problems or addiction
- There's a concern you will run off with your child
- There's a concern that you will influence your child's testimony in court

6. IT'S RARE BUT YOUR VISITS MAY BE CANCELLED ON THE SPOT IF YOU:

- Are drunk or high
- Act aggressively or make threats
- Hit your child – including "popping"

How to Self-Advocate

1. Talk to your caseworker and lawyer about your visiting plan and ask for a copy of the court report.
2. Ask your caseworker to explain exactly what you need to do to make progress and ask for feedback after each visit.
3. Keep a "Visiting Notebook." Write down:
   - Whether you attended and if you were on time;
   - How the visit went;
   - If your visit was cancelled and why, and whether it was made up.
4. If your visit is cancelled, speak to your caseworker to reschedule. If your visits are not made up, show your Visiting Notebook to your caseworker's supervisor, a parent advocate and to your lawyer.

Rise

Building a Bridge

Stories about connections between parents and foster parents.

Video-visiting

Osborne Association

Child Center of New York

New York Public Library

ACS: CHIP Program