# CHAPTER 10: Understanding Children

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**Please read the material prior to attending the session.**

**Homework for Session:**
Read chapter 10; answer and submit chapter 10 review questions.

**Class Objectives:**
- Recognize a child's needs, using Maslow's hierarchy of human needs as a framework.
- Recognize children's behavior and typical reactions to separation and loss.
- Understand a child's need for permanence.
- Describe the concept of resiliency.


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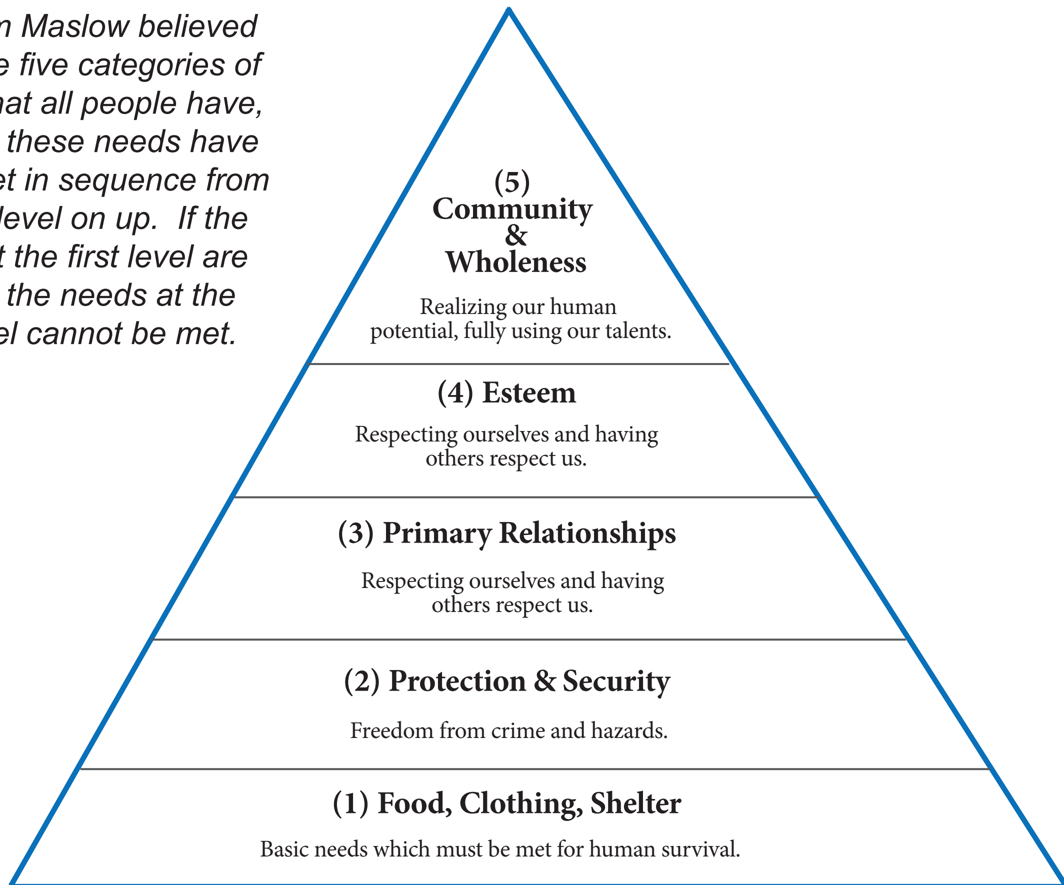
## Unit 1. What All People Need

### Heirarchy of Needs

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




The first two categories of needs are self-explanatory. In the third level, primary relationships, Maslow stated that people need to experience love and a feeling of belonging. They need to give and receive affection and belong to a group or to a society. Sound primary relationships make it possible for people's need for esteem -- the fourth of Maslow's categories of need -- to arise. Self-esteem and esteem from others allow people to feel self-confident and self-worthy. Without such respect in their lives, people feel inferior and worthless. When the need for esteem is met, the need for self-actualization surfaces. Maslow called this level "community and wholeness." At this level, people strive to realize their potential and exercise their talents to the fullest. Maslow noted that most people do not reach self-actualization because they never fully satisfy their needs for love and esteem.

