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SUPREME COURT
OF THE STATE OF WASHINGTON

In re the Welfare of B.P.,
In re the Welfare of K.M.M.

FILED *E*

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WASHINGTON STATE
SUPREME COURT *h*

***AMICI CURIAE* BRIEF OF DR. SUSAN SPIEKER AND DR.
MARIAN S. HARRIS, CONCERNED PRACTITIONERS IN THE
AREA OF ATTACHMENT AND CHILD WELFARE**

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ORIGINAL

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I. IDENTITY AND INTEREST OF *AMICI CURIAE*

The identity and interest of *amici* are set forth in the motion for leave to file an amicus brief, filed herewith.

II. STATEMENT OF THE CASE

Amici adopt the Statement of the Case set forth in the opinions entered by the Courts of Appeal in the respective cases, unless a transcript is otherwise cited.

III. THE COURT'S DECISIONS SHOULD BE BASED ON AN INFORMED UNDERSTANDING OF ATTACHMENT, ATTACHMENT SERVICES, AND THEIR ROLE IN PARENT-CHILD RELATIONSHIPS

This Court, in inviting this amicus brief, noted: "The records in these cases include testimony relating to services to remedy attachment issues or disorders. It may be helpful to the court, in understanding the record and addressing legal issues, to have submissions by amici curiae that have a demonstrated interest or expertise related to these matters." The following information is offered in response.

First, the complex nature of attachment must be considered. A summary definition of attachment is:

Attachment is one of a sub-set of bonds which tie one individual to another specific individual, binding them together in space and enduring over time. For reasons involving our evolutionary heritage, unless raised under highly anomalous conditions, first attachments to one or a few selected individuals are typically formed by three years of age and usually within the first year, a fact which has been confirmed across widely differing cultures.

Mary Main, Erik Hesse, & Siegfried Hesse, Attachment Theory and Research: Overview with Suggested Applications to Child Custody, 49 Fam. Ct. Rev. 426, 437 (2011), citing M.H. van IJzendoorn, & A. Sagi-Schwartz, Cross-cultural patterns of attachment: Universal and contextual dimensions, in HANDBOOK OF ATTACHMENT: THEORY, RESEARCH, AND CLINICAL APPLICATIONS 880 (J. Cassidy & P.R. Shaver eds., 2nd ed. 2008).

The literature further explains attachment for young children:

An attachment may be described as a bond which serves to focus attention on the physical whereabouts or accessibility of one or a few selected, non-interchangeable older individuals(s), whose proximity can then be sought in times of danger or fright. Separations from these selected “attachment figures” in unfamiliar or otherwise threatening environments is therefor expected to arouse distress, anxiety, or fear

Main, et al., *supra*, citing J. Bowlby, Attachment and Loss: Volume 1. Attachment (1969/1982).

Multiple attachments are common for young children; once the initial attachment has formed, the child may go on to form second attachments to another person. The second attachment may be to another parent, a grandparent, and/or a child care provider. Throughout a child’s life there are multiple attachments, because a child is capable of multiple attachments. One attachment does not have to end in order to create another attachment. Even in adolescence and in adulthood new attachments are formed with friends and romantic partners, and have the same properties of both a desire for proximity, and distress at separation. Main, et al., *supra*, at 437. The only requirement for a second attachment is that the first has occurred.

The type of attachment a child has is not stagnant. Infants tended to be secure when mother was living in favorable circumstances (e.g., financially secure), and to become insecure when her circumstances changed unfavorably. *Id.*, at 433. See also, citing B. Vaughn, B. Egeland, A.L. Sroufe, & E. Waters, Individual Differences in Infant-Mother Attachment at 12 and 18 Months: Stability and Change in Families Under Stress, 50 *Child Development* 971 (1979).

The different forms of attachment must also be recognized. Initially there were two categories of attachment were recognized— secure and anxious attachment. The category of anxious attachment was later expanded into avoidant, ambivalent, and disorganized attachment.

The percentage of the population with anxious attachment is shockingly high, indicating the impact the Court’s decision here might have:

In all versions of attachment theory, anxious attachment includes a large segment of the population (one-to two-thirds of the population), most of whom have neither psychiatric problems, nor child maltreatment of any sort. (Greenberg, 1999, Sroufe, 1988, van IJzendoorn, 1995) Thus, although essentially all families coming to court attention are characterized by insecure attachment, the overwhelming majority of insecurely attached people do not need intervention at all.

