CHAPTER 34

Foster Care in Early Childhood

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Both the serious maltreatment that precipitates a young child's entry into out-of-home care and the experience of separation from parents and family members can impact the child and his or her family for years to come. Removal is initiated when it is believed the risks caused by separating a child from his or her parents/caregivers are secondary to the risks posed to the child's well-being if allowed to remain in the home. Reunifying the family remains the primary goal for almost all young children brought into foster care. Some maltreating parents were foster children themselves (Lillas, 2010) and went into and out of the system without adequate resolution of the factors that brought them to the attention of child protective services. Involving biological parents, foster parents, and child protection workers as a team, in a respectful way, as they work toward the goal of reunification is an essential element in meeting the young foster child's need for love and stability (Lutz, 2005).

Notably, when foster and biological parents "coparent" young children, that is, work together in partnership, focused on creating the best experience possible for the young child, there is the opportunity for young foster children to thrive (Petcovich, 2010). Maintaining *child-centered* foster care, rather than *extended-respite* foster care (Smyke & Breidenstine, 2009) or *adult/system-centered* foster care, keeps the process focused on the needs of young children. Whenever a decision is made about a young child in foster care, we should be asking ourselves: "Whose needs are being met here?" If the answer is not that the child's needs are being met, but rather that priority is being given to the easiest transportation option, or the child protection worker's schedule, or the biological parents' lack of resources, or the foster parent's aversion to meeting the biological parents, or any such non-child-centered reason, then we must rethink our decision-making process to prioritize the needs of the child.

This chapter is based on the premise that foster care should be understood not only as a safe place for children to reside in out-of-home care but also as a systematic means to help young children to recover from the impact of abuse and neglect (Smyke & Breidenstine, 2009). In this chapter, we review statistics about young children in foster care and examine specific challenges for caregivers of young children, including those who are interested in family building through foster care and relative caregivers. We also explore interventions aimed at improving the experience of out-of-home care for young children. Throughout, we emphasize the importance of prioritizing developmentally informed foster care for young children (Zeanah, Shauffer, & Dozier, 2011) aimed at strengthening relationships between young foster children and their caregivers.

In addition to protecting the child from further abuse or neglect, a child's stay in foster care should be an opportunity for maltreating parents to improve their protective capacity and learn more empathic, appropriate ways to interact with their children. There are many interventions used with biological parents for this purpose, but we note that interventions focused on increasing the parents' understanding of the child's attachment needs, such as Circle of Security (COS; Powell & Cooper, 2014), those facilitating sensitive parenting for mothers in substance abuse treatment, such as the Mothers and Toddlers Program (Suchman, DeCoste, & Mayes, 2009), or those that treat parent–child relationships affected by trauma, such as child–parent psychotherapy (CPP; Lieberman, Ghosh Ippen, & Van Horn, 2016; Lieberman & Van Horn, 2009), may be invaluable for children affected by maltreatment and their parents.

Who Are the Young Children in Foster Care?

Children under 5 years of age are at increased physical risk for maltreatment given their small size and absolute dependence on adult care to survive. In the United States, children less than 4 years of age accounted for 77.7% of those under age 18 who died from child abuse in 2014 (Child Welfare Information Gateway, 2016a). On September 30, 2014, there were 164,542 children ages 5 and younger residing in the U.S. foster care system. They were 39% of the 415,129 children in foster care in the United States (U.S. Department of Health and Human Services, 2016). Overall, foster children were evenly represented in gender (female 48%) and their median age was 8 years. Among all foster children, 42% were European American, 24% were African American, 22% were of Hispanic origin, and 10% were categorized as other/biracial. In fiscal year 2014, the last year for which we have data, 126,091 (46%) of the 264,746 total children entering foster care were 5 and younger when they entered the child welfare system (U.S. Department of Health and Human Services, 2016).

Whereas a school-age child can convey to adults that he or she is being abused and neglected, this is much more difficult for a young child who may be limited by his or her language capabilities, or who may not be around other adults capable of providing protection. Injuries to infants and toddlers, such as shaken baby syndrome, can lead to lifelong disabilities (Smyke & Breidenstine, 2009). Subclinical injuries that do not result in full-blown shaken baby syndrome or prenatal exposure to illicit substances may cause greater infant distress and crying, thus further stressing parents who are ill-equipped to handle their babies' distress. We focus in this chapter on the ways in which the youngest children in the foster care system have special needs that are dictated by their age, their cognitive capabilities, and their developmental imperative to establish and maintain attachment relationships with their caregivers.

