What Attachment theory and trauma-informed practice mean for Child Welfare?

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Goals of This Training

- Provide an overview of children who enter care and their needs.
- Educate Child Welfare Professionals about what attachment-theory and trauma-informed practice have to offer in the way of thinking about Child Welfare policy and practice.

Goals of This Training, cont'd

- Assist child welfare workers in achieving the Child and Family Services Review (CFSR) goals of ensuring that all children involved in the nation's child welfare system achieve a sense of:
  - Safety
  - Permanency
  - Well-being

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

Trauma-Informed Child Welfare Practice

The trauma-informed child welfare worker:

- Understands the impact of trauma on a child's behavior, development, relationships, and survival strategies
- Can integrate that understanding into planning for the child and family
- Understands his or her role in responding to child traumatic stress

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

Trauma-Informed Child Welfare Practice, cont'd

The Essential Elements:

- Are the province of ALL professionals who work in and with the child welfare system
- Must, when implemented, take into consideration the child's developmental level and reflect sensitivity to the child's family, culture, and language

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

Trauma-Informed Child Welfare Practice, cont'd

The Essential Elements:

- Help child welfare systems achieve the CFSR goals of safety, permanency and well-being

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

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Essential Elements of Trauma-Informed Child Welfare Practice

1. Maximize the child's sense of safety.
2. Assist children in reducing overwhelming emotion.
3. Help children make new meaning of their trauma history and current experiences.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

Essential Elements of Trauma-Informed Child Welfare Practice

4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships.
5. Coordinate services with other agencies.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

Essential Elements of Trauma-Informed Child Welfare Practice

6. Utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services.
7. Support and promote positive and stable relationships in the life of the child.
8. Provide support and guidance to child's family and caregivers.
9. Manage professional and personal stress.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

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Why is this Important?

- 520,000 children in foster care in the U.S. in 2003.
- 22,000 children freed for adoption in Canada, only 1,700 are adopted per year.

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Why is this Important?

- In 2005, out of seventy-four million children in the US, there were nearly 900,000 substantiated and indicted cases of child maltreatment (DHHS 2005).
  - Nearly three quarters of these children had no reported history of prior victimization (Child Maltreatment, 2007).

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Why is this Important?

- It is primarily children younger than four years of age that are at greatest risk, accounting for 79% of child maltreatment related fatalities (DHHS 2005).
  - Of sixteen million U.S. children under four years of age, 267,479 were victims of maltreatment in 2005 alone (DHHS 2005).

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Why is this Important?

- Early chronic maltreatment in a care-giving relationship (Complex Trauma) results in significant impairment in several domains:

Domains of Impairment

- Attachment
- Biology
- Emotional Regulation
- Dissociation
- Behavioral Regulation
- Cognition
- Self-Concept

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Why is this Important?

- Maltreatment during early childhood can cause vital regions of the brain to develop improperly, leading to a variety of physical, emotional, cognitive, and mental health problems (DHHS 2001).

Why is this Important?

- Children with histories of maltreatment, such as physical and psychological neglect, physical abuse, or sexual abuse, are at risk of developing severe psychiatric problems (Gauthier, Stollak, Messe, & Arnoff, 1996; Malinosky-Rummell & Hansen, 1993).
- These children are likely to develop Reactive Attachment Disorder (Lyons-Ruth & Jacobvitz, 1999; Greenberg, 1999)

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Why is this Important?

- Children with histories of maltreatment are at risk, as adults, of developing personality disorders, including:
  - Antisocial personality disorder (Finzi, Cohen, Sapir, & Weizman, 2000),
  - Narcissistic personality disorder,
  - Borderline personality disorder, and
  - Psychopathic personality disorder (Dozier, Stovall, & Albus, 1999).

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Foster Care & Parent Problems

- Drug & Alcohol Abuse in 85% parents
  - babies have drug exposure
- [illegible]
- Domes[illegible]
- Poverty, Lack of
- Mental Illness

Do these parental problems all go away prior to child-parent reunification????

