

Missouri



Respite Care Provider Training

An Introduction
to
Foster Care

Missouri Respite Care Service Provider Training

An Introduction to Foster Care



Every foster and adoptive family can potentially benefit from respite care. The healthier, happier, and most functional families are the ones who can find time for respite in their busy lives. Successful completion of this training is intended to prepare a respite care service applicant for providing respite services.

The goals for the training are to:

- Develop trust between providers, families, and the respite program agency, and help them work together in children's best interests
- Build relationships and communication between providers and families
- Share information about the children who will be using respite services and develop a deeper understanding of their needs
- Prepare providers with information and strategies to care for children with a variety of special needs
- Provide expectations regarding the role of a respite provider
- Provide information regarding available resources

Respite Training Outline

This training can be completed self-taught or in an instructor-led classroom setting. Instructor-led classroom activities are shaded in grey for each part of the training. Two (2) hours of training credit may be awarded for completion of this training. If self-taught, the Knowledge Assessment must be completed and submitted to the licensing worker for applying training credit hours in FACES.

- Part 1 Getting Started
- Part 2 Communication & Relationships
- Part 3 Special Needs
- Part 4 Behavior Management
- Part 5 Respite Care Provider's Role and Tools for Success
- Part 6 Knowledge Assessment

This training is intended to provide a preview of a portion of the responsibilities required of individuals who become licensed resource parents. This training is not the pre-service training required to be licensed as a resource parent.



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Part 1 Getting Started

Instructor-led classroom option ice breaker:

Start the training by establishing common ground related to experiences, knowledge, and concerns regarding caring for children with special needs who have been adopted or who are in foster care.

Call for a show of hands in response to the following questions:

1. How many of you have provided respite care in the past?
2. How many of you have a child with special needs?
3. How many of you are working with agencies that serve children with special needs?
4. How many of you are friends of people with adoptive, foster, relative or kinship children?

After you have established common ground, ask the following questions to generate discussion:

1. How would respite services help your friend/family member?
2. What would be your greatest concern about leaving your child with another provider?
3. Why do people need respite?
4. Why is respite important to the health of a family?

Research Regarding Respite

Respite care increases:

- Feelings of well-being for families
- Community and peer contacts for the children
- Social activities for families

Respite improves:

- Coping abilities of families
- Attitudes about caring for a child with challenges
- Families' ability to care for their child at home

Respite care reduces:

- Stress in families
- Risk of abuse and neglect
- Marital or partnership tension
- Feelings of depression and isolation

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Most important outcome of respite:

Effective respite care reduces out-of-home placements, disruptions, and dissolutions so that children can stay at home with their families.

Handouts:

Research Regarding Respite

- http://archrespite.org/images/docs/Factsheets/fs_33-adoptive_families.pdf
- http://archrespite.org/images/docs/Factsheets/FS_34-SeriousEmotionalDisturbance_Respites_15_12.pdf
- http://archrespite.org/images/docs/Factsheets/fs_32-foster_parents.pdf

Why Is Respite Training Important?

- Training providers to develop their skills and the quality of care they can offer to families helps families to feel comfortable leaving their children with a provider. Without this comfort level, parents may not be willing to access respite care.
- Equally important is the task of preparing providers to do their job well. They experience success and the rewards of their service, and are more likely to continue to provide respite care.



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Part 2 Communication & Relationships

Developing communication between parents, youth, and respite care providers

Communication between the parent and respite care provider is imperative. Over time parents have developed success strategies for discipline and building a relationship with their children. They need to share this information so that respite care providers can experience success right away and will want to care for the child again.

One example: A mother of five children gave her son his medication to treat ADHD 20 minutes before he or anyone else was awake. She would go into his room, briefly wake him up, give him his medication, rub his back and quietly tell him she would wake him up in about 20 minutes. This routine dramatically affected his relationships with his siblings, his parents, and helped ensure positive relationships and outcomes at school.

Instructor-led Classroom Option 1: Using the *Child Information Form for Respite Provider, CD-110*, divide the larger group into small group discussions, and then have each group report back to the larger group.

Some questions providers may want to ask parents are:

- What are four important things I should know about your child?
- Does your child have special routines and schedules?
- What are your child's likes and dislikes?
- What are the expectations at bedtime? When is bedtime? Are there special routines? Does the child wake up, sleep walk, and wander at night? Does the child wet the bed? How do you handle these issues?
- Does your child require special food preparation or have any food allergies?
- Is your child safe alone?
- Does your child play well with other children?
- Can your child be outside? Will your child wander?

Information parents may want to share with a provider are:

- Sensitivities your child has to touch, teasing, sound, and light
- How your child best communicates with others
- Calming activities that soothe your child
- Past abuse experiences that may be triggered by specific activities; how to avoid such situations, and strategies for providers if your child becomes upset
- Your child's fears
- How you respond to certain of your child's behaviors

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Option 2: Break the large group into up to five smaller groups with each group assigned one of the following scenarios:

- A parent interviewing a potential respite provider
- A provider who has a concern to discuss with a parent
- A provider who needs to control the behavior of a child with special needs
- A parent who is upset with something a provider has done or failed to do
- A provider, parent, and child doing a routine “debriefing” after respite services

Give the groups 10 minutes to discuss their scenario and either role-play or talk about how they would communicate so that relationships remain positive. When the groups return, ask what lessons they learned. Write replies down on a whiteboard or flipchart.

Whether you choose option 1 or 2, after your discussion distribute *Tips for Being a Nurturing Parent* and/or *Why Children Need Ongoing nurturing Relationships* and talk about the importance of also building a relationship with children and youth.

Handouts:

Child Information Form for Respite Provider, [CD-110](#)

Tips for Being a Nurturing Parent,

<http://www.childwelfare.gov/preventing/supporting/resources/tips.cfm>

Children Need Ongoing Nurturing Relationships

<http://www.scholastic.com/teachers/article/professional-development-why-children-need-ongoing-nurturing-relationships>



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Part 3 Special Needs

There are many issues that may be addressed in this part of the training:

- Attachment
- Effects of child abuse and neglect
- Child development
- Issues of adoption/foster care/kinship care
- Mental health diagnosis
- Attention deficit hyperactivity disorder (ADHD)
- Fetal alcohol spectrum disorder (FASD)
- Other common special needs

Instructor-led Classroom Option 1: Visible to everyone, display four large sheets of flipchart paper with the following headings:

- What are the core issues in adoption/foster care?
- What are ways to encourage attachment?
- What are effective ways to work with or parent children with FASD or ADHD?
- How does abuse and neglect affect children?

Invite the audience to discuss each question and learn from each other.

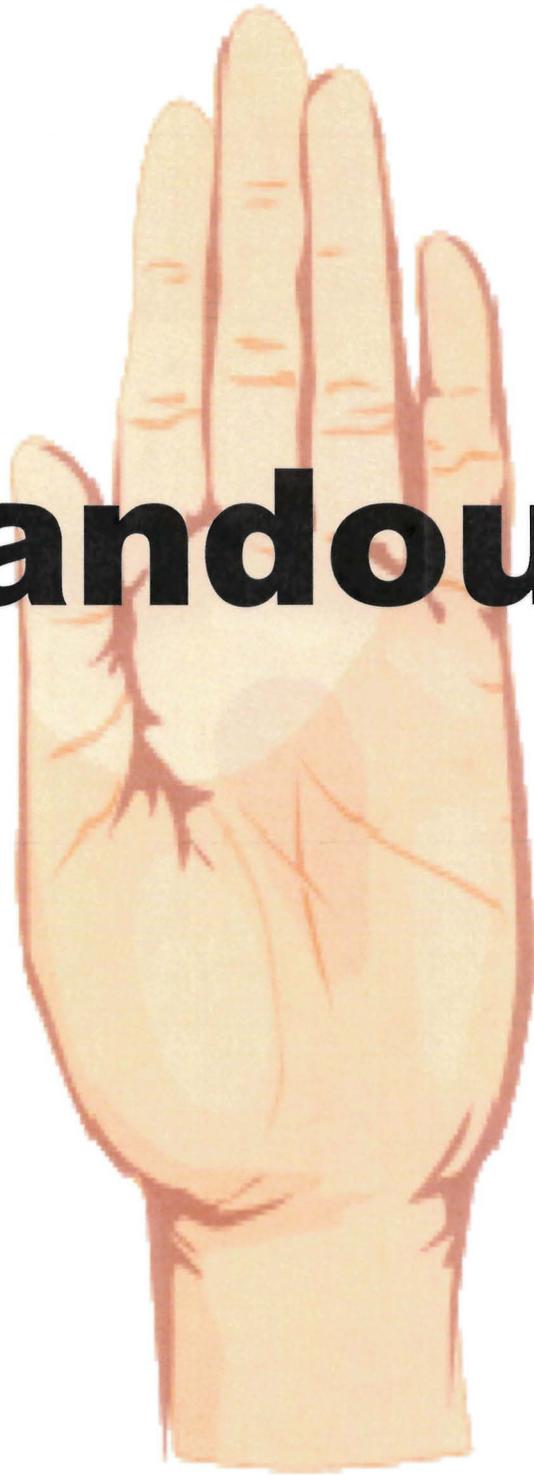
Instructor-led Classroom Option 2: Invite a panel of parents to the training to present the issues they deal with in raising children with special needs. The panel can share experiences briefly, and then the audience can ask questions and discuss concerns.

Handouts:

Common Special Needs in Adoption/Foster Care
Attachment Disorder
Attention Deficit/Hyperactivity Disorder
Fetal Alcohol Spectrum Disorder
Sensory Integration
Core Issues in Adoption
Positive Adoption Language
Resource List for Special Needs



Handouts



HANDOUT 2

Common Special Needs in Adoption

Adjustment Disorder

The development of emotional or behavioral symptoms—such as depression, anxiety, sleeping problems, inappropriate conduct, etc.—in response to an identifiable stress event that are more intense than one would expect.

Alcohol-Related Birth Defects

Physical or cognitive deficits in a child that result from maternal alcohol consumption during pregnancy, including but not limited to fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE).

Attachment Disorder

The inability of a child to form significant emotional connections with other people. Children who have experienced abuse and neglect, even when very young, will sometimes find it difficult to form significant ties. While they may be very charming, their relationship to others may be superficial. Lying, being out of control, lack of conscience development, and the inability to maintain direct eye contact are among the signs of attachment disorder.

Attention Deficit Disorder (ADD)

A child with ADD is not hyperactive but may have many of the following difficulties: has concentration problems, has difficulty following directions, has difficulty completing tasks, is easily distracted, loses things, and is overly messy or overly neat.

Attention Deficit Hyperactivity Disorder (ADHD)

A disorder that involves problems with attention span, impulse control, and activity level. Typical behaviors include fidgeting, difficulty remaining seated, distractibility, difficulty waiting for turns, difficulty staying on task, difficulty playing quietly, excessive talking, inattention, and engaging in physically dangerous activities without considering consequences.

Bipolar Disorder

A mental illness characterized by cycles of mania and depression. During manic periods, individuals may seem very happy and be hyperactive. In severe episodes, psychotic symptoms may also be present.

