Oppression and Addiction Break Families

Calling Somatic Practitioners to Repair Attachment

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ABSTRACT

This article reviews the literature related to the disproportionate representation of Black, Indigenous, and other People of Culture children raised in the foster care system. We address the role of bias in referrals made to Child Protective Services, and situate that bias in the greater systems of traumatic oppression that both shape referring professionals' perspectives and systematically wear down families who are pressed to the margins of society, increasing their risk for referral. We explore the role of addiction as a common trauma response and etiology implicated in foster care involvement and question how families are inequitably punished for it. Finally, we call on trauma-informed, anti-oppressive somatic practitioners to help break the cycles of addiction, insecure attachment, involvement in the foster care system, and compassion fatigue for those in its trenches.

Keywords: Addiction, attachment, disproportionate representation, foster care, oppression

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The foster care system in the United States has previously maintained roughly 440,000 children entering into state-run care since 2012 (ACF, 2021; VFC, 2023). With the onset of the COVID-19 pandemic in 2020, the number of children residing in the state-run system decreased to consistently remain at roughly 400,000 children (ACF, 2021). There are also possibly hundreds of thousands more in informal kinship or community care that are not accounted for in official federal or state numbers (Gupta-Kagan, 2021), known in foster care culture as "sweetheart placements." These placements do not seek state funds to subsidize the cost of caring for these children, and therefore are not trained or regulated by the state-run system in their oversight.

The foster care system was originally intended to provide a safe haven for children as they or their families of origin experience adversities. According to the National Children's Alliance, parents have lost custodial rights because Child Protective Service workers determined "more than 75% of victims were neglected, 16% were physically abused, 9% were sexually abused, and 0.2% are sex

trafficked" (2023, p. 1). However, statistics show that grossly disproportionate numbers of children are referred to and remain in the foster care system based on race and ethnicity (ACF, 2023; Merkel-Holguin et al., 2022; Yi et al., 2023). In the 2020-2021 fiscal year, 391,098 children were living in the state-run foster care system, with 222,110 (60%) identifying as a race other than white (U.S. Department of Health and Human Services, 2022). Given the United States is 75.8% white alone, and therefore approximately 34% Black, Indigenous, other People of Culture (BIPOC; Menakem, 2022), and mixed (United States Census Bureau, 2023), this egregious disparity requires critical examination and anti-oppressive intervention.

For instance, compared to white children, Native American children are 18.2 times more likely to enter foster care. Children identifying as two or more races are 5.1 times more likely to enter foster care. African American children are over 2.9 times more likely to be placed in foster care (U.S. Department of Health and Human Services, 2022). Also of consideration is that a systematic review found "a parent with a learning disability or substance abuse concern, or a family with a larger number of children, receiving public benefits, or experiencing housing instability were significantly associated with decisions to investigate (for abuse)...suggest(ing) that decisions to investigate need to be considered in a wider context, including how vulnerable populations are supported in communities and society" (Damman et al., 2020, p. 801).

The National Coalition for Child Welfare Reform works to make these racially and economically-driven disparities known, and to change the law accordingly (2023). Areas of concern that highlight oppressive experiences for foster children and families include the mandated reporting and investigation referral process, removal process, family team, decision-making meetings, treatment planning meetings, and medical or mental health treatment toward reunification or permanency planning (AAP, 2015; Merkel-Holguin et al., 2022; NCCWR, 2023; Raz, 2022). Additionally, many planning meetings resemble more traditional case management meetings that are directed by one or a small group of child welfare system employees in power, further limiting the voice of birth families, foster families, and the child directly (Merkel-Holguin et al, 2022). As summarized by Merkel-Holguin, "what is supposed to be a support

system to protect the most vulnerable has morphed into a fortified composite of structures and administrative barriers that are not only dismembering the family network and thus harming children, but also perpetuating discrimination" (2022, p. 1). This is further clarified by the Child Welfare Information Gateway:

> Racial disparities occur at nearly every major decision-making point along the child welfare continuum. At the national level, African-American families are overrepresented in reports of suspected maltreatment (Krase, 2013) and are subjected to child protective services (CPS) investigations at higher rates than other families (Kim et al., 2017). In addition, African-American and American Indian or Alaska Native children are at greater risk than other children of being confirmed for maltreatment and placed in out-of-home care (Yi et al., 2020). Families of diverse racial and ethnic backgrounds also experience disparate treatment once they are involved with child welfare. Relative to other children, African-American children spend more time in foster care (U.S. Government Accountability Office, 2007a) and are less likely to reunify with their families (Lu et al., 2004), and compared with White children, they are less likely to receive services (Garcia et al., 2016). In addition, African-American and American Indian or Alaska Native children are more likely than other children to be removed from their homes (Maguire-Jack et al., 2020) and to experience a termination of parental rights (TPR) (Yi et al., 2020; CWIG, 2021, p. 3).

These unjust facts mean that marginalized families are at higher risk for systematic disruption of their potential to develop secure attachment between generations, and merit enhanced therapeutic attention toward the goal of secure attachment.

Attachment factors

According to the American Academy of Pediatrics (AAP), attachment is defined as "the relationship between two people and forms the basis for long-term relationships or bonds with other persons" (AAP, 2000, p. 1146). Attachment theory is used to explore the relationships between a primary caregiver and child. Grounded in his early study of maternal deprivation (1951), Bowlby proposed that an infant child requires a stable, ongoing relation-

ship with a loving caregiver as foundational for a healthy experience of their development (Bowlby, 1988; Bretherton, 1992; Nowacki & Schoelmerich, 2010). Through a comprehensive global research program now spanning six decades, attachment studies have found the expanded elements of how biopsychosocial attachment can influence a child's ability to connect with caregivers and peers, as well as the lifelong conferral of benefits or pitfalls depending on how well attachment forms across a spectrum (Coker et al., 2023; Harlow, 2021; Karen, 1998).

Children form either more secure attachments or more insecure attachments (which further differentiate into anxious-ambivalent, anxious-avoidant/resistant, fearful-avoidant/disorganized). Secure attachment is established by having at least one caring and consistent parental figure during their early childhood developmental years, thus encouraging the positive view of self-worth and confidence in the child's relationship with themself and with others (Bowlby, 1969; Miranda et al., 2019). Counter to this, insecure attachment occurs when a child does not feel a stabilizing secure and/or emotional bond with their primary caregiver. This may be influenced by the child's experiences with caregiver inconsistencies, abuse, neglect, maltreatment, or other adverse experiences (Miranda et al., 2019). Insecure attachments experienced in childhood can lead to higher risks of chronic medical diagnoses (e.g., higher blood pressure, risk of stroke, etc; Lewczuk et al., 2021; McWilliams & Bailey, 2010; Pietromonaco & Powers, 2015), personality disorders, mood disorders, lower educational attainment, relational instability, and fiscal instability in adulthood, as well as conferring insecure attachment on one's offspring (Miranda et al., 2019).

For those who end up insecurely attached, the key missing feature appears to be *secure base provision*, which includes soothing a baby to a "fully calm and regulated state while in chest-to-chest contact …(so the) infant learns…whether the caregiver can be counted on to be available as the infant achieves a calm state or whether (they) typically must stop crying alone" (Woodhouse et al., 2020, p. 249). When babies are born into situations where this regularly occurs, the emotional stability and availability of the caregiver is more likely to remain consistent over time and adjust accordingly as the

baby matures (Coker et al., 2023). However, when this preliminary co-regulation is not provided due to caregiver limitation, the available evidence suggests that subsequent adjustment for developmentally-appropriate caregiving continues to be lacking, for any host of reasons (Coker et al., 2023).