Developmentally Informed Foster Care for Young Children

A primary developmental task of the young child is to establish an attachment relationship with a caregiver. It is beyond the scope of this chapter to go into depth about the development and maintenance of the parent–child attachment relationship (see Boris, Aoki, & Zeanah, 1999), although issues of attachment and loss have particular relevance to the maltreated young child in foster care (Zeanah, Berlin, & Boris, 2011). If the child enters foster care before 6 months of age, we would expect that he or she has not yet reached the stage of forming a focused attachment with his or her biological parents and may readily establish one instead with the foster parents later in the first year. Children who enter state's custody during the time when they are expected to be developing a focused attachment relationship (ages 7–9 months), or after they have already established one, are likely to experience a disruption of that relationship.

Visitation with biological parents often occurs on a weekly basis for an hour or two, which is insufficient time either to develop or maintain an attachment relationship (Smariga, 2007). Because of their immature cognitive development, even multiple visits a week are usually insufficient for young children to maintain or create a meaningful attachment relationship, which depends on repeated, daily caregiving interactions over time. Especially objectionable is the mandated minimum number of visits per week. Individualizing recommendations is always preferable because of myriad factors that must be considered.

Many factors affect a child's comfort level when he or she visits with his or her biological parents, including the nature of the parent–child relationship before entry into foster care (e.g.,

neglectful, role-reversed/inappropriate), as well as whether there were traumatic events involving the parents prior to the child's removal (e.g., physical abuse, sexual abuse, intimate partner violence). The presence of the foster parent (the child's attachment figure), with proper preparation, can make the visit more meaningful for both child and biological parent.

In our experience, the importance of parents making progress in needed interventions while having one or two supported, well-designed weekly visits with their children typically supersedes the idea that all children and their parents should visit multiple times per week, for long periods of time. As parents make meaningful progress in their case plans and approach reunification, visits can be increased to build the attachment relationship prior to a transition home (as we discuss later). If visitation is consistent and frequent (e.g., weekly), it is possible for children to become or to remain comfortable with their biological parents (Smyke, Brown, & Sommer, 2012) but they are quite likely, and indeed biologically driven, to establish an attachment relationship with the caregivers with whom they spend the most time, their foster parents.

Not surprisingly, young children in foster care may need and benefit from a variety of types of support in accomplishing the important milestone of forming an attachment relationship. For example, they may need support in establishing attachment relationships with their new caregivers, the foster parents, particularly if they have experienced multiple placements since coming into the state's custody (Pasalich, Fleming, Oxford, Zheng, & Spieker, 2016). Young children may also "miscue" their emotional and relational needs (Powell & Cooper, 2014) based on their past histories of maltreatment, which can push away or confuse new caregivers and interfere with the formation of healthy attachment relationships. Young children also may need support in the context of visitation (Beyer, 2004), especially if they experience their parents as "trauma triggers," due to their association of their parents with traumatic events.

Challenges for Foster Parents

Relationships with Child Protective Services

In our experience, even committed foster parents often feel unsupported by "the system." There are a number of reasons why the fit between the foster parent and the child protection worker may not be a good one (e.g., the foster parent is seen as advocating "too much" for the child, blocking access to the biological parents by scheduling appointments during visit times, or refusing to transport the child). Consistent communication between the foster parent and child protection worker is essential to the young foster child's well-being.

Uncertainty

Foster parents are asked to commit to children in the context of a great deal of uncertainty. Too often, children are moved precipitously for reasons that are system-related rather than due to a focus on the needs of the young child. For example, although efforts to place a child with family members so he or she can be with people he or she knows are important, these efforts sometimes occur after a child has been in a foster placement for many months, developed an attachment, and become fully part of the foster family. Foster parents who care for the child as they would their own biological child may sometimes be judged as "too attached" by child welfare professionals who do not understand the importance of attachment for the young foster child.

Reunification, even when biological parents have learned to be safe parents for the child, can become a significant challenge for foster parents who have cared for the child in their home for a long period of time. Occasionally, we hear reports that child welfare personnel have told prospective foster parents that there is "no way" the biological parents will be able to get their child back, but the parents do indeed work hard and become safe enough to parent their child. Even foster parents who did not plan to be long-term caregivers for a child and who supported reunification efforts may have anticipatory grief when faced with a child leaving their home and may worry about the child's future.

