Meeting 2:

Chronological List of Handouts Presentation Slides

Handouts

1. Meeting 2 Agenda
2. The Cycle of Need
3. The Alliance Model of Child Welfare Practice
4. The Role of Foster and Adopt Parents in Building Alliances with Parents of Children in Foster Care
5. Steps in a Foster Care Case*
6. Erikson's Stages of Development
7. Understanding Child Traumatic Stress (NCTSN)
8. Lily's Stages of Development
9. Components of Well-being of Children and Youth in Foster Care
10. Assessing the Well-Being Needs of Children and Youth – Worksheet
11. Child Welfare's Next Challenge: Parenting Meth's Young Victims
12. Important Informations about Pareting Children Who Have Been Diagnosed with Diabetes Glossary
13. Important Information about Parenting Children with Fetal Alcohol Syndrome or Fetal Alcohol Effect (FAS/FAE)
14. Important Definitions for Foster/Adopt Parents of Children Who Learn and Grow Differently
15. Important Information for Foster/Adopt Parents about Parenting Youth Who are Gay, Lesbian, Bisexual or Transgendered
16. Strengths/Needs Worksheet

Supplemental Handout: Feedback Form

* Handout needs to be developed by agency.

Presentation Slides

01. Indian Child Welfare Act (ICWA)
02. Multiethnic Placement Act of 1994 and Amendment of 1996 (MEPA/IEP)
03. The Alliance Model of Child Welfare Practice
04. The Cycle of Need
05. The Role of Foster and Adoptive Parents in Building Alliances with Parents of Children in Foster Care
06. Erikson's Stages of Development
07. Directions for Small Group Work – Assessing Well-Being Needs of Children and Youth
08. Roadwork Assignment

Meeting 2: Where the MAPP Leads: A Foster Care And Adoption Experience

Agenda

Time	Meeting and Topic
(35 Minutes)	**2-A. INTRODUCTION TO MEETING 2**
	▹ Welcome back
	▹ Meeting 2 agenda
	▹ Reintroduction
	▹ Mutual selection issues
	▹ Bridge from Meeting 1
(60 Minutes)	**2-B. WHERE THE MAPP LEADS: A FOSTER CARE AND ADOPTION EXPERIENCE**
	▹ How a family becomes a client
	▹ Family alliance building
(10 Minutes)	**BREAK**
(60 Minutes)	**2-C. ADOPTION AND FOSTER CARE TODAY**
	▹ The Role of Foster/Adoptive Parents in Assessing the Needs of Children and Youth in Foster Care
	▹ The Impact of Abuse and Neglect on Child Development
	▹ Assessing the Needs of Eight Children and Youth in Foster Care

Agenda continued

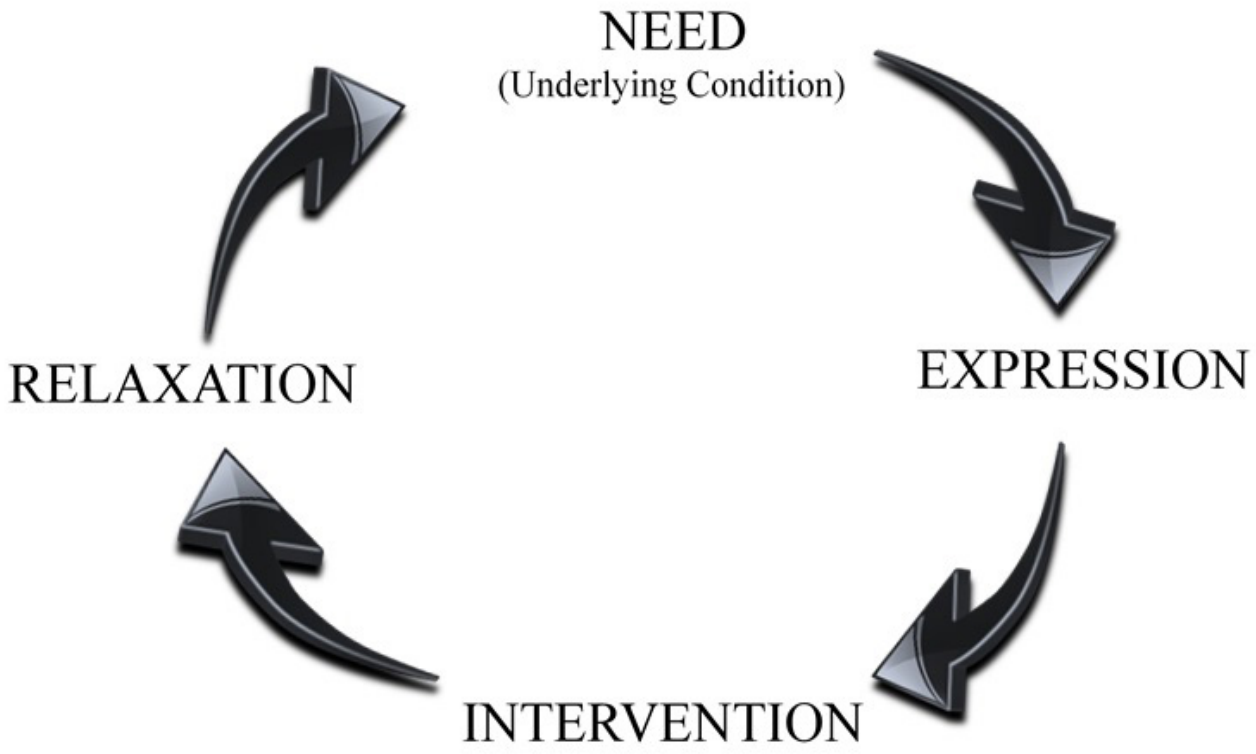
Time	Meeting and Topic
(15 Minutes)	**2-D. MEETING 2 SUMMARY AND PREVIEW OF MEETING 3**

- Summary of Meeting 2
- Strengths/Needs Assessment
- Preview of Meeting 3
- Next step in the mutual selection process
- A Partnerships in Parenting Experience

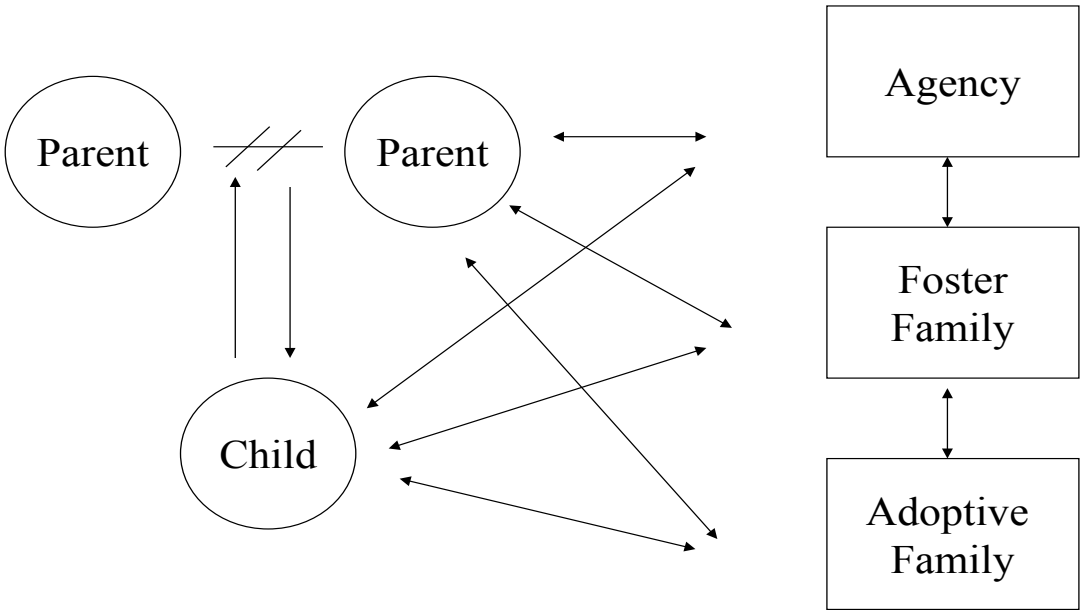
Roadwork

- Complete your Strengths/Needs Worksheet and Feedback to the Leader(s) – have ready to hand in at Meeting 3.
- Review all the handouts from Meeting 2.
- Read about Meeting 3 on Meeting 1, Handout titled, "Description of TIPS-MAPP Group Preparation and Selection Program Meetings and Steps."
- Read about birth parents trauma on the NCTSN resource guide titled "Birth Parents with Trauma Histories in the Child Welfare History."
- Complete the Profile or schedule your Family Consultation.

The Cycle of Need



The Alliance Model of Child Welfare Practice*



The Alliance Model is an idea developed for staff and parents in child welfare to promote partnerships in parenting. This model of practice is even more important today with the passage of legislation such as the Adoption and Safe Families Act, Public Law 105-89, also known as ASFA. ASFA was designed to focus child welfare agencies on the issues of safety, well being and more timely permanence for children. With abbreviated time frames, it is important that parents of children in foster care begin working together quickly, whenever possible.

This diagram is called "The Alliance Model." An alliance in a family refers to two members sharing a common goal or interest that is not detrimental to any other members of the family. The lines and arrows in the diagram represent alliances.

The line between the two parents show that they are united, or have formed an alliance, to care for the child and meet his or her needs so that the child can concentrate on growing up and completing important developmental tasks. The slash marks represent a damaged or broken parental alliance. When the positive alliance of parents is damaged or broken, children respond in a variety of ways. Some children who perceive that their parents are not united in seeking the collective good of the family often try to "fix" the family. They begin parenting the parents, as well as younger siblings. When they do this, they often rise above the normal parental boundary line. Other children respond by creating a decoy for all the battling. They may begin acting in ways that capture the parents' attention. Parents may begin aiming their tensions at the child rather than at each other. In the child's mind, at least the parents are united again. Other children respond to the parents' broken alliance by withdrawing, which likewise, can serve to unite the parents around the child's good.

*Adapted from Thomas D. Morton, "Partnerships in Parenting," Child Welfare Institute

Whatever the response, the energy of the child is directed toward preserving the family, rather than toward the "job" of childhood, which entails growing into a healthy and strong adult. Consequently, at best, the family is at risk of deteriorating in function. At worst, the family is at risk of disintegrating altogether, leaving the child at risk of being without the love and nurturance needed for him or her to grow and develop.

In this circumstance the child must develop two separate alliances in a two-parent home – one with Mom and one with Dad – in order to survive. No longer can he or she rely on the parental alliance. Children faced with this conflict often shield their loyalty to one parent from the other. Alternatively, they may feign dislike for one parent as a way of preserving loyalty to the other. In either case, the child is emotionally at risk and must divert energy toward social survival in the conflicted world of the adults.

