ZERO TO THREE

January 2011 Volume 31 No. 3

Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Improving the Lives of Infants and Toddlers in Foster Care

New Analysis of Foster Care and Adoption Data

A *Call to Action* for Policymakers

Enhancing the Skills of Foster Parents

Understanding Post-Adoption Depression

Also in This Issue:
The Effects of Fetal Alcohol Spectrum Disorders

THIS ISSUE AND WHY IT MATTERS

The youngest children in the child welfare system face the greatest risks. In this issue's first article, researchers from the Center for State Foster Care and Adoption Data, a part of Chapin Hall at the University of Chicago, share new data analysis revealing that the rate of children less than 1 year old entering foster care is on the increase, making up 25% of the total number of children entering care. Minority children continue to be particularly vulnerable, and the disparity in the foster care placement rates between minority and White children is greatest for those less than 1 year old. Black infants are nearly 5 times as likely to enter foster care compared to Hispanic and White children. The authors also discuss indicators related to placement settings, length of stay, placement stability, exit reasons, and reentry.

A disturbing trend in the child welfare system is the cycle of abuse that can affect families for generations. In an article describing how abusive parents are often the victims of childhood trauma themselves, the author describes how intervention with these parents must address this historical trauma in order to build healthy parent–child relationships. Unfortunately, some adults are so damaged by their life experiences that they may never be able to take care of their children.

The issue of how to partner effectively with parents is the topic of an article by the founder of The Children's Ark, a unique residential program for children in foster care in which their mothers can also live. The author describes what it takes to effect change through ongoing, trusting, and supportive relationships. Her remarkable story demonstrates the power of putting relationships at the center of how services are provided to vulnerable children and families. Similarly, the importance of attachment is highlighted in the article describing the evidence-based Attachment and Biobehavioral Catch-up intervention. The program aims to help foster children develop trusting relationships with foster parents and develop better biological and behavioral regulation. The results of randomized clinical trials show promising results.

Additional articles in this issue of *Zero to Three* raise awareness in several important areas of emerging interest. One article explores the concept of post-adoption depression, and how it is similar to and different from post-partum depression. Another article describes the latest knowledge on Fetal Alcohol Spectrum Disorders and presents strategies professionals can use when working with affected children and parents. And the third area of interest is the impact of social and political conflict that results in forced or accidental separation of children from their caregivers.

The challenges and issues facing the child welfare system are complex, but much can be done to improve outcomes for children. To better address the needs of infants and toddlers in the child welfare system, ZERO TO THREE executive director Matthew Melmed presents a Call to Action advocating for a policy agenda that makes vulnerable infants and toddlers a priority and ensures that the knowledge derived from the science of early childhood development is reflected in the policies and programs for young children and their families. Visit www.zerotothree.org to join the Policy Network and learn how you can make a difference!

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National Center for Infants, Toddlers, and Families

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Cover photo: Isaac Koval

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Zero to Three is the bimonthly journal of ZERO TO THREE: National Center For Infants, Toddlers, and Families. **ISSN 0736-8038** National Center For Infants, Toddlers, and Families, 1255 23rd Street, NW, Suite 350, Washington, DC 20037, (202) 638-1144; *Customer Service:* 1-800-899-4301

The Foster Care Baby Boom Revisited

What Do the Numbers Tell Us?

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At the height of the crack cocaine epidemic in the late 1980s and early 1990s, places such as New York City experienced a surge in the number of infants entering foster care. Today as then, the fraction of all children less than 1 year old entering out-of-home care for the first time is on the rise. Just as the baby boom during the great postwar rise in the birth rate led to a demographic shift in the United States and had a significant structural effect on society generally, the rise in infants in foster care is having a structural impact on the child welfare system as a whole.

The Center for State Foster Care and Adoption Data supports child welfare agencies in using longitudinal data to improve outcomes for children. For the purposes of this article, we analyzed data for 14 states from 2000 to 2008. In those states, more than 500,000 children entered out-of-home care for the first time. Of those, children less than 1 year old at the time of placement represent the most important population of foster children when viewed from any one of several policy, programmatic, and fiscal perspectives.

The focus on the effects on infants within the foster care context has two main threads. The first thread is developmental; the second is epidemiological (e.g., trends in prevalence, frequency, duration, etc.). The developmental argument is fairly persuasive on its own: As a distinct group, infants spend more time in out-of home care than any other group of children, so the developmental effect of the time spent there is substantial. Interventions that improve the quality of family life for babies should be high on any policy and practice agenda. That said, our focus here is on basic epidemiological evidence: What is the risk of placement facing infants relative to older children, and how does the placement experience of infants differ from what other children experience?

Data

The Multistate Foster Care Data Archive is the source of the data used for this analysis. The Archive is maintained by the Center for State Foster Care and Adoption Data, operated as part of Chapin Hall at the University of Chicago in cooperation with the National Association of Public Child Welfare Administrators and the Center for Social Services Research at

Abstract

The Center for State Foster Care and Adoption Data, operated by Chapin Hall at the University of Chicago, supports child welfare agencies in using longitudinal data to improve outcomes for children. For the purposes of this article, the authors analyzed data for 14 states from 2000 through 2008 to examine trends in foster care placement, length of stay, stability, reason for discharge, and reentry to placement. One of the findings is that the number of infants entering foster care is on the rise; however, younger infants are less likely to experience disruptions in their placement. The result of the analysis underscores that infants in foster care experience unique challenges and vulnerabilities compared with older children.

University of California, Berkeley. Among other objectives, the Center provides states with a source of longitudinal placement data that the states can use to understand a range of issues facing public child welfare agencies.

The data allow Center staff members to track the number of admissions, the number and timing of moves between placement settings, the length of time spent in foster care, permanency outcomes, and whether the child returns to care. When combined with census and other types of data, the longitudinal data provide a powerful way to understand basic patterns of service utilization, including core child welfare outcomes.

The 14 states selected for inclusion in this analysis are those that provide placement information for all years from 2000 to 2008. The selected states represent a diverse group; for example, the size of the foster care populations in the study ranged from less than 1,000 to more than 20,000. All regions of the country are represented. With respect to the placement activity recorded, the analysis uses the full placement history of children admitted for the first time between January 1, 2000, and December 31, 2008.

For this analysis, we define *infant* as any child placed before his first birthday. In addition, we sometimes highlight children who were less than 3 months old at admission.

Photo: ©iStockphoto.com/Maria Pavlova

The number of infants entering foster care is on the rise.

Measures

The analysis of the data presented here is built around a set of core indicators, or measurements, that are routinely used to understand what happens when children are placed in out-of-home care. These indicators include the following:

Number of first admissions and incidence rate per 1,000 children are basic indicators of placement risk. The number of admissions each year includes children placed for the first time only. The incidence rate is the number of children placed divided by the number of resident children (in the risk set) multiplied by 1,000 (i.e., [number of children placed / number of resident children] × 1,000). Incidence rates are also presented for Black, White, and Hispanic children separately. The race/ethnicity-specific data are the basis for calculating disparity ratios, which express the likelihood of placement for one group of children relative to the likelihood of placement for some corresponding group (see Tables 1 and 2).

Table 1. Number of Children Admitted to Foster Care for the First Time by Urbanicity, Age, and Year: 2000, 2005, and 2008

	Number			Percentage		
Urbanicity and age at admission	**2000**	**2005**	**2008**	**2000**	**2005**	**2008**
Total	56,220	61,926	55,853	100%	100%	100%
Infants	10,688	13,000	12,216	19%	21%	22%
Older children	45,532	48,926	43,637	81%	79%	78%
Urban[1]	17,489	14,343	15,555	100%	100%	100%
Infants	3,954	3,460	3,662	23%	24%	24%
Older children	13,535	10,883	11,893	77%	76%	76%
Secondary urban	18,967	23,472	19,225	100%	100%	100%
Infants	3,948	5,182	4,588	21%	22%	24%
Older children	15,019	18,290	14,637	79%	78%	76%
Rural	19,764	24,111	21,073	100%	100%	100%
Infants	2,786	4,358	3,966	14%	18%	19%
Older children	16,978	19,753	17,107	86%	82%	81%

[1] Urban counties are the largest counties in each of the states; size is based on total population. Secondary urban counties are all of the other counties containing a large city; rural counties are all of the other counties in the state.

Table 2. Rate of Placement per 1,000 Children and Placement Disparity by Age and Age and Race/Ethnicity: 2000 and 2008

	Entry year	
Child characteristics	**2000**	**2008**
Entry age		
Infants	3.9	4.1
Older children	0.9	0.9
Age disparity	4.3	4.6
Age by Ethnicity		
Infants		
White (W)	4.5	5.9
Black (B)	21.1	17.5
Hispanic (H)	5.3	6.0
Disparity (B/W)	4.7	3.0
Disparity (H/W)	1.2	1.0
Older children		
White (W)	1.4	1.3
Black (B)	3.7	3.2
Hispanic (H)	1.4	1.5
Disparity (B/W)	2.6	2.5
Disparity (H/W)	1.0	1.2

Figure 1. Predominant Placement Setting by Year of Admission and Age at Admission: 2000, 2005, and 2008

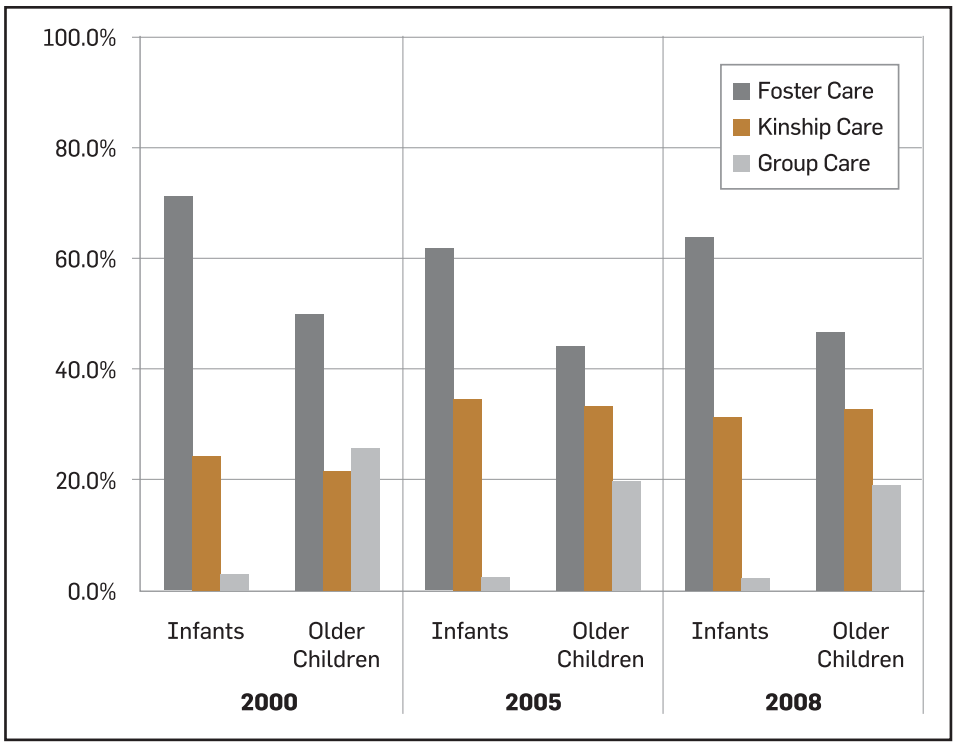


Table 3. Median Months in Care by Age at Admission and Year of First Entry: 2000, 2005, and 2007

	Year of first entry to care		
Entry age group	**2000**	**2005**	**2007**
All ages	11.8	11.8	12.1
Less than 3 months	19.9	17.7	17.3
3 to 12 months	14.1	14.2	14.2
Older children	10.8	11.0	11.2

Table 4. Average Moves Per Child by Admission Cohort, Age at Admission, and Placement Duration: 2000 and 2004

	Placement interval (duration in months)							
Entry cohort and age at admission	**0–6**	**7–12**	**13–18**	**19–24**	**25–30**	**31–36**	**27–42**	**43–48**
2000								
0 to 3 months	0.63	0.22	0.19	0.16	0.15	0.12	0.11	0.12
3 to 12 months	0.68	0.23	0.21	0.21	0.16	0.13	0.14	0.15
Older children	0.79	0.37	0.33	0.32	0.32	0.30	0.31	0.31
2004								
0 to 3 months	0.65	0.22	0.19	0.15	0.19	0.15	0.11	0.09
3 to 12 months	0.66	0.25	0.21	0.23	0.19	0.19	0.16	0.14
Older children	0.78	0.36	0.33	0.37	0.36	0.36	0.34	0.34

Placement setting refers to the type of care. Because states differ with respect to how many unique care types are differentiated, the Foster Care Data Archive uses four basic care types: foster care, kinship care, group care, and other. *Foster care* is the term used to describe care in family settings where the caregiver is not related to the child. *Kinship care* refers to family settings where the child has a relationship to the caregiver. *Group care* refers to a wide variety of settings, including group homes and residential care. Because children move between settings, we use the predominant care type in this analysis. Predominant care type is the care type associated with 50% or more of the total time spent in care. Predominant care type understates the type of first placement (i.e., where children go when they enter care). However, first placement type may understate where children spend most of their time. We opted to report the predominant care type (see Figure 1).

Length of stay is measured as the median time to exit. For each cohort of children admitted, we ask how much time elapsed before 50% of the children had been discharged. The median length of stay is preferred over the average length of stay because less time is needed to observe the median. In that way, we can assess how long children are staying in care without (necessarily) waiting until all the members of an (recent) admission group have been discharged from care. (See Table 3.)

Placement stability is measured using a period-specific movement rate. More often than not, placement stability is measured using a per-child indicator (i.e., the number of moves per child). As an indicator, moves per child provide a general sense of how often any given child moves, but the measure does not take length of stay into account. Children with longer lengths of stay have greater exposure to the risk of movement, which means that, in some populations, the risk of movement is greater simply because of how long children are in care. To overcome this deficiency in the standard indicators, we adjusted for length of stay by asking, given the number of children at the start of a 6-month interval, how many of those children move within the next 6 months. Adjusting for length of time in care in this way removes the confounding effects of length of stay and makes it easier to see when during the time children are in placement the risk of movement is greatest (see Table 4).

Exit or discharge reason is defined by the living arrangement of the child when the state relinquishes legal custody of the child. We classify exit reasons into two types: permanency and nonpermanency. Permanent exits are reunification, adoption, and guardianship/relative custody. Nonpermanent exits

Table 5. Number and Percentage of Children Admitted to Foster Care, Discharged From Foster Care by Age at Admission, and Reason for Leaving Foster Care: 2000 Through 2007

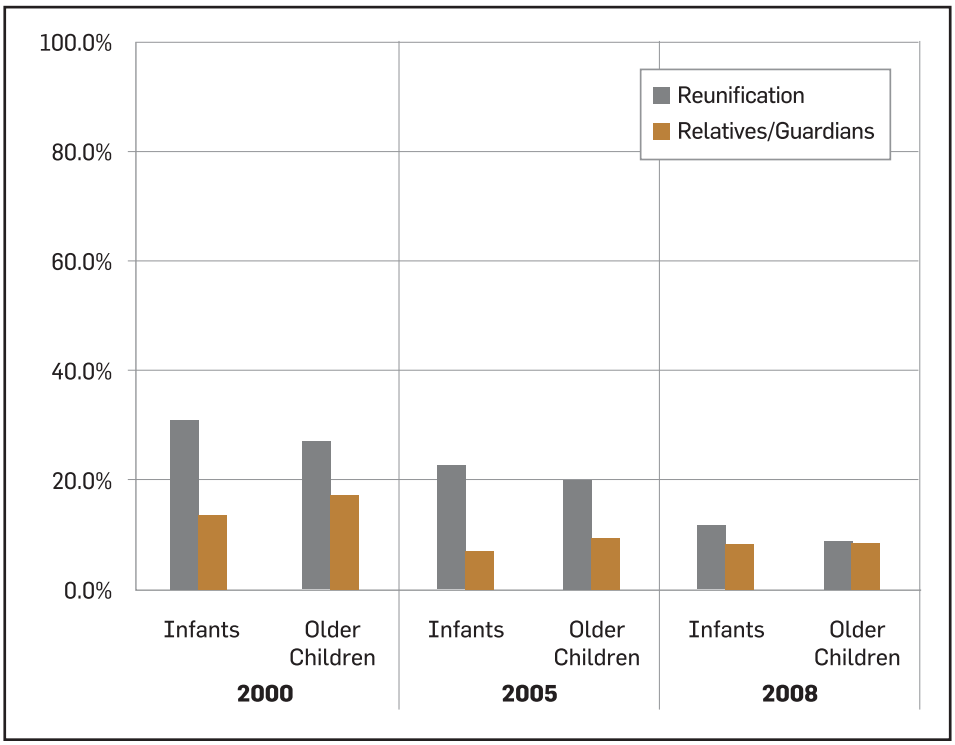
			Exits to permanency				
Age at admission	**Admissions**	**Discharges**	**Reunifications**	**Relative**	**Adoption**	**All other exits**	**Still in care**
All ages	473,567	421,463	217,033	67,152	75,540	61,738	52,104
Less than 3 months	59,619	52,190	16,468	7,286	25,690	2,746	7,429
3 to 12 months	36,756	32,635	15,441	5,942	9,589	1,663	4,121
Older children	377,192	336,638	185,124	53,924	40,261	57,329	40,554
Row percentages							
All ages	100%	89%	46%	14%	16%	13%	11%
Less than 3 months	100%	88%	28%	12%	43%	5%	12%
3 to 12 months	100%	89%	42%	16%	26%	5%	11%
Older children	100%	89%	49%	14%	11%	15%	11%
Column percentages							
All ages	100%	100%	100%	100%	100%	100%	100%
Less than 3 months	13%	12%	8%	11%	34%	4%	14%
3 to 12 months	8%	8%	7%	9%	13%	3%	8%
Older children	80%	80%	85%	80%	53%	93%	78%

Note. Row percentages answer the question, "Of all 3- to 12-month-olds, what fraction was adopted?" Column percentages answer the question, "Of all adoptions, what fraction was 3- to 12-month-olds?"

are all other exit types and include such reasons as running away, aging out, and transfer to another child-serving system (see Table 5).

Reentry occurs when a child discharged to permanency (excluding adoption) comes back to placement. For this particular analysis, we did not adjust for how long children have been out of care. In other words, the measure of reentry used asks whether the child ever reentered between the date of discharge and the last date of observation, which is December 31, 2008 (see Figure 2).

Figure 2. Reentry by Year of Admission, Reason for Discharge, and Age at Admission: 2000, 2005, and 2008



Number of Placements, Incidence, and Disparity

In this section, we are interested in understanding what fraction of all children entering out-of-home care for the first time are less than 1 year old at the time of admission. In addition, we are interested in knowing how that fraction has changed over time and whether the fraction differs depending on the urban character of the county. We grouped counties into three categories. Urban counties are the largest counties in each of the states; size is based on total population. Secondary urban counties are all of the other counties containing a large city; rural counties are all of the other counties in the state.

Twenty-two percent of children admitted to foster care are less than 1 year old. Presented in Table 1, the data that portray the age structure of the foster care population are compelling from several perspectives. Starting with the most basic fact, in 2008, 22% of all children admitted for the first time were less than 1 year old at the time of admission. That was an increase from 19% in 2000.

The number of infants entering foster care is on the rise. The population trend underlying the change in proportion is equally interesting. When compared with the number of infants entering foster care in 2000, the number of infants placed in 2008 is actually higher. For older children, there were fewer admissions in 2008 than in 2000.

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Black infants are nearly 5 times as likely as White and Hispanic children to enter foster care.

In urban areas, infants make up 24% of the admissions (1 in 4). Similarly, in secondary urban areas, 24% of the admissions were less than 1 year old. In rural areas, infants make up a smaller proportion of the admissions, but the growth of the infant group between 2000 and 2008 was far more dramatic, rising from 14% of admissions to 19%.

As an important aside, it should be noted that overall admissions in urban areas in 2008 were above the level reported in 2005, reversing the decline between 2000 and 2005.

Infants are 4 times more likely than older children to enter foster care. The question of placement risk is addressed in Table 2, which displays entry rates per 1,000 children by age and race/ethnicity of the child. For example, between 2000 and 2008, the risk of placement for infants increased from 3.9 to 4.1 per 1,000 children. During that same period, the rate for all older children stayed at just under 1 per thousand (0.9/1000). This is consistent with the change in the proportion of all children admitted to foster care who are less than 1 year old.

The age disparity—differences in the likelihood of placement based on the age at admission—is also presented in Table 2. These data show that infants are four times more likely to enter out-of-home care than children of all other ages combined. Moreover, because the rate of placement for infants increased while the rate for older children stayed level, age disparity in 2008 was actually greater than in 2000.

Black infants are nearly 5 times as likely as White and Hispanic children to enter foster care. Among infants, Black infants are particularly vulnerable. In 2000, the rate of placement among Black infants was 21 per 1,000. The comparable figure among Whites and Hispanics was 4.5 and 5.3, respectively. The Black/White difference translated into a disparity rate of 4.7.

Placement rates dropped for Black infants and increased for White infants between 2000 and 2008, a pattern that mirrors the urban/rural changes pointed out earlier. As a consequence, disparity dropped to 3.0, which is nevertheless greater than the comparable figure for older children.

Among older children, placement rates generally declined for both Whites and Blacks.

Placement Settings

Although it is difficult to be sanguine about the trends overall, the data on placement settings do point to some positive changes in placement experiences, all things being equal.

More infants in foster care are being placed with relatives. For much of the past decade, if not longer, child-placing agencies have looked to relatives as placement resources, with the idea that kin offer familial continuity for children who cannot live at home. The effect of this practice shift is readily apparent in the data that are presented in Figure 1.

For children placed in 2000, 2005, and 2008, these data show the placement settings where children spent at least 50% of their time. Data are presented for both infants and all older children separately. Placement settings are divided into regular family foster care, kinship care, and group care as described previously.

As context for understanding the changes in use of kinship care, it is important to note that, regardless of age, more children and youth spend most of their time in regular foster care homes than in other placement settings. Among infants, at least 60% of the children admitted spent most of their time in regular foster family care. The comparable figure for older children is slightly lower, having hovered over time between 44% and 50%.

Kinship care use increased between 2000 and 2005 for children of all ages. In 2000, about 20% of children admitted spent most of their time in kinship placements; by 2005, the comparable figure was slightly more than one third, which was true in 2008 as well.

Infants spend less time in group care than in any other setting. With respect to placement settings, the most striking difference pertains to group care. Less than 6% of infants spend more than 50% of their time in a group care setting. When it does happen, it can be because the placement involves a short stay in a medical setting before the child leaves placement. Older children are much more likely to spend more time in group settings, although use of group care by older children dropped between 2000 and 2008.

Placement Stability

Placement stability is another way to characterize what happens when children are placed away from their parents. The preference for stable child–caregiver relationships is well established in both policy and practice: Stable placements offer a better developmental context for children growing up.

Young infants are less likely to experience disruptions in their placement. Data that capture placement moves by age and time in care are presented in Table4. Here the infant group is divided into two groups: children less than 3 months old at the time of admission and all other children 3 to 12 months old. In addition, the time spent in care is divided into 6-month intervals. Dividing time in care this way provides a way to determine whether the likelihood of changing placements depends on how long a child has been in care. To calculate the moves per child per interval, we ask whether the child was in care at the start of the interval and, if so, whether the child moved at any time during the next 6 months.

Presented this way, the data show that placement moves are much more common during the first 6 months than at any other time, regardless of age. For example, among children less than 3 months old, the number of moves per child in the first 6 months in 2000 was 0.63. That is to say, after counting all the children admitted and counting all the moves those children made, the per-child

average was 0.63 during the first 6 months of placement. Among children whose placement lasted at least 6 months, the number of per-child moves between months 7 and 12 was 0.22, a change in the likelihood of movement of about 66% when compared with the first interval.

Younger children are less likely to experience placement changes. Overall, the likelihood of movement for young children is lower than it is for older children, regardless of how long children have been in care. In particular, very young children (less than 3 months old) are about half as likely to move as older children (more than 1 year old) and slightly less likely than 3- to 12-month-olds.

Over time, from 2000 to 2004, these patterns have changed little, with one exception. Among children in care for more than 18 months, the likelihood of movement has increased. However, examining those reasons are beyond the scope of this article.

Length of Stay and Reason for Leaving Foster Care

When children are placed in foster care, the state assumes a limited set of parental responsibilities. Policy and tradition in the United States protect a family's right to raise their own children, so placement away from parents should be as brief as possible given the reasons why the child was removed from her home in the first place. *Exits to permanency* is the phrase used to group the different reasons why children leave placement and includes reunification, adoption, and guardianship. In each case, when a child achieves permanency, it means that the state has relinquished the limited set of parental responsibilities it assumed when the child was placed. Of course, children leave placement for reasons other than permanency, such as running away and aging out of the system.

Infants who enter care at less than 3 months old are in foster care 50% longer than older children. Age at placement is an important correlate of how long children can be expected to stay in placement. Younger children almost always stay longer, in large part because younger children are so much more likely to be adopted. Notwithstanding efforts to plan concurrently, adoption takes longer because reunification has to be ruled out first.

Table 3 shows just how striking the connection between age and time in care is. Among all children, the median length of stay was about 12 months: Half the children admitted stayed less than 12 months, and half stayed more than 12 months. Over time, from 2000 to 2007, the median increased slightly, from 11.8 months in 2000 to 12.1 months in 2007. That difference translates into about 10 days.

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Nearly 1 in 3 infants who were reunified had to reenter foster care.

As for age differences, two patterns stand out. First, for children admitted within 3 months of birth, the median duration is more than 33% longer than other infants and nearly 50% longer than older children. Second, although the overall median increased between 2000 and 2007, the median for very young children (less than 3 months old) fell by 2 months, whereas for older children, including 3- to 12-month-olds, it increased slightly.

