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Healthy Attachment for Very Young Children in Foster Care

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Attachment Relationships in Young Children

Understanding secure and insecure attachments can help attorneys and judges make informed decisions about placements, visits, and other issues that affect the lives of foster children. Reading in a case report that a child spent half of a visit with her mother playing independently could indicate that the child has a healthy attachment, although it may seem counterintuitive. A child who flails and kicks when reunited for a regular visit with mom may be saying, "This is not a safe person for me, I am afraid" or he may be saying, "Where have you been mom? Why did you leave me? I have been scared!"

Secure Attachments[1]

When an infant or toddler has a good and loving relationship with a caregiver he will most likely develop a secure attachment to that caregiver, formed through ongoing interactions. This relationship goes beyond the baby simply having his physical needs met, it also extends into emotional and psychological domains. A secure attachment reflects a child who has come to understand that her caregiver is available to her emotionally and physically and that she can feel safe and cared for by him. The security of this relationship also provides the foundation for all future relationships the child will experience. The positive relationship this child develops also provides the basis for being able to explore the world around him (because he feels safe enough to try new things).

Having secure attachments can help infants and toddlers grow into successful and happy children and adults. These children are more self-aware, have better social and sensorimotor skills, and have more developed and earlier language skills. Secure attachments also support the child in developing a healthy self image. Their experiences tell them "I am worthy of being loved" and "I can trust others to care for and nurture me."

Over time, children develop attachments with many people in their lives. These attachments tend to be hierarchical, and may change over time as the relationships with the people change. For example, an infant may develop an attachment to mom, dad, grandma, foster mother, day care provider, or a sibling. Based on the interactions and level of emotional and psychological connection within these relationships, the nature of the attachment will vary. The child could develop a secure attachment to a foster father and an insecure attachment to a birth mother, or vice versa.

Even a child who has developed a problematic relationship or connection with one or both of their parents may still have experienced loving, supportive care by someone else. A grandmother may have provided an opportunity for a healthy secure attachment or a day care provider may have given the child enough stability and proper care that the child may have developed some healthy social skills, helping him transition or adapt at a higher level. It is important to understand the various relationships to which the child has been exposed.

Children who have at least one

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secure attachment may experience benefits even if they also have one or more insecure attachments, but it is essential that the healthy attachment be supported and continue. For children in foster care, this means ensuring contact with caregivers to whom they are attached even if the child does not live with the caregiver. It also means fostering new secure attachments while in care—particularly for children with insecure attachment histories (discussed below).

Insecure Attachments

A child who lacks a fulfilling and close relationship with his caregiver may experience things very differently. Attachment relationships that are insecure can manifest in several ways. Infant mental health experts often recognize different types of attachment by observing children's behavior with caregivers and with strangers:

- *Anxious-ambivalent insecure attachment:* A child with this type of attachment may become needy and clingy with his caregiver, fearing any separation will be a permanent separation. He may also reject his caregiver out of anger and frustration since he has not had his needs met consistently. He may appear nervous with a caregiver and may not interact with strangers even if a caregiver is nearby. He may become very upset when the caregiver leaves and have mixed reactions—both clingy and angry—when she returns.
- *Anxious-avoidant insecure attachment:* A child who has not become securely attached to a caregiver may also go the opposite route and withdraw, having learned not to depend on her to get what he needs. This child may not appear to mind when a caregiver departs and may avoid both her caregiver and strangers when she is with them. This child may be unlikely to explore or play in a new setting, even if the caregiver is nearby.
- *Disorganized/disoriented attachment:*[2] Some children may seem frightened or out of sorts when with a caregiver. These children have not developed an organized strategy to connect with or depend on their caregiver (often seen in abusive relationships). Upon the departure and later return of a caregiver, this child may collapse at her feet and avoid further interaction. These children often have a great deal of difficulty recovering from even brief separations and emotionally "fall apart," unable to get to a place where they can begin exploring their environment again.