Cerebral Palsy

A non-hereditary condition resulting from brain damage before, during, or after birth. Children with cerebral palsy lack muscle control in one or more parts of their bodies or may experience speech and language difficulties, depending on the area of the brain damaged. Individuals with cerebral palsy can possess very normal mental functions.

Conduct Disorder

A condition characterized by a strong unwillingness to meet societal norms or expectations.

Cognitive Delays

Delays in the customary development of a person's ability to process information or think logically or analytically.

Developmental Disabilities

Often used to describe a variety of conditions, with implications ranging from mild to severe. It is usually used to describe any condition or disorder—physical, cognitive, or emotional—that interferes with a child's normal progress.

Emotional Behavior Disorder (EBD)

Children who are diagnosed with emotional or behavioral disorders have an established pattern of behavior characterized by one or more of the following:

- Severely aggressive and impulsive behaviors.
- Severely withdrawn or anxious, depression, mood swings, pervasive unhappiness.
- Severely disordered thought processes manifested by unusual behavior patterns; atypical communication styles, and distorted interpersonal relationships.
- Inability to build or maintain satisfactory interpersonal relations necessary to the learning process with peers, teachers, and others.
- Failure to attain or maintain a satisfactory rate of educational or developmental progress that cannot be improved or explained by cognitive, sensory, health, cultural, or linguistic factors.

Emotional Disabilities

Some children, due to their past history, genetics, or both must cope with emotional difficulties in their daily living. These children may require special therapeutic school programs and special living arrangements.

Educable Mental Retardation (EMR)

Mental retardation affects people in different ways. Some have educable retardation, meaning they can be educated and trained for future responsibilities. EMR classes and programs help them achieve a level of independence. Roughly 85 percent of those with retardation fall into this category.

Fetal Alcohol Spectrum Disorder (FASD), Fetal Alcohol Syndrome (FAS), and Fetal Alcohol Effects (FAE)

Conditions that result from alcohol use by the birth mother during pregnancy. Children born with FAS or FAE can have organic brain damage, low birth weight, birth defects, mental retardation, and learning impairments in varying degrees.

Impaired Motor Skills

A person who does not have the ability to use large and small muscle groups or has limited ability has impaired motor skills. Gross motor skill refers to use of large muscles in activities such as running or jumping. Fine motor skills refer to the small muscle coordination required for things like writing or buttoning a shirt.

Impulse Control Disorder

A mental disorder characterized by an individual's recurrent failure to resist impulsive behaviors that may be harmful to themselves or others.

Learning Disabilities (LD)

Some children find learning in regular classrooms difficult. Children with learning disabilities may be of average or above average intelligence, but have difficulty learning, sorting, and storing information.

Oppositional Defiant Disorder (ODD)

A disorder characterized by behavior such as frequent loss of temper, a tendency to argue with adults, refusal to obey adult requests, deliberate behaviors to annoy others, spiteful and vindictive behavior, use of obscene language, and a tendency to blame others for mistakes. Symptoms sometimes indicate the early stage of conduct disorder.

Post Traumatic Stress Disorder (PTSD)

PTSD develops when a child experiences or witnesses, an extremely traumatic event. This could include actual or threatened death, serious injury or a threat to the physical integrity of self or others. For children, sexually traumatic events may include developmentally inappropriate sexual experiences or the threat of them to the child or others. These incidents cause the child to experience intense fear, helplessness, or horror. The child may also exhibit various physical symptoms related to this disorder.

Prenatal Drug Exposure

Cocaine or other drugs used during pregnancy can significantly increase the risk of damage to the child's nervous system. Children exposed to drugs in-utero may appear stiff and rigid, have prolonged and piercing crying episodes, are easily over stimulated, and face an increased risk of Sudden Infant Death Syndrome. Long-term effects are uncertain.

Reactive Attachment Disorder (RAD)

A condition resulting from an early lack of consistent care characterized by an inability to make appropriate social contact with others. Symptoms include developmental delays, lack of eye contact, feeding disturbances, hypersensitivity to touch and sound, failure to initiate or respond to social interaction, indiscriminate sociability, and self stimulation.

(Adapted from Minnesota Adoption Resource Network's (MARN) web site: www.mnadopt.org)

ATTACHMENT DISORDER

Compiled by Cathy Bruer-Thompson, Training Coordinator,
Hennepin County Adoption Program

(Materials from Evergreen Consultants www.attachmenttherapy.com,
Daniel A. Hughes' *Adopting Children with Attachment Problems*)

Attachment disorder is a condition in which individuals have difficulty forming loving, lasting, intimate relationships. Attachment disorders vary in severity, but the term is usually reserved for individuals who show a nearly complete lack of ability to be genuinely affectionate with others. Attachment is the result of the bonding process that occurs between a child and caregiver during the first 2 years of the child's life. When the caretaker recognizes and attends to the child's needs innumerable times a year, the child learns the world is a safe place and trust develops. The emotional connection also forms. The child feels empowered in their environment, and develops a secure base from which to explore the world. Attachment is reciprocal as the baby and caretaker create a deep, nurturing connection together. It takes two to connect. It is imperative for optimal brain development and emotional health, and its effects are felt physiologically, emotionally, cognitively, and socially.

Children without proper care in the first few years of life have an unusually high level of stress hormones, which adversely effect the crucial aspects of the brain and body develop. Conscience development is dependent upon brain development and follows attachment. Therefore, these children lack pro-social values and morality as well as demonstrating aggressive, disruptive and antisocial behaviors.

There are many reasons why the development of this connection and attachment can be disrupted:

- Premature birth
- In-utero trauma, such as exposure to alcohol or drugs
- Unwanted pregnancy
- Separation from birth mother
- Postpartum depression in mother
- Severe abuse and/or neglect in the first years of life
- Multiple caretakers
- Hospitalizations
- Unresolved pain
- Painful or invasive medical procedures
- Insensitive Parenting

These children have learned at a pre-verbal stage that the world is a scary and distrustful place. This lesson has taken place at a biochemical level in the brain. For this reason, these children do not respond well to traditional therapy or parenting since both rely on the child's ability to form relationships that require trust and respect. Children who have Reactive Attachment Disorder require a different type of therapy to address these early attachment difficulties.

There is a range of attachment problems resulting in varying degrees of emotional disturbances in the child. Some of these children may have concurrent diagnoses such as Oppositional Defiant Disorder, Conduct Disorder, ADHD, Mood Disorders such as Depression or Bipolar Disorder, and Posttraumatic Stress Disorder. Unfortunately, many children with RAD are often misdiagnosed and receive inadequate therapy for years. Without proper treatment, these children and the societies in which they reside will pay a very high price indeed.

Symptoms of Attachment Disorder

The Child may have some of the following behaviors/symptoms:

- Superficially charming, acts cute to get what he/she wants
- Indiscriminately affectionate with unfamiliar adults
- Resists genuine affection with primary caregivers, on parental terms (especially mother)
- Controlling, bossy, manipulative, defiant, argumentative, demanding
- Impulsive, no “stops” on their behaviors
- Fascinated with fire, death, blood, weapons, evil or gore
- Cruelty to animals, destruction of property, aggression toward others or self
- Destructive, accident-prone
- Very concerned about tiny hurts, but brushes off big hurts
- Rages or has long temper tantrums, especially in response to adult authority, being told “no”
- Poor eye contact... except when lying will look you in the eye with the most innocent eyes
- Blames others for their problems
- Lacks self-control
- “Crazy” lying (about the obvious); steals, shows no remorse, no conscience, defiant
- Food issues- hoards or sneaks food, gorges, refuses to eat, eats strange things, hides food
- Poor hygiene: wets or soils self
- Poor peer relationships
- Underachiever
- Persistent nonsense questions and incessant chatter
- Abnormal speech patterns or language problems
- Grandiose sense of self, lacks trust in others to care for him/her

The Parents’ may exhibit some of the following symptoms:

- Feel helpless, demoralized, emotionally exhausted
- Appear angry, frustrated and hostile
- Feelings of inadequacy and guilt
- May look overly controlling and rigid

Helpful Resources: www.attach.org www.attachmenttherapy.com

Adopting Children with Attachment Problems, Daniel A. Hughes, Child Welfare League, 1999.

Attaching in Adoption by Deborah D. Gray, Perspectives Press, 2002.

Theraplay by Ann M. Jernberg and Phyllis B. Booth, Jossey-Bass, 2001.

Parenting the Hurt Child: Helping Adoptive Families Heal and Grow
by Gregory C. Keck, Regina M. Kupecky, 2002

How to Parent and Help a Child With Attachment Disorder?

Find appropriate therapy: Traditional therapy is based on the belief that the child has the readiness and ability to form a therapeutic relationship... these kids are not capable of this. Use attachment therapy and skilled therapists with experience. Be present in the therapy!

Spend a lot of time together, be physically close, take time off work. Parents need to help their child develop a secure attachment for the first time in their life... a "psychological birth." The parents can make many of the choices for the child and provide both a sense of safety and fewer consequences for misbehavior... because there will be fewer misbehaviors, and the child is not repeatedly experiencing failure and shame.

- Parental attitude that communicates empathy, acceptance, affection, curiosity, and playfulness increases the child's ability to respond like a securely attached infant.
- Learn to parent differently. Enlarge your "bag of tricks"
- Get support for yourselves: support groups, on-line RAD parent groups.
- Use natural and logical consequences. Accept the child's choices and show empathy for the consequences, striving to be "sad for" his distress over the consequence rather than being "mad at" him for his behavior.
- The behaviors may be more frequent, more intense and last longer, so you need to hang in there!
- Use respite care; find one who understand the nature and severity of the child's attachment problems, false allegations, need to follow parent's guidelines. Take care of yourself!
- Be prepared "for the long haul since 18-24 months may be required to see significant progress.
- Get in-home supportive services a few hours a week: must be knowledgeable of attachment.

Reactive Attachment Disorder Assessment Checklist

(Cicchetti, 1989)

- How severe, chronic and pervasive were the child's experiences of neglect and abuse?
- How many caregivers did the child have? (Disrupted relationships with foster parents are likely to be experienced as rejection and abandonment. With each subsequent disruption, a child's readiness to form an attachment with the next caregiver is likely to be less.)
- Were there any positive, continuing relationships during the first 2 years of the child's life?
- Has the child begun to show any significant improvements in his current family foster home?
- Is there any selectivity in the child's attachments?
- Has the child ever shown grief over loss?
- Does the child accept help and comforting?
- Can the child enjoy, without disrupting them, close and playful interactions that are similar to the attunement interactions mothers have with their infants?
- Can the child ever directly show shame over his behaviors?
- Does the child ever show sadness over the consequences of his behaviors, rather than being enraged over the perceived unfairness? Can the child experience and give expressions to sadness and to fears?

