

Vulnerability, Risk, Protective Factors, and the Quality of Child-Parent Attachment in Foster and Adoptive Families

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Abstract

This review of the literature uses the theoretical perspective of attachment theory to examine key factors in the parent/child relationship in foster and adoptive families. Discussion of these factors is organized using Begun's delineation of vulnerability factors (those internal to the child and parents) and risk and protective factors (those external to the child and parents). The concept of reactive attachment disorder (RAD) is used to understand the vulnerability the abused/neglected child brings to subsequent attachments. Several implications of research findings from the attachment tradition are noted for human services professionals or organizations working with or on behalf of foster/adoptive families.

Introduction

Why is it that many foster or adoptive parent/child relationships result in long-range benefits for parents and children, while others end in disruption and are fraught with heartache? This paper is based on a review of the literature pertaining to the vulnerability created by reactive attachment disorder (RAD) in children who have been abused and neglected, and the impact of RAD on the quality of the attachment relationship for foster and adoptive families. One way to predict the resilience of children exposed to abuse and neglect is Begun's (1993) model of vulnerability, risk, and resiliency factors. *Resilience* is defined as "an ability to cope with adversity, stress and deprivation" (Begun, 1993, pp. 28–29). The author delineates a five-step process for determining probable resilience, in which the interrelated variables of vulnerability and risk are assessed. Vulnerability and risk are identified as presenting along a continuum. *Vulnerability* (and, by extension, the contrasting factor of invulnerability)

is defined as "what individuals bring to a situation, experience, or context, including their past experiences and learning." *Risk* and the contrasting protective factors are "factors extrinsic to individuals" (Begun, 1993, p. 31).

This paper is organized using Begun's concepts of vulnerability (factors internal to the child and parents) and risk (external factors that impinge on their relationship). First, we discuss factors that both the foster/adoptive child and family bring to the relationship (*vulnerability*). Then, we consider factors and persons in the systems interacting with foster/adoptive families (*risk* and *protective factors*), including medical community/health care providers, social workers and counselors, schools/educators, and child welfare service providers. Finally, we discuss some implications for creating a better future.

Vulnerability: What Children and Parents Bring to Their Relationships

Applying Bowlby's attachment theory

To understand vulnerability, risk, and protective factors in attachment, one must first understand a healthy attachment process. The parent/child relationship forms the basis of the child's experience of the quality of attachment, and strengthens or weakens the child's innate endowments and temperament. In this context, children exposed to various forms of stressful parenting relationships will suffer from maladaptive attachment patterns that can persist throughout the life cycle if unaltered by subsequent relationship experiences (Sroufe, 2005). Clearly, a central, healing potential of foster and adoptive parenting relationships is that they can provide healthy attachments

to assist children in developing their own capacities for healthy self-regulation and attachment. The following discussion of attachment disorders rests on the assumption that the children's difficulties in attachment are related to trauma experienced in the relationship with the family of origin.

One of the primary factors a child brings to a foster/adoptive parenting relationship is his or her ability to attach with caregivers. Bowlby hypothesized that "the child's tie to his mother [or other primary caregiver] is a product of the activity of a number of behavioural systems that have proximity to mother as a predictable outcome" (Bowlby, 1982, p. 179). In other words, a baby has instinctual drives, present at birth, designed to cause the baby to act so as to keep the mother close, in order to help the baby thrive. From this theoretical perspective, Bowlby observed behaviors associated with the quality and strength of the parent/child bond and the ways in which it forms and develops. Bowlby also focused on the long-term impact of separation, loss, wounds, and deprivations: classifying them, and from these behavioral observations and classifications developing a theory.

According to Bowlby, the child develops "working models" of the child/parent relationship. Two factors influence the development of working models. First,

From the early months onwards . . . the actual presence or absence of an attachment figure . . . determines whether a person is or is not alarmed by any potentially alarming situation; . . . a second major variable is a person's confidence, or lack of confidence, that an attachment figure not actually present will none the less be available, namely accessible and responsive, should he for any reason desire this (Bowlby, 1973, pp. 203–204).