Historically, child welfare agencies have primarily emphasized their mission of child protection; therefore, the primary helping alliance has been with the child. The purpose of this alliance is to ensure that the child's needs of nurturance and safety are met. Since the main threat to child safety is generally parental behavior, the alliance seeks to shield the child from risk created by the parents. While the intended benefits of safety are real, both the child and the parents may tend to experience the intervention as reducing emotional and physical safety, rather than increasing it.

With the mission of protecting the child, the agency's natural tendency is to align with the child. The agency seeks to restore the flow of nurturance and limit excessive parental control. Since this intervention is mostly involuntary on the part of the parent, the agency must first establish blame and damage, or risk of damage, before it can legally intervene. These two circumstances generally cause the parents to see the agency as a threat to their attachment to their child.

Agencies often use attachment to extract change in parental behavior. The offered social contract with the parent is, "If you meet the terms of the case plan, you can keep your child in your family." The threatened loss of the child is used by the agency to socially control the parental behavior that is placing the child at risk.

Although services are offered to the parent and are intended to support the parent, the parent may not experience that support as nurturance. To the extent that the parents have been engaged around their needs, especially the needs and goals for the development and safety of their children, the offers may be experienced as nurture. To the extent that the parents are engaged primarily around the agency's needs to ensure child safety, the parents may experience the offer in much the same way as the truant youth who is ordered to attend school, presumably for his own benefit. If the youth were experiencing success at school, the order would probably not be necessary. The order in and of itself, however, will not alter the experience of attending school.

The child also may sense the intervention as a threat to his or her emotional security. To the extent that the agency's alliance with the child creates conflicting loyalty between the parental attachment and the child's relationship to the agency, the child will experience the situation in a similar way as when conflict began between his or her parents.

A problem of a control-centered intervention is that it tends to place the parents in a childlike position. In terms of family systems, this places the parent below the parental boundary and confuses the parent-child relationship. Although control of parental behavior may be necessary to protect a child, ultimately the success of the intervention will require attention to parental needs as well. Since 99 percent of interventions begin with the preservation of the family or the return of the child to the family as a goal, nurturing the child through the parent is an essential condition for the future.

When safety cannot be ensured within the family, a foster family is frequently chosen for a child. Through the preparation and selection process, foster parents are initially aligned with the agency. Since the primary role of foster parents is to meet the child's needs for nurturance and safety, the foster family quickly works to form a positive alliance with the child, although today they also form alliances with biological parents.

More than the agency's alliance with the child, the attachment of the foster family to the child is likely to be perceived by the birth parents as a serious threat to their attachment with the child. The child is presented with a new dilemma. Attaching to the foster family may be an essential condition to getting his or her needs met. However, this attachment may jeopardize his or her attachment to the birth family. Maintaining the birth family attachment may also similarly reduce the motivation of the foster parents to form an attachment with the child, which is an essential component in their motivation to nurture and protect the child. The child may give up on the parental attachment, fail to attach to the foster family or seek to maintain a dual, and somewhat secret system of parallel alliances.

Any of these are costly choices for the child. The best of all possible worlds is that the child can openly seek and maintain all connections necessary to his or her needs. The possibility for this depends on the teamwork of the agency and foster parents and the strength of their partnership with the child's birth parents.

When a child cannot be parented by his or her birth parents or adopted by a foster family, then another family is found to provide the life-long attachment for the child. When this happens, the adoptive family works to form a positive alliance with the child. Since a stronger attachment is often necessary for a lifetime commitment or attachment to be formed, the adoptive parents may view detaching the child from connections with the agency, foster parents and birth family as a necessary act in ensuring the full attention of the child to the attachment with the adoptive family. Unfortunately, the loss of these connections at the psychological level leaves holes in the child's identity and undermines the child's concept of self.

At worst, the child may feel conflict between loyalties to the birth family, foster family and adoptive family. When the parents compete for the child's loyalty, the child is again left with the dilemma of having to manage all the adult alliances, which diverts energy from growth to psychological security.

When a child in a foster or adoptive home perceives that the adults are not allied around his or her welfare, the child will feel threatened. Maintaining a relationship with the birth family is important to the child because identity and self-concept begin with that alliance. The alliance with the agency is important because the agency represents the power to move children at will, or so it seems to

the child. The foster family or adoptive family alliance is important because daily nurturing and care is ensured there. So, when a child perceives that adults are not allied among themselves, the child responds in ways similar to his or her response to parental conflict. The difference is that now there are more alliances to manage or "fix", and even less energy remains for the child to grow and enjoy his or her childhood. That is why we say the adults in a child's life must work together as team members or as partners.

Teamwork – Teamwork involves two or more people working together according to a coordinated plan, in a relationship where team members assume different roles and responsibilities, all designed to reach the same goal. Team members can be relied upon to assume their specific jobs or responsibilities.

Within the Alliance Model, child welfare staff and foster parents work as a team. As with any effective team, players have different roles, responsibilities and tasks, but each team member has the same goal, in this case, to preserve, or rebuild, the family around the long-term welfare of the child. This requires that the team members form a partnership or positive alliance with the birth parents, always seeking to keep parents focused on the welfare of the child.

Partnership – A partnership is a relationship where two or more parties each contribute something of value in order to receive benefits. The nature of the contribution and the distribution of benefits are defined by the social contract between the parties.

Social Contract – A social contract is an agreement entered into by the mutual consent of parties desiring to exchange something of value. When there is coercion, a contract is not valid. When there is no exchange, there is no contract. When there are no contributions, there is no partnership.

Since we define teamwork and partnership a bit differently in the Alliance Model, we usually use the term "team" to describe the staff, foster parents and other professionals working together. Hopefully the birth parents can become team members. However, at the beginning of the relationship, the best we can hope for is to negotiate good working agreements in partnership. Building partnerships builds trust and agreement between people over time.

Within the Alliance Model, the agency's goal is to establish an alliance with parents to protect their children rather than just an alliance with children to protect them from their parents. Overwhelmingly, agency efforts are directed toward the goal of maintaining the birth family as the primary parenting resource for children. Given this fact, agency efforts are judged by the extent to which they strengthen parenting capacities and family attachments. Foster parents can help or hinder these efforts. Therefore, foster families need to know the framework or model the agency uses in its child welfare practice. If a person is primarily interested in becoming a foster parent in order to protect and save children from harmful parents, his or her needs may not be met through the foster care program. The agency recruitment and public education efforts must reflect the philosophy of the agency's model of practice.

Foster parents play vital roles, supplementing and supporting birth families rather than substituting for them. They, too, need explicitly defined social contracts with birth families. Foster parents must

be prepared to care for a child independently while psychologically sharing the child with others. Foster parents make a vital contribution to the partnership when they accept a child's relationships.

The job of public or private child welfare agencies is to preserve, or help rebuild, families at risk of deterioration. The single most powerful relationship upon which to build is the connection between the child and his or her parents.

The Role of Foster and Adoptive Parents in Building Alliances with Parents of Children in Foster Care*

Recognize and Support Parent Strengths

The best place in most cases to begin working with a parent of a child in foster care is to begin looking for each parent's strengths. The parents obviously have needs or their child would not have been placed in care. But we are beginning our work with them counterproductively if we focus our attention too tightly on those needs. When we see only a parent's needs, we are defining the parent in our minds in a negative way. When we have defined the parent in our minds in a negative way, it is difficult for us to be or even seem genuinely engaged in working with him or her. By contrast, when we recognize a parent's strengths, we feel better about working with him or her, and we will have a positive place to begin talking and working with that person.

Use Strengths to Engage Parents

Once you have recognized a parent's strengths, you can use the following questions to create ways to use those strengths to build a partnership with the parents:

- How can I use that strength to begin engaging parents to work with me in partnership?
- What is something I as a team member might want from this parent who has this strength?
- What is something I as a team member might offer to this parent based on this strength?
- What is something this parent might want from me as a team member based on this strength?

Maintain Confidentiality

There are rules and restrictions about confidentiality and what information agency staff can share, even with fellow team members such as foster/adoptive parents. However, parents themselves may share information with foster/adoptive parents. All personal information must be held in confidence, with the understanding that foster/adoptive parents must share information with the agency staff. Parents need to know that agency staff and foster/adoptive parents share information.

Even when policy supports agency staff sharing certain information with foster/adoptive parents, some agencies may interpret policy conservatively. In this case the agency's procedures restrict sharing information; thus, the agency perceives a barrier to sharing such information, though there is in reality no legal or policy barrier. It will be healthy if agencies revisit their procedures around the sharing of information to ensure that they are not being counterproductively restrictive. Foster/adoptive parents should have complete access to information that is relevant. The obvious question arises from what is or is not "relevant." For example, a mother may have had an affair during her marriage when her child was living with her. The child does not know about the affair, but the husband knows about the affair and his anger may cause the marriage to fall apart.

* Adapted from material developed by Thomas D. Morton, Child Welfare Institute.

Should the caseworker tell the foster parents about this? In many cases, the foster/adoptive parents would have no need for the worker to share this information. However, if the parents fight about this issue every time the child comes home, the child could be sufficiently affected that the worker would need to tell the foster/adoptive parents so they would be able to perform their role and responsibilities. The foster/adoptive parents would be responsible for holding the family's information in confidence.

Manage Personal Emotions

It is a natural human response to feel strong emotions when learning of a child's suffering. While the "Alliance Model of Child Welfare Practice" readily recognizes the validity of such emotions, it also takes a practical approach toward attempting to help parents change so they will no longer behave in a way that makes foster/adoptive parents and workers feel anger, disgust or some other negative emotion. Foster/adoptive parents may ask themselves, "How can I be respectful to someone who did those things?" The answer is that a positive, constructive working relationship is the most effective route to help the parent never again do "those things."

Foster/adoptive parents may be judging the parent by the worst thing that parent ever did in his or her life. All of us probably have a worst thing that we did in our lives, and we do not want to be judged by that forever. How would any of us feel if we were judged by the worst thing we ever did? A foster/adoptive parent could be an important part of the process of helping that parent change. Even in the case of adoption, adoptive parents will need to talk with children about what happened in their past and to be able to do it in a way that is not condemning of the parents.

Also foster/adoptive parents may be surprised upon getting to know the parent that they are better able to empathize with the parent. For example, we may care for a boy who was sexually abused by his father. Initially we may think the father must be a monster and wonder how anyone could possibly expect us to treat him with respect. But what if we learn the father as a boy was also sexually abused by his own father? Suddenly we have a glimpse past the "monster" we had previously seen the father to be, and we instead are able to see a human being in pain and confusion. We see that although this father indeed committed a monstrous act, he is not a monster; rather, he went through experiences as a boy that confused him about what is acceptable in how fathers relate to sons. When we realize this, we can begin supporting this person to help him find a way to parent that will take the pain away not only from his son, but also from himself.

