Clinical Work with Young Children in Foster Care

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Who We Are

New York Center for Child Development

- NYCCD has been a major provider of early childhood mental health services through federal, state, city and philanthropic funded programs in New York
- NYCCD has a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice

Training and Technical Assistance Center (TTAC)

- NYCCD was selected by the New York City Department of Health and Mental Hygiene under Thrive NYC to develop a citywide Early Childhood Mental Health Training and Technical Assistance Center (TTAC)
- NYCCD's Subcontractor in the TTAC Center is New York University McSilver Institute for Poverty Policy & Research which offers clinic, business, and system transformation supports statewide to all behavioral healthcare providers.

http://www.TTACny.org

Topics/Learning objectives

- Characteristics of young children in foster care, of their caregivers, and of the child welfare system as a context for this work
- Complex clinical issues posed for the therapist
- When and how children's therapists can make a difference for children, parents and foster parents
- Evidence-based therapeutic approaches for young children in foster care
- Therapeutic resources

Young children are disproportionately represented in foster care

- Children under 6 make up a disproportionate percentage of foster care entries
- Though they are one-third of the child population, they constitute 47% of foster care entries
- Despite large reductions in out-of-home care during the past decade, the population of children birth to five has not experienced similar declines

(Casey Family Programs, 2013)

Infants and Toddlers

- Infants and toddlers are the largest cohort of children who enter foster care, nationally and locally
- 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 families
- 20-25% of infants who are reunited with their parents return to foster care
- Multiple (more than 2) foster care placements are typical

A vulnerable stage of development

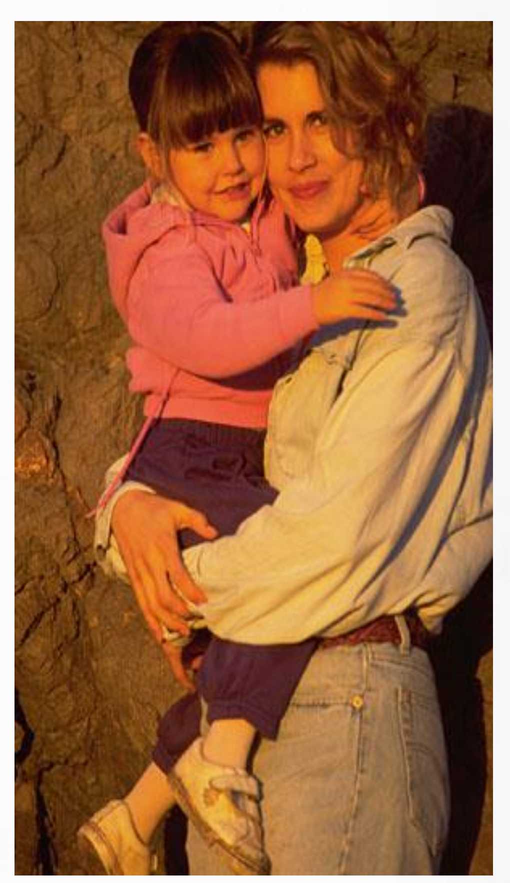
- Very young children are the most vulnerable with respect to both their child welfare system and their developmental trajectories
- Critical period for the development of attachment, language and cognitive development, self-regulation, social competencies and school readiness
- Exposure to traumatic events and disruptions of primary attachments have their most deleterious impact in these earliest years of life

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
- Poverty
- Housing insecurity/homelessness
- Multiple caregivers and/or multiple changes in caregivers
- Intergenerational patterns of insecure attachment
- Unmet needs (safety, shelter medical care, 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 activities and arrests, substance abuse, sexual activity)

Attachment Disruptions

- Parental incapacitation
- Parental death
- Parental incarceration
- Abandonment
- Removal from parents
- Multiple moves in foster care
- Reunification with parents