Patricia McKinsey Crittenden, Steve Farnfield, Andrea Landini & Ben Grey, Assessing Attachment for Family Court Decision Making, 15 *Journal of Forensic Practice* 237, 238 (2013).

A. The History of Attachment Theory

John Bowlby discovered and named the phenomena of attachment in the 1950s. Over a thirty year period, through his study of primate behavior, he came to believe that evolutionary theory explained the intensity of the responses of separated children from their parents. Based on the evolutionary concept of survival of the fittest children instinctively know to attach to an older individual who can protect them. Bowlby believed that a child attached to a specific non-interchangeable person with whom the child had a history of contingent social interactions. Main et al., *supra*, at 429.

The widely held belief before the introduction of Bowlby's attachment theory was that if the child was under three years old there was no harm caused by removing a child from his mother for an extended period of time. The belief was that the only reason a child missed his mother was because she had breast fed him at some point, so that anyone could step in to feed him; a child under three years old would not remember his mother long enough to be able to mourn her absence. *Id.* This resulted in hospitals providing only one hour of parental visiting time with their sick child per day, and in week long stays in nurseries while the mother went to have another baby. To demonstrate to others that these assumptions were wrong, Bowlby filmed the children to show them crying out loudly for their parent, throwing themselves about, and in every way showing how distraught they were.

In the mid-1950s another major advancement in attachment theory occurred through the work of Mary Ainsworth, a clinical and developmental

psychologist. She conducted studies on attachment in families in Uganda and in middle class Baltimore. Dr. Ainsworth first made observations in the family home and then had the parent and child come to a controlled setting. She developed a procedure, known as the Strange Situation, that took place in a toy-filled playroom to which the child was introduced by his/her mother. Two maternal leave-takings, and two reunions were orchestrated. During one separation the infant was left with a friendly stranger, while in the second the infant was left entirely alone. Separation episodes in which the infant exhibited excessive distress were curtailed, so that some procedures lasted only 15 minutes.

The results were surprising to Dr. Ainsworth and the attachment community. Less than half responded as expected by engaging in exploration and play prior to maternal leave-taking, showing distress upon separation (usually by crying), seeking proximity or contact upon reunion, and shortly thereafter returning happily to play – secure attachment. Some displayed distress throughout much of the procedure, even in the mother's presence. On reunion, proximity seeking was mixed with subtle to open anger, and the infants – usually too distressed to return to play – were termed insecure-ambivalent. In those cases the mother had been inconsistently responsive and sometimes insensitive to the child's signals when observed in their home. Other infants behaved in a detached manner, by not crying or showing other signs of distress upon separation, but rather focused upon the toys and actively avoided the mother on reunion. These

infants were termed insecure-avoidant; these mothers showed rejecting of attachment behavior in the home. Main, et al., *supra*, at 432.

Ner Littner, a child and adolescent psychiatrist, was the first to stress the importance of attachment to biological parents for youth in foster care. Littner proposed that youth in foster care who are not able to visit their families could develop an unrealistic image of their biological parents which could damage their self-esteem and ability to relate to others. In 1975, Littner declared, "For better or worse, they are his roots to the past, his support and foundation. When he is separated from them he feels that he has lost a part of himself." Lenore M. McWey, Alan Acock, & Breanne E. Porter, The Impact of Continued Contact with Biological Parents upon the Mental Health of Children in Foster Care, 32 Children and Youth Services Review 1338, 1339 (2010).

B. The Neuroscience of Attachment and Developments in Therapy

Dr. Allan Schore, renowned scientist, clinical psychologist, and clinical neuropsychologist credits Bowlby with providing the basis for the neuroscientific study of attachment:

Bowlby used the perspectives of both Freud and Darwin in order to understand the instinctive mother-infant bond in terms of psychoanalysis and behavioral biology and he even speculated about the brain systems involved in the evolutionary mechanism of attachment. Today, it is clear that framing attachment solely in terms of psychology is inadequate. And so we are now exploring the underlying neurological and biological mechanism of attachment.

Allan Schore & Jennifer McIntosh, Family Law and the Neuroscience of Attachment, Part I, 49 Fam. Ct. Rev. 501 (2011).

Dr. Schore went on to explain:

Number one, from psychology: . . . we now have good evidence that the prenatal and postnatal stages of human infancy represents the critical period for the organization of the central dimensions of the personality. Number two, from neuroscience: the peak interval of attachment formation overlaps the most rapid period of massive human brain growth that takes place from the last trimester of pregnancy through the end of the 3rd year.