Increasingly, judges and child protection workers have begun to recognize the importance of developing an individualized transition plan when a child must move from one placement to another (Smyke, Miron, & Larrieu, 2012). Such a plan might typically extend over a month or so and allow the child to add another attachment figure (the biological parent) rather than experiencing an abrupt disruption from the foster parents, with the additional task of

establishing a new attachment relationship. We recognize that abrupt transitions are essential when there is danger to the child, such as during the initial removal of the child from unsafe biological parents. However, other transitions in the child welfare system (e.g., from foster parent to foster parent, from foster parent to relative caregiver, from foster parent to biological parent) are rarely emergencies, and every effort should be made to allow the child to first form a relationship with the biological parents or prospective caregiver. Weekly hour-long visits, for example, are not sufficient to develop or maintain an attachment relationship, so increasing contact both in terms of hours per visit and number of days on which visits occur allows for a less disruptive transition for the child. Scheduling abrupt transitions because a worker is going on vacation, for example, is not a sufficient reason to create an attachment disruption for a young child.

Unfortunately, many child welfare workers and judges may not recognize the importance of planful transitions and may abruptly move the child from a placement (Smyke, Miron, et al., 2012). This may result in the child being transferred at a court hearing, without returning to the foster home, causing feelings of loss and distrust in the foster parent (Edelstein, Burge, & Waterman, 2001), but more importantly, in the young child. Given the child's biological imperative to attach and to learn to trust at this age, there is no supportable reason for unplanned transitions other than safety.

Of course, there may be times during reunification, for example, when foster parents and biological parents are unable to cooperate in fulfilling a planful transition (Edelstein et al., 2001), creating tension for the child as he or she transitions from caregiver to caregiver. Each plan should be reassessed continually to ensure that the young child's needs are being met. If the adults are unable to work together in the interest of the young child and are creating more rather than less stress for the child, then the transition should be accelerated. The adults should, of course, be able to work together to promote the young child's well-being. Stating expectations clearly from the beginning would be one way to help foster parents understand their role if the parents have done or may do the work to reunify with their children. Another goal of approaches such as the Quality Parenting Initiative (QPI) is to establish positive interactions between biological and foster parents early on, as coparents of the young child, with the goal of continuing those connections as the child is transitioned home and allowing the child to maintain important relationships as he or she grows.

Planful transitions, which meet the specific needs of the transitioning child and are responsive if those needs change, rather than a "one size fits all" approach, constitute another essential element for the appropriate care of young foster children. This is particularly true given the evidence that multiple and abrupt transitions are associated with negative outcomes for young foster children (Pasalich et al., 2016).

Family Building

Caregivers who are building their families through foster care may have experienced previous feelings of grief and loss if they have had fertility challenges or been unable to have biological children (Cudmore, 2005). Rates of international adoption have decreased steeply since a peak in 2004 (U.S. Department of State, 2015), making this avenue to parenthood less available. For those unable to afford the expense of a private adoption, or who are drawn to helping children who are already in the system, foster care may be a viable alternative.

Over 50% of biological parents are reunified with their children (U.S. Department of Health and Human Services, 2016), another factor contributing to the inherent uncertainty for foster caregivers. Like most parents, foster parents develop hopes and dreams about the children placed with them (Edelstein et al., 2001). The challenge is that it is necessary for foster parents to care for young children as if they were their own: Love the child, advocate for the child, and provide a nurturing, attachment-rich environment. Nevertheless, multiple factors may disrupt the dream of forming a permanent family with that child, including decisions to move the child to reside with family members or to reunify the child with his or her biological parents after they have become safer caregivers.

Even if all the adults are focused on the needs of the young child, the foster parents' desire to create a family may be in conflict with the biological parents' desire to reunite their family. This uncertainty and associated emotional vulnerability is a challenge that most foster parents are able to manage, but there are times when foster parents may seem to undermine efforts at reunification by scheduling appointments during visit times, suggesting that the child is

negatively affected by visits with the parent, or scheduling a family vacation during the reunification period (Edelstein et al., 2001).

With regard to postvisit behavior, the foster parent typically knows the child best and is an important reporter on the child's responses to visits. Although most foster parents understand their role and fulfill it to the best of their capability, some foster parents may seem to sabotage reunification efforts. This, in turn, may cause child welfare personnel to feel that foster parents, in general, cannot be trusted to accurately represent the child's experience. This is a disservice to the child and another reason that efforts such as the QPI, to support foster parents and help them to prioritize the child's well-being, are so important.

