Understanding and building attachment

“Attachment is a word like self-esteem that becomes less clear the longer it is used and popularized.”

William N. Friedrich

The Hand That Rocks the Cradle
They say that man is mighty
He rules o’er land and sea.
He wields a mighty scepter
Over lesser powers that be.
But, a mightier power and stronger
God from his throne has hurled,
For the hand that rocks the cradle
Is the hand that rules the world.

Author Unknown
Attachment refers to a special emotional and social connection between children and their caregivers that emerges during the first year of life.

Fahlberg’s Arousal/Relaxation Cycle

- Arousal
- Relaxation
- Child Expresses Need
- Caregiver Meets Need
- Security/Attachment

Two Primary Parenting Behaviors Important in Developing Attachment

1. The adult readily recognizes and responds to the child’s physical and emotional needs.
2. The adult regularly engages the child in lively social interactions.
The Secure Foundation - Attachment

Future Relationships
Self-Reliance
Social Interaction
Conscience Development
Self-Esteem
Trust and Security
Language and Communication

Secure Attachment

• Birth to 12 months - explores environment, views mother as secure base, cries less than other groups

• Pre-school - makes friends with peers, is flexible and resilient under stress, exhibits positive self-esteem

• School-age - forms close friendships, is confident, exhibits good self-esteem

• Adolescence - values relationships, can manage conflicts, is better equipped to deal with stress
Attachment Patterns

Secure | Insecure (anxious)
- Avoidant
- Ambivalent (Resistant)
- Disorganized

Insecure Avoidant

- Birth to 12 months – shows random anger at mother, is unresponsive when held, is upset when put down
- Pre-school – shows frequent anger, is aggressive and defiant, withdraws when upset or in pain
- School-age – has no close friends, shows marked exclusivity, jealousy, and trouble with large-group interactions
- Adolescence – is distant from peers, idealizes family, has no happy childhood memories
Activity Handout 1

Insecure Ambivalent

- Birth to 12 months: cries frequently, is clingy and demanding, exhibits limited exploration
- Pre-school: is fretful, overwhelmed with anxiety, and doesn’t cope well with stressful situations

- School-age: displays difficulty functioning within peer groups and maintaining friendships, may be socially immature
- Adolescence: is angry, anxious, has disjointed memories, tends to dwell upon self, exhibits fear of abandonment

Disorganized

- Birth to 12 months: shows random anger, combines elements of avoidant and ambivalent, shows severe anxiety in presence of mother
- Pre-school: continues to combine elements of both avoidant and ambivalent, appears dazed, shows regressive behavior
Disorganized

- School-age - disconnect between thoughts and behavior, may show dissociative behaviors, exhibits poor self-esteem
- Adolescence - dissociative patterns may continue, significant relationship problems appear, truancy common, exhibits insensitivity to others, lacks self-control

Attachment Patterns Represented in Non-Clinical Families

- Secure - 40%
- Ambivalent - 20%
- Disorganized - 5% - 10%
- Ambivalent - 10% - 15%

Insecure Attachment averages 85% in maltreated children.

CRISIS

Crisis is described as a predictable emotional state that results from exposure to overwhelming and unmanageable stress.
Stages of Grief

- Shock and Denial
- Anger/Protest
- Bargaining
- Depression
- Acceptance

"The central developmental problem that anxiously ( insecurely ) attached children experience is coping with unusually complex interpersonal circumstances in the context of usually little support from attachment figures."

P. Crittendon, 1992

Degree of Trauma in Separation Is Linked to:
- Significance of person lost
- Whether separation is temporary or permanent
- Issue of fault
Degree of Trauma in Separation is Linked to:

• Availability of support
• Age at time of placement
• Degree of change
• Loss of culture and identity confusion

Factors Associated with Positive Placement Outcomes

• Age of child
• Expediency of intervention
• Quality of care provided
• Number of placements

Factors Associated with Positive Placement Outcomes

• Earlier experiences of attachment
• Available supports to maintain and build attachment
• Cultural continuity
Parenting Patterns

Unresponsive Parent = Avoidant Child

- Suppress or overcome anxiety
- Act with pseudo-independence
- Appear indifferent
- Are unaffectionate
- Don’t rely on others

Inconsistent parent = Ambivalent child

- Sometimes available
- Sometimes unavailable
- Show high anxiety
- Are demanding
- Are whiny
- Show anger
- Avoid relying on others
- Want contact
- Resist contact

Violent, Abusive parent = Disorganized child

- Is unpredictable
- Chronically frightens or hurts the child
- Is frightened
- Shows superficial affection
- Perceives caregiver as dangerous or frightening
- Is emotional
- Is sneaky
- Is manipulative
Foster Caregivers Must...

- Understand that these patterns of relating have "worked" for children
- Remember the behaviors are usually not intended to aggravate caregivers.
- Accurately reinterpret their foster child’s signals and behaviors
- Provide nurturance
- Develop strategies to provide nurturing care when children are distressed
- Provide a predictable, responsive, safe environment to maximize the development of secure attachment
- Flex or tailor their caregiver/parenting to meet the needs of each individual entrusted to them.

Attachment-Focused Parenting

- Correcting the Working Model
- Alliance-building
- Acceptance
- Safety

Building the House from the Bottom Up

Pre-Placement Visits Serve to...

- Decrease fears and worries of the unknown
- Extend attachment to new caregivers
- Assist and initiate the grieving process
Pre-Placement Visits
Serve to...

• Empower foster caregivers
• (The primary family’s ability to have input increases the likelihood they will support foster parents’ attachment and parenting.)
• Encourage future commitments (How will we all work together on child’s behalf?)

Pre-Placement Safety

• Gather as much information as possible
• Ask about child’s fears, anxieties
• Establish what primary family contacts will be (who, where, when, type of contact)
• Know special people in child’s life
• Know what activities child enjoys
• Give child tour of house
• Drive child on tour of neighborhood, school, church, etc.
• Learn about child’s daily routine

Each group is assigned one stage of placement.

• Spend 3 minutes generating ideas for safety strategies for your stage. Write these on the flip chart.
• Rotate to the next chart as directed. You must develop new strategies not mentioned by the previous group(s).
“What we do to build attachment must not be driven by what we expect from our efforts.”

**Acceptance**
- Acceptance includes regard for child’s entire self.
- Child’s experience should not be denied.
- Child must recognize the emotional/behavioral he has.
- Caregiver must flex his parenting to the child’s attachment patterns/needs.
- Caregiver communicates daily the child is a prized member of the family.

**Activity**
- **Avoidant Arnold, age 3**
  Rolls away from caregiver when she tries to hug him before bed
- **Ambivalent Alice, age 7**
  Plays with only one of the permanent kids in the foster home and avoids the other two
- **Disorganized Diane, age 11**
  Laughs and jeers at other children in home when they get hurt
- **Disorganized David, age 15**
  Destructive with his belongings after seeing his primary family
Alliance Formation: Caregiver Variables that Influence Attachment

- Commitment
- Attunement
- Consistency
- Positive regard for child
- Capacity to modulate own emotions and needs

Alliance formation Strategies

- Increase eye contact
- Maximize touch
- Move with your child
- Nurture with food
- Enhance communication
- Get warm and cozy
- Just have fun

Correcting the Child's Working Model

- Don’t reject child because of his behavior
- Avoid over-emotion, negative or positive
- Communicate and adhere to your boundaries and expectations in relationship
- Encourage child to make choices
- Look for opportunities to help child name feelings about primary family
- Model empathy
- Teach problem-solving in relationships
- Remember children want, but are afraid of, relationships
Action Plans

How will you use this information?
Understanding and Building Attachment

**Agenda:**
- Section I: Introductions and Definition of Attachment
- Section II: Insecure Attachment Styles Across Development
- Section III: Crisis, Separation and Placement
- Section IV: The Effects of Parenting on Attachment
- Section V: Attachment-Focused Parenting
- Section VI: Case Studies, Closing, and Evaluation

**Learning Objectives:**
- Participants will become acquainted with each other and acknowledge their years of experience as foster caregivers.
- Participants will understand that secure attachment is highly correlated with the quality of the child/primary caregivers interactions during the child’s first 36 months of life.
- Participants will understand that secure attachment influences and facilitates other aspects of child development.
- Participants will learn the three main insecure attachment patterns and their attendant characteristics.
- Participants will consider and identify the influences of culture on attachment experience.
- Participants will understand that the separation-placement process experienced by foster children will likely lead to crises for the child and primary family.
- Participants will recognize that the crises of placement will lead to the grieving process in foster children.
- Participants will review the stages of grief and identify grieving behaviors they have observed and worked with in their fostering experiences.
- Participants will consider the attachment patterns of four children presented in case studies and discuss the influence attachment has on the grieving process of each child.
- Participants will understand what factors mitigate the trauma of separation placement.
- Participants will become aware that their own attachment experiences will influence their parenting patterns or philosophies and behaviors.
- Participants will learn what parenting characteristics and practices are associated with insecure attachment in children.
- Participants will understand that relationship patterns developed by insecurely attached children have been adaptive in their previous environments.
- Participants will develop empathy for the relationship problems children experience as a result of insecure attachment.
Participants will understand the importance of creating an environment and atmosphere of safety in order to maintain and build attachment.

