# Field Guide to Child Functioning

For

Initial Assessment Question #3

*"How do the children function on a daily basis?"*

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# Field Guide to Infant Functioning

**I. Initial Assessment Question #3**
**II. Typical Consequences of Abuse and Neglect on an Infant's Development**
**III. Developmental Milestones**

## I. Initial Assessment Question #3

### How does the normal infant (0 - 1 year) function on a daily basis?

#### Infant's physical development.

- Good muscle tone.
- Responds to noises, movement, people (startle response).
- Tracks objects and people with eyes.
- Gross Motor: developing from flailing to crawling and toddling.
- Fine Motor: developing from fisted to pinching.

#### Infant's emotional and social development.

- Shows preference for care by primary caregiver (attachment milestone).
- Enjoys physical contact, reaches for caregiver.
- Responds to soothing.
- Shows interest in human face.
- Responds to angry, sad, joyful facial expressions with emotion.
- Responds to emotions in the environment.

#### Infant's unique developmental needs.

- If ILP services are in place, inquire about visits and follow up with ILP worker.
- Review signs of behavioral  or developmental delays with forensic nurse or psych nurse.
- Review recent medical history and follow up on concerns or missing checkups.
- History of abuse and/or neglect? (see Part II)

#### Infant's mood / temperament.

- A range of individual temperaments in infants is normal. It is important to note what is typical and what is outstanding for each infant. Infants may range from:
    - Demanding to easily soothed.
    - Outgoing to shy.
    - Fussy to cheerful.
    - Easily engaged to easily distracted.
    - Most babies are consistently egocentric, curious, and vocal about needs.

### Infant's speech and communication.

- Communicates needs and interests through body language, facial expressions, and vocalizations (crying, cooing, smiling, etc.).
- Responds to the human voice.
- Appears startled by loud noises.
- Appears quieted by soft sounds.
- Mimics facial expressions and language.
- Developing first words. (Note: There is a range of normal linguistic development in the first year. This can differ depending upon the individual child, family communication styles, culture and languages spoken in the home. If a baby appears to be delayed in linguistic development, pay special attention to parent-child interaction, particularly whether the caregiver talks to the baby.)

### Infant's general behavior.

- How does the infant express needs and interact with caregivers? Does the baby reach, babble, coo, cry, fuss, sleep, stay quiet, stare (without affect), smile, etc.
- Is the infant typically interested in stimuli or do they turn or pull away?
- Sleep patterns can range from regular to irregular, but regular sleep patterns can be encouraged.
- Frequency of feeding and regularity as well as diet.
- Shows preferences for comfort, eating, and sleeping routines.
- Alert, aware, interested in environment. Look for active alert, quiet alert, and drowsy states.

### Infant's characteristics that contribute to their vulnerability and their ability to self protect.

### The following are common to all infants:

- Cannot protect themselves physically.
- Cannot report abuse or neglect.
- Rapid brain and body development makes infant very susceptible to effects of malnutrition.
- Soft skull and muscles do not adequately protect head and body from injury.
- Neck muscles are not strong enough to withstand even a mild shaking.
- Infants are especially vulnerable to thoracic and abdominal injuries due to small body mass (greater forces applied per unit of body area and proximity to vital organs), flexibility of cartilage and rib structures. Impacts to upper chest can result in compression of vital organs. These types of injuries are a leading cause of infant deaths and are usually not visible on the skin.

**The following may affect some infants:**

- Interrupted sleep patterns.
- Crying or screaming that is distressing to parents.
- Premature infants, and infants with colic, or other medical conditions that require special care.
- Prenatal exposure to alcohol or other substances.
- Prenatal trauma (i.e, mother experienced violence during pregnancy).
- Physical injury can interfere with physical exploration of the environment leading to possible delays in cognitive development.
- Abuse and neglect can interfere with attachment of infant to caregiver leading to possible lifelong emotional and personality problems.

## II. Typical consequences of abuse and neglect on an infant's development

### *Physical*

- Chronic malnutrition of infants results in growth retardation, brain damage, and potentially, mental retardation.
- Head injury can result in severe brain damage, including brain stem compression and herniation, blindness, deafness, mental retardation, epilepsy, cerebral palsy, skull fracture, paralysis, and coma or death.
- Injury to the hypothalamus and pituitary glands in the brain can result in growth impairment and inadequate sexual development.
- Less severe but repeated blows to the head can also result in equally serious brain damage. This type of injury may be detectable only with a CT scan, and, in the absence of obvious signs of external trauma, may go unnoticed.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Shaking can result in brain injury equal to that caused by a direct blow to the head, and spinal cord injuries with subsequent paralysis.
- Internal injuries can lead to permanent physical disability or death.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, vision problems from untreated strabismus (crossing of the eyes), respiratory damage from pneumonia or chronic bronchitis, etc.
- Neglected infants and toddlers have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills.

### *Cognitive*

- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.
- Brain damage from injury or malnutrition can lead to mental retardation.
- Abused and neglected toddlers typically exhibit language and speech delays.They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay, which may begin to be evident in infancy.
- Maltreated infants are often apathetic and listless, placid, or immobile. They often do not manipulate objects, or do so in repetitive, primitive ways. They are often inactive, lack curiosity, and do not explore their environments. This lack of interactive experience often restricts the opportunities for learning. Maltreated infants may not master even basic concepts such as object permanence, and may not develop basic problem-solving skills.

### *Social*

- Maltreated infants may fail to form attachments to primary caregivers.
- Maltreated infants often do not appear to notice separation from the parent and may not develop separation or stranger anxiety. A lack of discrimination of significant people is one of the most striking characteristics of abused and neglected children.
- Maltreated infants are often passive, apathetic, and unresponsive to others. They may not maintain eye contact with others, may not become excited when talked to or approached, and often cannot be engaged into vocalizing (cooing or babbling) with an adult.

### *Emotional*

- Abused and neglected infants often fail to develop basic trust, which can impair the development of healthy relationships.
- Maltreated infants are often withdrawn, listless, apathetic, depressed, and unresponsive to the environment.
- Abused infants often exhibit a state of “frozen watchfulness,” that is, remaining passive and immobile, but intently observant of the environment.

## III. Developmental Milestones (Birth to 1 year)

### *Physical Developmental Milestone*

- (Birth - 1 year) - The development of control and mastery over one's own body in both gross and fine motor skills is the infant's primary physical task, culminating toward the end of the first year in walking

### *Cognitive Development Milestone*

- (Birth - 1 year) - Cognition begins with alertness, awareness, recognition, and interest in visual, auditory, and tactile (touch) stimuli. As motor development improves, the infant begins to explore and manipulate objects and develops a rudimentary understanding of their properties. Infants develop *object permanence* toward the end of the first year.

### *Social Development Milestone*

- (Birth - 1 year) - The most important social task is the development of attachment to the primary caretaker, most often the child's mother.

### *Emotional Development Milestone*

- (Birth - 1 year) - The development of basic trust, a derivative of the positive attachment between the infant and the primary caretaker, occurs during the first year. This is a cornerstone of emotional development. This trust grows out of an infant's sense that attempts to communicate basic needs will result in a positive response from the caregiver.

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **INFANT** | Infants cognitive limitations greatly increase their experience of stress. | Infants will be extremely distressed by changes in the environment and caregivers.<br><br>Expect the infant to show stress in bodily functions such as eating, sleeping and being "fussy". | Help parent understand why infant may be distressed.<br><br>Infants should have people they "know" help with all transitions from one caregiver to another.<br><br>Do not force an infant to eat or sleep during a visit.<br><br>Have caregiver and parent share information with each other on how the infant shows stress and how to comfort child. |
| | Drug exposed infants | Hard to comfort, feed and may not want to be held. | Meet infant's needs before visit.<br><br>Teach parent how to understand needs and respond to infant. |
| | Infants have few internal coping skills.<br><br>Infants do not generally turn to others for help and support. It needs to be provided. | Adults must "cope" for them.<br><br>Infants who have too many changes will be impacted at a higher level | Give the infant items that bring her comfort such as a blanket or stuffed animal.<br><br>Engage in bonding activities during visits.<br><br>Allow infant to choose who or what they want to be comforted by. Praise parent who is able to allow others to comfort their infant. |
| | Infants experience the absence of caregivers immediately. | Infants will forget people who are absent from their life.<br><br>Infants may cling to new caregiver and refuse to go to parent.<br><br>Infants need multiple contacts each week to maintain an active memory of a person and to attach to that person | Inform parent of this normal behavior.<br><br>Have visit as soon as possible after placement<br><br>Use voice recordings, phone calls, & pictures to keep memory active.<br><br>Always say good-bye - do not let parents disappear hoping that will not upset the infant.<br><br>Do visits/contacts several times a week and encourage the birth parent to "provide care" for the infant during a visit so attachment is maintained. |
| | Separation during the first year can interfere with the development of trust. | Expect that a healthy infant will attach to his caregiver and that will help with the child continuing his developmental tasks | Let parent know that attachment to caregiver does NOT interfere with attachment to birth parent.<br><br>Praise the parent for supporting the infant's developmental need to attach. |
| | Attachment is essential for the infant to live and develop. | Infants can attach to more than one caregiver. | Minimize the number of changes in caregivers that an infant has. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **INFANT** | Consistency and schedules are critical for an infant's development. | Infants‟ distress will be lessened if their new environment can be made consistent with the old one. | Keep the child on the same food, schedule and other routines – changes should occur slowly.<br><br>Follow a regular schedule – preferably the infant's. |
| | Infants miss the parent even if that parent was inconsistent before separation (incarceration) and they have no cognitive memory of that parent. | Even children adopted at birth want to have contact with their parents.<br><br>Birth family is always a part of who a child/adult is | Infants need visits even when they have not had a prior relationship or cannot remember their parent.<br><br>Ensure infant has contact with birth family; including siblings and extended family. |
| | Infant's developmental changes can occur weekly. | Parents may not recognize the infant's changes or act as if the infant has not changed. | Inform parent of the changes.<br><br>Teach parent how to adapt to new skills of the infant. |

# Ensuring Safety, Permanency and Well- Being: Suggestions for Conducting Contacts with Children and Caregivers

# Infants: (0-18 months)

## Reviewing Safety with Caregivers

### Basic Safety

- Did this child have any serious injuries, either before or since coming into your care?
- Does your child have any chronic health conditions? Do you have all of the necessary medications and supplies?
- Do you have a First Aid Kit in your home?

Things to Check For:

- Are TVs and other pieces of standing furniture secured so that they cannot be pulled over?
- Are exposed wires or appliance cords in reach of children?
- Are firearms, chemicals, medications, alcohol and other substances secured out of reach of crawlers and toddlers?

### Preventing Falls

- Are there child safety window guards on all windows above the first floor?
- Are safety gates installed at the top and bottom of all staircases?

### Sleep Time Safety

- Please show me where the child sleeps. What do you do if the child has trouble falling asleep? Does the child have nightmares?
- When you put your child to sleep, do you put him/her on his/her stomach or back? (Sleeping on back is recommended.)
- What type of bedding do you use for the child? (Avoid soft bedding. toys or pillows in the crib.)
- Does your child ever sleep in bed with you or with other children?
- Are there any window blinds or curtain cords near your baby's crib or other furniture?
- Does your child use a pacifier? Do you attach the pacifier to the child? How? (Should not tie anything to the child using string or ribbon.)
- Do you ever cover mattresses with plastic or a plastic bag? (Avoid plastics that could interfere with breathing.)
- Is there smoking of drugs or tobacco in the home? If so, are there efforts to ensure the baby has clean air for breathing?

### Crib Safety

- Check for the following types of issue regarding the place where the child sleeps:
    1. Does the crib have any missing, loose, improperly installed or broken hardware?
    2. Are crib slats more than two and three-eighths inches apart?
    3. Are there any corner posts over the end panels of crib?
    4. Do the headboards or footboards have any cutout areas?
    5. Is paint cracked or peeling?
    6. Are there any splinters or rough edges?
    7. Are top rails of crib less than ¾ of the child's height?

### Bath Safety

- What do you do if the telephone or doorbell rings while you are giving your child a bath?
- What type of bathtub seat do you use? (Check for suction cups.)
- How do you check the water temperature to make sure that the bath is not too hot or too cold?

### Child Care Safety

- Who takes care of your child when you are not home? How do you know this person? How old is this person? Is there a way for that person to reach you when you are away from home?
- Is there a list of phone numbers for your doctor, local hospital, police department, fire department, poison control center and a friend or neighbor near the phone?
- Does this child go to daycare? If so, how many hours per week? How does your child get there? Who is responsible for drop-off and pick-up?

### Safety Outside

- How do you watch your child when s/he plays outdoors?
- What does your child do if a stranger talks to him or her?

## Safety suggestions are NOT requirements for birth parents.

## Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the child's personal things, toys, comfort item (like a blanket) or other things s/he plays with. How does this child comfort himself/herself?
- Show me the child's bedroom. Who else lives in this room?

## Daily Routine:

- Describe a typical day for this child.
- If you had to teach this child a new skill, like walking, how do you do that?
- Describe the child's sleeping pattern. Describe the child's feeding pattern, habits, favorite food, etc.

## Social/Emotional:

- Have you seen any signs that the child is feeling grief, loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the child handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the child transitioned into your home/family? What have you been able to do to help the child transition (i.e. cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the child's home, etc.)?
- How does this child show warmth and affection? What does s/he do when s/he is happy? How does the child show that s/he is upset, hurt, sad or other emotions?
- Who does this child seek comfort from when s/he is hurt, frightened, or ill?
- Is this child able to seek you out and accept your help when needed?
- Does this child show preference for a particular adult or child?
- What does this child do when upset? How easy is it to soothe this child when s/he is upset?
- How has this child changed since coming here? What do you think about that? In what ways has the child adjusted to this placement?

## Family and Friends:

- Besides the primary caregivers, who is important to the child?
- Does the child ever spend time in another home?
- Explore interactions and behavior and ask other caregivers about the infant's development. What observations or concerns do they have?
- Is the child's behavior different with these people than with the primary caregiver? In what ways?

## Special Interests:

- What kinds of things does this child like to do?

## Education:

- Would you describe this child as developmentally typical or not? Can you give me examples of his/her behaviors/skills/developmental progress or regression? Do you think the child needs any help in any developmental skills?
- Does this child go to day care? Who is her/his teacher(s)?

## Health:

- Who is taking the child to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the child should have? Does the child have any special medical problems? Do you know how to provide the care for this type of condition? Where do you keep the child's medical records? Show me any recent medical report so I can have a copy for the child's records.
- Describe the child's sleeping pattern. Describe the child's eating habits.
- Have you seen any weight changes since this child has been with you? Any other type of changes?
- Has the infant been developing typically? What major milestones have occurred recently? (Talking, walking, rolling-over, eating solid food, etc.)

## Case Planning:

- Is this child receiving any developmental, medical and/or other services? Which ones? How often? What do you think/feel about these? Do you think that the services are meeting this child's needs? Are there any other services that you think this child needs?
- What is your greatest fear about this child returning home? What is your greatest fear if this child does not return home?
- When the child visits his/her parents or other family members, what happens? How does the child behave before or after the visit? What do you think of the family visits with the child?
- What are the case goals for this child and his/her family and what do you think/feel about those goals? What makes them okay, not okay?
- If the child goes home, how do you imagine you might still be involved with the child and his/her family? If the child cannot go home to any family member, how might you imagine being involved with the child?
- What is the permanency goal for this child? What do you think/feel about this? What makes it okay, not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the child that would help all of us do a better job making this child safe and getting him/her a permanent family?

**Self-Care:**

- On a scale of one to ten, with ten being the easiest child you have ever cared for, how easy is it to parent this child? Describe who this child is. What about the child is easy and most pleasurable? What is the most difficult aspect of this child for you to deal with? What are the things about this child that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this child in your home. What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this child? What has been the effect on your family of having this child placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this child.
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this child?

**Culture:**

- What is important for your child to learn about where s/he is from?
- How do you teach your baby about who you are?
- What do you do to connect your child to your culture?

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# Field Guide to Toddler Functioning

**I. Initial Assessment Question #3**
**II. Typical consequences of abuse and neglect on a toddler's development.**
**III. Developmental Milestones**

## I. Initial Assessment Question #3

**How does the normal toddler (1 to 3 years) function on a daily basis?**

### Toddler's physical development.

- Rule of threes; 3 years, 3 feet tall, 33 pounds (+3 to 4 inches per year).
- Good muscle tone with strong neck, shoulder, arm, and leg muscles.
- Learning to walk and talk (three word sentences by three years old).
- Hand eye coordination easily is easily recognizable.
- Manipulates objects with good finger thumb opposition.

### Toddler's emotional and social development.

- Reacts to pain and pleasure.
- Appears relaxed and happy.
- Exhibits observable fears that are age-appropriate.
- Reacts positively to physical closeness.
- Responds to separation from primary caregivers.
- Responds to primary caregiver's return.
- Seeks interaction from primary caregiver.
- Can play independently and keep occupied in a positive way.
- Explores independently.
- Imitates social roles.

### Toddler's predominant behavior.

- Special Needs?
- Special Education/ Services?
- Chronic medical conditions?
- Developmental delays or disabilities?
- Mental health challenges?
- History of abuse and/or neglect? (see Part II)

### Toddler's mood / temperament.

- Curious and explores the environment.
- Appears to be outgoing (range of individual temperaments).
    - From demanding to easily comforted.
    - From outgoing to shy.
    - From easily engaged to easily distracted.

      But always egocentric, generally curious, and vocal about.
- Needs Initially anxious around new people ("stranger anxiety").
- Desire for independence can be expressed as frustration, stubbornness, obstinacy, and "temper tantrums" ("the terrible twos").

### Toddler's Speech and communication.

- Is able to express emotions.
- Expresses frustration, especially regarding ability and desire to accomplish new tasks.
- Seeks positive approval from primary caregiver.
- Responds to parental directions.
- Responds to the limits set by primary caregiver.
- Responds to parental efforts to help or assist.
- Communicates in at least three word sentences by age of three (rule of threes).

### Toddler's general behavior.

- Learning daily routines (bedtime, mealtime, playtime, etc.).
- Learning self-care (getting dressed, brushing teeth, combing hair, etc.).
- Learning rules and expectations.
- Can play on their own or simple games with caregiver ("parallel playwith peers).
- Shows preferences for certain toys and activities.
- Busy exploring, jabbering, and interrupting.

### *Emotional*

- Abused toddlers may feel that they are “bad children.” This has a pervasive effect on the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of healthy personality. Children may become chronically dependent, subversive, or openly rebellious.
- Abused and neglected toddlers may be fearful and anxious, or depressed and withdrawn. They may also become aggressive and hurt others.

## III. Developmental Milestones (1 to 3 years)

### *Physical Development*

- (Age 1 - 2 years) - The infant perfects the gross and fine motor skills that emerged during the first year by developing balance, coordination, stability, and an improved ability to manipulate objects.
- (Age 2 - 3 years) - The child develops increased strength and uses motor skills to master challenges in the environment, such as bicycles, stairs, balls, playground equipment, eating utensils, crayons, and other objects. The child is developmentally ready to master toilet training.

### *Cognitive Development*

- (Age 1 - 2 years) - The emergence of symbolic thought is central to cognitive development. This results in the ability to understand and produce language.
- (Age 2 - 3 years) - Perfection of language skills and the use of language to communicate with others are the principle cognitive tasks.

### *Social Development*

- (Age 1 - 2 years) - The child develops affectionate and trusting relationships with other family members and with adults outside the family. The child can also be engaged in simple games and play.
- (Age 2 - 3 years) - The child develops rudimentary relationships with other children, which are usually characterized by “parallel play,” that is play in the presence of, rather than in interaction with, other children. Children also begin to imitate social roles at this time. Toilet training represents a significant internalization of social rules and expectations.

### *Emotional Development*

- (Birth - 1 year) - The development of basic trust, a derivative of the positive attachment between the infant and the primary caretaker, occurs during the first year. This is a cornerstone of emotional development.
- (Age 1 - 3) - The primary developmental task involves the development of autonomy, which includes mastery and control over oneself and one’s environment. Children develop a rudimentary self-concept, experiencing pride and pleasure at being “good” and embarrassment, shame, and distress at being “bad.”

**Toddler's characteristics that contribute to their vulnerability and their ability to self-protect.**

- Demanding and egocentric.
- Desire for independence can be expressed as frustration, stubbornness, obstinacy, and "temper tantrums" ("the terrible twos").
- "Temper tantrums" can distress primary caregiver; can be misperceived as sign of inadequate parenting.
- Cannot protect themselves physically.
- Very limited ability to report abuse or neglect.
- Since not in school, often socially isolated.
- Toilet training can be one of the most stressful tasks for children and primary caregiver.
- Physical injury can interfere with physical exploration of the environment leading to possible delays in cognitive development.
- Abuse and neglect can interfere with attachment of a toddler to caregiver leading to possible lifelong emotional and personality problems.

## II. Typical consequences of abuse and neglect on a toddler's development

### *Physical*

- Chronic malnutrition of infants and toddlers results in growth retardation, brain damage, and potentially, mental retardation.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, vision problems from untreated strabismus (crossing of the eyes), respiratory damage from pneumonia or chronic bronchitis, etc.
- Neglected infants and toddlers have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills.

### *Cognitive*

- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.
- Brain damage from injury or malnutrition can lead to mental retardation.
- Abused and neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay, which can also affect social development, including the development of peer relationships.