Challenges for Relative Caregivers

Overall, 29% of children in out-of-home placements are cared for in relative foster care (U.S. Department of Health and Human Services, 2016). Kinship caregivers experience a range of emotions as they care for their youngest relatives. Some may not have learned that the child was in foster care for some time (Youth Law Center, 2014). The transition from the role of grandparent or favorite aunt to that of primary caregiver can bring with it a sense of loss, as the relative must take on a variety of roles he or she did not previously have. These roles include assuming the significant instrumental care that comes with being the primary caregiver for a young child, from feeding to diaper changing, to getting up during the night with a baby who needs a bottle or a traumatized young child who needs reassurance. In addition, they may need to provide discipline, whereas previously they had expected this to be the parents' responsibility. Many relative caregivers have shared that they did not anticipate that their dreams of travel or retirement would be replaced by the relentless day-in, day-out work involved in the care of a young child.

Relative caregivers also are frequently involved in intense loyalty conflicts—between what is best for their young foster child and what their adult relatives wish. How they navigate these dilemmas, if they occur, has important implications for the young child. Although the parent whose child has been removed from them may appreciate the sacrifice that their relatives are making to keep the young child in the family, this is not always the case. Maltreating parents may become resentful and angry with the caregiver, accusing him or her of "trying to steal my child." Biological parents who find themselves in this circumstance may have difficulty coming to grips with taking responsibility for their child's placement in the child welfare system, preferring instead to blame the relative caregiver. On the other hand, relative caregivers may have difficulty recognizing the impact of the abuse and neglect that the young child has experienced. For grandparent caregivers, rather than encouraging their adult child to seek assistance in alleviating the factors that brought the child into foster care, they may instead join with them in their anger toward "the system," and allow the young child for whom they care to visit their parents without informing the child welfare professional, regardless of whether or not the maltreating parent is a "trauma trigger" for the child.

Many maltreating families have ongoing issues that may involve multiple generations, and it is impossible to remove these strained feelings from the relative caregiving scenario. For example, a biological parent who feels that his or her own parent was abusive, but never interacted with the child welfare system, may be angry that the grandparent now has their child. The choice that grandparents must make as to whether to meet the needs of the young child or the needs of their adult child can be a difficult one. On the one hand, they love their adult child; on the other hand, they disapprove of the adult child's use of substances, engagement in intimate partner violence, or maltreatment of the child. They may feel loyalty to their adult child or, at times, frightened or intimidated by the biological parent of the young child. They may feel that the visiting schedule arranged for the biological parent or the various services that they must complete are unfair. A grandparent may feel some shame with regard to their adult child's behavior that has involved them with "the system."

Grandparents may find that they have a growing attachment to the young child in their home and may feel ambivalent about this. Many relative caregivers note that they must constantly remind the young child not to call them "Mama," saying instead, "I'm not your mama, I'm your grandma." Of course, it is difficult for the young child to make this distinction, particularly if there are other children in the home referring to the relative caregiver as "Mama."

It may be painful for the adult child to hear the child "slip" and refer to the relative caregiver as "Mama." In a situation filled with feelings of loss on the part of many people, this is a particularly difficult challenge. Nevertheless, *the* salient developmental task of the young child is to become attached to a caregiver capable of protecting him or her and organizing his or her feelings. It is both natural, and expected, that the young child would develop an attachment to the caregiver, often quite quickly, sometimes within a few weeks of placement.

Biological parents may feel that because the child is placed with a relative, they should be able to call the child at any time, or to drop by and visit whenever they want, despite the child welfare worker's statement that there would be specific visitation times set up. The relative caregiver can be caught in the middle as he or she tries to respect the rules set up by the foster care worker. He or she may be reluctant to upset or create conflict with the child's parent, but afraid that if he or she does not comply with the system's decisions, the young child might be removed.

Among myriad feelings, relative caregivers sometimes experience profound sadness that their adult child finds him or herself in these circumstances, that their young grandchild has been abused or neglected, or even that the private business of their family has become so public. Additionally, they may be certain that they did not raise their adult child to act in this way and ask themselves what happened to cause this. In addition, relative caregivers open themselves up to the judgment of those in the child welfare system who worry that "the apple does not fall far from the tree," as they try to find a safe placement for the young child. In addition, relative caregivers may feel hamstrung by rules that state they are not allowed to use physical punishment to discipline their young relatives.

More resources for relative caregivers are becoming available, including newsletters about relative caregiving (e.g., Adoption Resources of Wisconsin, 2011), as well as handbooks to guide the experience of those caring for young relatives both informally, and in the case of foster care, more formally (Child Welfare Information Gateway, 2016b). It is also important to provide funding sources for caregivers who wish to provide permanency for their young relatives but do not have resources to do so (Child Welfare Information Gateway, 2016b).