The connection between length of stay and exits to permanency is alluded to in Table 5, which shows the number and percentage of children admitted and discharged from foster care by age at admission and reason for leaving. As context, the group includes all children admitted for the first time between 2000 and 2007, inclusive (N = 473,567). About 11% of the children were still in care as of December 31, 2008, with most of those children coming from the more recent entry cohorts. The reason for pointing out the number still in care is to highlight the fact that once the exit reason for these children is known (i.e., once more recent data are available), the number of children in each category will change.

Infants who enter foster care less than 3 months old are much more likely to be adopted than reunified. Among the youngest children (less than3 months old), 43% were adopted. The comparable figure for 3-month-olds to 1-year-olds was 26%. Only 11% of the children who were older than 1 year at the time of admission were later adopted.

Of all completed adoptions, 47% involved children who were less than 1 year old at the time of admission.

Infants accounted for only 15% of the children reunified and 20% of the children discharged to relatives or guardians.

Reentry

The last indicator studied shows the likelihood of reentry. In this case, reentry measures whether a child ever returned to care after reunification or placement with a guardian, regardless of how long the child was in care and regardless of how long the child was out of care. Children who have been out of care longer (i.e., children from the 2000 cohort) will have a higher reentry rate because of how much time we have had to observe the process. If children do return to care, it typically means that the child is facing renewed risks in the family context.

Nearly 1 in 3 infants who were reunified had to reenter foster care. Once again, these data point to specific risks facing infants. Generally speaking, excluding infants who were adopted, the risk of returning to placement was just under 1 in 3, if the child was reunified. For infants discharged to a (relative) guardian, the reentry rate was closer to 14%.

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Center for State Foster Care and Adoption Data
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Generally, infants have higher reentry rates than older children if they were reunified; if the path to permanency involved guardianship, the reentry rate for older children is slightly higher but always lower than it is for reunification.

Summary

It is increasingly important that policymakers, practitioners, and advocates use evidence when planning interventions designed to improve the life chances of children. Epidemiological evidence is a particularly important type of evidence, especially when the evidence shows clear patterns of risk within distinct developmental periods.

With respect to foster care, the evidence is unequivocal—when compared with children of other ages, infants experience unique challenges and vulnerabilities:

- Nearly 1 in 4 children admitted to foster care enters placement for the first time before their first birthday.
- The risk of placement for infants is more than 3.5 times greater than it is for most other children.
- Racial disparity is greatest among children less than 1 year old.
- Nearly half the children admitted at less than 3 months old will leave foster care with a new set of legal parents.
- Of all the adoptions completed ($n = 75{,}000$), fully one third involved children who were less than 3 months old. If all children less than 1 year old at placement are included, the figure is closer to 50%.
- Reentry rates for infants reunified with their parents are above 30%.

Simply put, improving outcomes for children involved in the foster care system has to take the unique developmental challenges of infants into account. To do otherwise means an important opportunity is lost.

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Being in Relationship

Paradoxical Truths and Opportunities for Change in Foster Care

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One September, in the early years of The Children's Ark, a young woman showed up on our doorstep. "Desirae*" had just given birth to her second child, who was removed from her custody because of prenatal drug exposure. She was currently in drug treatment and desperate to reunify with both her newborn and her older son, who was also in foster care. Because we offered mothers the opportunity to reside full-time with their children while participating in services, The Children's Ark (see box, next page) was an attractive option for this mother.

Typically, families were referred to The Children's Ark by the Department of Social and Health Services. The kind of initiative that this young woman demonstrated by arriving without a referral was unusual, and was perhaps our first hint that she had courage and wisdom well beyond her 17 years, buried beneath her tough exterior. Desirae's journey with us over the next 12 months and, indeed, to the present day, has taught us some invaluable lessons.

The following story of Desirae and her children highlights the sometimes paradoxical truths about families in crisis and the nature of lasting change that challenge the current system's good faith attempts to assist families fractured by addiction, abuse, and neglect. If those of us who work in the child welfare system are to make a lasting difference in the lives of at-risk families, we must find ways to reconcile each family's complex needs with the efficient functioning of a system and with what is in the best interests of the children. Much of it in Janet Mann's words, this article focuses on Janet's experience with Desirae at The Children's Ark and in the years following Desirae's departure from The Ark. As such, Janet's voice throughout the paper is primary; unless otherwise indicated, all first person referents involve her direct work with Desirae and her insights regarding that work.

Desirae and Her Children

Desirae had a familiar history. She had been physically and sexually abused as a child and had been in and out of foster care herself. Her childhood experience of violence, deprivation, and abandonment had already played out in dramatic ways in her life. After being found guilty of second degree manslaughter following the death of a fellow gang member when she was just 12 years old, she had served time in a lockup facility and was still on probation. Her first son, Jacob, was removed from her care when he was a toddler, after he swallowed cocaine. At the time we met Desirae, Jacob was 2 years old and living in a local foster home. Desirae's second son, David, was a newborn, and it was with him that she requested entry to The Children's Ark.

Desirae and David moved into The Children's Ark, together, a few weeks after she first knocked on our door. It was immediately clear that Desirae was suffering from depression, struggling to bond with her infant son, and preoccupied with her older son, Jacob. She was resistant, defensive, cold, and harsh, both with her baby and with the other parents and staff. Her tendency toward chaos and disorganization were problematic, and she and I were constantly in conflict as I struggled to find a way to connect with and help her.

Jacob began visits shortly after Desirae and David entered The Children's Ark, and

Abstract

This article focuses on the experience of "Desirae," a young mother who participated with her children in services at The Children's Ark, an attachment-based intervention for families in foster care. The story of Desirae and her children highlights both the sometimes paradoxical truths about families fractured by addiction, abuse, and neglect and the nature of lasting change that challenge the current child welfare system. Informed by attachment theory and other psychodynamically oriented perspectives as well as Buddhist psychology and mindfulness, the authors stimulate further thinking about how professionals can manage challenges with creativity and compassion by keeping relationships at the center of care for families in crisis.

* The names of the mother and her children have been changed to protect their privacy; however, Desirae read the final draft of this paper so is fully aware and affirming of its content.

The Children's Ark

The Children's Ark was developed by foster parents, Janet and Paul Mann, as a placement option for children in foster care, in which mothers could also live. Grounded in attachment theory, The Children's Ark provided a safe, structured, and therapeutic environment in which mothers retained primary caregiving responsibilities, under the supervision of the Ark staff, while they worked toward improving their capacities for parenting and self-sufficiency. Shortly after its development, Nancy Worsham and Molly Kretchmar were invited to engage in a descriptive study of The Children's Ark focusing on the experiences and outcomes of the mothers and children (Kretchmar, Worsham, & Swenson, 2005; Mann, Kretchmar, & Worsham, 2008; Worsham, Kretchmar-Hendricks, Swenson, & Goodvin, 2009). Although space precludes a more complete presentation of our findings, the analysis of Desirae's case completed for research purposes further confirms Janet's experience as described in this article.

in the early spring, we had transitioned him into The Ark full-time. Things deteriorated quickly with Jacob also in the house. Desirae was stressed beyond her coping abilities trying to manage two children, go to school, and maintain even minimal living skills in The Children's Ark environment. On May 1, she negotiated an exit. Jacob returned to his former foster home, David stayed on in care with us, and Desirae moved in with her boyfriend.

Over the next 5 months, we cared for David while trying to inform those in charge of this family's future what we had learned during our 7 months living with them. It was our strong opinion that Desirae would not be able to care for her children safely, and we worked harder than we usually do to discourage reunification. The following is an excerpt from one of the letters we sent to Desirae's case worker.

...Desirae's internal working model is based on experiences in relationship with primary caretakers that were characterized by abandonment, insensitivity, devaluation, bullying/belittling, aggression and so on. Desirae learned that the experience of being attached is unpredictable, chaotic, frightening, and dangerous. As she enters into relationship with her own children, the same dynamics will likely play out, just as they did so clearly here at The Children's Ark.

Abandonment or avoidance was an issue from the beginning with David. There was little interaction between them. She often placed him facing away from her, sat with her back to him, and spent long periods of time not speaking to him. She seemed to have the most difficulty responding to his cries, when he needed her the most. The first night that Jacob spent at The Ark (after being in foster care for more than a year), Desirae took free time and was gone for the evening, leaving Jacob without her in his new surroundings.

Desirae devalued, bullied, and belittled both children in many ways. She carried David under her arm like a football even when he was a very small infant. She resisted soothing him when he was distressed. She mocked and teased him, once reportedly blowing a horn loudly in his ear and laughing at his frightened response. Desirae engaged in derisive name calling and frequently yelled at both boys. This alternated with periods in which she was flamboyantly affectionate, kissing them in a way that was overwhelming and intrusive.

Desirae's aggression towards both boys escalated as her confusing and sometimes frightening behavior (loud voice, threatening posture, sudden mood shifts, and so forth) and failure to set appropriate and consistent limits involved them in frequent power struggles. Jacob's bedtime was a good example. Her lack of consistency coupled with a need to be obeyed led to a nightly screaming match. One incident of striking Jacob was reported to CPS. We then entered into a contract to discourage the verbal and physical aggression and instituted an "open door" policy, a step we felt necessary to ensure the safety of the children.

Desirae's developing relationship with her children, then, mirrors her own experience in relationship with a caregiver. Her children have also come to expect that closeness to her is unpredictable, chaotic, and frightening.

My assessment of what happened here at The Children's Ark is that Desirae became overwhelmed and "hit the wall." This was the result not only of the circumstances of her life, but also of her beginning to come to grips with her past in a way that exposed the pain of her own internal working model. She was not yet ready to confront that pain. Lack of information is not the problem: she knows intellectually that hitting and screaming are not the best ways to parent. If Desirae is ever to have access to her full potential as a parent, however, she will need to explore more completely her past relationships with caregivers and the role they played in her own emotional development. She needs to understand her working model and let down the armor of her defenses. She needs to grieve for her pain and losses and eventually find resolution. That will be a very long process. In the meantime, in my opinion, her children would be at very high risk for abuse and/or neglect should they be returned to her.

In spite of our concerns, and after 12 months with us, 13-month-old David was returned to Desirae's custody and care, along with Jacob. Life became even more complicated for Desirae. Unbeknownst to us, she was pregnant when she left The Children's Ark. She married her boyfriend and soon was also parenting one of his children from a previous relationship. The state of Washington then placed in their custody her sister's three children, so suddenly there were seven.

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One Halloween, Desirae, her husband, and all of the children arrived on our doorstep, and this began a tradition of a visit each year.

Desirae and her husband struggled over the years to create and maintain a home for themselves and the children, participating in drug treatment, parenting classes, and family preservation services. Sometimes the family was split up with some of the children living with relatives. Sometimes Child Protective Services was just a half step behind. Always they flirted with addiction, homelessness, poverty, and simply being overwhelmed by life.

Although we worked hard to discourage reunification after Desirae left The Children's Ark, we worked equally hard to stay in relationship with her, and not ambush, mislead, or abandon her. I visited occasionally during the first 2 years or so, when I was able to keep track of an address. On occasion, they would contact us, usually when their backs were against the wall. Then one Halloween, Desirae, her husband, and all of the children arrived on our doorstep, and this began a tradition of a visit each year, something we looked forward to immensely. Over the years, we noticed that, in spite of their continuing struggles, Desirae and her husband were becoming more attuned to, more sensitive to, and more affectionate with the children, and the children were less chaotic, calmer, and more direct about their emotional needs.

Each Halloween we hugged them and told them to come and visit anytime. Each year they came only at Halloween. Then last January, in a follow-up to a promise for pictures of David in his football uniform, I received an email from Desirae, updating us on the children. Her "love you guys lots" salutation prompted a response from me including "I think about you with such admiration, Desirae; you have hung in for yourself and these kids with such strength and courage and wisdom against so many odds at such a young age. I truly stand in awe." Several emails later, we set up a lunch during which we discussed her time at The Children's Ark and the events of the intervening years.

The Lessons

Desirae's reflection on her own experience coupled with Janet's insight and interpretation has helped to frame the following lessons and their implications for practice. In its initial conceptualization, The Children's Ark was informed and influenced by attachment theory (Bowlby, 1969/82). As reflected in the following, our thinking is also influenced by other psychodynamically oriented perspectives (Fosha, 2000; Heineman & Ehrensaft, 2006; Richo, 2008) as well as by work in Buddhist psychology and mindfulness (Bayda, 2002; Kabat-Zinn, 1990).

Lesson 1: Safe parenting is not an information issue, but an emotional integration issue.

Like you could pull on the grownup end and sooner or later you would get to the child, just like pulling a bucket out of a well. Like you would never be left holding a broken end, with nothing attached to it at all (Cleave, 2008, p. 70).

Decades of research show that the intergenerational forces operating on one's parenting are powerful, that even when parents intend to care for their children differently they often find themselves repeating what they experienced. Researchers and clinicians have described how the parent, once the child, reenacts dynamics of previous formative relationships with her own children, whether those are rooted in security and trust or in insensitivity and pain (Fraiberg, Adelson, & Shapiro, 1975; Kovan, Chung, & Sroufe, 2009; Kretchmar & Jacobvitz, 2002; Richo, 2008). Desirae's interactions with her own children illustrate how these dynamics play out.

Desirae's Story

Desirae came to The Children's Ark a charming, intelligent, strong, insightful young woman, who knew that hitting and yelling were not the way she wanted to parent. And yet, as her time with us demonstrated, she repeated with her own children many of the behaviors she herself experienced as a child. She was somehow unable to translate her insight into action, but retreated instead into defensive withdrawal or hostile self-reliance. Clearly Desirae possessed a softer, more sensitive, vulnerable side. The challenge was in overcoming her fear of parenting from that sensitive place inside of herself. When faced with her children's need for open-hearted tenderness, whenever they cried out to be seen, heard, understood, and held, Desirae's own emotional deprivation and longing were triggered. The pain was then too deep, the risk too great. Her only option was to protect her own heart.

These history-in-the-moment experiences powerfully color, shape, and drive parents' behavior even when they have some insight into them. Desirae stated to her Ark therapist, "I feel like I'm living with my mother and nothing I say matters, and it is never good enough." This emotional reenactment with me of her own experience threw Desirae into a protective, defensive stance that felt critically necessary to her survival on some level, but from which she could not possibly parent with any sensitivity.

What she needed were not instructions regarding the proper way to interact with children, but some experience herself of how security felt. Parents cannot give their children what they have never experienced, partly because they cannot bear to acknowledge what they did not have, or their yearning for it, and partly because only in receiving security are they able to soften and open the heart enough to give it.

So what Desirae needed were repeated overriding experiences during which she felt all the nurturing care her childhood lacked. She needed these experiences long enough to begin to trust them, to let them in. Only then would she be able to nurture her children in the same way. Providing her with opportunities to grieve what she did not get would also be essential in helping her integrate her own painful experience enough to operate from the more positive feelings generated by her new relationships.

Lesson 2: Being engaged in a caring, long-term relationship within the safety of a holding environment optimizes growth and change.

No longer is insight and interpretation the key to therapeutic success; the current consensus is that the actual relationship between therapist and child is what results in change (Bonovitz, 2006, p. 148)

Desirae, like all people, seeks connection; even while she resists it. All people develop, and can change, within the context of relationship. In order to begin to trust new transforming relationships, however, or to embark on the important work of grieving what they did not have, they require a reliable, safe haven or holding environment. Until they feel the safety of an environment that can contain the vulnerability of everything they think, feel and are, they will not come out from behind their protective walls.

Although my relationship with Desirae was conflicted, we both held on to a strong

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Decades of research show that the intergenerational forces operating on one's parenting are powerful.

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Having compassion does not mean condoning behavior that harms children.

enough thread to keep the connection alive. Even as we at The Ark fought reunification, we were careful to maintain enough relationship with Desirae that she always knew we were available to her and that our care for her was unconditional. For her part, Desirae contacted us just enough to stay "on our screen." I remember, for instance, a call from her several years after her exit from The Ark asking us how to cook an artichoke. In the end, that thread of relationship is what made it possible for us to connect again in a significant way. At that recent lunch, Desirae talked, with warmth and wisdom, about how all we had offered her at The Children's Ark had gone in at some level, but she was just too overwhelmed in the moment to use it. She talked about knowing always that everything we did and everything we said, we did and said out of love for her and her children. She understood too that, even when she couldn't hear it, we cared about her. All knowledge that she could hold—because there was "enough" relationship—until she was in a place where she could access it, articulate it, and act on it.

Desirae also talked about how, upon leaving The Children's Ark, she had to keep all that she had learned tucked away behind her tough, self–reliant front until she had tried many parenting strategies and had become more grounded. Then, years down the road, as she watched others all around her parent from defended, fearful places, she kept hearing our voices and could finally open herself up to the tender, real place in herself that knew what to do. What she was finally able to do, in essence, was meet her children's vulnerability with her own. That is where — vulnerability meeting vulnerability—change happens.

Lesson 3: Meeting the needs of children at risk requires an ability to hold with compassion the ambiguity of good people doing bad things.

I realized that genuine compassion can never come from fear or from the longing to fix or change. Compassion results naturally from the realization of our shared pain (*Bayda, 2002, p. 138*).

How easy it is to reach out to and love a battered baby; how much harder to hold compassion for the batterer. No matter how angry and frustrated the cruelty human beings inflict upon one another makes professionals feel, without the compassion that understanding another's pain brings, those who engage in this work can be of no help to anyone, including the children. Living with Desirae's abandoning, belittling, insensitive, devaluing, and aggressive behavior toward her children was never easy...making us want to scream out with frequency, "STOP IT!" As the stories of her childhood began to unfold, however, and her pain and fears were revealed, our hearts began to open in understanding and compassion.

Over one of the Christmas holidays at The Children's Ark, the mothers were sharing stories. Desirae started talking about how many agencies "adopted" her family at Christmas when she was little, and how as each stranger arrived bearing gifts, the pile of toys and goodies under the tree grew larger and larger. But then as her mother, who was an addict, fell into more depression and desperation—along with her own painful ghosts from the past—the pile began diminishing. As Christmas approached Desirae witnessed kids in the neighborhood riding "her" bike and playing with "her" doll. Tears rose in Desirae's eyes as she described the shame, humiliation, and deep pain of watching others with gifts intended for her because her mother put her next drug fix before her children.

Suddenly instead of wanting to respond with "STOP IT!" we were thinking, "OF COURSE." As Desirae was faced with her children's genuine need to be met and embraced, she could only be plummeted into grief and despair regarding her own unmet needs. In order to survive, she chose to protect and defend, at great cost to herself and her children.

Having compassion does not mean, however, condoning behavior that harms children; any more than understanding the genuine need behind children's difficult behavior means condoning their misbehavior (Mann & Kretchmar, 2006). Having compassion also does not necessarily mean recommending that families be reunited. Compassion requires facing the truth. We did not support Desirae's children being returned to her, but we were honest with Desirae about what we were doing and why. We were clear also that we cared about her as well as her children and that our position in no way diminished our care and concern for her. She was, in our opinion, just not ready. She had more work to do.

Lesson 4: Real change takes time.

But walls, whether built by bricks or isolation, don't come down without a corresponding amount of labor (*Caldwell, 2010, pp. 86–87*).

The walls that take a lifetime to build up also take time to dismantle; there are no quick fixes or easy roads. The challenge, of course, is to give families the time they need—and deserve—to do the work, while not leaving children in limbo for too long. At our recent lunch Desirae talked about how it took time: time to try other, easier routes; time for life to get manageable enough to access and use her knowledge; time to allow herself to work through the pain and grief of her own experience so that her knowledge was more integrated; time to let her carefully constructed defenses fall enough that she could operate from a softened, opened heart; and so on. Anything less time-consuming would probably have been compliance, and thus transparent and transient. In essence what Desirae was talking about was the beginning

of a rewiring of her way of seeing the world and herself in it, giving her access to her full potential as a parent, referred to in the letter above.

The Implications

What are the implications in practice? How do child welfare professionals reconcile the need for timely resolutions for children with the time it takes parents to do the work they need—and should be allowed—to do, all within the constraints of an overwrought system? There are, of course, no simple or easy solutions, but there are things each of us can do to render interventions with fragile families both more nurturing and more effective.

First, the best interests of the children must always lead, especially the need for timely resolutions (Hudson et al., 2008; Katz, 1990; Mann et al., 2008). While keeping that in mind, and insisting that it drive and shape decisions, professionals must also do a better job of considering the bigger picture in which children exist. Abuse and neglect do not effect only the children, they impact whole families, and sometimes multiple families. Although a primary goal is to reconcile families, the professionals in charge often put families at the mercy of an adversarial system that pits party against party, parent against parent, parent against treatment provider, and, sometimes it even seems, parent against child. Until professionals manage the whole family, with creativity and compassion, they are not really helping anyone and in some cases are adding to the harm.

Next, not only must the whole family be considered, but also the whole family should be treated. Although individuals bring unique histories, issues, and ways of being in the world, problems reside in the dynamics between individuals, or in relationships (Sameroff & Emde, 1989). Professionals must therefore treat relationships: parents and children together (Cooper, Hoffman, Powell, & Marvin, 2005). Really serving children may mean offering services to them, both with their biological parents and with their foster parents. Children will resolve and heal only if those with whom they are in relationship, past and present, are on board and aware of their own contributions to the relationship dynamic.

Parents and children may well also benefit from individual treatment in conjunction with the relationship-based treatment. Two factors are important to remember regarding any treatment. One is that change is optimized within in the context of a safe relationship; and so, whenever possible, therapists and treatment providers should remain constant. For example, The Children's Psychotherapy Project, started by a nonprofit organization called A Home Within, developed the following model for its work with children and youth in foster care: "One child. One therapist. For as long as it takes" (Heineman, 2006, p. 3). This approach grew out of a consistent finding in research and clinical work: "The single most important factor in the lives of children and youth in foster care is a stable and lasting relationship with a caring adult" (Heineman, p.11).

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The challenge is to give families the time they need—and deserve—to do the work, while not leaving children in limbo for too long.

Related to the idea of constancy, the system should not change or rotate workers and providers except when absolutely necessary, and parents should be discouraged from repeatedly changing providers, except in the case of a truly inappropriate match. In Desirae's case, several gaps in case workers allowed an advocacy group to take a stronger role in decision-making than they were authorized to provide, which ultimately shifted the process toward reunification, despite our deep concerns.

The second factor regarding change is that it takes time. Not only should parents be required to attend services, they also have the right to complete the work they've begun. That may mean that treatment continues after children are returned home. That may even mean that parents be allowed to continue treatment after relinquishing children, both for their own benefit and also for the benefit of any future children. Children also are entitled to ongoing, uninterrupted treatment that follows them wherever they go and involves their current caretaker.

Finally, relationships between biological families and foster families or relatives should be encouraged and facilitated, not discouraged (Ehrensaft, 2006). Not only do the children benefit from all their caretakers working together, but foster families and relatives can often be the best resource for a family in crisis. Foster families are entitled to information about the children in their care specifically, and they should be better trained about the needs of children facing significant loss and trauma generally (Bass, Shields, & Behrman, 2004; Dozier et al., 2009). A well-intended, well-informed, well-supported foster or relative family can be a critically important member of the team and a caring bridge between parents and children at risk (Harrison, 2004). Had Desirae and I not been able to tolerate each other's imperfections enough to stay connected over time, she would never have been able to use what The Children's Ark had to offer.

Conclusion

At its core, Desirae's story reflects the importance of relationships. A primary paradox facing the foster care system is that relationships take time, but it is time that none of us has. Given that paradox, our goal in this article was to stimulate further thinking about possibilities for approaching challenges with creativity and compassion by keeping relationships at the center of how all of us care for our society's most vulnerable children and families.

Learn More

Circle of Security Early Intervention Program
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A Home Within
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More of Desirae's Story

Just as Desirae maintained enough connection to ultimately access the softer, wiser part of herself, so David held, on some level, the "knowing" of another way to be in relationship. One day, about 2 years after the family had left The Children's Ark, I encountered Desirae, David, and the new sibling (who was now 2 years old) at a nearby park. David was playing in the wading pool. Desirae called him over to say hello to me. Quite appropriately, he first peeked out from behind his mother's skirt, then ran off to play on the climbing equipment with his sister. As I left the park I walked by where David was playing up on a platform and stood eyeball to eyeball with him. I said hello to his sister, tousled her hair, and remarked, "You don't know me, do you?" as she stared at me with a bit of apprehension. David, however, was staring intently into my eyes. I said quietly, "But you do, don't you?" David nodded, slowly, almost imperceptibly, without taking his eyes off me. Finally he fell into my arms and held on tight and long. Even after 2 years something in his deeply rooted, perhaps unconscious, memory system allowed him to trust the safety and connection in my arms. That moment in the park floated through my mind recently as I stood with Desirae on the sidelines of the now-14-year-old David's football game, cheering him on.

Janet C. Mann, *with her husband Paul, founded The Children's Ark in 1994 where she served as its director until she retired in 2009. Since 1988, Mrs. Mann and her husband have loved, nurtured, and transitioned more than 120 foster children to permanent homes . For the past 17 years she has trained in the areas of object relations theory, attachment theory, brain development, and child development. In December of 2005 she completed an advanced training in infant mental health assessment and in January of 2008 she passed Level One certification in Circle of Security Assessment and Treatment Planning. The Manns have been the recipients of numerous awards including the first annual Foster Parent Leadership Award from Children's Administration, Region One in 2007.*

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Authors' Note

Janet Mann extends her gratitude to her family as well as to the families and staff at The Children's Ark. In particular, she wishes to acknowledge therapist Glen Cooper for his support of her relationship with Desirae. All of us are deeply grateful to Desirae for her honesty and insight and for her permission to publish this account. Correspondence concerning this article should be addressed to Molly Kretchmar, Department of Psychology, 502 E. Boone, Gonzaga University, Spokane, WA, 99224.

