FINDING HELP FOR YOUNG CHILDREN WITH SOCIAL-EMOTIONAL-BEHAVIORAL CHALLENGES AND THEIR FAMILIES: THE VERMONT CHILDREN'S UPSTREAM SERVICES (CUPS) HANDBOOK

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This Handbook reflects the input of many people who work for the social and emotional well-being of infants, young children and their families in Vermont. A number of authors with many years experience drafted chapters. Others reviewed these drafts, and helped with editing and honing each chapter. We wish to acknowledge the skills, hard work and support of the many people involved in preparing the Vermont CUPS Handbook, and the many young children and families who have inspired this work.

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CUPS

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UPstream
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TABLE OF CONTENTS

Manual Page

PREFACE – By Jane Knitzer, Ed.D. ..... p-i

INTRODUCTION 1

VERMONT CULTURE 5

GUIDING PRINCIPLES OF PRACTICE 8

CUPS HANDBOOK CHAPTER SUMMARIES 9

PART ONE: THE CONTEXT FOR FAMILY LIFE 14-57

CHAPTER 1. FAMILY LIFE IN THE 21ST CENTURY 16

CHAPTER 2. HEALTH, WELFARE AND SAFETY RESOURCES 26

CHAPTER 3. FAMILIES IN TRANSITION 40

PART TWO: SPECIALIZED ASSESSMENT AND EARLY INTERVENTION 60-107

CHAPTER 4. EARLY DEVELOPMENT, DEVELOPMENTAL DIFFERENCES AND DELAYS 62

CHAPTER 5. ASSESSMENT AS DISCOVERY 82

CHAPTER 6. MAKING SENSE OF CHALLENGING BEHAVIORS 96

PART THREE: UNDERSTANDING AND RESPONDING TO DIFFICULT FAMILY CIRCUMSTANCES 110-165

CHAPTER 7. TEEN PARENTING 112

CHAPTER 8. PARENT SUBSTANCE ABUSE 120

CHAPTER 9. WHEN ILLNESS OR DISABILITY AFFECTS PARENTING 130

CHAPTER 10. FAMILIES IN CRISIS OR EXPERIENCING SEVERE STRESS 146

CHAPTER 11. REFUGEE AND IMMIGRANT FAMILIES 160

Manual Page

PART FOUR: UNDERSTANDING AND RESPONDING TO YOUNG CHILDREN IN TRAUMATIC CIRCUMSTANCES ***168-213***

CHAPTER 12. TRAUMA AND BRAIN DEVELOPMENT IN YOUNG CHILDREN ... 170

CHAPTER 13. CHILD ABUSE: PHYSICAL, SEXUAL AND EMOTIONAL 182

CHAPTER 14. CHILD NEGLECT 194

CHAPTER 15. CHILDREN EXPOSED TO DOMESTIC VIOLENCE 202

PART FIVE: APPENDICES ***216-250***

APPENDIX I: VERMONT GENERAL RESOURCES 218

APPENDIX II: NATIONAL ORGANIZATIONS AND WEBSITES 240

APPENDIX III: ABOUT THE CUPS TEAM 248

PREFACE

By Jane Knitzer, Ed.D.

I had the privilege of being part of one of the earliest planning sessions for the Vermont Children's UPstream Services (CUPS) Project. It was clear to me then, and further confirmed as the project unfolded, that CUPS was an extraordinary opportunity and that an innovative and thoughtful group of people were ready to provide leadership and guidance.

Through the CUPS initiative, Vermont has been a pioneer in calling attention to the need to provide mental health services to young children and to design a service delivery system deeply respectful of families and communities. Its core values, so clearly stated early in this handbook, signal a deep appreciation of the reality that, for the most part, the best way to help young children is by helping their parents and other caregivers develop new understanding and skills in how to promote their healthy social and emotional growth.

CUPS represents an important marker, not only for Vermont, but for states across this country. Compelling research, such as that described in *From Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), tells us that the earliest experiences, and especially parent-child relationships, are the foundation for how children learn, feel about themselves, and relate to others. It sends a very clear signal: invest in strategies to ensure that all young children get off to a healthy emotional start, particularly those whose early childhoods may be marred by the impact of risks such as poverty, parental depression, substance abuse and domestic violence.

In truth, there has been relatively little investment in developing, and especially sustaining, initiatives such as CUPS. Instead, my own research, and that of others, tells us that there are more and more young children who are too sad, or too mad, to experience an early childhood full of exploration and curiosity, and who are not likely to succeed in the early school years. Anecdotal reports and research also suggest that all over the country, child care providers, pediatricians, teachers, home visitors and others who work directly with young children and families are feeling stressed, and sometimes overwhelmed by the numbers of infants, toddlers and preschoolers who are not getting off to a healthy emotional start. Even worse, they feel at a loss about how to help, and seldom have available early childhood mental health specialists to whom they can turn for guidance.

> "Usually when kids go for counseling, we [child care providers] don't get to meet with the counselors. We don't get to consult with them about what they see might be causing the behaviors. But in this [CUPS] mental health consultation model, the mental health worker…does the training right with us at the center. The mental health worker travels to us, which has been wonderful."

This thoughtful and gentle handbook is a critically important part of the CUPS legacy. It cannot substitute for building stronger cadres of early childhood mental health specialists, but it is an important resource for families and others who come into contact with children whose social and emotional needs are not developing in age-appropriate ways.

Written in a direct, straightforward and sensitive way, it is packed with important information about how to recognize and understand what young children may be experiencing, as well as what kinds of help may be most useful in different circumstances. The *CUPS Handbook* also reflects an extraordinary effort to identify and synthesize information about an astonishingly broad set of resources. Each section is rich with leads for how to get further information and help.

Perhaps most important, the handbook does not flinch from a straightforward discussion about the more difficult challenges that young children and families face. The sections addressing these challenges – parenting in very stressful circumstances and exposure to trauma through violence and abuse – are carefully crafted to be useful to a wide range of individuals, for example, child development specialists, child care providers, early childhood mental health (CUPS) workers and staff in domestic violence shelters, who come into early contact with young children and their families. Building on the earlier *Knowledge and Practices* document produced by the CUPS Team that address more basic developmental issues, these sections, as the Introduction says, offer help "when the roof leaks, or there is a crack in the foundation."

In the end, what lingers from reading this wonderful resource is that it recognizes that whatever the daily struggles, the developmental delays or even the traumatic experiences with which young children and families must cope, the most profoundly essential and enduring gift for all children is caring. In the authors' words, "a child is a child first; and nurturing is the primary need of every child." The *CUPS Handbook* is written in everyday language, but the message comes from a rich and deep melding of developmental and clinical wisdom. It holds out a vision for all who love, care for and want to help young children thrive.

References

Shonkoff, J. & Phillips, D., (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, D.C.: National Academy Press.

Moroz, K., Blanchard, J., Darsney, A.M., McMains, W., Schoenberg, S., Stevens, P., Sugarman, N. & Walker, J. (2001). *Knowledge and practices to promote the emotional and social development of young children.* Waterbury, VT: CUPS Core Competencies Task Force, VT DDMHS.

INTRODUCTION

In 2001, the Vermont Children's UPstream Services (CUPS) published *Knowledge and Practices to Promote the Emotional and Social Development of Young Children*. Based on an extensive two-year collaborative process, this guide brought together the perspectives of early childhood care and education, mental health, health and family-centered practices. Through many meetings, discussions, drafts, reviews and revisions, a practical guide to specific knowledge and practices emerged that highlights the interconnectedness of young children's social and emotional development across developmental domains.

The original *Knowledge and Practices* document identifies competencies in four domains: 1) the infant and young child, 2) the family, 3) the community and 4) interpersonal relationships/teamwork. From the start, we envisioned it as a work in progress to help family members, community participants and service providers identify and appreciate each other's strengths and contributions, and prompt them to talk with each other about how best to provide for the emotional and social wellbeing of infants and young children in their care.

Many people requested a second part to *The CUPS Knowledge and Practices*, focusing on specific difficulties that might affect an infant's or young child's natural developmental progression, and providing guidance on how to get support when needed. As one provider explained, "It's good to know how to build the house, but after that you need to know what to do when the roof leaks or there's a crack in the foundation."

Thus, this publication, *Finding Help for Young Children with Social-Emotional-Behavioral Challenges and Their Families: The Vermont Children's UPstream Services (CUPS) Handbook* emerged out of requests for a practical guide to understand difficulties, significant concepts related to these difficulties, and how to access relevant resources. The development of the *CUPS Handbook* followed a similar process to the first document, bringing together the voices of many Vermonters with diverse perspectives, all of whom share a commitment to the well-being of infants and young children and their families. The *CUPS Handbook Editing Committee* (listed in "Acknowledgments") took the lead on prioritizing the topics to be addressed, organizing them into chapters, recruiting authors, and setting the direction, tone and audience for the content.

The Editing Committee agreed that *The CUPS Handbook* should directly build on the framework presented in the *CUPS Knowledge and Practices* document. Specifically, the set of characteristics termed "Vermont Culture" and the "Guiding Principles of Practice" presented in that publication guided our thinking throughout the development of the *CUPS Handbook.* We have included "Vermont Culture and Guiding Principles of Practice" in this publication on page 5, followed by "Chapter Summaries."

A number of other considerations, stemming from multiple discussions regarding the objectives, audience, and style of this publication, influenced the direction taken in preparing the *CUPS Handbook.* These are as follows:

Targeting risk and protective factors. Underlying every chapter is the understanding that all children come into the world with a unique set of challenges and strengths, which experts in early childhood development term "risks and protective factors," and that early intervention with children, their families, and others close to them can have a tremendous impact on how these individual and environmental factors play out in infants' and young children's development. Our approach reflects the work of Kaufman and Dodge (1997), who reviewed the research on risk and protective factors in early childhood, and present three core findings:

- Enhancing protective factors and reducing risks can effectively promote positive outcomes.
- Interventions that target multiple risk factors are more likely to be successful than those that target only one or two.
- Interventions must comprehensively address strengths and vulnerabilities at the individual, family and community levels.

Kaufman and Dodge conclude, "An individual is affected not only by his or her own genetic and biological make-up, but also by the environment in which he or she lives. Thus, for young children, one of the most important influences is family."

Taking a family-centered approach to services and supports*.* The *CUPS Handbook* is written from the perspective that helping infants and young children must occur within the context of their families. Parents are the real experts on their children. They need to be included as key partners in decisions regarding their children, with interventions designed to reinforce and respect parents' strengths, culture, beliefs and circles of support in their own communities.

Recognizing the central role of early relationships. The chapters are written to underscore our recognition that emotional health is deeply embedded in nurturing relationships. Encouraging strong attachments between parents and their infants and young children is a key theme. We also stress the importance of close, caring relationships between child care providers, early childhood educators and the young children in their charge.

Responding to research on the importance of early experience to brain development. We now have solid scientific evidence that infants' and young children's earliest relationships and experience affect their neurological make-up, which in turn influences their future social, emotional and intellectual development. This key finding guides the discussion in several of chapters of the *CUPS Handbook.*

Ensuring an integrated, comprehensive approach to addressing needs. We recognize the problem inherent in separating the complex world of the emotional and social growth of infants and young children into distinct categories. We do not want this handbook to contribute to the illusion of borders around a given challenge and preclude exploration into other considerations. The *CUPS Handbook* hopes to further the understanding that collaborative efforts among parents and providers where everyone's voice is valued best serves infants and young children and their families.

Working toward early identification of potential difficulties or disabilities. Throughout the document, warning signs of potential trouble are provided. These "red flags" should receive attention, so that problems can be addressed early on, and young children and their families can be linked with the appropriate supports and services prior to entering the school system.

Assuring children's safety as a priority in all interactions with infants and young children. Infants and young children need constant, nurturing supervision. However, parents and other caregivers sometimes need extra help to provide safety for children in their care. One of the most difficult situations is when a caregiver or other support person has concerns about whether children are safe in their own homes. This handbook provides guidance for such difficult situations.

Guiding, not prescribing. As each child and family is unique, there are no easy or global solutions. Rather than advocating for particular techniques, methods, formulae, or treatment approaches, we offer this handbook to enhance understanding, stimulate thinking about specific concerns and provide direction for those seeking to help infants, young children and their families get appropriate assistance with emotional, social, and developmental issues. We invite users of this handbook to combine their knowledge of the people and challenges they face with the range of resources available, to create a response that best fits the situation at hand.

Providing a selected sample of resources. For each chapter, easily a hundred or more resources could be listed. However, rather than risk drowning readers in an ocean of publications, websites and organizations, we have chosen to present a sampling of solid resources that are known to be helpful and are often gateways to other resources. Key websites are often linked to other relevant sites. Organizations can be founts of information, support and guidance to further help.

Using reader-friendly language. We have tried to avoid professional jargon and legal terminology to the extent possible. The *CUPS Handbook* uses broad, everyday definitions rather than "official" definitions from Child Protective Services, Family Court or other formal legal or social systems.

Our intention is to provide a reference that is easy to use, practical, and readily understandable to all who are concerned with the emotional and social welfare of infants and young children in our communities. While this audience includes family members and policymakers, the primary purpose of this guide is to help service providers become truly useful in their partnering with family members to support the emotional and social development of infants and young children. We designed this guide for a wide circle of service providers including early child care and education providers, outreach workers, family support workers, mental health clinicians, medical health providers, social workers and social service providers, case managers and consultants to early development programs and organizations.

For the sake of organization, we have divided *The CUPS Handbook* into 15 chapters, organized under four broad themes. Each chapter includes an introduction to the topic, general information and specific points to consider, and the listing of several recommended resources for more information. In most cases, resources include annotated descriptions of written materials for adults, written resources for families and children, videotapes, organizations and web sites.

Many people and resources have informed the content of *The CUPS Handbook.* Much more could be said about each topic, and in fact, at times we agonized over the question of what was most important to include. Our hope is for each chapter to provide sufficient (but not definitive) practical guidance in the pursuit of effective helping.

References

Kaufman, R. & Dodge, J. (1997). *Prevention and early interventions for young children at risk for mental health and substance abuse problems and their families: A background paper.* Washington, DC: National Technical Assistance Center for Children's Mental Health.

Moroz, K., Blanchard, J., Darsney, A.M., McMains, W., Schoenberg, S., Stevens, P., Sugarman, N. & Walker, J. (2001). *Knowledge and practices to promote the emotional and social development of young children.* Waterbury, VT: CUPS Core Competencies Task Force, VT DDMHS.

VERMONT CULTURE

The process of thinking about the mental health needs of infants and young children took place within the context of our location in the northwest corner of New England. We could easily have borrowed lists from other parts of the country, but these did not quite fit. Vermont has a long history of independent thinking and action. Our culture, traditions, history, values, customs and practices are strong guides in all aspects of our lives. It is helpful to identify, celebrate and appreciate these aspects that inform and support us in our work to promote the mental health of infants, young children and their families.

The community context is very important to Vermonters. There is a tradition of

- Strong community identity
- Local control practices
- Service providers interacting with families in multiple roles

Vermonters have a long history of a rural orientation, including

- Rural values of independence, resourcefulness, practicality, informality, down-to-earth, "hand-shake" contracts
- "Barn-raising" traditions of helping out neighbors in need
- Geographical and kinship roots
- Inter-generational support systems; extended families often nearby

Vermonters experience cultural diversity in such ways as

- Economic and social differences, including poverty and marginal income
- A history of settlements by such groups as native Abenaki Indians, French-Canadian farmers and mill workers, and Italian stone-cutters
- Recent growth of new immigrant and refugee populations
- Non-traditional partnerships and families, including legally recognized civil unions

Vermonters tend to rely less on formal services, provided by experts and professionals, and more on

- The use of informal support networks such as family, neighbors, local clubs and churches
- Family-to-family and community-based networks

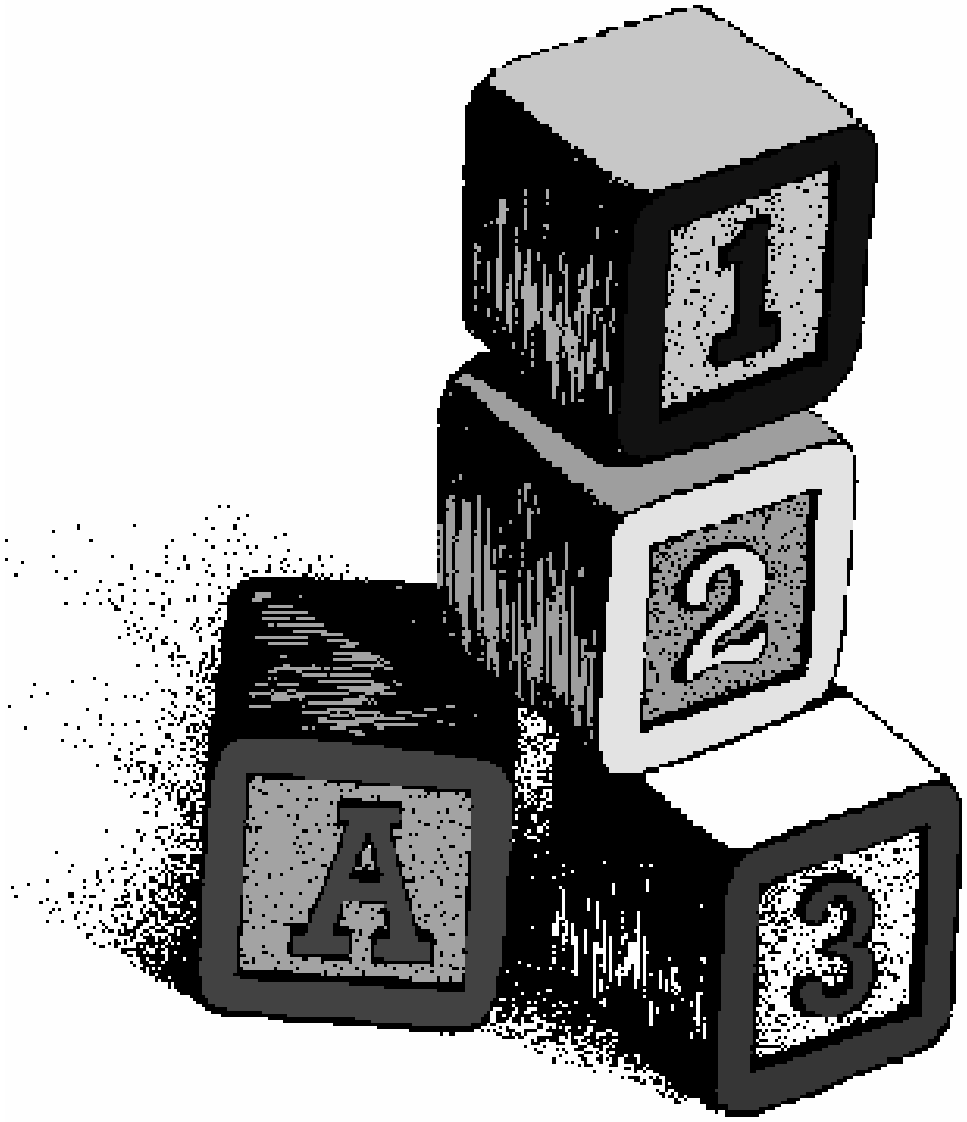
Vermonters are few in number. Like other rural areas of the country, there are

- Smaller groups of recipients who qualify for services
- Fewer formal resources available
- Smaller pools of service providers
- High expectations for accountability and responsibility

These characteristics contribute to how Vermonters think about helping each other and how formal services are utilized. They are critical to how we think about nurturing the emotional and social development of infants, young children and their families. For example, we tend to practice the use of informal social supports, locally designed programs and active inclusion of parents and other family members in creating programs that involve their children.

References

Moroz, K., Blanchard, J., Darsney, A.M., McMains, W., Schoenberg, S., Stevens, P., Sugarman, N. & Walker, J. (2001). Vermont Culture and Guiding Principles of Practice. *Knowledge and practices to promote the emotional and social development of young children. (pp. 5)* Waterbury, VT: CUPS Core Competencies Task Force, VT DDMHS.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GUIDING PRINCIPLES OF PRACTICE TO PROMOTE THE EMOTIONAL AND SOCIAL DEVELOPMENT OF INFANTS AND YOUNG CHILDREN

We Believe That

1. All children have the right to be protected and to be cared for in environments that promote their health and development.

2. Nurturing relationships promote healthy emotional, social and neurological development in infants and young children.

3. Obstacles to healthy development should be identified as early as possible and appropriate resources/services provided without delay.

4. Families, as they define themselves according to biological and/or social kinship, play the leading role in children's social and emotional development.

5. Building on families' skills and knowledge strengthens caregiving for infants and young children.

6. Families' networks of natural supports offers them enduring and essential resources, whereas professional services come and go.

7. Individuality, as well as social, economic and cultural diversity, must be honored and reflected in practice.

8. Communities need to actively support the critically important work of parents and early child care providers to nurture and care for infants and young children.

9. Communities need to provide safe, accessible and quality environments for infants, young children and their families.

10. A team approach provides a strong and inclusive way to support parents and young children.

References

Moroz, K., Blanchard, J., Darsney, A.M., McMains, W., Schoenberg, S., Stevens, P., Sugarman, N. & Walker, J. (2001). Vermont Culture and Guiding Principles of Practice. *Knowledge and practices to promote the emotional and social development of young children. (pp. 6)* Waterbury, VT: CUPS Core Competencies Task Force, VT DDMHS.

CUPS HANDBOOK CHAPTER SUMMARIES

Part One: The Context for Family Life

Chapter 1, *Family Life in the 21st Century,* addresses how changing definitions of family, cultural differences and changing relationships between family members and service providers influence our approach to finding help with social, emotional, behavioral challenges for young children and their families. This chapter describes ways in which living with poverty impacts the lives of many children and families in the United States and specifically families living in Vermont. The chapter also raises the importance and serious shortage of high quality child care, especially for families who live in poverty.

Chapter 2, *Health, Welfare and Safety Resources,* provides an overview of resources to help ensure the health, welfare and safety of young children and their families. Many of the resources are aimed at supporting and strengthening all families, including those with infants and young children. We include statewide and local services and supports for families on limited incomes, as well as information and resources on safety issues.

Chapter 3, *Families in Transition,* addresses a range of significant transitions that many young children may experience by the time they reach elementary school. These include separation and divorce, stepfamilies, joining a new adoptive or foster family, the birth or adoption of a sibling, relocation or moving, and starting childcare or school. Each section identifies common stressors, reactions expressed through the behavior of infants and young children, tips for those in a position to consult with and support families, and specific resources for more information.

Part Two: Specialized Assessment and Early Intervention

Chapter 4, *Early Development, Developmental Differences and Delays,* stresses the crucial relationship between early experience and brain development, and highlights the importance of warm, nurturing relationships to infants' and young children's emotional and social development. Young children, including those with a number of risk factors, can benefit tremendously from interventions aimed at promoting healthy development. This chapter lists the risk factors contributing to developmental delays and disabilities and provides Vermont resources to assist infants and children with disabilities or conditions calling for specialized help and their families.