Participants will understand their responsibility to reinterpret their children’s behaviors and tailor their parenting practices to convey an attitude of acceptance to their children.

Participants will understand the significance of forming an alliance with their children.

Participants will understand that helping their children reconstruct their relationship patterns will require commitment, tolerance, and time.

Participants will evaluate four case studies to identify attachment-building barriers perpetuated by various members of the child welfare team.

Participants will develop strategies to address and correct the barriers they identified in ways that provide opportunities to build attachment.

**Competencies:**

<table>
<thead>
<tr>
<th>Competency Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>924-01-001</td>
<td>Understands why it may be difficult for children to attach to the caregiving or adoptive family</td>
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<tr>
<td>924-01-002</td>
<td>Understands how abusive, neglectful parents can cause insecure attachment</td>
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<tr>
<td>924-01-003</td>
<td>Understands the lifelong impact of separation/abandonment on a child’s ability to develop secure attachment</td>
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<tr>
<td>924-01-004</td>
<td>Understands the lifelong impact of multiple placements on a child’s ability to develop secure attachment</td>
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<tr>
<td>924-01-005</td>
<td>Understands how insecure attachment develops and knows signs of insecure attachment</td>
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<tr>
<td>924-01-006</td>
<td>Understands the short and long term outcomes of insecure attachment for children's development</td>
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<tr>
<td>924-01-007</td>
<td>Understands common emotional conflicts children may have when they are placed in care</td>
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<tr>
<td>924-01-009</td>
<td>Can identify indicators of insecure attachment</td>
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<tr>
<td>924-03-001</td>
<td>Knows how to help children develop secure attachments with their caregiver(s)</td>
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<tr>
<td>924-03-002</td>
<td>Knows how to care for infants and toddlers who have experienced separation and placement</td>
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<tr>
<td>924-03-003</td>
<td>Knows how to care for preschoolers who have experienced separation and placement</td>
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<tr>
<td>924-03-004</td>
<td>Knows how to care for adolescents who have experienced separation and placement</td>
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<tr>
<td>924-03-005</td>
<td>Knows how to create an environment of trust and safety in the caregiving home to help children and adolescents discuss issues and problems</td>
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<tr>
<td>924-03-006</td>
<td>Can use parenting strategies to help children develop attachments with caregivers</td>
</tr>
<tr>
<td>925-02-008</td>
<td>Knows how to handle misbehavior in ways that build and strengthen attachment</td>
</tr>
<tr>
<td>926-06-006</td>
<td>Understands how crisis may be an opportunity to build attachment with a child</td>
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# ATTACHMENT PATTERNS

<table>
<thead>
<tr>
<th>AGE</th>
<th>SECURE</th>
<th>INSECURE AVOIDANT</th>
<th>INSECURE AMBIVALENT(RESISTANT)</th>
<th>DISORGANIZED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-12 mo.</td>
<td>- Explores environment&lt;br&gt;- Uses mother as “secure base”&lt;br&gt;- Cries less than other three groups&lt;br&gt;- Is most compliant with mother&lt;br&gt;- Is easily put down after being held</td>
<td>- By end of first year seeks little physical contact with mother&lt;br&gt;- Shows random anger toward mother&lt;br&gt;- Is unresponsive when held, but often upset when put down</td>
<td>- Cries frequently&lt;br&gt;- Is clingy, demanding and angry&lt;br&gt;- Is upset by small separations&lt;br&gt;- Is anxious in relation to mother&lt;br&gt;- Pursues limited exploration</td>
<td>- Combines elements of avoidance and ambivalence&lt;br&gt;- May initiate closeness with mother but cry and become very upset upon achieving it&lt;br&gt;- Shows severe anxiety in presence of mother&lt;br&gt;- Exhibits repetitive behaviors</td>
</tr>
<tr>
<td>Pre-School</td>
<td>- Makes friends with peers&lt;br&gt;- Spends more time with peers&lt;br&gt;- Is flexible and resilient under stress&lt;br&gt;- Exhibits positive self-esteem</td>
<td>- Shows frequent anger, is aggressive and defiant&lt;br&gt;- May tend to isolate self or be isolated from peers&lt;br&gt;- Hangs around parent or teacher&lt;br&gt;- Withdraws when upset or in pain</td>
<td>- Is fretful, easily overwhelmed by anxiety&lt;br&gt;- Doesn’t cope well in stressful situations&lt;br&gt;- Is overly dependent on adults&lt;br&gt;- Is subject to being bullied</td>
<td>- Continues to combine elements of avoidance and ambivalence&lt;br&gt;- Has difficulty focusing&lt;br&gt;- May stare, appear dazed&lt;br&gt;- May be isolative or controlling with peers&lt;br&gt;- Exhibits regressive behaviors</td>
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<tr>
<td>School-Aged</td>
<td>- Forms close friendships&lt;br&gt;- Can sustain friendships in large peer groups&lt;br&gt;- Is confident&lt;br&gt;- Exhibits good self-esteem</td>
<td>- Has no close friends, or friendships are marked by exclusivity, jealousy&lt;br&gt;- Has trouble with large-group interactions/activities&lt;br&gt;- Tends to isolate self from groups</td>
<td>- Has difficulty functioning in peer groups&lt;br&gt;- Has difficulty maintaining friendships when in large groups&lt;br&gt;- May appear socially and emotionally immature</td>
<td>- Has disconnect between thoughts and emotions&lt;br&gt;- May show dissociative tendency when threatened or traumatized&lt;br&gt;- Lacks ability to make/maintain relationships&lt;br&gt;- Has poor self-esteem&lt;br&gt;- Lacks empathy</td>
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<tr>
<td>Adolescence</td>
<td>- Is articulate with regard to relationships&lt;br&gt;- Values relationships&lt;br&gt;- Can manage conflicts&lt;br&gt;- Is assertive but able to entertain others viewpoints&lt;br&gt;- Is better equipped to deal with stress, time management and emancipation</td>
<td>- Is distant from peers&lt;br&gt;- May idealize family but be unable to describe happy childhood memories&lt;br&gt;- Devalues attachment experiences&lt;br&gt;- Is angry or haughty with peers</td>
<td>- Is angry and anxious&lt;br&gt;- Has disjointed childhood memories&lt;br&gt;- Tends to dwell upon self&lt;br&gt;- Has fear of loss or abandonment in relationships</td>
<td>- Dissociative patterns may persist&lt;br&gt;- Has significant relationship problems&lt;br&gt;- Has poor performance or failure in school&lt;br&gt;- Exhibits truancy&lt;br&gt;- Is insensitive to others, blames others&lt;br&gt;- Lacks self-control</td>
</tr>
</tbody>
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Attachment Definition and Attachment Pattern Representation In Middle-Class, Non-Clinical U.S. Families

Attachment:

- a special emotional connection infants develop with their caregivers, initiated during the first year of life

- a close, enduring, affective connection that develops throughout life

Attachment Pattern Representation:

- Percentage of pattern representation in children of middle-class, non-clinical United States families.
  - Secure = 60%  Ambivalent = 10-15%
  - Avoidant = 20%  Disorganized = 5-10%

- Insecure attachment in maltreated children averages 85%. One Minnesota study found 82% of the maltreated children sampled classified as disorganized in their attachment pattern.

