

CHAPTER 6

Understanding Children



ABLE OF CONTENTS

Getting in Gear, Goal & Objectives	6-3
Unit 1	
What All People Need	6-5
Unit 2	
How Children Grow & Develop	6-11
Unit 3	
Attachment	6-23
Unit 4	
Separation	6-27
Unit 5	
Permanence for Children	6-33
Unit 6	
Educational, Emotional & Psychological Issues for Children	6-35
Unit 7	
Resiliency	6-43
Resource Materials	6-47
Parking Lot	6-89

CHAPTER 6

Understanding Children



Getting in Gear

There is no new assignment for this chapter. Many of the activities in this chapter rely on the material in the Parker-Solano training case. You may wish to skim the material again prior to beginning this chapter.



Goal

In this chapter, I will learn about child development, attachment, separation, permanence, resiliency, and other issues for children.



Objectives

By the end of this chapter, I will be able to...

- ✓ Analyze a child's needs using Maslow's hierarchy of human needs as a framework.
- ✓ Identify age-appropriate behavior for children from birth through adolescence.
- ✓ Name behavioral signs of attachment and lack of attachment in children.
- ✓ Recognize typical reactions of children and their parents to separation and loss.
- ✓ Understand a child's need for permanence.
- ✓ Identify warning signs of educational, emotional, and psychological issues that might require professional assessment and/or treatment.
- ✓ Describe the concept of resiliency and identify protective factors.



Reporting In

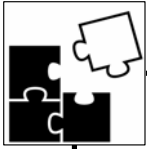
In this chapter you will find one or more assignments identified by the “Reporting In” heading (as seen above). You will need to complete, copy, and submit these assignments as prearranged to CASA/GAL program staff for review at the debriefing session for this chapter.



Parking Lot

At the end of this chapter you will find a page designated as the “Parking Lot.” Find and bookmark this page now, and use it throughout the chapter to note any questions, ideas, or concerns that you wish to discuss with CASA/GAL program staff.

UNIT 1: What All People Need



Activity 6A: Human Needs

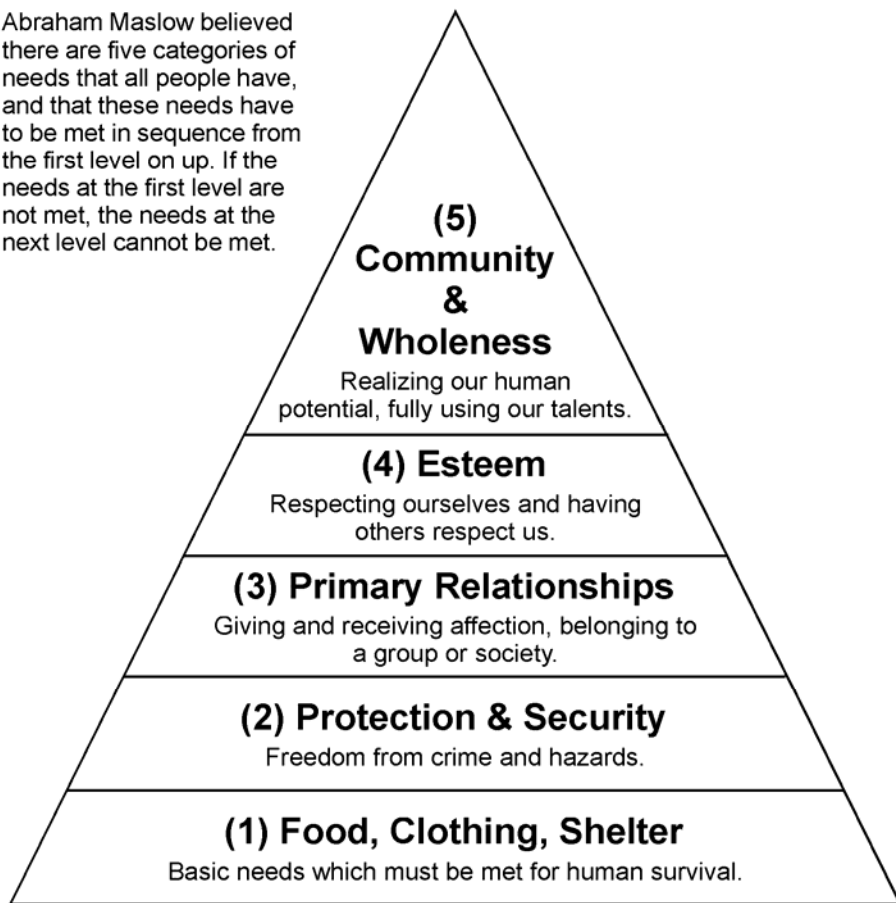
In the table below, write three things you need in your life.

Next, read the information about Abraham Maslow's theory of human needs, often called "Maslow's hierarchy of needs." Analyze which categories your three needs fall under on the hierarchy and list the corresponding category in the second column of the table.

Things I Need	Maslow's Category

Hierarchy of Needs

Abraham Maslow believed there are five categories of needs that all people have, and that these needs have to be met in sequence from the first level on up. If the needs at the first level are not met, the needs at the next level cannot be met.



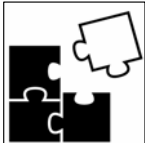
Motivation and Personality, Abraham Maslow, New York: Harper & Row, 1960.

The first two categories of needs are self-explanatory. In the third level, primary relationships, Maslow stated that people need to experience love and a feeling of belonging. They need to give and receive affection and belong to a group or to a society.

Sound primary relationships make it possible for people's need for esteem—the fourth of Maslow's categories of need—to arise. Self-esteem and esteem from others allow people to feel self-confident and self-worthy. Without such respect in their lives, people feel inferior and worthless. When the need for esteem is met, the need for self-actualization surfaces. Maslow called this level "community and wholeness." At this level, people strive to realize their potential and exercise their talents to the fullest. Maslow noted that most people do not reach self-actualization because they never fully satisfy their needs for love and esteem.

The Needs of Children

Children represented by CASA/GAL programs come to the court's attention because their most basic needs—for protection and security—are not being met by their parents or caretakers. To make sure these children are protected from maltreatment, many of them are removed from their homes and their primary relationships. Usually, parents are their children's advocates—a CASA/GAL volunteer is needed only when the parents cannot fill that advocacy role for their children. Later, this chapter will look more closely at the consequences of disturbing children's attachments to their primary caretakers, even if the removal from home is necessary to ensure the children's protection.



Activity 6B: The Needs of Children

Review the following list of things that all children need. What would you add to this list? Write your additions in the space provided.

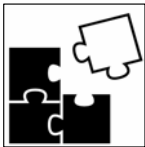
- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Among the Things That Children Need Are...

- ✓ Food
- ✓ Shelter
- ✓ Security
- ✓ Clothing
- ✓ Protection
- ✓ Medical Care
- ✓ Education
- ✓ Nurturing
- ✓ Family Connections, Including Culture
- ✓ Stability
- ✓ What Else?

Important Points About Children’s Needs

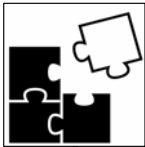
- To advocate for a child, the CASA/GAL volunteer must keep the child’s needs clearly in mind. The child’s needs are paramount.
- Human needs can be ordered in a sequential hierarchy (i.e., Maslow’s survival, security, primary relationships, esteem, and community/wholeness).
- Healthy growth and development depend on adequately meeting more basic needs before other needs can be addressed (e.g., the development of friendships depends on more basic needs being met).
- Children’s needs depend on their age, stage of development, attachment to their family/ caregivers, and reaction to what is happening around them.
- The essence of the role of the CASA/GAL volunteer is to identify the child’s unmet needs and then find the appropriate person or service to meet those needs.



Activity 6C: The Needs of Damien & Ben

Part 1: Think about Damien, the younger child in the Parker-Solano case. If you were assigned as the CASA/GAL volunteer in Damien’s case, which of the needs from the previous activity would you wish to address for Damien? Analyze where Damien’s needs fall on Maslow’s hierarchy of needs. List your responses below.

Damien’s Needs	Maslow’s Category



Activity 6C: The Needs of Damien & Ben

Part 2: There are unique issues for a CASA/GAL volunteer working with a child who has reached adolescence. Read the material below on working with adolescents, and refer to the list of tips for assisting youth in the transition to adulthood. Go through the tips and identify one strategy for each tip that you might use if you were appointed as Ben's CASA/GAL volunteer. Write your ideas below.

TIP	STRATEGY
1	
2	
3	
4	
5	
6	
7	
8	

Refer back to Maslow's hierarchy of needs when answering the following question:

At which level of Maslow's hierarchy do Ben's current needs fall?

Working with Adolescents

Working with adolescents presents unique challenges for the court system and the CASA/GAL volunteer. In many states, children above a certain age are to receive notice of court hearings in which their permanent plan will be addressed. The CASA/GAL volunteer can help the young person decide the best way to participate in these events. It empowers the young person to have a voice in planning for his/her own future. Additionally, in every court proceeding, the CASA/GAL volunteer advocates for the child's needs *and* informs the court of the child's wishes. A relationship built on trust is essential if the CASA/GAL volunteer is to know the young person well enough to inform the court regarding these issues.

To help adolescents become healthy, self-sufficient adults, a plan should be created that enhances their opportunities to participate in meaningful independent- or transitional-living programs that meet their special needs. The CASA/GAL volunteer can play a special role with a young person as he/she prepares to live independently. If the CASA/GAL volunteer has a relationship with the child that is built on mutual trust, he/she may be the person that the young person turns to when making choices and decisions about the future. Also, the CASA/GAL volunteer should see that the caseworker arranges for the child to be informed about puberty and what is happening to his/her body during this time of rapid change.



Did You Know That...

According to a study of ex-foster children in Wisconsin twelve to eighteen months after they left foster care, half were employed, a third were on welfare, a fifth of the girls had given birth, and more than a quarter of the boys had been imprisoned.

American Bar Association Center on Children and the Law, 1999.

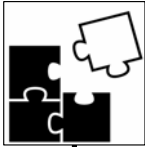
Eight Tips for Assisting Youth in the Transition to Adulthood

1. Paint a positive and realistic picture of the future;
2. Respect the grief that comes from loss of family;
3. Tailor services to their needs;
4. Don't leave them hanging—advocate for resources;
5. Help them understand their rights and responsibilities, and what you see as best for them;
6. Involve them in decisions;
7. Help them develop support systems—lifelong connections; and
8. Know what permanence means to them; it can mean having something and someone to fall back on—adequate support systems to meet emotional, financial, scholastic, and intellectual needs.

Materials for this unit were adapted from "Litigating the Independent Living Case," Kathi Grasso, *ABA Child Law Practice*, October 1999.

UNIT 2: How Children Grow & Develop

When children's needs are being met appropriately, they are able to grow and develop optimally. It is important in your work as a CASA/GAL volunteer to be able to assess age-appropriate behavior for children from birth through adolescence. This unit examines materials on growth and development that will be a resource to you in your work.



Activity 6D: Ages & Stages

Part 1: Read the following material on how children grow and develop. Consider which of the following age groups you have the most interest in or experience with. Select and circle two different age groups from the list below.

- birth to six months
- six to twelve months
- twelve to eighteen months
- eighteen months to three years
- three to five years
- six to nine years
- ten to fifteen years
- sixteen to twenty-one years.

How Children Grow & Develop

1. No two children are alike. Each one is different. Each child is a growing, changing person.
2. Children are not small adults. They do not think, feel, or react as grown-up people do.
3. Children cannot be made to grow. On the other hand, they cannot be stopped from growing.
4. Even though children will grow in some way no matter what care is provided for them, *they cannot reach their best growth possibilities unless they receive care and attention appropriate for their stage of development.*
5. Most children roughly follow a similar sequence of growth and development. For example, children scribble before they draw. But no two children will grow through the sequence in exactly the same way. Some will grow slowly while others grow much faster. Children will also grow faster or slower in different areas of development. For example, a child may be very advanced in language development but less advanced, or even delayed, in motor coordination.
6. During the formative years, the more successful a child is at mastering the tasks of a particular stage of growth, the more prepared he/she will be for managing the tasks of the next stage. For example, the better a child is able to control behavior impulses that he/she has as a two-year-old, the more skilled he/she will be at controlling behavior impulses he/she has as a three-year-old.

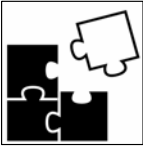
7. Growth is continuous, but it is not always steady and does not always move smoothly forward. You can expect children to slip back or regress occasionally.
8. Behavior is influenced by needs. For example, the active fifteen-month-old baby touches, feels, and puts everything into his/her mouth. His/her whole person is responding to a growth need; he/she is not intentionally being a nuisance who gets into everything.
9. Children need to feel that they are loved, that they belong, that they are wanted. They also need the self-confidence that comes from being able to meet situations adequately.
10. It is important that experiences that are offered to children fit their own maturity level. If a child is pushed ahead too soon, and if too much is expected of him/her before he/she is ready, failure may discourage him/her. On the other hand, a child's growth may be impeded if parents or caregivers do not recognize when he/she is ready for more complex or challenging activities. Providing experiences that tap into skills that the child feels confident in, as well as some new skills that will challenge him/her, will provide the balance of activities that facilitates healthy growth.

Resources for Child Caring, Inc., Minnesota Child Care Training Project, Minnesota Department of Human Services, 1986.



