



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

WDS Workforce Development
and Support

CWS1031W: Separation and Loss Issues in Human Service Practice

PARTICIPANT HANDOUTS

COURSE COMPETENCIES AND LEARNING OBJECTIVES

COMPETENCIES

1. The trainee understands the reciprocal process and dynamics of normal attachment of children to their families, parents, and significant others.
2. The trainee understands the potentially traumatic outcomes of the separation and loss experiences for children, adolescents, and their families.
3. The trainee recognizes the precipitation of psychological crises which can result in the serious disruption of families and disturbances in the child's or adolescent's cognitive, emotional, social, and physical development.
4. The trainee has an understanding of the concepts of reunification and permanency planning, and understands the impact of change on children and adolescents.
5. The trainee can recognize the physical, emotional, and behavioral indicators of grief in children, adolescents, and families.
6. The trainee can work collaboratively with the family's extended support system to assess the child's and family's needs in coping with separation and loss.
7. The trainee understands the personal and psychological stresses associated with human services practice and can identify strategies to prevent emotional distress.
8. The trainees has the ability to identify and support children who have experienced trauma

LEARNING OBJECTIVES

Participants will be able to:

1. Understand attachment behaviors as the foundation of healthy relationships.

LEARNING OBJECTIVES CONTINUED NEXT PAGE

LEARNING OBJECTIVES (CONTINUED)

2. Understand the relationship between parent and child as a reciprocal relationship.
3. Understand factors that contribute to separation trauma.
4. Identify and empathize with the feelings associated with separation.
5. Assess the impact and effect of traumatization on a child's development.
6. Understand the grief process and examine the diagnostic implications and behaviors associated with each stage.
7. Identify how grief reactions are different in children than adults.
8. Understand and identify the symptoms of Post Traumatic Stress Disorder.
9. Demonstrate the ability to involve formal and informal support networks in the problem solving process.
10. Understand the impact of service delivery on birth parents, children being served, and foster caregivers.
11. Demonstrate self-awareness in being able to apply the models to the worker's losses and identify their own losses and the feelings associated with these losses.
12. Differentiate the types of family and life events that cause trauma for children.
13. Analyze how child welfare interventions, including separation and out-of-home placement, can be traumatic for children.
14. Can discuss the potential for children reared in dangerous home and neighborhood environments to have experienced significant trauma.
15. Can summarize the potential for parents, caregivers, and caseworkers to experience secondary trauma from working with and caring for traumatized children.

INFANTS SEQUENCE OF ATTACHMENT OUTLINE

Rudolph Schaffer and Peggy Emerson (1964) after studying 60 babies at monthly intervals for the first 18 months of life discovered that baby's attachments develop in the following sequence:

- Up to 3 months of age - Indiscriminate attachments. The newborn is predisposed to attach to any human. Most babies respond equally to any caregiver;
- After 4 months - Preference for certain people. Infants learn to distinguish primary and secondary caregivers but accept care from anyone;
- Around 7 months - Special preference for a single attachment figure. S/he shows fear of strangers (stranger fear) and unhappiness when separated from a special person (separation anxiety).
- After 9 months - Multiple attachments. The baby becomes increasingly independent and forms several attachments.

This is a guide. Some babies show special preference at 6 months for one person and demonstrate separation anxiety when that person is not there.

From McLeod, S. A., "Attachment Theory". Retrieved
<http://www.simplepsychology.org/attachment.html>

OBSERVATION CHECKLIST
What to Look for in Assessing Attachment & Bonding: Birth to One Year

<i>Does the child?</i>	<i>Does the parent?</i>
<input type="checkbox"/> Appear Alert	<input type="checkbox"/> Respond to the child's vocalizations
<input type="checkbox"/> Respond to people	<input type="checkbox"/> Change voice tone when talking to or about the baby
<input type="checkbox"/> Show interest in the human face	<input type="checkbox"/> Engage in face to face contact with the infant
<input type="checkbox"/> Track with his/her eyes	<input type="checkbox"/> Exhibit interest in and encourage age appropriate development
<input type="checkbox"/> Vocalize frequently	<input type="checkbox"/> Respond to the child's cues
<input type="checkbox"/> Exhibit expected motor development	<input type="checkbox"/> Demonstrate the ability to comfort the infant
<input type="checkbox"/> Enjoy close physical contact	<input type="checkbox"/> Enjoy close physical contact with the baby
<input type="checkbox"/> Signal discomfort	<input type="checkbox"/> Initiate positive interactions with the infant
<input type="checkbox"/> Appear to be easily comforted	<input type="checkbox"/> Identify positive qualities in the child
<input type="checkbox"/> Exhibit normal fussiness	
<input type="checkbox"/> Exhibit excessive fussiness	
<input type="checkbox"/> Appear outgoing	
<input type="checkbox"/> Appear passive and withdrawn	
<input type="checkbox"/> Appear to have good muscle tone	

OBSERVATION CHECKLIST

What to Look for in Assessing Attachment & Bonding: One to Five Years

<i>Does the child</i>	<i>Does the parent</i>
<input type="checkbox"/> Explore his/her surroundings	<input type="checkbox"/> Uses disciplinary measures appropriate for the child's age
<input type="checkbox"/> Responds positively to parents	<input type="checkbox"/> Respond to the child's overtures
<input type="checkbox"/> Keep himself/herself occupied	<input type="checkbox"/> Initiate affection
<input type="checkbox"/> Show signs of reciprocity	<input type="checkbox"/> Provide effective comforting
<input type="checkbox"/> Seem relaxed and happy	<input type="checkbox"/> Initiate positive interactions with the child
<input type="checkbox"/> Look at people when communicating	<input type="checkbox"/> Accept expressions of autonomy
<input type="checkbox"/> Show emotions in a recognizable manner	<input type="checkbox"/> See the child as positively "taking after" a family member
<input type="checkbox"/> React to pain and pleasure	<input type="checkbox"/> Initiates positive interactions with the infant
<input type="checkbox"/> Engage in age appropriate activities	<input type="checkbox"/> Seem aware of the child's cues
<input type="checkbox"/> Use speech appropriately	<input type="checkbox"/> Enjoy reciprocal interactions with the child
<input type="checkbox"/> Respond to parental limit setting	<input type="checkbox"/> Respond to the child's affections
<input type="checkbox"/> Demonstrate normal fears	<input type="checkbox"/> Set age appropriate limits
<input type="checkbox"/> React positively to physical closeness	<input type="checkbox"/> Respond supportively when the child shows fear
<input type="checkbox"/> Show a response to separation	
<input type="checkbox"/> Note the parent's return	
<input type="checkbox"/> Exhibit signs of pride and joy	
<input type="checkbox"/> Show signs of empathy	
<input type="checkbox"/> Show signs of embarrassment, shame or guilt	

OBSERVATION CHECKLIST

What to Look for in Assessing Attachment & Bonding: Grade School Years

<i>Does the child?</i>	<i>Does the parent?</i>
<input type="checkbox"/> Behave as though he/she likes him/her self	<input type="checkbox"/> Uses disciplinary measures appropriate for the child's age
<input type="checkbox"/> Show pride in accomplishments	<input type="checkbox"/> Respond to the child's overtures
<input type="checkbox"/> Share with others	<input type="checkbox"/> Initiate affectionate overtures
<input type="checkbox"/> Accept adult imposed limits	<input type="checkbox"/> Accept expressions of negative feelings
<input type="checkbox"/> Verbalize likes and dislikes	<input type="checkbox"/> Show interest in the child's school performance
<input type="checkbox"/> Try new tasks	<input type="checkbox"/> Provide opportunities for child to be with peers
<input type="checkbox"/> Acknowledge mistakes	<input type="checkbox"/> Handle problems between siblings with fairness
<input type="checkbox"/> Express a wide range of emotions	<input type="checkbox"/> Assign the child age appropriate responsibilities
<input type="checkbox"/> Establish eye contact	<input type="checkbox"/> Seem to enjoy this child
<input type="checkbox"/> Exhibit confidence in own abilities	<input type="checkbox"/> Know the child's likes and dislikes
<input type="checkbox"/> Appear to be developing a conscience	<input type="checkbox"/> Respond to the child's affections
<input type="checkbox"/> Move in a relaxed manner	<input type="checkbox"/> Give clear messages about behaviors that are approved or disapproved of
<input type="checkbox"/> Smile easily	<input type="checkbox"/> Comment on positive behaviors as well as negative
<input type="checkbox"/> Look comfortable when speaking with adults	
<input type="checkbox"/> React positively to parent being physically close	
<input type="checkbox"/> Have positive interactions with siblings and/or peers	

OBSERVATION CHECKLIST
What to Look for in Assessing Attachment & Bonding: Adolescents

<i>Is the adolescent?</i>	<i>Does the parent?</i>
<input type="checkbox"/> Aware of personal strengths	<input type="checkbox"/> Set appropriate limits
<input type="checkbox"/> Aware of personal weaknesses	<input type="checkbox"/> Encourage self-control
<input type="checkbox"/> Comfortable with his/her sexuality	<input type="checkbox"/> Trust the adolescent
<input type="checkbox"/> Engaging in positive peer interactions	<input type="checkbox"/> Show interest in and acceptance of adolescent's friends
<input type="checkbox"/> Performing satisfactorily in school	<input type="checkbox"/> Display interest in the teen's school performance
<input type="checkbox"/> Exhibiting signs of conscience development	<input type="checkbox"/> Exhibit interest in teen's activities
<input type="checkbox"/> Free from severe problems with the law	<input type="checkbox"/> Have reasonable expectations regarding chores and household responsibilities
<input type="checkbox"/> Aware of his/her parent's values	<input type="checkbox"/> Stand by the adolescent if he/she gets in trouble
<input type="checkbox"/> Keeping him/her self occupied in appropriate ways	<input type="checkbox"/> Show affection
<input type="checkbox"/> Accepting of adult imposed limits	<input type="checkbox"/> Think this child will "turn out" okay
<input type="checkbox"/> Involved in interests outside the home	
<input type="checkbox"/> Developing goals for the future	
<input type="checkbox"/> Emotionally close to parents	

Fahlberg, Vera. **A Child's Journey Through Placement.** p.41- 44. 1991.
Perspectives Press, Indianapolis, IN 46290-0318.

CATEGORIES/ PATTERNS OF ATTACHMENT

A compilation from Dr. Mary Ainsworth's research and Dr. Bruce Perry's, "Bonding and Attachment in Maltreated Children", www.ChildTrauma.org;

Securely Attached children feel a consistent, responsive, & supportive relation to their mothers/primary caregivers even during times of significant stress; Comfortable with closeness; balances closeness with distance; self-soothing

Insecurely attached children feel inconsistent, punishing, unresponsive emotions from their caregivers and feel threatened during times of stress.

- **Insecure: avoidant** – emotional distance, not comfortable with closeness, wants control; restricted empathy,
- **Insecure: resistant/ambivalent** – desires closeness but never seems to have enough; Can't self-soothe- clings-criticizes; preoccupied with abandonment-enmeshed
- **Insecure:** disorganized, disoriented, lack of empathy; terrified of abandonment but sabotages closeness; uses things to soothe-prone to addictions; attracted to people who victimize; children scripted into parent's unresolved trauma-chaos

"Since attachment patterns are normally enduring, if not addressed and resolved in childhood, the child with insecure attachment will most likely form an Insecure attachment to his/her own children, thus repeating the cycle."(Sharon M. Brammer, LPC, RPT-S, PC of Roanoke, VA)

RISK FACTORS WHICH INCREASE THE PROBABILITY OF ATTACHMENT DISORDER

DSM-V CRITERIA for REACTIVE ATTACHMENT DISORDER (RAD)

- A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:**
1. The child rarely or minimally seeks comfort when distressed.
 2. The child rarely or minimally responds to comfort when distressed.
- B. A persistent social or emotional disturbance characterized by at least two of the following:**
1. Minimal social and emotional responsiveness to others
 2. Limited positive affect
 3. Episodes of unexplained irritability, sadness, or fearfulness that is evident even during nonthreatening interactions with adult caregivers.
- C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:**
1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation and affection met by caring adults
 2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care)
 3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child to caregiver ratios)
- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).**
- E. The criteria are not met for autism spectrum disorder.**
- F. The disturbance is evident before age 5 years.**
- G. The child has a developmental age of at least nine months.**

Specify if Persistent: The disorder has been present for more than 12 months.

Specify current severity: Reactive Attachment Disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

ATTACHMENT DISORDER SYMPTOMS

- Superficially engaging & charming
- Do not trust caregivers or adults in authority
- Little eye contact with parents
- Indiscriminately affectionate with strangers
- Lack of Affection with parents on their terms (not 'cuddly')
- Destructive to self, others and material things ('accident prone')
- Cruelty to animals
- Lying about the obvious ('crazy' lying)
- Stealing
- No impulse controls (frequently acts hyperactive)
- Covertly manipulative or overtly hostile
- Triangulation of adults
- Learning Lags
- Lack of cause-and-effect thinking
- Lack of conscience,
- Lack of empathy;
- Lack of compassion
- Abnormal eating patterns
- Poor peer relationships
- Preoccupation with fire
- Inappropriately demanding & clingy
- Abnormal speech patterns
- Resist parents', caregiver's efforts for nurturance and guidance

This is a partial listing of symptoms which are found on many different websites. This particular listing comes from www.attachment.org (Families by Design), and from the book, (p. 31-32) ADOPTING THE HURT CHILD (1995) by Gregory Keck and Regina Kupecky, Pinon Press, Colorado Springs, Colorado.

ASSESSMENT

Attachment Disorder Maryland on their website, www.attachmentdisordermaryland.com/intro.htm state,

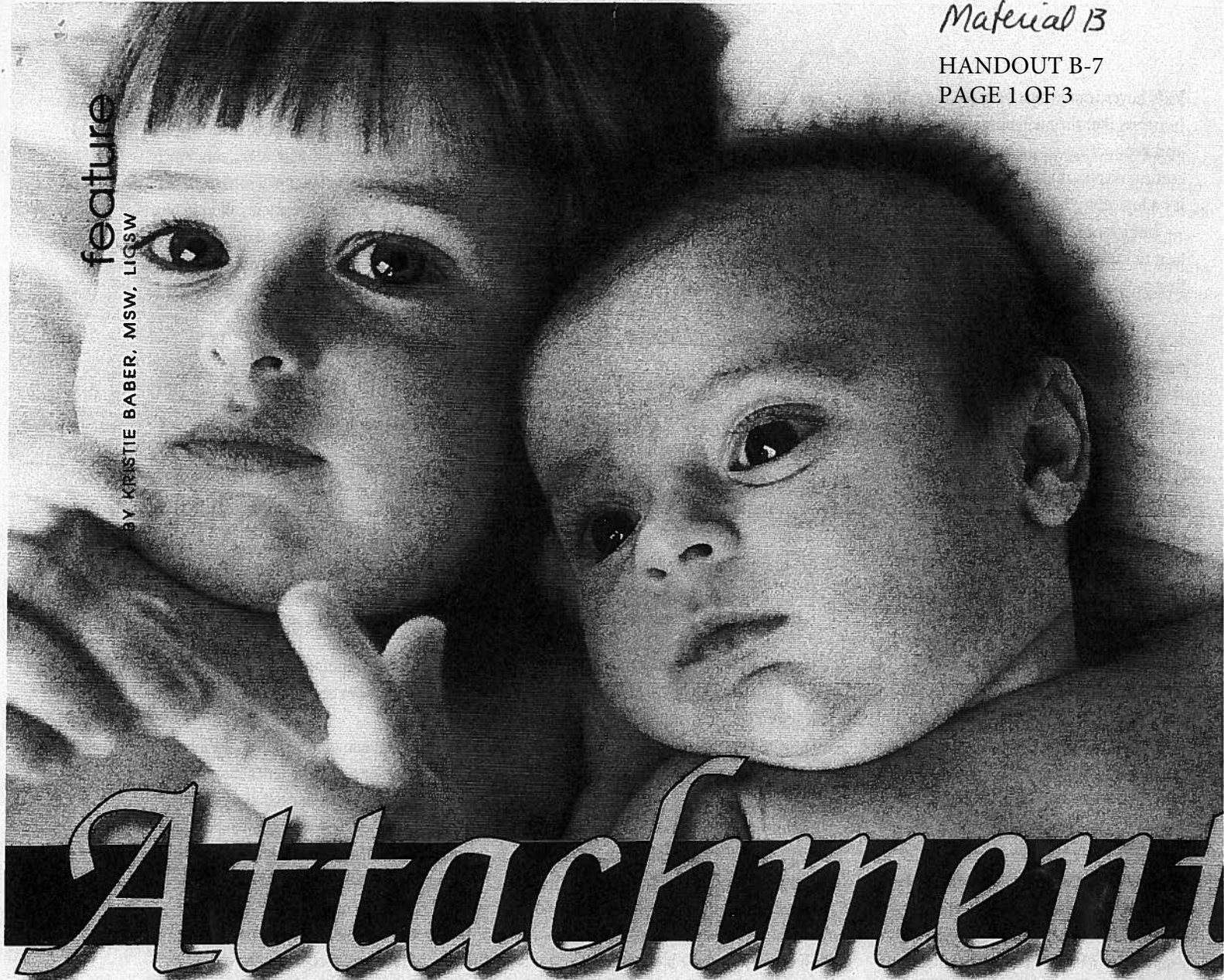
“A.D. is a very complex entity. As such, trying to assess it in any single diagnostic appointment... is very prone to go astray. It is a disorder which manifests in the nuances of day to day life, and data on day to day functioning is therefore the most relevant. By definition, “day to day functioning” can’t be observed in a meeting or two, nor can it be captured by comprehensive testing procedures, all of which are still snapshots in time and place. There are several behavioral checklists for AD. However, as with other disorders, none of these checklists are diagnostically conclusive.

