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ORIGINAL PAPER

Attachment as a Tool in the Treatment of Children Within Foster Care

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Abstract
Despite nearly 20% of marriage and family therapists graduated from COAMFTE accredited programs work within adoption and foster care agencies, less than 5% of COAMFTE accredited programs offer formal education and guidance focusing on working with foster care children. Some estimates suggest over 500,000 children in the United States enter the foster care system every year with many of them encountering mild to severe emotional, mental, and physical health concerns. Focusing on strengthening attachment between the foster child and parent could assist in alleviating many of these concerns. In an effort to begin addressing this notable gap in training paired with a demand for competent therapists who can serve children within the foster care system, this article has a twofold purpose. First, through synthesizing existing literature this article offers context and education about adverse experiences and concerns of children in foster care. Second, through an attachment lens clinical suggestions and interventions are discussed to assist MFTs in improving many of the emotional, mental, and physical health concerns found in this population.

Keywords Attachment · Foster care · Marriage and family therapy

Introduction

The large number of children in foster care system should be of growing concern to marriage and family therapists. The Adoption and Foster Care Analysis Reporting System (AFCARS) reports that over half a million children entered the foster care system at some point in 2015. According to AFCARS, a large percentage of children in the foster care system experienced trauma with reports indicating that 61% experienced neglect, 32% had a parent that abused drugs, 13% experienced physical abuse, 10% experienced inadequate housing, 8% percent experienced parent incarceration, 6% experienced a parent that abused alcohol, and 4% experienced sexual abuse in 2014 (2016).

Due to trauma, children in foster care may be less likely to develop a secure attachment (Jankowska et al. 2015). An insecure attachment style may lead to negative mental and physical consequences. Previous research suggests that an insecure attachment style may be linked with mental health diagnoses, which in turn may negatively affect physical health (McWey 2004). Not surprisingly, children in foster care experience a higher prevalence of both mental and physical health concerns and diagnoses (McWey 2004; Szilagyi et al. 2015). Research suggests that foster children are ten times more likely to develop a mental health diagnosis (McWey 2004). In addition, 30–80% of children enter the foster care system with health issues, and close to one-third enter with a chronic medical condition (Szilagyi et al. 2015). Although addressing insecure attachment styles may improve mental and physical health, this marginalized population is often overlooked, and treatment options may be limited due to the lack of evidence-based treatments available for attachment disorders (Zilberstein and Messer 2010).

In some instances, marriage and family therapists are responding to the overwhelming needs presented by the foster care community According to assessments completed by the Counseling and Related Educational programs (CACREP) and the Counsel of Social Work Education (CSWE), almost 20% of marriage and family therapy graduates from COAMFTE accredited programs work for adoption or foster care agencies. Marriage and family therapists' education comprises an emphasis in human development, an understanding of family dynamics, and a systems theory perspective. Although this education provides a valuable

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resource, additional training addressing specific challenges unique to foster families is lacking (Weir et al. 2008). Nearly one-fifth of MFT graduates work in agencies that aid foster and adoptive families, but only 4.8% of COAMFTE programs provide specific coursework on foster care education. As a result, most MFTs learn to work with the foster families in the field without prior education (Weir et al. 2008).

The purpose of this article is to offer approaches to treating children in the foster care system with complex histories and challenges by addressing attachment needs. Our intention is to inform clinicians how to utilize attachment theory with foster families in order to facilitate emotional, mental, and physical healing. We will first describe common challenges experienced by foster youth and families. Then we will examine how attachment theory can be implemented to address trauma, stress, mental, and physical healing. Next, we explore the foster parent's role in the process of healing. Lastly, we delineate specific interventions for clinicians.

Challenges for Foster Care Families

Many children and their families within the foster care system face unique challenges. As systemic professionals, it is important for marriage and family therapists to be aware of these challenges to best treat the individual and the broader system. Although the challenges delineated below are not exhaustive, they are common concerns highlighted within the present literature and ones that we believe are notable for therapists to consider when serving children within the foster care system.

Continuity of Care

The United States holds onto values that children have the right to live with their families of origin, unless they experience harm (Leloux-Opmeer et al. 2016). Since children need to grow in an environment providing safety, support, and protection (United Nations 1989), they are placed in foster care when unstable home environments hinder development. Some avenues leading to foster care include the following: parents with substance use disorders, inadequate housing or living conditions, reported abuse or neglect, and incarcerated parents (AFCARS 2016). Although many factors contribute to foster care placement, the leading cause is child maltreatment (Sobel and Healy 2001).