Reactive Attachment Disorder is a very real illness. Children with Reactive Attachment Disorder are reacting to events in their early life that may include prenatal exposure to alcohol or drugs, neglect, abuse, or multiple caretakers. The brain's development may actually be altered to impair

Minnesota Adoption
Support and
Preservation
612-798-4033
www.mnasap.org

Attention-Deficit/Hyperactivity Disorder and Adoption

Attention-deficit hyperactive disorder (ADHD) is probably the most controversial medical health issue of our time. While some suggest that no such disorder exists, new brain scan tests of adults diagnosed with ADHD have located a chemical imbalance in a part of the brain that uses the nerve messenger dopamine. Dopamine helps regulate attention and inhibits impulsive behavior. A public perception exists that ADHD is over-diagnosed, although the Council on Scientific Affairs of the American Medical Association recently determined that this is not the case. Adoptive parents need to be vigilant since the incidence of learning disabilities such as ADHD appears to be higher among adopted children than among non-adopted children.

ADHD brings the nurture vs. nature debate to the adoption floor. A genetic pattern of multigenerational transmission of ADHD has been documented, as well as a high incidence among children born in a crisis. The crisis may be generational and connected to addiction, depression and/or abuse. While genetic influences may offer cause-effect explanations to the diagnosis, environmental factors may also be at play. Some experts believe that the added childhood task of trying to make sense of altered life circumstances influences the learning styles of children who are adopted.

ADHD symptoms, manifested by the age of seven, include developmentally inappropriate impulsivity, inattention, and in some cases, hyperactivity. This neurobiological disorder affects three-to-five percent of school-age children. Symptoms typically continue into adulthood with a two to four percent occurrence among adults. The disorder results from parts of the brain being under-active, not hyperactive.

Three variations of ADHD exist:

- * Combined (most common) – hyperactive, impulsive, inattentive
- * Predominantly Inattentive – (most common in girls and adults)
- * Predominantly Hyperactive/impulsive

Determining if a child has ADHD is a multifaceted process that requires separating out biological and psychological problems that mirror those exhibited by children who may not have ADHD. A comprehensive evaluation by a specialist in the field should include a clinical assessment of the child's academic, social/emotional functioning and developmental abilities. A medical exam by a physician is also important.

By federal law, children suspected of having ADHD must be evaluated at the school's expense and, if found to be eligible, provided services under either The Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973. Some of the services that could be provided to eligible children include modified instructions, assignments, and testing; assistance from a classroom aide or a special education teacher; assistive technology; behavior management; and the development of a positive behavioral intervention plan.

In order to adapt education to the needs of youth with ADHD, educators need to:

- * Send clear messages and teach for understanding
- * Use multi-sensory teaching techniques and active learning strategies
- * Provide clear, explicit structure for class time, space, materials and course of study
- * Provide frequent assignments with meaningful feedback and evaluation
- * Expose and teach the skills, information and expectations hidden in the curriculum
- * Offer alternative assignments, when indicated
- * Involve and respect students as central partners in learning
- * Intervene early and effectively with individual students who have difficulty learning

Alternative schools with smaller classrooms or home schooling may suit youth whose educational needs are not being met in larger public school settings. Smaller classrooms offer less distraction compared to typical larger classes where attention strays to 30 voices, 30 faces, 30 bodies moving around.

ADHD presents some paradoxes, including:

- * Psychostimulants prescribed for ADHD calm those with ADHD but can be potentially over-stimulating and even dangerous to those without the disorder
- * Children with ADHD resist the structure they desperately need for symptom relief
- * They love distractions, but function and feel best when hyper-focused
- * They seek stimulation to stave off boredom and depression, but over-stimulation exacerbates their symptoms, causing distress
- * They are capable of making connections between ideas/people at the speed of light, yet may act scattered and socially backward

Since children with ADHD often appear bright and capable, parents may find themselves arousing the suspicion of others who blame a child's behaviors on poor parenting. Child raising experts suggest that parents receive training specific to ADHD, get individual/family counseling, investigate a medical regimen, and create interventions based on these guidelines:

- * Raise the bar; don't lower it
- * Make life challenging in fun ways, not less
- * Keep the stakes high with individual tasks

Untreated children with ADHD are "at-risk" for potentially serious problems: academic underachievement, school failure, difficulty getting along with peers, and problems dealing with authority. In the pre-teen and teen years, youth diagnosed with ADHD may be at greater risk for substance abuse if they turn to substances to mask the negative effects. Recent research investigating the calming effects of nicotine on ADHD may explain why many who have the disorder smoke. Studies show that children who receive adequate treatment for ADHD have fewer problems with school, peers and substance abuse, and show improved overall functioning, compared to those who do not receive treatment.

RESOURCES

Adoption and the Schools: Resources for Parents and Teachers, edited by Lansing Wood and Nancy Ng. Published by FAIR (Families Adopting in Response) P.O. Box 51436, Palo Alto, CA 94303, www.fairfamilies.org

How To Reach and Teach Teenagers with ADHD by Grad L. Flick, Ph.D.
Center for Applied Research in Education: New York, 2000.

Special Kids Need Special Parents: A Resource for Parents of Children with Special Needs by Judith Loseff Lavin,
Berkley Books: New York, 2001.

Taking Charge of ADHD: The Complete Authoritative Guide for Parents by Russell A. Barkley, Ph.D.
The Guilford Press: New York, 2000.

C.H.A.D.D. (Children and Adults with ADD)
8181 Professional Place, Suite 201
Landover MD 20785
CHADD National Call Center (800) 2334050
www.chadd.org

Fetal Alcohol Spectrum Disorder—Part 2 Strategies and Interventions

Fetal Alcohol Spectrum Disorder (FASD) is permanent brain damage that results from prenatal exposure to alcohol. If your child has been diagnosed with FASD, you will need to find ways to parent and teach your child that will fit their abilities. Children with FASD typically do not learn nor respond as other children. New ways of behavior management, parenting skills, medication and teaching methods will have to be applied.

Children and adolescents with FASD act in ways that seem inappropriate to their age, but in actuality are acting within their developmental age. Educators and parents need to review the child's behavior within the context of the FASD diagnosis. Many of these behaviors continue into adulthood.

- The stubborn acting out child doesn't understand verbal directions.
- A child who keeps repeating the same mistakes in what seems like defiance can't recall what was learned yesterday or a year ago.
- Often late and disorganized, the child can't understand time since time is an abstract concept. Any type of math such as multiplications, division or fractions that have to be visualized because they can't be "touched" may not be understood.
- Squirmy and intent on bothering others, the child's brain communicates a need to move while learning.
- Unable to be safely left alone, the child is unable to understand danger.

Methods that work with other children to help them "act their age" won't work with these children who take longer to grow up and require alternative behavior management, parenting skills, medication and teaching methods. A rule of thumb for parents and teachers is to "think younger" when a child or adolescent seems unable to complete tasks or displays inappropriate behaviors.

For those who teach and parent children and youth diagnosed with FAS, it is important to know:

- Symptoms that are based on the developmental level of the young person..
- How to get correct assessments .
- How to access educational services and community resources.
- Effective methods of parenting and teaching adapted to needs of youth with FAS.
- Support systems that bolster the family as well as the child or youth with FAS.

When an intervention is not working with a student with FAS, it is best to:

- Stop the action!
- Observe.
- Make eye contact with the child.
- Listen carefully to find out where he/she is stuck.
- Ask: What is hard? What would help?

Strategies to keep in mind are :

- Keep information concrete.
- Consider poor behavior as a physically-based unmet need.
- Maintain consistency.
- Use repetition.
- Maintain stable routines
- Keep it short and sweet.
- Be specific.
- Provide structure
- Be vigilant with supervision.
- Sensory awareness and sensory interventions work well. (See Sensory Integration Dysfunction Fact Sheet)
- Teach incorporating as many of the senses as possible.

Alternative Methods in Dealing with Children/Youth with FASD						
Concrete	Supervision	Specific	Structure	Consistency	Repetition	Routine
Talk and educate in concrete terms.	Constant supervision is the rule since the child may not understand consequences nor perceive danger.	Say exactly what you mean to help the child who has difficulty with abstractions.	Structure is the "glue" that helps the world make sense to someone with FASD.	To accommodate the inability to generalize learning from one situation to another, provide consistency.	To address short term memory problems, re-teach, re-teach, re-teach.	Provide a daily stable routine to decrease anxiety and enable learning.
Avoid double meanings and idioms such as "catch the bus."	Develop habit patterns of appropriate behavior since child may be socially inappropriate.	Avoid the abstract and generalizations.	Adjust expectations to meet the child's/youth's developmental level.	Provide an environment with few changes.	Practice teaching concepts in a variety of environments	Provide assistive technology within a routine (a watch with alarm).
Give instructions at lower age/grade level than chronological age.	FASD creates naiveté and danger, so adults need to be vigilant.	Students with FASD are unable to "fill in the blanks" when given directions.	Adapt work and study schedules to child's/youth's frustration level.	Teachers and parents need to use the same key words for oral directions.	Patiently explain step by step with external supports and lots of cues.	Allow adequate time to complete tasks within a daily routine.

Traditional interventions do not work with FASD youth who cannot associate a consequence with a behavior. The best discipline is to keep the child or youth from needing discipline. If a discipline technique is NOT working, don't try harder. Change your course of action. Redirect activity. Devise a prearranged gesture or signal as an automatic intervention to help a child understand that they need to stop whatever he or she is doing.

Without appropriate support services, youth with FASD have a high risk of developing secondary disabilities as teenagers or as young adults including mental illness; getting into trouble with the law; abusing alcohol and other drugs; and unwanted pregnancies. Families who understand the realities of this disability soon realize it requires the parents to have a life-long commitment to the son or daughter who has been diagnosed with FASD. All family members including siblings will need support, respite and coping skills.

Resources

Adoption and Prenatal Alcohol and Drug Exposure: Research Policy and Practice
by R. Barth, M. Freundlich, and D. Brodzinsky (ed.)

Addresses long-term developmental issues with counseling suggestions. Illustrates the remedial effects of a positive postnatal environment, including services and support systems.

Our Fascinating Journey: The Best We Can Be – Keys to Brain Potential Along the Path of Prenatal Brain Injury
by Jodee Kulp

Comprehensively addresses FASD interventions with topics ranging from brain basics to creating an educational environment.

The Challenge of Fetal Alcohol Syndrome: Overcoming Secondary Disabilities
by Ann Streissguth and Jonathan Kanter

Summarizes recent findings and recommendations from twenty-two experts in the fields of human services, education, and criminal justice regarding FASD.

Fetal Alcohol Syndrome: A Guide for Families and Communities
by Ann Streissguth

A leading authority on FAS draws on her life's work to give information about FAS diagnosis; brain damage; physical and behavioral manifestations; and services for high-risk mothers. Also, case studies, photos, illustrations and validated empirical research highlighting the cultural, racial and economic diversity of FAS.

The Way to Work: An Independent Living/Aftercare Program for High Risk Youth
by Amy J.L. Baker, David Olson and Carolyn Mincer

A Child Welfare League publication that presents a 15-year longitudinal study profiling successful programs serving youth such as those with FASD.

Websites

FAS Alaska

Comprehensive website includes numerous links to resources around the world, training and consultations, research, connections to families, articles, homeschool resources. Focuses on intervention techniques for educators.
www.fasalaska.com

FASCETS- Fetal Alcohol Syndrome Consultation, Education and Training Services Inc.

