

PRACTICE NOTES

For North Carolina's Child Welfare Workers

From the NC Division of Social Services and the Family and Children's Resource Program

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In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!

To comment about something that appears in *Practice Notes*, please contact:
John McMahan
Jordan Institute for Families
School of Social Work
UNC-Chapel Hill
Chapel Hill, NC 27599-3550
jdmcmaho@unc.edu

Newsletter Staff

Mellicent Blythe
Sarah Marsh
John McMahan
Laura Phipps

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Attachment and Child Welfare Practice

Parent-child attachment has a powerful influence on child welfare work. Healthy attachment gives children a solid foundation for their cognitive, social, and emotional development. When attachment is secure, often things are much easier.

Unfortunately, secure attachment isn't all we see in our work. Because abuse and neglect interfere with attachment, we frequently encounter children and families struggling with attachment security.



Why Attachment Matters

Most of us are aware attachment is an important part of healthy development. Yet we may not know exactly **why** attachment is so important or understand how secure attachment occurs.

Secure Attachment

Attachment occurs when a child has a secure, consistent, reciprocal relationship with a preferred person—typically the child's primary caregiver. When the caregiver is sensitive to the child's needs and responds in ways that are warm, nurturing, and make the child feel safe, the child begins to use this person as a secure base from which to explore and, when necessary, as a haven of safety and comfort (Waters & Cummings, 2000 cited in Benoit, 2004; Moulin, et al., 2014).

If a caregiver is consistently available, responsive, and nurturing, by the final months of the first year the child's attachment to that person is very likely to be "secure," meaning the child is confident the caregiver will always be available to help or save them (Bowlby, 1982; Wolpert, 1999).

Attachment matters. Although it's most obvious when we're young, its powerful influence is felt throughout our lives.

To successfully ensure the safety, permanence, and well-being of children it really helps to be "attachment literate." This means knowing what attachment is, how it works, and how to respond effectively to attachment problems.

We hope this issue of *Practice Notes* will be a helpful resource in your ongoing study of this important topic. ♦

To succeed in child welfare practice, it helps to be "attachment literate."

Benefits of Secure Attachment

Secure attachment has been linked to many positive child outcomes, including:

Brain Development. The brain grows rapidly during the first three years of life. Experiences shape how the brain grows. When it is stimulated in positive ways, the brain forms connections related to those experiences. For example, talking, singing, and reading to children help form brain pathways related to language.

Attachment affects brain development in two important ways. First, because the child feels safe and cared for, the brain can use its energy to develop pathways crucial for higher level thinking. Secure attachment is particularly related to the development of the frontal cortex, which is responsible for decision making, judgment, and reasoning (DeBellis & Thomas, 2003; Dozier, et al., 2008).

Second, by providing a "home base" from which a child can safely explore the world, secure attachment allows the child to have more varied experiences and therefore build more connections in the brain.

Social & Emotional Development. Attachment to a primary caregiver is the foundation of all future relationships. When there is a secure attachment, cont. next page

Why Attachment Matters

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you learn how to trust others, how to respond emotionally, and how others will respond to you (Bowlby, 1982).

In addition, secure attachment leads to the development of **empathy**. If a child sees herself as worthwhile and deserving of care, she is also able to see others that way. Only when a child believes her own basic needs will be met can she attend to others' needs. The child works first to please her primary caretaker and over time extends her concerns to siblings, friends, classmates, community members, and, as her moral development continues, to people she has never met.

Self-Regulation. When caregivers respond to them, infants learn to manage their own feelings and behavior. When infants are overwhelmed, stress hormones are released in the brain. When caregivers respond with soothing behaviors, they help the child reduce these hormones.

Over time, the brain develops pathways that allow this soothing behavior to kick in during periods of stress. Eventually the child is able to calm themselves when they are angry or disappointed.

Trauma and Attachment

Inherent in the trauma of child abuse and neglect are experiences of fear, stress, and rejection by the very person who is supposed to protect and soothe the child. Because these emotional experiences are in direct conflict with the experiences that promote attachment, it follows that children with a history of maltreatment often have attachment problems.

Children with trauma histories may have a wide range of problems related to lack of secure attachment; these include developmental delays, difficulty with emotional regulation, impaired social relationships, aggression, low self-esteem, and depression (Hildyard & Wolfe, 2002; Erickson & Egeland, 2002; Shipman, et al., 2005).