The website authors go on to say, “The richest database for assessing AD is the information provided by parents, as they clearly have the most extensive data on daily functioning over time. This is supplemented by observations of parent-child interactions in therapy (just one reason parents need to be present in attachment work). Data provided by teachers is the next best source, though of considerably less value than parental input, given the differences in the relationships with the child.”

Website: www.attachment.org, states, “Some infamous people with Attachment Disorder that did not get help in time – Saddam Hussein, Edgar Allen Poe, Jeffrey Dahmer, and Ted Bundy. One famous person with Attachment Disorder who did get help in time (in 1887!) and became one of the greatest humanitarians is Helen Keller.”

feature

BY KRISTIE BABER, MSW, LICSW



Attachment

Attachment seems to be the word of the day in foster care — and rightfully so. We've been taught in PRIDE classes and parenting seminars that attachment is the foundation of a child's life — self-esteem, cognitive abilities, behavioral control, social skills and emotional sensibilities are all based on this early attachment relationship. We understand the concept that every young child needs at least one intimate adult relationship that is reliable, responsive, nurturing and provides the child with security and opportunities for exploration. What we don't spend much time talking about is how attachment develops and what to do when it

doesn't seem to develop in our foster children as we had hoped.

Like most therapists, I am a hypocrite when it comes to self-care. We talk a good game about how you need to take care of yourself before you can take good care of others (think: oxygen mask speech from the airline attendant), but rarely do it. I'm sure that this is in no way familiar to foster parents. In any case, I do try to attend a weekly zumba class. Last night as I sat panting after the workout, I reflected on the new instructor. She seemed to be an energetic soul with a bright smile and an endearing effort to remember

our names. I thought it odd that I wasn't warmer in response to her greeting, but then it occurred to me — she was the sixth new "permanent" instructor that I had met in as many months. Somewhere inside without my being aware of it, my cheery "hello there!" had given way to a neutral "we'll see," and finally deteriorated into a somewhat jaded "yeah, right" response. I just didn't believe these instructors anymore that they would stay with the class.

I was struck that this is exactly the world view that we must try to understand as the caregivers of foster children. Many of our

kids hover somewhere between skeptical and hopeless that they will be loved, protected and kept permanently, and their behavior communicates that clearly. It isn't personal — it's a logical average of their early experiences — but it sure feels that way to us. It is important to understand how this happened in the first place in order to straighten things out.

Anyone who has been a caregiver of an infant can tell you it's a bit of a one-sided relationship. Babies have few skills and even fewer ways to communicate, but they sure catch on fast. Just like 90 percent of the budget and infrastructure of a skyscraper goes into the foundation, 90 percent of the human brain develops in size by a child's third birthday. By this time, children have already learned what to expect of themselves, their caregivers and the world. How did that happen so quickly?

Typically when a baby cries, he or she is signaling the need for something — a bottle, a clean diaper, a cuddle. When the parent responds in a timely fashion and meets those needs over and over, day in and day out, the child learns that he or she is a valuable little person. The child signals a need, and a caregiver responds and helps him or her to feel better. Not only does the baby learn that he or she is valuable, but also that the caregiver is clearly trustworthy, and the world in general seems like a pretty safe place. That frees up a lot of energy for development and exploration.

What about the baby who doesn't have his or her needs met? Perhaps the child's mom ignores his or her cries because she is depressed or high. Or, perhaps the baby's demands upset the mom and she yells for the child to be quiet. Over time, the baby learns that she is not a valuable person because no one is listening or taking good care of him or her. The child determines that Mom is not trustworthy and may or may not attend to her, and guesses that the world isn't safe either. The child is spending a lot of energy on survival and figuring out strategies to get

needs met in an uncertain world without upsetting any of the big people.

As these little ones grow up, they carry this world view with them until someone intentionally teaches them that things are different in this family. And that takes time, patience and a lot of effort. When you consider that

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one-third of the children in foster care are younger than 5, you can see how so many of our kids struggle with attachment problems, according to the February 2005 issue of the *Child Maltreatment Journal*.

By the time our foster children reach our homes, they have often learned adaptations to survive in the world as they know it. Consider the child who hits his or her head on the TV cabinet, but staggers off to a corner to half-heartedly move blocks around rather than cry or ask for soothing. This is called a miscue — something a child does to prevent a genuine need from being exposed and unmet. While this served an adaptive role in an earlier environment — he or she would avoid a reprimand by not crying, for instance — it is no longer necessary in your home.

This is where your intervention-parenting comes in. If you ignored the miscue, and instead walked over to the child, picked him or her up and narrated, "Oh, you bumped your head! Ouch! That must have really hurt. I'm going to give you a hug and hold you until you feel better" you would help the child change his or her world view and revise his

or her expectations. Perhaps the child is valuable after all. Perhaps this new caregiver will meet his or her needs. Mind you, this won't be easy at first. The child will likely balk at being picked up, arch as you try to hold him or her and deny the need, but over time the child will start to cue you directly and appropriately. A sprawl on the pavement will result

in wailing and running to you for a kiss, just as you would have expected.

Stability is an enormous challenge for our foster kids. Generally, the older they are, the more attachment-related social, emotional and behavioral problems they can have. The more problems, the more likely they are to move homes. The greater the number of placement transitions and losses, the more social, emotional and behavioral problems the kids have. In short, children who feel unlovable behave unlovably and this is the pattern that we need to break. Here are some tips:

- Be consistent, predictable and reliable. An entire article could be written on the benefits of this alone, but suffice to say that these parenting characteristics will provide your child with a sense of safety and security contributing to the emergence of healthy attachment patterns.
- Seek to understand behaviors before consequence. Due to their histories, our children's behavior often has a deeper meaning under the surface. For instance, hoarding

food might be viewed as stealing. However, consider that this might be a natural reaction to being food deprived earlier in life and that punishment would only increase the child's anxiety and need to hoard. A food shelf at the child's level with parent-approved snacks might reassure a neglected child until we can accomplish the

that attachment work generally requires a dyadic approach. This means that the child is seen in therapy along with the foster parent, and the caregiver is the identified attachment figure. If your child is young (0-5 years), ask for an Infant Mental Health therapist that is familiar with Child-Parent Psychotherapy. For older children with

Try to be patient with your foster child... and with yourself for that matter. Changing a child's world view takes time.

longer-term goal of convincing them that there will always be enough food provided in this new home.

- Try to be patient with your foster child... and with yourself for that matter. Changing a child's world view takes time. You are making progress — it will just take some time for it to become visible.
- A therapist versed in attachment theory can be enormously helpful and will understand

attachment issues, ask for a therapist who is familiar with Dyadic Developmental Psychotherapy or has specialized training in foster care and adoption issues.

- Because there is much overlap in developmental domains in the early years of life, concurrent developmental assessment and intervention can often be beneficial. For young children (0-3 years), contact your local Early Intervention provider for a developmental evaluation and services

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(motor, speech and language, education, etc.) For children older than 3, contact your local school district for testing and services.

For more information on brain development in young children and the importance of attachment, check out Zero to Three at www.zerotothree.org or the Talaris Institute at www.talaris.com. For additional reading, try the incomparable Deborah Gray's "Attaching in Adoption" and "Attachment, Trauma & Healing" by Terry Levy, Ph.D., BCFE, Michael Orlans, MA, DAPA. For additional resources, as well as services in Washington state, visit www.lodestartertherapy.com. ☘

ABOUT THE AUTHOR: Kristie Baber, LICSW is in private practice at Lodestar Therapy in Seattle. She is a children's mental health specialist and certified in adoption and foster care therapy. Baber teaches nationally for the CWLA, DEC, NICWA and others, and is on the advisory board for the UW's post-graduate psychological trauma certificate program. Her practice focus is early childhood mental health and development.

(kids in waiting)



Domonica, 13, is ready to perform her latest ballet dance for you, and you will be amazed at her talent. Family outings make her so happy that she's ready to pack up her bag right now, and swimming is another of her favorite activities. Although it may take her a little time to warm up, once she gains trust, she is extremely loyal and giving.

In the seventh grade, Domonica benefits from an Individualized Education Plan, as well as counseling, which will need to continue after placement.

This young woman will be a dynamite addition to your family. She remains in contact with her siblings. Her caseworker prefers a two-parent or single-mother U.S. family willing to participate in a transitional plan prior to placement; however, all family types will be considered. Financial assistance may be available for adoption-related services.

For New Mexico children, both homestudied and non-homestudied New Mexico families are encouraged to inquire; only homestudied families from other states should do so. For more information, contact The Adoption Exchange at (800) 451-5246. New Mexico, ID 8600

VIDEO:
**“Trauma, Brain and Relationships: Helping Children
Heal”**

by The Post Institute

<https://youtu.be/jYyEEMIMMb0>

Powerful documentary featuring Bryan Post, Bruce Perry, M.D., Daniel Siegel M.D., Marti Glenn PhD and other renowned experts in the field of childhood trauma, and attachment and bonding. This is a great way to share with friends, colleagues, and caregivers this new understanding of how trauma effects the development of the mind body system, and how it affects children's behaviors and social relationships. This is a popular training video with agencies for training and for group presentations. Copies can be purchased at www.postinstitute.com/dvds. Video originally produced by Santa Barbara Graduate Institute which has since been merged with a major university and no longer exists as a separate entity.

HIERARCHIAL BRAIN

Brain is put together like building blocks.

CORTEX – executive branch of the brain, organizes, plans, strategizes, regulates decision-making, is not fully mature until person is age 25 (remember crazy stunts as teenagers/ college students = invincible thoughts); thinking at top shuts down when child lives in fear; domestic violence, abuse. **“Neglect has been shown to harm the frontal cortex”, affecting planning, decision-making, and memory (p.2 Children Services Practice Notes, Vol 18, no. 1, January 2013)*

LIMBIC -controls emotions and long-term memories; it can override rational thoughts. *“A part of limbic system is involved in attaching emotions to memory... every time we remember an event, the emotion comes along with it.”*

MIDBRAIN –controls sleep, arousal responses, appetite and motor movements such as running and skipping; *“controls the visual and auditory systems as well as eye movements”*

BRAINSTEM – Main control panel for body, passes messages back and forth, must be fully functional at birth in order for infant to survive, responsible for survival functions such as blood pressure, heart rate, body temp, breathing.

Each child is born with about 100 billion brain cells. At birth the connections between the cells are not very fast... The more the brain is stimulated, the faster and stronger these connections become, and they become a part of the permanent structure of the brain. When the connections or synapses are not used, they are “pruned” or eliminated.

From Nurturing Parenting Programs®, 2007 & 2012, Family Development Resources, Inc., Park City, Utah; and “Understanding the Effects of Maltreatment on Brain Development”, from Child Welfare Information Gateway, November 2009.

TRAINER'S KEY to Hand-out C-3 BRAIN FACTS WORKSHEET, True or False?

____ **At birth all of baby's internal organs: the heart, lungs, kidneys and brain are completely developed.**

False: unlike other organs the brain is undeveloped at birth. Between birth and 3 yrs. of age, brain reaches 90% of its adult size and complexity.

____ **A newborn a few minutes old is capable of recognizing his/her father's voice.**

True: a Baby can hear in utero. If father has been present and talking with mother during pregnancy, a newborn will recognize father's voice.

____ **Brain development is the process of creating, strengthening and discarding connections, also called synapses, among the neurons.**

True

____ **Relationships during first 3 years of life can change the size and structure of the brain.**

True: Healthy brain connections are completely dependent on healthy human connections. Babies without adequate human contact lose brain matter.

____ **Nurturing and Abusive touch change the chemistry of the brain.**

True: Touch is the first and perhaps most important sense. Touch triggers the release of many chemicals in the brain that calm the body and brain.

____ **The brain is easiest to modify in the first (1st) 5 years of life,**

True: the younger the child is, the more sponge-like is their brain; but this same biological sponginess also makes children more vulnerable to trauma.

____ **Not all traumatic events lead to disastrous mental health issues.**

True: Whether an experience is traumatic depends on how the child interprets the experience and the support, nurturance the child receives in the aftermath.

____ **Brain of child will become exactly what child is exposed to.**

True: Brain is mirror to child's developmental experience. Family chaos, threat, stress, abuse, and neglect alter a child's developing brain. If parents are good at self regulation and positive attention to child, then child experiences that.

____ **A child will not go to an attachment figure who is the source of Distress or terror**

False: When an attachment figure is source of distress or terror, child's brain has 2 processes going on at once, one says, "Go to attachment figure; the other says, don't." The child feels traumatized. What to do?

BRAIN FACTS True-False Worksheet, an adaptation of the Nurturing Parenting Programs® (2007), Family Development Resources; and Dr. Bruce Perry and Child Trauma Academy.

MORE ON ATTACHMENT THE BRAIN & TRAUMA

Attachment and Brain Development

- The infant's right brain begins to develop before the left brain
- The right brain is the part of the brain which includes visual cues, sensory data, emotions, non-verbal communication. It is the part of the brain that attachment impacts
- The left brain is where language develops and does not begin to mature before 18 -24 months
- Attachment behaviors engaged in by the caregiver regulate the infant's right brain and the maturing limbic system.
- The limbic system is fundamentally associated with emotional functions
- The right brain structures are underdeveloped, damaged or distorted in children with RAD

Trauma and Secure Attachments

- Whether an experience is traumatic depends on how the child interprets the experience
- Presence of a secure attachment figure makes trauma less devastating
- Following a traumatic experience, the presence of a comforting familiar person can quickly reduce physiological effects of stress
- The resolution of PTSD is much more difficult for children who do not have a secure attachment relationship

Putting it all together...

- Attachment and Trauma affect to overall functioning and brain development of all children.
- These children often present a very complex picture with global developmental delays
 - Try to understand the mind of the traumatized child and see the world through their eyes

Types of Therapy [these are not endorsements]:

** Play with Them: Theraplay Groups in the Classroom by Rubin and Tregay – www.theraplay.org

** Circle of Security – www.circleofsecurity.org – treatment for caregivers to modify insecure attachment patterns.

** Dyadic Developmental Psychotherapy by Dan Hughes – attachment focused therapy for childhood trauma and abuse. The adult's emotional and self-regulation abilities... serve as a model for the child

** Attachment and Bio-behavioral Catch-Up (ABC) – short term, in-home intervention to improve regulation and bio-behavioral regulation in maltreated children, designed for infants and toddlers living with birth parents, kinship, or foster care. Designed to strengthen caregivers' sensitivity and responsiveness to infant's cues.