- Insecure attachment does not necessarily lead to problematic relationships/behaviors.

- Anxious attachment in combination with highly stressful experiences places children at risk of developing emotional, social, and behavioral problems.
Attachment Explanation to Caregivers

Children, like other living beings, are born with a drive to survive. Infants do this by staying close to caregivers to get safety and be comforted when they are distressed. When caretakers are protective, attuned, and responsive, children feel secure and develop a secure “attachment style.” The caregivers become a “secure base” from which children can explore their environment and learn to handle separation without serious distress.

Children are believed to develop “working models” for relationships from these early experiences that influence how they think about themselves and about other people. For example, children whose caretakers are protective and responsive learn that they are worthy (positive self) and that other people can be counted on (positive other).

Sometimes children have experiences with caregivers that lead them to develop an insecure “attachment style.”

Unresponsive Caretaker

Children experience these caretakers as not being there for them. They handle their anxiety by suppressing or mastering it. The children may react by being aloof, distant, unusually independent, unaffectionate, and showing indiscriminate friendliness to strangers. These children are learning not to rely on others to meet their needs.

Inconsistent Caretaker

Children experience these caretakers as sometimes being there for them and sometimes not being there. This causes intense anxiety in children. Children may react by being whiny, clingy, and demanding, or by having angry outbursts. These children are trying to get their needs for comforting met and express their distress.

Violent/Abusive/Unpredictable Caretaker

Children experience these caretakers as frightening and dangerous as well as sometimes a source of comfort. They may respond by being manipulative, sneaky and deceptive, and by showing counterfeit/superficial emotionality. The children are trying to control and influence their caretakers to avoid being harmed.

All of these ways of relating are adaptations designed for survival. There may be mixtures of styles in a particular child. Abused children are much more likely to have insecure attachment styles, but there can be other causes. These ways of relating can persist even when the caretaker improves, or children can transfer the style to new caretakers (e.g., foster or adoptive parents). Although the behaviors can cause aggravation, frustration, disappointment, or even anger, that is not the intent. It is important to realize that it may take a long time for children’s style to change and, in some cases, caregivers will have to make adjustments to the children’s style.
ATTACHMENT-FOCUSED PARENTING

1) Create Safety to Allow Attachment
   - Conduct pre-placement visits
   - Involve primary family ASAP
   - Create and maintain a physically and emotionally safe environment to minimize ambivalence and anxiety

2) Acceptance
   - What we do to build attachment must not be driven by what we expect from our efforts
   - Accept child’s entire self
   - Don’t deny or become overwhelmed by child’s history of maltreatment
   - Help child recognize emotional, social, behavioral difficulties he has in a developmentally attuned way
   - Flex/tailor parenting to child’s attachment style
   - Provide support and nurturing when child is highly distressed- develop comfort with expression of child’s negative emotions
   - Foster a sense of relatedness
   - Communicate daily that child is prized

3) Alliance Formation
   - Develop a sense of connectedness with child through caregiver qualities of commitment, attunement, consistency, positive regard for child, modulating your own emotions and needs
   - Extend/adapt caregiver qualities to interactions with child’s primary family
   - Make placement rewarding (see additional information HO)
   - Work collaboratively to solve problems child is facing
4) Correcting the child’s “working model” for relationships
- Practice more neutrality in parenting
- Be mindful that, while insecurely attached children desire relationships, they may be distrusting or fearful of them. They need a more precise view of what relationships can mean. Interactions they’ve experienced with primary families aren’t the only way people respond
- Engage in activities with the child that allow him to take the lead and make choices to increase his sense of efficacy
- Look for opportunities to model empathy
- Assist the child in naming feelings and expressing thoughts about adults in his life
- Model/teach the child how to respond to problems in relationships
- Work with a therapist
PLACEMENT STRATEGIES:
Minimizing Trauma and Grief
Maximizing Safety and Security

Effective Placement Strategies Serve to:

- Minimize the degree of stress experienced by the child - the loss of one’s family, friends, a familiar environment, and routine is anxiety provoking.

- Increase the child’s ability to cope with the multitude of losses and changes by: 1) involving her in the planning of the move; 2) preparing her for the placement; 3) conducting placement activities in steps.

- Assist children to achieve a realistic perception of the reasons for the placement process - children frequently blame themselves as the cause of the separation.

- Enhance the child’s adjustment to the placement setting while allowing the child to retain his own culture and traditions - new environments mean new rules, roles, responsibilities, traditions, foods, activities, limits, and boundaries.

- Provide the child a sense of control over the placement - a child described the placement experiences as feeling like “The house in the ‘Wizard of Oz.’ You get sucked up, spun around and dropped; over and over again.”

- Maintain, repair, build, sustain, and/or strengthen relationship between “lost” parent and child - relationships between caregivers and children should not be severed carelessly.

- Meet the child’s developmental needs - despite the separation, the child’s development processes must still continue.
Pre-Placement Visits:

- Have primary parent accompany to placement
- Participate in at least one pre-placement visit
- Give child a tour of entire house
- Arrange first visits when only one or two family members are at home
- Maintain as much continuity for the child as possible
- Allow periods of respite away from the new home

Strategies At Time of Placement:

Infancy: Birth – 2 years

- Prepare stable environment
- Accompany infant with familiar objects
- Provide sense of continuity for child

Preschool: 2-5 years

- Explain reasons for placement calmly
- Discuss placement on child’s level
- Introduce child to family and relatives
- Develop relationship with child
- Give physical reassurance
- Encourage child to make decisions about dress, etc.
- Give a tour of entire house again
- Encourage child to bring “security item”
- Arrange contact with familiar people if placed in child’s own neighborhood

School Age: 6-9 years

- Encourage child to talk about placement experience
- Elicit, acknowledge and accept feelings of child
- Ensure rules of home are clarified by new family
- Reiterate why the child had to move
- Give tour of house and show child “her space”
- Permit and acknowledge value of child’s security items
- Describe caregiver’s family in non-threatening way
- Assist child in developing a “cover story” for school and community
- Talk openly if child is placed with family of different cultural background
- Encourage child to maintain previous relationships and activities

**Pre-adolescent: 10-12 years**

- Explain reasons for placement; provide opportunity for questions and concerns
- Encourage child to make decisions
- Emphasize child need not make choice between primary and new caregivers; loyalty concerns
- Review rules, responsibilities, routines of home
- Develop a “cover story” to be used in public
- Help child to discuss concerns about acceptance if placed in culturally different environment

**Early and Middle Adolescence: 13-17 years**

- Adolescents are able to provide new caregiver reasons for move, future plans, and placement concerns
- Refer to foster family as something other than “Mom or Dad”
- Engage participation in placement process
- Explain placement and prepare adolescent for distressful feelings
- Recognize developmental needs of the teen
- Provide opportunities and environment for continuing growth
- Assure adolescent the ability to maintain his cultural/ethnic identity while in placement
Strategies During Placement:

- Help child develop story to explain reasons for placement
- Help child develop identifying term for caregiver
- Help child maintain sense of community/cultural identity
- Support regular/frequent visitation with family and other significant individuals
- Provide opportunities for development of attachments and significant relationships
- Have pictures of primary parents, siblings, and other attachment figures displayed in child’s room

Strategies for Reunification and Post Placement:

- Current information regarding plans should be given to the foster caregiver
- Inform child when reunification activities begin
- Encourage child to express any adverse feelings
- Expect recurrences of acting-out behaviors
- Encourage child to take mementos
- Encourage contact with caregivers, if desired
- Provide ongoing contact
PART ONE

SHAVONNE TYLER

Shavonne T., age 11 months, has been in the same foster home since she came into care at 2 months of age. She was removed from the home of her parents, Debbie T., age 19, and Steve T., age 29. Both of them come from rather problematic backgrounds. Debbie’s parents both worked long hours out of the home, leaving Debbie primarily responsible for her own care, beginning at age 8. Debbie was lonely most of the time and never felt close to her parents. Steve grew up with a paranoid schizophrenic mother who would rage and become violent, not necessarily with Steve, but certainly within the household. Debbie ran away from home at age 17 ½ to marry Steve. Both Steve and Debbie have a drug and alcohol history that began in early adolescence. Steve has been in treatment twice for alcoholism and barbiturate abuse, but he has resisted attempts by others to help him deal with his alcohol and drug problems.