Supporting Secure Attachment

As a child welfare worker you are

Some Indicators of Secure Attachment	
Child's behavior	Parent's behavior
1 to 18 months	
<ul style="list-style-type: none"> • Signals needs; relaxes when need is met • Responsive; has full range of emotions • Checks back to parents for reassurance when strangers are present • Exhibits anxiety, anger, or flattened affect when parents leave • Pleased when reunited with parents • Checks in to feel safe when exploring • Turns to parents for comfort 	<ul style="list-style-type: none"> • Responds to baby's signal; identifies needs most of the time • Returns to relaxation along with baby; feels good about self and child • Offers nurturing, soothing responses • Woos child, initiates positive interactions, calls baby by name • Makes frequent eye contact with child • Encourages safe exploration
18 Months to Five Years	
<ul style="list-style-type: none"> • Can handle longer periods of separation (in hours) without anxiety • Increasing ability to accept redirection, discipline, and authority • Shows empathy, remorse, and guilt • Uses "wooing" and "coercion" to try to influence parents 	<ul style="list-style-type: none"> • Responsive to child's needs and cues • Encourages growing autonomy and praises accomplishments • Redirects/sets limits when needed without overreacting to bad behavior • Enjoys reciprocal affection and interaction with child
Grade School	
<ul style="list-style-type: none"> • Behaves as though he likes himself • Shows pride in accomplishments • Exhibits confidence in own abilities • Accepts limits imposed by adults • Establishes eye contact • Expresses likes and dislikes 	<ul style="list-style-type: none"> • Interested in child's school performance • Accepts expression of negative feelings • Responds to child's needs and fears • Initiates appropriate signs of affection • Seems to enjoy the child • Knows child's likes and dislikes
Adolescents	
<ul style="list-style-type: none"> • Knows personal strengths/weaknesses • Engages in positive peer interactions • Exhibits signs of conscience • Involved in interests outside the home • Developing goals for the future • Emotionally close to parents 	<ul style="list-style-type: none"> • Encourages self-control • Trusts adolescent with increasing levels of responsibility • Interested in/accepts teen's friends • Interested in teen's school performance • Shows affection
Sources: Queensland Department of Child Safety, 2007; Fahlberg, 1991	

in a position to help support secure attachment with both biological and resource parents. Here's how:

Educate. Make sure caregivers know why secure attachment matters and the behaviors that build it. Messages to send include (Dozier, et al., 2008; Wittamer, 2011):

- Be responsive and warm
- Respond to children's needs
- Soothe children in distress
- Learn to read and respond to children's cues
- Spend time together (quantity matters)
- Engage in positive physical contact (hugging, singing, holding, etc.)
- Play with children, specifically in activities that support reciprocity.

Provide concrete supports. Overwhelmed caregivers have difficulty focusing on the needs of children and are not as effective at reading and responding to cues. Providing concrete supports and resources that help caregivers manage stress allows them to focus on their children's needs.

In addition, young and inexperienced parents may need to build their knowledge of parenting and child development. Although parenting programs can help with this, they are not all alike. Look for programs, such as the Incredible Years, Attachment and Biobehavioral Catch-Up, and Circle of Parents, that have a specific focus on cultivating skills that build attachment (Wittamer, 2011). ♦

Identifying Attachment Problems

Understanding the quality of a child’s attachment with his caregivers can help you intervene more effectively to promote safety, well-being, and permanence.

Every Child Has Attachment

Before we go further, it’s important to understand one fundamental concept about attachment. The question isn’t whether or not children are attached to their caregivers. Attachment isn’t something a child has or doesn’t have.

Attachment develops even in the face of maltreatment and severe punishment. It is the quality of the attachment relationship that is compromised in these circumstances, not the presence or strength of attachment (Carlson, et al., 2003).

In other words, no matter how harmful a child’s parents might seem, the child still has a strong attachment to them that needs to be respected. A child removed from an abusive or neglectful home will experience just as much pain and trauma, and possibly even more, than a child separated from a healthy and loving parent. As you probably know from experience, children are unlikely to be relieved or grateful at being “rescued,” regardless of how clear-cut the danger may appear to us. In fact, for children who lack a safe and secure attachment figure in their lives, being removed from their home is likely to reinforce their negative beliefs about themselves and the world around them.

The table below provides detail on the different categories of attachment and what you might see in each when a child is in distress. As the table indicates, there are two main categories of attachment—organized and disorganized.

Organized Attachment

When most people hear the words “organized attachment,” they usually think of secure attachment. This is nat-

ural. Most children have attachment that can be described as secure. The benefits and hallmarks of this type of attachment are described in detail in the preceding article.