### *Social*

- Abused or neglected toddlers may not develop play skills, and often cannot be engaged into reciprocal, interactive play. Their play skills may be very immature and primitive.

| TODDLER | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | Typical reactions by toddlers: fear, regression, fantasy, guilt, bewilderment, change in level of aggression, generalized emotional neediness, inability to enjoy play or using play to recreate the family. | Toddler will test their "new world" to try to understand how it works.<br><br>Toddler behaviors that some find hard to handle will increase after being traumatized.<br><br>Workers, caregivers and parents often want to blame someone or interpret the behaviors as related to things besides the separation, i.e. XXX must not be a good parent of the child. | Expect toddler to show behavioral signs of trauma and loss.<br><br>Do not blame adults or shame the toddler.<br><br>Provide structure, rules, consistency and stability for the toddler – minimize how many changes the toddler must have – make changes slowly.<br><br>Reassure the toddler that he/she is loved.<br><br>Control behaviors that can cause harm to the toddler or others but do not overreact. |
| | The toddler needs dependable adults to help him/her cope | Child can turn to relative, substitute caregivers or a known and trusted worker for help and support during the placement process. | Early & regular contact with parent or other who the toddler has emotional ties.<br><br>Do bonding activities.<br><br>Place siblings together and/or provide time for them to comfort each other.<br><br>Provide toddler with his/her favorite comfort item. |
| | The toddler is likely to have an inaccurate and distorted perception of the placement experience. | Toddler may make up stories about abuse, what occurred, why it occurred, what is happening to him in care, etc. This can appear to be lying to others | Discuss reality and fantasy with the child.<br><br>Do not punish child for "telling lies". |
| | See people on extremes of all good or all bad | Toddler may fear new caregiver or environment. | Assure toddler he/she is safe with caregivers.<br><br>Inform parents and caregivers of these issues so they do not overreact to things he/she may tell them, e.g., "My new mommy is mean to me." |
| | Any placement of more than a few weeks is experienced as permanent. | Without visits, the child may assume parents to be gone, dead or not coming back.<br><br>A toddler can complete the grief and loss cycle in a few weeks. A toddler believes what they see and experience and not what they are told | Do frequent visits, if not possible, have pictures, talk about the absent parent or have phone calls or audio tapes.<br><br>Prepare the parent for the toddler's behavior and lack of memory if visits have not occurred regularly.<br><br>Give the toddler a chance to remember or reestablish a connection with the parent at the beginning of a visit. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **TODDLER** | The toddler will often view separation and placement as a punishment for "bad" behavior. | Toddler will cling to her own explanation for the placement.<br><br>Self-blame increases anxiety and lowers self-esteem.<br><br>Toddler may believe if she repeats the bad behavior, which she believes caused the placement, the new family will send her home. | Explain, in simple language, that the adults are responsible and will fix the problem. May need to repeat this information multiple times<br><br>Help parent learn how to explain what happened in a way that will not increase the toddler's belief that she is responsible.<br><br>Let toddler know that her being good or bad will not change things such as where she is placed, when she gets to go home, etc. Try to avoid replacing the toddler and stating to the toddler that she caused the change due to her behavior. |
| | Because the toddler cannot generalize experiences from one situation to another, all new situations are unknown and therefore, more threatening. | Even what appears to be a small change to adults can be a new trauma to the toddler, i.e. changing beds at the home, change in caregivers, or changes of when visits occur. | Prepare child for any changes, new experiences and what will happen "next". "Today is a special day so you will see your dad at lunch but not at bedtime."<br><br>Have a schedule and keep it unless there is no other choice.<br><br>Have toddler practice things ahead of the event, i.e. going through screening at the jail, bedtime routine, riding to jail. |
| | Want to please their parents and adults they are attached to. | Confused when given mixed messages about which parent he can trust or love.<br><br>Will act differently with different parents in response to trying to please that person. | Give child clear boundaries and messages.<br><br>Do not ask the child to choose between parents.<br><br>No bad talk about the other parent.<br><br>Each adult be consistent in his/her messages. Child is able to respond to differences among adults. |
| | The toddler will display considerable anxiety about the new home. | Toddler may express anxiety through behaviors and bodily functions.<br><br>Most often, while verbal reassurances are helpful, the child needs to experience the environment to feel comfortable in it | Help the parent (or someone the toddler trusts) comfort the toddler and address her anxieties.<br><br>Let the child know that it is OK to have feelings and that you want to know what they are.<br><br>Teach child safe ways to express emotions; crying, hitting a pillow, quite time, cuddling, etc.<br><br>Use games to teach the child about the new home and family.<br><br>Allow the child to have comfort items such as blankets, toys, or pacifier. This is not the time to ask a toddler to give up comfort items |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **TODDLER** | Placement, without proper preparation, may generate feelings of helplessness and loss of control, which may interfere with the development of autonomous behavior | The toddler will revert to infant like behaviors; wanting their bottle, asking to be feed, wetting their pants or bed, etc. They may become whiney and clinging to any adult who shows affection | Expect this behavior; do not take it "personally" when a child acts out his feelings. Inform parent of changes in behaviors or skills.<br><br>Allow the behaviors without comment during the transition time. When the toddler is more secure slowly work towards regaining these developmental skills. Often the toddler will do this on his own once he feels secure.<br><br>Allow the toddler time to be clinging – may need to start the goodbye part of the visit early so there is enough time.<br><br>Practice how to say goodbye with the toddler, i.e. you will have X number of kisses and hugs.<br><br>Make sure people the toddler is attached to say goodbye before they leave. Do not "disappear" or sneak out |

# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Children and Caregivers

# Toddlers (18-36 months)

## Reviewing Safety with Caregivers

### Basic Safety

- Did this child have any serious injuries, either before or since coming into your care?
- Does your child have any chronic health conditions? Do you have all the necessary medication and supplies?
- Do you have a First Aid Kit in your home?

Things to Check For:

- Are TVs and other pieces of standing furniture secured so that they cannot be pulled over?
- Are exposed wires or appliance cords in reach of children?

### Preventing Falls

- Are there child safety window guards on all windows above the first floor?
- Are safety gates installed at the top and bottom of all staircases?

### Bath Safety

- What do you do if the telephone or doorbell rings while you are giving your child a bath?
- Do you use bathtub seats with suction cups?
- Do you check the water temperature to make sure that the bath is not too hot or too cold?

### Sleep Time Safety

- Please show me where the child sleeps. What do you do if the child has trouble falling asleep? Does the child have nightmares?
- When you put your child to sleep, do you put him/her on his/her stomach or back? (Sleeping on back is recommended.)
- What type of bedding do you use for the child? (Avoid soft bedding or pillows.)
- Does your child ever sleep in bed with you or with other children?
- Are there any window blinds or curtain cords near your baby's crib or other furniture?
- Does your child use a pacifier? Do you attach the pacifier to the child? How? (Should not tie anything to the child using string or ribbon.)
- Do you ever cover mattresses with plastic or a plastic bag? (Avoid plastics that could interfere with breathing.)

### Bed Safety

- Check for the following types of issues regarding the place where the child sleeps:
  1. Does the crib have any missing, loose, improperly installed or broken hardware?
  2. Are crib slats more than two and three-eighths inches apart?
  3. Are there any corner posts over the end panels of the crib?
  4. Do the headboards or footboards have any cutout areas?
  5. Is paint cracked or peeling?
  6. Are there any splinters or rough edges?
  7. Are the top rails of the crib less than ¾ of the child's height?
- Does the child climb out of bed/crib? What do you do to prevent the child from falling or getting into an unsafe situation?

### Child Care Safety

- Who takes care of your child when you are not home? How do you know this person? How old is this person? Is there a way for your child to reach you when you are away from home?
- Is there a list of phone numbers for your doctor, local hospital, police, fire department, poison control center and a friend or neighbor near the phone?
- Does this child go to daycare or pre-school? If so, how many hours per week? Who is responsible for drop-off and pick-up?

### Safety Outside

- How do you watch your child when s/he plays outdoors?
- What does your child do if a stranger talks to him or her?

## Safety suggestions are NOT requirements for birth parents.

## Reviewing Safety with Toddlers

- Who takes care of you?
- Do you ever sleep over at somebody else's house?
- Do you go to school or day care?
- Do you go outside? Who goes outside with you?

## Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the child's personal things, toys, books or other things s/he plays with. How does this child comfort himself/herself?
- Show me the child's bedroom. Who else lives in this room? How does the child get along with the others in the family?

## Daily Routine:

- Describe a typical day for this child.
- If you had to teach this child a new skill, like picking up his/her toys, how do you do that? If the child does not follow rules, what do you do? How does the child respond to this?
- Describe a typical time when the child did not follow a rule. How does this child comply with your requests and demands? When the child does not follow family rules, what type of discipline do you use?

## Social/Emotional:

- Have you seen any signs that the child is feeling grief, loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the child handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the child transitioned into your home/family. What have you been able to do to help the child transition (i.e. cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the child's home, etc.)?
- How does this child show warmth and affection? What does s/he do when s/he is happy? How does the child show that s/he is upset, hurt, sad or other emotions?
- Who does this child seek comfort from when s/he is hurt, frightened, or ill?
- Is this child able to seek you out and accept your help when needed?
- Does this child show preference for a particular adult?
- What does this child do when upset? How easy is it to soothe this child when s/he is upset?
- How does this child comply with your requests and demands?
- How has this child changed since coming here? What do you think about that? In what ways has the child adjusted to this placement?
- Is this child involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the child's parents/siblings/family? What happened when you meet them? Do you have any concerns or questions about the family?
- Whom does the child talk to, play with, or spend time with? Is the child's behavior different with these people than with you? In what ways?
- Is the child allowed to call family from your home?

## Special Interests:

- What kinds of things does this child like to do?
- What do you do to support the child in being involved in things s/he likes to do? Do you need any help to do this?

## Education:

- Would you describe this child as developmentally normal or not? Can you give me examples of his/her behaviors/skills/developmental progress or regression? Do you think the child needs any help in any developmental skills?
- Does this child go to school or day care? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the child were to have troubles at school, who would you contact?
- How has the child transitioned into his//her new school?

## Health:

- Who is taking the child to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the child should have? Does the child have any special medical problems? Do you know how to provide the care for this type of condition? Where do you keep the child's medical records? Show me any recent medical report so I can have a copy for the child's records.
- Describe the child's sleeping pattern. Describe the child's eating habits.
- Have you seen any weight changes since this child has been with you? Any other type of changes?
- What developmental milestones has the toddler achieved?

## Case Planning:

- Is this child receiving any developmental, medical and/or psychological services? Which ones? How often? What do you think/feel about these? Do you think that the services are meeting this child's needs? Are there any other services that you think this child needs?
- What is your greatest fear about your child returning home? What is your greatest fear if your child does not return home?
- When the child visits his/her parents or other family members, what happens?
  How does the child behave before or after the visit? What do you think of the family visits with the child?
- What are the case goals for this child and his/her family and what do you think/feel about that? What makes that okay; not okay?
- If the child goes home, how do you imagine you might still be involved with the child and his/her family? If the child cannot go home to any family member, how might you imagine being involved with the child?
- What is the permanency goal for this child? What do you think/feel about this? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the child that would help all of us do a better job making this child safe and getting him/her a permanent family?

**Self-Care:**

- On a scale of one to ten with ten being the easiest child you have ever cared for – how easy is it to parent this child? Describe who this child is. What about the child is easiest and most pleasurable? What is the most difficult aspect of this child for you to deal with? What are the things about this child that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this child in your home? What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this child? What has been the effect on your family of having this child placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this child?
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this child?

**Culture:**

- What is important to your child to learn about where s/he is from?
- How do you teach your toddler about who you are?
- What do you do to connect your child with your culture?

## Reviewing Well-Being & Permanency with Toddlers

**Living Arrangements:**

- Who lives with you at your house?
- Where do you sleep?
- Does anyone sleep by you?

**Special Interests:**

- What toys do you like to play with? Does anyone else play with toys with you?
- Do you like to have stories/books read to you? Who reads stories/books to you?
- Do you like to color or draw?
- What do you like to eat?
- What is your favorite toy? Can you show me?

### Social/Emotional:

- Does _____(caregiver's name) ever get mad at you?
- Does _____(caregiver's name) ever get mad at anyone?
- Are there any grownups or kids who do things that make you feel happy?
- Are there any grownups or kids who do things that make you feel sad?

### Education:

- What do you like to do at school/day care? Is there anything that you don't like about school/day care?

### Friends and Family:

- Whom do you play with?
- What kinds of things do you do with your mommy and/or daddy?
- What kinds of things do you do with your brothers and/or sisters?
- Is there anyone or anything you miss (friend, family, pet, belonging) from your house?
- Do you have a grandma, grandpa, etc..? Do you like to visit_____?

### Health:

- Does your stomach or head ever feel bad?
- Have you been to see a doctor?

  Have you been to see a dentist (a special doctor who looks at your teeth)?

### Sources:

Adapted from sources by Rose Marie Wentz and Joan Morse, 2009

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# Field Guide to Preschooler Functioning:

**I. Initial Assessment Question #3.**
**II. Typical consequences of abuse and neglect on a preschooler's development.**
**III. Developmental Milestones.**

## I. Initial Assessment Question #3

**How does the normal preschooler (3 to 5 years) function on a daily basis?**

### Preschooler's general behavior.

- Very busy, can't sit still.
- Most talk non-stop.
- Love to play and direct play (example "Ok, now you be the dragon and I'll be the princess‖).
- Understand and comply with some day-to-day routines and rules of the household.

### Preschooler's physical abilities.

- Rule of threes; 3 years, 3 feet tall, 33 pounds (+3 to 4 inches per year).
- Few new physical abilities emerge.
- Practicing gross and fine motor skills during play.
- Very busy, can't sit still.

### Preschooler's emotional and social development.

- Reacts to pain and pleasure.
- Toys! Favorite toys, focus on toys, love of toys and play.
- Can play independently.
- With help of parent, learning how to: share, take turns, cooperate, and manage impulses.
- Discharges emotions and reduces fears through play.
- Parallel play evolves into cooperative play.
- Then friendships develop.

### Preschooler's predominant behavior.

- Special Needs?
- Special Education/ Services?
- Chronic medical conditions?
- Developmental delays or disabilities? Mental health challenges?
- History of abuse and/or neglect? (see Part II)

### Preschooler's mood / temperament.

- Self-directed, self-starter, and likes to direct others during play.
- Curious, explores environment.
- Learning self-control: temper tantrums decrease, can cope with some frustration and discomfort on their own.
- Learning to delay gratification.
- Turns tears off and on.
- Feels pride when doing something right, shame when doing something wrong, with subsequent sense of self-esteem.
- Anxious without rules, vulnerable to punishment.
- Egocentric.

### Preschooler's speech and communication.

- Seeks interaction from parents.
- Responds to parental directions.
- Seeks positive approval from parents.
- Responds to the limits set by parents.
- Responds to parental efforts to help or assist.
- Has established patterns of communication and play with parent.
- Most talk non-stop and interrupt.
- Make up stories.
- Magical thinking: draw conclusions from limited information, limited understanding of cause and effect, and limited ability to abstract.
- Difficulty with concepts of time and sequencing Narratives are influenced by above.

### Preschooler's general behavior.

- Very busy, can't sit still.
- Most talk non-stop.
- Love to play and direct play (example "Ok, now you be the dragon and I'll be the princess").
- Understand and comply with some day-to-day routines and rules of the household.

**Preschooler's characteristics that contribute to their vulnerability and their ability to self-protect.**

- Demanding, egocentric, busy, talk non-stop and interrupt
- Can understand and comply with some rules and routines but parent's expectations can be too high (example: sitting still for long periods or good table manners).
- Very limited ability to protect themselves physically.
- Can report abuse and neglect or be interviewed but their narrative is limited by unclear speech, inability to sequence events, magical thinking, desire to please adults, and susceptibility to suggestion and/or coaching.
- Vulnerable to punishment and harsh criticism, can impact self esteem.
- Can appear independent but still vulnerable to danger and neglect if not adequately supervised.
- Turning tears on and off can be misperceived.
- Without support from a skilled caregiver, frustration, stubbornness, obstinacy, and "temper tantrums" can persist and escalate.

## II. Typical consequences of abuse and neglect on a preschooler's development

### *Physical*

- They may be small in stature, and show delayed physical growth.
- They may be sickly, and susceptible to frequent illness; particularly upper respiratory illness (colds, flu) and digestive upset.
- They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, awkward gait, lack of muscle strength.
- Gross motor play skills may be delayed or absent.

### *Cognitive*

- Speech may be absent, delayed, or hard to understand. The preschooler whose receptive language far exceeds expressive language may have speech delays.
- Some children do not talk, even though they are able. The child may have poor articulation and pronunciation, incomplete formation of sentences, incorrect use of words.
- Cognitive skills may be at a level of a younger child.
- The child may have an unusually short attention span, a lack of interest in objects, and an inability to concentrate.

### *Social*

- The child may demonstrate insecure or absent attachment; attachments may be indiscriminate, superficial, or clingy. Child may show little distress, or may overreact, when separated from caregivers.
- The child may appear emotionally detached, isolated, and withdrawn from both adults and peers.
- The child may demonstrate social immaturity in peer relationships; may be unable to enter into reciprocal play relationships; may be unable to take turns, share, or negotiate with peers; may be overly aggressive, bossy, and competitive with peers.
- The child may prefer solitary or parallel play, or may lack age appropriate play skills with objects and materials. Imaginative and fantasy play may be absent. The child may demonstrate an absence of normal interest and curiosity, and may not actively explore and experiment.

### *Emotional*

- The child may be excessively fearful, easily traumatized, may have night terrors, and may seem to expect danger.
- The child may show signs of poor self-esteem and a lack of confidence.
- The child may lack impulse control and have little ability to delay gratification. The child may react to frustration with tantrums, aggression.
- The child may have bland, flat affect and be emotionally passive and detached.
- The child may show an absence of healthy initiative, and often must be drawn into activities; may emotionally withdraw and avoid activities.
- The child may show signs of emotional disturbance, including anxiety, depression, emotional volatility, self-stimulating behaviors such as rocking, or head banging, enuresis or encopresis, or thumb sucking.

## III. Developmental Milestones (3 to 5 years)

### *Physical Development*

- Most basic gross motor abilities have emerged. Existing skills are practiced and perfected, and the child develops mastery in applying motor skills to increasingly challenging and complex situations.

### *Cognitive Development*

- Language develops rapidly. Grammar and syntax are refined, and vocabulary increases geometrically. The child uses language as a communication tool.
- Thinking is concrete and egocentric in nature. Problem solving is illogical, and magical thinking and fantasy are prevalent.

### *Social Development*

- The child expands social relationships outside the family and develops interactive and cooperative play skills with peers.
- The child begins to understand, explore, imitate, and practice social roles.
- The child learns concepts of “right” and “wrong” and begins to understand the nature of rules. He experiences guilt when he has done something wrong.