(Source: Steven D. Blatt, MD., Children's Hospital, Upstate Medical School, Syracuse, NY, 2008)

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Babies & Cocaine

- Half of very young children placed in foster care had been prenatally exposed to cocaine
- Children born to substance-abusing women have a rate of physical abuse 2-5 times higher than matched children

(Source: Steven D. Blatt, MD., Children's Hospital, Upstate Medical School, Syracuse, NY, 2008)

Health Status of Children Entering Foster Care: Infants

- Drug Exposure 50%
- HIV Exposure 30-50 times community
- Growth Failure 20-40%
- Immunization Delay in 75% at 7 months
- Behavioral Problems: 40% vs. 3-6%
- Developmental Delay-50% vs. 4-10% in general population

(Source: Steven D. Blatt, MD., Children's Hospital, Upstate Medical School, Syracuse, NY, 2008)

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Prevalence of Mental Health Conditions

- 50-95% children entering foster care have significant mental health problems
- Range of common clinical problems include:
  - Relational & coping difficulties (attachment)
  - School failure
  - Externalizing disorders: conduct disorder, attention deficit disorder, aggressive behavior
  - Internalizing disorders: depression

(Source: Steven D. Blatt, MD., Children's Hospital, Upstate Medical School, Syracuse, NY, 2008)

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Why is this Important?

- Sexually abused children are at significant risk of developing:
  - anxiety disorders (2.0 times the average),
  - major depressive disorders (3.4 times average),
  - alcohol abuse (2.5 times average),
  - drug abuse (3.8 times average), and
  - antisocial behavior (4.3 times average)

  (MacMillian, 2001).

Children in Care in Texas
2007 Statistics Texas Department of Family & Protective Services 2007 Data Book

- CPS cases open to Service: 25,543
  - In-home care 18,035
  - Family Substitute 7,418
- # Children Removed from Home as a result of completed CPS investigation:
  - 15,920

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Children in Care in Texas
Texas Department of Family & Protective Services
2007 Data Book

- 28,904 children in DFPS care 8/31/08
  - 18,462 in Foster Care (64%)
  - 10,442 in other care (36%)
    - 8,801 Kinship Care
    - 855 Adoptive Homes
    - 786 Other (independent, AWOL, etc)

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Children in Care in Texas
Texas Department of Family & Protective Services
2007 Data Book

- 18,462 in Foster Care
  - 0 – 2 21%
  - 3 – 5 16%
  - 6 – 9 18%
  - 10+ 45%

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Children in Care in Texas
Texas Department of Family & Protective Services
2007 Data Book

- CPS Outcomes
  - Family reunification 36%
    - 2.2 placements
    - 9.6 months avg LOS
    - Reunification < 12 mo 65%
  - Adoption 25%
    - 3.4 placements
    - 13 months avg LOS
    - Adopted <24 mon 49%

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Children in Care in Texas
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2007 Data Book

- CPS Outcomes
  - Relative Care 26%
    - 2.4 placements
    - 13 months avg LOS

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2007 Data Book

- Length of Time in Care for Children who were granted permancy status
  - 0 – 12 months 63%
  - 13 – 24 months 24%
  - 24+ months 13%

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What are Adverse Childhood Experiences?

- **Growing up (prior to age 18) in a household with:**
  - Recurrent physical abuse.
  - Recurrent emotional abuse.
  - Sexual abuse.
  - An alcohol or drug abuser.
  - An incarcerated household member.
  - Someone who is chronically depressed, suicidal, institutionalized or mentally ill.
  - Mother being treated violently.
  - One or no parents.
  - Emotional or physical neglect.

