Chronological List of Handouts

Handouts

1. Meeting 2 Agenda
2. Family Genogram and Background
3. Safety Considerations and the Permanency Planning Process*
4. Erikson's Stages of Development
5. An Overview of Brain Development
6. Understanding Child Traumatic Stress
7. Lillie's Stages of Development
8. Components of Well-being of Children and Youth in Foster Care
9. Assessing the Well-being Needs of Children and Youth in Foster Care – Worksheet
10. Helping the Premature Infant or Prenatally Drug-exposed Baby Attach and Develop
11. Important Information about Parenting Children Who Have Been Exposed to the HIV Virus
12. Important Information for Foster and Adoptive Parents about Parenting Youth Who Are Lesbian, Gay, Bisexual, Transgender, or Questioning
13. Important Information about Parenting Children with Fetal Alcohol Syndrome or Fetal Alcohol Effect (FAS/FAE)
14. Important Definitions for Foster and Adoptive Parents of Children Who Learn and Grow Differently
15. Strengths/Needs Worksheet – Meetings 1 and 2

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

Agenda

Time	Topic
(45 Minutes)	**A. Introduction to Meeting 2**
	◆ Welcome back
	◆ Meeting 2 agenda
	◆ Reintroduction
	◆ Mutual selection issues
	◆ Bridge from Meeting 1
(60 Minutes)	**B. Where the MAPP Leads: A Foster Care Experience**
	◆ How a family becomes a client
	◆ The first foster family
	◆ The second foster family
	◆ The visit
	◆ Family reunification
(10 Minutes)	**BREAK**

Time	**Topic**

(50 Minutes) **C. Children and Youth in Foster Care – Assessing Their Needs**

- The role of foster 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 four children and youth in foster care

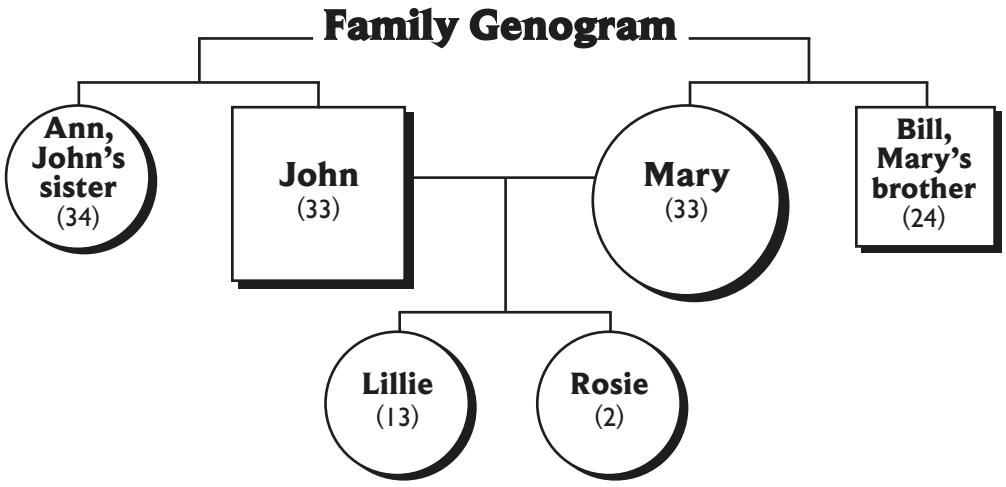
(15 Minutes) **D. Meeting 2 Summary and Preview of Meeting 3**

- Summary of Meeting 2
- Strengths/Needs Assessment
- Preview of Meeting 3
- Next step in the mutual selection process
- A Partnership 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 3, "Description of GPSII/MAPP Program Meetings and Steps."
- Complete the Profile or schedule your Family Consultation.

Family Genogram and Background



Background:

This is the story of one family's experience with foster care placement. The parents are John and Mary and their daughters are Lillie, age 13, and Rosie, age 2.

Ever since he was a teenager, much of John's socialization with his friends and male relatives has involved drinking. Unfortunately, John could become angry and has been violent when intoxicated. When he was fifteen, he threw a beer bottle and knocked out the front tooth of a neighbor who came to complain about a "loud party." Ashamed of his behavior, John successfully completed a Family Court-ordered alcohol awareness program. He worked after school to pay his neighbor's dental bills and his after-school job left no time for beer parties and "hanging out." Today, he drinks socially but he makes sure he stops before losing control.

John and Mary met their senior year in high school and fell in love. They married right after graduation and had Lillie ten months later. She was a colicky baby who shook their confidence as young parents, so they waited a long time before trying for a second child. They were thrilled and relaxed when Rosie was born, and she has been "a piece of cake" compared to Lillie.

Current Situation:

John is a hard worker and has done well to support his family. In fact, John had the opportunity for a better job within the company if he agreed to move the family. Their new apartment is some distance away from where they grew up. The move caused the family to become increasingly isolated from family and friends. Mary's brother, Bill, had lived with them, but he moved out abruptly and they don't know how to contact him. John's sister, Ann, lives nearby but Mary does not get along with her so there has been very little contact. There are no other relatives.

Mary has a part-time job on the 11:00 p.m. – 7:00 a.m. shift so she can be an "at home mom" during the day, and she loves that role. John is home at night, while the girls are

sleeping. John and Mary spank their kids as a last resort. They would both like to learn new ways since they realize Lillie is too old to spank. They have considered talking with her teacher about some suggestions that she may have.

Strengths:

- John takes responsibility for his own behavior (made restitution to neighbor).
- John and Mary's willingness to take risks to improve life for their family (moving to take a better job).
- John successfully completed an alcohol awareness program as a youth and drinks socially as an adult.
- Mary and John want to learn some parenting skills for disciplining their daughters, especially Lillie.
- John and Mary are committed to each other.
- The family has an average income, with both parents working.
- Both parents value free time together as a family.
- The family has stayed together as a family in good and bad times.

Needs:

- Both John and Mary have limited options for disciplining the girls and rely on spanking, especially when they are stressed.
- Both John and Mary have few personal coping strategies when stressed.
- John needs to spend more time with Mary, Lillie, and Rosie, rather than working long hours.
- John and Mary both need to manage stress differently when they're worried about the family.
- John and Mary need to develop supports in their new community.