### *Emotional Development*

- The preschool child has been described as “on the make.” Erikson refers to the child’s primary mode of operation during this stage as initiative. The child is intrusive, takes charge, is very curious and continually tries new things, actively manipulates the environment, and is self-directed in many activities.
- The child’s ability to understand “right” and “wrong” leads to self- assessments and affects the development of self-esteem.

| PRESCHOLLER | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | The child may wonder how the necessities of life (food, toys, etc.) will be provided. | This feeling can lead to overeating, begging or manipulation.<br><br>Child may refuse to let go of an item. | Reassure the child that his/her needs will be met.<br><br>Do not try to remove comfort item from child unless necessary.<br><br>Most behaviors are temporary and will go away once the child feels secure so do not overreact. |
| | The child needs dependable adults to help him cope. | Child can turn to a relative, substitute caregivers or a known and trusted worker for help and support. | Visits should always include at least one person the child trusts.<br><br>Prepare parent if the child does not currently trust/remember the parent.<br><br>Regular contact is necessary to build trust and maintain memories. |
| | The preschool child is likely to have an inaccurate and distorted perception of the placement experience. | Magical thinking can cause them to make up stories about their parent or their situation.<br><br>Look for clues the child has fantasies and talk to the child about the fantasies such as: feelings of pain, of sorrow, of being responsible for the situation. | Try to explain when things will occur in a manner the child will understand. Do not wait for the child to ask for the information.<br><br>Do not treat child's perception/magical thinking as a lie.<br><br>Do not avoid talking about a traumatic placement or event in the hopes that the child will forget the event.<br><br>Use books and stories to help the child understand what is real.<br><br>Ask the child to tell you her "story" about what happened.<br><br>Drawing or playing is a way for the child to share her perceptions. |
| | They may believe they are responsible for their parent being in jail, getting a divorce or why family violence occurred | Self-blaming can be shown through regression in behaviors or skills such as bed-wetting, trouble sleeping, developing fears (monster in the closet), nightmares and toddler like tantrums. | Inform the parent of the child's behaviors or belief that he/she caused the parent's arrest.<br><br>Parent and others to give clear message the child is NOT responsible. Especially important if the child did something like call the police. |

| | Impact of Separation | | |
|---|---|---|---|
| **PRESCHOLLER** | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | Any placement of more than a month is experienced as permanent. | Without visits, the child may assume parents to be gone, dead or not coming back.<br><br>Child does not understand time periods such as six months or two years.<br><br>Child may "forget" many things about birth family within a short time. (Short term cognitive memory but child usually has a long term subconscious memory of that parent.)<br><br>Child will go through grief and loss cycle quickly. Expect changes in behaviors such as denial, anger, and bargaining.<br><br>Child may try to bargain (not always stated aloud). If I am good can I go home?<br><br>Child may not know how to express emotions or fears expressing emotions. | Ensure that the child has immediate contact after placement and frequent visits thereafter.<br><br>Pictures and phone calls can help supplement visits.<br><br>Talk to the child about the next visit but do not try to explain things that may take months or years to occur.<br><br>Do not deny visits in the hope that the child will adjust faster to new home if there is no contact.<br><br>Address the child's need for love and stability NOW.<br><br>Prepare parent for child's lack of memory if the visits do not occur regularly.<br><br>Give the child time to reestablish a relationship with a parent he/she has not seen in weeks or months.<br><br>Child's anger at parent may be related to anger phase of grief/loss cycle or shows anger to another person.<br><br>Talk to the child and assure him that he will have a family and that the adults will work to be sure the child is loved even by family members whom he has not seen for a while. |
| | The child will display considerable anxiety about the new home/family. | Child may try to do things that make new home be more like parent's home. This may be seen as not following the rules.<br><br>Caregiver should check how the child is doing regularly especially during the first days of placement. | Ask parent about the child's schedule and home life.<br><br>Use that information to make things in the caregiver home mimic the child's home; food, routines, toys, clothes.<br><br>Parent asks child about new home and schedule. Encourage and praise the child for adjusting to his new home.<br><br>While verbal reassurances are helpful, the child needs to experience the environment to feel comfortable in it. Make changes slowly. Provide clear and simple rules to the child to follow. |

| PRESCHOLLER | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | Child may say things to be in control or express anger that upset others: (not unusual for normal child/parent interactions for this age) "*I hate you, you're not my friend, you can't make me*." | Child may have emotions she does not know how to handle. | Prepare parent for these behaviors/emotions.<br><br>Do not overreact or the child will probably repeat the statement or behavior.<br><br>Often occurs when parent is trying to set boundaries. Continue to enforce boundary/rule. "John, you may not want to be my friend but you cannot hit me." |
| | Placement, without proper preparation, may generate feelings of helplessness and loss of control, which may interfere with the development of autonomous behavior. | Child is likely to regress on one or more developmental tasks.<br><br>Child may refuse to be alone, try to control world, or display symptoms similar to depression.<br><br>Child may lack concentration and is not able to enjoy normal activities.<br><br>Child needs to know that she has some influence on adults to get her needs met. Child may manipulate, have repeated requests or insist on their own way. | Prepare the parent for this to occur.<br><br>Expect behavioral changes and emotional reactions; the child may act out his emotions towards the parent, caregiver or social worker.<br><br>Do not take it "personally" but allow the child a safe way to act out the emotions.<br><br>Encourage child to do things that have brought him joy in the Past, but do not pressure the child.<br><br>Allow child to express his emotions and show him that you still love him when he expresses his emotions. He does not have to be perfect to be loved.<br><br>Acknowledge child's emotions and praise him for even small steps he makes towards adjusting to the situation.<br><br>Meet the child's needs. Allow the child control over safe things like what to wear to the visit, which vegetable to eat, etc. |

| Impact of Separation | | |
|---|---|---|
| **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| Child attaches to new caregiver or to primarily to one parent and feels loyalty conflicts | Child calls new caregiver mom/dad<br><br>Child shows signs of confusion about who is my parent/family<br><br>Child's self-esteem is connected to everyone he considers his family.<br><br>Adults should talk to each other directly and never use the child to send messages. | Inform the parent of the child's behavior and how this is normal and healthy<br><br>Parent assures the child that he can love two moms or dads.<br><br>Do not ask the child to choose between parents.<br><br>Maintain frequent contacts with all birth parents or past caregivers.<br><br>One adult should never talk negatively about another adult with whom the child is attached.<br><br>Explain to the child that many children have multiple families (divorce) and that this is normal. |
| Child needs to know what happened to parent or what she is doing while away from the child. Especially for parents in jail, hospital or settings away from family home. | Child wonders what their parent's life is like in jail or hospital. She may ask a lot of questions this is normal for this age.<br><br>Child will make up worse stories about parents life if no information is given. | Answer the child's questions. You may need to repeat the answers.<br><br>Do not wait for the child to ask. Provide information about things like where you sleep, what you eat, do children live there, etc.<br><br>Draw or take pictures of yourself in jail or where you are now.<br><br>Do not share information on difficult things you may experience in jail or hospital. |

# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Children and Caregivers

# Pre-School (3-6 years old)

## Reviewing Safety with Caregivers

### Basic Safety

- Did this child have any serious injuries, either before or since coming into your care?
- Does the child have any chronic health conditions? Do you have all the necessary medications and supplies?
- Do you have a First Aid Kit in your home?

Things to Check For:

- Are TVs and other pieces of standing furniture secured so that they cannot be pulled over?
- Are exposed wires or appliance cords in reach of children?

### Preventing Falls

- Are there child safety window guards on all windows above the first floor?
- Are safety gates installed at the top and bottom of all staircases?

### Bath Safety

- What do you do if the telephone or doorbell rings while you are giving the child a bath?
- Do you check the water temperature to make sure that the bath is not too hot or too cold?

### Child Care Safety

- Who takes care of the child when you are not home? How do you know this person? How old is this person? Is there a way for the child to reach you when you are away from home?
- Is there a list of phone numbers for your doctor, local hospital, police department, fire department, poison control center and a friend or neighbor near the phone?
- Does this child go to daycare or pre-school? If so, how many hours per week? How does the child get there? Who is responsible for drop- off and pick-up?

### Safety in the Streets

- How do you watch this child when s/he plays outdoors?
- What does this child do if someone they know talks to him or her?
- Does this child know your address or where they live and phone number? (Kids this age may know only part of the answer to these questions.)

**Safety suggestions are NOT requirements for birth parents.**

## Reviewing Safety with Preschoolers

- Do you know the where _____ (caregiver's name)'s house is? Do you know the telephone number for _____ (caregiver's name)? What is the phone number?
- Do you ever stay by yourself at home without any grownups around?
- Who takes care of you if _____ (caregiver's name) is not at home? What is it like when this person stays with you? Do you like it? What kinds of things do you do with this person?
- If something really bad or scary happened, like if there were a fire, what would you do?
- Do you ever sleep over at somebody else's house? Do you like this? Do you do this a lot?
- Are you able to call _____ (caregiver's name) when they are not at home? How do you do this?
- Do you go to school/day care? Who takes you to school? Who picks you up from school?
- When you go outside, who is with you?
- Do you know what to do if someone you don't know talks to you or asks you to go somewhere with him/her?
- What is your favorite toy? Can you show me?

## Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the child's personal belongings, toys, books or other things s/he plays with. How does this child comfort himself/herself?
- Show me the child's bedroom. Who else lives in this room? How does the child get along with the others in the family?

### Daily Routine:

- Describe a typical day for this child.
- If you had to teach this child a new skill, like picking up his/her toys, how would you do that?
- Describe a typical time when the child did not follow a rule. How does this child comply with your requests and demands? When the child does not follow family rules, what type of discipline do you use? How does the child respond to this?

## Social/Emotional:

- Have you seen any signs that the child is feeling grief or loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the child handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the child transitioned into your home/family. What have you been able to do to help the child transition? (For example, cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the child's home, etc.)
- How does this child show warmth and affection? What does s/he do when s/he is happy? How does the child show that s/he is upset, hurt, sad or other emotions?
- Who does this child seek comfort from when s/he is hurt, frightened, or ill?
- Is this child able to seek you out and accept your help when needed?
- Does this child show preference for a particular adult?
- What does this child do when upset? How easy is it to soothe this child when s/he is upset?
- How does this child comply with your requests and demands?
- How has this child changed since coming here? What do you think about that In what ways has the child adjusted to this placement?
- Is this child involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the child's parents/siblings/family? What happened when you met them? Do you have any concerns or questions about the family?
- Whom does the child talk to, play with, or spend time with? Is the child's behavior different with these people than with you? In what ways?
- Is the child allowed to call family from your home?

## Special Interests:

- What kinds of things does this child like to do?
- What are this child's special talents?
- What do you do to support the child in being involved in things s/he likes to do? Do you need any help to do this?

## Education:

- Would you describe this child as developmentally typical or not? Can you give me examples of his/her behaviors/skills/developmental progress or regression? Do you think the child needs any help with any developmental skills?
- Does this child go to school or day care? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the child were to have troubles at school, who would you contact?
- How has the child transitioned into his//her new school?

**Health:**

- Who is taking the child to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the child should have? Does the child have any special medical problems? Do you know how to provide care for this type of condition? Where do you keep the child's medical records? Show me any recent medical report so I can have a copy for the child's records.
- Describe the child's sleeping pattern. Describe the child's eating habits.
- Have you seen any weight changes since this child has been with you? Any other type of changes?

**Case Planning:**

- Is this child receiving any educational, medical and/or psychological services? Which ones? How often? What do you think/feel about these services? Do you think that the services are meeting this child's needs? Are there any other services that you think this child needs?
- What is your greatest fear about your child returning home? What is your greatest fear if your child does not return home?
- When the child visits his/her parents or other family members, what happens? How does the child behave before or after the visit? What do you think of the family visits with the child?
- What are the case goals for this child and his/her family and what do you think/feel about the goals? What makes them okay; not okay?
- If the child goes home, how do you imagine you might still be involved with the child and his/her family? If the child cannot go home to any family member, how might you imagine being involved with the child?
- What is the permanency goal for this child? What do you think/feel about this? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the child that would help all of us do a better job of making this child safe and getting him/her a permanent family?

**Self-Care:**

- On a scale of one to ten, with ten being the easiest child you have ever cared for, how easy is it to parent this child? Describe who this child is. What about the child is easiest and most pleasurable? What is the most difficult aspect of this child for you to deal with? What are the things about this child that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this child in your home? What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this child? What has been the effect on your family of having this child placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this child.
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this child?

### Culture

- What is important to for your child to learn about where s/he is from?
- How do you teach your child about who you are?
- What do you do to connect your child with to your culture

## Reviewing Well-Being & Permanency with Pre-schoolers

### Living Arrangements:

- How is it for you living at _____'s house?
- Who else lives here with you? What do you think about the other people who live here? Do you like living with them? Tell me about that.
- Do you know why you are living here with _____ (caregiver's name)? Do you like _____ (caregiver's name)? Tell me about that.
- Do you think that _____ likes you? Tell me about that.
- Where do you sleep? Do you share a room with anyone? If so, ask: Who? Do you like sharing a room with this person? How come?
- Are there things that you can and can't do at _____'s house? What are some of these things?
- What happens if you do something that you are not supposed to do? Has this happened one time or more than one time?

### Daily Routine:

- Describe what happened since you woke up today.
- Do you wake up by yourself in the morning or does someone else wake you up? If it's someone else, ask: Who?
- What do you do in the morning to get ready for school? Does anybody help you? If so, what do they do? What do you do by yourself to get ready in the morning?
- Does anyone make breakfast for you? Who? What are some things that you eat for breakfast?
- If child goes to school: Do you bring your lunch with you to school or do you get lunch at school? What are some things that you eat for lunch? Where do you go after school? How do you get there? What do you do after school? Do you like what you do after school?
- Who makes you dinner? What are some things that you eat for dinner? What are some things that you do after you eat dinner?
- What time do you go to bed? Does anyone help you to get ready for bed? If so, what do they do to help you?
- What do you do on Saturday and Sunday? Who do you do this with? What do the other people in _____'s house do on Saturdays and Sundays? If applicable: Is this the same as what you used to do on weekends when you lived with (previous guardian) or is it different? What is different about it?

## Special Interests:

- What kinds of things do you like to do for fun? (For example, sports, music, art, video games, etc.) Do you do these things while you are living with _____?
- Are there any things that you'd really like to be doing that you aren't doing now? What do you miss?
- What's your favorite food? When do you get to eat that?
- What is your favorite toy? Can you show me?

## Education:

- Do you go to school? If so, do you like it? How come? What do you do at school? Who do you do this with?
- If child goes to school: What are some of the things that you like the most about school? What are some of the things that you don't like so much about school?
- Can you show me something you learned at school?

## Family and Friends:

- Do you get to see your mom, dad, grandma, pets, etc.? How is this for you? Do you see your brothers and/or sisters? What kinds of things do you do together?
- Who are some of your friends? What do you do with them? Where do you see them?
- Is there anyone you want to see or talk to?

## Social/Emotional:

- Does _____ (caregiver's name) ever get mad at you? What happens if _____ gets mad at you? Does this happen a lot of the time or a little of the time? What do you feel like when gets mad?
- Does _____ (caregiver's name) ever get mad at someone else who lives in the house with you? Does this happen a lot of the time or a little of the time? What do you feel like when gets mad at these other people? What are some of the things that s/he gets angry at other people about?
- Tell me one time when you felt sad, mad or scared about something that happened at _____'s house. What did you do? What did the adults do?
- Who do you go to when you need help?
- Is there anyone at _____'s house or anywhere else who makes you feel scared? Are there any grownups or kids who do things that make you feel sad, mad, or scared?
- Do you ever get scared when you are playing outside or walking around by _____''s house? If yes, what are the things that make you scared? Can you talk to someone about this? If so, who?
- What is the best thing about living with _____? Is there anything bad about living here?
- Do you have a favorite thing you do when you feel sad? Do you have a favorite thing that helps you feel happy? (For example, a toy, stuffed animal, or blanket.)
- Do you ever get scared at night? If so, ask; what do you do when this happens? Do you ever go into 's room when this happens? If so, ask; what do they do?
- Do you ever wake up in the middle of the night? If so, ask; what do you do when this happens?
- If something is really worrying or bothering you, who can you talk to? If you want to talk to me, do you know how you can do that?

## Health:

- Are you ever sick? Tell me about what happened when you felt bad.
- Have you been to see a doctor since you've been living with _____? What did you see this doctor for? Have you been to any other doctors? If so, why did you go to them?
- Have you seen a dentist since you've been living with _____?

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Adapted from sources by Rose Marie Wentz and Joan Morse, 2009

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# Field Guide to Grade School Age Child Functioning:

**I. Initial Assessment Question #3**
**II. Typical consequences of abuse and neglect on a grade school age child's development**
**III. Developmental Milestones**

## I. Initial Assessment Question #3:

**How does the normal grade school age child (5 to 11 years) function on a daily basis?**

### Grade school age child's physical development.

- Slow steady growth; +3 to 4 inches per year.
- Practices and masters gross and fine motor skills with sports, music, art, games, etc.
- Rarely walk when they can run, climb, or skip.
- Very busy, difficulty sitting still.
- Moves in an open, relaxed way — is not rigid.

### Grade school age child's emotional and social development.

- Can share, take turns, cooperate, and collaborate.
- Developing a social life and meaningful friendships.
- Imitates and adopts age appropriate social roles.
- Understands and relies on rules to dictate proper social behavior.
- Developing an ability to understand another person's perspective.

### Grade school age child's predominant behavior.

- Special Needs?
- Special Education/ Services?
- Chronic medical conditions?
- Developmental delays or disabilities?
- Mental health challenges?
- History of abuse and/or neglect? (see Part II)

### Grade school age child's peer and school behavior.

- School performance.
- Favorite subjects and interests at school.
- Some challenges and dislikes at school.
- Understands and follows rules at school.
- Some ability to sit still and quietly.
- Participates well in group activities in classroom and playground.
- School friends.

### Grade school age child's mood / temperament.

- Has self control, frustration tolerance, and can accept mistakes.
- Becoming decisive, responsible, and dependable.
- Self directed, productive, and tries new tasks.
- Acts in a way that demonstrates that she/he likes herself/himself.
- Shows accomplishments and appears proud of them.
- Demonstrates a range of emotions — affection, caring, fear, anger, acceptance, etc.
- Smiles easily.
- Does not frequently express lack of confidence by saying "I don't know" or "I can't.

### Grade school age child's speech and communication.

- Is able to identify own strengths.
- Expresses emotions.
- Feels comfortable in speaking to adults.
- Take pleasure in conversation with adults and peers.
- Can listen, ask questions, ask for help, ask for directions.
- Narratives are more logical, rational, and sequential.

### Grade school age child's general behavior.

- Has friends and interests in activities.
- Learning to complete self-care daily routines independently.
- Understands and follows rules of home and school.
- Understands and follows general schedule of school, play, homework, bedtime, etc.

**Grade school age child's characteristics that contribute to their vulnerability and their ability to self-protect.**

- Developing ability to physically protect themselves and others can escalate conflicts.
- Can report abuse and neglect but susceptible to threats, intimidation, retaliation and bribes.
- Blame themselves for abuse, neglect, or other problems in the home.
- Developing sense of self-esteem and independence is vulnerable.
- Vulnerable to punishment and harsh criticism, can impact self-esteem.
- Developing friendships and social life is vulnerable.
- Can appear independent but still vulnerable to danger and neglect if not adequately supervised.

## II. Typical consequences of abuse and neglect on a grade school age child's development

### *Physical*

- The child may show generalized physical developmental delays; may lack the skills and coordination for activities that require perceptual-motor coordination. The child may be sickly or chronically ill.

### *Cognitive*

- The child may display thinking patterns that are typical of a younger child, including egocentric perspectives, lack of problem solving ability, and inability to organize and structure his thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on schoolwork, and may not be able to conform to the structure of the school setting. The child may not have developed basic problem solving or "attack" skills and may have considerable difficulty in academics.

### *Social*

- The child may be suspicious and mistrustful of adults; or, overly solicitous, agreeable, and manipulative, and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms about her family; may exhibit "role reversal" and assume a "parenting" role with the parent.
- The child may not respond to positive praise and attention; or, may excessively seek adult approval and attention.
- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by peer expectations for performance, and may withdraw from social contact; may be scape-goated by peers.

### *Emotional*

- The child may experience severe damage to self-esteem from the denigrating and punitive messages received from the abusive parent, or the lack of positive attention in a neglectful environment.
- The child may behave impulsively, may have frequent emotional outbursts, and may not be able to delay gratification.
- The child may not develop coping strategies to effectively manage stressful situations and master the environment.
- The child may exhibit generalized anxiety, depression, and behavioral signs of emotional distress; may act out feelings of helplessness and lack of control by being bossy, aggressive, destructive, or by trying to control or manipulate other people.
- The child who is punished for autonomous behavior may learn that self- assertion is dangerous and may assume a more dependent posture. He may exhibit few opinions, show no strong likes or dislikes, may not be engaged into productive, goal-directed activity. The child may lack initiative, give up quickly, and withdraw from challenges.

## III. Developmental Milestones (5 to 11 years)

### *Physical Development*

- The child practices, refines, and masters complex gross and fine motor and perceptual-motor skills.

### *Cognitive Development*

- Concrete operational thinking replaces egocentric cognition. The child's thinking becomes more logical and rational.
- The child develops an ability to understand another's perspective.

### *Social Development*

- Relationships outside the family increase in importance, including the development of friendships and participation in a peer group.
- The child imitates, learns, and adopts age appropriate social roles, including those that are gender-specific.
- The child develops an understanding of rules. Rules are relied upon to dictate proper social behavior and to govern social relationships and activities.