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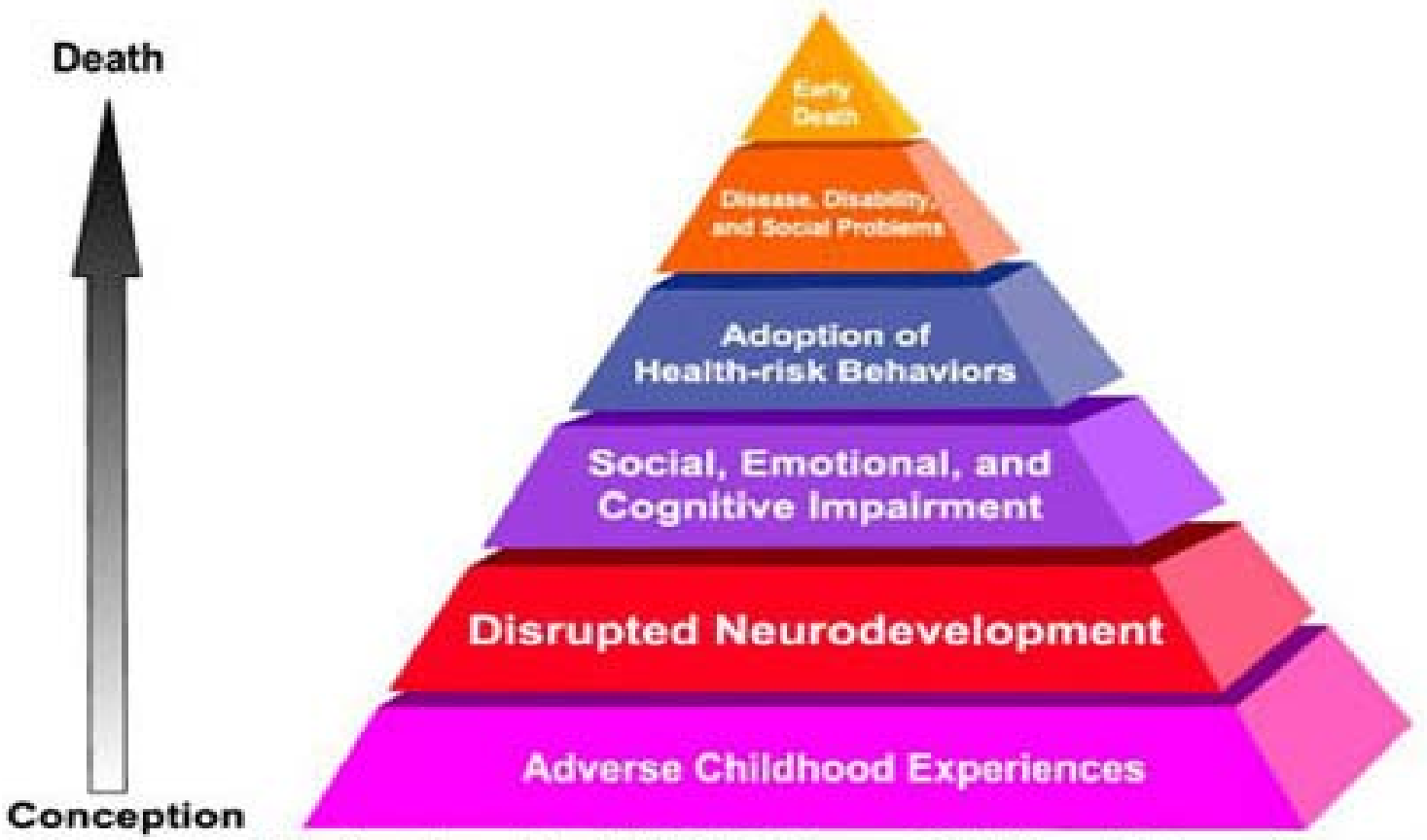
Link between ACE's and health



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

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Adverse Childhood Experiences Are Very Common

Percent reporting types of ACEs:

Household exposures:

Alcohol abuse	23.5%
Mental illness	18.8%
Battered mother	12.5%
Drug abuse	4.9%
Criminal behavior	3.4%

Childhood Abuse:

Psychological	11.0%
Physical	30.1%
Sexual	19.9%

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Estimates of the Population Attributable Risk* (PAR) of ACEs for Selected Outcomes in Women

Mental Health:	PAR
Current depression	54%
Depressed affect	41%
Suicide attempt	58%
Drug Abuse:	
Alcoholism	65%
Drug abuse	50%
IV drug abuse	78%
Promiscuity	48%
Crime Victim:	
Sexual assault	62%
Domestic violence	52%

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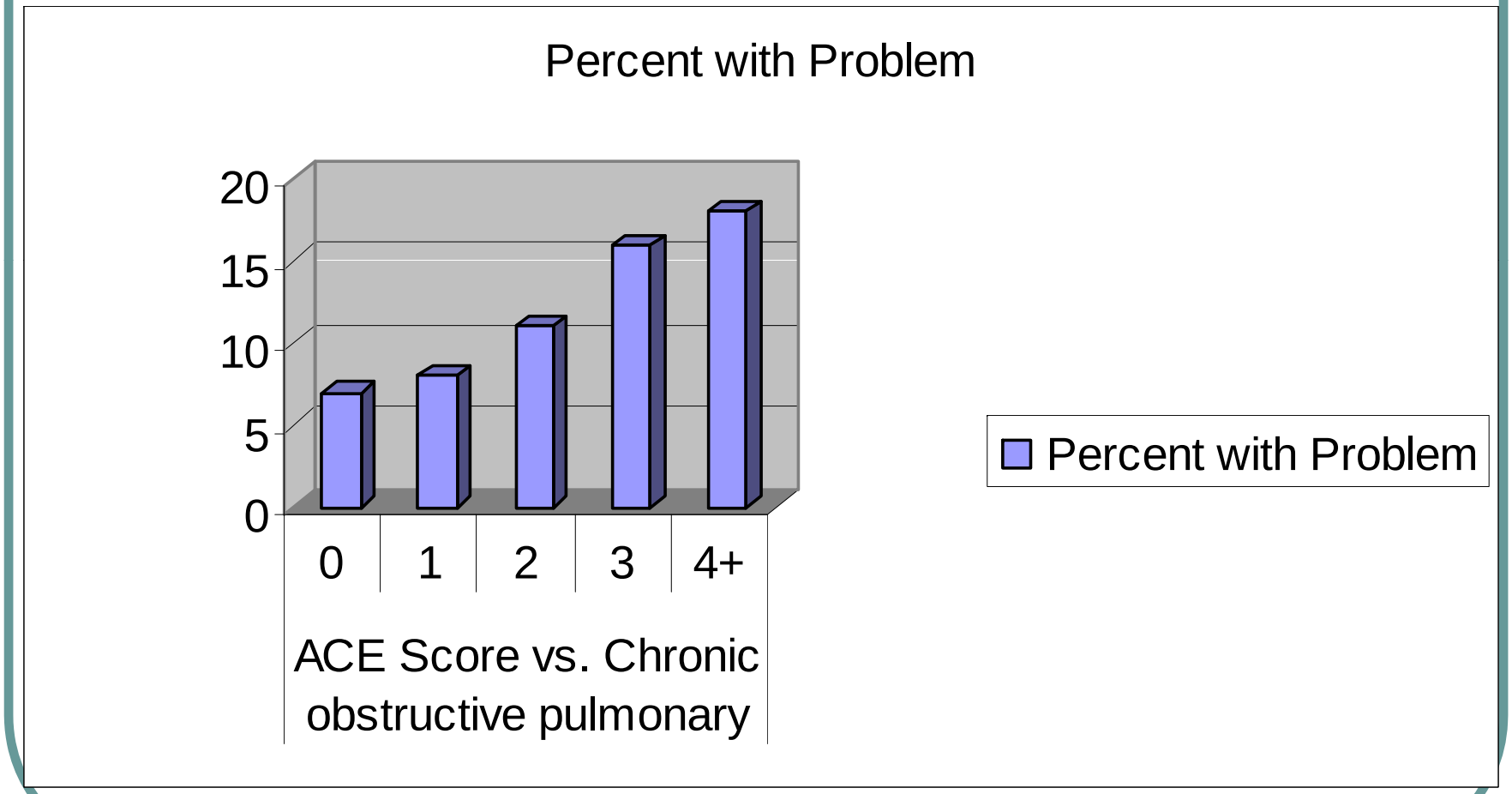
ACE's & COPD



