

**COORDINATING ATTACHMENT AND PERMANENCY (CAP) PROJECT
FINAL REPORT**

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TABLE OF CONTENTS

I. EXECUTIVE SUMMARY	1
II. INTRODUCTION AND LITERATURE REVIEW	4
COMPLICATIONS IN THE ATTACHMENT PARADIGM	5
AN OVERVIEW OF ATTACHMENT TREATMENT MODELS	8
<i>Cognitive and Behavioral Approaches</i>	8
<i>Holding and Rebirthing Approaches</i>	12
<i>Play Therapy Approaches</i>	15
<i>Other Approaches to Attachment Therapy</i>	17
<i>Summary and Conclusion</i>	19
III. ATTACHMENT AND CHILD WELFARE.....	20
IV. ATTACHMENT AND PERMANENCY: THE CAP APPROACH.....	22
GRIEF AND ATTACHMENT	22
STAFFING ISSUES.....	23
STRUCTURE OF CAP GROUPS.....	24
STRUCTURE OF FOLLOW-UP	27
V. EVALUATING OUR EFFORTS.....	29
OBJECTIVES 1 & 2: REDUCE BARRIERS TO ATTACHMENT & INCREASE ATTACHMENT SECURITY.....	29
<i>EVALUATION—Process</i>	29
<i>EVALUATION—Results from the treatment program</i>	33
<i>OUTCOMES</i>	35
OBJECTIVE 3: INCREASE FOSTER/ADOPTIVE PARENTS’ ABILITY TO HELP WITH ATTACHMENT ISSUES.....	39
<i>RESULTS</i>	39
<i>OUTCOMES</i>	42
OBJECTIVE 4: INCREASE BIRTHPARENTS OR RELATIVES’ ABILITY TO HELP WITH ATTACHMENT ISSUES.....	43
<i>RESULTS</i>	43
<i>OUTCOMES</i>	46
OBJECTIVE 5: INCREASE CLINICAL CASEWORK COMPETENCY REGARDING CONCURRENT PLANNING ISSUES.....	47
<i>OUTCOMES</i>	48
VI. LESSONS LEARNED AND BEST PRACTICES	49
LESSONS LEARNED.....	49
UNANTICIPATED BENEFITS.....	54
BEST PRACTICE RECOMMENDATIONS	55
<i>Strengthen attachment relationships for children involved in the child welfare system</i>	55
<i>Increase access to services and programs for birth families</i>	55
<i>Increase capacity of foster parents to attach to children in their home</i>	57
VII. CASE SUMMARIES.....	58
VIII. FINAL COMMENTS.....	75
APPENDIX A	80
CAP CURRICULUM	80
APPENDIX B	81
FOLLOW-UP ACTIVITIES AND SAMPLE ASSESSMENTS	81
APPENDIX C	82
COMMENTS FROM EVALUATION FORMS.....	82

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In the spirit of permanency for all children,
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CAP Project Coordinator

COORDINATING ATTACHMENT AND PERMANENCY (CAP) PROJECT FINAL REPORT

I. EXECUTIVE SUMMARY

Bellefaire JCB's Coordinating Attachment and Permanency Project (CAP) was conceptualized as a proactive therapeutic response to the issues raised by reduced timeframes from initial custody to permanency for children in foster care as required by the Adoption and Safe Families Act (ASFA) of 1997. Ohio's implementation of ASFA requires that agencies must attain permanency for foster children by the 12th month they are in out-of-home care during a 22-month period. ASFA also allows the use of concurrent planning where the caseworker simultaneously attempts to help the birthfamily reunify while constructing an alternative permanency plan in case reunification isn't possible.

While this concurrent plan is important for reducing the total amount of time a child stays in foster care, it can create ambiguity and uncertainty for children. Children now have two goals operating at the same time: one to work toward reunification with their parents, and the other to be adopted by their foster parents or another resource family if reunification isn't achieved quickly. CAP is designed to help children deal with the conflicting emotions created by their entry into foster care and their experiences with concurrent planning. Specifically, we developed a consistent, proactive therapeutic approach to increase attachment security between the child and their primary, and hopefully permanent, caregiver by addressing issues of emotional turmoil, ambiguity, loss, grief, and attachment.

We had five primary goals in the CAP project: 1) reduce barriers to attachment by helping children resolve feelings of ambiguity, loss and grief; 2) increase foster children's level of attachment security to the primary caregiver; 3) increase foster parents sensitivity to, knowledge about, and skill with supporting children and their feelings; 4) increase birthparents

or relative caregiver's sensitivity to, knowledge about, and skill with supporting children and their feelings; and 5) increase clinical casework competency in Cuyahoga County regarding concurrent planning and emotional issues.

To achieve the project goals, foster children, foster parents, birthparents and/or relative caregivers participated in program activities including parallel groups with children and their foster, adoptive, or birth parents or relative caregivers, lifebook work, visitation, individual counseling, and assessments. Each family participated in five weeks of group activities with other families and then 12 months of in-home follow-up activities with CAP specialists and foster care case managers. The specific framework for these interventions is described in Section IV (page 22) of this report.

Our premise is simple: We believe that addressing children's reactions, feelings, and fears realistically and honestly in a supportive group setting with peers will help resolve them and enable children to form healthier and stronger attachments to others. In addition, helping the caregivers understand the underlying issues and giving them practical methods and tools to use to continue helping the children once social workers are out of their lives will also help children form stronger attachments. Underlying all of these assumptions is our core belief that children in foster care have strengths that can be accessed and built upon so they can not only survive abusive pasts, but can also go on to thrive in healthy functional relationships. Many of their reactions to past abuse and neglect and the trauma of being removed from birthfamily are normal. When they are viewed as such, adults can begin to understand the child's perspective and "start where the child is."

CAP was a demonstration project, and as such, we were able to try a number of innovative techniques to test our assertions and to meet our objectives. Anecdotally we heard

early in the project that our techniques were effective with the children and families. While a more rigorous research design would be needed to have more conclusive evidence, we did systematically evaluate our efforts in a pre-test, post-test one group monitoring design. By the end of the project on average, children were functioning better on almost all of our subscales and reported feeling more able to deal with the issues we targeted. We met some of our objectives, exceeded some, and did not meet others. Following is a description of the CAP program, our findings, and recommendations for further study and practice implementation.

II. INTRODUCTION AND LITERATURE REVIEW

One of the primary goals of CAP was to increase attachment security between the child and their primary caregiver. We did not attempt to “treat” children diagnosed with Reactive Attachment Disorder. Instead, we chose to focus on building attachment and trust between foster children and their caregivers through interactive activities and discussions. Our assertion is that trust, not love, is the foundation of attachment, and for most of the children we worked with, their trust in the adults in their lives had been damaged many times over. Following is a brief literature review about attachment and the range of treatments proposed for children with attachment issues and problems. Later, we will describe how CAP differed from traditional and more controversial treatments for attachment issues.

Attachment is a physical, social and psychological bond between a child and a caregiver or caregivers. Attachment has become a dominant paradigm from which to evaluate and make predictions about children and their future, especially for foster and adoptive children. Various epistemological frameworks influence current practices relate to attachment.

Epistemology means ways of knowing. Knowledge implies certainty (Rynin, 1967). One of the tasks of epistemology is to elucidate from among multiple ways of knowing the basis on which assertions are considered true. From a philosophical standpoint -- from which develops religion and spirituality -- the way of knowing is based on belief and faith. Social fact from this perspective is irrelevant or secondary. From a normative perspective, frameworks for understanding social phenomenon are developed from day-to-day experience. From a scientific perspective, there must be adequate evidence from qualitative or quantitative methodologies to support a hypothesis. However, knowing and believing are distinct (Danto, 1967). If we claim to know, then we need to be explicit about the supporting evidence; believing or supposing has

little to do with providing information and evidence (Lemmon, 1967). Belief gives the believer the right to disregard evidence or information.

In attachment conceptualization and treatment, we need a clearer distinction between belief and knowledge. We also need to explicate those tenets and approaches that have evidence, those that are theoretically based without empirical support, and those that are neither conceptually nor empirically supported. In the following review, we differentiate between belief and science in the state of knowledge of attachment treatment. We raise issues that should be of concern to practitioners and policy makers that fund various treatment approaches. We offer a model for building attachment in older children and evaluate our efforts with this model. We conclude with case examples based on our experiences, including cases where we had success and those cases where we were not successful.

Complications in the Attachment Paradigm

Not only are some of the techniques associated with attachment therapy contentious, so are some of the concepts. While initially research in attachment suggested that relations were unidirectional (from mother to child), it is widely recognized that there is a dynamic interaction between caregivers and children. Not only do patterns of behavior affect attachment behaviors in the child, but also attachment behaviors affect patterns of behavior in the caregiver (Hinde, 1983). Also, while one parent may be the primary caregiver, infants soon have relationships with more people than just the mother or father, both within the context of the immediate nuclear family as well as the extended family system and primary groups involved with the family (i.e., work relationships, neighbors, people from church or the synagogue, etc). As Hinde writes (1983), "... every relationship is embedded in a nexus of other relationships and cannot be

considered in isolation” (p. 68).

Several other difficulties are also apparent in the existing literature on attachment. Most information about attachment and adoption has focused on infant adoptions. The concepts are less well articulated for older children (O’Connor & Zeanah, 2003; Carlson, Sampson, & Sroufe, 2003). Also, attachment means different things to different people. Rutter (1997) suggests that the term refers to a discrete pattern of behavior such as proximity seeking behavior, to a dyadic relationship, to a predisposition of certain ways of relating to individuals, and to a cognitive model of relationships (see also Hinde, 1982). In trying to even define what attachment means there is little uniformity.

Other complications in attachment research and practice include:

- attachment cannot be directly measured but must be inferred from select criteria (i.e. behavioral, verbal, cognitive cues)
- attachment is dynamic, not static; it is both process and outcome
- attachment is reciprocal and interactive
- attachment is multidimensional

Assessing or measuring attachment is a complicated issue for practice and research. In part, the issues outlined above account for part of the complication. In addition, the measures developed for attachment have been oriented to infants and toddlers, not older children. Even those measures of infant attachment are problematic, particularly when it comes to the measure of secure attachment. Rutter (1997) suggests that there is much individual variation in degree of security for infants not captured in current measurement systems. Just as challenging, there is not a consensus about the categories of problematic attachment. Bowlby and Ainsworth offered three categories, Main and Weston offered a fourth, and Zeanah offers a different typology.

Researchers cannot assess attachment by counting the frequencies or duration of any one type of behavior (Hinde, 1983, p. 59). The amount of contact is not a measure of the strength of the attachment relationship; attachment is evaluated by the qualitative differences in the way the types of attachment behaviors are organized (Hinde, 1983). Attachment is best expressed as a multi-dimensional organization of behaviors, and understood within the context of the caregiver and the environment (Sroufe & Waters, 1977; Ainsworth, Blehar, Waters, & Wall, 1978).

Rutter (1997) also indicates that patterns of attachment are activated to social-situational factors, consistent with initial conceptualizations, but also by neurobiological factors. The increase in research in neurobiological and neurochemistry has and will result in reconceptualizing and refining the theory and measures of attachment (see also Crittenden, 1997).

Internal working models as a concept is problematic, according to Rutter (1997), because it cannot lead to testable hypotheses or testable explanatory power. All relationships cannot be reduced to conceptions of attachment qualities (Rutter, 1997). Rutter (1997) decries the "...tendency to discuss relationships as if attachment security was all that mattered . . . children's relationships with other people are complex and involve a range of different dimensions and functions" (p. 26). According to Ainsworth and colleagues (1978) and Hinde (1983), attachment concepts were useful in understanding research findings and giving directions for future research, but were not meant to be a set of propositions for intervention. They had heuristic value for understanding the development of children, not necessarily to be used to develop clinical interventions.

The predictive quality of attachment relationships is also problematic. Development is lawful (Atkinson, 1997) but not determinism. Events occurring at any point in the lifespan may

have implications for subsequent outcomes (see Atkinson, 1997; Belsky & Nezworski, 1988) but the role of early experience in later outcomes is not always clear or direct. Even when an experience was negative or traumatic, it may not lead to psychopathology. Attachment has no direct relationship with later psychiatric disorders (Rutter, 1997; Sroufe, 1988). In addition, as Goldberg (1997) states: “. . .an established link between parent-child relationships and psychopathology can only be one element in a complex process. Parent-child relationships are not the only or even the most important determinant of childhood behavior problems” (p. 171). While several studies support that children with insecure attachment are more likely to develop behavior problems, there are also studies that find no such relationship (Goldberg, 1997). In part, this may be due to indications that patterns of attachment are not entirely stable over time. Goldberg and colleagues (Goldberg, Washington, Birenbaum, & Simmons, 1994) report that less than 50% of children maintained their same pattern of attachment from infancy to age 4.

In summary, there is still so much to learn about attachment as a concept as well as the measures to use to assess attachment for research and clinical purposes (O'Connor & Zeanah, 2003). In addition, the knowledge of appropriate and effective attachment treatment is still lacking. The following section reviews the various treatment models, drawing from the conceptual issues as outlined above.

An Overview of Attachment Treatment Models

Cognitive and Behavioral Approaches

Ethological theory and personal/participant observation influence the concepts of attachment developed by Bowlby (1969, 1973, 1988). He developed a theory of trauma based on the physical separation of the mother from the child to explain abnormal development (Atkinson, 1997). His attachment concepts were further refined by the field research and laboratory studies

of Ainsworth (1979). According to this approach, one way to classify certain behaviors of children is as an attachment behavior system. These behaviors function to maintain or increase proximity of a child to a mother or mother figure or cause the mother figure to move towards the child (Hinde, 1983). The behavior system promotes and is affected by relationship experiences. As a child interacts with the primary caregiver and other people, he or she develops a sensitivity to and expectation about others (Hinde, 1983) or, as Bowlby suggests (1969), a working or cognitive model of themselves, their caregivers and others.

As expected, an attachment behavioral system changes as a child grows and develops. While initially there is little coherence in behavior patterns, by the middle of their first year of life, these patterns become organized (Bowlby, 1969; Hinde, 1983). Patterns of attachment have been classified into three main typologies: secure, anxious-resistant (ambivalent) or anxious-avoidant (Ainsworth, 1973; Bowlby, 1988). Anxious-avoidant attachment patterns include displaying minimal affect or distress, and avoiding attachment figures under circumstances that would elicit interaction from those who are securely attached. Anxious-resistant attachment patterns include eliciting ongoing interaction with attachment figures while simultaneously lacking the ability to be comforted or calmed when distressed. Children with secure attachment elicit and respond to comfort and interactions with attachment figures in consistent and age-appropriate ways.

Main and Weston (1981) suggest another classification of attachment patterns resulting from maltreatment. They suggest that some children evidence a disorganized/disoriented pattern of attachment. This pattern blends contradictory strategies for dealing with separation and reunion. In other words, children use strategies that blend both avoidant and ambivalent

classifications of attachment and do not exhibit a coherent behavioral strategy to obtain security needs from their caregivers (Boris, Wheeler, Heller & Zeanah, 2000).

In addition to developmental research -- much of which is based in lab settings or in field research -- clinical research and experience have developed different typologies of problematic disturbances of attachment. Zeanah (2000) has defined two patterns of problematic attachment under the DSM-IV diagnosis of reactive attachment disorder. The first pattern is the failure to initiate or respond appropriately during social interactions. This pattern is similar to autism in that it is characterized by unresponsive social interaction except for aggression, staring at spinning objects, failure to protest at separation, and reluctance to communicate due to language/speech delays.

The second pattern involves indiscriminate attachment. Zeanah (2000) states that the two overarching features are reckless or accident-prone behavior and socially promiscuous behavior. Reckless/accident-prone behavior is characterized by actions that place the child at-risk, such as wandering off and not checking with the caregiver. Socially promiscuous behavior is characterized by superficial social responses and indiscriminate friendliness (Zeanah, 2000; Chisholm, 1998). While it is not clear how to classify "indiscriminate friendliness" in attachment paradigms (Zeanah et al., 2002), it is a concern for parents and practitioners that requires investigation in attachment research.

A central component of these models is that biologically based behaviors are later translated into patterns of social behaviors as well as cognitions about relationships. Internal working models are a central feature of cognitive-behavioral approaches to treating attachment problems (Beck, Rush, Shaw & Emery, 1979; Robins & Hayes, 1993; Teasdale, 1993; Bowlby, 1988). Bowlby (1988) suggests five tasks in therapeutic work with persons with attachment

difficulties. His recommendations rely on the use of relationship-based cognitive therapy to restructure the client's representation of work, others, self and relationship to others.

The basic tenets of cognitive-behavior theory are that a person's thoughts influence their mood and behavior. In addition, cognitive-behavior theory asserts that all psychological disturbances have distorted or dysfunctional thinking at their core (Beck, 1995). While Beck initially developed his theory and therapy method to treat depression, cognitive behavioral therapy has since been applied to a wide range of populations with a wide range of psychological and medical problems. Cognitive therapy has been used with children as young as three, families, groups, medical patients and prison inmates, as well as for individuals with obsessive-compulsive disorder, post-traumatic stress disorder, recurrent depression, personality disorders, and schizophrenia (Beck, 1995).

The basic premise of cognitive therapy is that to effect change in a client, the therapist and client must work together to identify cognitive distortions and then change those patterns of thinking and believing. Changing those distortions to thoughts that are more accurate should thus result in enduring emotional and behavioral change. In addition, there are ten principles of cognitive therapy: 1) the client formulates their problems in cognitive terms which can change over time; 2) requires a sound therapeutic alliance; 3) emphasizes collaboration and active participation; 4) is goal oriented and problem-focused; 5) emphasizes the present; 6) emphasizes relapse prevention through education; 7) is time-limited; 8) therapy sessions are structured; 9) teaches patients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs; and 10) uses a variety of techniques to change thinking, mood, and behavior (Beck, 1995).