### *Emotional Development*

- The child is industrious, purposeful, and goal directed in her activities. She is confident and self-directed.
- The child is developing a better sense of herself as an individual, with likes and dislikes and special areas of skill. She is capable of introspection.
- The child evaluates her worth by her ability to perform. Self-esteem is largely derived from one's perceived abilities.

| | Impact of Separation | | |
|---|---|---|---|
| **GRADE SCHOOL AGE** | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | The child will compare one parent to another. | The child may talk about what the "other" parent does or does not do. | Let the parent know that this is normal.<br><br>Let the child talk without assuming that he prefers one person over the other.<br><br>Never talk negatively about the other parent/caregiver.<br><br>Don't push a child to provide information about the other parent(s). |
| | The child can develop new attachments and turn to adults to meet his/her needs | Child will call caregivers mom and dad.<br><br>If given permission, the child may be able to establish relationships with caregivers without feeling disloyal to own parents.<br><br>Child may bond with other children who are a part of the new family. | Allow the child to determine what names/titles are used; what to call foster parents, stepparents, other children in the home, etc.<br><br>Prepare the parent for this normal reaction and that this shows that the child is healthy and normal.<br><br>Adults should give positive support of each other's role. Disagreements should be handled without placing the child in the middle.<br><br>Keep child in contact with caregivers and others in the home when the child moves to another home. |
| | Child will have intense emotions and may not know how to handle them. | Anger, sometimes quite intense, is expressed as both an honest reaction to what is happening to him/her and as an externalizing attempt to cope with his/her pain, sadness, and helplessness. | Allow the child ways to express emotions in a safe manner.<br><br>Let her know it is OK to have these emotions.<br><br>Do not be defensive or tell child not to feel that way |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **GRADE SCHOOL AGE** | *The loss of siblings, peer group and friends may be almost as traumatic as the loss of parents.* | *Making new friends may be difficult.*<br><br>*The child may be embarrassed and self- conscious about "foster child" status.*<br><br>*Children who lose too many relationships may refuse to form new friendships.*<br><br>*Keep siblings together whenever possible.* | *When possible allow the child to attend the same school.*<br><br>*If not possible, ensure the child can maintain contact with friends.*<br><br>*Encourage the child to make friends but acknowledge to the child that it is normal to be afraid that this may cause more loss.*<br><br>*Have the child get involved in activities and hobbies.*<br><br>*Parents and caregivers work to maintain these connections.*<br><br>*Have the child develop a scrapbook to save pictures, letters and stories of the people in his/her life.* |
| | *The child may be confused if the rules and expectations in the caregiver's home are different from what she is used to.* | *The child may not want to ask about the rules or is in shock in the first days and does not remember the rules.*<br><br>*The child may feel a need to test the rules to see what happens.* | *Caregiver should learn from the child and family about the rules the child had in last home.*<br><br>*Whenever possible maintain those rules. Example: Keep bedtime the same. If change is needed slowly move bedtime to meet the rules of the new family.*<br><br>*Be non-judgmental of the rules of the other parent/caregiver.*<br><br>*Provide clear rules and do not overreact if the child does not follow all the rules immediately.*<br><br>*Give the child some choices, "Would you like to store your shoes under your bed or in the closet?"* |
| | *The child has a better understanding of time. Placements of a few months can be tolerated without affecting attachments.* | *The child is capable of remembering a parent they have not seen in months or years.*<br><br>*The child may be shy when they first see their parent if contact is not frequent.*<br><br>*The child is likely to have emotions such as fear, angry, disappointment regarding the parent.* | *Have regular visits and use photographs, letters and phone calls to supplement the contact.*<br><br>*Involve the child in planning the visit.*<br><br>*Be sure the visit does not regularly interfere with the child's schedule, school attendance or time with peers.*<br><br>*Provide parent with information on the child's life, school and friends – help the parent have information that can be used to talk to the child* |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **GRADE SCHOOL AGE** | The child has an increased ability to understand the reasons for the separation. | With help, the child may be able to develop a realistic perception of the situation and avoid unnecessary self- blame.<br><br>Do not over estimate his ability to fully understand.<br><br>Language skills are more advanced than cognitive and abstract thinking skills. | Give the child honest answers about the situation and the adult's responsibilities.<br><br>Include the child in court hearings or provide him information. Do not assume he does not know or care about court.<br><br>Parent and others should answer the child's questions honestly and as completely as possible.<br><br>Do not wait for child to ask the questions. |
| | The child may be worried about family members she does not live with and may demonstrate considerable concern for siblings and parents. | Child may ask questions, be protective of siblings to the point of interfering when adults try to discipline the sibling.<br><br>Child may be "parentified" in his behaviors towards siblings or parents. | Ensure frequent contact and when not possible share information so the child is assured of everyone's safety.<br><br>Provide information about the parent's whereabouts and condition.<br><br>Allow for early & regular phone calls to parent or other family members.<br><br>Allow child time to adjust and feel secure before trying to change behaviors that are protective of siblings or parent.<br><br>Do not force the child to give up parentified behaviors immediately. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **GRADE SCHOOL AGE** | The child may be embarrassed and self-conscious regarding family's problems and foster care status, which may contribute to low self-esteem. | Child is very aware of being different and may deny or hide the fact that she is a foster child or that parents have divorced.<br><br>Child may not want to go on visits, especially if that will make her seem different.<br><br>Child may want to hide the fact that her parent is in jail or hospitalized.<br><br>Severe reactions may include the child refusing to visit a parent.<br><br>Child may be taunted by others for what the parent did (committed a crime).<br><br>Child may refuse to go to school. | Help the child develop ways to explain situation to peers. Have visits in locations where the child is comfortable, i.e. the child may not want caregivers or parents to attend school events where the child has to explain what is happening to her friends.<br><br>Allow the child to not tell others about parents being in jail.<br><br>The child can benefit from supportive adult intervention, such as counseling, to help sort through his feelings about the situation.<br><br>Talk to the child about how he is doing at school, if he is being taunted or treated badly due to parent's actions.<br><br>Get child to help with the planning of the visit and changes in her life. Allow some choices and control. |
| | Shaken sense of identity – Who am I? Who is my family | May delay the child's development<br><br>The child may need help resolving family relationship issues so he can continue to progress. | Inform the parent it is developmentally normal for children in this age to start to "pull" away and not want to be with his parents in public places. This is not an indicator of a lack of attachment.<br><br>Share family history or stories to help enhance family connections.<br><br>Do not expect child to spend every minute with the parent on longer visits. |
| | Moral lapses are not rare, as the foundation of development of morality (parent) is shaken and the child experiences painful injustices. | This may be evidenced in such behavior as lying and stealing.<br><br>Aware of concepts of justice, crime and punishment. | Parents and caregivers should discuss moral development and have consistent expectations and consequences when the child does not meet expectations.<br><br>Non-custodial parent should be actively involved in setting expectations, boundaries and enforcing discipline.<br><br>Help child to understand why parent is in prison. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **GRADE SCHOOL AGE** | Shows stress with symptoms such as headaches and stomach aches. | Child may become ill or say she does not feel well when experiencing stress or to avoid a situation. | All medical issues should be evaluated by a physician.<br><br>Teach the child methods of handling stress.<br><br>Track to see if there is a pattern when the child is sick or uses illness as a way of escaping.<br><br>Try to get her to discuss what is causing her stress rather than focusing on the illness. |

# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Children and Caregivers

# School-Age Children (5-11 years old)

## Reviewing Safety with Caregivers

- Who takes care of the child when you are not home? How do you know this person? How old is this person? Is there a way for your child to reach you when you are away from home?
- How does this child get to and from school?
- Who watches the child when they play outdoors?
- Does the child know your address and phone number?
- What have you told the child to do if a stranger talks to him/her on the street?
- Can you show me the family's list of phone numbers for your doctor, local hospital, police department, fire department, poison control center and a friend or neighbor near the phone?
- Tell me what you expect this child to do in case of an emergency.
- Did this child have any serious injuries, either before or since coming into your care?
- Does the child have any chronic health conditions? Do you have the necessary medications, medical equipment, and medical staff support to adequately deal with this condition? Do you need any help in caring for this child?
- Do you have a First Aid Kit in your home? Does the child know where it is and how to use it?
- Are there child safety window guards on all windows above the first floor?
- How do you get the child to wear safety gear, including a helmet, for activities such as cycling, in-line skating, skateboarding or riding a scooter?
- What are your rules for the child when s/he is with friends or alone?
- Do you know the child's friends? What are the names and phone numbers of the parents of the child's friends?
- Who is the child's teacher? Tell me how the child is doing in school. What, if any, type of problems or issues does the child have about school? (For example, friends, other students, bus rides, following rules, etc.)

## Safety suggestions are NOT requirements for birth parents.

# Reviewing Safety with School-aged Children:

- Who takes care of you when your family is not at home? How do you feel about staying with this person? Do you know how to reach your parent when s/he is away from home?
- Do you know where _____ (caregiver's name) lives? Do you know _____ 's (caregiver's name) phone number? What is it?
- Can you make phone calls in this house without anyone listening to the call?
- Who takes care of you when _____ (caregiver's name) is not at home? How do you feel about staying with this person?
- Are you ever left alone without any grownups around?
- Do you ever stay over at someone else's house? How often do you do this? Do you like this?
- Do you know how to reach _____ (caregiver's name) when s/he is away from home or you are away from home?
- How do you get to and from school?
- When you play outdoors, is there anyone watching you or close by?
- Do you know what to do if someone you don't know talks to you? What would you do if someone asks you to do something you know is wrong?
- Do you go on the internet? What type of websites do you go on? Does the family have any rules for you about being on the internet?
- Can you show me your room? Do you sleep with anyone else?
- Tell me about the other children in the house? Do you like them? What happens if there is a fight between kids in the house?
- What do you do if something bad or scary happens, like if there is a fire? What would you do?
- If something bad happened late at night and you needed to call someone outside of the house to ask for help, whom would you call? Would you be able to make that call? Do you know the phone number and have access to a phone?
- What can I do as your caseworker to help you?

# Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the child's personal belongings, books or other things s/he plays with.
- How does this child comfort himself/herself?
- Show me the child's bedroom. Who else lives in this room? How does the child get along with the others in the family?
- What type of chores or expectations do you have for this child?

## Daily Routine:

- Describe a typical day for this child.
- If you had to teach this child a new skill, like cleaning the house, how would you do that?
- Describe a typical time when the child did not follow a rule. How does this child comply with your requests and demands? When the child does not follow family rules what type of discipline do you use? How does the child respond to this?

## Social/Emotional:

- Have you seen any signs that the child is feeling grief or loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the child handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the child transitioned into your home/family. What have you been able to do to help the child transition? (For example, cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the child's home, etc.)
- How does this child show warmth and affection? What does s/he do when s/he is happy? How does the child show that s/he is upset, hurt, sad or feeling other emotions?
- Who does this child seek comfort from when s/he is hurt, frightened, or ill?
- Is this child able to seek you out and accept your help when needed?
- Does this child show preference for a particular adult?
- What does this child do when upset? How easy is it to soothe this child when s/he is upset?
- How does this child comply with your requests and demands?
- How has this child changed since coming here? What do you think about that?
- In what ways has the child adjusted to this placement?
- Is this child involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the child's parents/siblings/family? What happened when you met them? Do you have any concerns or questions about the family?
- Who does the child talk to, play with, or spend time with? Is the child's behavior different with these people than with you? In what ways?
- Is the child allowed to call friends from your home? Have friends over for a visit? Visit a friend's home?

## Special Interests:

- What kinds of things does this child like to do? What does the child do besides school and case activities?
- What are this child's special talents?
- What do you do to support the child in being involved in things s/he likes to do? Do you need any help to do this?

## Education:

- Would you describe this child as developmentally typical or not? Can you give me examples of his/her behaviors/skills? Do you think the child needs any help with any developmental skills?
- How is the child doing in school? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the child were to have troubles at school, who would you contact?
- Has the child begun to attend a school where s/he has multiple teachers? How has the child transitioned into his/her new school? Is the school very different from the last school the child attended? (Going from a single teacher to multiple teachers is one example of a large transition for a child this age.)

## Health:

- Who is taking the child to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the child should have? Does the child have any special medical problems? Do you know how to provide the care for this type of condition? Where do you keep the child's medical records? Show me any recent medical report so I can have a copy for the child's records.
- Describe the child's sleeping pattern. Describe the child's eating habits.
- Have you seen any weight changes since this child has been with you? Any other type of changes? Has the child begun the physical changes into adolescence? Who is talking to the child about these changes?

## Case Planning:

- Is this child receiving any educational, medical and/or psychological services? Which ones? How often? What do you think/feel about these? Do you think that the services are meeting this child's needs? Are there any other services that you think this child needs?
- What is your greatest fear about your child returning home? What is your greatest fear if your child does not return home?
- When the child visits his/her parents or other family members, what happens? How does the child behave before or after the visit? What do you think of the family visits with the child?
- What are the case goals for this child and his/her family and what do you think/feel about those goals? What makes them okay; not okay?
- If the child goes home, how do you imagine you might still be involved with the child and his/her family? If the child cannot go home to any family member, how might you imagine being involved with the child?
- What is the permanency goal for this child? What do you think/feel about this? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the child that would help all of us do a better job making of this child safe and getting him/her a permanent family?

**Self-Care:**

- On a scale of one to ten, with ten being the easiest child you have ever cared for, how easy is it to parent this child? Describe who this child is. What about the child is easiest and most pleasurable? What is the most difficult aspect of this child for you to deal with? What are the things about this child that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this child in your home. What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this child? What has been the effect on your family of having this child placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this child.
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this child?

**Culture:**

- What is important for your child to learn about where s/he is from?
- How do you teach your child about who you are?
- What do you do to connect your child to your culture?

## Reviewing Well-Being & Permanency with School-age Children

**Living Arrangements:**

- On a scale of one to ten, where ten is the best place to live and one is the worst, how would you rate this family? What makes it a _____? Is there something that could be done to make it better? How is it for you living at _____'s house?
- Who else lives here with you? What do you think about these other people who live here? What is it like living with them?
- How do you feel about _____ (caregiver's name)? How do you think that they feel about you?
- Who do you want to live with? How would that be better than where you live now?
- Are there things that you can and can't do at 's house?
- What are some of these rules? What happens if you break a rule? How often does this happen?

## Daily Routine:

- Tell me what a typical day is like from when you get up to when you go to bed. (Encourage the child to tell their story rather than just asking them a list of questions.) Here are some prompts if you are having difficulty getting the child to answer:
    - How do you wake up in the morning?
    - What do you do in the morning to get ready for school?
    - Does anyone make breakfast for you? Who? What are some things that you eat for breakfast?
    - Do you bring lunch with you to school or do you get lunch at the school cafeteria? What are some things that you eat for lunch?
    - Who makes you dinner? What are some things that you eat for dinner?
    - What do you do after dinner?
    - What time do you go to bed?
    - Where do you sleep? Do you share a room with anyone? Who? What is this like for you?
    - What type of chores do you do? How often? Do you get allowance for doing chores?

## Social/ Emotional:

- If life could be just as you wanted, what would it be like? How is that different from what is happening now?
- If you are upset or angry about something that happens at _____'s house, is there anyone that you can go to? Who?
- What happens when _____ (caregiver's names) get angry at you, each other, or someone else who lives in your house? How often do they get angry? What does it feel like for you when they are angry? What are some of the things that they get angry about?
- Is there anyone at 's house or anywhere else that you go who makes you feel scared? Are there any grownups or kids who do things that make you feel sad, mad, scared or confused?
- Do you ever get scared playing in your neighborhood? If so, what are the things that make you scared? Is there anyone who you are able to talk to about this?
- Do you ever wake up in the middle of the night? If so, what happens? If something is worrying you, whom can you talk to?
- If you need to get in touch with me, do you know how to do that? How?
- Are you involved in any religious, spiritual or cultural activities? Who takes you?
- Tell me about a time when you felt sad, mad or scared about something that happened at 's house. What did you do? What did the adults do?
- Do you have a favorite thing you do when you feel sad? Do you have a favorite thing that helps you feel happy? (For example, a toy, stuffed animal, or blanket.)

## Family and Friends:

- How are visits with your family? What kinds of things do you with your family on visits? How often do you see them? Do you speak with them on the telephone in between visits?
- Do you see your brothers and/or sisters? How is to see them? Do you see other members of your family (e.g., grandparents, aunts, uncles, pets)?
- Who are your friends? What do you like to do with them? Where do you see them? Do you get to visit with friends from your last school or past foster families who you miss?
- Is there anyone you want to see or talk to that you do not see now? (For example, former foster parents, other kids in the foster home, school friends, family, etc.)

## Special Interests:

- What do you do on the weekends? Whom do you do this with? What do the other people in _____'s house do? If applicable: Is this different from what you used to do on weekends? If so, how is it different?
- What kinds of things do you like to do for fun? (For example, sports, music, art, video games, etc.) Do you do these things while you are living with _____'? Are there any things that you'd really like to be doing that you aren't doing now?

## Education:

- You are in the ___ grade, right? Tell me about what happens in that grade? Who is your teacher(s)? How is school? What are some of the things that you like best about school? What are some of the things that you like the least about school? How is that different than your last school?
- Are there any subjects at school, like math or reading that are hard for you? If so, do you get any kind of special help with these subjects? What can I do to help you?
- Where do you go after school? How do you get there? What do you do after school? What things do you do after school? Are you in any special things like sports, music, scouting, art, or other activities? Do you like doing this?
- Do you have friends at school? Does anyone cause you problems?

## Health:

- Are you ever sick? Tell me about what happened when you felt bad.
- Have you been to see a doctor since you've been living with ? What did you see this doctor for? Have you been to any other doctors? If so, why did you see them?
- Have you seen a dentist since you've been living with ?
- Do you go to see a counselor or therapist? What is this like for you? Do you know why you are seeing them?

### Case Planning:

- Tell me what you know about why you live with this family.
- What question do you have about what will happen in the future?
- It is your right to go to the court hearing and to attend some of the meetings where we talk about what might happen to you in the future. Do you want to attend? What do you want to know about these meetings/hearings?
- Do you have a CASA/GAL or attorney? How often do you talk to this person? Do you feel like this person is helping you?
- If you could choose, what would happen? What would be good about this? Do you have any fears or concerns about the future?
- Many children have mixed feelings about their birth parents and foster parents. What are your feelings?
- If you woke up tomorrow and everything was perfect, what would be happening? How is that different than now?
- What is your biggest fear/concern?
- Tell me whom you would call if you had questions or a problem. Do you know how to reach me?

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Adapted from sources by Rose Marie Wentz and Joan Morse, 2009

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# Field Guide to Adolescent Functioning:

**I. Initial Assessment Question #3**
**II. Typical consequences of abuse and neglect on a adolescent's development**
**III. Developmental Milestones**

## I. Initial Assessment Question #3

**How does the normal adolescent (12 to 19 years) function on a daily basis?**

### Adolescent's physical development.

- Evidence of growth spurt (wide range).
- Well-developed gross and fine motor skills with clumsy phases and a varied range of proficiency.
- Early or late onset of puberty with variable emotional responses.
- Inaccurate body image/ self-consciousness.

### Adolescent's emotional and social development.

- Independence from parents.
- Strong identification with peers.
- Focus on social status and social acceptance leading to…
    - Insight, self-revelation, and understanding another person's perspective.
    - Focus on loyal, trusting friendships.
    - Good friends, social life, and school participation.

### Adolescent's predominant behavior.

- Special Education/ Services?
- Chronic medical conditions?
- Developmental delays or disabilities?
- Mental health challenges?
- History of abuse and/or neglect? (see Part II)

**Adolescent's peer and school behavior.**

- Self-motivation for good school performance.
- Favorite subjects and interests at school support sense of individual identity.
- Strong opinions about rules, standards, teachers, etc.
- Follows rules within reasonable limits.
- Ability to give focused attention to tasks.
- Can collaborate independently with peers.
- School and social life overlap.

**Adolescent's mood / temperament.**

- Enjoys emotionally intense experiences and sometimes risky behavior.
- Emotionally labile (moody).
- Blatant rejection of standards.
- Can accept reasonable limits - does not always need to be involved in control battles.
- Has the ability to keep self-occupied in non-harmful way Leads to…
    - Self-confidence enough for independence.

**Adolescent's speech and communication.**

- Can provide detailed, sequential narrative of events.
- Can converse and understand another's perspective.
- Expresses feelings and emotions in a comfortable way.
- Expresses desire for independence.
- Is able to express values and beliefs.
- Can express their strengths and needs.

**Adolescent's cognitive abilities.**

- The ability to think hypothetically, logically, and to think about thought.
- Systematic problem solving
  Leads to…
    - Perspective taking.
    - And… Development of morality…
        • First… School Age morality (doing what you are told because otherwise you will get in trouble).
        • Then later… Adult morality (belief in the efficacy of "The Golden Rule" – and "Law and Order").

### Adolescent's general behavior.

- Good school performance.
- Regular activities outside of school.
- Social life and friends.
- Routines and daily organization managed independently.
- Independent interests in larger culture (music, fashion, entertainment, politics, literature, etc.).
- Trusting relationship with an adult.

### Adolescent's characteristics that contribute to their vulnerability and their ability to self-protect.

- Ability to physically protect themselves and others can escalate conflicts.
- Can report abuse and neglect but susceptible to threats, intimidation, retaliation, bribes, and desire to protect parents.
- Problems in home can be acted out and/or internalized as behavior problems or mental health symptoms.
- Developing sense of self-esteem and independence is vulnerable.
- Vulnerable to punishment and harsh criticism, can impact self-esteem.
- Developing friendships and social life are vulnerable.
- Vulnerable to manipulation due to desire for status among peers.

## II. Typical consequences of abuse and neglect on an adolescent's development

### *Physical*

- The youth may be sickly or have chronic illnesses.
- Sensory, motor, and perceptual motor skills may be delayed and coordination may be poor.
- The onset of puberty may be affected by malnutrition and other consequences of serious neglect.

### *Cognitive*

- The youth may not develop formal operational thinking; may show deficiencies in the ability to think hypothetically or logically and to systematically problem solve.
- The youth's thinking processes may be typical of much younger children; the youth may lack insight and the ability to understand other people's perspectives.
- The youth may be academically delayed and may have significant problems keeping up with the demands of school. School performance may be poor.

### *Social*

- The youth may have difficulty maintaining relationships with peers; they may withdraw from social interactions, display a generalized dependency on peers, adopt group norms or behaviors in order to gain acceptance, or demonstrate ambivalence about relationships.
- The youth is likely to mistrust adults and may avoid entering into relationships with adults.
- Maltreated youth, particularly those who have been sexually abused, often have considerable difficulty in sexual relationships. Intense guilt, shame, poor body image, lack of self-esteem, and a lack of trust can pose serious barriers to a youth's ability to enter into mutually satisfying and intimate sexual relationships.
- Youth may display limited concern for other people, may not conform to socially acceptable norms, and may otherwise demonstrate delayed moral development.
- Maltreated youth may not be able to engage in appropriate social or vocational roles. They may have difficulty conforming to social rules.

### *Emotional*

- Maltreated youth may display a variety of emotional and behavioral problems, including anxiety, depression, withdrawal, aggression, impulsive behavior, antisocial behavior, and conduct disorders.
- Maltreated adolescents may lack the internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent and sometimes volatile mood swings.
- Abused and neglected youth may demonstrate considerable problems in formulating a positive identity. Identity confusion and poor self-image are common. The youth may appear to be without direction and immobilized.