Id., at 502.

Neuroscientists now agree that the essential task of the first year of life is the co-creation of a focused attachment bond of emotional communication between the infant and his/her primary caregiver. This ability to communicate emotional states and the resulting learning to self-regulate those emotional states as taught by the primary caregiver, is the basis for all subsequent social relations. *Id.*, at 503.

To understand the stressing of the attachment system during critical periods requires determining where the child is developmentally.

In the 1st year, and much of the 2nd, separation from the primary caregiver and change in caregiving arrangements are potent stressors of the right brain, and will alter its early maturation. To interpersonally stress a system while it is organizing in the 1st year will have a much more negative impact than if you exposed the child to the same stressor at 3 years. In the 3rd and 4th year of life, most children can begin to use both hemispheres to deal with stress.

Id., at 506.

Attachment trauma can cause emotional and even cognitive consequences. However as to abuse or neglect, Dr. Schore states: Relational traumas during infancy (early abuse and neglect) override all genetic, temperamental, constitutional, and intellectual factors and negatively impact right brain

development, leading to a predisposition to future psychopathologies.

Id., at 508. Neglect can have a more negative effect on brain development than abuse. Either abuse or neglect by the primary caregiver presents the greatest danger. This can lead to a predisposition to violence which affects the male brain more than the female brain. *Id.*, at 510.

Even as to working parents, Dr. Schore expresses concern for children:

Still, not one neurobiological study has been done on the brains of infants who enter early day care, yet in the United States, over 50% of mothers with children under 1 year are in the work force. Due to the poor national policy on maternal leave, many return to work after six weeks, and place the child in day care. It is now widely accepted that the quality of day care is poor in the United States.

Id., at 508.

Neuroscientist, Dr. Daniel Siegel, explained there are at least eight integrative functions that emerge from attachment experience, expressed through an area of the brain called the pre-frontal cortex, which are:

1. Balancing your body: the regulation of the heart and being in time with your own bodily experiences. . . ; 2. Attuning to others: where you are open and receptive to how they are. . . ; 3. Balancing your emotions . . . ; 4. The emotional ability to extinguish fear inside of yourself. . . ; 5. The ability to have response flexibility: to . . . stop an impulse. . . ; 6. Insight into oneself . . . ; 7. Empathy. . . ; 8. Morality: the capacity to think of the larger social good and act on that sense even when alone . . .

Daniel Siegel & Jennifer McIntosh, Family Law and the Neuroscience of Attachment, Part II, 49 Fam. Ct. Rev. 513, 515 (2011).

Research has shown that a child's attachment security is not genetically determined. A child's brain may have different models of attachment such

that he would have a secure attachment with his father, but an insecure attachment with his mother. Thus two attachments made in different ways in a child's brain. *Id.*, at 514.

Neuroscience has proven, "there are now effective mother-infant psychotherapy programs that focus on attachment." Schore & McIntosh, *supra*, at 511. These therapies can improve and enhance a child's attachment and the harm caused by the lack of a healthy attachment.

C. Only Three Evidence Based Assessments Validly Measure the Quality of Attachment

There are only three measures of attachment that provide scientific evidence: the Attachment Q-Sort, the Strange Situation, and the Adult Attachment Interview. Unfortunately, these have been more frequently and regularly used for mothers, not fathers. Main, et al., *supra*, at 449.

The Strange Situation is described on page 5, above. The Adult Attachment Interview (AAI) is a standardized protocol for assessing an adult's ability to converse coherently and collaboratively regarding their own childhood attachment-related experiences. *Id.*, at 428. Attachment Q-Sort is a systematic procedure used directly following extensive observations of children within a given parent's home environment. *Id.*, at 428. In order to conduct all of these tests, training must be done to learn how to administer the test and how to interpret the results. *Id.*, at 448. See also, McKinsey Crittenden et al., *supra*, at 244. There are no available tests that are able to quantify the quality of attachment.

D. Proven Services to Improve Attachment, Including Visitation

Babies are very responsive to methods to improve their attachment to their parent.

The goal is to enable the pair (*mother and child*) to synchronize with each other, to get the attachment system back on track developmentally, and to co-create a relational environment that optimizes brain development. When that child is older, it may take much longer to psychotherapeutically undo pathological attachment histories.