While Beck (1995) states that empirical evidence supports the effectiveness of cognitive-behavior therapy with a diverse range of psychiatric and other problems, she does not

specifically address treating attachment disorders in children. However, numbers two and three of the above-named principles appear to be particularly problematic in attachment therapy. For example, if it is necessary to form a therapeutic relationship for cognitive therapy to work and the basic problem with attachment difficulties is an inability to form relationships, then there will be little to no foundation on which to form a relationship. Also, children with attachment disorder are often described as “manipulative” and disingenuous in their relationships, which will be a barrier to forming a truly collaborative therapeutic relationship as required in principle number three. Clearly, to use cognitive-behavioral interventions with children who have attachment difficulties, the initial focus must be on building the therapeutic relationship—a significant task that requires much time and effort.

Holding and Rebirthing Approaches

While highlighting their roots in Bowlby’s work, the proponents of holding and rebirthing approaches to attachment problems build their treatment on early thinking of attachment that subsequently have been dropped or modified over the years. In particular, this approach builds on early conceptualizations that emphasized the first two years of life as the sensitive or critical period in which a child needs to develop selective attachments. As Rutter writes (1997), “In keeping with the changes that have taken place in thinking about sensitive periods more generally, it has become clear that this all or nothing view required modification. There is a sensitive period during which it is highly desirable that selective attachments develop, but the time frame is probably somewhat broader than initially envisaged and the effects are not fixed and irreversible as once thought” (p. 19). In addition, as Rutter (1997) writes, while children have a hierarchy of attachments, children often develop selective attachments with a number of people involved in their care.

Welch (1988) was one of the first writers to propose holding as a technique to build or repair parent-child (and particularly mother-child) attachment relations. Drawing from clinical experience, she developed a technique in which the child is held in such a way to make direct eye contact with the parent while controlling the children's protest, struggle or attempt to escape. She describes three phases that include (1) confrontation; (2) rejection; and (3) resolution. While she offers case examples of situations where the technique was helpful, she speculates about other cases where it could have been helpful. In this way, she moves from observation and science to supposition and belief. It is problematic that she offers holding as a panacea of all family and child problems without offering evidence of the mechanism or the outcomes. She goes as far as to suggest that improving mother-child attachment will improve the marital relationship, although it is not clear how this would occur. She suggests that the experience is cathartic for mother and child and it is through the catharsis that resolution occurs. It may be that she mistakes compliance and acquiescence with attachment. From her description, it is easy to trace her thinking to the foundation of her approach, which is psychoanalytic theory. The empirical evidence that she suggests supports forced closeness comes from animal studies. This in and of itself should make proponents of holding approaches cautious. While generally deterministic in her thinking, she offers the caveat that a lack of holding time does not necessarily lead to difficulties later in life.

This initial work was codified in holding therapies, which were originally referred to as Rage Reduction Therapy. The premise is that children with Reactive Attachment Disorder use a front of rage to cover their feelings of fear, sadness, and grief. Rage Reduction Therapy starts with rubbing the rib cage to induce rage in the child. Then the child is confronted about their rage by their therapist and/or parent. The idea behind this is to get underneath the rage to the

vulnerable feelings and connect the child to the parent (Evergreen Consultants in Human Behavior).

Today, some proponents of holding techniques are not as extreme as in the past (see Minnis & Keck, 2003). According to Keck, new methods involve the child lying over the laps of the parents or therapist with the arm closest to the parents wrapped around their backs. The parent holds the free arm of the child lightly. The therapy requires this position so the child is in close physical contact that lends itself to forced eye contact, which proponents believe is essential for successful treatment. This position is intended to make the child feel vulnerable, yet safe to express anger, rage, sadness, and other feelings (Attachment and Bonding Center of Ohio).

Holding techniques are controversial because, in their essence, the child is restrained in the holding position until the child stops resisting. This forced closeness leads to forced attachment. Some states have even gone so far as to pass laws that prohibit restraining children unless they are going to hurt themselves or others (House Bill 356).

Closely related to holding therapy is rebirthing therapy. This therapy contends that the child can go back to their “birth” and come out attached to their adoptive or new parents. The rebirthing therapy that is known in the attachment world is not the rebirthing therapy that was created by Orr in the 1970’s (Swint, 2000). Orr proposed rebirthing as a breathing technique that connects the inhale to the exhale, making the individual feel as if they have left their body and are looking down on their life. If done correctly, proponents say that a person can disconnect from their body and “watch” their birth. This technique is used to help remember past events in order to work through them (Swint, 2000).

Rebirthing therapy in attachment treatment is physical. In 1997, a young girl died during a rebirthing episode. During the therapy session, the girl was wrapped in many tight blankets that were to represent the womb. The therapists and assistants were pushing against her with pillows to represent contractions. The girl was supposed to work her self out of the blankets to symbolize her birth. Tragically, the child was not able to do this and she died of asphyxiation (Swint, 2000). The idea behind this intervention was that after her “birth” her parents would be there to help her. She would be able to go back to her birth and “recreate” her life with her new family. Her family would be able to meet her needs as parents and she will be able to trust them from her “birth” on. Colorado passed a law that outlaws any type of rebirthing technique (House Bill 01-1238).

Though these approaches have many proponents, there is a dearth of empirical evidence for their efficacy. James (1994) writes:

“I believe these coercive techniques are cruel, unethical, and potentially dangerous and must not be used unless and until they are shown safe . . . We know that people with a history of abuse and traumatic loss are more sensitized to traumatic experiences and re-traumatization when exposed to stimuli or physical coercion that is likely to remind them of the original abusive situation . . . Coercive therapy is terroristic and abusive as well as dangerous” (p. 94).

The death of several children over the last few years from the rebirthing approach underscores the concerns raised by James (1994). Her most serious objection to holding and rebirthing approaches is that they are coercive techniques that foster the development of trauma bonds based in terror and do not facilitate healthy attachment.

Play Therapy Approaches

Play therapy is a type of creative therapy. It “ingeniously undertakes the hard work of child psychotherapy in the appealing guise of play” (Webb, 1999, p. 29). Through play, children are able to express their feelings, recount past experiences, and work through their problems

(Webb, 1999). Working with children through play can help support and create a therapeutic bond. The goals of therapy are reached through recognition of a child's feelings as expressed in the play, and through the therapist's belief in the child's strengths and potential for growth and change.

The basic tenet of play therapy is that children are helped through "the symbolic communication of play" (Webb, 1999 p. 30). Play therapists are first trained in another helping profession like social work, psychology or counseling and then become certified through additional play therapy training. Play therapy is both verbal and behavioral and works toward the dual goals of relieving clinical symptoms and removing impediments to the child's continuing development. Playing is not an end unto itself in play therapy. Instead, therapists focus on helping the child reduce anxiety by using play to express thoughts and emotions that they are unable to verbalize. Play therapy can include, art, dolls, puppets, storytelling, board games, sand, photography, and gardening (Webb, 1999). Play therapy has been used effectively with individual children and adults as well as with groups to treat a wide range of issues including, social and emotional maladjustment, conduct disorder, school problems, anxiety/fear, self-concept issues, sexual abuse, depression, post-traumatic stress disorder, ADHD, and alcohol and drug abuse (Webb, 1999; Ray & Bratton, 1999). Though play therapy seems better suited to individual therapy, it has been shown to be effective with groups and families, which can help form and strengthen attachment (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Glass, 1986; Glover, 1996; and Harris, 1995).

Play therapy is non-intrusive in that it uses observation of and intervention with children in settings that are more natural and changes behaviors through structured activities. In addition, the role of the therapist is to follow the child's lead, setting limits and guiding the play, and

gently making connections between the child's play and their own lives (Webb, 1999). Although research has not been conducted on using play therapy with children who have Reactive Attachment Disorder, Webb (1999) asserts via case examples that therapists have been successful in increasing attachment security to primary caregivers other than biological parents through play.

Other Approaches to Attachment Therapy

Recent focus on attachment has shifted to include an understanding of attachments in larger family groups instead of just the parent-child dyad. Sydow (2002) proposes integrating systems theory and attachment theory to present a more complete theoretical framework from which to understand and research human relationships in all their complexities. To build this new framework, Sydow (2002) uses three fundamental ideas from Bowlby's attachment paradigm: 1) attachment needs are inborn and necessary for all people; 2) experiences in relationships are internalized and shape future personality and behavior (internal working models); and 3) inner working models of attachment are relatively stable over time, but are changeable via new relationship experiences. In addition, she uses the systems theory concept of triadic attachment patterns that asserts that all humans have multiple relationships that affect and are affected by their internal models of attachment, which will in turn affect all other relationships. In other words, systemic theory goes beyond observing the infant-mother relationship as the primary or only prototype for all future relationships and includes relationships formed after infancy. Finally, Sydow (2002) proposes five other positions to complete her integrated model of attachment: 1) attachment is both intrapsychic and interpersonal instead of either a personality trait or an attribute of a relationship; 2) internal models and interpersonal relationships influence each other; 3) using a normative and

competence orientation instead of deficit-based descriptions and definitions (i.e., careful attachment versus dismissing); 4) focus primarily on present and future relationships instead of past; and 5) be sensitive to losses and “inherited trauma” or unresolved losses and separations from the past by using genograms. This last principle has been key to the CAP project.

Sydow’s (2002) integrated systemic attachment theory also offers a paradigm of fundamentals for psychotherapeutic work with individuals and families with an attachment focus. While many of the eight fundamentals are similar to other therapeutic models (e.g. using the therapeutic relationship as a ‘secure base.’), Sydow (2002) does integrate other principles to consider when doing family attachment work. Specifically, she supports the use of genograms to identify and support the impact of past losses, to remain strengths-based and focus on the client/family’s competence and resources instead of deficits, and to respect clients’ attachment styles in the therapy sessions and offer flexibility in location and intensity of therapeutic interactions. Unfortunately, Sydow (2002) stops short of describing a specific therapeutic method but instead focuses on the emphasizing the fundamentals of any therapy that has an attachment focus. Her proposal, however, is useful in expanding attachment therapy approaches to include whole family systems.

In contrast to using attachment theory for work with whole family systems where the individuals involved already know each other and have some basis for a relationship, other researchers have tackled the question of doing attachment work in a group setting where the individuals are not known to each other ahead of time. Brennan (1999) questioned the overall effectiveness of attachment theory in group work because the secure relationship is harder to create in a group setting where more individuals are involved. Other research demonstrates that therapeutic groups work especially well for children and adolescents since groups are familiar

and comfortable, especially in comparison to a one-on-one therapeutic setting (Dwivedi, 1993). Further advantages to treatment groups are the installation of hope, peer feedback, and reality testing as group members recreate problems or situations (Toseland & Rivas, 2001).

According to Toseland and Rivas (2001), “group work entails the deliberate use of intervention strategies and group processes to accomplish individual and group goals utilizing the value base and ethical practice principles of the social work profession” (p. 3). The size of treatment groups can range from three to fifteen, with seven often cited as the ideal size for a group. However, there is little empirical research to confirm this suggestion, which could just as easily be for behavior management reasons as for therapeutic effectiveness (Toseland & Rivas, 2001). In addition, parallel groups, a type of group designed with concurrent interventions for both children and parents, are often used to work with families experiencing domestic violence and for early intervention services (Auseinet, 2003). However, attachment therapy in a group setting of any type has not been studied to date.

Summary and Conclusion

There are multiple ways to think about attachment and multiple therapies, all drawing from Bowlby’s basic conceptual framework but leading to different approaches to dealing with attachment problems. In evaluating the state of knowledge for treating attachment problems, we start from the perspective of “above all else, do no harm.”

Holding and rebirthing approaches may yet prove to be appropriate for certain disorders of attachment with certain types of children, but much more research needs to be done in the areas of assessment, diagnosis, effectiveness and standardization of treatment, and credentialing of people conducting this approach. Holding and rebirthing should not be the first intervention used for children with attachment problems nor is it appropriate for all children. Particularly for

children who have already been physically victimized, the approach re-victimizes traumatized children.

Understanding the issues in attachment and attachment therapy was a framework for developing the project reported here. In order to understand the intervention program, it is important to examine the reason attachment is important to child welfare practice.

III. ATTACHMENT AND CHILD WELFARE

Many children involved in the child welfare system have been hurt by people they have trusted, if not once, many times. Once hurt, children may start to believe that no one can be trusted. Some children have been subjected to repeated abuse, so their experience teaches them that the world is not a safe and caring place. These events can lead to attachment problems.

Neglect may be even more harmful to children than abuse. Infants, toddlers and young children cannot meet their own needs. Adults are left to the task of meeting the basic needs of a child, such as food, shelter, safety from harm, clothing, medical care, and emotional connectedness, among other things. When an adult, whom a child has been told to trust and look up to, does not meet these needs, the child starts to depend on his or her self. Many children in foster care came into the system because they learned that they had to meet these needs for themselves. As the children grow older, they will not ask for help because this lack of reliance on others has become an ingrained mechanism for survival. Constant repetition leads to the action becoming entrenched, which has the unfortunate consequence of making it difficult for them to connect to others.

Once a child is removed from their biological home, they move into a stranger's home. All too often, the lives of children in foster care are built upon pain, disruption, and mistrust.

These children push people away, act out, and run from anyone who shows them compassion and love. In addition, if children move from one foster home to another, the stability that is so important for building relations is disrupted. Paradoxically, while they might act as if the move has no effect, in actuality it compounds any emotional difficulties and increases the likelihood of difficulties in attaching to others.

Often, foster parents are not trained about the importance of attachment or the difficulty in forming attachments that some foster children have. For many families and adults, attachment was an easy process. They did not have to learn to attach to their families and parents; their needs were met as a child and building a connection to others came naturally. Thus, teaching adoptive and foster parents about aspects of attachment can be difficult because they have no personal experience to base their understanding on. In addition, foster and adoptive parents have many dreams and expectations about their families. They expect that if they foster or adopt a child, the child will listen, love, and appreciate the fact that the parents want to help them. Unfortunately, when a child comes into a foster or adoptive home they have already learned that adults can and will break their trust. If they have lived in even a few placements, attaching to the new parental figure will be even more difficult. Conversely, if a parent appears with unrealistic expectations of the child displaying attachment behaviors, their feelings likely will be hurt, their expectations will be unmet, and they are more likely to give up on the child and the placement. Hence, attachment is a cornerstone of successful foster and adoptive family arrangements.

IV. ATTACHMENT AND PERMANENCY: THE CAP APPROACH

Grief and Attachment

The CAP program was meant to help address issues raised by concurrent planning by designing and implementing an innovative parallel group curriculum and follow-up services for foster children and either their foster, adoptive, or birthparents or relative caregivers. Bellefaire JCB (BJCB) is a private, non-profit child welfare and behavioral health agency that offers a wide array of services to families and children, including adoption and foster care. BJCB's foster care department provides case management and community support services to children from public custodial agencies all over Ohio, but primarily from Cuyahoga County Department of Children and Family Services where the children in foster care are predominately African American (85%). BJCB's specialized and therapeutic foster care programs serve children with mental health or medical diagnoses who require a higher level of care than "traditional" foster children. Thus, foster parents and social workers are highly trained and skilled at working with a wide range of difficult behaviors from a mental health perspective. For example, foster parents all must receive a minimum of 36 hours of training before becoming certified as a foster parent and then an additional 30 hours per year to maintain their license. Another notable fact is that over 70% of BJCB foster parents adopt their foster children when they become legally free to be adopted.

That being said, we noted that while children's mental health was being addressed adequately, often some of the more basic child welfare issues of loss, grief, and security of attachment were often overlooked until the adoption process began. In addition, we began to wonder if some of the problematic behavioral issues we saw in some children were in actuality normal grief reactions that were going unaddressed. According to Goldman (1997), "grief

issues... can inhibit learning and development, resulting in ... children having social and academic difficulties in and out of school” (p. 208). She also notes that “a grieving child often is misdiagnosed as learning disabled or as having Attention Deficit Disorder [and] may become hyperactive, easily distracted, or impulsive” (p. 209). When social workers must remove a child from an abusive or neglectful home, we do so because we feel it is in the child’s best interest. Often, however, we fail to recognize that we are inflicting additional trauma by causing the child to lose everything familiar to him, especially when we place him with strangers. Because we know as adults that the child is safer, we often fail to acknowledge the tremendous losses a child experiences and instead focus on changing his behavior or treating his mental illness. Because the resulting behavior can be so problematic, especially to foster parents and social workers who have no prior knowledge of how the child would normally act, it is not surprising that we don’t initially think of grief as at least one possible underlying cause.

With these issues in mind, we wanted to create an intervention that begins to address grief and loss issues to resolve some of the feelings and behaviors that become barriers to attachment and permanency. In addition, for the cases where the children’s case plan goal is to return to biological parents, the loss of trust and security needs to be addressed to help rebuild and strengthen relationships to help ensure successful reunification.