Activity 6D: Ages & Stages

Part 2: Cut out the Ages & Stages cards found on the following pages. Several different age groups' behaviors are represented on these cards in no particular order. Spread the cards on a table and pick out two sets of cards that you think are descriptive of the two different age groups you chose in Part 1 of this activity. ***Don't look ahead at the Child Development chart before completing this part of the activity!*** After you have finished selecting the cards for your two age groups, check your work by referring to the Child Development chart. As you review the chart, note your questions in the margin.



Activity 6D: Ages & Stages Cards

Cut apart the following two pages of Ages & Stages cards on the dashed lines.

Smiles at mother/ caretaker.	Feels totally dependent on mother/caretaker.	Boys first have erections.	Head is not very steady.
First learns to clench hands.	Can say "mama," "dada," and two or three other words.	Stretches arms to be picked up.	Can roll over.
Holds cup with two hands.	Understands the meaning of "no."	Can combine two words, such as "daddy bye-bye."	First plays by himself/herself.
Begins to fear authority figures.	Begins to walk.	Can turn pages of a book, two or three at a time.	Paints with whole arm movement.
Period of rapid language growth.	Can say first name.	Can point to the things he/she wants.	Knows what authority figure wants.
Early sex-role development.	Can run.	Can throw a ball.	Can use a spoon.

Has an extensive vocabulary but cannot sequence.	First learning to cooperate.	Self-esteem is dependent on authority figures.	Can cut with small scissors.
Can ride a tricycle.	Has a vocabulary of 1000 words.	Begins to follow peer's fads.	Sexual identity established.
Buttons and unbuttons large buttons.	Can use the toilet independently.	Can think using symbols.	Knows common opposites.
Develops identity outside of family.	Chooses own friends.	First development of a conscience.	Can tie shoes.
Understands hypothetical situations (i.e., what if...)	Increasing focus on peer relationships.	Worries about being normal.	Feels strange or awkward about his/her body.
Girls can masturbate to orgasm.	Greater physical coordination, manual dexterity, growth patterns vary widely.	Uses formal logic and can change sides in a debate.	Conflicts with parents begin to decrease.
Couples pair off into stable sexual relationships.	Experimentation with sex and drugs.	Feelings of love and passion emerge.	Increased capacity for tender and sensual love.
Heightened physical power, strength, and coordination.	Girls develop faster than boys.	Begins to separate from mother.	

Child Development...

	0 to 6 Months	6 to 12 Months	12 to 18 Months
COGNITIVE	Recognition of mother; no concept of past or future; reaches for familiar people or toys.	Objects can be held in memory; learns through routines and rewards; recognizes name; says two to three words besides “mama” and “dada”; imitates familiar words.	Experiments with physical environment; understands the word “no”; comes when called to; recognizes words as symbols for objects (cat —meows); uses 10 to 20 words, including names; combines two words such as “daddy bye-bye”; waves good-bye and plays pat-a-cake; makes the sounds of familiar animals; gives a toy when asked; uses words such as “more” to make wants known; points to his/her toes, eyes, and nose; brings objects from another room when asked.
PSYCHOLOGICAL	Attachment to mother/ caretaker; totally dependent; totally trusting; learns intimacy.	Separation from mother; begins to develop a sense of self; learns to get needs met; trusts adults; stretches arms to be picked up; likes to look at self in mirror.	Early social development; egocentric; accepts limits; develops self-esteem (love from family); plays by self.
MORAL	None.	None.	Fear of authority figures.
SEXUAL	Erections possible; both sexes can be stimulated.	Generalized genital play.	Continued generalized genital play.
MOTOR	Sucking; hands clenched/ grip; neck muscles develop; pulls at clothing; laughs/ coos.	Rolls over; stands with support; creeps/crawls; walks with help; rolls a ball in imitation of adult; pulls self to standing position and stands unaided; transfers object from one hand to the other; drops and picks up toy; feeds self cracker; holds cup with two hands; drinks with assistance; holds out arms and legs while being dressed.	Creeps up stairs; gets to standing position alone; walks alone; walks backward; picks up toys from floor without falling; pulls and pushes toys; seats self in child-size chair; moves to music; turns pages two or three at a time; scribbles; turns knobs; paints with whole arm movement; shifts hands; makes strokes; uses spoon with little spilling; drinks from cup with one hand unassisted; chews food; unzips large zipper; indicates toilet needs; removes shoes, socks, pants, sweater.

Child Development...		18 to 36 Months	3 to 5 Years	6 to 9 Years
COGNITIVE	Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conversation with self and dolls; asks “what’s that?” and “where’s my...?”; has 450-word vocabulary; gives first name; holds up fingers to tell age; combines nouns and verbs “mommy go”; refers to self as “me” rather than by name; tries to get adult attention, exclaiming “watch me”; likes to hear same story repeated; may say “no” when means “yes”; talks to other children as well as adults; names common pictures and things.	Can conduct experiments inside head; cannot sequence; capacity to use language expands; understands some abstract concepts: colors, numbers, shapes, time (hours, days, before/after); understands family relations (baby/parent); can tell a story; has a sentence length of 4 to 5 words; has a vocabulary of nearly 1000 words; names at least one color; understands “tonight,” “summer,” “lunchtime,” “yesterday”; begins to obey requests like “put the block under the chair”; knows his/her last name, name of street on which he/she lives and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions “I hope”; identifies shapes.	Can think using symbols; can recognize differences; makes comparisons; can take another’s perspective; defines objects by their use; knows spatial relationships like “on top,” “behind,” “far,” and “near”; knows address; identifies penny, nickel, dime; knows common opposites like “big/little”; asks questions for information; distinguishes left from right.	
PSYCHOLOGICAL	Autonomy struggles; learns system of meeting needs; social development increases; points to things he/she wants; joins in play with other children; shares toys; takes turns with assistance.	Can cooperate; self-perceptions develop; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feelings (sad, jealous, embarrassed); plays and interacts with other children; dramatic play is closer to reality, with attention paid to detail, time, and space; plays dress-up.	Early close peer relationships; presence of well-developed defenses; develops identity outside family (school, friends); has likes and dislikes (food, friends, games); chooses own friends; plays simple table games; plays competitive games; engages in cooperative play with other children involving group decisions, role assignments, fair play.	
MORAL	Knowledge of preferences of authority figures.	Self-esteem dependent on authority figures; follows peers’ fads; negotiates to get needs met.	Has a conscience; refinements in moral development.	
SEXUAL	Continued generalized genital play; early sex-role development.	Generalized genital play in males; masturbation to orgasm in females is possible; early experimentation; gender identity established.	Defenses reduce experimentation, but some continues.	

Child Development...		18 to 36 Months	3 to 5 Years	6 to 9 Years
		MOTOR	Can run, throw ball, kick ball, jump; goes up stairs with one hand held by adult; turns single pages; snips with scissors; holds crayon with thumb and fingers (not fist); uses one hand consistently in most activities; rolls, pounds, squeezes, and pulls clay; uses spoon with little spilling; gets drink from fountain or faucet independently; opens door by turning handle; takes off and puts on coat with assistance; washes and dries hands with assistance.	Swings/climbs; uses small scissors; jumps in place; walks on tiptoes; balances on one foot; rides a tricycle; begins to skip; runs well; bathes and dresses; runs around obstacles; walks on a line; pushes, pulls, steers wheeled toys; uses slide independently; throws ball overhead; catches a bounced ball; drives nails and pegs; skates; jumps rope; pastes and glues appropriately; skips on alternating feet; pours well from small pitcher; spreads soft butter with knife; buttons and unbuttons large buttons; washes hands independently; blows nose when reminded; uses toilet independently.

Child Development...		10 to 15 Years	16 to 21 Years
		COGNITIVE	Can engage in inductive and deductive logic; neurons are present; understands hypothetical situations; conflicts with parents increase.
PSYCHOLOGICAL	Increased autonomy struggles; increased focus on identity; focus on peer relationships; rebellious; often moody; romantic feelings; struggle with sense of identity; feels awkward or strange about his/her body; worries about being normal; frequently changing relationships.	Interest in relationships; solidifies personal identity; becomes goal directed; sometimes rebellious; increased concern for others; increased concern for future; places more importance on his/her role in life.	
MORAL	Moral development is legalistic; recognition of principles (e.g., justice); selection of role models.	Identifies with moral principles, rules, and limit testing; experimentation with sex and drugs; examination of inner experiences.	

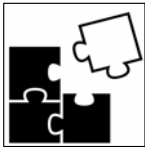
		10 to 15 Years	16 to 21 Years
		SEXUAL	Puberty; sex organs mature; males ejaculate and have wet dreams; both sexes able to masturbate to orgasm with fantasies; girls develop physically sooner than boys; may display shyness, blushing, and modesty.
MOTOR	Greater body competence (e.g., physical coordination); manual dexterity; growth patterns vary.	Heightened physical power, strength, coordination.	

Chart compiled by Katie Thompson, Elon College student intern, NC Guardian ad Litem Program. Sources include: "Infant and Toddler Development," Dr. Maureen Vandermaas-Peeler, Elon College; "Child Development," Ray Newnam, Ph.D.; "LD In Depth," LD OnLine, www.ldonline.org; "Growing Up," Pasternak and Kroth; "Your Child's Growth: Developmental Milestones," American Academy of Pediatrics, www.aap.org; and "Normal Adolescent Development," American Academy of Child and Adolescent Psychiatry, www.aacap.org.

¹ Materials about working with gay and lesbian youth appear in the Resource Materials section of this chapter.

In using tools such as the preceding child development chart, keep in mind that:

- ✓ There is a wide range of typical behavior, and at any particular age twenty-five percent of children will not have reached the behavior or skill, fifty percent will be showing it, and twenty-five percent will already have mastered it;
- ✓ Some behaviors may be typical—in the sense of predictable—responses to trauma, including the trauma of separation as well as abuse and neglect;
- ✓ Prenatal and postnatal influences may alter development;
- ✓ Other factors, including culture, current trends, and values, also influence what is defined as typical; and
- ✓ A CASA/GAL volunteer needs to become aware of his/her own values, attitudes, and perceptions about what is typical in order to be more objective and culturally sensitive when assessing a child's needs.



Activity 6E: Ages & Stages—Damien & Ben

Keeping in mind the principles of development that you reviewed earlier, complete the following activity.

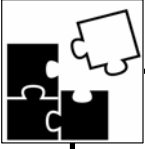
Part 1: Think about Ben, the older child in the Parker-Solano case. Using the child development chart, try to place Ben’s developmental level in each of the areas discussed: motor, sexual, moral, psychological, and cognitive. Is he on target? What might a CASA/GAL volunteer do to gather additional information in order to assess Ben? What might help Ben in any areas in which he is lagging behind? Fill out Ben’s section of the developmental needs chart.

Part 2: Think about Damien, the younger child in the Parker-Solano case. Using the child development chart, try to place Damien’s developmental level in each of the areas discussed: motor, sexual, moral, psychological, and cognitive. Is he on target? What might a CASA/GAL volunteer do to gather additional information in order to assess Damien? What might help Damien in any areas in which he is lagging behind? Fill out Damien’s section of the following developmental needs chart.

Ben’s Developmental Needs...		Think of an example from the Parker-Solano case that illustrates this area of development.	What might a CASA/GAL volunteer do to gather more information?	Identify resources to help the child in this area.
	COGNITIVE			
	PSYCHOLOGICAL			
	MORAL			

Damien's Developmental Needs...	SEXUAL			
	MOTOR			
		Think of an example from the Parker-Solano case that illustrates this area of development.	Identify sources of information or materials for further assessment in this area.	Identify resources to help the child in this area.
	COGNITIVE			
	PSYCHOLOGICAL			
	MORAL			
	SEXUAL			
	MOTOR			

UNIT 3: Attachment



Activity 6F: The Attachment Cycle

Part 1: Read the following summary of what attachment means in child development and what the risks are for children who lag developmentally or lose the ability to attach to a parent or caretaker. Look at the diagram of the cycle of attachment and think about the ramifications of a break in the attachment cycle at various stages of attachment.

What Is Attachment?

Attachment can be defined as:

- The psychological connection between people that permits them to have relational significance to each other.
- An affectionate bond between two individuals that endures through space and time and serves to join them emotionally.
- A strong and enduring bond of trust that develops between the child and the person(s) he/she interacts with most frequently.

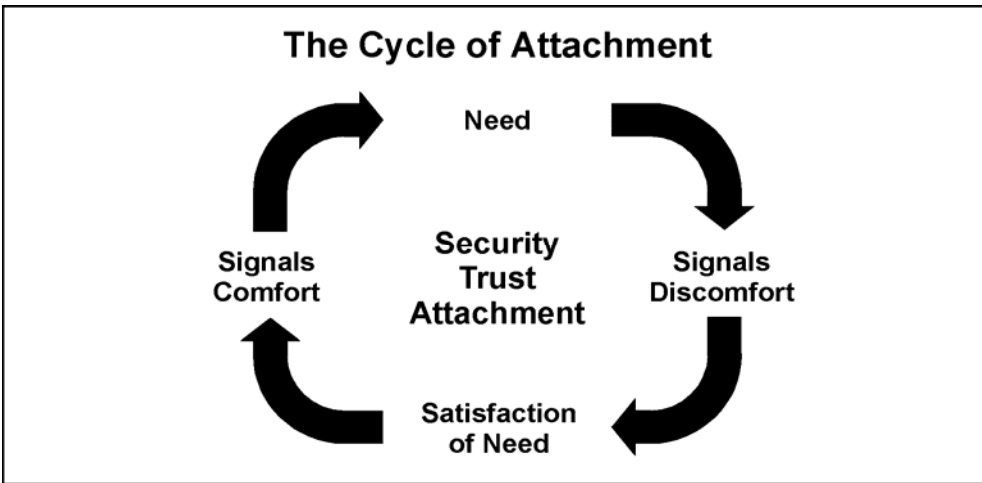
Attachment is a skill that begins to be learned shortly after birth and develops intensely throughout the first three years of life. After the age of three, children can still learn how to attach; however, this learning is more difficult. The child's negative experiences with bonding will strongly influence the child's response to caregivers and other individuals throughout the child's lifetime.