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Rationale for proposed foster care policies

- Multiple foster placements increase the likelihood of permanency placement disruption (Fisher, Burraston and Pears, 2005)
- Foster placement instability is associated with poor child outcomes (Rubin, O'Reilly, Luan and Localio, 2007)
- Placement stability and attachment and trauma resolution promote healthy development in children

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Why do some foster placements breakdown?

- Foster parent is under prepared to meet child's needs
- Foster child poses a risk to foster parent(s) or natal children
- Other: (Health of foster family members, age, marital difficulties)

  (Brown and Bednar, 2006)
- Foster parent feels unsupported by system

  (Rodger, Cummings and Leschied, 2006)

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Why do some foster placements succeed?

- Commitment of foster parent(s) (Dozier and Lindhiem, 2006)
- Adequate information, knowledge, training, felt support.
- Natal children are not adversely affected

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21 Proposed Foster Care Policies

Pre-service and continuing education:

1. Recruitment of families that takes into account the family's clinical status; state of mind with respect to attachment.
2. Education in Complex Post Traumatic Stress Disorder.
3. Training and education in attachment-facilitating parenting.

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21 Proposed Foster Care Policies

Assessment:

4. Swift and appropriate referrals for the child for professional help.
5. Adequate assessment of sibling groups to determine best placement grouping.

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21 Proposed Foster Care Policies

Treatment:

6. Treatment with an evidence-based approach by a properly trained therapist.
7. Treatment involving sibling group, if indicated.

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21 Proposed Foster Care Policies

Support by the System:

8. Adequate pay that reflects the degree of commitment and excellence required.
9. Continuity social worker who follows the child from initial placement until permanency.
10. Continuity of therapist from placement to permanency.
11. An appropriate educational placement. An advocate (therapist) to assist.

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21 Proposed Foster Care Policies

Support in the home:

12. Emotional support that is readily available (ideally the therapist)
13. Staff support in the home from a professional childcare worker who is adequately trained
14. Relief: Help developing a natural network for "baby-sitting" and child minding.

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21 Proposed Foster Care Policies

Structures that promotes Safety:

15. Own room for the child.
16. Family, home and staff support that permits adequate supervision of the child by the foster parent which will reduce likelihood of adverse events.
17. When possible, foster children should be younger than the natal children in the home

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21 Proposed Foster Care Policies

Foster Child's Relationship with his or her Family:

18. When possible, development of a collaborative relationship between foster and natal families.
19. Therapeutic access with natal family, when this is in the child's best interest.

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21 Proposed Foster Care Policies

Remembering the Natal Children

20. Adequate support for the natal children of the foster family.
21. Adequate parental time with natal children of the foster family.

(Höjer, 2007)

1. Maximize the child's sense of safety.

- Traumatic stress overwhelms a child's sense of safety and can lead to a variety of survival strategies for coping.
- Safety implies both *physical* safety and *psychological* safety.
- A sense of safety is critical for functioning as well as physical and emotional growth.
- While inquiring about emotionally painful and difficult experiences and symptoms, workers must ensure that children are provided a psychologically safe setting.