** Experiential Therapy that Engages the Sensory System...
Often people cannot talk about their trauma. There are limits to language...the language part of the brain shuts down during severe trauma.

** "Therefore all trauma can be seen as a pre-verbal experience but people remember that sensory input from the trauma." Bessel van der Kolk Professor of Psychiatry Boston University.

[From: "Understanding the Impact of Attachment and Trauma on Brain Development", Illinois State Board of Education , Best Practices and Guidelines for Non-Public Special Education Programs; Presented by: Karen Doyle Buckwalter, LCSW, kbuckwalter@chaddock.org; www.chaddock.org]
http://www.isbe.state.il.us/spec-ed/np_handouts/2010/session9.pdf

Derek's Story:

Derek came into care when he was about 6 ½ years old due to neglect and physical abuse. His grandparents who lived close by, report that before the age of 3, he spoke in a normal, clear way. By age 3 he was stuttering and his words were not clear; it was reported that his mother's boyfriend was physically "hard" on the child, and that Derek would run to hide. (Later it was learned that Derek's birth mother was physically punitive too.) By the age of 4, Derek would crawl out of his window and go to his grandparents; his grandparents would take him back in the morning to his mother's.

Derek would sometimes hide around his grandparents' place so no one would find him; sometimes the police would be called as his birth mother and the family would be looking for him. Derek learned that if his mom or her boyfriend got really mad and were after him, he could run to the woods and hide there even when it was dark.

Eventually Social Services placed Derek in a foster home. When asked about his running and hiding, "Weren't you afraid to be in the woods at night?" He would answer, "No. I knew where to hide; I felt safe." When also asked, "How did you know when you could come home?" He answered, "I knew my mom would get tired and fall asleep."

When he came into Care, understanding Derek when he talked was difficult (even now two years later his speech is not clear. He needed to have lights on in order to sleep and wanted the dogs in the family to sleep with him. One day something stressed or triggered Derek, he left to go into the woods near his new home without telling anyone. His foster parents were Scared! But Derek would later say he was "fine" in the woods.

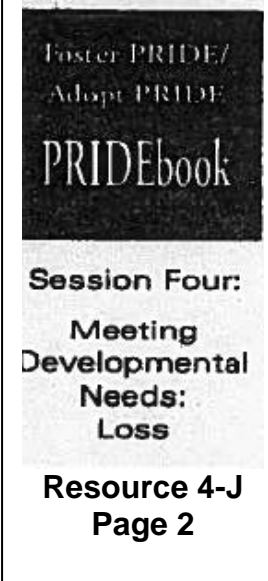
Questions:

- 1.] When you think about Derek's strengths, what would you point out to Derek and his families?
- 2.] What losses has Derek experienced?
- 3.] How did maltreatment and the subsequent Trauma affect Derek's brain And his behavior
- 4.] What survival behavior becomes problematic for Derek now that he is in a foster to adopt home?

© 2012 by C. D. McMurray, MSW, ACSW, Trainer/Adoption & Life Book Consultant. Derek is a compilation of a couple children, working with the child and all families to create their Life Books. Permission is granted to have this write up included in CWS 1031 only.

Handout D-1

Name: _____ Date: _____ Family Developmental Specialist: _____				
Age at Time of Loss	Type of Loss (Remember that losses can include an important person, health or sense of safety and well-being)	What Happened? (What were the circumstances of the loss?)	Effects of the Loss on You	Help You Received



Pasztor, E and Leighton, M. Homeworks #2. At-Home Resources for Foster Parents and Adoptive Parents: Helping Children and Youth Develop Positive Attachments. Washington DC: Child Welfare League of America. © 2009 by CWLA

“ASK US WHO WE ARE?” QUESTIONS

1. ***What do you hear these former foster youth identify as their losses and their feelings?***
2. ***What is said about the impact of moving from their own home, even an abusive one?***
3. ***Other significant messages heard.***
4. ***How can their messages help us in our Work?***

Understanding and Helping Children with the Impact of Separation and Loss			
Age	Developmental task	Effect of separation and loss	Help to minimize trauma
Infant	Infants develop a sense of security and trust from day-to-day experiences. Their primary job is to develop a sense of trust in others. By 7-9 months they know family members and fear others. Their dependency on mother decreases as trust develops.	They react to difference in temperature, noise, visuals. They may lose their sense of being able to rely on the environment and the individuals within it. May become less flexible. Rebuilding trust in adults is major task.	Be attentive to needs. Keep changes in daily routine to a minimum.
Toddler	They separate from their mothers, begin to develop self-confidence and self-esteem, and begin to feel capable of doing things themselves.	Damages their sense of independence, self-confidence, and self-esteem. Toddlers may regress to younger behaviors.	Need help developing independence, or a balance between dependency and independence. Tolerate clingy behavior, as they do not trust adults will be there when they need them. May behave like they want to parent themselves. Need opportunities for trust and autonomy, and opportunities to control their environment. Be aware of all events surrounding the separation or loss, as similar events will reawaken memories in the future.
Preschooler	Become good at self-care at home, typically ask a lot of questions, become more individual and more independent. Show tremendous interest in and excitement with the world. Develop language skills. Unable to understand cause and effect.	World is confusing, fear abandonment, susceptible to misperceptions as to the reasons for moves, and will blame selves.	Listen for odd or peculiar statements for clues suggesting a child's misperceptions about the reasons for the placement. Be attentive to the child's development. Language delays are common in children who have been abused or neglected. Need consistency and predictability to regain sense of trust and control.

(continued next page)

Understanding and Helping Children with the Impact of Separation and Loss <i>(continued)</i>			
Age	Developmental task	Effect of separation and loss	Help to minimize trauma
Six-to-ten year-old	Learning in school, developing motor skills, and same-sex peer relationships are important. Moral development includes a heightened sense of right and wrong. Become more assertive; the issue of fairness is very important. Increased ability to understand and conceptualize.	Interferes with ability to learn and develop friendships. Regression to earlier stages is common.	Need help to reason out loss. Need information about their past to help them with identity issues. Need help with peer relationships, poor school performance, and identifying and managing angry feelings. Children who have been sexually abused need nurturing in nonsexual relationships.
Adolescent	Need to be accepted by peer group versus need to belong in family. Must cope with abundant sexual and aggressive impulses. Beginning to find place in the world. Want independence from family; control battles common. Developing intellectual and reasoning abilities. Sense of belonging and peer relationships are very important.	Loss is intensified due to adolescent's emotional instability and impulsivity. Loss complicates issues of identity and self-esteem. Separation from family at a stage of desiring independence confuses the anger.	Need to be full participants in the helping plan. Need to feel their desires are considered at all times. Need help acknowledging and managing sad and angry feelings, and low self-esteem. Need to be acknowledged for responsible behaviors. Need help in resolving sexual issues in nonsexual relationships. Need support in peer relationships; for example, help to manage peer pressure.
A move/loss is a time of high anxiety and discomfort for children. Being aware of all their feelings, and responding in a helpful way can support the attachment process between the child and the new family.			

This chart is a composite of information found in a collection of work by Vera Fahlberg called, "Putting the Pieces Together," which includes the book: Attachment and Separation. The collection, "Putting the Pieces Together," was originally published in 1982, and republished and distributed in January 1988 by Spaulding for Children, Michigan.

REPRINTED WITH PERMISSION FROM:

Child Welfare League of America, & Illinois Department of Children and Family Services. (2009). *FosterPRIDE/AdoptPRIDE PRIDEbook* (Resource 4-H, pp. 131-132). Washington, DC: CWLA Press.

SYMPTOMS OF NORMAL GRIEF

BEHAVIOR

- sleeplessness
- loss of appetite
- poor grades
- crying
- nightmares
- dreams of deceased
- sighing
- listlessness
- absent mindedness
- clinging
- overactiveness
- social withdrawal
- verbal attacks
- fighting
- extreme quiet
- bed-wetting
- excessive touching
- excessive hugging

FEELINGS

- anger
- guilt
- sadness
- mood swings
- depression
- hysteria
- relief
- helplessness
- fear
- loneliness
- anxiety
- rage
- intense feelings
- feeling unreal

THOUGHT PATTERNS

- inability to concentrate
- difficulty making a decision
- self-destructive thoughts
- low self-image
- preoccupation
- confusion
- disbelief

PHYSICAL SYMPTOMS

- headaches
- fatigue
- shortness of breath
- dry mouth
- dizziness
- pounding heart
- hot or cold flashes

Physical Symptoms continued next page

REPRINTED FROM:

Goldman, L. (2000). *Life & loss: A guide to help grieving children* (2nd ed., pp. 49-50).
Philadelphia: Accelerated Development.

PHYSICAL SYMPTOMS (CONTINUED)

- heaviness of body
- sensitive skin
- increased illness
- empty feeling in body
- tightness in chest
- muscle weakness
- tightness in throat
- stomachaches

COMMON FEELINGS, THOUGHTS, AND BEHAVIORS OF THE GRIEVING CHILD

- Child *retells events* of the deceased's death and funeral.
- Child *dreams* of the deceased.
- Child *idolizes or imitates behaviors* of the deceased.
- Child *feels the deceased is with him or her* in some way.
- Child *speaks of his or her loved one in the present*.
- Child *rejects old friends and seeks new friends* who have experienced a similar loss.
- Child *wants to call home* during the school day.
- Child *can't concentrate* on homework or class work.
- Child *bursts into tears* in the middle of class.
- Child *seeks medical information* on death of deceased.
- Child *worries excessively* about his own health
- Child sometimes *appears to be unfeeling* about loss.
- Child becomes the "*class clown*" to get attention.
- Child is *overly concerned* with caretaking needs.

CHILDREN'S REACTIONS TO LOSS: COMMON BEHAVIOR PATTERNS OF THE GRIEVING PROCESS

SHOCK/DENIAL

General Description of Stage

- The person appears compliant and disconnected from the event, as if the loss were of little significance.
- The person may be stunned, robot-like, "shell shocked."
- The person may deny the event and/or the feelings accompanying the event. There is little emotional expression.

Behavioral Expressions in Separated Children

- The child often seems indifferent in affect and behavior.
- The child may not show an emotional reaction to the move.
- The child may appear to make a good adjustment for period of time, often referred to as the "honeymoon period."
- The child may go through the motions of normal activity but shows little commitment or conviction.
- The child may be unusually quiet, compliant, eager to please. In retrospect, the child's behavior may appear passive and emotionally detached or numbed.
- The child may deny the loss, and may make statements such as, "I'm not staying here. Mommy will get me soon."

Diagnostic Implications

- Caseworkers, foster parents, and parents may misinterpret the child's compliant and unemotional behavior, believing the child "did fine ... it was an easy move." When a child is thought to have handled a move

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 45-51; Handout #2, pp. 1-5) [Core Curriculum]. Columbus, OH: Author.

ADAPTED WITH THE FOLLOWING PERMISSION:

Reproduced and adapted, with permission, from Rycus, J.S., Ginther, N., & Hughes, R.C. (1999). *Separation, Placement, and Reunification in Family-Centered Child Protective Services (Core Curriculum Module IV)*. Child Welfare League of America and Institute for Human Services. All Rights Reserved.

without distress, later behavioral signs are often not recognized as separation trauma and part of the grieving process.

- Children who have not developed strong attachments to their parents or caregivers may not display an emotional reaction to the move at all.
- The absence of an emotional response by children in placement beyond the short time period of the "shock" phase should be of considerable concern to the caseworker and foster parent, as it may indicate underlying emotional disturbance.

ANGER OR PROTEST

General Description of Stage

- The loss can no longer be denied. The first emotional response is anger.
- Anger may be directionless or directed at a person or object thought to be responsible for the loss.
- Guilt, blaming others, and recriminations are common.

Behavioral Expressions in Separated Children

The child may:

- Be oppositional and hypersensitive.
- Display tantrum behaviors and emotional, angry outbursts.
- Withdraw, sulk or pout, and may refuse to participate in social activities.
- Be crabby and grouchy, hard to satisfy.
- Exhibit aggressive, rough behavior with other children.
- Break toys or objects, lie, steal, and exhibit other antisocial behaviors.
- Refuse to comply with requests.
- Make unfavorable comparisons between her own home and the foster home, and her own home is preferred.
- Display sleeping or eating disturbances, and may not talk.

Diagnostic Implications

- The child's oppositional behavior may be disruptive to the foster caregivers.
- Confrontations between the caregivers and the child may lead to a struggle for control.

CONTINUED NEXT PAGE

ANGER OR PROTEST/DIAGNOSTIC IMPLICATIONS (CONTINUED)

- The child may be inappropriately diagnosed as "severely behaviorally handicapped," or "emotionally disturbed," or may be punished for misbehavior.
- Caretakers can be more supportive and helpful in redirecting the child's feelings if the behavior can be properly identified as part of the grief process.

BARGAINING

General Description of Stage

- Behavior during this stage is often an attempt to regain control and to prevent the finality of the loss.
- The person may resolve to do better from now on.
- The person may try to "bargain" with whomever is thought to have the power to change the situation.
- The child may believe that a certain way of behaving or thinking will serve to prevent the finality of the loss.

Behavioral Expressions in Separated Children

- The child may be eager to please and will make promises to be good.
- The child may try to undo what she feels she has done to precipitate the placement.
- The child may believe that behaving or thinking in a certain way will bring about a reconciliation. These behaviors may become ritualized, which may be the child's attempt to formalize her "good behavior" and assure its consistency.
- The child may try to negotiate agreements with the foster caregiver or the caseworker, and may offer to do certain things in exchange for a promise that he will be allowed to return home.
- Caretakers can be more supportive and helpful in redirecting the child's feelings if the behavior can be properly identified as part of the grief process.
- The child may appear moralistic in his beliefs and behavior; these behaviors often are a defense against failure in upholding his end of the "bargain."

BARGAINING (CONTINUED)

Diagnostic Implications

- The child's behaviors represent a desperate attempt to control the environment and to defend against feelings of emotional turmoil.
- In reality, there is little chance of the child's behaviors producing the desired results or reunification. The worker who understands this stage can provide needed support when the child realizes the ineffectiveness of the bargaining strategy and begins to experience the full emotional impact of the loss.

DEPRESSION

General Description of Stage

- This stage is characterized by expressions of despair and futility, listlessness, with or without extraordinary episodes of fear and panic, withdrawal, and a generalized lack of interest in people, surroundings, or activities. The individual often cannot be comforted.

Behavioral Expressions in Separated Children

- The child appears to have lost hope and is experiencing the full impact of the loss.
- Social and emotional withdrawal and failure to respond to other people are common.
- The child may be touchy, "out of sorts," may cry with little provocation.
- The child may display signs of anxiety, and be easily frightened.
- The child may be easily frustrated and overwhelmed by minor events and stresses. The child may be listless, without energy.
- Activities are mechanical, without direction, investment, or apparent interest.
- The child may be distractible, have a short attention span and be unable to concentrate.
- Regressive behaviors are common, such as thumb sucking, toilet accidents, baby talk.
- Generalized emotional distress may be exhibited in both emotional and physical symptoms, particularly in young children. These include whimpering, crying, rocking, head banging, refusal to eat, excessive sleeping,

digestive disorders, and susceptibility to colds, flu, and other illness.

Diagnostic Implications

- This is a critical period in the child's relationship with the parent. Once the child has completed the grieving, it will be extremely difficult to re-establish the parent/child relationship.
- There may be a lapse of time between the separation and the onset of depression.
- Foster caregivers may feel frustrated and helpless by their inability to comfort or to help the child.
- The worker who recognizes the child's depression as part of the grief process will be more able to provide support, or to increase visitation to prevent the child from emotionally detaching from the parent.

RESOLUTION

General Description of the Stage

- Symptoms of depression and distress abate. The person begins to respond to people around him in a more normal manner.
- The person begins to invest emotional energy in the present or in planning the future, and less in thinking about the past.
- The final stage of grieving ends when the person returns to an active life in the present.