Safety Considerations and the Permanency Planning Process

A. Definition of Safe (Protective)

A child is "Safe" when there is no immediate or impending danger of serious harm to a child's life or health as a result of acts of commission or omission (actions or inactions) by the child's parent(s) or caretaker(s).

B. Safety Factors

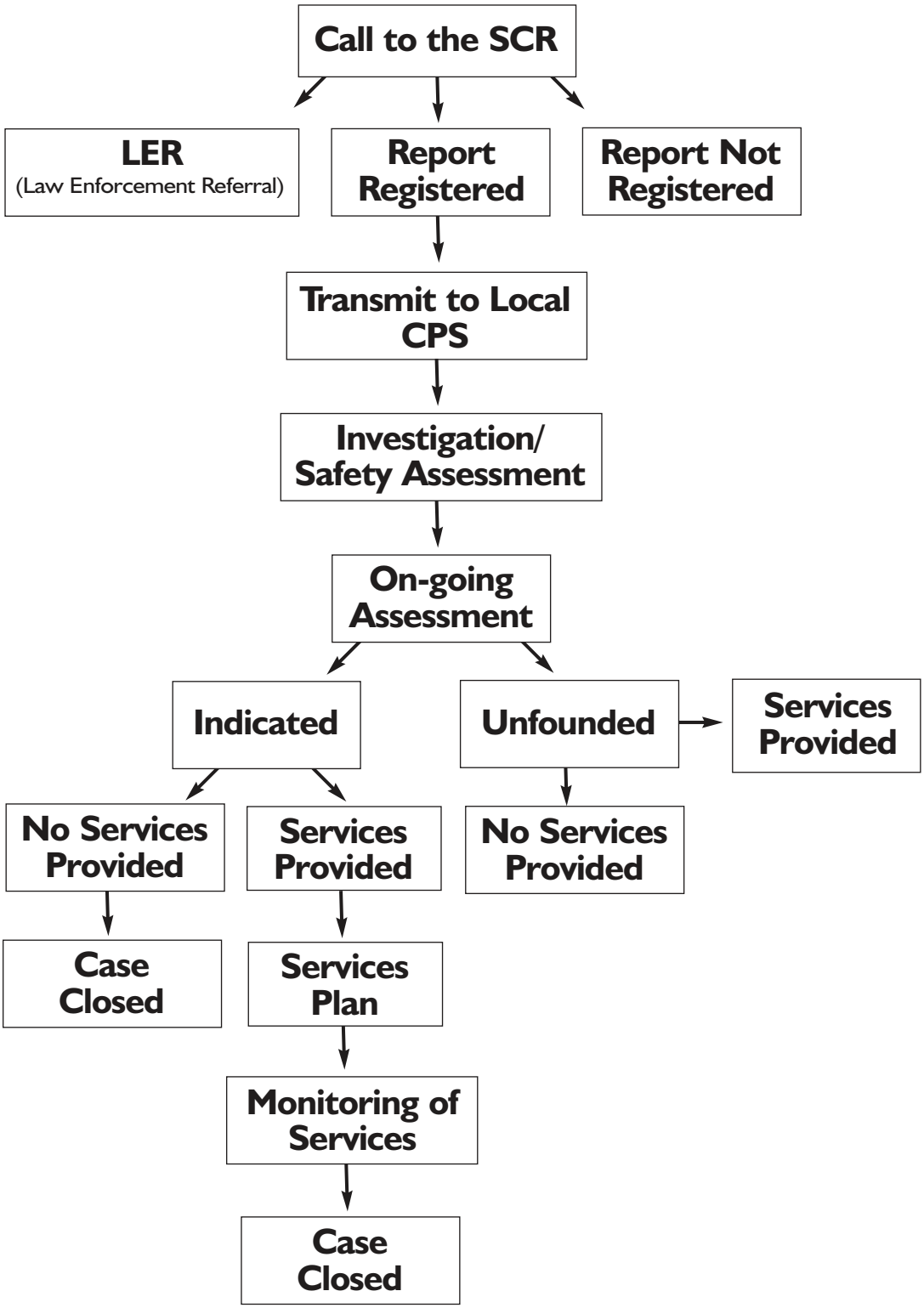
Safety Factor Definition: A Safety Factor is a behavior, condition, or circumstance that has the potential to place a child in immediate or impending danger of serious harm.

There are 18 Safety Factors:

1. Based on your present assessment and review of prior history of abuse or maltreatment, the Parent(s)/Caretaker(s) is unable or unwilling to protect the child(ren).
2. Parent(s)/Caretaker(s) currently uses alcohol to the extent that it negatively impacts his/her ability to supervise, protect and/or care for the child(ren).
3. Parent(s)/Caretaker(s) currently uses illicit drugs or misuses prescription medication to the extent that it negatively impacts his/her ability to supervise, protect and/or care for the child(ren).
4. Child(ren) has experienced or is likely to experience physical or psychological harm, as a result of domestic violence in the household.
5. Parent(s)/Caretaker(s)' apparent or diagnosed medical or mental health status or developmental disability negatively impacts his/her ability to supervise, protect and/or care for the child(ren).
6. Parent(s)/Caretaker(s) has a recent history of violence and/or is currently violent and out of control.
7. Parent(s)/Caretaker(s) is unable and/or unwilling to meet the child(ren)'s needs for food, clothing, shelter, medical or mental health care and/or control child's behavior.
8. Parent(s)/Caretaker(s) is unable and/or unwilling to provide adequate supervision of the child(ren).
9. Child(ren) has experienced serious and/or repeated physical harm or injury and/or the Parent(s)/Caretaker(s) has made a plausible threat of serious harm or injury to the children.