Diversity in Foster Care: Racial Disproportionality

White children represent 42% of children in foster care, the largest single racial group of children in the U.S. Child Welfare system (U.S. Department of Health and Human Services, 2016). There is an overrepresentation of nonwhite children in the system (56%) compared to their percentage in the overall population (41%; Kaiser Family Foundation, 2015). Black people, for example, comprise 12% of the overall population but represent 22% of the children in foster care. This disproportionality exists throughout the system, from the child's first entry into care to the child's achievement of permanency (Child Welfare Information Gateway, 2011, 2016c). Differential handling of children of color and their families, which may indeed be a function of implicit bias, can be found throughout the family's timeline (Annie E. Casey Foundation, 2011). Whereas white families are more likely to receive family preservation services designed to keep the maltreated child in the home, these services are less likely to be provided to families of color, as are interventions once the child is placed in foster care (Child Welfare Information Gateway, 2011, 2016c). Furthermore, efforts to achieve permanency may be significantly affected by the race of the child. The North American Council on Adoptable Children (NACAC; 2014) lists the current rates and criteria for children to receive adoption subsidies. Subsidies are designed to assist children with "special needs," that is, children who are more difficult to place, in achieving permanency through adoption. Such special needs may include older age, behavioral difficulties, sibling group, gender, and minority status (NACAC, 2014).

In a report from the National Center for Youth Law (NCYL), Lee, Bell, Ackerman-Brimberg, Harris, and Benton (n.d.) examined the effects of implicit bias in the child welfare, education, and mental health systems. Although NCYL focuses primarily on Juvenile Justice issues, they noted that involvement in that system was often preceded by difficulties involving the other systems. Implicit bias against children of color and their families impacted their trajectory toward Juvenile Justice involvement and could be found at all levels of child welfare, from initial screening to decisions about placement in foster care (Lee et al., n.d.). They suggested, for example, that criteria for deciding that a child

should enter foster care may be more subjective than they appear. Given this subjectivity, child welfare personnel may use other criteria or may rely more on their own beliefs about certain types of families than on truly objective criteria. Goff, Jackson, DiLeone, Culotta, and DiTomasso (2014) found that black boys, for example, are judged to be older and "less innocent" than their similar appearing white counterparts, factors which may affect child welfare decision making. Like other parts of our society, taking steps to eradicate implicit bias from our institutions and helping agencies will result in fairer provision of services. In the case of young children in foster care, more equitable provision of services might lead to better recovery from the trauma of abuse and neglect, and for maltreating parents, improved ability to more effectively prioritize their children's safety.

Interventions for Young Children in Out-of-Home Care

Interventions in the lives of young children in the child welfare system must maintain a trauma-informed and developmentally appropriate perspective as they attempt to optimize the young foster child's experience. There are a variety of approaches to improve the care that young children receive when they are removed from parents who are unwilling or unable to care for them safely. Some, such as the Bucharest Early Intervention Project, represent a radical shift in the life of the young child (Dozier, Zeanah, Wallin, & Shauffer, 2012), with the child's removal from the institution and placement in the family setting of foster care (Smyke & Breidenstine, 2009; Smyke, Zeanah, Fox, & Nelson, 2009). Others include the New Orleans Intervention Model (Zeanah & Smyke, 2006), which was developed in Louisiana and more recently has been implemented elsewhere in the United States and tested in the United Kingdom (Turner-Halliday, Watson, & Minnis, 2016). The New Orleans Intervention Model approach provides assessment and direct support to foster parents, as well as developmental screenings/treatment and behavioral interventions for young foster children (Zeanah & Smyke, 2006). In addition, this approach delivers assessment and psychotherapeutic interventions for biological parents and provides information to child welfare personnel and judges for use in permanency decisions (National Society for the Prevention of Cruelty to Children, 2016; Zeanah & Smyke, 2006).

It is important to note that in addition to the specific interventions we describe next, many young maltreated children may need additional therapeutic interventions to address symptoms related to past trauma. There are a number of developmentally appropriate, evidence-based interventions that can be implemented with young children and their foster parents in order to reduce trauma symptoms and promote healthier social–emotional functioning, such as CPP (Lieberman et al., 2016) and Preschool Posttraumatic Stress Disorder (PTSD) Treatment (PPT; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Other interventions, such as Attachment and Biobehavioral Catch-Up (ABC) developed by Dozier, Lindhiem, and Ackerman (2005) and Trust-Based Relational Intervention (TBRI), developed by Purvis, Cross, Dansereau, and Parris, are reviewed below. They represent direct interventions in the foster caregiver–child relationship. In addition, we review the Quality Parenting Initiative (QPI), which aims to rebrand foster care in a more positive light and include the foster parent as a respected, full member of the team addressing the needs of the young child in foster care, thereby strengthening foster care and those who provide it.