## III. Developmental Milestones (12 to 19 years)

### *Physical Development*

- Physiological changes at puberty promote rapid growth, the maturity of sexual organs, and development of secondary sex characteristics. The youth must become accustomed to the changes in his/her body and adapt behavior accordingly.

### *Cognitive Development*

- During early adolescence, precursors to formal operational thinking appear, including a limited ability to think hypothetically and to take multiple perspectives.
- During middle and late adolescence, formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

### *Social Development*

- Social relationships in early adolescence are centered in the peer group. Group values guide individual behavior. Acceptance by peers is critical to self- esteem. Most peer relationships are still same-sex.
- Young adolescents become interested in sexual relationships, but most contact is through groups. Some youth may begin to experiment with sexual behavior, but many early adolescents are not sexually active with other youth.
- Social roles are still largely defined by external sources.
- During middle and late adolescence, values become individualized and internalized after careful consideration and independent thought.
- Friends are more often selected on personal characteristics and mutual interests. The peer group declines in importance, individual friendships are strengthened, and more youth “date” in one-on-one relationships.
- The youth experiments with social roles and explores options for career choice.

### *Emotional Development*

- The early adolescent is strongly identified with the peer group. Youth depend upon their peers for emotional stability and support and to help mold the youth’s emerging identity. Self-esteem is greatly affected by acceptance of peers.
- Early adolescents are emotionally labile with exaggerated affect and frequent mood swings. They are very vulnerable to emotional stress.
- During middle and late adolescence, identity is more individualized, and a sense of self develops and stabilizes that is separate from either family or peer group.
- Self-esteem is influenced by the youth’s ability to live up to
- Internalized standards for behavior. Self-assessment and introspection are common.

| | Impact of Separation | | |
|---|---|---|---|
| **ADOLESCENT** | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| | Early adolescence is an emotionally and physically chaotic period for all teens. | Any additional stress has the potential of creating "stress overload" and may precipitate crisis. | Teach the youth methods of handling the stress.<br><br>Do not overreact to outward changes – hair, clothes.<br><br>Give youth choices in planning visits and changes in his life.<br><br>Ensure that the youth has at least one trusted adult in his life |
| | The youth may resist relationships with adults. Dependence upon adults threatens "independence". | By rejecting adults, the youth deprives self of an important source of coping support. | Allow the youth choices in how the relationship will occur but not whether he should have relationships with adults.<br><br>Even youth who state they do not want a relationship have told researchers that they wanted the relationship and feared rejection so acted as if they did not want adult relationships.<br><br>Prepare parent for this normal teen behavior. |
| | The youth may deny much of own discomfort and pain, which prevents him/her from constructively coping with those feelings. | Developmental regression, evidenced as choosing younger friends, withdrawing, interrupted school achievement | Teach the youth it is OK to have emotions and how to handle the pain.<br><br>Provide emotional support even if this is initially rejected by the teen.<br><br>These reactions are usually temporary. Do not overreact. |
| | Separation from parents, especially if the result of family conflict and unruly behavior on the part of the youth, may generate guilt and anxiety. | Denial of emotions, physical illness, eating disorders, depression, suicide, etc.<br><br>Acting out behaviors | It is important that ALL the adults who are responsible develop an agreed upon plan to handle the youth's behavior.<br><br>Adults work together with youth to set consistent boundaries and consequences.<br><br>Support from parents, adults or therapist is essential. |
| | Identity is an emerging issue; dealing with parents" shortcomings is difficult. . | Parents may be idealized or shortcomings may be denied.<br><br>May see adults as all good or all bad. | Do not take it personally when youth "notices" your shortcomings.<br><br>Honest, open discussion of parent's behaviors. Most helpful if parent initiates this discussion and takes responsibility. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **ADOLESCENT** | Exploring his/her sexual identity. | Entry into sexual relationships may be very frightening without the support of a consistent, understanding adult.<br><br>Sexual relationship may start earlier for traumatized teens and teen may be susceptible to abuse by others. | Be willing to discuss or provide the youth information about sex, your values and expectations. |
| | The youth has the capacity to participate in planning and to make suggestions regarding own life. | He may refuse to attend visits.<br><br>He may act as if he does not care or want to be involved in planning. | He should be included in developing visit plans.<br><br>Persistent repeated attempts to engage the youth by parent or worker can have very positive results.<br><br>When possible, longer visits with opportunities to learn from parent (cooking, driving, sports, shopping, etc.) provide normal interaction activities.<br><br>Predictable schedules is not as important as allowing the youth choices. |
| | The youth will be mourning the loss of family and home. | Symptoms of mourning may include such things as feelings of emptiness, tearfulness, difficulty concentrating, chronic fatigue, and troublesome dreams.<br><br>May choose to join a new family such as a gang. | Talk to the youth about her feelings, refer her to counseling and monitor for suicidal thoughts.<br><br>Do not expect teen to quickly bond to new caregiving family or follow new household rules; the teen may see this as denying her birth family or the other parent. |

| | Impact of Separation | | |
|---|---|---|---|
| | **Issue/Developmental** | **Behaviors/Impact** | **Visit planning strategies** |
| **ADOLESCENT** | Anger, both as a direct response to disruption and circumstances surrounding it, and to cover feelings of powerlessness, vulnerability, and grief. | Expect withdrawal, both psychological and physical distancing and detachment. Adolescents, because of their greater independence, mobility, and access to resources (e.g. friends, organizations) outside the home, are often able to withdraw from the problems of the home to maintain their equilibrium<br><br>Watch out for social and behavioral problems, such as sexual misconduct, truancy, delinquency, substance abuse, eating disorders and gang activity. | Encourage the youth to be involved with friends and activities that bring her joy.<br><br>Adults regularly check with teen. Do not accept “no” if you suspect there is a problem.<br><br>Prepare parent for teen’s emotions. Have parent accept responsibility for how his/her actions contributed to these emotions.<br><br>Do not overreact and/or expect teen to deny emotions.<br><br>Connect teen with other people or groups that are a positive “family” – sports, church, hobby groups, school activities, cultural groups, extended family, etc. |

# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Children and Caregivers

# Early Adolescence (10–12 years old)

## Reviewing Safety Concerns with Caregivers

- Who provides supervision for this child when you are not home? How do you know this person? How old is this person? Is there a way for this child to reach you when you are away from home?
- How does this child get to and from school?
- Did you know where the child was when s/he was not at school and was away from home? What are your rules for your child when not s/he is not at school or home? Is there a way for the child to reach you when s/he is away from home?
- Does the child know your address and phone number?
- What have you told your child to do if a stranger talks to him/her on the street?
- Can you show me the family's list of phone numbers for your doctor, local hospital, police department, fire department, poison control center and a friend or neighbor near the phone?
- What is the emergency plan for your family in case of fire? Does this child know where smoke alarms and carbon monoxide alarms are located in your home?
- If the worst case situation were to occur and this child was in danger of being abused again, does this child know what to do? Is there someone besides you available 24/7 the child can call for help?
- Did this child have any serious injuries, either before or since coming into your care? How did you handle them? How is this condition being handled since foster care placement? How will you handle this condition when the child returns home?
- Have you noticed any physical or emotional changes in this child? As the child is becoming a teenager, are there changes in his/her behaviors? How has that changed your relationship with this child? Has it changed how you discipline this child or the rules you have for this child?
- Does this child have any chronic health conditions? Do you have the necessary medications, medical equipment, and medical staff support to adequately deal with this condition? How do you handle this condition?
- Do you have a First Aid Kit in your home? Does this child know where it is and how to use it?
- How do you get the child to wear safety gear, including a helmet, for activities such as cycling, in-line skating, skateboarding or riding a scooter?
- What are your rules for the child when s/he is with friends or alone?
- Do you know the child's friends? What are the names and phone numbers of the parents of the child's friends?
- Does the child have any problems or issues about safety at school? (Friends, other students, bus rides,

following rules, etc.)

## Safety suggestions are NOT requirements for birth parents.

## Reviewing Safety Concerns with Early Adolescents

- Who takes care of you when your family is not at home? How do you feel about staying with this person? Do you know how to reach your parent when s/he is away from home?
- What is your safety plan if your parent or someone else tries to harm you or is just getting out of control? Who can you call if something happens in the middle of the night? What are your fears? (Specific questions related to the type of maltreatment the child experienced should be included. Example: When you see your mother's red flags that she might be thinking about taking drugs, what is your plan for safety?) Would you be able to make that call? (Do you know the phone number, have access to a phone, etc.?)
- Do you know what to do in case of an emergency, like a fire? Can you tell me what you would do?
- Do you know where the First Aid Kit is kept? Do you know how to use the different items in it?
- Are you ever left alone without any adults around? What is this like for you?
- Do you ever stay over at someone else's house? How often do you do this? Do you like this? Are you allowed to do this as frequently as you want?
- How do you get to and from school?
- Does your family know where you are when you are away from home and not at school? What are your family's rules about being away from home or school? (Curfew rules, reporting in rules, who you are with, where you can or cannot go, etc.)
- What do you do if someone you don't know talks to you or asks you to go somewhere with him or her? Does anyone you know ever ask you to do things you are not sure are ok?
- Do you spend time on the internet? Have you ever had anyone on the internet ask you to do something? What was it?
- What can I do as your caseworker to help you? Tell me how you would reach me if you wanted to talk.

## Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the child's personal things, books or other things s/he plays with. How does this child comfort himself/herself?
- Show me the child's bedroom. Who else lives in this room? How does the child get along with the others in the family?
- What type of chores or expectations do you have for this child?
- Describe a typical day for this child.

## Daily Routine:

- If you had to teach this child a new skill, like cleaning the house, how would you do that? If the child does not follow rules, what do you do? How does the child respond to this?
- Describe a typical time when the child did not follow a rule. How does this child comply with your requests and demands? When the child does not follow family rules, what type of discipline do you use?

## Social/Emotional:

- Have you seen any signs that the child is feeling grief, loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the child handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the child transitioned into your home/family? What have you been able to do to help the child transition (i.e. cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the child's home, etc.)?
- How does this child show warmth and affection? What does s/he do when s/he is happy? How does the child show that s/he is upset, hurt, sad or feeling other emotions?
- Who does this child seek comfort from when s/he is hurt, frightened, or ill?
- Is this child able to seek you out and accept your help when needed?
- Does this child show preference for a particular adult?
- What does this child do when upset? How easy is it to soothe this child when s/he is upset?
- How does this child comply with your requests and demands?
- How has this child changed since coming here? What do you think about that? In what ways has the child adjusted to this placement?
- Is this child involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the child's parents/siblings/family? What happened when you met them? Do you have any concerns or questions about the family?
- Whom does the child talk to, play with, or spend time with? Is the child's behavior different with these people than with you? In what ways?
- Is the child allowed to call friends from your home? Have friends over for a visit? Visit a friend's home?

## Special Interests:

- What kinds of things does this child like to do? What does the child do besides school and case activities?
- What are this child's special talents?
- What do you do to support the child in being involved in things s/he likes to do? Do you need any help to do this?

## Education:

- Would you describe this child as developmentally typical or not? Can you give me examples of his/her behaviors/skills? Do you think the child needs any help in any developmental skills?
- How is the child doing in school? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the child were to have troubles at school, who would you contact?
- Has the child begun to attend a school where s/he has multiple teachers? How has the child transitioned into his//her new school? Is the school a very different type than the last school the child attended? (Going from a single teacher to multiple teachers is one example of a large transition for a child this age.)

## Health:

- Who is taking the child to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the child should have? Does the child have any special medical problems? Do you know how to provide care for this type of condition? Where do you keep the child's medical records? Show me any recent medical reports so I can have a copy for the child's records.
- Describe the child's sleeping pattern. Describe the child's eating habits.
- Have you seen any weight changes since this child has been with you? Any other types of changes? Has the child begun the physical changes into adolescence? Who is talking to the child about these changes?
- Are there any signs the child is involved in sexual activities, using drugs, harming himself/herself or any other dangerous activities?

## Case Planning:

- Is this child receiving any educational, medical and/or psychological services? Which ones? How often? What do you think/feel about these? Do you think that the services are meeting this child's needs? Are there any other services that you think this child needs?
- What is your greatest fear about your child returning home? What is your greatest fear if your child does not return home?
- When the child visits his/her parents or other family members, what happens? How does the child behave before or after the visit? What do you think of the family visits with the child?
- What are the case goals for this child and his/her family and what do you think/ feel about that? What makes that okay; not okay?
- If the child goes home, how do you imagine you might still be involved with the child and his/her family? If the child cannot go home to any family member, how might you imagine being involved with the child?
- What is the permanency goal for this child? What do you think/feel about this? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the child that would help all of us do a better job making this child safe and getting him/her a permanent family?

**Self Care:**

- On a scale of one to ten with ten being the easiest child you have ever cared for – how easy is it to parent this child? Describe who this child is. What about the child is easiest and most pleasurable? What is the most difficult aspect of this child for you to deal with? What are the things about this child that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this child in your home. What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this child? What has been the effect on your family of having this child placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this child.
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this child?

**Culture:**

- What is important for your child to learn about where s/he is from?
- How do you teach your child about who you are?
- What do you do to connect your child to your culture?

# Reviewing Well-Being and Permanency with Early Adolescents

**Living Arrangements:**

- On a scale of one to ten, where ten is the best place to live and one is the worst, how would you rate this family? What makes it a _____ ? Is there something that could be done to make it better? How is it for you living at _____'s house?
- My biggest fear is…..?
- Who else lives here with you? What do you think about the other people who live here? What is it like living with them?
- What are some of rules this family has? What happens if you break a rule? How often does this happen?
- Who do you want to live with? How would that be better than where you live now?

  Are there things that you can and can't do at _____'s house?

## Daily Routine:

- Tell me what a typical day is like from when you get up to when you go to bed. (Get the child to tell their story rather than just asking him/her a list of questions.)
- Here are some prompts if you are having difficulty getting the child to answer:
    - How do you wake up in the morning?
    - What do you do in the morning to get ready for school?
    - Does anyone make breakfast for you? Who? What are some things that you eat for breakfast?
    - Do you bring lunch with you to school or do you get lunch at the school cafeteria? What are some things that you eat for lunch?
    - Who makes you dinner? What are some things that you eat for dinner?
    - What do you do after dinner?
    - What time do you go to bed?
    - Where do you sleep? Do you share a room with anyone? Who? What is this like for you?
    - What type of chores do you do? How often? Do you get allowance for doing chores?

## Social/Emotional:

- If life could be just as you wanted, what would it be like? How is that different from what is happening now?
- If you are upset or angry about something that happens, what do you do to calm yourself? Is there anyone that you can go to? Who?
- What happens when the adults in the house get angry at you, each other, or someone else who lives in your house? How often do they get angry? What does it feel like for you when they are angry?
- Is there anyone at home or anywhere else that you go who makes you feel scared? Are there any adults or kids who do things that make you feel sad, mad, scared or confused?
- Do you ever wake up in the middle of the night? If so, what happens?
- Do you ever get scared hanging out in your neighborhood or anywhere else you go? If so, what are the things that make you scared? Is there anyone who you are able to talk to about this?
- If something is really worrying you, who can you talk to? If you need to get in touch with me, do you know how to do that? How? Are you involved in any religious, spiritual or cultural activities?
- Tell me about one time when you felt sad, mad or scared about something that happened at _____'s house. What did you do? What did the adults do?
- Do you have a favorite thing you do when you feel sad? (Check other emotions, too.) Do you have a favorite thing or activity that helps you feel happy? (For example, a personal belonging, listening to music, reading, etc.)
- Do you go to any religious activities? How do you get there?

## Family and Friends:

- How are visits with your family? What kinds of things do you with your family on visits? How often do you see them? Do you speak with them on the telephone in between visits? What could be done to make visits better?
- Do you see your brothers and/or sisters who are in foster care or live somewhere else? How is it to see them?
- Who are your friends? What do you like to do with them? Where do you see them? Do you get to visit with friends from your last school or past foster families who you miss? Do you get to call them?
- Is there anyone who you miss or would like to visit? (For example, former foster parents, other kids in the foster home, school friends, family, etc.)
- Do you have a boyfriend or girlfriend? Tell me about him/her?

## Special Interests:

- What do you do on the weekends? Who do you do this with? What do the other people in _____'s house do? If applicable: Is this different from what you used to do on weekends? If so, how is it different?
- What kinds of things do you like to do for fun? (For example, sports, music, art, video games, etc.) Do you do these things while you are living with _____ ? Are there any things that you'd really like to be doing that you aren't doing now?

## Education:

- What is your current school like? How is that better or worse than your last school? A lot of kids find it hard to move to a new school in the middle of a year. How has the move to this new school been for you?
- You are in the grade, right? Tell me about what happens in that grade. Who is your teacher(s)? How is school? What are some of the things that you like best about school? What are some of the things that you like the least about school? How is that different than your last school?
- What things do you do after school? Are you in any special things like sports, music, scouting, art, or other activities?
- Who helps you with homework or other school assignments? Do you have access to a computer or other things you need to do your school work?
- Do you have friends at school? Does anyone cause you problems?
- Who helps you choose your classes?
- Do you ever have problems at school, between classes, going home from school, etc. with any other kid or adult?

**Health:**

- Are you ever sick? Tell me about what happened when you felt bad.
- When was the last time you went to the doctor? What did you see this doctor for? Have you been to any other doctors? If so, why? Do you take any medications? Have you seen a dentist in the last six months?
- Who do you go to when you have questions about your health or body? On a scale of 1 to 10 where 10 is: I have adults I trust and can talk to about this, where would you place yourself regarding:
    - smoking
    - drugs
    - changes in my body
    - sex and sexuality
- What can I do to help with any of these important issues?
- Do you go to see a counselor or therapist? What is this like for you? Do you know why you are seeing this person?
- Have you ever thought about hurting yourself in any way? Tell me more about that?
- Have you thought about killing yourself? If yes, when was the last time you were thinking this?
- Have you ever tried alcohol, smoking, illegal drugs, prescription drugs, etc.? Do you know other kids who do this? What do you think about that?

**Case Planning:**

- Tell me what you know about why you live with this family.
- What questions do you have about what will happen?
- It is your right to go to the court hearing and to attend some of the meetings where we talk about what might happen to you. Do you want to attend? What do you want to know about these meetings/ hearings?
- Do you have a CASA/GAL or attorney? How often do you talk to this person? Do you feel like this person is helping you?
- If you could choose, what would happen? What would be good about this?
- Do you have any fears or concerns about the future?
- Many children have mixed feelings about their birth parents and foster parents. What are your feelings?
- If you woke up tomorrow and everything was perfect, what would be happening? How is that different than now?
- What is your biggest fear/concern?
- Tell me who you would call if you had questions or a problem? Do you know how to reach me?
- Tell me what I can do to make things better for you?

**Sources:**

Adapted from sources by Rose Marie Wentz and Joan Morse, 2009

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# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Youth and Caregivers

# Middle Adolescence (13–17 years old)

## Reviewing Safety Concerns with Caregivers

- Who provides supervision for this youth when you are not home? How do you know this person? How old is this person? Is there a way for this youth to reach you when you are away from home?
- How did this youth get to and from school?
- Did you know where the youth was when s/he was not at school and was away from home? What are your rules for the youth when not s/he is not at school or home? Is there a way for the youth to reach you when s/he is away from home?
- Does the youth know your address and phone number?
- What have you told the youth to do if a stranger talks to him/her on the street?
- Can you show me the family's list of phone numbers for your doctor, local hospital, police department, fire department, poison control center and a friend or neighbor near the phone?
- What is the emergency plan for your family in case of fire? Does this youth know where smoke alarms and carbon monoxide alarms are located in your home?
- If the worst case situation were to occur and this youth was in danger of being abused again, does s/he know what to do? Is there someone besides you available 24/7 whom the youth can call for help?
- Did this youth have any serious injuries, either before or since coming into your care? How did you handle them? How is this condition being handled since foster care placement? How will you handle this condition when the youth returns home?
- Have you noticed any physical or emotional changes in this youth? As this youth is becoming a teenager, are there changes in his/her behaviors? How has that changed your relationship? Has it changed how you discipline this youth or the rules you have for him/her?
- Does this youth have any chronic health conditions? Do you have the necessary medications, medical equipment, and medical staff support to adequately deal with this condition? How do you handle this condition?
- Have you explained the concept of date rape to this youth? How have you empowered him/her to resist being pressured or forced into unwanted sexual activity? Could you give me an example of things you have said in your conversations with him/her?
- How have you talked to this youth about the health risks of alcohol, tobacco and drug abuse? If this youth has a problem with any of these issues, how will you deal with them when they return home? What is the safety plan if this youth is abusing substances upon return home? Who can you call to help you?
- Do you have a First Aid Kit in your home? Does this youth know where it is and how to use it?
- How do you get the youth to wear safety gear, including a helmet, for activities such as cycling, in-line

skating, skateboarding or riding a scooter?

- What are your rules for the youth when s/he is with friends or alone?
- Do you know the youth's friends? What are the names and phone numbers of the parents of the youth's friends?
- Does the youth have any problems or issues about safety at school? (For example, with friends, other students, bus rides, following rules, etc.)