Children who are learning to attach will be influenced by three specific factors:

1. The child's genetic predisposition;
2. The conditions under which the child is taught; and
3. The child's "teachers" (the parents or caretakers).



Healthy attachments are not based on genetic ties to or the gender or culture of the caretaker. They are based on the nature of the relationship between the child and the caretaker.

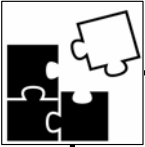


When a baby cries, the caretaker responds by picking up the child. The caretaker continues to stroke, talk to, and hold the baby while the child is fed. After several days of this routine the child learns that to get needs met, all he/she has to do is cry. The caretaker responds and immediately begins to soothe the infant, resulting in an increased sense of trust and security. This cycle of having needs consistently met creates a secure attachment between the infant and caretaker. It is referred to as the “cycle of attachment” or the “trust cycle.”

The basic needs of many of the children in the CASA/GAL program have not been met. Some children may cry for hours at a time, or may get hit when they do cry. This could result in a child who does not cry when hungry and does not trust adults. This child might turn away from the caregiver, refuse to make eye contact, push away or fight to avoid being close with another individual. When this type of child is distressed, he/she may not seek out a caregiver for soothing or comfort, or may be indiscriminate—seeking satisfaction from any potential caregiver, including a total stranger.

It is very important to understand the normal process of attachment because the experiences of most of the children in the child protection system increase the likelihood that they will have attachment problems, which may or may not rise to the level of a reactive attachment disorder.

Think about what you have observed in a healthy relationship between a child and parent. There is a distinct cycle of infant attachment development: (1) expressing a need (by crying); (2) having that need met (feeding, diapering, holding); (3) growing familiar with the person who meets the need; and (4) trusting that the caretaker will be there every time. This leads to “bonding” with that person, the trusted caretaker. This is the healthy attachment cycle.



Activity 6F: The Attachment Cycle

Part 2: Read the following material on reactive attachment disorder, then review the two scenarios that appear below. Consider where in the attachment cycle a break might have occurred for each child and circle the appropriate answer.

A three-year-old who will go to anyone, sit on anyone's lap, and shows no emotion when her primary caretaker leaves. This child had numerous caretakers as a child because her mom was in jail.			
NEED	SIGNALS DISCOMFORT	SATISFACTION OF NEED	SIGNALS COMFORT
A seven-year-old child who hoards food in foster care. As an infant being raised by heroin-addicted parents, this child was sometimes left to cry for hours and other times fed on demand.			
NEED	SIGNALS DISCOMFORT	SATISFACTION OF NEED	SIGNALS COMFORT

Reactive Attachment Disorder

Some children with extreme attachment issues develop reactive attachment disorder (RAD). It is thought that only a small percentage of maltreated infants will be diagnosed with this disorder. It is important to learn some of the following warning signs because many children who have been abused or neglected have less severe attachment issues that may still impair their ability to form healthy relationships.

- Superficially engaging and charming child.
- Indiscriminately affectionate with strangers.
- Destructive of self, others, things.
- Developmentally behind, even in favorable environments.
- Will not make eye contact.
- Not cuddly with parents.
- Cruel to animals, siblings.
- Lacks cause-and-effect thinking.
- Has poor peer relations.
- Is inappropriately demanding or clingy.
- Engages in stealing, lying.
- Has poor impulse control.
- Has abnormal speech patterns.
- Fights for control over everything.

"Children at Risk for Reactive Attachment Disorder: Assessment, Diagnosis and Treatment," Keith Reber, *Progress: Family Systems Research and Therapy*, 1996, Volume 5, (pp. 83-98). Encino, CA: Phillips Graduate Institute.

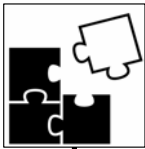
There are many factors that can contribute to the lack of healthy attachments. A lack of attachment may be due to a substance abuse issue, the immaturity of the caretaker, a mental health issue, or other problems that parents experience. An attachment may be broken when a child loses contact because he/she may have been moved many times, or when visitation does not occur frequently and on a regular basis when the child is very young. At the most serious end of the continuum is reactive attachment disorder. Note the list of warning signs above. If you have concerns about a child, an assessment by a qualified mental health professional should be considered, and possibly requested.

(Note: Additional materials about reactive attachment disorder are found in the Resource Materials section of this chapter.)

UNIT 4: Separation

Understanding typical reactions of children and their parents to separation and loss provides motivation for the CASA/GAL volunteer in fulfilling an advocacy role. Integrating this understanding about separation and loss with information on child development, behavior, attachment, and a child's sense of time allows CASA/GAL volunteers to more accurately assess a child's needs.

When children are removed from their homes, no matter how strong or weak the attachment, they feel isolated and detached. Not only do they worry about not seeing their parents, but they also suffer from fears of losing peer groups and siblings, changing schools, or missing something as simple as their bed or toys.



Activity 6G: The Separation Experience for Children

Part 1: Read the Separation Experience Scenario that follows. As you read, imagine the experience of being a child who is removed from his/her home as a result of the local child protection agency filing a petition for abuse or neglect. Sometimes this exercise makes people feel sad or uncomfortable as they think about experiences that they have had or as they feel how difficult it is for a child experiencing separation from his/her parents. Take a break if it gets difficult for you.

Separation Experience Scenario

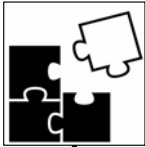
For the next few minutes, sit comfortably and close your eyes as you visualize yourself as a four-year-old boy or girl at home one evening with your mom and dad. Continue to imagine yourself as this child as you open your eyes and read the following story...

A lady came to the daycare center today and asked you lots of questions about what your mom and dad do when you are bad, whether you have enough food at home, how much your daddy drinks, and how often he hits your mommy. You are pretty sure you are going to be in a lot of trouble because the lady said she had to tell your parents that she talked to you. You can barely eat your dinner and your mom is already mad about that. Your dad is drinking another beer, which usually is a bad sign.

There is a knock on the door and that same lady is standing there with a policeman. Now you know you are really in big trouble. She tells your mom and dad that she is taking you away with her. Will they put you in jail? She sits near you at the table and tells you not to worry. She asks your mom or dad to get some clothes together. She asks if there is any special toy or blanket that might help you sleep better. You just can't imagine what it will be like to sleep in jail with all of those mean people that were there with your dad the last time he went.

But the lady doesn't take you to jail. The policeman and the lady take you to a big house in another part of the town. They are chatting and laughing on the way. You can tell they are trying to be nice, but you are really scared. The lady walks you to the door and another lady opens it up. She has a big smile on her face and takes your bag of stuff and says, "Come right in." Behind her is a man. He is smiling, too. There are a bunch of other kids who are all looking at you. The new lady says, "Welcome. This is your new home. We are so glad to have you." She keeps smiling and seems really nice, but there must be some mistake. You didn't ask for a new home... You already have a mom and dad... You don't have brothers and sisters... This isn't your room... And what is this food that they are giving you? You realize that this is all your fault and that your mom and dad must be really mad now. You wonder if you'll ever see them again.

There are a number of things that a CASA/GAL volunteer can do to help a child who is experiencing difficulty with the separation from his/her parents. Children in the foster care system are damaged every time they are moved from one place to another. Each placement increases the likelihood of irreversible damage to the child's emotional and psychological health. However, because a child's safety has to be the primary consideration, sometimes he/she must be moved for protection. A CASA/GAL volunteer is generally not assigned to the case until the child has been removed from the home. Once you are appointed, you can advocate that the child not experience multiple placements.



Activity 6G: The Separation Experience for Children

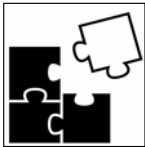
Part 2: Describe below how your feelings would have been different during your reading of the Separation Experience Scenario given the following circumstances:

If the foster parents were of a different race... _____

If they were very old... _____

If the foster mom was in a wheelchair... _____

If both foster parents were women... _____



Activity 6H: Separation—What a CASA/GAL Volunteer Can Do

Read the following description of separation anxiety disorder and the list of things a CASA/GAL volunteer can do to help. Think about what you might add to the list. Use the space below to write down your additional suggestions.

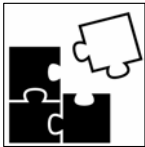
Separation Anxiety Disorder

While all children would be expected to show signs of distress if removed from their homes, some children have extreme reactions. In a child with separation anxiety disorder, the feelings of anxiety become so intense that they interfere with the child's ability to perform daily activities. Typically, the child will think morbid thoughts about being harmed or never being able to see his/her caretaker again. Below, you will find several characteristics of a child who suffers from separation anxiety disorder. He/she may have:

- ✓ Recurrent excessive distress when separation from home or caretakers occurs or is anticipated;
- ✓ Persistent and chronic worry about losing a caretaker or that person being hurt;
- ✓ Persistent worrying that an event will lead to separation from a caretaker (e.g., getting lost or being kidnapped);
- ✓ Reluctance or refusal to go to school because of the fear of separation;
- ✓ Excessive fear of being alone at home or elsewhere without a caretaker;
- ✓ Reluctance or refusal to go to sleep without being near a caretaker or when away from home;
- ✓ Nightmares involving separation; and/or
- ✓ Complaints of physical symptoms (headaches, stomachaches, nausea, vomiting) when separation from a caretaker takes place or is anticipated.

What a CASA/GAL Volunteer Can Do...

- Advocate for additional therapeutic services;
- Explain to the child when he/she might see his/her parent (but don't make promises!);
- Take a strong stand against a court hearing continuance; and/or
- Advocate for a maximum amount of visitation, when appropriate.



Activity 6I: The Separation Experience for Parents

Read the material about a parent's feelings about the separation experience. List any similarities you notice between a parent's and a child's experiences with separation in the space provided.

Consider how knowing this information about the separation experience for parents might impact a CASA/GAL volunteer's recommendations for visitation and his/her expectations about parents' compliance with court orders.

A Parent's Feelings About the Separation Experience

Comment [v1]: Larger space to write

Following is one parent's description of the feelings she experienced when her children were placed in foster care. Knowledge about parents' feelings, coupled with helping parents express their feelings, leads to more meaningful contact with parents. The CASA/GAL volunteer will often observe a similar reaction to the separation experience in both the parent and the child because grief and loss are experienced universally as a series of emotions including denial, anger, sadness, and, eventually, acceptance. Sometimes these reactions proceed in the order outlined below; sometimes people skip around or cycle back to a previous stage as they work through their personal reaction to grief and loss.

STAGE 1: Denial

When the loss of your child hits you, it is like going into shock. You may cry, feel shaky, and find it hard to hear what people are saying to you. You can't think of anything except the child who has been placed. You take care of the rest of the family or go to work like a sleepwalker without really knowing what you're doing. You wonder what your child is doing now. If you have a car and know where the foster home is, you may drive by just to be sure it is there.

You wonder if the foster parents are taking good care of your child and doing all the things the way he/she is used to. You may think you hear your child or see him/her in his/her old room. You remember all the good times, even if there weren't very many. You try to keep busy and not think at all, but you keep coming back to your last glimpse of your child. This shock usually lasts from a few days to a few weeks. Other people may try to be comforting to you, but you feel distant to and "outside" the rest of the world.

STAGE 2: Anger

As you come out of the numbness of shock, you experience sadness, anger, and physical upset. You might lose your appetite, or you might eat constantly. It may be hard to fall asleep. You may increase your use of alcohol, cigarettes, or sleeping pills. You may find yourself suddenly tearful "over nothing." You are afraid of what people think of you.

You are angry at perfect strangers on the street because it is you going through this and not them. You are angry with God. If your child was placed in foster care against your wishes—or even if he/she wasn't—you are furious at the social agency, the court, and everybody there. You are mad at yourself and go over and over and over in your mind what happened to see what you could have done to make it different. You can't come up with anything, but you can't quit thinking about it either.

You are angry at your child and feel he/she was difficult on purpose. You tell yourself you are glad your child is gone and never want him/her back. You think how nice it is without him/her. Above all, you resent your child for making you go through all this pain.

You get scared at how angry you are or feel guilty about the anger and start avoiding your child or your work. But it is normal to feel angry when things are not the way you would like them to be. Anger sometimes helps you act to change things. When anger doesn't help, you learn to give it up and try something else to get what you want. You might stay with being angry because it hurts less than the next step, which is despair.

STAGE 3: Sadness

When the anger has worn off, you go into the blues. You may feel you don't care about anybody or anything. It isn't worth getting up each day, and nothing interests you. You may feel worthless and no good. You might think about suicide. You might get ill.

If you are a single parent and all your children have been placed, you may feel desperately lonely. You don't know who you are without your children to care for, or what to do with your day with no one to fix meals for. The world seems barren and silent, and you feel empty and hollow.

You might feel guilty because there is less stress with the child out of the home. You might find you can survive without your child, but feel bad because of it.