Staffing Issues

Although staff turnover is often a problem in social work and on demonstration projects, CAP had relatively stable staffing over the three years. Of the five primary permanency planning specialists who worked on CAP, three were master’s level social workers and the other two were Bachelor’s level social workers with over six years of foster care and adoption experience each when they were hired. We had two other masters’ level social workers who

worked on CAP for six months, but each had a primarily medical model orientation and moved on to other fields. Because we were trying to integrate therapeutic interventions with child welfare practice, we felt it was important to have seasoned, well-trained workers who also either had experience in adoption or who believed in our mission of permanency for all children. In addition, we had originally intended to hire an art therapist to help with the groups and follow-up and a driver to transport children and families when necessary. Due to lack of availability of licensed art therapists and drivers who wanted to work part time, we decided instead to pay for art therapy services for children who needed it and to pay for cab fare or bus transportation when needed.

Structure of CAP Groups

CAP staff worked closely with BJCB foster care case managers to identify children who would be appropriate for the CAP groups. We used the following criteria to determine eligibility: 1) Children older than 8 and younger than 18; 2) Not currently experiencing a “crisis” that would prevent them from engaging in group activities; and 3) ability to communicate with peers at a developmental level over age eight. Each series of group was focused on one of three age groups: 8-11 year olds; 12-15 year olds; and 15 and up. We often made exceptions, however, depending on a child’s developmental level, if their siblings were also in the group and they were younger or older than the cutoff age, or if they were participating in group with their birthparents. Children could attend the group with either their foster parents, adoptive parents, birthparents or relative caregivers, depending on their current case plan goals and visitation status. During each series of group, all the children attended with the same type of caregiver (i.e. all birthparents/relatives or all foster/adoptive parents). For each session, we had at least one social worker with the adult’s group and two with the children’s group. For those sessions where

we did work with children in a wide age range, we could split the children's group in half to utilize age-appropriate activities.

The groups were broken down into five, once a week sessions on the following topics: 1) getting acquainted/introduction/ambiguity; 2) loss and separation; 3) grief and anger; 4) attachment and belonging; and 5) identity and goodbye (see appendix A for a copy of the group curriculum). For the half hour before each session, we provided full dinners and set up tables so that each family would have time to visit ahead of time and eat a meal together. This allowed us to start sessions earlier in the evening and was one more way to reduce the barriers to family participation. The sessions then ran for two hours, with a ten-minute snack break halfway through and took place in two rooms – a bigger one for the whole group and a smaller one for the parents or children to break off into when doing separate activities.

Every session used several activities designed to address the topic for the evening. During the early weeks, much of each session was spent with the adults in one group and the children in a separate group so that they all started to view their peers as supports and recognized that there were others who have had similar feelings and experiences. Each week ended with children and adults doing an activity together to promote attachment. However, later sessions were much more focused on attachment-oriented activities throughout the sessions until the last session that offered only family activities. At the end of each session, families received homework assignments that became part of the next week's session.

The intent of each week focused on activities to address that week's topic. However, specific activities could vary depending on the age of the child and who the adults that attended were. For example, when we worked with birthparents in session two (loss and separation), we used the exercise "The place of your life" which is designed to help them identify their current

feelings about their life and losses through art and imagery. At the same point in the session with foster parents, we used the activity “Picking up the pieces” which is designed to help foster parents identify with the losses foster children may have. Although we wanted to educate any adult caregiver about the children’s issues, we felt that “Picking up the pieces” was too intense to do with birthparents we were just meeting and wanted to add exercises that could also be therapeutic for birthparents who were working through their own issues.

Once a case manager identified children who would be appropriate for the group, CAP staff contacted the families and explained the CAP program and identified barriers to the family’s attendance. We did everything we could to remove barriers so that everyone would have the opportunity to attend. The most common issue was transportation, which we addressed by arranging and paying for taxis to pick up and drop off parents and sometimes older children at specified times and locations and then come back and take them home again when group was over. For younger children, CAP workers or foster parents would transport them. One family had both parents living in different places and another had the four children living in different places, so we arranged several different transportation methods. Another major hurdle we overcame was helping foster parents pay for childcare for their other children not participating in CAP. Sometimes we offered childcare on site and others we gave families a stipend to cover their expenses. We also faced scheduling conflicts with school or church activities that the children or families were involved in so we sometimes changed the day we offered the groups to accommodate their schedules. Ultimately we tried to maintain flexibility so that if a case manager felt the group would be beneficial for the child, we were able to make it feasible for the child and family to attend.

In addition to overcoming barriers, we also offered additional benefits to adults who attended our groups. For example, another issue we faced early on was that foster parents were already heavily scheduled due to the large number of training hours required every year for re-certification. We developed training and educational materials to coincide with our session topics so that foster parents who attended could receive credit toward their training hours. For birth parents, the dinner before sessions and the yearlong follow-up after group offered an additional, and sometimes only, chance to visit with their children.

Structure of Follow-up

Once families completed the five group sessions, CAP permanency-planning specialists were assigned to specific families to conduct in-home follow-up interventions at least monthly for twelve months. Although some talk-therapy approaches were used, most interventions were art or play therapy focused and usually included all members of the family including birth children and siblings not living together. For the birth parent groups, follow-up often took the place of some of the family visits and CAP workers provided structured activities for the visit instead of the typically unstructured visits they were used to. CAP workers chose follow-up activities based on the issues that arose during group as well as what events might be occurring in the child's life (i.e., court hearings, termination of parental rights, adoption, reunification, moves from one family to another). Some follow-up was conducted with case managers present so that they could continue the work during appointments between CAP follow-up visits and after the year was complete. The vast majority of follow-up activities involved participation from all family members. Some of the most successful follow-up activities were: therapeutic use of preparing the child's lifebook; life road/timelines; creating poetry; playing therapeutic games like the Ungame, Life Stories, emotions flashcards, The Talking, Feeling, and Doing game, and

the Journey through the Land of Feelings game; drawing family portraits; meeting Antwone Fisher, seeing the movie based on his life, and writing about their responses to the movie; doing family bonding activities like a dinner cruise, dining out, bowling, and movies; and using the ABC feelings coloring book.

For children participating in CAP with their birth parents or relative caregivers, CAP workers spent a larger amount of time conducting follow-up visits and interventions than with children participating with their foster parents. On average, CAP staff spent more follow-up time with birthparents and children than with foster parents and children. There are several reasons for this difference. First, although most birthparents were initially reluctant to participate in CAP, once they began the groups they saw the CAP workers and other birthparents as sources of support. CAP was not mandatory, nor was CAP determining the outcome of their custody issues. Once follow-up began, most birthparents called CAP staff for support, advice, and clarification about what was happening with their children. Most birthparents had an adversarial or at least uncomfortable relationship with their child's agency social worker, but felt safe asking for help from CAP staff. In contrast, BJCB foster parents have multiple sources of support including case managers and other foster parents. While they did participate and sometimes ask for help from CAP staff, we were not their primary or sole source of information as we often were for birthparents or relatives. Finally, many of the birthparents participating in CAP reunified with their children during the follow-up period, so we put a lot of time and effort into helping the families adjust to living together again and helped birthparents know what to expect in terms of behavior, reactions, and feelings from their children. Because our foster families are highly trained and skilled at working with children, we felt birthparents' chance of successful reunification was higher if they received some of the same information foster parents

have. Ultimately, we offered more services to birthparents and they wanted more services than foster parents.

V. EVALUATING OUR EFFORTS

As soon as we received funding for this project, we developed an evaluation plan with our outside evaluator, Dr. Victor Groza, which we reviewed in meetings with CAP staff and Dr. Groza on a quarterly basis. Following is a description of each of our objectives, our target population, and the procedures, interventions and activities we planned to do to meet those objectives. Following each section of the plan, we discuss what we did, the results of our activities and the data we gathered. For a full discussion of what we learned, please refer to Section VI (page 49).

Objectives 1 & 2: Reduce Barriers to Attachment & Increase Attachment Security

TARGET: Children in the custody of Cuyahoga County and in Bellefaire JCB's foster care program

OBJECTIVE: Reduce Barriers to Attachment & Increase Attachment Security

PROCEDURES/INTERVENTIONS/ACTIVITIES

- Group therapy to help children increase their ability to cope with feelings of ambiguity, loss, and grief and increase their level of attachment security to their primary caregiver.
- Individual counseling

EVALUATION—Process

Group Therapy

Once children were identified to participate, CAP workers obtained assessments of the child's functioning on several instruments. We then administered assessments every three months until the child completed the groups and follow-up. For all children, we administered the

Behavioral and Emotional Rating Scale (BERS), which is a strengths-focused assessment of the child's functioning. When we wrote the project proposal, we also planned to use the Child Behavior Checklist (CBCL) that was used throughout our agency for assessment purposes. At the beginning of the project period, however, BJCB research staff changed the mandatory assessment to the Child and Adolescent Functioning Assessment Scale (CAFAS), so CAP switched as well. Unfortunately, a year into the project the research staff changed instruments again and began using the mandatory Ohio Scales forms, so CAP switched again to maintain compliance with the agency. These changes resulted in our project not having good comparison data and using assessments that are not widely recognized as reliable and valid in measuring attachment issues.

As is common in any project that must collect data, getting the completed assessments from families and social workers was sometimes challenging. The most reliable results occurred when the CAP workers completed the assessments with the foster families and social workers either by phone or in person. These one-on-one interviews also helped families get clarification on questions as well. Unfortunately, when we completed the assessments in person, the time we could have spent with interventions during follow-up was used filling out paperwork.

Following is a brief discussion of the pros and cons of each instrument:

- **Behavioral and Emotional Rating Scale (BERS)** worked well, was easy to complete, and provided clear feedback about changes in the child's strengths.
- **Child and Adolescent Functioning Assessment Scale (CAFAS)** took up to two hours to administer and had to be completed in person. Social workers had to attend several hours of training to be certified in its use. BJCB discontinued the use of the CAFAS

agency-wide, therefore CAP stopped using CAFAS for new participants after the second round of group. We did not find this instrument clinically useful.

- **Ohio Youth Problem, Functioning, and Satisfaction Scales (Ohio Scales)** was never fully utilized because we were unable to collect all three necessary forms (child, social worker and parent) on any child for all assessment points. We continued to collect the information for the agency, but we did not use it in the final analysis of outcomes because we have so much missing data. We also were not convinced that the instrument was relevant in assessing the issues of most concern to the project.

Group Curriculum

We based our idea for running parallel groups on the North American Council on Adoptable Children's Adoption Opportunities grant product "Family Preservation: The Second Time Around" (ACYF grants #90CO00410 and #90CO00470). In NACAC's program, adoptive families and their children participate in groups to discuss adoption-related issues like birthparents, identity, entitlement, and attachment. Once we started developing our own curriculum, however, we discovered that the issues we wanted to address required different exercises than what NACAC's curriculum used. In addition, we decided to shorten our group series from eight to five weeks to better ensure participation from busy parents and children. Hence, we collected exercises from multiple sources including previous practice experiences, books, videos, and classes. We met twice weekly for several weeks to discuss and try exercises to see if they could address the issues we wanted to treat. We developed a standard format for each session that included a feelings check-in for the children, some psycho-educational material for parents, and at least one family activity that they had to complete together. Beyond that, we held up as our standard that we had to have at least one exercise that would give parents an "aha"

moment where they realized something about their children that they never had before. For the children, we wanted to help them recognize feelings and be able to put a name to them, so we focused on emotions each week. When we couldn't find an exercise or activity to address a certain topic, we brainstormed until we invented one that met our requirements.

Once we had the basic curriculum developed, we did a "test run" with a small group of foster children and their foster parents. Each day after a group session, we met as a team and critiqued the activities and our intervention skills. We replaced some activities and removed some based on our own observation and on participant feedback. Mostly we found that we had more activities to do than we realistically had time for and we continually maintained and updated our resource files so we could access an appropriate activity for follow-up or training as needed. We also continued to "tweak" the curriculum each time we ran a series of groups based on the children's ages and parental participation.

Individual Therapy

- Summary of contact forms from case manager will verify content of sessions related to feelings of ambiguity, loss, grief, and/or attachment at one hour per month for 12 months

When we designed the CAP project, we intended foster care case managers to continue the work we began in group sessions. Once we began implementing our project, however, we were faced with the reality that case managers were focused on mental health treatment and community support services for children because of BJCB's contractual obligations to custodial agencies and to be eligible to receive payment from insurance for the services they were providing. Therefore, CAP workers teamed with case managers when possible and worked individually other times to address the issues raised by CAP. Ultimately, CAP workers provided at least two hours – and often much more -- of follow-up interventions per month for 12 months

post-group. In addition, most CAP follow-up sessions focused on ambiguity, loss, and increasing attachment. Although we focused on anger and family identity in group sessions, when we did follow-up the children and families didn't see those as much of an issue.

EVALUATION—Results from the treatment program

Group therapy: Targets and Actual Results

- 240 children will receive 10 hours each of group therapy during the 3 years of the project
 - 65 children received 10 hours each of group therapy during the 3 years of the project. Of the 59 children who completed the full CAP program, 36 were females and 23 were males.

Right after the CAP grant was funded, BJCB received greatly increased documentation requirements from several funding agencies and new licensing standards for foster homes. Unfortunately, this increased regulation led to staff and foster home turnover. In addition, a large number of foster parents adopted the children in their homes and then withdrew their foster care license shortly thereafter. So while it was conceivable that BJCB would have 200 children in foster homes at any given time before these events, during the CAP project time period, only 65-80 children were in care, many of whom were too young to participate in CAP groups. In addition, although CAP overlapped group sessions by three weeks to increase the number of groups accessible to families, we still were unable to meet the projected number of 240 children participating. On the other hand, we had great success in retaining participants once they began the program. Of the 65 total children who began CAP, 59 (91%) finished group sessions and participated in follow-up activities.

- 2,400 units of group service will be provided during the 3 years of the project
 - 650 units of group service were provided during the 3 years of the project

See above for an explanation of the low numbers of participants.

Individual counseling

- 240 children will discuss feelings of ambiguity, loss, and grief and attachment with their case manager, permanency planning specialist, or with both together as a team a minimum of two hours monthly for each year of the project.
 - 59 children received follow-up services from their permanency planning specialist for a minimum of two hours monthly.

While we did not reach the number of children we intended, we provided at least two hours of follow-up services to children who participated in CAP. In some cases, CAP workers teamed with foster care case managers, but more often they met with the children and families on their own.

- 5,720 hours of discussions of feelings of ambiguity, loss, grief and attachment will be documented by case managers during the 3 years of service
 - Based on case notes and weekly meeting minutes, we estimate that CAP staff provided at least 2,016 hours of individual follow-up services in addition to attendance at staffings, court hearings, and family visits (912 hours to children and birthparents and 1,104 hours to children and foster parents).

Again, due to the decrease in the foster care census and the increased time requirements for foster parents, participation in CAP groups was lower than expected which led to lower follow-up numbers. However, we were able to provide at least four hours monthly to children and birthparents as opposed to children and foster parents. Whether CAP's non-adversarial approach or the otherwise dearth of services for birthparents contributed to birthparents greater participation in CAP, we did find that they were more motivated to attend group and follow-up

sessions than many of our foster parents.

OUTCOMES

- 80% of the children will increase their ability to cope with feelings of ambiguity, loss, and grief
 - At the end of CAP follow-up, participants' average scores on all four subscales of BERS that indicate ability to deal with difficult emotions by increasing their strengths (i.e., interpersonal strength, family involvement, intrapersonal strength, and affective strength; see charts 1-5 in the next section). Higher scores indicate better functioning/more strengths.
 - Of the 59 children who completed groups and follow-up, 52 (88%) either maintained their current placement, reunified with birthparents, or were adopted – all indicators of emotional stability. Seven children (12%) disrupted due to emotional instability (five to more restrictive settings including residential treatment and jail) during the follow-up period.

We noted that most children who completed the group sessions showed an immediate decrease in functioning on the BERS at the 3-4 month mark and then gradually rebounded until their scores indicated higher functioning by the end of the 12 months of follow-up. This was most remarkable for school functioning. We believe this indicates that the groups brought emotional issues to the surface that had previously gone unaddressed. After several months of individual follow-up, children's functioning increased again, indicating a growing tolerance and ability to cope with those feelings. More research is needed to test this hypothesis.

- 70% of children will develop a secure attachment to their primary caregiver(s)

- 51 (86%) children started CAP with a secure attachment to their caregiver as indicated by scores landing in the 63rd percentile or higher on the family involvement subscale for children with emotional or behavioral disorders. Of the 8 (14%) children who scored in the 50th percentile or lower, 3 (38%) raised their scores to the 50th percentile or higher. Finally, on average CAP children's raw scores and percentile ranks increased from the 91st percentile for both males and females to the 95th for boys and 98th for girls (see charts 2, 6 & 7 in next section).
- 80% of the children will show and maintain significant improvement on a minimum of 5 of the 8 subscales of the CAFAS
 - After the first two group sessions, this assessment tool was dropped from our project due to a change in mandatory agency testing. We substituted the Ohio Scales assessment tools, but were unable to consistently collect the data necessary to analyze progress over time.
- 70% of children will score within the acceptable range of attachment and strengths on the BERS
 - Following are charts showing the average scores for children participating in CAP on the various subscales of the BERS. The charts show average raw scores of girls and boys combined. In terms of attachment, which we measure using the family involvement subscale, raw scores for all CAP children went from 21 to 25 on a scale of 30. Female participants started in the 91st percentile for girls with emotional and behavioral difficulties before CAP and ended in the 98th percentile at the end of follow-up. Male participants also started in the 91st percentile for family involvement and increased to the 95th percentile by the end of their

involvement with CAP. Because almost all of our children started in the acceptable range for strengths on BERS, we feel it is necessary to review the change in level of strengths rather than whether it is in the acceptable range or not.