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

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

**Among the Things That Children Need Are:**

- Food
- Shelter
- Security
- Clothing
- Protection
- Medical Care
- Education
- Nurturing
- Family Connections, including Culture
- Stability
- **What Else?…**

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## Important Points About Children's Needs

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

## Working with Adolescents

Working with adolescents presents unique challenges for the court system and the CASA volunteer. At times a child may wish to participate in their court hearing. This is particularly true of adolescents. The CASA volunteer can help the young person decide the best way to participate in these events. It empowers the young person to have a voice in planning for his or her own future. Additionally, in every court proceeding, the CASA volunteer advocates for the child's needs and informs the court of the child's wishes. A relationship built on trust is essential if the CASA volunteer is to know the young person well enough to inform the court regarding these issues.

To help adolescents become healthy, self-sufficient adults, a plan should be created that enhances their opportunities to learn about becoming an adult in a way that meets their special needs. The CASA volunteer can play a special role with a young person as he or she prepares to become an adult. If he or she has a relationship with the child that is built on mutual trust, the CASA volunteer may be the person that the young person turns to as he or she begins making choices and decisions about the future. Also, the CASA volunteer should see that the caseworker arranges for the child to be informed about puberty and what is happening to his or her body during this time of rapid change.

**Did You Know That…**

Ohio has a greater percentage of foster children aging out of the system without the hope of having a permanent family than the national average. It is detrimental to these children, and to society, when they age out of foster care without a home. Twenty five (25%) percent of children who have aged out of foster care do not have a high school diploma or GED. Less than 2 (2%) percent of them complete college. More than 50 percent experience at least one episode of homelessness. And, nearly 30 percent are incarcerated at some point in their lives.

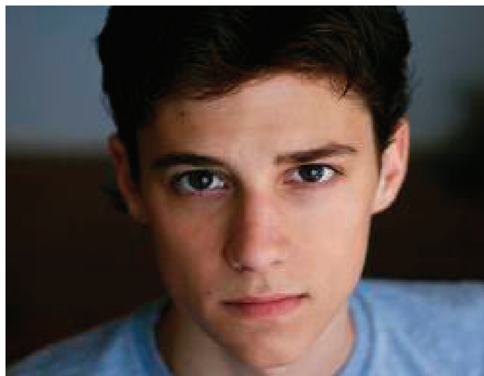
*McCoy-Roth, M., DeVooght, K., Fletcher, M. (2011, August 10). Number of Youth Aging Out of Foster Care Drops Below 28,000 in 2010, p.3*

*Ohio Child Fatality Review Board. (2012, September 30). 12th Annual Report, p.45.*

**Tips for Assisting Youth in the Transition to Adulthood:**

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

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



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## UNIT 2: How Children Grow & Develop

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

**How Children Grow & Develop**

1. No two children are alike. Each one is different. Each child is a growing, changing person.

2. Children are not small adults. They do not think, feel, or react as grown-up people do.

3. Children cannot be made to grow. On the other hand, they cannot be stopped from growing.

4. Even though children will grow in some way no matter what care is provided for them, they cannot reach their best growth possibilities unless they receive care and attention appropriate for their stage of development.

5. Most children roughly follow a similar sequence of growth and development. For example, children scribble before they draw. But no two children will grow through the sequence in exactly the same way. Some will grow slowly while others grow much faster. Children will also grow faster or slower in different areas of development. For example, a child may be very advanced in language development but less advanced, or even delayed, in motor coordination.

6. During the formative years, the more successful a child is at mastering the tasks of a particular stage of growth, the more prepared he or she will be for managing the tasks of the next stage. For example, the better a child is able to control behavior impulses that he or she has as a two-year-old, the more skilled he or she will be at controlling behavior impulses he or she has as a three-year-old.

7. Growth is continuous, but it is not always steady and does not always move smoothly forward. You can expect children to slip back or regress occasionally.

8. Behavior is influenced by needs. For example, the active fifteen-month-old baby touches, feels, and puts everything into his or her mouth. His or her whole person is responding to a growth need; he or she is not intentionally being a nuisance who gets into everything.