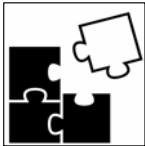
STAGE 4: Acceptance

One day things just seem to be better. You begin eating and sleeping well again. You miss your child but are now more realistic about his/her being in foster care. You again pay attention to the house, your work, and the rest of the family. You get interested in keeping your agreements about visiting your child and making your appointments with your caseworker. You begin to realize that you may actually have more time with your child now and feel better when you're with him/her than you did before the foster care, when you were trying to handle too much. You begin to see that both you and your child need relationships with others to deal with the loneliness, and now you have some energy for that.

Adapted from *The Parents' Guide to Foster Family Care*, Barbara Rutter, New York: Child Welfare League of America, 1978.

UNIT 5: Permanence for Children

Understanding a child’s need for permanence can guide the CASA/GAL volunteer’s advocacy for placement and services that are in the best interest of the child, honoring the child’s sense of time.



Activity 6J: Permanence for Children

Begin your examination of the meaning of permanence for children by watching the video “The Adoption and Safe Families Act (ASFA) of 1997: The Essential Voice of Child Advocates.”

As you watch this video, think about the issues that have been addressed in this chapter so far: what children need, how children grow and develop, attachment, separation, a child’s sense of time, and other issues of childhood. A child’s need for permanence is the guiding light in the work of the CASA/GAL volunteer.

Following the video, read the material on permanence in this chapter and consider how you will use this information during your first case, your second, and your fifth.

Permanence

All children need a “parent,” a primary attachment figure who will care for them through life’s ups and downs, protect them, and guide them now and into adulthood. In our culture, typically the parents are a father and mother, but one or more other caring adults who are willing to commit unconditionally to the child can also meet the child’s need for permanence. A primary goal of the CASA/GAL volunteer is to advocate for a safe, permanent home as soon as possible, honoring the child’s sense of time. While there is never a guarantee of permanence, having such intentions can ensure that you are working toward a plan that supports permanence.

At a very basic level, permanence is most probable when the *legal* parent is also the *emotional* parent as well as the *parenting figure present in the child’s life*.

There are two possible “permanent” resolutions:

- 1. Return to parent, or**
- 2. Adoption by a relative or non-relative.**

A third option, while not truly “permanent,” is sometimes considered an appropriate option when the other two are not available to a child. It is the “next best thing”:

- 3. Placement and custody or guardianship with relatives.**

(Note: Some Indian people have a strong bias against adoption, and certain tribes do not approve of adoption. This creates a special situation when considering the permanent options for an Indian child. In some cases, placement with an Indian custodian can truly be considered permanent.)

Concurrent Planning

Given these possible outcomes, the CASA/GAL volunteer encourages what is called “concurrent planning,” a plan to work toward reunification while exploring other permanent options from the very beginning of the case. A CASA/GAL volunteer starts the case with the end in mind. Traditionally, case management in child welfare has consisted of efforts to reunite children with their parent(s), and if those efforts failed, a second plan would be pursued. This created a process that kept many children in foster care for too many years. Concurrent planning was developed as an alternative that moves a case more quickly through the system with better results. The concurrent planning approach is family-centered, with parents involved in decision making from the start. Throughout the case, parents are regularly given direct, culturally sensitive feedback about their progress. From the start of the case, while providing services to the parents, the caseworker explores kinship options, the applicability of the Indian Child Welfare Act, and possible foster/adoptive situations for the child.

(Note: Additional materials about permanence and concurrent planning can be found in the Resource Materials section of this chapter.)



Activity 6K: How Many Placements?

Taking into account the issues that are raised for children when they are moved, think about the Parker-Solano training case. Answer the following questions:

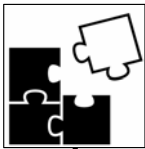
When Ben was initially removed, Damien remained in the home. What issues does this raise for these children?

Similarly, at the end of the case, Damien is living with his father and Ben is still in an out-of-home placement. What issues does this raise for these children?

UNIT 6: Educational, Emotional & Psychological Issues for Children

The issues explored in this section can impact any child, not just those who have come to the attention of the child protective services system as a result of abuse or neglect. It is not the purpose of this training to make you an expert in child development or psychology, but to help you recognize warning signs that might indicate the need for evaluation and treatment by an educational specialist or qualified mental health professional.

(Note: There is additional information about each of these issues in the Resource Materials section of this chapter.)



Activity 6L: Researching an Issue

Part 1: Read the information about children's issues, which appears on the pages following this activity. As you read, think about which of the eight topics listed below you would like to know more about. Review the additional materials for that topic in the Resource Materials section of this chapter. You may also want to seek additional information at your local library or on the Internet.

1. Learning Disabilities
2. Attention-Deficit/Hyperactivity Disorder
3. Special Education Services
4. Childhood Depression
5. Conduct Disorder
6. Post-Traumatic Stress Disorder
7. Fetal Alcohol Syndrome
8. Professional Assessment of Children

School Issues

Chaos in the lives of the children with whom you will work as a CASA/GAL volunteer often results in the neglect of educational concerns. Parents or caregivers may not be available to help with homework, attend school conferences, or make referrals for evaluation when concerns arise. Children entering foster care often have school issues. Addressing these issues can allow a more positive experience for a child who hasn't known the rewards of success in school.

For CASA/GAL volunteers, teachers who see the children every day have a wealth of knowledge about the child's behavior, attitude, likes, and dislikes, and about the best ways to communicate with that child. As you inquire about the child's progress in school, you may discover that your child has special educational needs and should be referred for an evaluation. In some areas, there may be an abundance of available resources for special-needs children, and in other areas, you may have to advocate for the creation of needed resources.

Children from a different race or ethnic background than the majority culture may also have special needs based on discriminatory practices in the educational system. For instance, children may face racial taunts, teachers who believe they can't learn, and testing that is racially/culturally biased. It is important to realistically assess the school difficulties of any child and determine what role the educational system, as well as the child's particular school setting, may be playing in creating or sustaining those problems.

Learning Disabilities

Following, you will find a list of possible indicators of specific learning disabilities. Children with learning disabilities are typically of average to above-average intelligence; they simply process information differently. Keep in mind that the earlier a child is diagnosed, the better his/her chances are to enjoy and succeed in school and life!

EARLY WARNING SIGNS	
Pre-School	Grades K-4
<ul style="list-style-type: none"> ✓ Late talking ✓ Slow vocabulary growth ✓ Inability to find the right word ✓ Trouble learning numbers, alphabet, days of the week ✓ Extremely restless ✓ Poor ability to follow directions ✓ Trouble interacting with peers 	<ul style="list-style-type: none"> ✓ Slow to learn connections between letters and sounds ✓ Confuses basic words (run, eat, want) ✓ Makes consistent reading and spelling errors including letter reversal (b/d) ✓ Transposes number sequences and confuses arithmetic signs ✓ Slow recall of facts ✓ Slow to learn new skills, relies heavily on memorization ✓ Impulsiveness, lack of planning ✓ Unstable pencil grip ✓ Trouble learning about time

Attention-Deficit/Hyperactivity Disorder

Many children have specific learning disabilities/challenges as described in the previous section. For some children these may be paired with other disorders such as attention-deficit/hyperactivity disorder (AD/HD)—previously called attention-deficit disorder (ADD) and attention-deficit hyperactivity disorder (ADHD). This disorder may also be present in children without learning disabilities. The main characteristics of children with AD/HD include hyperactivity, a short attention span, distractibility, an impulsive nature, and constant motion. This disorder is more common in boys than girls, and the symptoms are typically present before the age of seven. Several diagnostic criteria must be met before a child can be diagnosed with AD/HD, including that the behaviors must occur in more than one setting and over a period of time.

The best news about AD/HD is that it is a treatable disorder. Through the use of medication, special education programs, counseling, and parent training, children’s behavior can be greatly improved and they can become better able to concentrate. This results in better relationships with peers, teachers, and family members.

Special Education of Children

After a child is diagnosed with special learning needs, you may hear the term “Individualized Education Program (IEP).” The IEP is a written document that guides both teachers and parents in the appropriate education of the child for a period of one year. There is a required meeting at least once each year for review of this document. Teachers, caseworkers, parents, foster parents, CASA/GAL volunteers, and other people who interact with the child should be invited to this meeting, where they discuss what type of services the child needs and the frequency with which the child should receive these services.

If a child is in the custody of the local child protection agency, he/she must be assigned an education surrogate/surrogate parent—a trained community member who advocates for appropriate educational services for the child. The surrogate parent gives permission for testing and for services to meet the needs of the child. Some counties have a list of people who are qualified to assume the role of the surrogate parent, and with training, foster parents or CASA/GAL volunteers may be permitted to assume this role.

Other Issues That Affect Children

The children with whom you will be working may exhibit symptoms or behaviors that require professional assessment. A specific behavior may be a warning sign of a particular problem but may also be attributable to a variety of other causes. ***It is critical that the CASA/GAL volunteer not try to diagnose.*** A referral to a competent mental health professional is the best course of action if you learn about or observe red flags as you complete your initial investigation and as you continue to monitor the child’s situation.

Following are some of the possible diagnoses that may apply to the children with whom you work.

Grief & Depression

Many of the children in the CASA/GAL program experience a tremendous amount of sadness after being removed from their homes. Despite their strong emotions, often children cannot verbally express their persistent feelings of sadness and emptiness. At earlier developmental stages, abstract thinking and vocabulary do not exist. Children may not know why they feel sad; they simply do. Some key behaviors to look for are loss of appetite and change in sleeping patterns. Listed below you will find several characteristics of grief and depression:

- Sudden drop in school performance;
- Loss of appetite;
- Suicidal thoughts;
- Expressions of fear or anxiety;
- Aggression, refusal to cooperate, antisocial behavior;
- Use of alcohol or drugs;
- Outbursts of shouting, complaining, unexplained irritability, or crying;
- Withdrawal; and
- Change in sleep patterns.

If these characteristics are present in a child with whom you are working, request that an assessment be completed by a qualified mental health professional who can diagnose and treat childhood depression. The local child protection agency will need to make the referral for this assessment.

Conduct Disorder

Children with conduct disorder show a chronic disregard for the norms and rules of society. Oftentimes this disorder is ignored and the child is simply labeled a juvenile delinquent. However, children with conduct disorder have underlying emotional problems that need to be dealt with in a therapeutic setting. Below you will find a list of common conduct disorder behaviors. A child needs an assessment if he/she displays several of these behaviors within a six-month time frame.

- Starting fights;
- Skipping school;
- Constantly lying;
- Forcing sexual activity;
- Breaking into homes, cars, or offices;
- Setting fires; and
- Cruelty to animals or humans.

Through counseling, children can begin to appreciate the effect their behavior has on others and learn new ways to get their needs met without harming others.

Post-Traumatic Stress Disorder

Post-traumatic stress disorder, otherwise known as PTSD, develops as a reaction to a terrifying event or series of events, such as severe child abuse or witnessing domestic violence. PTSD typically appears within six months of the event and can last for many years. Symptoms of PTSD are placed into three categories.

Intrusion (re-experiencing the trauma)	Avoidance/Numbing (avoidance of things that remind one of the trauma)	Hyperarousal (increased tenseness and heightened awareness)
<ul style="list-style-type: none"> ● Flashbacks and/or nightmares in which the person experiences the same feelings of distress that took place during the initial event. 	<ul style="list-style-type: none"> ● Avoids close emotional ties. ● Supersensitive to activities or situations that remind one of the trauma. ● Feelings of numbness. 	<ul style="list-style-type: none"> ● Exaggerated startled response (jumpy and easily startled). ● Irritable and explosive. ● Hypervigilance (always being watchful of potential danger).

Therapy or a combination of therapy and medication can relieve some of these symptoms and provide temporary relief from the trauma of this disorder. Ideally, both the memories of the trauma and the symptoms will fade after a period of therapy and/or medication. As with any other childhood disorder, it is critical to have a competent professional assess the child. Post-traumatic stress disorder, reactive attachment disorder, separation anxiety disorder,

and simple anxiety are often misdiagnosed as attention-deficit/hyperactivity disorder. Currently, there is great controversy about the possible overdiagnosis—and overmedication—of children with AD/HD. Obtaining a second opinion is good practice. The more relevant information the CASA/GAL volunteer gathers, the more likely he/she is to understand the needs of the child and to make appropriate recommendations to the court.

Fetal Alcohol Syndrome

Fetal alcohol syndrome, better known as FAS, is described as a set of particular facial features, growth deficiencies, and central nervous system damage resulting from alcohol exposure during pregnancy. Mothers who do not receive prenatal care and who regularly consume alcohol during pregnancy have an increased risk of delivering a child who has FAS. Some physical characteristics at birth include a poor sucking reflex, small eyes, thin upper lip, cleft palate, heart defects, and possible joint deformities.

Psychological Assessment of Children

During a case, recommendations may be made for children to undergo psychological assessment. Assessment is a process, not just a series of tests. The reasons why assessment is recommended, the particular instruments (tests) used, the individual conducting and evaluating the instruments, the timing of the assessment in the context of the child's life, and the intended uses of the assessment are all important parts of this process. Following is a brief overview of reasons that children are referred for assessment.

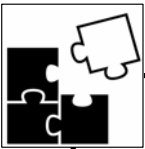
(Note: Information about the instruments used in assessments appears in the Resource Materials section of this chapter.)