Due to instability that many foster children experience once entering the foster care system, continuity of care and support is difficult to maintain. It is not unusual for a foster child to experience living with at least three different foster families (McGill 2016). In addition, many foster children experience a variety of foster care workers. The nationwide average turnover rate for social workers, many of which serve the foster care community, is less than 2 years (Strolin et al. 2007). Disrupted continuity of care can lead to complications with confidentiality, which can limit foster parents or medical professionals from accessing pertinent information (Sobel and Healy 2001). As children cycle through foster homes and social workers without a consistent advocate, valuable information regarding their health is lost (McGill 2016).

Instability can also impact the level of sex education teenagers in the foster care system receive. Sex education is often overlooked as foster children rotate through families and social workers. As a result, teenagers are often not properly educated about healthy sexuality as well as sexually transmitted infections. This lack of critical education may further complicate health issues that teenagers in the foster care system experience (McGill 2016).

Psychosocial Concerns

Many children within the foster care system experience emotional, mental, and social difficulties. In 2015, more than half experienced neglect, almost a fifth experienced some type of abuse, and nearly 70% experienced a parent who was unable to provide care due to the following circumstances: substance abuse, incarceration, death, inability to cope, and abandonment (AFCARS 2016). Not only do children enter the foster care system with a history of trauma, but removal from a family of origin and placement in a new environment can be traumatic as well (Szilagyi et al. 2015). Placement instability can exacerbate the trauma that foster children have already experienced. One study observing 1635 children in foster care reported that 41% experience three or more placements (Rubin et al. 2004). Other research suggests that adults who had been placed in the foster care system at some point during adolescence experienced post-traumatic stress disorder twice as often as combat veterans (Szilagyi et al. 2015).

Since psychological distress can play a major role with physical health (Priest et al. 2015), it is important to increase awareness of obstacles that prevent children in foster care from addressing psychosocial issues. When the presenting need is related to psychological distress, a large percentage of patients visit primary care doctors instead of mental health specialists. As a result, psychosocial issues often remain underdiagnosed (Woods et al. 2015). Among a general population, one study revealed that 46% of primary care patients surveyed indicated a need for further mental health screenings, yet only 23% of the 46% had a mental health diagnoses in their file. Psychosocial issues are often not addressed by primary care physicians because they are not adequately trained to handle mental health issues. Even physicians that receive limited training have difficulty addressing mental health issues due to job demands. To further complicate this issue, clients often underreport

symptoms. Client communication is often inhibited by concerns regarding race, stigma surrounding mental health issues, and concerns about treatment. These undiagnosed or neglected psychosocial issues can exacerbate health issues (Woods et al. 2015).

A large percentage of children placed in foster care lived in poverty prior to entering the foster care system. Contrasted to children raised in more privileged socio-economic environments, children raised in poverty are exposed to more dangers in their family and community that can affect various aspects of their lives. Some dangers include prenatal exposure to drugs and alcohol, violence in the home and community, malnutrition, and exposure to disease. Adequate resources are often unavailable to combat obstacles that children living in poverty face (Sobel and Healy 2001).

Medical Concerns

Children in the foster care system have a much higher prevalence of health issues than children in the general public (Szilagyi et al. 2015). As a result, the American Academy of Pediatrics (AAP) classified foster children as having special health care needs (Szilagyi et al. 2015). In many regards this higher prevalence of medical concerns is due to maltreatment or neglect (Sobel and Healy 2001). Maltreatment or neglect can lead to attachment insecurity, which is associated with stress and disease (Maunder and Hunter 2001). Chronic stress, combined with poor psychosocial resources and poor coping skills, is linked with both mental and physical health disorders (Schneiderman et al. 2008). Chronic stress alters the amygdala, hippocampus, and right prefrontal cortex, which leads to poor emotional regulation, aggression, hyperactivity, inattention, impulsivity, and dissociation between thoughts and emotions (Szilagyi et al. 2015). Health symptomology can increase even when chronic stress is perceived. For example, one study suggests that patients with ulcerative colitis were three times more likely to have an increase in symptomology if they experienced perceived stress for long periods of time (Szajinberg et al. 2011). Trauma-induced stress may also have a negative impact on the health of foster children as indicated by a decade long study. Traumatic experiences such as physical abuse, emotional neglect, divorce, or substance abuse experienced as a child within one's family of origin is linked with poorer health, lower overall well-being, and higher rates of disease later in life (Taylor et al. 2015). Insecure attachment is also associated with increased risk-taking behaviors that can negatively impact health (Maunder and Hunter 2001). In contrast, attachment security may buffer the negative effects of stress while also providing social support (Maunder and Hunter 2001). Social support is associated with better cardiovascular, neuroendocrine, and immune system function (Uchino 2006). Foster parents play a vital role in providing social support and helping foster children to emotionally bond. Research suggests that when foster parents demonstrate sensitivity to the formation of secure attachment, a supportive presence, and respect for autonomy, a secure attachment is more likely to form (Gabler et al. 2014).