Chapter 5, *Assessment as Discovery*, gives an overview of assessment as a joint discovery process to help parents and providers organize their observations and exploration into the child's strengths and vulnerabilities. Readers are urged to take a holistic, comprehensive view of assessment, as opposed to treating each area of development as separate and distinct. This chapter provides guiding principles for assessment, as well as a series of charts providing key information about recommended screening, assessment and evaluation tools.

Chapter 6, *Making Sense of Challenging Behaviors,* begins with a description of behavior as the natural language of the infant and young child. This chapter offers approaches to making sense of children's behavior including interventions at home and in early childhood programs. Additional sections give options for families seeking additional support in attachment building, relationship enhancement, play therapy, and/or referral to specialists; and resources for specific behavioral challenges including sleep, eating, toileting, attention seeking and/or demanding behaviors, anxiety, aggression, and social avoidance and/or isolation.

Part Three: Understanding and Responding to Difficult Family Circumstances

Chapter 7, *Teen Parenting*, offers a brief overview of general adolescent development, a guide to supporting adolescents through pregnancy and parenting, a description of risky behaviors potentially impacting the lives of pregnant teens and teen parents, and safety concerns and possible risks to the young child. The importance of helpers addressing both the physical, emotional and social needs of pregnant and parenting teens as well as helping these young parents meet the developmental needs of their infants and young children is covered in this chapter.

Chapter 8, *Parent Substance Abuse,* we include definitions of terms, the effects of alcohol and other drug use during pregnancy, the impact on infants and children of growing up in a family with substance abuse, physical and behavioral indicators of substance abuse in families, and specific issues in addressing substance abuse in families. An additional section gives steps to consider and practice in having a "caring conversation," which can contradict the common practice of secrecy when there is substance abuse within the family.

Chapter 9, *When Illness or Disability Affects Parenting,* addresses additional stress experienced by children and their parents due to physical, mental, mental health, or developmental difficulties. In particular, we focus on a) postpartum mood reactions, b) psychiatric illnesses such as schizophrenia, bipolar disorder, major depression and severe anxiety, c) cognitive limitations and d) long-term illness, severe injury, recent physical disability, or hospitalization of a parent. The chapter discusses how to help children and their parents deal with each of these issues.

Chapter 10, *Families in Crisis or Experiencing Severe Stress,* focuses on a number of circumstances that commonly create severe family stress or crisis that can affect the care of young children. We discuss helpful ways to address the death of a family member, loved one, or pet, as well as when an infant or young child dies; disasters such as flood, fire, earthquake and war; the incarceration of a parent; and homelessness.

Chapter 11, *Refugee and Immigrant Families*, we offer an overview of issues impacting refugee and immigrant families. In particular, a family's native culture may offer significantly different childrearing practices which can result in misunderstandings and conflicts between parents and caregivers. This chapter addresses changes in family dynamics and parent roles, second language acquisition, medical care, and starting preschool or childcare. A section provides specific tips for how supporters can be helpful to immigrant and refugee families.

Part 4: Understanding and Responding to Young Children in Traumatic Circumstances

Chapter 12, *Trauma and Brain Development in Young Children,* includes an overview of the importance of understanding the impact of trauma on young children, both in terms of the effects of trauma on the developing child's brain and the tremendous consequences that trauma can have on children's emotional and social development. The chapter explains how young children cope with the shock and fear of trauma through adaptive responses, and describes the behaviors associated with these responses.

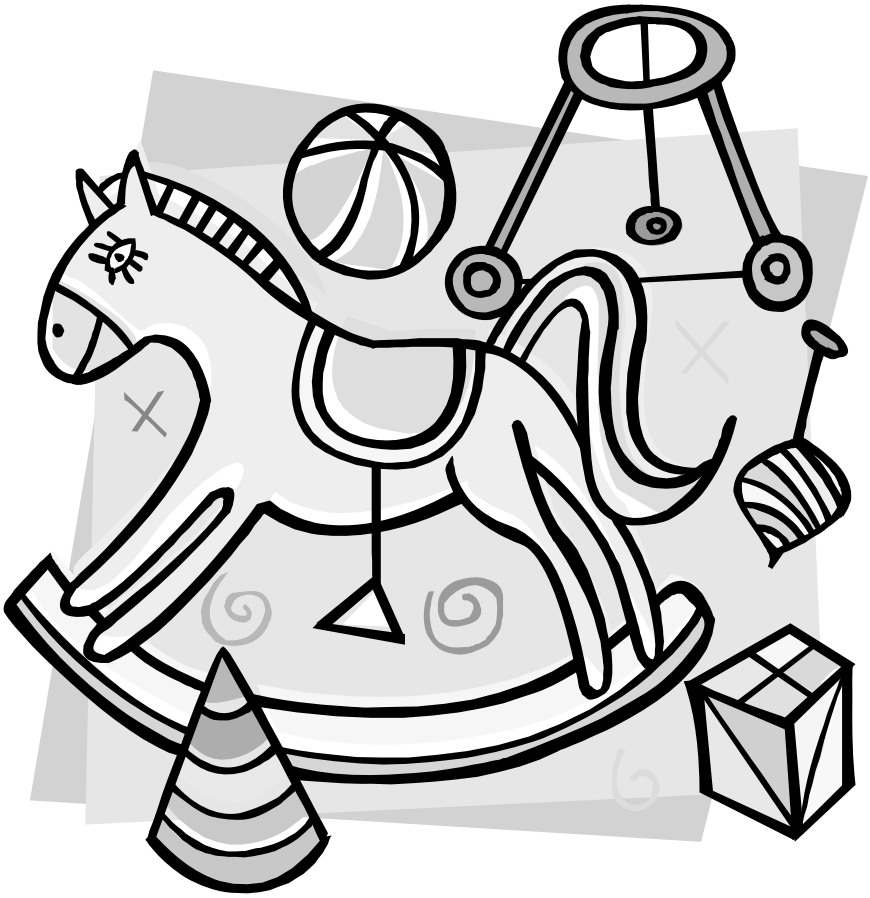
Chapter 13, *Child Abuse: Physical, Sexual and Emotional,* addresses the effects of physical, sexual and emotional child abuse on children's emotional well-being and how they view themselves and others. This chapter explores the relationship between trauma, child abuse and attachment, with specific sections on physical abuse, sexual abuse, and emotional or psychological abuse. As well, we address the assessment of abuse that can lead to making a report and finding help for children and their families.

Chapter 14, *Child Neglect,* focuses upon the range of ways, either blatant or subtle, in which parents can fail to meet the basic and necessary needs of the child. We address contributing factors to parental neglect, possible indicators of child neglect, specific actions to help a family when neglect occurs, the importance of a strong, healthy attachment, and cultural factors that may be mistaken for evidence of neglect.

Chapter 15, *Children Exposed to Domestic Violence*, begins by defining the problem and its scope in the United States. The chapter provides evidence of the broad impact of exposure to domestic violence on young children, general strategies such as safety planning for those working with young children, specific ways to respond to children who experience domestic violence, ways to support parents who are victims of domestic violence, and contact with the battering parent. The Vermont Network Against Domestic Violence and Sexual Assault is identified and described as a key resource in Vermont.

PART ONE

THE CONTEXT FOR FAMILY LIFE



CHAPTER 1
FAMILY LIFE IN THE 21ST CENTURY

What is a Family?
Definitions, Cultural Differences and Changing Roles

During the last half of the 20th Century, families in the United States changed dramatically. We moved away from a limited concept (stay-at-home mother, father away at work, and two or more biological children) to broader, more inclusive and diverse descriptions. At the beginning of the 21st Century, American families come in many configurations. Children in a typical child care center or school classroom reflect the wide spectrum of domestic arrangements that we now celebrate as "family."

Many families have only one parent. A second non-blood-related adult may join the family. Many new families are formed when two adults remarry. Gay and lesbian families have two fathers or two mothers. Other families are multigenerational with three or four generations living together, or children are raised by relatives other than biological parents. Increasingly, families blend racial, religious and ethnic backgrounds. Foster families and families that have come together through adoption are much more common.

Awareness of cultural differences has sensitized us to the diverse ways people from different backgrounds define family and practice the roles and responsibilities within families. Cultural customs influence dietary choices, language, relationships between child and adult, discipline practices, and more.

Roles within families have undergone significant changes. Until recently fathers were less involved with infant care and were rarely primary caregivers. Increasingly we see fathers and mothers sharing all aspects of child care. More fathers are choosing to stay at home to care for children and manage the household while mothers provide for the financial needs of the family. In some families, grandparents and other relatives are critical providers of nurturing, physical care and wisdom. Many families make periodic moves, reflecting the more mobile society in which we live.

Infants and young children naturally accept their families as “normal.” When children of non-traditional families are criticized or treated as different from others, they may be confused, which is stressful for both children and their parents. Parents can be caught between wanting to protect their children from the negative messages (retreat) and educating others about who they are and the biases that perpetuate prejudice, fear and hostility (exposure.)

Families are groups of two or more people bound together by mutual love and interdependency. The adults in the family have the privilege and challenge of nurturing, protecting, encouraging and promoting the healthy development of the children. Families are the first and primary unit within which children learn about the world, other people, and their own competency and efficacy. It is within the family that children first learn about their culture, their community and their society. The family is the first classroom for imparting values and personal meaning.

The importance of the family in a young child's life cannot be overstated. For this reason, we respect, celebrate and honor all kinds of families. We also recognize the responsibility of the community to support children and their families to help ensure that children thrive within the broad spectrum of families that exists.

Our language sometimes fails to adequately capture the diversity of families in the 21st Century. We struggle to find words that are not judgmental or condescending. For example, a family with lesbian parents might be labeled "alternative," which connotes outside the norm. Or foster parents might be referred to as "substitute caregivers," which subtly diminishes their significance in a child's life. In the coming years, we hope that parents, those supporting families, and other community members will grapple with language and dare to create new terms more supportive of the range of family structures.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES FOR ADULTS

Coll, C.G., Surrey, J.L., and Weingarten, K., (Eds.). (1998). *Mothering against the odds.* New York: Guilford Press.
Chapters by mothers in poverty, mothers of color, homeless and incarcerated mothers, single, lesbian, adoptive and teen mothers.

Drucker, J. and Schulwei, H.M. (2001). *Lesbian and gay families speak out: Understanding the joys and challenges of diverse family life.* New York: Perseus Books.
An in-depth look at gay and lesbian parenting in America; stories of over two dozen families in which gay fathers and lesbian mothers are raising children in an atmosphere of love, in a wide variety of settings and styles.

Gay Parent Magazine features personal stories of lesbian, gay, bisexual and transgendered (LGBT) parents from around the country. Also featured are book reviews, news, activities and events pertaining to LGBT parents and their children. Contact:

GPM,
PO Box 750852,
Forest Hills, NY 11375-0852.
www.gayparentmag.com

WRITTEN RESOURCES FOR FAMILIES AND CHILDREN

Gillespie, P. (Ed.). (1999). *Love makes a family: Portraits of lesbian, gay, bisexual, and transgender parents and their families*. Family Diversity Projects.
Combines photos and interviews with parents and their children; included are people from diverse racial, ethnic and economic backgrounds. "Provides clear evidence that family roles and responsibilities need not be based on gender, and that children thrive in an atmosphere in which understanding, respect and love transcend the prejudices of the day."
www.familydiv.org/lovemakesafamily

Gillespie, P. (2002). *Of many colors: Portraits of multiracial families.* Family Diversity Projects.
www.familydiv.org/lovemakesafamily Or order from ChrisComm Marketing and Management, (570) 675-4933.

Newman, L. and Souza, D. (2000). *Heather has two mommies.* Boston: Alyson Publishing.
Heather, a preschooler with two moms, discovers that some of her friends have very different sorts of families.

Redleaf Press offers a variety of cultural awareness books, curricula for early childhood classrooms and families, and books that celebrate diversity.
1-800-423-8309. www.redleafpress.org

WRITTEN RESOURCES FOR FAMILIES AND CHILDREN *(CONTINUED)*

Register, C. (1990). *"Are those kids yours?!": American families with children adopted from other countries.* New York: Simon and Schuster.

Skutch, R. and Nienhaus, L. (1998). *Who's in a family?* Berkeley, CA: Tricycle Press.
Depicts single parent families, same gender parent families, grandparent-headed families, and a married couple without children as well as animal families.

Willhoite, M. (1991). *Daddy's roommate.* Boston: Alyson Publishing.
The story of a boy whose gay father lives with another man.

ORGANIZATIONS AND WEBSITES

Adoptive Families Association of British Columbia offers a comprehensive, annotated list of books about adoption as well as books and links to resources on lesbian and gay parenting.
www.bcadoption.com

Connect for Kids is dedicated to supporting adults who are working to make their communities better places for families and children.
www.connectforkids.org

In our family: Portraits of all kinds of families. Describes a touring photo-text exhibit, mounted by Family Diversity Projects, that celebrates families of every kind including adoptive & foster families, divorced and step-families, single-parent families, multiracial families, lesbian/gay parented families, interfaith families, immigrant families, families facing physical and/or developmental/mental health challenges.
www.familydiv.org/inourfamily

Mister Roger's Neighborhood provides ideas and resources related to all kinds of families.
www.pbskids.org/rogers

Parents, Families and Friends of Lesbians and Gays (PFLAG)

- National PFLAG, Washington, D.C., www.pflag.org
- Vermont PFLAG, Champlain Valley, (802) 863-4285
- PFLAG White River Junction, (802) 295-7064

Changes in Relationships Between Families and Service Providers

Until recently, service providers were viewed by both themselves and most families as experts who knew the best solutions to problems, by virtue of their education and professional roles. This imbalance in power defined the service provider as "expert," or more knowledgeable, while minimizing family members' skills and intimate knowledge of their children.

Lately there has been a shift toward more consumer-oriented practices, in which service providers are in ongoing consultation with family members concerning their needs and how to best meet them. Parents no longer assume a secondary role of simply following the professionals' recommendations. They are viewed as the experts on their children, with parenting skills that are respected, supported and strengthened. Service providers strive to understand and incorporate differences in families' cultural and ethnic traditions. Furthermore, difficulties that families experience are perceived, not as flaws within individual family members, but as challenges and stressors that families and professionals working together can reduce or transform.

A key proponent of developing collaborative partnerships between parents and professionals is Dr. T. Berry Brazelton, renowned expert on infant and toddler development and author of bestselling books for new parents. Brazelton has developed the “Touchpoints” model, which stresses relationship-building between parents and providers centered on “Touchpoints,” predictable periods in children’s development when gearing up for developmental advances is accompanied by behavioral “disintegration” and periods of regression. These changes, while normal, can be upsetting and frustrating to parents.

Through the Touchpoints approach, these periods of disorganization provide opportunities for parents and providers to work together to support children’s development through valuing the contributions of parents and others caring for the child. Service providers use empathic listening, anticipatory guidance and curiosity to support the relationship between parents and children, and between parents and service providers. The Touchpoints model, which is in wide use in Vermont, encourages supporters of families with infants and young children to adopt a perspective of joining and sharing in their care of children, while recognizing parents as the experts on their children (Brazelton, 1992; Brazelton, Greenspan and Sparrow, 2002).

The model we advocate for effective, supportive relationships is family-centered, parent-driven, community-based and collaborative. Families may seek both competent professional services as well as involvement with informal supports such as recreation, church, and other community support services. Often, parents desire connection with other parents who understand through personal experience their particular challenges and what responses work best. Ideally, informal support and professional services work hand-in-hand to meet the specific needs of a family. Parents are active participants in addressing their own needs and those of other families, including service planning and delivery, evaluation, training and policy development.

The family support movement encourages parent-to-parent support and the active participation of parents in leadership roles. Many agencies and organizations offer support, training, advocacy, information, and resources to family members and service providers alike. In Vermont, these organizations have come together to form The Vermont Family Consortium, whose goals are to support families with information, training and personal assistance, and to help families, youth and individuals engage in their community's decisions and activities.

Happily, our communities have become more diverse. Even where there is little ethnic diversity, those who support families have the pleasure of learning about different cultural experiences through the range of religious beliefs, ancestral heritage, and social/economic differences reflected in Vermont’s families. It is important for everyone concerned with the wellbeing of children to be mindful of their own cultural beliefs and possible biases. Parents will be aware of judgments and biases held by those that are helping them, which can undermine the possibility of developing an alliance. Helpers must make allowances for a range of appropriate responses to infants and young children and learn to appreciate these differences.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Brazelton, T. B. (1992). *Touchpoints: Your child's emotional and behavioral development: Birth to three.* New York, NY: Perseus Publishers.
From a highly respected pediatrician who describes the physical, emotional, social and cognitive development of infants and young children and the important role of parents in their lives. Explains Brazelton' concept of "Touchpoints," the "universal spurts in development and accompanying periods of regression."

Brazelton, T.B., Greenspan, S.I. & Sparrow, J. (2002). *Touchpoints 3 to 6.* New York, NY: Perseus Publishers.

Dunst, C., Trivette, C. & Deal, A. (Eds.). (1994). *Supporting and strengthening families, Volume I: Methods, strategies and practices.* Cambridge, MA: Brookline Books.

Sax, M. (2000). *Finding common ground between human service seekers, providers and planners: a re-authoring conversations approach.* Unpublished dissertation. Santa Barbara, CA: The Fielding Institute.
Applies the concepts and practices of narrative therapy to explore "common ground experiences" between parents of young children experiencing emotional and behavioral challenges, service providers and human service planners. Common ground experiences are described as "relationships that express friendship skills and contradict established practices of distancing."

Tannen, N. (1996). *Families at the center of the development of a system of care.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health.
Straightforward, detailed description of one community's success at establishing a family-designed, family-led system of care for children with mental health needs and their families.

ORGANIZATIONS AND WEBSITES

Brazelton Touchpoints Center (BTC) is a training organization housed at Children's Hospital, Boston. BTC offers training nationwide based on the work of Dr. T. Berry Brazelton, which combines relationship building and child development into a framework that professionals can use to enhance their work with families. BTC trains professionals from a variety of disciplines and settings who incorporate the model into their individual practice or more broadly into the community.
www.touchpoints.org

Family Support America is a national parents' self-help organizations whose message is, "If you want to help families, ask parents what they want."
www.familysupportamerica.org/content/home.htm

The Vermont Family Consortium consists of agencies and organizations that provide support, training, advocacy, information, and resources for people with disabilities, their families, and providers. A brochure is available through the Center on Disability and Community Inclusion, University of Vermont.
(802) 656-4031. See *Appendix I* for a list of Family Consortium member organizations/agencies.

Children Living in Poverty

Nearly a quarter of all young children and their families in the United States live below the poverty line. A disproportionately high number of these households are headed by women who must struggle to find jobs that provide a livable wage as well as available and adequate child care.

Children who live in poverty are less likely to receive medical and dental care, less likely to have adequate housing and nutrition and less likely to live in safe, child-friendly neighborhoods. The consequences of poverty in the first years of life may result in developmental delays and learning problems when the child enters school. This, in turn, may result in academic and social problems in school, failure to finish school, and continued economic disadvantages that come from under- or unemployment.

Those who support families with infants and young children will want to be sensitive to ways in which poverty has played a role in how families strive to meet the needs of their children. The persistent struggles for families living in poverty can lead to increased levels of stress, which may translate to feelings of exhaustion, isolation, and despair. Among the contributing factors are the need to work long hours or multiple jobs to make ends meet; the challenges of providing food, clothing, and affordable housing; the lack of reliable transportation; and the difficulty of navigating multiple service systems to meet family needs such as medical and dental care, social services, income supports and childcare. Addressing poverty and its long-term impacts demands a comprehensive approach which considers the underlying issues that contribute to the perpetuation of poverty as well as the immediate consequences of poverty.

Most parents living in poverty work very hard to provide for their children's needs. When support is offered, it needs to be in response to the parents' views of their children's present and future needs. With respect, compassion, hope and a collaborative spirit, parents, social service providers, medical/dental practitioners, early care and education providers and others in the community can work together to address the realities and ameliorate the consequences of poverty on young children.

RESOURCES FOR MORE INFORMATION

ORGANIZATIONS AND WEBSITES

Vermont Office of Economic Opportunity (OEO) "seeks to increase the self-sufficiency of Vermonters and strengthen Vermont communities." Main office is located at 103 South Main Street (Osgood Building, First Floor), Waterbury, VT 05671-1901.
(802) 241-2450, www.ahs.state.vt.us/oeo/, or see *Appendix I* for Regional Community Action Programs.

Vermont Department of Prevention, Assistance, Transition, and Health Access (PATH) oversees many programs to help families struggling with inadequate financial resources.
1-800-287-0589 or (802) 241-2800, www.path.state.vt.us, or see *Appendix I* for a listing of regional offices.

National Center for Children in Poverty "identifies and promotes strategies that prevent child poverty… (and) improves the lives of low-income children and their families."
www.nccp.org

See Chapter 2, *Health, Welfare and Safety Resources* for more services and supports for families on limited incomes.

Quality Child Care

Over the past several decades, the numbers of infants and young children in child care has steadily increased. At one level, communities face the challenge of ensuring sufficient child care capacity to meet the demand for out-of-home care. Beyond this is the greater challenge of making sure that the child care provided is of high quality, so that infants and young children are safe, nurtured, nourished, loved, and stimulated, and have their needs met in developmentally appropriate ways by competent, consistent, trained child care providers.

When families live in poverty, the child care dilemma becomes even more pronounced. For these families, especially, child care options may be limited; many families in such situations turn to informal (and hence, unregulated) child care.

As is true elsewhere, most Vermont communities suffer from a serious shortage of high quality child care. As they work to fill this gap, it is important to keep in mind the criteria that must be met in order to provide adequate child care for all those who need it. These include the following:

> "Matthew got let go by two daycares. He was very active, very hyper, unruly. They just didn't want to deal with him. A lot of people don't want to deal with challenged children. Then I found this great lady that ran a child care center near my dad, and she knew all about Matthew's situation…she knew the signs."

- Readily accessible child care options (affordable, close to public transportation, within families' neighborhoods, user-friendly hours, accessible to children and parents with physical challenges).
- Appropriate child care for children with special needs.
- Training and support for child care providers.
- Positive regard for child care providers and adequate wages that attract and keep well-trained, highly-skilled people.
- Community investment in the value of early care and education programs.
- Sufficient financial resources to create and sustain growth and to pay child care providers livable wages.

We now live in an era when quality child care is not only a necessity for most families, but is also an opportunity to enhance young children's healthy development and to strengthen families. At its best, quality child care provides a place where whole families are supported, respected, guided and nurtured. Unfortunately, many families have to struggle to find and pay for quality care for their young children. Those who support young children and their families need to be aware of this stressor and be willing to help families secure quality care for their children. In Vermont a statewide network of Child Care Resource and Referral Agencies offers practical support to families seeking child care and to child care providers.

RESOURCES FOR MORE INFORMATION

ORGANIZATIONS AND WEBSITES

Vermont Association of Child Care Resource and Referral Agencies (VACCRRA) is a "statewide network of non-profit agencies which share a common commitment to the development and support of quality child care options for Vermont children and their families."
State Office: Toll free: 1-877-822-2772, www.vermontchildcare.org, or see *Appendix I*.