A place for foster/adoptive parents to start working with a case worker in such a situation is for them simply to think together about the best starting place in working with such a parent in a constructive way with a goal of reunification. The foster/adoptive parent will eventually need to be in the parent's presence, if only at a planning meeting, so the foster/adoptive parent will need to think of what would contribute to his or her comfort so that the foster/adoptive parent and the parent will be able to contribute to the child's plan.

There are ways for foster/adoptive parents to show respect for parents without having direct contact with the parents. A foster/adoptive parent must realize that as long as the child is in his or her house, the foster/adoptive parent has a relationship with the parent through the child, because the child will be bringing memories of the parent into the foster/adoptive parent's house. The way the foster/adoptive parent talks to the child around these memories and the issues related to these memories is a crucial starting point.

Team members might feel safety risks in working closely with some parents. Team members should not feel that to implement the alliance model of practice they must be prepared to jeopardize their safety. Workers and foster/adoptive parents should follow a standard practice of never being alone with anyone with whom they feel unsafe. Team members may be concerned that some parents in some situations might become angry, out of control or might show up at their house, perhaps intoxicated. When foster/adoptive parents participate in developing a plan with the workers, they can plan for these possibilities. An obvious action in such situations is to call the police. However, plans should also be developed to avoid such crisis measures and to avoid foster/adoptive parents feeling vulnerable. Such plans would involve progressions which ensure safety at each step, starting with in-office contacts, progressing to exchange of visits, then progressing to a neutral setting. If a parent is violent and out of control, the plan would include only in-office visits until this pattern of behavior alters. In such cases, if the foster/adoptive parents want the location of their home kept secret, the case worker should support them in this. A particularly volatile case might never progress beyond in-office visits.

A key dimension of the alliance model centers around how decisions are made in teams. Working in teams, workers will be more positioned to hear foster/adoptive parents' input, rather than workers being positioned so they are more likely to have to rely on "pulling rank" over foster/adoptive parents in making decisions. Sometimes foster/adoptive parents as team members may be wrong, of course, so that a case worker may need to make the final decision. By the same token, case workers can be wrong, and, if a foster/adoptive parent feels strongly about his or her view, the foster/adoptive parent could request that someone else - perhaps the case worker's supervisor - be brought in so that the foster/adoptive parent's concerns could be included on the record. In such a case, it would be best for foster/adoptive parents to be able to cite examples of behavior, rather than their own feelings. For example, a foster/adoptive parent may be concerned about the child's safety when the parents use alcohol or other drugs; this foster/adoptive parent would be behaviorally oriented in describing a mother by saying, "The mother has had alcohol on her breath the last three times I saw her, and she acted intoxicated. No one has done a drug screen to determine if she is using drugs or alcohol."

Share Power and Control

When parents are brought into decision-making, they will be more invested in contributing to a process which they helped to plan. In the partnership/teamwork approach, more information is available. First, case workers and foster/adoptive parents gain more firsthand information from interacting with parents. This added information aids in decision-making. Second, when parents are included in partnership, they gain more first-hand information about the case worker and foster/adoptive parents, which could build trust.

When case workers rely too heavily on their personal power to move a case forward, they may not always be aware of how ineffective their power is in real terms. Power often only lasts as long as the person with the power is there to enforce it. When a case worker or a foster/adoptive parent is in the room with parents, he or she might be very powerful; however, when the parents are away from the case worker or foster/adoptive parent and have the child, they can be very powerful. The alliance model seeks a greater degree of shared influence to influence people's actions and behaviors beyond what happens in a room during a meeting, or in a foster home during a visit. A parent's personal investment in a process often does not come out of response to power; rather,

parents' personal investments derive from their wanting the same goals and their being willing to achieve those goals.

Model Effective Parenting Skills, Mentor and/or Teach Parents

When there is direct contact between foster/adoptive parents and parents, the foster/adoptive parents often serve as mentors or teachers. Minimally, they model effective parenting for the parents whose children are in foster care. Sometimes the process is formalized; sometimes it is informal. Good teachers do four things. First, teachers or mentors share practical information. For example, foster/adoptive parents may be in a position to teach a parent about grieving behaviors, in order to normalize angry and depressed behaviors in children. Second, teachers or mentors provide examples or applications for the information. For example, a foster/adoptive parent trying to teach a parent ways to handle grieving behavior may explain specific ways a child has reacted to loss and specific ways the foster/adoptive parent effectively dealt with the child's behavior. Third, teachers or mentors give the learner an opportunity to practice. In the case of a foster/adoptive parent teaching a parent about dealing with grieving behaviors, perhaps the foster/adoptive parent can facilitate a discussion between the parent and child. Fourth, teachers or mentors provide feedback. Without feedback the learner doesn't know what was done well, or poorly. So, foster/adoptive parents need to tell parents specifically what they did that was effective, as well as offer suggestions.

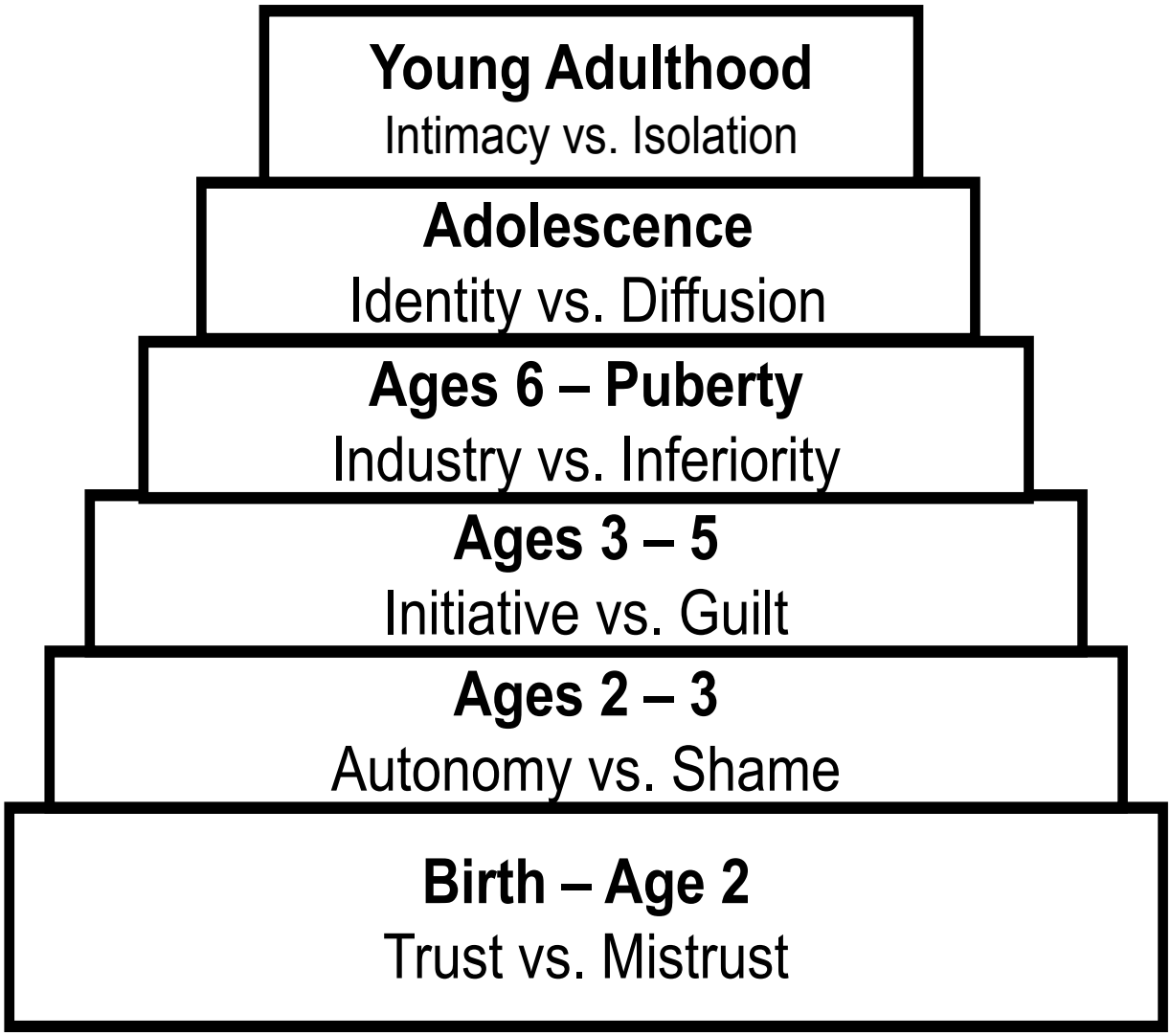
Steps in a Foster Care Case

Do Not Copy! This is a Handout to Be Developed By the Child Welfare Agency Describing Typical Steps in Foster Care Cases.

Include information such as:

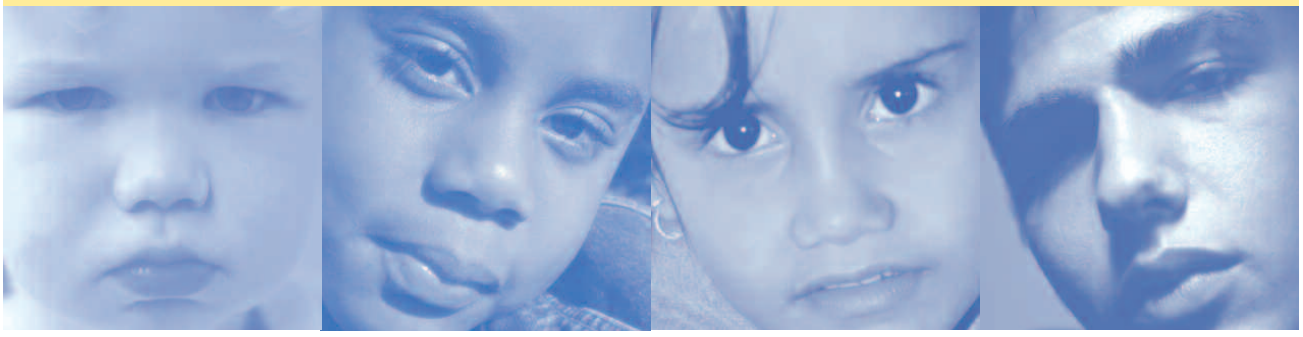
- **The investigation and intake process within the agency and judicial system**
- **The ways foster parents are involved in the assessment process**
- **The ways foster parents are involved in the planning process**
- **The ways foster parents are involved in the review process, both within the agency and within the court**
- **The ways foster parents are involved in outcomes:**
  - **Reunification**
  - **TPR (termination of parental rights)**
  - **Adoption by foster parent**
  - **Adoption by another family**

Erikson's Stages of Development*



* Adapted from Eric Erikson.