9. Children need to feel that they are loved, that they belong, that they are wanted. They also need the self-confidence that comes from being able to meet situations adequately.

10. It is important that experiences that are offered to children fit their own maturity level. If a child is pushed ahead too soon, and if too much is expected of him or her before he or she is ready, failure may discourage him or her. On the other hand, a child's growth may be impeded if parents or caregivers do not recognize when he or she is ready for more complex or challenging activities. Providing experiences that tap into skills that the child feels confident in, as well as some new skills that will challenge him or her, will provide the balance of activities that facilitates healthy growth.

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

**The following charts are for future reference. Remember that children develop at different rates and may have skills in age categories above and below their calendar age. As a CASA volunteer you should see continued growth and progress. Your training and CASA Manager will help you develop resources or a plan when developmental intervention is necessary.**

*Child Development...*

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

| Child Development... | 18 to 36 Months | 3 to 5 Years | 6 to 9 Years |
|---|---|---|---|
| COGNITIVE | Can conduct experiments inside head but limited to experience; rapid language growth; copies adult chores in play; carries on conversation with self and dolls; asks "what's that?" and "where's my...?"; has 450- word vocabulary; gives first name; holds up fingers to tell age; combines nouns and verbs "mommy go"; refers to self as "me" rather than by name; tries to get adult attention, exclaiming "watch me"; likes to hear same story repeated; may say "no" when means "yes"; talks to other children as well as adults; names common pictures and things. | Can conduct experiments inside head; cannot sequence; capacity to use language expands; understands some abstract concepts: colors, numbers, shapes, time (hours, days, before/after); understands family relations (baby/ parent); can tell a story; has a sentence length of 4 to 5 words; has a vocabulary of nearly 1,000 words; names at least one color; understands "tonight," "summer," "lunchtime," "yesterday"; begins to obey requests like "put the block under the chair"; knows his or her last name, name of the street on which he or she loves and several nursery rhymes; uses past tense correctly; can speak of imaginary conditions "I hope"; identifies shapes. | Can think using symbols; can recognize differences; makes comparisons; can take another's perspective; defines objects by their use; knows spatial relationships like "on top," "behind," "far," and "near"; knows address; identifies penny, nickel, dime; knows common opposites like "big/little"; asks questions for information; distinguishes left from right. |
| PSYCHOLOGICAL | Autonomy struggles; learns system of meeting needs; social development increases; points to things he or she wants; joins in play with other children; shares toys; takes turns with assistance. | Can cooperate; self-perceptions develop; cannot separate fantasy from reality; has nightmares; models on same-sexed parent; experiences and copes with feelings (sad, jealous, embarrassed); plays and interacts with other children; dramatic play is closer to reality, with attention paid to detail, time, and space; plays dress-up. | Early close peer relationships; presence of well-developed defenses; develops identity outside family (school, friends); has likes and dislikes (food, friends, games); chooses own friends; plays simple table games; plays competitive games; engages in cooperative play with other children involving group decisions, role assignments, fair play. |
| MORAL | Knowledge of preferences of authority figures. | Self-esteem dependent on authority figures; follows peers' fads; negotiates to get needs met. | Has a conscience; refinements in moral development. |

**Child Development...**

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

**Child Development...**

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

| | 10 to 15 Years | 16 to 21 Years |
|---|---|---|
| MOTOR | Greater body competence (e.g., physical coordination); manual dexterity; growth patterns vary. | Heightened physical power; strength, coordination. |

*Chart compiled by Katie Thompson, American Academy of Pediatrics, www.aap.org; and "Normal Adolescent Development," American Academy of Child and Adolescent Psychiatry, www.aacap.org.*

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

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

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

## Unit 3. Attachment

**Attachment can be defined as:**

- The psychological connection between people that permits them to have relational significance to each other.

- An affectionate bond between two individuals that endures through space and time and serves to join them emotionally.