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Intervening With Foster Parents to Enhance Biobehavioral Outcomes Among Infants and Toddlers

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Twenty-month-old Jason was placed into foster care for the first time with Betty, an experienced foster mother who had previously fostered more than 50 children. Betty ran a family child care center in her home with 6 children from the neighborhood. Jason and the other foster child were sent out to another child care center, however, because Betty had the maximum number of children for whom she could care in her center. Jason had some difficulty adjusting to the transition to the other child care center every day and was difficult to manage. The day care administrator asked Betty not to bring Jason back because he required more staff time than other children, so Betty let the foster care unit know he would need a new foster home. The foster care unit moved Jason from Betty's to Charlene's home.

Charlene had previously fostered only one child. When first placed with Charlene, Jason did not turn to Charlene for reassurance but rather turned away from her. Charlene was very patient and nurturing, and over time Jason gradually began turning to her when distressed. Charlene was enrolled in a 10-session intervention, the Attachment and Biobehavioral Catch-Up (ABC) intervention, that helped her provide nurturance to Jason early on and follow his lead with delight. She felt as if she could see the changes in both herself and Jason as she progressed through the intervention.

As with Jason, the capacity of young children in foster care to form trusting relationships with their foster parents and to regulate behavior and physiology are affected by many things—issues including what the children bring to the new relationship, what the foster parents bring to the relationship, and how the system of foster care operates. Here we describe some of these issues that we consider most salient and then describe an intervention developed to target these issues. Finally, we discuss issues within the foster care system that affect outcomes.

Issue 1: Babies in foster care often do not know how to seek comfort from foster parents. When Jason was placed with Charlene, he behaved in ways that suggested to her that she was not needed. The "natural" way to respond to his behavior would have been to withdraw; fortunately, Charlene was enrolled in an intervention that helped her to see that he needed nurturing care, even though he did not behave as if he needed such care.

Through a diary study with foster parents (Stovall & Dozier, 2000; Stovall-McClough & Dozier, 2004), we found that children who were older than about 10 or 11 months when they were placed into foster care often acted as if they did not need their foster parents (e.g., turned away from foster parent when upset) or were unsoothable (e.g., continued

Abstract

Children in foster care face a number of challenges that threaten their ability to form attachment relationships with foster parents and to regulate their behavior and biology. The authors describe the Attachment and Biobehavioral Catch-Up (ABC) intervention, an evidence-based intervention aimed at helping foster children develop trusting relationships with foster parents and develop better biological and behavioral regulation. The authors present research that led to the development of the ABC intervention, outcome research of randomized clinical trials, and a case example of a foster parent and child who participated in the ABC intervention. Finally, issues related to the broader system of care that are likely to affect children's adjustment (e.g., foster caregiver commitment and placement stability) are discussed.

fussing when foster parent tried to soothe them) when they were distressed. Even more concerning than children's behaviors, however, was that foster parents tended to respond in kind to children: When children acted as if they did not need them, foster parents acted as if they were not needed and thus failed to provide nurturing care; when children acted as if foster parents could not soothe them, many foster parents responded in an irritated or angry fashion. The foster parents' reactions concerned us because it seemed that foster children were "leading the dance" with foster parents—that although foster parents might have been nurturing under other circumstances, they were not nurturing to these young children in their care. We identified the ability of the foster parents to provide nurturing care as the first target for intervention.

Issue 2: Young children in foster care often experience dysregulation. When children experience early adversity, they are at increased risk for becoming dysregulated biologically. We have found that children in foster care often show atypical patterns of cortisol production (Dozier et al., 2006). Cortisol is a hormone that is secreted as an end product of the hypothalamus-pituitary-adrenal (HPA) axis, which is a complex set of interactions between these organs. This axis, or set of interactions, has a number of functions, including the maintenance of a diurnal pattern, or daily sleep-and-wake cycle; the diurnal pattern is characterized by high levels of cortisol produced in the morning, decreasing by midmorning to its lowest level at bedtime. The diurnal pattern is involved in helping humans to get up in the morning and go to bed at night. The opposite pattern is seen among nocturnal creatures, such as some rodents. To look at how adversity affects this diurnal pattern, we have assessed morning and bedtime levels of cortisol among children living under normative, low-risk conditions with their birth parents, children living under high-risk conditions with their birth parents, and children in foster care (Bernard, Butzin-Dozier, Rittenhouse, & Dozier, 2010). The pronounced diurnal pattern of children living in low-risk conditions is illustrated in the steep slope of children in Figure 1. These low-risk children show the steepest slope in cortisol change across the day, with the largest decrease from wake-up to bedtime values, relative to other children. Children who are currently experiencing high-risk conditions show the flattest slope, whereas children in foster care show an intermediate slope, midway between low-risk children and maltreated children living with their birth parents. Thus, children in foster care show some dysregulation of their HPA axis, although not as profoundly as shown by children living with high-risk birth parents. These findings suggest that young children in foster care need help developing the ability to regulate their physiology optimally, so we identified this capacity as the second intervention component.

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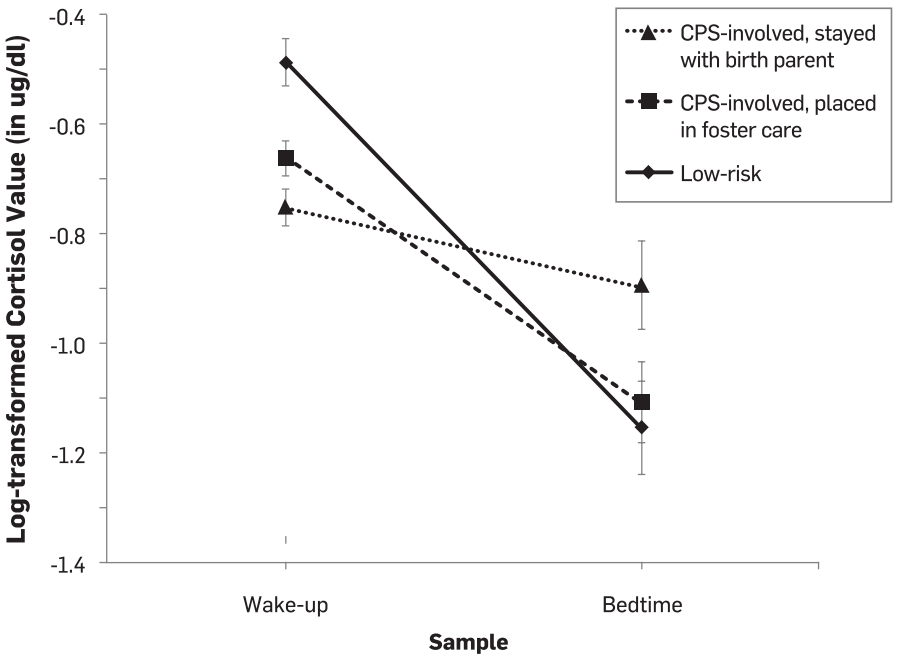
Babies in foster care often don't know how to seek comfort from foster parents.

Issue 3: Foster parents' own issues sometimes interfere with their providing sensitive, nurturing care. For some adults, sensitive care comes naturally; for example, when a child is distressed, they would consider it important to soothe the child. For other adults, sensitive care does not come naturally; they may worry about spoiling the child or may find crying aversive and want to quiet the child quickly. There are several factors that probably contribute to this. Among these issues are parents' own attachment experiences; for example, if parents were typically reassured when they were distressed as children, it is more likely that they will provide nurturance to their children than if they did not typically receive nurturing care (Kovan, Chung, & Sroufe, 2009; van IJzendoorn, 1995).

For young children in foster care, it is especially important that parents are nurturing and sensitive. When placed with foster parents who are not nurturing and sensitive, young children in foster care are at increased risk for developing disorganized attachments (Dozier, Stovall, Albus, & Bates, 2001). Disorganized attachments represent a breakdown in attachment strategy and put children at increased risk for problems regulating physiology (Bernard & Dozier,

Figure 1. Comparison of Diurnal Cortisol Production



Comparison of diurnal cortisol production among low-risk children living with birth parents, children who continued living with high-risk birth parents after involvement of Child Protective Services (CPS), and children living in foster care after involvement of CPS. Adapted with permission from "Cortisol Production Patterns in Young Children Living With Birth Parents vs. Children Placed in Foster Care Following Involvement of Child Protective Services," by K. Bernard, Z. Butzin-Dozier, J. Rittenhouse, & M. Dozier, 2010, *Archives of Pediatrics and Adolescent Medicine, 164* (5), 438–443. Copyright © 2010 American Medical Association. All rights reserved.

Table 1. Attachment and Biobehavioral Catch-Up Intervention Targets

Problematic issue	Target
Children push caregivers away.	Foster parents provide nurturing care even though children do not elicit it.
Children are dysregulated behaviorally and biologically.	Foster parents provide a responsive interpersonal world by following children's lead with delight.
Caregivers' own issues interfere with providing sensitive care.	Foster parents provide sensitive care even though it doesn't come naturally to them.

in press-a; Hertsgaard, Gunnar, Farrell, Erickson, & Nachmias, 1995) and controlling behavior (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010). Given that young foster children placed with foster parents are at risk for disorganized attachment, and that disorganized attachment puts children at risk for later problems, helping foster parents override their own issues that might get in the way of providing sensitive, nurturing care was identified as the third intervention component.

An Intervention for Babies in Foster Care

We developed the ABC intervention for infants and toddlers in foster care that targets the several issues identified as critical (see Table 1). Given the evidence that many young children in foster care have difficulty forming attachments, our first intervention component helps foster parents to reinterpret children's alienating behavioral signals that tend to push foster parents away. Second, given that young children are often dysregulated behaviorally and biologically, we help foster parents follow their children's lead with delight as a way of enhancing their children's regulatory abilities. Third, we have found that foster parents' own issues sometimes get in the way of parenting in sensitive ways. We help foster parents override their usual way of responding, providing nurturing care and following their children's lead even if it does not come naturally.

The ABC intervention includes a manual and 10 interactive sessions. Each session has a specific focus, with the overall goals of helping foster parents to provide nurturance when children are distressed and follow children's lead with delight when they are not distressed. Sessions 1 and 2 help foster parents reinterpret children's behavioral signals, providing nurturance even when it is not elicited. Sessions 3, 4, and 5 help foster parents learn to follow children's lead with delight. Sessions 7 and 8 help foster parents override their own issues that can get in the way of providing nurturing, sensitive care. Sessions 6, 9, and 10 provide connections between and reinforcement of issues.

The sessions are implemented in families' homes; foster parents, their children, and others in the home, are included in sessions. In the case of Jason and his foster mother, the interventionist (or parent trainer) went to Charlene's house to meet with Jason and Charlene. In other cases, as many as 6 children and 3 adults have been included in sessions. Given the research on context-dependent learning (Bouton, Woods, Moody, Sunsay, & Garcia-Gutierrez, 2006), we consider it critical to have foster parents work on changing their parenting under conditions most similar to their usual home life. If foster parents were to come into an office or clinic with their foster child to work on skills, it would be less likely that the skills would generalize to their behaviors at home. Similarly, if foster parents were to be trained before having a foster child placed in their home, it would be unlikely that training would carry over into daily life.

Foster parents participate in a number of activities with their foster children through the intervention. Some of the activities are intentionally provocative. For example, we ask foster parents to follow their children's lead as they make pudding. During this activity, foster parents are asked to follow along with the child's cues, show delight in the child's efforts, and provide support for the child when necessary. This pushes the limits of what even highly sensitive parents can manage. Many parents tend to be overly directive or controlling because they want to complete the task or want to prevent their child from making a mess. After foster parents learn to take delight as they follow their child's lead during such a task, following the lead in everyday contexts often seems easy. Nonetheless, it is critical that parents recognize that the objective is not to engage in occasional or special activities such as making pudding with their child more often but rather to follow the child's lead and delight in their ordinary interactions.

The interventionists, or parent trainers, help parents to make changes in several ways. First and most important is providing in-the-moment feedback. Parent trainers highlight the intervention components by commenting on foster parents' interactions with their children as they observe them. For this to be effective, it is critical that parent trainers are supportive and positive and that they notice foster parents' strengths. For example, as Charlene struggled to follow Jason's lead in the pudding activity, the parent trainer commented on such things as how Charlene lit up when Jason turned to her and the smile on Jason's face when Charlene copied Jason's behavior by banging the spoon on the side of the bowl. For example, the parent trainer noted, "I just have to stop to say what a wonderful example that was of your following Jason's lead. He held out the spoon for you to lick and you put it right in your mouth. Did you see that smile on his face?" By highlighting these examples, parent trainers help foster parents become less threatened by the parent training and accentuate their strengths. Video feedback is used in similar ways. After specific activities, parent trainers use brief video segments of the past and current sessions to highlight foster parents' strengths.

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Young children in foster care often experience dysregulation.

Evidence of Effectiveness

We have tested the effectiveness of the ABC intervention in randomized clinical trials with both foster parents and neglectful birth parents, and the results provide strong evidence of the intervention's effectiveness. First, we found that the intervention enhances neuroendocrine regulation among children in foster care whose foster parents

received the ABC intervention, compared with children whose foster parents received a control intervention (Dozier et al., 2006; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008). The production of cortisol among children whose foster parents received the ABC intervention resembled the cortisol production of low-risk children. Furthermore, attachment security, as assessed through parental diary report, was enhanced among children whose parents received the ABC intervention relative to those who received the control intervention (Dozier et al., 2009).

The ABC intervention was adapted for birth parents whose children returned home to them after foster care placement and for birth parents monitored for neglect. Again, neuroendocrine regulation and attachment organization were enhanced among children whose parents received the ABC intervention relative to the control intervention. Assessing children's attachment through the Strange Situation (Ainsworth, Blehar, Waters, & Wall, 1978), we found that fewer children whose parents received the ABC intervention showed disorganized attachment than children of parents who received the control intervention (Bernard, Dozier, Bick, & Carlson, 2010). Furthermore, children whose parents received the ABC intervention showed less cortisol reactivity after the Strange Situation than did children from the control intervention (Bernard & Dozier, 2010). The dampened cortisol reactivity shown by children in the ABC group resembled the normative pattern of children whose parents serve as effective buffers of stress (Bernard & Dozier, in press-a; Hertsgaard et al., 1995).

The ABC Intervention With Jason

As with every foster parent and child with whom we intervene, we tried to identify the central issues for Jason and Charlene early and develop a strategy for addressing them while adhering to the manualized intervention. Two issues were especially salient for them. First, Jason turned away from Charlene, suggesting through his behavior that he did not need nurturing care. Second, Charlene had difficulty following Jason's lead. We set out to change these two things while remaining open to the possibility that we would need to update our conceptualization of Jason and Charlene.

In Sessions 1 and 2, Charlene and the parent trainer discussed Jason's alienating behaviors as resulting from his history of difficult early experiences. As expected, Charlene found it easy to reinterpret his behavioral signals, providing nurturance even when he did not elicit it. She was able to gradually and gently provide nurturance without pushing or coercing Jason. In a little over a week, Jason was beginning to look to Charlene for comfort more than he had initially. Although this concept was especially intuitive for Charlene, we find that these first two sessions rarely threaten parents. The focus is primarily on the child rather than the parent and thus provides a relatively safe place to start. Focusing as we do on strengths of the parents, they often become very engaged and invested by the time we have shifted to a focus more on their behavior than on that of the child.

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Foster care for infants and toddlers is fundamentally different than foster care for older children.

In Session 3, the parent trainer introduced the importance of following Jason's lead and delighting in him. As expected, Charlene found this issue more challenging than providing nurturance. Charlene explained that she was concerned that Jason was at risk for developmental delays and that it was important that she provide a "stimulating environment for learning." When reading a book together, Charlene asked Jason to name colors and shapes, even when he showed little interest. Rather than point out how Charlene was taking the lead, the parent trainer pointed out that Jason turned toward her when she briefly followed his lead, smiling at Jason when he took a shape out of the book and banged it against her knee. The parent trainer helped Charlene recognize how much more engaged Jason became when she followed his lead. They watched this example together many times through video feedback and contrasted it with times when Charlene was leading. Charlene gradually began to allow Jason take the lead more. Sessions 4 and 5 gave Charlene more practice in delighting in Jason while following his lead. She continued to struggle at times but made steady improvements. By Session 5, Charlene even started to catch herself leading and said, "Oh, there I go again! I'm supposed to be following, aren't I?" Still, this remained the most challenging issue into Sessions 7 and 8.

The parent trainer went into Session 7 with two video clips: one in which Charlene had followed Jason's lead with delight and one in which she tried to get Jason to name the animals in a book. Charlene was asked to think of whether her parents delighted in her and followed her lead when she was a child. She immediately thought of times when she felt "squelched" by her parents when she was excited about something and times more recently when she had seen her mother taking the lead with her nephews. The parent trainer talked about these experiences as representing "voices from the past" when Charlene was interacting with Jason. Her automatic response was to behave in accordance with these voices from the past. The parent trainer talked with her about overriding this automatic response, delighting in Jason even though she felt as if she should direct his activity. Charlene began to become aware that she had responded to Jason almost reflexively at times. As she became aware of how her parents' behaviors affected her parenting behaviors, she became better able to override the voices from the past. The most important offshoot of this was that she began to follow Jason's lead rather than teaching him, finding the new style of interactions engaging and rewarding.

Sessions 9 and 10 helped Charlene consolidate the gains she had made through the first

8 sessions. Although the sessions had specific content related to physical touch and expression of negative emotions, their primary role was to help Charlene continue to practice following Jason's lead with delight. By Session 10, it seemed that Charlene would continue the new behaviors long after training.

System of Care Issues

We have presented evidence that the ABC intervention is effective in enhancing children's attachment and neuroendocrine functioning. There are few evidence-based practices for this population, and we consider the intervention important. Nonetheless, we are aware that this intervention must be implemented in the context of a system of care that serves the needs of young children well. We feel that we would be remiss if we did not point out how critical such issues are.

Zeanah and colleagues (2001) have suggested the importance of thinking of foster care for infants and toddlers as fundamentally different from foster care for older children. Young children are biologically dependent on their caregivers, so they need a constant, stable, loving caregiver. Infants are unable to keep parents "in mind" for long periods of time in the parents' absence (Kagan, 2008). That is, when parents are absent, young children can no longer hold onto their image—and cannot hold on to the hope that they will return. Whereas older children often hold on to the hope of being reunited with birth parents, infants do not have this capacity. Thus, for infants in foster care, a committed, loving foster parent and stability of placement are critical.

Babies and young children need someone who feels a strong connection to them. We have found that foster parents who are more highly committed to their foster children show greater delight in their children behaviorally than foster parents who are not as committed (Bernard & Dozier, in press-b). Children whose parents are more committed show fewer behavior problems than other children (Lindhiem & Dozier, 2007), and children whose parents are more accepting of them show higher levels of self-esteem than other children (Ackerman & Dozier, 2005). When foster parents are more highly committed, the relationships are less likely to be disrupted than when foster parents are not highly committed (Dozier & Lindhiem, 2006). One of the characteristics of foster parents that predicts commitment is how many children a foster parent has fostered previously; the more children fostered previously, the lower the commitment (Dozier & Lindhiem, 2006). Although Jason was eventually placed with Charlene, a highly committed foster parent, his first placement with Betty, a foster parent with low likelihood of committing to his care, might have been avoided.

At times, the foster care system functions in ways that support commitment, but at other times, the foster care system may undermine foster parents' commitment to their children. Foster parents are sometimes told not to become attached or not to think of children as their own. Given how critical a committed caregiver is for infants and toddlers, we suggest that the system of foster care might need to be reconfigured with developmental needs in mind. Rather than rely on a highly professionalized and small cadre of individuals who have fostered many children, it may make sense to "cast the net more broadly." People who may not have seen themselves as foster parents might be recruited to foster one or two children in their lifetime. Instead of being told that they should not become attached to these children, perhaps foster parents should be encouraged to become attached, knowing that the children might well return to their birth parents. If ongoing contact with birth parents is encouraged, the foster parents could develop relationships that serve important functions. For example, birth parents might be able to rely on foster parents for support in times of stress, and foster parents might be more likely to become highly committed, knowing that they could remain involved with the child over time. Most important, however, children's chances of having a strongly committed caregiver will be enhanced.

Placement stability is also critical for infants and young children in foster care. Children who experience multiple foster placements are at increased risk for problematic outcomes (Lewis, Dozier, Ackerman, & Sepulveda-Kozakowski, 2007; Newton, Litrownik, & Landsverk, 2000; Rubin et al., 2004; Rubin, O'Reilly, Luan, & Localio, 2007). Given that the infant considers the person who has been caring for him or her as the parent, the experience of loss is likely just as devastating when the infant is moved from a loving, committed foster parent as when he or she is moved from a committed biological parent.

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Children whose foster parents are more committed show fewer behavior problems than other children

Decisions about the placement of young children are sometimes made with developmental needs in mind, and sometimes not. Sometimes young children are moved with little warning from one foster home to another or from a foster home to the home of a biological relative. From an infant's point of view, biological relatedness is inconsequential. Therefore, decisions to move young children from a potentially adoptive home to the home of an uninvolved relative should be made with developmental needs in mind.

Summary

The ABC intervention targets issues that have been identified as being specifically problematic for infants and toddlers in foster care. Foster parents are helped to provide nurturing care even if the child does not elicit it, and they are helped to follow children's lead with delight. Results of randomized clinical trials offer evidence of enhanced attachment quality and neuroendocrine regulation among children whose parents received the ABC intervention. Although these results are exciting and important, we suggest that is it also critical to address foster children's needs for committed parents and stable placements, which may require changes to child welfare system policies.

Learn More

Infant Caregiver Project
http://icp.psych.udel.edu
The Infant Caregiver Project at the University of Delaware is a developmental psychology laboratory directed by Mary Dozier. The project's research concerns the development of children who have experienced early adversity and the effectiveness of parent training programs for improving developmental outcomes among these children.

Mary Dozier, *PhD, is the Amy E. DuPont Chair of Child Development in the Department of Psychology at the University of Delaware. She studies the development of infants and young children who have experienced maltreatment and disruptions in their relationships with caregivers.*

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Parents Were Children Once Too

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When babies and toddlers are abused and neglected by the people who brought them into the world observers' sympathies naturally go to the children. Children cannot defend themselves against aggressors who are much bigger and more powerful than they are. They cannot understand why they cry and no one comes or are hungry and no one feeds them. Why would anyone fail to nurture and protect these small precious beings? It is only by looking at the long-term effects of childhood trauma that professionals begin to appreciate the reasons why some parents cannot provide safe loving homes for their children.

Professionals working with families who come to the attention of the child welfare system need to look deeper than the allegations made about the parents' failure to protect their children. Very often they are themselves victims of childhood trauma. The lessons they learned in childhood prepared them for early parenting, intimate partner violence, intractable poverty, substance abuse, and child maltreatment. If professionals hope to interrupt the intergenerational transmission of child abuse they need to uncover the stressors that are influencing parents' ability to be appropriate caregivers for their children. With a better understanding of parents' trauma histories professionals can craft interventions that have some hope of safely reuniting the parents with their children, or, at the very least, permitting them to have an ongoing relationship with their children even if they cannot be the day-to-day parents.

Parents learn how to be parents from their own experience of childhood. In a 2010 ZERO TO THREE survey, more than 80% of parents of infants and toddlers reported their parents as important influences on their own parenting (Hart Research Associates, 2010). This is true in happy families and it is no less true in families where children are abused or neglected. Having grown up in an environment where family meant danger or indifference, survivors of abuse and neglect approach parenting with disabling wounds. Memories of childhood maltreatment manifest themselves in many of the same behaviors that were so destructive to today's parents when they were children.

In a major retrospective study of adults conducted at Kaiser Permanente in San Diego, investigators surveyed 17,000 members of the health maintenance organization on their exposure to 10 adverse childhood experiences (ACE):

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- Emotional neglect
- Physical neglect

Abstract

Parents who love their children sometimes harm them. They harm them by physically or sexually abusing them and by failing to provide the nurturance that children have the right to expect. They neglect and abuse their children because they lack the necessary combination of knowledge, patience, empathy, and problem-solving capabilities. Intervening effectively requires a careful assessment of the parents' lives, both past and present. This article provides an overview of the overarching problems maltreating parents bring to their interactions with their young children.

Photo: Marilyn Nolt

Parents who abuse their children are often the victims of childhood trauma.

- An alcohol and/or drug abuser in the household
- An incarcerated household member
- A member of the household who is chronically depressed, mentally ill, institutionalized, or suicidal
- Mother is treated violently
- One or no parents (Middlebrooks & Audage, 2008)

Each factor was separately tallied and each study participant was given an ACE score of the number of separate ACE they reported experiencing as children. The prevalence of child abuse and neglect found among the study sample suggests that official statistics dramatically underestimate the prevalence of child maltreatment (Felitti, 2002). The most striking finding was that 22% of the respondents had been sexually victimized as children.

ACE exposure was linked to:

- Teen pregnancy
- Sexual behavior
- Alcoholism
- Stability of relationships
- Risk of revictimization
- Mental health problems (Anda, 2007)
- Suicide attempts: between 67% and 80% of all suicide attempts were attributable to ACE (Felitti, 2002).

When the investigators correlated the number of ACE with the patients' current medical status their findings confirmed that the more troubling the childhood, the greater the number and severity of medical and psychological conditions in adulthood. Of special note here are the findings related to alcohol and drug use. Adults whose parents abused alcohol when the study participants were children were more likely to be depressed as adults (Redding, 2003). Childhood sexual abuse was much more likely when the parent was an alcoholic (Redding).