Understanding Child Traumatic Stress



NCTSN The National Child Traumatic Stress Network

Understanding Child Traumatic Stress

What Is Child Traumatic Stress?

When a child feels intensely threatened by an event he or she is involved in or witnesses, we call that event a trauma. Child traumatic stress (CTS) is a psychological reaction that some children have to a traumatic experience.

Children who suffer from CTS have developed reactions to trauma that linger and affect their daily lives long after the traumatic event has ended. These children may experience:

> "Children who suffer from child traumatic stress have developed reactions to trauma that linger and affect their daily lives long after the traumatic event has ended."

There are numerous kinds of traumas, such as:

- Automobile accidents
- Serious injuries
- Acts of violence
- Terrorism
- Physical or sexual abuse
- Medical procedures
- The unexpected death of a loved one
- Life-threatening natural disasters

- Intense and ongoing emotional upset
- Depression
- Anxiety
- Behavioral changes
- Difficulties at school
- Problems maintaining relationships
- Difficulty eating and sleeping
- Aches and pains
- Withdrawal
- Substance abuse, dangerous behaviors, or unhealthy sexual activity among older children

Not every child experiences CTS after a trauma. All children are different, and many children are able to adapt to and overcome difficult events and situations. But one out of every four children will experience a traumatic event before the age of sixteen, and some of these children will develop CTS.

If left untreated, CTS can interfere with a child's healthy development and lead to long-term difficulties with school, relationships, jobs, and the ability to participate fully in a healthy life. Fortunately, there are proven and effective treatments for CTS, and it's the mission of the National Child Traumatic Stress Network (NCTSN) to bring awareness of CTS and effective treatments to a wide audience.

How Danger Becomes Trauma

Before understanding what is meant by a traumatic experience or traumatic stress, we must first think about how we recognize and deal with danger. Our minds, our brains, and our bodies are set up to make sure we make danger a priority.

Things that are dangerous change over the course of childhood, adolescence, and adulthood.

- For very young children, swimming pools, electric outlets, poisons, and sharp objects are dangerous.
- For school-age children, walking to school, riding a bike in the street, or climbing to high places present new dangers.
- For adolescents, access to automobiles, guns, drugs, and increased independence, especially at night, are new dimensions to danger.

We live with dangers every day. They can become traumatic when they threaten serious injury or death or when they include physical or sexual violation. The witnessing of violence, serious injury, or grotesque death can be equally traumatic.

"We live with dangers every day. They can become traumatic when they threaten serious injury or death or when they include physical or sexual violation. The witnessing of violence, serious injury, or grotesque death can be equally traumatic."

In traumatic situations, we experience an immediate threat to ourselves or to others, often followed by serious injury or harm. We feel terror, helplessness, or horror because of the extreme seriousness of what is happening and the failure of any way to protect against or reverse the harmful outcome. These powerful, distressing emotions go along with strong, even frightening physical reactions, such as rapid heartbeat, trembling, stomach dropping, and a sense of being in a dream. When our reactions persist, they can become CTS or sometimes the more well-known posttraumatic stress syndrome (PTSD). CTS and PTSD share many features, but PTSD is a formal psychiatric diagnosis that is made when specific criteria about the number, duration, and intensity of symptoms are met. CTS is not a formal diagnosis but describes a range of a child's or adolescent's distressing reactions to trauma.

Responding to Trauma After the Event

For reasons that are basic to survival, traumatic experiences, long after they are over, continue to take priority in the thoughts, emotions, and behavior of children, adolescents, and adults. Fears and other strong emotions, intense physical reactions, and the new way of looking at dangers in the world may recede into the background, but events and reminders may bring them to mind again.

have nightmares. We have strong physical and emotional reactions to stress reminders that are often part of our daily life. We may have a hard time distinguishing new, safer situations from the traumatic situation we already went through. We may overreact to other things that happen, as if the danger were about to happen again.

- Third, our bodies may continue to stay "on alert." We may have trouble sleeping, become irritable or easily angered, startle or jump at noises more than before, have trouble concentrating or paying attention, and have recurring physical symptoms, like headaches or stomachaches.

"For reasons that are basic to survival, traumatic experiences, long after they are over, continue to take priority in the thoughts, emotions, and behavior of children, adolescents, and adults."

There are three core groups of posttraumatic stress reactions.

- First, there are the different ways these types of experiences stay on our minds. We continue to have upsetting images of what happened. We may keep having upsetting thoughts about our experience or the harm that resulted. We can also
- Second, we may try our best to avoid any situation, person, or place that reminds us of what happened, fighting hard to keep the thoughts, feelings, and images from coming back. We may even "forget" some of the worst parts of the experience, while continuing to react to reminders of those moments.

Child Development and Traumatic Stress

"More than twenty years of studies have confirmed that school-age children and adolescents can experience the full range of posttraumatic stress reactions that are seen in adults."

Age, developmental maturity, and experience can influence the way we react to stress after the traumatic experience is over. More than twenty years of studies have confirmed that school-age children and adolescents can experience the full range of posttraumatic stress reactions that are seen in adults. We might wish to believe that children under five years of age are too young to know what was happening during a traumatic event and that whatever impression was left would be forgotten soon. However, recent studies show that traumatic experiences affect the brains, minds, and behavior of even very young children, causing similar reactions to those seen in older children and adults.

Artwork provided courtesy of La Clinica del Pueblo, Inc.

Traumatic Stress and Young Children

Think of what it is like for young children to be in traumatic situations.

- Young children can feel totally helpless and passive.
- Young children can cry for help or desperately wish for someone to intervene.
- Young children can feel deeply threatened by separation from parents or caretakers.
- Young children become particularly upset when they hear cries of distress from a parent or caretaker.
- Young children can be the target of physical and sexual abuse by the very people they rely on for their protection and safety.
- Young children can witness violence within the family or be left helpless after a parent or caretaker is injured, as might occur in a serious automobile accident.

It is extremely difficult for very young children to experience the failure of being protected by adults when something traumatic happens.

"It is extremely difficult for very young children to experience the failure of being protected by adults when something traumatic happens."

Young children rely on a protective shield provided by adults and older siblings who can judge the seriousness of danger and ensure their safety and welfare.

- Young children often don't recognize a traumatic danger until it happens —for example, in a near drowning, an attack by a dog, or an accidental scalding.
- Young children may become passive and quiet, easily alarmed, and less secure about being provided with protection.
- Their minds may stay on a central action, like being hit or seeing someone fall to the floor.
- Young children may have simple thoughts about protection, for example, "Daddy hit mommy, mommy call police."
- Young children can become more generally fearful, especially in regard to separations and new situations.
- In circumstances of abuse by a parent or caretaker, the young child may act confused as to where to find protection and where there is threat.
- A child may respond to very general reminders of a trauma, like the color red or the sounds of another child crying.

The effects of fear can quickly get in the way of recent learning. For example, a child may start wetting the bed again or go back to baby-talk. Because a child's brain does not yet have the ability to quiet down fears, the preschool child may have very strong startle reactions, night terrors, and aggressive outbursts.

Traumatic Stress and School-age Children

School-age children start to face additional dangers, with more ability to judge the seriousness of a threat and to think about protective actions.

- School-age children usually do not see themselves as able to counter a serious danger directly, but they imagine actions they wish they could take, like those of their comic strip heroes.
- In traumatic situations when there is violence against family members, they can feel like failures for not having done something helpful.
- School-age children may also feel very ashamed or guilty.

They may be without their parents when something traumatic happens, either on their own or with friends at school or in the neighborhood. Sexual molestation occurs at the highest rate among this age group.

The reactions of school-age children after a trauma include a wide range of intrusive images and thoughts.

School-age children think about lots of frightening moments during their traumatic experiences. They also go over what could have stopped them from happening and what could have made them turn out differently.

- More than any other group, school-age children may go back and forth between shy or withdrawn behavior and unusually aggressive behavior.
- School-age children can have thoughts of revenge that they cannot resolve.

"The reactions of school-age children after a trauma include a wide range of intrusive images and thoughts."

School-age children respond to very concrete reminders about the trauma, such as:

- Someone with the same hairstyle as an abuser
- The monkey bars on a playground where a child got shot
- A feeling of being alone inside like they had when one parent attacked the other

They are likely to develop intense specific new fears that link back to the original danger. They can easily have fears of recurrence that result in their avoiding even enjoyable things they would like to do.

- Normal sleep patterns can be easily disturbed. They can move around restlessly in their sleep, vocalize, and wake up tired.
- Their lack of restful sleep can interfere with their daytime concentration and attention.
- It can then be more difficult for them to study because they remain on alert for things happening around them.

"During traumatic situations, adolescents make decisions about whether and how to intervene, and about using violence to counter violence."

Traumatic Stress and Adolescents

With the help of their friends, adolescents begin a shift toward more actively judging and addressing dangers on their own. This is a developing skill, and lots of things can go wrong along the way. With independence, adolescents can be in more situations that can turn from danger to trauma. They could:

- Be drivers or passengers in car accidents
- Be victims of rape, dating violence, and criminal assault
- Be present during school or community violence
- Experience the loss of friends under traumatic circumstances

During traumatic situations, adolescents make decisions about whether and how to intervene, and about using violence to counter violence.

They can feel guilty, sometimes thinking their actions made matters worse. Adolescents are learning to handle intense physical and emotional reactions in order to take action in the face of danger. They are also learning more about human motivation and intent and struggle over issues of irresponsibility, malevolence, and human accountability.

Adolescents are particularly challenged by reactions that persist after traumatic experiences.

- Adolescents can easily interpret many of these reactions as being regressive or childlike.
- Adolescents may interpret their reactions as signs of "going crazy," of being weak, or of being different from everyone else.
- Adolescents may be embarrassed by bouts of fear and exaggerated physiological responses.
- Adolescents may harbor the belief that they are unique in their pain and suffering.

These reactions may result in a sense of personal isolation. In their posttrauma thoughts, adolescents think about behavior and choices that go back to well before a traumatic situation. They are also very sensitive to the failure of family, school, or community to protect them or carry out justice. Afterward they may turn even more to peers to judge risks and to take protective action. They may be especially "grossed out" or fascinated by grotesque injury or death and remain very focused on their own scars that serve as daily trauma reminders.

While younger children may use play, adolescents may respond to their experience through dangerous reenactment behavior, that is, by reacting with too much "protective" aggression for a situation at hand. Their behavior in response to reminders can go to either of two extremes: reckless behavior that endangers themselves and others, or extreme avoidant behavior that can derail their adolescent years.