## Safety suggestions are NOT requirements for birth parents.

## Reviewing Safety Concerns with Early Adolescents

- Who takes care of you when your family is not at home? How do you feel about staying with this person? Do you know how to reach this parent when s/he is away from home?
- What is your safety plan if your parent or someone else tries to harm you or is just getting out of control? Whom can you call if something happens in the middle of the night? What are your fears? (Specific questions related to the type of maltreatment the youth experienced should be included. Example: When you see your mother's red flags that she might be thinking about taking drugs, what is your plan for safety?) Would you be able to make that call? Do you know the phone number and have access to a phone?
- Do you know what to do in case of an emergency, like a fire? Can you tell me what you would do?
- Do you know where the First Aid Kit is kept? Do you know how to use the different items in it?
- Are you ever left alone without any adults around? What is this like for you?
- Do you ever stay over at someone else's house? How often do you do this? Do you like this? Are you allowed to do this as frequently as you want?
- How do you get to and from school?
- Does your family know where you are when you are away from home and not at school? What are your family's rules about being away from home or school? (For example, curfew rules, reporting in rules, who you are with, where you can or cannot go, etc.)
- What do you do if a stranger talks to you on the street or asks you to go somewhere with him or her? Does anyone you know ever ask you to do things you are not sure are ok?
- Do you spend time on the internet? Have you ever had anyone on the internet ask you to do something? What was it?
- What can I do as your caseworker to help you? Tell me how you would reach me if you wanted to talk.

## Reviewing Well-Being & Permanency with Caregivers

## Living Arrangements:

- Show me the youth's personal belongings, books or other things. How does this youth comfort himself/herself?
- Show me the youth's bedroom. Who else lives in this room? How does the youth get along with the others in the family?
- What type of chores or expectations do you have for this youth?

## Daily Routine:

- Describe a typical day for this youth.
- If you had to teach this youth a new skill, like cleaning the house, how would you do that? If the youth does not follow rules, what do you do? How does the youth respond to this?
- Describe a typical time when the youth did not follow a rule. How does this youth comply with your requests and demands? When the youth does not follow family rules, what type of discipline do you use?
- How are you helping the youth to be ready for adulthood (i.e. learning to take care of himself/herself, learning about buying and cooking food, learning about money management, etc.)?

## Social/Emotional:

- Have you seen any signs that the youth is feeling grief or loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the youth handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the youth transitioned into your home/family. What have you been able to do to help the youth transition (i.e. cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the youth's home, etc.)?
- How does this youth show warmth and affection? What does s/he do when s/he is happy? How does the youth show that s/he is upset, hurt, sad or other emotions?
- Who does this youth seek comfort from when s/he is hurt, frightened, or ill?
- Is this youth able to seek you out and accept your help when needed?
- Does this youth show preference for a particular adult or friend?
- What does this youth do when upset? How easy is it to soothe this youth when s/he is upset?
- How does this youth comply with your requests and demands?
- How has this youth changed since coming here? What do you think about that? In what ways has the youth adjusted to this placement?
- Is this youth involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the youth's parents/siblings/family? What happened when you met them? Do you have

any concerns or questions about the family?

- Who does the youth talk to, play with, or spend time with? Is the youth's behavior different with these people than with you? In what ways?
- Is the youth allowed to call friends from your home? Have friends over for a visit? Visit a friend's home?
- Does the youth date or have a special relationship with any one person?

**Special Interests:**

- What kinds of things does this youth like to do? What does the youth do besides school and case activities?
- What are this youth's special talents?
- What do you do to support the youth in being involved in things s/he likes to do?
- Do you need any help to do this?

**Education:**

- Would you describe this youth as developmentally typical or not? Can you give me examples of his/her behaviors/skills? Do you think the youth needs any help with any developmental skills?
- How is the youth doing in school? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the youth were to have troubles at school, who would you contact?
- Does the youth attend a school where s/he has multiple teachers? How has the youth transitioned into his//her new school? Is the school very different from the last school the youth attended? (Going from a single teacher to multiple teachers is one example of a large transition for a youth this age).
- Does the youth have career or education plans? Who is helping the youth with this?

**Health:**

- Who is taking the youth to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the youth should have? Is the youth involved in medical decisions? Does the youth have any special medical problems? Do you know how to provide care for this type of condition? Where do you keep the youth's medical records? Show me any recent medical report so I can have a copy for the youth's records.
- Describe the youth's sleeping pattern. Describe the youth's eating habits.
- Have you seen any weight changes since this youth has been with you? Any other type of changes? Has the youth begun the physical changes into adolescence? Who is talking to the youth about these changes?
- Are there any signs the youth is involved in sexual activities, using drugs, harming himself/herself or any other dangerous activities?

## Case Planning:

- Is this youth receiving any educational, medical and/or psychological services? Which ones? How often? What do you think/feel about these? Do you think that the services are meeting this youth's needs? Are there any other services that you think this youth needs?
- What is your greatest fear about the youth returning home? What is your greatest fear if the youth does not return home?
- When the youth visits his/her parents or other family members, what happens? How does the youth behave before or after the visit? What do you think of the family visits with the youth?
- What are the case goals for this youth and his/her family? What do you think/feel about the goals? What makes them okay; not okay?
- If the youth goes home, how do you imagine you might still be involved with the youth and his/her family? If the youth cannot go home to any family member, how might you imagine being involved with the youth?
- What is the permanency goal for this youth? What do you think/feel about this goal? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the youth that would help all of us do a better job making this youth safe and getting him/her a permanent family?

## Self-Care:

- On a scale of one to ten, with ten being the easiest youth you have ever cared for, how easy is it to parent this youth? Describe who this youth is. What about the youth is easiest and most pleasurable? What is the most difficult aspect of this youth for you to deal with? What are the things about this youth that you think will help him/her in the future? What do you think might be harder for him/ her?
- Tell me how you handle the stress of having this youth in your home. What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this youth? What has been the effect on your family of having this youth placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this youth.
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this youth?

# Reviewing Well-Being and Permanency with Middle Adolescents

## Living Arrangements:

On a scale of one to ten, where ten is the best place to live and one is the worst, how would you rate this family? What makes it a _____? Is there something that could be done to make it better? How is it for you living at _____'s house?

My biggest fear is…..?

Who else lives here with you? What do you think about the other people who live here? What is it like living with them?

What are some of rules this family has? What happens if you break a rule? How often does this happen?

Who do you want to live with? If applicable, how would that be better than where you live now?

Are there things that you can and can't do at _____'s house?

## Daily Routine:

Tell me what a typical day is like from when you get up to when you go to bed. (Encourage the youth to tell their story rather than just asking a list of questions.) Here are some prompts if you are having difficulty getting the youth to answer:

- How do you wake up in the morning?
- What do you do in the morning to get ready for school?
- Does anyone make breakfast for you? Who? What are some things that you eat for breakfast?
- Do you bring lunch with you to school or do you get lunch at the school cafeteria? What are some things that you eat for lunch?
- Who makes you dinner? What are some things that you eat for dinner?
- What do you do after dinner?
- What time do you go to bed?
- Where do you sleep? Do you share a room with anyone? Who? What is this like for you?
- What type of chores do you do? How often? Do you get allowance for doing chores?
- Do you have a job that pays you money?

## Social/Emotional:

- If life could be just as you wanted, what would it be like? How is that different from what is happening now?
- If you are upset or angry about something that happens, what do you do to calm yourself? Is there anyone that you can go to? Who?
- What happens when the adults in the house get angry at you, each other, or someone else who lives in your house? How often do they get angry? What does it feel like for you when they are angry?
- Is there anyone at home or anywhere else that you go who makes you feel scared? Are there any adults or youths who do things that make you feel sad, mad, scared or confused?
- Do you ever wake up in the middle of the night? If so, what happens?
- Do you ever get scared hanging out in your neighborhood or anywhere else you go? If so, what are the things that make you scared? Is there anyone who you are able to talk to about this?
- If something is really worrying you, who can you talk to? If you need to get in touch with me, do you know how to do that? How?
- Are you involved in any religious, spiritual or cultural activities? How do you get there?
- Tell me about a time when you felt sad, mad or scared about something that happened at ’s house. What did you do? What did the adults do?
- Do you have a favorite thing you do when you feel sad? (Ask about other emotions, as well.) Do you have a favorite thing or activity that helps you feel happy? (For example, a personal belonging, listening to music, reading.)

## Family and Friends:

- How are visits with your family? What kinds of things do you with your family on visits? How often do you see them? Do you speak with them on the telephone in between visits? What could be done to make visits better?
- Do you see your brothers and/or sisters who are in foster care or live somewhere else? How is to see them?
- Who are your friends? What do you like to do with them? Where do you see them? Do you get to visit with friends from your last school or past foster families who you miss? Do you get to call them?
- Is there anyone who you miss or would like to visit? (For example, former foster parents, other kids in the foster home, school friends, family, etc.)
- Do you have a boyfriend or girlfriend or someone with whom you have a special relationship? Tell me about that person.
- Do you have someone in your life that you consider your mentor? What are the qualities that person possesses?

## Special Interests:

- What do you do on the weekends or during your free time? Who do you do this with? What do the other people in _____'s house do? If applicable: Is this different from what you used to do on weekends? If so, how is it different?
- What kinds of things do you like to do for fun? (For example, sports, music, art, video games, etc.) Do you do these things while you are living with _____ ? Are there any things that you'd really like to be doing that you aren't doing now?
- What are some things you do that nurture your spirit? (For example, art/drawing, journaling, reading, martial arts, meditation, religious classes, going to church, prayer groups, etc.)

## Education:

- What is your current school like? How is that better or worse than your last school? A lot of kids find it hard to move to a new school in the middle of a year. How has the move to this new school been for you?
- You are in the__ grade, right? Tell me about what happens in that grade. Who is your teacher(s)? How is school? What are some of the things that you like best about school? What are some of the things that you like least about school? How is that different than your last school?
- What things do you do after school? Are you in any special things like sports, music, scouting, art, or other activities?
- Who helps you with homework or other school assignments? Who helps you choose your classes? Do you have access to a computer or other things you need to do your school work?
- Do you have friends at school?
- Does anyone cause you problems? Do you ever have problems at school, between classes, going home from school, etc. with any other youth or adult?
- Do you have plans for school beyond high school? Who is helping you with planning for this?

## Employment:

- Have you ever had a part time job? What types of jobs have you held? What types of jobs have you liked best? What part of the job did you enjoy most?

**Health:**

- Are you ever sick? Tell me about what happened when you felt bad.
- When was the last time you went to the doctor? What did you see this doctor for? Have you been to any other doctors? If so, why? Do you take any medications? Have you seen a dentist in the last six months? Do you feel like you have all the information you need about your current health or health history?
- Who do you go to when you have questions about your health or body?
- On a scale of 1 to 10 where 10 is: I have adults I trust and can talk to about this, where would you place yourself regarding:
    - smoking
    - drugs
    - changes in my body
    - sex and sexuality
- What can I do to help with any of these important issues?
- Do you go to see a counselor or therapist? What is this like for you? Do you know why you are seeing this person?
- Have you ever thought about hurting yourself in any way? Tell me more about that?
- Have you thought about killing yourself?  If yes, when was the last time you were thinking this?
- Have you ever tried alcohol, smoking, illegal drugs, prescription drugs, etc.? Do you know other kids who do this? What do you think about that?

**Case Planning:**

- What are your goals for the future?
- Do you feel listened to by the adults in your life about your future plans? Do you feel included in the agency conferences?
- Tell me what you know about why you live with this family.
- What questions do you have about what will happen in the future?
- It is your right to go to the court hearing and to attend some of the meetings where we talk about what might happen to you in the future. Do you want to attend? What do you want to know about these meetings/hearings?
- Do you have a CASA/GAL or attorney? How often do you talk to this person? Do you feel like this person is helping you?
- If you could choose, what would happen? What would be good about this?
- Do you have any fears or concerns about the future?
- Many youth have mixed feelings about their birth parents and foster parents. What are your feelings?
- If you woke up tomorrow and everything was perfect, what would be happening? How is that different than now?
- What is your biggest fear/concern?
- Tell me whom you would call if you had questions or a problem. Do you know how to reach me?Tell me what I can do to make things better for you.

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# Ensuring Safety, Permanency and Well-Being: Suggestions for Conducting Contacts with Youth and Caregivers

# Transition Age Youth (18-21 years old)

## Reviewing Safety Concerns with Caregivers

- How did this youth get to and from school or other activities? Does this youth drive or ride in cars with other youth?
- Did you know where the youth was when s/he was not at school and was away from home? What are your rules for him/her when not s/he is not at school or home? Is there a way for the youth to reach you when s/he is away from home?
- What is the emergency plan for your family in case of fire? Does this youth know where smoke alarms and carbon monoxide alarms are located in your home?
- If the worst case situation were to occur and this youth was in danger of being abused again, does s/he know what to do? Is there someone besides you available 24/7 the youth can call for help?
- Did this youth have any serious injuries, either before or since coming into care? How did you handle them? How is this condition being handled since foster care placement? How will you handle this condition when the youth returns home?
- Have you noticed any physical or emotional changes in this youth? As the youth is becoming an adult, are there changes in his/her behaviors? How has that changed your relationship with this youth? Has it changed how you discipline this youth or the rules you have for him/her?
- Does this youth have any chronic health conditions? Do you have the necessary medications, medical equipment, and medical staff support to adequately deal with this condition? How do you handle this condition?
- Have you explained the concept of date rape to your youth? How have you empowered him/her to resist being pressured or forced into unwanted sexual activity? Could you give me an example of things you have said in your conversations with him/her?
- How have you talked to your youth about the health risks of alcohol, tobacco and drug abuse? If the youth has a problem these issues, how will you deal with them when they return home? What is the safety plan if the youth is abusing substances upon return home? Who can you call to help you?
- What are your rules for the youth when s/he is with friends or alone?
- Do you know the youth's friends? What are the names and phone numbers of the parents of the youth's friends?
- Does the youth have any problems or issues about safety at school? (For example, with friends, other students, bus rides, following rules, etc.)

## Safety suggestions are NOT requirements for birth parents.

# Reviewing Safety Concerns with Transition Age Youth

- Do you know how to reach your parent when s/he is away from home?
- What is your safety plan if your parent or someone else tries to harm you or is just getting out of control? Who can you call if something happens in the middle of the night? What are your fears? (Specific questions related to the type of maltreatment the youth experienced should be included. Example: When you see your mother's red flags that she might be thinking about taking drugs, what is your plan for safety?) Would you be able to make that call? Do you know the number and have access to a phone?
- Do you ever stay over at someone else's house? How often do you do this? Do you like this? Are you allowed to do this as frequently as you want?
- How do you get to and from school? Do you drive? Do you ride with other youth who drive?
- Does your family know where you are when you are away from home and not at school? What are your family's rules about being away from home or school? (For example, curfew rules, reporting in rules, who you are with, where you can or cannot go, etc.)
- Does anyone you know ever ask you to do things you are not sure are ok?
- Do you spend time on the internet? Have you ever had anyone on the internet ask you to do something? What was it?
- What can I do as your caseworker to help you? Tell me how you would reach me if you wanted to talk.

# Reviewing Well-Being & Permanency with Caregivers

### Living Arrangements:

- Show me the youth's personal things, books or other belongings. How does this youth comfort himself/herself?
- Show me the youth's bedroom. Who else lives in this room? How does the youth get along with the others in the family?
- What type of chores or expectations do you have for this youth?

### Daily Routine:

- Describe a typical day for this youth.
- If you had to teach this youth a new skill, like cleaning the house, how would you do that? If the youth does not follow rules, what do you do? How does the youth respond to this?
- Describe a typical time when the youth did not follow a rule. How does this youth comply with your requests and demands? When the youth does not follow family rules, what type of discipline do you use?
- How are you helping the youth to be ready for adulthood (i.e. learning to take care of himself/herself, learning about buying and cooking food, learning about money management, etc.)?

## Social/Emotional:

- Have you seen any signs that the youth is feeling grief, loss, or is traumatized by the events in his/her life? What are they? How have you tried to help the youth handle this? Have the behaviors/emotions gotten better or worse?
- Describe how the youth transitioned into your home/family. What have you been able to do to help the youth transition (i.e. cook food s/he is familiar with, have pictures of his/her family in the bedroom, have books or music from the youth's home, etc.)?
- How does this youth show warmth and affection? What does s/he do when s/he is happy? How does the youth show that s/he is upset, hurt, sad or feeling other emotions?
- Who does this youth seek comfort from when s/he is hurt, frightened, or ill?
- Is this youth able to seek you out and accept your help when needed?
- Does this youth show preference for a particular adult or friend?
- What does this youth do when upset? How easy is it to soothe this youth when s/he is upset?
- How does this youth comply with your requests and demands?
- How has this youth changed since coming here? What do you think about that? In what ways has the youth adjusted to this placement?
- Is this youth involved in any religious activities? Any cultural activities?

## Family and Friends:

- Have you met the youth's parents/siblings/family? What happened when you met them? Do you have any concerns or questions about the family?
- Whom does the youth talk to, play with, or spend time with? Is the youth's behavior different with these people than with you? In what ways?
- Is the youth allowed to call friends from your home? Have friends over for a visit? Visit a friend's home?
- Does the youth date or have a special relationship with any one person?

## Special Interests:

- What kinds of things does this youth like to do? What does the youth do besides school and case activities?
- What are this youth's special talents?
- What do you do to support the youth in being involved in things s/he likes to do? Do you need any help to do this?

## Education:

- Would you describe this youth as developmentally typical or not? Can you give me examples of his/her behaviors/skills? Do you think the youth needs any help with any developmental skills?
- How is the youth doing in school? Who is her/his teacher(s)? Have you gone to a school conference or received any reports from school? Can I see them so I can make a copy of the file? If the youth were to have troubles at school, who would you contact?
- Does the youth attend a school where s/he has multiple teachers? How has the youth transitioned into his/her new school? Is the school very different from the last school the youth attended? (Going from a single teacher to multiple teachers is one example of a large transition for a youth this age.)
- Does the youth have career or education plans? Who is helping the youth with this?

## Health:

- Who is taking the youth to medical examinations? Who decides what type of medical care (even routine care such as immunization shots) the youth should have? Is the youth involved in medical decisions? Does the youth have any special medical problems? Do you know how to provide care for this type of condition? Where do you keep the youth's medical records? Show me any recent medical report so I can have a copy for the youth's records.
- Describe the youth's sleeping pattern. Describe the youth's eating habits.
- Have you seen any weight changes since this youth has been with you? Any other type of changes? Has the youth begun the physical changes into adolescence? Who is talking to the youth about these changes?
- Are there any signs the youth is involved in sexual activities, using drugs, harming himself/herself or any other dangerous activities?

## Case Planning:

- Is this youth receiving any educational, medical and/or psychological services? Which ones? How often? What do you think/feel about these services? Do you think that the services are meeting this youth's needs? Are there any other services that you think this youth needs?
- What is your greatest fear about the youth returning home or going out on his/ her own? What is your greatest fear about his/her future plans?
- When the youth visits his/her parents or other family members, what happens? How does the youth behave before or after the visit? What do you think of the family visits with the youth?
- What are the case goals for this youth and his/her family and what do you think/feel about the goals? What makes them okay; not okay?
- If the youth goes home, how do you imagine you might still be involved with him/her and his/her family? If the youth cannot go home to any family member, how might you imagine being involved with the youth?
- What is the permanency goal for this youth? What do you think/feel about this goal? What makes it okay; not okay?
- How have you been included in the family conferences/treatment/team case planning meetings? What is your role in achieving the case goals?
- What do you need to know or tell me about the youth that would help all of us do a better job making this youth safe and getting him/her a permanent family?

## Self-Care:

- On a scale of one to ten, with ten being the easiest youth you have ever cared for, how easy is it to parent this youth? Describe who this youth is. What about the youth is easiest and most pleasurable? What is the most difficult aspect of this youth for you to deal with? What are the things about this youth that you think will help him/her in the future? What do you think might be harder for him/her?
- Tell me how you handle the stress of having this youth in your home. What do you do to take care of yourself?
- What are your concerns right now? How can I help you?
- What was/is it like for you to care for this youth? What has been the effect on your family of having this youth placed in your home? What did you expect it to be like? Help me understand what it has been like for you dealing with this youth?
- To whom do you go if things aren't going too well?
- What things do you need to support your continued care of this youth?

# Reviewing Well-Being and Permanency with Transition Age Youth

### Living Arrangements:

- On a scale of one to ten, where ten is the best place to live and one is the worst, how would you rate this family? What makes it a _____? Is there something that could be done to make it better? How is it for you living at _____'s house?
- My biggest fear is…..?
- Who else lives here with you? What do you think about the other people who live here? What is it like living with them?
- What are some of rules this family has? What happens if you break a rule? How often does this happen?
- Who do you want to live with? How would that be better than where you live now?
- Are there things that you can and can't do at _____'s house?

### Daily Routine:

- Tell me what a typical day is like from when you get up to when you go to bed. (Encourage the youth to tell their story rather than just asking a list of questions.) Here are some prompts you can use if you are having difficulty getting the youth to answer:
    - How do you wake up in the morning?
    - What do you do in the morning to get ready for school?
    - Does anyone make breakfast for you? Who? What are some things that you eat for breakfast?
    - Do you bring lunch with you to school or do you get lunch at the school cafeteria? What are some things that you eat for lunch?
    - Who makes you dinner? What are some things that you eat for dinner?
    - What do you do after dinner?
    - What time do you go to bed?
    - Where do you sleep? Do you share a room with anyone? Who? What is this like for you?
    - What type of chores do you do? How often? Do you get allowance for doing chores?
    - Do you have a job that pays you money?