Behavioral Expressions in Separated Children

- The child begins to develop stronger attachments in the new home and tries to establish a place for herself in the family structure.
- The child may begin to identify herself as part of the new family and will demonstrate stronger emotional attachments to family members.
- The intensity of emotional distress decreases and the child can once again experience pleasure in normal childhood play and activities.
- Goal directed activities reoccur. The child's play and activities become more focused and playful. The child is better able to concentrate.
- Emotional reactions to stressful situations diminish as the child becomes more secure in the new environment.

RESOLUTION (CONTINUED)

Diagnostic Implications

- Behaviors suggesting resolution are generally positive signs, if the case plan includes permanent separation of the child from his family. However, it is inappropriate and harmful for the child to resolve the loss of his family if our goal is reunification.

UNDERSTANDING BIRTH PARENTS' REACTIONS TO TRAUMA

Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.

Assess a parent's history with an eye towards trauma and how it impacts parenting

Remember that **traumatized parents are not "bad"** and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.

Build on parents' desires to be effective in keeping their children safe and reducing their children's challenging behaviors.

Pay attention to ways trauma can play out during case conferences, home visits, visits to children in foster care, court hearings, and so forth. Help parents anticipate their possible reactions and develop different ways to respond to stressors and trauma triggers.

Source:

National Child Traumatic Stress Network Guidance (www.nctsn.org) *Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Child Welfare Staff*

IDENTIFYING CHILDREN FOR PROFESSIONAL EVALUATION

The Harvard Child Bereavement Study found that, while bereaved children show a variety of behaviors, many of the so-called "disturbed behaviors" are short lived and drop out on their own without any intervention. The focus should not be on the presence of a symptom or behavior but on its duration. If any of the following red-flag behaviors continue for several months, a professional evaluation should be warranted.

1. **TALKING ABOUT DEATH:** If the child has *persisting difficulty talking about the dead parent*, this can be a sign for further investigation. The emphasis here is on persisting difficulty. Some children are so uncomfortable when the conversation turns to the dead parent that they may leave the room. If this continues, check it out.
2. **AGGRESSION:** *Aggressive behavior* is not uncommon after a loss but should be monitored. If the aggressive behavior persists or takes the form of property destruction, then this child should be evaluated.
3. **ANXIETY:** As with aggression, it is not uncommon for a child to feel *anxiety* after the death of a parent. A number of children in the Child Bereavement Study felt increasingly anxious about their surviving parent during the first year of bereavement. For most children this anxiety attenuates over time. However, if anxiety persists for the child, and especially if the child clings to the surviving parent or exhibits phobic behavior about going to school, then evaluation is warranted.
4. **SOMATIC COMPLAINTS:** Some children express their grief through *somatic complaints* such as stomachaches, headaches, and the like. Most of these physical symptoms are self-limiting, but if a child experiences prolonged bodily distress after a parent's death or if the child develops psychosomatic problems, then evaluation is in order. Occasionally a child will experience the exacerbation of a preexisting physical condition within the context of a loss and this, obviously, requires medical attention.

ADAPTED FROM:

Worden, J. W. (1996). *Children and grief: When a parent dies* (pp. 147-149). New York: The Guilford Press.

5. **SLEEP PATTERNS:** It is not uncommon for children to experience *sleeping difficulties* after the death of a parent. In the Child Bereavement Study 30% of the children experienced some kind of sleep disturbance during the first year of bereavement. Disturbances ranged from difficulty falling asleep to early morning awakening. If sleep disturbance persists for a number of months, the child should be evaluated by a professional. The same would hold true if the child experiences persisting nightmares.
6. **EATING BEHAVIOR:** *Eating disturbance* may be a sign of clinical depression, both overeating and not eating well. Eating behavior is so variable in children that this sign must be looked at with some caution — one must not rush to the conclusion that a problem exists. However, eating disturbances can arise in a bereavement context and persisting changes in eating patterns need to be watched and possibly evaluated.
7. **WITHDRAWAL:** One should be concerned when a child shows *marked social withdrawal* after a death, wanting to be by him- or herself, particularly when this pattern was not present prior to the death. This is not so worrisome in the short term, but if such behavior persists, it might be worthy of evaluation.
8. **DIFFICULTIES IN SCHOOL:** *School difficulties or serious academic reversal* can be a sign of poor adaptation to a loss. In the Boston study school difficulties were experienced by 20% of the children during the first year of bereavement but dropped to 15% during the second year. Persisting school difficulties should be seen as a red flag, possibly requiring further evaluation.
9. **SELF-BLAME OR GUILT:** *Persistent self-blame or guilt* following a death should also lead to concern. Guilt, along with an overall sense of unworthiness, is often found in clinical depression and is sometimes the characteristic distinguishing depression from grief. Although grief and depression share many common features — such as dysphoria, low energy, and eating and sleeping problems — a pervasive sense of unworthiness is usually not present after a death and, if it is, usually points to clinical depression.
10. **SUICIDAL:** The child who is showing *self-destructive behavior* or who is expressing *a desire to die* should always be referred regardless of the

length of time. Although this behavior is less common, it must be taken seriously. Some children miss their dead parent or loved one so much that they express a desire to die and to rejoin the lost individual. This may be more true of children with a less well-developed understanding of concepts related to death, such as finality and irreversibility. Children who have lost a parent to suicide may also think about this option for themselves. Some people are hesitant to ask children about their suicidal wishes, fearing that the question may plant the idea in the child's mind. However, this is not the case — a gentle inquiry is appropriate if one has any suspicions that such thoughts may be present. Simple questions like "Have you ever thought of hurting yourself?" or "Have you ever threatened or attempted to hurt yourself?" are often sufficient to open up a discussion of this important area.

RESOURCES FOR GRIEVING CHILDREN

The Cove Center for Grieving Children, www.covect.org, founded by Jim and Mary Ann Emswiler, authors of Guiding Your Child Through Grief; this book is recommended on the NPEN List Serve.

The Dougy Center for Grieving Children & Families: <http://www.dougy.org>

The National Child Traumatic Stress Network – NCTSN: <http://www.NCTSN.org>

National Association of School Psychologists (NASP): <http://www.nasponline.org>

National Center for PTSD: <http://www.ncptsd.va.gov>

Centering Corporation – Catalog of Grief Resources:
<http://www.centeringcorp.com/catalog>

Tapestry Books — Adoption Book Catalog: <http://www.tapestrybooks.com>

Claudia Jewett Jarratt's 1994 classic, Helping Your Child Cope with Separation and Loss, found in the general resource section.

Note: Web sites and the information therein are continually subject to change.

ACTIVITIES FOR INTERVENTION

Whatever model is chosen for intervention, specific activities, selected as relevant to the age of the child, can be used to meet the needs of bereaved children. The activities listed here are intended to help bereaved children in several ways:

- They help facilitate the various tasks of mourning.
- They provide children with acceptable outlets for their feelings, including ways to address their fears and concerns.
- They help children get answers to their questions.
- They help counter misconceptions that children have about the death.
- They make discussions of death a normal part of the child's experience, something that may not be happening at home or in other settings.

Art Activities

Art activities are easy to use because children, from early ages on, love to draw and to express themselves with crayons, paper, and sculpting with clay. These expressive activities have several advantages. Children can remember their pain in measured amounts and attend to one aspect of the death at a time. Sadness and other feelings can be shared with an interested adult, and some of the inner turmoil a child may be experiencing can be put into words. Completing an art project can also provide the child with an important sense of mastery, something that death challenges in us all.

Drawing

When using drawing as a bereavement activity, the counselor provides the child with the materials and may suggest subjects. Some ideas follow.

“DRAWING” CONTINUED NEXT PAGE

ADAPTED FROM:

Worden, J. W. (1996). *Children and grief: When a parent dies* (pp. 161-168). New York: The Guilford Press.

- Draw something you worry about.
- Draw something that makes you mad.
- Draw yourself and write words that describe yourself.
- Draw your favorite memory of your dead father, mother, sister, and so forth.
- Draw a recent dream that you have had.
- Draw the ugliest picture you can.
- Draw your family.
- Draw yourself before your parent died; draw yourself now.
- Draw something that scares you.

To make these art activities effective, the children must be encouraged to share their pictures and to talk about them. In a group setting pictures can be shared with another child, then with a group of four children, and finally with the whole group.

Some counselors take a different approach when using art work with bereaved children. They will not suggest a specific topic for a drawing but will give materials to the children and then play various types of background music (harsh, peaceful, lively). Children are then free to draw whatever they like, but there is usually a relationship between the themes of the drawings and the flavor of the music being played. Again, these drawings, and the feelings elicited, can be shared with the counselor or the entire group.

Clay Modeling

The use of clay is another effective way to involve bereaved children in art activities. In both drawing and in clay sculpting, the colors selected by a child may reflect his or her feeling tone. For example, the use of red may reflect angry feelings or blue, sad feelings. However, lay counselors shouldn't make deep psychological interpretations of the children's work and should ask the children themselves how and what they are feeling. When using clay, the counselor can either suggest things to be sculpted, such as "create

your anger," or let children sculpt against the background of music or simply on their own.

Puppet Activities

Children of all ages like to use puppets, which appeal to adults as well. Manipulating a puppet removes children from speaking for themselves and gives them an opportunity to project onto the puppet thoughts and feelings that may be difficult for them to own. It offers a safe distance but is still a very energized activity. Puppets can be provided by the counselor or they can be made by the children. Small paper bags that fit easily over the child's hand can be drawn on, with holes for the eyes and mouth. Some counselors have the child make a puppet that looks like each of the family members, including the deceased parent. Letting each of these family members interact in the form of puppets can give the counselor, as well as the child, important insights into thoughts, feelings, and misperceptions that are current for the child.

Writing Activities

In addition to art activities, the various needs of the bereaved child can be facilitated through a number of writing activities, including the following.

- **Journaling.** Writing journals is an activity that appeals to and can be used with older children. The child is provided with a notebook and is encouraged to write down feelings, thoughts, and questions about the lost loved one. The child can also be encouraged to write down dreams, especially dreams that involve the deceased. Some children enjoy writing poems and these can be written in their journals. Counselors should be aware of privacy issues associated with this activity and should obtain the permission of the child if this material is to be shared with others.
- **Letters.** Writing letters to the deceased can also be used, but the counselor must use discretion here. One does not want to confuse the child whose concepts of death do not include finality and irreversibility, or the child who believes that the parent or sibling is just "away for a while" and will be returning. When appropriate, letters can include things the child wanted to say to the parent, such as statements of caring or asking forgiveness for something not done or said before the death. These letters can be kept, sent heavenward in a balloon, buried in the

ground, or expedited in a number of different ways. Practitioners familiar with Gestalt psychotherapy often have clients write letters to deceased individuals in order to complete unfinished business. Letters written in the present tense and directed toward the lost loved one can be more effective in the completion of these issues than merely talking with the counselor about them.

- **Lists.** Some children like to make lists, which can then be shared with the counselor or members of a group. Lists are especially useful in assessing the children's understanding about death and the specifics regarding their own loss. Lists can also be a useful tool in identifying and discussing misinformation. Children can list the facts about their parent's death, and they may list ideas such as that the dead can see or hear, that the body cannot move, and when you die you have a funeral. Then the children can make lists of their "fantasies" about the parent's death. They may list that "he or she can still see me, he or she will be mad if I do poorly in school," and so forth. Discussions can then take place regarding the reality underlying these facts and fantasies.

Memorials

Children can be asked to design a memorial service for their parent. This may include the activities, location, and things they want said about their parent that will help them and others remember. This is often an activity that captures the imagination of children, although younger children may not be able to do this without assistance. When children in the Child Bereavement Study were asked to redesign their deceased parent's funeral two years after the death, more than half of them redesigned the service. A similar activity asks the child what he or she would write on the parent's memorial marker, a phrase that would epitomize the life of the parent, or something that would communicate to others who the parent was.

Memory Book

A memory book is a scrapbook of memories about the deceased. In it children can place pictures they have drawn, stories they have written, and photographs they have selected. The memory book may contain artifacts from activities that the child remembers doing with their dead parent, and things that they will want to remember in the future. For example, one child wanted to focus on his trip to Disney World, while other children in the same

family had other remembrances that were special for them and included materials in the book that reflected these particular memories.

The memory book is best done as a family activity, with each child and other family members contributing to the book. It can provide a way for families to ensure memories and to talk about the deceased with each other.

Another important advantage of the memory book is that it gives children something to revisit and review as they move through the various developmental stages of their life. Many bereaved children have the fear that they will forget their lost parent. A memory book can give them something concrete to hold onto and to ensure that this won't happen. Younger children who had a more limited contact with their deceased parent can learn more about the dead parent as they grow and their interest in who their parent was changes.

Storytelling Activities for Young Children

There are a number of good books that deal with grief and bereavement written for children of various age levels. These include *The Fall of Freddie the Leaf*, written by Leo Buscaglia, and *Aarvy Aardvark*, written by Donna O'Toole. These stories can be read to bereaved children and then discussed individually or in a group. Children can tell how the story made them feel. Another good way to open up a dialogue is to have them draw their personal reactions to the story. A more indirect approach to feelings is to read the story to the children and then ask them how the bereaved character in the story might have been feeling. Counselors can also ask children to write a story about their own loss and then share this story with the counselor or with the group, combining storytelling and writing activities.

Games

Games are very useful in group settings. Children love games of all kinds and, because it is "only a game," it becomes easier for bereaved children to express taboo feelings and beliefs. Games in which all the children participate are a good way to normalize discussions of death. Games can also give children new ways of coping and relating to other children. There are many different kinds of games suitable for use with bereaved children and a few follow here.

- ***Five Faces (Jewett, 1982)***

Children are given crayons and five blank cards. They are asked to draw five different faces representing five different feelings — sad, glad, mad, scared, and lonely. Children love competition, so the leader can ask who can draw the saddest face. After each child has completed his or her five faces, the cards are shuffled into a face-down pile. Each child gets an opportunity to select a card and then tells the group about an experience that made them feel like the feeling portrayed on the card. As an alternative procedure, completed cards can be shuffled and five cards dealt to each child. When a child gets two cards representing the same feeling, he or she tells the group about experiences associated with that feeling.

- ***Question Box (Segal, 1984)***

Each child in the group is handed slips of paper on which they can write their questions about death or funerals. There should be one question per slip. Question slips are then collected and placed in a box. Each child is given the opportunity to select a question, to read it to the group, and to lead a discussion on the question.

- ***It's Not Fair When ... (Jewett, 1982)***

Each child is given a small box, such as a shoe box. Going around the circle, each child is given an opportunity to complete the sentence "It's not fair when ...," while slamming the box down onto the floor. After each child has participated, the boxes are stacked in a pile and knocked down by the children. The goal of this activity is to help the children to connect their actions with their words, and to find an acceptable way to express their anger.

- ***Changes***

Each child is given a piece of paper and crayons and is asked to divide the page by a vertical line. On the left side the child is asked to draw his or her family before the death. On the other side the child is asked to draw the family since the death. These pictures are shared with the rest of the children in the group.

- ***The Weather Inside***

Children are given paper and crayons and asked to draw what the weather was like on the day of their parent's funeral. After they do this,

they are asked to draw what the weather was like inside of them on that day. These drawings are then discussed.

- ***Show and Tell***

This is not really a game but is similar to the "show and tell" activity often used in school settings. Children are encouraged to bring to the group a picture of their dead parent or some object that is associated with a special memory of their parent. Each child, in turn, is given the opportunity to share these objects and pictures.

- ***Feeling Circle***

Each child is given a page with a large circle drawn on it. Children are asked how they are feeling today and then are asked to select a colored crayon that represents that feeling. The children color the circle and write the name of the feeling or feelings under it. As an alternative, circles can be drawn on a page and children with multiple feelings they want to express can color different circles to represent their various feelings.

REFERENCES REPRINTED FROM WORDEN

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About Child Trauma

Published on *The National Child Traumatic Stress Network* (<https://www.nctsn.org>)

What Is a Traumatic Event?

A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic. This is particularly important for young children as their sense of safety depends on the perceived safety of their attachment figures.

Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event. Children may feel terror, helplessness, or fear, as well as physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who experience an inability to protect themselves or who lacked protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses.

Even though adults work hard to keep children safe, dangerous events still happen. This danger can come from outside of the family (such as a natural disaster, car accident, school shooting, or community violence) or from within the family, such as domestic violence, physical or sexual abuse, or the unexpected death of a loved one.

What Experiences Might Be Traumatic?

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters or terrorism
- Family or community violence
- Sudden or violent loss of a loved one
- Substance use disorder (personal or familial)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness
- Military family-related stressors (e.g., deployment, parental loss or injury)

When children have been in situations where they feared for their lives, believed that they would be injured, witnessed violence, or tragically lost a loved one, they may show signs of child traumatic stress.

What Is Child Traumatic Stress?

Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the events have ended. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.

Children who suffer from traumatic stress often have these types of symptoms when reminded in some way of the traumatic event. Although many of us may experience reactions to stress from time to time, when a child is experiencing traumatic stress, these reactions interfere with the child's daily life and ability to function and interact with others. At no age are children immune to the effects of traumatic experiences. Even infants and toddlers can experience traumatic stress. The way that traumatic stress manifests will vary from child to child and will depend on the child's age and developmental level.

Without treatment, repeated childhood exposure to traumatic events can affect the brain and nervous system and increase health-risk behaviors (e.g., smoking, eating disorders, substance use, and high-risk activities). Research shows that child trauma survivors can be more likely to have long-term health problems (e.g., diabetes and heart disease) or to die at an earlier age. Traumatic stress can also lead to increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems. Adult survivors of traumatic events may also have difficulty in establishing fulfilling relationships and maintaining employment.

Reminders and Adversities

Traumatic experiences can set in motion a cascade of changes in children's lives that can be challenging and difficult. These can include changes in where they live, where they attend school, who they're living with, and their daily routines. They may now be living with injury or disability to themselves or others. There may be ongoing criminal or civil proceedings.

Traumatic experiences leave a legacy of reminders that may persist for years. These reminders are linked to aspects of the traumatic experience, its circumstances, and its aftermath. Children may be reminded by persons, places, things, situations, anniversaries, or by feelings such as renewed fear or sadness. Physical reactions can also serve as reminders, for example, increased heart rate or bodily sensations. Identifying children's responses to trauma and loss reminders is an important tool for understanding how and why children's distress, behavior, and functioning often fluctuate

over time. Trauma and loss reminders can reverberate within families, among friends, in schools, and across communities in ways that can powerfully influence the ability of children, families, and communities to recover. Addressing trauma and loss reminders is critical to enhancing ongoing adjustment.

Risk and Protective Factors

Fortunately, even when children experience a traumatic event, they don't always develop traumatic stress. Many factors contribute to symptoms, including whether the child has experienced trauma in the past, and protective factors at the child, family, and community levels can reduce the adverse impact of trauma. Some factors to consider include:

- **Severity of the event.** How serious was the event? How badly was the child or someone she loves physically hurt? Did they or someone they love need to go to the hospital? Were the police involved? Were children separated from their caregivers? Were they interviewed by a principal, police officer, or counselor? Did a friend or family member die?
- **Proximity to the event.** Was the child actually at the place where the event occurred? Did they see the event happen to someone else or were they a victim? Did the child watch the event on television? Did they hear a loved one talk about what happened?
- **Caregivers' reactions.** Did the child's family believe that he or she was telling the truth? Did caregivers take the child's reactions seriously? How did caregivers respond to the child's needs, and how did they cope with the event themselves?
- **Prior history of trauma.** Children continually exposed to traumatic events are more likely to develop traumatic stress reactions.
- **Family and community factors.** The culture, race, and ethnicity of children, their families, and their communities can be a protective factor, meaning that children and families have qualities and or resources that help buffer against the harmful effects of traumatic experiences and their aftermath. One of these protective factors can be the child's cultural identity. Culture often has a positive impact on how children, their families, and their communities respond, recover, and heal from a traumatic experience. However, experiences of racism and discrimination can increase a child's risk for traumatic stress symptoms.

TRAUMA AND CHILDREN: A PARENT HANDOUT FOR HELPING CHILDREN HEAL

Background

Every parent at one time has worried about harm befalling their children. When trauma to children occurs, the territory of everyday life becomes frightening and unfamiliar not only for children but parents as well. Parents may find themselves overcome with anxiety and fear. Trauma may send a shockwave to the system and parents may respond with a wide range of feelings. These feelings may include a sense of disbelief, helplessness, isolation, despair, or horror. Parents may try to make sense out of a senseless act. Who can prepare for their children being physically or sexually assaulted, kidnapped, mugged, robbed or involved in a severe automobile accident? Who can prepare for children being diagnosed with a life threatening illness or experiencing a natural or man-made disaster?

Traumas typically occur suddenly, often leaving children little or no time to prepare physically or emotionally. Traumas are unpredictable and outside what is to be expected in children's lives. During a trauma, children experience intense fear, horror or helplessness. Typical methods of coping no longer work. Following trauma, children require extra support and need to learn new coping strategies.

Parents can be instrumental in their children's recovery. Therefore, helping children recover from a trauma is a family matter. Parents need to take the lead and model positive coping. Yet parents themselves may require extra information, support and resources to assist their children. Some first steps that parents can take are to understand the impact and symptoms of trauma and how to help in the aftermath. This handout provides this information.

REPRINTED FROM:

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The Impact of Trauma

Trauma can change the way children view their world. Assumptions about safety and security are now challenged. Children's reactions will depend upon the severity of the trauma, their personality makeup, their characteristic coping style and the availability of support. It is common for children to regress both behaviorally and academically following a trauma. A constructive way to view the situation is that they are normal children in an abnormal circumstance.

It is natural for children to first experience some sort of *denial*. For example, children may insist upon returning to a house that has been destroyed. *Fears, worries or nightmares* are common following a trauma. *Sleep disturbances or eating difficulties* may happen. Also children may begin to *regress emotionally* or act younger than their chronological age. They also may become more *clinging, unhappy and needy of parental attention and comfort*. Feelings of *irritability, anger, sadness or guilt* may often emerge. *Somatic complaints* such as headaches, stomachaches or sweating are not unusual. Some *loss of interest in school and poor concentration* are some other common reactions.

Symptoms Associated with Post Traumatic Stress Disorder

Following a trauma, children may experience some of the symptoms of Post Traumatic Stress Disorder (PTSD). The main symptoms are as follows:

Re-experiencing of the trauma during play or dreams. For example, children may:

- Repeatedly act out what happened when playing with toys
- Have many distressing dreams about the trauma
- Be distressed when exposed to events that resemble the trauma or at the anniversary of the trauma event
- Act or feel as if the trauma is happening again

Avoidance of reminders of the trauma and general numbness to all

emotional topics. For example, children may:

- Avoid all activities that remind them of the trauma
- Withdraw from other people
- Have difficulty feeling positive emotions

Increased "arousal" symptoms. For example, children may:

- Have difficulty falling or staying asleep
- Be irritable or quick to anger
- Have difficulty concentrating
- Startle more easily

What Can I Do as a Parent Following a Trauma?

- **Establish a sense of safety and security.** It is essential that children feel protected, safe and secure in the aftermath of a trauma. Ensure that all basic needs are met, including love, care and physical closeness. Spend extra time to let children know that someone will nurture and protect them. Children will need a lot of comforting and reassurance.
- **Listen actively to your children:** Seek first to understand before trying to be understood. Parents may underestimate the extent of the trauma experienced by their children. It is often not as important what you say, but that you listen with empathy and patience. In some instances your children may be reluctant to initiate conversations about trauma. If so, it may be helpful to ask them what they think other children felt or thought about the event. Also, it may be easier for children to tell what happened (e.g., what they saw, heard, smelled, physically felt) before they can discuss their feelings about the trauma. In other instances, children will want to tell their parents the story of the trauma over and over. Retelling is part of the healing process. Children need to tell their stories and have their parents listen again and again to each and every agonizing detail.
- **Help your children express all their emotions.** It is important to talk to your children about the tragedy — to address the suddenness and

irrationality of the disaster. Reenactment and play about the trauma should be encouraged. It is helpful to ensure that children have time to paint, draw or write about the event. Provide toys that may enable children to work through the trauma. Examples may include such items as a toy fire engine, ambulances, fire extinguisher, doctor kit, etc., for a girl injured in a fire. Imagining alternate endings to the disaster may help empower your children and allow them to feel less helpless in the aftermath of a tragedy.

- ***Validate your children's feelings.*** Help children understand that following a trauma all feelings are acceptable. Children will probably experience a myriad of feelings which could include shame, rage, anger, sadness, guilt, pain, isolation, loneliness and fear. Help your children understand that what they are experiencing is *normal* and to be expected.
- ***Allow your children the opportunity to regress as necessary.*** This is important so that they may "emotionally regroup." For example, your children may request to sleep in your bed with the lights on or you may need to drive your children to school. Previously developed skills may seem to disappear or deteriorate. Bed-wetting or thumb sucking may occur. Aggression and anger may emerge in a previously non-aggressive child. Be patient and tolerant and never ridicule. Remember that most regression following a trauma is temporary.
- ***Help children clear up misconceptions.*** Help correct misunderstandings regarding the cause or nature of the trauma, especially those that relate to inappropriate guilt, shame, embarrassment or fear. (Examples may be "I should have been able to save my brother from the car wreck." "God struck my sister dead because God was angry at her." "My father died of cancer and I will catch it from him.")
- ***Educate yourself about trauma and crisis.*** The more you know about trauma, the more empowered you may feel. To help educate yourself, consider setting up a conference with the school psychologist or mental health professional in your school. A good place to start is by reading the texts listed below under "Resources for Parents."
- ***Help predict and prepare.*** If your children need to go to a funeral or deal with surgery, carefully explain what will happen each step of the way.

Allow your children to ask all kinds of questions. If they need to appear in court, explain what they will see, hear, do, etc.

- **Arrange support for yourself and your family as necessary.** Consult with your clergy, rabbi, physician and friends as necessary. You may need extra emotional, religious, medical and/or psychological support. If possible take appropriate time for recreational or pleasurable experiences with your children to establish a sense of normalcy and continuity.
- **Communicate with the school and staff about what occurred.** Most teachers will be understanding and helpful if they know that children had a traumatic experience. Teachers may be able to provide additional support both educationally and emotionally. They can also provide information to doctors or therapists or alert you to troublesome behaviors they observe.
- **Affirm that your children are capable of coping and healing in the aftermath of a trauma.** Plant "emotional seeds" that express confidence in your children's ability to heal. Remember the messages that you give your children have incredible power.
- **Seek professional assistance for your children and family as necessary.** When seeking help, make sure the professional has experience with children and has treated crisis and trauma. Feel free to discuss with the therapist all your concerns and all aspects of treatment. If your children are experiencing the symptoms of PTSD, then therapy may be warranted.

What Can I Say as a Parent Following a Trauma?

- Sometimes knowing exactly what to say is difficult. However, your emotional **expression of love and concern** is more important than words. Just saying "This is very hard for us" can lead to emotional relief and understanding.
- **Always be honest** with your children about what has happened and what may occur. Remember that following a trauma, children may lose a sense of trust about the safety and security of the world. Therefore, honesty is essential so your children can maintain a sense of trust.

- ***Respect your children's fears.*** Children cannot be helped by trying to argue them out of their fears by appeals to bravery or reason. What is most helpful is an approach that says, "I know you are feeling frightened of - - - - now." This can be followed by an offer of assistance and support by saying, "Let's see what we can do to make this less scary for you."
- Make sure that your children know that ***you are aware of the seriousness of the situation.*** Allow your children to cry. Saying to your children "Don't cry, everything will be fine" denies the seriousness of the situation.
- ***Try to recognize your children's feelings*** and put them into words. For example, if a child's close friend died in an automobile accident, you might say to your child "You are sad and angry that your friend was killed. I know that you must miss him very much." Or if a child feels overwhelmed by fears in the aftermath of a hurricane, you may say, "I know that you are frightened, but we have a plan to protect us if another hurricane occurs."

What Should I Do if I Believe My Child May be Suffering from PTSD?

Consult with your local school psychologist or contact a mental health professional who has experience in this area such as a psychiatrist, psychologist or mental health counselor. Your school psychologist or pediatrician may direct you to the appropriate resources.

What Type of Therapy is Recommended for Traumatized Children?

A variety of methods may be used depending on the orientation of a particular therapist. Very different approaches to the same problem can be equally effective when undertaken by an insightful and skilled professional. Approaches may include individual, group or family therapy. Therapists often use play, art and drama methods in their treatment as well as "cognitive-behavioral" approaches, which help children reinterpret events and feelings in a more positive way, or in some cases they might use clinical hypnosis. As

part of the therapy experience, children will be guided to reprocess the trauma in a safe and supportive environment. In some instances medication may be used to control severe anxiety, depression or sleeplessness. However, medication should not be used as a substitute for psychotherapy for traumatized children.

If I Seek Therapeutic Services for My Children, What Will be the Goals of Therapy?

The goals of therapy with traumatized children should include:

- Gaining a sense of mastery and control over one's life
- The safe expression and release of feelings
- Relief of painful symptoms and post traumatic behaviors
- Minimizing the scars of trauma
- Corrections of any misunderstandings and self-blame
- Restoration of hope regarding the future
- Establishing a renewed sense of trust in oneself and the world
- Developing perspective and distance regarding the trauma

Summary

Helping children recover from trauma is a family matter. It is important to maintain an open discussion of the trauma and recognize the feelings of all family members. Focus on the immediate needs of the children and take a one-day-at-a-time approach. Find and use support systems outside of the family. Always maintain a positive image of your children as healers and survivors.

Resources for Parents

Brooks, B., & Siegel, P. (1996). *The scared child: Helping kids overcome traumatic events*. New York: John Wiley.

Monahan, C. (1997). *Children and trauma: A parent's guide to helping children heal*. San Francisco: Jossey-Bass.

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National Association of School Psychologists: <http://www.nasponline.org>

National Center for PTSD:
http://www.ncptsd.org/facts/specific/fs_children.html

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NOTE THAT SOME INFORMATION IN "RESOURCES FOR PARENTS" IS SUBJECT TO CHANGE.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT — INFANCY

INFANCY (Birth-18 Months)

Cognitive Development

- The infant has ***not developed object permanence***; when things are out of sight they are GONE. Even temporary losses of significant care-takers is experienced as total. (They cannot comprehend that mother "will be right back.")
- Infants have ***short attention span and memory***.
- They ***do not understand change***: they only feel it.
- Because they don't understand, ***changes*** and unfamiliar sensory experiences (sights, noises, smells, sound levels, touch, people) ***frighten them***.
- They have little or no language ability and therefore ***cannot communicate***, except by crying.

Infants' cognitive limitations greatly increase their experience of stress. Without a well-developed cognitive perception of the event, any change is threatening. The child becomes accustomed to the caregiver's voice, scent, touch, and method of meeting needs. Cultural norms regarding caregiving may include when and how long a baby should cry, the use of bottle or breast feeding, schedules and routines, stimulation, exercise and play. Infants will be extremely distressed simply by changes in the environment, changes in patterns of caretaking and the absence of trusted caretakers.

Infants and toddlers have a poorly developed sense of time, or no sense of time. They do not understand the concept of "temporary" placement; a

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 25-28) [Core Curriculum]. Columbus, OH: Author.

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"temporary" placement may amount to half of the infant's life. Placement plans (whether they be temporary or permanent) for infants and toddlers should be expedited whenever possible.

Infants have limited ability to remember people and places they do not regularly see. Frequent visitation (i.e.: daily) should occur between infants and their parents in order to maintain attachment between them.