Yet some children’s attachment can be considered “organized,” even though it is not secure. When caregivers are unable or unwilling to respond to a child’s basic need for food, comfort, and nurturing, children figure out other ways to get their needs met. In the process they may develop patterns of behavior with their caregiver that elicits what they need despite the lack of consistent, sensitive care. Some of these patterns are considered “organized” because, in a sense, the child knows what to do and does the same things repeatedly.

While to an outsider the behavior looks problematic, it helps the child survive. It is a coping mechanism that makes sense in the context of the child’s primary relationship. However, when transferred to other people, these behaviors create barriers and can make others turn away from giving the child what he most needs: safe, consistent care.

There are two types of insecure attachment:

Insecure-Avoidant

- Child explores with minimal interaction or checking in with the caregiver.
- No extra emotion in sharing delight or upset with parent.
- Child doesn’t seek interaction or closeness to the caregiver after separation or when distressed, and doesn’t respond when caregiver provides it.
- When distressed, child avoids parent and minimizes emotions.

Attachment isn’t something a child has or doesn’t have. It develops even in the face of maltreatment or severe punishment.

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Attachment Category	ORGANIZED <i>Child <u>knows</u> what to do to meet emotional needs</i>			DISORGANIZED <i>Child <u>doesn’t know</u> what to do to meet emotional needs</i>
	Secure	Insecure/Avoidant	Insecure/Resistant	Disorganized
Parenting Style When Child Is Distressed	Sensitive, loving (pick up and reassure)	Insensitive, rejecting (ignore, ridicule, become annoyed)	Inconsistent, unpredictable, or self-centered (overwhelmed or wanting child to meet their needs)	“Frightening, frightened, dissociated, sexualized, or otherwise atypical” (Lyons-Ruth, et al., 1997)
Child’s Response Exhibited <u>only</u> when child is distressed and needs caregiver support	Seek out and stay close to parent	Avoid interaction with parent, minimize emotion	Cry and seek out parent even before separation, then show anger and struggle when comforted; exaggerated response to get parent’s attention	Inconsistent, contradictory responses; freezing; self-stimulating behavior (rocking, pacing, head banging, etc.)

Identifying

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Insecure-Resistant

- Child seems wary of strangers and shows little interest in normal exploration.
- Child often cries or seeks caregiver even before separation. Unable to happily move away.
- Having the caregiver return or attempt to provide comfort doesn't help or reassure. Child alternates between actively seeking contact and struggling/crying/stiffness.
- Child shows anger and anxiety when caregiver attempts to comfort.
- When distressed, child exaggerates resistance and distress to try to get needed attention from inconsistent or unresponsive caregiver.

(Benoit, 2004; Carlson, et al., 2003; Flaherty & Sadler, 2011)

Disorganized Attachment

This is the category that describes children with the most significant attachment problems. It's likely you work with children who have this type of attachment due to their histories of abuse and severe neglect. In a large analysis that looked at over 80 studies, up to 80% of children with a history of parental maltreatment or drug abuse had disorganized attachment. By contrast, only about 15% of children from low-risk families had disorganized attachment (Van Ijzendoorn et al. 1999, cited in Green & Goldwyn 2002).

Disorganized Attachment

- Caregiver's behavior is "frightening, frightened, dissociated, sexualized, or otherwise atypical" (Lyons-Ruth, et al., 1997).
- Child shows apparently undirected, inconsistent, and sometimes contradictory responses to parent (e.g., an infant who kicks, struggles, fails to focus attention on any one person or activity, without any apparent pattern or rhyme or reason).
- Sometimes child shows abnormal behavior (freezing, repetitive self-stimulating behaviors).

What About RAD?

Is Reactive Attachment Disorder a form of disorganized attachment?

No, RAD is entirely different. As we have seen, disorganized attachment is a form of insecure attachment caused by maltreatment and/or other actions of the child's caregiver.

In contrast, RAD is a very rare disorder that results from **non**-attachment. With RAD, it is the child's lack of a caregiver to attach to that causes the problem. According to Gleason and colleagues (2011), RAD also likely has a genetic component. To learn more about RAD, see page 8.

- Child's behavior believed to result from caregiver being a source of fear; child is in conflict between wanting to flee to and flee from the caregiver.

(Benoit, 2004; Carlson, et al., 2003; Flaherty & Sadler, 2011)

These children exist in a chronic, low-level state of arousal and stress: in survival mode. If you have learned that people who try to care for you are dangerous or untrustworthy, then even a caring and well-meaning foster parent who tries to offer comfort could be perceived as a threat.

Children with attachment insecurity, especially disorganized attachment, are at increased risk for oppositional defiant disorder (ODD) and related behavioral disorders, as well as dissociative disorders, and are more likely to have academic and social deficits (Boris, et al., 2007).