Fetal Alcohol Spectrum Disorders

Substance abuse is a factor in the vast majority of child maltreatment cases. In cases involving infants and toddlers this fact raises the specter that alcohol and drug use probably began before the children were born. Prenatal alcohol use causes permanent damage to the developing brain (Herrick, Hudson, & Burd, this issue, p. 44). It is estimated that 1 in 100 U.S. adults has been exposed to alcohol prenatally (Burd, Cotsonas-Hassler, Martsolf, & Kerbeshian, 2003). There has been very little focused research done on the prevalence of prenatal alcohol exposure. In a study of a related group, incarcerated juveniles, 23% of the youth were diagnosed with a Fetal Alcohol Spectrum Disorder (FASD; Fast, Conrey, & Loock, 1999). Although more work is needed to confirm these findings, this study suggests that almost 1 in 4 children in the juvenile justice system are victims. The close relationship between child welfare and juvenile justice populations leads to the hypothesis that similar prevalence exists among parents involved with the child welfare population.

Parents' own fetal alcohol exposure can interfere with their caregiving abilities. They are at heightened risk for substance abuse themselves because their prenatal exposure to alcohol predisposes them to seek it out. Years of inaccurate mental health diagnoses compounds the attractiveness of alcohol and drugs. They have difficulty with memory and paying attention. Developmentally they remain many years younger than their chronological age. They have impulse control issues which lead to:

- Irritability
- Aggression
- Episodes of rage
- Promiscuity
- A lot of time spent in the principal's office, in in-school detention, suspension, and ultimately expulsion if their aberrant behavior is dangerous enough
- Delinquent acts as adolescents that turn into repeated offenses as they age, escalating the legal consequences with each arrest
- Unreliable memory. They may remember on Monday but forget on Tuesday or remember the appointment but forget where they are supposed to go (Hudson, Burd, Kelley, & Klain, in press)

Secondary characteristics develop when the person is repeatedly diagnosed with problems that don't address the underlying neurological deficits caused by fetal alcohol exposure. The misdiagnoses lead to therapeutic interventions that ask people affected by FASD to change their behavior. Because the behavior is caused by permanent brain damage, such behavioral interventions cannot work. Secondary symptoms include:

- Fatigue
- Anxiety
- Aggressiveness
- Destructiveness
- Social isolation
- Family or school problems (e.g., fighting, suspension, expulsion)
- Trouble with the law
- Depression

People affected by FASD do not accurately read other people's behavioral cues. They cannot apply the lessons learned in one situation to another similar situation. They are easy victims because they are so suggestible. More than 70% of adolescents and adults with FASD were physically or sexually abused as children (Kelly, 2005).

Child Sexual Abuse

The link between child sexual abuse (CSA) and many of the other risk factors for becoming an abusive or neglectful parent is very strong. One retrospective study found that maltreating mothers were 8 times more likely to have been incest victims (Spieker, Bensley, McMahon, Fung, & Ossiander, 1996). Among the adult problems of CSA survivors are:

- Posttraumatic stress disorder
- Suicidal behavior
- Depression
- Anxiety
- Low self-esteem
- Dissociation
- Obsessive–compulsive disorders
- Phobias
- Paranoid thoughts
- Substance abuse
- Eating disorders
- Personality disorders (Roberts, O'Connor, Dunn, Golding & The ALSPAC Study Team, 2004)
- Increased risk for marrying an alcoholic (Middlebrooks & Audage, 2008)

The amount of adult dysfunction is mediated by a number of factors including the

duration of the abuse (e.g. one incident of rape by a stranger vs. an ongoing pattern of abuse inflicted by a parent), the child's relationship to the perpetrator, and the reaction of adults if the abuse is discovered (Hindman, 1999).

CSA does not lead parents to any one specific type of maltreatment (e.g., abuse, neglect, incest) but survivors are at high risk for poor parenting (Spieker et al., 1996). Higher frequency and longer duration of CSA are related to increased symptoms for victims.

For many victims of sexual abuse the rage incubates over years of façade, coping, and frustrating, counterfeit attempts at intimacy, only to erupt as a pattern of abuse against offspring in the next generation. The ungratifying, imperfect behavior of the young child and the diffusion of ego boundaries between parent and child ... provide a righteous, impulsive outlet for the explosive rage (Summit, 1983).

CSA is strongly linked with teen parenting (Spieker et al., 1996). As parents, CSA survivors who began having children as teenagers are less in tune with their children and are less responsive to their children's needs. Adults who were sexually abused as children use more punitive child-rearing practices and physical methods of discipline (Mapp, 2006). Having never had their personal boundaries respected, they are disrespectful of the child's boundaries. Unable to appropriately read a baby's cues, they are physically intrusive (e.g. they poke and prod, disrupt sleep, and ignore signs that the baby has had enough to eat).

Maternal Depression

Maternal depression coexists with every other risk factor described in this article. Experiencing child maltreatment between birth and age 2 years is associated with depression in adulthood (Cooper, Banghart, & Aratani, 2010). Women who were victims of CSA were found to be at increased risk for maternal depression (Mapp, 2006).

The childhood experience of the mother leads to increasing risks for her children:

- Maternal depression during the prenatal period is associated with complicated deliveries and after birth with crying, fussiness, and inconsolability in newborns (Vericker, Macomber, Golden, 2010).
- Four out of every 10 poor infants lives with a depressed mother (Vericker et al.).
- Almost half (48%) of parents evaluated by the Early Head Start Research and Evaluation Project were found to be depressed (Knitzer & Perry, 2009).
- Depressed mothers are at increased risk for committing physical abuse (Jones Harden, 2007).
- Substance abuse and domestic violence frequently occur in homes with depressed mothers (Mapp; Vericker et al.).

Historical Trauma

Historical trauma is a term that describes the emotional weight carried by people whose race, religion, sexual identity, or ethnic heritage has resulted in victimization of entire groups over extended periods of time. Members of groups who have weathered discrimination for generations live with the reality that the dominant U.S. culture does not view alternate world views as equally valid (Robinson & James, 2003). Worse, most members of the dominant culture do not even understand that they have privileges not available to members of minority groups.

Life in the U.S. is easier for white middle class Americans than it is for people of color, non-Christian religions, non-European forebears, nonheterosexual orientation, or subjugated indigenous civilizations (e.g., Native Americans, Native Hawaiians).

Social privilege is usually something that facilitates the optimal development of an individual, increases access to societal opportunities, or simply makes life easier but is not acquired by virtue of merit or personal effort. It is gained simply by being a member of the group that is privileged... The privileged characteristic is legitimized as the norm and those who stand outside of it are considered deviant, deficient, or defective (Greene, 2003).

A simple example illustrates this concept: many Americans grew up when the rosy colored bandages still sold today were marketed as "skin color" as though there were only one skin color in the U.S.

Related to the traumatic baggage the parents carry are the ways in which their normative cultural framework differs from the expectations of the dominant culture. The freestanding nuclear family is the cultural norm for white middle class society. Extended family and important—but not blood-related—friends play critical nurturing roles in ethnic minority families (Lewis & Ippen, 2007). When helping professionals assume that all successful families will be freestanding nuclear families, they unintentionally undermine the family's identity and overlook potential protective factors.

Historical injuries often begin under the sponsorship of the government and become embedded in widely held beliefs. Other longstanding prejudices represent the dominant culture's dismissal of cultural or religious beliefs different from its own:

- The forebears of most African-Americans were brought to the U.S. as slaves and subjugated for hundreds of years. The end of slavery did not lead directly to equality. African-Americans still confront racial stereotypes that question their intelligence and capabilities.
- After September 11, 2001, hate crimes targeted people who were perceived as Arabs; prejudice still equates the entire Muslim religion with Al Qaeda.
- Native American tribes were decimated by warfare and genocidal actions. In the 1870s, the U.S. Bureau of Indian Affairs opened boarding schools. The founder of the boarding schools described the mission of these schools: "Kill the Indian in him, and save the man" (Bear, 2008). Children were removed from their families as young as 5 years old. Students at the boarding schools were punished if they were discovered speaking their tribal languages. They were forced to cut their hair and give up the cultural traditions of their people. These attempts to eradicate Native American cultures took a tremendous toll on the children. As parents and grandparents, they suffer emotionally, conflicted about whether they should pass on the lessons learned in boarding school or celebrate their rich tribal heritages as they raise their families.
- In Hawaii, there were also laws banning native language in schools where children

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Attempts to eradicate Native American cultures took a tremendous toll on the children.

Photo: ©iStockphoto.com/Catherine Yeulet

Substance abuse is highly correlated with child maltreatment.

were beaten for speaking their language. To protect their children, parents didn't speak the language any more to children to prevent the beatings. Native Hawaiians expressed a cultural survival instinct by supressing the transmission of cultural beliefs and practices so the next generation would survive the assault of the dominant alien culture (Kenui, 2003; M. Taum-Deenik, personal communication, October 28, 2010).

These few examples only begin to illustrate the ways in which historical trauma might affect parenting. Professionals working with families must ask themselves, "Does the clinical intervention with these children and their caregivers—to assist with their individual experiences of grief, bereavement, and trauma—impact what might be the more powerful ethnic and cultural legacies associated with the trauma?" (Lewis & Ippen, 2007).

Domestic Violence

Intimate partner violence is experienced by the child as a form of child maltreatment. The behavior of the parents threatens the young child's innate knowledge that his parents will keep him safe (Lieberman, Briscoe-Smith, Ippen, & Van Horn, 2006; Lieberman, & Van Horn, 2007). Witnessing or experiencing violence is a major risk factor for growing up to become abusive in intimate relationships (National Center for Injury Prevention and Control, 2009). The ACE Study found correlations between the number of adverse childhood experiences and the likelihood of perpetrating or experiencing intimate partner violence. In fact, childhood exposure to domestic violence, physical abuse, and sexual abuse made women 3.5 times more likely to be victims of domestic violence as adults (Middlebrooks & Audage, 2008). Adult victims suffer from low self-esteem, eating disorders, and depression. They are at risk for suicide (National Center for Injury Prevention and Control).

Poverty

"Poverty has a particularly pernicious effect on development when it is experienced during the early years" (Jones Harden, 2007). Being born poor is a good predictor of later poverty. The risk is cumulative (i.e., the more years the child spends in poverty the worse her adult outcomes). Such adults are less likely to graduate from high school and they continue to be poor as adults. Adolescent childbearing is 3 times more likely among women who were born poor (Ratcliffe & McKernan, 2010). Poor women who are mothers of infants and are suffering from severe depression are more likely to be dealing with domestic violence and substance abuse (Vericker et al., 2010).

Parents Who Abuse or Neglect Their Children

Parents who maltreat their children are likely to have been raised in families where they themselves were maltreated. "Mothers with a history of abuse reported less supportive relationships with their parents, more family abuse dynamics, more pre-pregnancy drug use, and more foster care, compared to mothers with a history of no abuse" (Spieker et al., 1996).

Mothers who experienced child maltreatment are likely to use punitive parenting behaviors. The relationship between such mothers and their children is characterized by an insecure attachment. The child can never be sure of his parent's responses to him and he develops coping strategies to insulate himself from harm. These coping strategies can make him hypervigilant, withdrawn, depressed, angry, and anxious.

A history of childhood physical abuse is closely associated with becoming physically abusive as a parent (Jones Harden, 2007). Parents who physically abuse their children share several characteristics:

- Impaired social skills
- Impaired cognitive skills
- Poor problem-solving skills

Their view of their children's "bad" behavior comes from their unrealistically high expectations for how their children should behave (Jones Harden, 2007). Their problems with parenting center around their very negative perceptions of their children. They perceive their children's actions as a threat or stressor. They think that their children's transgressions are worse than other children's. They expect their children to have higher levels of behavior problems and noncompliance than other people's children.

Adults who experienced emotional neglect as children also carry the trauma forward into adulthood. They tend to begin parenting at a very young age. They suffer from low self-esteem and are very likely to experience maternal depression and substance abuse. They possess very little knowledge about child development and are not able to muster the empathy necessary to be nurturing parents. They have inflexible and inaccurate ideas about why people behave as they do, which impairs their expectations of their children's behavior. Neglectful mothers are less developmentally appropriate with their infants and less responsive to their babies' signals. Young mothers don't provide appropriate supervision of their children, putting the children at risk for injury. They tend to be less motivated and to possess fewer problem-solving and social skills (Jones Harden,2007).

Putting the Pieces Together

The impact of negative parenting is quickly apparent in children. In a study tracking children from birth through age 4 years, children of CSA survivors exhibited more problems generally and more problems specifically related to conduct, peer interactions, and emotional adjustment (Roberts et al., 2004). It comes more naturally to professionals to appreciate the need to intervene on behalf of young children because they understand the connection to school success and adult productiveness. Professionals need to become equally attuned to the challenges the parents carry forward with them from their earliest experiences.

The diagnostic tool box must expand. Good child welfare practice requires an assessment of the child's well-being that includes both a medical examination and a developmental screening and services as necessary. Parents should be encouraged to participate in similar evaluations. Medical conditions can cause depression and uncontrolled anger. Mental health considerations should include the full spectrum of possible stressors described in this article. Research into child abuse cases that ended with the child's death offers important insights into working effectively with families:

- Use risk assessment instruments, checklists, and guidelines when evaluating

family functioning. The use of intuition "is a hazard, a process not to be trusted, not only because it is inherently flawed by 'biases' but because the person who resorts to it is innocently and sometimes arrogantly overconfident when employing it" (Munro, 1999).

- Examine all the evidence before reaching a conclusion and keep an open mind. Munro found a disturbing trend to rely on first impressions of families that were not revised despite new evidence that should have raised red flags. More troubling was the social workers' unwillingness to believe things that conflicted with their initial impressions.
- Reevaluate the family's strengths and challenges regularly. Look for patterns of behavior over time rather than basing decisions only on present-day issues.
- Incorporate research findings about risk factors for child maltreatment into analysis of each family's circumstances. More than half of Munro's study sample failed to take into account the significance of known risk factors.
- Review written records. Witnesses are unreliable for a host of reasons including their feelings about the parents and the children.

Identifying parents who may have disabilities caused by fetal alcohol exposure is a critical step. Treatment planning for people with FASD-related cognitive and information processing deficits will look very different from treatment planning for people who have the ability to learn from their mistakes, predict the future on the basis of past experiences, and remember instructions. There is currently no universal testing protocol for maternal use of alcohol during pregnancy or any universal screening of newborns. Learning about prenatal alcohol exposure will require sensitively and specifically asking questions to reach accurate calculations about maternal drinking. Simply asking, "Did you (or your mother) drink during pregnancy?" is likely to garner a one word negative reply. Many people consider drinking to involve "hard" liquor only. Beer, wine coolers, and hard lemonade are not necessarily considered by people when asked if they drink.

Substance abuse, although not specifically called out in this article, is very frequently associated with the traumatic events and conditions described. It is highly correlated with child maltreatment. However it is a mistake to attempt to mandate sobriety without addressing the underlying problems. Alcohol and drugs are used to make otherwise unbearable circumstances bearable. Unless and until the painful memories and current stressors are addressed, substance abuse will continue to be the chief symptom of the parent's dysfunctional relationship with her child.

Photo: ©iStockphoto.com/Daniel Bendiy

More than 80% of parents of infants and toddlers reported their parents as important influences on their own parenting.

Building a healthy parent–child relationship requires a focus on that relationship. Professionals can support this goal through:

- Child–parent psychotherapy
- Parent–child contact that includes a therapeutic or coaching component
- Foster placements either for parents and child together, or where the foster parent mentors the birth parents, or both
- Recognition and support of parents in coming to terms with their traumatic histories

Many of the parents who come into the child welfare system are very damaged by their experiences in life. Some of them are so damaged that they may never be appropriate caregivers for their children. Without careful analysis of their unique situation and structured support that addresses their deepest problems, it is impossible to know whether or not they can safely care for their children. Respecting their strengths—as well as recognizing their challenges—gives them dignity. In the end, professionals' respect for their efforts to succeed as parents may be all they can offer. That is not an inconsequential act. But if professionals are able to help parents overcome their challenges so they can raise their children, that is a true gift to parents, children, and society.

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A Call to Action for Infants and Toddlers in Foster Care

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Abuse and neglect—and how our child welfare systems often respond—threaten the healthy future of thousands of infants and toddlers. Their brains are developing at life-altering rates of speed. Maltreatment chemically alters that development and can lead to permanent damage to the brain's architecture. Every year, 196,476 children from birth to 3 years old come into contact with the child welfare system (U.S. Department of Health and Human Services [DHHS], 2010b); 76,862 are removed from their parents' care (DHHS, 2010a).

As a society, we have a moral imperative to protect children. This is especially so in cases where it is determined that children need to be removed from their parents or caregivers. We must do all that we can to ensure that all children are in a safe environment and that no child falls through the cracks. We cannot afford to discard potentially productive members of our workforce by ignoring their developmental needs. Put another way, we cannot afford to burden our economy with the demands that maltreated babies will make as they grow up. Costs associated with special education programs, foster care, incarceration, mental health services, drug and alcohol rehabilitation, and the risk of continuing the cycle of maltreatment with their own children are burdens our society can ill afford.

However, there has been no concerted effort to focus child welfare policy and practice on this age group with its unique developmental needs and opportunities. The threats to young children who are at risk for abuse or neglect or who are placed in foster care are significant; however, very few initiatives, policies, or practices recognize their special vulnerabilities. Current practices compound the effects of maltreatment. When young children are placed in nonfamily group settings, moved from home to home in foster care, denied developmental assessments and services, and kept from frequent visits with parents and siblings, developmental damage continues to escalate. We have an opportunity to protect these children and resolve the developmental damage caused by early maltreatment.

It is time for a call to action on behalf of these extremely vulnerable infants and toddlers and their families. The guiding principle: The care of very young children known to the child welfare system must be designed according to—and with the goal of meeting—their developmental needs. Policymakers at all levels of government and infant–toddler practitioners need to place a high priority on meeting the needs of this age

Abstract

Almost 200,000 infants and toddlers come into the child welfare system each year. They do so during the period of the most rapid brain development. Maltreatment can damage the architecture of the developing brain, with lifelong consequences for both baby and society. The child welfare system has not done well at addressing the developmental needs of infants and toddlers (in some instances, actually doing more harm). The author, the executive director of ZERO TO THREE, argues for a policy agenda making vulnerable infants and toddlers a priority and creating a developmental approach to their care, with a call to action for policymakers and practitioners to join this effort.

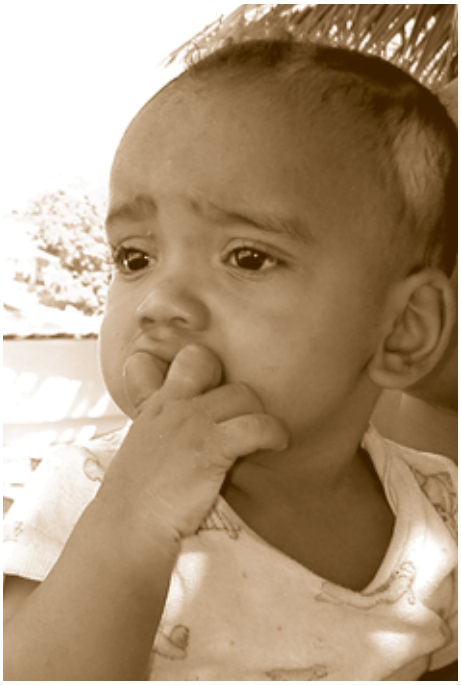

Photo: Marilyn Nolt

Infants are much less likely to achieve reunification with their families than children in any other age group.

group, raising awareness, designing policies, and implementing practices to ensure that (a) when infants and toddlers are known to the child welfare system but remain with their families, there are preventive services available to support the protective factors that promote healthy development; and (b) when infants and toddlers must be removed from their homes, the foster care that ensues and the supports offered to their parents will help heal the effects of maltreatment and support healthy development. The federal government should show leadership in creating such a focus. However, state and local child welfare agencies, as well as local communities and practitioners, are in a position to make real changes in how the needs of very young children and their families are met and should also move forward to meet this goal.

A Portrait of Infants and Toddlers in the Child Welfare System

Infants and toddlers are the largest single group of children entering foster care. Of the children who entered foster care during fiscal year 2009 (FY2009), 31% were less than 3 years old (DHHS, 2010a). Forty-five percent of all infant placements occurred within 30 days of the child's birth. Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer. Half of the babies who enter foster care before they are 3 months old spend 31 months or longer in placement (Wulczyn & Hislop, 2002). The most recent look at data on infants and toddlers in foster care, reported by Wulczyn, Chen, Collins, and Ernst (this issue, p. 4) shows that these trends continue.

Unquestionably, infants and toddlers are the most vulnerable age group (see box At a Glance). They constitute almost one third of all children who are abused or neglected. Of the estimated 1,740 children who died from abuse and neglect in 2008, more than three quarters (79.8%) were 3 years old or younger (DHHS, 2010b).

Children who initially enter the foster care system as infants have considerably different discharge patterns than their counterparts who enter foster care at older ages.

Infants are much less likely to achieve reunification with their families than children in any other age group. As Wulczyn and colleagues (this issue, p. 4) illustrate, infants who enter foster care before they are 3 months old are unlikely to return to their parents. For those infants who do achieve reunification, one third will re-enter the child welfare system (Wulczyn & Hislop, 2000). Almost half (49%) of the children waiting to be adopted in FY2009 were 3 years old or younger when they were removed from their parents or caretakers; 25% were less than 1 year old. However, only 2% of children adopted in FY2009 were less than 1 year old, because of the length of time it takes to go through the process leading to adoption (DHHS, 2010a).

Approximately one third of infants and toddlers investigated by child welfare services have a developmental delay. Data from the National Survey of Child and Adolescent Well-Being indicate that 35% of children from birth to age 3 years who were involved in child welfare investigations were in need of early intervention services. However, only a small number (12.7%) of these children in need were receiving the Individualized Family Service Plans to which they were entitled under federal law (Casanueva, Cross, & Ringeisen, 2008).

The Developing Brain Is Harmed by Abuse and Neglect

Neuroscientific research on early brain development indicates that young children warranting the greatest concern are those growing up in environments, starting before birth, that expose them to abuse and neglect. It is during the first years of life when the brain undergoes its most dramatic development and children acquire the abilities to think, speak, learn, and reason. Early experiences, both positive and negative, have a decisive effect on how the brain is wired (National Research Council & Institute of Medicine, 2000). In fact, early and sustained exposure to risk factors such as child abuse and neglect can influence the physical architecture of the developing brain, preventing infants and toddlers from fully developing the neural pathways and connections that facilitate later learning. Maltreatment experiences alter the brain's architecture (Shonkoff, 2007). These changes in the brain give rise to several psychological difficulties—cognitive delays, poor self-regulation, and difficulty in paying attention (Jones Harden, 2007).

At a Glance: Facts About Infants and Toddlers

- Children between birth and 1 year old have the highest rates of victimization (DHHS, 2010b).
- Infants and toddlers constitute more than one quarter of all children who are abused or neglected (DHHS, 2010b).
- Every day, 210 babies are removed from their homes because their parents cannot take care of them (DHHS, 2010a).
- Infants and toddlers accounted for 31% of children who entered foster care in 2009—the largest single group of children entering care (DHHS, 2010a). Sixteen percent were less than 1 year old.
- Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer (Wulczyn & Hislop, 2002).
- A total of 1,740 children died from abuse and neglect in 2008; more than three quarters (79.8%) of these children were 3 years old or younger (DHHS, 2010b).

Infants and Toddlers Need at Least One Nurturing Relationship to Thrive

The first relationships a child forms with adults have the strongest influence on social and emotional development (National Research Council & Institute of Medicine, 2000). Infants and toddlers rely on their closest caregivers for security and comfort. Those who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments (National Research Council & Institute of Medicine, 2000). They also show a greater capacity for self-regulation, effective social interactions, self-reliance, and adaptive coping skills later in life (Goldsmith, Oppenheim, & Wanlass, 2004). Those who do not form an attachment with at least one trusted adult suffer, and their development can deteriorate rapidly, resulting in delays in cognition and learning, relationship dysfunction, and difficulty expressing emotions. Young children

with unhealthy attachments are also at much greater risk for delinquency, substance abuse, and depression later in life. Researchers have found that approximately 82% of maltreated infants show disturbances in their attachment to their caregivers (Goldsmith et al., 2004).

Infants and Toddlers Are Vulnerable to the Effects of Maltreatment and Negative Experiences Related to Foster Care

Research indicates that each domain of developmental functioning is affected by the early experience of maltreatment. Negative foster care experiences may extend and compound these developmental impairments (Jones Harden, 2007). Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that may have precipitated out-of-home placement, can leave infants and toddlers dramatically impaired in their emotional, social, physical, and cognitive development (Lieberman & Van Horn, 2007). Research shows that young children who have experienced physical abuse have lower social competence, show less empathy for others, have difficulty recognizing others' emotions, and are more likely to be insecurely attached to their parents (National Research Council & Institute of Medicine, 2000). According to the National Survey of Child and Adolescent Well-Being, half of maltreated infants exhibit some form of cognitive delay. They are more likely to have deficits in IQ scores, language ability, and school performance than other children who have not been maltreated (National Research Council & Institute of Medicine, 2000). Maltreated infants and toddlers are also more likely to have physical health difficulties—greater neonatal problems, higher rates of failure to thrive, and dental disease.

Maltreated Infants and Toddlers in Foster Care May Not Realize Their Full Potential

The toll extracted by maltreatment and the inadequate response of the child welfare system through inadequate policies, programs, and responses can resonate throughout a child's life. Disproportionate exposure to early trauma and other developmental risk factors can result in a variety of mental health disorders. Physical abuse impairs a young child's social adjustment, including elevated levels of aggression that are apparent even in toddlers. Long-term negative outcomes include school failure, juvenile delinquency, substance abuse, and the continuation of the cycle of maltreatment into future generations. Too often, foster children become parents themselves too soon and have little experience with loving, nurturing relationships to guide their own parenting.