Children with insecure attachments often show little interest in others or their environment or they may develop superficial connections with anyone available—interacting with but never really developing a significant attachment relationship. As a result, they usually fail to develop the emotional and psychological foundation to help them grow into successful older children and adults. Children with insecure attachments may not reach out to adults for help because they have learned not to depend on caregivers to meet their needs. This deprives them of an opportunity to have basic needs met, as well as to learn and be exposed to new language and information. They may also be less likely to initiate peer interactions and have a harder time engaging in nonviolent, enjoyable play.

Insecure attachments can often become secure with the right help and support, as discussed below. Parents can learn to be consistent, be more emotionally available, follow their child's lead to meet their needs, and comfort them in supportive ways. Substitute caregivers can also help children develop secure attachment histories, as discussed later

Lessons in Attachment

Stella

Stella's mom welcomes a new neighbor to her home. Stella, age 14 months, is playing with blocks. She takes notice of the neighbor, looking at him then quickly looking to her mom. She thinks, "Mom's not getting upset, this might be okay." Feeling somewhat reassured, Stella crawls over to her mother. Stella grabs onto her mom's leg, and pulls herself up, while keeping an eye on this new person in her home. Her mom introduces the neighbor. Stella feels her mother's calmness; she is reassured by hugging her mom's leg. Within a few seconds, Stella smiles at the neighbor, she crawls over toward him, but stops suddenly looking back at mom, who is also smiling. She then reaches for one of her blocks, rolls it in her hands a few times, then offers it to the neighbor. Stella has figured out it is safe to play and share with the neighbor. She can do this because she is secure in her attachment relationship with her mother.

Rosie

Rosie's mother allows the new visitation supervisor to come into the visitation room, offering a seat on the corner chair. Rosie, age 14 months, is playing. She looks up at the supervisor, dropping her toys. She moves quickly toward this new person, babbling to her. Rosie grabs onto the supervisor's knee, then tries and pull herself up onto her lap. Rosie's mother watches, commenting "Rosie is very friendly, she likes everybody!" Rosie seems to have forgotten her mother is in the room, she does not search for her or seek her approval. Once on the stranger's lap, she reclines against her and appears comfortable. Rosie is trying to connect with the stranger, she demonstrates no need for her mother. Rosie's mother tries to interest her in different toys, but Rosie focuses on the stranger so intensely she does not return to play. She is unable to rely on her mother for a sense of safety and security and instead tries to connect with someone she has met only moments ago. When it is time for the visit to end, Rosie walks calmly out with the foster father who had just arrived, avoiding her mother's multiple attempts to get her to say or wave goodbye. Rosie does not look back. Rosie is showing signs of an insecure attachment relationship with her mother.

in this article. Knowledge about healthy attachment allows judges and attorneys to order or advocate for appropriate services, break unhealthy cycles, and improve the lives of children and their caregivers.

Children in Foster Care and Attachment

Prolonged separation or repeated separations from a consistent primary caregiver—whether the attachment is secure or insecure—can be traumatic for a very young child. When a secure attachment is disrupted a child has a higher likelihood of negative outcomes such as mental health issues, trouble in school, and poor social skills. Once this relationship proves unreliable it may be harder for her to trust a new caregiver and form a secure attachment to that adult. When an insecure attachment is disrupted, the impact could be even stronger, because the child is starting out at a disadvantage (e.g., was learning and exploring less before the disruption). For example, when a child has already developed an insecure relationship with a primary caregiver and is then placed in foster care the child is experiencing a huge change—it does not matter if it is a change for the good or for the worse—it is a change and it can be overwhelming. To deal with the stress of the change the child needs adequate coping and adaptation skills. These skills are likely to be underdeveloped if the child has only experienced problematic relationships.

A healthy, secure attachment generally means the child has been supported in learning coping skills, helped to adapt to changes, learned to contain and soothe distress, and learned to self-regulate their emotions and behaviors. These skills all come into play with major life changes, such as loss of a primary caregiver. However, the child can really only use them successfully within the context of a relationship with a healthy adult. On their own, such skills are not enough to maintain the child's stability and promote healing.

A child with an insecure attachment has not had the opportunity to develop a healthy repertoire of coping or adaptation skills. They often become quickly overwhelmed by loss and change. This can take its toll not only emotionally and psychologically, it can also take a physical toll, interrupting growth and development. When placed with caregivers who promote healthy relationships, the child may begin to develop the necessary skills quickly; however, healing may take time. Some children may have periods of growth and improvement as well as periods of regression.