Shavonne was placed in care at an early age after some infant health problems and two referrals by the infant health agency. The referrals involved failure of the parents to follow through with treatment at home, and their failure to begin infant immunizations. Children Services found Shavonne to be at high risk after performing a thorough risk assessment. The investigator was particularly concerned that Steve was selling their WIC coupons for cash to buy drugs.

Steve and Debbie have been sporadic in attending family interactions (visitation), missing appointments due to the influence of alcohol and drugs. When the agency moved to a concurrent case plan about six months ago, Debbie entered into a drug treatment program, but Steve disappeared. While she was in treatment, a parent visitation monitor took Shavonne to the treatment center for family interaction three times weekly. The monitor reported that Shavonne (now eight months old) seemed comfortable at the center, even when various staff approached her or picked her up.

Debbie has now moved to outpatient status and is maintaining three family interactions weekly at the agency. The caseworker, who is now observing the family interactions, has noticed that Debbie becomes impatient with Shavonne when Shavonne
is upset. If Shavonne is not quickly comforted when Debbie picks her up, Debbie places her on the bed and quickly walks away, clearly frustrated by Shavonne’s whining. The worker has also noticed that Debbie overlooks or is slow to respond to Shavonne’s basic needs, like being hungry or needing a diaper change.

Shavonne has lived with Mr. and Mrs. Hughes and their two children, ages 5 and 8, her entire placement. Mrs. Hughes has been ill and extremely tired for several months, sometimes to the extent that she has not been able to care for Shavonne or her own children adequately. Consequently, the Hughes children have tried to provide care for Shavonne. The 8 year old discovered that if they put Shavonne in a swing and leave the room, she usually stopped crying. The Hughes felt Shavonne adjusted to their home quickly and commented to the caseworker what a quiet baby she was. The only difficulty they reported was with Shavonne’s behavior after family interactions. Shavonne would appear agitated and anxious, and sometimes refused to eat. Mrs. Hughes told the caseworker that Shavonne would push away from her if she picked her up, but tantrum if she put her down. Mrs. Hughes found that if she left Shavonne alone with some toys, Shavonne would begin to entertain herself.

Three months ago, Mrs. Hughes gave in to her husband’s pleas to see a doctor and was diagnosed with incurable cancer. After her first chemotherapy treatment, it became evident to Mrs. Hughes that she could not care for Shavonne or her other children. She went to the agency, told the worker about her illness and asked to have Shavonne removed. She tearfully shared that she felt guilty about her request, but was too sick to transition Shavonne. She explained that she had packed Shavonne’s belongings and requested that the worker remove Shavonne the next day while she was having chemotherapy. The agency acceded to this request. They moved Shavonne the next day to what they believed to be an “at risk” adoption placement with the Johnson family.
PART TWO
SHAVONNE TYLER

The Johnsons are new to the program and only recently approved. Like the Hughes, they believe Shavonne, now 13 months old, is adjusting well to their family. They have commented on how quiet and independent she is; and how able she is to amuse herself.

The placement has been extended for six months to give Debbie time to improve her parenting skills. Debbie sees Shavonne, under supervision, five times a week. Debbie is much more interactive with her, but continues to be frustrated and unwilling to comfort Shavonne when she cries.

During the first two months of placement, Ms. Johnson began working with an experienced foster parent mentor who recommended a training on attachment issues. As a result of the training, Ms. Johnson asked the caseworker if she could meet Debbie. The caseworker agreed and invited Ms. Johnson to join the family interaction at the agency. Ms. Johnson decided to allow family interaction in her home.

When Debbie first arrives at the Johnson’s, Shavonne appears happy to see her, but when Debbie hugs her, she wiggles out of her arms and goes off to play by herself. Debbie consistently attempts to play blocks or puzzles with Shavonne, but Shavonne gives up and gets angry when she encounters any difficulty in play, sometimes hitting at Debbie or throwing the toys. Mrs. Johnson suggests that Debbie leave Shavonne alone, because she has observed that Shavonne calms down more quickly on her own.

However, after several family interactions, Ms. Johnson becomes concerned that Shavonne is becoming less interested in play with her mom and that Debbie and Shavonne do not seem very close. In fact, the connection seems very different from the relationship she had with her parents as a child. She discusses the issue with her foster parent mentor and caseworker, who agree that Shavonne may be showing some issues of insecure attachment. Ms. Johnson, the mentor, and caseworker set up several strategies to enhance the attachment between Debbie and Shavonne to maximize the likelihood of reunification.
PART ONE
DONNIE ROGERS

Donnie Rogers, age 3 ½, spent the first 18 months of his life in his home with his single birth mother. He was with his maternal grandmother for eight months after coming out of his own home. He has been in a foster home for the last 16 months.

Donnie was born to Melinda Rogers, a single parent, who was age 21 at Donnie’s birth. She finished high school and has held about 15 jobs from high school graduation until age 21. Melinda had a series of live-in boyfriends and she became pregnant. Paternity tests were done for three of the five possible fathers, who proved not to be Donnie’s father. Melinda could not identify the other two men.

Melinda gave Donnie inconsistent care during the first 18 months of his life. Sometimes she was very capable, but at other times she ignored him. As Donnie went through early childhood development, she attempted to assist him in various developmental tasks. But if she thought it was taking too long, she would lose patience. For example, as Donnie struggled with putting shapes in a box, Melinda would grab his hand and force him to put the shape in the correct opening. Melinda is quick to anger. As a child, she was diagnosed with attention deficit hyperactivity disorder. She became hypersensitive to Donnie when he expressed fear, dropping everything to pick him up and hold him. But other times when he was lonely or crying, she would ignore him.

There were multiple referrals on Donnie, some dating from infancy. He was left with inappropriate caregivers, and on one occasion actually left alone. Melinda provided him with inconsistent medical care in that she missed appointments, and then rushed him to the emergency room for illnesses that could have been treated in a doctor’s office.

The incident that brought Donnie into care was a referral from Melinda’s sister. Melinda came to her house distraught and crying because her present boyfriend had left her. Even though he had been somewhat abusive to her, she wanted to find him. Melinda told her sister that Donnie had been particularly bad and that she could not handle him. When her sister changed Donnie’s diaper, she discovered his bottom was
badly bruised. Melinda’s sister and mother contacted the agency because they feared for Donnie’s safety.

Melinda reluctantly agreed to make a placement. Rather than relinquish custody to the agency, she asked her mother to take legal custody of Donnie and care for him. Her mother did as Melinda asked and took Donnie into her home. Melinda disappeared from the family at this time. Her sister learned that Melinda was living on the street.

Donnie’s behaviors included kicking, screaming, and crying sometimes for hours for no apparent reason. He appeared to have no apparent expectation that anyone would respond. His grandmother found these behaviors difficult to handle. She was employed outside the home, and experienced great difficulty keeping daycare providers. Donnie often cried for long periods of time when Grandma left him at daycare, but he would hit his grandmother when she came to pick him up. Later on he would cling to her, not wanting to let her go. Donnie went through three day care providers who found him too hard to handle.

About eight months after placement, Donnie’s grandmother contacted the agency and stated that she could not care for Donnie adequately. She also advised the agency that she had developed some serious physical problems that made it impossible to move Donnie around when he was having a temper tantrum. None of the other relatives could take Donnie because Melinda kept appearing at their houses unannounced, asking if she could “hang out” for a while.