Many children living in the foster care system are faced with limitations in consistencies that may further impact their development and ability to form secure attachments after their preliminary opportunity with family-of-origin caregivers was interrupted. Their developmental interruptions are continuous and multifaceted due to ongoing movement between placements and providers; they face the obstacles of building lasting attachments with foster parents/caregivers, peers, teachers, and family members, as well as medical and mental health providers (Mountjoy & Vanlandingham, 2015). Additionally, they face limitations in building socioemotional attachments that can buffer against the development of chronic physical health conditions and increased mental health concerns (e.g., PTSD; Bartlett & Rushovich, 2018; Jacoby, 2021). As one foster youth stated to a current author in their role as newly assigned counselor, "I'm just gonna call you #14".

Unfortunately, limited research has been published to date on the relationship between attachment styles and foster or alternative care (Garcia Quiroga & Hamilton-Giachristis, 2016; Miranda et al., 2019; Schofield & Beek, 2009). However, research on children raised in orphanages, and the known experiences that children living in foster care often have, the available literature suggests that children who feel like they lack control, have experienced caregiver and placement inconsistencies, and who have experienced abuse or neglect in some form are much more likely to form insecure attachments (Jacoby, 2021; Karen, 1998; Miranda et al., 2019; Schofield & Beek, 2009). Systematic review has found that the more diffuse the caregiving across disparate providers, the more disorganized the child's attachment strategies are likely to be (Garcia Quiroga & Hamilton-Giachristis, 2016).

Addiction's role

Addiction is increasingly understood as a symptom of coping with a toxic culture (Maté, 2022). For multiple stress families continually pressed

to the margins of society in the pigmentocracy of a white body supremacist structure (Menakem, 2022), numbing the pain of chronic oppression with substances makes perfect sense (Maté, 2022; Menakem, 2022). Based on the rates of substance use in the last year across racial and ethnic demographics (Center for Behavioral Health Statistics and Quality, 2021, pp. 36-40), it appears financially and racially privileged families (i.e., insured and white) may be presumed to often receive the benefit of the doubt and enhanced access to support where substance use and addiction may be implicated in any form of CPS involvement, given white families' underrepresentation in the foster care system.

As affective science moves somatic interventions from the niche to the gold standard, somatic practitioners will increasingly be needed by addiction centers. The United States Association for Body Psychotherapy is making inroads with addiction treatment centers to begin including somatic interventions in their holistic treatment (LaPierre, personal communication, May 2023). This is a pathway for somatic practitioners to prevent or reduce child abuse and neglect, intervene with adults who suffered child abuse and neglect, and therefore play a significant part in reducing the attachment trauma moderated by addiction and child welfare. For somatic practitioners who do not enjoy working with children directly, working with adults and parents on harm reduction and abstinence programming through skilled somatic care can reduce their risk of relapse, and potentially, child welfare involvement.

Oppression as moderator

Marginalization in a capitalist society. Historically, children were removed from their homes of-origin predominately for living in poverty (Raz, 2022). The framework of the foster care system shifted to include removal due to poverty and other adverse experiences in the late 1960s, when the development of Parents Anonymous support groups led to panic about child abuse rates, predominantly targeting African American families (Raz, 2022). This foundation for removing children based on familial wealth and historical racialized trauma has perpetuated the ongoing marginalization of children and families. Although the foster care system has been reorganized and redeveloped since its

inception, the structure and bias that still exists in the child welfare system reinforces the undesirable outcomes of oppressive experiences upon children, particularly people of culture (Merkel-Hoguin et al., 2022).

The issues of marginalization and racial disproportionality in the foster care system are representative of the ongoing systemic prejudice within the U.S. (Ackerman, 2017). When a child enters foster care, their birth family and foster families are in need of support and services to help facilitate the child's healthy development and attachment (Ackerman, 2017). Unfortunately, birth families involved in the foster care system report many barriers to receiving support and services for themselves and in attending to their child's needs. Foster parents also report feeling inadequately trained to offer a safe space for a child in their home, and receive poor compensation from the foster care system to support the needs of the child (Ackerman, 2017).