Vermont Child Care Consumer Concern Line provides support to consumers who seek background information about child care providers, or wish to voice a concern about care their child is receiving.
1-800-540-7942. www.state.vt.us/srs/childcare

Vermont Child Care Subsidy Program, provided by Vermont Social and Rehabilitation Services (SRS) Child Care Services Division, provides financial support for child care for low-income parents when they participate in training and employment.
1-800-649-2642 or see *Appendix I* for location of local SRS office to inquire about eligibility.

Vermont Parent-Child Center Network is a network of centers that support young parents and provide early care programs for their children.
(802) 388-3171, www.vermontfamilyresource.org/PCCCNetwork, or see *Appendix I* for location of local centers.

See *Appendix II* for national organizations concerned with quality child care.

CHAPTER 2
HEALTH, WELFARE AND SAFETY RESOURCES FOR YOUNG CHILDREN AND THEIR FAMILIES

Introduction

Helping infants and young children often means assisting parents to find services and resources that enable them to meet their children's and families' basic needs. Many Vermont parents struggle with poverty and the tremendous challenges of housing, feeding, and clothing their children on too little money. Reliable transportation, telephone service, and home heating in Vermont's harsh winters can become major issues for those with limited resources, including thousands of parents working at low-paying service and clerical jobs. Parents with limited education or with disabilities often face steep hurdles in obtaining secure employment that pays enough so they can adequately provide for their children. Those supporting families who face these kinds of difficulties will want to work in close communication with parents to assist them in prioritizing and obtaining help with those issues that the parents feel are most pressing.

Child care providers and parents also need to know about safety issues, and how to keep their children from being exposed to dangers in their homes and communities. Parents may be unaware of potential environmental hazards or where to turn if they do have a concern about their family's safety. Exposure to environmental hazards can affect young children in multiple ways, including harming their social and emotional well-being.

This chapter is a general resource guide for service providers and parents. With a few exceptions, the resources are not aimed specifically at infants and young children. Rather, these are resources that provide key support and help that can strengthen all families, including those with young children. They are of two kinds: services and supports for parents and other adults on limited incomes, and information and resources on safety issues for families. While the contact information provided is at the state level, many of the resources listed have local offices throughout Vermont.

Services and Supports for Families on Limited Incomes

Cash Assistance and Services for Low-Income Families

Reach Up (Vermont's Temporary Assistance for Needy Families (TANF) Program provides cash assistance and services to help Vermont families in poverty achieve self-sufficiency. *Reach Up* provides services that support work, cash assistance for basic necessities and health insurance. Eligibility depends on income, resources, living expenses, who lives in the home, ability to work, and other factors. The Vermont Department of Prevention, Assistance, Transition, and Health Access (PATH) operates *Reach Up* through PATH District Offices. Further information can be found on the PATH website, www.path.state.vt.us, call 1-800-287-2800, or see *Appendix I* to locate regional PATH offices.

Vermont Office of Economic Opportunity (OEO) and *Community Action Agencies* provide funding and assistance to low-income Vermonters through food, shelter, and other services. OEO funds Community Action Programs throughout Vermont to provide a wide range of services and training aimed at alleviating poverty. These include housing assistance, emergency fuel and utility assistance, food and nutrition education, emergency food shelves, case management, transportation assistance, and other services. OEO also funds homeless shelters and other homeless service providers through a combination of federal and state funding.

For further information, or to locate a local OEO Community Action Program, see *Appendix I*, call (802) 241-2454, or email www.ahs.state.vt.us/oeo.

Emergency Assistance

General Assistance (GA) and *Emergency Assistance (EA)* programs provide aid such as housing and utilities, food and personal needs money, and medical assistance to individuals and families who have experienced a catastrophe and, as a result, are unable to provide for their basic needs. In non-catastrophic situations, assistance for emergency basic needs is available only to certain households. Eligibility is based on low income, assurance that assets have been exhausted (with certain exceptions), and active pursuit of all sources of potential income. The applicant must be responsible for the care of one or more dependent children, or be elderly or not able-bodied. In Vermont, emergency assistance is available through the Department of Prevention, Assistance, Transition and Health Access (PATH) District Offices. www.path.state.vt.us or call 1-800-287-2800. See *Appendix I* for listing of District Offices.

Housing

Low-Income Housing Programs: Housing financing and management programs assist low-income families to secure adequate and affordable housing. Public Housing (government-owned housing), Assisted Housing (housing that is subsidized to make it more affordable), and Affordable Housing (subsidies to enable low or moderate income persons to reside in housing they can afford), programs are available through the Vermont Housing Authority at (802) 828-3295. The Vermont Housing Authority can provide referrals to local Housing Authority offices. These programs include:

- *Section 8 Rental Assistance* provides rental assistance to help eligible families live in safe and decent housing of their choice. After a family applies and is determined eligible, they are placed on a waiting list until funds become available to assist them.
- *Project-Based Certificate and Moderate Rehabilitation Program* is project-specific housing. Tenants are selected from the existing waiting list, owners and/or managers determine suitability and the State Housing Authority determines eligibility for participation in the program. Eligibility is tied to the housing unit, not the family.

- *The Mainstream Housing Program* funds rental assistance for disabled families.
- *Rental Assistance* is also available through the state housing authority.
- *Homeless Programs* (shelters and services for people who are homeless) administered through the Vermont Housing Authority consist of:
  - The Shelter Plus program. Provides rental assistance to homeless people with disabilities.
  - The Family Unification program. Promotes family unification by providing rental assistance to families for whom the lack of adequate housing is a primary factor in the separation, or threat of imminent separation, of children from their families.

There are a number of homeless shelters in Vermont. Contact the Vermont Office of Economic Opportunity at (802) 241-2454 for information about local programs.

Financing Housing, Tenants' Rights and Fair Housing Information

Housing development organizations throughout the state can provide information about tenants' rights, homeownership, financing, health and safety, etc. To find out more about these organizations, visit the Vermont Department of Housing and Community Affairs website at www.dhca.state.vt.us or (802) 828-3211.

Fair housing laws are intended to prevent discrimination in how housing is sold, rented, appraised, financed, and advertised. If families believe they may be experiencing discrimination they can contact the U.S. Department of Housing and Urban Development, Burlington Field Office 159 Bank Street, 2nd Floor, Burlington, VT 05401, (802) 951-6290.

Household Management Needs

Home Heating – Fuel Assistance: To apply for fuel assistance an application must be filled out each and every year even if a family is found eligible in a previous year. An application can be obtained by contacting the Vermont Fuel Office at 1-800-479-6151 or (802) 241-1165.

Food Expenses – Food Stamps: These are benefits for low-income Vermonters to use for food purchases. They can be used at most stores that sell food. For more information contact the Department of PATH at 1-800-287-0589.

Phone Expenses: Lifeline Telephone Credit offers a discount of at least $13.00 per month to eligible applicants. *Link-Up Vermont* is a program designed to make home phone service more affordable for Vermonters with limited incomes by cutting the cost of phone installation. For more information about both programs contact the Department of PATH at 1-800-287-0589.

Weatherization: The Vermont Office of Economic Opportunity provides funds to Community Action Agencies to help reduce energy costs for low-income families, particularly for elderly persons, people with disabilities, and children, by improving the energy efficiency and comfort of their homes while ensuring their health and safety. For more information contact the Office of Economic Opportunity at (802) 241-2452, or see *Appendix 1* for a listing of Regional Offices.

Health Care

Below is a list of Vermont programs that assist eligible families with young children to obtain the health care they need. Information is available from the Vermont Department of Prevention, Assistance, Transition and Health Access (PATH). For more information visit the website at www.path.state.vt.us, call 1-800-287-2800, or see *Appendix I* for location of PATH offices.

Medicaid: Supports children, pregnant women and adults who meet income eligibility requirements by covering costs of doctor visits, prescriptions, hospital care (including emergency care), tests, x-rays, family planning, mental health services, substance abuse services, home health care, dental care, eye care, occupational therapy, physical and speech therapy and more.

Dr. Dynasaur: With broad income guidelines designed to cover as many families as possible, this program supports pregnant women, children, and teens under 18. Benefits for children and teens under 18 help cover the costs of doctor visits, prescriptions, dental care, hospital care, occupational therapy, physical and speech therapy, vision care, immunizations, mental health care, and more. Benefits for pregnant women help cover the costs of doctor visits, hospital care, lab work, tests, prescriptions (including prenatal vitamins), and more.

Vermont Health Access Programs (VHAP): Supports adults (18+) who don't have health insurance and do not qualify for Medicaid or Medicare. Benefits help cover costs of doctor visits, prescriptions, hospital care (including emergency care), tests, x-rays, family planning, mental health services, substance abuse services, home health care, and more.

Prescriptions: VHAP-Pharmacy helps cover the cost of drugs for both short-term and long-term medical problems for low-income aged or disabled persons not eligible for Medicaid or VHAP who do not have pharmacy insurance. "VScript" and "VScript Expanded" helps cover the cost of drugs for long-term medical problems for low to moderate-income aged or disabled Vermonters not eligible for Medicaid or VHAP who do not have pharmacy coverage.

Vermont WIC is a Special Supplemental Nutrition Program for Women, Infants and Children to enhance the health of infants, young children, pregnant women and new mothers. Its goal is to improve health by teaching families about good nutritional practices and by providing nutritious foods to eligible low-income Vermonters. WIC is available to financially eligible women who are pregnant or have been pregnant within the past six months. If the woman is breastfeeding, the eligibility period may be extended to the infant's first birthday. Infants and children up to age 5 are also included. For more information contact the Department of Health's district office serving the family's town of residence, call 1-800-214-4648, or see *Appendix I* to locate regional Department of Health offices.

Physical, Mental Health or Cognitive Disabilities

There are programs that assist adults with disabilities and encourage employers (in compliance with the Americans with Disabilities Act) to make reasonable modifications to rules, policies or practices through the removal of architectural, communication or transportation barriers, or the provision of auxiliary aids and services.

The Vocational Rehabilitation Program funded under Title 1 of the Rehabilitation Act of 1973, assists individuals in preparing for and engaging in gainful employment. It provides a wide range of services and job training to individuals who have physical or mental impairments that are substantial impediments to employment and who require specialized services to prepare for, enter or engage in employment. For more information contact the Division of Vocational Rehabilitation of the Vermont Department of Aging and Disabilities at www.dad.state.vt.us.

ARC (Advocacy, Resources and Community for Persons with Disabilities and their Families) Vermont provides information, resources and support to Vermont citizens with developmental disabilities and their families. ARC advocates for the rights of every individual with a disability to have opportunities to participate in the life of our Vermont communities as valued citizens. A specific focus is on transitions for high school students so they may have successful post-secondary experiences and supports over which they and their families have maximum control. ARC can be reached at (802) 846-7295 extension 91 or www.arcvermont.org.

Community Mental Health Centers (CMHC) cover the 12 regions throughout the state. They provide services and supports to Vermont citizens with developmental disabilities and mental health needs to live as independently as possible. Assistance is offered in supported and competitive employment toward the goal of achieving independence in the marketplace. See *Appendix I* to locate your CMHC.

The Vermont Center For Independent Living is an organization of citizens with disabilities working together for dignity, independence and civil rights. The website, www.vcil.org, has information about resources, programs, free services, legislation, and advocacy issues. Or call 1-800-639-1522.

Transportation

The lack of reliable transportation in the rural, wintry state of Vermont can pose major obstacles to families in all areas of their lives. Without a car or regular bus services, parents have difficulty seeking and maintaining employment, shopping for food and other necessities, and bringing their children to often faraway towns for medical and dental care and other services. Several state-funded programs provide assistance with transportation needs:

> "Transportation was an issue. The district wouldn't provide transportation to the day care if it was outside of the district. So we were held hostage. We had to find day care [in our district.] It was either that or I quit my job."

The Vermont Public Transportation Association administers and develops transportation services throughout the state. Call (802) 296-2143 for a list of local agencies that are contracted to provide the following transportation services:

Medicaid Transportation provides cost-effective and appropriate transportation based on individual needs, medical circumstances, and available community resources to those Medicaid recipients eligible for transportation services. For information about eligibility contact the district office of the Department of Prevention, Assistance, Transition and Health Access (PATH) or call 1-800-287-0589.

Commuter Transportation: Vermont Rideshare Program is a comprehensive transportation program that encompasses carpooling, ridematch, pool-to-school, employer-based rideshare, emergency ride home, interest-free van loans and private sector van leasing. For more information about any of these programs call the Vermont Public Transportation Association at 1-800-685-RIDE (1-800-685-7433.)

Transportation for the Disabled: The Vermont Public Transportation Association disseminates funds to purchase lift-equipped mini-buses or maxi-vans, and to purchase services. These special services are available but vary around the state. Consult with the local transportation provider in your area to learn more.

The Good News Garage: Offers affordable vehicles that have been donated to the program by private individuals. Currently, highest priority is given to applicants needing transportation to get a job or keep a job. Other issues taken into consideration are: verifiable income not exceeding 150% of the government's poverty level; valid driver's license; urgency; need for transportation to a training program; medical needs; family needs; other transportation options, such as access to public transportation. This agency is located in Burlington and can be contacted by calling (802) 864-3667.

Child Passenger Safety Program: Whatever vehicles are used to transport families with young children, child passenger safety is important. The Vermont Department of Public Safety (DPS) provides education, information and referral about child passenger issues. DPS offers a program through which parents can have car seats checked for safety. Call 1-800-TOT-SEAT (1-800-868-7328).

Adult Education and Training

State-funded programs are available to help adults who have not finished high school as well as providing support for post-secondary education and career training.

Vermont Adult Learning (VAL) provides educational instruction to adults (16 years or older) who have not finished high school. Instruction is available in reading, writing, math, balancing a checkbook, following maps, reading the want ads, preparing for the GED test, the driver's permit test, U.S. citizenship and much more. The program is open all year and adults can begin at any time. All classes are free and open to the public. The Chittenden County office offers classes in English for Speakers of Other Languages. For information about local offices contact the Vermont Department of Employment and Training at (802) 828-4000 or www.det.state.vt.us.

Vermont Student Assistance Corporation (VSAC) provides grants, loans, scholarships, career and education planning and general information to help Vermonters go to college or receive other training after high school. The phone number is 1-800-642-3177 or www.vsac.org.

Safety Issues for Families

Child Safety

Children develop and learn best when they are safe and live in safe environments. Any situation that is physically hazardous, unhygienic, or exposes children to illness can endanger their wellbeing, sometimes with permanent effects. Parents and caregivers concerned with safety issues can obtain information about general safety standards from the following organizations:

- Child Care Center Safety Standards: www.state.vt.us/srs/childcare/licensing
- National Playground Safety Institute: (703) 858-2148
- National Program for Playground Safety: www.uni.edu/playground
- Vermont Agency of Natural Resources, Ecological Solutions: www.anr.state.vt.us/ecosolutions

One of the most common dangers to children is overexposure to sun. In addition to the discomfort of sunburn and the hazards of dehydration for young children, too much sun can lead to serious health problems, including skin cancer. It is very important to protect infants and young children from the sun, and avoid their becoming sunburned or dehydrated. For guidelines on how to protect infants and small children from the sun, contact the Environmental Protection Agency's Stratospheric Ozone Hotline 1-800-296-1996, or http://www.epa.gov/ozone/uvindex/uvkids.html.

Toxins in the Environment

Children face numerous environmental hazards, including exposure to ozone, radon, radiation, solvents, lead and mercury. Here are some examples and actions to take (excerpted from *Growing Up Healthy: A Guidebook for New Families).*

Lead Paint and Mercury: Buildings constructed prior to 1978 should be checked for lead paint, which can cause irreversible brain damage in young children, who may accidentally ingest paint chips. Here are some tips:

- The Childhood Lead Poisoning Prevention Program of the Vermont Department of Health can check homes for lead paint.
- A doctor can check the blood lead levels of children living in your home.
- Repair deteriorating paint and wash floors and window sills to protect children from paint dust and paint chips contaminated with lead – especially from windows in older homes.
- Run tap water until it runs cold (2-3 minutes) before use in order to flush lead from copper pipes joined with leaded solder.

If there are questions about possible lead poisoning, contact:

- Child's health care provider:
- Vermont Department of Health: 1-800-439-8550
- Healthy Homes: (608) 262-0024 or http://www.uwex.edu/homeasyst
- National Lead Information Center: 1-800-424-LEAD (1-800-424-5323).

Pesticides and other Toxic Chemicals: Devices that diffuse airborne chemicals harmful to humans, such as anti-pest strips, plug-in air fresheners and aerosol sprays, should be kept out of the presence of young children. Read product labels and follow all directions carefully.

Carbon Monoxide Poisoning: Carbon monoxide (CO) is a gas you cannot see, taste or smell. Carbon monoxide can be found in any fuel-burning appliance, such as heaters, furnaces or wood stoves and can cause poisoning if the appliance is not working right. Early symptoms of CO poisoning are like the flu, such as headaches, dizziness, nausea, and fatigue. Children can be poisoned more quickly than adults and exposure can result in death. If anyone in your home experiences these symptoms and you think it may be carbon monoxide

poisoning, leave your home immediately and seek medical help. Some gas companies will sell carbon monoxide detectors to their customers directly. Check with a local gas company or hardware store.

For more information contact:

- American Lung Association of Vermont: 1-800-586-4872
- EPA Indoor Air Quality Information Clearinghouse: 1-800-438-4318 or www.epa.gov/iaq/
- Vermont Department of Health Environmental Health Program: 1-800-439-8550, extension 5.

Radon: Radon is a gas you cannot see, smell or taste. Families may be exposed to radon gas in their homes without knowing it. Radon occurs naturally and can enter a home through the basement from the rocks and soil beneath, or through well water. Breathing radon over time can cause serious health problems. Fortunately, radon is easy to detect and, if it is found to be present, can be corrected. To test the air in your home for radon levels, get a free kit from the Health Department 1-800-439-8550.

To get more information contact:

- American Lung Association of Vermont: 1-800-586-4872
- EPA Indoor Air Quality Information Clearinghouse: 1-800-438-4318 or www.epa.gov/iaq/
- Vermont Department of Health Environmental Health Program: 1-800-439-8550, extension 5
- US Consumer Product Safety Commission: 1-800-638-CPSC (1-800-638-2727).

Polluted Water: Water can contain pollutants that are hard to detect because they have no taste, odor or color. Children are more sensitive to unsafe water than adults because their bodies are still growing, and their immune systems are not yet fully developed. Biological and chemical contaminants found in water can affect children's health through their formula, drinking water, food cooked or washed in water, drinks with ice cubes, and brushing teeth. Wells that are poorly constructed or leaks from a septic system can contaminate a water supply with bacteria and viruses. These organisms can cause gastrointestinal problems, vomiting, diarrhea and dehydration in children.

Nitrates, fertilizers, and manure use by nearby farms can pollute water sources. High levels of nitrates in children can cause "Blue Baby Syndrome" which is evidenced by a loss of oxygen, possibly resulting in suffocation and death. Lead can also pollute well water.

Some ways to protect families from water pollutants include:

- Test well water yearly for coliform bacteria.
- Buy bottled water for drinking, cooking, washing produce, ice cubes, making baby formula or brushing teeth instead of using contaminated water.
- Make sure that water comes from a known safe source such as a public supply, a tested private supply, or bottled water.

For more information about water concerns contact:

- EPA Safe Drinking Water Hotline: 1-800-426-4791 or www.epa.gov/safewater
- EPA Children's Environmental Hotline: Toll free: 1-877-590-KIDS (1-877-590-5437)
- Vermont Department of Health Environmental Health Hotline: 1-800-439-8550 extension 5
- Vermont Department of Health Laboratory: 1-800-660-9997 (they can test the water)
- Vermont Department of Environmental Conservation, Water Supply Division (for public water system questions): 1-800-823-6500

Second Hand Smoke: More than ten million children under the age of five are exposed to cigarette smoke in their homes. Children who live with smokers inhale many of the pollutants known to cause cancer: Infants and children who breathe tobacco smoke are more likely to:

- Develop asthma and have more asthma attacks
- Have allergies
- Have increased risk of Sudden Infant Death Syndrome
- Have more ear infections

Children should not be exposed to smoke in their own homes and should not ride in cars with smokers.

For more information about the effects of second hand smoke contact:

- Vermont Department of Health Environmental Health Program: 1-800-439-8550 extension 5
- American Lung Association of Vermont: 1-800-586-4872
- Healthy Homes: (608) 262-0024 or //www.uwex.edu/homeasyst
- EPA Indoor Air Quality Information Clearinghouse: 1-800-438-4318 or http://www.epa.gov/iaq/
- US Consumer Product Safety Commission: 1-800-638-CPSC (1-800-638-2772)

One of the most positive actions that parents can take on behalf of their children's health and wellbeing is to stop smoking. Help with adult smoking cessation is available as follows:

Telephone Quit Line is a statewide toll-free number where callers can learn about a variety of quit options. Call 1-877-YES-QUIT (1-877-937-7848).

Cessation Classes are available through most local hospitals. Call any hospital to ask about these free stop smoking classes.

Quit Help on the Internet is available from the American Lung Association. *Freedom From Smoking Online* offers free smoking cessation support online. Find it on the Internet at www.lungusa.org/ffs/index.html

Neighborhood Safety

Every child deserves to live in a community where he or she feels safe and secure from violent crime. Violent neighborhoods hold victims, families and friends hostage. Violence has many contributing factors. Some are immediate (e.g., easy availability of a weapon, a situation in which an aggressor thinks violence brings quick rewards, or anger that sees no other outlet.) Some are less direct, such as community tolerance of high violence levels, reinforced by news and the entertainment industry or media.

Research shows that there is less crime where communities are working together to become and stay healthy. An excellent source of ideas for maintaining family and community safety is:

- *The National Crime Prevention Council (NCPC)* at ncpc.org/ncpc/.

Here are some tips to building and maintaining safe neighborhoods, adapted from the NCPC publication, "Making Children, Families and Communities Safer from Violence," available at the NCPC website address above, or by calling 1-800-WE-PREVENT (1-800-937-7383):

- Get to know your neighbors including the children in your neighborhood.
- Start, join, or reactivate a Neighborhood Watch or Block Watch. Publicize ways neighbors can watch out for situations that might threaten children with violence.
- Work together to establish safe conditions in your neighborhood. With a group of neighbors, scan streets, yards, alleys, playgrounds, ball fields, and other areas. Ask the police department for pointers or other helpful strategies.
- Talk with other adults in the neighborhood about handling fights among children. Who should step in? How? Under what conditions? Make sure the children know that adults are prepared to help stop any form of violence.

- Share information on basic child protection. Help each other learn about signs of drug abuse and gangs, along with where to find help in your community to address these problems.
- Agree on what a "trusted adult" will do for children in the neighborhood during troubling situations – being threatened, finding a gun or drugs, being approached by a stranger.
- Know where and how to report potentially violent situations in your community, or conditions that encourage violence. Ask your police department for help in identifying what to report, when, to whom, and how.
- If you see a crime or something you suspect might be a crime, report it. Agree to testify if needed.
- Learn about hotlines, crisis centers, and other help available to victims. Find out how you can help those who are victims, or are exposed to violence.

For more information about what can be done to prevent and reduce the potential for neighborhood violence contact:

- The Vermont Center for Crime Victim Services. Provides information and referrals to statewide victim services. Call 1-800-750-1213.