Several factors create obstacles that prevent foster children from receiving adequate health care services. Most foster children do not receive medical, dental, vision, or other health care related screenings prior to entering the foster care system (Sobel and Healy 2001). As a result, children often enter the foster care system with preexisting conditions resulting from inadequate health care, neglect, abuse, or trauma. Unfortunately, these medical issues often persist once children enter the foster care system. Previous medical records can be difficult for foster care workers and foster families to access, masking health care diagnoses, medications, and immunizations (Simms and Halfon 1994). Incomplete medical histories make it challenging for foster parents and foster care workers to ensure that medical needs are met (Sobel and Healy 2001).

Insurance requirements create further obstacles. Children in foster care receive Medicaid, but unfortunately many health care providers do not accept this insurance (McGill 2016). Health care providers are often hesitant to offer services to patients with Medicaid due to low reimbursement from insurance companies and time-consuming paperwork (Sobel and Healy 2001). As a result, children in foster care often experience delays or are prevented from receiving quality medical care (McGill 2016).

Challenges Experienced by Foster Parents

In addition to typical challenges associated with parenting, foster parents are assailed with added difficulties. Often, foster parents are not provided with the foster child's medical or trauma history, which prevents them from connecting their foster child to beneficial resources. Additionally, inadequate training leaves foster parents unprepared for times when a foster child exhibits physical and mental health conditions. Furthermore, prejudices and misunderstandings can create a culture of isolation. The choice to become a foster parent can be misunderstood by friends, family, and community and motives are often questioned. Foster parents can experience shame over activities such as using food stamps. Often judgements are made when a child looks physically different from their parents. Some health care professionals avoid offering services to foster families due to their negative biases. In addition, it is not uncommon for foster parents to be blamed by physicians for a foster child's medical condition. Many health care providers are reticent to offer services to foster families due to the possibility of receiving a subpoena to testify in court on the foster child's behalf. The isolation,

judgement, misunderstanding, overwhelming challenges, and lack of resources may create insurmountable obstacles for foster parents (Sobel and Healy 2001).

The reunification process for biological parents and foster children can create additional challenges for foster families. Regular parent visitation is required by the Child Welfare Act of 1980 for families working towards reunification (Adoption Assistance and Child Welfare Act 1980). According to the Department of Human Services (DHS), visitation is an interactive face-to-face contact between a foster child and bio family. Visitation can include parents, siblings, and extended family members. The purpose of visitation is to help a foster child maintain an attachment to their birth families, and to alleviate a foster child's anxiety surrounding foster care placement (Department of Human Services 2007).

Regaining parental custody often hinges on the biological parents' ability to follow agency mandated steps to improve the home environment (e.g. terminating a relationship with an abusive partner, attending parenting classes, etc.), but these steps are often perceived by parents as difficult and unattainable (Nelson et al. 2000). Although the percentage of children reunified with their families in less than 12 months varies from state to state, the national average is 67.8%. For some foster children, reunification is not permanent (national average of 7.3%) and they transition back into the foster care system within 12 months (U.S. Department of Health and Human Services 2016). Research suggests that foster parents may play an important role in the reunification process (Burton and Showell 1997; Linares et al. 2006; Pasztor et al. 2005). According to Sanchirico and Jablonka, foster parent support of contact between biological parents and foster child is linked with greater biological parent participation and engagement in visitation opportunities (2000).