Research confirms that the early years present an unparalleled window of opportunity to effectively intervene with at-risk children (National Research Council & Institute of Medicine, 2000). Intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse. To be effective, interventions must begin early and be designed with the characteristics and experiences of these infants, toddlers, and families in mind (Jones Harden, 2007). If services are not provided until a child is 6, 7, or 8 years old, the most critical opportunity for prevention and intervention is missed (Infant Mental Health Project, Center for Prevention and Early Intervention Policy, 2010). A study of the cumulative costs of special education from birth to age 18 years found that intervening at birth resulted in lower costs over the course of childhood than services started later in life (approximately $37,000 when services were begun in infancy, 28% to 30% lower than when begun after age 6 years; Wood, 1981).

Given this window of opportunity, there are a number of ways that policymakers and practitioners can intervene to improve outcomes. The bottom line is that child welfare practices that are largely focused on child safety often are not structured to promote healthy development and the formation of a secure attachment. In fact, they may actually play a negative role in early development. A reorientation of thinking is needed to reform approaches to infants and toddlers who land in the child welfare system at such a developmentally critical time.

Toward a Developmental Approach to Child Welfare Policy and Practice for Infants and Toddlers

Elements of an agenda focused on infants, toddlers, and their families should follow a framework of guiding principles for infant and toddler development as well as knowledge of the protective factors that help families mitigate the trauma of maltreatment and provide a nurturing environment for young children.

- *Stable caring relationships are essential for healthy development.* At least one loving, nurturing relationship is the linchpin of positive early development. Federal, state, and local child welfare policies and practices should make supporting responsive, secure bonds between the youngest children and their parents and caregivers a central goal. Key areas of concern are as follows:
  - *Lack of emphasis and support for parental visitation.* Visitation, which has been called "the heart of permanency planning" (Hess & Proch, 1988), is widely viewed as the most important strategy for reunifying families and achieving permanency (Haight, Sokolec, Budde, & Poertner, 2001). Very young children need to see their parents every day if possible, and those visits need to be supported in ways that help repair and strengthen the parent–child bond. However, current state child welfare policies vary widely and may call for visits once a week or even less frequently. Little information is available on how often visits actually occur. For infants and toddlers, infrequent visits are not enough to establish and maintain a healthy parent–child relationship. Visitation for infants and toddlers should be as frequent as possible (e.g., daily or multiple times per week) and be conducted in locations that are familiar to the child (Jones Harden, 2007).
  - *Incidence of multiple placements:* Children in foster care frequently experience multiple moves. In one state, 25% of infants and toddlers had three or more moves within the first 3 months of care (Hornby, Zeller, & Cotton, 2009). Multiple moves place children at an increased risk for poor

Photo: Andrea Booher

The care of very young children known to the child welfare system must be designed with the goal of meeting their developmental needs.

Photo: Jonathan B. Rivera

Infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer.

outcomes with regard to social–emotional health and the ability to develop secure healthy attachments (Gauthier, Fortin, & Jéliu, 2004). When a baby faces even one change in placement, fragile new relationships with foster parents are severed, reinforcing feelings of abandonment and distrust. Even very young babies grieve when their relationships are disrupted, and this sadness adversely affects their development. Policies and practices for infants and toddlers in foster care need to be reoriented toward the goal of making the first placement the last placement.

— *Use of congregate care:* Some infants and toddlers are still placed in congregate care—group settings, typically with rotating, 24-hour child care staff (Jones Harden, 2007). Data suggest that institutional care for infants leads to a range of harmful developmental outcomes including motor and language delays and a variety of social–emotional deficits, such as lack of attachment, lack of a sense of trust, and absence of social play (Jones Harden, 2002). Researchers have also documented elevated levels of cortisol, a stress hormone, in these children. Although the use of congregate care facilities has increased over the past 2 decades because of the crack/cocaine and methamphetamine epidemics and the decrease in the number of available foster homes, no very young child should be placed in congregate care facilities unless in a facility with her parent (Jones Harden, 2007).

— *Length of time to permanency:* During the earliest years of life when growth and development occur at a pace far exceeding that of any other period of life, time goes by quickly. Babies can drift for years in foster care, from one foster home to another. Standard child welfare practice is to seek reunification when in the best interest of the child, but this may take several months or years. Concurrent planning for infants and toddlers is not systematically used, and often an alternate permanency plan is considered only when reunification fails to occur. Concurrent planning means that children have two permanency goals, typically reunification and placement with a relative. Both goals are actively pursued at the same time. Infants and toddlers need a stable, loving family as soon as possible. The shift in philosophy required by concurrent planning, coupled with real barriers including providing adequate supportive services to parents and locating family members or other potential adoptive homes, can be difficult to achieve. However, it creates opportunities for innovation in supporting young children and families and an impetus for robust efforts to provide services to parents. New models of foster parenting need to be explored so that, when initially removed from their parents, very young children are placed with families who are able to support reunification efforts with the parents but who would provide a permanent home if reunification is not possible.

- *Early intervention can prevent the consequences of early adversity.* Federal, state, and local policies, as well as child welfare practice, should ensure that the developmental needs of infants and toddlers, as well as those of their parents, are identified and addressed. This means routinely using screening and assessments and intervening early with developmental services. As noted by Hudson (this issue, p. 23), policy and practice at all levels must ensure a focus on the needs of parents as well as those of children. Often services are lacking, especially to strengthen the parent–child relationship. Without adequate supports for parents to provide a healthy environment for their child, very young children can suffer depression and other mental health problems. Practitioners and services for infant and early childhood mental health—which differ substantially from those for older children—are scarce. However, an overarching principle of infant mental health intervention is that relationships (e.g., between parent and child as well as between family and interventionist) are the conduit for change in the young children and families served (Jones Harden, 2007). For young children in child welfare, healing the relationship between the baby and parent is critical; however, services remain extremely limited and reimbursement

Learn More

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Join the ZERO TO THREE Policy Network and access resources and tools to help you in advocating effectively for infants, toddlers, and their families. Learn more about the public policy process and download tools to advocate for infants, toddlers, and their families. The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. The Policy Center brings to bear ZERO TO THREE's more than 30 years of research-based expertise on infant and toddler development to ensure that public policies reflect best practices and current research in support of our nation's very young children.

for child–parent therapy is often problematic.

- *Every child welfare decision and service should have a goal of enhancing the well-being of infants, toddlers, and their families to set them on a more promising developmental path.* Federal, state, and local child welfare policy, as well as practice, should be focused on building and maintaining a well-trained child welfare, social service, early childhood, and legal workforce educated in the science of early childhood development and informed by the most relevant and recent data. This would require ongoing training and continuing education, sound recruitment and retention policies, improved supervision, and appropriate workloads for workers.
- *Families and communities must be key partners in efforts to ensure the well-being of every child.* The child welfare system cannot go it alone. It is important that we support child welfare policy that seeks to encourage coordination among agencies whose goal is to assist at-risk families. Assisting at-risk families will require a comprehensive approach that seeks to "break down the silos" that currently exist. We should encourage and support the development of community-based networks of social service supports to assist infants, toddlers, and their families known to the child welfare system. For at-risk families with young children, building strong friendships and connections to their community that reduce isolation is critical to providing a network of support during challenging times.
- *Child welfare administration at the federal, state, and local level must include a focus on infants, toddlers, and their families in such functions as data collection, research, and attention to special populations.* Too often we find we just do not know enough about what is occurring with the youngest children in the child welfare system or about what works best in addressing their needs. The youngest children are overlooked in research design, data collection, and analysis. Placing a priority on addressing the needs of infants and toddlers in the child welfare system means ensuring that they are considered in every aspect of program administration.

A Call to Action

Every day in the United States, 210 infants and toddlers leave their parents and are placed in the care of someone else, often a stranger. We believe that these babies cannot wait until someone notices them later in their lives, most likely for the wrong reason. Accordingly, ZERO TO THREE has convened a national coalition of organizations that are leaders in child welfare policy, including the Child Welfare League of America, the Children's Defense Fund, the Center for the Study of Social Policy, and the American Humane Association, to develop and implement a shared child welfare policy agenda for infants and toddlers. The shared agenda will raise awareness of these critical issues and seek to make them a priority at all levels of government. Our ultimate goal is to ensure that the practices used in the child welfare system incorporate what we know from the science of early childhood development into what we do for the youngest children. Our national partners each bring their own historical knowledge, wealth of experience, and perspective about the needs of young children in the child welfare system, which is crucial in developing a joint agenda. Through this unique partnership, we hope to highlight and lend urgency to opportunities for both short- and long-term policy changes at the federal, state, and local levels to benefit infants and toddlers in the child welfare system.

It is clear that the effect of maltreatment and negative foster care experiences on healthy development can have lifelong implications if not properly addressed. We at ZERO TO THREE call on policymakers at all levels of government and infant–toddler practitioners to act now to ensure that our nation's most vulnerable infants and toddlers get the best possible start in life.

Photo: Andrea Booher

Each domain of developmental functioning is affected by the early experience of maltreatment.

Matthew E. Melmed, *JD, executive director of ZERO TO THREE, has significantly expanded the organization's impact in promoting the health and development of infants and toddlers. Mr. Melmed is committed to translating what we know into what we do for America's youngest children.*

Since 1995 he has guided the considerable growth of the organization's activities in support of professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers. Under his leadership ZERO TO THREE has launched a number of major programmatic and policy initiatives.

Mr. Melmed currently serves as the first elected chair of the Children's Leadership Council, a coalition of 55 leading national policy and advocacy organizations working to improve the health, education and well-being of America's children and youth. In addition, he serves as vice-chair on the board of Generations United and was recently elected a trustee of the Turrell Fund in New Jersey.

Mr. Melmed served for 13 years as executive director of the Connecticut Association for Human Services and prior to that was a managing attorney for Connecticut Legal Services. He is a Phi Beta Kappa graduate of SUNY Binghamton and received his Juris Doctor degree from SUNY Buffalo.

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Post-Adoption Depression

Clinical Windows on an Emerging Concept

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I thought I really wanted to be a mother. I had dreamed and planned for it for so long, but an hour after he was put in my arms I started feeling sick. I couldn't hold him or even hear his name without having a sick feeling in my stomach. At night it was better and I'd wake up feeling OK, but as soon as I started thinking about the day ahead and the feeding and changing, I'd start feeling so heavy, just such dread.

—Laura

These could be the words of a new mother with postpartum depression, but Laura became a mother through international adoption. Her story begins to give clinical insight into the experience of parents who struggle with depression following adoption.

At the airport where she first met her son, Danny, Laura became seriously ill with nausea and vomiting. Others thought she had the flu, but as she told me "I knew it wasn't a coincidence." The sick feelings continued for weeks, she lost 20 lbs., and she was admitted to a hospital for medical evaluation. When medical tests were negative, the focus shifted to Laura's emotional state, and she was put on medication and eventually found her way to the Early Connections program at the Center for Early Relationship Support, Jewish Family and Children's Service of Greater Boston (Spielman, 2002). Early Connections offers treatment to parents and their young children struggling with early relationship challenges, most often related to maternal mental health issues. Although we at Early Connections primarily see families formed by birth, our work with adoptive parents and children has given us the opportunity to see both the parallels between the depression/anxiety that surrounds birth and adoption and the particular stresses and challenges faced by adoptive parents.

In the months of my work with Laura, we came to understand some of the multiple meanings of Laura's reactions to becoming a mother, her visceral response of bodily terror and rejection, and her dread and anger about this dependent baby in her life. At some point in our work, Laura was reflecting back in time and said, "Do you think what I was going through was like a postpartum depression, only without the hormone part?" We agreed that the concept of post-adoption depression was a helpful way of framing her experience.

Research and Literature

I WAS SEEING Laura in 2000 and found that the literature had little to offer in the way of research on the post-adoptive emotional experience of parents. June Bond wrote an article for the adoption community in 1995 coining the term *post-adoption depression syndrome*, on the basis of her experiences as an adoption professional.

Abstract

In recent years, the concept of post-adoption depression—with both parallels and differences from postpartum depression—has emerged as a salient descriptor of the experience of a significant minority of newly adoptive parents. This article offers a clinical perspective on post-adoption depression through the stories of several families seen in parent–child psychotherapy. Adopting parents face potential challenges from multiple sources, such as personal histories, the context of emotional loss and legal uncertainty, and the demands on reflective function. Increasing awareness of post-adoption depression among providers and families can enhance possibilities for support and appropriate services.

Photo: ©iStockphoto.com/Sheryl Griffin

The lengthy history of disappointments, losses, and intrusion that precede adoption is a source of vulnerability.

In 1999, an Internet-based survey of parents adopting internationally found that 65% of responding parents reported significant depression (McCarthy, 2000). Gair's (1999) interview study of newly adoptive mothers identified 32% as scoring in the depressed range. Risk factors for depression among these mothers included lack of sleep, difficult infant temperament, and lack of support.

In the decade since these earliest citations, growing interest and visibility regarding post-adoption depression can be found on the Internet and in the popular press. Articles in the *New York Times* Health/Science section, mentions in *Oprah* magazine, and multiple Web sites and blog postings have given personal evidence for the existence of the phenomenon of post-adoption depression. The reports and conversations on the Web have created space for mothers to share their darker feelings post-adoption and to get support and reassurance that they are not alone and that their feelings have a name. In the past year, two research studies have been published that add data to support the existence of post-adoption depression and suggest that parental expectations (Foli, 2010) and environmental stressors (Payne, Fields, Meuchel, Jaffe, & Jha, 2010) play significant roles in its development.

The phenomenon of post-adoption depression has clear parallels to postpartum depression in parents' descriptions of their struggles and symptoms (McEnany, 2008). Low mood, tearfulness, difficulties eating and sleeping, disinterest in activities and people, anxiety, irritability, and guilt characterize both postpartum and post-adoption depressions. These similarities challenge the commonly held view of postpartum depression as a hormonally triggered event. Recent studies of postpartum depression have shown that the contribution of hormones may be quite minor (O'Hara & Swain, 1996). The principal risk factors seem to lie in the social and emotional realities of new parenthood. For our clinical program, seeing the similarities in struggles between newly adoptive mothers and newly partum mothers has helped clarify the powerful, destabilizing experience that becoming a parent can be, whether for the first time or subsequent times. This article offers windows into this phenomenon through the lens of clinical practice.

Laura's Story

As Laura shared the details of her journey to parenthood, a picture emerged of powerful ghosts in Danny's nursery (Fraiberg, Adelson, & Shapiro, 1975). In our mother–baby sessions, Laura told me of her years of infertility, her miscarriage, and the story of the baby she did not adopt. Some months earlier, a baby had been identified for Laura and her husband; they were thrilled beyond words, sent his photo to family and friends, and named him. While waiting for the bureaucratic process to move forward, they learned that this baby had been injured and had neurological symptoms of potentially serious consequence. Laura and her husband agonized over the decision and decided that they could not adopt this baby. In sharing this, Laura was wracked with self-hate and remorse, feeling that she had been weak and murderous and that she was to blame for the baby's injuries. What emerged was Laura's feeling that she—and the baby—had been punished because they'd named him for a relative of Laura's who was a controversial figure in her family of origin. After their decision to not adopt this ill baby, they wanted to move forward quickly, and the adoption agency soon matched them with another baby.

The couple's response this time was dramatically different, signified starkly in not naming Danny before he came home. Here now is a recent ghost inhabiting Danny's nursery—the conflicted feelings Laura had regarding the baby who was "damaged," whom they had chosen not to adopt. Her inability to feel open to Danny seemed linked in part to her guilt and unprocessed grief. This led to other layers of meaning and unresolved loss: Laura was deeply religious and had felt that her infertility was a sign that she was not meant to be a mother. She was going against this feeling in choosing to adopt, but the first baby's infirmity and then her own illness seemed proof to her that she should not have gone against nature and become a mother. Themes of damage, punishment, and guilt echoed back through several generations in Laura's history, particularly in the stories of mothers and their children.

The depth of Laura's ambivalence toward being with and caring for Danny was alarming to her husband and others in her family. They could not understand how she could have worked so hard for something and now seem not to want it. Their lack of understanding further isolated her and drove her into deeper feelings of shame and self-hate. This is a common experience for adoptive parents who cannot share their feelings of doubt and regret in the face of others' assumptions about their finally achieving what they had long awaited. Adoption agency professionals are often in this group of people with whom difficult feelings cannot be shared. Adopting parents fear that the adoption will not go forward if the agency knew of the parent's struggles.

Angela and Maria

Angela sought help from our program while in the process of adopting a 1-year-old daughter, Maria, through the public child welfare system. She was concerned about Maria's behaviors and talked openly about her struggles with feeling overwhelmed by this little girl's needs and confused about how to respond to her. Maria had been removed from her biological mother when she was 6 weeks old and lived in foster care for the next 9 months. Now, at home with Angela, she had long bouts of crying, angry outbursts, and fears of people. She was difficult to soothe, vulnerable to frequent illnesses, and unpredictable in her mood. In

our conversations, Angela was very careful in keeping the focus on Maria, and she let me know that she did not consider talking about her own history or life experiences as relevant. She was open, however, to my thoughts about the possible causes and feelings behind Maria's difficult behavior and easily shared her feelings of upset about managing Maria. She was angry at Maria's biological mother, who had been involved in drugs and criminality, and she worried that Maria's behavior was genetically based.

In these months of treatment, Angela's mood was changeable; she was often overwhelmed and exhausted and questioned her decision to take on this adoption. There were other times, however, when she expressed a strong sense of optimism that she and Maria were going to make it together. Hanging over our work and their relationship was the uncertainty of finalization; the child welfare social workers were requiring immediate biological family visitations for Maria before allowing the adoption to move forward. This was a source of constant stress for Angela—her relationship with her daughter was in legal limbo, and she felt powerless and angry. Her confusion about responding to Maria's needs would meet up with her frustration with the agency's obstacles and leave her regretting her decision to adopt Maria and considering "giving her back."

I had tread carefully with Angela, focusing on helping her make sense of others' behavior: that of both her daughter and the child welfare workers. However, I also shared with her my disagreement with the social worker's expectations and my view of Maria's critical needs, as those of a very anxious, dysregulated 1-year-old, for an environment of predictability and emotional safety. I felt committed to supporting Angela's stance with the child welfare agency, and I intervened with the staff on her behalf. This was an important piece of trust building between us as I learned later. She had, at that point, begun to share small bits of her own story with me, but she viewed these as off-topic, and in one session she apologized for talking about herself rather than what she termed, "Maria's attachment problems."

Our work shifted dramatically after the adoption finalization. When I arrived for a session to celebrate the court finalization, Angela greeted me with a notebook of handwritten pages that she asked me to read. She disappeared to attend to Maria while I read, and this became a ritual between us in this next phase of treatment: I would arrive and she would ask me to read what she had written during the week. Through this writing, Angela was able to begin to tell me her story, a story of early loss and trauma that she had never shared before. In the course of our sessions in those months, Angela identified her meeting Maria 14 months earlier as the trigger for deep feelings related to her past; our discussions began to loosen the tight walls she had erected against remembering the pain and losses of her own childhood.

Similarly to Laura, Angela made the comparison with postpartum depression, saying:

When Maria came to live here, I think I had a post-adoption depression and I didn't understand why. I thought it was because she was so difficult and I wasn't ready for her but now I think it's because getting to know her and her past stirred up my feelings about my past and my mother.

Angela's mother had abandoned her family when Angela was a baby, and she had been mistreated and terrorized by her older siblings, her father, and neighbors. She had survived sexual and emotional trauma through her sharp intelligence, fantasy life, and resilience, but at the expense of her emotional life, deciding that she had to pretend to be perfect to everyone. However, with no source of protection from her own past, how could she be a protective presence in Maria's life?

Being in such close proximity to Maria's difficult behavior—her crying, her outbursts, her fearfulness—had gotten through to Angela on an emotional level, triggering flashbacks and dissociative moments. Our discussions of the fears and confusion that Maria must be experiencing because of loss and abuse had been gradually taken in by Angela as being also about her own fears and confusion, the feelings of a small child without an anchor of love and safety in the world. After a year of legal uncertainty—an emotional rollercoaster—the finalization of the adoption seemed to give a level of security that allowed Angela to begin to acknowledge, first on paper and then aloud, the suffering that she had experienced as a child and to begin to have a full story of her own life, far from a perfect story, but one that helped her make sense of her experiences, her feelings, and her struggles.

Laura's and Angela's stories are quite different in many ways but are linked by the experience of a very challenging emotional adjustment to adoptive parenting that stirred old ghosts in such deep ways that mother, child, and the adoption itself were all in jeopardy; yet, in this process, there are also significant growth-affirming opportunities for these mothers, opportunities to re-feel, rework, and heal old wounds.

The Challenges of Adoption

Although there are clear similarities in these stories to those of women suffering from postpartum depression, adoptive parents face special challenges that can leave them vulnerable to anxiety and depression. Two factors noted in the case material bear highlighting. First, the often lengthy history of disappointments, losses, and intrusion (medical and otherwise) that can precede adoption is a source of vulnerability. The focus for months and years on a goal (first, pregnancy and later, adoption) takes time, energy, and money that leaves little left over for contemplating a real child that will come into their lives and stir feelings, potentially very complicated feelings. For adoptive parents, experiencing those feelings of regret, resentment, and doubt can be disorienting and shameful. The surrounding support system is often baffled and even impatient with any signs of unhappiness, intensifying the shame and isolation.

The second point relates to the legal context of adoption and the emotional consequences of this context. The uncertainty of permanent parenthood that is the hallmark of bringing an adopted child home is inherently stressful, and parents respond to this stress in different ways. For some parents, the ambiguity is managed through emotional distancing or withholding. For other parents, the anxiety of this time may be intense and generalize to other arenas of worry and fearfulness. The experience of being evaluated and watched is a source of stress and can exacerbate feelings of guardedness and mistrust. Adoptive

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Adoptive parents are forced into multiple experiences of powerlessness in the process of adoption.

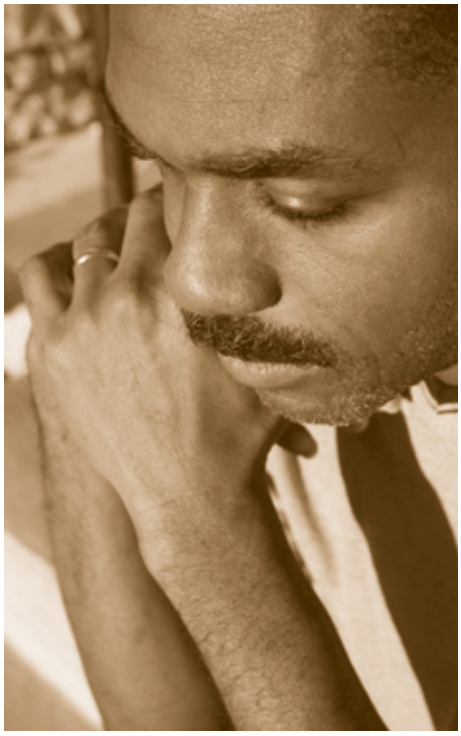


Photo: ©iStockphoto.com/Sheryl Griffin

The extra difficulties in parenting an adopted child can be sources of early strain for the mother or father.

parents are forced into multiple experiences of powerlessness in the process of adoption that can tax even the most functional personal coping systems. Symptoms of anxiety, numbing, anger, irritability, or a combination of these can develop in response to feeling powerless, and this may be an important dimension of a post-adoption depression.

Several themes related to maternal identity have emerged in my Early Connections work that may play a role in post-adoption depression. Adoptive mothers have asked, "Am I really a mother if I haven't given birth?" "Do I belong to this motherhood club?" "Am I just faking it?" "How will other mothers see me?" Compounding this may be issues related to female and body identity. Long-term, unresolved infertility can leave a woman with feelings of failure and shame. Preoccupation with self-doubt about her femininity and bodily wholeness may be exacerbated by not breastfeeding: An adoptive mother may ask herself, "If I feel like a failure as a female, how can I be a success as a mother?" These questions may be significant sources of vulnerability for women struggling with post-adoption depression.

Adoptive mothers have also talked about emotional conflicts related to thoughts about the birth mother of their child. One mother talked about her feelings on Mother's Day that were tinged with guilt, as she felt so happy to finally be able to celebrate this holiday but could not stop thinking of the sadness that she imagined her son's birth mother was feeling on the same day. Feeling that one's own fulfillment and joy have come at another's expense and pain can be a source of hidden tension for some. For others, anger at the birth mother can be preoccupying, particularly if the child shows special needs that could be related to genetics, inadequate pregnancy care, or early circumstances.

The extra difficulties in parenting an adopted child can be sources of early strain for the mother or father. When a child comes home after the newborn period, the issue of developmental expectations can be challenging, as the parents need to account for two different ages, the child's chronological age and the age of the parent–child relationship. A mother in the Early Connections program had adopted a 2-year-old from Eastern Europe. She sought help when her daughter was 2½ years old, and they were caught in escalating cycles of conflict regarding sleep and feeding. The mother was frequently irritable and angry as she experienced her daughter as being oppositional and needing clear limits. Much of the early work revolved around holding the tension, and helping the mother hold the tension, between her little girl being 2 years old but their relationship being only 6 months old. Each of these developmental moments suggested different needs and issues, leading to understandable confusion.

As in the story of Angela and Maria, the special needs that many adopted children bring are a clear source of potential emotional stress for adopting parents. In our work with postpartum mood disorders, we at Early Connections know that, for a vulnerable new parent, having a baby who is difficult to soothe and easily dysregulated can be a trigger for depression. In adoption, these special needs are especially common among older children and those adopted from foster or orphanage care and can exacerbate parental mood vulnerabilities.

The Challenge of Mentalization in Adoption

Adoptive parents face unique challenges in the arena of mentalization or reflective function. *Reflective function* refers to the capacity to take in the experience of the other, see that experience as separate from one's own thoughts and feelings, and be curious about the meaning behind external behavior (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Slade, 2005). Parents with strong mentalizing capacities are able to think about their child's inner world, what makes the child tick; they can step into their child's skin and also know it as different from theirs. For adoptive parents, this can be especially difficult: To fully consider the early experience of their child is to "think about the unthinkable"—namely, what it may feel like to be abandoned, given up, or left by a birth parent; what the early period of life may have been like; and, possibly, what it may feel like to then leave again the orphanage or foster home that was home for weeks, months, or years.