Maintaining an infant or toddler's attachment relationship with a primary caregiver is critical, however, some caregivers may not be safe or best for the child. This is often true when domestic violence, substance abuse, and severe parental mental illness are present. When young children require a safe home and caregivers who can adequately meet their needs, there are many ways judges and attorneys can help support healthy attachments with substitute caregivers, and improve the quality of attachments with biological parents. Strategies include:

Respect Babies' Routines: All babies benefit from routines, but foster children, because of other disruptions and trauma in their lives, may need them even more. Encourage caseworkers to schedule visits, medical appointments and other services around the child's nap and feeding times (e.g., don't schedule a speech therapy appointment when the baby would normally be sleeping, and if a visit overlaps with the baby's normal lunch time, encourage the parent to feed him during the visit).

Minimize Placement Changes: The idea that a baby won't be damaged by disrupted relationships because she is too young to know what's going on is simply untrue. Consider whether a child could safely remain at home if

Further Reading

The work of John Bowlby and Mary Ainsworth is the foundation for current attachment theory. These readings provide a closer look at the basics of attachment in very young children:

- Ainsworth, MDS & B.A. Wittig. "Attachment and Exploratory Behavior in One Year Olds in a Strange Situation." In *Determinants of Infant Behavior,* edited by BM Foss. London: Methuen, 1969, 113-136.
- Bowlby, J. *Attachment and Loss, Volume 2: Separation, Anxiety, and Anger.* London: Penguin Books, 1973.
- Bowlby, J. *Attachment and Loss, Volume 1: Attachment. Revised Edition.* London: Penguin Books, 1984.
- Bowlby, J. *A Secure Base: Clinical Application of Attachment Theory.* London: Routledge, 1988.

intensive in-home services are offered. Ensure that initial foster care placement decisions are well thought out and investigated and that caregivers receive every possible service (e.g., respite care, home nurse visits) to prevent or resolve problems so the placements can last until permanency is achieved. Choose a foster home that has the potential to become an adoptive home and begin concurrent planning as early as possible.

Minimize Chaos: Transitions tend to be vulnerable times for most infants and toddlers. Between visits, services, and child care, a young child could be handed off from one adult to another and change environments many times in a typical day (e.g., dropped off at day care by a foster father, picked up and taken to a visitation center by a caseworker, visit for two hours with biological mother, home with the foster mother for a few hours, then out again to a physical therapy appointment). Ask what the infant or toddler's daily schedule might include and see where the number of transitions in a day can be lessened to increase stability.

Move Quickly: For a six-month-old, four weeks is a significant portion of her life. Avoid court continuances and don't wait for court appearances to act on information, requests for services, etc.

Encourage Child Development Education: Unrealistic expectations of a young child can have disastrous consequences and interfere with the development of healthy attachments. Some parents incorrectly believe that a two year old should be able to read a book to himself, a six month old shouldn't cry so much, a three month old should be able to feed herself, or a 15 month old should be able to potty train. If the parent believes the baby is not performing tasks she should be able to, the caregiver may get frustrated or angry with the baby, or not give enough positive reinforcement, missing out on an opportunity to nurture health attachments. Birth and foster parents should take parenting classes tailored to the needs of infants and toddlers so caregivers can learn appropriate developmental expectations.

Address Caregiver Mental Health: Birth or foster parents who are experiencing untreated mental health issues, such as depression, may have difficulties interacting with their child, leading to poorer quality attachments. Depressed caregivers often withdraw from their children, setting up a neglectful pattern of interaction. Caregivers experiencing psychosis can often become so confused by their own thought processes that they fail to keep their child safe or expose them to odd and confusing interactions. Ensure that caregivers receive necessary assessments and services if there is reason to suspect depression or other mental health issues.

Support Visitation: Birth parents who have had difficulties understanding their babies or dealing with mental illnesses often need support around visitation. Providing an infant mental health specialist who can "coach" interactions between parent and child can help the parent learn new and effective ways to interact with their child, leading to more successful interactions and healthier attachment relationships.[3] A substitute caregiver may also help model positive interactions and parenting skills for biological parents.