Infants have no ability, and toddlers have very limited ability to discuss the placement process, or their reactions to it. Furthermore, infants and toddlers have a limited circle of trusted individuals. Therefore, they must experience their new environments in a sensory manner, with the support and "permission" of a trusted caregiver. For these reasons, extreme care should be taken whenever changing an infant or toddler's placement. Preplacement visits should occur daily; longer time periods between visits may not allow the infant or toddler to become accustomed to the new environment. Further, whenever feasible, the infant should be introduced to the new caregiver in the home of the infant's trusted caregiver, where the infant feels safe and secure. New caregivers should gradually assume a nurturing role with the infant. Visits in the new caregiver's home should occur only after the infant has begun to recognize and trust the new caregiver. Former caregivers should visit the infant in his new home in order to promote continuity and security for the child.

Caseworkers can use play techniques with toddlers, to help them understand the placement process.

Emotional Development

- Infants are emotionally ***dependent upon others*** for survival, nurturance, and care to meet their basic needs.
- Infants generally form strong attachments to their primary caretaker and have developed a sense of trust in that person. They often ***cannot be comforted by others when distressed***.
- After 5-6 months, the infant can easily discriminate between people and ***displays anxiety in the presence of unknown persons***.
- The infant experiences ***anxiety in the face of change***. Emotional stability depends upon similarity, continuity, and stability in the environment and the continued presence of their primary caretaker. When an infant is

placed in a foster/kinship/or adoptive home, the differences in caretaking behaviors and routines may create anxiety for the child.

Social Development

- Without language, infants have ***few ways to communicate their needs***. Most communications are nonverbal. If adults are not familiar with their cues and do not recognize their distress, their needs may remain unmet.
- ***Social attachments are limited*** to immediate caretakers and family members.
- Infants have immature "social skills" and ***do not easily engage into relationships with unfamiliar persons***. Adults must generally initiate, and reinforce, interactions.

Implications for Separation and Placement

Infants' ***cognitive limitations greatly increase their experience of stress***. Without a well-developed cognitive perception of the event, any change is threatening. Infants will be extremely distressed simply by changes in the environment and the absence of trusted caretakers.

Infants have ***few internal coping skills***. Adults must "cope" for them by removing stressors from their lives and meeting all of their needs. When deprived of adults upon whom they have learned to trust and depend, they are more vulnerable to the effects of internal and external stresses.

The infant experiences the absence of caretakers as immediate, total and complete. Infants ***do not generally turn to others for help*** and support in the absence of their primary caretaker. An infant who has lost its primary caretaker often cannot be comforted by the caseworker, foster caregiver or others.

If separation occurs during the first year, it can ***interfere with the development of trust***. Repeated experiences with separation and placement may further interfere with the development of trust.

The child's distress will be lessened if his ***new environment can be made very consistent with his old one***, and if the birth parent can visit regularly, preferably daily, and provide direct care to the child in the placement setting.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT— PRESCHOOL

PRESCHOOL (2-5 Years)

Cognitive Development

- The child uses language to communicate but has a limited vocabulary and does not understand complex words or concepts. Many thoughts or feelings cannot be fully expressed.
- The child does not have a well-developed understanding of time, particularly of long time periods. The child cannot discriminate between "next week," "next month," and "next year."
- The child has difficulty understanding cause and effect and is often unable to discern how events relate to one another, to explain why things happen, or to predict what may happen next.
- The child may display magical thinking and fantasy to explain events. The child may feel that his actions or thoughts have exaggerated effects on events in his environment.
- The child displays primarily egocentric thinking, which means he is not capable of understanding perspectives which are different from his own. The world is as he views it. Other people's explanations of events may make no sense to him, and he will stubbornly cling to his own explanation. His logic is faulty by adult standards, but it makes perfect sense to him.

"COGNITIVE DEVELOPMENT" CONTINUED NEXT PAGE

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The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 28-31) [Core Curriculum]. Columbus, OH: Author.

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COGNITIVE DEVELOPMENT (CONTINUED)

- The child may not generalize experiences from one situation to another. For example, despite the fact that his house and all his friends' houses have bathrooms, he may still doubt the existence of a bathroom in the foster home until he sees it for himself.

Emotional Development

- The child is still dependent on adults to meet his emotional and physical needs. The loss of adult support leaves him feeling alone, vulnerable, and anxious.
- Development of autonomy and a need for self-assertion and control make it extremely difficult for a child this age to have things "done to him" by others. When thwarted by adults, the child is likely to create and engage in battles with adults to maintain some degree of control.

Social Development

- The child is beginning to relate to peers in reciprocal, cooperative and interactive play. Cultural expectations regarding how and what the child plays will influence the child's play patterns. For example, there are often cultural expectations regarding the degree to which children are expected to explore their environments.
- The child relates to adults in playful ways and is capable of forming attachments with adults other than parents. The child can turn to other adults to meet his needs.
- "Good" and "bad" acts are defined by their immediate, personal consequences. Children who are bad are punished; children who are good are rewarded. The child's self-esteem is often influenced by how "good" he believes he is.

Implications for Separation and Placement

- The child is still essentially dependent and has limited coping abilities.

"IMPLICATIONS FOR SEPARATION AND PLACEMENT" CONTINUED NEXT PAGE

IMPLICATIONS FOR SEPARATION AND PLACEMENT (CONTINUED)

He still needs dependable adults to help him cope. However, emotionally healthy children of this age can turn to substitute caregivers or a known and trusted caseworker for help and support during the placement process. Having some relationship with an adult in the new home prior to placement also helps to reduce the child's stress during the placement.

- The preschool child is likely to have an inaccurate and distorted perception of the placement experience.
- Due to his immature conception of time, any placement of more than a few weeks is experienced as permanent. Without frequent contact with his parents, the child may assume that the parents are gone and are not coming back. He may abandon hope relatively quickly and attempt to establish a permanent place for himself in the substitute care home.
- The child will often view separation and placement as a punishment for "bad" behavior. Egocentric thinking limits his understanding. That he had to leave home because someone else (his parent) had a problem makes no sense. Children this age will cling to their own explanation for the placement, despite attempts by adults to explain otherwise. This self-blame is a threat to the child's self esteem and increases his anxiety.
- Because the child cannot generalize experiences from one situation to another, all new situations are unknown and therefore more threatening, which greatly increases the anxiety experienced by the child.
- The child will display considerable anxiety about the new home. He will be concerned about being cared for, but may not have adequate language to express the concerns in detail. He will likely be confused and perhaps anxious about expectations for his behavior, especially if the codes of conduct in the foster home are different from his parents' codes of conduct. His insecurity may be expressed with questions such as, "Do they have band-aids at their house?" "Does the dog bite children?" "Am I allowed to ...?" He needs reassurance that he will be fed, clothed, and that the new family will care for him when he is sick. Repeated separations and placements will likely compound the child's anxiety.

"IMPLICATIONS FOR SEPARATION AND PLACEMENT" CONTINUED NEXT PAGE

IMPLICATIONS FOR SEPARATION AND PLACEMENT (CONTINUED)

- Most often, while verbal reassurances are helpful, the child needs to experience the environment to feel comfortable in it.
- Forced placement, without proper preparation, may generate feelings of helplessness and loss of control, which may interfere with the development of self-directed, autonomous behavior. The child may learn that he cannot influence the environment and becomes placid and unassertive; or, he may become engaged in a power struggle with adults in an attempt to assert and assure his autonomy.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT— SCHOOL AGE

SCHOOL AGE (6-9 Years)

Cognitive Development

- The child has developed cognitively to the stage of concrete operations. She understands cause and effect and logical relationships between events. She will have difficulty understanding abstract relationships. "Your mother gave you away because she loved you" is a logical inconsistency for her.
- The child has limited perspective taking ability. She can, at times, understand other people's feelings and needs. She is beginning to understand that things happen to her which are not her fault.
- The world is usually experienced in concrete, black and white terms. The child is most comfortable if her environment is clearly structured and she understands the rules about how things should be done, and what is right and wrong. She is concerned with fairness and often has difficulty accepting ambiguity or changes in previously defined rules.
- The child has a better perspective regarding time and is able to differentiate between days and weeks, but cannot fully comprehend months or years. A school year is perceived as an eternity.

Emotional Development

- The child is a performer. Her self esteem is strongly affected by how well

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 31-34) [Core Curriculum]. Columbus, OH: Author.

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she does things in her daily activities, including academic performance and play activities.

- She is anxious when she does not have structure, and when she does not understand the "rules" of the situation. If expectations for her behavior are ambiguous or contradictory, she does not know what is right and often feels helpless to perform properly.
- The child's primary identification is with her family. Her sense of self and her self esteem are closely tied to her perception of her family's worth. If other people talk about her family in negative terms, this reflects upon her as well.

Social Development

- The child can form significant attachments to adults and to peers.
- The child derives considerable security from belonging to a same-sex social group. For many children this age, their circle of friends are the focus of most activities and social interactions.
- The child recognizes that being a foster child is somehow "different" from the other children, at a time when it is very important that she be more like them.
- The child is fiercely loyal and exclusive in her relationships, and may have difficulty when she must choose between relationships with more than one person. The child may not understand how she can like both her old friends and her new ones, or love her mother and foster mother too.
- Her value system has developed to include "right" and "wrong," and she experiences guilt when she has done something wrong.

Implications for Separation and Placement

- The child can develop new attachments and turn to adults to meet her needs. If previous relationships with unrelated adults have been positive, she will be likely to seek out help from adults when she needs it. This increases her ability to cope in stressful situations.

"IMPLICATIONS FOR SEPARATION AND PLACEMENT" CONTINUED NEXT PAGE

IMPLICATIONS FOR SEPARATION AND PLACEMENT (CONTINUED)

- The child's perception of the reason for the separation may be distorted. She may verbalize that she is not at fault, particularly if this is reinforced by persons she trusts. She will not want to accept that her parents are at fault either. Her self esteem is closely tied with their worth, and she needs to view them positively. However, in her cognitively concrete world, someone must be blamed; and often the caseworker, the agency, or the foster caregivers are faulted.
- The child will compare foster/kinship/or adoptive caregivers to her parents, and the caregivers will generally lose the competition.
- Each placement, in effect, is cross-cultural, in that the specific culture of each family is unique. The degree of difference between the culture of the child's former home and the child's foster home will vary, and may be most pronounced if there are racial differences. The child may experience confusion, hostility and resentment regarding these differences. These may include differences in codes of conduct, and expectations for behavior, mastery of developmental tasks, and social and familial roles. Derogatory statements about his culture or race may damage his self esteem, as well as the development of his cultural identity. The foster parent caregiver may need to deal with the child's confusion, resentment, or hostility in relation to cross-cultural placements. Elements of the child's culture, such as foods, language, music and art, religion, etc., should be maintained in order to provide stability, continuity, and security for the child.
- The loss of her peer group and friends may be almost as traumatic as loss of her parents. Making new friends may be difficult. The child may be embarrassed and self-conscious about her "foster child" status, and she may feel isolated. Maintaining contact with her old peer group is helpful. The child may also benefit from a "cover story," to use with her peers to explain her foster child status and the reasons for her placement.
- The child will be very confused if the "rules" and expectations in the foster home are different from what she is used to. She will be anxious and uncomfortable until she fully understands what is expected of her. She may perceive differences in rules as "unfair."

"IMPLICATIONS FOR SEPARATION AND PLACEMENT" CONTINUED NEXT PAGE

IMPLICATIONS FOR SEPARATION AND PLACEMENT (CONTINUED)

- The child may be confused by differences in expectations for her behavior, dress, food, activities, especially if the child is placed in a home that is culturally different from her home.
- The child may not be able to continue with extracurricular activities, such as sports, either because the school or community of the foster home does not offer that activity, or because registering for those activities was disrupted during the crisis which led to her placement.
- The child has a better understanding of time. Placements of a few months can be tolerated, if the child understands she is eventually to go home. Longer placements may be experienced as permanent. Because the child needs concreteness, if she cannot be told exactly when she is to return home, her anxiety increases.
- If the child was placed after some perceived misbehavior, she may feel responsible and guilty, and anxious about her parents accepting her back.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT— PREADOLESCENCE

PREADOLESCENCE (10-12 Years)

Cognitive Development

- Most of the child's thinking is still concrete. However, some preadolescent children show a beginning ability to think and reason abstractly, and to recognize complex causes of events.
- The child is able to understand perspectives other than his own. Some children have developed insight and can recognize and respond to the needs and feelings of others. They may recognize that their parents have problems which contributed to the need for placement. ("My Dad is nice until he gets drunk, and then he gets mean and hits us.")
- The child's time perspective is more realistic. He is able to recall events which occurred months, and probably years, earlier, and can maintain a sense of continuity over time.

The child can generalize experiences from one setting to another. (He will not question whether the foster family has a bathroom, even though he has never been to the foster home, because he understands that houses have bathrooms.)

- § The child understands that rules often change depending upon the situation. The child can more easily adapt his behavior to meet the expectations of different situations.

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 34-36) [Core Curriculum]. Columbus, OH: Author.

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Emotional Development

- Self esteem and identity are still largely tied to the family. Negative comments regarding the family reflect upon him as well.
- The child has increased ability to cope independently for short periods of time. He can feed, dress and care for himself, and travel independently around the neighborhood. He can manage some problems and resolve them without assistance from adults. However, he still turns to significant adults for approval, support, and reassurance when things are difficult.
- He may be very embarrassed by his foster child status. He is self-conscious about his differentness.

Social Development

- The child's social world has expanded to include many people outside the family.
- Peers are extremely important. Most peer relationships are of same-sex. Both boys and girls may have "very best friends" who form their social support network, as well as peer groups with whom they identify.
- Opposite sex friendships exist, but unless the child has been prematurely introduced to sexuality, these are of no special interest or concern.
- The child still needs trusted adults for leadership, support, nurturance, approval.
- "Right" and "wrong" are complicated and evolving concepts. For most children this age, right and wrong are determined by principles which they believe apply to all people, including their parents. While the child may not understand the sources of, or the reasons for, this moral code, they can begin to understand that their parents have the capacity to do wrong.
- The preadolescent has integrated cultural information into his/her identity and has developed pride in his/her heritage. Cultural codes of conduct and values provide guidance regarding the mastery of several adolescent developmental tasks, such as managing emerging sexuality, becoming independent, and relationships with peers.

Implications for Separation and Placement

- The child has an increased ability to understand the reasons for the separation. With help, the child may be able to identify the causes of the family disruption. He can be helped to realistically assess the degree to which his behavior contributed to the problems. With proper assistance, the child can develop a realistic and accurate perception of the situation, and can avoid unnecessary and unreasonable self-blame.
- The child can benefit from supportive adult intervention, such as casework counseling, to help sort through his feelings about the situation. Some children this age are able to acknowledge their anger and ambivalent feelings and "talk them out." This assists them to cope with the situation.
- If given permission, the child may be able to establish relationships with caregivers without feeling disloyal to his parents. If this is possible, placement in substitute care may not be as threatening. Caseworkers and therapists should help the child understand that he is "allowed" to love both his parents and foster caregivers; and that loving the foster caregivers does not indicate disloyalty to his parents.
- The child is aware of the perceptions and opinions of other people. He may be embarrassed and self-conscious regarding his family's problems and inadequacies, and regarding his foster care status. This may contribute to the development of low self esteem.
- The child may be worried about his family as a unit and may demonstrate considerable concern for siblings and parents. He will want reassurance that they are OK and are getting the help they need.
- Preadolescents may be preoccupied with fantasies of returning to earlier attachment figures (primary parents, kin, or earlier foster caregivers). These fantasies can interfere with the child's successful attachment and adjustment in his new home.
- The loss of "best" friends, boyfriend/girlfriend, and peers may be particularly difficult for the child. It may be difficult to replace these relationships in the foster/kinship or adoptive care setting. The child may be lonely and isolated.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT— EARLY ADOLESCENCE

EARLY ADOLESCENCE (13-14 Years)

Cognitive Development

- The child's emerging ability to think abstractly may make complicated explanations of reasons for placement more plausible. However, she still may be confused if the factors are too abstract. While some children may be developing an ability to understand complicated and multiply caused events, other children will not. As with adults, such ability may depend upon the individual's general intellectual potential.
- The child may have an increased ability to identify her own feelings and to communicate her concerns and distress verbally.