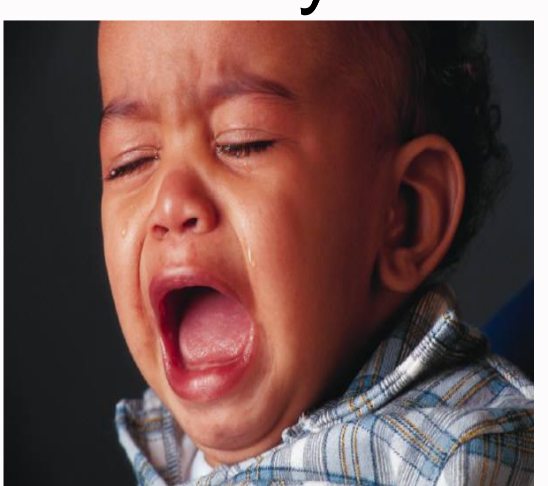
TOXIC STRESS

“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

- Financial Stress/Poverty
- Homelessness/housing insecurity
- 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
- Low level of educational achievement
- Criminal charges/justice system involvement
- High levels of conflict, stress in family

(Wulczyn, Ernst, & Fisher, 2011)

Child welfare system

- Multiple professionals and limited communication between them
- Frequent turnover of casework staff and of attorneys
- Punitive/critical stance toward parents
- 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
- Limited expertise in infant and early childhood development including critical areas such as attachment theory and research and developmental neuroscience

History of Poor Outcomes

CHILDREN

- High rates of health/ medical problems
- Developmental problems
- Emotional/behavioral problems
- Placement breakdowns
- Long periods of instability
- Poor access (or not timely access) to corrective/therapeutic services)
- Poor 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

Complex Trauma

- Early-life onset exposure to multiple, chronic and prolonged 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

Typical Child Welfare Interventions/ Service Plan Requirements

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

Complex Clinical Issues

- Children with complicated clinical presentations and co-morbidities
- Multiple parents/caregivers
- Multiple perspectives to hold
- Multiple systems involved

Complex clinical issue

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 a child has already consolidated attachment with an alternate caregiver (i.e., foster parent)

Common clinical disorders (DC:0-5 framework)

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

Multiple Caregivers

- One or two parents: can be respondent parent(s), non-respondent parent)
- Foster parent(s): kinship or non-related (who 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

Legal and child welfare team

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

Service providers

- Pediatrician
- Early intervention providers
- Child care providers/preschool teachers
- Power of Two coaches
- Child or 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
- Conflict 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? Who do we have access to?

- Foster parent initiates referral
- Foster agency initiates referral
- 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)
- Tendency to judge, protect child from, parent especially when not known

Multiple Perspectives: The child's experience

- Intense fear and helplessness
- Loss
- Unacknowledged Grief
- Disorientation
- Sadness
- Conflicted loyalties
- Secrets
- Rejection/unworthy of love
- Helpless
- Bowlby – on knowing what you are not supposed to know and feeling what you are not supposed to feel

Points of stress for young children

- Neglect
- The event(s) that resulted in removal
- Removal from parent
- Children's 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

- Necessary and important
- Highly correlated with reunification
- Often stressful for child and parent
- Supervised or unsupervised; at the foster agency or in the community
- Often occur in small, crowded spaces with insufficient toys/materials
- No opportunity for parents' caregiving (feeding, bathing, putting to sleep)
- Highly triggering for parents and children
- Severe dysregulation in children after visits

Clinical Issues for Therapists

- 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)
- Is it ok to discuss with child?
- 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

Personal Issues for Clinicians

- SADNESS
- Anger
- Frustration
- Vicarious trauma

Where can we make a big difference?

- Trauma narrative for children
- Narrative around separations
- Explanations in general (child doesn't know foster parent is not birth parent); adoption – avoid colluding with avoidance
- Trauma informed, strength-based approach to parents
- Supporting children's relationships
- Developmentally appropriate transitions
- Parent/foster parent relationship (book reading, face time)
- Psycho-education to foster parents about trauma, neglect, attachment disruptions; prevent placement breakdown
- Psycho-education 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 Work with Children

- Attune to child's cues and miscues and resonate to their feelings and experiences; make them feel understood
- Trauma narratives
- Narratives about separations
- Pictures, picture albums
- Explanations in general (different families; two mommies; adoption, agency/court/judge)
- Developmental monitoring
- Preschool consultation