The agency assigned a worker to the case who agreed to find a place for Donnie. The worker was very angry with Donnie’s grandmother because the worker believed it was morally wrong to “give back” a family member into foster care. The worker arranged a placement for Donnie without involving the grandmother, and moved him without the grandmother’s assistance. She encouraged the grandmother not to visit Donnie in placement so that he would “adjust.” The worker often expressed her frustration that Donnie’s grandmother was “giving up” on him and that no one in Donnie’s extended family was willing to care for him.
PART TWO
DONNIE ROGERS

At 26 months, Donnie was placed with the Mace foster home. The foster home included a divorced single foster mother with four preadolescent sons, ages 11, 13, 15 and 16. Mrs. Mace became a foster parent after she and her sons watched a TV program about foster children that might be available for adoption. Mrs. Mace felt that her sons were old enough to handle a young child. She was in a good position financially, between child support for the boys and her own employment outside the home. She felt she had the time and energy to give to a young child. She might consider adopting a foster child if he or she fit into her family.

Donnie displayed extremely immature behaviors during and after placement. For example, he was not able to assist in dressing himself, or able to feed himself, even though he had performed these tasks in his grandmother’s home. He was extremely whiny and anxious. Small changes bothered him very much. He was completely unable to begin toilet training. The four older brothers would do many things for Donnie rather than put up with his whining about doing them. Mrs. Mace encouraged Donnie to do more of these things himself, recognizing that he was very late developmentally in doing them. But even she would do things for Donnie, especially if his reluctance was slowing the family down in leaving for an activity.

Donnie often lay in bed at night crying for “Nana,” and wanting to see her. No one ever arranged contact with his grandmother. On the other hand, he had several family interactions with Melinda. On those occasions, he vacillated between anger and affection. She attempted to interact with him, but when he walked away or began to fuss, she ignored him. She would check her makeup in the mirror, or talk with the worker, without even realizing where Donnie was. At the same time, she made a number of complaints about the foster home. She felt the foster family did not take good care of Donnie, and expressed how she would care for him if only the agency would let him come home to her.
Immediately after placement, the worker established a case plan with Melinda that required her to have a psychological assessment and to maintain stability in her life. Specifically, Melinda was required to get housing, employment, and counseling, if indicated by the psychological assessment. If Melinda achieved these goals, Donnie would return to her. If she did not, the agency would continue to explore placement with other family members. If this proved impossible, Donnie would be permanently placed for adoption outside the family. Melinda did not comply with her case plan. She did not maintain employment or a stable home. She missed two appointments for her psychological assessment. The agency filed for permanent custody. Melinda did not even attend the hearing, and permanent custody was granted to the agency.

Recalling the hostility of the worker toward Donnie’s grandmother, none of the rest of his family believed the agency would consider placing Donnie with them. Many of his family resented the worker’s attitude toward Donnie’s grandmother, and felt that the agency had mistreated her. For one or both of these reasons, no one in Donnie’s family contacted the agency about adopting Donnie. The agency did not contact any members of Donnie’s family concerning an adoptive placement.

Mrs. Mace decided not to pursue adoption of Donnie either, largely because she believed that she could not devote the time to her children that they deserved while she parented a child as needy as Donnie. Mrs. Mace was willing to keep him in her home as a foster child, and was willing to assist in an adoptive placement for Donnie.
PART ONE

MATT SANCHEZ

Matt Sanchez, age 11, lived with his single father, Paul Sanchez, for several years. Matt’s mother disappeared when he was three years old. Matt’s father is a very volatile man and feels children should obey without question. His rigid beliefs resulted in several episodes of physical and emotional abuse of Matt.

Matt began taking charge of more household responsibilities to appease his dad. Since Matt was as young as nine years old, he would make dinner for the two of them. The incident that brought Matt into care involved preparing dinner. Dad would say that dinner should be ready at 5:15, so that they could sit down to eat at 5:30. Dad called one evening saying that he was going out for a drink with a friend. He than became unreasonably angry that dinner was cold when he arrived home at 9:00 PM. He forced Matt to eat the entire cold meal, bruising his mouth when he forced food in.

The next day Matt went to school, where the teacher noticed bruises on his arms and around his mouth. She sent Matt to the school nurse, who checked him out thoroughly and found dark blue bruises on the back of his body from his waist to his knees. When the children’s services worker came, Matt became extremely anxious and fearful and refused to talk. Dad later said, “Go ahead. Take him now and ruin any authority I have. Hell yes, I hit him. It was just a spanking and he earned it.”

The worker placed Matt in a shelter care home for 30 days. During this temporary placement, the agency would look for a foster care placement closer to Matt’s home and in his own school district.

Matt was placed in the Samuels’ shelter care home. Matt seemed to continue to regard himself as a caretaker of the family while in placement. One day, during his first week of placement, he noticed dinner was laid out. He immediately concluded that he should cook. But he didn’t know what to cook with the ingredients he saw on the table. He became exceedingly anxious, and tried to combine ingredients as best he knew how. He was even more upset because none of the food was familiar to him, and he worried that it wouldn’t be good to eat.

As Matt was cooking, Mr. Samuels came into the kitchen. He asked Matt why he was cooking, since no one had asked him to cook. Matt answered that he had been told to cook and he had to finish. Mr. Samuels told him to stop what he was doing. Matt looked confused and became very resentful, telling Mr. Samuels that he had cooked before, and that he knew what he was doing. Mr. Samuels responded that in his house children did not cook the meals. Children were not to talk back either.
At this point Matt appeared to lose control completely. He began running around the house, screaming and laughing hysterically. He ran up to Mr. Samuels, taunting him with gestures, and screaming, “Chase me! Chase me!” Mr. Samuels tried patiently to settle Matt down. After much further screaming and running, Matt finally calmed enough to tell Mr. Samuels that John, another foster child in the home, told Matt that he had to cook dinner and that Matt had to figure out what dinner was about. John was not at home at this time. Mr. Samuels sent Matt to his room to work on being calm and quiet.

At dinner, Matt sat quietly in his seat. He refused to eat dinner, and said that he wasn’t hungry. When John returned home, he denied that he had ever told Matt to cook dinner. Over the next several days, John found several things missing from his room. Almost immediately, the missing items began to appear in Susie’s room. Susie insisted that she was not the thief.

Later in his first week of placement, Matt got up before the rest of the household and made coffee for all the adults in the house. The foster parents thanked him, but told him again that he was not responsible for cooking.

Over the next several weeks, Matt told the Samuels family how much he wanted to see his father virtually every day. He called his worker constantly about more family contact. He had family interaction (visitation) three to four times per week. The Samuels reported that Matt vomited before and after every family interaction. Mr. Sanchez attended every family interaction, but did not actively engage with Matt. Matt appeared anxious and fidgety.

As the 30-day period came to a close, the worker changed her plan and decided to place Matt in a newly organized group home for preteen boys. She concluded that Matt acted out in the Samuel’s family because family relationships were too intimate.
PART TWO
MATT SANCHEZ

Because the Samuels were concerned that Matt would be particularly disruptive during the move, his adjustment to the new placement was jeopardized. The Samuels and the caseworker decided to make the move easier, so the Samuels told Matt he would be going for a weekend of respite care at the Jones home. The caseworker would pick him up Monday after school to “return to the Samuels,” but instead she would have his clothes and move him to the Jones home. The Jones preteen group home was a very large house in which each child had his own room. Each room had its own TV and VCR. He learned he would be going shopping soon for all new clothes. Each child had a series of chores to do, and each would be responsible for part of the household. All this would enable Matt to function as part of the household without being too intimately involved with the foster parents or the other children, which the worker believed would be helpful for Matt.

Very shortly into his stay, it became apparent that Matt gravitated toward the foster mother. Sometimes Matt would be crying late at night, and Mrs. Jones would soothe him. At the same time, her personal belongings started to disappear, and most were found again in another child’s room. Mrs. Jones refused to believe that the same child she comforted in the night could be stealing from her. Matt told Mrs. Jones that he was never hit at home, he never had bruises, and that a teacher who was out to get him made up the whole story. He told her that he helped Dad out because he loved Dad. He also said that, since he couldn’t be with Dad, he was glad to be able to be close to Mrs. Jones.