Research regarding visitation benefits for foster children is mixed. Some research suggests that visitation can provide benefits for children in foster care such as fewer behavior problems (Cantos et al. 1997). Additional research suggests that more frequent parental visitation is linked with stronger biological parent–child attachment, which is beneficial for families working towards reunification (McWey and Mullis 2004). Other research suggests that visitation can be an emotionally trying time for foster parents, biological families, and foster children. Some literature has suggested that foster children demonstrated negative reactions (e.g. nightmares, difficulty sleeping) surrounding visitation, even when visitation went well (Haight et al. 2002). Other research suggests that frequent parent visitation can cause a foster child to experience conflicting allegiances to biological parents and to foster parents, which is linked to both emotional and behavioral disturbances (Leathers 2003). These mixed findings may be reflective of the nature of the parent–child attachment relationship. Visitation may trigger trauma symptoms for children with an insecure attachment to their biological parent (Haight et al. 2003).

Attachment Theory

Attachment theory, developed by John Bowlby, was originally created to examine and understand an infant's bond with mothers and/or primary caregivers (Bowlby 1982). An integral component of attachment theory is Bowlby's concept of the "internal working model", or the individual's mental representation of the world, others, relationship to others, and self (Bowlby 1969/1982, 1973). Attachment theory suggests that the internal working model is influenced by an attachment figure, or caregiver (Bowlby 1969/1982, 1973). For example, a child experiencing a caregiver who is emotionally available may form an internal working model of the self as worthy of love, whereas a child experiencing a caregiver who is rejecting may form an internal working model of the self as unlovable. According to attachment theory, the internal working model shapes expectations and guides behavior (Bowlby 1969/1982, 1973) and new situations are viewed through a lens formed by previous caregiver-child experiences (Sroufe et al. 1999).

Attachment may be defined as "an affectional tie that one person or animal forms between himself and another specific one—a tie that binds them together in space and endures over time" (Ainsworth and Bell 1970). The purpose of attachment behavior is to seek proximity to or contact with an attachment figure (Ainsworth and Bell 1970; Bowlby 1969/1982, 1973). The caregiver-child interaction that shapes a child's internal working model influences a child's attachment style. Children who experience a sense of safety from their caretakers are considered securely attached, whereas children who do not experience this sense of safety may develop an insecure attachment (Zilberstein and Messer 2010). Mary Ainsworth classified attachment styles into four categories: secure, insecure/avoidant, insecure/resistant, and insecure/disorganized (Broussard 1994). Research suggests that a secure attachment is developed when caregivers are accessible, responsive, and nurturing (Atkinson and Zucker 1997). A child with a secure attachment demonstrates interest in proximity or interaction with the caregiver (Broussard 1994). In contrast, if physiological and psychological needs remain unmet, insecure attachment styles may develop (Shirvanian and Michael 2017). An insecure/resistant attachment, also known as anxious attachment, involves angry, aggressive, and resistant behavior towards an attachment figure. An insecure/avoidant attachment, also known as avoidant attachment, involves detached behavior, actively avoiding, or the turning away from an attachment figure (Ainsworth and Bell 1970). Insecure/disorganized behavior involves a combination of insecure/resistant and insecure/avoidant,

or behavior that is disorganized, disoriented, odd, or dazed (Broussard 1994). Although insecure attachments styles may be reflective of a destructive internal working model, insecure attachment styles are not necessarily a permanent condition. New narratives told by caregivers and restorative caregiver-child experiences can reshape a child's destructive working model (May 2005).

Attachment Outcomes

Developing a secure attachment has positive outcomes. Infants and children can develop a better self-esteem and self-regulation when they can rely on their caregivers (Shirvanian and Michael 2017). A child with a secure attachment is more likely to develop a sense of worth and belonging and to express negative emotions without fear of pushing a loved one away (Shirvanian and Michael 2017). Children that develop a secure attachment can internalize a sense of safety which facilitates better self-regulatory skills, social development, academic performance, higher achievement, and overall resilience (Zilberstein and Messer 2010; Shirvanian and Michael 2017). A child securely attached to a caregiver is also more apt to explore surroundings (Ainsworth and Bell 1970; Shirvanian and Michael 2017). A secure attachment promotes an adolescent's ability to adapt to circumstances as well as regulate emotions more effectively and engage in positive interpersonal relationships (Bloch and Guillory 2011). In addition, it is also linked to the prevention of mental health disorders (Shirvanian and Michael 2017). In contrast, insecure attachment is linked with negative outcomes. Insecure attachment styles are formed when the caregiver is unavailable, neglectful, or abusive (Jankowska et al. 2015). Attachment behavior is heightened when triggered by feelings of fear, distress, or the threat of separation from an attachment figure (Ainsworth and Bell 1970; Bowlby 1977; Foroughe and Muller 2011). Fear of rejection, abandonment, disappointing oneself, or disappointing others can trigger attachment threats and lead to feelings of shame, defensiveness, and self-protecting strategies (Vetere and Dallos 2008). Some research has found that children who are abused are more likely to develop an avoidant attachment, and children who are neglected are more likely to develop an anxious attachment (Jankowska et al. 2015). Chronic abuse and neglect can have long-term consequences. Research suggests that chronic abuse and neglect can disrupt the healthy attachment process and inhibit a child's ability to form healthy relationships in the future (Perry 2001). Sadly, children in foster care frequently present with avoidant attachment regardless of the type of maltreatment (Jankowska et al. 2015).