10. Parent(s)/Caretaker(s) views, describes or acts toward the child(ren) in predominantly negative terms and/or has extremely unrealistic expectations of the child(ren).
11. Child(ren)'s current whereabouts cannot be ascertained and/or there is reason to believe the family is about to flee or refuses access to the child(ren).
12. Child(ren) has been or is suspected of being sexually abused or exploited and the Parent(s)/Caretaker(s) is unable or unwilling to provide adequate protection of the child(ren).
13. The physical living condition of the home is hazardous to the safety of the child(ren).
14. Child(ren) expresses or exhibits fear of being in the home due to current behaviors of Parent(s)/Caretaker(s) or other persons living in, or frequenting the household.
15. Child(ren) has a positive toxicology for drugs and/or alcohol.
16. Child(ren) has significant vulnerability, is developmentally delayed, or medically fragile (e.g. on Apnea Monitor) and the Parent(s)/Caretaker(s) is unable and/or unwilling to provide adequate care and/or protection of the child(ren).
17. Weapon noted in CPS report or found in the home and Parent(s)/Caretaker(s) is unable and/or unwilling to protect the child(ren) from potential harm.
18. Criminal activity in the home negatively impacts Parent(s)/Caretaker(s)ability to supervise, protect and/or care for the child(ren).

C. Case Reporting Process Flow Chart



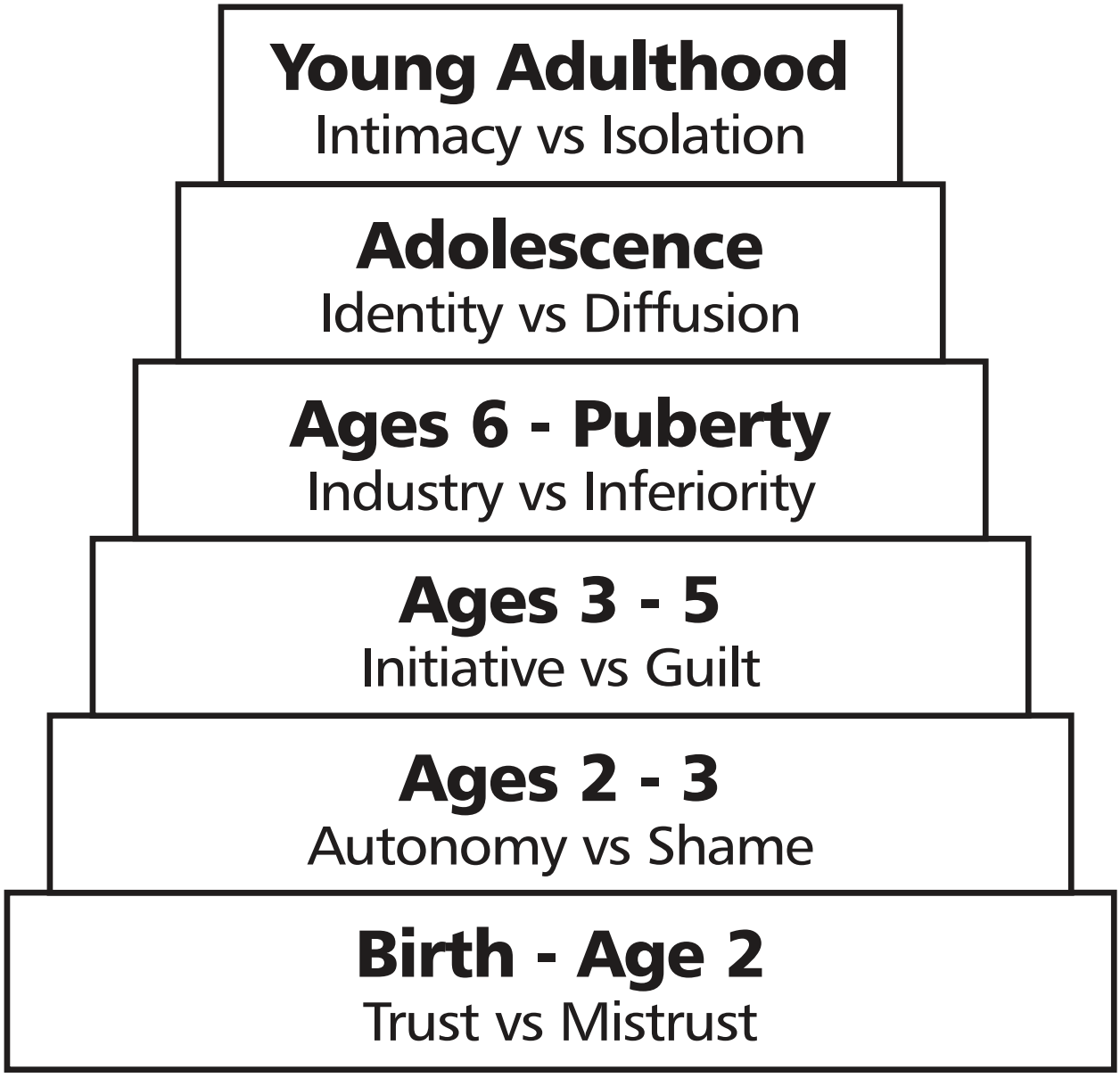
D. Supporting Permanency in Foster Care Cases

Do Not Copy!

The remainder of Handout 3 should be developed by the agency to describe the specific steps followed in foster care cases to support the permanency planning process. 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*



* Erickson, E.H. Childhood and Society, 2d ed. NY: WW Norton, 1963.

An Overview of Brain Development

Introduction

"Imagine that a baby's brain is like a house that has just been built. The walls are up, the doors are hung. Then you go to the store and buy electrical wiring, switches, a fuse box and other electrical supplies. You bring these supplies to the new house and set them on the floor. Will they work? Probably not. You first must string the wiring and hook up all of the connections. This is quite similar to the way our brains are formed. We are born with as many nerve cells as stars in the Milky Way galaxy. But these cells have not yet established a pattern of wiring between them—they haven't made their connections….

Now the sensory experiences must take this rough blueprint and progressively refine it…. This incredibly complex network of connections…is referred to as the brain's "circuitry" or "wiring."… As synapses in a child's brain are strengthened through repeated experiences, connections and pathways are formed that structure the way a child learns.... Early experiences have a decisive impact on the actual architecture of the brain" (Brotherson 2009, 2-4).

Nature, Nurture, and Early Brain Development

- Development results from the dynamic interplay of nature and nurture. From birth on, we grow and learn because our biology is programmed to do so and because our social and physical environment provides stimulation.