In the Early Connections clinical program, adoptive parents have responded to this challenge in very different ways. Some do not allow themselves to consider the inner life of their child and the significace of their early experiences and losses. These parents shut off from the possible pain involved in thinking of their child's earlier months or years. They may not report being depressed but may have symptoms of emotional withdrawal, irritability, and disconnection. This can be thought of as low reflective function; one adoptive father expressed a lot of anger at his toddler daughter who was just home from an orphanage and concluded, "She's a difficult kid and I just don't like her." These parents can be seen as being particularly vulnerable to acting out on their feelings because they have no perspective on them.

Other adoptive parents are haunted by their imaginings of their child's past to the point of preoccupation and confusion about whose experiences belong to whom. They may have difficulty finding the boundary between being open to considering potentially painful questions and assuming the meanings and reverberations of these early experiences. An adoptive mother sought help around sleep problems. She had her own early loss issues and was overwhelmed by the pain she imagined her child felt at having been abandoned at 3 months of age. If she put him down to sleep and he expressed any distress, she felt she was repeating his early abandonment. She found herself preoccupied with thoughts of his early suffering and felt paralyzed by fear that she was causing him more anguish. The challenge of mentalizing is to balance empathic understanding and separateness, to feel for the other but know one's own experience as distinct from that: "I will try to understand your feelings but know they are not my feelings."

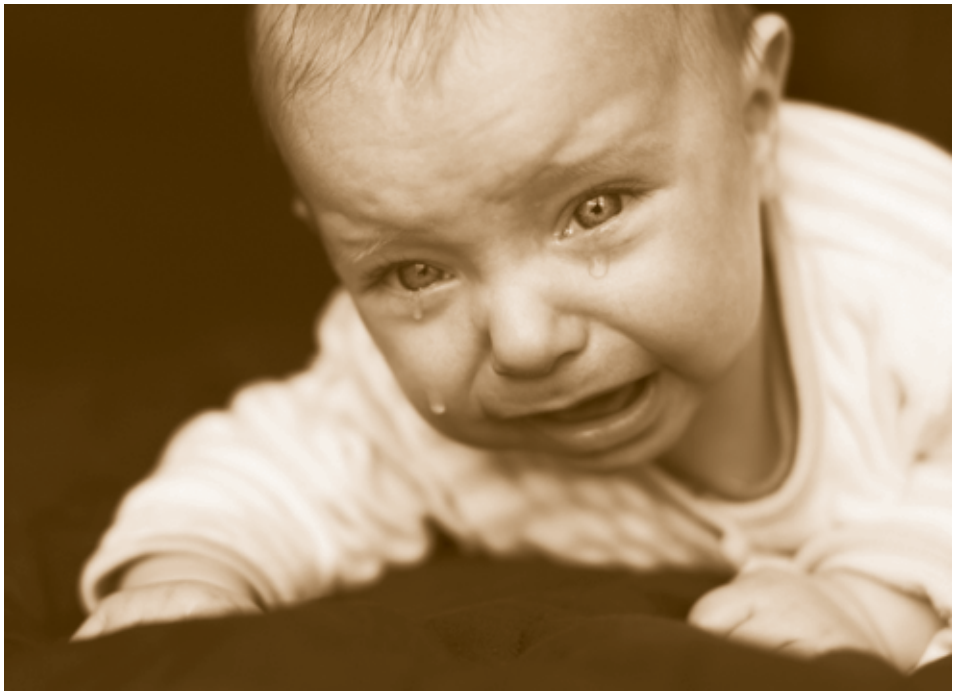
Joanne and Tara

A vignette from a parent consultation highlights this challenge of mentalization for adoptive parents from a contrasting light, a mother who had some anxieties but was not suffering from depression. Joanne had adopted her 1-year-old daughter, Tara, from Russia. She had questions about her daughter's behavior and sought out consultation to talk about her concerns and to tell me of Tara's history.

Tara was born at 26 weeks gestation to a very young mother who induced labor

supposedly to terminate her pregnancy. Tara was left at a hospital where she stayed for 2 months before going to an orphanage. Tara was malnourished and sick; she came home at 9 months old, weighing 9 lbs. and with a severe skin infection. During their visit at the orphanage, Tara showed few signs of relatedness, and Joanne and her husband felt prepared for her having serious physical and emotional problems when she came home.

In our consultation, Joanne showed herself to be both a keen observer of Tara's behavior and sensitive in her responses to Tara. She had many questions but engaged readily in sharing her own thinking. For example, she wondered why Tara clung to her and then told me, "I think she's holding on for dear life." She went on to wonder about this feeling, given the precariousness of Tara's coming into the world, how easily she might not have had life. Joanne was very invested in making sense of how Tara's history of severe deprivation and unwantedness might affect her now and in the future. She was struggling to really grasp what her daughter's earliest weeks and months must have felt like—to imagine the unimaginable. She wanted help in thinking about this, in trying to consider what Tara needed now from her and to anticipate her future needs. She was not avoiding taking in her child's early deprivation, nor was she overwhelmed by it. She could feel deeply for her daughter's experience and the possible challenges ahead but simultaneously see the value of building and offering her own sensitive understanding. This mother's high reflective capacities may be seen as protective against a post-adoption depression.



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For any vulnerable new parent, having a baby who is difficult to soothe and easily dysregulated can be a trigger for depression.

Implications

These clinical windows on post-adoption struggles bolster the emerging research and personal stories to suggest a need to attend to the phenomenon of post-adoption depression. For adoptive parents who are struggling, it can be extremely relieving to learn that there is a name for their experience and they are not alone. There are many parallels to the state of understanding of postpartum depression 10 or 15 years ago. Naming the experience and getting it on the radar of professionals and parents is a key step in the process of relieving the silent suffering of so many new parents.

In working with mothers with postpartum mood disorders, the staff at Early Connections hears frequently about the shame and isolation that mothers feel when they do not conform to the popular perception that new motherhood should be a time of joyful bliss. For adoptive parents, there is even less room for experiences of ambivalence and darkness. The more that post-adoption depression can be recognized and understood as a potential reality, the more likely it is that adoptive parents may reach out for help or that those close to them may offer understanding.

For adoption agencies, preparation for parents needs to include anticipating the challenges of their own transition to parenthood and awareness of the possibilities of depression and anxiety. One adoptive father who was struggling to feel connected to his daughter noted that their agency worker had talked about how a child from an orphanage may have trouble bonding to the parents but never mentioned that the parents may have trouble bonding with the child. Agency staff needs to understand the parents' needs for security, their vulnerability to emotional strain, and the potential benefit of confidential post-adoption support. Training for adoption workers should include a focus on the vulnerability of parents to anxiety and depression and ways to talk with adopting parents about this.

Families formed by adoption are frequently seen in Early Intervention programs, and Early Intervention staff would benefit from increased understanding of the vulnerabilities of newly adopting parents to anxiety and depression. Further academic research—both qualitative and quantitative—will be important in helping all who work with adoptive families to have greater insight into the prevalence, causes, and treatment of post-adoptive challenges. For clinicians, the concept of reflective function may have particular relevance in framing assessment and treatment with adoptive families.

These clinical stories provide windows into the range of needs and struggles of parents facing post-adoption depression. Specialized services for this population that would include the range from prevention to treatment are not yet widely available. The field may not be far along in understanding post-adoption depression, but taking these first steps—naming this experience and taking time to listen to adoptive parents who are struggling—represents a critical beginning.

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Acknowledgments

I'd like to thank Peggy Kaufman, director of the Center for Early Relationship Support, and the staff and clients of Early Connections for their contributions to this article.

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Infants and Toddlers in Foster Care and Their Therapists

Mirrored Helplessness

SANDRA R. WOLKOFF
Marks Family Right from the Start 0-3+ Center
North Shore Child & Family Guidance Center

"I am going to resign if I have to go back to court!" Rachel* was serious. Twenty–five years in the field, many of them working with children in foster care, and after four days in court being grilled by attorneys, this senior clinician felt awful. She had been subpoenaed to appear in Family Court to present information about two clients. Siblings, they were 2 and 5 years old when removed from their biological parents and placed in foster care and therapy.

Many professionals are all-too-familiar with the family issues that create the danger that warrants a child's removal from his parents. Abuse and neglect, or perhaps just allegations and statements, are enough to start a process that often substitutes one kind of pain for another. The social worker assigned to address the social and emotional needs of the children in foster care has an enormous responsibility not only to understand these needs but to work with the multiple systems of care that converge to make decisions in the best interest of the child.

Social workers, especially those working in independent agencies, are also working within the mandates of the institutions involved in these children's lives. Rachel, perhaps like the children she was treating, felt like a pawn on a chessboard. Law guardians, foster parents, family court judges, and attorneys all accompany these young children on their travels, hopefully leading to safety and stability. However, in this case, each wanted the social worker to support their goals, asking her questions such as: What did this child say? How did they say it? What is your opinion about the ability of the parent to care for this child? How do you know the child is not being coached?

These two young children were wrapped in conflicting stories; frightened and angry parents, helpless and involved foster parents all circled around them. How could they know who to trust and love? Complications including developmental delays, the difference in ages, and the different experiences each child had in their biological family had made a challenging situation more complex. At each treatment review, at each case conference, and within the agency and local county departments case conferences, our team would assess how the children were doing. Had the parents attended parenting groups, and who was observing their visits? Had the foster parents complied with the foster agency's requests? Was the Department of Social Services still looking to terminate parental rights?

All these meetings were punctuated with carefully worded summaries of sessions. Rachel, now a supervisor, was always conscious of being true to presenting information about the treatment sessions as accurately as possible. Clinical supervision wasn't enough to help us unravel the issues in the family and service systems. As the program director, and Rachel's supervisor, my sessions with her often included phone calls to the agency attorney with anxious questions. Rachel thought her every word and comment was scrutinized and she feared that she would fail her clients. She felt vulnerable herself and grew increasingly overwhelmed by the angry calls from parents and frightened calls from the foster parents, all wanting to know what the children were saying, thinking, and doing in the sessions. Yet throughout this process, Rachel and the team she worked with consistently focused on the children; their behavior, growth, developmental needs, and progress.

Canceled therapy sessions, postponed court dates, missed visitations, and the months and years have gone by. The 2-year-old is now 7 and has no memory of living with his biological parents. The 5-year-old is now 10 and yells, sulks, and fights,

* Some details have been changed for confidentiality

wanting to know why he has no say in the decisions about his life. And I listen to Rachel, overwhelmed by the endless letters to the court, the anxiety of subpoenas, the seeming failure of her interventions to help these children.

My job is to make sure that the children in my center are given the best services possible, but I also have to pay attention to the clinicians. They write endless treatment plans talking about helping their clients develop coping skills, but how do I help the staff cope?

Recently, Rachel came in to talk about a session with the now 10-year-old. She identified with his frustration, feeling that there was no purpose to his being in play or talk therapy—nothing we did was going to make a difference. She thought there were too many systems, too many agendas, and could see no purpose in continuing to be involved with the children.

First, I just listened. I told her I would set up a meeting with the supervising judge of the county Family Court to discuss the difficulties created by the use of so much social work time for testimony in court. We even planned a meeting with our agency's attorney to help all our staff find ways to feel more safe and clear when working with complex family and legal systems.

Rachel and I continued to talk about how she defined success and failure in the treatment of these children. I asked her to think about problem solving, coping skills, strength and humor, and all the other things this now preadolescent could say and do today that had eluded him 5 years ago. We talked about her fears and lack of safety in court and feeling "helpless" in such a public way. We talked about courage and how brave and professional she had been. Rachel started thinking about how much these children might have learned, not just how much they lost, or might still lose. And then we talked about relationships; the time she had spent with both these children that would stay with them forever.

We finally talked about the mutuality of the treatment experience; in this case, the mirrored helpless of both the child and the therapist. In the midst of the weight and anxiety of serious emotional and legal decisions, it is difficult for a clinician to stay alert to the experience of self and other, but yet there is no time that it is more important. The tools of the treatment are not only in the toys in the playroom but in the personal and interpersonal experiences of the therapist and client. The more Rachel could make sense of her feelings, the easier it might be for her to make sense of her client's.

Photo: ©iStockphoto.com/Kirby Hamilton

A fragmented delivery system, where children, parents, foster parents, and therapists are all standing in different corners of a boxing ring, seems to help no one.

Rachel did not want to testify again but felt more comfortable continuing treatment with her client. She felt clearer with the children and the other professionals in the system working with her. Within weeks, however, the court delivered another subpoena. Rachel felt she could not help her clients when her own anxiety was so debilitating. Our agency administration began the process to quash the subpoena and Rachel's doctor said he would write a letter stating that the stress of appearing in court would exacerbate an underlying medical condition.

A recently completed forensic evaluation by an independent clinician was brought to the judge and Rachel heard that the evaluator was considering postponing reunification with the biological parents The judge ruled that the siblings should be separated, with the younger child returning to the biological mother and the older son staying with his foster parents. The children were not going to continue in treatment.

Babies come into foster care in danger, and many parents have trouble committing to, and maintaining, the changes they need to make to ensure their child's safety. It is not unlikely that warring parents have their own independent legal cases as each one fights for reunification, and custody and postponements are rampant. The clock ticks and the foster family, in the best and worst case scenarios, fall in love with the children. A fragmented delivery system, where children, parents, foster parents, and therapists are all standing in different corners of a boxing ring, seems to help no one. I can't imagine that everyone doesn't feel a sense of sadness and helplessness.

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The Elephant in the Cradle

Fetal Alcohol Spectrum Disorders

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Although legal, alcohol is a substance of abuse for many individuals. Alcohol can permanently damage children born to mothers who drink when they are pregnant. The amount of damage varies, depending on when and how much the mother drinks during her pregnancy, but every drop is potentially damaging (Helfer et al., 2009). Think of it as IQ points slipping away.

The effects of alcohol and fetal alcohol syndrome (FAS) are becoming increasingly known, but many more people are affected by fetal alcohol spectrum disorders (FASD) than those who have the characteristic facial features of FAS. In fact, most people with an FASD do not have the FAS facial characteristics and are hence living with a real but invisible disorder (Kelly, 2005).

The severe implications of FASD make early diagnosis critical. The best outcomes are for people diagnosed before age 6 (Kelly, 2005). If FASD is not diagnosed (or if it is incorrectly diagnosed as one of many other conditions with similar symptoms), the child is at risk to develop secondary disabilities. These additional problems are potentially preventable and are often due to inappropriate treatment resulting from a misunderstanding of the link between the child's brain damage and behavior (Malbin, 1999; Streissguth, 1997).

The goals of this article are:

1. To provide an overview of FASD;
2. To increase knowledge about FASD and hence to increase the visibility of the disorders;
3. To educate more people on the harm of drinking during pregnancy to reduce the number of prenatally exposed births in the future.

Why Care About FASD?

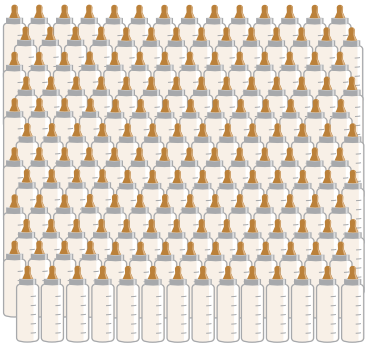
Despite its invisibility, FASD is a large problem that affects society every day. In the United States, approximately 40% of all pregnancies have some alcohol exposure before birth, and 3–5% of pregnancies are heavily exposed to alcohol before birth (Burd, 2006; Centers for Disease Control and Prevention, 2004). Approximately 1% of all U.S. newborns are diagnosed with a birth defect or developmental disability related to prenatal alcohol exposure (Burd & Christensen, 2009; Sampson et al., 1997). That may seem like a small percentage, but the number of new cases of FASD each year exceeds the number of cases of muscular dystrophy, spina bifida, and Down syndrome combined (National Organization on Fetal Alcohol Syndrome, n.d.-a). FASD also affects more children than autism (Autism Society of America, 2010).

The lack of an accurate understanding of FASD often leaves parents searching to try to understand why their child learns and behaves in ways that create such conflict with society. They spend years seeking treatment

Abstract

Alcohol can tremendously inhibit the lives of children exposed prenatally, yet many pregnant women still fail to recognize the seriousness of prenatal alcohol exposure and the alcohol-related disabilities captured under the umbrella term fetal alcohol spectrum disorders. Prenatal alcohol exposure can cause extensive damage that alters the formation of the brain and vital organs, causing lifelong damage. The consequences of prenatal alcohol exposure are often grave, inhibiting both physical and intellectual development, societal acceptance, and adult success. This article describes the negative effects alcohol can have on the developing fetus and the coping strategies professionals can use when working with affected children and parents.

Table 1. Drinking During Pregnancy

Drinks Per Day	Cumulative Fetal Exposure (Drinks per day x 270)	Fetal Exposure to Absolute Alchohol in Ounces	Full Baby Bottles
1	270	135	15 
2	540	270	33 
10	2700	1350	168 

Source: University of North Dakota Fetal Alcohol Syndrome Center. Reprinted with permission.

Fetal Alcohol Spectrum Disorders (FASD) in the United States

Every year:

- Exposed pregnancies: 1,560,000
- Pregnancies with frequent heavy drinking: 137,000
- New cases of FASD: 40,000

Every day:

- Birth of a child with FASD: 109 (4 per hour)
- Cost of health care and related services: $55.4 million
- Lost productivity: $2.3 million (Burd, 2006; Lupton, Burd, & Harwood, 2004)

for problems experienced but not correctly identified. Not only is the process frustrating for the parents and child, but the economic cost of this process is staggering; the facts are summarized in the box Fetal Alcohol Spectrum Disorders in the United States.

The publicity and concern over the use of crack cocaine and other drugs during pregnancy eclipse professional and popular concern about the use of alcohol during pregnancy. However, it is alcohol that causes the most serious neurobehavioral effects in the fetus and long-term deficits when compared with other abused substances such as marijuana, cocaine, heroin, and tobacco (FASLink Fetal Alcohol Disorders Society, 2010; Gray et al., 2009). Children in foster care are at an even greater risk for FASD. Whereas 40% of children are prenatally exposed to alcohol in the general population, nearly 70% of children in the foster care system were prenatally exposed (National Organization on Fetal Alcohol Syndrome, n.d.-b).

What Is FASD?

FASD has clear implications for society, yet many people are still unaware of what FASD is or what its effects are. FASD is an umbrella term that covers a range of disorders caused by prenatal alcohol exposure. These disorders include the following:

- **FAS:** This is often considered the most serious in the FASD spectrum because, in addition to central nervous system damage, stunted growth and facial abnormalities are present.
- **Alcohol-related neurodevelopmental disorder:** This disorder describes individuals with confirmed maternal alcohol use, neurodevelopment abnormalities, and behavioral or cognitive abnormalities that compromise their development. This category was previously referred to as fetal alcohol effects.
- **Alcohol-related birth defects:** This term is used to describe individuals with confirmed maternal alcohol use and one or more congenital defects that include heart, bone, kidney, vision, or hearing abnormalities. This category is rarely used as a diagnosis.

Because the mother's drinking history is a key for diagnosis on the FASD spectrum, many children are not accurately diagnosed. Most professionals working with parents are reluctant to question women about alcohol consumption during pregnancy. When they ask at all, they ask in a way that elicits misinformation. "Did you drink during pregnancy?" is easily misinterpreted to mean only hard liquor. Wine, beer, and hard lemonade are just a few of the alcoholic beverages that are overlooked when pregnant women and mothers reply to this question.

Causes of FASD

Despite the fact that 40% of pregnancies are exposed to alcohol prenatally, 1% of children are diagnosed with an alcohol-related disorder (Burd & Christensen, 2009; National Organization on Fetal Alcohol Syndrome, n.d.-b; Sampson et al., 1997). What makes some children more susceptible to FASD than others? It is still unclear what in a genetic makeup makes some children resistant to FASD and why some genes increase risk from the harm of alcohol. One factor that has been shown to contribute is birth order. Younger children in the birth order are more likely to be affected by FASD than older children. The younger sibling of a child with an FASD is at an increased risk for an alcohol-related disorder and should be screened (Abel, 1998). In addition, even if a mother drinks the same amount of alcohol through three pregnancies, it is possible that the youngest child might be the only one with an FASD. Mother's age also contributes. The older the mother is, the higher the risk is that her child will have an FASD if exposed to alcohol prenatally (Abel, 1998). This is not to imply that young women are not at risk to have a baby with an FASD, but rather that older women have increased risk.

Although genes play a role, alcohol consumption during pregnancy is the essential cause of FASD. Despite this fact, there are a number of myths about drinking during pregnancy. Many people believe that some alcohol is okay (e.g., the medicinal glass of wine before dinner) while "hard" liquor is harmful to the developing fetus. In fact, all kinds of alcohol are equally to blame for FASD. There is no level of drinking during pregnancy that is known to be safe. Obstetricians who counsel their patients to enjoy a glass of wine each evening are putting the fetus at risk. More

importantly, patients who bring up the subject of drinking with their obstetrician are raising a red flag that alcohol may be playing an unhealthy role in their lives.

Every week of development is crucial to a baby's development; hence, any amount of alcohol can affect the baby's development at any time during the pregnancy. Alcohol can damage different body systems related to the fetal development that is happening during each week of pregnancy. The brain is developing throughout the entire gestational period. As a result, alcohol can have a very large impact on brain development and babies' ability to think, communicate, learn, and understand the world around them.

FASD in Infants and Toddlers

The signs and symptoms of FASD change with age (see box Diagnosing Fetal Alcohol Spectrum Disorders). It is important to remember that the signs and symptoms listed here are the general ones for very young children (although some of these symptoms can be seen later in life as well). Because FASD is unique to each person, affected children may display only some of these symptoms. In addition, these symptoms are experienced in varying degrees ranging from mild to severe. The box Signs and Symptoms of Fetal Alcohol Spectrum Disorders lists those that are most frequently seen for the birth to 3 years age group.

Just as the signs and symptoms differ from person to person, successful strategies differ as well. It might take time to find the strategies that work best for the FASD-affected person. A good place to start is with the following strategies that many have found useful when working with the birth to 3 years age group:

- **Reduce noise and keep lights low.** This will reduce distractions and help the child sleep better.
- **Introduce stimuli one at a time.** FASD-affected children react better to one change at a time. Instead of introducing a child to a group of people, introduce the child to one person at a time. FASD-affected children can also be overstimulated by a large selection of toys. Reducing toy selection may improve behavioral outcomes.
- **Use calming techniques.** When an infant gets upset, a warm bath or shower, music, and rocking might help. Swaddling is the most highly recommended calming technique for infants.
- **Develop and follow routines**. Routines help with all aspects of managing the child's symptoms, but they especially help to reduce temper tantrums and to aid in sleeping.
- **Simplify.** Because FASD-affected children are easily distracted, white or plain colors lessen distractions. Special attention should be paid to minimizing the use of overstimulating colors (e.g., bright red, lime green, or yellow) and decoration (e.g., multiple themes or clutter) in the bedroom.

Photo: University of North Dakota Fetal Alcohol Syndrom Center

A drink a day during pregnancy

Diagnosing Fetal Alcohol Spectrum Disorders

If you think someone has Fetal Alcohol Spectrum Disorders (FASD), it is important to start the diagnostic process. It is also important to remember that getting a diagnosis can be difficult. Here are some tips for getting a diagnosis:

1. An honest appraisal of the mother's drinking during pregnancy is important. Many diagnosticians will not make a diagnosis without this information.
2. Early diagnosis is critical: If you suspect FASD, do not delay in getting a diagnosis.
3. It may take several tries to get a diagnosis. Persist if you believe the child is affected.
4. Contact the National Organization on Fetal Alcohol Syndrome to get advice on where to get a diagnosis and where people who live in your area have found support.

Signs and Symptoms of Fetal Alcohol Spectrum Disorders

Signs and symptoms of Fetal Alcohol Spectrum Disorders (FASD) in children from birth to 3 years old include the following:

a. Prematurity
b. Low birth weight
c. Sleep disturbances (up frequently at night)
d. Difficulty feeding—infants with FASD often have a hard time sucking
e. Failure to thrive
f. Low muscle tone
g. Excessive crying
h. Irritability
i. Extreme sensitivity to sound and light
j. Easily distracted or hyperactivity
k. Difficulty following directions
l. Delays in walking, talking, and toilet training
m. Hearing problems potentiated by frequent ear infections
n. Heart problems
o. Tremors
p. Vision problems

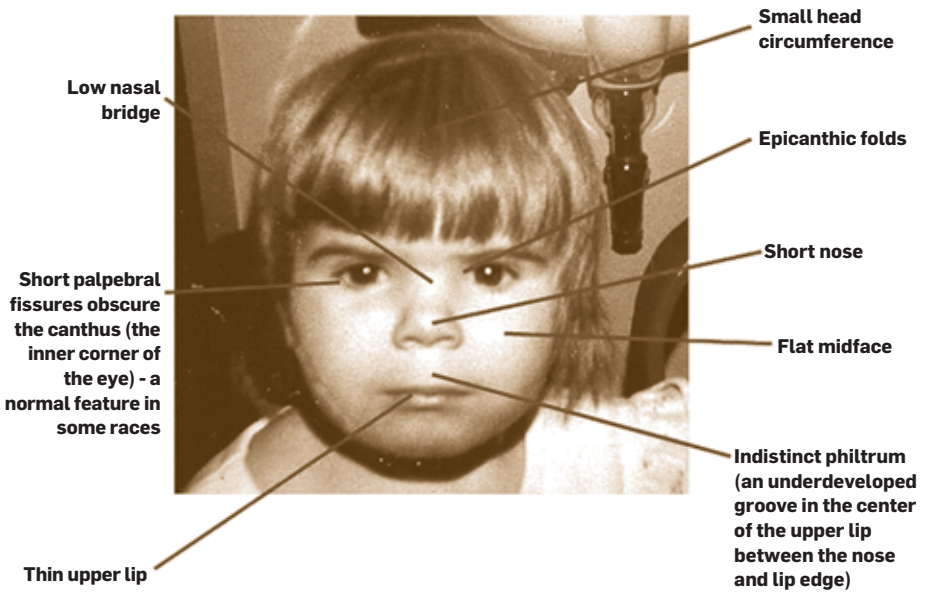
- **Use simple words when giving directions.** Speak slowly, and repeat what you have said. Directions should be given one step at a time rather than all at once. Picture cues can also be helpful (e.g., a picture posted over the toy box showing the child putting toys in the toy box).
- **Provide calming activities.** As children reach the toddler age, they are likely to become hyperactive. It is important to provide calming activities that do not overstimulate. Some suggestions might be coloring, singing, working with play dough, or finger painting.
- **Provide a safe place.** When children are overwhelmed or overstimulated, they need a spot that is uncluttered and offers relaxation. A corner space, in a muted color, with a soft comfortable mat, a blanket, and one special stuffed animal might provide the ambience to help an overstimulated child calm down. The caregiver will have to work with the child to teach him to utilize this spot when he is overstimulated. It is important that this spot be viewed as the child's special safe spot and not a disciplinary (e.g., time–out) location (Streissguth, 1997).