Trauma, Stress, Health, and Attachment

Children in foster care are at a disadvantage due to their exposure to adverse childhood experiences (Maunder and Hunter 2008). This is problematic because adverse experiences may prevent the development of a secure attachment to parental figures (Shirvanian and Michael 2017). Since a secure attachment is associated with improved mental stability, physical health, self-esteem, future relationship building, and other individual and systemic outcomes (Taylor et al. 2015), identifying specific adverse childhood experiences common to children in foster care may be helpful for clinicians working with this population. Children in foster care experience a high amount of loss including sibling separation, parent abandonment, high conflict, trauma, and multiple placements in different foster homes (Foroughe and Muller 2014; McWey 2004). Loss impacts emotional regulation and behavior which are linked to psychological well-being (McWey 2004). Additionally, children who experience trauma or high conflict have less psychosocial awareness and lower rates of self-esteem (Foroughe and Muller 2014). Not surprisingly, psychiatric disorders, and psychiatric medication and developmental delays are associated with disrupted early attachment (Fonagy et al. 1996; McWey 2004). Furthermore, psychological well-being is linked to physical health (Taylor et al. 2015). Thus, by addressing the attachment relationship between foster parent and child, may provide better social, mental, and physical health outcomes (Taylor et al. 2015).

Chronic Illness and Attachment

Chronically ill children have a greater chance of developing an insecure attachment style. Infants and young children with chronic illnesses are often temperamental. It can be difficult for emotional bonds to form when negative emotionality is often displayed. A study completed by Goldberg et al. (1995) followed a sample of young children with cystic fibrosis and congenital heart disease to identify connections between chronic illness and attachment. Both groups of children displayed similar results. Compared to the control group, a lower percentage of chronically ill children exhibited a secure attachment style (33 vs. 48%). In addition, a higher percentage of chronically ill children had a disorganized attachment style (29 vs. 12%). The duration of an illness can impede the development of a secure attachment. One study suggested that adapting parent–child interactions once a child recovers is difficult. Caregivers readjusted interactions with their infant if an illness lasted less than 2 weeks, but if an illness lasted 4–6 weeks, caregivers struggled to change their interactions once the child recovered. Months after recovery, caregivers still treated their child as if he or she were still ill (Minde 1999).

Stress caused by illness can also negatively impact a family's functioning and create barriers to forming secure attachments (Simms and Halfon 1994). Placement instability increases by up to 60% when foster children with health issues enter a new home. (Woods et al. 2012). This may be due stress caused by chronic illness and legal limitations. Foster parents spend time and energy taking children to multiple appointments but are restricted legally from making decisions regarding a foster child's health. Outside sources make decisions that impact the foster family's resources and quality of life (Simms and Halfon 1994).

Chronic illness is linked to behavior problems, which can impact placement stability. Children in the general population experiencing chronic illness have more behavior problems and lower emotional well-being than children without a chronic illness. A foster child's history of trauma and instability, complicated by chronic illness, can exacerbate low levels of well-being and lead to an increase in behavior problems (Woods et al. 2012).

With many children in the foster care system experiencing multiple placements and caregivers, some may argue that building a secure attachment with a temporary caregiver could be detrimental to the well-being of a foster child. The foster care system is an imperfect solution to a complex problem, but in considering whether or not foster children should form a secure attachment with a temporary caregiver, it may be helpful to consider that a positive environment of any length promotes healthy brain development in areas of personality traits, learning processes, and coping with stress and emotions (American Academy of Pediatrics 2000). With over one-third of the children in the foster care system being under the age of five (AFCARS 2016), it is vital to consider the neurodevelopment of children since much of the brain's development takes place during a child's preschool years (Brown and Jernigan 2012). Further, research indicates that foster children raised in a stable, long-term foster home are psychologically healthy (Jacobsen et al. 2014). In reality, not all children within foster care may not experience a long-term placement, however with the assistance of a clinician and an involved foster parent, a child could experience stability that is offered through an attachment focused approach. This strengthened attachment relationship between foster parent and child may then result in a plethora of positive outcomes previously outlined.