Resource limitations

As addressed previously in this article, inequities regarding access to resources for children living in foster care, as well as for their birth families and foster families, are implicated in the quality of intervention necessary to maintain families intact. There is a tremendous amount of medical and social services literature that addresses the needs of children in foster care; however, recommendations on the frequency of care and care coordination remain scarce (AAP, 2015). Additionally, the literature is focused on white individuals and built on persistent systemic and institutional racism, with limited information on how to support BIPOC children. BIPOC children living in foster care are at increased risk for unmet culturally-affirming mental health and physical health needs. However, they are less likely to receive or benefit from the services available due to accessibility and availability limitations, appropriateness of treatment or provider, and stigma-based experiences that clients or families hold towards providers based on negative personal experiences (Metzger et al., 2023).

Public education. Families pressed to the margins need public education to introduce and develop skills to break problematic patterns arising from unresolved historical trauma and ongoing oppres-

sion. For instance, it is increasingly standard for basic sexual education to be taught through physical education courses, or specific guest lectures structured for the developmental stage of the audience in elementary and junior high public schools. However, it is not standard for all public education students to be taught about healthy boundaries, domestic violence, how to protect themselves from abuse, or how to prosocially assert themselves when raised with neglect. It is also not common for all students to be taught about the centrality of attachment, how human beings are wired to stick to people and be deeply shaped by them, whether or not the relationship is healthy. This means that the general public often copes with whatever attachment or substance use pattern they have been handed without really knowing there are other options, unless they happen to end up in therapy at some point with an attachment-oriented or recovery provider.

Therefore, another way somatic practitioners can improve the lives of the public. and hopefully reduce child welfare involvement, is to provide outreach psychoeducation through their local school districts. Providing family information nights and large-scale presentations to entire classes and schools is another way to make explicit how important sobriety and secure attachment are, how to get help to improve attachment or harm reduction at home, how to heal our own attachment wounds, and how to connect with local providers for more in-depth, ongoing help. Sending out information and resources about earned secure attachment to all families in a district through a weekly email can also begin to plant seeds for families who may know they need help, but aren't sure where to start.

Limited access to services. Unlike adult clients with means, who can choose to self-refer to a consistent provider of their preference, families at risk and children who have been pulled from their families are at the mercy of county mental health safety net systems. These safety net systems have a very high bar for entry due to the limited public funding they draw upon to run, and have high turnover due to burnout, low pay, little room for advancement, and other quality of life impingements that can make these jobs unsustainable (AAP, 2015; SAMHSA, 2022). Furthermore:

> Healthcare access for traumatized children is time-consuming and challenging. Care coordination is particularly difficult for children in foster care because of the transient nature of the population and diffusion of authority among parents, child welfare, professionals, and courts. Receipt of health care is often fragmented and crisis-oriented rather than planned, preventative, and palliative. Evidence indicates that FP and CW may not fully appreciate all of the child's health conditions and lack the expertise to access and negotiate a complex health care system on behalf of children with significant needs (AAP, 2015, p. 1133).

Clearly, somatic practitioners can help these overwhelmed systems by offering sliding scale services for the frontline workers and foster care providers and children. Monthly trainings and support groups for workers, and consultations with management to support more coherent and cohesive functioning, is also another way bottom-up processing can be infused into systems these marginalized clients must navigate. Regularly bringing embodied regulation into these systems that must down-regulate so much activation can help reduce the load on frontline staff, which theoretically will reduce fragmentation and crisis reactivity over time.