Schore & McIntosh, *supra*, at 511. In lay terms, the therapy teaches the mother to note when a child's signal (i.e. crying) occurred, interpret the signal accurately, and then respond promptly and appropriately. Parent-Child Interactive Therapy (PCIT) is an example of an effective service. This intervention focuses on teaching the birth parent specific skills for improving the quality of the parent-child relationship. It is important for children while in foster care and their birth parents to have an opportunity to maintain the attachment relationship. See generally, Mark Chaffin, Beverly Funderburk, Beverly, David Bard, Linda Anne Valle & Robin M. Gurwitch, A combined motivation and parent-child interaction therapy package reduces child welfare recidivism on a randomized dismantling field trial, 79 *Journal of Counseling and Clinical Psychology* 84 (Feb. 2011); Susan G. Timmer, Anthony J. Urquiza, & Nancy Zebell, Challenging foster caregiver-maltreated child relationships: The effectiveness of parent-child interaction therapy, 28 *Children and Youth Services Review* 1 (2006).

The International Association for the Study of Attachment (IASA) has developed a Family Attachment Court Protocol for assessment and

formulation of attachment issues. The purpose is to provide a guide to good practices and to begin a process of improving the application of attachment to family court proceedings. The IASA has found:

Currently, most information about attachment that is presented to courts is generated in informal and unique ways, e.g., through home or contact observations by many types of professionals. The observers are not trained to evaluate attachment and do not provide evidence that other professionals can view and evaluate. That is, these professionals provide expert opinion without being experts in attachment and without offering verifiable evidence for their opinion.

McKinsey Crittenden et al., *supra*, at 240.

The IASA encourages evaluators to videotape their observation of an attachment assessment (such as the Strange Situation.) This not only helps the court understand the basis for the expert's opinion, and develops a basis for comparison to other parents, but also, allows the parent to actually see how they acted during the assessment. Parents who seem positive and caring may not realize that their actions may be ignoring of, or withdrawing from, the child. Effective interventions can be developed to address these issues with the parent. *Id.*, at 240-241.

For children in foster care, the first service that is needed to benefit the child and the child's attachment to his/her parents is visitation. Visitations are infrequently used to provide services to facilitate or enhance the attachment. Visitation may be the most often lost opportunity.

In a study examining depression and externalizing problems of children in foster care, the writers found:

The theoretical assumptions associated with the importance of visitation for children in foster care and their biological parents have been empirically tested. Some studies show that continued contact between children involved in the foster care system and at least one biological parent is positively correlated to children's current well-being (Cantos, Greies & Slis, 1997; McWey & Mullis, 2004). Simsek, Erol, Oztop and Munir (2007) found that regular contact with parents was a significant protective factor against internalizing and externalizing problems. **Researchers have also demonstrated that children who continue to visit their biological parents tend to form new relationships with fewer relationship difficulties.** (Egeland & Stroufe, 1981; Finzi et al., 2001; McCarthy & Taylor, 1999; Wekerle & Wolfe; 1998.)

McWey et al., *supra*, at 1339 (emphasis added).

However, using visitations to observe and make a determination about attachment is not effective. A child who may appear to have an insecure attachment (clinging to the mother), may be displaying a secure attachment by using the parent as a safe haven. Wendy Haight, Jill Doner Kagle, & James E. Black, Understanding and Supporting Parent-Child Relationships during Foster Care Visits: Attachment Theory and Research, 48 Social Work 195, 201 (2003).

A recent study conducted over a two year period in Washington State called Promoting First Relationships (PFR), was promising. The program set out to improve attachment. The study was:

Based on prior research services to support birth-to-three children who have been reunified with their birth parent must work in the "real world", which means they should be short-

term, efficient, and feasible. The results of a comprehensive meta-analysis . . . indicated that home visiting services, which are the most feasible for reunified birth families given the demands of full-time parenting, the need to participate in mandated services and transportation barriers, are most efficient when there are fewer than 16 sessions and when the service uses video feedback.

Monica L. Oxford, Maureen Marcenko, Charles B. Fleming, Mary Jane Lohr, & Susan J. Spieker, Promoting Birth Parents' Relationships with Their Toddlers Upon Reunification: Results from Promoting First Relationships Home Visiting Program, 61 *Children and Youth Services Review* 109, 111 (2016). The conclusion of the study found that the parents saw their child in a more positive light and demonstrated improved parenting behavior. *Id.*, at 115.