Work with Foster Parents

- Psycho-education about the impact of neglect, trauma and attachment disruptions on very young children and on their behavior
- Responsive support to expressed needs
- Guidance on behavior management in the context of trauma and loss
- Importance of touch, comfort
- Acknowledge and address their conflicts in role
- Assistance with referrals and complex systems

Trauma informed approach to parents

- Two thirds of parents (63%) of young children in foster care have experienced 4 or more ACEs
- Trauma negatively affects the parts of the brain involved in planning, evaluating situations, thoughtful decision making, and problem solving.
- This leads to difficulty with scheduling, keeping appointments, and making appropriate safety judgments

(Zero to Three: Putting the Science of Early Childhood to Work in the Courtroom, 2019)

Understanding Parent Behavior as Trauma Responses

- Avoidance: coming to the foster agency for visits, or to court, may remind parents of the trauma of their child's removal, or of their own childhood histories in foster care
- Fight or flight response: Over-reactive to stressors, focused on threats, behavioral dysregulation or agitation
- Mistrust of relationships and authority figures
- Feelings of helplessness and hopelessness
- Substance use disorders are often strategies to cope with intolerable feelings and body sensations (associated with fear, stress, anxiety and depression)

Psychotherapeutic Approaches

- Therapeutic stance of positive regard
- Look for personal strengths and underscore them
- Explain things repeatedly as needed
- Attempt to solve problems of daily living
- Support appointment keeping (text reminders, calendars)
- Psycho-education about trauma responses
- Psycho-education regarding children's attachments
- Highlight parenting strengths and children's positive response to parent
- Acknowledge pain of repeated separations
- Ask about visit supports
- Teach ways of interacting with infants and young children

Lofty (but Important) Goals

- Support the relationship between parents and foster parents
- Advocate for developmentally appropriate transitions for children
- Provide therapeutic support for visits
- Support children's relationships

Therapeutic Modalities

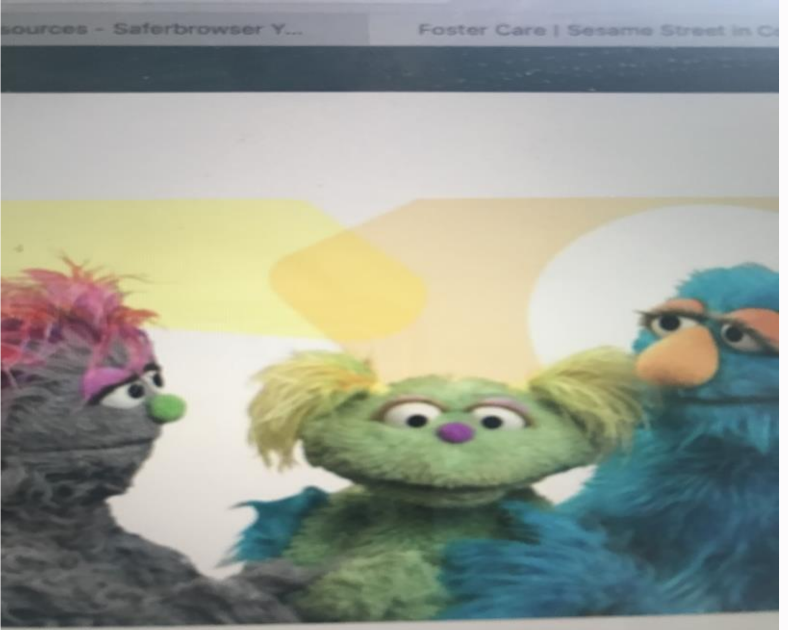
- Child Parent Psychotherapy
- Attachment and Bio-Behavioral Catch Up
  Power of Two
- FILM: Filming Interactions to Nurture Development, (video-coaching) Phil Fisher, University of Oregon

For parents:

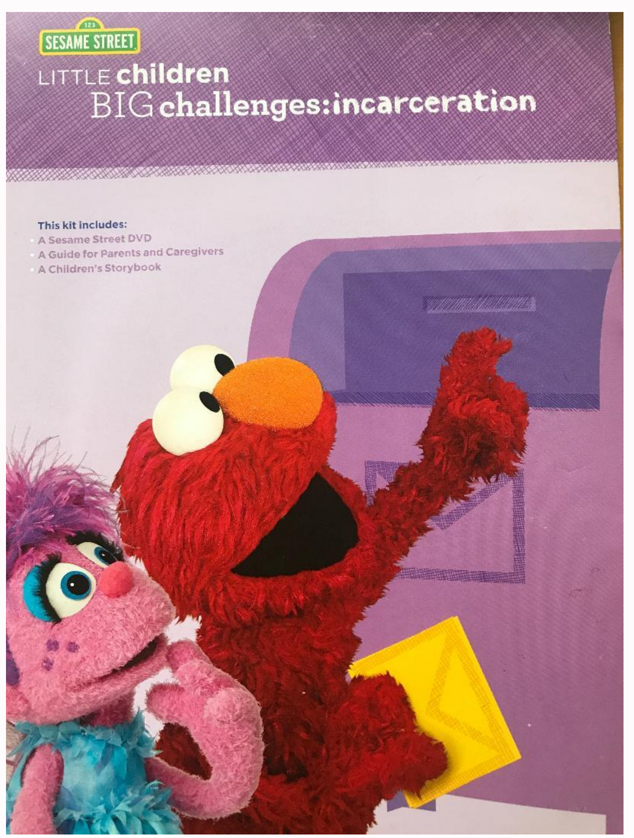
- Parenting Journey
- Circles of Security

Sesame Street

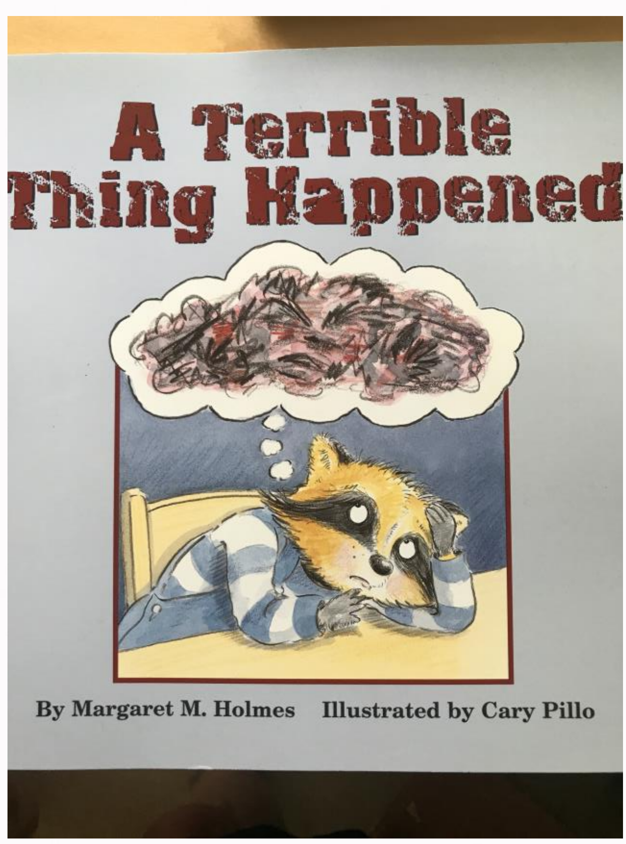
- New muppet in foster care, Karli, and her "for-now parents"
- Interactive storybook, printable activities, videos