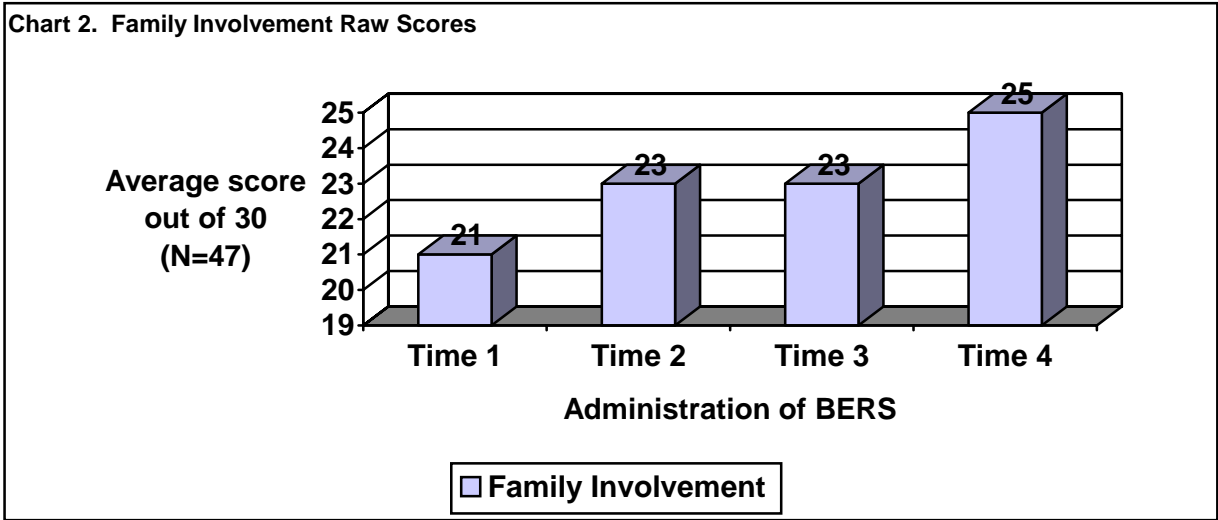
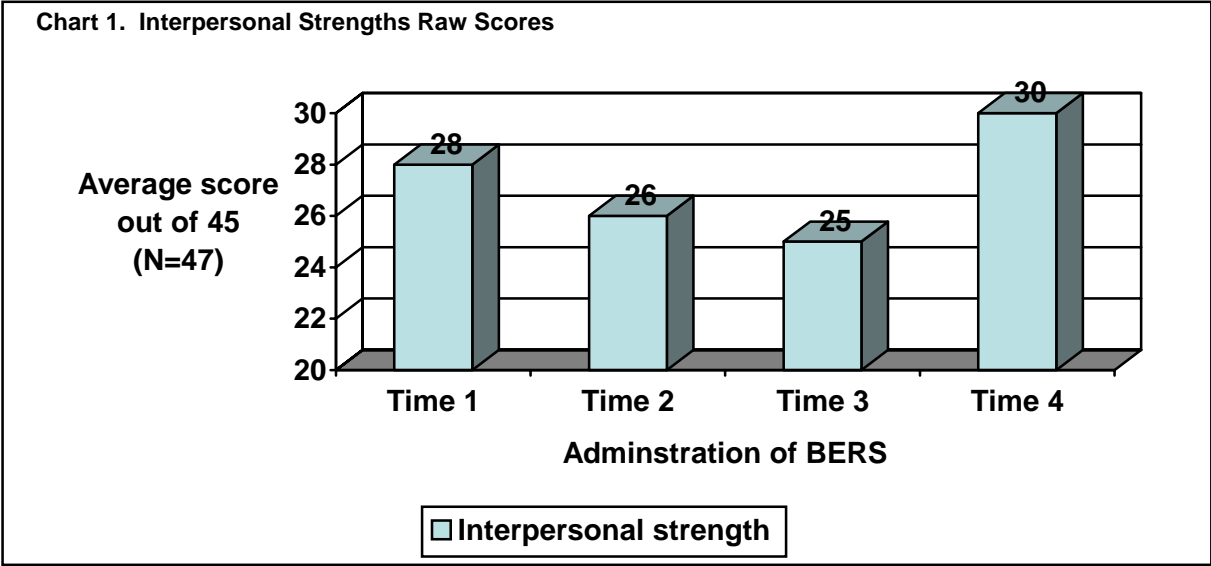


Chart 3. Intrapersonal Strengths Raw Scores

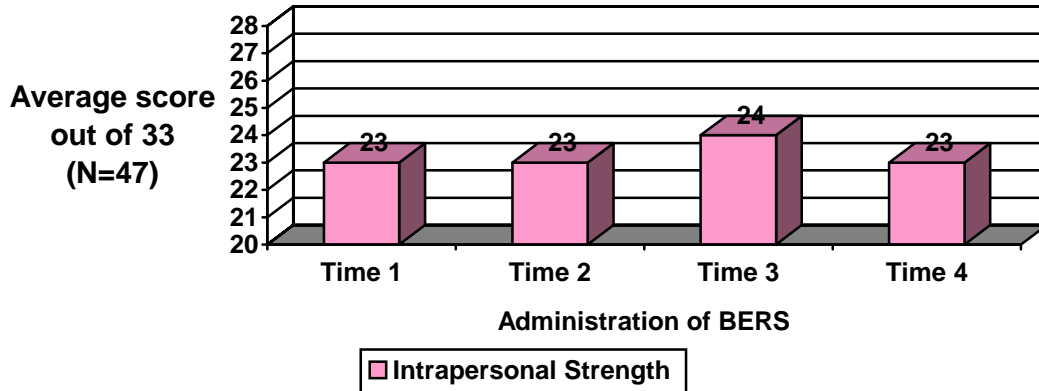


Chart 4. School Functioning Raw Scores

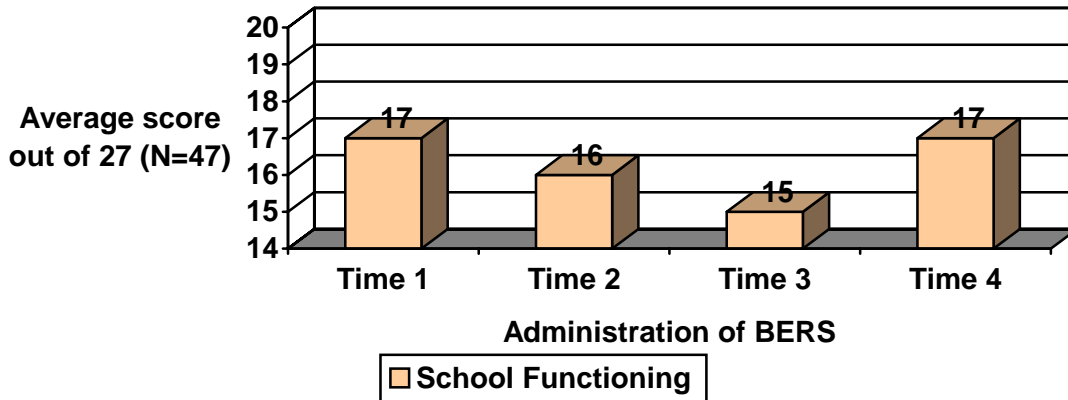
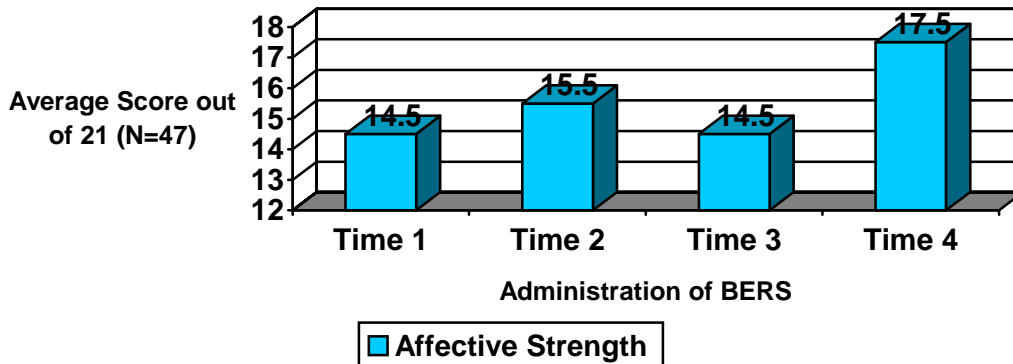


Chart 5. Affective Strength Raw Scores



Objective 3: Increase foster/adoptive parents' ability to help with attachment issues

TARGET: Foster and Adoptive Parents

OBJECTIVE: Increase foster/adoptive parents' ability to help children with attachment issues

PROCEDURES/INTERVENTIONS/ACTIVITIES:

- Basic training regarding children's feelings of ambiguity, loss, grief and attachment of one hour will be added to the pre-service training curriculum
- Advanced training regarding children's feelings of ambiguity, loss, grief and attachment; three hours will be added to the ongoing foster care training curriculum
- Participation in parallel groups

RESULTS

Basic training regarding children's feelings of ambiguity, loss, grief and attachment of one hour

- Goal: 450 prospective foster parents will receive basic training during the 3 years of the project
 - Result: 491 prospective foster parents participated in basic training between October 2000 and September 2003. We exceeded our goal on this objective.

Advanced training regarding children's feelings of ambiguity, loss, grief and attachment

- Goal: 135 licensed foster/adoptive parents will receive a three (3) hour training during the 3 years of the project
 - Result: 273 licensed foster/adoptive parents received a three-hour training on CAP issues between October 2000 and September 2003. CAP staff provided direct training to 143 parents and outside trainers provided advanced attachment, grief, loss, and ambiguity training to 130 foster and adoptive parents during the same period. We doubled our goal

on this objective.

- Goal: 405 hours of advanced training will be provided during the three years of the project
 - Result: CAP provided 819 hours of advanced training during the three years of the project period. We doubled our goal on this objective.

Participation in parallel groups

- Goal: foster/adoptive parents representing 140 children will participate in parallel groups during the three years of the project
 - Result: 45 foster parents representing 46 children participated in parallel groups

As stated above, CAP faced several difficulties in recruiting enough participants to meet our projected goals. Despite these difficulties, we made consistent efforts to identify and enroll foster and adoptive families in CAP over the three years. These efforts included attending foster parent cluster (support) meetings; contacting case managers about specific children; attending foster care staff meetings; mailing flyers to case managers and families; asking CAP participants to speak to families; speaking at other department meetings; and advertising CAP groups in our newsletter.

Despite these efforts, we faced several challenges that limited the number of potential families shortly after funding was awarded. For example, Bellefaire JCB experienced a great deal of change in the numbers of foster children and foster homes in our agency. The State of Ohio passed two laws in July 2000 that resulted in a large number of new rules and regulations for foster care agencies and foster parents. One of the more significant changes is that for foster parents who are considered “treatment homes” – which includes all of Bellefaire JCB’s homes – the State has increased the number of ongoing training hours from 12 per year to 30. In addition, the rules require updated criminal and safety checks and extensive reviews of the foster family

on an ongoing basis. Many foster parents have withdrawn from fostering altogether, or have moved to other agencies that are not considered “treatment” agencies and thus do not have the more extensive requirements. In addition, 70% of BJCB foster children are adopted by their foster parents. Once they adopt, many families discontinue fostering because they no longer have room or the time to bring additional children into the home. Thus, there was a significant decrease in the number of available foster homes to participate in the CAP groups. In addition, recruitment of new homes was initially sporadic due to personnel issues.

Furthermore, we found that adoptive parents with children who were not in crisis – one of our requirements for group participation – did not see a need for attachment-based treatment once their adoptions were finalized. Some adoptive families took our invitation to participate as an indictment of their relationship with their children as not being attached. Unfortunately, even those families who initially agreed to participate often called to cancel or did not show up for groups. Due to the extensive pre-group assessment work and coordination, along with scheduling staff time and coordinating space, a group that did not get enough participants in the first week could be postponed for one week but then had to be cancelled if it didn’t work out the next week. Another constraint on scheduling groups was that all of the CAP workers were also carrying adoption or foster care caseloads. Although they were reduced loads, these other cases also had to be scheduled and worked in between the CAP work, so any large deviation in the plan was difficult to accommodate without advance notice. Finally, some foster families noted that because CAP was an adoption grant, they didn’t want to participate because they were afraid that adoption was going to “be forced on them.” While this was not the case, we found it difficult to overcome this fear for a small number of families.

- 3,400 units of service will be provided during the 3 years of the project
 - CAP provided 2,864 hours of direct service to foster families during the 3 years of the project. This includes 491 hours of basic training, 819 hours of advanced training, 450 hours of parallel groups, and 1,104 hours of follow-up work.

OUTCOMES

- 85% of foster/adoptive parents will improve knowledge about how to help children establish healthy attachments by resolving feelings of ambiguity, loss and grief
 - In addition to increased scores on post-tests, foster parents received notebooks to refer back to activities that help increase attachment security. Also, foster parents received 819 hours of advanced training about grief, loss, ambiguity and attachment including specific methods to increase attachment security. Finally, 91% of foster/adoptive parents who started CAP groups also finished CAP and began follow-up.
- Pre-test & post-test; 85% of participants will increase score by 50%; 80% of participants will score correctly on the post-test
 - Foster/adoptive parents answered 90% of post-test questions correctly as opposed to 85% on the pre-test. All foster parents got the question “It is okay for my child to love their birthparents and their foster parents” correct on both pre and post tests. However, only 57% of foster parents got “my relationship with my child’s birth parents affects my child” correct on the post-test.
- Case managers will evaluate parent-child interaction in relation to the emotional issues related to concurrent planning between 3-6 month after parallel group on a 5 point Likert Scale with higher scores representing more positive interaction; 85% of parents will be

rated at 3 or above

- We did not administer the Likert Scale to case managers due to constraints on their time and the change from case managers doing follow-up to CAP staff doing it. Instead, we rated progress based on our own interactions with foster parents during follow-up and their completion of the BERS strength based assessment on family involvement. As stated above, most children improved their family interaction scores from Time 1 to Time 4. In addition, most children had a large increase in scores on the school functioning subscale, which could indicate more stable interpersonal interactions as well.

Objective 4: Increase birthparents or relatives' ability to help with attachment issues

TARGET: Birth parents or relative caregivers

OBJECTIVE: Increase birth parents or relative caregivers ability to help children with attachment issues

PROCEDURES/INTERVENTIONS/ACTIVITIES:

- Participation in parallel groups to learn how to help children establish healthy attachments by resolving feelings of ambiguity, loss and grief
- Individual support to learn how to help children establish healthy attachments by resolving feelings of ambiguity, loss and grief

RESULTS

Participation in parallel groups

- Birth parents or relative caregivers representing 30-37 children will participate in groups over the 3 years of the project
 - 13 birth parents representing 19 children participated in groups over the 3 years of the

project

Again, the decrease in the total number of children in foster care at BJCB during the CAP project meant there were fewer children whose case plan goal was reunification. However, of the birthparents identified to work with CAP by foster care case managers, only four declined to participate. While many were cautious at first, they said they participated because it was another chance to see their children. In practice, birthparents received a lot more services from CAP staff than originally planned because they had such a positive reaction to the program. CAP became a safe haven for birthparents who were trying to work their case plans to reunify with their children. In addition to attachment and grief work, CAP staff provided traditional social work services in an attachment and strengths-based paradigm. Families responded tremendously well.

Of the 13 birthparents, 9 were birthmothers, 3 were birthfathers and one was a grandmother. One birthfather came to group covered in dirt and grease one night and expressed embarrassment to the CAP facilitators. He said that he had gotten a flat tire on the way to the group that night and thought about just going home after fixing it because he didn't want to show up dirty. He said that he then thought about his son's sadness if he didn't show up and he decided to come anyway. Birthparents often expressed a feeling of being overwhelmed by all that they were asked to do, but said they came to CAP despite their schedules because they liked the peer support and the feedback from CAP facilitators. Of the 19 children who attended CAP groups with the birthparents, 10 were reunified, 3 shifted to a Planned Permanent Living Arrangement (PPLA), and a sibling group of 3 currently has a permanent custody hearing pending. The other 3 children are still in the process of reunifying with birthparents.

- 300-370 units of service will be provided to birth parents during the 3 years of the project

- 130 hours of group work service was provided to birthparents during the CAP project.

See above goal for an explanation of the reduced hours provided to a lower than projected number of birthparents.

Individual support

- Birth parents or relative caregivers will receive 4 or more hours of individual counseling per month
 - 13 Birth parents or relative caregivers received a minimum of 4 hours of follow-up services and individual counseling per month for 12 months.

In addition to the face to face individual and family counseling provided by CAP staff, we also attended more ancillary meetings and provide more referrals and traditional social work services like locating resources for housing and medical needs. So, in actuality, birthparents and relatives received much more than the minimum 4 hours per month from CAP.

We encountered much less resistance from birthparents than we were led to expect. Although we felt CAP was helpful to most children, we felt and were told that birthparents experienced greater gains from our work than the foster parents. There are several reasons for this. First, our foster parents are already highly trained and supported. Conversely, birthparents are usually without resources, knowledge of accepted child rearing practices, and support. CAP provided all of those things in a non-adversarial, welcoming format with other birthparents experiencing the same losses. The birthparent group offered parents a supportive environment in which to discuss their similar experiences working with and navigating the county system. Birthparents were able to share their stories and gain feedback from others with an understanding of the feelings they have regarding the loss of their children. In addition, CAP facilitators were advocates for the birthparents, a resource that they are lacking. On evaluation forms,

birthparents noted that they appreciated CAP staff's non-judgmental environment/attitude, that they were offered a chance to have a "clean slate," could make connections with other birthparents, and that CAP acknowledged that they suffered a loss despite their own role in causing the children to be removed from their care. For a full listing of comments made on evaluation forms, see Appendix C.