Reasons for Assessment

Children are referred for psychological assessment for many reasons, including:

1. **Dysfunctional and negative behavior**, such as tantrums, a demanding personality, excessive crying and whining, delinquency, defiance of rules and limits.
2. **Developmental concerns**, such as perceptual and motor problems, speech and learning problems, delayed development, school readiness determination.
3. **Educational problems**, such as inadequate performance and progress, aggressive behavior, dislike or disinterest in school.
4. **Sleeping and eating problems**, such as infant feeding and nursing problems, excessive crying, bulimia, anorexia nervosa, over- and undereating, and any suspected nutritional deficiencies that may be contributing to learning problems, sleep and behavior problems, fatigue.
5. **Toilet training problems**, including any manifestations of encopresis (soiling), enuresis (bedwetting), or excessive fear of going into the bathroom.
6. **Behavioral issues**, such as poor self-control, lack of motivation, irresponsibility, lying, stealing, dependence/independence conflict, setting fires, “mean” behavior toward animals and others, self-inflicted injuries, sexuality issues.

7. **Family problems**, such as sibling conflict, dysfunctional communication, inadequate support system in social relationships and skills, attachment and separation problems, aggressiveness, and abuse. Problems of change prompted by divorce, custody issues, separation, adoption, termination of parental rights, moving, visitation issues, grieving and death issues. Problems related to how the child learns and processes information that the family presents (the belief system within the family leading to attitude, temperament). Parents' negative feelings for the child, poor relationship indicators, conflict over discipline, family arguing.
8. **Medical considerations**, such as psychophysiological reactions to stress, adjustment to illness of a child or family member, terminal illness of the child or family member, physical or sexual abuse, neglect, drug and alcohol abuse by child or other family member.
9. **Psychiatric manifestations**, including personality disorder, cyclothymic mood disturbance (alternate periods of elation and depression), disassociation and psychic numbing (emotional shutting down and flat affect), excessive fears, harming others, and psychotic behavior such as hallucinations and thought disorder.



Activity 6L: Researching an Issue

Part 2: Use the Researching Children's Issues Reporting In form to summarize three things you learned while researching your chosen topic. When you have completed the Reporting In form, make a copy of your work to submit to CASA/GAL program staff at the debriefing session for this chapter.



REPORTING IN

Researching Children's Issues...

Directions: Check the box below that corresponds to the topic you selected to learn more about. Use the space provided to summarize three things you learned from researching your topic.

- | | |
|---|---|
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Attention-Deficit/Hyperactivity Disorder |
| <input type="checkbox"/> Special Education Services | <input type="checkbox"/> Post-Traumatic Stress Disorder |
| <input type="checkbox"/> Childhood Depression | <input type="checkbox"/> Fetal Alcohol Syndrome |
| <input type="checkbox"/> Conduct Disorder | <input type="checkbox"/> Professional Assessment of Children |

1. _____

2. _____

3. _____

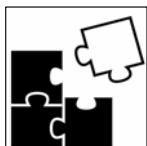
Submit a completed copy of this form to CASA/GAL program staff.

UNIT 7: Resiliency

Resiliency & Its Relationship to High-Risk Children

Not all children subjected to lives of severe adversity go on to suffer problems or disorders. While experiencing several risk factors certainly increases the likelihood of developing problems, some children rise above the risks. This is resiliency. In short, resiliency theory suggests that certain children (and adults) have qualities of personality, family, relationships, outlooks, and skills that allow them to rise above enormous hardship. Resilient people are those who escape the ravages of poverty, abuse, unhappy homes, parental loss, disability, or many of the other all too common risk factors known to set many people on a course of life anguish. Numerous studies of resilient people have identified the presence of the same protective factors—aspects of the child, their family, or their experience that help resilient youth succeed in their lives, while other high-risk children succumb to the risks present in their lives.

(Note: Additional information about resiliency and protective factors can be found in the Resource Materials section of this chapter.)



Activity 6M: Resiliency

Review the following chart of the various psychological risk and protective factors that help some children overcome multiple risk factors. Check off (✓) those protective factors present in your own life. Next, circle the protective factors that you believe can be changed or influenced. For example, a person cannot do much to become the first-born child, but he/she could become a better reader.

Choose two protective factors that you circled. As a CASA/GAL volunteer, how could you impact these protective factors on behalf of the child you represent? Write your responses below.

Protective Factor	How to Change/Influence Protective Factor

RISK FACTORS

Early Development

- Premature birth or complications
- Fetal drug/alcohol effects
- “Difficult” temperament
- Long-term absence of caregiver in infancy
- Poor infant attachment to mother
- Shy temperament
- Siblings within two years of child
- Developmental delays

Childhood Disorders

- Repeated aggression
- Delinquency
- Substance abuse
- Chronic medical disorder
- Behavioral or emotional problem
- Neurological impairment
- Low IQ (less than 80)

Family Stress

- Family on public assistance or living in poverty
- Separation/divorce/single parent
- Large family, five or more children
- Frequent family moves

Parental Disorders

- Parent(s) with substance abuse problem
- Parent(s) with mental disorder(s)
- Parent(s) with criminality

Experiential

- Witness to extreme conflict, violence
- Removal of child from home
- Substantiated neglect
- Physical abuse
- Sexual abuse
- Negative relationship with parent(s)

Social Drift

- Academic failure or drop-out
- Negative peer group
- Teen pregnancy, if female

PROTECTIVE FACTORS

Early Development

- “Easy” temperament
- Positive attachment to mother
- First born
- Independence as a toddler

Family

- Lives at home
- Parent(s) consistently employed
- Parent(s) with high school education or better
- Other adult or older children help with child care
- Regular involvement in church
- Regular rules, routines, chores in home household
- Family discipline with discussion and fairness
- Positive relationship with parent(s)
- Perception of parental warmth
- Parental knowledge of child’s activities

Child Competencies

- Reasoning and problem-solving skills
- Good student
- Good reader
- Child perception of competencies
- Extracurricular activities or hobbies
- IQ higher than 100

Child Social Skills

- Gets along with other children
- Gets along with adults
- “Likeable” child
- Sense of humor
- Empathy

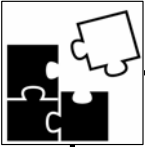
Extra-Familial Social Support

- Adult mentor outside family
- Support for child at school
- Support for child at church
- Support for child from faith, spirituality
- Support for child from peers
- Adult support and supervision in community

Outlooks & Attitudes

- Internal locus of control as teen
- Positive and realistic expectations of future
- Plans for future
- Independent minded, if female teen

Adapted from materials by Marci White, Methodist Home for Children, Raleigh, NC, 1999.



Activity 6N: Key Ideas About Children

Reflect upon the materials you've read and the ideas you've been exposed to in this chapter. Then, in the space below, summarize three things you've learned about children.

1. _____

2. _____

3. _____



RESOURCE MATERIALS

Included in this section:

Working with Gay & Lesbian Youth	6-49
Reactive Attachment Disorder	6-51
Separation Anxiety Disorder	6-53
“Permanent” Resolutions	6-55
Placement with Relative or Kin	6-57
Long-Term Foster Care: An Impermanent Solution	6-59
Principles of Permanence	6-61
Learning Disabilities	6-63
Attention-Deficit/Hyperactivity Disorder	6-65
Special Education Services	6-67
Childhood Depression	6-71
Conduct Disorder	6-73
Post-Traumatic Stress Disorder	6-75
Fetal Alcohol Syndrome	6-77
Professional Assessment of Children	6-79
Resiliency: The 40 Developmental Assets	6-85

Working with Gay & Lesbian Youth

Lesbian, gay, bisexual, and transgender¹ youth as a population are often at greater risk for neglect and/or abuse, discrimination, and dependency problems due to prejudice based on a lack of understanding and acceptance by the dominant cultural group. Consider these statistics:

- Eleven and a half percent of gay and lesbian youth report being physically attacked by family members;
- Fifty percent of gay and lesbian youth are rejected by their parents due to their sexual orientation;
- It is estimated that twenty-six percent of gay and lesbian youth are forced to leave their homes because of conflict with their families over their sexual orientation;
- Gay, lesbian, bisexual, and transgender youth are two to three times more likely to attempt suicide than heterosexual youth; and
- Forty-two percent of homeless youth identify themselves as gay, lesbian, bisexual, or transgender.

The result of these alarming figures is that many youth feel very lonely and isolated. These young people need additional resources and advocacy that may not be available in certain communities due to discrimination and/or a lack of services. CASA/GAL volunteers can advocate for additional services and educate themselves about lesbian, gay, bisexual, and transgender youth.

To gain a better understanding, it helps to consider what it means to be lesbian, gay, bisexual, or transgender. Clinical psychologist Rob Eichberg describes homosexuality well when he says:

Some of us are heterosexual and others of us are homosexual and no one really knows why. Though many people might desire to do away with homosexuality in themselves or in others, there are now, have always been, and always will be lesbians and gay men. Being attracted to one's own sex is as natural for someone who is homosexual as being attracted to the opposite sex is for someone who is heterosexual. Much like the differences in the colors of our hair, eyes, or skin; the shape of our bodies; or being right- or left-handed; it is not good or bad, right or wrong, or better or worse to be homosexual or heterosexual—it just is.

From *Coming Out*, Rob Eichberg, New York: Plume, 1990.

¹ Definitions of these specific terms can be found in the Glossary of this manual.

Reactive Attachment Disorder



Difficulty forming loving, lasting, intimate relationships, due to a failure to attach, to bond, or to trust a primary caregiver during the first two years of life.

What Causes Reactive Attachment Disorder (RAD)?

Any of the following factors, especially occurring to a child during the first two years of life, puts a child at high risk of developing an attachment disorder:

- ✓ Maternal drug and/or alcohol use during pregnancy;
- ✓ Premature birth;
- ✓ Abuse (physical, emotional, sexual);
- ✓ Neglect;
- ✓ Sudden separation from primary caretaker (illness or death of mother, chronic illness or hospitalization of child);
- ✓ Undiagnosed and/or painful illness (colic, chronic ear infections);
- ✓ Frequent moves or placements;
- ✓ Inconsistent or inadequate daycare;
- ✓ Chronic maternal depression;
- ✓ Teenage mothers with poor parenting skills; and/or
- ✓ Drug-addicted infant.

What Are the Signs of Reactive Attachment Disorder?

Although the following symptoms may be seen in many children, a child suffering from reactive attachment disorder will display all or most of them:

- ✓ Manipulative, superficially engaging, or charming;
- ✓ Abnormal eye contact;
- ✓ Indiscriminately affectionate with strangers;
- ✓ Lacking ability to give and receive affection;
- ✓ Extreme control battles often manifest in covert or “sneaky” ways;
- ✓ Destructive to self, others, animals, material things;
- ✓ Accident prone;

- ✓ Stealing;
- ✓ Hoarding or gorging food, abnormal eating patterns;
- ✓ Preoccupation with fire, blood, gore;
- ✓ Lack of impulse control and cause-and-effect thinking (frequently acts hyperactive);
- ✓ Learning lags and speech disorders, abnormal speech patterns;
- ✓ Lack of conscience;
- ✓ Crazy, chronic, obvious lying;
- ✓ Poor peer relationships;
- ✓ Persistent nonsense questions and incessant chatter; and/or
- ✓ Inappropriately demanding and clingy.

What Treatments Are Available?

Children need extensive treatment to learn how to trust, thus enabling them to love. The most recent treatment of choice is attachment therapy. It uses a combination of therapeutic techniques, such as body therapies, psychodynamic techniques, holding techniques, and grief and loss work. The treatment of choice for RAD is a highly controversial issue. In any case, these children need extensive treatment at an early age in order to make up for the neglect they received in utero and as infants.

Separation Anxiety Disorder



Excessive anxiety about being away from home or separated from people to whom one is attached.

What Causes Separation Anxiety Disorder?

The disorder may be triggered by life stress, such as the death of a relative, friend, or pet; geographic move; or a change in schools.

What Are the Signs of Separation Anxiety Disorder?

Separation anxiety disorder lasts at least a month, causing significant distress or impairment in functioning; the duration of the disorder reflects its severity.

A child suffering from separation anxiety disorder may:

- ✓ Experience great distress (crying, clinging, panic) when separated from home or people to whom he/she is attached;
- ✓ Need to know the whereabouts of these people;
- ✓ Be preoccupied with fears that something terrible will happen to them;
- ✓ Be uncomfortable traveling alone;
- ✓ Refuse to attend school or camp or to visit a friend's house;
- ✓ Be unable to stay alone in a room;
- ✓ Cling to a parent or shadow the parent around the house;
- ✓ Have difficulty at bedtime;
- ✓ Be reluctant to sleep alone;
- ✓ Experience nightmares that reveal the anxiety; and/or
- ✓ Experience physical problems (nausea, stomachaches, dizziness).

What Treatments Are Available?

The child should receive a thorough evaluation before treatment is started. For some children, medication can significantly reduce the anxiety and allow them to return to school. These medications may also reduce the physical symptoms. Generally, psychiatrists use medications as an addition to psychotherapy. Both psychodynamic play therapy and behavioral therapy have been found helpful in reducing anxiety disorders. In psychodynamic play therapy, the therapist helps the child work out the anxiety by expressing it through play. In behavioral therapy, the child learns to overcome fear through gradual exposure to separation from the parents.

“Permanent” Resolutions

The following “permanent” resolutions are most possible when the supporting questions can be answered and the underlying issues they suggest have been dealt with. There are only two truly permanent resolutions: return to parents and adoption.

Return to Parents

- Have issues that brought the child into care been addressed by the agency?
- Have the parents made the changes that the child protective services agency requested?
- Has the CPS caseworker observed and documented a reduction of risk?
- What have the visits we observed told us about the parents’ ability to care for the child?
- Have we considered recommending a trial placement as a way to observe actual changes in child care?
- Have new issues that relate to risk been observed and addressed?
- Has CPS changed the rules or “raised the bar” in reference to expectations that are not related to risk?
- Would CPS remove this child today?
- Is this a multi-problem family that is likely to relapse?
- What services can be put in place to prevent relapse?
- Have the legal and/or biological fathers been identified?
- Have we recognized the child’s grief and need to reconnect to the family of origin?