When Mr. Jones learned what Matt had told Mrs. Jones, he confronted Matt. Matt told him several times that he is not his father, and that his father has raised him quite successfully and never hit him. Mr. Jones grounded Matt to his room until he stopped lying. After a week, his privileges would be restored so long as he didn’t tell lies. As placement continued, the Joneses added another child to the home. Things were being broken in the home, and personal items were stolen. In spite of being grounded repeatedly, Matt insisted he knew nothing about it.

One day Matt got out of school early. Mrs. Jones forgot he was coming home early, and was out of the house running errands. She arrived about an hour after Matt got home to find him in the living room crying uncontrollably. When she approached him, he jumped up, pushed past her, and bolted from the house. When she went after him, she found he had disappeared. She went up to his room to discover that he had thrown things on the floor, written on the walls, and shredded his bedspread with scissors. She noticed a smell coming from the closet, and found that he had urinated in the corner of the closet, probably more than once.

Mrs. Jones felt angry, confused, and betrayed. She immediately called the worker to ask for Matt’s removal because he was physically violent with her.
PART ONE

DEANNA EVANS

Deanna Evans, age 14 years 9 months, came into care approximately three months ago. Mrs. James, her mother, brought her to the agency, stating Deanna was incorrigible. Mrs. James related that early in Deanna’s life Deanna was easier to handle. She had raised Deanna as a single mother for eight years because Deanna’s father disappeared shortly after Deanna’s birth. Six years ago she married again, this time to a man about 10 years her senior. They had a son together named Sam, age five. Mr. James has no other children. Mrs. James has worked throughout this entire period as a dietary technician at the local hospital, and has had a rather successful career.

Mrs. James experienced trauma in her childhood that remains unresolved. Her mother was drug and alcohol addicted as Mrs. James was growing up. During the periods her mother was using, Mrs. James suffered physical abuse from inappropriate care providers and her mother’s boyfriends. Mrs. James alludes to possible sexual abuse as well. Mrs. James lived with nine different relatives as she grew up. These represented the times her mother was in rehab or in jail.

Mrs. James suffered episodes of serious depression, perhaps as a result of her unresolved childhood trauma. Her doctor prescribed anti-depressant medication that she rarely took. During the period of single parenting, she related to Deanna as a friend, telling her about her boyfriends, her problems, and other information inappropriate for a young child to hear. She grew to depend more and more on Deanna for support and assistance. Mrs. James has often been described as passive, somewhat rejecting, needy, and dependent on Deanna.

The school contacted Mrs. James several times with concerns about Deanna. They were concerned that she seemed chronically tired, distracted, and isolated herself from her peers.
When Deanna was about 12 years old, she began to get out in the neighborhood. She began to change from a passive child who tried to meet her mother’s needs to an acting-out adolescent. She refused to obey her mother anymore. She was often truant and she was failing in school. She associated with delinquent adolescents.

When Mrs. James brought Deanna to the agency, she said that stress over Deanna was destroying her marriage. She and her husband were fighting over Deanna and what should happen to her. They were trying to rear a five year old, who needed lots of attention himself, and they could not continue to deal with Deanna. Consequently, Deanna was placed in the Carter foster home.

The foster parents, Mr. and Mrs. Carter, have been licensed for only one year. They are a couple in their 50’s, who raised three children now grown and out of the home. They have always been comfortable with teenagers, especially teenage girls. They are not comfortable working with birth families, but they are always curious about where the foster children come from and why they act the way they do. They are influenced by Deanna’s worker, who feels great empathy for Deanna and shows very little regard for her mother. Mrs. Carter is puzzled because Deanna defends her mother whenever anyone says anything negative about her. Mrs. Carter also discovered when checking on Deanna that she sleeps with her mother’s picture in bed with her.

After three months, Mrs. James has not followed through with the case plan to which she agreed. Specifically, she has not started counseling to assess her depression, nor has she started counseling with Deanna around behavior issues.

Family interaction often takes place when Mrs. James wishes, and changes to suit her schedule. It does not center on Deanna and her needs. When interaction takes place in the birth home, they are almost always late returning. Mrs. James states that Deanna hangs out in the neighborhood and refuses to come in on time. Mrs. James never enters the foster home. She stops in the driveway and waits for Deanna to arrive, and drops Deanna off after the family interaction.
PART TWO

DEANNA EVANS

After two more months elapsed, Mrs. James had done nothing to complete her case plan. The agency planned to consider an alternate plan for permanency for Deanna.

Mr. and Mrs. Carter have been attending training and working with several experienced foster parents. Deanna continues to long for her mother. Her behavior in the foster home has deteriorated significantly. She has been even more defiant and controlling in the foster home. She has been suspended from school on several occasions. One day Mrs. Carter thought she smelled alcohol on Deanna’s breath. The Carters have consistently consequenced all her behaviors, but nothing seems to help.

Mrs. Carter has been very frustrated with all these developments and has wanted to help Deanna any way she could. She decided to establish contact with Mrs. James, after getting the worker’s half-hearted approval. She wrote a note to Mrs. James, stating she realized how difficult it must have been for Mrs. James to parent Deanna. Her note also expressed the wish to meet Mrs. James to find ways to relate to Deanna, and indicated that Mrs. Carter had some ideas about this. Mrs. Carter concluded by saying that a meeting would help both of them since they both wanted Deanna to get better.

Mrs. James wrote a short note back to Mrs. Carter indicating that she would be willing to meet, but also that she was very tired of the way the agency blamed her for everything. She was frustrated that nothing seemed to work for Deanna, including placing her in foster care.

They met at a coffee shop near the hospital after Mrs. James got off work. Mrs. Carter said that she was a nurse and had worked in the hospital for several years before she decided to stay home with her own teenage girls. She had never gone back to nursing. Both women felt more comfortable to discover they shared a hospital background.

Mrs. Carter then asked Mrs. James to help her understand Deanna by telling her all she could remember about raising Deanna, both as a young child and when she
became a teenager. Mrs. James began to talk about her daughter, crying occasionally. She stated that she had always wanted to be a good parent, partly because her mother had been such a poor one. She said she had no idea why Deanna had become so difficult. Mrs. Carter shared that Deanna slept with her mother’s picture and found ways to defend her mother if others said negative things about her. Mrs. Carter asked Mrs. James not to mention this to Deanna because Mrs. Carter did not want to share information without telling Deanna about the meeting first.

By the end of the meeting the two women had formed a tenuous relationship based on their concern for Deanna. Mrs. Carter suggested that the next family interaction take place at her home. She said that she would try to coax Deanna to help cook a meal for all of them.

When Deanna learned about the meeting, she sarcastically remarked that it must take two adults to handle her. Mrs. Carter agreed, to Deanna’s surprise, and said that sometimes several people had to raise a child. At first Deanna balked at the idea of inviting her mother for dinner, but eventually she agreed and helped to plan the event.

Dinner prompted several more informal contacts in the coming week. Mrs. Carter suggested that a counselor who would come to the home might help all of them improve their relationships. The agency found an outreach counselor that everyone agreed on.

Slowly some of Deanna’s behaviors began to subside. She was less hostile and controlling. Her school attendance improved as well.

Mrs. James and her husband began counseling around their adult issues. The focus of the counseling quickly moved to Mrs. James’ unresolved childhood issues, which were creating some of the stress in the marriage. As the counseling moved to adult issues, Mrs. James became less concerned with blaming Deanna.

As the worker became aware of all these developments, she became concerned that the families were working the case plan without her active involvement. At one point she asked her supervisor to consider moving Deanna so that the agency could be in charge. The supervisor wisely refused, stating the case plan was going amazingly well.
CLASSIFICATION QUESTIONNAIRE

Each paragraph below describes how a person might have felt about his mom or primary caregiver. Read each paragraph and mark whether the paragraph is like you or not. Base your responses on your memories and perceptions of your childhood relationship with your mom or primary caregiver.

When you are finished, pick the paragraph that is most like you.