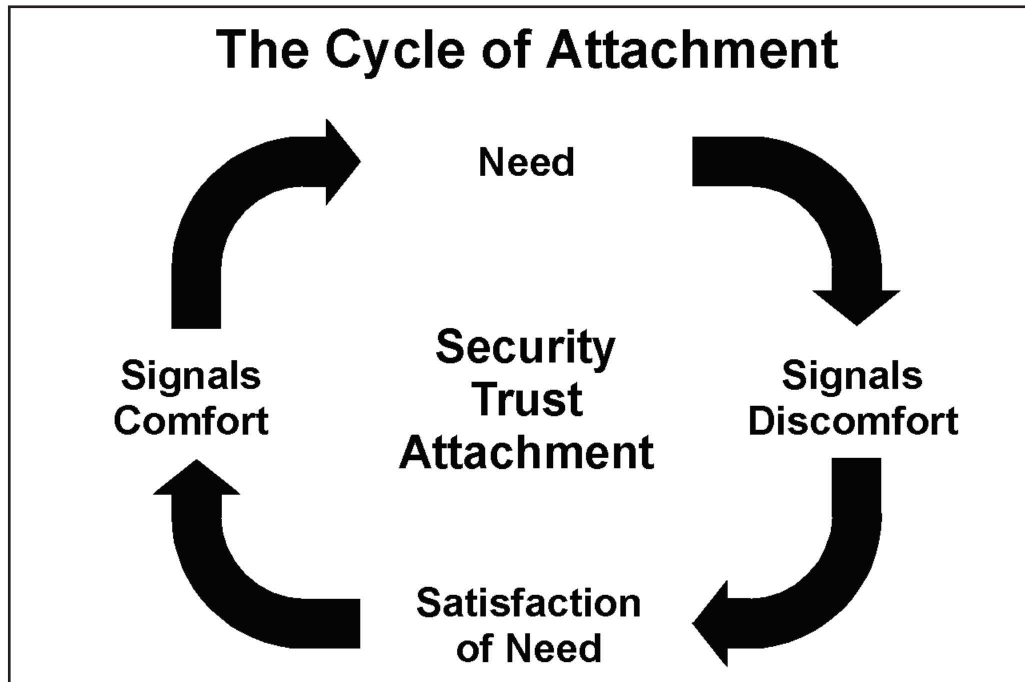
- A strong and enduring bond of trust that develops between the child and the person(s) he or she interacts with most frequently.

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

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

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

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




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

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

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

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

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

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

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

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

## The Child's Sense of Time

***The time it takes to break an old or to form a new attachment***

### DAYS

A very young child (0-2) is just learning to attach and trust. These developing attachments are easily broken in a **matter of days** and the young child's primitive attachment skills are severely tested or damaged if the separation experience is repeated.

### WEEKS

A child 2-5 years usually has a stronger attachment to the primary caretaker and attachment skills are more established. A good attachment experience prepares the child for other attaching, but it will take about **2 months** and careful assistance to break and old or form a new attachment.

The attached child 5-12 years has more invested in the primary attachments and remains loyal to them. Changing attachments will be a struggle for this child for **6 months** or more.

### YEARS

The attached child 12 years or older will maintain old attachments for **years**. New attachments may never completely replace established ones.

## Classifications of Attachment

Child to Parent . . .

| ATTACHMENT TYPE | DESCRIPTION |
|---|---|
| Secure Attachment | The child is confident that the parent figure will be responsive, available, comforting, and protective, particularly under distressful circumstances. This assurance enables the securely attached child to explore the environment and test his or her developing abilities. ***(Ainsworth et al., 1978)*** |
| Anxious -- Ambivalent Attachment | The child is uncertain whether the parent will be responsive, available, or protective when needed. Anxious-ambivalent children tend to be clingy, greatly distressed by separation, and often fearful of their environments. This pattern is associated with inconsistency in parental availability and threats of abandonment. ***(Ainsworth et al., 1978)*** |
| Anxious -- Avoiding Attachment | This child has no confidence that the parent will be responsive, caring, or protective and expects to be ignored or rebuffed. Such a child will attempt to live life without the love and support of others. Conflicts regarding dependency needs are hidden. ***(Ainsworth et al., 1978)*** |
| Disorganized -- Disoriented Attachment | This child behaves erratically and inconsistently, often sending opposing messages at the same time. These children appear confused and engage in "incomplete or undirected movements or expression." ***(Main & Solomon, 1990, p. 122)*** These children were often found to be victims of abuse/neglect or their parental figure was grossly preoccupied with own problems. ***(Crittendon, 1988; Main & Solomon, 1990)*** |