If You Suspect Attachment Problems

The next article offers suggestions for what to do if you suspect a family you are working with is struggling with insecure or disorganized attachment.

Before you turn the page, it may be helpful to note that not all children will continue to have severe attachment problems throughout their lives. In one of the few long-term studies that has been done, 25% of children who were attachment disorganized as infants did not show disorganized attachment at age seven (Lyons-Ruth et al. 1997, cited in Green & Goldwyn, 2002). ♦



NC Revamps Key Course to Increase Focus on Attachment and Trauma

This spring the NC Division of Social Services retired one course on attachment and launched another. Recently the Jordan Institute for Families at UNC-Chapel Hill undertook a major revision of the well-known course *Effects of Separation and Loss on Attachment* (ESL). In the end the revision—which introduced new research on trauma and attachment to the course—was so extensive that ESL was renamed "Assessing and Strengthening Attachment."

This new two-day classroom training teaches about the attachment process, how secure and insecure attachment affect child development, and how to assess and build secure attachments between children and their caregivers. Participants leave this course with new skills and ideas to use in their work with families. To learn more or sign up to take *Assessing and Strengthening Attachment*, log in to www.ncswLearn.org.

Child Welfare Practice When Children Have Attachment Issues

What can child welfare professionals do to help children who have insecure or disorganized attachment? The primary goal is to give the child a chance to create a secure attachment with a safe, consistent, sensitive primary caregiver. Once you identify a birth or foster parent who could provide the loving, reciprocal relationship the child needs, there are two challenges that often need addressing (Dozier, et al., 2009; Speltz, 2002):

- Caregivers' own attachment and loss issues can make it hard for them to focus on the child's needs.
- Children with attachment issues tend to send confusing signals. Even well-attuned, empathic parents sometimes struggle to figure out what the child needs and how to comfort or calm the child.

Here are suggestions for overcoming these challenges, along with informa-

tion about attachment-informed mental health treatments, which are often a critical part of effective intervention.

Supporting Caregivers

Help caregivers address their own attachment and trauma histories.

People who are wounded or overwhelmed by their own histories may not have developed the capacity to read and respond to their children's cues (Dozier, et al., 2009; Speltz, 2002). A parent's history of trauma has many implications for their ability to regulate their emotions, maintain their physical and emotional health, parent effectively, and maintain family stability (NCTSN, 2011). Parents with unaddressed trauma histories are likely to treat their own children the way they were treated, and often have difficulty forming healthy attachments with their children (Chadwick, 2013).

Trauma Exposure Screening Tool for Adults

For a simple, free trauma exposure screening tool you can use with yourself or other adults, go to <http://bit.ly/1nLhMWp>

As a child welfare professional, it's important to ask caregivers about their history of trauma and to get a sense of what their primary attachments were like as a child. The box above provides a link to a short, simple, free trauma screening tool for adults.

Many caregivers never have the chance to think about their own parenting and the way they were raised (Dozier, et al., 2009). Asking open-ended questions and exploring their own and their parents' discipline

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Rebuilding Ourselves by Nicole Goodwin

I learned early on that black women are supposed to be "strong" and endure pain in silence. The three years I spent in the military and the five-and-a-half months I spent stationed in Iraq taught me the same lessons: Be strong. Be silent.

A month after my daughter, Shylah, was born, I kissed her good-bye and flew off to Iraq. When I came home, I brought painful memories with me in the form of Post-Traumatic Stress Disorder (PTSD). I was riddled with anger, self-hatred, and loneliness.

A Joyful Reunion. The one bright spot was my daughter. Seeing her eyes light up when it dawned on her that I was her mom gave me great hope that I could make things right.

But over the years, my PTSD grew worse. I had nightmares so bad I would wet the bed. Eventually I had trouble getting up in the mornings.

Then one day in January 2010, when I was having a particularly hard time, I slapped Shylah, who was 6. She told her therapist and the therapist called Child Protective Services.

My daughter was in care for six months. Most of that time, I was lucky to see her almost every day.

I also spent six weeks in a veterans' hospital for women who had been raped while serving their country. There I got to talk about other problems that I'd never dealt with, like being molested in childhood and the rift it put between my mother and me. When I left, I thought I was ready for Shylah.

An Angry Reunion. But when Shylah came home, she would go from zero to sixty having complete meltdowns. When I told her she needed a time out, she would kick, punch, and bang her head. When we argued, she would say the most hurtful things, like, "You don't love me," or "You never wanted me."

For about four months, the battles continued. Then the social worker at Shylah's school introduced me to the Child Welfare Organizing Project (CWOP), a parent-led advocacy organization in New York.