Lack of public systems investment. The Mental Health Services Act does occasionally support basic professional development (i.e., completion of a master's degree) of some qualifying county safety net workers. Unfortunately, public mental health workers are largely undervalued, much like public school teachers, and find themselves barely able to care for their own financial and physical needs month to month. Chronic stigmatization about mental health needs crosses all demographics, but the result is that widespread acknowledgement about what is needed for human beings to function well still isn't part of the cultural fabric in most countries, and being a part of the public mental health workforce can therefore be a lonely experience for workers (Stuber et al., 2014). The grant funding necessary to provide enhanced trauma resolution training for the public mental health workforce is very scarce, which creates competition amongst lateral programs to fight over who is worth training. Given there is not much power or glory from working in public safety net settings, one must have a deep sense of internalized purpose and calling to sustain the emotional demands,

while knowing there is no natural stopping place with the work. This results in predictable risk factors for all levels of public systems workers, some of which can become irreversible if not tended to vigilantly.

Compassion fatigue. Compassion fatigue, also known as vicarious traumatization in the helping professions, is a chronic risk factor for child welfare workers (Allen, 2010; Campbell & Holtzhausen, 2020; Conrad & Keller-Guenther, 2006; Zerach, 2013). The vulnerable populations they serve, their high caseloads, the helplessness to change the systems they operate in, and the sense of inevitability of poor outcomes can compound general burnout and ongoing exposure to traumatized clients into a sense of being traumatized by one's work (Audin et al., 2018; Rothenberg et al., 2008). Compassion fatigue can affect entire organizations, thus reducing the perception of available support for workers to recover from the ongoing demands they face, and normalizing a dismissive tone to human needs and feelings (Sinclair et al., 2017). This erosion of the capacity to empathize with client stories and needs can result in the silencing response, whereby the helping professional directly or indirectly shuts down client processing of overwhelm and pain (Chun et al., 2023).

Compassion fatigue can also impact foster care providers' sensitivity to foster children's needs (Teculeasa et al., 2022). Given the shortage of foster care providers and workers, the resource limitation of compassion satisfaction likely effects everyone who finds themselves trying to navigate the demands of this system, and merits therapeutic support from skilled trauma professionals who are not absorbed in the system itself. This is another way somatic practitioners can bring their advanced skills to bear for the good of all involved, by offering bottom-up training and group support to the care providers and workers who uphold the majority of front line service.

Placement instability. While living within the foster care system, the fluidity of placement creates instability for many. Children may experience placement disruption for a number of reasons, including demonstrated negative behaviors, maltreatment from caregivers, unsafe living conditions in foster homes, and state mandates indicating removal (Jacoby et al., 2023). Additionally, factors including age and race also indicate higher rates of place-

ment instability among children living in foster care (Jacoby, 2021; Koh et al., 2014). Within the current literature available, it remains unclear as to why children of culture experience higher rates of placement disruptions. Some studies have predicted that this may be due to the over-representation of Black children living in the foster care system, while others have indicated that this may be because BIPOC children seem to have longer stays in the foster care system compared to white children (Foster et al., 2011; Kennedy et al., 2022; Sattler & Font, 2021). However, literature is available on the psychological impact experienced by children living in foster care due to placement instability (Ackerman, 2017; Greiner & Beal, 2017; Turney & Wildeman, 2016, 2017). At this time, a lack of adequate samples is available to provide further explanation for this inconsistency in the foster care system. The current authors posit that the historical and persistent institutional trauma of racism does not have a null effect on the over-representation of BIPOC children placed in foster care, the lack of consistency and equitable care provided to them once in it, and the length of time they are held in it rather than returned to their families because culturally-affirming, anti-oppressive, effective intervention has been provided.