Non-profit organization that provides direct services for individuals, family systems and professionals affected by Fetal Alcohol Spectrum Disorder including information, training, consultation and resources.
www.fascets.org

FAS Characteristics

Log on to view facial characteristics and a list of symptoms associated with FASD.
www.come-over.to/FAS/faschar

Sensory Integration Dysfunction and Adoption

In her book, *The Out-of-Sync Child*, Carol Stock Kranowitz defines Sensory Integration Dysfunction as the "inefficient neurological processing of information received through the senses, causing problems with learning, development, and behavior." In simple terms, children diagnosed with SI Dysfunction have brains that are wired differently than their peers, making it difficult for them to make sense of messages received through any of the five senses. They are often delayed and prone to explosive outbursts. Their reactions are often out of proportion, going into a frenzy when viewing a brightly painted wall or being so much an "escape artist" that parents have to put an alarm on the child's bedroom door.

For children of adoption, SI Dysfunction rates are higher than with non-adopted children, requiring their parents to gain an understanding of the many complex skills that are required to do what seems to be a simple act such as tying a shoe or playing a board game. With such children, the interventions that illustrate "good parenting" such as setting firm limits simply do not work, causing their parents to be blamed and shamed for the child's behavior. The child may also be treated unfairly with no regard to this invisible disability. As early as preschool, the child may be labeled as a bully.

Inefficient sensory intake translates into taking in too much or too little information. With too much information, the brain is on overload and causes an individual to avoid sensory messages. With too little information, the brain seeks more sensory stimuli.

Only an occupational therapist that has been carefully trained in sensory integrative theory and treatment can properly diagnose SI Dysfunction (for a list of Minnesota therapists who specialize in SI Dysfunction, go to www.mnasap.org/pages/resources/pediatric_clinics.htm). A teacher and/or parent can learn to recognize signs that a child may be having sensory processing difficulties. The teacher can initiate an evaluation so the child may eventually receive appropriate therapy.

A high correlation exists between SI Dysfunction and Learning Disabilities (LD), with 70 percent of children diagnosed with LD having SI Dysfunction. SI Dysfunction resembles ADHD with some overlapping symptoms. The optimum treatments for the two differ. While the symptoms of ADHD may be eased with medicine such as psychostimulants, targeted occupational therapy tailored to the individual needs of the child is more helpful in cases of SI Dysfunction. An overloaded child needs less stimulation such as dimmed lights, comforting with "deep pressure" bear hugs, or a "nest" of pillows and blankets under the dining room table. An under-responsive child requires more sensory stimulation with daily activities, gentle roughhousing, and perhaps a trampoline. Therapy that is appropriate to the child's type of SI Dysfunction can ease underlying difficulties.

Kranowitz suggests that parents of a child diagnosed with SI Dysfunction do the following:

- Be a detective! Keep notes on your child's atypical behavior. Does his reaction to a sensory stimulus occur with **frequency**, **intensity** and **duration**? For instance, does the child have a heck of a time calming down after getting a splinter or being knocked down?
- Ask yourself the "WH" questions, i.e., When did it happen? Where? Who was involved? What happened or what was said? How did your child respond? After taking notes for a while, you may be able to see the pattern and find the answer to the trickier question of "Why did it happen?"
- Find an occupational therapist certified to provide SI Dysfunction treatment.

Symptoms of Sensory Integration Dysfunction

(This material is reprinted with the permission of the Childhood Apraxia of Speech Association of North America on the Apraxia-Kids (SM) Internet Resources at www.apraxia-kids.org)

Sensory	Symptoms
Auditory	Responds negatively to unexpected or loud noises Holds hands over ears Cannot walk with background noise Seems oblivious within an active environment
Visual	Prefers to be in the dark Hesitates going up and down steps Avoids bright lights Stares intensely at people or objects Avoids eye contact
Taste/Smell	Avoids certain tastes/smells that are typically part of children's diets Routinely smells nonfood objects Seeks out certain tastes or smells Does not seem to smell strong odors
Body Position	Continually seeks out all kinds of movement activities Hangs on other people, furniture, objects, even in familiar situations Seems to have weak muscles, tires easily, has poor endurance Walks on toes
Movement	Becomes anxious or distressed when feet leave the ground Avoids climbing or jumping Avoids playground equipment Seeks all kinds of movement and this interferes with daily life Takes excessive risks while playing, has no safety awareness
Touch	Avoids getting messy in glue, sand, finger paint, tape Is sensitive to certain fabrics (clothing, bedding) Touches people and objects at an irritating level Avoids going barefoot, especially in grass or sand Has decreased awareness of pain or temperature
Attention, Behavior and Social	Jumps from one activity to another frequently Has difficulty paying attention Is overly affectionate with others Seems anxious Is accident prone Has difficulty making friends, does not express emotions

Occupational therapists suggest activities to help children increase their ability to regulate themselves and to be more in control of behavior and impulses. These include working on:

- Joints and muscles—Joint compression, mini tug-of-war, roll up in a blanket
- Sense of touch—brushing, vibration, loufah sponges
- Deep pressure—squeeze hands, weighted blanket, ace bandage wrap, wet suit
- Overall movement and gravity—mini trampoline, rocking chair, roller skating
- Oral—sucking on ice, chewing, crunching, blowing cotton balls

Books

(For book ordering information, log onto www.mnasap.org)

Answers to Questions Teachers Ask About Sensory Integration
by Carol Stock Kranowitz

Challenging Behavior in Young Children: Understanding, Preventing, and Responding Effectively
by Barbara Kaiser

The Out-of-Sync Child : Recognizing & Coping with SI Dysfunction
by Carol Stock Kranowitz

The Out-Of-Sync Child Has Fun: Activities for Kids with Sensory Integration Dysfunction
by Carol Stock Kranowitz

101 Activities for Kids in Tight Spaces: At the Doctor's Office, on Car, Train, and Plane Trips, Home Sick in Bed
by Carol Stock Kranowitz

Websites

Sensory Integration International

A non-profit, tax-exempt corporation concerned with the impact of sensory integrative problems on people's lives.
310-787-8805
info@sensoryint.com
www.sensoryint.com

Learning Disabilities Association of America (LDA)

Dedicated to identifying causes and promoting prevention of learning disabilities and to enhancing the quality of life for all individuals with learning disabilities and their families by encouraging effective identification and intervention, fostering research, and protecting their rights under the law.
412-341-1515
info@ldaamerica.org
www.ldanatl.org

Developmental Delay Resources

Dedicated to meeting the needs of those working with children who have developmental delays, publicizing research and networking for parents and professionals after a diagnosis to support children who have special needs.
412-422-3373
devdelay@mindspring.com
www.devdelay.org

Apraxia-Kids

This online source provides comprehensive information about Childhood Apraxia of Speech* and is designed for families, professionals and all those who care about a child with apraxia.

**Childhood Apraxia of Speech is sometimes called Developmental Apraxia of Speech, Developmental Verbal Dyspraxia, Oral-motor Speech Disorder and other terms*

760-632-5020
helpdesk@apraxia.org
www.apraxia-kids.org

Core Issues in Adoption

(Adapted from work by Deborah N. Silverstein and Sharon Kaplan)

1. Loss

Adoption is created through loss. All members of the adoption triad—birth parents, adoptive parents, and adoptees—feel the loss. The hub of the wheel that connects all members of the triad is loss.

Transracial adoptees can also experience the loss of a connection to their race and/or culture of origin.

Adoptees—experience the loss of separation from their birth family and/or foster parents or first caregiver. They are aware of adoption at different developmental stages and sometimes feel as if they are learning about their adoption for the first time when they reach a new developmental stage. They don't have closure on those losses.

Birth parents—experience the loss of their genetic connector, the loss of a role, and the loss of contact with their child

Adoptive parents—experience the loss of their dream child and feel the impact of infertility.

How You Can Help

- Recognize and acknowledge all the losses and the effect loss has on their lives
- Understand that the loss is never totally forgotten; there is a conscious or unconscious awareness of the loss
- Loss is always a part of triad members' lives
- Understand and consider your own losses—how did you come to terms with losses in your life?
- Help to minimize future losses by keeping siblings together and allowing contact with grandparents and former foster parents
- Encourage adoptive parents to establish and maintain connections to the child's culture of origin and surround their child with role models from his racial or ethnic group.

2. Rejection

To be *chosen* into an adoptive family, you must first be *unchosen* by another family.

Transracial adoptees can also feel because they are perceived as “different” by their culture of origin and their adoptive culture, they don't feel fully accepted anywhere. They may also feel rejected by their culture of origin because no one from that culture chose to adopt them.

Adoptees—personalize rejection; “Why did she leave me?” is a frequently asked question, either verbally or internally. The birth parent has often chosen a lifestyle over the child. The child is confused, feels unlovable, unwanted, unworthy, or defective. The child wonders “would they

PARENTING CHILDREN WITH SPECIAL NEEDS

A Child's Journey through Placement, Vera Fahlberg, Perspectives Press, Inc., IN, 1991.

A Parent's Guide to Understanding Sensory Integration, Sensory Integration Intervention. (Call 310-320-9986 to order.)

Adopting and Advocating for the Special Needs Child, L. Anne Babb and Rita Laws, Bergin & Garvey, Westport, CT, 1997.

Adopting the Hurt Child, Gregory Keck, Ph.D. and Regina Kupecky, L.S.W., Piñon Press, Colorado Springs, CO, 1995.

The Healing Power of Families, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 1995.

Helping Children Cope with Separation and Loss, Claudia Jewett, Harvard Common Press, Harvard, MA, 1994.

Grandparents as Parents: A Survival Guide for Raising a Second Family, Sylvie DeToledo and Deborah Edler Brown, The Gilford Press, New York, NY, 1995.

Parenting the Hurt Child, Gregory Keck, Ph.D. and Regina Kupecky, L.S.W., Piñon Press, Colorado Springs, CO, 2002.

Parenting Your Adopted Older Child, Brenda McCreight, Ph.D., New Harbinger Publications, Inc., Oakland, CA, 2002.

Safe Passage: A Summary of the Parent 2 Parent Mentoring Program, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 2000.

Small Feats: Unsung Accomplishments and Everyday Heroics of Foster and Adoptive Parents, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 2002.

Troubled Transplants: Unconventional Strategies for Helping Disturbed Foster and Adopted Children,

Richard J. Delaney, Ph.D., and Frank R. Kunstal, Ed.D., Horsetooth Press, Fort Collins, CO, 1993.

Scholastic,
www.teacher.scholastic.com/professional/bruceperry/index.htm (Internationally known Dr. Bruce Perry lists his published articles on topics such as brain development, attachment, and learning strategies. They are available to be copied by teachers and parents.)

VIDEOS:

Multiple Transitions: A Young Child's Point of View on Foster Care, Michael Trout, The Infant-Parent Institute, Champaign, IL.

Parent to Parent Video: A Mentoring Program, Richard J. Delaney, Ph.D., Wood 'N' Barnes Publishing, Oklahoma City, OK, 1999.