The avoidant life of an adolescent may go unnoticed.

- Adolescents try to get rid of post-trauma emotions and physical responses through the use of alcohol and drugs.
- Their sleep disturbance can remain hidden in late night studying, television watching, and partying.
- It is a dangerous mix when adolescent thoughts of revenge are added to their usual feelings of invulnerability.

Recovering from Traumatic Stress

How children or adolescents recover from trauma depends a lot on the different ways that their lives are changed by what happened.

Cognitive-behavioral therapies have been proven effective in helping children with CTS. These therapies generally include the following features:

"Foregoing help can have long-lasting consequences, and fortunately, entering treatment can have concrete beneficial results."

There may be a dramatic change because of the loss of a family member or friend during the traumatic situation. Dealing with both posttraumatic and grief reactions can make recovery much more difficult. If a child you know has experienced any of the symptoms or signs of ongoing difficulties following a traumatic experience, it's important to seek help for them. Foregoing help can have long-lasting consequences, and fortunately, entering treatment can have concrete beneficial results.

- Teaching children stress management and relaxation skills
- Creating a coherent narrative or story of what happened
- Correcting untrue or distorted ideas about what happened and why
- Changing unhealthy and wrong views that have resulted from the trauma
- Involving parents in creating optimal recovery environments

The National Child Traumatic Stress Network

The National Child Traumatic Stress Network (NCTSN) is working to advance effective interventions and services to address the impact of traumatic stress. Our nation is in a position to take advantage of the full range of scientific knowledge, clinical wisdom, and service sector expertise to preserve and restore the future of traumatized children across the United States.

Comprising over 50 centers from across the United States, the NCTSN integrates the strengths of academic institutions that are dedicated to developing research-supported interventions and training people to deliver them, and community-based treatment and service centers that are highly experienced in providing care to children and families.

As an outgrowth of bipartisan federal legislation, the Donald J. Cohen National Child Traumatic Stress Initiative was funded in October 2001. Under the leadership of the U.S. Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Center for Mental Health Services (CMHS), this Initiative has represented a unique opportunity to contribute to our national agenda to transform our mental health systems of care.

The NCTSN has developed a comprehensive website that provides a range of resources for professionals and the public about child traumatic stress, including informational guides, statistics, breaking information in the field, and access to the latest research and resources. For more information about child traumatic stress and the NCTSN, visit **www.NCTSN.org** or e-mail the National Resource Center at **info@NCTSN.org**.

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11150 West Olympic Boulevard
Suite 650
Los Angeles, CA 90064
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National Center for Child Traumatic Stress—Duke University
905 West Main Street
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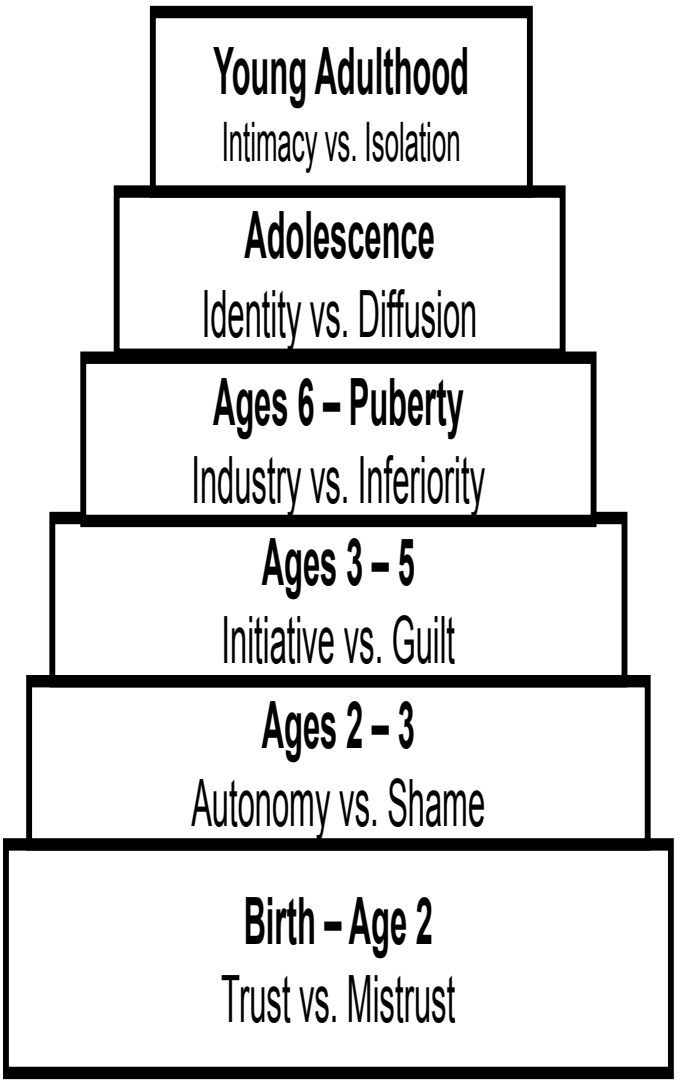
Images are used for illustration only.

Lily's Stages of Development



Lily's Behaviors and Possible Corresponding Stage of Development

Components of Well-being of Children and Youth in Foster Care

Here are several questions to help foster parents assess the components of well-being of children in foster care:

- ✧ Is this child or youth **physically healthy**? If not, does this child have the medical attention required to restore or optimize health, given the condition?
- ✧ Is this child or youth **emotionally healthy**? Does this child experience being lovable, capable and worthwhile?
- ✧ Is this child or youth **socially healthy**? Does this child interact in work and play activities at a level appropriate for age and abilities?
- ✧ Is this child or youth **intellectually** on target? If not, does this child have the educational resources required to optimize intellectual growth?
- ✧ Is this child or youth **morally/spiritually healthy**? Does this child have a sense of right and wrong and an ability to understand the feelings of others? Does this child have hope in the future? Does this child have a belief in a positive power greater than himself or herself?
- ✧ Does this child or youth have healthy **attachments**, including **cultural and family connections**?
- ✧ Is this child or youth **grieving loss** in a healthy way through expressions of anger, sadness, fear and sorrow?
- ✧ Is this child or youth able to **manage his or her own behavior** in an age-appropriate way?

Assessing the Well-Being Needs of Children and Youth in Foster Care – Worksheet

Reason for Placement/Stage of Development	**Case Example**	**List ways this child is developmentally different from other children his/her age.**	**List child's specific needs related to well-being.**
Neglect/ Infants and Toddlers (Infant prenatally exposed to drugs and/or alcohol)	**Joey** is in care because of neglect. He is one year of age. His mother is 17 and was also neglected. She cannot provide food, clothing, shelter, medical care and supervision for Joey. Joey tested positive for meth when he was born. His mother used meth throughout the pregnancy. His mother took off with her boyfriend when Joey was 9 months old. Joey's mother returned two weeks ago. Joey is not interested in anything or anyone; looks sad; is just learning to stand; sometimes has respiratory (breathing) problems; cries a lot and is not easily comforted by being held or fed.		
Physical Abuse/ School Age (Child from a family where there is domestic violence)	**Jenny** is in care because of physical abuse. She is six years old. Jenny had a broken leg, multiple bruises and burns when she came into foster care. Her mother's boyfriend is accused of the abuse. Her mother is overwhelmed and frustrated and says she cannot handle Jenny by herself. She says she loves Jenny. Jenny's mother is living with her boyfriend who threatens and sometimes hits her too. Jenny disobeys deliberately; doesn't want to be touched; is afraid of stairs, bathtubs and strangers, and she screams whenever she sees someone with a cigarette. Jenny is attending school at grade level and is good at taking care of herself.		

Reason for Placement/ Stage of Development	**Case Example**	**List ways this child is developmentally different from other children his/her age.**	**List child's specific needs related to well-being.**
Neglect/ School Age (Prenatal and perinatal exposure to the HIV virus)	**Beau** is 8 and is diabetic. He entered foster care 18 months ago because of neglect. He was exposed to the HIV virus in his mother's womb, but he did not become infected because his mother received treatment immediately before he was born. Beau is angry that his mother has diabetes, as well as AIDS, and is not expected to live long. She is receiving services from a local hospice. Beau is on daily insulin shots and has had periodic hospitalizations. His must eat a restricted diet. He is in the third grade and goes to public school. Beau doesn't like the insulin shots he must give himself or testing his blood sugar levels. Beau is close to his grandmother and uncle, who have poor relationships with Beau's mother. Beau has three close friends and has dreams of flying an airplane some day. He likes learning but does not like the way most of the other kids treat him when he has to eat snacks or receives other attention because of his diabetes at school. Beau cries before going to his medical appointments. Sometimes Beau yells at his best friends and says he doesn't want to be friends anymore.		
Emotional Maltreatment and Lack of Supervision/ School Age	**Anton** is 11 years old. He is in care because of emotional maltreatment and lack of supervision. His mother is an alcoholic and cannot provide for Anton, and his father is in jail. Both parents say they love Anton. Anton has little self-confidence; his most common expressions are "I don't know" and "I can't;" he clings to his foster mother; he is of average intelligence but can't read and is repeating the fifth grade; looks and acts more like an eight-year-old; wets the bed almost every night and acts depressed and sad. Anton gets along well with younger children.		

Reason for Placement/ Stage of Development	**Case Example**	**List ways this child is developmentally different from other children his/her age.**	**List child's specific needs related to well-being.**
Neglect and Sexual Abuse/ School Age (Child in transracial placement)	**Jeryce** is an 11 year-old girl who came into care a month ago as a result of neglect and sexual abuse. Jeryce's father and mother are separated, but continue to spend time together, especially to use drugs. Jeryce has been mostly on her own throughout her childhood because her parents are usually high on drugs. Several older adolescents in the neighborhood who do drugs with her parents have sexually abused Jeryce. Jeryce's grades have slipped dramatically during the past two years. She has begun skipping school since she came into foster care. Jeryce is African American and identifies with the Omaha Tribe but is not eligible for enrollment. She is living with a white foster family in a working class, white neighborhood. Some of the neighborhood kids have yelled racial slurs to her. She has mentioned this incident to her foster mother but has expressed no emotions about it..		
Neglect and Medical Neglect/ Adolescent (Child with medical needs)	**Karen** is 16 and has been in foster care several times during her life due to neglect and medical neglect. Her mother has recurrent problems with drugs and alcohol. Her father died from complications as a result of alcoholism. Karen has been in this foster home for three months; this is the second time she has lived here. Karen has Fetal Alcohol Syndrome. She also has a heart murmur. She is about three years behind her grade level in school and has been diagnosed with dyslexia, a reading disorder. Karen has two friends from her foster parents' church, who are two years younger than she is. Karen has a big smile when she is happy and she loves to dress up. Most of the time Karen is very quiet and wants to stay in her room by herself. She looks forward to Sundays when her mother eats dinner with the foster family.		