The variables of (1) a parent's presence or absence and (2) a parent's focused responsiveness change in importance as the child develops, with the strength of the first

variable maintaining importance up until the age of three, and the impact of the second variable stronger from age three onward. A child's working model—that is, his or her sense of confidence in the world—interacts with other biopsychosocial variables, thereby affecting the quality of foster/adoptive family relationships. Traumatized children develop working models of attachment that are anxious-ambivalent, anxious-avoidant, or disorganized.

Mary Ainsworth elaborated on Bowlby's hypothesis by identifying five phases of attachment: indiscriminating, differential responsiveness, separation anxiety, active initiative, and stranger anxiety. Based on information collected in her experiment "The Strange Situation," Ainsworth also identified and classified three separate attachment patterns: securely attached, anxious-ambivalent, and anxious-avoidant. According to Ainsworth, Blehar, Waters, and Wall (1978), in the anxious-ambivalent attachment pattern children are chronically anxious in relation to mother, have slower cognitive development, a lower tolerance for frustration, and a conflicted response to close bodily contact with the mother. Children's anxious-avoidant attachment patterns include gaze aversion toward the mother and a low threshold for high-intensity interactions with her (pp. 314–319).

Along with anxious-ambivalent and anxious-avoidant, the disorganized pattern is also a maladaptive style of attachment. Mary Main, a student of Ainsworth, identified similarities between behaviors of the disorganized, anxious-ambivalent, and anxious-avoidant types; she also found the disorganized working model and behaviors more confused and controlling. These children had experienced trauma that caused their approach behavior with their parent to be physically disorganized and also intermittently disoriented and frozen (Karen, 1994, p. 235). Alternatively, children with disorganized attachment models were more likely to express frustration against their parents and to be more frantically controlling and dominating in their effort to

secure the responsiveness they clearly felt was not reliably available to them (Karen, 1994, p. 219).

Child factors that affect relationship development in foster/adoptive families

The age of the child when he or she joins the foster/adoptive family is the most predominant factor affecting relationship development. This is understandable from the standpoint of attachment theory, which would lead one to hypothesize that a child who has developed disordered working models of attachment will have more trouble changing them as they become more habitual and entrenched over time. In fact, research has shown that the older the child, the more likely the risk of disruption of foster care or adoptive relationships.

There are several reasons for this. First, the younger the child, the more likely it is that he or she will be able to develop a secure attachment with a foster/adoptive family. For example, one study found that “children placed into foster care prior to 12 months of age often form secure attachments readily to foster mothers who have autonomous states of mind . . . [whereas] children placed later than about 12 months do not usually form secure attachments over an extended period of time.” *Autonomous states of mind* are defined as “speak[ing] openly and non-defensively about early attachment experiences and demonstrate[ing] clear valuing of attachment” (Dozier and Albus, 2000, pp. 176–180).

Another factor associated with the child’s age is the effect of exposure to abuse and neglect on brain development. Although child abuse receives the most attention, child neglect, which typically affects younger children most profoundly, is the most prevalent form of child maltreatment in the United States today. Consider the following: in 1999, 58% of the children reported for maltreatment nationwide were neglected; 38% of the 1,100 child maltreatment deaths were associated with neglect; and more than 86% of the child deaths from neglect

situations were children younger than six years of age (Petras, Massat, and Essex, 2002, p. 3).

Both abuse and neglect affect attachment. First, during the first three to four years of life, “the anatomic brain structures that govern personality traits, learning processes, and coping with stress and emotions are established, strengthened, and made permanent” (Committee on Early Childhood, 2000, p. 11). Second, the processes of “attachment, affect regulation, and memory are interdependent neurological processes When a child’s neurological response to fear is a hyperaroused stance [such as in instances of abuse], cortical activity is suppressed by the organism’s sense of impending catastrophe” (Heineman, 1998, pp. 66–73). The result of this cortical suppression is that the child’s fear of the abusive situation is not stored in cognitive memory, which limits accessibility of the memory of abuse by the child’s recall system. Instead of reflective memory, the child expresses anxiety, anger, and other feelings connected with abuse through interactions in relationships with caregivers. The child’s behavior can negatively affect relationships with foster/adoptive family members who had no involvement in the initial abuse, but must deal with the impact of the child’s prior toxic environment.