Hotline Numbers:

- "911" for immediate assistance.
- Domestic Violence Hotline: 1-800-228-7395
- Sexual Violence Hotline: 1-800-489-7273
- Reporting Child Abuse/Neglect: 1-800-649-5285
- Vermont Police Departments: See local listings and post the number near phones.

CHAPTER 3
FAMILIES IN TRANSITION

Introduction

Nearly all children in our society experience significant transitions by the time they reach elementary school. Some of the most common ones are generally cause for celebration: a new sibling joins the family, the family relocates for better work opportunities or a young child begins preschool. Other transitions are the result of difficult circumstances: parents separate and divorce, or a child is taken from his family and must enter foster care due to neglect or abuse. Families may make a major life change, such as immigrating to the United States, where everything is new and strange, or parents with children remarry and set about creating a blended family.

Transitions always involve loss, whether it is the loss of a significant person in the child's life, loss of familiar surroundings and objects, loss of routines, loss of status in the family and/or loss of predictability. Even the most positive transitions involve a period of adjustment. There is a great deal of individual variation in how young children react and adjust to changes. These individual differences are guided by a number of factors, including the child's temperament, developmental age, the nature of the change, the quality and quantity of supports available to the child and family, and the reactions to the change by the child's primary caregivers. Infants or young children may show signs of the stress of transitions in different ways, such as changes in

- mood (irritability, lethargy, anger)
- health (physical complaints, aches)
- behaviors (hitting, biting, changes in eating and sleeping patterns, soiling/wetting, reverting to “baby-talk”)
- interactions with caregivers (clinging, withdrawal, alternating between clinging and pulling away)

For some infants and young children, this transition time is brief, and soon the child settles into a new routine, family configuration and/or surroundings. For others, a transition such as entering a new child care setting might upset the child's sense of equilibrium for a period of time. While transitions are challenging experiences, they also can be opportunities for children to learn mastery, flexibility and adaptation.

It is important that parents, child care providers and others be aware of the impact of transitions on children. The way infants and young children experience change is different from how it affects adults due to developmental differences. Adults can help prepare children for the physical and emotional upheaval of upcoming changes in their lives. Understanding that it is normal for infants and young children to have grief reactions when faced with transitions or losses will help all involved to respond thoughtfully and beneficially to the child, rather than blaming or punishing the child for disagreeable behaviors.

This chapter covers a number of transitions that infants and young children may experience that call for special attention to help them adjust to change in healthy, positive ways. These include:

- Separation/divorce
- Blending of families (step-families)
- Joining a new adoptive or foster family
- Birth or adoption of a sibling
- Relocation/moving
- Starting day care or school

Chapter 10, *Families in Crisis or Experiencing Severe Stress* also deals with transitions and adjustments, but of a more catastrophic nature.

Parent Separation/Divorce

When the relationship between two parents unravels, infants and young children respond to the emotional climate this creates. Even before an actual separation occurs, they sense the tension within the family, notice changes in availability and other behaviors of each parent, and possibly witness physical and/or verbal fights. Infants and young children are, by nature, egocentric and tend to engage in “magical thinking.” They reason that they make things happen simply by imagining or wishing for them. They do not understand that adults have motives and agendas outside of their children. When tensions, fights, and absences occur, young children may "reason" that they caused these “bad things” to come about.

Separation and divorce often results in a period of instability on all fronts. Once the parents actually separate, infants and young children feel the loss of familiar routines. New schedules are initiated and, over time, frequently reorganized by the adults, such as moving the infant or young child back and forth between two houses. This is highly stressful for young children who may now have two bedrooms and two places in which to keep cherished objects, toys, games, clothing, books and the like. Belongings can be left behind or lost in the process of pickups and deliveries of the child.

The relationship between the separating/divorcing parents may disintegrate to a point where there is no, or only angry, communication between the adults. Or one parent may completely disappear from the child’s life. In cases of violence, the mother may escape with her children to a temporary shelter or safe home with uncertainty about the family’s future.

Finances which previously were shared are now stretched. One or both parents may be in a state of distress and depression, thereby compromising their emotional availability to the child. A parent who was the primary caregiver may now need to go to work and place the child in day care, creating a period of adjustment for both parent and child.

Particularly stressful for infants and young children are the spoken and unspoken expressions of anger, blame, put-downs, and even hatred one or both parents may express about the other one. Young children usually feel connected to and dependent on both parents, even if a parent has mistreated them or the other parent. Sometimes, a parent will communicate to their young child that they are not to care for, talk about, or even think about the other parent. Such messages are painfully confusing to young children.

Infants and young children may begin to exhibit behaviors such as clinginess, aggression or regressions that prompt parents or other caregivers to seek help. It can be particularly challenging to address children's needs when parents are at war with each other, and one or both parents may try to persuade others to side with them. Those who are in a position to consult with and support families must maintain a strong focus on the needs of the children and, as much as possible, maintain neutrality about the parents.

In providing support to children whose parents are in the midst of divorce or separation, the following considerations apply:

- Take into account the developmental stage of children at the time of separation and at present, and consider how to best meet their developmental needs, for example expecting that young children may exhibit sleep problems or be more "fussy" and readily upset for a time.
- Provide developmentally appropriate opportunities for children to express thoughts and feelings about the change in their family through play and art materials, picture books about separation/divorce, dramatic play, dollhouses, animal families.
- Address children's potential misunderstandings of their parents' separation or divorce, including self-blame, fantasies of reunification, and fears of loss of a parent, favorite possessions, siblings, friends, caregiver, etc.
- Assess the safety of the child and take appropriate action if the child is in danger while in the care of either parent.

> "My CUPS Worker was supportive of my decision [to have my husband leave]. She goes, 'You have to stand strong if this is what you are going to do. You do this for yourself and for your kids. If you honestly want him back, I'll support you in that as well.' She was supporting my decision and helping me stay on track as far as what I want for my life and for my kids."

Those working with parents who are separating or divorcing should:

- Stress the importance of parents maintaining respect, or at least neutrality, regarding what is communicated to the child about the other parent, and respect the child's love for both parents.

- Help parents negotiate their arrangements around meeting the child's needs, (e.g., establish a schedule and agree on a system of communication that is least stressful for the child.)
- Maintain one's own neutrality about the parents and their conflict so that the children and their needs remain paramount in planning and decision-making.

If a mental health clinician is asked to consult with a family, he/she needs to clearly delineate their role vis-à-vis the parents. It should be determined at the outset if the clinician is being asked to evaluate a family in order to advise the court about custody. If the role of the clinician is to consult with the parents about what their child needs and how they can best meet these needs, it may take time to establish a relationship in which neither parent feels judged by the clinician. As trust builds, parents and the clinician can work together to establish physical care and avenues of communication that are best for their child. It is always in the best interest of children if parents can avoid a custody battle. If they are able to work with a mediator, this may help them fashion an agreement acceptable to both parents.

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Bondowski, S. (Workbook Edition, 1999). *Tots are non-divorceable: A workbook for divorced parents and their children, ages birth-5.* Chicago: ACTA Publications.

Garrity, C.B. & Baris, M.A. (1994). *Caught in the middle: Protecting the children of high-conflict divorce.* NY: Lexington Books.
Explores how unresolved conflicts between parents impact on children and how to help parents move toward some degree of resolution so that their children are not "caught in the middle."

Kalter N. (1990). *Growing up with divorce: Helping your child avoid immediate and later emotional problems*. NY: Fawcett Columbine.
Guide for parents and those supporting families about how divorce affects children, with a focus on three key factors (stage of the divorce process, child's level of development, and child's gender). Several chapters deal specifically with infants, toddlers and young children.

Ricci, I. (Revised ed. 1997). *Mom's house, dad's house: Making two homes for your child*. NY: Fireside Books.
"How-to" classic for separated, divorced, and remarried parents for setting up strong, working relationships between ex-spouses in order to make two loving homes for the children.

Trout, M. (1999). Video: *Family transitions: Young children speak their minds about divorce.* The Infant-Parent Institute, 328 N. Neil Street, Chicago, IL 61820.
A video collage of voices speaking the poignant words of young children who express their view of divorce and how it affects them. It is designed for use with divorcing parents to help them hear what their infant or young child may be going through.
(217) 352-4060. www.infant-parent.com

Wolf, A. (1998). *Why did you have to get a divorce? and when can I get a hamster?: A guide to parenting through divorce***.** NY: Noonday Press.
Humorous yet practical guide for parenting through divorce; chapters address various aspects of how to talk about divorce.

WRITTEN RESOURCES FOR CHILDREN

Brown, L.K. & Brown, M. (1986). *Dinosaur's divorce.* NY: Little, Brown & Co.
A delightfully illustrated book for preschoolers that covers all aspects of divorce including step-parents and step-siblings. A glossary defines "divorce words" so they make sense to young children.

Ives, S.B. Fassler, D., & Lash, M. (1985). *The divorce workbook: A guide for kids and families.* Burlington, VT: Waterfront Books.
Pictures and words by children who describe what it feels like when parents get divorced. Prompts are provided for children to draw and write, or dictate, their own images and words. Chapter titles: *Marriage, Separation, Divorce, Legal Stuff, Feelings, Helping Yourself.*

Mayle, P. & Robins, A. (1988). *Why are we getting a divorce?* NY: Harmony Books
Focuses on children's feelings; addresses why people get married and what can go wrong; children's common misconceptions about divorce; how to help children accept a new partner in their parent's life; how to adjust to living with one parent and how to deal with the feelings of loss and hurt that often accompany divorce.

Thomas, P. (1998). *My family's changing*. Hauppauge, NY: Barron's Educational Series.
A comprehensive overview for older preschoolers about what happens when parents divorce. Interspersed are questions for the young reader to answer, (e.g., "Do you know any other children whose parents are divorced?")

Blended Families (Step-Families)

Connecting with a new spouse or partner can be a joyful experience for a parent; however, the adjustment for some children can be difficult. The child may experience conflicted feelings of loyalty, competition for love and attention, and fears of no longer being special to his parent. Creating a new family with children from one or both adults presents particular challenges:

- Blended families are rooted in loss; children and adults need to be allowed to grieve.
- The creation of a blended family often means there is no time for the couple to bond as a couple without children.
- External pressure may build as some relatives and friends express skepticism about the new partnership and whether it will (or should) survive.
- One or both parents may carry unresolved grief or guilt about the divorce, recoupling, spending money on someone else's children, etc.
- The "other" parent is an ever-present reality.
- A single parent and child(ren) may have a close relationship and well-developed routines; the step-parent may feel like an outsider, intruding upon his or her new partner's family.
- A blended family means changes of status and roles within the family which can create stress and confusion (such as an upset in birth order for a previously "oldest" child.)

- The child may experience changes in her parent that, even when positive, can be disconcerting and confusing.
- The child must adjust to the habits, idiosyncrasies and needs of a new adult.
- The child who lives primarily with his other parent may feel like a visitor or intruder when spending time with the blended family.
- Some children, even very young children, may feel the need to comfort and meet the emotional needs of the parent who hasn't repartnered, or they may absorb sad, angry or resentful feelings of this parent toward the repartnered ex-spouse.
- Because young children often imagine that their parents will reunite, they may view the introduction of a step-parent as a threat to this fantasy.

As two repartnered adults come to share parenting, there may emerge different beliefs and practices about behavioral expectations for children, how adults and children should treat each other, and how to discipline children. If difficulties arise, families may find value in seeking outside help to effectively address these issues.

Particularly challenging in blended families is the emergence of a new adult as one who sets limits, enforces rules, and gives consequences. Many parents feel that it is important for their children to accept and regard the new parent as equal in their status as parent. This sometimes occurs when a single mother who repartners hopes that a new father will step in and “make her child(ren) behave.” However, step-parents lack a history of nurturing the children, an important prerequisite for the mutual trust, respect, and love necessary for effective parenting. Taking on a new parenting role in a pre-existing family is best done gradually, enabling step-parents and children to spend time getting to know each other, and building mutual trust and respect, before moving the new partner into an active parenting role.

A blended family can become a laboratory for learning new skills and provide opportunities to observe a new model of commitment, respect and support in a marriage and family. Blending two families has many challenges, and rarely occurs without a period of adjustment that is stressful to all involved. However, there is also great potential to enrich and enhance children's lives, including

- An expanded circle of love and support, especially as step-siblings come to regard each other as friends and allies
- Exposure to diverse experiences, interests and skills
- Creation of new rituals that define and celebrate the blended family
- Acquisition of survival skills, flexibility, and the ability to adapt

Sometimes young children who have experienced parental separation, divorce and/or parent repartnering benefit from the opportunity to meet with someone who is completely removed from the family. This might be a child therapist, an early child care or education provider or other family support person. The most natural vehicle for helping children express their feelings is through expressive materials such as dramatic play, dancing, art, dolls and doll house play, animal families, and puppets, as well as

picture books about separation/divorce and blended families. Through observing children's actions and expressions, a trained outside helper can validate their feelings, correct misinformation and, when appropriate, help parents understand what their children are thinking and feeling. Play materials can also be used for family sessions in which other family members communicate through art/play/dance among themselves and with young children. Using the language of play helps children to feel included in the conversation and reinforces that the adults in their lives truly care about their thoughts and feelings.

It is important to remember that a successful and satisfying blended family is not an automatic benefit of two adults joining together. Reaching this stage takes a lot of hard work; a blended family grows and strengthens over time. It typically takes at least several years before a blended family is stable. With mutual respect, ongoing communication, a willingness to try new approaches, shared humor, and lots of patience, blended families can be nurturing seedbeds in which children thrive.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Burns, C. (Revised, 2001). *Stepmotherhood: How to survive without feeling frustrated, left out, or wicked*. NY: Three Rivers Press.
An amusing, helpful book that looks beyond the maligned image of the wicked stepmother to understand the dynamics and conflicts that stepmothers face. The author helps stepmothers navigate through these inevitable challenges.

Pickhardt, C.E. (1997). *Keys to successful stepfathering*. Hauppauage, NY: Barrons Educational Series.
Common sense advice to stepfathers on practicing tolerance, making compromises and maintaining a healthy marriage.

Wisdom, S. & Green, J. (2002). *Stepcoupling: Creating and sustaining a strong marriage in today's blended family*. NY: Three Rivers Press.
Tips, strategies and advice from real-life step-couples on dealing with the issues remarried couples face.

(Also see Resources under "Parent Separation/Divorce" in this chapter)

ORGANIZATIONS AND WEBSITES

Stepfamily Association of America provides a great deal of practical information about stepfamilies, resources and links.
www.saafamilies.org

Stepfamily in Formation is "a research-based educational site to help co-parents (bio-parents and step-parents) build high-nurturing relationships and families by learning key life skills and concepts and avoiding or healing the roots of divorce."
www.stepfamilyinfo.org

Stepfamily Seattle provides a helpful bibliography with descriptions of books on divorce, parenting, for kids, stepfamilies, stepmothers, and stepfathers.
www.stepfamilyseattle.com

Joining a Family through Foster Care or Adoption

Infants or young children who join families through adoption or foster care bring with them their own personal histories. Children enter the world with their own unique stories, which includes the *in utero* and birth experience, their birth parents and everything they experience prior to arrival in their adoptive or foster families. Even newborns who leave the hospital nursery with adoptive or foster parents experience certain losses. An important part of assuring healthy development over time is understanding children's losses and the importance of preserving their history and heritage.

Today there are many different kinds of adoption and foster care, including international adoptions, privately arranged adoptions, open adoptions, older or special needs adoptions, kinship care, therapeutic foster care, and others. Each way of joining a family involves a unique set of considerations. For example, in an open adoption the inclusion of birth parent(s) in the child's life needs to be carefully thought out. With therapeutic foster care, which is provided for children with serious behavioral and emotional/social needs, foster parents participate in specialized training and receive ongoing support from a social worker, which can at times seem intrusive.

International adoptions involve a tremendous transition from one culture into another, perhaps from living in an orphanage or large family to living in a single-family home with two adults, or a single parent and one or two other children. There are immense adjustments to experiencing a new language, sights, sounds, smells, tastes, textures, level of physical contact, and climate. American-based adoptions sometimes involve a geographical relocation for the child, moving to a part of the country where people talk differently and the natural world looks, sounds and smells different.

Even if a child had lived across the street, living with a new family would be a major adjustment. It is important that the child's new family, and all those supporting the child and family, honor and respect the child's ethnic, religious, and cultural heritage. This should include learning about the child's original culture (foods, holidays, customs, language) and folding these into the family's practices.

During the first several months of joining a new family the highest priority is the process of building attachment between a child and her adoptive or foster parents. This can seem like an all-consuming, immensely challenging task, especially in the case of an older infant or young child who did not experience a previous secure attachment to a caregiver. Those supporting the family will need to help parents focus on this task and provide extra support along the way. In some cases, it may be helpful to consult or work with a trained attachment therapist. The investment of securing this primary attachment will become the bedrock of the child's subsequent development and the parents' feelings about their child.

Before an infant or young child joins a family via adoption or foster care, preparation with the parents will help facilitate a smoother coming together. A family support person

might explore with the family how to prepare, physically and emotionally for the child in some of the following ways:

- Make available as much information as possible about the child to foster/adoptive parents.
- Facilitate candid discussion about expectations, fears, hopes and dreams about the child.
- Connect the family with other foster/adoptive families.
- Anticipate the frustrations and challenges of foster or adoptive parenting and how to get support when these arise.
- Plan for changes in routines, how to meet the demands of the child and reactions of other children in the family.
- Provide as much continuity for the child as possible, such as using the same laundry detergent (smell), encouraging the use of cherished objects (stuffed animal, blanket or other possessions to which the child has a strong connection), providing familiar foods, music, pictures and routines.

Children who join a family via adoption or foster care may carry with them the baggage of prior experiences such as witnessing domestic violence, victimization or trauma (e.g., physical or sexual abuse, war, evacuation, loss of primary caregivers), physical, medical or emotional neglect, psychological abuse, living with a substance abusing parent or a parent in need of mental health services. The child may have lived in poverty, and without health care, proper nutrition or adequate housing. Adopted and foster children sometimes need much more than love and attention. Their new families might be tested, and rewarded, in ways they never imagined.

Both adoptive and foster children benefit from having as much of their past preserved as possible including objects, photos, letters and drawings. A “Life Book” can be created to stay with the child and be added to over time. In the Life Book are such items as copies of the birth certificate, photographs of people and places in the child's life (including a photo of where the child was born), a lock of baby hair, and letters from anyone who has known the infant or young child. For example, a social worker might write about what the child likes to do, and his favorite foods, toys and picture books. These letters might describe the child's strengths, early personality traits, and what the writer liked about the child.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Adoptive Families, a magazine for families before, during and after adoption. Subscription Service 1-800-372-3300. www.adoptivefamilies.com

Best, M.H. (1998). *Toddler adoption: The weaver's craft*. Indianapolis, IN: Perspectives Press.
Focuses on parenting adopted children from one to three years of age; discusses both the joys of toddler adoption and the many challenges.

Fostering Families Today, a magazine "for all persons committed to services and permanency for children – including foster and adoptive parents and all professionals who work on their behalf."
Toll free: 1-888-924-6736. www.fosteringfamiliestoday.com

Houle, S.G. (1999). *When do I go home? Intervention strategies for foster parents and helping professionals.* Washington, DC: Child Welfare League of America
Practical suggestions for how to help foster children adjust to their new homes.

Hughes, D.A.. (1999). *Building the bonds of attachment: Awakening love in deeply troubled children*. Northvale, NJ: Jason Aronson.
Follows the story of an emotionally troubled young child in foster care. She and her foster mother participate in attachment therapy that demonstrates the possibility of transformative intervention.

O'Malley, B. (2000). *LifeBooks: Creating a treasure for the adopted child*. Winthrop, MA: Adoption-Works.
Describes the process of making an adoption "life book" (different from a scrapbook or baby book).

Melina, L. (Revised Edition, 1998). *Raising adopted children: Practical reassuring advice for every adoptive parent.* NY: HarperCollins.
Updated "Dr. Spock for adoptive parents." Covers open adoption, international adoption, trans-racial adoption, bonding and attachment, dealing with schools, privacy issues, adopting a child with disabilities, adopting as a single parent.

WRITTEN RESOURCES FOR CHILDREN

Cole, J. and Chambliss, M. (Revised, 1999). *How I was adopted: Samantha's story.* NY: HarperCollins.
Explains adoption and how it happens; ages 2-5.

Koehler, P. (Reprinted, 1997). *The day we met you*. NY: Simon Schuster.
A picture book about one family's homecoming; ages 2-5

Livingston, C. & Robins, A. (20th Anniversary Edition, 1997). *Why was I adopted?* NY: Carol Pub Group.
A classic for parents to help their child understand the circumstances of their "birth" into an adoptive family.

Pellegrini, N. (1991). *Families are different.* NY: Holiday House.
Presents a variety of multi-ethnic families; explains that all families are held together by special glue called "love."

Zick, M. (2001). *The best single mom in the world: How I was adopted*. Morton Grove, IL: Albert Whitman & Co.
An international adoption story told by parent and child with brightly colored illustrations.

ORGANIZATIONS, AGENCIES AND WEBSITES

Adoption.com provides an array of resources and links, including Education Center (with factsheets), newsletters, research, and discussion groups.
www.adoption.com

National Adoption Information Clearinghouse, a comprehensive website for all aspects of adoption including many helpful fact sheets, such as "Creating a Family Through Birth and Adoption," "Foster Care and Adoption for Waiting Children," "Foster Parent Adoption," "Gay and Lesbian Adoption," "Explaining Adoption to Your Children, Family, and Friends," and "Single Parent Adoption."
www.calib.com/naic/

PACT is an adoption alliance focused on adoption and race. Website has many resources for all parties in the adoption triad (birth parents, adoptive family, and child).
www.pactadopt.org

Vermont Foster and Adoptive Family Partnership (FAPTP) is a collaborative project between the University of Vermont, Department of Social Work and the Vermont Department of Social and Rehabilitation Services (SRS). It provides regular training to foster parents throughout Vermont, pre-adoption training to foster parents and others preparing to adopt, and is a sponsor of the annual fall and spring conferences sponsored by the Vermont Foster and Adoptive Families Association (VFAFA).
(802) 657-3301. www.uvm.edu/~socwork/childwelfare/foster

The Vermont Adoption Consortium is a group of agencies working together to improve access to services and supports for all adoptive families in Vermont. Services include counseling, information and referral, advocacy, support, discussion groups, educational resources, linkage to respite services, and intensive supports where needed. Member agencies:

- Adoption Advocates, Shelburne: (802) 985-8289
- Casey Family Services, White River Jct.: 1-800-607-1400, Waterbury: 1-800-244-1408
- Easter Seals of Vermont, Berlin, Toll free: 1-888-372-2636
- Northeast Kingdom Human Services - Futures Unlimited, St. Johnsbury and Newport: 1-800-649-0118
- Vermont Children's Aid Society, Winooski: 1-800-479-0015, Woodstock: (802) 457-3084
- Vermont Department of Social and Rehabilitation Services (SRS) Adoption Coordinator, Waterbury: (802) 241-2131

See *Appendix I* for additional relevant Vermont organizations and websites.