- At birth, the human brain is still under development. The brain's neurons exist mostly apart from one another. The brain's task for the first three years is to establish and reinforce connections between neurons. These connections form synapses.

- As the child develops, the synapses become more complex, like a tree growing ever more branches. Between birth and age 3, the brain creates more synapses than it needs. The synapses that are used a lot become a permanent part of the brain. The synapses that are not used frequently are eliminated. Experience plays an important role in wiring a young child's brain. For children to develop trust, secure attachments, and the "wiring" to succeed, they need many positive social and learning opportunities so that the synapses associated with these experiences become permanent.

- Research reveals that the brains of young children through adolescence have both fast-growing synapses and sections that remain unconnected. This leaves teens easily influenced by their environment and more prone to impulsive behavior, even without the impact of hormones and any genetic or family predispositions.

- The brain grows and changes continually in young people. It is only about 80 percent developed in adolescents. The largest part, the cortex, is divided into lobes that mature from back to front. The last section to connect is the frontal lobe, responsible for cognitive processes such as reasoning, planning, and judgment. Normally this mental merger is not completed until somewhere between ages 25 and 30.

Early Trauma and Brain Development: When Things Go Wrong

- For some children, early experiences are neither supportive nor predictable. Research indicates that early exposure to violence and other forms of unpredictable stress or trauma can affect the way the brain develops.
- If a child has been raised in an environment that is threatening or dangerous, the child's brain may develop a "sensitized" alarm response. The child readily interprets verbal and nonverbal cues as threatening, i.e., his or her threshold for feeling in danger is reached well before what's considered "normal." This increased reactivity may result in dramatic changes in behavior in the face of seemingly minor provocative cues.
- Trauma may affect communication or "cross-talk" between the brain's hemispheres, including parts of the brain governing emotions. In an environment that feels dangerous or unpredictable, the child may become too fearful to relax and trust his or her caregiver, which can result in the child not becoming attached.
- An adult caregiver's depression can also interfere with infant brain activity. When care givers suffer from depression, they may fail to respond sensitively to infant cries or smiles. Adult emotional unavailability is linked with poor infant emotional expression. Infants with depressed caregivers do not receive the type of cognitive and emotional stimulation that encourages positive early brain development.

Nurturing Brain Development: Tips for Caregivers*

- Even when children have had less-than-optimal experiences early in life, there is hope for the future because the brain continues to grow until about age 25. Secure and dependable relationships that provide love and nurturance, responsive interaction, and encouragement for exploration can help children's brains develop, make up for early adversity, and promote resiliency.
- During the first three years of life, the brain takes in the external world through its system of sight, hearing, smell, touch, and taste. Infants' and toddlers' social, emotional, cognitive, physical, and language development are stimulated by multisensory experiences. They need to participate in a world filled with stimulating sights and sounds and caring people.
- Before children talk, emotional expressions are the language of relationships. Research shows that infants' positive and negative emotions, and caregivers' sensitive responsiveness to them, can help early brain development. For example, laughing and smiling together engages brain activity in positive ways and promotes feelings of security.

*Adapted from: Sean Brotherson's, Sara Gable's, and Bruce Perr's publications. See source list for full citations.

- One method of supporting optimal brain development is to make daily routines and experiences as enjoyable and stimulating as possible. For example, encourage a young child to use all five senses during a meal by talking about the foods being eaten ("This is your orange. It is sweet and juicy. Feel its bumpy skin!").
- Once children can talk, it is important for them to have a loving, nonjudgmental audience to try out their new vocabulary and to learn the power of words. They also need opportunities to create, explore, imagine, build up, and tear down. Talking, singing, playing, and reading are key activities that build a child's brain.
- If the child has negative beliefs and expectations, and demonstrates these through challenging behaviors, it can be important to remember that the child is not consciously choosing to act in this way. The child's brain may be wired to expect abuse or rejection. To prevent a cycle of negative interactions, caregivers need to respond to the child with new, positive messages that tell the child that he or she is safe, wanted, and capable. Children can create new synapses in their brains by having repeated, positive experiences.
- With teenagers, it may be important to remember that although they can have the verbal ability of an adult, their brains are not as mature as their mouths. Boys especially under estimate risks and tend to be more impulsive. Providing positive, repetitious experiences will eventually overcome negative conditioning. Especially when teens are struggling to achieve autonomy (by taking risks), they need opportunities to feel worthwhile and capable and still be safe. Identify the types of things the teen would like to do and promote his or her opportunity to participate (e.g., by taking karate or guitar lessons). They need to channel their energy in positive, productive ways.

Sources:

- Brotherson, Sean. "Understanding Brain Development in Young Children." NDSU Bright Beginnings #4, FS-609 (April 2005, reprinted March 2009): 1-8. http://www.ag.ndsu.edu/pubs/yf/famsci/fs609.pdf
- Gable, Sara. Human Development: Nature, Nurture and Early Brain Development. Pamphlet GH 6115. Missouri University Extension, University of Missouri-Columbia (January 2000). http://www.classbrain.com/cb_pta/missouri_pdfs/kidsbrains.pdf
- National Child Traumatic Stress Network. Child Welfare Training Toolkit. 2008.
- Perry, Bruce D. "The Neurodevelopmental Impact of Violence in Childhood." "Chapter 18: In Textbook of Child and Adolescent Forensic Psychiatry," edited by D. Schetky and E.P. Benedek, 221-238. American Psychiatric Press, Inc.: Washington, D.C. 2001. Web version available
- online at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.132.8229&rep=rep1&type=pdf
- Ruder, Deborah Bradley. "The Teen Brain: A Work in Progress," The Harvard Magazine. September/ October
- 2008. http://harvardmagazine.com/2008/09/the-teen-brain.html

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.

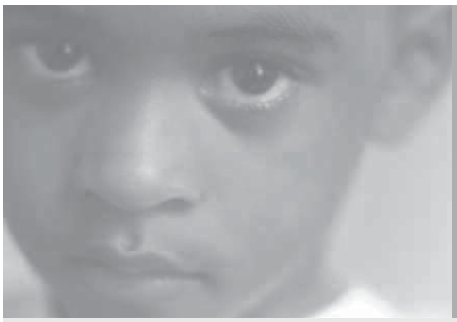
Things that are dangerous change over the course of childhood, adolescence, and adulthood.