Adult to Adult . . .

| ATTACHMENT TYPE | DESCRIPTION |
|---|---|
| Secure Attachment | The secure person has a positive view of self and others, a moderate to high level of intimacy and autonomy, and a moderate to low level of dependency. ***(Bartholonew & Horowitz, 1991)*** |
| Pre-Occupied Attachment | An interpersonally preoccupied person strives for self-acceptance "by gaining the acceptance of valued others." ***(Bartholonew & Horowitz, 1991, p.227)*** Experience is characterized by a sense of unworthiness juxtaposed against a positive view of others. |
| Dismissive Attachment | A dismissive person has a positive view of self and a negative view of others. ***(Bartholonew & Horowitz, 1991; Main & Goldwyn, 1985)*** A dismissive person protects the self against disappointment by "avoiding close relationships and maintaining a sense of independence and invulnerability." ***(Bartholonew & Horowitz, 1991, p. 227)*** |
| Fearful-Avoidance | A fearful-avoidance person has a negative attachment view of self and others and anticipates, betrayal, rejection, and criticism. Such a person is likely to protect him or herself from rejection or attack by avoiding involvement with others. ***(Bartholonew & Horowitz, 1991)*** |
| Compulsive Self-Reliant | A compulsive self-reliant person avoids turning to others for comfort, attachment support, or affection and places a high premium on self-sufficiency. However, this form of avoidance is motivated by a counter-dependent need to be self-sufficient, rather than by outright disdain for others. ***(Bowby, 1977; West & Sheldon, 1988)*** |
| Compulsive Caregiving | A compulsive caregiver insists on taking the caretaker role in all relationships, never allowing others to reciprocate. These people's own needs are met by caring for others, thus they insist on providing help whether it is requested or not. Attachment is associated with feelings of self-sacrifice and self-neglect. ***(Bowlby, 1977; West & Sheldon, 1988)*** |

Parent to Parent . . .

| ATTACHMENT TYPE | DESCRIPTION |
|---|---|
| Compulsive Care Seeking | A compulsive care seeker experiences a constant need to confirm the availability and responsiveness of attachment figures. These people have a heightened sense of vulnerability to loss, they tend to define their attachment in terms of receiving care, and feel unequipped to take responsibility for themselves. ***(West & Sheldon, 1988)*** |
| Angry -- Withdrawal Attachment | An angry--withdrawal person is likely to react to responsiveness and unavailability with anger and defensiveness. ***(West & Sheldon, 1988)*** |
| Obsessive -- Compulsive Personaility | An obsessive-compulsive personality style is characterized by excessive differentiation and a rigid adherence to a vision of how things should be. Such a person regards relationships as secondary to work and productivity, and prefers not to discuss problems and feelings with others. ***(Pilkonis, 1988)*** |
| Lack of Interpersonal Sensitivity | An interpersonally insensitive person is unaffected to external feedback, is oblivious to the effect of his or her actions on others, tends to engage in anti-social behavior without guilt or remorse, and resents being held back by external demands. ***(Pilkonis, 1988)*** |

## Unit 4: Separation

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

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

**Separation Experience**

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

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

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

## What a CASA can do…

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

## A Parent's Feeling About the Separation Experience

Following is one parent's description of the feelings she experienced when her children were placed in foster care. Knowledge about parents' feelings, coupled with helping parents express their feelings, leads to more meaningful contact with parents. The CASA volunteer will often observe a similar reaction to the separation experience in both the parent and the child because the experience of grief and loss is experienced universally as a series of emotions including denial, anger, sadness, and, eventually, acceptance. Sometimes these reactions proceed in the order outlined below; sometimes people skip around or cycle back to a previous stage as they work through their personal reaction to grief and loss. Some may never reach acceptance.

**STAGE 1: Denial**
When the loss of your child hits you, it is like going into shock. You may cry, feel shaky, and find it hard to hear what people are saying to you. You can't think of anything except the child who has been placed. You take care of the rest of the family or go to work like a sleepwalker without really knowing what you're doing. You wonder what your child is doing now.