At CWOP I joined a reunification group where we read *Rise* magazine stories by parents who had reunified. Those stories helped me see that believing in your family's recovery is the most important thing.

The Mom I Want to Be. I also took a class called the Parenting Journey. There I wrote a letter to my mother expressing the feelings of abandonment that were at the core of my sadness. Writing that letter helped me focus my energies on the mother I wanted to be—a mother that listens, is nurturing and forgiving, and takes responsibility.

With Shylah, I went to family therapy. Over time, I learned that Shylah had cried for me every night, and that she felt blamed for what was happening. One of the hardest things for me to hear was that Shylah felt abandoned by me. Even though it hurt to hear how I had hurt my daughter, I realized all my hard work was paying off when she wanted to hold my hand again, or be held, or, here and there, gave me a kiss.

For a long time I thought my traumas made me strange and unlovable. At some points, I thought I didn't deserve to have my daughter. My daughter hugs me now for no reason, and it feels glorious. Little by little we're rebuilding ourselves.

Reprinted, with permission, from Rise, © 2013 by risemagazine.org. Rise is a magazine written by and for birth parents involved in the child welfare system.

After Iraq—and removal—I had to heal myself and my daughter.

Practice

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methods, communication styles, and relationships can help caregivers gain valuable insights. Once parents acknowledge their histories, they may be ready to explore how their past affects their current functioning and parenting.

Being involved with the child welfare system can be re-traumatizing for parents. For example, parents' anger or avoidance may be a reaction to their own traumatic experiences, not to their child welfare worker. Involvement with CPS may inadvertently return parents to a position of vulnerability and fear (CWIG, 2013).

If they are not viewed through this "trauma lens," parents' behaviors can be easily misunderstood. The more you can be attuned to the fear beneath the parent's response, the more you will help them do the same for their children. Once parents feel accepted

and can build trust, they may be more willing to develop a different sense of themselves and their children.

Help caregivers respond sensitively, even if children seem to reject them.

Even well-attuned, empathic caregivers can struggle to understand and respond sensitively to children who have attachment issues. When children have experienced trauma, their fear remains even when the risk of physical harm is gone. A certain sensation or situation can trigger a memory or flashback of their original trauma. These trauma triggers cause children to have a physical and emotional fear response. Sometimes the child may not even be fully aware of the response or why it's happening (Klain & White, 2013).

When caregivers see a child's distress and try to provide comfort, this can feel threatening to the child, esca-

lating their fear response. As a result, the child may behave in confusing and contradictory ways that leave caregivers uncertain and frustrated. For example, a child may react with anger or recoil when a foster parent tries to hug them. The foster parent may then feel angry and rejected, straining the relationship and continuing the cycle of insecure attachment and rejection (Dozier, et al., 2005).

Helping Break the Cycle

Here are some things child welfare professionals can do to help break this cycle:

Help caregivers see the world from the child's point of view. Some caregivers need to learn to be aware of their child's physical and mental state. You want the caregiver to begin asking herself, "Why is my child doing this?" To encourage this, notice out loud what the child is doing and why

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Supporting Child Welfare Worker Resiliency

Asking parents about their attachment and trauma histories can be stressful for child welfare professionals. They are likely to hear difficult things, and they may experience vicarious trauma. If agencies are going to take trauma and attachment seriously, it's important to have a plan in place for supporting workers' resiliency and responding sensitively to vicarious trauma. Below are strategies for doing just that.

- Review recruitment and hiring practices with a focus on building resiliency, professional training, and preparedness
- Provide routine training, education and support to all staff about secondary traumatic stress and how to recognize and manage their reactions
- Acknowledge that secondary trauma is an occupational hazard; promote open discussion of secondary traumatic stress among staff
- Use self-assessment measures to evaluate the impact of secondary trauma exposure on child welfare workers
- Consider agency policies that may exacerbate secondary trauma (e.g., agency response to high-stress events) and how policies can be amended to enhance staff resilience
- Ensure peer and professional counseling resources are available to staff at all times (not only after a crisis)
- Provide good mental health coverage and an Employee Assistance Program
- Cultivate a workplace culture that normalizes (and does not stigmatize) getting help for work-related stress
- Implement a comprehensive program to address secondary trauma, such as the Resilience Alliance (<http://bit.ly/1nXi9gz>).