E. Attachment Disorders

A proper understanding of attachment disorders is needed here; they are the psychological effect of significant social neglect, that is, the absence of adequate social and emotional caregiving during childhood, disrupting the normative bond between children and their caregivers. These disorders, formerly considered a single diagnosis, are now, according to The Diagnostic and Statistical Manual of Mental Disorders (hereinafter DSM-V), divided into reactive attachment disorder (RAD), and disinhibited social engagement disorder (DSED). The following are the symptoms of RAD:

- A child who rarely or minimally seeks comfort when distressed
- A child who rarely or minimally responds to comfort when distressed
- Minimal social and emotional responses to others
- Episodes of unresolved irritability, sadness or tearfulness
- Limited expressions of positive affect or joy
- Evidence of inadequate basic emotional and social caretaking.

DSM-V, 265 (Am. Psychiatric Ass'n 5th ed., 2013); Matt Woolgar & Stephen Scott, The negative consequences of over-diagnosing attachment disorders in adopted children: The importance of comprehensive formulations, 19 *Clinical Child Psychology and Psychiatry*, Jul. 2014, at 355.

DSM-V requires social neglect (defined as an absence of adequate caregiving during childhood) for a diagnosis of either RAD or DSED. Their common etiology notwithstanding, the two disorders are expressed in distinct ways. RAD is expressed as an internalizing disorder with depressive symptoms and withdrawn behavior, whereas DSES is expressed through disinhibition and externalizing behavior. No specific physical signs of attachment disorders exist. The specific DSM-V diagnostic criteria for RAD are as follows:

- A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers
- A persistent social and emotional disturbance
- A pattern of extremes of insufficient care
- The care described in the third criterion is presumed to be responsible for the disturbed behavior described in the first criterion
- The criteria for autism spectrum disorder are not met
- The disturbance is evident before age 5 years
- The child has a developmental age of at least 9 months

DSM-V, *supra.*, at 265; Woolgar & Scott, *supra.*, at 355.

IV. ERRONEOUS POINTS REGARDING ATTACHMENT IN BP AND KMM

There are a number of statements in BP and KMM regarding attachment that are inaccurate and misleading. In BP, the statements from the counselors, Lori Eastep, a family therapist, and Carol Thomas, the parenting

assessment provider, are contrary to the body of knowledge and evidence-based studies in the attachment theory field.

A child is not limited to one attachment at a time. Ms. Eastep alleges that if a child already has a secure attachment with one person, the child will not attach to another. Opinion-Dissent p. 11. As cited above, the exact opposite is true. After a child has one attachment then multiple attachments can occur and they can be secure attachments, Main et al., *supra*, at 438. There may be a different quality of the attachments, but a child should and at age two would have more than one attachment - their other parent, grandparent, aunt, uncle, etc.

In the case of BP, since she lived solely with her mother from September of 2011 to July of 2012, BP should have had a fully formed attachment to her mother which had developed over the entire first year, as attachments typically do. This is an important foundation, developmentally. BP may have a preverbal, body memory of her mother's face, voice and smell that would contribute to her re-attachment to her mother. The number of placements BP had is not healthy for any child and may have harmed her. However, return to a primary attachment figure is unlikely to be causal of attachment disorder as long as enough support is provided. If Ms. Eastop is correct that BP had an attachment to her foster parents then that should be taken as a positive sign that she could re-attach to her mother.

There is no set period of time that it takes to establish an attachment. As Dr. Ainsworth's study in Uganda in 1967 showed, the parent's responsiveness rather than the physical care or simple amount of

time spent with the infant was more likely to lead to attachment formation. Main et al., *supra*, at 439. Both Ms. Eastep (Opinion p. 8) and Ms. Thomas (Opinion-Dissent p. 13) unexplainably thought it would take a specific number of contacts (hundreds to thousands of contacts) and one year to attach, respectively. Ms. Eastep and Ms. Thomas are espousing falsehoods as conclusive facts. There is no basis in science to come to either conclusion.

The information referenced by the court does not provide a basis to conclude that the child would be unable to form an attachment with the mother. In a re-unification setting, the development of adequate attachment relationships between the child and her foster and biological parents should be supported. One is not exclusive of the other. Haight et al., *supra*, at 198.

KMM: In KMM there is no evidence that the issue between the father and daughter is attachment. This may be a situation where there are other psychological and/or developmental issues for this child that is causing her not to want to see her father.