- 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.

> "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 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.
- 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.
- 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.

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 posttrauma 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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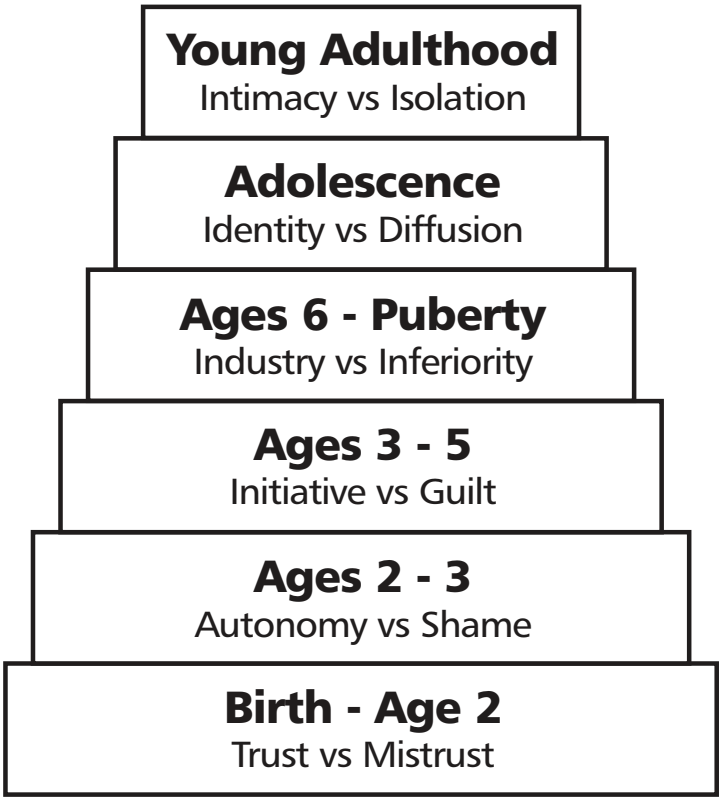
Lillie's Stages of Development



Lillie'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 **spiritually/morally 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 for 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 and permanence.
Neglect of an infant or Toddler (Infant prenatally exposed to drugs and/or alcohol)	**Joey**, age one, was born to a twenty-two-year-old mom dependent on crack cocaine. He tested positive for crack cocaine and the hospital made a report to the State Central Registry (SCR). Mom's drug use and its overall effect on her physical, emotional, and mental health directly affected her ability to meet Joey's or her own basic needs. Mom requested that Joey be placed with his great aunt. This aunt was a source of stability and support to mom in her own chaotic youth. His great aunt reports that Joey is not interested in anything or anyone, tends to look sad, is just learning to stand, cries often, and is not easily comforted. She loves him deeply and wants to adopt him but she doesn't know how to help him.		

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 and permanence.**
Neglect of a School Age Child (Prenatal and perinatal exposure to the HIV virus)	**Beau** is eight-years-old. He is HIV positive and symptomatic. Beau entered foster care eight months ago because his mother could no longer care for him; she has AIDS. The local hospice is providing services to her and she is not expected to live long. His father died of an AIDS-related condition several years ago. Beau is close to his grandmother and uncle and they are unable to provide a home for him due to their own disabilities. Beau states that he is angry that his mother is sick. Beau takes medication daily and has had periodic hospitalizations. He cries before going to his medical appointments. Not only does he not like the shots he must receive, he also dislikes having his blood drawn for various tests. A third-grader, Beau attends public school half days. He has three close friends although sometimes he yells at them and says that he doesn't want to be friends anymore. He dreams of flying an airplane some day. He likes animals and wants to have a cat, but cats can carry a disease that can be dangerous to Beau, so he cannot have one.		

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 and permanence.**
Neglect and Sexual Abuse of a School Age Child (Child in transracial placement)	**Jeryce** is an eleven-year-old girl who came into care two months ago as a result of neglect and lack of supervision. Jeryce's parents struggled from the beginning to feed, clothe, and give Jeryce those "little extras" they wanted their baby girl to have. Everything changed when a friend introduced the parents to crystal meth when Jeryce was nine. Jeryce's father and mother are separated and spend time together using drugs. For long periods of time Jeryce had to find her own food and shelter, because her parents were unable to provide for her most basic needs. Jeryce was sexually assaulted by neighbor adolescents while her parents were getting high and were unable to protect her. Her parents blame themselves, each other, and a neighborhood boy for Jeryce's placement. Once an average student, 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 is living in a white foster home in a working class, white neighborhood. Some of the neighborhood kids have yelled racial slurs at her. She has mentioned these incidents to her foster mother but has expressed no emotions about them.		

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 and permanence.**
Physical Abuse of an Adolescent (Youth who is gay)	**Jason** is fifteen and has been in care for a year. Jason hasn't seen his mother since he was a toddler. His father, who physically abused him, has just started a ten-year prison sentence for drug-related charges. The agency is seeking to terminate his parental rights. Jason was living with his paternal grandmother until last year, when she died. No other family members can provide a home for him so Jason has been in foster care for a year. He recently disclosed to his foster mother that he is gay. 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 grandmother, father and mother. His foster mother is willing to adopt him but Jason doesn't want to think about being adopted.		

Helping the Premature Infant or Prenatally Drug-exposed Baby Attach and Develop *

Many of the symptoms and behaviors of infants who are prenatally drug exposed are also common in premature babies. It is believed that even when born at full-term, the nervous systems of prenatally drug-exposed infants are not functioning at the expected level for newborn babies.

Infants who are prenatally drug exposed exhibit behaviors that make it very difficult for their parents or caregivers to respond in ways that promote social, physical and psychological development. The difficulties in attachment can be serious enough to be life threatening.