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

**STAGE 2: Anger**
As you come out of the numbness of shock, you experience sadness, anger, and physical upset. You might lose your appetite, or you might eat constantly. It may be hard to fall asleep. You may increase your use of alcohol, cigarettes, or drugs. You may find yourself suddenly tearful "over nothing." You are afraid of what people think of you.

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

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

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

**STAGE 3: Sadness**
When the anger has worn off, you go into the blues. You may feel you don't care about anybody or anything. It isn't worth getting up each day, and nothing interests you. You may feel worthless and no good. You might think about suicide. You might get ill.

If you are a single parent and all your children have been placed, you may feel desperately lonely. You don't know who you are without your children or what to do with your day. The world seems barren and silent, and you feel empty and hollow. You might feel guilty because there is less stress with the child out of the home. You might find you can survive without your child, but feel bad because of it.

**STAGE 4: Acceptance**
One day things may seem to be better. You begin eating and sleeping well again. You miss your child but are now more realistic about his or her being in foster care. You again pay attention to the house, your work, and the rest of the family. You get interested in keeping your agreements about visiting your child and making your appointments with your caseworker. You begin to realize that you may actually have more time with your child now and feel better when you're with him or her than you did before the foster care, when you were trying to handle too much. You begin to see that both you and your child need relationships with others to deal with the loneliness, and now you have some energy for that.

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

# CHAPTER 10: Understanding Children

## Unit 5: Permanence for Children

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

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

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

There are two possible "permanent" resolutions:

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

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

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

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

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

# CHAPTER 10: Understanding Children

## Unit 6: Emotional & Psychological Issues for Children

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

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

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

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

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

If these characteristics are present in a child with whom you are working, request that an assessment be completed by a qualified mental health professional who can diagnose and treat childhood depression. The HCJFS's (Hamilton County Job & Family Services) caseworker will need to make the referral for this assessment.

### Conduct Disorder

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

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

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

### Post-Traumatic Stress Disorder

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

| **Intrusion** (re-experiencing the trauma) | **Avoidance/Numbing** (avoidance of things that remind one of the trauma) | **Hyperarousal** (increased tenseness and heightened awareness) |
| --- | --- | --- |
| . Flashbacks and/or nightmares in which the person experiences the same feelings of distress that took place during the initial event. | . Avoids close emotional ties.<br>. Supersensitive to activities or situations that remind one of the trauma.<br>. Feelings of numbness. | . Exaggerated startled response (jumpy and easily startled).<br>. Irritable and explosive.<br>. Hypervigilance (always being watchful of potential danger). |

Therapy, or a combination of therapy and medication, can relieve some of these symptoms and provide temporary relief from the trauma of this disorder. Ideally, both the memories of the trauma and the symptoms will fade after a period of therapeutic intervention.

As with any other childhood disorder, it is critical to have a competent professional assess the child. Post-traumatic stress disorder, reactive attachment disorder, separation anxiety disorder, and simple anxiety are often misdiagnosed as attention-deficit/ hyperactivity disorder. Currently, there is great controversy about the possible overdiagnosis -- and overmedication -- of children with AD/HD. Obtaining a second opinion is good practice. The more relevant information the CASA volunteer gathers, the more likely he or she is to understand the needs of the child and to make appropriate recommendations to the court.

**Fetal Alcohol Syndrome**

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

**Psychological Assessment of Children**

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

**Reasons for Assessment**

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

1. Dysfunctional and negative behavior, such as tantrums, a demanding personality, excessive crying and whining, delinquency, defiance of rules and limits.

2. Developmental concerns, such as perceptual and motor problems, speech and learning problems, delayed development, school readiness determination.

3. Educational problems, such as inadequate performance and progress, aggressive behavior, dislike or disinterest in school.

4. Sleeping and eating problems, such as infant feeding and nursing problems, excessive crying, bulimia, anorexia nervosa, over- and undereating, and any suspected nutritional deficits that may be contributing to learning problems, sleep and behavior problems, fatigue.

5. Toilet training problems, including any manifestations of encopresis (soiling), enuresis (bedwetting), or excessive fear of going into the bathroom.