Adoption

- Are we ready to proceed with a termination of parental rights (TPR) case?
- Do legal grounds exist?
- Have we also considered the best interest issues that must be presented to the judge?
- How long will the court process take?
- Have the parents been asked to release the child for adoption?
- Is the child already living with caretakers who are willing and able to adopt?
- Are there relatives who are available to adopt?
- How soon can the child be placed?
- Who can help the child through the placement process?
- Have we assessed and evaluated the child’s particular needs and strengths?
- What is the child’s relationship with his/her siblings?
- Should the child be placed with siblings? Can the child be placed with siblings?
- Have we identified a placement option that will be able to meet the child’s needs?
- Have the child’s ethnic and cultural needs been considered and addressed?
- Are we holding up the child’s placement waiting for a specific type of family?
- Are the child’s needs so severe that finding appropriate parents is unlikely?
- Is the child able to accept “parenting”?

Materials created by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice. Used with permission.

Placement with Relative or Kin

Living with someone the child already knows and feels safe with can mitigate the child's feelings of loss, which are part of any placement. The use of a relative or kin placement should be evaluated from the beginning of agency involvement. The following questions should serve as guidance in considering both the pitfalls and benefits involved with kin and relative placements:

- Have the relatives/kin been carefully evaluated? Is there a written home study?
- What are the parents' thoughts and wishes in reference to this relative?
- What will be the ongoing relationship with the parents?
- Will the parents create problems with the placement or compromise the child's safety?
- Will the relative be able to protect the child from hostile or inappropriate parental behavior?
- Will the relative be able to be positive about the parent to the child?
- Will there be an "unofficial" return to the biological parents?
- Will this relative support the present service plan?
- If the plan changes, will the relative support the change?
- How will visitation be accomplished?
- Are the relatives able to understand and cooperate with agency expectations?
- Have the relatives of both parents been considered, regardless of the removal home?
- Is placement with relatives a way we can protect the child's roots in his/her community?
- Will placement with a particular relative mean that the child must leave the community?
- Will placement with a particular relative mean that the child will lose other important relative or kinship ties?
- Will a relative placement mean that the child will have to endure another move?
- What losses will the child experience if another move is required?
- Have we considered sibling attachments, as well as any "toxic" sibling issues?
- Is this potential caretaker related to all the siblings?
- Is this relative able and willing to take all the siblings?
- Will placement with the siblings be positive for this child?
- Will this placement support the child's ethnic and cultural identity?
- Is this seen as permanent by the potential caretakers?
- Would this relative consider adoption?
- Are there the same issues in the extended family that existed with the parents?
- What preplacement relationship existed?
- Does the child have any attachment to these relatives?
- Have the child's wishes been considered?

Materials created by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice. Used with permission.

Long-Term Foster Care: An Impermanent Solution

Despite the advocacy efforts of CASA/GAL volunteers and the hard work by caseworkers, many children remain in foster care and a family is not found for them. These children live in foster homes or group homes—or move from placement to placement during their time in care.

Long-term foster care becomes the plan for older or difficult children for whom there is no identified family. Sometimes these children are actually placed in a family setting but their caregivers do not want to adopt them. In any case, when the plan is permanent foster care, what the child protective services system is actually doing is planning for these children to belong to no one. Clearly this is unacceptable. When faced with this as the “only” alternative, it is our obligation to insist that this not be the end of the planning process, but rather the beginning of a new dialogue around how to make permanence a reality, even for the most difficult child. Begin this dialogue with these questions:

- What other options have been explored?
- Does the child need specialized care? Is it possible for him/her to have a legal and emotional attachment with a person with whom he/she does not live?
- Is there a significant role model or mentor involved with this child? What barriers exist to this person becoming the legal parent?
- What are the barriers to the caregiver adopting? How can these barriers be removed?
- Have all adoption subsidies, other financial resources, and continuing services been explored and offered?
- Who have been the child’s support and attachments in the past? Can any of them be involved now?
- Who are the child’s attachments and support in the present? What is their current involvement?
- What family or kin connections are available—especially with siblings?
- Can parents or other kin be involved anew in this stage of the child’s life?
- What does the child want?
- What resources and persons will be available when this child is an adult?
- Who will be this child’s family for the rest of his/her life?

Materials created by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice. Used with permission.

Principles of Permanence

There are many principles that you can follow as the child’s advocate to ensure that the child in the system will not be forgotten. A number of these are listed below. Following them will ensure that your advocacy is focused on permanence for the child.

- **Constantly examine your own value system.**
Understand the difference between poor parenting and abuse and neglect. Make sure that you can accept a variety of parenting styles, even those that include behavior of which you do not approve.
- **Carefully examine the CPS case record.**
Understand the issues that brought the child into foster care. Ask agency staff about anything that does not make sense.
- **Ask the parents why they think they lost custody of their child.**
Do not assume that they understand or agree with the agency’s reasons.
- **Recognize that the “system” should be operating on the child’s sense of time.**
Help others to hear the clock that is ticking that childhood away.
- **Understand grief and the effects on children of moving and waiting.**
Keep permanent resolution as the focus of your efforts.
- **Stay child-centered and family-focused.**
Children need a permanent family—theirs, if possible—but not if it means the loss of their childhood.
- **Recognize parents’ strengths, but do not ignore their failings.**
Advocate to return the child when the parents have “fixed” what brought their child into care. Advocate for termination of parental rights if the conditions persist.
- **Be a team player.**
Attend reviews, continue to investigate and assess, and share with the caseworker and the court what you learn.
- **Aggravate the system if you have to—be a catalyst for change.**
- **Work for justice—act with mercy.**

Contributed by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice.

Learning Disabilities



Inability to acquire, retain, or broadly use specific skills or information, resulting from deficiencies in attention, memory, or reasoning, and affecting academic performance.

What Causes Learning Disabilities (LD)?

Many types of learning disabilities exist, and no single cause accounts for them. However, the basis of all learning disabilities is believed to be abnormal brain function. An estimated three to fifteen percent of school children in the United States may need special educational services to compensate for learning disabilities. Boys with learning disabilities outnumber girls five to one.

What Are the Symptoms of Learning Disabilities?

A child suffering from a learning disability may:

- ✓ Have problems coordinating vision with movement;
- ✓ Be clumsy at physical tasks (cutting, coloring, buttoning, tying shoes, running);
- ✓ Have problems with visual perception;
- ✓ Have problems with phonologic processing (recognizing sequences or patterns and distinguishing among sounds);
- ✓ Have problems with memory, speech, reasoning, and listening;
- ✓ Have problems with reading, arithmetic, or writing (most learning disabilities are complex, with deficiencies in more than one area);
- ✓ Be slow to learn the names of colors or letters, to assign words to familiar objects, to count, and to progress in other early learning skills;
- ✓ Exhibit delayed learning to read and write;
- ✓ Have a short attention span and memory span;
- ✓ Have difficulty with printing and copying (activities that require fine motor coordination);
- ✓ Have difficulty communicating and controlling impulses;
- ✓ Have discipline problems; and/or
- ✓ Be easily distracted, hyperactive, withdrawn, shy, or aggressive.

How Is a Learning Disability Diagnosed & Treated?

A doctor examines the child for any physical disorders. The child then takes a series of intelligence tests, both verbal and nonverbal, including testing for reading, writing, and arithmetic skills. Psychological testing is the final step of evaluation. No drug treatment has much effect on academic achievement, intelligence, and general learning ability. However, certain drugs, such as methylphenidate, may improve attention and concentration. The most useful treatment for a learning disability is an education that is carefully tailored to the individual child.

Attention-Deficit/Hyperactivity Disorder



Excessive, long-term, and pervasive behaviors, including distractibility (poor sustained attention to tasks), impulsivity (impaired impulse control and delay of gratification), or hyperactivity (excessive activity and physical restlessness).

What Causes Attention-Deficit/Hyperactivity Disorder (AD/HD)?

AD/HD is not caused by poor parenting, family problems, poor teachers or schools, too much TV, food allergies, or excess sugar. AD/HD is very likely caused by biological factors that influence neurotransmitter activity in certain parts of the brain and have a strong genetic basis. Approximately four to six percent of the U.S. population has AD/HD; however, if one person in a family is diagnosed with AD/HD, there is a twenty-five to thirty-five percent probability that another family member also has AD/HD.

What Are the Signs of AD/HD?

The American Psychiatric Association's *Diagnostic and Statistical Manual* recently renamed the disorders formerly known as ADD and ADHD to be AD/HD.

AD/HD includes three subtypes:

1. A predominantly inattentive subtype (formerly ADD). Signs include:
 - Easily distracted by irrelevant sights and sounds;
 - Failing to pay attention to details and making careless mistakes;
 - Rarely following instructions carefully and completely; and
 - Losing or forgetting things like toys, pencils, books, and tools needed for a task.
2. A predominantly hyperactive-impulsive subtype (formerly ADHD). Signs include:
 - Feeling restless;
 - Fidgeting and squirming;
 - Running, climbing, leaving a seat in situations where sitting or quiet behavior is expected;
 - Blurting out answers before hearing the entire question; and
 - Having difficulty waiting in line or for a turn.
3. A combined subtype, which is the most common of the three.

AD/HD refers to all types of attention-deficit disorders, both with and without hyperactivity. To be considered for a diagnosis of AD/HD, these behaviors must appear before age seven and last for at least six months. The level of disturbance must occur more frequently and in a more severely pronounced manner than among other children in the same age group. And above all, these behaviors must create a real handicap in at least two areas of a child's life, such as school, home, or a social setting.

What Treatments Are Available?

Clinical experience has shown that the most effective treatment for AD/HD is a combination of medication and therapy or counseling to learn coping skills and adaptive behaviors. The most well known treatments of AD/HD are psychostimulants, such as Ritalin and Dexedrine, and some antidepressants that affect the levels of dopamine, noradrenaline, and serotonin in the central nervous system. Taken in normal doses, stimulants can result in decreased appetite, stomachaches, agitation, irritability, and insomnia for some children. The long-term effects of taking these drugs are not yet known.

Medications can result in an improvement in core symptoms such as impulsive behavior and inattention as well as improved school and social performances. For that reason, treatment for AD/HD is more effective when regular use of drugs is combined with behavior treatment. Reward systems for appropriate behavior or performance, teaching parents child-management skills, and therapy that instructs parents and teachers in improved contingency management skills can help most children. Children who regularly take their medication and practice behavior techniques routinely do better than those who rely on stimulants alone.

When Should a Person Seek Help?

Since many children exhibit occasional inappropriate or hyperactive behaviors, widespread confusion has arisen about the diagnosis and treatment of AD/HD. Due to those uncertainties, parents and guardians should not attempt to diagnose their children. Children who are responding to stressful family situations, are bored in the classroom, or are passing through certain stages of development may appear inattentive, hyperactive, or impulsive—yet they do not have AD/HD.

To determine whether a child needs to be examined by a physician, psychologist, or other medical specialist, you should consider several critical questions:

- ✓ Are the child's troublesome behaviors excessive, long-term, and pervasive?
- ✓ Do they occur more often than in his/her peers?
- ✓ Are his/her behaviors a continuous problem and not just a response to a temporary situation?
- ✓ Do his/her behaviors occur in several settings, or only in one specific place, such as the playground or school?

You should talk to the child's teacher to get a clearer reading on the child's daily behaviors. You should also seek a consultation with a health professional to rule out other possible psychological problems, such as depression or a learning disorder.

Special Education Services

The Individuals with Disabilities Education Act:

What Is the Individuals with Disabilities Education Act (IDEA)?

The **Individuals with Disabilities Education Act (IDEA)**, a federal law originally passed in 1975 as PL 94-142 and amended in 1984, 1990, and 1997, mandates that all eligible children receive a free, appropriate public education regardless of the level or severity of their disability. It provides funds to assist states in the education of students with disabilities and requires that states make sure that these students receive an individualized education program based on their unique needs in the least restrictive environment appropriate. IDEA also provides guidelines for determining what related services are necessary and outlines a “due process” procedure to make sure needed services are provided.

Who Is Eligible for Services Under IDEA?

Children ages three through twenty-one who need special education and related services because of a disabling condition are eligible. Eligibility for services is determined through “nondiscriminatory evaluation.” This requires that school districts use testing materials free from racial or cultural discrimination and presented in the child’s native language or means of communicating. Tests must be chosen that assess the child’s actual abilities if sensory, motor, or language impairments are present. Evaluations cannot be based solely on one general test, such as an intelligence test, and the child is to be assessed across all areas related to the disability by a “multidisciplinary team.”

An appropriate education may include an out-of-district or private school placement if the school district cannot provide appropriate services in the district. The courts have also ruled, however, that an “appropriate” education is not always the same as the “best” education as long as the education services adequately meet the child’s needs.

What Is an IEP?

An IEP refers to the Individualized Education Program. This is a written, legal document that describes the specialized educational plan and related services to be provided to the student. It is developed in a team meeting in which all members of the IEP team decide what is an appropriate education for the child who needs services. The team can include the CASA/GAL volunteer, also acting as the education surrogate/surrogate parent. The main goal of the IEP meeting is to discuss the educational needs of the student and write a program that identifies goals and objectives and related services needed for the year.

What Is the School’s Responsibility in Developing an IEP?