## Social/Emotional:

- If life could be just as you wanted, what would it be like? How is that different from what is happening now?
- If you are upset or angry about something that happens, what do you do to calm yourself? Is there anyone that you can go to? Who?
- What happens when the adults in the house get angry at you, each other, or someone else who lives in your house? How often do they get angry? What does it feel like for you when they are angry?
- Is there anyone at home or anywhere else that you go who makes you feel scared? Are there any adults or kids who do things that make you feel sad, mad, scared or confused?
- Do you ever wake up in the middle of the night? If so, what happens?
- Do you ever get scared hanging out in your neighborhood or anywhere else you go? If so, what are the things that make you scared? Is there anyone who you are able to talk to about this?
- If something is really worrying you, who can you talk to? If you need to get in touch with me, do you know how to do that? How?
- Are you involved in any religious, spiritual or cultural activities?
- Tell me one time when you felt sad, mad or scared about something that happened at_____'s house. What did you do? What did the adults do?
- Do you have a favorite thing you do when you feel sad? (Ask about other emotions, as well.) Do you have a favorite thing or activity that helps you feel happy? (For example, a personal belonging, listening to music, reading.)
- Do you go to any religious activities? How do you get there?

## Family and Friends:

- How are visits with your family? What kinds of things do you with your family on visits? How often do you see them? Do you speak with them on the telephone in between visits? What could be done to make visits better?
- Do you see your brothers and/or sisters who are in foster care or live somewhere else? How is to see them?
- Who are your friends? What do you like to do with them? Where do you see them? Do you get to visit with friends from your last school or past foster families who you miss? Do you get to call them?
- Is there anyone who you miss or would like to visit? (For example, former foster parents, other kids in the foster home, school friends, family, etc.)
- Do you have a boyfriend or girlfriend (or someone who is special or you spend a lot of time with)? Tell me about him/her.
- Do you have someone in your life that you consider your mentor? What are the qualities that person possesses?

### Special Interests:

- What do you do on the weekends or during your free time? Who do you do this with? What do the other people in _____'s house do? If applicable: Is this different from what you used to do on weekends? If so, how is it different?
- What kinds of things do you like to do for fun (sports, music, art, video games, etc.)? Do you do these things while you are living with _____? Are there any things that you'd really like to be doing that you aren't doing now?
- What are some things you do that nurture your spirit? (For example, art/ drawing, journaling, reading, martial arts, meditation, religious classes, going to church, prayer groups, etc).

### Education:

- What is your current school like? How is that better or worse than your last school? How has the move to this new school been for you?
- How is school? What are some of the things that you like best about school? What are some of the things that you like least about school? How is that different than your last school?
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- Have you ever had a part time job? What types of jobs have you held?
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- Are you ever sick? Tell me about what happened when you felt bad.
- When was the last time you went to the doctor? What did you see this doctor for? Have you been to any other doctors? If so, why? Do you take any medications? Have you seen a dentist in the last six months?
- Do you feel like you have all the information you need about your current health or health history?
- Whom do you go to when you have questions about your health or body?
- On a scale of 1 to 10, where 10 is: I have adults I trust and can talk to about this, where would you place yourself regarding:
    - smoking
    - drugs
    - changes in my body
    - sex and sexuality
- What can I do to help with any of these important issues?
- Do you go to see a counselor or therapist? What is this like for you? Do you know why you are seeing this person?
- Have you ever thought about hurting yourself in any way? Tell me more about that.
- Have you thought about killing yourself?  If yes, when was the last time you were thinking this?
- Have you ever tried alcohol, smoking, illegal drugs, prescription drugs, etc.? Do you know other kids who do this? What do you think about that?

### Case Planning:

- What are your goals for the future?
- Do you feel listened to by the adults in your life about your future plans?
- Do you feel included in the agency conferences?
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- It is your right to go to the court hearing and to attend some of the meetings where we talk about what might happen to you. Do you want to attend? What do you want to know about these meetings/ hearings?
- Do you have a CASA/GAL or attorney? How often do you talk to this person? Do you feel like this person is helping you?
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- Do you have any fears or concerns about the future?
- Many youth have mixed feelings about their birth parents and foster parents. What are your feelings?
- If you woke up tomorrow and everything was perfect, what would be happening? How is that different than now?
- What is your biggest fear/concern?
- Tell me who you would call if you had questions or a problem? Do you know how to reach me?
- Tell me what I can do to make things better for you.

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# Appendix

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# Promoting Attachment

These approaches are appropriate for age groups. Implementation is adapted to the developmental level of the child.

### Arousal-Relaxation Cycle

Parents or caregivers deliberately, consistently meet the needs of the infant and relieve tension and stress that usually accompanies the expression of need. The caregiver should be continually alert to obvious signs of stress (crying, fussiness, etc). However, some children do not outwardly communicate distress; caregivers must learn to read subtle cues. The relief of tension and stress when the need is met leads to contentment and comfort, thereby enhancing the attachment. Also, the parent helps the child regulate his emotions (often called co-regulation) which is necessary for the child to learn to regulate his own emotions.

Examples include: empathic care during feeding, bathing, dressing. For older children: soothing the child after he gets hurt; sensitively helping the child talk about his feelings (such as frustration, anger) following an emotional outburst.

### Positive Interaction Cycle

The caregiver involves the child in pleasing social interactions. Social activities may be less threatening than physical affection or emotional intimacy.

Examples for babies include cooing, singing to babies. Examples for young children include spending one-on-one time with the child, reading, doing activities together, etc.

### Claiming behaviors

Parental responses that indicate that the child is part of the family. This strategy is often used by adoptive parents.

Examples of claiming behaviors include: —introducing the child to others as a member of the family; consciously including references to the child in family histories; giving the child a special role or responsibility in family traditions; including the child in important family eventsǁ. (Rycus, 1998).

### Mental health therapy

Mental health treatment focuses on using short term, specific counseling to provide stability in the relationship, and increasing the positive quality of the parent-child relationship. The focus is on providing a stable environment for the child, and taking a calm, sensitive, non-intrusive, nonthreatening, patient, predictable and nurturing approach to parenting. This approach emphasizes teaching positive parenting skills, rather than the child's pathology. (Chaffin, 2006)

**SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS**

# Fetal Alcohol Spectrum Disorder

Sokol et al (2003) state that prenatal alcohol —exposure has been implicated as the most common cause of mental retardation and the leading preventable cause of birth defects in the United States, accounting for significant educational and public health expenditures.‖ (Page 4). Keith

Alcohol destroys and damages cells in the central nervous system. Widespread destruction of brain cells in early fetal development results in malformations in the developing brain structures. This, of course, can produce abnormalities in brain function.

Some physicians and researchers are now using the term, Fetal Alcohol Spectrum Disorder to indicate the continuum of effects, from severe to mild. The most severe end of the spectrum is often called Fetal Alcohol Syndrome. It refers to a combination of symptoms that are associated with prenatal exposure to large amounts of alcohol. The outcomes of Fetal Alcohol Syndrome typically include the following. Fetal Alcohol Effect is a milder form, and refers to children who have some of the following outcomes. Since there are no physical features, these children often are not recognized as having FAE.

Outcomes of FASD

- Pre- and post-natal growth deficiency (failure to grow.)
- An average IQ of 63, which falls within the mild range of mental retardation.
- Irritability in infancy
- Inattention, distractibility, hyperactivity, mood disorders in childhood (Sokol, et. all, 2003):
- Decreased reaction time in infancy and preschool children.
- Mild to moderate degrees of microcephaly. (Microcephaly is small head circumference. It is usually associated with varying degrees of mental retardation and abnormal brain development.)
- Dysfunction in fine motor control, such as weak grasp, poor eye-hand coordination, and tremulousness.
- Specific facial features, including thin upper lip, epicanthal folds, low nasal bridge, minor ear abnormalities, flat midface. These features often become less obvious during adolescence.

- Difficulties with executive functioning: problem solving, higher level thinking, self- monitoring, regulation of emotion, motivation, judgment, planning, working memory, time perception. These behaviors are often misinterpreted as willful, deliberate, or “bad behavior”. This is unfortunate, because children with these problems may not be accurately diagnosed, and may not receive the developmental services.

- The degree and type of damage done to the developing fetus depends upon several factors including which developmental processes where occurring when the alcohol was ingested, how much was ingested, and whether the drinking was chronic or binge drinking. Research has shown that even low levels of alcohol consumption and that infrequent binges can damage the developing fetus. Research has not identified a safe limit for drinking during pregnancy. “The only prudent conclusion is that alcohol can affect the developing brain even a low exposure levels. Abstinence during pregnancy is the only way to avoid such effects”.
(Goodlett and West, 1992, p 64-65, found in Streissguth, page 61)

## Recommended interventions

- Prevention, including counseling to pregnant women regarding the risks to their offspring, and referral to medical services and Alcohol programs.

- Developmental assessment of children thought to have been exposed prenatally to alcohol to identify growth retardation and delay, and to diagnose fetal alcohol syndrome.

- Referral of affected children to infant stimulation and early intervention programs.

- Training the parent or caregiver to plan and implement activities that will address developmental delays and promote healthy development of their children.

- Advocating for special school, social, and work accommodations throughout the child’s life so that he/she can function to his/her full potential, and to prevent “secondary conditions” such as depression, anxiety.

- Counseling and education for parents regarding meeting the child’s developmental needs, and promoting optimal development and adjustment

**SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS**

# Prenatal Exposure to Drugs

The effects of drug exposure upon children during pregnancy are not completely understood. What was once believed to be a consistent syndrome of symptoms known as crack/cocaine exposure to infants and children is now not believed to be totally attributable to crack/ cocaine exposure during pregnancy. While research indicates that children who are exposed to other stressors in utero often suffer a variety of developmental difficulties, the specific effects of various illegal or street drugs are not completely known.

A number of factors known to affect the fetus during pregnancy probably combine to place the newborn child at risk for a variety of developmental problems. These factors include cigarettes, marijuana, cocaine, poor prenatal care and parenting practices, poverty and low socioeconomic status including low education level and associated social risks, and the risks associated with drug-seeking behavior.

## Infants

Infants who have been drug exposed during pregnancy may be very irritable and difficult to soothe. These children are often labeled “disorganized” or lacking the ability to self-regulate their emotional states. At birth and shortly thereafter these children are often identified as stiff and irritable by caretakers. These patterns are usually short-lived and seldom continue beyond infancy.

Drug exposed infants have a tendency to be smaller in terms of birth weight and length. They typically catch up to non-exposed children with proper care and nutrition.

Other symptoms in newborns include gaze aversion, frowning or furrowed brow giving the infant a worried look, motor agitation, hiccups, spitting up and crying.

Caretakers should receive education and instruction in strategies to soothe the newborn and learn to reduce their level of stress. Examples of soothing strategies include providing firm touch, swaddling the infant with arms close to his/her body, using a pacifier, and vertical rocking. It is often helpful to reduce the amount of stimulation in the newborn’s environment. Finally, it is critical for parents and caretakers to learn to “read” the infants’ cues, and adjust their interactions with the baby so as not to overwhelm or irritate the baby.

## Toddlers and preschool children

Children exposed to drugs in utero are more likely to experience delays in development for a number of reasons. While the precise origin of the delays are not known it is important that children with developmental delays to receive appropriate services. Early intervention services that stimulate cognitive, motor, language, and social development are effective for children with delays due to drug-exposure.

## Treatment

Early intervention services that stimulated cognitive, motor, language, and social development are effective for children with delays due to drug-exposure.

Caretakers of children who are drug exposed should be aware of indicators of developmental delays and should seek medical, developmental or psychological assessments for children who exhibit difficulty. Drug exposed children may exhibit any number of symptoms. Common problems include behavioral symptoms such as low tolerance for frustration, distractibility, and impulsive behavior. Language delays are frequently found in children with impoverished home environments. These problems may appear as articulation problems or as delays in verbal expression.

**SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS**

# Special Care for Severely Abused Infants

Infants, who have been abused severely, and at an early age, demonstrate predictable developmental patterns and delays, as follows:

- They are withdrawn, apathetic, and look weak and sick.
- They allow manipulation of their bodies with no protest.
- They do not enjoy being touched or held, and are not positively responsive to affectionate handling.
- They exhibit generalized passive compliance.
- They appear to enjoy nothing. They do not laugh or smile; they show no interest in objects or people. They do not take pleasure in feeding, bathing, play, or other normal activities.
- They do not risk contact with people. They appear to feel best when they are left alone.
- Their movements are slow and cautious; they display limited mobility. They may stay in one place for long periods of time.
- They do not often cry. They may occasionally whimper, or wail.
- They do not cling to parents or other adults in threatening situations.

## Treatment Interventions

Specialized treatment methods are necessary if we are to help this child. Simply eliminating the abuse is not enough. Parents and foster caregivers must be trained to nurture this child in a predictable, measured fashion. “Too much too soon” can overwhelm the child and have the effect of further closing him off. As a result, treatment may take months.

- Move SLOWLY! Take care to approach the child slowly at all times, and do not institute too many changes at once.
- Create a calm, comfortable environment. The environment should not, however, be sterile and devoid of stimulation. Stimulation must be given in measured doses. A foster home with five noisy and active children may not be the best environment for this infant.

- Read the child's cues regarding her needs. When the child withdraws from an approach, back off, and approach again more slowly or tentatively. The child will have to become acclimated. There is a fine line between providing nurturance and overwhelming the child.

- Choose times in which to interact with the infant, and keep these times short at first.

- Talk to the child using a soft, affectionate tone of voice. QUIET and COMFORTING is the rule.

- Introduce pleasure into care giving. Any interaction with the child, including feeding, bathing, and changing clothes should be performed gently, allowing the infant to experience normal infant pleasures. Adequate time should be taken; these activities should not be rushed.

- The child should not be harshly or firmly disciplined. If the child approaches a dangerous situation, she should be gently redirected or removed.

- The parent or caregiver must allow latitude in permitting the child to behave in ways that are developmentally more appropriate for a young infant. For example, messing with food, spitting, splashing in the bath, and otherwise "making a mess" are preferable to withdrawal and immobility. After several months, gentle limits may be set.

- Do not force physical affection. Begin with gentle touching, patting, and stroking. When holding the child, hold lightly. Cuddling is fine when the child appears to respond positively by conforming to the adult's body, or "settling in." Follow the child's cues about physical affection.

- After a period of time the child may exhibit such behaviors as thumb sucking, clinging, other dependent behaviors, frequent crying, stranger anxiety, separation anxiety, and other signs of social need. These must be viewed as PROGRESS rather than as problem behaviors.

**SPECIAL DEVELOPMENTAL PROBLEMS OF INFANTS AND TODDLERS**

# Failure to Thrive

## Definition

The term "failure to thrive" has been used to describe a wide variety of conditions in which infants fail to achieve age appropriate weight and height levels. Block et al (2005) state that "inadequate nutrition and disturbed social interactions contribute to poor weight gain, delayed development, and abnormal behavior. The syndrome develops in a significant number of children as a consequence of child neglect."

The one characteristic common to these children is nutritional deficiency. This can be caused by a number of problems, and is often caused by a combination of the following factors:

- *Unintentional:* Breast-feeding problems, errors in formula preparation, poor diet selection, improper feeding technique
- *Organic diseases:* Including but not limited to cystic fibrosis, cerebral palsy, HIV infection or AIDS, inborn errors of metabolism, celiac disease, renal disease, lead poisoning, major cardiac disease
- *Child neglect:* Treatment approaches must include both medical and environmental management, regardless of the cause of the problem. (Block, 2005)

FTT from neglect often indicates attachment problems. FTT is often not merely a feeding problem; it often indicates serious problems in the attachment, especially disorganized attachment, between the baby and primary caretaker. (Carlson, 2003) However, not every child with FTT has an attachment problem.

## Physical characteristics of children with FTT associated with neglect

- Most appear emaciated, pale, and weak; has little subcutaneous fat and decreased muscle mass.
- The infants are often below their birth weight, indicating weight loss; or their weight is well below the normal range.
- Most are listless, apathetic, and motionless, and at times, irritable.

- Some infants are unresponsive or resistant to social involvement. Others become actively distressed when approached. Many show a preference for inanimate objects.

- Infants may sleep for longer periods of time than is appropriate for age.

- Infants may display immature posturing, more appropriate for newborn or very young infants, including lying with hands held near or behind the head; legs flexed in a “frog” position; thumbs closed inside fists.
  Some children display self-stimulatory rocking, head-banging, or rumination (vomiting and swallowing).

- Developmental assessment will likely reveal primary delays in gross motor and social domains.

**Common characteristics of parents of malnourished children are as follows:**

- Research has repeatedly described mothers of underfed children as depressed, socially isolated, withdrawn, and anxious.

- Many parents have histories of abuse and neglect, including an absence of attachment, in their own early childhoods.

- Parents often fail to interact warmly and in a nurturing manner with their infants.

- Many parents are “overwhelmed” by chronic stress, which can be exacerbated by the demands of caring for an infant.

- Parents often show little ability to empathize with their infants; they often misread or ignore their infant’s cues. They behave in ways that meet their own needs rather than the needs of their infants.

- The parent may create an unpleasant or painful feeding situation for the infant; as a result, the child may not be cooperative or may reject food. The parent might be impatient, might force-feed the child, or might remove food abruptly. When the child resists or fails to eat, the parent may assume the child is not hungry and discontinues the feeding.

- Some parents, while expressing sincere concern about their children’s conditions, appear not to know how to engage in meaningful activity with their infants. There is typically little interpersonal activity between the parent and the infant. Some parents played with their infants in the manner of a competitive peer rather than a nurturing adult.

**Specific problems related to feeding might include:**

- The parent may not realize the child is failing to grow, nor recognize the lack of weight gain and emaciation.

- The child's feeding problems may be noticed but thought to be the result of vomiting, diarrhea, or other physical illness, rather than problems in the feeding situation itself. The parent may believe the child is being adequately fed.

- The parent may not be able to accurately report feeding times, schedules, or the quantity of formula the infant has taken. The parent may not be assuring adequate caloric intake.

- The parent may allow long periods of time to elapse between feedings because "the baby doesn't appear to be hungry." Apathy and listlessness that result from low caloric intake are mistaken for the absence of hunger.

- Breast-fed infants can be undernourished if the mother does not produce adequate milk or does not know how to nurse her infant. Breast-fed infants over the age of 5 months may not be able to get adequate nutrition from breast milk alone.

## Recommended treatment for malnourished infants and their families

- A thorough medical assessment must be conducted to determine the etiology of the failure to thrive.

- The American Academy of Pediatrics (Block, 2003) states that in severe cases, where the child's weight is less than 70% of expected weight-for- length, urgent intervention is needed. Immediate hospitalization may be necessary or placement in foster care. A treatment that provides caloric intake far in excess of that needed for maintenance under normal conditions. This typically leads to rapid weight gain, called "catch-up growth," in children who are undernourished from underfeeding. Some infants achieve age- appropriate weight within a couple of weeks.

- Rapid "catch-up growth" during hospitalization is diagnostically significant for this syndrome, particularly when the child is fed in the hospital with the same formula used at home.

- Some secondary physical conditions affecting the infant, as well as apathy and depression, appear to be resolved as a result of intensive feeding programs.

- A team approach to treating FTT is needed. The team includes child welfare caseworker, physician, nurse, and often includes a dietician.

- Parents should be directly involved in all aspects of the treatment program. Supportive counseling and education by a caring, nurturing professional can help parents feel less guilty, anxious, and depressed, and can teach and reinforce proper feeding methods and improve parent-child interactions. This treatment program should begin in the hospital. If the parents are not treated, the child can be expected to quickly regress when returned to the home. In severe cases, death can occur.

**SPECIAL DEVELOPMENTAL PROBLEMS OF INFANTS AND TODDLERS**

# Cerebral Palsy

Cerebral palsy is a developmental disability. According to the National Institute of Neurological Disorders and Stroke, “cerebral palsy is an umbrella-like term used to describe a group of chronic disorders that appear in the first few years of life and generally do not worsen over time. The disorders are caused by faulty development of or damage to motor areas in the brain that disrupts the brain’s ability to control movement and posture”. (NINDS web page 9-22-06)

There are multiple potential causes of cerebral palsy, including prenatal and postnatal abuse and neglect. Most often, cerebral palsy is present at birth, and is thought to be the result of some prenatal insult from illness, injury, or presence of toxic substances. Mothers who have no prenatal care or who abuse alcohol or drugs increase the risk of cerebral palsy in their infants.

Child welfare workers must be skilled at recognizing the early warning signs of cerebral palsy in populations of abused and neglected infants and children. This can insure that optimum early intervention can be provided.

Early symptoms of cerebral palsy are variable. In milder cases, problems may not be apparent until the child reaches school age. Generally, the more severe the condition, the earlier it can be detected.

There are many different conditions that fall within the broad terminology of “cerebral palsy,” and there are considerable differences in descriptive terminology in the literature. The types of cerebral palsy can, however, are broadly divided into three major categories.

**Spastic** cerebral palsy is characterized by stiff, chronically tensed muscles combined with muscle weakness.

**Athetoid** cerebral palsy is characterized by slow, writhing, involuntary and uncontrolled muscle movements, with muscle weakness.

**Ataxic** cerebral palsy is characterized by motor incoordination and difficulty with balance and depth perception.

Many persons with cerebral palsy have mixed types. 90% of cerebral palsy is either spastic, athetoid, or a combination of both.