Emotional Development

- Preadolescence is a time of emotional "ups and downs." The child may experience daily (or hourly) mood swings and fluctuations. At its worst, it can be a chaotic time. At best, the child is still volatile, unpredictable, and emotionally charged.
- § Physical and hormonal changes, including significant and rapid body changes, generate a beginning awareness of sexuality. The child experiences many new feelings, some of which are conflicting and contradictory. Emotional changes may be accompanied by solicitous and exaggerated behavior toward the opposite sex, or anxious withdrawal. Many

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 37-40) [Core Curriculum]. Columbus, OH: Author.

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children display both behaviors at different times as they experiment with new feelings.

- The child begins to feel a desire to be "independent." However, she is not emotionally ready for true independence. Independence is expressed by verbally rejecting parental values and rules and adhering to the values of her peers.
- Despite a verbalized rejection of adult rules and values, the child experiences considerable anxiety when deprived of structure, support and rules.

Social Development

- The child may be embarrassed to admit her need for adult approval, support, and nurturance. This makes it difficult for her to enter into relationships with adults.
- The child is status conscious. Much of the child's self-esteem is derived from peer group acceptance and from being in the "right" peer group. These groups, and their membership, may change from day to day. Some children may reject their childhood friends for acceptance into a more "popular" subgroup. Standards of acceptance are rigid, and many children this age typically feel they do not adequately measure up.
- The child may feel a need to keep up appearances and may defend her family in public and to adults, even if she personally believes her parents to be at fault.
- The child is beginning to become aware of social roles, and she experiments with different roles and behaviors. Consistent social role models are needed. Because sexual identity is becoming an issue, improper sexual behavior on the part of the child's parents (sexual abuse, promiscuity) may be of increasing concern.
- Although many children will have developed a moral attitude with clearly defined "rights" and "wrongs," these values may take a back seat to their friends' opinions and attitudes regarding their thoughts and actions. The values of the peer group often supersede their own.

Implications for Separation and Placement

- Early adolescence is emotionally a chaotic period. The child experiences many stresses as a result of internal, biological changes, and changes in the environment's expectations for her behavior. Any additional stress has the potential of creating a "stress overload" situation for the child and may precipitate crisis.
- Early teens who separated from friends and/or girlfriends/boyfriends will experience considerable distress. Relationships with peers are tremendously important to the young adolescent, and they may run away from the foster home to be close to them.
- Young adolescents may feel they are unable to "fit in" to their new social environments, especially if there are obvious cultural differences between him and his peers. This can result in considerable anxiety, and sometimes, depression. The adolescent's cultural identity formation may be compromised. These issues also affect later stages of adolescent development.
- Cultural differences between the young teen's previous home and the foster home (such as expectations regarding dress, language, choice of friends, dating, and level of independence) may affect the success of the young teen's placement. The substitute caregiver and caseworker should talk openly with the teen about these differences, and develop methods of helping the teen feel "at home" and comfortable in his new setting. These issues also affect later stages of adolescent development.
- The child may resist relationships with adults and may describe adults in uncomplimentary terms. In the child's mind, dependence upon adults threatens her "independence." The child may not be able to admit her need for support, nurturance, and structure from adults. Without these, however, the child may flounder and experience considerable anxiety. By rejecting adults, the child deprives herself of a source of coping support. The peer group, to whom the child turns, cannot generally provide the stability and help the child needs.
- The child may deny much of her discomfort and pain. This prevents her from constructively coping with these feelings, and they may be expressed through volatile, sometimes antisocial, behavior. The general emotional

upheaval of this developmental period will be exhibited in mood swings and erratic temperamental behaviors.

- Separation from parents, especially if the result of family conflict and unruly behavior on the part of the child, may generate guilt and anxiety.
- At a time when identity is an emerging issue, the child may have difficulty in realistically dealing with her parents' shortcomings. The parent may either be idealized and their shortcomings may be denied; or, they may be discounted, verbally criticized, and rejected.
- Entry into sexual relationships may be very frightening without the support of a consistent, understanding adult.
- The child has the capacity to participate in planning and to make suggestions regarding her own life. This provides a sense of involvement, worth, and control. The child will be less likely to resist or thwart a plan if she has been involved in developing it.
- Persistent, repeated attempts to engage the child by a caseworker can have very positive results. Even if the child never acknowledges that the caseworker is of help, she may greatly benefit from the support and guidance of the worker.

EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCES DURING SEPARATION AND PLACEMENT— MIDDLE ADOLESCENCE

MIDDLE ADOLESCENCE (15-17 Years)

Cognitive Development

- The child has the cognitive capability to understand complex reasons for separation, placement, and family behavior. He can understand that things happen for many reasons, that no one person may be "at fault," and that his parents aren't perfect. (He may not, however, be able to accept it emotionally.)
- The ability to be self-aware and insightful may be of help in coping with the situation and his conflicting feelings about it.
- The child is more able to think hypothetically. He can use this ability to plan for the future and to consider potential outcomes of different strategies.

Emotional Development

- The child is developing greater self-reliance. He is more able to independently make, or contribute to making, many decisions about his life and activities. This helps him to retain a degree of mastery and control, which helps reduce anxiety.
- The development of positive self-esteem is as dependent upon acceptance by peers of the opposite sex as it is in being accepted by same-sex peers.

"EMOTIONAL DEVELOPMENT" CONTINUED NEXT PAGE

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (pp. 40-42) [Core Curriculum]. Columbus, OH: Author.

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EMOTIONAL DEVELOPMENT (CONTINUED)

- Identity is being formulated by considering and weighing a number of influences, including family, peers, and one's own values and behaviors. The adolescent is beginning to formulate many of his own beliefs and opinions. Many behaviors and ways of dealing with situations are tried, and adopted or discarded in an attempt to determine what feels right for him.

Social Development

- Opposite-sex relationships are as important as same-sex relationships. Much social behavior is centered around dating. Group identification is important, but less so. Individual relationships are becoming more important.
- The child is very interested in adults as role models. He will be very responsive to adults who are honest, and who will talk about their ideas without enforcing behavioral expectations or values. The child is often willing to listen and to try new ways of thinking and behaving.
- The child is beginning to focus on future planning and emancipation. The child is developing, and experimenting with, self-reliance. The child still needs the consistent backing of a family, but is essentially growing away from the family.
- Toward the end of middle adolescence, many children may begin to question previously held beliefs and ideas regarding "right" and "wrong," and they may be less influenced by peer attitudes. An emergence of independent ethical thinking may be evident.

Implications for Separation and Placement

- The child will probably experience ambivalence about his family. He may need to reject them to support his own sense of independence; and he may also need their backing, support, and caring. Separation from them deprives him of the opportunity to work out this conflict within the family setting. With help and reassurance that ambivalence is normal, the child may be able to accept his feelings and be able to be

angry at and love his family at the same time.

- The child's need for independence may affect his response to placement in a family setting, especially if the substitute family expects that he "become one of us." The child's family identity may remain with his birth family, and he may be unwilling to accept the substitute family as more than a place to stay. This may be perceived as the child's failure to "adjust" to the placement, even though it is a healthy, and expectable, response.
- The child may not remain in a placement if it does not meet his needs. Some children this age would rather find their own solutions and placements.
- The child may constructively use casework counseling to deal with the conflicts of separation and placement in a way that meets the child's needs without threatening his self-esteem and independence. A strong relationship with a trusted caseworker can provide support, offer guidance and direction, and help the child develop realistic, accurate perceptions of the situation and his role in it.

MINIMIZING THE TRAUMA OF MOVES: DEVELOPMENTAL CONSIDERATIONS

INFANTS

Emphasis on transferring attachment and caregiving routines during pre-placement contacts. Maintain as many routines as possible in new setting. After move, provide consistency and meet needs on demand.

Strategies:

TODDLERS

Preplacement preparation is crucial to reduce long-term anxiety and fear regarding separation, loss, and lack of safety with caregivers. Primary goal during moving process is to transfer attachment; best facilitated by cooperative contact between the parents the child is leaving and new parents/caregivers. Provide support and understanding if regression occurs after move; undue pressure may have negative long-term effects. Note events surrounding the move on the child's permanent record, as this information may help caregivers and helping professionals understand the child's future actions and issues. Postplacement contacts with previous caregivers are important so that children understand the reasons for the move as they grow older.

Strategies:

ADAPTED FROM:

Levy, T.M., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorder in children and families* (p. 227). Washington, DC: CWLA Press.

PRESCHOOL YEARS

Explaining in "child-friendly" language what is occurring and why reduces magical thinking and helps the child attain a sense of control over events. Preplacement services aid in transferring attachment to new caregivers and initiating the process of grieving. Identifying and modifying the child's negative perceptions (e.g., "It is my fault I lost my mom") prevents future emotional problems. As child develops increased cognitive skills, around 8 or 9 years old, caregivers and/or helpers need to review the past, so that the child is not misinterpreting those events.

Strategies:

GRADE SCHOOL AGE

Despite increased cognitive and verbal skills, it remains necessary to identify and correct magical thinking and misperceptions. It is important to help the child understand what is happening, and to provide aid in identifying and constructively expressing emotions. Adults are responsible for decision making, but the child needs to be included as an active participant in the moving process. The child is encouraged to share feelings, worries, and desires regarding the transition. After the move, discussions about grief-related (or other) feelings helps the child free up energy for social, academic, and additional activities and accomplishments.

Strategies:

ADOLESCENCE

Moves during early adolescence (12 to 14) are more difficult than in later adolescence, because individuation is a major developmental task of this

stage. It is difficult to encourage attachment to new caregivers when the child is in the process of emotionally separating from family. Parents need to be sensitive to these development issues; children do best with a clear and concrete commitment ("contract") to the new caregivers. Adolescents need to have input into decision making about their lives and future, consistent with their need to have increasing control over life events in general. They should be a part of the process of deciding where to live, except in special situations (e.g., displaying poor judgment). Commitments and contracts are helpful in clarifying and attaining goals. Parents, caregivers, and helping professionals can assist the adolescent "come to terms" with prior losses and trauma, and encourage a healthy balance of dependence and independence [adapted from Fahlberg, 1991].

Strategies:

Fahlberg, V.I. (1991). *A child's journey through placement*. Indianapolis, IN: Perspectives Press.

CONDUCTING PLACEMENT ACTIVITIES TO REDUCE STRESS AND TRAUMA

Conduct Placement Activities in Steps

Dividing placement activities into parts or steps, including preplacement visits, allows the child to develop familiarity with, and comfort in, the new environment before he is placed there. The worker should:

- Schedule at least one, and preferably several, preplacement visits in the new home. Allow the child to experience the home at different times of day, and under different circumstances.
- The child should be given a tour of the entire house. Those areas which are "hers" (bed, closet, dresser drawers, toy box, etc.) should be pointed out, and she should be encouraged to begin to use them to store her belongings.
- Schedule the first visits when only one or two family members are at home. One family member, usually a parent, should be identified to begin to develop a relationship with the child. Too many people greeting the child at one time can be frightening.
- Foster caregivers should try to maintain the child's schedule as much as possible during visits. When the child has "settled in," the foster caregiver can gradually revise the child's schedule to better conform to that of the foster family.
- During the placement process, periods of respite away from the foster home should be arranged. It is best if the child can return to familiar surroundings in his own home or a relative's home. These respite periods allow the child to recoup his strength and be given support by known and trusted persons.

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (Handout #4, pp. 1-2) [Core Curriculum]. Columbus, OH: Author.

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Determine the Child's Own Rate of Mastery and Gauge the Rate of the Placement to Reduce Stress

- The caseworker must recognize normal signs of stress in children and use this information to assess the child's ability to cope with the placement situation.
- When the child shows signs of excessive stress, the caseworker should provide the child with ample support and should "slow down" the placement process.
- At times, providing too long a preparation and preplacement period can increase the child's anxiety. Under most circumstances, the child can be informed of the move, attend preplacement visits, and move within a week or two.
- If the child does experience clinical crisis, intensive casework and support should be provided to help the child during the crisis period. Mental health counseling or play therapy may be useful.
- The caseworker should allow the child to be involved in decisions as often as possible, even if these decisions are small. It allows the child to retain some control.

Provide the Child With Opportunities to Talk About the Placement Experience and His Feelings About It

- As with any victim of trauma, the child needs to talk about the trauma and his feelings, perhaps many times over for a period of weeks or months, with a supportive and caring listener.
- Unexpressed negative feelings reduce the child's ability to concentrate, interfere with school work, prevent him from dealing with fears about attachments, and keep him preoccupied with his own needs. These feelings may be expressed in unacceptable behaviors.
- One of the worker's most important roles in the placement process is to develop a supportive, nurturing relationship with the child and to encourage the child to communicate his painful feelings in words, through play, or through emotional expressions such as crying, expressing anger and fear, and by verbally stating his concerns. Open expression of painful feelings should be encouraged, but the child should be allowed to express them at his own rate and in a manner with which he is comfortable. The worker should educate the foster caregiver to do the same. The child must understand that he is entitled to hurt, and that people care about him and understand.

HELPING CHILDREN MAINTAIN CONTINUITY AND IDENTITY: THE LIFEBOOK AND STORY ABOUT THE CHILD

Children in lengthy out-of-home placements should have their own Lifebooks to document their personal histories as they go through the foster care and adoption process. A Lifebook is a scrapbook that contains photographs, drawings, anecdotes, stories about the child, his/her family and friends, and other memorabilia. The child can participate in developing the Lifebook, and in dictating or writing his/her own contributions to the history.

The Lifebook provides continuity, helps establish a positive identity, and allows the child to share his/her past life with others. Lifebooks are an excellent tool for caseworkers in helping children understand the reasons for placement. Lifebooks can also help children from ethnically and culturally diverse backgrounds maintain a positive cultural identity and self-esteem.

There are many ways caseworkers can gather information for a Lifebook. Foster parents or relatives are often eager to help, and can assume most of the responsibility for gathering contents and compiling the scrapbook. There are many sources of valuable information:

- The worker can approach biological parents and other relatives and request pictures of the child. Families are often willing to provide pictures, if the purpose is explained, and if they are assured that the pictures will always be in the child's possession. If they have only original prints, photo shops can make copies, and the originals can then be returned to the family members.
- Family members can contribute pictures of themselves. This should include parents, siblings, extended family, family friends, and others who have been important to the child. This is particularly important if the child's biological parents are, or have been, absent.
- The worker can approach previous foster parents or caregivers; they may have many pictures of the child in their own family albums. They can

ADAPTED FROM:

Rycus, J.S., & Hughes, R.C. (1998). *Field guide to child welfare: Placement and permanence* (Vol. 4, pp. 757-759). Washington, DC: CWLA Press; Columbus, OH: Institute for Human Services.

provide negatives or extra photos, or copies can be made from prints or slides. Workers may find photos documenting a child's first tooth, first steps, birthday parties, and other family events. Photos of previous foster families should also be obtained.

- The worker can return with the child to her previous schools, neighborhoods, and communities, and together they can photograph people and places familiar to the child. The worker can also obtain class pictures from the school, and school pictures from the school photographer.
- The worker can call the hospital where the child was born, inquire whether infant photos were taken, and contact the photography department to obtain the negative or a reprint. Footprints and other documentation may also be available. The hospital building can be photographed also.
- The worker can ask relatives and previous caregivers for examples of the child's drawings and artwork.
- The worker can ask key informants to tell their "cute story" about the child, and then write these up into a narrative, identifying each storyteller and his or her relationship with the child.
- Workers can encourage current caregivers to document what appear to be unimportant daily events. These current events will one day be the child's history, and this documentation will be of particular importance if the child leaves their home.