Birth or Adoption of a Sibling

The arrival of a sibling is the first major adjustment in many children's young lives. It is a significant adjustment for the parents as well. Pre-arrival conversations and picture books are a great help, but for the young child about to become "big sister" or "big brother" there is nothing in their experience to truly prepare them to share Mommy, Daddy, relatives and friends, their home, time, space and toys. Sensitivity, modeling, and patience from others will help older siblings adjust to their new role within the family and all the other changes that accompany the arrival of another family member.

While parents may imagine their children living in harmony and feeling close to one another, this may or may not come to pass. Most siblings do, in fact, come to feel proud and protective of their siblings but they may not always feel or act as if this is the case. It may be helpful to explore with parents awaiting the arrival (through birth or adoption) of another child the sibling-related hopes and beliefs they have. This may help parents to distinguish their dreams from realistic expectations regarding sibling relations.

Several factors contribute to how young children respond to a new addition to the family: their developmental stage at time of arrival, the gender of each child, and the specific circumstances under which the child arrives. For example, two year olds may demand a lot of attention and supervision, not only because of the presence of a new child, but because they are going through a developmental need to establish autonomy by pushing/pulling away from their parents. Five year olds, on the other hand, might exhibit pseudo-parenting behaviors. One of the best ways to help older siblings prepare for and work through their feelings about the change in the family is with a baby doll, ideally one that looks like a real baby and can wear newborn clothing. Providing opportunities for the child to mimic nurturing behaviors with their own baby helps them to master this new experience.

Those who support families may have opportunities to help parents and young children talk about and prepare for the arrival of a sibling. Parents can be encouraged to plan ways they can continue to spend time with the older sibling after the arrival of the second child. Parents should be reassured that it is not unusual for older siblings, once they realize the new addition to the family is not going away, to express a wish to get rid of the baby. It is important to accept these expressions for what they are - a longing to have things the way they used to be - and not to punish or belittle the children for expressing themselves, though of course they must not be allowed to do anything that harms the baby, themselves or others. It is helpful for parents to remember to give frequent positive attention and individual time to the older child, and ensure that visitors to the home do not ignore the older child as they admire and play with the new baby or young child who has joined the family.

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Faber, A. & Mazlish, E. (1987). *Siblings without rivalry.* NY: W.W. Norton & Co.
Practical guide for responding to sibling conflicts and building strong family bonds.

Johnston, P.I. (1998). “Sibling Attachment” fact sheet addresses issues related to birth as well as adopted siblings, including multi-racial families.
www/pactadopt.org/press/articles

Mister Rogers’ Neighborhood Adoption Programs (1985). Available through Adoptive Families of America, 2309 Como Avenue, St. Paul, MN 55108, 1-800-372-3300.
Two 30-minute shows anticipating the arrival of the Jones’ newly adopted baby; Fred Rogers tells how he became a brother when his parents adopted a sister.

Smith, D. (1996). “Creating a Family by Birth and Adoption” fact sheet covers such topics as raising birth and adopted children together, sibling rivalry, and resources.
www.adoptions.com/aecbirthandadopt

WRITTEN RESOURCES FOR CHILDREN

Greenfield, E. & Steptoe, J. (1974). *She came bringing me that little baby girl.* NY: HarperCollins.
A young boy now has a baby sister; feelings of jealousy become transformed as he learns about becoming a big brother.

Lansky, V. and Prince, J. (1991). *A new baby at koko bear's house.* Minnetonka, MN: Book Peddlers Press.
Koko bear moves through the experience of mother's pregnancy, birth and homecoming of a sibling.

Little, J. and Plecas, J. (2001). *Emma's yucky brother.* NY: HarperCollins.
Describes Emma's mixed emotions about the arrival of her 4 year-old adopted brother.

Ormerad, J. (1987). *101 things to do with a baby.* NY: William Morrow & Co.
A six-year old tells 101 things she can do with her baby brother.

Relocation

Moving from one house to another and from one neighborhood to another can be a time of increased stress for both parents and children. For parents, there are innumerable details to tend to at both the place being left and the new home. For infants and young children, it is a time of upheaval and confusion. Young children cannot fully comprehend what it means to move. Many of their emotions about the move will mirror the feelings of the significant people in their lives.

Several factors contribute to how a young child handles a move:

- Current developmental stage,
- Temperament and personality
- The reason for the move, and how the parent(s) present it
- How the move is carried out

Infants and very young children will not understand the concept of moving, but they will react to changes in routine, loss of parental attention and the general emotional "temperature" in the household. Once settled into a new house and new room, they may experience disorientation and need reassurance until the new surroundings become familiar to them. Much of their knowledge about the move will be related to sensory input, such as hearing new house and neighborhood sounds that adults may not even notice. However, even quite young children will remember their former home and may mourn the loss of familiar sights and sounds for a period of time.

Older toddlers and young children can benefit from reading and discussing picture books about moving, participating in preparations for the move and opportunities to say "goodbye" to people and places they care about. Parents may need help understanding that infants and young children can grieve after the move and feel a sense of loss. This loss is further deepened if children are leaving caregivers to whom they are attached.

When a move is sudden and there is no one to help them express feelings, young children may become very sad about their loss. This may show up in increased irritability, clinginess, lethargy, aggressive and/or regressive behaviors. It is important that these behavioral expressions of sadness not be punished or criticized, but responded to with understanding and compassion.

Infants and young children who tend to seek out novel experiences and not be very routine-bound may find moves interesting and exciting. Infants and young children who tend to be cautious in new situations and are more comfortable with predictable routines will probably take longer to adjust. Whatever a child's style of interacting with the world, it will likely be in evidence during the move.

If the move is a positive one to which parents are looking forward, the stress of moving will be countered by the anticipation of its benefits. However, if the move is necessitated by unhappy events, young children will naturally absorb some of the negative emotions felt by the adults around them. The spirit in which adults plan for the move and present it will affect how well young children manage this transition.

Older toddlers and preschoolers should be encouraged to express their thoughts and feelings about moving through play, art, and other expressive activities. By using play figures, dollhouses, vehicles and props (such as cardboard packing boxes) to represent packing and unpacking, young children benefit from playing out the activities involved in moving. An adult might help a young child create her own "Moving Book" in which she draws pictures and attaches photographs of her old and new homes, friends and neighborhoods and dictates the story of the move.

Another aspect of moving that affects young children is the loss of a friend who moves away. When a young child exhibits a change in mood or behavior adults should explore if there has been a loss of a playmate or caregiver/teacher in his child care setting or preschool. Because of the young child's lack of experience with moving and fledgling coping skills, he may have difficulty comprehending this loss and expressing thoughts and feelings about it.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Oesterreich, L. (1996). *Understanding children: Moving to a new home.* Iowa State University Extension Office. Pm 1529g
www.extension.iastate.edu/pubs/fa.htm

WRITTEN RESOURCES FOR CHILDREN

Asch, F. (1986). *Goodbye house.* Englewood, NJ: Prentiss Hall.
Baby bear says goodbye to each room in his now empty house, remembering all the good things about each room to keep with him forever.

Berenstain, S. & Berenstain, J. (1981). *The berenstain bear's moving day.* NY: Random House.
Berenstain bear family moves into their treehouse; explores Brother Bear's feelings.

WRITTEN RESOURCES FOR CHILDREN *(CONTINUED)*

Carlstrom, N. & Wickstrom, T. (1999). *I'm not moving, mama.* NY: Aladdin Library.
When Little Mouse refuses to leave his room on moving day, Mama Mouse responds calmly and positively helping him talk about his feelings.

McGeorge, C.W. & Whyte, M. (1994). *Boomer's big day.* NY: Chronicle Books.
On moving day the family is too busy to notice golden retriever, Boomer's, anxiety about his missing ball.

Viorst, J. (1995). *Alexander, who's not (do you hear me? I mean it!) going to move.* NY: Atheneum Books.
Alexander is adamant about not leaving his house, friends, and neighborhood, but eventually softens after his parents reassure him.

Waber, B. (1991). *Ira says goodbye.* Boston, MA: Houghton Mifflin.
Ira has many feelings about his best friend Reggie moving away.

VIDEO RESOURCE FOR FAMILIES

Murphy, J. & Tucker, K. (1990). *Let's get a move on! A kid's video guide to a family move.* Newton, MA: Kidvidz. 25 min.
Video designed to help children ages 4-10 survive the impact of moving, saying goodbye and meeting new people; covers hearing the news about a move, getting ready to move, the actual move, and adjusting to a new home and friends.

Starting Child Care or School

Starting child care or school can be one of the most significant passages in a young child's life, both for the child and for the parents. Some infants begin child care at six weeks of age, others at three months, and still others at later stages during infant and early childhood years. Whenever it occurs, this passage marks the end of that time when the parents fully control how the child is cared for, what the child is exposed to, and how the child is disciplined. It is the beginning of sharing their child with others and, in a sense, with the world. Parents may need to negotiate with others differences in philosophy and practices of child rearing, including physical care, responsiveness to the child's demands, how to discipline, and exposure to popular culture. Sometimes the adjustment to non-familial care of an infant or young child is greater for the parents than for the child. Parents may feel guilty about leaving their child in another's care, anxious about returning to work, worried about the quality of child care and sad about losing a certain closeness with their child.

A foundation of trust between parents and care providers is essential, but necessarily takes time and effort. Sometimes parents feel jealous toward the caregiver whom their child will come to love and depend on. The relationship between the child and care provider or teacher may, at times, threaten a parent's sense of importance in the child's life. Sensitive providers understand this possibility and will spend time getting to know the parents and communicate to them that parents are the most important people in children's lives. The collaborative spirit between care providers or teachers and parents directly affects children's adjustment to their new environment.

When considering care for their infant/young child, parents will think about issues such as whether to seek in-home care, kinship care, registered home care or center care. Regional child care resource referral organizations, state licensing offices, and local elementary schools can help parents locate child care providers and early childhood programs. Parents may need support in finding quality care and learning how to assess a program or care giver's services. These decisions can be particularly daunting for first-time parents as they begin to explore resources within the community. When quality care is not readily available, parents feel increased stress about their child's wellbeing. The child may be moved in and out of care environments because of concern about quality of care. This increases the level of stress for both parents and young children.

The young child starting child care or preschool has many adjustments to make including

- Separation from parents and transfer of trust to new adults
- Learning the behavioral expectations and culture of a new environment, some of which will differ from home
- Abiding by limits set by new adults
- Learning to share adults, toys, and space with other children
- Getting used to strange sounds, sights, smells, tastes, textures
- Exposure to germs and childhood diseases
- Changes in sleeping, eating and elimination situations

Individual temperament will greatly affect how each infant/young child adjusts to starting or changing child care or preschool. Those infants and young children who thrive on novelty and change may find great pleasure in exploring new environments. Infants and young children who are more cautious in approaching new situations will take longer to adjust. It is important to not judge the style of adjustment but to understand there is a wide variation in how infants/young children (and also parents) adapt to new situations.

During the initial adjustment to a new environment, an infant or young child may exhibit regressive behaviors, clinginess, withdrawal or aggressive behaviors. Usually these behaviors are transitional while everyone settles into the new situation of shared care. Parents can be helped to understand the possibility of a period of adjustment that might include such reactions as irregular sleep patterns, more crying than usual, and feelings of being overwhelmed - and that most children eventually settle down and adapt well to their new situation.

When three to five-year olds have their first experience of starting preschool or going to a child care center, they, too, will experience an adjustment to being in a group program and accepting guidance and authority from other adults. These children may go through a time of regression, anxiety and increased fearfulness - all of which is developmentally normal. The child starting a new school or care program is very much like an adult starting a new job: filled with a multitude of feelings, working hard to learn the ropes, and exhausted at the end of the day.

Most children are social beings by nature. Once they have settled into their preschool, they will enjoy the challenges, social opportunities, and fun of being in a group setting. Parents can be encouraged to participate in their child's program, to share their skills and time, and get to know the other children and parents.

Unfortunately, some early care/education situations do not fit the needs of a particular family. Parents may need help assessing the appropriateness of their care situation and how to proceed. Sometimes it is helpful for an outsider to observe the child in their care/education program. When a child's adjustment is not successful or there are persistent and concerning patterns of behavior, these may be red flags that there are underlying issues with the child beyond normal adjustment, or there are problems with the care provider or the program. A child's participation in a child care or preschool environment may provide an opportunity for a team of observers (parents, providers, teachers, consultants) to begin a discovery process if there are concerns about the child's adjustment or development.

The key to successful child care and education experiences is mutual trust and respect between parents and providers. Ideally, parents and providers work in partnership to provide the very best developmentally appropriate care for each child. Sometimes parents and/or providers need help with noticing and appreciating the other's expertise and intentions. A family support person may help to build and reinforce mutual understanding, respect, and appreciation between parents and providers.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES FOR ADULTS

Balaban, N. (1985). *Starting school: From separation to independence*. NY: Teachers College Press. Covers a full range of topics about children beginning an early childhood program or kindergarten; concludes with an extensive annotated bibliography of books for children, parents and teachers.

Vermont Early Childhood Work Group has published pamphlets for parents including

- *Off to kindergarten: A booklet for parents, caregivers, and schools* (Revised, 2001).
- *Moving on up: Transition to kindergarten for young children with special needs* (2003).

Available from Vermont Department of Education.
(802) 828-5115. www.ahs.state.vt.us/earlychildhood

WRITTEN RESOURCES FOR CHILDREN

Appelt, K. & Dyer, J. (2000). *Oh my baby, little one.* NY: Harcourt Children's Books.
Baby Bird and Mother must say goodbye each day when he goes to day care and she to work, but first she assures him that her love is always with him; very helpful book for very young children in child care and their parents.

Kantrowitz, M. & Parker, N.W. (1989, reprint). *Willy bear.* NY: MacMillan.
Willy Bear talks to his teddy bear reassuringly about going to his first day of nursery school, what to expect, and, in the end, assuring himself.

Tompert, A. & Kramer, R. (1992 reprint). *Will you come back for me?* Albert Whitman and Co.
Suki misses her mother while at day care; this book explores the fears of separation young children experience and how they cope.

VERMONT RESOURCES

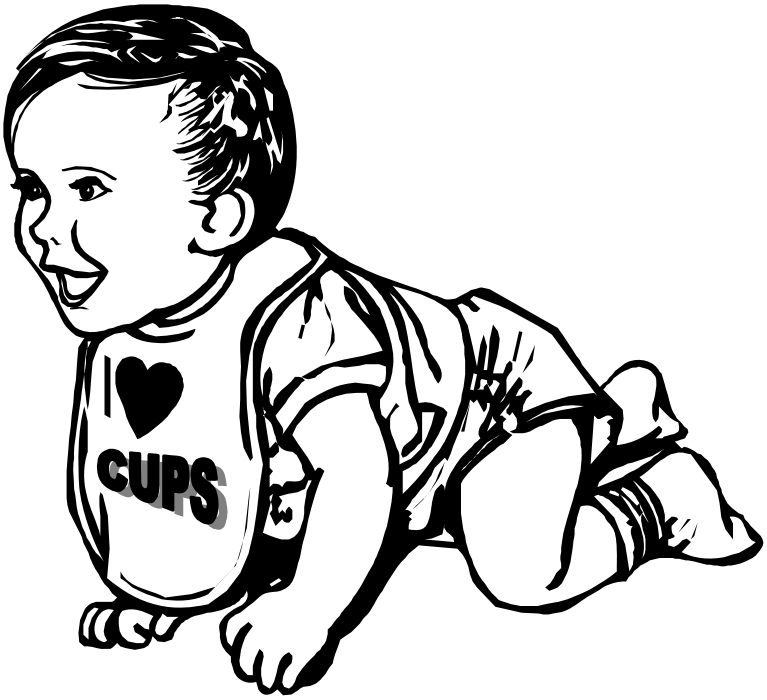
Vermont Association of Child Care Resource and Referral Agencies (VACCRRA) "is a statewide network of non-profit agencies who share a common commitment to the development and support of quality child care options for Vermont children and their families." Provides information about local child care options, access to Vermont Child Care Subsidy Program and other sources for financial aid, and education about how to choose child care/early education programs; also provides start-up training and assistance, individual consultation, information about professional development, and lending-resources libraries of equipment, toys and materials.
Toll free: 1-877-VACCRRA (1-877-822-2772), www.vermontchildcare.org, or see *Appendix I* for list of local offices.

Vermont Association for the Education of Young Children advocates for quality childcare and education, provides training opportunities for early care/education providers, and collaborates with local, state and national organizations.
www.vaeyc.org

See *Appendix I* for additional relevant Vermont organizations and websites.

PART TWO

SPECIALIZED ASSESSMENT AND EARLY INTERVENTION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CHAPTER 4
EARLY DEVELOPMENT, DEVELOPMENTAL DIFFERENCES AND DELAYS

Early Development

We have long known that children's experiences and environment in their early months and years lay a foundation for future development. Recent research has provided significant new information on very early development. According to the landmark publication, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Shonkoff & Phillips, (Eds.), 2000), two major changes have taken place that affect what we know about how to meet the needs of very young children and their families. First is the tremendous gain in knowledge that has occurred in recent years regarding what influences child development. Second is the high proportion of families with very young children facing economic hardship and social pressures that impinge on child and family development.

In this book, Shonkoff and Phillips list the following research-based findings on very early development (p. 393):

- "The importance of *early life experiences*, as well as the inseparable and highly interactive influences of genetics and environment, on the development of the brain and the unfolding of human behavior.
- The central role of *early relationships* as a source of either support and adaptation or risk and dysfunction.
- The powerful *capabilities*, *complex emotions* and *essential social skills* that develop during the earliest years of life.
- The capacity to increase the odds of favorable developmental outcomes through *planned intervention*."

These findings have wide-ranging implications for how we view early childhood development and the importance of early interventions on children's future development. Shonkoff and Phillips provide important guidance for the early childhood field by reporting that:

- "The traditional 'nature versus nurture' debate is simplistic and scientifically obsolete.
- Early experiences clearly influence brain development, but a disproportionate focus on 'birth to three' begins too late and ends too soon (e.g., it is never too late to intervene and support).
- Early intervention programs can improve the odds for vulnerable young children, but those that work are rarely simple, inexpensive, or easy to implement.
- How young children *feel* is as important as how they *think*, particularly with regard to school readiness [emphasis theirs].
- Healthy early development depends on nurturing and dependable relationships.

- Culture influences all aspects of early development through child-rearing beliefs and practices.
- There is little scientific evidence that special 'stimulation' activities above and beyond normal growth-promoting experiences lead to 'advanced' brain development in infancy.
- Substantial scientific evidence indicates that poor nutrition, specific infections, environmental neurotoxins, drug exposures, and chronic stress can harm the developing brain.
- Significant parent mental health problems (particularly maternal depression), substance abuse, and family violence put heavy developmental burdens on young children."

In addition, the "*I Am Your Child Campaign,"* a national, non-profit public awareness effort that comes out of the need to interpret the brain research information that flooded the airwaves and publications during the 1990's, states that,

> "At birth, a baby's brain has about 100 billion nerve cells.
>
> But the cells have not yet formed the critical connections that determine an individual's emotional, social, and intellectual make-up. Most of this 'wiring' develops from birth to age three.
>
> By age three, a child's brain has twice as many synapses - or connections - as an adult's. This suggests that infants and toddlers are biologically primed for learning, as synapses are a fundamental basis of learning. When a connection is used repeatedly in the early years, it becomes permanent. But a connection that is used rarely, or not at all, is unlikely to survive. For example, studies show that a child who is rarely spoken to or read to in the early years may have difficulty mastering language skills later in life. Similarly, a child who is rarely played with may have difficulty with social adjustment as she grows.
>
> Scientists have found that parents' relationship with their child affects his brain in many ways. By providing warm, responsive care, parents strengthen the biological systems that help him handle his emotions. Research also shows that a strong, secure connection with a child helps him withstand the ordinary stresses of daily life - not just today, but in the future. A strong bond doesn't just reassure him, it actually affects the biological systems that adapt to stress (*I Am Your Child Foundation*, 2003, p. 1)."

As more information about brain development has emerged, the importance of attending to emotional and social development during the first years of life has become increasingly evident. Every major report on children and school readiness published in the last dozen years stresses the critical nature of early and ongoing responsive

relationships to all aspects of development. Unfortunately, attention to social and emotional development is generally given short shrift compared with the focus on learning achievements and cognitive development. Children are constantly learning *and* feeling (together) – it is critical to see and attend to their interrelationship.

A refreshing, interesting and easily understandable report highlighting the significance of social and emotional development in young children is *Heart Start: the Emotional Foundations of School Readiness* (National Center for Clinical Infants Program [Now ZERO TO THREE: National Center for Infants, Toddlers and Families], 1992). Considered a new classic by many in the child development field, this report provides an important alternative to the kindergarten readiness movement that continues to focus almost exclusively on cognitive abilities and what children need to know. The *Heart Start* report, along with the Carnegie Foundation report *Starting Points* (1994) and T. Berry Brazelton's major work *Touchpoints* (Brazelton, 1992) were the precursors to *From Neurons to Neighborhoods* and other recent major reports addressing early childhood development, all stressing the need to highlight social/emotional development and relationship-based services. These include the following:

- *Mental Health: A Report of the Surgeon General – Chapter 3: Children and Mental Health* (USDHHS,1999)
- *A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed* (The Child Mental Health Foundations and Agencies Network (FAN), 2001)
- *Bright Futures in Practice: Mental Health* (Jellinek, Patel & Froehle, (Eds.), 2002)

The *Heart Start* report (p. 7) highlights the following qualities that define social and emotional health in young children:

- *Confidence* – A sense of control and mastery of one's body, behavior and world; the child's sense that he is more likely than not to succeed at what he undertakes, and that adults will be helpful.
- *Curiosity* – The sense that finding out about things is positive and leads to pleasure.
- *Intentionality (purposefulness)* – The wish and capacity to have an impact, and to act upon that impact with persistence. This is related to a sense of competence, of being effective.
- *Self Control* – The ability to modulate and control one's own actions in age-appropriate ways; a sense of inner control.
- *Relatedness (relationships)* – The ability to engage with others based on the sense of being understood by and understanding others.
- *Capacity to Communicate* – The wish and ability to exchange ideas, feelings and concepts with others. This is related to a sense of trust in others and of pleasure in engaging with others, including adults.
- *Cooperativeness* – The ability to balance one's own needs with those of others in a group activity."

As an example of the impact of very early experience, the *Heart Start* report states, "The infant who finally pulls herself upright in her crib and is greeted by a parent's expression of admiration will have quite a different attitude about herself, and about the importance of curiosity and persistence, than the child whose achievement is ignored – or who is yelled at to lie down and go to sleep (National Center for Clinical Infant Programs [now ZERO TO THREE], 1992)."

As attention has turned to the importance of attending to social/emotional emotional development in infants and young children, it is important to keep in mind that all children have five basic needs (*Heart Start*, 1992), as follows:

- Basic physical health
- Sufficient time for caregiver and child together, so that supportive, close relationships can develop
- Responsive caregiving, based on understanding how children develop, and using that information to encourage and respond to that development
- Safe and supportive environments
- Special help for children and families who need it and want it

Attending to these needs clearly means giving high priority to social and emotional development issues.