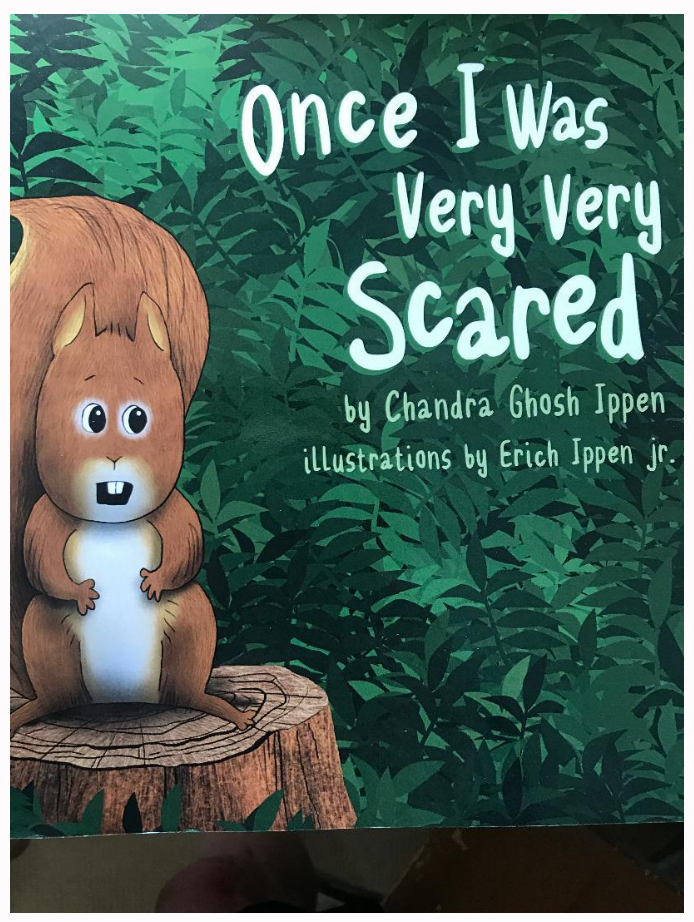
Sesame Street Tool Kit



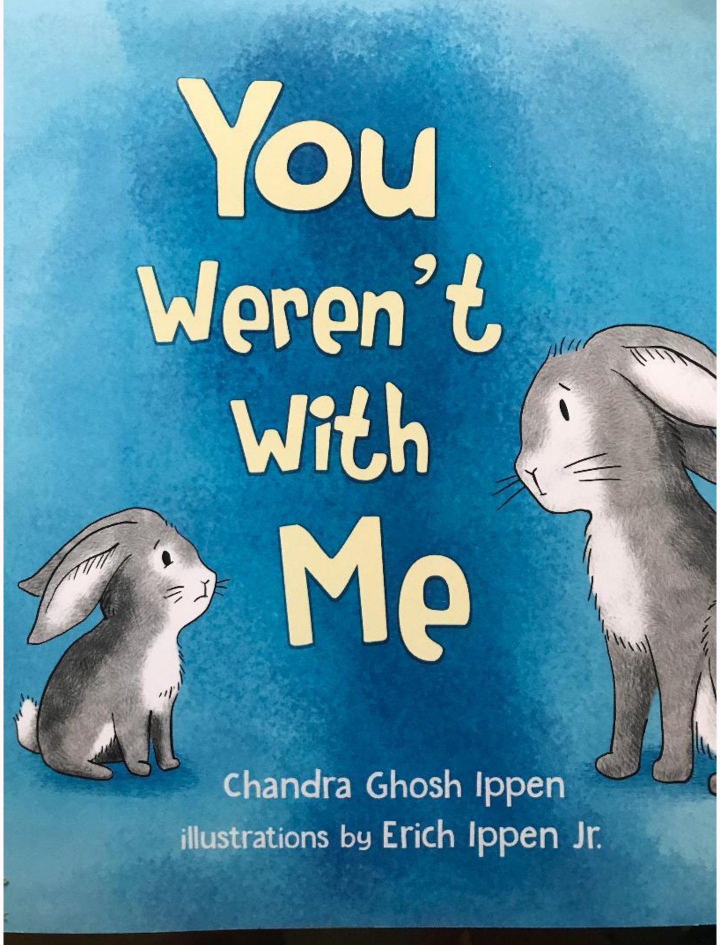
Therapeutic Resources for Working with Young Children and Families