Role of the Caregiver

Understanding a caregiver's own attachment and relationship history can help shed light on the caregiver's behaviors and interaction patterns. A mother may love and care deeply for her child but still not have good, or even adequate, interactions with her child. If her own needs were rarely met, she may not be able to understand how to meet her child's needs. If she has experienced rejection throughout her own childhood, she may interpret her own child's actions as another rejection in her life.

If a baby turns his head, cries, or pulls away when she tries to hold or feed him, a mother with a history of rejection may interpret the baby's actions as a rejection and feel that he doesn't need or want her. This interpretation may cause her to withdraw further from her child, setting up a cycle of rejection between parent

Programs for Caregivers

Infant mental health specialists can work with biological parents, kinship caregivers and foster parents to help them create healthy attachments with babies. The following early intervention resources use attachment theory to promote bonding between foster youth and their biological or foster parents:

Attachment and Biobehavioral Catch-up (ABC) Intervention

800/377-5557; http://icp.psych.udel.edu

ABC Intervention is a home-based program that addresses the special emotional and relationship needs of children who have experienced disruptions in care. It works birth parents, foster parents and relative caregivers of children up to 20 months of age. This program encourages caregivers to provide nurturance even when it does not come naturally or when the child does not appear to need it, and is being used across the country. It also helps create a calm and predictable home environment, so that children can learn to regulate their behaviors and emotions. Trainers visit the family for an hour each week over a period of about 10 weeks.

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is a therapeutic treatment originally designed to help young children exposed to domestic violence. The model was later extended to include children up to age seven dealing with various kinds of trauma, including entry into the foster care system. CPP is usually home-based and occurs during weekly sessions in which the clinician works to facilitate and strengthen a parent-child bond. A circle image serves as a graphic teaching tool to symbolize the child's needs and attachment system. CPP has been adopted by various social service agencies nationwide and is described at length in: Lieberman, A.F. & Van Horn, P. *Don't Hit My Mommy: A Manual for Child-Parent Psychotherapy with Young Witnesses of Family Violence.* Washington, DC: Zero to Three (2005).

The Circle of Security (COS)

509/455-7654; http://www.circleofsecurity.org

Circle of Security teaches parents the basics of attachment theory—using graphics, video clips and live instruction—so that they can better understand their own children. Professionals use the Circle of Security protocol to work with parents through home visits, family therapy or a 20-week series of group sessions. COS is unique in that in addition to individual therapy, participants have the option of receiving group-based services (e.g., three to six caregivers with their infants). Parents improve their ability to recognize and respond to their children's needs, and to understand their own strengths and weaknesses.

Minding the Baby

203/785-5759; http://childstudycenter.yale.edu/services/baby.html

This is a preventative, home visiting program that pairs a pediatric nurse practitioner and a clinical social worker with at-risk, medically-underserved young families. The focus of each team is to enhance attachment relationships by helping parents develop the ability to recognize their own positive and negative parenting behaviors, and supporting positive parenting behaviors, child health and safety, maternal health, and child development. The program, based on attachment theory, is available beginning during pregnancy and lasting until the child's second birthday and has been used across the country. The intervention is flexible and can be individualized to respond to the unique needs and beliefs of multicultural families and teen mothers.

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and child. Alternatively, a parent with a healthier attachment history may take the child's head turning and crying as a sign that the baby is upset and put more effort into soothing and engaging him.

Having a poor attachment or relationship history does not mean a parent cannot become a better parent. Many current programs (see list above) have demonstrated that most parents can become good, healthy caregivers with the right instruction and support. There are many ways to give caregivers and children the best chance at healthy relationships:

Take Advantage of Infant Mental Health Services: Several Infant Mental Health programs across the country work with parents and infants to improve interactions and relationships. In these programs, infant mental health specialists work with parents to address their own insecurities and to reframe their responses to their children. They help parents interpret their child's signs and bids for attention through a healthier lens. They help

parents communicate with, connect to and nurture their children, and help parents overcome barriers such as their own anxiety or fears. (See p. 89 for list of programs.)