Rebuilding the Broken Bond #1: For Reactive Attachment Disorder, Nancy Thomas, P.O. Box 2812, Glenwood Springs, CO, 1998.

Rebuilding the Broken Bond #2: For Reactive Attachment Disorder, Nancy Thomas, P.O. Box 2812, Glenwood Springs, CO, 1998.

Redefining Success: Raising Children Exposed Prenatally to Alcohol, Ministry of Children and Family Development, British Columbia, Canada, 2001.

Re-Education of Foster and Adopted Children: Prospects for a Healthy Life, by Vera Fahlberg, M.D., (70-minute video & viewer's manual or DVD & viewer's manual)

Safe Environment for Foster Children Parts I & II: Managing Acting Out Behavior, (41 min. video and viewer's manual)

Safe Environment for Foster Children Part III: A Time and Place for Healing with Dr. Vera Fahlberg, (40 min. video and viewer's manual)

Tender Healing, by Vera Fahlberg, M.D. and Richard J. Delaney, Ph.D., (45-minute video) (To order call 800-777-6636 or www.sociallearning.com)

have loved me if I were cuter, taller, less demanding?" The child feels like he was "damaged goods" or she "was not good enough" for birth parents.

Birth parents—condemn themselves for being irresponsible.

Adoptive parents—struggle with issues of entitlement. Fear of rejection from a child with attachment problems. Concern about rejection as the child matures. They should not create fantasies for the adoptee about the birth family. This creates further rejection.

How Can You Help:

- Help sort out the facts about the adoption from the feelings—support and validate those feelings.
- Help build self esteem—rejection chips away at self-esteem.
- Understand the adoptee's wariness of intimate relationships because of rejection—help build intimacy through small steps.
- Don't reject or fear the child's pain—comfort the child.
- Encourage parents to maintain contacts and relationships with people from their child's past and/or establish new relationships with people from their child's culture of origin.

3. Guilt & Shame

There is tremendous guilt and shame for all members of the adoption triad.

Adoptees—believe something is intrinsically wrong with them or that their actions caused the loss to occur, often internalizes feelings, and feel shame for having been "given up".

Birth parents—feel guilt and shame because of an unplanned pregnancy and for having been sexual and intimate.

Adoptive parents—feel shame for taking someone else's child, infertility, or defective bodies. They also have guilt and shame for not making up for the losses in their children's lives.

How You Can Help

- Have a "letting go" ceremony to let go of shame and guilt. (Ex. Have client or patient write down what they feel guilty or shame about, crumple the paper and burn it in a ceremony to let go of those feelings.
- Talk about how the adoptee or adoptive parents have grown from the struggle, how they have survived.
- Acknowledge the pain of guilt and shame and share it with each other.

4. Grief

Adoptees—are often stuck in denial or anger. Understand that the developmental unfolding of cognitive processes is slow and that youth do not fully understand the impact of grief until they are adults.

Birth parents—are often told to move on and as a result deny their grief.

Adoptive parents—may grieve over the inability to bear children and/or grieve over their inability to spare their children grief from parental loss.

How You Can Help

- Discuss the stages of grief with the family. Help them to identify where they are and help them move through the stages: denial, anger, bargaining, depression, and acceptance.
- Help parents and children express grief openly, listen carefully, and offer them comfort and hope in the process.
- Help parents accept that their joy may conflict with the grief of their child.

5. Identity

Adoptees—often lack medical, genetic, religious, and historical information. Identity is defined both by what one is and what one is not. The adoptee is expected to “borrow” the identity of the adoptive family.

Transracial adoptees can have an especially difficult time with identity formation. They often wonder where they fit in. They may learn to feel comfortable in both cultures but also feel that others perceive them as not fitting into either culture.

Birth parents—can feel “I am a parent, but not a real parent” and wonder how to respond to the question: “Do you have children?”

Adoptive parents—are often made aware of the opinions of others that imply that adoptive parents are not real parents. They often have to deal with the questions: “Do you have children of your own?” or “Do you have any real children?”

How You Can Help

- Use appropriate adoption language. (Handout can be found in fact sheet: *Adoption and the Schools*)
- Children need accurate information about their past but it needs to be framed in a positive way. (Ex. Instead of labeling a birth mother as a prostitute, she is described as a person who chose an unhealthy lifestyle and made risky choices.) The child needs a way to build a positive self-image, not feel linked to negative choices of birth parent, and believe there is or was something good about the parent(s) who terminated rights.
- Children need hands-on memorabilia from their past. Do whatever you can to help get pictures of the children and encourage foster and adoptive parents to hang on to toys, a blanket, a doll or anything given to the child from the birth family. Encourage foster and adoptive families to make a scrapbook or lifebook. It is too hard for children to hold onto a past that is only an idea in their heads.
- Transracial adoptees need to stay connected to and continue to have experiences with their culture of origin—through relationships with other people, eating ethnic food, listening to or making music, dancing etc.

6. Intimacy

Other core issues impede intimacy issues.

Adoptees—may seem to hold back. A child may have a lifetime of emptiness related to longing for a birthmother the child may never see. The adoptee will most likely have attachment issues because of what did or didn't happen during the first three years of life—the period of normal child development when healthy attachments are first formed. The adoptee may have had disrupted bonding or no clear attachment figure.

Birth Parents—may equate sex, intimacy, and pregnancy with pain leading to loss.

Adoptive parents—may be challenged by the need to nurture and parent a child who has core issues. The reality that “this child is really different than me” sets in and parents may wonder “how can I love him/her?”

How You Can Help

- Counsel parents to *show* their children they were and are a choice in their parent's lives.
- Give parents attachment activities to do at every stage of development.
- Encourage families to have rituals and ceremonies to celebrate the adoption journey.

7. Mastery and Control

All members of the triad are forced to give up control.

Adoptees—are keenly aware of not being part of the decisions surrounding the adoption. The adoptee has no control over the loss of the birth family. Life altering choices were made for them. Adolescents often engage in power struggles and feel a lack of internalized self-control.

Birth parents—did not grow up thinking they would be “giving up” a child or that they would be a less-than-perfect parent.

Adoptive parents—may have parental entitlement issues, and as a result may be overprotective or controlling or rigid.

How You Can Help

Understand and recognize the inner strength and resources that many adoptees have developed to become deeper and more thoughtful people because of their struggles. These core issues are a part of the lives of the triad members, often regardless of the circumstances of the adoption. Professionals, family members, friends, and school personnel can help by being willing to engage in open dialogue and understand the core issues of adoption.

Resources

ATTACHMENT

Attaching in Adoption: Practical Tools for Today's Parents, Deborah D. Gray, Perspectives Press, Inc., Indianapolis, IN, 2002.

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families, Terry M. Levy and Michael Orlans, Child Welfare League of America Press, Washington DC, 1998.

Building Bonds of Attachment: Awakening Love in Deeply Troubled Children, Daniel A. Hughes, Jason Aronson Inc., Northvale, NJ.

Facilitating Developmental Attachment, Daniel A. Hughes, Jason Aronson Inc., Northvale, NJ, 2000.

Fostering Changes: Treating Attachment-Disordered Foster Children, Richard Delaney, Walter Corbett Publishing, Fort Collins, CO, 1991.

When Love Is Not Enough: A Guide to Parenting Children with RAD—Reactive Attachment Disorder, Nancy Thomas, (Order from Families By Design, P.O. Box 2812, Glenwood Springs, CO.)

Raising Children Who Refuse to be Raised: Parenting Skills and Therapy Interventions for the Most Difficult Children, David Ziegler, Ph.D., SCAR/Jasper Mountain, Jasper, OR, 2000.

The Association for Treatment and Training in the Attachment of Children (ATTCh), www.attach.org
Child Trauma Academy, www.childtrauma.org

ADD/ADHD

Attention Deficit Disorder Sourcebook, edited by Dawn D. Matthews, Omnigraphics, Detroit, MI, 2002.

How to Reach and Teach ADD/ADHD Children, Sandra F. Rief, Jossey-Bass, 1993. (To order call: 800-288-4745; Item 087 6284136)

Living with ADHD: A Practical Guide to Coping with Attention Deficit Hyperactivity Disorder, Rebecca Kajander, C.P.N.P., M.P.H., distributed by Park Nicollet Health Source, Minneapolis, MN. (800-372-7776)

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), www.chadd.org

FASE

Children with Fetal Alcohol Syndrome: A Handbook for Parents and Teachers, Larry Burd, Ph.D., 1999. (Must be ordered from: Larry Burd, 1300 S. Columbia Road, Grand Forks, ND.)

Fantastic Antoine Grows Up: Adolescents and Adults with Fetal Alcohol Syndrome, edited by Judith Kleinfeld and Siobhan Wescott, University of Alaska Press, Fairbanks, AK (907-474-6389).

Fantastic Antoine Succeeds: Experiences in Educating Children with FAS, edited by Judith Kleinfeld and Siobhan Wescott, University of Alaska Press, Fairbanks, AK (907-474-6389).

Fetal Alcohol Syndrome and Fetal Alcohol Effects, Minnesota Department of Health, St. Paul, MN, 1999.

Fetal Alcohol Syndrome and Fetal Alcohol Effects, Diane Malbin, Hazelden Books, Minneapolis, MN, 1993.

Recognizing and Managing Children with Fetal Alcohol Syndrome/Fetal Alcohol Effects: A Guidebook, Brenda McCreight, Child Welfare League of America, 1997.

The ABCs of FAS/FAE: Teachers Guide and Resource Booklet, www.lcsc.edu/education/fas/FAS.html

Fetal Alcohol Syndrome, www.come-over.to/FAS/

Missouri Respite Care Service Provider Training

An Introduction to Foster Care

Part 4 Behavior Management

Dealing with children's behavior is typically the biggest day-to-day concern of respite providers. One effective way to manage the behavior of children with special needs is to carefully plan activities that are fun, safe, and developmentally appropriate. In addition, providers need to know how to redirect the behavior of children with special needs and ensure that the children are safe.

Instructor-led Classroom Option 1:

Invite a panel of parents, providers, special educators, and social workers to talk about how they deal with specific behaviors. Be sure that panelists are consistent and know what state regulations are regarding behavior management.

Confidentiality

Information regarding the child or children in respite care will be provided to the potential respite caregivers. Remember that all information about the child, their birth/first families, or adoptive and kinship families is considered confidential and must not be shared with others.

Instructor-led Classroom Option 2:

Moderate a discussion answering questions that illustrate effective behavior management techniques:

- When do problems need to be managed?
- What are some basic rules for behavior?
- When do you notice that problems generally occur?
- How can you track behaviors, anticipate problems, and redirect the child before the trouble starts?
- How can you best handle behavior problems during transitions between activities?
- How can you improve cooperation and impulse control?
- How can you best use structure and consistency to manage behavior?
- What behavior management techniques may be used?
- What behavior management techniques are prohibited?
- How can families and providers manage their own mounting frustration when trying to manage children with special needs?

Encourage experienced providers to offer examples of effective behavior management techniques.