Attachment and Biobehavioral Catch-Up

Young children who have experienced maltreatment, neglect, and separation from primary caregivers are at risk for a variety of concurrent and future behavioral, emotional, and interpersonal difficulties. The ABC intervention was created by Mary Dozier and her colleagues, with a focus on improving caregiver–child relationships and the regulatory capacities of infants and toddlers in foster care (Dozier, Higley, Albus, & Nutter, 2002; Dozier et al., 2005). We briefly review the intervention here. For more information and details about the ABC intervention, see Dozier and Bernard (Chapter 31, this volume).

The development of organized attachment relationships and regulatory capabilities are two important tasks of infancy and early childhood that are vulnerable to the damaging effects of inadequate care and relationship disruptions (Dozier, Albus, Fisher, & Sepulveda, 2002). Because of their histories, infants and toddlers in foster care often fail to elicit nurturance, are

at high risk for behavioral and neuroendocrinological dysregulation, and are at increased risk for forming disorganized attachment relationships (see Bick & Dozier, 2013, for a review). Traumatized young children need particularly sensitive and nurturing care to help reduce further risk and increase the likelihood of healthier outcomes (Dozier, Stovall, Albus, & Bates, 2001), but many caregivers may not be prepared to provide this type of care without assistance. ABC was originally designed to enhance foster parents' sensitivity, so that they could meet the special needs of young foster children, thereby improving children's ability to regulate their physiology, behavior, emotions, and cognition (Bick & Dozier, 2013; Lind, Raby, Caron, Roben, & Dozier, 2017). Incorporating prior research findings, ABC was designed to be relatively brief, to be conducted with children and caregivers together, to focus on changing parenting behaviors rather than internal representations, to be manualized, and to be conducted in the home (Bernard et al., 2012).

ABC is a 10-session, manualized intervention for children ages 6–24 months. Sessions take place in the foster home, with the child and caregiver present, delivered by a trained parent coach who reviews session content as specified by the manual, tailors the session to meet individual foster parent needs, and comments on ongoing interactions between the foster parent and child (Bick & Dozier, 2013). The intervention focuses on helping caregivers behave in synchronous ways with their children, in order to target and enhance children's self-regulatory capabilities (Dozier et al., 2012). ABC also targets the quality of the caregiver–child attachment relationship by teaching caregivers to act in nurturing, nonfrightening ways, even when children do not clearly demonstrate their need for closeness and nurturance (Dozier et al., 2012).

Well-designed randomized controlled trials have examined the effects of ABC, both when used with foster parents and with high-risk birth parents. Overall, ABC has been shown to improve caregiving sensitivity and positive parenting behaviors (Berlin, Shanahan, & Carmody, 2014; Bick & Dozier, 2013; Caron, Weston-Lee, Haggerty, & Dozier, 2016); promote secure attachment (Bernard et al., 2012); and enhance the physiological, emotional, and cognitive regulatory capabilities of young children who experienced early adversity, with both foster parents and biological parents (Dozier et al., 2006, 2009; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008; Lewis-Morrarty, Dozier, Bernard, Terraciano, & Moore, 2012; Lind, Bernard, Ross, & Dozier, 2014). ABC has been given the highest rating, a "1," on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale, indicating that ABC is well supported by research evidence (*www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up*).

An expanded version of ABC, called Attachment and Biobehavioral Catch-Up for Toddlers (ABC-T), was also created to help foster parents with children ages 2–4 years provide sensitive caregiving, promote secure attachment relationships, and assist children in developing healthy physiological and behavioral regulation (Lind et al., 2017). There is also an adapted version of ABC, called Fostering Relationships (previously ABC for Visitation, or ABC-V), which has the goal of improving visits between parents and children recently removed from their care due to maltreatment. A preliminary evaluation of Fostering Relationships was recently conducted with a group of 11 foster children, birth parents, and foster parents. The researchers found that six of the seven families participating in Fostering Relationships and one out of four families in the control group followed the child's lead in visits more often than not. Also, all birth parents in Fostering Relationships attended all five visits, as opposed to two of the four parents in the control group, who did not complete visitation (Roben, Neely, Shauffer, & Dozier, n.d.). Dozier and colleagues intend to further examine Fostering Relationships and its effect on parent-child visits.