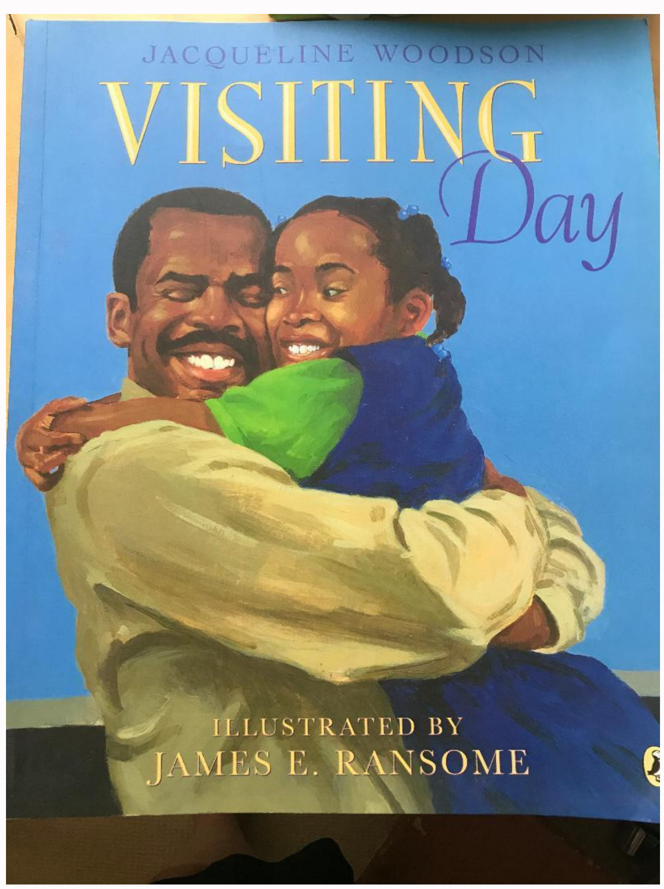
Books by Chandra Ghosh Ippen



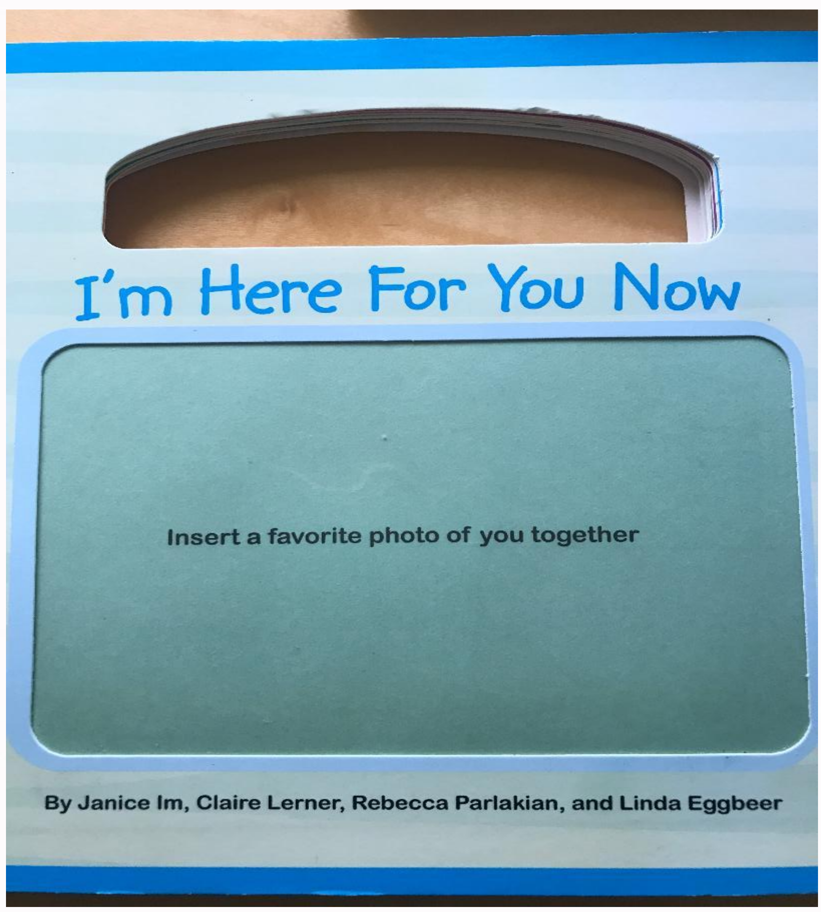
Separations



Children with Incarcerated Parents



I am Here for You Now



I see Mommy!