Source: *National Child Traumatic Stress Network (January 2013). Child Welfare Trauma Training Toolkit: Comprehensive Guide-3rd Edition.*

Finding Effective Treatment for Parents



Parents involved with child welfare may need treatment to address their trauma and attachment histories. According to the National Child Traumatic Stress Network (2011), "interventions that do not take into account parent's underlying trauma issues—such as parenting classes, anger management classes, counseling, or substance abuse groups—may not be effective."

SAMSHA's National Registry of Effective Programs and Practices states that the following models integrate issues of trauma, mental health problems, and substance abuse for more effective comprehensive treatment:

- Seeking Safety
- The Trauma Recovery Empowerment Model (TREM)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Helping Women Recover/Beyond Trauma/Helping Men Recover

To learn more, visit the Registry at <http://www.nrepp.samhsa.gov/>

he or she is doing it.

I see that Johnny looks really sad right now. He went into the other room, has his head down on the table, and looks like he is going to cry. I wonder why?

If the caregiver has a negative interpretation of the child's behavior, point it out.

It must be frustrating when Johnny ignores you. I see why you would think it's because he doesn't respect you and wants to be the boss. I wonder why else he might be doing that?

Help the caregiver read cues to identify the child's states and moods. Help her feel more confident and competent as a parent.

How did you know that Sally was hungry? What does she do to let you know? What about when she's tired?

Encourage the caregiver to talk to and bond with the child with simple

acts of caretaking, engaging, and playing. Point out what you see that shows the child responding positively.

Wow, Johnny just loves showing you what he's made! Look how proud he is!

Help the caregiver understand all children need nurturing, even if they don't show it. Children may turn away or seem angry when parents try to provide comfort or reassurance. This is because the child is used to people not responding to or taking care of them. Encourage caregivers to be patient, go slow, and see the need and fear underneath the behavior.

Children need a strong, secure attachment. If they're not confident they will be cared for and accepted, the risk of getting hurt again will be too great and behaviors won't change (Berliner, 2002). Teach caregivers to

send the message, "You are part of our family. You are loved no matter what you do."

Ensure caregivers have support and respite. Children with insecure attachment can show extremely frustrating behavior. Caregivers need help, understanding, and time away to keep themselves healthy and energized (Berliner, 2002).

Conclusion

Working with children and families struggling with attachment problems can be tough, but it can also be incredibly rewarding. By teaming with caregivers, mental health providers, and others, over time you can help bring about deep changes in children that will allow them to form positive relationships and lead healthy, successful lives. ♦

Be Sure to Advocate for Effective Treatment

Attachment-Focused Models

Many children with attachment difficulties need mental health treatment by clinicians trained to address attachment and trauma. Because attachment is all about relationships, a caregiver should be actively involved in the treatment, too.

The interventions below include a focus on attachment and are offered in our state. Each has enough evidence of effectiveness to have been rated by the California Evidence-Based Clearinghouse for Child Welfare.

Well-Supported by Research (*highest possible evidence rating*)

Nurse-Family Partnership. For children ages 0-5 and their caregivers. Provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Available in many NC counties. www.nursefamilypartnership.org/locations/North-Carolina

Parent-Child Interaction Therapy (PCIT). For children ages 2.5 to 7.5 and their caregivers. Provides a behavioral intervention focused on decreasing the child's behavior problems (e.g., defiance, aggression), increasing the child's social skills and cooperation, and improving the parent-child attachment relationship. NC clinicians are being trained in PCIT through PCIT of the Carolinas. www.ccfhnc.org

Promising Research Evidence

Attachment and Biobehavioral Catch-Up (ABC). For foster parents of children ages 0-5. Provides home visits designed to enhance caregivers' ability to respond sensitively to children who have experienced early trauma or maltreatment. NC clinicians are being trained in ABC through the Center for Child and Family Health. www.ccfhnc.org

Parents as Teachers. For parents of children ages 0-5. Provides early childhood parent education, family support, and school readiness through home visiting by trained parent educators. Available in many NC counties. www.parentsasteachers.org/location

Trauma-Focused Models

In addition, a number of evidence-based treatments for child trauma include components related to insecure attachment, such as helping clients safely acknowledge and understand their history and learn how to manage emotions (self-regulation) and improve psychological safety. These include:

Well-Supported by Research

Trauma Focused Cognitive-Behavioral Therapy (TF-CBT). For children ages 3-18. For a list of clinicians in your county certified in TF-CBT, visit the NC Child Treatment Program at <http://ncctp.med.unc.edu> or call 919/419-3474 ext. 300.