1. I am not very sure about how much my mom loved me, and I don’t think she could help me with my problems. I usually didn’t talk to my mom when I was feeling bad because she didn’t understand me and it didn’t make me feel any better.

   Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

2. My mom and I got along pretty well, but I didn’t really need her to help me with my problems. When I felt bad, I usually didn’t talk to my mom about it. Sometimes it was just easier to do things by myself than with my mom.

   Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

3. I am sure that my mom loved me and could help me with my problems. I talked to my mom about the good and bad things I felt. My mom let me try lots of new things on my own and helped me when I needed it. I usually felt good when she was around.

   Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

4. I am not always sure about how much my mom loved me or whether she could have helped with my problems. I usually didn’t like to try new things on my own. I liked to stay close to my mom, because sometimes I worried that she would not be there if I needed her.

   Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me
MATERNAL/PRIMARY CAREGIVER ATTACHMENT CLASSIFICATIONS

Disorganized – Fearful =
I am not very sure about how much my mom loved me, and I don’t think she could have helped me with my problems. I usually didn’t talk to my mom when I was feeling bad because she didn’t understand me and it didn’t make me feel any better.

Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

Avoidant =
My mom and I got along pretty well, but I didn’t really need her to help me with my problems. When I felt bad, I usually didn’t talk to my mom about it. Sometimes it was just easier to do things by myself than with my mom.

Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

Secure =
I am sure that my mom loved me and could help me with my problems. I talked to my mom about the good and bad things I felt. My mom let me try lots of new things on my own and helped me when I needed it. I usually felt good when she was around.

Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me

Ambivalent =
I am not always sure about how much my mom loved me or whether she could have helped with my problems. I usually didn’t like to try new things on my own. I liked to stay close to my mom, because sometimes I worried that she would not be there if I needed her.

Really Like Me  Sort of Like Me  Sort of Not Like Me  Really Not Like Me
The Foster Caregiver as a Role Model/Support for the Primary Family

Foster caregivers can work with primary families and can provide an array of services not normally available through community service agencies. Because foster caregivers are aware of the risk and safety factors that were considerations in the decision to place, they can work with the primary family in activities designed to strengthen family characteristics that can mitigate risk. In the informal and natural setting of the foster home, primary families can learn parenting and home management skills and can practice them with the support and coaching of the caregiver. Some of these activities and skills can include:

- cooking, cleaning, and managing a household
- shopping economically and budgeting on a limited income
- physically caring for their infant or young child
- disciplining their child with effective/safe strategies
- playing with their children to stimulate cognitive and language development
- nurturing behaviors and attachment-building strategies
- behavior management strategies
- age-appropriate expectations for their children
- accessing and using community resources and services
- social skills, including effectively communicating and working with others to resolve problems, and advocating for their child in school/community

The caseworker and foster caregivers should mutually decide on how to best utilize caregivers in providing supportive services to primary families.
ALLIANCE FORMATION, STRATEGIES AND ACTIVITIES THAT BUILD ATTACHMENT

1. Strategy: Increase Direct Eye Contact and Look at Things Together
   Activities:

   - Write an “I love you” message in soap on a mirror. Stand behind the child when he reads it. You may get a glance in the mirror. If not, you still said I love you.
   - Play peek-a-boo when holding your child.
   - Paint his face; allow him to paint yours.
   - Look at each other and name the ways you are alike – freckles, hair color, eye color, etc.
   - Play an eye signal game. The child stands 10 steps away from you. He looks in your eyes, you blink once, he takes one step forward. You blink twice, he takes one step backward. When he reaches you he wins.
   - Compare pictures of you as a child with his pictures of himself.
   - Give him a disposable camera when attending a family event. See the event through his eyes.
   - Place a sticker between your eyes, making no comment. Eventually the child will look at you and laugh.
   - Let your child put eye shadow on you. Return the favor.
   - Buy colored hairspray and spray a streak in each child’s hair to show who belongs to the family. Look in each child’s eyes as you spray.

2. Strategy: Maximize Touch
   Activities:

   - Comb, brush, braid child’s hair.
   - Scratch his back.
   - Give him a back or foot rub.
   - Give and receive “butterfly kisses” (fluttering eyelashes on cheek).
   - Hold and cuddle child every day, even when you’re tired or busy.
   - Play hand holding games (younger children) like “London Bridge” or “Ring-Around-the-Rosie.”
   - Give a group hug before going separate ways in the morning.
   - Play tag.
- Put matching temporary tattoos on each other.
- Teach a skill, such as in-line skating, somersaults, or bike riding. You touch him as part of the lesson.

3. **Strategy: Moving with Your Child**

   **Activities:**

   - Rock together at any age. For older, larger children, sit beside them in chair or on porch swings.
   - Teach your child a dance you did when you were younger and have him teach you one of his own.
   - Draw together. If the child is very young or has small motor problems, use fat crayons.
   - Blow bubbles. Chase them and pop them.
   - Turn off the TV and go for a walk. Count the number of animals you see on the way. Walk in the rain and jump in the puddles. Walk when the moon is full.
   - Build something together – a bird house, model airplane, something out of blocks or Legos.
   - Sew something together
   - Clean out a junk drawer together.
   - Divide the family into teams and do a scavenger hunt.
   - Cook together – make a hamburger with all your child’s favorite toppings and name it after him.

4. **Strategy: Nurture through Food**

   **Activities:**

   - Serve a dessert for dinner. For no reason. Just because. Just once.
   - Buy a fancy plate at a garage sale. Serve the child meals on it.
   - Buy some M&M’s. Sort them by color. Eat them together.
   - Pack a picnic in the winter. Take the basket into the living room and eat on the floor on a blanket.
- Take turns taking each of your children to the grocery store. That child picks out the cookies and cereal for the week.
- Eat by candlelight… with the kids.
- Get a plain tablecloth and fabric markers. Design a tablecloth with your child that’s used just for your family.
- Let the child make dinner or plan the menu.
- Put a love note in his lunchbox.
- Go out to dinner with your teen. Take him to dinner with you and your friends. Take him to dinner with his friends.

5. **Strategy: Enhance Communication**

**Activities:**

- Read the funnies together. Choose cartoons that mirror your family and make a scrapbook of them for later laughs.
- Listen to music together. Teach your child one of your favorite songs and learn one of his.
- Read a book together, one chapter or portion a day. This helps teach delayed gratification.
- Make an audio tape of your family singing. It’s especially fun if you can’t sing well.
- Discuss where you would go if you could fly.
- Interview your helpers – nurse, doctor, social worker, therapist – and see who can name all of Disney’s Seven Dwarfs.
- Post a happy note on your child’s door or pillow.
- Trace a word on the child’s back with your finger. If he guesses the word, he gets a point. (This allows for touch, spelling practice, and fun.)
- Look in the mirror and make sad, glad, mad, or scared faces with the child in response to different questions. “How would you feel if someone took your favorite toy?” or “How would you feel if you could eat a hot fudge sundae for breakfast?” or “How would you feel if you heard a ghost story?” (This can assist the child in identifying emotions and demonstrating appropriate affect.)
- Go to a concert with your adolescent. You don’t have to like the music – just be there with him.
6. **Strategy: Getting Warm and Cozy** – (Some of these activities provide a sense of containment for the child, others just increase that warm and cozy feeling.)

**Activities:**

- Set up a pup tent in the living room. Zip the child in to play and zip him out when he wants out – or let him do it by himself.
- Set up a card table. Put a blanket over it and play underneath. (Don’t do this with more than one child if any of the children has issues of sexual or physical abuse.)
- Make or buy a soft blanket/throw to use while watching TV or engaging in quiet activities.
- Let your child sleep in a sleeping bag on the bed instead of under a blanket, or warm a blanket in the dryer to “tuck” your child into.
- Put gloves and scarf in the dryer for a few minutes to make them warm. They’ll feel wonderful and will send him off to school with a comfy feeling.
- Make a “nest” for you and your child – a cozy little place to share time.
- Share a lap robe while watching television.
- Serve hot soup as an after school snack.
- Steam up the bathroom with all of you in it. Draw on the mirror.
- Cold car in the morning? Take a blanket to tuck around your child’s legs.