A child’s temperament can also affect the development of foster/adoptive family relationships. Kagan, a behavioral geneticist, has conducted studies regarding genetic and constitutional variables affecting personality. His studies in temperament found that there are two types of temperaments in children: inhibited (high reactive) and uninhibited (low reactive). In a study of Caucasian children, Kagan found that inhibited children display “avoidant, fearful behavior in new situations. These children hesitate in their approach to objects, remain quiet with new people, and stay close to their mothers [Uninhibited children] are relatively sociable [and] fearless. They approach objects without hesitation, talk spontaneously to unfamiliar persons, and spend little time in proximity

to their mothers” (Arcus and Kagan, 1995, p. 1530). It is essential to evaluate the fit between the child’s temperament and the temperament of the foster/adoptive parent, because mismatches can be stressful for parent and child and require more assiduous support from caseworkers until the attachment is stable.

It is also important to examine the child’s behavioral responses to unstable environments. “These behavioral strategies may, in the words of Alan Sroufe [1988] be adaptive but not competent” (cited in Dozier and Albus, 2000, p. 172). Because these children have often had to live in unpredictable, traumatic, and frightening environments, “[c]hildren’s behaviors must be explored as skills resulting from coping with their abusive histories rather than as negative attributes” (Henry, 1999, 527). Thus, foster and adoptive parents need to be helped to understand the reasons for the children’s seemingly irrational behavior.

Being born with a cocaine or alcohol addiction has been shown to influence a child’s temperament. For example, prenatal drug or alcohol exposure may be associated with hypersensitivity and a difficult temperament in infancy. Rodning et al. (1991) found “a heightened risk for insecure attachment among infants prenatally exposed to drugs” (cited in Dozier and Albus, 2000, p. 181). This is relevant because an insecure attachment style may develop in an infant because of circular causality. In other words, the infant’s irritability may cause behaviors that caregivers find difficult to understand. The caregiver may unconsciously react to the child with less interaction or more frustration. This in turn may cause the infant to react with more irritability or withdrawal, setting up a maladaptive, circular relationship cycle.

Access to the knowledge of the neurological impact of abuse and neglect on children may allow foster and adoptive parents to reframe their perceptions of their child’s behaviors utilizing a strengths perspective. With parental expectations reframed through cognitive behavioral

therapy, the child can be more successful, providing opportunities to develop self-esteem; in turn, the frustration level for foster/adoptive parents decreases, creating a more harmonious environment for all family members.

Before making the decision to foster or adopt, these prospective parents need to examine their own attachment patterns. According to a study by Main et al. (1985), “parents’ caregiving patterns with their children seemed to change when the parents had gained a more coherent understanding of their own childhood attachment histories” (cited in Pistole, 1999, p. 443). Because of the exhausting nature of parenting an attachment-disordered child, therapeutic support for the foster/adoptive parents should be provided free of charge, especially for the mother. For example, Smith (1992) studied the effects of family centers on families living in stressful environments. One mother stated: “It’s calmed me down a bit, I think. It’s made me look at things a bit more in perspective instead of getting so wound up” (cited in Howe, Brandon, Hinings, and Schofield, 1999, p. 264).

Parental factors that affect relationship development in foster/adoptive families

As with the child, characteristics of the foster/adoptive parents—including being a victim of abuse, unresolved loss, and harsh parental expectations—influence parents’ attachment styles (Sroufe, 2005). In particular, parents’ unresolved traumas can contribute to disorganized attachment behaviors in infants. Unresolved trauma is defined as “losses and traumatic experiences indicated by lapses in the monitoring of reasoning or discourse.” *Disorganized behavior*, a symptom of unresolved trauma, is a “display of contradictory attachment behavior patterns, or display of indices of apprehension of the parent” (pp. 278–279). For example, Schuengel, van Ijzendoorn, Bakermans-Kranenburg, and Blom (1998) examined a low-risk, low-stress sample of mothers with unresolved trauma, and found “a 75% correspondence between

unresolved loss or unresolved trauma [in the mother] and infant disorganized attachment behavior." This study also demonstrates a correlation between the parent's internal working model and its impact on the child's working model.