V. CONCERNS REGARDING USE OF ATTACHMENT THEORY IN DEPENDENCY CASES

Dependency cases should be about the child's well-being which in the context of attachment theory means protecting and furthering a child's attachment to their parent. Attachment theory should not be a justification to prevent reunification with the child's parent. The exact opposite is true if the child's best interest is to be served by the system, because a child is best served by having the attachment strengthened with the parent as that parent

corrects their parental deficiency (i.e. drug/alcohol, mental health, etc.) The failure of the system to safeguard the child's attachment to the biological parent, and to facilitate not only the child's attachment to his/her foster parents, but also to the parent should not be the basis to terminate parental rights, but should be a necessary service to be offered and provided throughout the child's time in care.

Face-to-face visitation as well as therapeutic visitation to strengthen the attachment must be provided. A parent's inability to support an attachment due to a limitation of the parent (mental health issues) is very different and should not be treated the same by the courts as the child welfare agency failing to provide the opportunity to form the attachment.

Studies have shown that there are basic services and practices that should be implemented to keep a child safe. Simply removing a child from a dangerous home environment is not enough to protect a child's right to basic health, safety and welfare. The following provides just the bare minimum of what should be done for children taken into the child welfare system.

1. Prevent multiple placements for infants and toddlers in foster care. Attachment is one of the most critical developmental tasks of infancy. Early relationships and attachments to a primary caregiver are the most consistent and enduring influence on social and emotional development for young children. Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments. Multiple placements

present a host of traumas for very young children. See, From Neurons to Neighborhoods: The science of early childhood development (J. Shonkoff & D. Phillips eds., 2000).

2. Ensure developmentally appropriate visitation practices for infants and toddlers in foster care. One of the major challenges faced by young children in foster care is maintaining attachment relationships with their parents. Infants and toddlers build strong attachments to their birth parents through frequent and extended contact. There is widespread consensus that one of the best predictors of successful family reunification is frequency of parent-child visits. It is highly significant to have early and regular parent-child visits soon after the child is placed in foster care. See generally, Marian S. Harris, *Racial Disproportionality in Child Welfare* 36-90 (2014); P. Hess & K. Proch, Visiting: The heart of reunification, TOGETHER AGAIN: FAMILY REUNIFICATION IN FOSTER CARE (B. Pine, R. Warsh & A. Maluccio eds., 1993); A. Maluccio, E. Fein & K. Olmstead, Working with Children, PERMANENCY PLANNING FOR CHILDREN: CONCEPTS AND METHODS 156 (1986); McWey et al., *supra*.

3. When young children are placed in foster care, AFSA requires states to provide services that enhance birth parents' capacity to provide care for their children. Therefore, foster care placement or risk of foster care placement can provide an opportunity to provide specialized services that improve the quality of the parent-child relationship. An intervention with research support in the child welfare field is Parent-Child Interaction Therapy (PCIT). This intervention focuses on teaching the birth parent

specific skills for improving the quality of the parent-child relationship. It is important for children while in foster care and their birth parents to have an opportunity to maintain the attachment relationship. See generally, Chaffin et al., *supra.*; Timmer et.al, *supra.*

4. Early child development research shows that babies 4 months old or younger can experience depression; babies as young as 6 months old suffer long term effects from witnessing trauma, and babies as young as one month old can sense whether or not a birth parent is depressed or angry and is affected, therefore, by her/his parent's mood. Judge Cindy Lederman, Joy D. Osofsky & Lynne Katz, When the bough breaks the cradle will fall: Promoting the health and wellbeing of infants and toddlers in juvenile court, 52 *Juvenile and Family Court Journal*, Sept. 2001, at 33. Consequently, it is imperative to assure that infants and young children in foster care receive early childhood mental health assessment and treatment services. It is also important to remember that birth mothers also experience trauma when the attachment relationship is disrupted because their children are placed in foster care and need services to address their traumatic experiences. See generally, Marian S. Harris, Adult attachment typology in a sample of high-risk mothers, 81 *Smith College Studies in Social Work* 41 (2011); Lederman et al., *supra.*

5. Finally, when there is a disruption of the attachment relationship it is important for children to be placed in an environment where they can have healthy emotional development; this type of development can only occur when children have a caregiver who responds to their needs in a nurturing

and caring manner. Birth parents need to receive services that assure the attachment relationship with their children is maintained when children are placed in foster care. It is critical that child well-being be the first priority in all child welfare cases.

The child welfare system should not create attachment issues for the child by having multiple placements for the child, and the court needs to step-in to prevent that from occurring when it is happening not merely comment on it at the termination trial.

VI. CONCLUSION

Given the prevalence of insecure attachment (one- to two-thirds of the population), an insecure attachment should neither be a basis for State intervention nor the basis to terminate parental rights.

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