Reason for Placement/ Stage of Development	**Case Example**	**List ways this child is developmentally different from other children his/ her age.**	**List child's specific needs related to well-being.**
Physical Abuse/ Adolescent (Youth who is gay)	**Jason** is 15. His father, who physically abused him, is now in prison for drug-related charges. Jason hasn't seen his mother since he was a toddler. Jason has been in foster care for a year and recently disclosed to his foster mother that he is gay or two-spirited, as he prefers. He says that he has known that he is gay for as long as he can remember. He says he is not sexually active and that no one else knows he is gay. Jason gets along well with his classmates, but he has no close friends. Jason does well in school and is affectionate in the family. He becomes very sad at times, but is able to talk about his feelings, especially about his father and mother.		
Child in Need of Supervision and Neglect/ Adolescent (Adolescent parent)	**Alana** is 15 and the mother of Matthew, 6 months. Her father and her grandmother have raised Alana and her two sisters since she was a toddler. Alana's mother disappeared when Alana was four years old. When Alana became pregnant, her grandmother talked her father into placing Alana in foster care. That was a little over a year ago. Neither of the adults felt like they could control Alana's behavior. Todd, the father of Alana's baby, is also 15 and wants to be involved with Matthew. Alana and Todd want to marry when they are legally old enough to do so. Both of them are attending school. Alana's father and grandmother do not want Alana to spend any time with Todd. Alana is searching for her mother who struggles with drug use and is known to be a victim of sex trafficking. Alana is very attentive to Matthew's needs and is helpful in the foster home. She becomes very sad, and sometimes angry, after visits with her father. Her grandmother refuses to see her or allow her to see her two younger sisters. She can talk about her anger toward her grandmother.		

Child Welfare's Next Challenge: Parenting Meth's Young Victims

by Diane Riggs

How seriously is methamphetamine (meth) use affecting child welfare? The answer varies by state and region, but Congress, when it reauthorized the Safe and Stable Families Program in September, agreed to spend $40 million on the problem in fiscal year 2007. That's how much states—through $500,000 to $1 million grants—will have to address child welfare problems caused by addiction to meth and other drugs.

Once viewed as a crisis for only western states, meth use has been steadily tracking east in the past decade. Addiction and attendant family problems are now firmly anchored in the Midwest and further south, and in many states, foster care entries are rising as a result. In turn, more foster parents and other caregivers are parenting children who have been exposed to meth in utero or in their environment. The task can be overwhelming at times, but when parents know what to expect, have chances to learn more about their children, and receive adequate support, child outcomes can vastly improve.

The Scope of the Problem

"Meth has emerged as nothing short of a weapon of mass destruction," declared Marion County Oregon's district attorney in May. Home to the state's capitol city, the county used to see fewer than 40 children entering care each month, but it now takes in at least 100 children per month.

In Missouri, about 12 percent of children in state care were removed from homes where meth was being made, sold, or used in 2005. In Montana, where drug abuse plays into 66 percent of foster care placements, meth is the drug more than half the time. Released by the Department of Public Health and Human Services, statistics indicate that meth poses nearly as big a child welfare problem as alcohol.

Parenting Meth-Exposed Babies

As meth awareness grows, more hospitals are testing moms and babies for the drug. Positive tests or other signs of use give child protection workers the authority to place babies in foster care or with relatives.

Infants who are exposed to meth in utero have an elevated risk of being born prematurely and developing serious medical and neurological issues—including brain and spinal cord damage, heart defects, skeletal abnormalities, and improper intestinal development. Even full-term newborns tend to weigh less and have smaller heads than their peers.

In April, Dr. Rizwan Shah—a pediatrician who has been studying meth-exposed children since 1993—released findings from a study that showed:

- nearly 20 percent of meth-exposed infants fell below the 10th percentile for weight;

- more than one-third experienced feeding problems, often due to a poor suck or swallow reflex;
- 25 percent of pregnant meth users studied delivered babies pre-term; and
- breathing problems, including sleep apnea, as well as over- or under-sensitivity to stimulation were common.

Before welcoming a newborn home, caregivers should learn if he was exposed to alcohol or drugs besides meth. They should also learn infant CPR and be trained on equipment—like an apnea or heart monitor or feeding tube—that comes home with the baby. Once home, caregivers should closely watch for any signs of distress that might signal a breathing problem. Some other ideas:

- Monitor the baby's sensitivity to different stimuli. If he complains when a bright light is turned on, keep lighting softer. If he kicks off his blanket, bed him down in a one-piece sleeper.
- If hypersensitivity to light or sound keeps the baby from sleeping, keep her sleeping environment dark and quiet.
- If the baby is constantly fussy, consider "wearing" the baby in a soft carrier. Because babies are sensitive to caregivers' emotions, close proximity to a consciously tranquil and caring parent can ease distress and promote bonding.
- By the same token, avoid passing meth-exposed babies around to strangers. Seeing new face after new face can be over-stimulating and disconcerting.
- Introduce changes (noise, light, smells, environment, people) gradually.
- Consult with the baby's pediatrician before giving any medication, particularly any drug with ephedrine or pseudoephedrine, a component of meth.

One pound, 14 ounces at birth, Madilyn was born with fluid on her brain, cerebral palsy, a potentially blinding eye disorder, and chronic evolving lung disease. Doctors never expected her to walk, talk, eat independently, or take in stimulus. But her adoptive parents, Alissa and Sean, were firmly committed to Madilyn and even worked to bond with her during hospitalizations. Alissa tells parents:

- Impress upon hospital staff that families are part of the treatment team.
- Insist on being present during medical procedures. Your child needs to know you will not abandon her during these stressful times.
- To avoid further trauma, teach medical staff to avoid forcibly holding the child down or poking her with needles any more than is absolutely necessary.

Yasmin* weighed one pound, 13 ounces when her mother, Angelica, gave birth at 26 weeks. She struggled with chronic lung disease, as well as a partially detached retina, defective heart value, paralyzed vocal chord, and severely weakened immune system. Yasmin spent nearly three months on life support, and had a feeding tube for more than two years. She was also hospitalized 14 times before age two.

Angelica reports that the hardest thing was dealing with the medical problems, machines, and therapy techniques. She also struggled with often paralyzing guilt for having caused her daughter's problems. A recovering meth addict, Angelica got the best support—useful caregiving tips and emotional assistance—from caring social workers and Yasmin's former foster parent. To other parents, she says:

- Learn all you can about how drug exposure affects infants.
- Focus on the day-to-day tasks of helping the child so you don't get overwhelmed by ongoing problems.
- Join a parent support group with experienced infant caregivers.
- Don't try to do it on your own; invite service providers into your home.
- Find a mentor who has first-hand experience dealing with premature infants.

Parenting Meth-Exposed Children

Based on her research, Dr. Shah says 6 to 18 months of age is a relatively symptom free time for meth-exposed babies. While this is less true for medically fragile babies like Alissa's and Angelica's, early breathing and excessive fussing problems can dissipate as the meth-exposed child approaches his second birthday.

As the toddler matures, however, parents may notice continuing problems with sensory integration dysfunction (a child's inability to process sensory input correctly), and more trouble with paying attention, controlling anger, and having aggressive outbursts. Once the child enters a more structured school setting, learning difficulties may become evident.

Overall, behaviors are consistent with those exhibited by many foster children, so caregivers must be ready to advocate for the child at school and seek other services that can help each child, given his specific challenges, to manage life more effectively. For example:

- If a child has a sensory integration dysfunction, track his behavior and note what may have provoked the behavior. If a child rejects certain clothing, fabric, or food textures, he may be hypersensitive to touch. An aversion to loud noises would signal auditory hypersensitivity, and conversely, under-sensitivity to body movement could provoke a child to strive for perpetual motion.
- When you find out what causes certain behaviors, try to avoid the triggers and teach others to do the same. The child might also benefit from a sensory integration evaluation and occupational therapy. When treated at a young age, some children can gain better control over their sensory perceptions.
- Because attention deficit hyperactivity disorder-like symptoms can stem from sensory integration problems, check that possibility before seeking behavioral therapy or medicine. If ADHD is diagnosed, practice positive reinforcement, seek classroom accommodations, and consider programs where the child can have more individual attention.

- If speech delays are causing temper tantrums, introduce sign language.
- Learn to decipher messages behind behaviors. Children who prolong the bedtime ritual, for example, may unknowingly fear abandonment. When you know why your child is acting out, it is much easier to be objective and keep situations from escalating.
- Bring the whole family to therapy. Your child's issues must be addressed within the context of living with you.
- Consider options for schooling. Alissa, whose two youngest children were exposed to meth in utero, is home schooling them. She knows that the children, who are prone to infections and have trouble focusing, are much less likely to catch colds at home, will be spared damaging labels like bad or stupid, and will not pick up undesirable behaviors from other kids at school.

Environmental Meth Exposure

Legislation controlling the sale of cold medicines with a meth-making ingredient has diminished the appeal of home meth-labs. Drug use, however, fueled by meth superlabs in Mexico, continues to rise. Unfortunately, children who live with meth-addicted parents, in addition to possible in-utero drug exposure, may be subject to drug fumes; the violent, paranoid, and libidinous highs of meth users; and neglect in the wake of each crash.

Whether they are in a dead sleep or planning their next high, meth-addicted mothers and fathers are disinclined to take care of themselves, much less their children. Dr. Richard Delaney, a psychologist with expertise in child abuse and neglect, says many children whose parents use meth are essentially like orphans. Though they live with a parent, the parent is largely unavailable.

To survive, these children learn to meet their needs without depending on an adult. Adults in their life are not nurturing or trustworthy, and that view will not change overnight when they find themselves in a new family. In fact, depending on how old the child is and how long he has been fending for himself, bonding with a new parent may not be anything he even understands or seeks.

Services for these children, as for other children in or adopted from foster care, must be provided according to each child's needs. And, as Dr. Delaney asserts in Fostering Changes, "the most impacting, radical therapeutic relationship for troubled foster and adoptive children is the foster or adoptive family itself."

The Bottom Line

As states confront the rising tide of children coming from meth-addicted parents, they must offer caregivers—foster/adoptive/birth parents, and relatives—appropriate training and support. A parent who knows his child's history and prognosis, and has resources to meet her unique needs, can considerably improve outcomes for the child and the family.

Finally, despite troubles that can plague children exposed to meth, there is hope. According to Dr. Shah's early research, some children who are exposed to meth in utero catch up with their peers by grade school, especially if their birth mothers stopped using before the final trimester. In addition,

while premature babies may never fully outgrow some of their health issues, Alissa and Angelica are happy to report that their girls, one seven, one six, are living a much more normal life than anyone ever dreamed they would.