Parental attachment models also factor into foster/adoptive relationships. When parents open their hearts and homes to a child, there is an expectation that there will be a period of adjustment, but then the child will gradually exhibit behaviors of gratitude, bonding, and love toward the foster/adoptive family. The child will understand that this time the parents are different, and that the child will not be exposed to abuse, neglect, or rejection. Parents may also expect the child to behave in an age-appropriate manner that matches the child's physical or chronological age. However, this may be impossible if the child has experienced neurological damage due to abuse and neglect. Also, social learning plays a big part in this process, as the child imitates behaviors that he or she has learned, and often expects rejection.

Age and gender may affect the foster/adoptive relationship. A study of disrupted adoptions in adolescents (mean age 13.9) found that younger adoptive parents (37 years and 42 years) were more likely to have disrupted adoptions than older adoptive parents (44 years and 46 years). A study comparing the characteristics of foster parents who stopped being foster parents, considered stopping, and planned on continuing to foster found that continuing foster mothers were older than those in the other two groups, while the foster father's age, respondent's race, educational attainment, and employment status did not differ across groups (Rhodes, Orme, and Bueler, 2001, p. 95). Foster parents planning to quit were more likely to say that they needed day care, transportation, and help with health care costs—clearly, increased financial support for foster parents is sorely needed.

The presence or absence of other children in the home significantly influences the stability of foster and adoptive parenting. Berry and Barth found no disruptions if there were other foster children in the home; a 14% disruption rate if there were other adopted children in the home; a 27% disruption rate if there were other pending adoptions in the home; and a 32% disruption rate if there were biological children in the home (Berry and Barth, 1990, p. 5). These studies demonstrate that each variable has a different effect on the stability of the foster/adoptive family relationship.

Most of the research regarding adoptive/foster parents has focused on the role of the mother as the primary caregiver. With today's changing climate, in which there are more stay-at-home fathers, research should also be conducted regarding the father's role in creating healthy attachment styles. In addition, the impact of extended family support for the foster/adoptive family in dealing with difficult children should be explored.

Another factor is whether the foster/adoptive relationship is formal or informal kinship care. *Kinship care* is defined as care by "any relative, by blood or marriage, or any person with close family ties" Takas, 1993 (cited in Hegar and Scannapieco, 1995, p. 1). Formal kinship care is defined as "kin act[ing] as foster parents for children in state custody" and informal is defined as "caregiving arrangements occur[ring] without the involvement of a child welfare agency" (Geen, 2000, p. 19). Most kinship caregivers are grandparents, older, single, and less educated; have lower incomes; and are less likely to report being in good health than nonkin foster parents (Geen, 2000, p. 22). For example, a study that examined kinship care in South Carolina found that "76 percent of the caretakers were grandparents or great-grandparents" (Edelhoc, Liu, and Martin, 2002, p. 27). Also, in the South Carolina Study, "91 percent of the caretakers said they would like to raise the child (or children) to the age of 18" (Edelhoc, Liu, and Martin, 2002, p. 27). In addition, kinship care offers greater

stability to foster/adoptive children. "The Westat study for the U.S. Children's Bureau [1997], which focused on children receiving child welfare services in 1994, found that children in kinship care experience an average of only one move, while children in foster care may average between five and ten placements" (Hill, 2000, p. 69).

Are racial characteristics of the foster/adoptive child and/or the foster/adoptive family contributing factors to the vulnerability, risk, and resilience of the foster/adoptive family relationship? Empirical research is limited. According to Smith (1994), 14% of all adoptions in the United States are transracial or transcultural (cited in Vonk, 2001, p. 246). In addition, Rushton and Minnis (1997) found that transracial adoptions of African-American children in the United States showed successful adjustments in the 70% to 90% range (cited in Vonk, 2001, p. 248). Bartholet, a proponent of transracial adoptions, argues that "there is not a shred of evidence that transracial placement[s] injure children; there [is] overwhelming evidence that suffering long delays in placement, or being denied an adoptive home, [because of time lags due to race-matching] cause[s] them significant harm" (Bartholet, 1999, p. 127). In fact, she likens the debate about transracial adoption to the furor that *Brown v. Board of Education* caused.