Trust-Based Relational Intervention

TBRI is described as an attachment-based, trauma-informed, "therapeutic model that trains caregivers to provide effective support and treatment for at-risk children" (Purvis et al., 2013, p. 360). Developed at the Texas Christian University (TCU) Institute of Child Development (now the Karyn Purvis Institute of Child Development), TBRI aims to teach caregivers ways to promote the healing of children who have experienced complex developmental traumas. The intervention tries to help caregivers recognize the needs of children who have experienced relational trauma and do what is needed to meet the children's needs (Purvis et al., 2015). The TBRI model grew out of a TCU

summer day camp for foster children and adopted children that began in 1999. Over time, the developers sought to incorporate strategies that they believed were effective at the camp into a program for caregivers. The TBRI model borrows principles and techniques from a variety of theoretical orientations, disciplines, and interventions, and lists its three core principles as Empowerment, or attention to physical needs; Connection, or attention to attachment needs; and Correction, or attention to behavioral needs (Purvis et al., 2013).

Each TBRI core principle has associated strategies to help create felt-safety, self-regulation, and connection for traumatized children (Purvis et al., 2015). The Empowerment principle has two sets of strategies: ecological strategies, such as creating rituals and managing transitions, and physiological strategies, such as providing for nutritional and hydration needs, and offering regular physical activities and sensory experiences. They posit that these strategies can enhance a child's ability to self-regulate, reduce the likelihood of negative incidents, and increase successful experiences of connecting and correcting (the second and third principles) (Purvis et al., 2015). Strategies associated with the Connecting principle include mindful awareness, including awareness of self, the child, and the environment, and engagement strategies, such as eye contact, healthy touch, attunement, and engaging in playful interactions (Purvis et al., 2013, 2015). The Connecting principle is described as critical for forming trusting adult–child relationships and is considered a necessary foundation for the other two principles to work (Purvis et al., 2015). The Correcting principle includes two sets of strategies: proactive strategies, including what are termed "Life Value Terms" and "Behavioral Scripts," and responsive strategies, which are called the "IDEAL Response" and "Levels of Response," to address challenging child behaviors (Purvis et al., 2015, p. 203). Some of the Correcting strategies involve practices such as teaching children to use words rather than engage in inappropriate behavior, enacting behavioral "re-dos" to practice effective rather than ineffective behaviors, and learning life values such as using respect and accepting consequences, and using a sequence of suggested adult responses to misbehavior to maintain connection with the child, while helping the child to regulate and return to appropriate behavior (Purvis et al., 2013, p. 373).

The developers of TBRI have described it as addressing "all major issues that are linked with complex developmental trauma" and as being adapted "for a variety of settings including international orphanages, residential group homes and treatment centers, adoptive and foster homes, schools, therapeutic day camps, and for all ages of children, including adolescents" (Purvis et al., 2013, p. 376). Anecdotally, there is enthusiasm for TBRI among some foster and adoptive parents, and there are elements of the intervention that appear grounded in principles and techniques from other evidence-based interventions. At this point, the research evidence supporting the broad effectiveness of TBRI, as described by its developers, is quite limited. The research conducted to date suggests that it may be associated with improvements in child functioning and may hold some promise, but the evidence is still quite limited in terms of identifying the nature and level of the intervention's effectiveness (McKenzie, Purvis, & Cross, 2014; Purvis & Cross, 2006; Purvis et al., 2013, 2015; Purvis, McKenzie, Razuri, Cross, & Buckwalter, 2014). TBRI has been given a moderate rating, a "3" on the California Evidence-Based Clearinghouse for Child Welfare scientific rating scale, indicating that it has some promising research evidence. In terms of TBRI's effectiveness and appropriateness for young children in foster care, there are no studies examining it with infants and toddlers under the age of 4 years. The promising results reported to date have also been found with highly motivated foster/adoptive parents and may not be generalizable to the overall population of foster parents.

The QPI

The QPI was developed through collaboration with the Youth Law Center (YLC) and the Eckerd Family Foundation. In 2004, foster care in the state of Florida was characterized by burgeoning foster homes that accepted many more children than they were capable of caring for; children for whom placements could not be found, who were forced to sleep at child protective services offices; and frequent moves for foster children (Shauffer, 2012). The state's system of foster care was in crisis. The YLC, based in California, joined with Florida State University to bring suit against the Florida Department of Children and Families (DCF) on behalf of Florida's foster children (Shauffer,

2012). The department settled the suit and the new Secretary for DCF met with the YLC and the Eckerd Family Foundation to find ways to address the significant issues that had been raised. Given the premise that foster care is a systematic means of addressing the impact of abuse and neglect, it was clear that the Florida child protection services had fallen short of their mission to protect their youngest citizens (Shauffer, 2012). The QPI (*www.ourcommunityourkids.org/qpi*) has expanded to several other states and includes some counties in California.