* Names in this story are changed to protect the family's privacy.

Reprinted from Adoptalk, the newsletter of the North American Council on Adoptable Children (NACAC). Learn more at www.nacac.org.

Important Information about Parenting Children Who Have Been Diagnosed with Diabetes Glossary*

A1C A blood test that measures average blood glucose over the past 2 to 3 months and is the best way to measure overall glucose control. It should be measured 2 to 4 times a year and the goal is less than 7%.

Blood Glucose A type of sugar that is created when the carbohydrate that one eats is broken down in the body. During digestion, glucose passes through the wall of the intestine into the bloodstream to the liver and eventually into the general circulation. From there glucose can then enter individual cells or tissues throughout the body to be used for fuel and provide energy.

Carbohydrate The main source of fuel for the body. Carbohydrate includes starches and sugars and are found in bread, pasta, fruits, vegetables, milk, and sweets. Carbs are broken down into a sugar called glucose.

Carbohydrate Counting A meal planning method commonly used by people with diabetes to plan their food and meal choices. Carbohydrate counting helps one achieve a balance between the amount of carbohydrate foods eaten and the available insulin.

Glycemic Index A system of ranking foods containing equal amounts of carbohydrate according to how much they raise blood glucose levels. For instance, the carbohydrate in a slice of 100% stone-ground whole wheat bread (a low glycemic index food) may have less impact on blood glucose than a slice of processed white bread (a high glycemic index food). The GI is an additional meal-planning tool to help one understand how carbohydrate foods can differ in their effects on blood glucose.

Insulin A hormone made in the pancreas that helps glucose pass into the cells where it is used to create energy for the body.

Keytones Acids produced due to lack of enough insulin to use the glucose in your bloodstream. Your body turns to its fat stores for energy. When this occurs, ketones are produced, which accumulate in the blood and spill into the urine. These ketones are made when fat is metabolized as a source of energy. The excessive formation of ketones in the blood is called ketosis, and the presence of ketones in the urine is called ketonuria.Allowed to go untreated, the combination of high blood glucose and ketones can lead to ketoacidosis (also called DKA).

*http://www.joslin.org/info/diabetes-glossary.html

Lancet A small needle used to get a drop of blood from your finger, arm, or other site. The blood is placed on a special strip, which is put into the meter. The meter "reads" the strip and gives a blood glucose reading.

Neuropathy Damage to the nerves. It is a condition that can be very debilitating and painful. There are two main types of neuropathy, depending on which nerve cells are damaged. One type is called sensory neuropathy, which affects feelings in the legs or hands and is referred to as peripheral neuropathy. The other type is autonomic neuropathy, which affects nerves that control various organs, such as the stomach or urinary tract**.**

Pancreas A small gland located below and just behind the stomach that makes a specific kind of hormone called insulin.

What Your Child Needs to Know About Their Diabetes

First, they need to know that it is not their fault that they have diabetes—nothing they could have done would have prevented it. They need to know that with help from you their healthcare providers, they can manage their diabetes and live healthy, active lives. Treatment depends on your child's age and maturity. Some children can learn to measure and inject their own insulin by early adolescence. But it is recommended that parents and caregivers share responsibility with their children for insulin injections until puberty is over, usually by mid-adolescence.

Every child is different in his or her capacity to cope with the demands of diabetes, but all children need and deserve their parents' help and support well into the teenage years. Before you give your child the responsibility for measuring and injecting insulin, remember that this is a serious and complex matter. Your child needs to be mature enough to handle the job, and generally, children are not capable of having sole responsibility for insulin injections until they are older adolescents.

How about checking their blood glucose? Children need to understand the rationale for regular checking, whether or not they can do these checks themselves. Most important, they need to learn the symptoms of a "low blood glucose reaction" (also called an insulin reaction) and how to take appropriate action. Later, as they begin to appreciate the overall goals of diabetes treatment, they will want to accept a greater role in their care. In fact, children quickly learn that maintaining good health is the ticket to joining their friends in every day activities.

http://www.joslin.org/info/if_your_child_has_type_1_diabetes_what_he_or_she_needs_to_know.html

Important Information about Parenting Children with Fetal Alcohol Syndrome or Fetal Alcohol Effect (FAS/FAE)[1]

FAE Fetal Alcohol Effects. As a result of prenatal alcohol exposure, the child may have abnormalities, but milder ones than those associated with FAS. Appearance and size of child are generally normal, but child may develop problems with learning and attention.

FAS Fetal Alcohol Syndrome. As a result of prenatal alcohol exposure, the child is small in size, has characteristic facial features (e.g., flat mid-face, thin upper lip) and developmental delays and mental retardation.

Medically Fragile An infant or child with special medical needs which place the child at risk of additional illnesses or death.

SIDS Sudden Infant Death Syndrome. A dysfunction of the neurocardiorespiratory mechanism that causes unexpected death in infants between the ages of two weeks to one year. In the United States, 1½ per 1,000 live births will be affected by SIDS. Thirty percent of all infant deaths are attributed to SIDS. Most deaths are seen between the second and fourth month after birth. Cold climates, poor prenatal care, premature birth, low birth weight and mothers addicted to drugs and/ or alcohol put infants at risk of SIDS.

FAS/FAE and Native Alaskan/American Indian (NA/AI) People:

According to the National Institutes of Health, the available literature points to a prevalence rate of FAS and other alcohol related birth defects to be at least 10 per 1,000, or 1 percent of all births. The NIH states, "this rate is too high for any population to accept." In its report on the prevalence of FAS, NIH found that the syndrome is significantly higher in the Native Alaskan/ American Indian (NA/AI) population, especially those living on reservations[2].

[1]From Craig-Oldsen, H. (1998). GPS Drug/HIV Leader's Guide. Atlanta, GA: Child Welfare Institute.

[2]May, P. and Gossage, J.P. Estimating the Prevalence of Fetal Alcohol Syndrome: A Summary. National Institutes of Health. Retrieved May, 2014, http://pubs.niaaa.nih.gov/publications/arh25-3/159-167.htm

Important Definitions for Foster Parents of Children Who Learn and Grow Differently*

Developmental Delay	A delay or gap in normal child development which can affect learning, social skills and physical abilities.
Drug Exposed	Refers to infant whose mother used drugs and/or alcohol during her pregnancy.
Failure to Thrive	When a child has had inadequate nutritional intake in the first two years of life.
IEP	Individual Education Plan
Medically Fragile	An infant or child with special medical needs which places the child at risk of additional illnesses or death.
Intellectual Disability	A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18. (American Association of Intellectual and Developmental Disabilities. http://www.aaidd.org/content_100.cfm)

*From Craig-Oldsen, H. (1998). GPS Drug/HIV Leader's Guide. Atlanta, GA: Child Welfare Institute.

Important Information for Foster Parents about Parenting Youth Who Are Gay, Lesbian, Bisexual or Transgender

Definitions:

Bisexual Having a sexual attraction to and/or engaging in sexual behavior with either sex.

Coming Out A process of becoming aware of one's sexual orientation and talking with others about it.

Gay A word for a homosexual orientation, often used by men and women to identify themselves as homosexual.

Heterosexism A belief that heterosexuality is the only acceptable sexual norm.

Homophobia Fear of and intolerance of homosexuality and bisexuality.

Homosexuality Sexual attraction to someone of the same sex.

In the Closet A term that refers to keeping one's sexual orientation a secret.

Lesbian A woman who is sexually attracted to women.

Transgender An umbrella term to describe people who act and think in a manner not socially approved for the gender assigned to them at birth.

Sexual Orientation During Adolescence[1]

- In a large-scale study of Minnesota junior and senior high school students, 88.2 percent described themselves as predominately heterosexual, 1.1 percent said they were either bisexual or predominately homosexual, and 10.7 percent were unsure of their sexual orientation.[2]
- Uncertainty about sexual orientation declined with age, from 25.9 percent of 12-year-old students to 5 percent of 17-year-old students.[3]
- 20 percent of self-identified gay and bisexual men surveyed on college campuses knew they were gay or bisexual in junior high school and 17 percent said they knew in grade school.[4]
- 6 percent of self-identified gay or bisexual women surveyed on college campuses knew that they were gay or bisexual in junior high school, while 11 percent knew in grade school.[5]

[1]Adapted from www.siecus.org/pubs/fact.
[2]Remafedi, G. et al. (April 1992). Demography of sexual orientation in adolescents. Pediatrics, 89, 4, p 174 .
[3]Ibid.
[4]Elliott, L. & Brantley, C. (1997). Sex on campus: The naked truth about the real sex lives of college students. New York: Random House.
[5] Ibid.

Strengths/Needs Worksheet - After Meetings 1 and 2

In the left column are the 12 Criteria for Mutual Selection of foster and adoptive families. These are provided to remind you of the twelve basic things you need to be able to do by the end of the TIPS-MAPP program. Mutual means that you and the agency will assess your willingness and ability to be successful foster and/or adoptive families. In the strengths and needs columns please write **at least three** strengths and needs you have already identified. As a reminder for you, pages 2-5 of this worksheet list the abilities developed in the learning activities so far in the program. Review them as you think about your strengths and needs.

Criteria for Mutual Selection	**Family strengths which will help us accomplish this ability**	**Family needs to be met in order to grow in our ability to do the task.**
1. Know your own family.		
2. Communicate effectively.		
3. Know the children.		
4. Build strengths; meet needs.		
5. Work in partnership.		
6. Be loss and attachment experts.		
7. Teach healthy behaviors.		
8. Build connections.		
9. Build self-esteem.		
10. Assure health and safety.		
11. Assess impact.		
12. Make an informed decision.		

Abilities Developed During Meetings 1 and 2

Following are the abilities developed or enhanced during Meetings 1 and 2 of the TIPS-MAPP program:

TIPS-MAPP Meeting 1 Abilities

By participating in this meeting, prospective foster parents and adoptive parents should be able to:

- Share something personal (within the group only) about two other participants in the group.
- Explain why ten weeks are needed to complete the group preparation and selection meetings.
- Explain what is expected of them in the mutual selection/preparation process (for example, roadwork, attending meetings, family discussions, etc.).
- Describe their role in the mutual selection process.
- Define the purpose of foster care and adoption.
- Explain the goal of the TIPS-MAPP Program.
- Explain the purpose of the "Criteria for Foster and Adoptive Parent Selection".
- Describe the feedback between leaders and participants that will be part of each meeting.
- Describe the purpose and use of the strengths/needs assessment.
- Define physical abuse.
- Define sexual abuse.
- Define neglect.
- Define emotional maltreatment.
- Define safety and risk as defined by federal and state child welfare law.
- Distinguish between risk and safety.
- Explain the concept of well-being as stated in federal and state law.