ADDITIONAL LIFEBOOK RESOURCES

My Foster Care Journey & Lifebooks: Creating a Treasure for the Adopted Child, both written by Beth O'Malley

Adoption-Works
440 Revere Street
Winthrop, MA 02152
800-469-9666
<http://www.adoptionlifebooks.com>

"ADDITIONAL LIFEBOOK RESOURCES" CONTINUED NEXT PAGE

ADDITIONAL LIFEBOOK RESOURCES (CONTINUED)

Foster Children's Life Books: A Caseworker's Handbook

The Center for Child & Family Studies
College of Social Work, University of South Carolina
Columbia, SC 29208
803-777-9408
<http://www.sc.edu/ccfs>

ON RESOURCE TABLE

PREPARING THE CHILD FOR PLACEMENT

Adequately preparing the child for the placement serves several important purposes:

- The worker can provide support and alleviate many of the child's anxieties, thereby greatly reducing the child's stress.
- The worker can use the preparation period to get to know the child and to assess the child's strengths and needs.
- Casework with the child during the preparation phase helps the worker establish a supportive relationship with the child, which can help the child during the placement and the early adjustment phase.

The child's level of development and cognitive maturity will affect the strategies used by the worker to prepare the child.

INFANCY (Birth to 24 Months)

- The worker should prepare the new environment and caregivers to receive the child and should maintain as much consistency and stability between environments as possible.
- An infant should have the opportunity to become accustomed to the foster caregiver prior to being moved, through pre-placement visits with the birth parent present, if at all possible.
- The worker and foster caregiver should talk to the child in very simple language about the move, and about the new parents. Pictures of the new family, audiotapes, and videotapes can be used to familiarize the child with the new caregivers' faces and voices.
- Very frequent contact with the parent is necessary to maintain the parent/child relationship, which is critical if reunification is planned.

SOURCE:

The Institute for Human Services. (1999, June). *Separation, placement, and reunification in family-centered child protective services (Core 104)* (Handout #3, pp. 1-3) [Core Curriculum]. Columbus, OH: Author.

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PRESCHOOL (Two to Five Years)

- The preschool child will become frightened and anxious when he perceives that the parent is upset. The worker, assisted by the parent, should explain each step in the move for the child in simple, concrete language. Photographs, drawings, and other visual aids can help the child understand what is happening.
- The child needs to feel security and support from the people around him.
- The worker can use play techniques to communicate information about the move.
- The child can be encouraged to make decisions for himself about the belongings she will take with her, where she wants to sit in the car, and what she wants the new Mom to give her for lunch.

SCHOOL AGE (Six to Nine Years)

- The school age child should be helped to talk about the placement and his experiences.
- The child will probably be able to recognize some of his feelings, including being sad, scared, mad, lonesome, and worried. These feelings should be elicited and acknowledged by the worker and by caregivers.
- The worker should insure that the "rules" in the new family are clarified for the child and that the child understands them.
- The caseworker should talk to the child about WHY she has to move. The child may think it a punishment for something she did wrong, often the last misbehavior for which she was punished. The worker should reassure the child and explain the reasons for the placement in terms the child can understand.

PREADOLESCENT (Ten to Twelve Years)

- The reasons for the placement should be fully explained, including the family problems that led to placement and the child's own need for safe care. The child should be encouraged to ask questions and express his feelings.
- The child should be encouraged to make as many decisions as possible about the placement. Making one's own choices increases one's feeling of control.

"PREADOLESCENT" CONTINUED NEXT PAGE

PREADOLESCENT (CONTINUED)

- The worker should provide a detailed description of the placement setting prior to taking the child for pre-placement visits.
- The child may feel conflicts about loyalty. He needs a consistent message from all persons involved that he does not have to choose between his parents and his foster caregivers.

EARLY AND MIDDLE ADOLESCENCE (13 to 17 Years)

- Preparation of adolescents should focus on discussing the reasons for the move, description of the placement setting, and plans for the future.
- Some adolescents retain considerable loyalty to their biological families; in these situations, foster care can be described as "a safe place to stay" rather than "a new family." This can help to prevent loyalty conflicts for the child.
- The adolescent should be encouraged to participate to whatever degree possible in choosing and planning the placement.
- The adolescent may try to hide his anxiety and distress regarding the move. The worker should explain all aspects of the placement and acknowledge how most children feel about moving, "just in case the information might be of interest."

ELEVEN-MONTH-OLD BUDDY

The hospital social worker just called your agency to report that an eleven-month-old African-American child named Buddy was brought to the emergency room at noon today by his grandmother, Pauline Hamilton. Her 21-year-old son had left Buddy with her the previous evening and said he would be back in a few hours. She hadn't seen or heard from him since. Mrs. Hamilton reported that Buddy had been crying almost constantly since his father left him. She noticed bruises on his upper back when she bathed him. His left arm and hand were swollen and beginning to look bruised as well, and he was not using them. The neighbor who brought Mrs. Hamilton to the hospital confirms that Buddy arrived the previous evening.

X-rays indicate a spiral fracture of the left arm that is 3-4 days old and previous fractures of the upper left arm and ribs. According to the doctor, the injuries are strongly suggestive of abuse. Buddy is also low weight for his age and is developmentally delayed. He has been clinging to his grandmother and was very resistive during the examination and x-rays.

Mrs. Hamilton is 66, nearly blind due to diabetes, and has a severe case of rheumatoid arthritis. She is moving to the nursing home at the end of the month where her husband now resides. Their only source of income is Social Security benefits.

Buddy visits Mrs. Hamilton often. She would like to care for him, but cannot provide the attention he needs. Her son has cared for Buddy since his girlfriend, Buddy's mother, left him several months ago. She has paranoid schizophrenia and did not respond to medication or counseling. Her whereabouts are unknown. Mrs. Hamilton knows of no other family members who can care for Buddy.

Mrs. Hamilton thinks her son is involved in drug culture. He disappears for long periods, often with Buddy. She worries that Buddy is being exposed to "bad elements" and is not getting the proper care.

Buddy needs placement to ensure his safety and reduce risk of re-abuse.

You are Buddy's intake worker and are planning his placement. Consider the following:

- (1) What caregiver qualities would you look for to meet Buddy's needs?**
- (2) What cultural factors should you consider?**
- (3) Identify Buddy's losses.**
- (4) Identify his attachments.**
- (5) How should Buddy and his grandmother be prepared for the move?**

THREE-YEAR-OLD BUDDY

The hospital social worker just called your agency to report that a three-year-old African-American child named Buddy was brought to the emergency room at noon today by his grandmother, Pauline Hamilton. Her 24-year-old son had left Buddy with her last night and said he would be back in a few hours. She hadn't seen or heard from him since.

Mrs. Hamilton reported that Buddy had been crying almost constantly since his father left him. She noticed bruises on his upper back when she bathed him. His left arm and hand were swollen and beginning to look bruised as well, and he was not using them. When Mrs. Hamilton touched the arm, Buddy began crying, "Hurts, hurts!" The neighbor who drove grandmother to the hospital confirms that Buddy arrived last night.

X-rays indicate a spiral fracture of the left arm and previous fractures of the upper left arm and ribs. According to the doctor, the injuries are strongly suggestive of abuse. Buddy is small for his age and has limited speech. He has been clinging to his grandmother and was resistive during the examination and x-rays.

Mrs. Hamilton is 69 and is nearly blind because of diabetes and her hands are crippled due to rheumatoid arthritis. She is moving to a nursing home at the end of the month where her husband currently resides. She and her disabled husband live on Social Security benefits. Buddy visits her often. She would like to care for him, but cannot lift him or provide the attention he needs. Her son cared for Buddy since his girlfriend, Buddy's mother, left ten months ago. She has paranoid schizophrenia and did not respond to medication or counseling. Her whereabouts are unknown. Mrs. Hamilton knows of no other family members.

Mrs. Hamilton thinks her son is involved in the drug culture. He disappears for long periods, often with Buddy. She worries that Buddy is being exposed to "bad elements" and is not getting the proper care.

Buddy needs placement to ensure his safety and minimize risk of re-abuse.

You are Buddy's intake worker and are planning his placement. Consider the following:

- (1) What caregiver qualities would you look for to meet Buddy's needs?**

- (2) What cultural factors should you consider?**

- (3) Identify Buddy's losses.**

- (4) Identify his attachments.**

- (5) How should Buddy and his grandmother be prepared for the move?**

NINE-YEAR-OLD BUDDY

Police call your agency to report the following:

Buddy came home from school to find his grandmother slumped in the chair. He called 911 and when the police arrived, they asked Buddy if he lived with his grandmother. Buddy told them that he was only staying with his grandmother for a couple of days until his father returned. Buddy indicated that he did not know where his father was and that he hadn't seen his mother in many months.

The neighbor indicated that she could help Mrs. Hamilton by keeping Buddy for a couple of days.

When the intake worker interviewed Buddy, a 9-year-old African-American, she noticed bruises on his face and upper arm. When asked about the marks, he said, "Dad found out I ditched school last week and let me have it." In addition, Buddy states there isn't much food in the house; sometimes he's alone overnight and doesn't know where his father is. When his father is home, Buddy frequently stays home to run "errands" for him.

Upon admission to the hospital, it was determined that Mrs. Hamilton was in diabetic shock.

The hospital social worker just called your agency to report that Mrs. Hamilton, age 74, is nearly blind due to diabetes and can no longer manage her injections. She is a recent widow and has no one to care for her and will be moving directly to the nursing home from the hospital. Her 29-year-old son had left Buddy with her and said he would be back in a few hours. That was four days ago.

Buddy visits Mrs. Hamilton often. She would like to care for him, but cannot due to her poor health. Her son cared for Buddy since his girlfriend, Buddy's mother, left ten months ago. She has paranoid schizophrenia and did not respond to medication or counseling. Her whereabouts are unknown. Mrs. Hamilton knows of no other family members who can care for Buddy.

Mrs. Hamilton thinks her son is involved in the drug culture. He disappears

for long periods, often with Buddy. She worries that Buddy is being exposed to "bad elements" and is not getting the proper care.

Buddy needs placement to ensure his safety and minimize the risk of re-abuse. You are Buddy's intake worker and are planning his placement. Consider the following:

- (1) What caregiver qualities would you look for to meet Buddy's needs?**
- (2) What cultural factors should you consider?**
- (3) Identify Buddy's losses.**
- (4) Identify his attachments.**
- (5) How should Buddy and his grandmother be prepared for the move?**

ELEVEN-YEAR-OLD BUDDY

Police call your agency to report the following:

Buddy came home from school to find his grandmother slumped in the chair. He called 911 and when the police arrived, they asked Buddy if he lived with his grandmother. Buddy told him that he was only staying with his grandmother for a couple of days until his father returned. Buddy indicated that he did not know where his father was and that he hadn't seen his mother in many months.

The neighbor indicated that she could help Mrs. Hamilton by keeping Buddy for a couple of days.

When the intake worker interviewed Buddy, an 11-year-old African-American, she noticed bruises on his face and upper arm. When asked about the marks, he said, "Dad found out I ditched school last week and let me have it." In addition, Buddy states there isn't much food in the house; sometimes he's alone overnight and doesn't know where his father is. When his father is home, Buddy frequently stays home to run "errands" for him.

Upon admission to the hospital, it was determined that Mrs. Hamilton was in diabetic shock.

The hospital social worker just called your agency to report that Mrs. Hamilton, age 76, is nearly blind due to diabetes and can no longer manage her injections. She is a recent widow and has no one to care for her and will be moving directly to the nursing home from the hospital. Her 31-year-old son had left Buddy with her and said he would be back in a few hours. That was four days ago.

Buddy visits Mrs. Hamilton often. She would like to care for him, but cannot due to her poor health. Her son cared for Buddy since his girlfriend, Buddy's mother, left ten months ago. She has paranoid schizophrenia and did not respond to medication or counseling. Her whereabouts are unknown. Mrs. Hamilton knows of no other family members who can care for Buddy.

Mrs. Hamilton thinks her son is involved in the drug culture. He disappears

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for long periods, often with Buddy. She worries that Buddy is being exposed to "bad elements" and fears he is being used as a "drug runner" by his father's friends.

Buddy needs placement to ensure his safety and minimize the risk of re-abuse. You are Buddy's intake worker and are planning his placement. Consider the following:

- (1) What high risk indicators contributed to the decision to place Buddy?**
- (2) How would you identify the best placement resources for Buddy? What caregiver qualities would you look for to meet Buddy's needs?**
- (3) What cultural factors should you consider?**
- (4) Identify Buddy's losses. His attachments?**
- (5) How would you prepare Buddy prior to the move?**
- (6) How would you prepare Buddy on the day of the move?**

FOURTEEN-YEAR-OLD BUDDY

Buddy was staying with his grandmother, Mrs. Pauline Hamilton, while being suspended from school. He went to the store, and when he returned, he found his grandmother slumped in the chair. He called 911. When the police came, Buddy told them he didn't know where his parents were; he was only staying with his grandmother for a couple of days.

When the intake worker interviewed Buddy, a 14-year-old African-American, she noticed bruises on his face and upper arm. When asked about the marks, he said, "Dad found out I ditched school last week and let me have it." In addition, Buddy states there isn't much food in the house; sometimes he's alone for several days and doesn't know where his father is. When his father is home, Buddy frequently stays home from school to run "errands" for him.

Buddy will stay with a friend's family for the weekend.

Mrs. Hamilton was in diabetic shock and is no longer able to manage her injections. Mrs. Hamilton is 79, nearly blind due to diabetes, and has a severe case of rheumatoid arthritis. She will be moving to the nursing home from the hospital. Her husband recently passed away.

She reports that her 34-year-old son had left Buddy with her and said he would be back in a couple of days. That was four days ago. She hadn't seen or heard from him since. Her son cared for Buddy since his girlfriend, Buddy's mother, left ten months ago. The whereabouts of Buddy's mother are unknown. She has paranoid schizophrenia and did not respond to medication or counseling. Mrs. Hamilton knows of no other family members who can care for Buddy.

Mrs. Hamilton thinks her son is involved in the drug culture. He disappears for long periods, often leaving Buddy home alone. She worries that Buddy is being exposed to "bad elements" and is becoming actively involved in the street culture.

Buddy needs placement to ensure his safety and minimize the risk of re-abuse. You are Buddy's intake worker and are planning his placement.

Consider the following:

- (1) What caregiver qualities would you look for to meet Buddy's needs?**
- (2) What cultural factors should you consider?**
- (3) Identify Buddy's losses.**
- (4) Identify his attachments.**
- (5) How should Buddy and his grandmother be prepared for the move?**

SEVENTEEN-YEAR-OLD BUDDY

Buddy was staying with his grandmother, Mrs. Pauline Hamilton, while being suspended from school. He went to the store, and when he returned, he found his grandmother slumped in the chair. He called 911. When the police came, Buddy told them he didn't know where his parents were; he was only staying with grandmother for a couple of days.

When the intake worker interviewed Buddy, a 17-year-old African-American, she noticed bruises on his face and upper arm. When asked about the marks, he said, "Dad got mad when I refused to run errands for him, and he let me have it." In addition, Buddy states there isn't much food in the house; sometimes he's alone for several days and doesn't know where his father is. When his father is home, Buddy frequently stays home from school to run "errands" for him.

Buddy will stay with a friend's family for the weekend.

Mrs. Hamilton was in diabetic shock and is no longer able to manage her injections. Mrs. Hamilton is 82, nearly blind due to diabetes, and has a severe case of rheumatoid arthritis. She will be moving to the nursing home from the hospital. Her husband recently passed away.

She reports that her 37-year-old son had left Buddy with her and said he would be back in a couple of days. That was four days ago. She hadn't seen or heard from him since. Her son cared for Buddy since his girlfriend, Buddy's mother, left ten months ago. The whereabouts of Buddy's mother are unknown. She has paranoid schizophrenia and did not respond to medication or counseling. Mrs. Hamilton knows of no other family members who can care for Buddy.

Mrs. Hamilton thinks her son is involved in the drug culture. He disappears for long periods, often leaving Buddy home alone. She worries that Buddy is being exposed to "bad elements" and is becoming actively involved in the drug culture.

Buddy needs placement to ensure his safety and minimize the risk of re-abuse. You are Buddy's intake worker and are planning his placement.

Consider the following:

- (1) What caregiver qualities would you look for to meet Buddy's needs?**
- (2) What cultural factors should you consider?**
- (3) Identify Buddy's losses.**
- (4) Identify his attachments.**
- (5) How should Buddy and his grandmother be prepared for the move?**