OUTCOMES

- At least 70% of birth parents or relative caregivers will increase their knowledge and skill in how to help children establish healthy attachments by resolving feelings of ambiguity, loss and grief
 - Based on birthparent self-report and evaluations, most feel more knowledgeable about establishing healthy attachments with their children. We do not have a tool to measure exact numbers for this area of evaluation.
- Pre-test & post-test; 85% of participants will increase score by 50%; 80% of participants will score correctly on the post-test
 - 76% of questions were answered correctly on the post-test as opposed to 73% on the pre-test. All birthparents got the question "It is okay for my child to love their birth parents and their foster parents" correct on both pre and post tests. However, only 44% of birthparents got the question "Foster parents should become attached to the children in their home" correct and only 22% got "My relationship with my child's foster parents affects my child" correct on post-tests.
- Case managers will evaluate parent-child interaction/relationship in relation to the emotional issues related to concurrent planning between 3-6 month after parallel group on a 5 point Likert Scale with higher scores representing more positive interaction; 85%

of parents will be rated at 3 or above

- As stated above, CAP facilitators completed follow-up with the children in CAP.

In addition, BJCB case managers have little to no contact with birthparents because the custodial agency develops and monitors case plan progress. Hence, all of our information about interactions is based on self-report and observation of CAP staff. Because 10 of 19 children reunified with their parents and an additional 3 are still in process, we believe that over half of children had improved relationships with their birthparents. In addition, another child who went into residential treatment and PPLA had a significantly better relationship with her mother based on their individual feedback and our and other mental health professionals' observations. While this child will not ever reunify, her mother is committed to maintaining contact with her now and still actively participates in her treatment.

Objective 5: Increase clinical casework competency regarding concurrent planning issues

TARGET: Child Welfare System

OBJECTIVE: Increase clinical casework competency in Cuyahoga County related to the ambiguity and uncertainty created in children during current planning

PROCEDURES/INTERVENTIONS/ACTIVITIES:

- Training

INTERIM RESULTS

- 40 staff members from Bellefaire JCB Foster Care or Adoption will receive a total of 5 hours (200 hours total) of training on the ambiguity of concurrent planning, loss, grief and attachment

- All Adoption and Foster Care staff received training on concurrent planning, loss, grief and attachment in 12 different trainings during CAP. This totaled 210 hours of training on relevant issues. We exceeded our goal on this objective.
- 150 staff from Bellefaire JCB, other private placement agencies, and DCFS will receive a minimum of 6 hours (900 hours total) of training on the issues of the ambiguity of concurrent planning, loss, grief and attachment in Year 2
 - During Year 2, 110 BJCB and other agency staff received introductory training on Trauma and Loss issues from Dr. William Steele over two days. In addition, staff provided training on CAP and related issues at the CWLA Midwest Regional Conference to 56 attendees for 1-½ hours (84 hours). In total, CAP provided 1,404 hours of training in year 2, which exceeds our goal on this objective.
- 150 staff from Bellefaire JCB, other private placement agencies, and DCFS will receive a minimum of 6 hours (900 hours total) of training on the issues of the ambiguity of concurrent planning, loss, grief and attachment in Year 3.
 - CAP sponsored training on attachment parenting with Nancy Samalin for parents and professionals; 36 professionals attended the two-hour training (72 hours). In addition, CAP sponsored William Steele over the course of four days to conduct a complete Trauma and Loss Specialist Certification program to BJCB and local staff. 75 professionals attended the 24 hours of training (1,800 hours). In total, CAP provided 1,872 hours of training to BJCB and other staff during Year 3, which more than doubles our goal on this objective.

OUTCOMES

- 85% of the workers participating in the training will increase their knowledge and skills

on the issues of ambiguity of concurrent planning, loss, grief and attachment

- Pre-test & post-test; 85% of participants will increase score by 50%; 80% of participants will score correctly on the post-test
- 6 months after training, participants will be surveyed to ascertain how many are utilizing the knowledge and skills obtained from training
- 6 months after training, participants will be surveyed to ascertain to what extent they are utilizing the knowledge and skills obtained from training
- 100% of participants at least partially utilize the knowledge and skills gained in a minimum of 4 cases

Due to staff turnover, we did not conduct follow-up surveys or complete pre and post-tests for this objective.

VI. LESSONS LEARNED AND BEST PRACTICES

Because CAP was a demonstration project, we knew that we would learn valuable lessons about attachment, concurrent planning and child welfare. However, we did not predict some of the unanticipated benefits and opportunities for professional growth that also arose. Because hindsight is 20/20, we outline here some of our lessons learned and give some recommendations for best practices for child welfare agencies.

Lessons Learned

One of the first lessons we learned was that, contrary to professional wisdom, birthparents willingly attended multiple group sessions and participated in CAP. Our program was never mandated for any of the clients, although it was strongly encouraged for a few. It may be that we ended up with clients who were more committed to reunification than the average

involuntary birthparent; however, even some of the birthparents who had previously developed a very bad relationship with other social workers were able to engage with CAP. With CAP staff's guidance, one birthmother was able to improve her interactions with the county social worker so much that the worker postponed filing for a termination of parental rights and the children were able to reunify during the follow-up period. With strengths-based approaches, many birthparents can and will engage with the system to make good and healthy decisions for their children, including volunteering to surrender their rights and helping the children move on to adoption (we had three clients do this during CAP).

Additionally, in retrospect, we wish we had developed a more rigorous research design with control groups and consistent data collection. While the data we gathered is good as a starting point, it does not adequately support the effectiveness of the program and our anecdotal evidence that CAP worked. The staff collecting the data and directing the project were social workers, and as such, they focused on the social work much more than the research and data collection. While we believe this was the right approach to take in a demonstration project focused on practice issues, in future work with this program, we would construct a stronger research focus with a much larger cohort of participants and control groups. Finally, we would choose our data collection tools and assessments and stick with them throughout the project instead of using agency-mandated tools that changed often and didn't measure what we were trying to influence.

Another staffing issue that arose was that of identifying appropriate staff who could most effectively round out the CAP team. An ideal team would be comprised of staff with expertise in recreational therapy who have or can develop an adoption/permanency focus. In addition, ideal staff would maintain a strengths-based approach to working with birthparents and foster parents

and have strong group and family social work skills. Although CAP did have a strong mental health component with our focus on attachment issues, the staff who did not do well with our project had a more rigid mental health/medical model focus who wanted to identify pathology and “fix” people. They did not understand that finding permanency and addressing loss issues could greatly decrease the symptoms of mental health problems, nor did they grasp the complicated child welfare issues and approaches that greatly influenced our work. The staff that were most effective with the families and children were also those with advanced degrees in social work and counseling or a significant number of years in the foster care and adoption fields. What was most important to the overall effectiveness was a consistent focus on teamwork. It was only through continuous and open communication and feedback that we were able to have good information about each family and help each other to deliver the best and most comprehensive services possible. In the rare instances when we did have staff turnover, more than one person held the nuances of information about the families that tend to get lost when staff leave.

Another lesson learned was that we needed to develop a more structured series of follow-up activities to ensure that the paradigm we introduced in group would continue during the follow-up period. While we did gather and create a huge number of attachment resources for follow-up, each CAP worker planned and designed their own course of treatment for each family. While that allowed them to be responsive to current issues as they arose, it did not help us maintain a strict focus on grief, loss and attachment issues. At times workers became more like case managers than workers with a set treatment agenda and goals. Thus, for a future project, we would focus strongly on developing a series of monthly interventions that logically continue the treatment flow that the groups begin.

A final lesson learned applies in general to management of a demonstration project in an agency setting. First, it is absolutely essential to identify and contract with an independent evaluator preferably at the grant writing stage, or, if necessary, as soon as funding is awarded. Having a person with both research and practice focus is most beneficial to ensure that projects address, document, and monitor all types of progress toward project goals and objectives in a realistic and accurate manner. We also found that regular meetings with our evaluator at least quarterly with frequent email and phone contact in between ensured continuous attention to deadlines and goals. For that reason, we were able to achieve or exceed most of our project goals, and worked to identify and overcome obstacles to goals that we were not reaching.

A second lesson about grants management arose out of our experiences with five demonstration projects over the past several years. We assert that there are basically two approaches to managing staff duties: 1) The grant personnel are 100% dedicated to performing grant activities and are separate from other agency duties, and 2) Grant personnel are split between grant activities and other agency responsibilities. Following is a table that outlines the benefits of each approach for the agency, staff, clients, and grant objectives:

TABLE A. COMPARISON OF THE BENEFITS OF STAFF ROLES

	STAFF DEDICATED 100% TO PROJECT	STAFF SPLIT BETWEEN AGENCY AND GRANT ROLES
Client	Staff attention is not divided among many types of responsibilities and could be more responsive	Staff are well versed and aware of a large number of interventions, events, values, and social work skills. Seamless transitions to information and services directly related to permanency.
Agency	Single project record keeping for payroll and job descriptions. When project ends, it is clear that their positions are no longer available.	Staff are versatile and able to meet changing agency needs for staffing during and after project. Staff are well informed about multiple agency functions. When grant ends, the agency benefits by

		having staff continue employment in other capacities.
Staff	Single project concentration of job descriptions and more focused, in depth work. Less role conflict with staff who are focused on single projects/activities.	Able to see a “bigger picture” for the client, identify and access multiple agency resources. Become part of a larger team and more likely to find continued work in the agency when the grant ends. Staff report they value having a diversity of activities.
Project	Focused attention on project goals and commitments.	Staff develop expertise in related fields that inform and improve their work with clients on the project. Staff more able to see alternatives and identify problems.

On CAP we took the approach that staff would be better able to serve their clients if they also worked in the adoption and foster care fields while concurrently working on the project. It is not a question of the right approach or the wrong approach, but rather which is the best fit for the agency, project, and client. What is clear is that it takes very skilled supervisors and staff to effectively prioritize and manage caseloads to balance client’s best interests and project goals. Finally, it was clear that the skills CAP staff learned while doing crisis pregnancy counseling (not part of the CAP project design) with birthparents considering adoption for their unborn children greatly influenced their ability to effectively identify and mediate loss issues for birthparents in CAP. Also, having staff who understand and can accurately describe the adoption process to foster parents and children became an invaluable tool in identifying fears and myths about what would happen if they went forward with an adoption. For CAP, having combined workloads worked by hiring five social workers to cover three FTE positions and using supervision time to continually prioritize cases and activities. However, for many agencies, this model of managing the staffing, funding streams, client needs and agency shifts over the period of three years would be too challenging and the difficulties would far outweigh the benefits.

Unanticipated Benefits

One of the unanticipated benefits we discovered was that follow-up became a very useful tool for sibling and family visits. In current child welfare practice in Cuyahoga County, family visits are conducted usually at the public agency in a large room with other families present and a county employee supervising multiple visits at the same time. Due to the artificial setting and the lack of structure, many birthparents struggle to make good use of the limited time they have with their children each month. Because we did come to visits with planned therapeutic activities, children and families were able to feel that their visits were successful. We also were able to transport children living in widely different areas so they could all visit together at the same place. In some cases, we were able to successfully change the location of the visits to more natural settings like parks, bowling alleys, and restaurants as long as we were supervising the visits.

Another unanticipated benefit was the large overlap that CAP work provided with our adoption work. We found that some of our approaches with CAP – e.g., using a “Life Road” to identify and talk about significant losses or completing family portraits – were particularly useful when doing preparation for adoption work with children. In addition, helping foster parents understand and empathize with what children were experiencing proved to be helpful when families were deciding whether to adopt or not. We know that CAP staff were instrumental in preserving several adoptive placements that became finalized adoptions. In each of these cases, the families had asked for the removal of the children before CAP staff using our interventions.

Best Practice Recommendations

Strengthen attachment relationships for children involved in the child welfare system

Specify Practice: Teach families about attachment-enhancing activities and engage in attachment-oriented interventions with clients.

Outline Clinical Basis/Wisdom for Practice: What we learned in our Kinship Adoption Project (KAP) was that the relatives and foster families who followed through with adoption did so because they felt attached and connected to the child regardless of his or her special needs and behaviors. In CAP, we learned that families were hungry for information about ways to enhance attachment with their children and that they actively engaged in our attachment-oriented games. The parents' evaluations provided feedback to us that they understood their children's reactions and feelings better and thus reported more positive feelings about their relationship with them. We also witnessed more claiming behaviors and an increased ability for children and parents to communicate and identify themselves as a family unit after participating in CAP groups. We also observed that children who experienced more placements were less attached than those with fewer placements. Additionally, children with a custody status of PPLA appeared more resistant to attaching to foster families and demonstrated greater loyalty to birthfamily during CAP activities.

Increase access to services and programs for birth families

Specify Practice: Provide strengths-based supportive services to birth families.

Outline Clinical Basis/Wisdom for Practice: What we believe to be true about voluntary birthparents in infant adoptions appears to be true for involuntary birthparents as well. That is, many birthparents are able to acknowledge their own limitations and recognize whether they are

the best person to parent their child. In addition, most birthparents truly love their children, regardless of their behavior toward them, and are willing to work to get them back. Perhaps we encountered an extraordinary group of birthparents, but we were able to engage all of them in working their case plans and acknowledging their limitations because they felt safe and not judged. Hearing peers express the same feelings they had helped them to accept their own mistakes and take responsibility to move forward. Three birthparents came to the realization that others would be better parents to their children and entered into “open” arrangements with foster parents.

Another issue that we saw was that reunification was being delayed because birthparents couldn't locate adequate housing that met county standards or that they were unable to attend visits due to lack of transportation or interference with work schedules. One birthmother had significant health problems that required frequent treatments, but she lacked transportation and in-home nursing help. CAP staff addressed these issues through traditional social work and case management services.

One of the services that birth parents are lacking is support. They do not have a support network within the Child Welfare System. Most of the workers involved with the birth parents dictate the case plan, rightly so sometimes. However, the birth parents feel judged, talked down to, and feel that they are “watched” all the time. The CAP group was able to provide the birth parents with a support system. The birth parents came to us with a “clean slate.” We did not know their history personally. We did not judge the parents or focus on their pasts. What we did focus on is their relationship with their child and encouraged them to focus on that also while completing their case plan. Offering birthparents support within the child welfare system is a radical idea, especially if we talk about grief and loss counseling for birthparents who lose a

child to adoption. Because termination of parental rights occurs as a result of something the birthparent did (or did not do), it is rare that they would be offered services to deal with the grief reactions that occur as a result of the loss of parental rights. However, helping the parent deal with their issues can potentially prevent future children being removed and can help the birthparent assist the current child in moving on to adoption in a healthy way. This view is unique and will be viewed by some as unrealistic, but we saw it happen in CAP, and we have seen it happen in previous projects. Some birthparents can and will be able to recognize that their children will be better off in another family, and they will do what they can to help that happen. Providing supportive services to them not only helps the birthparents, but can also break the cycle of child welfare involvement that we often see in dysfunctional family systems.

Increase capacity of foster parents to attach to children in their home

Specify Practice: Teach foster parents about typical experiences for foster children and the normal range of emotional and behavioral reactions to trauma and loss.

Outline Clinical Basis/Wisdom for Practice: Helping foster parents to understand their children's reactions fall within the normal range of behavior for someone who has had traumatic losses can help them develop empathy and connections with the child. The trend in child welfare is to take a set of behaviors and label them as mental illness or pathology when they can also be viewed as normal reactions to unusual and traumatic experiences. We observed many foster parents realize that their own losses had an impact on their behavior and they experienced them in the context of healthy supportive relationships. When we pointed out that foster children not only had extreme experiences of loss, but that they experienced them in unfamiliar settings with strangers, foster parents often had "aha" moments and realized that the children's reactions might not be that pathological after all.

Another issue that we stressed during groups and follow-up was that foster parents themselves experience feelings of loss each time a child leaves their home. In addition, we helped them realize that any unresolved issues of loss in their past would exacerbate any reactions to subsequent losses until they finally addressed them. Some foster parents expressed a desire to keep children at arms length so they wouldn't experience as great a loss if and when the child left the home. Other foster parents helped them to realize that they were keeping the child from experiencing a normal healthy attached relationship that would help them transition and form healthy relationships later. They helped each other to see that the adults needed to address their own loss issues separately to not rob the children of a chance at a stable family relationship.

VII. CASE SUMMARIES

In addition to the data that we did collect, we thought it would be helpful to include case examples to demonstrate how the project worked for different cases. These cases are presented below.

CAP Summary on A:

Participated in CAP groups from 4-18-01 to 5-16-01.

BACKGROUND INFO:

A was placed into foster care with Bellefaire JCB on July 12, 1991 at the age of 3 for physical evidence of abuse by her father and failure to thrive. She was placed in her first foster home until August 12, 1991. She stayed with her second foster home for 7 days before moving to her current placement on August 19, 1991. A has thrived in her foster home for the last 10 ½ years. She was placed adoptively with her foster family on March 21, 2002 the adoption finalization was July 12, 2002.

GROUP PARTICIPATION/PROGRESS:

4-18-01 to 5-16-01

A was an active participant in the groups. She was able to discuss her feelings and process why she had certain feelings. The attachment between A and her foster parents was evident from the beginning of the group. A's foster mother and father participated in the group and were supportive of A. A made a great analogy during "The Heart Story" activity – she described the importance of not having a wall around your heart but to instead protect it with a shield to help keep out most of the bad and to let the good in.