6. Behavioral issues, such as poor self-control, lack of motivation, irresponsibility, lying, stealing, dependence/independence conflict, setting fires, "mean" behavior toward animals and others, self-inflicted injuries.

7. Family problems, such as sibling conflict, dysfunctional communication, inadequate support system in social relationships and skills, attachment and separation problems, aggressiveness, and abuse. Problems of change prompted by divorce, custody issues, separation, adoption, termination of parental rights, moving, visitation issues, grieving and death issues. Problems related to how the child learns and processes information that the family presents (the belief system within the family leading to attitude, temperament). Parents' negative feelings for the child, poor relationship indicators, conflict over discipline, family arguing.

8. Medical considerations, such as psychophysiological reactions to stress, adjustment to illness of a child or family member, terminal illness of the child or family member, physical or sexual abuse, neglect, drug and alcohol abuse by child or other family member.

9. Psychiatric manifestations, including personality disorder, cyclothymic mood disturbance (alternate periods of elation and depression), disassociation and psychic numbing (emotional shutting down and flat affect), excessive fears, harming others, and psychotic behavior such as hallucinations and thought disorder.

## Unit 7: Resiliency

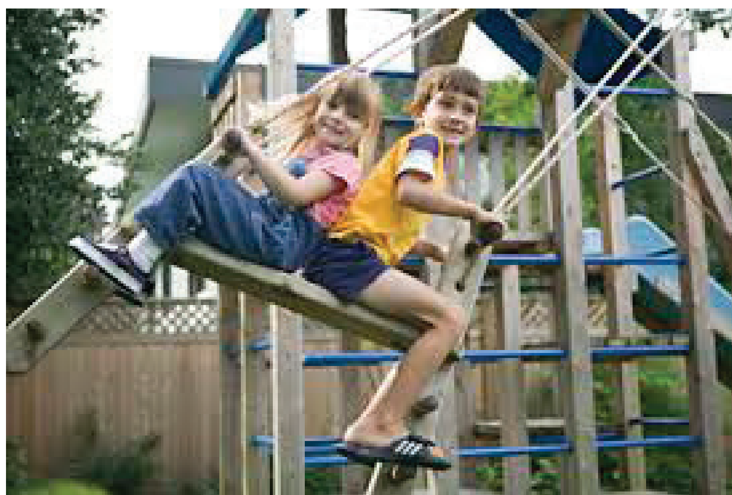
**Resiliency & Its Relationship to High-Risk Children**
Not all children subjected to lives of severe adversity go on to suffer problems or disorders. While experiencing several risk factors certainly increases the likelihood of developing problems, some children rise above the risks. This is resiliency.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

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

**Resiliency**

Read the following chart of the psychosocial risk and protective factors that help some children overcome multiple risk factors.

As a CASA volunteer, recognize how you can impact protective factors.



Psychological Risk & Protective Factor . . .

| RISK FACTORS | PROTECTIVE FACTORS |
| --- | --- |
| **Early Development**<br>. Premature birth or complications<br>. Fetal drug/alcohol effects<br>. "Difficult" temperament<br>. Long-term absence of caregiver in infancy<br>. Poor infant attachment to mother<br>. Shy temperament<br>. Siblings within two years of child<br>. Developmental delays<br>**Childhood Disorders**<br>. Repeated aggression<br>. Delinquency<br>. Substance abuse<br>. Chronic medical disorder<br>. Behavioral or emotional problem<br>. Neurological impairment<br>. Low IQ (less than 80)<br>**Family Strress**<br>. Family on public assistance or living in poverty<br>. Separation/divorce/single parent<br>. Large family, five or more children<br>. Frequent family moves<br>**Parental Disorders**<br>. Parent(s) with substance abuse problem<br>. Parent(s) with mental disorder<br>. Parent(s) with criminality<br>**Experiential**<br>. Witness to extreme conflict, violence<br>. Removal of child from home<br>. Substantiated neglect<br>. Physical abuse<br>. Sexual abuse<br>. Negative relationship with parent(s)<br>**Social Drift**<br>. Academic failure or drop-out<br>. Negative peer group<br>. Teen pregnancy, if female | **Early Developmental**<br>. "Easy" temperament<br>. Positive attachment to mother<br>. First born<br>. Independence as a toddler<br>**Family**<br>. Lives at home<br>. Parent(s) consistently employed<br>. Parent(s) with high school education or better<br>. Other adult or older children help with child care<br>. Regular involvement in church<br>. Regular rules, routines, chores in home household<br>. Family discipline with discussion and fairness<br>. Positive relationship with parent(s)<br>. Perception of parental warmth<br>. Parental knowledge of child's activities<br>**Child Competencies**<br>. Reasoning and problem-solving skills<br>. Good student<br>. Good reader<br>. Child perception of competencies<br>. Extracurricular activities or hobbies<br>. IQ higher than 100<br>**Child Social Skills**<br>. Gets along with other children<br>. Gets along with adults<br>. "Likeable" child<br>. Sense of humor<br>. Empathy<br>**Extra-Familial Social Support**<br>. Adult mentor outside family<br>. Support for child at school<br>. Support for child at church<br>. Support for child from faith, spirituality<br>. Support for child from peers<br>. Adult support/supervision in community<br>**Outlooks & Attitudes**<br>. Internal locus of control as teen<br>. Positive/realistic expectations of future<br>. Plans for future<br>. Independent minded, if female teen |