TIPS-MAPP Meeting 1 Abilities Continued

- Define permanency planning as established by PL 96-272, including the concepts of timeliness, best interest of the child (well-being), reasonable efforts, and child's need for a family intended to last a lifetime.
- Explain components of concurrent planning as defined in ASFA (PL 105-89) and state law.
- Explain the foster parent's and foster/adoptive parent's responsibilities and role in permanency planning.
- Provide at least four reasons children and birth parents may need foster care and adoption services.
- Describe how behaviors demonstrate feelings or emotional needs.
- Describe differences and similarities between foster parenting and adoptive parenting roles and responsibilities.
- Explain foster care and adoption to their family or to friends, and why partnership is so important.
- Make an informed decision about attending Meeting 2.

TIPS-MAPP Meeting 2 Abilities

By participating in this meeting, prospective foster parents and adoptive parents should be able to:

- Define shared parenting and alliance building.
- Explain how alliance building relates to shared parenting.
- Determine benefits of alliance building.
- State the agency's expectations about alliance building with parents of children and youth in foster care.
- Discuss the emotions that children and birth parents may feel during placement, visits and reunification.
- Communicate a willingness to support children's connections to their birth families.
- Begin to assess their own strengths and needs in helping a child move from temporary placement to permanency.
- Identify a child's needs, as expressed by their behaviors, to build on their strengths and meet their needs.

TIPS-MAPP Meeting 2 Abilities Continued

- Describe behavioral indicators of healthy physical, mental, emotional, social, intellectual and moral/spiritual development.
- Explain the normal stages of development for children through adolescence.
- Explain the beliefs and values of parents that affect a child's development.
- Explain the concept of well-being in terms of optimal mental, emotional, physical, intellectual and spiritual health.
- Explain how sexual abuse, physical abuse and neglect affect mental, emotional, physical, intellectual and spiritual health and well-being.
- Choose steps and strategies for assessing well-being of children and youths.
- In a case example, assess each of the components of well-being for infants and toddlers.
- In a case example, assess each of the components of well-being for school-aged children.
- In a case example, assess each of the components of well-being for an adolescent.
- In a case example, assess each of the components of well-being for an infant prenatally exposed to drugs.
- In a case example, assess each of the components of well-being for an infant prenatally or perinatally exposed to the HIV virus.
- In a case example, assess each of the components of well-being for children and youth with developmental delays.
- In a case example, assess each of the components of well-being for children and youth with disabilities.
- In a case example, assess each of the components of well-being for children and youth who are gay, lesbian, bisexual and transgendered.
- In a case example, assess each of the components of well-being for children and youth who are placed transracially.
- In a case example, assess each of the components of well-being for an adolescent mother in foster care.
- Make an informed decision about attending Meeting 3, based on their strengths/needs assessment and their understanding of partnership responsibilities.

NCTSN The National Child Traumatic Stress Network

Birth Parents with Trauma Histories in the Child Welfare System

A Guide for Parents

You may be one of the many parents involved with the Child Welfare System who has experienced or witnessed dangerous, even life-threatening, events known as trauma. If so, this resource is for you. It includes facts about trauma that you may find helpful and one parent's story.

KAREN'S STORY

Karen feels completely overwhelmed. She has been trying so hard to hold everything together, but no matter how much effort she puts in, she can't seem to do anything right. She has been through a lot. She remembers watching her father beat up her mother and being put in foster care. She didn't think anything could be worse than her own childhood, but seeing her own kids go through the same stuff is worse. She never intended to end up like her mom—it just seemed to happen. Her kids' father died three years ago, and Karen wound up with a partner who hit her and them. She felt helpless, unable to protect her kids from him, but sometimes she got so upset that she would hurt them too. Six months ago, Protective Services put her kids in foster care, and now she feels even more helpless. Every time she sees Jonathan, age 3, and Crystal, age 6, they are crying and yelling, and she just can't get them to behave. Karen gets upset when they call their foster mom "Grandma." On top of it all, the caseworker Linda accuses her of not working hard enough to do the things she said she'd do. Sometimes the system makes her feel like that six-year-old foster child all over again — alone and powerless.

Although Karen wants her children back, she worries that everyone may be right: she is a bad mother. Maybe that's why her kids aren't happy to see her and why they seem to like the foster parents more. While she knows some things she could do to improve, she is too exhausted to make any changes. Her house is getting really messy, but with her kids and her boyfriend gone, it doesn't seem to matter anymore.

Karen has gone to therapy a few times, but she's never liked it. It's easier to just forget about things. Talking about them over and over only makes it harder to sleep at night. Also, she's afraid about what the therapist is saying about her to the caseworker. The couple of times she has made it to her kids' therapy appointments, she thought the therapist acted as if he knew Jonathan and Crystal better than she does. If her kids could just come home, she knows she could work everything out.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

What is trauma?

A trauma is an intense event that threatens a person's life or safety in a way that is too much for the mind to handle and leaves the person powerless. Trauma can bring about physical reactions such as rapid heart rate, tense muscles, or shallow breathing. Common traumatic events could be going through or seeing:

- Family violence
- Sexual abuse
- Emotional abuse
- Violence in the community

For many parents, having a child removed from home and dealing with the child welfare system are traumatic events.

People who have experienced trauma might:

- Have nightmares, memories, or flashbacks that feel as if they're going through the traumatic event all over again
- Avoid things or people that remind them of the trauma
- Feel "on guard" or "jumpy," making it hard to sleep or concentrate

Karen experienced trauma both as a child and as an adult. She saw and heard her father beating her mother. She was removed from her parents' home and put into foster care. As an adult, her partner hit her. Now, she tries not to talk about any of it, because thinking about the past makes it hard for her to sleep.

How can trauma affect you and your parenting?

A history of trauma may make it difficult for you to:

- Recognize what is safe and what is unsafe, and keep you and your children from harm
- Stay in control of your emotions, especially in stressful situations like interviews with Child Protective Services, court hearings, or visits with your children
- Deal with stress in healthy ways
- Trust other people

When parents have lived through trauma, they may also struggle with reminders of those events. Reminders can happen without warning: a sound, smell, or even a feeling makes survivors of trauma feel the experience all over again. Reactions to reminders may include:

- Physical feelings: rapid heartbeat, shallow breathing, or tense muscles
- Emotional over-reactions: anger, fear, irritability in situations or toward people— without even realizing it
- Avoiding: staying away from others or putting off daily tasks—in order to avoid more reminders
- Using alcohol or drugs to try to feel better

Trauma can affect your relationship with your child:

- Your children may not trust that you can keep them safe.
- You and your children may remind each other of the traumatic event just by being together, even if you weren't together when it happened.
- You and your children may expect "bad things" to happen again.
- You may not recognize when your children's behaviors are caused by reactions to trauma reminders and think they are misbehaving on purpose to make you mad.

Karen has trouble trusting Linda, her case worker. Linda says she's there to help, but Karen can remember plenty of people who said they'd "be there," but have ended up hurting her. Also, Linda keeps telling her to talk to the therapist about her past, but Karen would much rather avoid thinking about it.

What can you do?

If you are a parent who has had trauma, consider trying the following:

- Remember that your symptoms are normal reactions to traumatic events.
- Talk about your thoughts, feelings, and reactions with people you trust.
- Become aware of reminders of traumatic events.
- Learn healthy ways to feel safe and relaxed:
  - Practice slow breathing
  - Say positive things to yourself ("This is scary, but I'm safe now")
  - Listen to a relaxation CD or to music that calms you
  - Leave on a night light
- Find someone who has been in your shoes—who understands what it's like to be in the system and has come through it well. Your community may offer Peer Mentors or Parent Advocates for parents in the child welfare system.
- Be patient with yourself. Healing is a process that takes time.
- Be patient with your children; they may misbehave because of the trauma.
- Seek professional help. Therapy is a good way to start making sense of what happened, how it has affected you, and how you can heal.

How can therapy help?

A therapist who understands trauma will work with you to do the following:

- Feel safe
- Decide on goals for therapy
- Learn about trauma and its effects on thoughts, feelings, and actions
- Use healthy ways to relax and cope with stress
- Make sense of the past and find ways to build a more hopeful future

SIX MONTHS LATER…

What Karen has to say: I didn't realize that the trauma I went through as a child was still affecting me—making me feel helpless. Having my kids removed was the worst thing that ever happened. My life started to change when I began to believe that I could make things better for me and my kids. It's been a long time, but I have started to heal. My therapist helps me learn ways to manage my trauma symptoms, like taking slow breaths when I start to feel upset. My Parent Advocate helps me understand how my trauma reactions affect my parenting. Now, I take better care of myself AND my kids. We go to the local community center for classes and family activities, and I go to a Domestic Violence Support Group. My children are doing better too, although they still talk about bad times and have nightmares once in a while. Crystal was in trouble at school for being too active and not listening to directions, so now my kids come to therapy with me. I guess we'll go for as long as we need too. Life can be difficult at times — because I am a single mom — but it sure is better than before. I don't ever want to go back, and I know now that I don't have to.

This fact sheet is one in a series of factsheets discussing parent trauma in the child welfare system. To view others, go to http://www.nctsnet.org/resources/topics/child-welfare-system

Resources:

National Child Traumatic Stress Network: www.nctsn.org
National Center for PTSD: www.ptsd.va.gov
Parents Anonymous: www.parentsanonymous.org

Supplemental Handouts

Leader Feedback Form

Leaders Names: _____ _____

Location: _____

Dates: _____

1. WHAT SQUARED (AGREED) WITH SOMETHING YOU ALREADY KNEW?

_____

_____

_____

2. WHAT DID YOU SEE FROM A NEW ANGLE?

_____

_____

_____

3. WHAT DID YOU LEARN THAT WAS NEW-THAT COMPLETED A CIRCLE OF KNOWLEDGE?

_____

_____

_____

4. WHAT NEW DIRECTIONS WILL YOU GO IN? WHAT ACTIONS WILL YOU TAKE?

_____

_____

_____

IN GENERAL, WITH REGARDS TO THE MEETINGS…

1. **WHAT WENT WELL AND SHOULD BE REPEATED DURING THE NEXT 8 MEETINGS AND WHY?**

   _____

   _____

   _____

2. **WHAT WOULD YOU CHANGE FOR THE REMAINING MEETINGS? EXPLAIN WHY AND RECOMMEND OPTIONS PLEASE.**

   _____

   _____

   _____

3. **PLEASE PROVIDE FEEDBACK FOR THE LEADERS-BY NAME!**

   _____

   _____

   _____

4. **ANY OTHER COMMENTS:**

   _____

   _____

   _____