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- Traumatic stress overwhelms a child's sense of safety and can lead to a variety of survival strategies for coping.
- Safety implies both *physical* safety, *emotional* safety, and *psychological* safety.
- A sense of safety is critical for functioning as well as physical and emotional growth.
- While inquiring about emotionally painful and difficult experiences and symptoms, workers must ensure that children are provided a psychologically safe setting.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

2. Assist children in reducing overwhelming emotion.

- Trauma can elicit such intense fear, anger, shame, and helplessness that the child feels overwhelmed.
- Overwhelming emotion may delay the development of age-appropriate self-regulation.
- Emotions experienced prior to language development maybe be very real for the child but difficult to express or communicate verbally.
- Trauma may be "stored" in the body in the form of physical tension or health complaints.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

3. Help children make new meaning of their trauma history and current experiences.

- Trauma can lead to serious disruptions in a child's sense of safety, personal responsibility, and identity.
- Distorted connections between thoughts, feelings, and behaviors can disrupt encoding and processing of memory.
- Difficulties in communicating about the event may undermine a child's confidence and social support.
- Child welfare workers must help the child feel safe, so the child can develop a coherent understanding of traumatic experiences.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

4. Address the impact of trauma and subsequent changes in the child's behavior, development, and relationships.

- Traumatic events affect many aspects of the child's life and can lead to secondary problems (e.g., difficulties in school and relationships, or health-related problems).
- These "secondary adversities" may mask symptoms of the underlying traumatic stress and interfere with a child's recovery from the initial trauma.
- Secondary adversities can also lead to changes in the family system and must be addressed prior to or along with trauma-focused interventions.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

5. Coordinate services with other agencies.

- Traumatized children and their families are often involved with multiple service systems. Child welfare workers are uniquely able to promote cross-system collaboration.
- Service providers should try to develop common protocols and frameworks for documenting trauma history, exchanging information, coordinating assessments, and planning and delivering care.
- Collaboration enables all helping professionals to view the child as a whole person, thus preventing potentially competing priorities.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

6. Utilize comprehensive assessment of the child's trauma experiences and its impact to guide services.

- Thorough assessment can identify a child's reactions and how his or her behaviors are connected to the traumatic experience.
- Thorough assessment can also predict potential risk behaviors and identify interventions that will ultimately reduce risk.
- Child welfare workers can use assessment results to determine the need for referral to appropriate trauma-specific mental health care or further comprehensive trauma assessment.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

7. Support and promote positive and stable relationships in the life of the child.

- Separation from an attachment figure, particularly under traumatic and uncertain circumstances, is highly stressful for children.
- Familiar and positive figures—teachers, neighbors, siblings, relatives—play an important role in supporting children who have been exposed to trauma.
- Minimizing disruptions in relationships and placements and establishing permanency are critical for helping children form and maintain positive attachments.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

8. Provide support and guidance to the child's family and caregivers.

- Resource families have some of the most challenging roles in the child welfare system.
- Resource families must be nurtured and supported so they, in turn, can foster safety and well-being.
- Relatives serving as resource families may themselves be dealing with trauma related to the crisis that precipitated child welfare involvement and placement.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

9. Manage professional and personal stress.

- Child welfare is a high-risk profession, and workers may be confronted with danger, threats, or violence.
- Child welfare workers may empathize with victims; feelings of helplessness, anger, and fear are common.
- Child welfare workers who are parents, or who have histories of childhood trauma, might be at particular risk for experiencing such reactions.

(Source: Child Welfare Training Toolkit, National Child Traumatic Stress Network, 2008)

References

Becker-Weidman, A., & Shell, D., (Eds.) (2005). Creating Capacity For Attachment, Oklahoma City, OK: Wood 'N' Barnes.

Becker-Weidman, A., (2006a). "Treatment for Children with Trauma-Attachment Disorders: Dyadic Developmental Psychotherapy," Child *and Adolescent Social Work Journal.* Vol. 23 #2, pp. 147-171.

Becker-Weidman, A., (2006b). "Dyadic Developmental Psychotherapy: A multi-year Follow-up", in, New Developments In Child Abuse Research, Stanley M. Sturt, Ph.D. (Ed.) Nova Science Publishers, NY, 2006, pp. 43 – 60.

Becker-Weidman, A., (2008). "Effects of Early Maltreatment on Development: A Descriptive study using the Vineland," manuscript submitted for publication.