Start Services Early: Repairing broken relationships takes time. To give very young children and their caregivers the best chance at a healthy relationship, however, sessions with an infant mental health specialist should begin as soon as an attachment or a relationship issue is detected, supported by frequent visitation. Infant mental health specialists can even begin at birth with a high-risk parent.

Be Able to Recognize Healthy Caregiver Behaviors: Many specific parenting behaviors support developing a healthy attachment relationship between a child and caregiver. For example, emotional availability, sensitivity, the ability to reciprocate, the ability to focus on the child and follow their lead, the ability to sooth distress, and the ability to verbalize actions and feelings to the child. A healthy relationship would also lack hostility toward the child such as calling them names, yelling at them, or mean teasing. The caregiver and child should be able to share attention on a task or object (even a three month old can do this), interact in a reciprocal manner, and jointly share an emotional state, such as joy.

Support Attachments with Multiple Caregivers: Even with professional help, not all parents will ultimately succeed within the timelines set by the Adoption and Safe Families Act of 1997. Concurrent planning should be established, so that the baby doesn't lose the opportunity to form other healthy attachments, and does not need to remain in care longer than necessary if his parents are not able to successfully engage. Attorneys and judges should also consider whether foster parents and children would benefit from infant mental health services.

Ensure the Child-Placing Agency Considers Foster Parents' Attachment and Relationship Histories: Research shows that a foster parent's past attachments also play an important role in the relationships they form with children. One study of infants who had been neglected and then placed in foster care before 12 months old showed that the babies who were placed with foster mothers who had secure attachment histories themselves developed secure attachments over the long term.[4] Infants placed with foster mothers who had insecure attachments formed disorganized attachments. Babies who have a history of trauma within their relationships should be matched with foster care providers who can provide sensitive and nurturing care within the context of a secure attachment history.

Conclusion

Having secure attachments can help very young children succeed later in life. Children with healthy attachments are more independent, and more likely to explore and interact with their environment, leading to earlier and greater learning. For any child, a stable relationship provides the structure they need to learn coping skills, adapt to changes, and soothe themselves when they are distressed. Having a consistent adult provides predictability and helps the infant understand what is happening around them.

In contrast, children with insecure attachments often experience the world as hostile, unforgiving, unpredictable, or simply uninterested in them or their needs. These children often become adults who develop relationships and patterns of interaction that mimic these experiences. As parents they may not know how to help their children develop secure relationships.

Ensuring that children and caregivers receive appropriate services and support helps children develop and maintain healthy attachments, and improves outcomes for families involved with the child welfare system.

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Endnotes

1. Attachment theory has evolved over the last several decades and reflects the pioneering work of John Bowlby and Mary Ainsworth. (See, e.g., Ainsworth, M., et al. *Patterns of Attachment.* Hillsdale, NJ: Erlbaum, 1978.) Many others have followed in their footsteps and both broadened the application and teased out the specific components that support the healthy development of a child-caregiver attachment relationship.

2. The disorganized attachment category was developed later than Ainsworth's original insecure attachment categories. See Main, M. & E. Hesse. "Parents' Unresolved Traumatic Experiences are Related to Infant Disorganized Attachment Status: Is Frightened/Frightening Parental Behavior the Linking Mechanism?" In *Attachment in the Preschool Years: Theory, Research, and Intervention,* edited by Greenberg, M.T. et al. Chicago, IL: University of Chicago Press, 1990, 161-182; Main, M. & J. Solomon. "Discovery of an Insecure-Disorganized/ Disoriented Attachment Pattern: Procedures, Findings and Implications for the Classification of Behavior." In *Affective Development in Infancy,* edited by T. B. Brazelton & M. Yogman. Norwood, NJ: Ablex, 1986, 95-124.

3. Infant mental health specialists are mental health professionals who have had specialized training in the needs of infants and toddlers. They can often be located through child development centers, child therapy practices, pediatrician offices, and university centers.

4. Stovall, K.C. & M. Dozier. "The Development of Attachment in New Relationships: Single Subject Analyses for Ten Foster Infants." *Development and Psychopathology* 12, 2000, 133-156.