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

# CHAPTER 10: Understanding Children

## RESOURCE MATERIALS


- Principles of Permanence 10–31
- Global Assessment of Functioning (GAF) Scale 10–32
- Resiliency: The 40 Developmental Assets 10–33

## Principles of Permanence

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

- **Constantly examine your own value system.**
  Understand the difference between poor parenting and abuse and neglect. Make sure that you can accept a variety of appropriate parenting styles, even those that include behavior which you would not exhibit.

- **Carefully examine the HCJFS case record.**
  Understand the issues that brought the child into foster care. Ask agency staff, other professionals, and family members about anything that does not make sense.

- **Ask the parents why they think they lost custody of their child.**
  Do not assume that they understand or agree with the agency's reasons.

- **Recognize that the "system" should be operating on the child's sense of time.**
  Help others to hear the clock that is ticking that childhood away.

- **Understand grief and the effects on children of moving and waiting.**
  Keep permanent resolution as the focus of your efforts.

- **Stay child-centered and family-focused.**
  Children need a permanent family--theirs, if possible--but not if it means the loss of their childhood.

- **Recognize parents' strengths, but do not ignore their failings.**
  Advocate to return the child when the parents have remedied what brought their child into care and are in a position to parent long-term. Advocate for termination of parental rights if the conditions persist.

- **Be a team player.**
  Attend reviews, continue to investigate and assess, and share with the caseworker and the court what you learn.

- **Aggravate the system if you have to -- be a catalyst for change.**

- **Work for justice -- act with mercy.**

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

## Global Assessment of Functioning (GAF) Scale

| Code | |
|---|---|
| 100 – 91 | Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought by others because of his or her many positive qualities. No symptoms. |
| 90 – 81 | Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members) |
| 80 – 71 | If symptoms are present, they are transient and expectable reactions to psycho-social stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupation, or school functioning (e.g., temporarily falling behind in schoolwork). |
| 70 – 61 | Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupation, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships. |
| 60 – 51 | Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). |
| 50 – 41 | Serious symptoms (e.g., suicidal ideation, severe obsesssional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning. |
| 40 – 31 | Some impairment in reality testing or communication (e.g., speech is a times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed and avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). |
| 30 – 21 | Behavior is considerably influenced by delusion or hallucinations OR serious impairment in communication or judgement (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day; no job, home, or friends). |
| 20 – 11 | Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute). |
| 10 – 1 | Persistent danger of severely hurting self or others (e.g., recurrent violence) Or persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death. |
| 0 | Inadequate information. |

*From the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (p. 32), by the American Psychiatric Association, 1994, Washington, DC. Author.*
*Copyright 1994 by the American Psychiatric Association.*

## Resiliency: The 40 Developmental Assets

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

## External Assets

### Support

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

### Empowerment

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

### Boundaries & Expectations

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

### Constructive Use of Time

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

## Internal Assets

### Commitment to Learning

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

### Positive Values

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

### Social Competencies

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

## Positive Identity

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

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