Building Healthy Attachment: Suggested Approaches

Despite research supporting the importance of secure attachment in the parent/child relationship, there is currently minimal guidance for attachment focused therapy for children in foster care. Therefore, it is vital for clinicians to implement interventions that have been proven to promote healthy bonding, through focusing on the key aspects of building attachment including empathy, mirroring, and emotional attunement (Zilberstein and Messer 2010). We propose that clinicians should utilize the following interventions Emotion Coaching, Dyadic Developmental Psychotherapy, and Trust Based Relational Intervention in order to begin the process of building a healthy bond. Each intervention focuses on important factors to build attachment. Emotion Coaching utilizes interventions to help caregivers cultivate empathy, Dyadic Developmental Psychotherapy highlights the importance of attunement, and Trust-Based Relational Intervention emphasizes building trust in order to create a space for emotional regulation through empowerment. These interventions can be utilized by clinicians to help the foster child and parent create necessary and secure bonds.

Considering the Foster Parent

Prior to reviewing the suggested interventions for clinicians to implement in the therapy room, it is important to note that it is important for caregivers to become aware how their own attachment styles impact parenting and emotional bonding. Previous research suggests that a parents' attachment experiences and overall attachment style may impact their parenting. Marriage and family therapists can educate foster parents how attachment styles impact behavioral patterns. As foster parents develop awareness of their own attachment styles, they may discover how they are impacted by their foster child's needs. For example, a foster parent with an anxious attachment style may become emotionally enmeshed with a foster child and struggle with allowing autonomy, or a foster parent with an avoidant attachment style may withdraw when a foster child expresses vulnerability. It is also important for foster parents to become aware how their attachment styles interact with the attachment style of their foster child. It takes incredible awareness on the part of the foster parent to recognize their attachment style, the attachment style of the foster child, and to respond to attachment needs in ways that facilitates healing (Walker 2008).

A foster parent's capacity to calm their own distressing thoughts and feelings precedes their ability to guide a foster child through a labyrinth of emotional reactivity (Walker 2008). Due to trauma, many foster children exhibit symptoms of post-traumatic stress disorder, making emotional regulation a challenge (Sobel and Healy 2001). It can be difficult for a foster parent who is unaware of personal emotional processes to teach a foster child how to calm emotions (Walker 2008). Marriage and family therapist can direct foster parents towards practices such as journaling, meditating, and processing emotions through creative forms such as art or music in order to become more attuned to their emotions. Foster parents can learn

that developing self-awareness of emotional experiences is a skill that can be cultivated through time, practice and solitude (Gottman 1997). Additionally, previous literature has indicated the importance of coordinating care among the many other systems and individuals possibly involved with the child including attorneys, social workers, court appointed special advocates (CASA), and others. This coordinating and communication will help all involved, including the foster parent, to better understand and support the many contexts the child is presently navigating (Scarborough et al. 2013).

Empathy

Parent empathy is associated with child attachment security (Stern et al. 2015). A foster parent's ability to view misconduct from a foster child's perspective and to identify what motivates negative behavior can facilitate emotional healing and bonding (Walker 2008). Due to past trauma, it is not uncommon for foster children to exhibit strong negative reactivity (Szilagyi et al. 2015). Demonstrating empathy while teaching a foster child to identify feelings and develop coping skills can expedite emotional bonding. Empathy plays a vital role throughout the teaching process; showing empathy towards a foster child's emotional experience also communicates respect and acceptance (Gottman 1997).