Close with encouragement and humor and talk about the importance of laughing with the children. Encourage respite providers to have fun with the children. These children need to have fun, and to be encouraged to learn new things and experience a variety of activities.

Be proactive when you take care of a child with special needs. If you want a child to succeed, it is better to over-supervise than to under-supervise, especially when the child

Missouri Respite Care Service Provider Training An Introduction to Foster Care

is in the provider's home. Providing structure and preventing problems is much better than trying to repair problems after they have happened.

Self-care for respite providers is important. What do you do to calm yourself? What is your back-up plan if you need help?

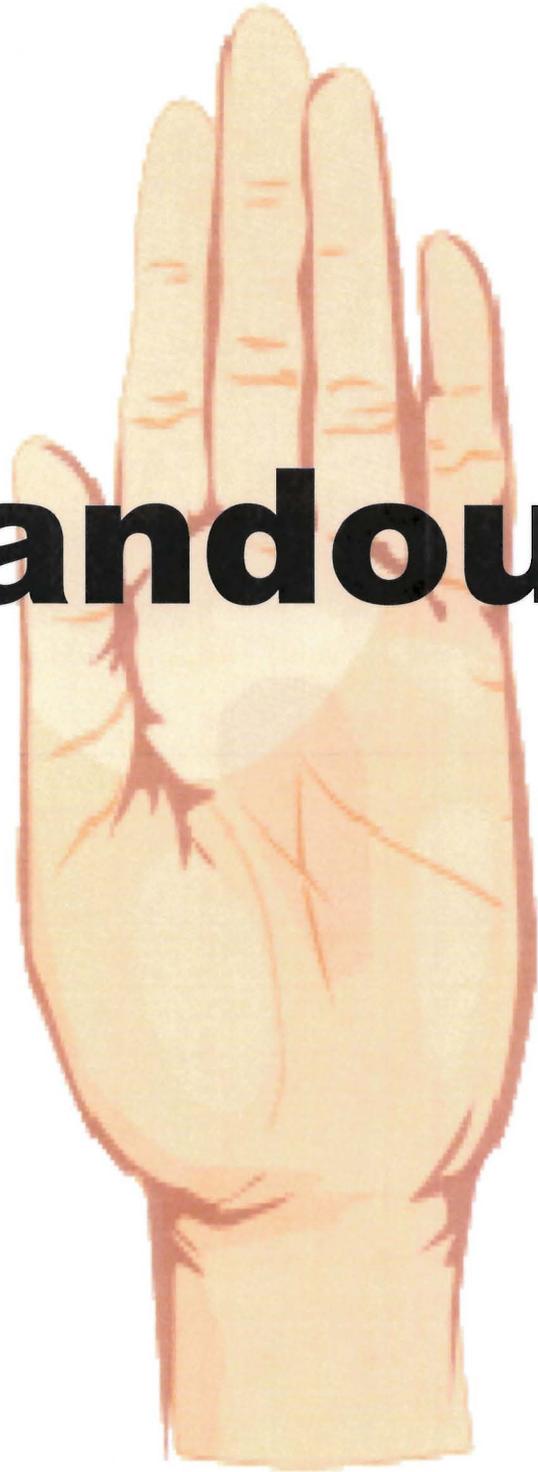
Handouts:

How to Mean Business without Being Mean
Tips for Parents & Caregivers of Children who have Experienced Trauma
Top Ten List for Parents Caring for Children with Multiple Diagnoses
Avoiding Power Struggles in Parenting

[Resource Parent Discipline Agreement, CD-119](#)



Handouts



How to Mean Business without Being Mean

by Deborah Hage, MSW

Deborah is co-director of Turning Point, a therapeutic agency that addresses both the therapeutic and parenting needs of children who have severe emotional and behavioral disorders due to early institutionalization, multiple moves, or abuse or neglect. She and her husband have parented two birth children, seven adopted children, and five children in therapeutic foster care, and Deborah often lectures about attachment and parenting. To learn more about Turning Point or view more parenting articles, go to www.deborahhage.com.

To enjoy being with our children, we must have a sense of joyful cooperation and operate within a reciprocal family environment; for children to enjoy being with us, they must be treated fairly and with respect. In addition, to grow into happy and productive adults, children must have good work skills and the ability to follow directions. Admittedly, this is a lot to ask of families whose children have been lovingly nurtured since conception.

For families whose children have a history of abuse, neglect, multiple moves, and abandonment, a positive family environment is even harder to achieve. Children often resist cooperating. Parents' expectations are dashed, tensions and voices rise, and stress permeates the home. Parents do not like what they have become, but are desperate to gain some cooperation from their son or daughter. Regrettably, there is no magical list of techniques we can apply to transform ourselves into the parents we want to be or our children into the children we want to raise. We can, however, develop the capacity to mean business without being mean.

Parenting Is Attitude

One key to meaning business without being mean is attitude—*our* attitude. When parents change their attitude, they change how they interact with their children. The process is the same when we ask children to change their attitude so their pattern of interaction with us will improve. We should not expect any more of them than we expect of ourselves.

To begin the attitude shift, parents must accept the simple fact that parenting is hard and is not likely to be just how we expected it would be. We may not live up to our ideal of what a parent should be and our children may not realize the potential we thought they would or should. That's reality.

When we accept the reality of our situa-

we will be perfect parents, and our children will be just how we envisioned, joyfully behaving the way we desire. When we let go of these expectations, we can accept what is and begin to defuse the disappointment or anger we feel when our children and our performance as parents fall short of our expectations.

Parenting Is Controlling Emotions

While we cannot control a child's behavior, we can choose our reaction to the behavior. By the same token, though we cannot choose happiness for our child, we can choose happiness for ourselves. When parents become excessively unhappy because of a child's behavior, they are ignoring their personal emotional well-being and sacrificing a measure of stability for the child. The child also receives the unhealthy message that personal happiness depends on the people around us and that others are to blame for our responses.

What our children need is a positive family environment—as reflected in our positive attitude—so they have a model for which to strive. As parents, our responsibility is to establish a healthy emotional tone in the home by maintaining, as much as possible, our equanimity.

Consider how professionals deal with misbehaving adults. Police officers don't start yelling at people who are pulled over for speeding. The speeders' actions do not affect the officer personally, so there is no emotional involvement. Instead, the officer just tells each violator about the law, how the person broke the law, and the resulting consequence.

If parents exhibit extreme emotionality at a child's misbehavior, the child thinks, "Wow, this sure is important to my parents. It's not nearly so important to me. No point in both of us worrying about it." The child might then back off of taking responsibility for his actions since the parents are so much more concerned about it

Words we speak in anger to our children diminish us and our children, and demonstrate that we are not in control of ourselves, much less anyone else. Parental anger makes children question our love since whatever we are angry about seems more important than they are. Then too, as soon we raise our voice, become sarcastic, or take a threatening stance, our children may stop paying attention to the message and focus on personal safety. Put another way, things we say in anger can lose all potential to affect change since our children will focus on our anger instead of their own misbehavior.

Every time a child hears, "You make me so angry!" the message conveyed is that, as individuals, we are not responsible for our emotions and the behaviors those emotions spark. Parents who make such declarations must not be surprised when their children hurl the same ill-conceived words back.

The general rule is that the person who has behaved the most irresponsibly should be the one experiencing the brunt of the emotionality. In other words, if someone is going to get upset over bad behavior it should be the one who exhibited the bad behavior, not the parents.

To teach children how to control their negative emotions, parents must be able to control themselves. If the parent does not stay in control when angry and upset, how can the child learn that such a goal is attainable? Understand and appreciate that no one can make you act out emotions negatively; you choose your response to all events. Parents should not be puppets on strings their children pull.

When you feel overwhelmed by anger, model the behavior you expect of your children when they are angry. Breathe deeply, close your eyes, and silently count to 10. Eat chocolate. Go for a walk. Separate yourself from the situation until you calm down. Demonstrate that people can be very angry and still no one gets hurt, no one is verbally demeaned, and nothing is broken.

Parenting Is Teaching

Demonstrating emotional control is one important parenting tool. Deliberate methods of enforcing discipline, assigning chores, and enabling children to make good choices are also ways to teach them to grow toward responsible adulthood.

We cannot *make* our children do any-

where appropriate choices are rewarded and inappropriate choices have consequences. Some children will make suitable choices and some may not, but those who don't must understand that their choices are about them, not about their parents. The trick, of course, is to impose consequences in such a way that, no matter what the child chooses, the parent and other family members are okay.

Say your family is planning to go to a movie, but Sammie is acting out when you need to leave. You have several options. Sammie could still come to the movie (to avoid punishing the whole family), but not get popcorn or soda. Sammie could go to a baby sitter while the rest of the family goes to the movie. Parents could take turns escorting the other children to the movie while Sammie stays home. In all cases, Sammie experiences a consequence, but the rest of the family still gets to see the movie.

Another important lesson for children is that of reciprocity. Put another way, the more we give of ourselves, the more we will get back in return. The more we behave responsibly, the more privileges and rewards we have. Children can learn this valuable lesson by doing chores, but to successfully teach chores, you may again need to shift your expectations, perspective, and attitude.

Teaching a child to do chores is a gift parents give their children to help them learn the skills of living with others. Following this logic, a child's failure to complete a task is not disrespectful; it is simply a lost opportunity. When a child says, "No!" to his parents, it is not about the parents. It is about the child.

When parents accept this truth, it becomes clear that children who refuse to do chores are robbing themselves of skills that will enable them to live happier lives. Children who won't cooperate may not even be making their parents' life any harder. In fact, it is often easier for parents to do jobs than get a child involved.

To effectively teach reciprocity, parents must not impose a task unless they know what the reward is if the child completes the task and what they will do if the child chooses not to complete the task. When caught off guard by a child's refusal to cooperate, parents find it much harder to avoid anger and confrontation. Planning for either eventuality helps parents stay on an even keel and keep a positive tone of voice.

When we deal with a child who is very likely to be uncooperative, we need to be especially careful about planning our responses. One useful technique that can short-circuit a child's habitual resistance and maintain a parent's emotion control is a double-bind or paradoxical directive—giving the child permission or telling the child to do what she is going to do anyway.

In such a scenario, if the child chooses the negative behavior her parents ask for, her parents win because she did what they told her to do. If she chooses to avoid the negative behavior to show her parents they can't tell her what to do, everyone wins because the child is making a good choice. When used appropriately, double binds move control battles from the parents to the child, and from outside the child to inside the child.

A classic example would be to tell a child who always throws a tantrum when asked to complete a chore that you are going to ask him to do something that will make him tantrum. "So," the parent would continue calmly, "you should go ahead and scream and yell and get that out of the way first." If the child pitches a fit, the parent is in control because that's what she asked the child to do. And parents have no reason to be upset if their child is following their directions. If the child defiantly declares he can do the chore without having a tantrum, the parent is still in control because the child has made a healthy choice.

Predicting for a child how she normally misbehaves under certain circumstances enables the child to make a different choice. The very foundation of healthy parenting is giving children the opportunity to make good choices.