Rise Magazine

Regular Editions

Special Topics

Tip Sheets

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.

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 protection 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.

PHOTO BY STEVEN ZESWITZ

Sharkkarah and her youngest child

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 failing 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

Continued on page 2

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 showing behavior changes related to the safety concerns in your case
- Being nurturing and loving

4. YOUR CASEWORKER REPORTS TO THE COURT WHETHER YOU:

- Attended your visit
- Came on time
- 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" your child – or threaten your child
- Blame, shame, or threaten your child in any way, especially saying that it's your child's fault that you have a case
- Can't calm down even after a warning
- Arrive very late without calling

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.

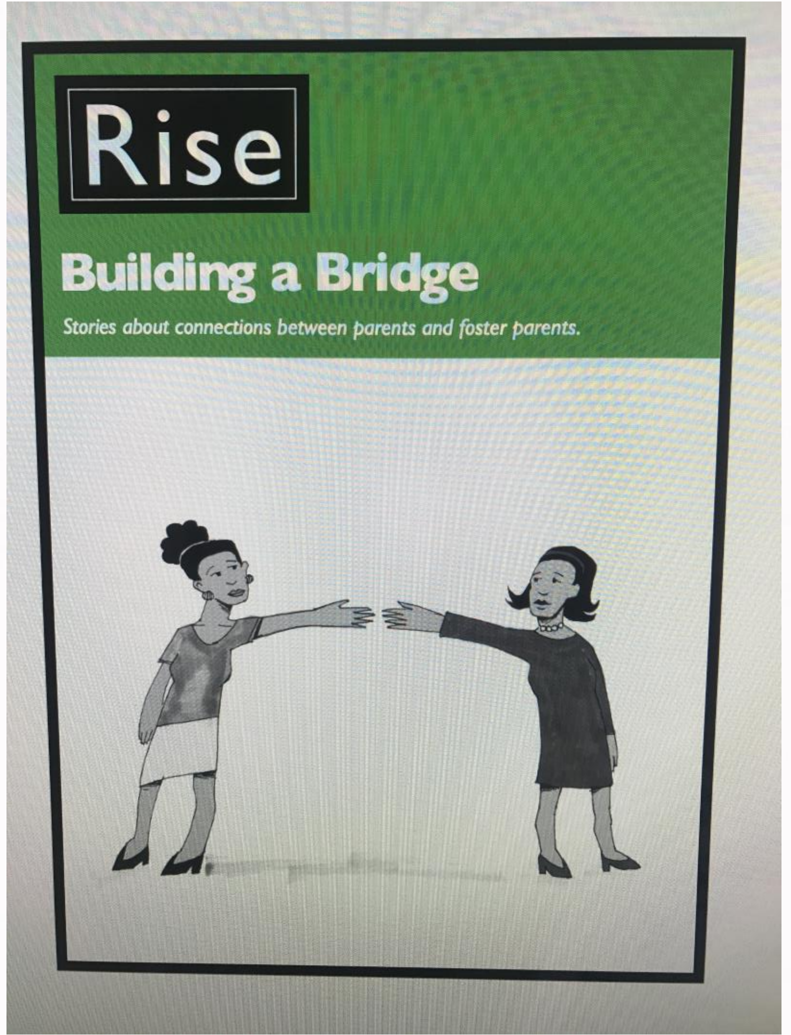
3. Keep a "Visiting Notebook." Write down:

- 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.

Please note: These are general gu... that may not apply in eve...

A COLLABORATION BETWEEN


Rise
Building a Bridge
Stories about connections between parents and foster parents.