### Abnormal Muscle Tone

Infants may exhibit either hypotonia, a significant lack of muscle tone characterized by loose, floppy muscles; or, hypertonia, an excessive degree of muscle tone characterized by tightness, stiffness, and constricted movement. Typical signs of hypertonia related to spastic cerebral palsy might include:

- Keeping one or both hands fisted, or keeping the thumb clenched inside the fist, if the child is over 4-5 months.
- Tightness of the hips, making it difficult to separate the infant's legs to diaper him.
- Keeping the legs in an extended position, or crossing the legs or ankles; kicking the legs in unison, bringing the knees together up to the chest, rather than the more normal alternating leg, bicycle style kicking.
- Evidence of lack of vision, inability to focus or to track moving objects.
- Tongue thrust, moving tongue in and out of the mouth, excessive drooling.

Typical signs of hypotonia or lack of muscle tone may include an inability to maintain head control, and a generalized "floppiness" that will contribute to delayed motor development.

### Abnormal Patterns or Delayed Motor Development

Delayed motor development may exhibit itself in numerous ways.

- Failure to achieve head control, or to lift head and chest from a prone position when the child is on his stomach, if older than 5 months.
- Failure to reach for objects or to transfer objects from one hand to the other, if older than 7 months.
- Collapsing forward when placed in a sitting position, or rounded back when seated, if older than 8 months.
- Inability to roll from back to front, if older than 6 months.
- Inability to stand, if older than 10 months.

Abnormal patterns of motor development refer to developmental milestones that are only partially completed, or to differences in the infant's skill in mastering motor tasks using various parts of the body. For example:

- Persistent use of only one hand when playing with a toy, including reaching across the body to retrieve an object, rather than reaching with the arm that is on the same side of midline as the object. Infants typically use both hands equally for the first 15 months of life.

- Good use of hands and arms, but drags legs. While many infants go through a stage of "G.I. Joe" crawling on their stomachs, failure to progress to more advanced use of the legs might be indicative of cerebral palsy.

- Trembling or inaccurate aim when reaching for an object may indicate athetoid cerebral palsy.

- Walking on tiptoes. Young infants typically stand on their toes when held in a standing position in an adult's lap. By the time the child learns to walk, heels should be flat on the floor. A persistent toe-walking reflex may be indicative of cerebral palsy.

### Treatment Recommendations

- Early intervention can increase range of mobility and prevent unnecessary deterioration of motor abilities.

- Early intervention can help children learn and grow in spite of their physical problems. (More than 50% of children with cerebral palsy have intellectual potential that is within the normal range.)

- Physical therapy and proper medical management are necessary on an ongoing basis.

- Developmental assessments should be performed to assist in determining treatment needs in all developmental areas.

- Special infant stimulation programs can greatly improve motor development as well as cognitive and social development.

- Vision and hearing should be routinely screened and monitored as the child develops. Both can be affected by cerebral palsy.

- Speech therapy should be provided for children whose motor ability to speak is involved. For severely involved persons, alternate communication systems (symbolic communication systems, "voice boxes," use of pictures) can increase language development even though speech is absent.

- Parents will need considerable support and education. Caring for a child with cerebral palsy can be stressful and difficult. Special services and support for the parent can greatly increase their ability to manage.

# Reactive Attachment Disorder Of Infancy or Early Childhood

## Description

Reactive Attachment Disorder is a diagnostic label described in the DSM-IV and refers to a disorder usually first diagnosed in infancy or childhood. As such, this disorder has specific diagnostic criteria. The disorder does not cover many of the behavioral concerns that may be observed when the attachment process is disrupted by separations, illnesses and disability on the part of the caretaker or even disturbed parenting practices. While these environmental conditions are often precursors to Reactive Attachment Disorder, the diagnosis of Reactive Attachment Disorder identifies criteria for both the behavioral characteristics and problematic environmental precursors necessary for making the diagnosis of Reactive Attachment Disorder.

Two general types of behavioral manifestations of Reactive Attachment Disorder are recognized by the DSM-IV. The **Inhibited Type** is characterized by a child who "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hyper vigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)." Diagnostic criteria for the **Disinherited Type** describe a child with "diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity and choice of attachment figures)." (DSM IV)

In either type, there must be evidence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years," (DSM IV) It is important to note that the criterion for disturbed attachment includes the following:

- That the developmentally inappropriate social relatedness is evident in most contexts. That the child exhibits the disturbances across settings and among different caretakers in most instances.
- Presumes that the disturbances in social relatedness are the result of parenting or caregiver practices, or disturbances and disruptions in the living environment.
- That the developmental disturbances in social relatedness are not caused by developmental delays related to Mental Retardation or a Pervasive Developmental Disorder.

The DSM-IV states, “by definition, the condition is associated with grossly pathological care that may take the form of persistent disregard of the child’s basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child’s basic physical needs; or repeated changes of primary caregiver that prevent formation of stable attachments”.

As children mature into adolescence Reactive Attachment Disorder can have many expressions. With the Disinhibited Type the hallmark criteria diffuse, indiscriminate sociability and difficulty making appropriate selective attachments. Interference with intimate social functioning is at the core of this disorder. Disturbances of conduct, oppositional behavior, and diffuse manifestation of disinhibition or impulsive behaviors are **not** core symptoms according to the DSM-IV.

## Treatment

Appropriate treatment emphasizes short term, specific counseling to provide stability in the relationship, and increasing the positive quality of the parent-child relationship. The focus is on providing a stable environment for the child, and taking a calm, sensitive, non-intrusive, non-threatening, patient, predictable and nurturing approach to parenting. This approach emphasizes teaching positive parenting skills, rather than the child’s pathology. (Chaffin, 2006)

## A cautionary word about “holding therapy”, or “attachment therapy”

Some therapeutic approaches have been developed for children with severe behavior and emotional problems that are attributed to attachment disorders. As discussed earlier, RAD is rare, and many children with diagnoses of RAD likely have other problems, such as conduct disorders. The rationales for these therapies usually hold that the child experiences intense rage in reaction to early maltreatment or traumatic separation. The rage purportedly prevents the child from forming attachments, and results in the child being manipulative and controlling, and having a number of behavior problems.

Treatment strategies include a variety of methods for catharsis, “rebirthing”, enforcing eye contact, holding and other coercive methods for forcing the child to submit to the will of the parent, and thereby form an attachment with him/her. Scientific research supports neither the underlying theory, nor the usefulness of the methods. In an extensive review of literature on this topic, Chaffin et. al (2006) found only one empirical study. The study showed modest success, but the methodology was so flawed, that the conclusions are not reliable.

These methods have had harmful effects on several children, including death. Several professional organizations have recommended against using these strategies, and the American Professional Society on the Abuse of Children formed a task force to study the issue and make recommendations. It also recommends against using these methods. Caseworkers should be careful when referring children to therapy for attachment problems, and should seek guidance from their supervisors if the therapist suggests using any of controversial “holding” or “attachment therapy” methods. (Chaffin, 2006)

# Anxiety Disorder

## Description

Anxiety disorders refer to a cluster of disorders whose primary features include excessive fearfulness and stress response. In general, the term anxiety disorder refers to an excessively fearful or stressful response to a perceived threat either in the present environment or anticipated future threat. Anxiety Disorders are relatively common among the mental disorders. Anxiety disorders usually include strong somatic symptoms, such as stomach aches, headaches, nervousness, problems with sleeping and eating that can be quite uncomfortable for the child.

The DSM-IV indicates that children can be diagnosed with the following anxiety disorders:

- panic disorder with agoraphobia
- panic disorder without agoraphobia
- acute stress disorder
- generalized anxiety disorder,
- post-traumatic stress disorder,
- adjustment disorder with anxiety, social phobia,
- specific phobia and
- obsessive-compulsive disorder.

Additionally, all forms of anxiety disorders involve the loss of functioning in important domains of life, such as school, social functioning and peer relationships.

As you can see by the number of DSM-IV diagnoses, anxiety can have many presentations. Human adaptive responses to severe stress vary widely and, as in all mental disorders, the outcome depends upon the nature and severity of the environmental stressors and the heritable characteristics of the person experiencing them. However child abuse and neglect increase children's vulnerability to anxiety disorders. Likewise, children who are exposed to domestic violence may be more likely to acquire an anxiety disorder.

In cases of extreme abuse and neglect children are believed to experience a chronic stress response that includes anxiety. This results in withdrawal and isolation, lethargy and unresponsiveness to the environment and is believed to be connected to neurological changes in brain chemistry and even structural changes in the brain. This can happen to very young children and often has deleterious effects to the attachment process and on social functioning.

## Physiology of stress reactions: *flight, flight, freeze*

Under conditions of stress or threat, (which research has concluded include severe neglect and abuse), the hippocampus chemically signals the pituitary which releases neurotransmitters which in turn signal the adrenal cortex to release stress hormones (such as cortisol and adrenaline) into the bloodstream. These chemicals prepare the body to respond to threat. They cause many changes in the body including increased alertness, heightened startle response, increased heart rate and other changes that increase the availability of oxygen to muscles and certain organs. The better to *flee* (run away from danger), *fight* (for survival), or *freeze* (refrain from reacting in order to fully perceive the threat) from whatever is perceived to be threatening. This is very adaptive, in that it ensures survival. In normal circumstances the brain stops the release of stress hormones when the threat is no longer present, and the person's functioning returns to normal. However, there are two ways in which this response can be problematic:

1. Chronic stress: Problems can occur when the child experiences chronic states of anxiety and perceived threat such as chronic abuse or neglect. In this situation, the body maintains its response to stress by continuing to release cortisol into the blood stream. It is believed this prolonged exposure to cortisol interferes with the brain's ability to stop the release of cortisol, when the threat or danger is removed. Therefore, children experience prolonged stress reactions, such as heightened awareness of danger, over- reaction to even mildly threatening situations and slow ability to calm down, or withdrawn behavior.. In other words, the child is in a persistent state of "flight – fight – freeze".

2. Additionally, problems can occur when a "trigger" event activates the fight – flight – freeze response. One of the body's adaptive responses to trauma (including severe abuse and neglect) is the capacity to generalize from circumstances of threat to other situations that contain similarities to the original threat. This response pattern can be maladaptive when the emotional and physiological response generalizes to non- threatening situations of daily life and interferes with normal functioning, as in Post Traumatic Stress Disorder (PTSD). For example, the smell of the cologne that a sexual abuse perpetrator wore can evoke, or "trigger" a fear and anxiety response when the child encounters that smell later, whether or not the perpetrator is present.

## Long term effects

People who have a history of severe stress as children remain vulnerable into adulthood, even when they recover to normal functioning. If they are subject to another trauma or experience a severe loss they remain more likely to have a catastrophic response (major depression, traumatic stress response) to the later event.

## Treatment for Anxiety

Cognitive Behavioral Therapy has been shown to have effectiveness in reducing anxiety symptoms. Treatment may involve exposing the child to anxiety producing event, in a safe and supportive environment and learning to relax instead of responding with anxiety. It can also involve self-talk to help the child correctly interpret the non-threatening environment, and interrupt and stop the escalation of his/her physiological reaction, and to think more accurately about the anxiety producing situation. For example: a child who responds with anxiety whenever she smells the cologne warn by the sex abuse perpetrator cologne may be taught to remind herself that lots of men wear that cologne, and the perpetrator is not present.

Some treatment protocols include a therapy component for parents as well.

Pharmacological therapies can by very beneficial as an adjunct to psychotherapy, but are not recommended as the sole form of treatment for trauma related disorders

# POST-TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder is a psychological disturbance resulting from a person's exposure to a traumatic event, such as inter-personal violence, natural disaster, plane wreck, etc. in which the person experienced overwhelming fear and anxiety regarding his safety. PTSD can also result from child abuse.

This condition is diagnosed when the following symptoms have been present for longer than one month:

- *Re-experiencing* the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.

- Routine *avoidance* of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).

- Increased sleep disturbances, irritability, poor concentration, startle reaction and regressive behavior.

Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2 percent after a natural disaster (tornado), 28 percent after an episode of terrorism (mass shooting), and 29 percent after a plane crash.

The disorder may arise weeks or months after the traumatic event. PTSD may resolve without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for traumatized individuals to have some of the symptoms of PTSD than to develop the full-blown disorder.

As noted above, people differ in their vulnerability to PTSD, and the source of this difference is not known in its entirety. Researchers have identified factors that interact to influence vulnerability to developing PTSD. These factors include:

- Characteristics of the trauma exposure itself (e.g., proximity to trauma, severity, and duration),

- Characteristics of the individual (e.g., prior trauma exposures, family history/prior psychiatric illness, gender—women are at greatest risk for many of the most common assault traumas), and

- Post-trauma factors (e.g., availability of social support, emergence of avoidance/numbing, hyper arousal and re-experiencing symptoms).

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Abnormal levels of brain chemicals that affect coping behavior, learning, and memory have been detected among people with the disorder. In addition, recent imaging studies have discovered altered metabolism and blood flow in the brain as well as structural brain changes in people with PTSD.

*Treatment*

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is cognitive behavioral therapy, or CBT. In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviors such as avoidance of reminders of the traumatic event. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid "catastrophizing." For example, they are reassured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc. Play therapy and art therapy also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have been found to help persons with PTSD include group and exposure therapy. A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances. Research has shown that support from family and friends can be an important part of recovery.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally charged memories and medications that may help block the development of symptoms. Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioral problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents.

There is accumulating empirical evidence that trauma/grief-focused psychotherapy and selected pharmacologic interventions can be effective in alleviating PTSD symptoms and in addressing co-occurring depression. However, more medication treatment research is needed.

A mental health professional with special expertise in the area of child and adolescent trauma is the best person to help a youngster with PTSD. Organizations on the accompanying resource list may help you to find such a specialist in your geographical area.

*Recent Research*

The National Institute of Mental Health (NIMH), a part of the Federal Government's National Institutes of Health, supports research on the brain and a wide range of mental disorders, including PTSD and related conditions. The Department of Veterans Affairs also conducts research in this area with adults and their family members.

Recent research findings include:

- Some studies show that counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of trauma/grief-focused psychotherapy among early adolescents exposed to an earthquake found that brief psychotherapy was effective in alleviating PTSD symptoms and preventing the worsening of co-occurring depression.

- Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counseling in order to be able to help her child.

- Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child.

- Community violence can have a profound effect on teachers as well as students. One study of Head Start teachers who lived through the 1992 Los Angeles riots showed that 7 percent had severe post-traumatic stress symptoms, and 29 percent had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be obedient or get along with each other.[31]

- Research has demonstrated that PTSD after exposure to a variety of traumatic events (family violence, child abuse, disasters, and community violence) is often accompanied by depression. Depression must be treated along with PTSD, and early treatment is best.

- Inner-city children experience the greatest exposure to violence. A study of young adolescent boys from inner-city Chicago showed that 68 percent had seen someone beaten up and 22.5 percent had seen someone shot or killed. Youngsters who had been exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year.

## *PTSD in Children*

***For children 5 years of age and younger,*** typical reactions can include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

***Children 6 to 11 years old*** may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt and emotional numbing or "flatness" are often present as well.

***Adolescents 12 to 17 years old*** may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don't fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem.[8-11] And the youngster who lacks family support is more at risk for a poor recovery.[12]

-- Adapted from the booklet, "Helping Children and Adolescents Cope with Violence and Disasters", at www.nimh.nih.gov/pulicat/violence/cfm

# DEPRESSION

## Description

Affective disorders, or mood disorders, can appear in children and, adolescents as well as adults. The Depressive disorders are one of the mood disorders and include Major Depression, Bipolar Disorder, and Dysthymic Disorder. Childhood depression can affect a child's cognitive functioning, emotional functioning, behavior and body functioning.

As with many disorders, there appear to be genetic links between generations that result in vulnerabilities for acquiring depressive disorders. Children of parents who have affective disorders are at increased risk for acquiring affective disorders themselves. Environmental factors including child abuse and serious neglect are correlated with children exhibiting depressive symptoms.

## Symptoms

In childhood, symptoms of depression can appear somewhat different than symptoms in adults. Irritability is often more prominent in children as opposed to a noticeable appearance of sadness that may be present in adults. In adolescents a pervasive lethargy may signal depression processes more so than in adults (but not always). Depressive symptoms in children and adolescents may include:

- sadness that won't go away
- hopelessness
- boredom
- unexplained irritability or crying
- loss of interest in usual activities
- changes in eating or sleeping habits
- alcohol or substance abuse
- missed school or poor school performance
- threats or attempts to run away from home
- outbursts of shouting, complaining
- reckless behavior
- aches and pains that don't get better with treatment
- thoughts about death or suicide

-- from National Institute of Mental Health —Fact Sheet "Major Depression in Childhood and Adolescence"

## Child Maltreatment and Depression

Being the victim of abuse and neglect, especially chronic abuse and neglect, is stressful and research indicates that exposure to such conditions is associated with depression symptoms. Experiences of loss such as prolonged separation or permanent separation from family and home makes a child vulnerable to depression. Workers involved with children undergoing such dramatic changes and losses must be aware of depression symptoms in order to identify and treat them as early as possible.

## Treatment for Depression

Childhood depression is a serious condition. There is increased susceptibility to alcohol and substance abuse problems, suicide risk and academic functioning problems for young people with depression. Interventions are available to help depressed children and adolescents. All children with depression should be evaluated by a physician to determine the likely causes of the depressive symptoms. Usually a combination of medical and psychological interventions is recommended in cases of moderate to severe depression. The need for psychopharmacological interventions should be assessed by a medical doctor.

Research has indicated that cognitive-behavioral therapy can be an effective psychological treatment for persons with depression. Counselors trained in treating depression can help educate caretakers about symptoms and treatment strategies for helping the depressed child or adolescent.

## Bipolar disorder

Bipolar disorder is a mood disorder that often presents some early symptoms of the disorder in childhood and adolescence. Bipolar disorder is a serious disorder that can persist through adulthood. This disorder can include fluctuations in mood, energy levels and disturbances in thought patterns that impair functioning in family relationships, academics and peer relationships. Treatment of bipolar disorder is often different from treatment for other forms of depression and early detection of bipolar disorder is important due to the differing treatment needs associated with bipolar disorder. However, symptoms associated with early onset bipolar disorder can be difficult to differentiate from other childhood disorders. The National Institute for Mental Health recommends that:

“A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness.” (Child and Adolescent Bipolar Disorder: An update from the NIMH, 2000)

# Conduct Disorder

## Description

According to the DSM-IV essential features of Conduct Disorder are characterized by “a repetitive and persistent pattern of behavior in which the basic rights of others or major age- appropriate societal norms or rules are violated.” It is important to differentiate occasional emotional outbursts that may be in reaction to specific events from Conduct Disorders. The differentiating factor is that a person with conduct disorder has a consistent, persistent pattern of these behaviors.

These behaviors fall into one of four general categories:

- Aggression to people and animals
- Destruction of property
- Deceitfulness or theft Serious violations of rules

According to the DSM-IV Conduct Disorder is generally diagnosed as one of two types the “Childhood Onset Type”, and the “Adolescent Onset Type” depending on when the behaviors began to emerge.

## Gender Differences

Prevalence rates for Conduct Disorder are higher for males than females.

The expression of Conduct Disorder behaviors is different between genders. Males tend to exhibit more physically aggressive behaviors such as physical fights, use of weapons to physically harm others and physical cruelty. Females with Conduct Disorder are more likely to exhibit aggression through social intimidation, social cruelty, running away, or staying out overnight despite parental prohibitions, truancy or other nonphysical behavioral expressions.

## Causes

Research indicates that Conduct-Disorder related behaviors may be caused by either environmental conditions or genetic pre-disposition, or a combination of both.

## Parental History

Parents with a history of Alcohol Dependence, Mood Disorders, Schizophrenia and biological parents with a history of Attention Deficit Hyperactivity Disorder or Conduct Disorder have an increased chance of having children with Conduct Disorder.

## Environmental Influences

Children who have been physically or sexually abused a more likely to exhibit aggressive, and antisocial or conduct-related behavior problems. Parents who utilize coercive means to manage children's behavior are more likely to have children who display externalizing behaviors (i.e.: aggression, acting out, disruptive behavior in school) and coercive behaviors.

Parental neglect is also a risk factor for the development of externalizing behaviors including conduct disorder symptoms.

## Associated Conditions

There are several known associated correlates to the development of Conduct Disorder. Although they are distinct disorders, Oppositional Defiant Disorder is frequently a precursor to Conduct Disorder. Attention Deficit Hyperactivity Disorder is also frequently found in histories of adolescents with Conduct Disorder. Persons with Conduct Disorder have a higher than expected chance of having a co-existing Learning Disability.

## Treatment

Early intervention is very important for parents of children with aggressive, destructive and defiant behavior. Conduct problems often persist into adolescence and beyond, especially when serious symptoms appear in childhood.

Parent training specifically designed for defiant and coercive behavior problems can be an effective intervention. It is important that therapy strategies be adaptable to the child's natural environment. Therefore engaging parents and school staff in learning effective strategies for managing the child's behaviors is often critical to success. Strategies could include providing a stable environment with predictable consequences for behavior, and anger management.

Portions of this Field guide were adapted from:

*Caseworker Core Module VII: The Effects of Abuse and Neglect on Child Development.* The Ohio Child Welfare Training Program. TOC Draft Sept. 2006

In addition to:

*Field Guide to Child Welfare.* Judith S. Rycus & Ronald C. Hughes. Child Welfare League of America Press. 1998

*Impact of Separation Chart,* Rose Wentz, wentztraining.com, June 2009