FOLLOW-UP:

A began follow-up in May 2001 and was involved in all follow-up sessions. In July 2001, A's younger sister who had been placed in residential treatment was reunified with their birth mother. Despite being in foster care for over 10 years, A was still in temporary custody and her birth family's parental rights had not yet been terminated. A began to show signs of depression and jealousy. She started to exhibit feelings of divided loyalty between her birth mother and her foster parents and family. A was struggling with the responsibility of deciding where she wanted to live, with her birthfamily with whom she had kept in contact or her foster family with whom she had lived for over 10 years. She frequently vacillated between wanting to stay with her foster family and be adopted, or return to live with her mother and sister. Her sleep, hygiene and school performance all suffered. She was also diagnosed with bipolar disorder during this time.

CAP staff used several of the grief and loss activities during this time with A and helped identify the significant attachments she had in her various families. Some of the activities led to a great deal of verbal processing and she ultimately stated that she wanted to stay with her foster family and continue visits with her mother and sister every month. On November 8, 2001 a permanent custody trial was held at Cuyahoga County Juvenile Court. CCDFS was granted

permanent custody with the judge insisting that visits would continue between A and her birth family. Following the custody decision, A began to improve – she became more relaxed and started sleeping better. She was more carefree and playful. The emotional and psychological improvements were evident in her physical appearance and reactions. She has started to accept the “loss” of her birth family.

A was active in visiting with her birth family as arranged by her foster family until January 2002. At this time, A began to call from visits to come home early or would refuse to go to visits. She stated to her foster mother that she did not feel a need to visit with her birth family. On March 21, 2002, A was placed adoptively with her foster family. A’s adoption was finalized on July 12, 2002. She was 13 years old.

CAP Summary for B (#28), C (#29), & D (#30)

Participated in Birthparent CAP groups from 6/25/02-7/23/02

BACKGROUND INFO:

D is a Caucasian female, age 13, C is a Caucasian female, age 11, and B is a Caucasian female, age 10. C and B are full sisters and D has a different father, though she has only known C and B’s father. CCDCFS took custody of the three girls on 1/31/02 because mom was being evicted from her apartment. Her apartment was not very safe or clean. There has also been a history of drug abuse, neglect, physical abuse from dad (2001), and sexual abuse in 1994 against D (from a family friend). Within a month in care, the three sisters disrupted from their foster home. All three girls were placed together until D disrupted to another foster home in April 2002, a third foster home in July 2002, and a residential treatment facility in January 2003. Each disruption was precipitated by D’s outbursts, aggression, depression, and suicidal ideation.

Both the biological mother and father of C and B, though separated, have tried to complete their case plan but cannot find housing. CCDCFS is filing to terminate parental rights for all three girls.

GROUP PARTICIPATION/PROGRESS:

The girls were involved in the birth parent group with their mother. Their father was very much against participating in the group. The girls have a very strong bond to their mother, so she attended each group and brought or made dinner for the girls because she wanted to have some special time with them before group started. Their mother was very involved in the group and became a leader for the other birth parents. The girls were active and important participants in the group also. The girls defended each other and their pasts, not wanting to share things that have happened to them (that is C being hit by their father). Their interaction with their mother was always strong but not in terms of mother/daughter but more like friends. Their mother definitely cares for them. Both mother and children are frustrated that they cannot be together.

FOLLOW-UP:

Follow-up took a different turn for this family. Dad decided that he wanted to participate in the follow-up. We met bi-monthly with the girls for an hour of follow-up. One week would be with their mother and the other week with their father. After the hour completed, the family visited for another hour.

Follow-up focused on their emotional and past issues. We dealt with anger, fear, loss, and individual roles of each person. The last few months of follow-up we worked on the children's Life Books. The parents were very involved during the Life Book activities and brought in pictures from the children's lives. The parents would tell the children where they

have lived, what they did as babies, who was involved in their lives, and sometime touched on why the children did not live with them.

Once D moved to the residential facility, we had the visits there with each parent. D's sister's were very concerned about her living at the residential facility and encouraged her to work her plan and get better. Once visits started here, the mother would bring the girls' half sister (who lived with her father). This sister was very disruptive to the group and mother did not have control over her actions.

Towards the end of the CAP program, the girls' father did not show up for his visits. They started to express their anger and frustration towards their father. They would comment about him lying to them and that they could not trust or depend on him. D and B would defend their father, but also agree with C. During this time, their mother was a big support to them while they were struggling with many emotions. We focused on ways they could express these feelings to their father. Though they wanted to let their father know how they were feeling, they were also afraid that he would hurt them, because he angers easily. Mother started coming to both sessions so they could visit and complete their life book. Both parents are still trying to reunify with their children although DCFS has filed for permanent custody of all three children. Both parents lack housing, birthmother does not provide stability or safety for the children and birthfather has not complied completely with anger management and other services on his case plan.

CAP Summary for E (#2) and F (#3)

Participated in Specialized Foster Care CAP groups from 4/18/01-5/16/01

BACKGROUND INFO:

F and E and their sister Z were placed into care in 1996 due to sexual victimization by their maternal grandmother. Their grandmother was convicted and incarcerated for the crime. In their first foster home, their Tae Kwon Do instructor sexually abused the girls. The instructor is now incarcerated. The girls were removed from this foster home due to F alleging that their foster mother's boyfriend was sexually abusing her. At the time of the allegations, the placement was moving towards adoption. The girls were moved to their current home in May 1999. They have maintained their placement. In December 2001, adoptive placement was made. Adoption finalization occurred on April 30, 2002.

GROUP PARTICIPATION/PROGRESS:

F actively participated in the group. She expressed and shared her feelings openly. The exercises during the group seemed to provoke a lot of thought for F. She was able to process her losses and her trauma of abuse. F demonstrated an attachment and bond to her foster mother. She always enjoyed the activities with the parents. F seemed to identify with her foster family.

E is a quiet girl who participated in the group when needed. She was thoughtful about her feelings and shared them with the group. She showed a strong bond and attachment with foster mother. She was able to talk about her losses with her peers. She expressed loss for her birth family. E feels a connection with her foster family and identifies them as her family.

FOLLOW-UP:

Follow-up focused on the transition from foster care to adoption. F began to struggle with feelings of divided loyalty between her foster/adoptive family and her birth family. She began to exhibit several unsafe behaviors that caused concern for her foster/adoptive parents. She tested her foster/adoptive parents to see how much they would take before they wanted her to move. Conversely, while testing her foster parents' commitment to her, F continued to

express a desire to stay with them. In December 2001, F and her sisters were placed adoptively. At this time F began to express that she did not want to be adopted. She began to see her CAP worker individually to engage in activities and discussions regarding her concerns about being adopted. F was able to actively engage in the work and her behaviors significantly improved at home and school. CAP also did a great deal of work with the parents to help them understand F's behavior and to help them develop strategies that kept her safe and communicated their commitment to her and sisters without discounting her connection to her birth family (especially an older sister who emancipated from foster care).

During the period when F was most disruptive, her sisters continued to express and demonstrate her attachment to her foster/adoptive family. Both sisters stated they were more connected to their foster/adoptive family than the birth family and were worried that F's behavior would disrupt their placement. E strongly stated that she wanted to stay with her foster/adoptive family regardless of F's outcome. Ultimately, the parents made a commitment to keep the siblings together and proceeded with adoption – a risky move since all children over 12 in Ohio have to consent to their own adoptions in front of the judge at Probate Court. The three sisters were placed adoptively In December 2001. F and E consented to their adoptions and finalization occurred on April 30, 2002.

CAP Summary on G (#1) and H (#4/12):

Participated in BP CAP groups from 1-17-02 to 2-14-02

BACKGROUND INFO:

JN and G our sisters they are 13 years old and 11 years old respectively. H and G have been in care since 1-22-99. They were placed into care for neglect, domestic violence, substance abuse, medical neglect of H's Sickle Cell Anemia, and alleged sexual abuse of G, which was

unsubstantiated. They were placed into a Bellefaire JCB foster home on 1-22-99. On 2-23-01, this placement disrupted due to abandonment. On 2-23-01 G and her sister were placed in their current foster home. CCDCFS was granted PPLA of the sisters in May 2001.

GROUP PARTICIPATION/PROGRESS:

1-17-02 to 2-14-02

During this 5-week group session, G participated in the group with her older sister and her birth parents. The first session of group G had a very difficult time sitting through the session and participating appropriately. It was found out later that she did not take her medication to control her ADHD. The following sessions G was appropriate and needed little redirection. She had difficulty each week identifying feelings. G had some difficulty during the time spent with the parents due to her parent's attention being focused on her sister. G's birthday was the day of group and her parents brought a cake to celebrate. G was very excited and affectionate towards her mother that evening. It was evident that G's attachment to her parents is much less than her sister's attachment.

4-18-01 to 5-16-01

During this series of group, H participated with her foster mother. H was a very active participant during the 5 weeks of group. She was the youngest participant and at times had difficulty relating to the other children. She was very talkative and would often get off task by responding to statements from others with comments that were not related to the topic. At times H annoyed the other children in the group. She enjoyed all the activities with the other children and with the foster parents. The attachment between H and her foster mother seemed to grow and improve as the group went on. At the time group started H had only been placed with her foster mother for just under 2 months.

1-17-02 to 2-14-02

During this 5-week group session, H participated in the group with her younger sister and her birth parents. She was very excited every week to see her parents. H needed to be redirected a few times from inappropriate affection towards her father for her age, such sitting on his lap and excessive “clinginess.” H had a difficult time expressing her feelings during group often describing herself not her feelings. She needed to be seated separately from her sister and a friend that was in the group. If she was not she became very silly and was resistant to participate. She was able to express feelings of loss and guilt due to not being with her parents. It was evident that H’s parents favored her over her sister and H enjoyed the extra attention that they gave her. H also began to recognize that her functioning level was higher than both her parents.

FOLLOW-UP:

Follow-up began following the group in February 2002. The sessions were held during family visits held at Bellefaire JCB. During the sessions, G had a difficult time due to her parents’ attention focused on her sister, H. This is more from their mother than father. Her father has little interaction with anyone at the session. G will often seek her mother’s attention and be ignored by her mother. G and H’s mother is mentally delayed and relates to the girls as a peer not a parent. She is very childlike in her interactions. It is evident during the session that G and H are more advanced than their mother.

Despite the girls’ young age, CCDCFS filed for and received PPLA for the girls which means they will not reunify but will never be adopted either. CAP staff conducted several activities and sessions with birth mom and the girls that focused on attachment and the girls need for permanency. During this period, birth mom described how painful it was not to have the

girls with her, but stated that she was now understood that the girls would not be coming home to her. She stated that she loved their foster mother and that if she couldn't get them back, she wanted the foster mom to adopt the girls. Based on this new view, G's statements that she wishes to be adopted by her foster mother, both parent's cognitive limitations and medical limitations, CCDCFS has refiled a motion for permanent custody. G's foster mother wishes to adopt G and her sister.

CAP Summary on: I (#15) and J (#16)

Participated in BP CAP groups from 1-17-02 to 2-14-02.

BACKGROUND INFO:

J is a nine year old, African American male. I is an eleven year old, African American female. She is the oldest of four children and he is the second oldest. J, I and their younger sister have been in CCDCFS custody since 2001. Their mother had been incarcerated for assault. During her incarceration she placed her children with a friend. The children were physically abused by the caretaker and removed from her home and placed in county custody. The siblings were placed in different homes. The youngest sibling was not taken into county custody initially and was placed with her paternal great-aunt. I and her younger sister were placed in a foster home together and J was placed in another foster home. The sisters disrupted out of their first foster home. They remained in their second foster home until reunified with their mother.

J quickly disrupted out of his first foster home and was placed in several foster homes thereafter. He was placed out of state for some time. J was admitted to a mental health hospital on a short-term basis on two occasions. Ultimately, he entered into a residential treatment

facility. He has a history of depressed mood and suicidal ideation. He becomes withdrawn, has difficulty dealing with separation from his family, and his school performance and social interactions were negatively affected. He remained in residential treatment for almost a year and then was placed in the foster home with his sisters before reunifying with their mother. The children's father is incarcerated in Michigan and not involved with the children.

CCDCFS filed for permanent custody of the siblings. The children were made aware of the filing and the possible outcomes if Permanent Custody was awarded to the County (i.e., adoption or PPLA). CCDCFS was filing for Permanent Custody due to birthmother's failure to complete her case plan; most importantly, not finding adequate housing for herself and her children. CCDCFS gained temporary custody of the youngest sibling during this time as well. She continued to reside with her paternal great-aunt.

GROUP PARTICIPATION/PROGRESS:

1-17-02 to 2-14-02

It is important to note that both J and his sister participated in the CAP groups. Throughout the groups, J was an integral member of group and appeared to enjoy the groups. J was particularly happy to see his siblings and his mother and the family demonstrated a strong bond through their interactions. He interacted well with other group members and was an active participant. J was willing to share in the group. He discussed his emotions surrounding his foster care placements and separation from his siblings and his mother (i.e., grief, loss, anger). J also discussed the abuse he and his siblings suffered when in previous placements.

I was also an integral member of group. Initially, she was giddy and had trouble focusing due to knowing some of the other group members. However, I's silly behavior did not last long and she was able to focus on the group and share substantially with the group.

Twice in the five-week series of CAP groups, J's and I's mother did not attend the group. J was able to state to facilitators that he was sad that his mother did not show for the group. During the groups that his mother did not attend, J continued to participate in the group but was more quiet than usual. J's sister was more open about expressing her disappointment with her mother's absence. J appeared to listen intently to his sister when discussing her feelings about their mother.

I reacted more strongly to her mother's absence from the group than her brother did. The first time, I was a lot quieter in group. She shared that she was willing to accept whatever excuse her mother had. The next time that her mother did not make it to group, I's mother called on the phone and requested to talk to her children. I did not want to talk to her mother and cut their conversation short.

Throughout the group, I initiated nagging with her brother. She called him names and had trouble engaging in an activity when they were meant to interact with one another. By responses to activities during the five-week series of group sessions and by behaviors during group activities, J and I both exhibit the need for anger management and self-esteem reinforcements.

FOLLOW-UP:

Because birth mom missed two group sessions, CAP staff were concerned that she would not participate in follow-up – a concern that they discussed with her while pointing out her children's reaction to her absence. CAP follow-up with J, I, their two siblings, and their mother was consistent. Workers attended scheduled family visits once a month for two hours. The family responded nicely to the follow-up. They participated in activities focused on what it means to be a family and family memories, commonalities and differences among family

members, how to interact with one another, and communication skills. Primary among the skills CAP focused on was helping birth mom learn to have more appropriate communication with the CCDCFS worker and to help her understand the importance of cooperating with the system instead of fighting it.

J openly expressed his emotions during follow-up. He became tearful at times when discussing the separation from his family. He was always very eager to see his mother and sisters and openly expressed his happiness when with them. He enjoyed the visits and the activities with his family. I took the role of the oldest sibling seriously. She tried to not show her emotions and appears to not let things (like being in foster care or having her mother miss a visit) bother her.

Overall, the bond among J, his siblings, and his mother is strong. The family enjoys time together and interacting. The birthmother began to make advances in her case plan by completing parenting classes, beginning anger management classes, and completing a court ordered Psychiatric evaluation. She also entered a residential program that offered support to women and their families. The program enabled her to have housing and provided services to help her to learn job skills and parenting skills. The program offered childcare and other much needed services. Upon securing stable housing, the children were reunified with their birthmother and CCDCFS withdrew its petition for Permanent Custody of the children.

Since their reunification with their mother, the birthmother has completed the trainings and has since moved from the residential program into a home of her own. She currently maintains employment and housing. She cares for her four children and shares they are doing well.

CAP Summary for K (#6/38)

Participated in SFC CAP groups from 7/24/02-8/21/02

BACKGROUND INFO:

N was abandoned by his mother on or around August 23, 2000, when she left him in the care of a baby sitter. This was the third (3rd) time that K had been in the custody of a children's service agency. K initially came into the Temporary Custody of CCDCFS on October 24, 1997. He was re-unified with his mother. On January 9, 1998, K again came into Temporary when his mother contacted CCDCFS from a bar on January 7, 1998, stating that she could not care for K. Birthmother's inability to care for her son was attributed to her continuous abuse of alcohol and chemical dependence. Again, he was re-unified with his mother, upon her completion of her case plan.

K and his mother moved to another county, where they resided together until he came into custody in August 2000. During the course of K's second placement with DCFS, K resided in the foster home of CL. Effective December 2000; K was again placed in CL's home. Although K possesses average and age appropriate academic abilities, his reluctance to accept adult supervision, re-direction and his poor peer relations continue to prevent academic success. K has the ability to interact appropriately with peers and adults, as long as he is having his way. When he does not have his way, K has a history of temper tantrums, hitting, picking with, and non-observance of his peer's boundaries. K continues to have difficulty adjusting to his multiple placements and separation from his mother. K was placed adoptively with his foster mother in November, 2002 and the adoption was finalized in May 2003.

GROUP PARTICIPATION/PROGRESS:

K was always an active participant in the group. He contributed many insightful and meaningful things the process. He felt comfortable expressing himself and feelings with group. K's comfort level feel when there were activities with the parents. He never ate dinner with his foster mother and at some sessions he would not eat. At others he would wait until his foster mother was finished and ate at a different table than her. During family activities, K and his foster mother often worked separately rather than as a team. During the family collaboration exercise, K's foster mother put him down in front of the entire group. K responded by becoming closed off to the group and the rest of his surroundings. K missed the second group due to a scheduling conflict.