Some Symptoms or Behaviors the Parents/Caregivers Might Encounter	Some Responses/Interventions the Parents/Caregivers Can Provide
Vomiting, Poor Feeding	**Vomiting, Poor Feeding**
◆ May vomit or spit up food often.	◆ If infant vomits, clean skin immediately to prevent irritation from stomach acids.
◆ May sleep through feeding (as much as 20 hours per day).	◆ Hold infant upright for feeding.
◆ May stop feeding before taking adequate nutrition.	◆ Give infant small amount frequently.
	◆ Wake infant for feeding.
	◆ After feeding, place infant on side-lying or prone position to prevent aspiration of milk.
Uncoordinated Swallowing or Sucking	**Uncoordinated Swallowing or Sucking**
◆ Unable to suck and swallow in a coordinated way.	◆ Hold infant in sitting position with trunk slightly curved during feeding.

* Lewis, K. D., Bennett, B. & Schneider, N. H., (September/October 1989). *The care of infants menaced by cocaine abuse*. MCN, 14.

Some Symptoms or Behaviors the Parents/Caregivers Might Encounter	**Some Responses/Interventions the Parents/Caregivers Can Provide**
◆ Weak or poor sucking ability. ◆ Tongue thrusting that interferes with sucking. ◆ Tongue tremors.	◆ If sucking is weak or difficult, support the infant's chin with your hand. ◆ Play soft, rhythmic music to facilitate rhythmic sucking.
Weak Pull-to-Sit Development	Weak Pull-to-Sit Development
◆ If pull-to-sit is delayed it may be due to lack of development of abdominal and neck muscle strength. The delay in this skill will also affect balance, sitting and walking.	◆ Move infant from lying (supine) to sitting while supporting the head. ◆ While moving the infant, support the shoulders. ◆ As you help the infant to the sitting position, encourage the infant to assist with pull-to-sit. ◆ Place infant in supported sitting position and move infant slowly backward within the range of head control. ◆ Slowly rock or move the infant back and forward to strengthen neck and abdominal muscles.
Tremors, Trembling and Extraneous Movement	Tremors, Trembling and Extraneous Movement
◆ Tremors of the hands, arms, legs chin and tongue.	◆ Swaddle or hold the infant close.

Some Symptoms or Behaviors the Parents/Caregivers Might Encounter	**Some Responses/Interventions the Parents/Caregivers Can Provide**
◆ Tremors may occur when infant is at rest or attempting a specific movement (for example, reaching for a toy).	◆ Hold the infant in a semicircular position with arms at midline, shoulders forward.
◆ Poor or delayed fine motor development.	◆ Hold infant so arms and legs are close to the body.
	◆ Touch trembling area firmly and calmly. Touch chest firmly and calmly.
Irritability and Sleeping Difficulty	Irritability and Sleeping Difficulty
◆ May have frantic crying state which seems uncontrollable.	◆ Reduce noise in environment.
◆ Irritability may make parents feel unsuccessful in parenting or unrewarded for their efforts.	◆ Turn down lights.
	◆ Swaddle infant in cotton blanket.
	◆ Put infant in bunting type wrapper and carry close to body.
	◆ Rock infant slowly and rhythmically holding either horizontally or vertically, whichever soothes.
	◆ Walk with infant.
	◆ Place in front pack carrier.
	◆ Give baby a pacifier.
	◆ Provide warm baths (hydrotherapy).
	◆ Respond to stress by stopping activities.
	◆ Play soft music or sing or hum quietly.
	◆ Place infant in quiet darkened room with no outside stimulation (this should be used only during high periods of stress when all else fails).

Some Symptoms or Behaviors the Parents/Caregivers Might Encounter

Stiffness and Rigidity

- Body and muscles may be stiff and rigid.
- This increased muscle tone interferes with infant's ability to cuddle, pull-to-sit, and control arms at midline.
- Infant may frequently arch their back when supine.
- Rigid muscles mean more effort needs to be exerted for critical fine motor skills.

Some Responses/Interventions the Parents/Caregivers Can Provide

Stiffness and Rigidity

- Bathe infant in warm water.
- Use gentle, calming massage.
- Swaddle with shoulders and arms close to body.
- Place infant in baby hammock.
- Do not leave infant flat on back for extended periods of time.
- Do not use baby walkers which increase muscle tension.

Important Information about Parenting Children Who Have Been Exposed to the HIV Virus

Terms

AIDS

Acquired **I**mmune **D**eficiency **S**yndrome is an infectious disease, stemming from the **H**uman **I**mmunodeficiency **V**irus (HIV), which damages an individual's immune system making it weaker, and more and more difficult to fight disease.

As defined by the Center for Disease Control, AIDS is "a severe late manifestation of infection with HIV that destroys or incapacitates important components of the human immune system. Individuals with this syndrome develop infections caused by microorganisms that usually do not produce infections in people with normal immunity."

Antibody

A protein in the blood produced in response to exposure to specific foreign molecules. Antibodies neutralize toxins and interact with other component of the immune system to eliminate infectious microorganisms from the body.

Antiretrovirals

Certain medicines, called antiretroviral, stop HIV from getting inside white blood cells (CD 4 cells) or work to stop HIV from making copies of itself. "Anti" means against, and "retro viral" means virus. Antiretroviral medicines can lower the amount of HIV in your child's blood.

Asymptomatic

Individual is infected with HIV but has no signs or symptoms of illness.

HIV

Human **I**mmunodeficiency **V**irus is a virus that attacks the immune system. The immune system fights infections and diseases in a person's body.

HIV antibodies

HIV antibodies are substances the immune system makes to fight HIV.

HIV antibody positive

For babies less than 18-months-old, being HIV antibody positive does not indicate they are infected with HIV. At birth, all infants will have HIV antibodies in their blood if their mothers have HIV. Until infants are six to 18-months-old, they have their mother's HIV antibodies.

To find out if an infant has HIV, a blood test called a PCR (Polymerase Chain Reaction) is done. A PCR test is different from an HIV antibody test. Rather than look for HIV antibodies, a PCR test looks for HIV in an infant's blood. In almost every case, the test can tell if an infant has HIV by the time he/she is between one and four months old. If HIV is found, the PCR test will be positive. This means the infant has HIV.