What cultural competence factors do foster/parents families bring to the development of foster/adoptive relationships? Although there are many suggestions in the literature, there is no agreement as to the specific attitudes, skills, and knowledge necessary to create parental cultural competence. Studies must be done about outcomes of foster/adoptive children in relation to the foster/adoptive parents' cultural competence. Vonk (2001) suggests three attitudinal factors in foster/adoptive parents that affect their relationship with the children they care for: racial awareness, survival skills, and multicultural family planning. *Racial awareness* is defined as "a person's awareness of how the variables of race, ethnicity, culture, language, and related

power status operate in one's own and other's lives." It also includes an understanding of the dynamics of racism, oppression, and other forms of discrimination. *Survival skills* are defined as "the recognition of the need and ability of parents to prepare their children of color to cope successfully with racism" (Vonk, 2001, pp. 249–251). *Multicultural planning* is defined as "the creation of avenues for the transracially adopted child to learn about and participate in his or her culture of birth."

Risk and Protection: The Influence of Surrounding Systems

Mental health care providers

If the child's ability to form stable relationships with the foster/adoptive family has been adversely affected by variables of temperament (especially related to prenatal drug or alcohol exposure), brain development, age at time of foster/adoptive placement, and abuse and/or neglect, the child might receive a psychiatric diagnosis of reactive attachment disorder (RAD). *The Diagnostic and Statistical Manual (DSM-IV-TR)* of the American Psychiatric Association (2000) defines RAD as characterized by a "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" (p. 127). Children are classified as having either the Inhibited Type or the Disinhibited Type of RAD. In the Inhibited Type, "the predominant disturbance in social relatedness is the persistent failure to initiate and respond to most social interactions in a developmentally appropriate way." In the Disinhibited Type, "the predominant disturbance in social relatedness is indiscriminate sociability or lack of selectivity in the choice of attachment figures" (p. 128).

What do these two subtypes mean in terms of the child's behaviors and the corresponding effect on the foster/adoptive family? Both the inhibited and uninhibited subtypes display several common behaviors, including the need to control people and situations, pathological lying, inability

to make eye contact, apparent lack of a conscience, and peculiarities associated with food. Among these behaviors, the child's need for control is the most prevalent, and is also an underlying motivation for all the other behaviors mentioned. Because their earlier lives lacked consistency, but did involve potentially life-threatening events, these children feel that they *must* control their environment or they will die. This need for control, which puts up an emotional wall between the parents and the child, can be the greatest barrier for foster/adoptive caregivers trying to parent these children. The parents may feel that they cannot connect with the children, who may avoid any close contact, even eye contact, out of fear. Second, pathological lying, often in situations in which it makes absolutely no sense to lie, may also be associated with the need to control. Children may feel that telling the truth is giving away their power, which they associate with survival. Finally, these children have unusual behaviors associated with food. Many of these children keep food in their rooms, "just in case," even after it is rotten or spoiled (Randolph, 1999).

Although many children display a mixture of the inhibited and disinhibited behaviors, some behaviors are specific to each subtype. The inhibited type does not enjoy being with others, is more interested in the environment than in people, and is hypervigilant. Inhibited children may wiggle, squirm, and scratch themselves to protect themselves from forced closeness with their parents. In addition, because they are uncomfortable about expressing their anger directly, it may come out indirectly, such as in forgetting to do things (Randolph, 1999).

The disinhibited subtype has different characteristics. First, disinhibited children can be superficially compliant and overly friendly with strangers. Although they are able to make friends, the friendships lack staying power. In teenagers, the disinhibited subtype may use sex to keep boyfriends/girlfriends. These children may show a total disregard for the consequences of their

actions. A behavior also associated with disinhibited control is nonstop chattering or making frequent comments under the breath (Randolph, 1999).