FASD in Older Children

As children grow, the impairments they live with often become more noticeable and may include deficits in the following:

- **Abstract reasoning.** The ability to analyze information and form theories to explain problems is very difficult for people with FASD, making it difficult for them to understand and participate successfully in the world around them.
- **Cause and effect.** FASD-affected people have difficulty learning from their mistakes. They have difficulty understanding that their behavior has consequences. This is why many FASD adults get in trouble with the law enforcement system.
- **Generalization.** Those affected by FASD have trouble applying information gained in one situation to another. For example, if Tommy borrows Pedro's bike without asking and is told not to borrow Pedro's bike without asking, Tommy might think it is okay to borrow Margaret's bike instead.
- **Right and wrong.** Children and adults affected by FASD have difficulty understanding why some actions are acceptable and other actions are not. And because they are readily influenced by other people, they are easily led into delinquent behavior.
- **Interpreting people's behavioral cues.** Although FASD-affected children and teens have an intense desire to please authority figures, they are not able to gauge facial and conversational cues that assist most people in understanding what other people are saying.
- **Time.** FASD-affected people have difficulty with time in two ways: telling time and understanding the passage of time. In children, this means that they don't understand warnings like "You have to clean up in 10 minutes."
- **Memory.** Though FASD-affected persons have difficulty with memory in general, short-term memory poses the greatest difficulty. As a result of this impairment, any instructions require regular and frequent repetition.
- **Behavior.** Many of the cognitive impairments translate into behavior more consistent with a much younger age than the person's chronological age. FASD-affected children are more comfortable interacting with children much younger than they are. A 10-year-old child will behave more like a 5-year-old and be happier engaged in activities appropriate for a 5-year-old.

Figure 1. Fetal Alcohol Syndrome



Source: University of North Dakota Fetal Alcohol Syndrome Center. Reprinted with permission.

It is critical that professionals working with children consider the possibility that these signs are potential symptoms of FASD; children who exhibit these difficulties should be tested as early as possible.

FASD in Parents

In adults, behavioral vulnerabilities continue. More problems surface as the added expectations of adulthood are not met. For example, the difficulties with math during the school years are the precursor to adult difficulties in telling time, managing money, and planning ahead for appointments such as court appearances or meetings with social services. Without services, adults with FASD continue to be unpredictable, volatile, and impulsive. Their inability to read the environment is demonstrated in difficulty understanding laws, evaluating social situations, and judging right from wrong. These symptoms often result in mental health problems, substance abuse, and difficulty finding or keeping employment. It is important to realize that these impairments vary from day to day and that doing well on one day does not mean that the person can do well every day; this variability often makes professionals think that problem days are a result of rebellion or a lack of commitment to services or to their children's well-being.

When FASD-affected adults become parents, they need varying levels of assistance depending on the severity of their alcohol-related disability. Adults who have been identified as FASD-affected and who have great supports can become successful parents. Unfortunately, many affected people are never correctly diagnosed, resulting in secondary disabilities that make parenting even more difficult. Some FASD-affected parents, identified by the child welfare system in relation to a child abuse or neglect allegation, still do not receive the diagnosis that would permit effective case planning. At that point, their disability is likely to be severe enough to require significant assistance, often for long periods of time. FASD impairments make typical case plan activities (e.g., parenting classes

or a job search) inappropriate for affected parents.

Parenting education programs often do not meet the needs of FASD-affected parents. One-to-one, hands-on instruction may be needed to help these parents meet their children's needs. Substance abuse treatment programs, which also rely on group interaction to accomplish their therapeutic goals, are less effective for FASD-affected parents because they cannot retain information unless it is presented simply and repeated often. They cannot focus well in group settings and can be disruptive to the group as well as to their own learning. In identifying possible employment, success will require a structured work environment with an understanding supervisor. Routine at work often helps. Transitions should be talked about ahead of time and practiced, and then should be implemented only if the parent is successful during practice.

It is crucial that professionals understand the problems parents face so that they can provide services that will allow adults to become successful parents and members of society. Eighty percent of adults with FASD have memory problems and executive functioning problems. And 75% also have residual attention deficit/hyperactivity disorder (Burd, Cotsonas-Hassler, Martsolf, & Kerbeshian, 2003). In addition to these problems, the average FASD-affected adult reads at a fifth-grade level, comprehends at almost a fourth-grade level, and can speak at a fifth-grade level (L. Burd, personal communication, 2010; see box Summary Characteristics). Additional symptoms of FASD in adulthood include the following:

- **No personal boundaries and impulsivity.** This can lead to promiscuous sexual encounters and increased risk of teen pregnancy.
- **Poor reasoning and judgment.** This contributes to high-risk behavior.
- **Inability to correctly interpret social cues.** Because FASD-affected adults do not process voice tone or unspoken forms of communication (e.g., body language or facial expressions), they convey a vulnerability that makes them easy targets for bullies.
- **Poor social skills.** Poor social skills increase risk of depression, isolation, and substance abuse.
- **Bad choices of friends.** These choices lead many into delinquent behavior and increase the risk of criminal acts.
- **Inability to learn from mistakes.** This inability leads FASD-affected adults to repeat bad decisions in new settings and with new people.

FASD-Adapted Treatment

The following suggestions can help parents with FASD be more successful in parenting intervention programs:

- Go slow (treatment or services may take much longer).
- Make it concrete (picture guide or lists are helpful).
- Reduce group size: Small groups lead to better participation and more attentiveness.
- Remember that anxiety increases impairment.
- Work on one problem at a time.
- Recognize and appreciate impairments.
- Develop a long-term plan that includes ongoing support services.
- Keep directions short.
- Anticipate needs and create opportunities for success.

Many interventions targeting maltreating parents (e.g., parenting education or substance abuse treatment) use a group setting. FASD-affected adults do not do well in these settings. They need very small groups in which people are prepared to listen patiently and discuss issues calmly. The FASD-affected person needs help to focus on what is being said so that she can, as much as possible, understand the situation.

Professionals working with FASD-affected parents need to orchestrate meetings with attorneys, child welfare agency staff, service providers, and parents so the parent can remain attentive. When people walk into the room and within 5 minutes have passed judgment on the parent, the meeting has failed. If the other individuals are not able to restrain expressions of frustration because the parent was late to the meeting, the parent will grow anxious and then become unable to pay attention to the content of the meeting.

In addition to programmatic supports, FASD-affected parents will need someone to advocate for them over the long term. This advocacy should include help with money management. Assistance with day-to-day tasks is critical. Lists provide a concrete form of repetition that helps FASD-affected parents accomplish what they must do to care for themselves and their children.

Avoiding Secondary Disabilities

Programs that address the adults' specific needs combined with good support not only increase their chance at success in life but reduce secondary disabilities. Secondary disabilities occur when FASD-affected people, frustrated by being misdiagnosed repeatedly and receiving interventions that don't improve their lives, turn to negative coping strategies. Temper tantrums, alcohol and substance abuse, quitting or being fired from jobs, inappropriate sexual behavior, and involvement in the criminal or juvenile justice system are all examples of secondary disabilities that can likely be prevented or decreased with an accurate diagnosis and treatment.

When FASD-affected children or adults continue to behave in ways that they have been repeatedly counseled against, those around them express stern disapproval of this apparent willfulness. However, what on the surface appears to be disobedience is in fact an inability to learn acceptable behavior. One simple change in approach to FASD-affected children and adults can make all the difference in the way professionals and parents approach them: When it appears that they are refusing to obey, it is often far more accurate to say they are not able to understand what is being asked of them. It's not that they won't behave, it's that they cannot. It is those who work and live with FASD-affected people who must change their interactions to accommodate the cognitive disabilities characteristic of FASD. Successful management of the multiple disorders in FASD is possible. It requires the following:

- **Long-term planning.** With the difficulties of each day, it is hard to think

Summary Characteristics of Adults With Fetal Alcohol Spectrum Disorders

A longitudinal study of adults with Fetal Alcohol Spectrum Disorders (FASD) conducted by the North Dakota Fetal Alcohol Syndrome Center found the following characteristics

- Reading: grade 5
- Oral comprehension: grade 5
- Reading comprehension: grade 4.5
- Percentage of adults with memory deficits: 80%
- Percentage of adults with attention deficit: 75%
- Percentage of adults with executive function impairments: 80%

The North Dakota Fetal Alcohol Syndrome Center serves the entire state of North Dakota. The center has been in operation for 18 years. The Fetal Alcohol Syndrome Clinic sees 150 new patients each year from across North Dakota and surrounding states. Burd, Fast, Conry, & Williams, in press; www.online-clinic.com

about planning in advance. Despite the difficulty, a long-term strategy focused on risk reduction will help the child avoid predictable dangers like school failure, teen pregnancy, and alcohol and drug use. Parents should work with their child early and often to prepare her for the teen and adult years that lie ahead.

- **Teaching the person to ask for help.** It is important to start working with the child to get him to recognize when he needs help and to learn to ask for help. The ability to ask for help will be very useful, especially when feeling overstimulated in school, or later on in life, such as at a workplace. It is equally important for professional staff to be able to recognize when the person with FASD is confused or does not understand.
- **Setting the child up for success.** If a toddler can only do two-piece puzzles, failing to put together a six-piece puzzle will lead to frustration. Give her two-piece puzzles until she struggles less. Then give her a three-piece puzzle. Being able to achieve success and be praised for success is much more helpful than failing.
- **Using praise.** Just as it is important to set the child up for success, it is important to focus on his positive behaviors and to praise them. It is critical to recognize the child's achievements and to praise him for the specific achievement he made (e.g., "good job building that tower" instead of "good job").

These strategies will go a long way toward reducing secondary disabilities and the havoc they reap in the lives of undiagnosed FASD-affected people.

Caring for the Caregiver

Working with someone affected by FASD is a difficult and taxing full-time job. It requires patience and persistence, devoted attention, and, despite a lot of effort, it can often feel as though there is no progress. Because a caregiver is so important in the life of a person with FASD, it is crucial to make sure the caregiver is cared for as well. Physical and mental breaks should occur regularly. Caregivers for FASD-affected persons recommend the approaches listed below:

- **Respite care.** A skilled caregiver comes into the home and works with the FASD-affected child for an hour or two while the parents go out or spend time in another part of the house.
- **Supportive friends and family.** A support system of caring people who are educated on FASD can remind the parents that they are handling things well and that it is worthwhile.
- **Support groups.** Some communities have support groups for birth, foster, and adoptive parents who are caring for a child affected by FASD. If the adults are high-functioning and not themselves FASD-affected, they can benefit from spending time with people experiencing similar frustrations and a similar day-to-day routine. The burden is lessened when it is shared with others who appreciate the struggle, and hopes are raised by those who have learned ways to cope well. If the adult is FASD-affected, support groups are not helpful. The time would be more productively spent providing direct services to them.
- **Health maintenance.** It might seem easy for the caregiver to forgo a routine doctor's visit when the caregiver already has many doctor's visits to attend for the child. It is very important that the caregiver does not push her own health aside for the child. This includes not just physical health but mental health as well.

Each caregiver is different and may use different methods to maintain his own physical and mental health. Regardless of the method, service providers, friends, families, and communities should encourage and support the caregiver because he is crucial to the success of an FASD-affected person.

Conclusion

FASD permanently affects the brain and the affected person's ability to function. Every fetus is at risk for FASD if the mother drinks during pregnancy. Because of the troubling circumstances that bring families to the child welfare system, children in foster care are at a vastly increased risk for these disorders. Professionals who work with children who are the victims of abuse or neglect must be vigilant in identifying the signs and symptoms of FASD and appropriately diagnose those who appear to be affected. Accurate diagnosis can lead to appropriate interventions. Appropriate interventions will reduce the risk of child maltreatment in FASD-affected families.

Katrine Herrick, *BS, is the database coordinator of the Court Teams for Maltreated Infants and Toddlers Project at ZERO TO THREE. She conducted research on FASD and its relationship to the work of the Court Teams Project prior to joining the staff in October 2010. She is responsible for ensuring consistent, thorough, and accurate data on the children served by the Court Teams and for contributing to data analysis that permits the Court Teams Project to make course corrections as needed.*

Lucy Hudson, *MS, is the director of the Court Teams for Maltreated Infants and Toddlers Project at ZERO TO THREE. She has more than 30 years of experience in project management, program implementation, and policy development in public and private sector child welfare, child care, mental health, and youth-serving organizations. She has been instrumental in the planning and development of the Court Teams Project and is responsible for the daily operation and oversight of all project activities, project staff, and fiscal matters.*

Larry Burd, *PhD, is a professor in the Department of Pediatrics at the University of North Dakota School of Medicine. He is the co-principal investigator for the Four-State Fetal Alcohol Syndrome Consortium and the Prenatal Alcohol and SIDS and Stillbirth (PASS) Network funded by the Substance Abuse and Mental Health Services Administration, which examines maternal and environmental risk factors for stillbirth, infant mortality including sudden infant death syndrome (SIDS), and FASD. Dr. Burd has been with the Pediatric Therapy Program for 25 years and has evaluated more than 13,000 children. He is also the director of the North Dakota Fetal Alcohol Syndrome Center and the FAS Clinic.*

Learn More

Centers for Disease Control and Prevention
www.cdc.gov/ncbddd/fasd/
Contains facts, data and statistics, research, free materials, and a list of treatments.

FAS Diagnostic & Prevention Network
http://depts.washington.edu/fasdpn/
Hosts trainings for clinicians and multidisciplinary workers interested in learning how to screen and plan treatment and primary preventions.

The FASD Center for Excellence
www.fasdcenter.samhsa.gov/
Contains information, publications, state systems, training, and more. Includes an online course that anyone can take to gain more information on FASD.

FAS Community Resource Center
www.come-over.to/FASCRC/
Contains several parent resources, as well as information on symptoms specific to age birth to 3 years.

National Organization on Fetal Alcohol Syndrome
www.nofas.org
Has fact sheets for all members of the community as well as a state-by-state resource guide.

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Separation and Loss Due to Political and Social Conflict

The Impact on Early Childhood Development

ZOHREH ZARNEGAR
Los Angeles County Department of Mental Health
American Indian Child & Family Services Program

The Convention on the Rights of the Child (1989) recognized that all children have basic human rights, and that people younger than 18 years old need special protection and care. The Convention spelled out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse, and exploitation; and the right to participate fully in family, cultural, and social life. However, during times of social and political conflict these rights are often ignored, and the suffering of children receives minimum attention when their needs are the greatest. In 2009 alone, 18,700 unaccompanied and separated children filed asylum applications seeking international protection (The United Nations High Commissioner for Refugees, 2010). In the last decade alone, more than 2 million children have died in wars. Four to five million have been disabled and a further 10 million have been traumatized (UNICEF, 1996). Scars from the trauma of war could be life-lasting and thus crippling the very people that the world depends on to rebuild their devastated homelands toward future peace and prosperity. During times of social and political conflict, young children may be traumatized because (a) they witness or are exposed to direct violence and they are subjected to physical, emotional, and psychological threats to their well-being; (b) they experience frightful, tragic events that they cannot control or understand; (c) they cannot process sensory stimuli because of their young age and limitations in their cognitive development; and (d) they lack a stable, reliable, and supportive adult relationship to protect them from negative impacts.

The Impact of War on Child Development

Atrocities of war and traumatic events experienced by displaced young refugee children prior to and during the migration and during resettlement put them at high risk for a wide range of problems impacting their health and well-being and normal development. Research on the developmental impact of the separation and reunification of young children and their parents because of social and political conflict is rare. Freud and Burlingham (1943) noted higher impacts of war-related atrocities on children who were separated from their caregivers in comparison to those children who remained with their caregivers. Within the last two decades, a number of publications have reported many symptoms experienced by refugee children, impacting their developmental processes, including, but not limited to developmental regressions in learning, attention and memory, and self-regulatory system; anxiety and depression; dysregulatory problems (over- or under-reactivity); introversion and withdrawal, or aggression and self-destructive behaviors;

Abstract

Social and political conflicts such as war cause systemic violence; an utterly destructive force impacting the whole society, causing migration and displacement of families, and often resulting in forced or accidental separation of children from their caregivers. In fear of war and political persecutions, thousands of families, including women and their young children, leave their homes to find safety (Doctors Without Borders, 2004). The United Nations High Commissioner for Refugees (2010) reported that 43.3 million people around the world were refugees at the end of 2009, and more than half of them were children. The systemic violence of war is an ongoing, intense, and traumatic experience, and infants and toddlers are the most vulnerable to the damaging effects of violence. The author describes the impact of separation, loss, and war-related trauma on very young children and strategies for supporting those affected.

disorganized behavior (e.g., eating and sleeping disorders, bed wetting and soiling, and crying with difficulty to soothe); psychosomatic disorders; and posttraumatic stress reactions such as recurring nightmares and startle reactions, frequent crying spells, withdrawal, avoidance, hypervigilance, and high reactivity (Almqvist & Brandell-Forsberg, 1997; Angel, Hjern, & Ingleby, 2001; Boothby, 1994; Felsman, Leong, Johnson, & Felsman, 1990; Goldstein, Wampler, & Wise, 1997; Harrell-Bond, 2000; Hjern, Angel, & Hoejer, 1991; Hodes, 2000; Lustig, et al., 2003; Macksoud & Aber, 1996; Masser, 1992; McCloskey & Southwick, 1996; McCloskey, Southwick, Fernandez-Esquer, & Locke, 1995; Mollica, Poole, Son, Murray, & Tor, 1997; Muecke & Sassi, 1992; Paaredekooper, de Jong, & Hermanns, 1999; Papageorgiou et al., 2000; Rousseau (1995).

Young children separated from their families may be subjected to additional difficulties including, but not limited to, loss of adult care, trust, and protection, and disruption of normal development and routines; loss of basic resources and community connections, such as home, school, and health care; loss of close and intimate relationships; subjection to neglect, abuse (physical, emotional and sexual), and re-victimization; discriminatory treatment because of parents' ethnic and cultural background separate from the dominant social group; exposure to trafficking; detainment; abandonment; and witnessing other human rights violations of their caregivers or others. The frequent use as a weapon in war of gender-specific violence against female children and their mothers results in added risk for death, injuries, and psychological complications (The Center for Victims of Torture, 2001; Women's Commission for Refugee Women and Children, 2004).

Biological Effects

The brain is rapidly developing during the first 3 years of life. Capabilities such as sensory motor processing, psychosocial development, and emotional and cognitive functioning are dependent upon use (Perry & Pollard, 1998; Perry & Rubenstein, 1999), and experiences of early childhood influence the structure and function of the brain (Schore, 2001; Siegel, 1999). The relationship between brain functioning and the cardiovascular system demonstrates how the physiology of children who have been traumatized or maltreated differs from that of other children when responding to frightening and stressful situations. Traumatized/maltreated children show a higher level of physiological reactive response, such as irregular breathing and elevated heart-rate and blood pressure (Perry, Pollard, Blakely, & Vigilante, 1995).

Stressors in life are of various types.

Photo: ©iStockphoto.com/Claudia Dewald

Studies have shown high rates of acute and chronic mental health problems among surviving children of recent wars.

Natural stressors are events that generate body's neuro-chemical reactions called stress response, preserving human survival. Depending on the body's tolerance and coping system, stressors are considered Positive Stress, Tolerable Stress, or Toxic Stress (Shonkoff, Boyce, and McEwen, 2009). Toxic stress withholds growth, leading to problems in all developmental domains and regulatory systems. Hunger, malnutrition, and disease experienced by these young children are added stressors to the impact of war.

Mental Health Effects

Studies have shown high rates of acute and chronic mental health problems among surviving children of recent wars (Eth, 2001; Thabet, Abu Tawahina, El Sarraj, & Vostanis, 2009; Yule et al., 2001). Survival of an organism depends not only on the fight or flight ability, but also "reorganization consequent upon some modification" (Piaget, 1971, p. 34) of the whole developing system. In cases of chronic stress leading to repeated fight or flight reactions (Perry, 2001), the young child is at high risk for a continued state of heightened arousal, causing the release of excessive cortisol in the brain, resulting in neurodevelopmental damage, regulatory disorders, hypervigilance, startle reactions and intrusive thoughts, mood and personality disorders, and disorganized and antisocial behavior in later years (Hickey, 1991; Perry & Azad, 1999; Perry & Pollard, 1998).

Young children, along with others who are migrating, displaced, or separated from their primary caregivers, are mostly housed in "protection", meaning refugee detention camps (Criswell & Gow, 2004). Young children are exposed to further traumatic events in these detention centers (Rothe et al., 2002). These young children find their world unstable and a dangerous place and they consider themselves abandoned and vulnerable.

Aggression may play a significant developmental role for these young children in presumption of a sense of control and competence. All professionals involved with service provision for these young children and their families must understand the harmful effects of such depersonalized institutionalizations on young children and use their efforts to optimize environmental capacities to secure the safety and well-being of young children and their primary caregivers.

Assessment and Intervention

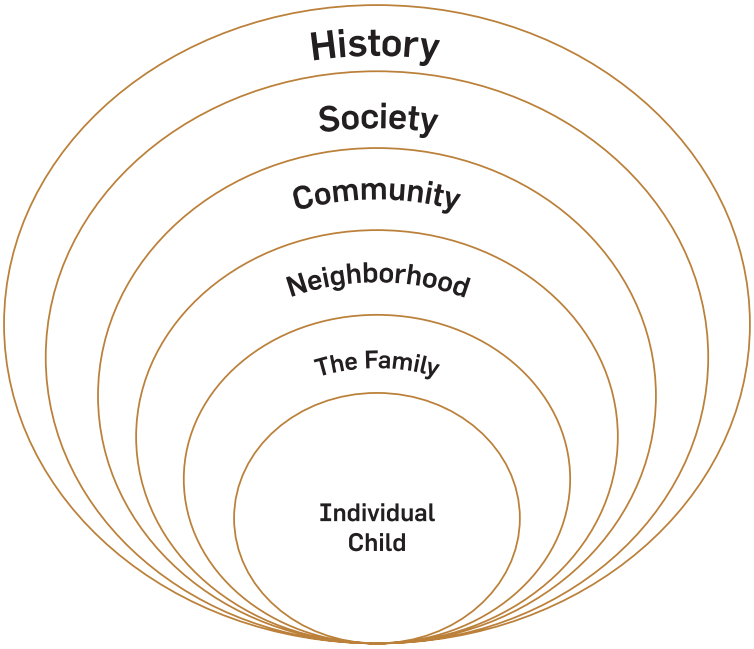
Early childhood assessment procedures for traumatized children should include the evaluation of family and social factors; the young child's developmental functioning in all domains; and the young child's relationship with his primary caregiver prior to the war, throughout the separation period, and through the reunification process, with a focus on improving young child's coping capacity and healing prognosis.

Bronfenbrenner's ecological model of child development (1979) is useful for assessing and children affected by war. An ecological model considers the child's sociocultural domain as multicontextual and multidimensional system. (See Figure 1 for an example of a multidimensional ecological model illustrating how the impacts of war are dynamic and spread across the system.) The

Photo: ©iStockphoto.com/Jean Nordmann

Young children who are migrating, displaced, or separated from their primary caregivers are mostly housed in refugee detention camps.

Figure 1. Multi-Dimensional Ecological Model Of Child's World



Zohreh Zarnegar (1999)

world of the young child is complex and at any given time reflects interactions between multiple factors such as those listed below:

(a) *Characteristics of the individual child*, such as temperament, gender, multi-axial developmental functioning (e.g., biological, neurological, emotional, psychosocial), and the age at the time of separation;

(b) *Characteristics of the caregiver*, such as the caregiver's physical and psychological capacities; cultural identity and belief systems about the needs and care of children; perception of parenting role and child-rearing practices; pre-existing trauma and impacts of past and present; literacy, especially that of the mother; knowledge of developmental processes; and social-economic, political, and psychosocial status; caregiver's interpretation and narrative of the traumatic event;

(c) *Child–parent relationship* prior to the war and separation; and

(d) *Characteristics of the environment*, such as the physical and social settings of everyday life, customs of child care and child-rearing practices (e.g., feeding, sleeping arrangements); history, traditional practices, concept of literacy, religion, community stability and services; and active support system.

These factors influence the health and quality of life of young children and their primary caregivers everywhere and cannot be considered separately or in isolation. An ecologically based intervention, beginning with the timely and comprehensive assessment, poses a great challenge. Ideally, there is some accurate and useful information for the child from the time prior to displacement, and the assessment process takes place at various points from displacement to re-settlement, and it includes the collaboration of an intervention team of professionals and significant adults in the life of a young refugee child. The intervention team should include a combination of core health and education professionals, caregivers, advocates, and members of local community, cultural consultant, and translator, all of whom should be trained in developmentally based, relationship-focused services for young traumatized/maltreated children.