HIV negative
An HIV negative test result means that a person is not infected with HIV. However, if a person recently engaged in a risk behavior (e.g., sex without a condom, sharing needles, or sharing works) and was infected with HIV, his/her immune system may not have made enough HIV antibodies for an HIV antibody test to detect. In this case, getting another HIV antibody test is recommended.

HIV positive
An HIV positive test result means that a person is infected with HIV.

Incubation period
The period between infection with HIV and the presentation of symptoms of illness. In some individuals, this period can last ten years or more.

Perinatal
Pertaining to or occurring in the period shortly before and after birth, variously defined as beginning with the completion of the 20th to 28th week of gestation and ending seven- to 28 days after birth.

T-cell count
T-cells are a subgroup of lymphocytes made up of "helper" T-cells and "suppresser" T-cells. Helper T-cells augment the function of the entire immune system of the body, while suppressor T-cells turn off the immune response when it is no longer needed. Normally, healthy people have twice as many helper T-cells as suppressor T-cells. The problem with HIV infection appears to be a disappearance or depletion of the helper T-cell population.

It is also referred to as T-4 cell count, the normal range being between 500-1000 per cubic millimeter of blood.

Seroconversion
The point at which antibodies to HIV become detectable in the blood.

Seroreversion
The process by which an **infant** sheds its mother's antibodies to HIV as its own immune system matures. This generally occurs in infants by eighteen months of age. (See above: HIV antibody positive)

Symptomatic
The term used to indicate the presence of HIV-related illnesses.

Viral Load
A blood test that can measure the amount of HIV in the blood. The results indicate whether antiretrovirals are working to combat HIV.

Window period
The period between infection with HIV and the body's production of measurable amounts of HIV antibodies. It is also known as the indeterminate period.

About Transmission

HIV is passed from person to person. This happens when a person with HIV gets his/her blood, semen, vaginal secretions, or breast milk inside another person's body.

There is **no risk** of getting HIV from the person's urine, sweat, tears, saliva, or vomit unless there is also blood in it.

A person of any age, sex, ethnic group, religion, economic background, or sexual orientation can get HIV. It is not who you are. It is what you do that puts you at risk. Anyone who shares needles, shares works to inject drugs, or has unprotected sex (sex without a condom) with someone who has HIV is at very high risk for getting infected. A mother with HIV can pass the virus to her baby during pregnancy, during birth, or by breast feeding.

It is not possible to tell if people have HIV by looking at them. People can have HIV for many years and not know they have it. They can pass it on to others without knowing it. That is why it is important for people to get tested to find out if they have HIV.

Universal Precautions

A child with HIV may not be able to fight off infections as well as other children so it is important to protect your child from germs that can cause infections. Use the following suggestions for everyone in your home.

- **Always avoid contact with anyone's blood, or any secretions mixed with blood.**
- **Cover with bandages any cuts, sores, or breaks in the skin of the caregiver and the child.**
- **Disinfect surfaces using disposable towels and mixture of bleach & water. Keep your house clean.**
- **Wash your hands.**

  Germs on people's hands spread many infections. Washing your hands is the best way to kill germs. Rub your hands together with soap under running water. If possible, use liquid soap. Do not forget to clean under your finger nails, and between your fingers. If your hands get dry or sore, put on hand cream or lotion.

- **Wash your hands and your child's hands often:**
    - After touching body fluids (blood, urine, bowel movements, mucus from mouth or nose);
    - After blowing your nose or helping child blow theirs;
    - Before handling, cooking, or serving food;
    - Before and after eating meals or snacks;
    - After using the toilet or changing diapers or after helping someone use the toilet;
    - After playing with pets or other animals;
    - After playing with or holding another child.

Changing diapers:

Babies have very tender skin. Keeping baby's skin clean and dry is important.

- Wash your hands before and after changing baby's diaper.
- If you have sores or scratches on your hands, wear latex gloves when changing or rinsing out diapers.
- If child has diarrhea or you can see blood in his/her bowel movement or urine, wear latex gloves.
- All babies get diaper rashes from time to time, so watch for diaper rash.
- Ask the baby's doctor what to do and when to call if baby gets a diaper rash.
- Change diaper more often if he/she has a rash. If the rash does not go away in a few days, call your baby's doctor.
- Use throw away or disposable diapers, if possible. Put used disposable diapers in a plastic bag and put it in a diaper pail or garbage with a tight fitting lid.
- Wash any surfaces that come in contact with child's bowel movement or urine.

Sources:

Caring for Children with Special Needs. NYS DOH & NYS OCFS

CDHS– Glossary "Caring for Foster Youth with HIV"

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

Definitions:

Bisexual:	An individual of any gender who is sexually attracted to both males and females
Coming Out:	A process of becoming aware of one's sexual orientation and telling others about it
Gay:	A male who is sexually attracted to other males
Heterosexism:	The belief that heterosexuality is the only acceptable or valid sexual orientation
Homophobia:	Fear, hatred, or prejudice against anyone who is LGBTQ
Homosexuality:	Sexual attraction to someone of the same sex
In the Closet:	A term that refers to keeping one's sexual orientation a secret
LGBTQ:	An acronym for "Lesbian, Gay, Bisexual, Transgender, or Questioning"
Lesbian:	A female who is sexually attracted to other females
Transgender:	A person who feels, thinks, and sometimes acts in a manner more consistent with the identity characteristics of the gender opposite to the gender they were born with or assigned to at birth
Questioning:	A person who questions his or her sexual identity, sexual orientation, or gender identity

Facts about gay and lesbian youth

- Five to six percent of American youth are lesbian, gay, bisexual or transgendered, i.e., there are between 2.25 and 2.7 million school-age LGBTQ youth. (Source: National Longitudinal Study of Adolescent Health (2001) available at: http://www.cpc.unc.edu/addhealth.)
- At any one time there are approximately 260,000 youth in the foster care system in the United States. While it is impossible to precisely determine the number of LGBTQ youth in this system, recent studies suggest that these youth make up between 5 and 10 % of the total foster youth population. (Source: Lambda Legal Defense and Education Fund, Youth in the Margins: A Report on the Unmet Needs of Lesbian, Gay, Bisexual, and Transgender Adolescents in Foster Care 11 (2001) [hereinafter Youth in

the Margins].