Understanding Developmental Delays and Differences

Children are born learning from their environments and through their relationships. Sometimes the capacity to learn in conventional ways is compromised in pregnancy (high risk factors such as substance abuse, environmental toxins, etc.) or through premature birth or by conditions that are diagnosed early in an infant's life. It may come to the attention of the parents, the family health care provider, a WIC program, an Early Head Start or Head Start staff person, child care provider or teacher that a child may have a delay in development. This could happen through observation, or observation and the use of screening tools that are mentioned in the chapter *Assessment as Discovery*.

There are many factors that can have powerful influences on children's development and educational achievement. Among these are genetic disorders, physiological and metabolic disorders, illness, infections, central nervous systems insults and disordered environments. Separately or in combination, these factors can produce disabilities and substantial risks for developmental difficulties. These disabilities in turn can affect children's adaptation and learning as well as threaten their families' functioning and well-being (Wolery, M. in Shonkoff & Phillips, (Eds.), 2000). As T. Berry Brazelton points out in *Heart Start: The Emotional Foundations of School Readiness*, "a baby who has an untreated learning disability, or who comes from an environment too chaotic or too hopeless to reinforce in him a feeling of success will demonstrate an expectation to fail (1992, p. 1)."

Developmental delays and disabilities can evolve early, over time and/or in relationship to a number of risk factors, including:

- Prematurity
- Accidents
- Maternal depression
- Illness
- Poor nutrition
- Dangerous environments
- Exposure to toxins, including alcohol and other drugs, during pregnancy and in infancy
- Undiscovered or late discovery of problems in how a child learns – tendency to minimize signals of potential delays
- Impact of relationships and environments on a child's capacities
- Interactions and insults from caregivers (insults meaning belittling, negating, discriminating)
- Reactions to stressors in a child's life, including poverty, racism, prior childhood abuse and witnessing personal or community violence
- Accumulation of risks

> "We could have crumbled, me saying, 'There's something wrong.' And him [my husband] saying, 'No, there's nothing wrong.' And finally both coming to terms with it, saying, 'Yes, there's something wrong but it's not our fault. It's a physical, chemical thing and there are things we can do to make it easier for ourselves.'"

Parents and their children face special challenges when there are early developmental differences and delays. These include both understanding the meaning of a diagnosis and dealing with the worries about the impact the diagnosis may have on relationship-building, attachment, and the kind of services and supports needed and desired by parents for their child.

The how and why of the disability is usually surpassed by parents' need to cope with the initial sadness and grief of realizing that their child may not be "perfect" and the fear that the child may not have an equal chance to reach the full and expected life of joy and success that accompanies the hope nearly all families initially experience with the birth of a child. In addition, there are likely to be adaptations within family relationships to accommodate how the parents, child and any siblings learn to compensate for the delays or disabilities at the same time they are accessing services to help them.

Through all of this, however, it is essential to keep in mind that a child is a child first, and nurturing is a primary need of every child. All too frequently, in the rush to address the skills that may be initially perceived to be missing or only slowly evolving, services are poured on with a focus on rote learning or domain-specific skill building. The child's need for love, nurturing and a sense of belonging is left un-addressed for too long. Cultivating and eliciting a sense of belonging and a sense of hope is at the very

foundation of a child's interest in learning. Using a lens of the characteristics discussed above (confidence, curiosity, cooperativeness …etc.), "skill building" can occur in the context of everyday routines that have meaning to the child and parents. If the activity proposed for intervention elicits confidence, is meaningful to the child and parents, is enjoyable and adds to the family's quality of life, then this is a path that one wants to take in intervention.

Interventions to address the disabilities and adaptations should be focused on family wellbeing and enhancement of the child's developmental abilities. This approach maximizes children's and families' potential and strengths, and helps to prevent future impairments or distresses that might increase the risk of impairment. Specifically, efforts should aim to reduce an individual child's risk factors, and enhance protective factors. Protective factors are individual or environmental characteristics that reduce that chance that a person will develop a certain condition or problem, even if he or she is at high risk. For young children, including those with several of the risk factors cited above, protective factors might include an attentive, caring child care provider, nutritional food through the WIC (Women, Infants and Children) program or early identification of a potential learning disability.

Ideally, interventions should be "seamless to the child," meaning that the child does not feel singled out as a special problem or as different from others (which children usually interpret as "bad"). Differences need to be honored in the positive context of understanding that we all share similarities and we all have differences. The emphasis here is to avoid isolating and labeling attributes that might be seen as stigmatizing. Children who look different from others in their community can face particularly difficult times socially and emotionally, making it important for adults to mediate respect for differences among peers. Often this can be done by arranging for joint activities of interest to several children, including the child who may have physical differences.

Behaviors related to disorders or delays vary in each child depending on the child's capacities and vulnerability, family and other key relationships and environments. All children are born learning; some children are more resilient than others, some more vulnerable. The safety and supportiveness of children's environments and the relationships key people in their lives have with them can make a measurable difference.

The more common disorders or problems among infants and young children that require special attention are the following:

- Developmental disabilities
- Attachment issues
- Attentional problems
- Autism
- Failure to thrive
- Serious emotional disturbance
- Communication problems
- Deafness and hearing loss

- Visual impairments
- Genetic and other birth-related conditions
- Serious illness and accidents with long-term impacts

There are many resources available, both within and outside of Vermont, that can help families, caregivers and teachers understand and support infants and young children with these developmental delays and differences. In the comprehensive *Resources for More Information* section that follows, we first provide organizations, and websites in Vermont, and then nationally, that address a wide range of disabilities and conditions, followed by chapter references and additional written resources for general developmental differences and delays. This is followed by listings of resources in Vermont and written materials addressing each of the specific conditions listed above.

RESOURCES FOR MORE INFORMATION

VERMONT ORGANIZATIONS AND WEBSITES - GENERAL

Children with Special Health Needs (CSHN), located within the Vermont Department of Health, provides a large selection of services to children who have complex health conditions and to their families.
Clinic services are provided by teams of health and child development specialists. Current clinics include: Cardiology, Child Developmental, Cleft Palate Craniofacial, Cystic Fibrosis, Epilepsy/Neurology, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Myelomeningocele, Orthopedic, and Rhizotomy. CSHN provides financial assistance to families for services related to CSHN. Funding for respite care is also available.

Vermont Department of Health, CSHN
108 Cherry Street, PO Box 70,
Burlington, VT 05402.
1-800-464-4343, or (802) 863-7200. www.healthyvermonters.org

Family, Infant and Toddler Program of Vermont is a family-centered coordinated system of early intervention services for infants and toddlers who have a delay in their development, or a health condition which may lead to a delay in development, and their families. Early intervention resources and supports might include help with obtaining and coordinating community services and supports, which may include:

- Assistive technology
- A trained home visitor/child development specialist
- Health services to help a child benefit from other early intervention services
- Nursing
- Physical and occupational therapy
- Counseling/psychological and social work services
- Special instruction
- Transportation assistance
- Medical diagnosis for evaluation and eligibility
- Hearing and vision services
- Nutrition
- Communication
- Social work

1-800-464-4343, or (802) 863-7200. www.healthyvermonters.org

VERMONT ORGANIZATIONS AND WEBSITES – GENERAL *(CONTINUED)*

Parent to Parent of Vermont is a statewide organization helping families with children with special needs find support from other parents, health care professionals, and the communities in which they live. Services include one-to-one peer matching with other parents, support groups, Medicaid and SSI consulting, resources for respite and personal care services, and funding opportunities for family-identified needs not covered by other sources. Parent to Parent's newsletter, "The Heart of It," can be accessed on their website.

600 Blair Park Road, Suite #240,
Williston, VT 05495-7549.
1-800-800-4005, or (802) 764-5290. www.partoparvt.org

Vermont I-Team assists local teams of families, educators, and other service providers in the delivery of quality educational services to students with intensive educational needs through technical assistance, professional development, and family support.
www.uvm.edu/~uapvt/programs/iteam.html

Vermont Parent Information Center (VPIC) is a statewide network of support and information for families who have a child with special needs or disabilities, and the professionals who work with them. VPIC empowers parents, families, and children with special needs to become effective advocates to improve the child's education and quality of life. VPIC offers individualized help regarding education, development and special needs; a lending library and newsletters; family scholarships; and an assistive technology center where families can sample equipment and software.

Chittenden County: (802) 658-5315
Outside of Chittenden County – Voice mail: 1-800-639-7170
www.vtpic.com

NATIONAL ORGANIZATIONS AND WEBSITES – GENERAL

Federation for Children with Special Needs provides information, support and assistance to parents of children with disabilities and their professional partners, access to sites describing programs, research and training.
www.fcsn.org

I am Your Child Foundation offers resources for parents, early childhood professionals, child advocates, health care providers, and others dedicated to the promotion of social, emotional, cognitive and physical well-being necessary to enter school and succeed.
www.iamyourchild.org

National Center for Children in Poverty "identifies and promotes strategies that prevent child poverty (and) improve the lives of low-income children and their families."
www.nccp.org

National Center for Early Development and Learning is dedicated to early childhood research that focuses on enhancing social, emotional and cognitive development in children from birth to age 8. Descriptions of research are available at the National Center's website.
www.fpg.unc.edu/~ncedl

National Dissemination Center for Children with Disabilities provides information on disabilities in children, programs and services for infants and children with disabilities, special education laws, research-based information on effective practices for children with disabilities; includes information related to specific disabilities, early intervention services for infants and toddlers, parent organizations and professional associations.
www.nichcy.org

ZERO TO THREE: National Center for Infants, Toddlers and Families
Provides the latest research, resources, information, technical assistance and training for parents and professionals working with infants and toddlers. Publications cover a wide range of relevant topics including developmental assessment, cultural awareness, attachment, pediatric medical care, parenting, quality early care, relationship-based practices, and special needs.
www.zerotothree.org

NATIONAL ORGANIZATIONS AND WEBSITES – GENERAL *(CONTINUED)*

See *Appendix II, National Organizations and Websites* for additional relevant organizations and websites.

REFERENCES AND OTHER WRITTEN MATERIALS FOR ADULTS – GENERAL

Brazelton, T. B. (1992). *Touchpoints: Your child's emotional and behavioral development: Birth to three.* New York, NY: Perseus Publishers.
From a highly respected pediatrician who describes the physical, emotional, social and cognitive development of infants and young children and the important role of parents in their lives. Explains Brazelton's concept of "Touchpoints," the "universal spurts in development and accompanying periods of regression."

Carnegie Corporation (1994). *Starting Points: Meeting the needs of our youngest children.* New York, NY: Carnegie Corporation.
This report of the Carnegie Task Force on Meeting the Needs of Young Children claims that almost half of infants and toddlers confront major risk factors and have inadequate supports to grow and thrive. The report discusses concerns and provides national policy recommendations to address this "quiet crisis."

Jellinik, M., Patel, B., Froehle, M., (Eds.). (2002). *Bright futures in practice: Mental Health – Volume I, Practice Guide, Volume II, Toolkit* Arlington, VA: National Center for Education in Maternal and Child Health.
Volume I provides information on early recognition and intervention for mental health problems and disorders, putting mental health in a developmental context. Volume 2 includes tools for mental health professionals and families to use in screening, care management, and health education.

Knitzer, J. (2001). *Building services and systems to support the healthy emotional development of young children: An action guide for policymakers.* New York, NY: National Center for Children in Poverty.
One of several books in the series, *Promoting the Emotional Well-Being of Children and Families,* this report describes various services available to help emotionally at-risk children and their families.

Shonkoff, J. & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, D.C.: National Academy Press.
A landmark book that reports on the findings of a federally-funded project to evaluate and integrate recent findings on the science of early childhood development. Discusses current knowledge on the nature of early development and the role of early experience, including its impact on brain development, as well as the implications of this recent research.

Shonkoff, J. & Phillips, D., (Eds.). (2000). *Handbook of early intervention services.* Washington, D.C.: National Academy Press.
One of several books Shonkoff has written or co-authored and which explores the need to promote social-emotional well-being in very young children.

The Child Mental Health Foundations and Agencies Network (FAN) (2001). *A good beginning: Sending America's children to school with the social and emotional competence they need to succeed*. Washington, D.C.: The Child Mental Health Foundations and Agencies Network.

U.S. Department of Health and Human Services (1999). *Mental health: A report of the surgeon general – Chapter 3: Children and mental health.* Rockville, MD: U.S. Department of Health and Human Services.
Summarizes current research and understanding about children's mental health from a developmental perspective. Discusses the role of risk and protective factors and prevention and treatment options.

Wolery, M., Behavioral and educational approaches to early intervention, in Shonkoff, J. & Phillips, D., (Eds.). (2000). *Handbook of early intervention services.* Washington, D.C.: National Academy Press.

REFERENCES AND OTHER WRITTEN MATERIALS FOR ADULTS – GENERAL *(CONTINUED)*

Zeannah, C. Jr., (ed.). (1993). *Handbook of infant mental health.* New York, NY: The Guilford Press. A comprehensive, research-based collection of articles covering the mental health of infants; covers social contexts, risk and protective factors, assessment and interventions.

ZERO TO THREE (1992). *Heart Start: The emotional foundations of school readiness.* Washington, D.C.: National Center for Infants, Toddlers and Families.

WRITTEN MATERIALS AND VERMONT ORGANIZATIONS FOR SPECIFIC CONDITIONS

DEVELOPMENTAL DISABILITIES (DOWN SYNDROME, FRAGILE X, FETAL ALCOHOL SYNDROME AND OTHERS)

WRITTEN RESOURCES

Kumin L. (2003). *Early communication skills for children with Down Syndrome: A guide for parents.* Bethesda: Woodbine House.
Focuses on speech and language development from birth through the stage of making 3-word phrases, which is often around kindergarten age, but can occur later. Offers a wealth of information on intelligibility issues, hearing loss, apraxia (difficulty planning oral-motor movements), and other factors that affect communication for children with Down syndrome. Explains how to prepare for and understand the results of speech-language assessment, and describes what to expect in the years ahead when a child enters elementary school.

Stray-Gundersen, K. (Editor) (1995). *Babies with Down Syndrome: A new parents guide.* Bethesda: Woodbine House.
Provides new parents with straightforward and compassionate advice and insight. Helps families become more confident in their ability to cope, to learn about their child's development, to know where to seek help, and to advocate for their child. Written by the same knowledgeable parents and professionals who contributed to the first edition, this second edition covers diagnosis; medical concerns and treatment; coping with your emotions; daily care; family life; early intervention; special education; and legal rights.

Streissguth, A. (1997). *Fetal alcohol syndrome: A guide for families and communities.* Baltimore: Paul H. Brookes Publishing Co.
Topics covered in the book include: diagnosis of FAS, teratology and brain damage, physical and behavioral manifestations, education, services for high-risk mothers, employment and advocacy, and public policy.

Weber, J.D. (2000). *Children with fragile X syndrome: a parent's guide.* Bethesda: Woodbine House.
This comprehensive book on fragile X syndrome for parents provides a complete introduction to fragile X syndrome. Explores issues and concerns affecting children and their families, such as: diagnosis, parental emotions, therapies and medications, development, early intervention, education, daily care, legal rights, and advocacy.

VERMONT ORGANIZATIONS AND WEBSITES

Vermont Department of Health, Division of Mental Health is responsible for the provision of services to children and adults who have developmental disabilities, a severe and persistent mental illness, and/or a severe emotional disturbance. The Department intends to have these services, to the extent possible, delivered within the context of the individual's family, home and community.
www.ddmhs.state.vt.us

VERMONT ORGANIZATIONS AND WEBSITES *(CONTINUED)*

SUPPORT GROUPS

Down Right Special, a support group for family members of children with Down Syndrome.
Contact: Tammy Stanwood, (802) 457-3409

Williams Syndrome, a support group for family and friends of children who have Williams Syndrome.
Contact: Cheryl Kingsbury, (802) 496-4690.

ATTACHMENT ISSUES

WRITTEN RESOURCES

Attachment theory and research: A framework for practice with infants toddlers and families. Special Issue of ZERO to THREE, Vol. 20, No. 2 (Oct./Nov. '99**).**
Discusses current research on infant and young children's development in the context of their environments; application of research-based knowledge to practice; training practitioners using research and clinical knowledge; and reaching out to parents, policymakers and others who care about healthy infant and young child development.

Best, M.H. (1998). *Toddler adoption: The weaver's craft*. Indianapolis, IN: Perspectives Press.
Focuses on parenting adopted children from one to three years of age; discusses both the joys of toddler adoption and the many challenges. Includes a strong chapter on attachment issues.

Hughes, D. A. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children***.** Northvale, NJ: Jason Aronson.
Overview for understanding and helping children who suffer from attachment problems. The background information about theories of attachment, therapeutic interventions and principles of parenting are clearly outlined and presented in user-friendly language. Case examples enliven the theoretical principles.

Hughes, D. A. (1998). *Building the bonds of attachment: Awakening love in deeply troubled children.* Northvale, NJ: Jason Aronson.
The story of "Katie" and how she and her foster-mother work to build attachment; describes the inner life of the child, the joys and struggles of the committed foster-mother, and the process of providing therapeutic guidance and support; a valuable tool for therapists, parents/caregivers and others seeking to understand how to help a child suffering from poor attachment.

ATTENTION PROBLEMS (ADHD, ADD AND OTHERS)

WRITTEN RESOURCES

Barkley, R. A. (2000). *Taking charge of ADHD, revised edition: The complete authoritative guide for parents.* New York: Guilford Press.
Contains hard data that clears up current controversies about increased diagnosis and stimulant use, new strategies that give children greater chances of success at school and in social situations, advances in genetic and neurological research that enhance our understanding of what causes ADHD, practical advice for parents on managing stress and keeping peace in the family, updated descriptions of books, organizations, and Internet resources that families can trust in school and in social situations.

Rief S. F. (1993). *How to reach and teach ADD/ADHD children: Practical techniques, strategies, and interventions for helping children with attention problems and hyperactivity.* San Francisco: Jossey-Bass.
For educators, specialists, and parents. Packed with classroom-tested techniques and practical know-how for helping children with attention deficit disorders--with or without hyperactivity. Addresses the "whole child," as well as the team approach to meeting needs of students with attention deficit hyperactivity disorder. Includes management techniques that promote on-task behavior and language arts, whole language, and multi-sensory instruction strategies that maintain student attention and keep students involved.

VIDEO

Attention Deficit Disorder in the 21st Century - A Conversation with Edward M. Hallowell MD (2002). Video series about kids and Attention Deficit Disorder - for families, kids, teachers and professionals. Edward M. Hallowell MD, adult and child psychiatrist, explains ADD in a positive and constructive way. Promotes knowledge, hope and self-esteem for these kids, their families, friends and teachers.

SUPPORT GROUPS

CHADD: Children and Adults with Attention-Deficit/Hyperactivity Disorder, in Chittenden County. (802) 651-7615

AUTISM SPECTRUM DISORDER (ASD), INCLUDING ASPERGER SYNDROME AND OTHER PERVASIVE DEVELOPMENTAL DISORDERS

WRITTEN RESOURCES

Bruey, C.T. (2003). *Demystifying autism spectrum disorders: A guide to diagnosis for parents and professionals.* Bethesda: Woodbine House.
Clarifies the process of diagnosis for parents who don't fully understand it or wonder whether another ASD diagnosis is more appropriate for their child. Explains the five types of autism that fall under the ASD umbrella: Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder, Rett's Disorder, and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS). An excellent tool for families who suspect their child has an ASD but don't yet have a diagnosis.

Ozonoff, S., Dawson, G. & McPartland, J. (2002). *A parent's guide to Asperger's Syndrome and high functioning autism: How to meet the challenges and help your child thrive.* New York: The Guildford Press.
A compassionate guide showing parents how to work with their children's unique impairments and capabilities to help them learn to engage more fully with the world and live as independently as possible. Packed with practical ideas for helping children relate more comfortably to peers, learn the rules of appropriate behavior, and participate more fully in school and family life. Explains current knowledge about autistic spectrum disorders and how they are diagnosed and treated.

Powers, M.D. (2000). *Children with autism: A parent's guide (second edition).* Bethesda: Woodbine House.
Provides information on autism and the other conditions within the spectrum of pervasive developmental disorder (PDD). Covers a multitude of special concerns, including daily and family life, early intervention, educational programs, legal rights, advocacy, and a look at the years ahead.

Small, M. & Kontente, L. (2003). *Everyday solutions: A practical guide for families of children with autism spectrum disorder.* Autism Asperger Publishing Company.
A comprehensive resource offering parents and other caregivers practical and effective approaches to solving the many puzzles of daily living with a child with autism spectrum disorders (ASD) - from dressing, toileting, and eating, to going to the playground, visiting the dentist, getting used to a new baby, and many, many more.

VERMONT ORGANIZATIONS AND WEBSITES

Autism Society of Vermont is a non-profit corporation serving the needs of the Vermont's autism community. Membership is comprised of individuals with ASD, their families, friends and service providers. The Society sponsors an annual seminar series, maintains a book and video library, supports members in their roles on other task forces, committees and boards, provides scholarships to individuals who might otherwise have no access to training, works in cooperation with other organizations and agencies to further the interests of people with ASD, provides free trainings including a new "make and take" series, and supports parents of newly diagnosed children.
1-800-559-7398. www.autism-info.org

SERIOUS EMOTIONAL DISTURBANCES (CHILDHOOD DEPRESSION, OBSESSIVE COMPULSIVE DISORDER, ANXIETY AND OTHERS)

WRITTEN RESOURCES

Miller, J. A. (1999). *The childhood depression sourcebook*. New York: McGraw-Hill/Contemporary Books.
Provides insight into why children get depressed, how to identify symptoms, and where to find appropriate treatment. Distinguishes how childhood depression differs from adult depression and how depression manifests during different developmental stages: early childhood, late childhood, and adolescence. Emphasizes working with schools on both the academic and social levels to help children adjust.

Manassis, K. (1996). *Keys to parenting your anxious child.* Hauppauge: Barrons Educational Series.
Provides information for parents to help their children learn to overcome anxiety. Explains what anxiety is (and is not), how it affects each member of the family, how to cope, how to communicate effectively with your child, and how to stop undesirable behavior. Addresses the effects of certain parenting styles and how they can help or hinder progress toward better mental health. Medications are discussed; if they are necessary and which ones are helpful. Also addresses how to communicate with others about your child's current situation (school, etc.)

VERMONT ORGANIZATIONS AND WEBSITES

Vermont Federation of Families for Children's Mental Health is a statewide, family-run network to providing support, information and advocacy for families of children and adolescents with serious emotional, behavioral, or mental disorders. PO Box 607, Montpelier, VT 05601-0607.
1-800-639-6071, or (802) 223-4917.

The Vermont Department of Health, Division of Mental Health, Division of Mental Health, Child, Adolescent and Family Unit is charged with planning and implementing a comprehensive community-based system of care for children and adolescents experiencing, or at substantial risk of developing, a severe emotional disturbance.

State of Vermont Department of Health, Division of Mental Health (DDMHS)
Division of Mental Health, Child, Adolescent and Family Unit
Weeks Building
103 South Main Street
Waterbury, VT 05671-1601
(802) 241-2650. www.ddmhs.state.vt.us

For a comprehensive list of mental health programs and service providers that serve children and families in your area or county, visit:
www.state.vt.us/dmh/sapp.htm or see *Appendix I* for a list of regional community mental health centers.