The local education agency is responsible for:

- ✓ Contacting parents about the need for an IEP;
- ✓ Setting a date, time, and location to meet that is convenient for everyone on the team, including the parent(s) or family member(s);

- ✓ Designating an official from the school district to be involved in and to conduct the meeting and ensure the team decisions are implemented;
- ✓ Inviting all members of the IEP team;
- ✓ Ensuring that the meeting is held, the IEP written, and placement decisions made; and
- ✓ Making sure that the IEP is reviewed at least annually and revised if necessary.

What Is the Parent’s Role in Developing the IEP?

In IDEA, the term “parent” refers to the child’s biological parent, a guardian, a person acting as the parent of a child (such as the grandparents), or a surrogate parent appointed if the child is a ward of the state or the parent is unavailable.

IDEA ensures that parents are equal partners in the IEP process. School personnel and parents must work toward the common goal of developing an effective education program for the child.

Parents should prepare for the meeting by reviewing their child’s past education records. IDEA ensures that parents are permitted to inspect and review records in a timely manner. Parents should also have in mind goals or objectives based on what they see as needed, and they may want to talk with their child’s teacher before the meeting. The IEP should describe the student’s educational goals and objectives, related services needed, and the school placement decision. If parents are dissatisfied with any aspect of the IEP and are unable to resolve the problem, they may request mediation and, if necessary, pursue due process hearing options guaranteed by the law. Parents may obtain assistance in preparing for and/or attending IEP meetings from the local chapter of organizations, such as the Arc or LDA, for parents of children who have a disability. Many communities also have advocacy organizations specifically serving the disabled. Every state also has a protection and advocacy (P and A) agency.

Who Should Be Involved in IEP Meetings?

IDEA requires that every IEP meeting, whether it is the initial meeting or a review, include:

- ✓ A person from the school district, other than the student’s teacher, who is qualified in special education or special education supervision;
- ✓ The student’s teacher;
- ✓ One or both of the student’s parents, family members, or guardians;
- ✓ The student, when appropriate;
- ✓ Someone qualified to interpret the instructional implications of evaluation (this may be one of the school personnel above); and
- ✓ Other people who are involved in the education of the student as identified by the school or the parent.

A meeting may be held without a parent attending if the parent is unable or unwilling to do so. The district must, however, invite the parents and document its attempts to set a time and place where all persons can attend. Parental absence from the meeting is not necessarily construed as reflecting dissatisfaction or disagreement, and IEP decisions, including school placement, will be made by the school in their absence.

What Is Included in an IEP?

IDEA requires that the following items be included in the IEP:

- ✓ A statement of the student's present levels of educational performance;
- ✓ A statement of the yearly goals and the instructional objectives that need to be met to achieve these goals;
- ✓ A statement of the special education and related services that will be provided to the student as well as how much the student will participate in regular educational programs;
- ✓ The dates these services will begin and how long they will last;
- ✓ For each student age sixteen and over, transition services that will be provided; and
- ✓ What the school must do to enable the student to meet the objectives, how this is to be measured, and annually, whether the objectives from the previous year's IEP have been met.

When Is It Appropriate for the Student to Participate?

Students need to participate in the IEP process as much as they can (some older children with mental handicaps may not have the intellectual ability to understand this process). Their opinions, preferences, and choices need to be part of the decision-making process. The chance to choose areas of instruction, based on their preferences, will help them develop skills that lead to independence and self-determination. Of course, there are several factors that limit how much students participate, including their age and their ability to make adequate decisions. However, almost all students can participate in some way in their IEP process.

What Is to Be Reviewed at IEP Meetings?

Each student's progress related to his/her Individualized Education Program must be reviewed yearly to determine current progress and future needs. The review needs to consider the general progress of the student, staff and parental concerns about the student's progress, whether objectives are reached according to the measures described in the IEP, and what changes need to be made to meet the student's needs.

Any significant changes in the student's program after the initial or annual IEP meeting necessitates another IEP meeting. IDEA requires that parents receive written notice whenever the district proposes or refuses to initiate or change anything related to the child's identification, evaluation, program, or placement.

Additionally, parents and educators should ensure that goals are functional and chronologically age appropriate, and that they prepare students for adulthood.

What Is Meant by Placement in the Least Restrictive Educational Environment?

The decision to place a student with a disability in a particular education program must be based on the factors specified during the IEP process. This decision must be reviewed at least annually, and placement may change if the child's education program or needs change.

IDEA requires that students with disabilities be educated with students who do not have disabilities to the greatest extent appropriate. The law states that “unless a child’s individualized education program requires some other arrangement, the child is (to be) educated in the school which he/she would attend if not disabled” [Section 121a.522(c)]. It requires that removal of the child from the regular classroom occur only when education in regular classes “with the use of supplementary aids and services cannot be achieved satisfactorily” [Section 121a.550(2)].

The Arc and other organizations interpret “least restrictive” as representing instruction in the regular classroom to the greatest extent possible or appropriate. Families need, through the IEP process, to ensure that adequate accommodation and support are provided before alternative placement is considered and that time spent outside of the regular classroom is based upon functional considerations such as community integration and instruction. The Arc is opposed to student’s placement in segregated facilities, as they do not provide opportunities for learning from nondisabled role models, although the law and many other parents and professional organizations support a full continuum of placements being available.

Adapted from materials created by the Exceptional Children’s Assistance Center, 1998-99.

Childhood Depression



A feeling of intense sadness beyond an appropriate length of time.

What Causes Childhood Depression?

Children who develop major depression are likely to have a family history of the disorder, often a parent who experienced depression at an early age. Depression in children can be triggered by events or problems, such as the death of a parent, a friend moving away, difficulty in adjusting to school, difficulty making friends, or drug or alcohol abuse. However, some children become depressed without profoundly unhappy experiences.

What Are the Symptoms of Childhood Depression?

The defining features of depression in children are the same as they are for adults. However, recognition and diagnosis of the disorder are more difficult in youth because expression of the symptoms varies with youth's developmental stage, and children may have difficulty properly identifying and describing their internal emotional or mood states. Therefore, symptoms of depression may manifest in children as the following:

- ✓ Frequent vague, nonspecific physical complaints, such as headaches, muscle aches, stomach-aches, or tiredness;
- ✓ Frequent absences from school or poor performance in school;
- ✓ Talk of or efforts to run away from home;
- ✓ Outbursts of shouting, complaining, unexplained irritability, or crying;
- ✓ Being bored;
- ✓ Lack of interest in playing with friends;
- ✓ Among older youth, alcohol or substance abuse;
- ✓ Social isolation, poor communication;
- ✓ Fear of death;
- ✓ Extreme sensitivity to rejection or failure;
- ✓ Increased irritability, anger, or hostility;
- ✓ Reckless behavior; and/or
- ✓ Difficulty with relationships.

Five or more of these symptoms must persist for two or more weeks before diagnosis of depression is indicated.

What Treatments Are Available?

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. In order to prevent the recurrence of depression, it is recommended that treatment be continued for at least six months after the remission of symptoms.

Conduct Disorder



A repetitive and persistent pattern of behavior in which children or adolescents violate the rights of others or violate norms and rules appropriate to their age.

What Causes Conduct Disorder?

Researchers have not yet discovered what causes conduct disorders, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against anxiety, an attempt to recapture the mother-infant relationship, the result of maternal deprivation, or a failure to internalize controls. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment, to get material goods that come with living in an affluent society, or to gain social status among friends. Other sociologists say inconsistent parenting contributes to the development of the disorders. Finally, biological theories point to a number of studies that indicate children could inherit a vulnerability to the disorders. Children of criminal or antisocial parents tend to develop the same problem. Other biologists believe that male hormones or problems in the central nervous system could contribute to the erratic and antisocial behavior. None of these theories can fully explain why conduct disorders develop. Most likely, an inherited predisposition and environmental and parenting influences all play a part in the illness.

What Are the Signs of Conduct Disorder?

Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- ✓ Steals, without confrontation (e.g., forgery) and/or by using physical force (e.g., muggings, armed robbery, purse-snatching, or extortion);
- ✓ Consistently lies (other than to avoid physical or sexual abuse);
- ✓ Deliberately sets fires;
- ✓ Is often truant from school or absent from work;
- ✓ Has broken into someone's home, office, or car;
- ✓ Deliberately destroys the property of others;
- ✓ Has been physically cruel to animals and/or to humans;
- ✓ Has forced someone into sexual activity with him/her;
- ✓ Has used a weapon in more than one fight; and
- ✓ Often starts fights.

What Treatments Are Available?

Treatments, including behavior therapy and psychotherapy (either individual or group sessions), are aimed at helping young people realize and understand the effect their behavior has on others. Some children also suffer from depression or attention-deficit/hyperactivity disorder; use of medications as well as psychotherapy has helped lessen their symptoms of conduct disorder. Moralizing and threatening do not work. Often the most successful treatment is to separate the child from a damaging environment and to administer strict discipline.

Post-Traumatic Stress Disorder



Re-experiencing a very distressing event that has overwhelmed a child's coping mechanism and has created intense feelings of fear and helplessness.

What Causes Post-Traumatic Stress Disorder (PTSD)?

A child who experiences a catastrophic event may develop PTSD. A stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred, such as experiencing or witnessing one of the following:

- ✓ Physical or sexual assault or abuse;
- ✓ Family and community violence;
- ✓ Severe accidents;
- ✓ Life-threatening illnesses; or
- ✓ Natural disasters (flood, fire, earthquakes).

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

What Are the Signs of PTSD?

PTSD affects how a child feels and acts. Signs of stress may include the following:

1. A child may re-experience the trauma by:
 - Talking about the trauma over and over again;
 - Including trauma-related events in play;
 - Dreaming about the trauma;
 - Feeling like the trauma is happening all over again; and/or
 - Becoming very distressed when reminded of the trauma.
2. A child might withdraw from the trauma experience by:
 - Avoiding thoughts or feelings about the trauma;
 - Avoiding activities associated with the trauma;
 - Forgetting parts of the trauma;
 - Losing skills such as toilet training or language skills;
 - Wanting to be alone more than usual;
 - Becoming less affectionate toward others; and/or
 - Feeling like there is nothing to look forward to in the future.

3. A child may experience restlessness and agitation, such as:
- Having difficulty falling asleep or staying asleep;
 - Becoming easily angered, irritable, or jumpy;
 - Having concentration problems;
 - Expressing fear (fear of being left alone or sleeping alone);
 - Becoming overly watchful and easily startled; and/or
 - Reporting physical complaints when reminded of the trauma.

What Treatments Are Available?

Treatment of PTSD in children generally involves “talking therapies” (such as cognitive behavioral therapy, family therapy, or brief psychotherapy) and may include the prescription of medication by a psychiatrist.

Fetal Alcohol Syndrome



A combination of particular facial features, growth deficiency, and central nervous system damage resulting from alcohol exposure during pregnancy.

What Causes Fetal Alcohol Syndrome (FAS)?

A fetus exposed to any amount of alcohol may suffer from fetal alcohol syndrome. Alcohol causes physical damage to the central nervous system. The risk of severe birth defects increases with the amount of alcohol consumption. However, even small amounts of alcohol can be harmful; therefore, women are recommended to avoid alcohol during the entire pregnancy.

What Are the Symptoms of FAS?

A child with this condition will have one or more of these effects:

- ✓ Poor sucking ability;
- ✓ Poor sleeping habits;
- ✓ Irritability from alcohol withdrawal;
- ✓ Unusually small body, head, eyes, or jaw;
- ✓ Cleft palate;
- ✓ Heart defects;
- ✓ Hip dislocation and other joint deformities;
- ✓ Mental retardation;
- ✓ Learning disabilities;
- ✓ Speech and language difficulties;
- ✓ Hyperactivity;
- ✓ Inappropriate emotional responses;
- ✓ Problems with fine and gross motor skills;
- ✓ Memory deficit or “quirky memory”;
- ✓ Inability to generalize from one situation to another;
- ✓ Easily stimulated or distracted;
- ✓ Difficulty with cause and effect;
- ✓ Seeming lack of remorse;
- ✓ Lack of boundaries;

- ✓ Overly affectionate;
- ✓ Hyper/under sensitivity to touch, sound, light, and textures; or
- ✓ Hygiene problems.

What Treatments Are Available?

There is no cure for fetal alcohol syndrome. However, children with FAS can be helped. The treatment involves recognizing the symptoms and addressing the problems by providing medical and dental care or placing them in special school programs.

Professional Assessment of Children

Tools for Assessment

The selection of instruments (tests) to be administered to a child must be appropriate for the purpose of the evaluation and must take into consideration the child's age and any special handicaps such as sensory deficits, physical or motor impairments, or speech disorders. Tests should also be culturally appropriate or at least be free of cultural bias.

Other factors of importance in selecting tests for individual examination are determined by the attributes of the tests. Among those to be considered in choosing one test in preference to another are:

- **Validity**
How well does the test measure what it is said to measure?
- **Reliability**
How consistently are the test results reproduced when the same individual is re-tested?
When the test is broken up via the split-half method and compared with itself, is it internally consistent?
- **Standardization**
The test norms should be derived from a representative sample of the population to whom the test is to be applied.
- **Objectivity**
An objective test involves specific responses to specific requests or situations. A standard set of directions is followed for administering and scoring the test. Any departures from these prescribed procedures must be reported.

(Note: No single test score is conclusive; professionals look for several sources of data to support conclusions they draw from the tests.)

Brief Descriptions of Some Commonly Used Assessment Tools

The following list of assessment tools is in no way intended to be complete. It does, however, give some examples of the types of instruments that may be used. The CASA/GAL volunteer is not expected to have an expert's knowledge of the use of assessment instruments. However, some familiarity with the types of instruments being used may help guide research and further discovery on behalf of the child.