There are several concerns with the reactive attachment disorder diagnosis. First, "the information currently available on children diagnosed with RAD is based primarily on clinical or anecdotal data. . . . There are no epidemiological studies that examine the prevalence, incidence, or natural course of RAD" (Hanson and Spratt, 2000, p. 140). Second, because of limitations in the *DSM-IV-TR*, to accurately capture all of the symptoms present in the child, children with RAD may be diagnosed as having both RAD and other disorders listed in the *DSM-IV-TR*, including mental retardation, autistic disorder, pervasive development disorder, social phobia, and attention-deficit/hyperactivity disorder. Finally, RAD is not readily distinguished from other disorders, especially oppositional defiant disorder (ODD) or conduct disorder (CD). According to Randolph (1999), "all of the children with [RAD] have 7-8 ODD symptoms, while behavior problem children who don't have [RAD] never have more than 5-6 ODD symptoms. Most children with [RAD] have 1-2 symptoms of [CD], usually deliberately destroying the property of others and stealing non-trivial items without confronting a victim" (pp. 7-8). The problems with the RAD nosological category "are now being addressed, beginning with efforts to reconceptualize the disorder" (Hanson and Spratt, 2000, p. 140).

There is no specific drug therapy for reactive attachment disorder. As a result, pharmacological treatment includes a cocktail of drug therapies used to treat the other disorders mentioned earlier, with limited evidence available about their effectiveness. Because recently adopted children and children in foster care have undergone the stress of abuse or neglect and separation from their families of origin, the use of medications can be problematic if the drugs mask the child's expressions of distress, which are natural efforts to

communicate inner suffering to a caregiver, and recover.

On a positive note, visiting nurses are a proactive response to neglect, abuse, and attachment issues. Sroufe, Carlson, and Shulman (1993) studied a sample of expectant mothers and found that “mother variables were powerful. Depressed mothers and those who had been rated by nurses as having low interest in their baby before it was born were more likely to have anxious children at one year” (cited in Karen, 1994, pp. 183–184). In a longitudinal study of home visiting by Olds et al. (1997, 1998), nurses visited unmarried, low-income teenage mothers, prenatally and during the first two years of the children’s lives. “Compared with families that received only transportation and developmental screening, nurse home visiting resulted in benefits to children’s behavior and the mothers’ life course 15 years later. The 15 year olds born to low-income, nurse-visited mothers had 46% fewer verified reports of child abuse and neglect and also 56% fewer arrests” (cited in Bogenschneider, 2001, p. 360).

Schools and educators

Is there a need for educators to develop programs to assist high-risk children found in some foster/adoptive families? Adelman (2002) examined school reform and found that in urban and rural schools serving economically disadvantaged families, teachers stated that only 10% to 15% of their students come to class motivationally ready to learn. By contrast, teachers rated 75% of students from suburban schools as ready to learn. A study of risk and protective factors regarding educational progress in youth with aggression and emotional disturbances found that “for educational progress, the essential protective factors included not only cognitive skills such as problem-solving ability, but also social competencies including general likeability and the ability to get along with peers and adults” (Vance, Fernandez, and Biber, 1998, p. 5). One response that is being tested for efficacy is school–community collaborations. This has

fostered programs such as school-linked services, coordinated services, wraparound services, one-stop shopping, full-service schools, and community schools. Establishing these programs is a challenge, but they can be both successful and cost-effective, and deserve more support from policymakers (Adelman, 2002, pp. 3–4).

Child welfare service providers

Opinions differ as to the optimum interventions by which social workers and counselors can address the risk and vulnerability factors in foster/adoptive families. First, social workers need reliable, objective, and relevant assessments. A study examining clinical assessments of children in child protection cases found that 65% of the assessments were psychological evaluations, and assessments of children often consisted of a single office session and used limited background sources. Psychological evaluations lacked an ecological focus, and tended to focus on a child’s limitations, whereas a child’s strengths were more likely to be reported in developmental assessments. Not surprisingly, most children (82%) were found to need therapy (Budd, Felix, Poindexter, Naik-Polan, and Sloss, 2002).