SUPPORT GROUPS

B.I.L.Y. (Because I Love You) is a support group for families of children with behavior problems. Located in Chittenden County.
(802) 863-4130.

COMMUNICATION PROBLEMS (INCLUDING SPEECH AND LANGUAGE DELAYS)

WRITTEN RESOURCES

Agin, M. C., Geng, L. F. & Nicholl M. (2003). *The late talker: What to do if your child isn't talking.* New York: St. Martin's Press.
Describes the kinds of language milestones kids should hit at certain ages and the warning signs of potential disorders. Provides an overview of speech disorders, focusing particularly on those in which language acquisition and speech sound production is affected. Includes ways to identify the warning signs of a speech disorder, information on how to get evaluations and therapy, ways to obtain appropriate services through the school system and health insurance, fun at-home activities parents can do with their child to stimulate speech, and advice from experienced parents on what to expect and what you can do to be your child's best advocate.

Apel, K. & Masterson J. J. (2001). *Beyond baby talk: From sounds to sentences, a parent's complete guide to language development.* New York: Prima Lifestyles.
Provides advice to early childhood educators and parents of preschoolers who have a language delay. Shares tips to help children progress on schedule, and easy methods to: evaluate and monitor a child's language development, understand and deal with environmental impacts such as television and cultural styles, and recognize the signs of language development problems.

VERMONT ORGANIZATIONS AND WEBSITES

Eleanor M. Luse Center for Communication Disorders (located at Pomeroy Hall on the University of Vermont campus) is a nonprofit organization providing speech-language pathology and audiology services to children and adults throughout Vermont. Services for infants, toddlers, and their families promote preverbal skills and communication development. High-risk infants are followed to monitor development and offer guidance to families. Services for preschool children include evaluation, consultation, and programming to aid development of language understanding, language use, speech production, and pre-academic skills.

Eleanor M. Luse Center, Department of Communication Sciences
Pomeroy Hall, 489 Main Street
Burlington, VT 05405
(802) 656-3861. www.uvm.edu/~cmsi

FAILURE TO THRIVE

WRITTEN RESOURCES

Failure to thrive. A clear, easy-to-understand explanation of failure to thrive, including diagnosis, causes and treatment.
www.familydoctor.org. Click on "KidsHealth" and then search for "failure to thrive."

American Academy of Pediatrics (1998). *Caring for your baby and young child: Birth to age 5.* New York: Bantam Books.
A comprehensive guide to basic care from infancy through age five, including guidelines and milestones for physical, emotional, social and cognitive growth. Also offers a complete health encyclopedia covering injuries, illnesses, congenital diseases, and other disabilities.

DEAFNESS AND HEARING LOSS

WRITTEN RESOURCES

Luterman, D.M. (1991). *When your child is deaf: A guide for parents*. Parkton, MD: York Press.
Discusses the emotions families experience, reveals how deafness impacts the entire family, offers specific suggestions for coping with deafness in a child, explains technological options, and addresses the controversial issues surrounding communication and education for deaf children. Includes an easy-to-understand chapter devoted to the basics of hearing loss, including anatomy of the hearing system, types of hearing tests available, and clinical results and what they mean.

Ogden, P.W. (1996). *The silent garden: Raising your deaf child* (Rev. ed.). Washington, DC: Gallaudet University Press.
Explains the broad range of hearing loss types, from minor to profound. Describes all forms of communication, including choices in signing. Technological alternatives are also discussed. Brings understanding about deafness to parents and to all the other family members, relations and friends.

Schwartz, S. (Ed.). (1996). *Choices in deafness: A parents' guide to communication options* (2nd ed.). Bethesda, MD: Woodbine House.
Explains medical causes of hearing loss, the diagnostic process, audiological assessment, and cochlear implants. Provides a thorough overview of the following communication methods for deaf children: Auditory-Verbal Approach, Bilingual-Bicultural Approach, Cued Speech, Oral Approach, and Total Communication. Children and parents also offer their personal experiences.

VERMONT ORGANIZATIONS AND WEBSITES

Austine School for the Deaf has been providing educational and residential services for Deaf and Hard of Hearing children and their families for over 90 years in Vermont. The Austine School for the Deaf is part of the Vermont Center for the Deaf and Hard of Hearing. Contact:

60 Austine Drive
Brattleboro, Vermont 05301-2694
Voice/TTY: (802) 258-9500.
www.state.vt.us/schools/aus

Vermont Center for the Deaf and Hard of Hearing provides a full array of family-based services including educational workshops, social opportunities, parent-to-parent networking assistance, community outreach education, American Sign Language instruction, deaf mentoring and individual family support. A parent newsletter, as well as a lending library, is provided in order to offer up-to-date information to families on relevant issues. Services are available to all families of deaf and hard of hearing children, as well as to any interested person or party, and are provided compassionately and with respect for families' individual needs.
(802) 879-4787 or (802) 258-9595 www.austine.k12.vt.us/Vermont_Center/family_services.htm

VISUAL IMPAIRMENTS

WRITTEN RESOURCES

Cay, M. (Ed.). (1995). *Children with visual impairments: A parent's guide.* Bethesda: Woodbine House.
Offers a great deal of information and reassurance to parents of young children with visual impairments. Provides information on assessment and causes of visual impairments and various educational interventions and settings. Addresses pertinent medical, emotional, social, educational, and family issues.

VERMONT ORGANIZATIONS AND WEBSITES

Vermont Association for the Blind and Visually Impaired offers services to families and children who are blind or visually impaired. Services include one-on-one instruction with infants and young children at home or at school. Contact:

37 Elmwood Avenue
Burlington, VT 05401
(802) 863-1358
www.vabvi.org

GENETIC AND OTHER BIRTH DEFECTS (INCLUDING SEIZURE DISORDERS, CEREBRAL PALSY, HYDROCEPHALUS, SCOLIOSIS, TAY SACHS SYNDROME, SPINA BIFIDA, CYSTIC FIBROSIS AND OTHERS)

WRITTEN RESOURCES

Freeman, J.M., Vining, E.P.G. & Pillas D. (1997). *Seizure and epilepsy in childhood: A guide for parents.* Bethesda: Johns Hopkins University Press
A resource for parent of children with epilepsy that is reader-friendly. It describes why seizures occur, diagnosing, treating, coping, and living with epilepsy.

Geralis, E. (Ed.). (1998). *Children with cerebral palsy: A parent's guide (second edition).* Bethesda: Woodbine House.
Provides information on cerebral palsy and its effect on children's development and education from birth through the first six years. Covers diagnosis, coping with your emotions, medical issues, daily care, family life, development, therapies, early intervention, special education, legal rights and advocacy. Offers information on the latest treatments for seizures, medications for muscle spasticity, and communication devices. Also included is a glossary, reading list, and resource guide.

Lutkenhoff, M. (editor) (1999). *Children with Spina Bifida: A parent's guide.* Bethesda: Woodbine House.
Addresses common questions and concerns parents have about their child's condition and development. Discusses what is spina bifida, its causes, prenatal diagnosis, coping with your emotions, the importance of neurosurgery, urological concerns, bowel management, orthopedic concerns, physical therapy, childhood development, and parenting a child with spina bifida.

Orenstein, D.M. (1997). Cystic fibrosis: A guide for patient and family (second edition). *Lippincott Williams & Wilkins Publishers.*
Offers clear explanations and advice on cystic fibrosis and its management. Provides practical and reassuring information for patients and families on issues such as school, travel, exercise, nutrition and medication, as well as on psychological effects, treatments, complications, long-term issues, and the prospects of a cure. Chapters begin with a "quick list", so the reader can know at a glance what topics are covered.

VERMONT ORGANIZATIONS AND WEBSITES

Please see *Organizations and Websites - General* and *References and Written Materials - General* above, many of which are applicable to these conditions.

SUPPORT GROUPS

Cerebral Palsy Family Support Group is a group for family members of children with cerebral palsy. Meeting dates and times vary. Contact Valerie Wood-Lewis at (802) 859-0049.

Epilepsy Foundation is a group for individuals with epilepsy and family members seeking information and support. Call the Epilepsy Foundation of Vermont for times and locations nearest you. 1-800-565-0972 or (802) 775-1686.

SERIOUS ILLNESS AND ACCIDENTS WITH LONG-TERM IMPACTS (CHILDHOOD LEUKEMIA AND OTHER CANCERS, PARALYSIS AND OTHERS)

WRITTEN RESOURCES

Keene, N. (2002). *Childhood leukemia: A guide for families, friends, and caregivers (third edition).* Sebastopol, CA: O'Reilly and Associates.
Parent guide covers detailed and precise medical information about leukemia and the various treatment options, and also day-to-day practical advice on coping with procedures, hospitalization, family and friends, school, social and financial issues, communication, feelings, and the difficult issues of death and bereavement. Also includes practical advice and the voices of parents and children who have lived with leukemia and its treatments.

Schoenbrodt, L. (2001). *Children with traumatic brain injury: A parent's guide.* Bethesda: Woodbine House.
Provides parents with support and information to help their child recover from a traumatic brain injury. Covers what is traumatic brain injury, medical concerns, rehabilitation and treatments, coping and adjustment, effects on learning and thinking, speech and language, and behavior, educational needs, and legal issues. Also included is a resource guide of support and advocacy organizations, a reading list, and a glossary.

Shiminski-Maher, T., Cullen, P.M. & Sansalon, M. (2001). *Childhood brain and spinal cord tumors: A guide for families, friends and caregivers.* Sebastopol, CA: O'Reilly and Associates.
Parent guide includes detailed and precise medical information about both benign and malignant brain and spinal cord tumors that strike children and adolescents. In addition, offers day-to-day practical advice on how to cope with procedures, hospitalization, family and friends, school, social and financial issues, communication, feelings, and, if therapy is not successful, the difficult issues of death and bereavement.

Woznick, L.A. & Goodheart, C.D. (2002). *Living with childhood cancer: A practical guide to help families cope.* Washington, D.C.: American Psychological Association.
Provides emotional guidance, useful information, and practical advice for families coping with childhood cancer.

VERMONT ORGANIZATIONS AND WEBSITES

Make-A-Wish Foundation of Vermont grants wishes to children who are living with a life-threatening illness. In every case, the entire immediate family is included as part of the wish to help create special family memories. The purpose is to emphasize the joy of the wish fulfilled; not the illness. Neither the child nor family is ever asked to pay for any portion of a fulfilled wish.
www.makeawishvermont.org

Please see *Organizations and Websites - General and References and Written Materials - General* above, many of which are applicable to these conditions.

SUPPORT GROUPS

The *Brain Injury Association of Vermont* hosts a support group for individuals, families and support persons who live with or care for individuals with traumatic brain injury. It meets the first Wednesday of the month at Fanny Allen Hospital in Colchester.
Contact: Deb Parizo at (802) 863-8644 or www.biavt.org

Heart to Heart is a support group for parents of children with heart conditions.
Contact: Betsy Lawrence at 1-800-660-4427, or Julianne Nickerson at (802) 899-3798.

SUPPORT GROUPS *(CONTINUED)*

For a comprehensive list of *written resources* that address many of the special health needs discussed in this chapter, contact Woodbine House, a publisher specializing in books about children with special needs. Over 65 titles are available within the publisher's Special-Needs Collection covering ADD/ADHD, autism, celiac disease, cerebral palsy, Down syndrome, fragile X syndrome, learning disabilities, spina bifida, traumatic brain injury, early intervention, inclusion, special education, communication skills, etc.
www.woodbinehouse.com

For a comprehensive list of *support groups* for these and other health and developmental concerns throughout Vermont for individuals, parents, caregivers, and support persons, contact Parent to Parent of Vermont or visit their Support Group website at:
www.partoparvt.org/supportgroups.html

Visit the Fletcher Allen Healthcare website for a list of the support groups FAHC sponsors state-wide.
www.fahc.org/General_Public/support.asp

See *Appendix II* for additional national organizations and websites concerned with support for children with special needs and challenges and their families.

CHAPTER 5
ASSESSMENT AS DISCOVERY

Overview

The intention of assessment is to address *both the unique needs and the strengths of children.* To best assess a child's development and identify areas that may need more attention, it makes sense to gather and use information from a variety of sources. Behavior is most likely a reaction to situations, relationships, environments or issues in other developmental areas beyond only the social and emotional domains. Thus, using a broad lens in this "assessment as discovery" process is essential to gaining a comprehensive understanding of what is happening developmentally with a young child. Figuring out with parents how well a child is growing and developing in relationship to other children of the same age, and in the context of what parents feel is important, is a first step in determining what interventions may need to be in place to produce positive outcomes for children. This should be an educational process that is enjoyable, supportive and meaningful for the parents and child.

This ongoing, dynamic process of discovering what is going on and what works well for the child and family is an evolving field, having gained respect in the last several decades. What is also new is the acknowledgement that the social and emotional development of young children is a key ingredient of school and life success and thus should not be ignored. In fact it needs to be highlighted, and should be central to efforts directed at helping young children. Besides common sense, this focus is supported by the fact that every major report on early childhood needs and school readiness in the last decade emphasizes the importance of social–emotional development and the ability to form and maintain relationships.

One goal for this chapter is to make a compelling case for a holistic, comprehensive and strengths-based approach to assessment. This approach stands in stark contrast to processes that focus on a particular area of development in isolation from other areas, and to problem-oriented treatment plans, both of which should be avoided.

Collaborative working relationships between family members and service providers are at the heart of assessment as a discovery process. The purpose of information collected is to support families, providers and communities to promote a young child's healthy social and emotional development. Assessment as a discovery process aspires to guide and inform decisions about services and interventions, with the ultimate goal of improved outcomes for children.

Gathering information about a child and family and their key relationships, interactions, the child's health status, everyday environments and daily routines is a key part of the assessment process. This information provides a foundation from which service providers can help parents and other family supporters address the unique needs and strengths of their child and family through individualized, or personalized, early intervention services. These early intervention services (such as early childhood

mental health, language development, physical therapy or a combination of services that focus on relationships and environments) should be regularly evaluated, guided by the question of whether the services and efforts of the providers/family are making a difference, with adjustments and re-direction occurring all along the way. In early childhood mental health, the focus is on the child *in relationship to others.* The emphasis is thus on interactions, and nearly always includes the parents, siblings and/or other key people in a child's life.

Definition of Terms

Assessment refers to the ongoing process of determining the child's and family's strengths and needs. The Individuals with Disabilities Education Act (IDEA) further defines family assessment as "family directed and designed to determine the resources, priorities and concerns of the family related to enhancing the development of the child." (34 CFR 303 Regulations for the Early Intervention Program for Infants and Toddlers with Disabilities, Part C of IDEA 303.322 Evaluation and Assessment (a) (2)).

The terms "screening," "assessment" and "evaluation" are often used interchangeably. For this handbook, we use the term "assessment" to mean an ongoing process. Assessment is itself an intervention, and can be a step on the path of change. We gather information through different methods and contexts. Interviews (formal and informal), checklists, health, nutrition and medical information and other measurement tools and observation are the most common methods. Screenings and evaluations should be done with the parents present, in surroundings familiar to the child and using culturally relevant approaches.

This process may begin with a snapshot of development, known as a *screening*. The screening is usually a brief, one-time process – by teachers, family members, health care providers, Early Head Start and Head Start staff, and staff of early childhood programs in Vermont. Screening tools used by these providers only give indicators that ought to be followed up – or looked at in a deeper, more thoughtful manner – through multidisciplinary assessments that look at all domains of development in more depth so as not to miss anything.

Evaluations for the purpose of this chapter are a more in-depth look at a particular area(s) of development that have been identified in the screening process or in the overall assessment process. Evaluation of particular issues such as attachment, relationship or behavioral concerns, communication (speech or language delays), physical (movement delays), learning challenges and self-help problems (dressing, toileting, eating, etc.) should be looked at in combination, rather than separately.

> "He went to Head Start and he was cutting little girls' hair; he was doing some behaviorally challenging things. And they were the first ones to actually say to me, 'Something's wrong. You need to go to a child development clinic and have him tested.' That was when he was three. They diagnosed him with a speech and language impairment."

A language delay, for example, could indicate a hearing problem, an attachment issue or another problem altogether. Attachment issues between a parent and child could stem from or indicate issues in communication, environmental stressors, etc. Thus a comprehensive assessment should be done, with specific evaluations added as warranted, in order to determine the presence and extent of a challenge, as well as teasing out causative factors. Information from the evaluation(s) offers more information about a particular area of development and, if used properly, contributes to effective planning regarding interventions to lessen delays and hasten improvements.

The literature on resiliency and at-risk children focuses on both *risk and protective factors*. The following summary of risk and protective factors is adapted from the Devereux Early Childhood Assessment Program (DECA,1998). Risk factors are "red flags" that increase the likelihood of a negative developmental outcome in a group of people. Protective factors minimize the negative effects of stress, and foster more positive behavioral and psychological outcomes in at-risk children. Longitudinal research shows that children with behaviors that reflect protective factors are more apt to overcome stress, whereas children under similar risk conditions with underdeveloped protective factors are more likely to develop emotional and behavioral problems. Assessment can identify specific protective and risk factors within a child, in the child's family and in the child's environment. Thus, the assessment of a young child looks at both biological and psychosocial factors.

Guiding Principles for Assessment

A useful set of principles to guide the assessment of young children emerged from the Zero to Three Working Group on Developmental Assessment (Meisels and Atkins-Burnett, 2000, p. 232):

Principles of Assessment in Infancy and Early Childhood

- Assessment must be based on an integrated developmental model.
- Assessment involves multiple sources of information and multiple components.
- An assessment should follow a certain sequence [starting from very basic and moving along a continuum to more advanced development].
- The child's relationship and interactions with his or her most trusted caregiver should form the cornerstone of an assessment.
- An understanding of sequences and timetables in typical development is essential as a framework for the interpretation of developmental differences among infants and toddlers.
- Assessment should emphasize attention to the child's level and pattern of organizing experience and to functional capacities, which represent an integration of emotional and cognitive abilities.

- The assessment process should identify the child's current competencies and strengths, as well as the competencies that will constitute developmental progression in a continuous growth model of development.
- Assessment is a collaborative process.
- The process of assessment should always be viewed as the first step in a potential intervention process.
- Reassessment of a child's developmental status should occur in the context of day-to-day family or early intervention activities, or both.

Foundations of Emotional Health in Early Childhood

While assessment tools rely on different scales or developmental indicators of health/emotional health, they share an assumed understanding of the foundations of emotional health in early childhood. The evaluator/observer must possess an excellent understanding of typical early childhood growth and development in order to recognize assets as well as areas of behavioral and other concerns. Assessment tools that look in depth at social and emotional development frequently reflect the following constructs, which are considered cornerstones of early childhood intervention and infant mental health (DECA, 1998, Partridge, S.E. in Marsh, J.D.B., (Ed.), 1996).

Attachment: Positive interactions between an infant/young child and his or her caregivers (reflective of the quality of caregiving) that encourage mutual, strong, long- lasting, nurturing relationships that engender a sense of trust and security in the child.

Social support: A family's circle of informal supports that can include extended family, friends, neighborhood, community, faith community, professional service providers and formal supports that include professional service providers, agencies and funding sources.

Self-control: The child's ability to use the words and actions deemed culturally appropriate to express his or her experience of a range of feelings and to regulate impulses toward others.

Initiative and mastery: The child's ability to use independent thought and action to problem solve, to meet his or her needs, and to experience a sense of competence.

Safety Concerns

In the process of gathering information, a service provider sometimes discovers that the safety of the child, or other family member(s) is at risk. Any worker who is a mandated reporter of abuse and/or neglect will need to approach this discussion with families in a

forthright and sensitive manner. Where there is suspected substance abuse or domestic violence, providers need to understand the real effects on families, as well as the legal ramifications. In both cases, knowing when and where to turn for "supervision and support" is critical.

Using Assessment Information in Intervention Planning

Referrals for services are often made by health care providers, child care programs, Early Head Start/Head Start programs, child welfare services, schools and families themselves. In order to have enough information to make a useful service or intervention plan for/with the family and child, existing information, available from family members, child care providers, physicians, clinics, WIC, etc. is gathered, and arrangements for obtaining new information are made (evaluations, new observations and the like).

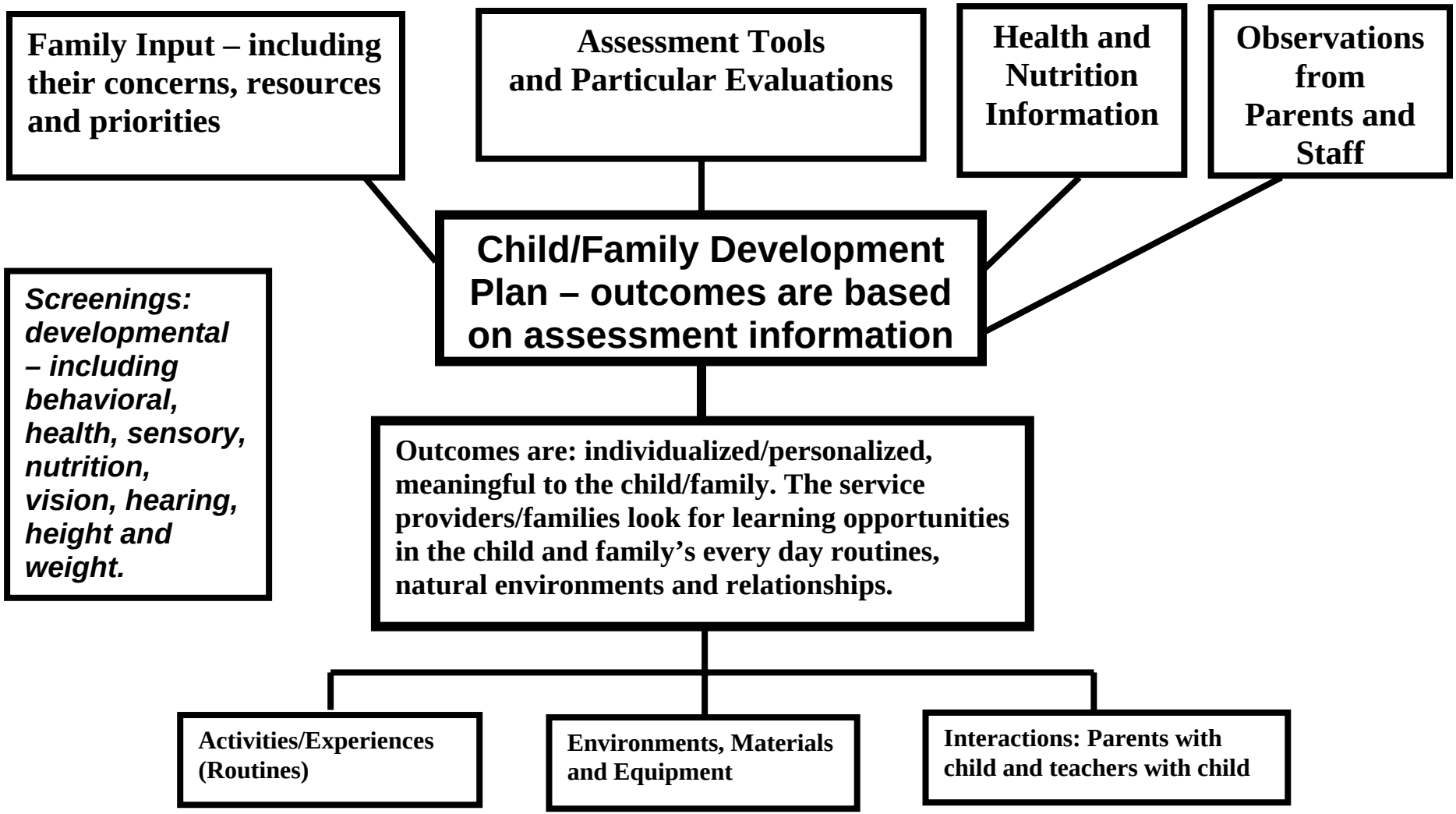
The assessment/discovery process is used as a foundation from which to plan with parents and/or other primary caregivers regarding outcomes to strive for, and to determine interventions that will most likely produce these outcomes. An intervention plan is developed after the initial assessment process indicates services are needed, and that the family and/or child is therefore eligible to access any number of early intervention services (those covered by Early and Periodic Screening, Diagnosis and Treatment/EPSDT and/or those offered through State-based programs).