Eye Movement Desensitization and Reprocessing for Children and Adolescents (EMDR). For children ages 2-17. According to the EMDR website, certified clinicians are available across NC. www.emdr.com/find-a-clinician.html

Supported by Research Evidence

Child-Parent Psychotherapy (CPP). For children age 0-5 and their caregivers. Clinicians are being trained in NC by the Center for Child and Family Health. www.ccfhnc.org

For more details on these programs, visit <http://www.cebc4cw.org>

Reactive Attachment Disorder

Reactive attachment disorder (RAD) is a disruptive disorder believed to be caused by chronic and severe neglect in early childhood. RAD was first added to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in the 1980s. Researchers and practitioners have been wrestling to clearly identify and treat it ever since.

RAD Has Been Redefined

Until recently there were two types of RAD: emotionally withdrawn/inhibited and indiscriminately social/disinhibited. Now the DSM-V, which appeared in 2013, classifies these disorders as separate diagnoses: RAD, which involves emotionally withdrawn and inhibited behaviors, and disinhibited social engagement disorder (DSED) which involves indiscriminately social and **disinhibited** behaviors.

RAD's new narrower, more targeted definition is now characterized by a child who is inhibited and withdrawn from adult caregivers, rarely seeks or responds to comfort when they are upset, and has persistent social and emotional disturbances, such as minimal responsiveness to others, minimal positive emotions, and irritability, sadness, or fear during non-threatening social interactions.

One of the reasons the DSM-V separates RAD and DSED are their different progressions. After children have been placed in a stable environment, research shows that signs of RAD disappear over time and become quite rare. Symptoms of DSED take much longer to resolve (Zeanah, et al., 2004).

Diagnosis Can Be Difficult

RAD is generally diagnosed in children between the ages of 9 months and 5 years. Assessments of RAD past school age can be quite difficult; by this age early attachment experiences are just one of many factors that determine emotion and behavior (Mercer, 2006). The American Academy of Child and Adolescent Psychiatry (Boris, et al., 2005) does not recommend diagnosing RAD in children over age 5.



RAD Training Resource

Understanding Child Mental Health Issues is an instructor-led online course that explores the childhood mental health problems most often seen in child welfare settings: pediatric depression, juvenile bipolar disorder, ADD, RAD, oppositional-defiant and conduct disorder, and post-traumatic stress disorder. For each diagnosis participants will learn the causes, symptoms, prognosis, risk factors, and treatments. To learn more or take the course, log in to www.ncswLearn.org.

Diagnosing RAD can also be difficult because it shares traits with disorders such as autism spectrum disorder, intellectual disability, oppositional defiance disorder, conduct disorder, social phobia, and PTSD. Diagnosis is further complicated by the fact that compared to other children, children with RAD experience higher rates of general behavior problems, social problems, somatic complaints, anxiety/depression, thought and attention problems, delinquent or aggressive behavior, and/or a lack of empathy (Buckner, et al., 2008).

It should also be noted that fetal alcohol exposure is quite common among children in foster care (Ospina & Dennett, 2013). Caregivers who see their child as having a Fetal Alcohol Spectrum Disorder (FASD) may be much more understanding of the child's behavior, since this is a neurological problem, not psychiatric. A more positive attitude by caregivers, in turn, may enhance attachment security and promote healthy development for the child (Potter, 2014).

RAD Is Rare

The DSM-V estimates that RAD is very uncommon, occurring in less than 10% of severely neglected children. A study in the United Kingdom looked at **all** children aged 6-8 in a low-income area and found RAD's prevalence rate to be 1.4% (Minnis, et al., 2013).

If You Think RAD's a Possibility

Child welfare professionals who see troubling behavior or are concerned about RAD due to the child's history should ensure the child is assessed by a skilled practitioner familiar with diagnosing and treating RAD. A

thorough psychosocial history of the child should be gathered to help with the differential diagnosis. Additionally, because serious, chronic, social neglect is inherent in a RAD diagnosis, child welfare workers should assess the child's living situation carefully to ensure the child is receiving attentive and appropriate care (Hornor, 2007).

Treatment

At present we do not have effective interventions specifically for RAD. Efforts are being made to develop them, however. For example, the latest NIMH grant for Attachment and Biobehavioral Catch-Up (ABC) is for treatment of RAD. The Bucharest Early Intervention Project, which began in fall 2000, is also designed specifically for the treatment of RAD.

In the meantime, other treatments aimed at attachment disorders in general have led to improvement for children with RAD. Programs such as Parent-Child Interaction Therapy, Behavior Management Training, and the Incredible Years may provide a place to start therapy. In time these programs may build the evidence base for effective RAD treatment (Buckner, et al., 2008).