Developmental Scales

Denver Developmental Screening Test (*1 month–6 years*)

Quick assessment of personal, social, fine motor, adaptive, language, and gross motor development.

Gesell Developmental Schedules (2 ½ years–6 years)

Thirteen tests assessing wide range of developmental factors in preschoolers. Assesses behavior and emotional and physical development. Used for screening, early intervention, or diagnosis.

Bayley Scales of Infant Development (2 months–30 months)

Two-scale test for infant mental and motor development and a behavior rating. Assesses early mental and psychomotor development. Used in the diagnosis of normal versus retarded development.

Intelligence Tests

Wechsler Intelligence Scale for Children–Revised (WISC-III) (5 years–15 years)

Twelve subtests divided into two major divisions yielding a verbal IQ, performance IQ, and full scale IQ for children tested individually. Provides verbal and nonverbal scales.

Wechsler Preschool & Primary Scale of Intelligence (WPPSI-II) (2 years–6 ½ years)

Ten standardized subtests divided into verbal and nonverbal scales to assess cognitive and reasoning abilities. Scores converted to deviation quotient comparing subject to age peers.

Stanford-Binet Intelligence Scale (SB-IV) (2 years–Adult)

Measures overall cognitive abilities. Emphasis at lower ages on sensorimotor performance; at school age and above, highly dependent on verbal skills. Verbal and nonverbal tests assess verbal reasoning, abstract/visual reasoning, quantitative comprehension, and short-term memory. Can be used to substantiate scores from group tests, to provide more comprehensive assessment, and when a subject has physical, language, or personality disorders that prevent group testing. Results can help identify subjects who would benefit from specialized learning environments.

Leiter International Performance Scale (2 years–18 years)

Multiple-item nonverbal task assessment of intelligence. Individual performance scale. Covers range of functions, non-timed, nonverbal, assumed to be culture-free. Useful for children with speech or language difficulties.

Wechsler Adult Intelligence Scale–Revised (WAIS-R) (16 years–Adult)

Eleven subtests yielding verbal IQ, performance IQ, and full scale IQ. Verbal and nonverbal scales. Popular and well-standardized test but considered not useful for exceedingly superior or for retarded.

Vocabulary

PPVT

Point to response nonverbal multiple-choice selection of picture associated to word spoken by examiner. Measures receptive vocabulary for Standard American English, estimates verbal ability, and assesses academic aptitude. Also used with English as a Second Language (ESL) students, mentally retarded, and gifted students. Vulnerable to deficit in visual/perceptual functions. Scores converted to mental ages, deviation IQ.

Full Range PVT

Similar to Peabody. Assesses individual intelligence when scores are converted to mental age and tables are available for comparable Wechsler Verbal IQ. May be used in testing special populations such as physically handicapped, uncooperative, aphasic, or very young subjects.

Perceptual- or Visual-Motor Integration Tests

Bender Visual-Motor Gestalt Test (3 years–Adult)

A paper-pencil test, untimed. Assesses visual-motor functions. Evaluates developmental problems in children, learning disabilities, retardation, psychosis, and organic brain disorders. Visual-perception, visual-motor integration, motor skill, and organizational ability are tapped by copying figures. Also used as projective test.

Illinois Test of Psycholinguistic Abilities (ITPA) (2 years–10 years)

Ten subtests evaluate child's cognitive and perceptual abilities in communication, auditory, psycholinguistic process of visual reception, levels of organization, sequential memory, association of symbols, ordering recall, discrimination and conceptualization of similarity, and closure.

Frostig Developmental Test of Visual Perception (pre-kindergarten)

Forty-one-item paper-pencil test assessing eye-motor coordination, figure-ground, form constancy, discrimination of position in space, and reproduction of spatial relationships. Evaluates children referred for learning difficulties or neurological handicaps.

Goodenough-Harris Drawing Test (3 years–15 years)

Assesses mental ability through nonverbal technique and drawing tasks. Revisualization, ability to reproduce representation of human figures. Developmental age scores. Also used as projective device.

Benton Revised Visual Retention Test (8 years–Adult)

Measures visual memory. Utilizes ten cards depicting one or more geometric forms exposed ten seconds. Assesses revisualization, spatial perception, and perceptual-motor reproductions. Scored for number correct and number of errors. Used as supplement to visual mental examinations.

Memory for Designs (Graham-Kendall) Test (8 ½ years–Adult)

Assesses revisualization and visual-motor coordination. Fifteen cards with simple geometric figures, each exposed five seconds, to be reproduced. Used to differentiate between functional behavior disorders and those associated with brain injury.

Auditory Processing Tests

Illinois Test of Psycholinguistic Abilities (ITPA) (2 years–10 years)

Assesses specific psycholinguistic abilities and disabilities in children. Facilitates assessment of child's abilities for remediation. Ten subtests of auditory-reception, association, sequential recall, grammatic closure, sound-blending, and verbal expressiveness. Assess decoding, ordering, memory, ability to analyze and synthesize parts-to-whole.

Goldman-Friscoe-Woodcock Test of Auditory Discrimination (4 years–Adult)

Diagnoses an individual's ability to hear clearly under increasingly difficult listening conditions. Twelve subtests measure auditory election, attention, discrimination, memory, and sound-symbol skills. Intersensory integration is involved in multiple-choice response to pictures associated with recorded words. Used for instructional planning.

Kinesthesia & Tactile Perception

Southern California Sensory Integration Tests (4 years–10 years)

Measures an individual's ability to see, touch, and move in a coordinated manner. Seventeen-item paper-pencil and task assessment tests measuring visual, tactile, and kinesthetic perception, and different types of motor development. Used to identify the degree and type of disorder often associated with learning and emotional programs, minimal brain dysfunction, and cerebral palsy.

Reitan-Indiana Neuropsychological Battery for Children (5 years–Adult)

Assesses brain-behavior functioning in children. Includes subtests of sensory perception, intersensory manual form perception, tactile localization, tactile-kinesthetic perception, learning, and recall. Used for clinical evaluations.

Motor Tests

Southern California Sensory Integration Test (4 years–10 years)

Five of six subtests require imitation of patterned movements, body positions, or response to verbal requests.

Southern California Motor Accuracy Tests (4 years–8 years)

Measures degree of accuracy in drawing a pencil line over a printed line. Used in diagnosis of perceptual-motor dysfunction in atypical children. Used in clinical evaluations.

Lincoln Oseretsky Motor Development Scale (6 years–14 years)

Measures motor development. Tests fine and gross motor skills. Used to supplement information obtained from other techniques concerning intellectual, social, emotional, and physical development.

Purdue Perceptual Motor Survey (6 years–10 years)

Range of postural, motor, body image, and form perception measures.

Frostig Developmental Test of Visual Perception (3 years–10 years)

Eye-motor coordination subtests measure skill of visually guided movements.

Bayley Scales of Infant Development, Motor Scale (2 months–30 months)

Assesses developmental levels of motor patterns, including prehension and locomotion.

Academic Skills & School Achievement

STANDARDIZED TESTS GIVEN BY SCHOOLS:

All measure reading, math, and writing skills.

- **Iowa Test of Basic Skills (ITBS)**
- **Washington Assessment of Student Learning (WASL)**

TESTS GIVEN BY SPECIALISTS:

Woodcock-Johnson Psychoeducational Battery (W-JPEB)

Twenty-seven-test battery. Evaluates individual cognitive ability, scholastic achievement, and interest level. Used to diagnose learning disabilities for instructional planning, vocational rehabilitation, and counseling.

Wide-Range Achievement Test–Revised (WRAT-R)

Three paper-pencil subtests, which measure basic educational skills of word recognition, spelling, and arithmetic. Identifies individual learning difficulties. Used for educational placement, measuring school achievement, vocational assessment, and job placement and training.

Peabody Individual Achievement Test (PIAT)

Four-hundred-item test of mathematics, reading, comprehension, and general information. Provides an overview of individual scholastic attainment. Used to screen for areas of weakness requiring more detailed diagnostic testing.

Adaptive Behavior Scales**Vineland Social Maturity Scale–Revised**

One-hundred-seventeen-item interview covering eight categories of self-help in general, eating, dressing, communication, self-direction, socialization, and locomotion. Measures successive stages of social competence and adaptive behavior. Used to measure individual differences, which may be significant in cases of mental deficiencies and emotional disturbances, in order to plan therapy or individual education.

Woodcock-Johnson Scales of Independent Behavior (SIB) (2 years–Adult)

Assesses functional behavior, self-help skills, and communication skills. Usually used with developmentally delayed individuals.

A.A.M.D. Adaptive Behavior Scale (3 years–6 years)

Assesses social and daily living skills of children whose adaptive behavior indicates possible mental retardation, emotional disturbance, or other learning handicaps. Used for screening and instructional planning.

Personality & Social/Emotional Functioning

A variety of tests can be used to examine various personality or emotional hypotheses about children. These tests include the following:

The Achenbach Child Behavior Checklist (CBCL) (2 years–16 years)

Assesses behavioral problems and competencies of children and adolescents. Evaluates child behavioral problems from subject's perspective with Youth Self-Report (for ages 8–11 years), from parent's point of view with Child Behavior Checklist, and from teacher's perspective on classroom behavior with Teacher Report Form. Direct Observation Form used by experienced observer to rate on basis of a series of at least six ten-minute observation periods.

Behavioral Assessment Scale for Children (BASC) (2 ½ years–18 years)

Assesses the range of behavior for typically developing children in order to look for areas of psychological damage.

**Minnesota Multiphasic Personality Inventory–Adolescent Version (MMPI-A)
(Adolescents–Adults)**

One-hundred-fifty-item true/false test of ten clinical variables or factors. Assesses individual personality. Used for clinical diagnosis and research on psychopathology.

Children's Depression Inventory (8 years–13 years)

Twenty-seven-item pencil-paper inventory measuring overt symptoms of child depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Assesses severity of depression in children and adolescents. Also used to measure progress during treatment.

Various Projective Tests**TAT, CAT, Robert's Apperception Test for Children, Piers-Harris Children's Self-Concept Scale, Sentence Completion Test**

Used with caution, as they are not standardized. They can be helpful when used with other sources and by a trained clinician.

Adapted from *Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business*, second edition, Richard C. Sweetland, Ph.D., and Daniel J. Keyser, Ph.D., general editors. Kansas City, MO: Test Corporation of America, 1986. Updated for NCASAA by Peggy Tribble, Ph.D., May 2000.

Resiliency: The 40 Developmental Assets

The Search Institute's Framework for Looking at Protective Factors

In an effort to identify the elements of a strengths-based approach to healthy development, Search Institute developed the framework of developmental assets. This framework identifies forty critical factors for young people's growth and development. When drawn together, the assets offer a set of benchmarks for positive child and adolescent development. The assets clearly show important roles that families, schools, congregations, neighborhoods, youth organizations, and others in communities play in shaping young people's lives.

External Assets

SUPPORT:

1. **Family support:** Family life provides high levels of love and support.
2. **Positive family communication:** Young person and his/her parent(s) communicate positively and young person is willing to seek advice and counsel from parent(s).
3. **Other adult relationships:** Young person receives support from three or more non-parent adults.
4. **Caring neighborhood:** Young person experiences caring neighbors.
5. **Caring school climate:** School provides a caring, encouraging environment.
6. **Parent involvement in schooling:** Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT:

7. **Community values youth:** Young person perceives that adults in the community value youth.
8. **Youth as resources:** Young people are given useful roles in the community.
9. **Service to others:** Young person serves in the community one hour or more per week.
10. **Safety:** Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES & EXPECTATIONS:

11. **Family boundaries:** Family has clear rules and consequences, and monitors the young person's whereabouts.
12. **School boundaries:** School provides clear rules and consequences.
13. **Neighborhood boundaries:** Neighbors take responsibility for monitoring young people's behavior.
14. **Adult role models:** Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence:** Young person's best friends model responsible behavior.
16. **High expectations:** Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME:

17. **Creative activities:** Young person spends three or more hours per week in lessons or practice in music, theater, or the arts.
18. **Youth programs:** Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
19. **Religious community:** Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home:** Young person is out with friends, “with nothing special to do,” two or fewer nights per week.

Internal Assets

COMMITMENT TO LEARNING:

21. **Achievement motivation:** Young person is motivated to do well in school.
22. **School engagement:** Young person is actively engaged in learning.
23. **Homework:** Young person reports doing at least one hour of homework every school day.
24. **Bonding to school:** Young person cares about his/her school.
25. **Reading for pleasure:** Young person reads for pleasure three or more hours per week.

POSITIVE VALUES:

26. **Caring:** Young person places high value on helping other people.
27. **Equality and social justice:** Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity:** Young person acts on convictions and stands up for his/her beliefs.
29. **Honesty:** Young person “tells the truth even when it is not easy.”
30. **Responsibility:** Young person accepts and takes personal responsibility.
31. **Restraint:** Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES:

32. **Planning & decision-making:** Young person knows how to plan ahead and make choices.
33. **Interpersonal competence:** Young person has empathy, sensitivity, and friendship skills.
34. **Cultural competence:** Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills:** Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution:** Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY:

- 37. Personal power:** Young person feels he/she has control over “things that happen to me.”
- 38. Self-esteem:** Young person reports having high self-esteem.
- 39. Sense of purpose:** Young person reports that “my life has a purpose.”
- 40. Positive view of personal future:** Young person is optimistic about his/her personal future.

Created by the Search Institute, www.search-institute.org/assets. Used with permission.