Research about treatment for RAD specifically is still sparse (Hughes, 1998, p. 295), because the behaviors associated with reactive attachment disorder are also found in children suffering from other forms of distress. Thus, it makes sense to borrow interventions from other therapies that have empirical support. Cognitive behavioral therapy (CBT) interventions, targeting symptoms such as fear, anxiety, and posttraumatic stress, have received the most empirical evaluation. Deblinger, Lippman, and Steer (1996) found that children who received CBT had a significant reduction in their posttraumatic stress disorder (PTSD) symptoms (cited in Cohen, Berliner, and Mannarino, 2000). Cohen and Mannarino (1996, 1998) compared the effectiveness of CBT to nondirective supportive therapy (NST) in two studies with sexually abused children. The first study found greater

improvement in symptoms of PTSD, sexually inappropriate behaviors, and internalizing and externalizing behaviors. The second study, utilizing a sample of 8- to 14-year-olds, found a greater improvement in depressive symptoms from CBT when compared to NST. These interventions typically include teaching the child positive coping and anxiety management skills, psychoeducation around sexual and/or physical abuse, and gradual exposure techniques to reduce trauma-related fear and anxiety (cited in Cohen, Berliner, and Mannarino, 2000).

Research with abused children has also indicated that caregiver involvement positively affects outcome. This may be due in part to parental reinforcement of therapeutic interventions at home (Cohen, Mannarino, Berliner, and Deblinger, 2000). For example, in the previously mentioned study of 8- to 14-year-olds who were sexually abused, parental support was shown to be a strong factor in predicting symptom resolution. Practice is always one step ahead of empirical research. However, service providers cannot wait for empirical results before trying to address the needs of children who have been traumatized. Given that premise, because CBT has been proven to be effective with sexually abused children, it cannot hurt, and might help, to implement the therapy in other situations (such as attachment disorders) and let the research come in after the fact (Cohen, Berliner, and Mannarino 2000).

A positive response to the lack of research regarding attachment therapies has been the formation of an organization known as The Association for Treatment and Training in the Attachment of Children (ATTACH). The goal of this international organization, comprised of parents and professionals, is to increase the awareness and importance of attachment with respect to human development. Similar to the National Association of Social Workers (NASW) Code of Ethics, the ATTACH *Professional Practice Manual* contains ethical standards for attachment therapists. For example, to become a member of ATTACH, one must

agree not to participate in controversial interventions if those interventions could compromise a child's safety (ATTACH *Professional Practice Manual*, 2001, pp. 1-16).

Child welfare policymakers

Given the climate of today's child welfare system, what policies, if any, provide an adequate foundation for enhancing the quality of foster/adoptive family relationships? The legislation of 1980, 1993, and 1997 lacked the cohesive practicality for successful implementation. The result? Children born in 1980 could have gone through three diametrically opposed policies regarding their relationship with their family prior to reaching adulthood. First, the 1980 Adoption Assistance and Child Welfare Act focused on eliminating foster care drift, utilizing a three-phased approach of family preservation, family reunification, and permanency planning. All three were to be implemented within the guidelines of reasonable efforts.

Next, the 1993 Family Preservation Act focused on keeping families intact. This act also specifically endorsed kinship care. There were two reasons for the passage of this law. First, because of the decreasing numbers of children in foster care, agencies redirected funding from foster care to family preservation and family support services. At the same time, there was a significant decrease in the number of foster parents. For example, "from 1984 to 1990, the supply of foster parents dropped from 147,000 to 100,000" (Danzy and Jackson, 1997, p. 3).

Finally, the 1997 Adoption Assistance and Safe Families Act focused on moving children out of foster care into adoptive homes. It amended the 1980 Act in three specific ways: (1) protect children's health and safety, (2) attempt to reduce foster care drift, and (3) increase the number of children moving from foster care to adoption. However, although research has demonstrated that postadoption service can improve the stability of parents raising older children and children with emotional problems, none of these acts

included increases in the provision of postadoption services.

Conclusions

How can the child welfare community and policymakers do a better job of responding to the needs of children and their families in foster/adoptive relationships? The relationship between children and their foster/adoptive parents is extremely complex: both children and parents bring vulnerabilities to the relationship, and systems that can aggravate risk or be protective impinge upon the relationship.

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- In trying to address that complexity in this paper, we have been impressed with how important it is for scholars to stay focused on the best interests of the child, because so many other variables affect these situations, and can distract from the priority of understanding and caring for these vulnerable children. More research about the factors that contribute to the development of successful foster/adoptive relationships is much needed; the findings would be useful springboards for professionals as they strive to help and provide supportive policies for foster and adoptive families.
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