Treatment for RAD should involve work with caregivers as well as the child, assuming caregivers are psychologically healthy enough to participate (Boris, et al., 2005). It may also be beneficial for the caregiver—whether foster, adoptive, or biological—to engage in their own therapy. Children with RAD often respond to caregivers in difficult ways. Therapy can help caregivers process their own reactions and learn to respond in a therapeutic manner (Lyons, 2007). ♦

“Fostering Health NC” Builds Medical Homes for Children in Foster Care

The North Carolina Pediatric Society (NCPeds), the state’s chapter of the American Academy of Pediatrics, has introduced **Fostering Health NC**, a multi-faceted approach to developing and strengthening medical homes for infants, children, adolescents and young adults in foster care.

A Unique Approach

The key to Fostering Health NC’s unique approach is integrated communication that ties health professionals together to provide better care for each child. “Fostering Health NC features a unique multi-disciplinary approach to ensure that each child’s medical care is overseen by a team of health professionals. Medical professionals, local Departments of Social Services and Community Care of NC Networks form the ‘three-legged stool’ or the foundation on which to build a medical home to meet the needs of each child,” said Leslie Starsonneck, Manager for Fostering Health NC.

The **medical home model** is a comprehensive approach to primary care to ensure all of the child’s medical and non-medical needs are met through a unique partnership involving the pediatric care team, the child and the child’s family. The medical home is a particularly good fit for children in foster care, whose families include foster and birth families, because of its emphasis on coordination and comprehensive care. Children in foster care suffer a higher incidence of problems with physical, oral, and mental health than any other group of children.

“Fostering Health NC is designed to help the 9,600 children in foster care statewide receive better care for improved health outcomes. An added bonus is that the focus on abundant coordination for these highly mobile children saves health care costs almost immediately,” said Starsonneck.

Fostering Health NC will bring technical assistance and consultation

to local primary care providers, county Departments of Social Services and each of the 14 Community Care of NC (CCNC) Networks. This will be supported by a state team that will oversee the work and develop policy solutions that facilitate the development of medical homes for children in foster care. The team will be comprised of professionals in child health, mental health and social services. Through monthly meetings, the team will identify and develop policy and practical solutions that promote the implementation of medical homes for children in foster care.

“Through various initiatives, CCNC regional networks and the NC Pediatric Society have been working to improve medical access in North

This effort will help children in foster care receive better care for improved health outcomes .

Carolina’s foster care system for years, and we are pleased about the possibilities that Fostering Health NC provides to continue that work,” stated Dr. Marian Earls, the lead pediatrician for CCNC Pediatrics.

Fostering Health NC is supported by a federal grant from the Children’s Health Insurance Program – Reauthorization Act (CHIPRA) administered by the North Carolina Foundation for Advanced Health Programs, Inc. in cooperation with Community Care of North Carolina.

Want to Learn More?

For more information or to request technical assistance, contact Leigh Poole (leigh@ncped.org) or if you have policy questions or recommendations, contact Adam Svolto (adam@ncped.org). ♦

Medical Homes Make a Difference

When they’re enrolled in Community Care of North Carolina, children are assured of having a medical home. With CCNC’s medical homes:

- **Families may have a care manager** who can help them manage the child’s health care, show them how to keep the child healthy, and access specialists and other service providers, such as Early Intervention.
- **Families can choose a medical home for the child or continue to use the child’s existing medical home.** If an enrolled child does not already have a medical home, one will need to be chosen. Many pediatricians and family doctors are already medical home providers with CCNC. Contact the Medicaid program in your agency for a complete list of CCNC medical home providers.
- **Families can call the medical home for advice 24/7.** For daytime and after-hours phone numbers, check the child’s Medicaid ID card.
- **The child will receive regular sick care and well care** at the medical home. Care by specialists is coordinated by the medical home.

Children in Foster Care

Some children in foster care in North Carolina today do not have a medical home through CCNC. As a child welfare professional, you can do something about this.

If you are a foster care (placement) worker, confirm that every child you work with already has a medical home. If so, try to ensure the child continues to see that provider. If that’s not possible, try to keep the child in the same CCNC network so information from the previous medical home can be shared with the new one.

If a child in foster care does not have a medical home, partner with the Medicaid staff in your agency to enroll the child in Community Care of NC.

Changing Medical Providers Is Easy

A common misconception about CCNC is that it can be hard to change providers. Actually, it’s easy. When a child or family wants to change primary care providers, they submit a change request to the Medicaid program within their county DSS. The new primary care provider’s number is entered, a new Medicaid card is automatically generated, and *voilà*, the change is made.

Find CCNC Providers Near You

Simply contact the Medicaid program in your agency for a complete list of medical home providers participating in CCNC.

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