In utero substance exposure. Fetal alcohol spectrum disorder is an over-simplified diagnosis that is prevalent and yet underdiagnosed (Weir, 2022); Alcohol-related neurodevelopmental disorder also does not clearly capture the synergistic effect drugs of abuse tend to have when any combination cross the placental barrier and impact the developing fetal brain and nervous system (AK Child & Family, 2020; Chasnoff et al., 1982-2015; Hagan et al., 2016; Peterson et al., 2020; Ross et al., 2015). The DSM-V has most recently attempted to capture the effect of *in utero* substance exposure with the "other specified neurodevelopmental disorder associated with prenatal alcohol exposure" (American Psychiatric Association, 2013; p. 86). However, none of these diagnoses acknowledge exposure to any other substances. Thus, the general mental health practitioner attempting to anchor services to an accurate diagnosis justifying medical necessity and related treatment planning may overlook research and training for nervous system and behavioral implications of a wide variety of drugs of abuse. This gap in understanding by clinical faculty and supervisors can result in misdiagnosis of chil-

dren, resulting in well-intended but insufficient treatment planning (Chasnoff et al., 2015). This problem is statistically significant, as Peterson and colleagues found that more than 60% of pregnant women report using illegal substances, and 15% have a substance use disorder. These women are often younger and experiencing material and social deprivation. Owing partially to its decriminalization, marijuana use during pregnancy has increased nearly seven-fold in the past decade. The U.S. opioid crisis has been associated with a concomitant epidemic of use among pregnant women, and with withdrawal syndromes in their prenatally exposed newborns. Cocaine use remains relatively stable, with approximately 750,000 pregnant US women using this drug annually (2020, p. 832).

Training to identify the genetic and epigenetic risk factors, facial dysmorphology, sensory processing and nervous systems difficulties, and complex learning and behavioral disorders typical of substance-exposed newborns (SEN; West et al., 2020a), neonatal abstinence syndrome (NAS; Wachman et al., 2018), and *in utero* substance-exposed children can be obtained through Arizona Trauma Institute (2021), Children and Family Futures (2023), Children's Research Triangle (2015), and the National Center on Substance Abuse and Child Welfare (n.d.), among other options local to practitioners' region of service. Wraparound service on a team addressing various family members and their relational needs is indicated. Thus, somatic practitioners with a heart for this work are encouraged to network through training sites to offer bottom-up trauma resolution and self-regulation skills via family therapy whenever possible (DiClemente et al., 2021).

Clinical and advocacy considerations

Prevention. Ideally, families at increased risk of referral to Child Protective Services would consistently be offered preventive support and intervention through community mental health agencies and preschools that are funded by grants so that the service is not experienced as a punitive requirement that must be chosen over food, rent, or medicine. Unfortunately, such prevention is not widely available. Larger metropolitan cities and some more rural towns are home to community-based agencies that seek related grant funding. Such

funding sources are often kept private-facing by the agencies in question to reduce stigmatization of families receiving services through them. However, the savvy clinician can run a search on child abuse prevention grant award winners in their area to find a list of recent awardees who would likely be grateful to have skilled trauma therapists provide prevention services, supervision, and/or line staff training. Therefore, somatic practitioners who have a heart for multiple-stress families and attachment trauma work are encouraged to consider offering supervision and/or direct preventive outreach to families at elevated risk through local community-based agencies that seek funding from the Office of Child Abuse Prevention (OCAP, 2023), Community-Based Child Abuse Prevention (Children's Bureau, 2022), etc.

Practitioners working in these or primary care settings may help interrupt *in utero* substance exposure by training as a perinatal educator, facilitating pregnancy dialogues (APPPAH, n.d.), and/or integrating Chasnoff's 4 P's Plus (2005), or the "I am Concerned..." booklet and shaking baby video with pregnant parents (NTI Upstream, 2020). Consultation with primary care providers and extended family networks to support substance recovery efforts are often necessary to support gestating parents who are early in Prochaska's stages of change (DiClemente et al., 2021). Those who specialize in this family development stage need to know that while many medical doctors were trained to believe that up to one drink per day is healthy for a pregnant parent, Chasnoff's decades of research have shown that no amount of alcohol or other substances, including tobacco, are safe for the developing fetus (Chasnoff et al., 1982-2015).