Emotion coaching is a practical intervention that can help foster parents cultivate empathy. According to Gottman, empathy is the foundation of emotion coaching and necessary for emotional bonding. Gottman (1997) developed emotion coaching to teach parents how to guide children in identifying and managing emotions. Emotion coaching may be especially beneficial to the foster care community since foster children often experience high levels of emotional reactivity (Szilagyi et al. 2015). Although parents must set limits on destructive behavior, parents can demonstrate empathy for their child's emotional experience. Empathy allows children to feel validated and understood by their parents. Trust is cultivated as parents respond with empathy instead of dismissing or criticizing emotional experiences. If emotional experiences are not accepted and validated by primary caregivers, children learn to ignore conflict and negative feelings. Avoiding conflict and negative emotionality leads to isolation, loneliness, and numbing behaviors (e.g. eating, TV, video games, substance abuse, etc.). The following five steps guide parents in becoming an emotion coach: (1) being aware of the child's emotions, (2) recognizing the emotion as an opportunity for intimacy and teaching, (3) listening empathically and validating the child's feelings, (4) helping the child verbally label emotions, and (5) setting limits while helping the child problem-solve (Gottman 1997).

Attunement

Attunement may play an important role in building attachment. Characteristics of attunement include levels of connectedness, joint attention, and reciprocity demonstrated in relationship between the caregiver and child (Woltering et al. 2015). Benefits of caregiver–child attunement are linked with better self-regulation (Calkins and Hill 2007). Lower levels of caregiver-child attunement can lead to both internalizing and externalizing negative behaviors in the child (Deater-Deckard et al. 2004). An intervention that supports caregiver–child attunement is Dyadic Developmental Psychotherapy (DDP). Dyadic Developmental Psychotherapy is a relationship-focused experiential therapy developed by the clinical psychologist Hughes (2004). Attachment theory provides a theoretical foundation for DDP, and various methods and techniques facilitate emotional bonding. Basic tenets of DDP include the following: an organized plan on how to best implement attachment strategies; intersubjective experiences characterized by shared affect/attunement; the use of PACE and PLACE; and interactive repair initiated by caregivers. Practical techniques include the following: caregiver presence, affective/reflective dialogue, responding to resistance, communication, touch, affect regulation and reflective function, and activities or objects. Although attunement is encouraged throughout DDP, intersubjective experiences facilitate caregiver–child attunement. The intersubjective experiences between a foster child and caregiver can encourage the synergistic effects of experiential reciprocity, which can lead to new perspectives that help foster children combat negative self-images stemming from traumatic experiences (Becker-Weidman and Hughes 2008).

Safety

One of the foundational aspects of building attachment is creating safety in the relationship. The foundation of a safe relationship is based on a child having consistent experiences of being protected, nurtured, and the caregiver being emotionally attuned. This responsiveness allows the child to feel safe to explore the world with reliability that the parent will be able to care for them (Zilberstein and Messer 2010). One way to create safety is through the Trust Based Relational Intervention. The Trust-Based Relational Intervention was developed specifically to cater to at-risk-children. The overall goal of this intervention is to teach caregivers to provide support, and to build trust or a secure attachment with at-risk children. The core principles of this intervention include empowerment, connection, and correction. Caregivers need to be attuned to the child's physical needs, attachment needs, and behavioral needs. Additionally, responses are categorized into four levels. Level one is Playful Engagement, level two is Structured Engagement, level

three is Calming Engagement, and level four is Protective Engagement. In each of these levels, the caregiver remains connected to the child while the child learns to self-regulate and maintain appropriate responses (Purvis et al. 2013).

Additional Resources

Although we discussed Emotion Coaching, Dyadic Developmental Psychotherapy, and Trust-Based Relational Intervention, other approaches can be used to address the attachment needs of children in foster care. Some additional approaches include: Family Attachment Narrative Therapy (Dallos 2004; Dallos and Vetere 2014; May 2005; Nichols et al. 2017), attachment-based family therapy (ABFT) (Diamond et al. 2010; Ewing et al. 2015; Shpigel et al. 2012), cognitive-behavioral and attachment-based family thearpy (CB-ABFT) (Siqueland et al. 2005), creative arts and play therapy (Malchioidi and Crenshaw 2015), and attachment in group psychotherapy (Marmarosh et al. 2013).

Conclusion

Despite the rates of MFTs serving children and families within the foster care system, there is limited training and guidance on best practices (Weir et al. 2008). In an attempt to begin addressing this gap, we offered common difficulties encountered by those in foster care as well as how cultivating a secure attachment relationship between foster child and foster parent may assist in alleviating many of the social, mental, and physical ailments that foster children encounter. We hope that this practical guidance can assist clinicians in being more informed of the unique challenges faced by this population as well as assisting these children to lead happy, healthy, and productive lives into adulthood.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Research Involving Human Participants and/or Animals This manuscript is strictly theoretical in nature, based entirely on prior research and literature. As such, there was no inclusion of human or animal research participants.

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