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References

Becker-Weidman, A., & Hughes, D., (2008) (Manuscript accepted for publication). "Dyadic Developmental Psychotherapy: An evidence based treatment for Children with complex trauma and disorders of attachment."

Briere, J., & Scott, C., (2006), Principles of Trauma Therapy, Thousand Oaks, CA: Sage Publications.

Brown, J.D. & Bednar, L. M., (2006) Foster parent perceptions of placement breakdown. *Child and Youth Services Review* 28, 1497-1511.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., et. al. (2005) Complex trauma in children and adolescents. *Psychiatric Annals*, 35:5, 390-398.

DHHS, (2005) Department of Health and Human Services (DHHS) (US), Administration on Children, Youth, and Families (ACF). Child maltreatment 2003 [online]. Washington (DC): Government Printing Office; 2005. [cited 2005 April 5]. Available from: URL: www.acf.hhs.gov/programs/cb/pubs/cm03/index.htm.

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References

Department of Health and Human Services (DHHS) (US), Administration on Children, Youth, and Families (ACF). In focus: understanding the effects of maltreatment on early brain development. Washington (DC): Government Printing Office; 2001.

Dozier, M. & Lindhiem, O. (2006) This is My Child: Differences Among Foster Parents in Commitment to Their Young Children. *Child Maltreatment* 11 (4), 338-345.

Dozier, M., Stovall, K.C., & Albus, K. (1999) Attachment and Psychopathology in Adulthood. In J. Cassidy & P. Shaver (Eds.). *Handbook of Attachment* (pp. 497-519). NY: Guilford Press.

Fisher, B.A., Burraston, P. & Pears, K. (2005) The Early Intervention Foster Care Program: Permanent Placement Outcomes from a Randomized Trial. *Child Maltreatment* 10 (1), 61-71.

Finzi, R., Cohen, O., Sapir, Y., & Weizman, A. (2000). Attachment Styles in Maltreated Children: A Comparative Study. *Child Development and Human Development,* 31, 113-128.

Gauthier, L., Stollak, G., Messe, L., & Arnoff, J. (1996). Recall of childhood neglect and physical abuse as differential predictors of current psychological functioning. *Child Abuse and Neglect* 20, 549-559.

Greenberg, M. (1999). Attachment and Psychopathology in Childhood. In J. Cassidy & P. Shaver (Eds.). *Handbook of Attachment* (pp.469-496). NY: Guilford Press.

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References

Höjer, I., (2007) Sons and daughters of foster carers and the impact of fostering on their everyday life. *Child and Family Social Work* 12, 73-83.

Hughes, D., (2006), Building the Bonds of Attachment, 2nd. Edition, NY: Rowman & Littlefield.

Hughes, D., (2007), Attachment-Focused Family Therapy, NY: Norton.

Lyons-Ruth K. & Jacobvitz, D. (1999) Attachment disorganization: unresolved loss, relational violence and lapses in behavioral and attentional strategies. In J. Cassidy & P. Shaver (Eds.) *Handbook of Attachment.* (pp. 520-554). NY: Guilford Press.

MacMillian, H.L. (2001). Childhood Abuse and Lifetime Psychopathology in a Community Sample. *American Journal of Psychiatry,* 158, 1878-1883.

Malinosky-Rummell, R. & Hansen, D.J. (1993) Long term consequences of childhood physical abuse. *Psychological Bulletin* 114, 68-69.

Perry, B., & Szalavitz, M., (2006), The Boy who was raised as a dog, NY: Basic Books.

Rodger, S., Cummings, A. & Lsechied, A. W., (2006) Who is caring for our most vulnerable children? The motivation to foster in child welfare. *Child Abuse and Neglect* 30, 1129-1142.

Rubin, D. M., O'Reilly, A. L. R., Luan, X. & Localio, A. R., (2007) The Impact of Placement Stability on Behavioral Well-being for Children in Foster Care. *Pediatrics* 119, 336-344.

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