Parenting Is Modeling

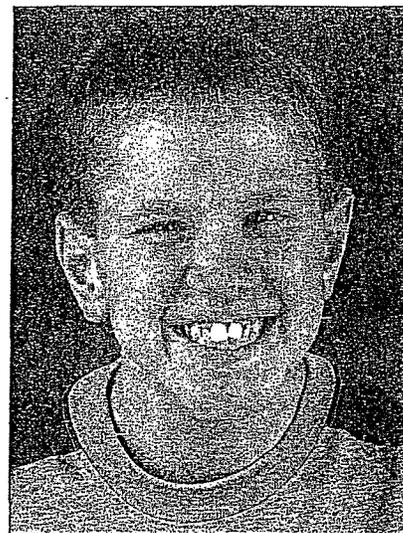
Whether we intend it or not, our children will learn from our behavior. One important lesson for children is that parents have the right to take good care of themselves. For parents who have especially challenging children, self-care is also a crucial means of developing the capacity to mean business without being mean. So, sleep long. Eat well. Exercise. Enjoy a massage. Establish a regular date night. Get filled up by association with others. Surround yourself with people who support you.

And remember, as much as we all want our children to be happy, our job is not to guarantee their happiness. Instead, our responsibility as parents is to demonstrate personal contentment, give our children opportunities for personal success, and offer rewards or impose consequences for the choices our children make.

By teaching lessons about emotional control, reciprocity, and task completion, parents give children keys to open doors to the rest of their lives. And it can all be done by parents with a positive attitude who are firm in what they expect and who, above all else, model that no one has to be mean when enforcing rules or imposing consequences. ✪

Matt

Born in January 1990, 15-year-old Matt is an outgoing, energetic, and optimistic young man who is enthusiastic about life and loves engaging in activities with other kids. In his free time, Matt enjoys swimming, taking things apart, and collecting watches. He is very good at setting the time on clocks. Due to moderate mental retardation and developmental delays, Matt spends time at school in an ungraded classroom where he receives extra one-on-one help. He also has a mild hearing loss and tends to do best with predictable structure and a lot of individual attention. Matt needs a permanent family who can provide him with love, diligent attention and care, patience, and understanding. Eager to please, Matt is an extremely friendly and engaging youth whom his worker describes as "delightful to be with." He would be a wonderful addition to the right family. To learn more about



Matt (CAP #0213) contact Children Adopting Parents, Inc. at 800 925 0002

**Tips for Parents and Caregivers
Of Children who have Experienced Trauma**
by Bruce D. Perry, MD, Ph.D.

1. **Nurture these children.** Be physical, caring and loving while being mindful that in some children touch may be associated with pain, torture or sexual abuse. In such cases, carefully monitor how they respond and act accordingly. Provide replacement experiences that should have taken place during their infancy, realizing that their brains are now harder to modify, requiring a more in-depth bonding experience to help develop attachment.
2. **Try to understand the behaviors before punishment or consequences.** Learn about attachment, bonding, normal and abnormal development in order to develop useful behavioral and social interventions. Hoarding food, for instance, should not be viewed as stealing but as a predictable result of being food deprived during early childhood. Punishing this behavior will increase the child's sense of insecurity and ultimately the need to hoard food. Get help from professionals in order to implement a practical, useful approach to such behaviors.
3. **Parent these children based on emotional age.** Abused and neglected children often are socially and emotionally delayed. When frustrated or fearful, they will regress so that a ten-year-old child may emotionally act as a two-year-old. Interact with them at their emotional level, parenting them as if they were two if they are tearful, frustrated and overwhelmed. Use soothing, non-verbal interactions, holding and rocking them while singing quietly.
4. **Be consistent, predictable and repetitive.** Maltreated children are sensitive to changes in schedule, transitions, surprises and any new situation. Birthday parties, sleepovers, the start or end of a school year can be overwhelming. Be consistent, predictable and repetitive to increase feelings of safety and security.
5. **Model and teach appropriate social behaviors.** Both model and narrate appropriate behavior with a play by play description, "I am going to the sink to wash my hands before dinner because..." Coach on ways to play and interact, explaining why another child might be upset if you take an object from them during a game. In cases of inappropriate physical contact behavior, gently guide with few words, relying on nonverbal cues.
6. **Listen to and talk with these children.** Find and make time to stop, sit, listen and play with a child so that they will sense that you are there just for them. Use such moment to reach and teach about feelings. Instill the principles that all feelings are okay to feel, modeling healthy ways to act, exploring how others may feel and how they show their feelings. Help children to put words and labels to their feelings.
7. **Have realistic expectations of the children.** A comprehensive evaluation by skilled clinicians can be helpful to define the skill areas of a child and areas where progress will be slower. Limit expectations accordingly.
8. **Be patient with the child's progress and with yourself.** Adoptive parents may feel inadequate when love, time and efforts seem not to have any effect. Don't be hard on yourself, allotting patience for yourself as well as for your child.
9. **Take care of yourself.** Parents and caregivers cannot provide the consistent, predictable, enriching and nurturing care needed by traumatized children if they are depleted. Get rest and support. Respite care can be crucial.
10. **Take advantage of other resources.** Look for support groups for adoptive or foster families. Professionals with experience in attachment problems or with maltreated children can be very helpful. The earlier and more aggressive the interventions, the better.

Top Ten List for Parents Caring for Children with Multiple Diagnoses

by Paul Buckley, Licensed Marriage and Family Therapist

Children with a mental health diagnosis typically display behaviors and responses to their life-space environment that create problems for them and difficulties for their caregivers as well. These problems cause significant distress in the form of discomfort and/or developmental delays. For example, a child might weep due to depression or be failing in school due to oppositional defiant behaviors. While all children cry and are oppositional, children with mental health diagnoses have more severe and persistent symptoms.

A dual diagnosis translates to a child meeting two or more diagnostic categories of a mental disorder. If your child has a dual diagnosis, don't panic. It's not uncommon. Statistics show that in 40 percent of cases, a child with ADHD will have a co-occurring diagnosis.

While families of children with multiple diagnoses can use similar parenting techniques that would work for any child, three general rules of thumb are:

- Increase structure in all settings
- Create nurturing moments
- Make sure as caregivers to get support and provide self care

The following top ten list is based on the experiences of many families and solid research findings. If one or two ideas resonate with you, focus on those.

1. Expect and accept setbacks, failures, embarrassment. Remember, difficult children often make very good parents look and feel bad. Keep in mind that over time the gradual shaping influence of your efforts is a tremendously important and convincing force.
2. Read to your children at times when they will accept your nurturing presence such as bedtime or mornings. Few activities have such a positive effect on the learning and emotional life of young people as reading.
3. Make use of empathy and natural consequences as often as possible. "Oh no, I'm sorry you spent all your allowance. I guess it'll be hard to go see that movie now."
4. Go to funny movies.
5. Use the child's diagnosis to your benefit. Use the treatment plan as a road map to assess services and as a guiding document to help you better understand your child's behaviors.
6. Make as few rules as possible, but increase the importance of those rules by posting them in writing. Regularly use and chart rewards and consequences.
7. Join your child's world now and then, using curiosity, empathy and lack of criticism. Too often a child's behaviors teach parents to be chronic critics, causing the child to not hear the criticism. Bake, play catch, listen to your child's favorite CD.
8. Blend your efforts with those of other adults such as coaches, educators, and clergy. The more adults who share a perspective about the child's problems, the greater the child's chances are for internalizing life lessons.
9. Develop consistent chores, routines and rituals. These elements of family structure should emerge from your core values and principles.
10. Bolster your support system, recreation and respite resources. One of the greatest risk factors for difficult children is that as they wear out parents and caregivers, problems cascade into even more difficulties.

RESOURCES

EP – Exceptional Parent magazine – Monthly periodical has information and support for the special needs community
Psy-Ed Corporation dba Exceptional Parent Magazine

65 East Route 4
River Edge NJ 07661

www.eparent.com

ADHD

Driven to Distraction by Edward M. Hallowell, MD and John J. Ratey

Eurkee the Jumpy, Jumpy Elephant by Cliff Corman, MD and Esther Trevino

Taking Charge of ADHD: The Complete, Authoritative Guide for Parents by Russell A. Barkley, PhD

How To Reach & Teach Teenagers with ADHD by Grad L. Flick, PhD

www.chadd.org - Children and Adults with ADD, 800-233-4050

www.add.org National ADD Association, 847-432-2332

Attachment

Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families
by Terry M. Levy

*Facilitating Developmental Attachment: The Road to Emotional Recovery and Behavioral Change in Foster and
Adopted Children* by Daniel A. Hughes

Attaching in Adoption: Practical Tools for Today's Parents by Deborah D. Gray

When Love is Not Enough: A Guide To Parenting Children with RAD – Reactive Attachment Disorder
by Nancy L. Thomas

www.attachmentdisorder.net

attachmentdisordersite@hotmail.com

FAS/FAE

Fantastic Antone Series by Judith Kleinfeld, Barbara Morse & Siobhan Wescott

Our FAScinating Journey by Jodee Kulp

The Best I Can Be: Living with Fetal Alcohol Syndrome or Effects by Jodee Kulp and Liz Kulp

www.betterendings.org Better Endings New Beginnings, 763-531-9548

www.mofas.org Minnesota Organization of Fetal Alcohol Syndrome, 651-917-2370

www.nofas.org National Organization on Fetal Alcohol Syndrome, 202-785-4585

Sensory Integration Dysfunction

The Out-Of-Sync Child by Carol Stock Kranowitz, MA

www.sinetwork.org Sensory Integration Resource Center

Multi-Diagnoses

Adopting the Hurt Child: Hope for Families with Special-Needs Kids by Regina M. Kupecky and Gregory C. Keck

Parenting the Hurt Child: Helping Adoptive Families Heal and Grow by Regina M. Kupecky and Gregory C. Keck

Special Kids Need Special Parents by Judith Loseff Lavin

Oppositional Defiant Disorder

Your Defiant Child: A Parent's Guide to Oppositional Defiant Disorder by Douglas A. Riley

The Explosive Child by Ross W. Greene, PhD

www.aacap.org American Academy of Child and Adolescent Psychiatry, 202-966-7300

Avoiding Power Struggles In Parenting

Parenting inevitably results in power struggles between the child and the parent as a normal, adaptive process. Engaging in power struggles is a lose-lose situation for parents when it comes to fighting with their child over a rule or consequence. A yelling parent is a hard fought reward for the acting out child who now feels in control. Instead, the adult needs to be calm, compassionate and in some ways almost automatic or robotic.

Children who have traumatic backgrounds may engage in frequent power struggles as a test of parental attachment or as a response to earlier trauma. It is paramount that adoptive parents and caretakers remain consistent and calm with such children. Consequences need to be explained in advance for a particular behavior, and these need to be short, direct and easy to track, since parents are obligated to fulfill the consequence as they would any promise. Punishments need to be fair and not humiliating or embarrassing to the child. Above all, consequences need to be designed to teach the child to make good decisions.