FOLLOW-UP:

Follow up focused on the transition from foster care to adoption. K continuously expressed his desire to be adopted through out the follow up period. Foster mother initially expressed ambivalence toward adoption and needed a lot of reminders and help in completing paperwork, which CAP staff provided. CAP follow up often focused on educating foster mother about K's needs and perspective. In addition, K did face loyalty issues with his birth family. He would often become upset when he spoke with his birth sister or mother. He would not be upset for any length of time. K continued to struggle with school through out the follow-up period and will remain in a special education program for the following school year. K expressed excitement and joy regarding the adoption and was looking forward to his finalization day. K was very happy on May 28, 2003, when his adoption was final. Since that day, K's behavior problems have decreased and he is more at ease in the family.

CAP INTERVENTIONS

The Ungame
Lifestories

Life Book
Art
Talking Feeling Doing Game
Imagine If

CAP Summary on: L

Participation Period: April 2002-September 2002

BACKGROUND INFO:

L is an African American, fifteen-year-old female. L participated in CAP groups with her birthmother M. Since the conclusion of group, L and her mother have been reunified. L originally was put into care due to her delinquent behavior and unruliness. L has not lived with and has not been parented by her mother for some time. L was living with her father before L came into care. She had moved in with her mother briefly before her mother pressed unruly charges against her. L remained in the foster care system for over a year.

GROUP PARTICIPATION/PROGRESS:

L participated in groups that ended on February 14, 2002. She was present for each group and participated with her birthmother M. At first, L and her mother both voiced that they did not like one another. As groups continued, the two discovered how much they had in common and began to communicate on a regular basis with one another.

FOLLOW-UP:

Follow-up has been consistent with M and L. They were the first parent-child pair to be reunified since the inception of the CAP groups. Follow-up concluded with M & L in February 2003. It consisted of usually two visits per month with both M and L. Once reunification was granted, follow-up was conducted in M's home rather than at the agency. Follow-up sessions

then transformed into meeting with just M or just L once a month for one hour and then both M and L together once a month for one hour.

Initially, M and L transitioned well. They went through a "honeymoon period" and then M was encouraged to define expectations, rules, and consequences for L since L seemed to be slipping back into old behaviors and attitudes. CAP staff suggested that M & L try to maintain regular, daily, positive communication together. M was asked what other services she felt she needed to better deal with L. M was asked on multiple occasions what her commitment level to L was. Workers stressed the difference between a friend relationship and a mother-daughter relationship to M to help her be more comfortable in a parental and authority role. Due to M's chronic health condition, CAP arranged and paid for respite care services in place for L with a former foster parent with whom L had a good relationship and who had once expressed desire to adopt her. This provided a little relief for both M & L, however, because they had reunified and CAP services were time limited which meant that both CCDCFS and Bellefaire would be out of their lives, M needed to be able to realize that she had to be the sole parent and be responsible for managing her child. L's behaviors continued to be disruptive. She continued to hang out with old friends and repeated old ways of breaking curfew, abusing phone privileges, mouthing off to adults, and lying. M & L reportedly spoke little to one another and independently lived their lives with little of the other's involvement.

Workers offered M alternative parenting techniques to combat L's behaviors. County provided in-home family preservation services for M & L, but they were never completed. Adoption alternatives were discussed with the respite care provider, as were returning L back over to the child welfare system. However, M continued to confirm her commitment to L and at last contact with CAP workers, was willing to do whatever it took to make their reunion

permanent. Workers later learned that M continued to utilize respite services after CAP stopped paying for them.

VIII. FINAL COMMENTS

The national standard of concurrent planning has begun to take shape and have a positive impact on child welfare by shortening the time children spend in out of home care. CAP has demonstrated that children need not suffer because of ambiguity resulting from concurrent planning. This report and evaluation demonstrate that children can indeed cope positively with the ambiguity of concurrent planning and in fact grow. The key factor is that all adults in a child's life have knowledge that embraces the understanding of how grief and loss affects a child.

The answers we have discovered point us to new questions and the future. What are the other applications the CAP model might be replicated to address? What other populations might benefit from the effectiveness of a CAP approach? Might a group similar in approach benefit large sibling groups and their caregivers? Perhaps a method of therapeutic visitation could evolve from the CAP model. And equally as critical since the question of any service at all is at hand, how can we sustain such an important intervention fiscally?

The CAP project has emerged as a meaningful and effective intervention for children and their foster, adoptive and/or birth parents. Our true hope is that we continue to reach for the knowledge where children become whole and families grow together.

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APPENDIX A

CAP curriculum

APPENDIX B

Follow-up Activities and Sample Assessments

APPENDIX C

Comments from Evaluation Forms

Was the group what you expected? Why/Why Not?

“No—I thought we [were] going to talk about stupid stuff which was not. We were talking about--real life situations.” (kid-birthparent group)

“No—Much better, informative, fun” (foster parent)

“No—I didn’t know what to expect” (foster parent)

“No—I thought it would boring, But I had fun” (foster parent)

“No—Because I didn’t know what to expect. I did enjoy the meeting.” (foster parent)

“I really wasn’t sure what to expect” (foster parent)

“No—I never knew what to expect but I really enjoyed this program.” (foster parent)

“No—Because I thought they (workers) were gonna talk to much and that I wouldn’t like the kids there” (kid-foster parent group)

“Yes—Cause we talked about how we like some of the stuff in our life like foster home.” (kid-foster parent group)

“Yes—Activities were fun” (foster parent)

“Yes—Everything was good” (foster parent)

“Yes—Cause I know they were going to play games” (kid-foster parent group)

“No—Because it was kinda boring.” (kid-foster parent group)

“No—It just was fun.” (kid-foster parent group)

“Yes—Because everyone was nice” (kid-foster parent group)

“Yes—It was boring and not helpful at all.” (kid-foster parent group)

“No- Because I thought it would be boring.” (kids, foster and birthparents)

“Yes—As a 1st time project, it was difficult to continue momentum of all the participants over the duration of the program” (foster parent)

“Yes, I did” (kid-birthparent group)

“No— ‘cuz I didn’t like it—it was boring and dumb” (kid—foster parent group)

“No—Because I just didn’t” (kid—foster parent group)

“Yes—I realize we all could come together” (birthparent)

“No—I expected it to be boring, negative, uncomfortable.” (birthparent)

“No—Treat people nice” (kid-foster parent group)

“Yes—It always helps me when I see my child” (birthparent)

“No—Because I thought it was going to be boring” (kid-foster parent group)

“No--more fun” (kid-TFC)

“Yes—helped me relax somewhat” (birthparent)

“Yes—I enjoy myself every week” (birthparent)

“No—Because I did not know we were to have candles (kid)

“Yes—and some more” (foster parent)

“Yes—It was fun.” (birthparent)

“Yes—I thought it was going to be very stupid, boring, and corny. I was right.” (kid-foster parent group)

“Not clear regarding program overview” (TFC foster parent)

“No—because it was different” (birthparent)

“Did not know what to expect” (TFC foster parent)

“Yes-Very informative and on target” (foster parent)
 “I expected it to be boring, negative, uncomfortable.” (birthparent)
 “Yes-This group is to help us(e)” (kid-birthparent group)
 “Yes--Was not sure--it was an enjoyable surprise” (TFC foster parent)
 “Yes—it was almost the same as [last] week” (kid-foster parent group)
 “Yes—Because I was here before” (kid-foster parent group)
 “Yes--It was more than I expected--very good” (TFC foster parent)
 “Yes—We dealt with separation and loss.” (foster parent)
 “Yes—Because I thought it was going to be fun and it was.” (kid-foster parent group)
 “Yes-This was a get to know each other night and break the ice night” (foster parent)
 “Yes—Because you learn more about your foster children” (foster parent)
 “Yes—Because she listen to what have to say” (birthparent)
 “No—I was not familiar with some of their problems.” (birthparent)
 “Yes—Because it was funny” (kid-foster parent group)
 “Yes—Because I did not know what we was going to do” (kid-foster parent group)
 “Yes--Heart is a good thing” (kid-TFC)
 “Yes—It is fun” (kid-birthparent group)
 “Yes—because it’s great” (kid-birthparent group)
 “No—Because it was corney” (kid-- foster parent group)
 “No—I thought it would long and drawn out” (kid—foster parent group)
 “Yes—because I did group already.” (kid-birthparent group)
 “Yes—I have to do the same thing at school” (kid-birthparent group)
 “Yes—Because I knew we would have to talk.” (kid-- foster parent group)
 “Yes—Because I thought it would be fun” (kid-birthparent group)
 “Yes—I knew that the class was about family togetherness” (foster parent)
 “No—I thought it would be a long drawn out conversation” (kid-foster parent group)
 “Yes--Because I liked it” (kid-TFC)
 “Yes-I seen my mother” (kid-birthparent group)
 “Yes—Because I liked it.” (kid-- foster parent group)
 “No—I did not understand” (kid-- foster parent group)
 “Yes—I liked the activities” (kid-birthparent group)
 “Yes—It was very informative and fun” (foster parent)
 “Yes—Because I feel much better now” (kid-- foster parent group)
 “No—It was not because I had not planned for it” (kid—foster parent group)
 “Yes—Attempts were made to deal with ansiey topics” (foster parent)
 “Yes-I knew it was our last night and it was a special group” (birthparent)
 “Yes—Because its always been the same” (kid-- foster parent group)
 “Yes—Very supportive group” (birthparent)
 “Yes—I thought it was fun” (kid-foster parent group)
 “No—Because I thought we just was going to talk” (kid-foster parent group)
 “Yes—Because we talked about our feelings. It was fun” (kid-foster parent group)
 “Yes—A fun place with work to do and was going to make new friends” (kid-foster parent group)
 “No—Because I don’t like people in my business” (kid-- foster parent group)
 “Yes—Because it is the same every time” (kid-- foster parent group)
 “No—I didn’t know we had rules and they were going to be nice” (kid-foster parent group)

“No—Never know what to expect..very interesting” (foster parent)
“Yes—I enjoyed being able to speak my mind in my cluster” (foster parent)
“Yes—Help each other to deal with sensitive issues with kids bad behaviors.” (foster parent)
“Much better” (foster parent)
“Yes—because I feel we had fun” (kid--foster parent group)
“No—Never is. It is always more informative than I expect” (foster parent)
“Yes—Interesting” (foster parent)
“Yes—Same oh, Same oh” (kid--foster parent group)
“Yes—because we had fun.” (kid--foster parent group)
“Yes—interaction” (foster parent)
“Yes—Because it is the same week after week” (kid—foster parent group)
“Yes—Because I left my madness at home.” (kid—foster parent group)
“No—Because it is a new experience and totally different from other training sessions” (foster parent)
“Yes—Because the same as last time” (kid-- foster parent group)
“Yes—A fun place to make new friends. A place that was helpful to share.” (kid-foster parent group)
“No—I thought it was going to be boring because it was all women.” (foster parent)
“Yes—Because it was fun and the people who work here were hilarious and the kids were nice.” (kid—birthparent group)
“Yes—Previous experience with group.” (foster parent)
“Yes—I talked more.” (kid-foster parent group)
“It was fun” (kid—birthparent group)
“Yes—It was very fun” (kid-foster parent group)
“Yes—feelings chart, love” (kid—birthparent group)
“No—I never know exactly what to expect but I continue to enjoy it.” (foster parent)
“Yes—unsure” (kid-TFC)
“No—because I felt bored” (kid—birthparent group)
“Yes—Because I was thinking about the game and I knew about the feelings chart” (kid—birthparent group)

What is something new that you learned today?

“Don’t give up on love, and loving someone.” (birthparent)
“Direction very different” (foster parent)
“Most of the children have about the same problem.” (foster parent)
“The other fosters treat their foster parents as mind do.” (foster parent)
“Everyone who is a foster parent or a foster child needs this kind of training.” (foster parent)
“Heart story can tell about your child” (foster parent)
“That if we put our minds to it we can do it.” (birthparent)
“I learned to act together” (birthparent)
“I learned to make a chain with my kids” (birthparent)
“The tumbling tower was interesting.” (kid-foster parent group)
“About feelings” (kid—birthparent group)
“Love people” (kid-foster parent group)
“We did the boxes” (kid—birthparent group)
“People” (kid-foster parent group)

“That some people just don’t talk as much as I do.” (kid-foster parent group)
“It is ok to have boundaries” (kid—birthparent group)
“I learned the heart could be fixed. The broken arrow game. The heart can go back (mend) when you feel happy.” (kid-foster parent group)
“I learned a lot of stuff” (kid—birthparent group)
“To be well open minded” (kid—foster parent group)
“To figure out some of my issues.” (kid—foster parent group)
“I learned about feelings” (kid—birthparent group)
“How to work with little kids” (kid—birthparent group)
“Yes I did” (kid—birthparent group)
“What kids was thinking about the situation they are in” (birthparent)
“How to interact with my kids” (birthparent)
“Nothing because I didn’t want to.” (kid--foster parent group)
“That children need to learn how to listen” (foster parent)
“Learned about your family” (kid-- foster parent group)
“How people speak to foster kids” (birthparent)
“Some of the ideas on grief and loss and how they affect behavior at various points in life” (foster parent)
“I leaned how to start talking to everybody” (kid—foster parent group)
“How much fun my foster child is” (foster parent)
“Keep the faith” (foster parent)
“How to coment people and I don’t do that often” (kid—foster parent group)
“To be creative” (kid—foster parent group)
“How to work toward breaking down barriers around the heart” (foster parent)
“How hard it is to remember a message (telephone game)” (foster parent)
“A broken heart is hard to mend” (foster parent)
“You can keep a promise. When you don’t keep the promise it can’t come back to friends and family” (kid-foster parent group)
“I could get along with others” (birthparent)
“ I learned that other people have the same feelings as me. And what my parents think about me” (kid-foster parent group)
“How to respect someone and forgive” (kid-foster parent group)
“How to relax” (kid—foster parent group)
“Some things about fellow foster parents” (foster parent)
“People are so silly” (foster parent)
“How to trust people” (kid-foster parent group)
“New ways to demonstrate what they kids go thru” (foster parent)
“Got a chance to bond and share other foster parents thoughts” (foster parent)
“I’m not alone” (foster parent)
“How confessing some of our orders are like to the children” (foster parent)
“That in every group there is a jerk” (kid--foster parent group)
“Yes—What ambiguity means” (kid--foster parent group)
“Nothing besides my point being proven that Bellefaire is stupid” (kid--foster parent group)
“How to talk to people and listen to others” (kid--foster parent group)
“How to play and cheat in the wizard game” (kid--foster parent group)
“I learned that talking about your feelings helps you feel better” (kid-foster parent group)

“How things you say to people will hurt the heart” (foster parent)
 “Nora and family can act” (kid-foster parent group)
 “That [foster brother] can talk nice” (kid-birthparent group)
 “How to open up to people” (kid- birthparent group)
 “To be open minded” (foster parent)
 “Getting acquainted” (kid—foster parent group)
 “Everybody has different feelings” (foster parent)
 “Nothing really cause I have to do all this in school” (kid-birthparent group)
 “All about emotions” (foster parent)
 “Social encounters with others” (kid-foster parent group)
 “Expectations of the program” (foster parent)
 “A lot of things” (kid-birthparent group)
 “The wizard game” (kid-birthparent group)
 “Peelings” (kid- birthparent group)
 “nothing” (kid-foster parent group)
 “Respect others” (kid- birthparent group)
 “Feelings about my girls” (birthparent)
 “Family chained” (foster parent)
 “How to play feelings charades” (kid-foster parent group)
 “[To] open up with other people and share things, something that I am not really good at doing” (birthparent)
 “How to feel if my heart gets hurt.” (birthparent)
 “That peers have thing thy want thourt” (kid-TFC)
 “About out lost feelings” (kid-birthparent group)
 “That all members of the family are unique, yet all connect to make a family” (TFC foster parent)
 “I did not learn anything” (kid-foster parent group)
 “That children are very good at charades” (foster parent)
 “How to deal with your child’s loss and separation” (foster parent)
 “How my children felt” (birthparent)
 “It’s the little things that make a family.” (birthparent)
 “I learned that [my foster mom] likes water just like I do.” (kid-TFC)
 “Trust” (kid-birthparent group)
 “The depth of loss that may go unaddressed” (TFC-foster parent)
 “[My foster child] shared something very special with me. She received a letter from President George W. Bush” (TFC-foster parent)
 “Family interaction creates bonding.” (TFC foster parent)
 “I am not the only parent going crazy without their kids.” (birthparent)
 “Not [to] fight your brother” (kid-birthparent group)
 “That I am not alone in this fight. Yeah!” (birthparent)
 “Enjoyed the groups interaction” (TFC foster parent)
 “My child’s emotions aren’t all that clear.” (birthparent)
 “Excited” (kid-birthparent group)
 “more about my feelings” (kid-TFC)
 “I knew everything” (kid-TFC)
 “My child’s emotions aren’t all that clear” (birthparent)