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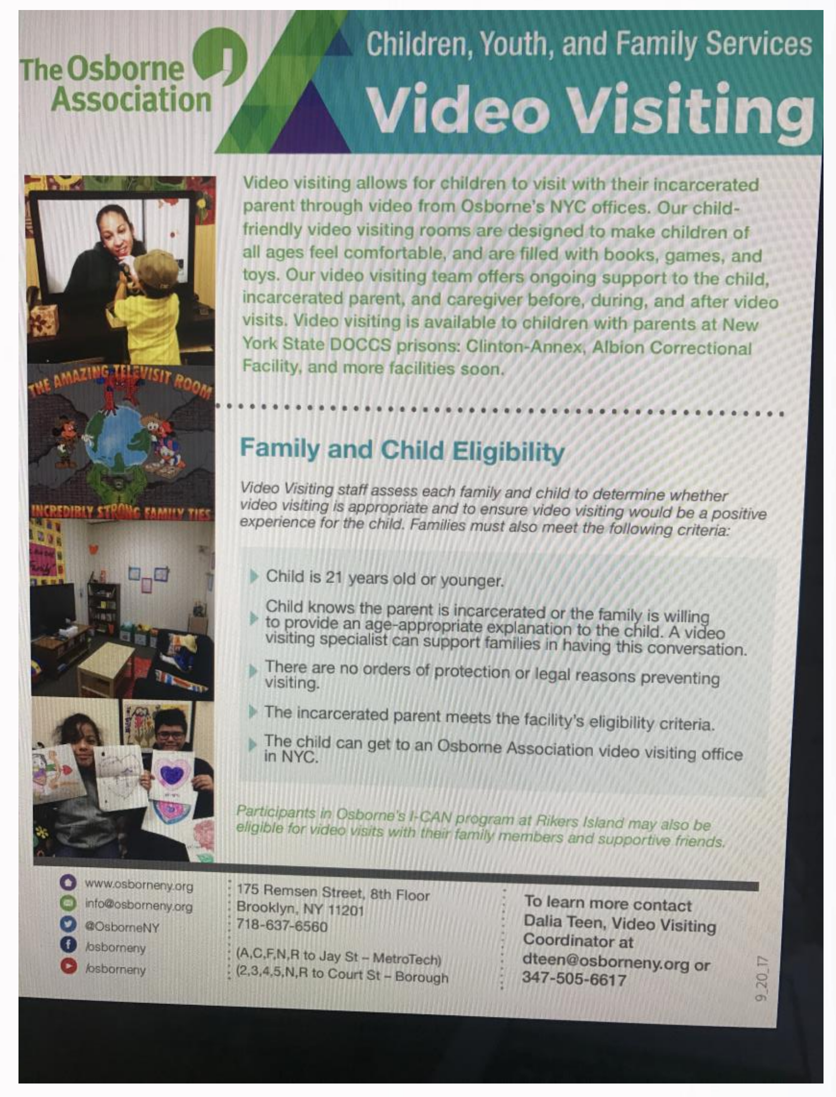
ACS: CHIPP Program



Reunification Supports

- Preventive Programs
- Home Visiting Programs (Healthy Families, Early Head Start, Parent Child Home Program)
- High quality early childhood programs
- Power of 2

QUESTIONS?

REFLECTIONS TO SHARE?

Visit our Website

TTACNY.org
ttac.info@nyu.edu

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Events

Wednesday, June 13, 2018
Sensory Integration and Self-Regulation: Sensory Contributions to Young Children's Social-Emotional Development

Monday, November 26, 2018
Foundations of Social-Emotional Development in Infants and Toddlers E-Learning Modules

view more >

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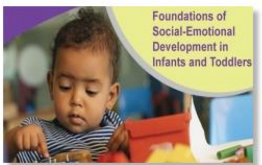
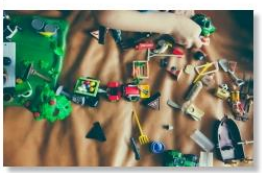
NYC DOHMH Bureau of Early Intervention E-Learning Modules



Foundations of Social-Emotional Development in Infants and Toddlers
Learn More

The Early Childhood Mental Health Network



Get to know the Early Childhood Therapeutic Centers (ECTCs)
Learn More

Thank you!