7. **Strategy: Just Have Fun** – Be Creative and Purposeful to Make Life Fun and Build Memories

**Activities:**
- Play hooky. Don’t go to work and keep child home from school. Have fun.
- Give everyone a day off from household chores. Make a list of what needs to be done, then rip it up and do something fun instead.
- Rituals are important to children. What fits your family? Try an Advent calendar or menorah.
- Wear the pin, scarf, or macaroni necklace the child gave you – even if it’s hideous.
- Make a magic wand. Use it to make wishes.
- Take a class together – painting, auto repair – anything. Learn a craft together.
- Complete a jigsaw puzzle as a family project.
- Have a pajama party with the family.
- Don’t make the beds for a whole week. Honestly – nothing bad will happen.
- Do something kind for a neighbor together. Volunteer together.

Adapted & Selected from Parenting The Hurt Child (Gregory C. Keck & Regina M. Kupecky)
### Observation Checklist: What to Look for in Assessing Attachment and Bonding

**Birth to One Year**

<table>
<thead>
<tr>
<th>Does the child...</th>
<th>Does the parent...</th>
</tr>
</thead>
<tbody>
<tr>
<td>appear alert?</td>
<td>respond to the infant’s vocalizations?</td>
</tr>
<tr>
<td>respond to people?</td>
<td>change voice tone when talking to or about the baby?</td>
</tr>
<tr>
<td>show interest in the human face?</td>
<td>engage in face-to-face contact with the infant?</td>
</tr>
<tr>
<td>track with his eyes?</td>
<td>exhibit interest in and encourage age-appropriate development?</td>
</tr>
<tr>
<td>vocalize frequently?</td>
<td>respond to the child’s cues?</td>
</tr>
<tr>
<td>exhibit expected motor development?</td>
<td>demonstrate the ability to comfort the infant?</td>
</tr>
<tr>
<td>signal discomfort?</td>
<td>enjoy close physical contact with the baby?</td>
</tr>
<tr>
<td>appear to be easily comforted?</td>
<td>initiate positive interactions with the infant?</td>
</tr>
<tr>
<td>exhibit normal or excessive fussiness?</td>
<td>identify positive qualities in the child?</td>
</tr>
<tr>
<td>appear outgoing or is he passive and withdrawn?</td>
<td></td>
</tr>
<tr>
<td>have good muscle tone?</td>
<td></td>
</tr>
</tbody>
</table>

# One to Five Years

<table>
<thead>
<tr>
<th>Does the child...</th>
<th>Does the Parent...</th>
</tr>
</thead>
<tbody>
<tr>
<td>explore his surroundings?</td>
<td>use disciplinary measures appropriate for child’s age?</td>
</tr>
<tr>
<td>respond positively to parents?</td>
<td>respond to the child’s overtures?</td>
</tr>
<tr>
<td>keep himself occupied?</td>
<td>initiate affection?</td>
</tr>
<tr>
<td>show signs of reciprocity?</td>
<td>provide effective comforting?</td>
</tr>
<tr>
<td>seem relaxed and happy?</td>
<td>initiate positive interactions with the child?</td>
</tr>
<tr>
<td>look at people when communicating?</td>
<td>accept expressions of autonomy?</td>
</tr>
<tr>
<td>show emotions in a recognizable manner?</td>
<td>see the child as positively “taking after” a family member?</td>
</tr>
<tr>
<td>react to pain and pleasure</td>
<td>seem aware of the child’s cues?</td>
</tr>
<tr>
<td>engage in age-appropriate activities?</td>
<td>enjoy reciprocal interactions with the child?</td>
</tr>
<tr>
<td>use speech appropriately?</td>
<td>respond to the child’s affection?</td>
</tr>
<tr>
<td>respond to parental limit setting?</td>
<td>set age-appropriate limits?</td>
</tr>
<tr>
<td>demonstrate normal fears?</td>
<td>respond supportively when the child shows fear?</td>
</tr>
<tr>
<td>react positively to physical closeness?</td>
<td></td>
</tr>
<tr>
<td>show a response to separation?</td>
<td></td>
</tr>
<tr>
<td>note the parent’s return?</td>
<td></td>
</tr>
<tr>
<td>exhibit signs of pride and joy?</td>
<td></td>
</tr>
<tr>
<td>show signs of empathy?</td>
<td></td>
</tr>
<tr>
<td>show signs of embarrassment, shame, or guilt?</td>
<td></td>
</tr>
</tbody>
</table>


*Understanding and Building Attachment*

*Ohio Child Welfare Training Program—January 2005*
Grade School Years

<table>
<thead>
<tr>
<th>Does the child...</th>
<th>Does the Parent...</th>
</tr>
</thead>
<tbody>
<tr>
<td>behave as though he likes himself?</td>
<td>show interest in child’s school performance?</td>
</tr>
<tr>
<td>show pride in accomplishments?</td>
<td>accept expression of negative feelings?</td>
</tr>
<tr>
<td>share with others?</td>
<td>respond to child’s overtures?</td>
</tr>
<tr>
<td>accept adult-imposed limits, verbalize likes and dislikes, and try new tasks?</td>
<td>provide opportunities for child to be with peers?</td>
</tr>
<tr>
<td>acknowledge his mistakes?</td>
<td>handle problems between siblings with fairness?</td>
</tr>
<tr>
<td>seem relaxed and happy?</td>
<td>initiate affectionate overtures?</td>
</tr>
<tr>
<td>express a wide range of emotions?</td>
<td>use disciplinary measures appropriate for child’s age?</td>
</tr>
<tr>
<td>establish eye contact?</td>
<td>assign the child age-appropriate responsibilities?</td>
</tr>
<tr>
<td>exhibit confidence in his own abilities?</td>
<td>seem to enjoy this child?</td>
</tr>
<tr>
<td>appear to be developing a conscience?</td>
<td>know the child’s likes and dislikes?</td>
</tr>
<tr>
<td>move in a relaxed manner?</td>
<td>give clear messages about behaviors that are approved or disapproved of?</td>
</tr>
<tr>
<td>smile easily?</td>
<td>comment on positive behaviors as well as negative?</td>
</tr>
<tr>
<td>look comfortable when speaking with adults?</td>
<td></td>
</tr>
<tr>
<td>react positively to parent being physically close?</td>
<td></td>
</tr>
<tr>
<td>have positive interactions with siblings and or peers?</td>
<td></td>
</tr>
</tbody>
</table>

## Adolescents

<table>
<thead>
<tr>
<th>Is the Adolescent…</th>
<th>Does the Parent…</th>
</tr>
</thead>
<tbody>
<tr>
<td>aware of personal strengths?</td>
<td>set appropriate limits?</td>
</tr>
<tr>
<td>aware of personal weaknesses?</td>
<td>encourage self-control?</td>
</tr>
<tr>
<td>comfortable with his sexuality?</td>
<td>trust the adolescent?</td>
</tr>
<tr>
<td>engaging in positive peer interactions?</td>
<td>show interest in and acceptance of adolescent’s friends?</td>
</tr>
<tr>
<td>performing satisfactorily in school?</td>
<td>display an interest in the teen’s school performance?</td>
</tr>
<tr>
<td>exhibiting signs of conscience development?</td>
<td>exhibit interest in the teen’s activities?</td>
</tr>
<tr>
<td>free from severe problems with the law?</td>
<td>have reasonable expectations regarding chores and household responsibilities?</td>
</tr>
<tr>
<td>aware of his parents’ values?</td>
<td>stand by the adolescent if he gets in trouble?</td>
</tr>
<tr>
<td>keeping himself occupied in appropriate ways?</td>
<td>show affection?</td>
</tr>
<tr>
<td>accepting of adult-imposed limits?</td>
<td>think this child will “turn out” okay?</td>
</tr>
<tr>
<td>involved in interests outside the home?</td>
<td></td>
</tr>
<tr>
<td>developing goals for the future?</td>
<td></td>
</tr>
<tr>
<td>emotionally close to parents?</td>
<td></td>
</tr>
</tbody>
</table>