“My feelings and how was your new school” (kid-birthparent group)
 “How to follow rules” (kid-birthparent group)
 “A lot of things” (kid-birthparent group)
 “feelings” (kid-TFC)
 “Enjoyed interacting with potential foster child and enjoyed the company of cluster members.”
 (TFC foster parent)
 “Multitude of emotions” (TFC foster parent)
 “I learned how other people feel when you make fun of others” (kid-birthparent group)
 “I learned about going to a new school.” (kid-birthparent group)
 “Fun group tonight” (TFC foster parent)
 “Charades” (kid-TFC)
 “How to express myself” (kid-TFC)
 “Group unity” (TFC foster parent)
 “The tower of trust” (kid-TFC)
 “That [my foster mom] likes Chinese” (kid-TFC)
 “love” (kid-TFC)
 “not really” (kid-foster parent group)
 “Not to make fun of people’s colors and times they moved” (kid-foster parent group)
 “wizard” (kid-foster parent group)
 “Not to tease” (kid-foster parent group)
 “That you could tell anybody anything” (kid-birthparent group)
 “I learned how to play the wizard game” (kid-foster parent group)
 “How to feel when you get adopted” (kid-foster parent group)
 “I learned what some words mean” (kid-foster parent group)
 “That you don’t have to be embarrassed about being in foster care.” (kid-foster parent group)
 “That I listen to my children” (foster parent)
 “The tanks of love” (kid-foster parent group)
 “Love between our misery” (birthparent)
 “That you can feel more than two feelings” (kid—foster parent group)
 “Patches” (kid—foster parent group)
 “Need to give more positive comments” (TFC foster parent)
 “To talk about what going on” (birthparent)
 “It’s the little things that make a family” (birthparent)
 “How to get along better with my child” (birthparent)
 “Learning more about my family” (foster parent)
 “Who people trust” (kid-birthparent group)
 “A lot of things” (kid-birthparent group)
 “I learned to try to not keep this block on my heart” (birthparent)
 “To learn more about your child” (foster parent)
 “Responsibility” (kid- birthparent group)
 “To be a family” (kid- birthparent group)
 “To talk instead of being scared” (kid-- foster parent group)
 “How to tell faces a little better” (kid-- foster parent group)
 “Emotions” (kid-- foster parent group)
 “I like the participation of children sharing in this experience” (foster parent)
 “Your heart can get broken” (kid--- foster parent group)

“How words can be turned around” (kid-- foster parent group)
“To try not to laugh so hard next time” (kid-- foster parent group)
“I am not alone” (foster parent)
“Things are never the same once its been torn” (foster parent)
“Once again , it is important to feel like the children; what it’s like to be in their shoes” (foster parent)
“The many talents of all the people” (foster parent)
“Put the thing we do in our house in words” (foster parent)
“How to get along” (kid--foster parent group)
“I’m learning more to express my feelings” (birthparent)
It is ok to love and mend” (birthparent)
“I learned that the games we play with our kids is ok” (birthparent)
“More about mending a broken heart” (birthparent)
“That I can talk about my feeling without feeling like a heel” (birthparent)
“I learn to show my emotions with the kids” (birthparent)
“Some things are fun” (kid--foster parent group)
“Broken families stay broken. Difficult to mend, never the same.” (foster parent)
“To be caring to each other” (kid—birthparent group)
“How to respect someone” (kid—birthparent group)
“Making the boxes” (kid-- foster parent group)
“About family and trust” (kid-- foster parent group)
“More about my family” (kid-TFC)
“Some stuff about people” (kid-foster parent group)
“About the Antwan Fisher Story” (foster parent)
“Group feelings on attachments” (foster parent)
“How I had a wonderful mom compared to the other people.” (kid-foster parent group)
“About situations with other foster parents” (foster parent)
“You can work with others and find a happy neduim in spite of our environmental backgrounds.” (foster parent)
“How much me and my mom got in common” (kid-- foster parent group)
“Patience” (foster parent)
“How close a family can become, when they are together a lot.” (foster parent)
“I learn how to work together.” (kid-foster parent group)
“The Tower of trust game.” (kid-foster parent group)
“A broken heart can mend” (foster parent)
“To move on with your life and let the past be the past.” (kid-foster parent group)
“about love” (kid-foster parent group)
“That we all need someone to talk to, eventually.” (kid-foster parent group)
“How people really feel about me.” (kid-foster parent group)
“I learned how to work as a family.” (kid-foster parent group)
“The heart story.” (kid-foster parent group)
“We have a lot in common” (kid—birthparent group)
“About either people being in foster care.” (kid—foster parent group)
“We learned to act together” (kid—birthparent group)
“What children go through to have their world town apart” (foster parent)
“Crafts can be fun. I have not done this in a long time.” (TFC foster parent)

What is something that you still think about when you leave?

- “To have fun and to let my mom know how I feel about her more often” (kid-- foster parent group)
- “How to listen to direction from my kids” (foster parent)
- “I think about my family.” (kid-foster parent group)
- “How I/we (my foster daughter) can help others in the group.” (foster parent)
- “All of it” (foster parent)
- “My foster child’s big smile while he was giving me directions on the back-to-back drawing game. He was so excited to do that, and it made me feel good also.” (foster parent)
- “New school and going to new places” (kid—birthparent group)
- “Ways to help our child to attach to us.” (foster parent)
- “Lots of stuff we all talked about.” (kid—foster parent group)
- “How we can still stay together as a family.” (foster parent)
- “The game we played” (kid—birthparent group)
- “How people feel about me.” (kid-foster parent group)
- “I had a good time” (foster parent)
- “The games” (kid—birthparent group)
- “My family” (kid—birthparent group)
- “I’ll feel happy” (kid—birthparent group)
- “Foster home” (kid-foster parent group)
- “How loss can impact people” (foster parent)
- “The loss thing” (kid-foster parent group)
- “My family” (kid-foster parent group)
- “The games that we play” (kid-foster parent group)
- “Feelings and listening” (kid—birthparent group)
- “How this was very helpful” (kid—birthparent group)
- “The boxes” (kid—birthparent group)
- “How we can trust people” (kid—birthparent group)
- “The wizard game” (kid—birthparent group)
- “Feelings and stuff and what I did with the game” (kid—birthparent group)
- “Mommy, because I like my mom and I love my mom and she is my favorite to the end” (kid—birthparent group)
- “To be positive and to think positive” (birthparent)
- To have my kids homes” (birthparent)
- “How the group was” (kid—birthparent group)
- “Love” (birthparent)
- “Talking with my kids at home” (birthparent)
- “That I am blessed to be able to come and learn new way to deal with my situation” (birthparent)
- “Help us to get to know our foster kids and us to know each other” (foster parent)
- “My children” (birthparent)
- “How my life is shaping up” (birthparent)
- “I think about my kids coming home” (birthparent)
- “I really got a chance to know the story on the Wright family” (foster parent)
- “Things these children go through” (foster parent)
- “How to get my foster child to participate” (foster parent)

“Everything we did” (foster parent)
“How I enjoyed this class (it was very productive)” (foster parent)
“How well I remember last weeks comments” (foster parent)
“How overwhelmed and stressed children can be.” (foster parent)
“All the fun and knowledge is power” (foster parent)
“Coming together and sharing ideas” (foster parent)
“Have a better understanding how my foster child might feel” (foster parent)
“How we had fun” (kid--foster parent group)
“Some did not participate and tried to hide the anger” (foster parent)
“All of the families” (foster parent)
“Why did I come here?” (kid—foster parent group)
“I am very proud of how well this is going for some of the kids” (foster parent)
“Remaining consistent” (foster parent)
“How a heart can break and then fill up again.” (foster parent)
“Why should I come back.” (kid—foster parent group)
“Why the hell I have to come back next week” (kid—foster parent group)
“I don’t know because I haven’t left yet, but I will come back” (kid—foster parent group)
“I will probably think about some of the memories that crossed my mind.” (foster parent)
“How exciting the class was at the end.” (foster parent)
“False expectations of new foster parents” (foster parent)
“Learning about the other families (personal stuff)” (foster parent)
“The more things change, the more they stay the same” (foster parent)
“The chain” (kid-- foster parent group)
“The family portrait” (kid-- foster parent group)
“The candle ceremony” (foster parent)
“Everybody has different feelings” (foster parent)
“Things that are on my mind” (kid-TFC)
“To think about other’s feelings” (kid-- foster parent group)
“None of your business so mind your own business” (kid- foster parent group)
“The boxes—tanks of love” (kid-- foster parent group)
“Cousins” (kid-- foster parent group)
“How my child is going to be.” (birthparent)
“About the game we played today, next time please bring a board game next time ok? (kid-- foster parent group)
“What is it going to be like” (kid-- foster parent group)
“How to help fill the heart back to normal” (foster parent)
“Getting things out in the open” (birthparent)
“My grandma” (kid-- foster parent group)
“How kids feel when they are torn apart from their families” (foster parent)
“My attitude about foster care” (kid-- foster parent group)
“Going home and not coming back” (kid-- foster parent group)
“I am going to be able to forgive my mother” (kid-foster parent group)
“Everything” (kid-birthparent group)
“Help from people” (kid- birthparent group)
“How I had fun” (kid-foster parent group)
“Are we going back home (to aunt’s house) (kid—foster parent group)

“My friends” (kid-foster parent group)
“Family Collaboration” (foster parent)
“Not to fight” (kid- birthparent group)
“I am still thinking will I pass the school test” (kid-foster parent group)
“How to assist the kids in their adjustment cycle as it changes with them and understanding of what’s going on in their lives” (foster parent)
“The heart story” (foster parent)
“Tanks of love” (kid—foster parent group)
“My mother, she didn’t come today” (kid- birthparent group)
“Love and the story we heard” (kid—foster parent group)
“People I like” (kid—foster parent group)
“Feeling charades” (kid—foster parent group)
“This class and coming back next week to learn more and I feel real good” (birthparent)
“Visualization of a significant loss” (foster parent)
“Nothing—just that I had fun” (kid-foster parent group)
“Adoption” (kid-foster parent group)
“The child adult cooperation game” (kid-foster parent group)
“My kids” (birthparent)
“Everything” (foster parent)
“The back-to-back game” (foster parent)
“Family” (kid-birthparent group)
“Mom and dad” (kid-birthparent group)
“Leaving the kids and hope to see them soon” (birthparent)
“Mother” (kid-birthparent group)
“My mom and dad” (kid-birthparent group)
“My children” (birthparent)
“My kids” (birthparent)
“mom” (kid-birthparent group)
“My mom” (kid-birthparent group)
“Telephone game” (birthparent)
“love” (kid-TFC)
“How to act when my child acts up” (foster parent)
“How good this CAP program is” (foster parent)
“My feelings when I was here” (kid-foster parent group)
“The way my foster kid feels about me and my family” (foster parent)
“the facilitators were nice” (kid-foster parent group)
“About my loss and separation” (foster parent)
“The tank of love and how much fun I had” (kid-foster parent group)
“Children’s participation” (foster parent)
“everything that we said” (kid-foster parent group)
“The word search my little girl did for me.” (foster parent)
“[My foster child’s] feelings about why he doesn’t chose to share with his group, which caused difficult behavior” (foster parent)
“the boxes [tanks of love]” (kid-foster parent group)
“my homework” (kid-foster parent group)
“Why I’m here” (TFC foster parent)

“The next group” (kid-TFC)
“Feeling charades is fun” (kid-foster parent group)
“The need to help my child to verbalize” (foster parent)
“More interactive with child” (TFC foster parent)
“How this program will end.” (kid-TFC)
“If I might come back” (kid-TFC)
“The next meeting” (kid-TFC)
“The foster children bonding as a unit” (TFC foster parent)
“What fun I had” (kid-foster parent group)
“the games” (kid-foster parent group)
“If I will be successful in my foster home. I hope I am though” (kid-TFC)
“The entire program” (foster parent)
“feelings” (kid-TFC)
“Just hoping to feel better” (kid-birthparent group)
“My love tank” (kid-TFC)
“My girls” (birthparent)
“People” (kid-TFC)
“Better ways to communicate” (TFC foster parent)
“My mother” (kid-birthparent group)
“What came up when the relationship” (kid-TFC)
“Kids” (birthparent)
“Liked the feelings chart” (TFC foster parent)
“The child’s feelings” (TFC foster parent)
“Being observant of the whole conversation verses what is being said” (TFC foster parent)
“family” (kid-birthparent group)
“The helpful words” (kid-TFC)
“If I will go home in time” (kid-birthparent group)
“If I go with my mommy” (kid-birthparent group)
“About going back home” (kid-birthparent group)
“To see my mom again” (kid-birthparent group)
“My mother” (kid-birthparent)
“My family” (kid-birthparent group)
“The Wright Game” (birthparent)
“The kids, looking forward to next time getting together, and to next session and what will happen.” (birthparent)
“When are we going back with my family where my mom and dad is” (kid-birthparent group)
“My mommy! Because I love her a lot!” (kid-birthparent)
“My daughter” (birthparent)
“When will I be with my child again” (birthparent)
“My children and I [wonder] if the teacher really cares or is she just doing her job.” (birthparent)
“This class and coming back next week to learn more and feel real good.” (birthparent)
“My mom” (kid-birthparent group)
“I can’t come back but I know I have a friend I can call on.” (birthparent)
“Am I going to be able to forgive my mother?” (kid-foster care group)
“Will I do good with [foster parent]. I hope I do.” (kid-TFC)
“The candle ceremony” (foster parent)

“The help I got from the class.” (foster parent)
“To keep my attitude under control” (kid-- foster parent group)
“The importance of realizing and being sensitive to the loss of our children.” (TFC foster parent)
“The group’s commitment to each other.” (TFC foster parent)
“[My foster child’s] reactions” (foster parent)
“How to help my child cope with his loss (foster parent)
“When will I be with my child again?” (birthparent)
“My mommy” (kid-birthparent group)
“My mom and dad” (kid-birthparent group)
“The people and the candles.” (kid-foster parent group)
“My mother” (kid-birthparent group)
“Not [to] fight your brother” (kid-birthparent group)
“My daughter” (birthparent)
“About going back home” (kid-birthparent group)

What was the most valuable aspect of the group?

-a mother said that she found out her daughter knew her better than she knew her daughter (birthparent)
“for them [facilitators] to listen and give us respect as a person” (birthparent)
“Playing the family portraits game”
“Just hoping to feel better” (kid-birthparent group)
“We weren’t afraid to speak about our feelings as foster parents” (foster parent)
“Making our love boxes and talking over our feelings” (kid-foster parent group)
“Bonding and the chance to express various feelings associated with loss” (foster parent)
“Was for them to listen and give us respect as a person” (birthparent)
“The heart story really made me think about something” (kid-foster parent group)
“Was when we had to talk about the past” (kid-foster parent group)
“The family portraits game and talking about being lonely also talking about how she feels” (kid-foster care group)
“the emotion” (birthparent)
“Sharing my thoughts and feelings and felt good about it.” (birthparent)
“To let our how you feel about your kids and when are you get them back” (birthparent)
“Everyone seemed to be ready to tackle problems.” (birthparent)
“We weren’t afraid to speak about our feelings as foster parents.” (foster parent)
“The heart story really made me think about some things.” (kid-foster care group)

Activities I enjoyed

-The heart story (foster parent)
 -“It brought up a lot of feelings for [my foster child]. (foster parent)
-The candle ceremony (foster parent)
 -“I enjoyed the candle. It made me feel special.” (kid-foster care group)
-Back-to-back drawing (birthparent and child)
-Tower of Trust (kid-foster care group)
- Feelings Chart (foster parent)

From all the sessions, what is the thing you enjoyed the most?

- “I enjoyed hearing the children explain their family drawings” (TFC foster parent)
- “Discussing things family likes to do together” (TFC foster parent)
- “All five weeks were very good and from time to time I will remember something I got.” (foster parent)
- “The last class” (birthparent)
- “Making chains” (kid—birthparent group)
- “Playing games and doing the activities” (kid—birthparent group)
- “Acting out in feeling charades.” (foster parent)
- “I enjoyed the tank of love.” (kid-foster parent group)
- “Having the time to spend with my foster child and getting to know about her.” (foster parent)
- “Working with good wholesome people who really care and believe in what their teaching and it goes beyond being just a job.” (foster parent)
- “Spending time with my kids. Telephone game” (birthparent)
- “Having fun” (kid-birthparent group)
- “Sharing with the others” (birthparent)
- “Acting out as a family” (foster parent)
- “Talking about family togetherness” (foster parent)
- “The wizard game” (kid- birthparent group)
- “Burning the candle” (kid-- foster parent group)
- “How you guys asked us how we felt each and every day” (kid-- foster parent group)
- “the activities” (kid—foster parent group)
- “The heart” (foster parent)
- “Everything” (foster parent)
- “Interactions with each other” (foster parent)
- “Talking and sharing our feelings” (birthparent)
- “Candle Ceremony” (TFC foster parent)
- “Today (fifth session)” (kid-birthparent group)
- “This last one with everyone saying how they feel about us and how we feel about them.” (kid-TFC)
- “Being with the kids, learning how to cope with problems” (birthparent)
- “All!” (birthparent)
- “Week five” (kid-foster parent group)
- “The games we played in CAP.” (foster parent)
- “The trust game” (foster parent)
- “The heart story” (kid-TFC)
- “The last session and the 4th session” (TFC foster parent)

Other comments

- “I love being with daddy, mommy.” (kid-birthparent group)
- “What I needed to feel; there is hope and understanding in the system.” (birthparent)
- “CAP was an enlightening experience and I hope it challenged the children to be in touch with their feelings and emotions. I am much older and feel very confident that I am in tune with my feelings and emotions and of others.” (foster parent)
- “[We] need more classes like this!” (foster parent)
- “You should have more games and more time to talk at the same time” (kid-foster parent group)

“If all this wasn’t true, I would not have wanted to come back for five weeks---thank you very much.” (foster parent)

“Do this class with all foster parents and children.” (foster parent)

“I was saddened to see that after 6 years and these 5 sessions, that my child could not verbalize or draw his feelings as to being a family.” (TFC foster parent)

“This program would be extremely helpful for new families and children entering the foster program.” (TFC foster parent)