With specific focus on the ecologically based factors listed above, treatment intervention must be planned and structured with the individual displaced young child in mind. Neurosequential developmental assessment will provide the treatment intervention team a road map for collaborative intervention with successful outcome (Perry, 2006, 2008, 2009). For one, it provides a description of child's past and present developmental domains, presenting the strengths and the areas needing rebuilding, catching-up, supportive care, and treatment intervention. Secondly, it leads the treatment team to choose developmentally appropriate intervention model of therapeutic.

Reunification and Recovery

Tracing and reunification programs that are designed to assist separated young children in finding their families or other caregivers or in receiving safe interim care or both, although helpful, need to be evaluated and monitored to prevent revictimization and to ensure they are supporting an effective healing process. Professionals who work with refugee families play a demanding and highly responsible role in the lives of young children. In addition to the knowledge of normal developmental stages of early childhood, they require specialized training and skill building to understand the emotional and psychosocial needs of young children affected by war. For example, the reunification process requires careful planning and preparation. Professionals need to be prepared to facilitate the primary caregivers' understanding of the complex needs of the traumatized/maltreated young children; help them with readjustment and problem solving; support the family–child reunification; and collaborate with other professionals and local organizations to improve access to community services. In the case of each young child, attention must be paid to both the child's and caregiver's strengths and vulnerabilities throughout the reunification process. Ideally, one person should be designated to act as a fixed point of responsibility, act as a member of the tracing and reunification team, and accompany the young child through the transitional process of the reunification

Resettlement in a new or changed homeland adds challenges to an already fragile family system. Families may experience difficulty understanding verbal and nonverbal communications, differences in the legal and educational systems, and differences in

lifestyles. When families experience events that contradict their cultural expectations, or cannot comprehend the interactions due to cultural and linguistic barriers, it raises the intensity of the trauma and compromises the healing process. Lack of information and a distrust of the system and organizations may play a significant role in limiting access to services and worsening of the existing symptoms. Thus, intervention programs designed for this population must be culturally sensitive when providing information and services. Trained, culturally sensitive and mindful professionals require considerable cross-cultural knowledge. Empathy toward the refugees and compassion for their plight are necessary to improve communication and prevent further alienation. Professionals must be sensitive and mindful of the fine line between cultural stereotyping, and culturally competent and ecologically mindedness (Vargas & Koss-Chioino, 1992).

Coping Strategies

Young child's own characteristics, such as gender; age; developmental stage and maturation; pre-, peri-, and postnatal developmental vulnerabilities and strengths; and temperament play significant roles in trauma-response and incoping capacity. Young children's responses to systemic violence depend on individual variations such as pre-separation trauma and relationships with the significant others in a child's life (Sameroff & Emde, 1989), as well as cultural constructs which impacted practice of parenting. Young children who have experienced nurturing, stable, and caring relationships with their primary caregivers prior to their exposure to systemic violence of war are more resilient and have a higher capacity to cope with stressors (Lieberman, 1997; Lieberman & Van Horn, 2008).

Young children's immediate environment, including the adult caregiver(s) and the professional support team, plays an important role in how traumatized young children recover from the complexities of war. According to many research findings, such as those by Marcus and Rosenberg, (1988), the most outstanding factor in fostering coping and resiliency in the face of traumatic experiences such as systemic violence of war is having a reliable, supportive, and consistent relationship. Galit Ben Amitay (2005) also noted that the duration and intensity of grief is influenced by the manner in which the family and the young child's support system react and interact. Mental health professional can help these young children to gain new coping skills through play therapy (Gil, 1991) individually, in group and/or in dyadic/triadic settings with the significant adults in their lives comforting and reassuring them of protection from harm. They may be helped by learning to express their intense emotions and feelings of fear and confusion among others, through art forms (Malchiodi, 2008), particularly music, known to be beneficial when appropriately applied (Glaser & Strauss, 1967; Oldfield, 2006).

Photo: ©iStockphoto.com/Danish Khan

Resettlement in a new or changed homeland adds challenges to an already fragile family system.

Young children exposed to systemic violence may use avoidance, suppression, and distraction as tools for coping (Herman, 1992), which may temporarily help to minimize painful memories, but does not aid in healing. The healing process for young children may not be the same as adults. Some of the goals for young children who find their world turned upside down, might include the ability to differentiate between reality and fantasy, to discriminate between good and bad intentions and actions, to recognize real danger, to develop resiliency, and to regain developmental capacities and emotional regulation. These goals are possible if they receive safe, steady, predictable supportive care from caregiving adults around them in spite of the chaotic and confusing external world.

The responsibilities of any professional helping traumatized refugee young children are manifold and should take into account the full range of human rights as described by the provisions and principles of the Convention on the Rights of the Child (1989). In the case of children affected by the trauma of war, these may include:

(a) Preventing any further harm directed toward them;

(b) Reestablishing lost sense of trust in adults by being patient, consistent, mindful—compassionate and empathic, and by coordinating efforts with other adults involved;

(c) Helping to reestablish a sense of safety and an opportunity to process memories and emotions important for recovery and coping with loss and traumatic experiences;

(d) Guiding these young children to make sense of the past events and helping them to build a positive sense of self by providing them positive transitional tools to facilitate this shift to recovery; and

(e) Assisting caregivers and significant others in understanding that traumatized young children's responses to extraordinary events in their lives are representations of their inability to make sense of these events and of their lack of skills to self-regulate and organize their intense emotions. When individuals are able to recognize and honor the rights of each child, and provide the protection and care necessary for all children—regardless of race, ethnicity, gender, language, religion, class, or ability—it will allow even the most vulnerable to reach their full potential.

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Field Notes

ZERO TO THREE Fellows share news and information about research, policy, and practice innovations in their work with infants, toddlers, and families.

Training Pediatricians to Ensure the Healthy Development of Infants and Toddlers in Foster Care

Sheryl Dicker, JD, Albert Einstein College of Medicine

Young children in the foster care system are America's most vulnerable because they often do not have an attachment figure and they are more likely to have serious medical conditions and developmental delays than other young children (Dicker, 2009). Thus, training on infant development and health is vital for all professionals who touch the lives of these children.

For 16 years, I directed the Permanent Judicial Commission on Justice for Children that worked to ensure the well-being of children in foster care. We developed materials for policymakers (Dicker, Gordon, & Knitzer, 2001) and checklists for judges, attorneys, and child welfare professionals (Dicker & Gordon, 2004). Most important, we developed a training curriculum for judges that focused on infant health and development (Dicker & Gordon, 2004).

After retiring from the Commission, I joined the faculty at Einstein College of Medicine. With the collaboration of the director of pediatric training at the Children's Hospital at Montefiore at Einstein, we developed a four-session series on foster care for all the pediatric residents. The goal of these sessions was threefold: to provide a basic understanding of the legal system, to grant a working knowledge of the foster care system and its impact on child health, and to train pediatricians to advocate for the health of children in foster care. The sessions reinforced the following:

- All children in foster care have a court order. It is imperative that all medical personnel know that only a court can order a child into foster care. The form and content of actual court orders were reviewed to identify important health-related information including the reason for placement, identification of any court-ordered exams or services, and specifications that could impact hospital visits.
- All children in foster care are eligible for Medicaid. Participants were taught that all medically necessary procedures could be ordered as all foster children are automatically eligible for Medicaid and exempt from managed care in New York. As all foster children are eligible for Medicaid, they are also entitled to Early Periodic Screening Diagnosis and Treatment, which requires a comprehensive examination, follow-up care at periodic intervals, a host of screenings, and treatment for all physical and mental health diagnosed conditions (P.L.101-239).
- Children in foster care have a high prevalence for serious medical conditions and developmental delays. More than half of foster children have a chronic medical problem and more than half have developmental delays—4–5 times the rate of other children. Understanding this reality can shape residents' approaches to children in foster care. Participants were provided in-depth information about the critical Early Intervention (EI) program including making referrals, completing EI forms; and monitoring services.(P.L. 99-457)

As a result of these trainings, we are beginning to see two positive results. First, pediatricians (fellows and even medical students who may attend the sessions) are approaching these children differently as they are armed with the knowledge of their high prevalence for health problems. Second, pediatricians are making referrals to EI for virtually every infant and toddler in foster care.

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Medicaid Amendments of 1989, P.L. 101-239 (1989) (EPSDT)

Early Intervention for Infants and Toddlers with Disabilities, P.L.99-457 (1986) (Part C)

A Home Within

Toni Heineman, MSW, DMH, and **Saralyn Ruff,** MEd, A Home Within, San Francisco, California

A Home Within, a national nonprofit dedicated to addressing the mental health needs of foster youth, has launched a new Web-based program called "Fostering Transitions: Opening Doors to Relationships." This program was designed to address two primary goals: (1) offering support and resources to direct service staff, and (2) offering a tool, guided by theory and research, for working with pregnant and parenting adolescents and transition-aged foster youth. Simply put, we know that staff must receive quality resources and support to guide their work and effectively meet the needs of their clients.

Pregnant and Parenting Foster Youth. Adolescent girls in the foster care system are at high risk for pregnancy. For example, one survey of foster youth in the Midwest found that nearly half of female foster youth reported a pregnancy by 19 years of age (Courtney et al., 2005). These young mothers are at greater risk for mental health problems, substance abuse issues, and homelessness because of their age, past traumatic experiences, and lack of social support. As a result, along with young fathers, these mothers tend to be ill-equipped to raise their children, perpetuating many of the same dynamics that they experienced. In particular, these parents are 5 times more likely than their peers to lose their children to foster care (Dworsky & DeCoursey, 2009). This intergenerational trauma cycle cannot be broken without interventions focused on the emotional, developmental, and social experiences of both parents and children. Fostering Transitions is a tool that can help to break this cycle.

Fostering Transitions. Fostering Transitions is a Web-based resource offering card-based curricula, theoretical overviews, case studies, implementation models, and a Forum to connect providers. The curricula consist of two decks of cards: one for pregnant and parenting adolescents and one for transition-aged youth. Each card is designed to guide discussion with clients in a structured way, focusing on assisting youth to build positive relationships with themselves, their children, and others.

Theoretical Underpinnings. Fostering Transitions is grounded in psychodynamic and attachment theory, and rooted in an understanding of adolescent development. We use attachment theory to help illuminate how the experiences of early relationships affect personality development, coping, self-perception, and beliefs about subsequent relationships. Fostering Transitions also relies on psychodynamic theory to provide an understanding of the complex relationships between individual development, environmental influences, attachment patterns, and the effects of traumatic experiences. That is, this theoretical basis helps staff consider the ways in which all aspects of the self are represented in behavior, and to understand the profound impact a youth's fragmented self-image can have on behavior, feelings, and relationships.

Research and Future Directions. Fostering Transitions is 5 years in the making. The program was successfully piloted from 2004–2009. Results from staff using the curricula indicated overwhelming appreciation for the program and the positive impact it had on their clients. Young parents were particularly drawn to the cards, finding the content thought-provoking and relevant to their concerns and experiences.

Currently, June Madsen Clausen, PhD, director of research and evaluation for A Home Within and associate professor at the University of San Francisco; the Foster Care Research Group of the University of San Francisco; and I are conducting an empirical outcome research study. We are excited to analyze the results in the coming year.

Courtney, M., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., & Bost, N. (2005). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 19.* Chicago: Chapin Hall at the University of Chicago.

Dworsky, A., & DeCoursey, J. (2009). *Pregnant and parenting foster youth: Their needs, their experiences.* Chicago: Chapin Hall at the University of Chicago.

"Holding Required, Baby On Board"

Deborah Harris, MSW, LISW, IMH-EIV, Santa Fe County Infant Mental Health Team, New Mexico

After many years of working with infants, toddlers, and preschool children who had been taken in to state protective custody, and with mounting frustration at a lack of service coordination and shared goals, I dreamed of an approach that would provide comprehensive and unified infant mental health and developmental services to infants in protective custody. Looking to existing models (primarily the infant team at Tulane University School of Medicine, and our mentors Drs. Zeanah and Larrieu, and the ZERO TO THREE Court Team models), my colleague, Jane Clarke, PhD, and I began last year to develop and implement the Santa Fe County Infant Mental Health Team (SF Infant Team) in northern New Mexico.

The SF Infant Team is a demonstration project funded by the state of New Mexico's Children, Youth, and Families Department. It is a collaboration between Child Protective Services (CPS), infant mental health services, mental health services and Part C providers in order to provide specialized, comprehensive assessment and treatment planning to infants from birth to 3 years old and their caregivers in protective custody. Our goal is to develop positive, productive working collaborations between all the parties involved in custody cases where there is evidence of abuse, so that the entire system works in best interest of the infant.

The purpose of the SF Infant Team is to assess the developmental and behavioral health needs of infants in protective custody. This includes completing a comprehensive assessment of the infant's significant caregiving relationships, coordinating services among numerous providers, and providing CPS and the Family Court with information needed to make treatment and custody decisions in the best interest of the baby.

We continue to refine the process of infant–caregiver assessment and reporting formats to develop an approach that is efficient in conveying the infant's needs to a diverse audience. In addition to the assessment and intervention and treatment services that we either provide or supervise, we meet regularly with the CPS-designated team to provide infant mental health training and to discuss specific issues, such as visitation recommendations, foster care support, and communication between the community providers and the CPS workers. This consistent, regular, and reflective meeting with the CPS staff has resulted in a working alliance that did not previously exist between the Part C providers, mental health, and CPS staff. As a result of better communication, increased trust, and coordinated reporting, CPS now actively seeks input from the SF Infant Team, relying on our expertise to guide services and recommendations.

A large part of SF Infant Team effort is aimed at educating the judge, the attorneys, the workers, providers, parents, and foster parents about the emotional needs of babies and very young children in protective custody. This requires a lot of holding (the term coined by Winnicott, 1965, as the provision of a safe, therapeutic

psychological container), including holding the providers (regular reflective supervision and availability), holding the CPS workers (monthly meetings and support at every family team meeting as well as weekly availability), and holding the families and all the time holding the babies so they are foremost in everyone's minds.

Winnicott, D. W. (1965). *Maturational processes and the facilitating environment.* London: Karnac.

Opportunities in Florida's Child Welfare System To Address the Developmental Needs of Infants & Toddlers

Mimi A. Graham, EdD, Florida State University, Center for Prevention & Early Intervention Policy, Tallahassee, FL

National data estimate 38–65% of infants and toddlers encountered by child welfare have delays (Barth, Scarborough, Lloyd, Losby, Casanueva, & Mann, 2008); yet, their needs far exceed states' capacity for early intervention. Despite good intentions, Public Law 108-36, the Child Abuse Prevention and Treatment Act (CAPTA) mandates screening without commensurate funding and omits child welfare children with the most frequent rates of delays. Screening is required only for substantiated maltreatment despite documentation of delays in the majority of unsubstantiated cases (Barth et al., 2008). Only 24% of investigations are substantiated (Florida Safe Family Network, 2010), so CAPTA-based screening efforts do not apply for the majority of children encountered by child welfare.

For the small group of substantiated cases who are routinely screened, few are eligible for Part C services; not because they don't have developmental delays, but because of increasingly restrictive criteria. Unfortunately, CAPTA equates the need for early intervention with the eligibility criteria of each state's Part C provider. Florida, like many states, narrowed eligibility to manage increased service demand and diminished resources. Delays must be 2 standard deviations below the mean in one area or 1.5 SD standard deviations below in two areas, which is enormous for an infant or toddler. But even using this stringent definition, national data indicate that 27.8% of children reported for maltreatment when they are 2 years old or younger would require early intervention; however, of those, only 13.4% had an individual family service plan indicating services (Casanueva, Urato, Fraser, Lederman, & Katz, 2010).

Using national longitudinal data cited above to estimate the number of infants and toddlers in Florida with delays further suggest that more children in child welfare quality for early intervention than are served. A total of 25,544 children ages birth to 3 years encountered by Florida's child welfare system in 2009–10 are estimated to have delays. This includes 65% or 18, 020 of the 27,723 children birth to 3 with "no findings" or "some findings"; 51% or 4,598 of the 9,015 children birth to 3 served in home; and 38% or 5,578 of the14, 680 children birth to 3 served out-of-home. (Radigan, Hogan & Graham, 2011).

The infants and toddlers encountered by Florida's child welfare system estimated to have delays (25,544) far exceeds the number of current children referred to Part C from child welfare. In fact, the numbers are almost double the total current number of Part C children served (13,261). Although there are not precise figures, clearly the number of children encountered by child welfare who need, and could benefit from, early intervention services is much greater than the current capacity of Part C. This suggests a tremendous opportunity to bring specialized developmental specialists with trauma and infant mental health expertise into child welfare systems, especially with flexible funding under Florida's Title IV-E Waiver. A lifetime cascade of problems could be minimized by addressing the needs of the most vulnerable infants and toddlers.

Barth, R. P., Scarborough, A. A., Lloyd, E. C., Losby, J. L., Casanueva, C., & Mann, T. (2008). *Developmental status and early intervention service needs of maltreated children: Final report.* Washington, DC: U.S. Department of Health and Human Services.

Casanueva, C., Urato, M., Fraser, J. G., Lederman, C., & Katz, L. (2010, December). *Need and receipt of early intervention services among infants and toddlers investigated for maltreatment.* Poster at ZERO TO THREE National Training Institute, Phoenix, AZ.

Florida Department of Children & Families, Office of Family Safety, Safe Family Network (2010). Data Repository, Run Date October 5, 2010. Tallahassee, FL.

Public Law 108-36, the Child Abuse Prevention and Treatment Act (CAPTA) June, 2003.

Radigan, L., Hogan, A., & Graham, M. (2011). *Helping the child welfare population in early intervention: Implications for practice.* Unpublished report available at www.cpeip.fsu.edu. Tallahassee, FL: Florida State University Center for Prevention.

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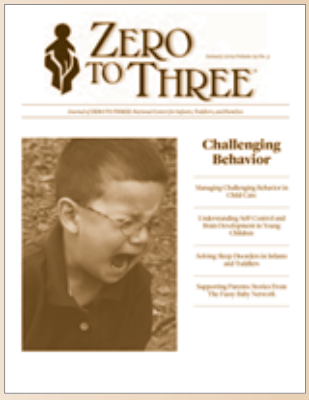
ITEM NO.: 249-OLB



Challenging Behavior
ITEM NO.: 405-OLB

Environmental Health Risks to Infants, Toddlers, and Families
ITEM NO.: 343-OLB

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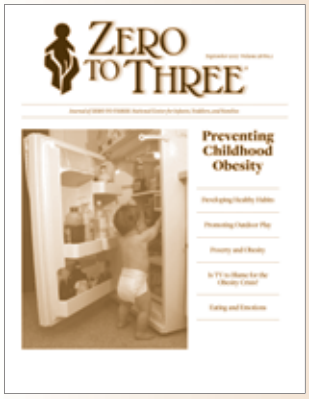

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ITEM NO.: 390-OLB

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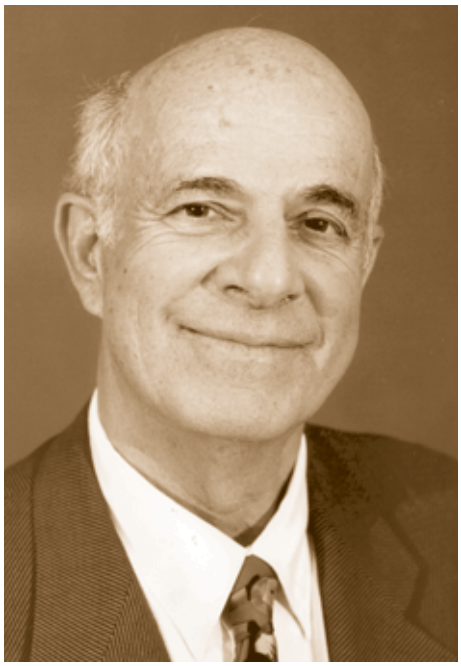
In Memoriam

Bernard Levy

On December 10, 2010, our nation's babies and toddlers lost a major champion. Bernie Levy, a Founding and current Board Member of ZERO TO THREE, was a successful businessman who was a passionate advocate for our youngest children. He dedicated his philanthropy to support a range of programs and services that helped all babies and toddlers have an equal chance to reach their full potential.



Bernie, a flourishing designer-wear businessman, made a life-changing decision at age 40. He enrolled in graduate school for a psychology degree in hopes of a career with more personal fulfillment. He became interested in the early years after taking a graduate course in psychopathology that began his "keen interest in human development." However, after further study, he announced that, "The last thing the world needs is more therapists. It needs prevention."

Bernie described his investment in the early years in a past issue of ZERO TO THREE's *Growth Chart.*

I realized the powerful influence the very first days, months and years of life have on a person's whole life. I understood that emotional and other difficulties can start very early on, and it is best to tackle them as soon as they appear. I wanted to do something to contribute.

And contribute he did for more than 33 years. It all started with Bernie's sharing his interest in early childhood with his cousin, Steve Sharfstein, then acting director of the National Institutes of Mental Health.

He invited me to sit in on meetings back in 1976 that involved some of the "titans" of the early childhood development field—people like Stan Greenspan, Sally Provence, T. Berry Brazelton, Al Solnit and Ron Lally. I was tremendously energized and excited. And best of all, I realized that I could bring my business mind to help concretize these experts' plans to advance the knowledge of the early years, and to share the perspectives of multiple disciplines to enrich that knowledge. They allowed me to join them and it has been a fabulous journey ever since.

Bernie made the initial $12,000 investment to create ZERO TO THREE and in doing so provided the "secure base" for researchers, scientists, and clinicians to share what they were learning and advance the field of infant mental health.

Bernie had a special passion for expanding primary pediatric care to better meet the needs of families with babies and toddlers. His vision was for all pediatric practices to provide comprehensive parenting and child development services to help parents promote their child's healthy overall development.

Bernie was also very committed to and supportive of ZERO TO THREE's efforts to spread the word and raise public awareness about the importance of the early years. In his own words, he explained,

Twenty-five years ago, if you explained that babies learn, react and relate to their environment right from the start, it would have largely fallen on deaf ears. Today, these facts are more generally accepted and that gives me great pleasure. I know that ZERO TO THREE had a great deal to do with it.

While proud of the advancements in the understanding of the importance of the early years, Bernie felt there was still much work to be done.

I feel that corporate America doesn't fully understand that investment in the early years would greatly contribute to our society's need for a steady stream of emotionally stable, highly skilled and educated workers. I hope we can achieve these goals in our next 25 years.

Some ZERO TO THREE leaders shared their reflections:

Bernie was a generous, joyful, clear-thinking and straight-talking man whose contributions were made quietly but had a long reach. He had a quick and irreverent sense of humor that he often used to laugh at himself because his own impressive achievements failed to impress him—he always kept in mind how much more remained to be done. One of his most endearing qualities was the combination of a passionate humanism and belief in a better future with a sharp and pragmatic mind and a refreshing impatience with intellectualism as a phony barrier to effective action. We are losing a dear, loyal, and invaluable friend, and I will miss him very much.

—Alicia F. Lieberman, PhD

Bernie was a passionate visionary who never stopped advocating for innovative ways to support young parents to ensure their babies have the best start in life. He inspired all of us to do all we can to support the healthy development of infants and toddlers. His passing is a loss for our field and babies throughout America.

—Matthew E. Melmed

Bernie Levy was adamant about helping young parents. He was such a keen observer and believed every person could benefit from guidance, support, and a vote of confidence as they embarked on and traversed the journey of parenthood. In his mind development had no bounds at any age or stage and insisted we support the development of children, parents, pediatricians, and educators from the start. It was a privilege to work with him and I will miss him.

—Serena Wieder, PhD

Bernie was a dedicated philanthropist, husband, father, grandfather, brother, uncle, and friend. He will be deeply missed by ZERO TO THREE!

Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three,* we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	*What it means*
Adverse Childhood Experiences (ACE) Study	The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. The ACE Study analyzes the relationship between multiple categories of childhood trauma and health and behavioral outcomes later in life. (Find it in Hudson, page 23)
Attachment and Biobehavioral Catch-up (ABC) intervention	The ABC intervention for children in foster care consists of 10 interactive sessions for foster parents and their foster children conducted in the home by professionals. Each session has a specific focus, with the overall goals of helping foster parents nurture children when children are distressed and follow children's lead with delight when children are not distressed. (Find it in Dozier, Bick, & Bernard, page 17)
Historical trauma	Historical trauma refers to an emotional stressor caused by trauma inflicted on an entire population. Some examples include the Holocaust, African slavery, and the attempted elimination of Native American cultures. (Find it in Hudson, page 23)
Hypothalamus-pituitary-adrenal (HPA) axis	The HPA axis is a complex set of interactions between the hypothalamus in the brain, and the pituitary and adrenal glands. This axis, or set of interactions, has a number of functions, including the maintenance of a diurnal pattern, or daily sleep and wake cycle. (Find it in Dozier, Bick, & Bernard, page 17)
Fetal Alcohol Spectrum Disorders (FASD)	FASD refers to a grouping of several developmental disorders that are all initiated by the child's exposure to alcohol while in the womb. FASD includes Fetal Alcohol Syndrome (FAS), alcohol-related neurodevelopmental disorder, and alcohol-related birth defects. (Find it in Herrick, Hudson, & Burd, page 44)
Neurobehavioral effects	The neurobehavioral effects of alcohol exposure on the developing fetus include a range of problems such as attention and memory problems; deficits in speech, vision, and information processing; distractibility; and an inflexible approach to problem-solving. (Find it in Herrick, Hudson, & Burd, page 44)

UPCOMING ISSUES

March: Early Intervention for Infants and Toddlers With Disabilities
May: Family Child Care
July: Professional Development

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