QPI training is conducted in person, and resource materials are available online, allowing access to materials that clearly describe the nature of foster parent training in the QPI model. The QPI has gathered a series of videos, often featuring respected professionals in the fields of attachment, trauma, foster care, and child welfare (for an example, see *http://centervideo.usf.edu/qpi/rad/start.html*). Also included are videotaped discussions of foster parents' experiences in reaching out to form relationships with biological parents as "coparents" of the same child (Pozo, 2010). This allows foster parents to understand basics such as what type of food the child likes to eat and what toys he or she enjoys playing with. In the QPI context, foster parents can also serve as supports or mentors for biological parents learning to safely parent their children.

The Annie E. Casey Foundation (2016) also has actively promoted the strengthening of foster parenting in the interest of the best possible care for children in out-of-home care. Instead of thinking of foster parents as long-term babysitters, it is important to acknowledge their essential contribution to the young traumatized child's well-being and to include them as active, respected members of the caregiving, child-focused team. This important concept addresses the strengths of both relative caregivers and certified foster parents.

Failing to include foster parents as members of the team restricts their access to information critical to their ability to best meet the needs of their young foster child. For example, if the child experienced a traumatic event at bath time and the foster parent has not been informed about this, he or she may be confused and uncertain when a young foster child has a severe reaction to his or her attempts to bathe the child. In turn, foster parents who feel that their ideas and observations are respected could inform the team about a child's unusual reaction to a commonplace caregiving situation and advocate for the child to receive appropriate trauma treatment.

In a recent report, the Annie E. Casey Foundation (2016) reviewed several programs, including the QPI, whose aim is to transform foster parenting. They suggested three mechanisms to improve foster parenting: (1) working toward improving the quality of care that children receive through targeted foster parent training and making sure that resources dedicated to young foster children are sufficient for their needs; (2) building strong relationships with foster caregivers particularly in terms of communication and involvement in the team's efforts (dedicating child welfare staff to promote this partnership would be one marker of the agency's commitment to creating and cultivating strong relationships with foster caregivers); and (3) making concerted efforts to find more foster caregivers, representing diversity in age, religious background, sexual orientation, and race, who would be open to fully meet all the needs that the young traumatized child brings to foster care, as well as support the efforts of biological parents to reunify with their children.

The QPI is a means of "strengthening foster care . . . using branding and marketing principles" (YLC, 2012, p. 1). The YLC contends that foster care, as it is currently viewed, has a negative connotation rather than being a service about which providers and others in the community are excited. The YLC did not create a manual dictating *the* best approach to foster care, but it identified core elements that should be part of the QPI process: being clear about what is expected of caregivers, communicating these expectations to caregivers, then ensuring that the agency is set up to support the achievement of these expectations by foster caregivers. Implementation of the QPI includes an initial planning period and formulation of the steps to be taken by an entity, such as a county or state, interested in using the QPI approach. This type of detailed planning for implementation results in enthusiastic stakeholders throughout the system and ensures that recruiting efforts are successful. Informing caregivers, on the front end, of the philosophy of the program and expectations of caregivers will help them to understand the mission they are being called upon to fulfill.

Efforts to provide continuing support and education to foster parents should help them to realize that assistance is available if they expe-

rience challenges rather than make them feel they will be judged if they have difficulties. Foster parents who empathize with the young, traumatized child also may experience secondary trauma (Conrad, n.d.; Parker, 2009) as they hear about horrific experiences their young foster children have survived. Appropriate and focused training before a child is placed, as well as continued support after the placement of the child, will help foster caregivers to recognize what they are experiencing and to reach out for assistance rather than feeling that they must manage challenging situations alone. The QPI represents a promising new approach to improving foster care for all children, but its principles might be expected to particularly impact the experience of very young children in foster care. The QPI has not been formally evaluated, and next steps should include research aimed at validating the approach and comparing it to standard foster care with regard to its impact on families and systems.

Conclusions

Foster care remains an essential intervention to protect young children from maltreatment, to assist them in recovering from trauma, to provide maltreating parents with the opportunity to learn to safely parent their young children, and, ultimately, to achieve permanency for the child. Though there are challenges inherent in foster care, providing interventions that focus on helping the child to develop secure relationships in the context of out-of-home care is an important way to meet the needs of young foster children. Furthermore, recognizing the importance of foster care and those who provide it is a vital means of improving the experience of young traumatized children. It is essential that all those in the child welfare system, including child protection workers, judges, interveners, as well as biological and foster parents, remain mindful of the imperative to provide *child-centered,* developmentally appropriate, and trauma-informed foster care, rather than making the important developmental needs of the young child subordinate to those of the system.

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