Another form of prevention for foster care involvement that attachment-oriented somatic practitioners are particularly well-suited for is the evidence-based practice for *in utero* substance exposure, Theraplay (https://theraplay.org/), which provides psychoeducation and gently sculpted attunement interactions to parents in recovery from substance use (Weir et al., 2021), domestic violence (Bennett et al., 2006), early developmental neglect and abuse resulting in relinquishment to adoption (Munns, 2015), and a host of other developmental delays from genetic and epigenetic risk factors that interrupt optimal development and secure attachment (Money et al., 2021).

Theraplay training happens in two stages. The first is a four-day cohort introduction to principles and skills, followed by a two-day trauma-informed assessment and skills practice intensive for either parent-child dyads or groups of children (e.g., for school settings). The second stage is an individual supervised practicum that supports skills development toward certification. For the purpose of supporting family networks, the parent-child dyad training is more relevant.

Intervention. Children whose families do not receive the preventive services they need to stay together healthfully may spend their young lives raised in the institution of foster care. They suffer multiple interruptions to their attachment systems and developing nervous systems, sometimes in addition to the lifelong implications of acquired brain and nervous system injuries for those who suffered *in utero* substance exposure (Chasnoff et al., 1982-2015). These folx predictably manifest reactive attachment disorder and insecure attachment across the lifespan at much higher rates than children who never enter the system (Garcia, 2021; Miranda et al., 2019; Perry, in press). Those with *in utero* substance exposure may be misdiagnosed with up to 13 diagnoses that they indeed qualify for; however, the etiology for the behavioral concerns is not captured (Chasnoff et al., 2015). This misdiagnosis can lead to ineffective treatment planning and intervention.

Such attachment trauma and ineffective intervention results in lifelong complications with achieving and sustaining stable relationships with peers, partners, and their own children. Simply having alternative caregivers who are themselves securely attached can increase the earned security of those insecurely attached they serve, even without the provision of logistical support (Saunders et al., 2011). Therefore, trauma-informed care is vitally important across the child welfare system (Beyerlein & Bloch, 2014), as is helping these youth get embedded in logistical support networks that can substitute for some of the life skills training typically scaffolded by one's family of origin.

It is well understood in the attachment literature that as social mammals, all human beings depend on at least one stable, predictable, calming relationship to develop towards earned secure attachment. Unfortunately, for children in foster care, this need often goes unmet (West et al., 2020b).

Therefore, the current authors urge somatic practitioners to realize that advanced trauma training centered in somatic approaches makes body-inclusive practitioners ideally suited to serve foster youth, alumni, or families trying to reunify. Offering a youth in foster care this quality of predictable co-regulating support can forever change their quality of life for the better.

A Home Within (n.d.) is a national volunteer network with 18 chapters that vets and trains mental health professionals of any clinical background to commit to a foster youth or alumni for life. While most A Home Within volunteers are traditionally-trained talk therapists with varied theoretical understandings of trauma, somatic practitioners' nuanced training in bottom-up trauma processing modalities increases the likelihood of sensitive relational trauma resolution and integration for foster youth and alumni. Such skilled support can literally be lifesaving, as it can engender the felt experience of professional help-seeking resulting in beneficial outcomes, while also developing portable self-regulation skills that many well-intended professionals simply are not trained to provide (Kozlowska et al., 2020; Kuhfuß et al., 2021; Neal, 2021; Rothberg, 2014).

Advocacy. Another organization desperately in need of skilled trauma therapists is Court Appointed Special Advocates (CASA). CASAs maintain a less formally therapeutic container and relationship with the youth they serve. They are similarly vetted and trained to understand the needs unique to the child/youth they will serve, and are provided group consultation for support around those needs as the child develops. CASAs are a voice for the child in child welfare court, often speaking to needs and desires that the child has no other way of expressing directly to their placement representatives or families (CASA/GAL, 2023). Spending more organic time with such a supportive, regulated adult whose intention is to articulate the child's voice in court likely affords many of the same benefits of focused trauma treatment, in particular for youth who developmentally cannot yet engage with a high degree of motivation in therapy.