- Schools are hostile environments for a distressing number of LGBTQ students, e.g., n a recent study, 61.1% felt unsafe at school because of their sexual orientation; 84.6 % were verbally harassed; 40.1% were physically harassed; and 18.8 % were physically assaulted. (Source: the Gay, Lesbian and Straight Education Network (GLSEN), The 2009 National School Climate Survey, available at www.glsen.org)
- Many LGBTQ youth face neglect or abuse from their families of origin because of their sexual orientation or gender identity. A study found that over 30% of LGBT youth reported suffering physical violence at the hands of a family member after coming out. (Source: Youth in the Margins, citing Philadelphia Lesbian and Gay Task Force, Discrimination and Violence Against Lesbian Women and Gay Men in Philadelphia and the Commonwealth of Pennsylvania, 1996.)
- Many LGBTQ youth in the foster care system experience verbal harassment and physical or sexual abuse because of their sexual orientation or gender identity. In one of the only studies of its kind, 100% of LGBTQ youth in New York City group homes reported that they were verbally harassed while at their group home and 70% reported physical violence due to their sexual orientation or gender identity. (Source: Urban Justice Center, Justice for All? A Report on Lesbian, Gay, Bisexual and Transgendered Youth in the New York Juvenile Justice System, 2001.)
- Gay and transgender teens who were highly rejected by their parents and caregivers were at very high risk for health and mental health problems when they become young adults (ages 21-25). Highly rejected young people were: more than 8 times as likely to have attempted suicide; nearly 6 times as likely to report high levels of depression; more than 3 times as likely to use illegal drugs; and more than 3 times as likely to be at high risk for HIV and sexually transmitted diseases compared with gay and transgender young adults who were not at all or only rejected a little by their parents and caregivers because of their gay or transgender identity. (Source: Ryan, Caitlyn. Family Acceptance Project, Supportive Families, Healthy Children, 2009. Available at: http://familyproject.sfsu.edu or fap@sfsu.edu)

Tips for foster and adoptive parents to help their LGBTQ youth

- Talk with your child or foster child about their LGBTQ identity.
- Express affection when your child tells you or when you learn that your child is gay or transgender.
- Support your child's LGBTQ identity even though you may feel uncomfortable.
- Advocate for your child when he or she is mistreated because of their LGBTQ identity.
- Require that other family members respect your LGBTQ child.
- Bring your child to LGBTQ organizations or events.
- Connect your child with an LGBTQ adult role model to show them options for the future.
- Welcome your child's LGBTQ friends & partners to your home.
- Support your child's gender expression.
- Believe your child can have a happy future as an LGBTQ adult.

(Source: Ryan, Caitlyn. Family Acceptance Project, Supportive Families, Healthy Children, 2009. Available at: http://familyproject.sfsu.edu or fap@sfsu.edu; reprinted with permission)

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

FAE	**F**etal **A**lcohol **E**ffect. 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	**F**etal **A**lcohol **S**yndrome. 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	**S**udden **I**nfant **D**eath **S**yndrome is one of the leading causes of death among infants one month through one year of age in the United States. Most victims are between two and four months of age. The National Institute of Child Health and Human Development (NICHD) defines SIDS as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. SIDS is therefore a diagnosis of exclusion, affixed only once all known and possible causes of death have been ruled out. SIDS claims the lives of almost 2,000 infants in the U.S. each year. SIDS deaths occur unexpectedly and quickly to apparently healthy infants, usually during periods of sleep. Two important preventive measures that reduce but do not completely eliminate the risk of SIDS are to put healthy babies to sleep on their backs and to keep cigarette smoke away from babies.

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

Important Definitions for Foster and Adoptive 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	Failure to thrive is a condition rather than a specific disease. Children who fail to thrive don't receive or are unable to take in adequate nutrition to gain weight and grow as expected. Common in premature babies (usually in conjunction with other medical problems), the condition can occur in full-term infants too. Whereas the average term baby doubles its birth weight by six months and triples it at one year, these children often do not meet those milestones. In the past doctors tended to categorize cases of failure to thrive as either organic (caused by an underlying medical disorder) or inorganic (caused by caregiver actions), but they are less likely to make such sharp distinctions today because medical and behavioral causes often appear together. It is important to determine whether the failure to thrive results from medical problems with the child or from psychosocial factors in the environment, such as lack of attachment, abuse, neglect, or poverty.
IEP	**I**ndividual **E**ducation **P**lan is a plan written by school system staff and parents to provide special education and other services to students with disabilities. An IEP is developed so that each student with a disability can receive a free appropriate public education in the least restrictive environment.
Medically Fragile	An infant or child with special medical needs which places the child at risk of additional illnesses or death.
Mental Retardation	Subnormal mental abilities and intelligence, reflected in difficulty with learning that results from genetic causes or brain damage. (**The American Heritage Dictionary**, 1989.)

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

Strengths/Needs Worksheet – Meetings 1 and 2

Now that you have completed your first two meetings, we would like you to think about your strengths and your needs, personal as well as family. For each bolded skill, please write an example of your strength and/or your need. You can provide as many examples as you'd like but please provide at least 3 strengths and 3 needs on the worksheet.

Skill	Activities	This is a strength for my family because….	This is a need for my family because…
1. Know your own family.	Meeting 1 The Profile		
2. Communicate effectively.			
3. Know the children.	Meeting 1 Reasons/Feelings/Behavior The Video Meeting 2 Lillie's Family Erikson's Stages of Development		

Skill	**Activities**	**This is a strength for my family because….**	**This is a need for my family because…**
4. Build strengths; meet needs.	Meeting 1 Matching Activity Robert's Strengths and Needs		
5. Work in partnership.	Meeting 2 Lillie's Family		
6. Be loss and attachment experts.			
7. Manage behaviors.	Meeting 1 Reasons/Feelings/Behavior		

Skill	**Activities**	**This is a strength for my family because….**	**This is a need for my family because…**
8. Build connections.			
9. Build self-esteem.			
10. Assure health and safety.	Meeting 2 Assessing the Well-Being Needs of Children and Youth in Foster Care		
11. Assess impact.			
12. Make an informed decision.			