For parents of older children adopted internationally or who have experienced multiple transitions, power struggles can come from simple requests like, "please hang up your towel" or "put on your shoes." The reason is that the children are fighting to be in charge because they are fearful and untrusting.

For children who have been severely neglected or who have attachment issues, a "time out" may not be wise. Such children need a consequence that does not separate them from the parent. If "time out" is appropriate and the child refuses, the child should be told that although a time out may be postponed, it will lengthen the time frame. Delayed consequences are less effective than immediate results. There should be a benefit for the child to readily see in completing the consequence, such as returning to be with family members. Parents may themselves need their own "time out" to compose themselves and devise a plan to restore calmness.

The parent's calm, cool, and persistent response helps the child recognize that rebelling against authority has no reward and does not reduce the consequence, but rather postpones returning to normal. When the parent can give a firm, calm, and consistent response and quietly restate the consequence repeatedly, the child will eventually get the message that they might as well get it over with rather than struggle against their parents.

A suitable consequence makes a connection between the action and the punishment, teaching how choices result in consequences, good or bad. Rather than removing something a child enjoys such as TV, consider designing a consequence directly related to the offense. If the youth didn't do his laundry, then the consequence might be to do the entire family laundry. If the child didn't come home on time, then he or she must come in earlier the next time.

A teaching moment can result from allowing children to make reasonable choices. If they are watching TV and you ask them to empty the garbage, give them the choice of doing it right away or waiting until the commercial. At the commercial, make sure they follow through.

Verbal Corrections

Discipline begins with strong, consistent explaining in order to teach decision making.

1. Begin by validating your relationship: "You are my daughter and I love you. Nothing you do will ever change that."
2. State your concern: "Your behavior at the store was unacceptable. I was embarrassed."
3. Remind your child of previous good behavior: "That's not like you. You are always very well behaved when we go shopping."
4. Separate your child from his behavior. Say, "That behavior is unacceptable." Do not say, "Anyone who would do that is stupid."
5. React appropriately to the size of the problem. If your child misbehaves while at a sporting event, restrict him from attending the next sporting event: "You can't go to the game with me for two weeks. You will have to stay home. I hope that when you can come with me again, you will behave."

It's important to clearly state the right thing to do rather than focus on the wrong. Instead of saying, "Don't jump on the couch," try, "Please sit on the furniture and put your feet on the floor."

Simple explanations work best. Save more constructive communication for a time when the child has cooled off or you will not be heard. With older children, practice saying, "When you.....I feel...because...I need ..." sentence. This wording focuses on what action you'd like changed and why and avoids having the youth feeling attacked. The parent might say, "When you didn't make your curfew, I felt angry. We had an agreement that you'd be home by 9 pm because I need to know where you are so that I don't worry."

Normalize misbehaviors and mistakes. Deal with these and then move on to other matters. Since children cannot build on a foundation of weakness, focus on strengths as much as possible. Find activities that you can do together that are not centered on expectations but pleasure. If a child lacks the ability for cooperative team sports, consider gymnastics or swimming.

Revenge can be expected from children who wish to deflect hurt and anger. Children who are developmentally delayed often feel, wrongly or not, that any consequence is unjust. Revenge-seeking youth know where and how to strike. They divide and conquer if they sense that spouses or partners are not solidly together in disciplining efforts. With adoptive parents, "You're not my real parent," can be a purposeful remark to cause hurt and feelings about failing as a parent. Have a calm, ready response to such remarks, such as, "I'll always love you even though I didn't give birth to you."

Be aware that vengeful words are designed to get what the child wants, for you to give in to whatever he or she wishes. Don't let the child make you feel like an inadequate parent. Believe in your parenting abilities, remaining strong through outside support and an

Adjust expectations without lowering the bar for your child to succeed. Adoptive parents tend to measure their worthiness by their child's behavior, taking it on as a personal badge of success or failure. A child acting out in public can raise insecurities in any parent. An understanding of developmental stages, the need for the child to test boundaries and how some children require healthy attachment before they can trust parents helps.

Children need to view possessions and activities as something they must earn rather than as automatics. Going out with friends, a shopping trip to the mall and having a cell phone are privileges that demand obligations from the child or youth. When children break house rules, parents can then say, "If you do not show respect for the rules, the privilege of riding your bike before dinner will be withdrawn the next time."

Anthony E. Wolf, the author of *Get Out of My Life, but First could You Drive Me and Cheryl to the Mall?* makes the point that withholding favors the child expected to be performed by parents can be an effective consequence. Wolf recommends using this tactic when prolonged poor behaviors continue and yet the child still expects the parent to provide entertainment, money for outings and rides to the mall.

Wolf characterizes the power struggle between parents and children as asking the child to accept a loss... that of not getting his or her way. Wolf says that the stage is set for a battle of wills in which parents must end their participation with one line that states their expectation: "Justin, take out the trash now!" or "Emily, you are to be home by eleven." No matter what the child says, the parent must keep focused on the issue at hand, state their position and not get sucked into an argument.

Before power struggles can begin, parents need to establish what is negotiable and what is not. Bottom Line expectations should include no harm to self or others. After doing so, parents can pick battles that matter. This doesn't mean giving in but rather that parents can work with their children to follow through to a resolution that can be a life lesson for the child.

For suggestions for books and resources about Power Struggles and other parenting issues, log onto:

http://www.mnasap.org/resources/books_other.htm

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Part 5 Respite Care Provider's Role and Tools for Success

Supporting the Family

A respite care provider's number one job is to support the family. Providers need to listen carefully to what parents tell them about their children, respect their knowledge and understanding of their children, and follow through with providing care according to the parent's wishes.

Instructor-led Classroom Activity:

Using a flipchart, write down the group's responses to ways they could support the family.

Getting Information

To be successful and support the family, providers need to get all the useful information they can about the child and the family.

Instructor-led Classroom Activity:

Hand out the respite packet forms that will help providers collect useful information, and go over the most important ones in the following order:

1. **Primary Caregiver Family Information**
2. *Child Information for Respite Provider*, [CD-110](#)
3. *Emergency and Care and Information*,
<http://extension.missouri.edu/explorepdf/commdm/emw1011.pdf>
4. **Authorization to Secure Emergency Services**
5. Foster Respite Care Provider Checklist, [CS-RC-2](#)

Sharing Strategies for Emergencies

It is very important to talk about emergency situations with the family *before* they happen. Know what providers' responsibilities are for the child and to the family.

Instructor-led Classroom Activity:

Talk about what providers will need to do to be successful and competent. Use the flipchart and have people share how they would talk with parents and discuss how to handle the following situations:

- A runaway child
- Raging behavior, violent outburst

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- Night terrors
- Inappropriate sexual behavior
- Stealing
- Legal matters
- Medical emergencies

Explore solutions for each of these areas. Any one of them can happen.

Reporting to Families

Remember that parents are arranging for respite care because their children have challenging needs and they need a break. The last thing they need after returning from time away is a play-by-play report of everything their child did wrong. Respite providers should talk about the positives first, and have a sense of humor about the respite experience. Respite providers need to focus on the big picture and trust that they will build a relationship with the child. Children often test a new caregiver to see what they can get away with, but as they build a relationship with you they will do less testing.

Respite Providers should think about the child too. How excited would you be to build a relationship with a provider that reports every little mistake you made? Would you want to trust or try to improve if the provider seems to be watching for and reporting your mistakes?

It is important not to pre-judging resource parents and teach them how to recognize children with attachment issues. Children with attachment issues are often charming and delightful around people they don't know very well, while at the same time, can seem to be oppositional with their parents. Resource parents may warn respite providers to expect extreme and difficult behaviors from their child. Respite providers may even witness the child display those behaviors with the parent, but find the child to be cooperative and well behaved in their care. Untrained respite providers may not realize they are experiencing a shallow bond with an unattached child, misinterpret their observations of the parents, and wrongly believe the parents are causing the child's misbehavior.

Instructor-led Classroom Activity:

Use the flipchart to get responses for how to report back the truth to parents but stay positive. Brainstorm ideas for what a provider can do to improve the outcome with a child the next time.

Providing Respite Is a Journey

Providing respite is a journey. You do not need all the answers. There will be:

- Opportunities for ongoing learning and training
- A learning curve
- Time to keep growing

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You are on this journey with parents, children, and other resource providers. Keep talking and learning from each other.

Instructor-led Classroom Conclusion:

Ask for final questions. Review all required forms. Thank everyone for their commitment to children and families.



Forms:

All the following forms are located on [Children's Division E-forms](#):

- Application to Provide Respite Care, CS-RC-1
- Foster Respite Care Provider Checklist, CS-RC-2
- Sign a Respite Care Provider Approval, CS-RC-3
- Sign a Cooperative Agreement for the Purchase of Respite Care Services with the Children's Division, CM-10
- Read, agree to and sign the Resource Parent Discipline Agreement, CD-119
- Read, agree to and sign the Safe Sleep Practices, CD-117

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Additional Resources

Adoption Competency

- North American Council on Adoptable Children, www.nacac.org
- Minnesota Adoption Support and Preservation, www.mnasap.org
- New York State Citizens Coalition for Children, www.nysccc.org
- Child Welfare Information Gateway, www.childwelfare.gov/adoption/
- Child Welfare League of America, <http://cwla.org/programs/adoption/default.htm>
- Spaulding for Children, www.spaulding.org/resourcecenter/index.htm

Attachment

- The Association for Treatment and Training in the Attachment of Children. (ATTCh). www.attach.org
- Child Trauma Academy, www.childtrauma.org

ADHD

- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), www.chadd.org

FASD

- The ABCs of FAS/FAE: Teachers Guide and Resource Booklet, www.lcsc.edu/education/fas/FAS.html
- Fetal Alcohol Syndrome, www.come-over.to/FAS/

Parenting Children with Special Needs

- Scholastic, www.teacher.scholastic.com/professional/bruceperry/index.htm
(Internationally known Dr. Bruce Perry lists his published articles on topics such as brain development, attachment, and learning strategies. They are available to be copied by teachers and parents.)

Promising Practice

- www.childwelfare.gov/permanency/overview/mediation.cfm

Fact Sheets

http://archrespite.org/productspublications/arch-fact-sheets#FS_32

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Part 6 Knowledge Assessment

Answers are True or False

1. A respite provider must complete all the same background checks as a foster parent applicant. True False.
2. A respite provider must be at least 21 years of age. True False.
3. A respite provider may be married or single. True False.
4. All information about the child, their birth/first families, or adoptive and kinship families is considered confidential and must not be shared with others. True False.
5. To provide respite services in my home the Respite Care Provider Checklist, CS-RC2, must be completed by a licensing worker. True False.
6. I have read all the handouts and resources provided for this training. True False.
7. I must be approved and sign a Children's Division Cooperative Agreement to provide respite services for foster parents. True False.
8. Part of the process to be approved to provide respite service requires the respite provider submit fingerprints True False.
9. The respite provider must sign the Resource Parent Discipline Agreement, CD-119, regarding types of discipline that is not allowed and alternative methods of discipline that may be used to train a child in a positive True False.
10. Respite providers are required to cooperate with the treatment team for the foster youth placed in their home for respite services True False.