Children's Advocacy Centers (CACs) are another avenue for somatic practitioners to engage in advocacy for foster youth and their families, where organizational structures already facilitate intentional movement toward family systems interven-

tion, rather than dismemberment. The primary goal of CACs is "to ensure that children are not further victimized by the intervention systems designed to protect them" (National Children's Alliance, 2023, p. 5). CACs recognize that the administrative and bureaucratic barriers erected by the child welfare system can perpetuate the overwhelm and loss of control that children pulled from their families already feel, and aspire to provide trauma-informed care through every process and relationship inserted into the life of a child navigating the foster care system. CACs also aim to place families of origin back in the wraparound treatment model to "better provide(s) help, support, and protection to children and families as they pursue healing and justice" (p. 5). This approach likely reduces compassion fatigue and burnout among workers; however, no published research to date addresses this attachment-centered prioritization of reunification.

Skilled clinical care that advocates for logistical support, and integrates embodied clinical skills for relational trauma resolution, will likely increase attachment security more effectively for the clients, while preserving compassion satisfaction for the workers. Such holistic care can transform clients' insecure attachment patterns toward more earned secure attachment. Therapy and/or advocacy resulting in earned secure attachment can then be paid forward via transgenerational transmission, as securely-attached parents, whether that security is continuous or earned, are more likely to confer security of attachment on their offspring than insecurely-attached parents (Bosquet Enlow et al., 2014; Saunders et al., 2011; Shah et al., 2010).

Conclusion

In the U.S., BIPOC children are disproportionately represented in the foster care system by nearly double their population ratio. Available literature points to bias and discrimination in mandated reporting practices, removal decisions, placement decisions, retention rates in maintaining stable placements, and reunification rates with families of origin. Furthermore, because the field of mental health is a predominantly white institution (Roller et al., 2023), front line staff and supervisors statistically do not match racially or ethically with this vastly underserved population. The insidious embodiment of prejudice makes accountability in

hierarchical systems of power that can break families apart very difficult to combat, therefore foster youth need decidedly anti-racist and anti-oppressive mental health practitioners to advocate for them as they navigate these decision-making processes beyond their control.

There is much work to be done to reconstruct a mental health system that does not replicate oppressive racist patterns seen at every level across the country. Efforts need to be made to prioritize family preservation over child removal (Littell & Schuerman, 2002, 2021; Ryan & Schuerman, 2004). Toward that end, the advanced skillset of anti-oppressive somatic practitioners makes them uniquely suited to prevent and intervene upon the impact of this form of systematic oppression, to optimize children's and families' strengths and resilience, and to support family preservation wherever possible.

Where children have already been removed, anti-oppressive somatic practitioners can help families work through the transgenerational transmission of trauma toward secure base provision and earned secure attachment by advocating toward reunification and sculpting attuned interactions. Where reunification has been irreversibly truncated by custody courts, somatic practitioners can support foster youth and alumni to effectively process their grief and rage, and to find emotionally available substitute caregivers who can also help with logistical support. Every consistent, skilled clinical effort to resolve attachment trauma serves fostered youth themselves, and also those who may some day depend on them to overcome their inheritance while hoping for a more stable and connected future.

We therefore call somatic practitioners to contribute to repairing attachment for marginalized families. We ask you to reduce their risk of engagement with oppressive systems by preventing substance use, as well as neglect and abuse between family members. By providing your highly skilled bottom-up processing for unresolved trauma that drives problematic coping, you will help reduce both danger-to-self and danger-to-other behaviors that result in transgenerational attachment trauma. For those families who have already been broken apart, we ask you to help resolve the attachment trauma of those foster youth and alumni who cannot be returned to their families. We ask that

you offer your advanced training in trauma resolution to the next generation of parents and community members, giving them the skilled support necessary to heal from the harm done by oppressive systems and substances that break families. We ask that you embody hope, connection, support and belonging for regulating, reliable, responsive care and healing.

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