It is critical to bring, with parental permission, the appropriate resources to the planning table so that service plans are comprehensive and reflect family resources, concerns and priorities. The plan should be developed with parents as partners in decision-making, with one of the goals being that the outcomes and interventions are, or aim to be, family-driven. Some common intervention plans for young children include: Individualized Plan of Care, often used in mental health and health prevention programs; Case Plan, used in Child Welfare; and Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP), used in early intervention programs and special education services.

Good intervention plans are based on engaging the parents and eliciting from them information about the child and family's daily routines, environments and interests (what is meaningful to them, their culture and their community). This key information is then used to develop an intervention plan that is comfortable for the parents and respects their goals and values. The regular reviews that are part of the ongoing assessment process examine with the parents how well intervention strategies are working. Thus, goals or outcomes and plans and services can be adjusted to address the issues that seem to be barriers to development-to better produce positive outcomes.

The chart on the next page illustrates this assessment and intervention process, demonstrating the various factors that go into assessment and planning and underscoring the fact that interventions are woven into a child's everyday activities, environments and interactions.

Assessment as Discovery



(Keith, 2003)

Following are recommended screening, assessment and evaluation tools with summary information about each one, including contact information, provided in chart form. The evaluation tools are generally used by experts in particular areas, such as early childhood mental health practitioners, speech and language pathologists, and autism experts. Additional resources are listed at the end of the chapter.

Selected Screening Tools

These provide "snap shot" pictures - a quick point-in-time look at a child's overall development or specific areas that indicate whether a child should be referred for a more detailed developmental assessment.

Ages and Stages

Age range	4 months to 60 months
Content	Communication, gross motor, fine motor, problem-solving, personal-social
Who completes	Parents, caregivers, service providers on home visits
Time to administer	10 to 30 minutes
Author	Jane Squires
Publisher	Paul Brookes Publishing Company. 1-800-638-3775. www.brookespublishing.com
Estimated cost	User's Guide and Forms $190.00
Other	

Ages and Stages – Social and Emotional

Age range	6 months to 60 months
Content	Social emotional (self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people)
Who completes	Teachers, caregivers, family/parents
Time to administer	10 – 15 minutes
Author	Jane Squires, Diane Bricker, Elizabeth Twombly
Publisher	Paul Brookes Publishing Company. 1-800-638-3775. www.brookespublishing.com
Estimated cost	User guide and Forms - $125 (Forms can be photocopied)
Other	Good engagement between families and caregivers about development

Checklist for Autism in Toddlers (CHAT)

Age range	18 months
Content	Social communication (e.g., joint attention, pointing to show and gaze-monitoring, pretend play)
Who completes	Parents, Primary health care worker First nine items are questions asked to the parents, and the last five items are observations made by the primary health care worker. Quick scoring done at the time of administration.
Time to administer	5 - 10 minutes
Author	S. Baron-Cohen, et al.
Publisher	British Journal of Psychiatry, 1992
Estimated cost	Free – no cost Can download tool from website: http://www.nas.org.uk/profess/chat.html
Other	The CHAT should not be used to diagnose autism. It is designed to be used as a screening instrument by health professionals. Failure of any of the items should alert the parent to the possibility of a developmental delay and should be followed up by a thorough evaluation by an Early Intervention professional.

Devereaux Early Childhood Assessment (DECA)

Age range	Two to five years of age.
Content	Norm-referenced assessment of Protective factors Behavioral Concerns Screener - The DECA is one component of a comprehensive program that includes observation of classrooms/ individuals, developing plans for the group and the individual and evaluating progress.
Who completes	Parents/teachers who know child for at least 4 weeks. Used mostly in Head Start and Child Care programs. To score – need familiarity with the DECA program and received training or orientation. Childcare providers are encouraged to score and interpret results and share with parents.
Time to administer	5 – 10 minutes
Author	Paul LeBuffe and Jack Naglieri
Publisher	Kaplan Press. 1-800-334-2014. www.kaplanco.com
Estimated cost	DECA kit - $199.95; materials also sold separately
Other	Initial and ongoing training and professional development available, many people in Vermont have received training and use this tool in ongoing assessment and thinking about child development planning. Contact Devereux Foundation at (641) 542-3109.

Early Language Milestone Scale (ELMs)

Age range	Birth to 36 months
Content	Communication screening: to screen for speech and language development during infancy. Includes auditory expressive, auditory receptive and visual.
Who completes	Provider familiar with the screening tool and its scoring
Time to administer	1 to 10 minutes
Author	James Coplan
Publisher	Pro-Ed. 1-800-897-3202. www.proedinc.com
Estimated cost	Kit includes manual, object kit, 100 record forms. Items sold separately.
Other	

Selected "All Developmental Areas" Child Development Assessment Tools

AEPS: Assessment, Evaluation, and Programming System for Infants and Children, 2nd Edition

Age range	Birth to six, broken down into a birth to three set and a three to six set for children with disabilities or at risk of disabilities.
Content	Assesses and monitors over time development in six areas: fine and gross motor, cognitive, adaptive, social-communication, and social.
Who completes	Early interventionists, special educators, teachers, caregivers, specialists
Time to administer	
Author	Diane Bricker, editor and author with Betty Capt; JoAnn Johnson, Kristie Pretti-Frontzack, Kristine Slentz, Elizabeth Straka, and Misti Waddell
Publisher	Brookes Publishing and others. Brookes Publishing. 1-800-638-3775. www.brookespublishing.com
Estimated cost	$150 – $250
Other	Valid and reliable - CD-Rom available as well; used by some FITP early interventionists.

Hawaii Early Learning Profile (HELP)

Age range	Birth to 36 months
Content	System that integrates family and health information with developmental assessment. Covers 8 domains – gross motor, fine motor, cognitive, communication, self-help, relationship to persons, emotions and feeling states and coping.
Who completes	Teachers- caregivers, early interventionists: Providers with knowledge of child development and familiarity with team process and parent-professional collaboration.
Time to administer	Varies; time is required to write a good report
Author	VORT Corporation
Publisher	VORT Corporation. Toll free: 1-888-757-VORT (1-888-757-8678). www.vort.com
Estimated cost	Call – or visit web site - Administration and reference guide - $49.95, HELP strands - $3.95 each; HELP charts - $3.00 ea. HELP checklist - $3, HELP Family Centered Interview - $2, HELP activity guide - $27.95, HELP at home - $79.95
Other	Used by a number of FITP early interventionists. Curriculum based.

Infant-Toddler Development Assessment (IDA)

Age range	Birth to 36 months
Content	Six domains – gross motor, fine motor, cognition, language, social and self-help. Family-centered interview and dedicated curriculum.
Who completes	Teachers-caregivers, early interventionists with knowledge of infants and toddlers with disabilities and skills in collaboration with other professionals/families encouraged.
Time to administer	Varies
Author	Sally Provence, J. Erikson, S. Vater, S. Palmeri
Publisher	Riverside Publishing Co. 1-800-323-9540. www.riverpub.com
Estimated cost	Complete kit - $527.50; without manipulatives – $291.50; Components (sold separately): Foundation and Study Guide, Readings, Administration Manual, Manipulatives Kit, Parent report forms, Health report forms, record forms.
Other	Used by a number of FITP early interventionists. Curriculum based.

Ounce of Prevention

Age range	Birth to 3 and a half years
Content	Personal connections, feelings about self, relationships with other children, understanding and communicating, exploration and problem solving, movement and coordination. Three components: Observation Record, Family Album and a Developmental Profile
Who completes	Providers in home or center-based settings. Parents/family members complete the Family Album.
Time to administer	Observations over time
Author	Sam Meisels, Diane Marsden, Amy Dombro, D. Weston, A. Jewkes
Publisher	Pearson Early Learning. 1-800-552-2259. www.PearsonEarlyLearning.com
Estimated cost	Standards and User's guide - $49; Observations records: for 8 age ranges/$24 for 10 pack; Family albums, same
Other	Early Head Start Programs in Vermont are receiving training on using this system of ongoing assessment for each of their enrolled children including children with disabilities.

Carolina Curriculum for infants, toddlers and preschoolers with special needs – 2nd edition

Age range	Birth to two years; preschoolers from 2 to five years
Content	Cognition, communication, social adaptation, fine and gross motor
Who completes	Practitioners in home, school or center-based environments
Time to administer	
Author	Nancy Johnson-Martin, Kenneth G. Jens, Susan Attermeier, Bonnie Hacker
Publisher	Brookes Publishing. 1-800 638 3775. www.brookespublishing.com
Estimated cost	Estimated at <$100.00
Other	Assessment logs tracks performance over time, links to developmental progress charts and in-home and in-center curriculum ideas. Observations that integrate goals and outcomes in natural environments.

A Selection of Targeted Assessment Tools

Following are some assessments that focus more intensely on one or two areas of development:

Devereaux Early Childhood Assessment (DECA – C) (2003)

Age range	2 to 5 years
Content	Behaviors related to both social emotional resilience and social emotional concerns.
Who completes	Parent and teachers complete questionnaires assessing protective factors and behavioral concerns. Must know the child for at least 4 weeks. To score – need training and knowledge in standardized assessment, familiarity with the DECA program and skills in communicating with parents/child care providers. Usually master's level or under close supervision of master's level. Training is available. For training details contact The Devereux Early Childhood Initiative at (616) 542-3109 or www.devereuxearlychildhood.org
Time to administer	10 – 15 Minutes
Author	Paul LeBuffe and Jack Naglieri
Publisher	Kaplan Press. 1-800-334-2014. www.kaplanco.com
Estimated cost	DECA-C kit - $125.95 Materials also sold separately. Kit contains 30 record forms, manual and norms, reference card
Other	See prior comments on the use of the DECA.

Functional Emotional Assessment Scale (FEAS)

Age range	Birth to four years.
Content	Curriculum based - Functional emotional developmental levels
Who completes	Practitioners with training in observation and assessment of infants and young children and training specific to scale.
Time to administer	Time to do in-depth observations
Author	Stanley Greenspan
Publisher	Stanley Greenspan. (301) 657-2348. www.stanleygreenspan.com
Estimated cost	Call – book and training available.
Other	

Communication and Symbolic Behavioral Scale (CBCS)

Age range	Eight months to six years
Content	Curriculum based and communicative behavior (e.g., joint attention, gestures, word inventory), and symbolic development (e.g., comprehension, complexity of action schemes, constructive play).
Who completes	Teachers, caregivers, early interventionists and others trained in assessment of young children
Time to administer	One hour
Author	A.M. Wetherby and B.M. Prizant
Publisher	Paul Brookes Publishing Co. 1-800-638-3775. www.brookespublishing.com
Estimated cost	Call – $399.00
Other	

Autism Diagnostic Observation Schedule (ADOS)

Age range	Toddlers to adults
Content	Communicative and social behavior (e.g., free play, response to name, social smile, symbolic imitation, construction task, joint interaction play, cartoons, emotions, creating a story, etc.)
Who completes	Any service provider who has been *trained* to administer.
Time to administer	35 – 40 minutes
Author	C. Lord, M. Rutter, S. Goode, J. Heemsbergen, H. Jordan, L. Mawhood, and E. Schopler.
Publisher	Western Psychological Services (WPS). 1-800-648-8857 (Pacific Time). www.wpspublish.com
Estimated cost	Call - wide range, depending on materials requested: $37.50 for one module booklet - $1,345.00 for entire Kit
Other	The ADOS consists of four modules, each requiring 35 to 40 minutes to administer. The individual being evaluated is given just one module, depending on his or her expressive language level and chronological age. You select the appropriate module for each individual. Module 1 is used with children who do not consistently use phrase speech, Module 2 with those who use phrase speech but are not verbally fluent, Module 3 with fluent children, and Module 4 with fluent adolescents and adults. The ADOS can be used with toddler who is nonverbal, but it does not accommodate nonverbal adolescents and adults.

References

Berman, C. and Shaw, E. (1996). Family-directed child evaluation and assessment under the individuals with disabilities education act (IDEA). In Meisels, S. and Fenichel, E. *New Visions for the Developmental Assessment of Infants and Young Children.* Washington, D.C., Zero to Three, 361-390.

Devereux Early Childhood Assessment Program (DECA) (1998), Villanova, PA: Devereux Foundation.

Meisels, S. and Atkins-Burnett (2000). The elements of early childhood assessment. In Shonkoff, J. and Meisels, S., (Eds.). (2000) *Handbook of Early Childhood Intervention.* New York, NY: Cambridge University Press.

Partridge, S.E. in March, J.D.B. (1996). Project AIMS: Developmental indicators of emotional health: A brief preventive intervention assessment system of practice for use with young children, birth through five years and their families. Portland, ME: Edmund S. Muskie Institute, Child and Family Policy Center of the University of Southern Maine.

Shonkoff, J. and Meisels, S., (Eds.). (2000). *Handbook of Early Childhood Intervention.* New York, NY: Cambridge University Press.

Sullivan, M. (2003). Presentation at *Seminar on Assessment for Family, Infant and Toddler Interventionists.* Berlin, VT: Family, Infant and Toddler Program (Part C of IDEA Early Intervention Program for Infants and Toddlers) and Essential Early Education (Part B of IDEA Pre-school Special Education Program).

CHAPTER 6
MAKING SENSE OF CHALLENGING BEHAVIORS

Behavior: The Natural Language of the Infant and Young Child

Behavior is the primary way infants and young children communicate with their parents and caregivers until languages skills are well developed. Infants cry to express hunger and discomfort and to bring a parent or other caregiver to help them. They coo and smile to engage caregivers.

Some behaviors of infants and young children are delightful or rewarding to adults. Others are challenging for adults to tolerate or manage. While what is challenging for one adult may not be for another, nearly all adults see extreme behaviors as problematic and in need of attention. When a challenging behavior is intense in quality, provokes a strong reaction from adults, and persists, the family and/or caregiver may need help.

Parents and caregivers strive to help children develop a positive sense of self, make friends and get along well with others, try and succeed at new experiences, recognize and express their needs and feelings, ask for help from caring adults, and control and modulate negative or strong thoughts and feelings. Sometimes a behavior gets in the way of a child achieving these developmental goals. For example, a child might consistently withdraw from social interactions, or another child might kick, scream, and grab others' toys when frustrated. Those caring for the child and supporting the family may become involved in helping to change a challenging behavior pattern so that the child can, ultimately, move toward his or her developmental goals.

All of us come into the world with our own set of neurological strengths and neurological vulnerabilities, which influence the development of our unique temperaments. Within the first few weeks of life a baby may be described as "easy-going" or "alert and active" or "sensitive." Over time, these qualities interact with environmental, social, and caregiving experiences, resulting in the development of one's behavioral style. Furthermore, our unique neurological characteristics contribute to how we learn to control or regulate different types of behaviors. As they grow, children must learn how to control or modulate thoughts, feelings, and behaviors in several areas of development, including:

- *Regulation of emotions*, especially the capacity to temper reactions to negative emotions.
- *Physiological regulation* resulting in regular sleeping, eating, and elimination cycles.
- *Regulation of attention* and the ability to focus on a specific person, object or task.

- *Motor/physical control* of one's body as children grow and learn to move about in their environments.
- *Social regulation*, which promotes the ability to connect and enjoy the give and take of interactions with others.

For many reasons, the efforts of young children to regulate themselves can be derailed or delayed and adults may begin to view this as problematic. When an infant's or young child's behavior becomes unsettling, it is important to remember several points:

- Each child and family is unique. A combination of historical, cultural, developmental, familial, and environmental aspects interact to produce each situation.
- Early attention to challenging situations may prevent the development of secondary problems or the growth of a small challenge into a much larger one.
- Challenging behaviors can affect the entire family by causing stress among family members, avoidance of social situations, and embarrassment, guilt and shame.
- Challenging behaviors involve acting out or "acting in" (e.g., withdrawing.) It is usually the acting out behaviors that are regarded as needing attention. It is important to recognize other behaviors as possible concerns, such as the child who avoids social contact or does not engage in social play.

When all those concerned with the care of infants and young children pool their knowledge and expertise, children can be successfully helped to change challenging behaviors.

Making Sense of Children's Behaviors

When parents and/or caregivers feel challenged by a child's behavior, the first step is to learn all about the behavior. This process of discovery begins with the understanding that parents are the experts on their children and can offer a great deal of important information concerning the behavior. Other sources of information might include extended family members, child care/early education providers and medical providers. This discovery process should include an exploration of the following:

- When the behavior started and how long it has been going on
- Under what circumstances the behavior is likely to occur
- How long the behavior lasts
- Factors in the child's environment that might contribute to the behavior
- How people have responded to the behavior

- Responses that have worked to change the behavior and those that have not
- What people believe the child is trying to communicate through the behavior

Whenever possible, children should be observed in their natural environments – at home with family members and in child care or preschool with caregivers and peers. Throughout the process of observing the child and collecting information from parents and others, it is important to maintain a focus on the child's behavior. Critical to this discovery process is the avoidance of labeling or blaming the child or parents, using professional jargon, or presenting oneself as the expert.

Through this process of exploring the child's behavior and life experiences, the family may identify specific stressors. Changes in routines, caregivers, environments, or seemingly minor things, such as a new laundry detergent, can trigger a behavioral response from an infant or young child. When a specific environmental stressor has been identified, plans can be made to reduce or eliminate the stressor. For example, a young child who starts child care or preschool may appear to be happy and thriving within the new program, but the excitement and anxiety of this major transition might come out in behaviors such as problems with sleeping or eating at home. Knowledge about the stress of transitions can help adults be empathic toward the child, rather than angry and punishing, and lead to planning strategies for easing the child's anxiety.

Sometimes a child's challenging behavior may be the result of preparing to move forward developmentally. Noted pediatrician and author T. Berry Brazelton has introduced the concept of "Touchpoints," which are periods of behavioral disintegration, a natural part of shedding the "old skin" and growing into the next developmental stage (1992). When an infant or young child is about to experience a developmental advance in one area, other areas may appear to fall apart. For example, a 10-month old infant may exhibit sleep problems and irritability because her physiology is preparing for and wanting to practice walking. Anticipatory guidance – Brazelton's term for helping parents learn what to expect in the next stage of development – prepares parents and caregivers for these natural, but challenging, periods of disintegration and reorganization.

Another example of developmentally driven challenging behaviors, common among three year-olds, is the appearance of suddenly unexplained fears (e.g., something under the bed, storms, being left, and certain animals). These occur because of cognitive advances that now prompt the child to think of things not immediately present. They can imagine, without physical evidence, something bad happening. The regression to clinginess, crying and irritability reflects a natural developmental movement and will eventually resolve itself as the child matures.

For some children, basic skills may not be developed, due to lack of social learning opportunities, or physiological or neurological factors. These can affect the development of communication, problem-solving, and social skills. For example, a four year-old child might avoid playing with other children due to lack of skills for joining into social play. Or another young child might hit and push due to an inability to

communicate verbally. The process of discovery will help guide adults toward recognizing skills that might need extra attention.

There may be times when a child is trying to communicate a serious problem that has not yet been noticed. Possible issues underlying the behavior include:

- A physical, medical, developmental or genetic problem
- Abuse, neglect or other trauma
- Environmental toxins, allergens or pollutants
- Poorly developed attachment between child and parent/caregiver
- Conflicts or tension among family members
- Domestic violence or substance abuse in the home
- Unrealistic expectations of parents or caregivers

Other chapters in this handbook deal with many situations that may manifest themselves in challenging behaviors. As those caring for the child or otherwise involved with the family explore the child's behavior, they might want to refer to other relevant chapters, such as Chapter 15, which explores domestic violence, if the child has witnessed violence in the home, or Chapter 4, *Early Development, Developmental Delays and Differences,* if there is a biological or neurological issue.

Parents and others caring for the child may find it helpful to keep a log for two or three weeks, in which they record details about the behavior, such as when it occurs, who is present, how often, other environmental information, how the behavior was responded to, how long before the behavior resolved, and so on. These observations can then be shared among those caring for the child and may serve as a springboard for creating a coordinated plan of action. In addition to observations, specific evaluation tools might be used to help understand the behavior. Chapter 5, *Assessment as Discovery,* more fully describes the process of cooperative information-gathering and lists several screening tools.

> "The teacher could not deal with Kevin. In preschool he was hitting and just very frustrated. He was always kind of all over the place, bouncing against the walls…At home he was hitting. I had a black eye one Christmas…The CUPS Worker came in and gave me a whole behavior plan about extending the positive and ignoring the negative. Like pulling over the car when things were going bad and waiting. I started doing that and slowly but surely Kevin came around…things were getting better and better."

Parents and caregivers working together to help the child should be aware that challenging behaviors can sometimes trigger anxieties in the adults who are around the child. These anxieties, in turn, can become barriers to the collective process of learning about and addressing the behavior. For example, if a young child has become aggressive at child care, providers may be tempted to blame parents for these behaviors (e.g., parents are too busy to give the child quality attention) – and parents

may assume that the behavior is caused by the child care environment (e.g., too many children so their child acts out to get attention). It is important that all concerned build alliances and caring relationships so they are able to share observations and concerns openly with each other and to work together to find solutions.

After the initial discovery process, a referral for further evaluation of physical, medical, developmental, psychiatric or genetic problems may be called for. The child's pediatrician, local school district, regional health department, or other family support people may be helpful in locating further evaluation opportunities. *Appendix I* lists state and local Vermont Department of Health offices as well as assessment centers.

Environmental toxins, allergens or pollutants may need to be evaluated and eliminated or minimized. If there is poorly developed attachment, a plan for helping to build nurturing relationships should be addressed. It is often difficult to assess for intra-family tension, domestic violence and/or substance abuse. However, the investment of building a strong trusting relationship between parents and support persons can help open the door to these issues.

Interventions at Home and in Early Childhood Programs

In order to successfully address challenging behaviors, families, and those supporting them, should observe the following:

- A respectful, family-centered, and collaborative orientation
- Realistic goals for creating change
- Measurements for recognizing progress
- User-friendly interventions that are acceptable to parents and caregivers
- Developmentally appropriate experiences for the child

Interventions should take place within all of the child's natural environments and directly involve all of those with significant involvement in the child's life (parents, grandparents, other extended family, caregivers, teachers). A guiding question is, "What can we change in the environment to bring about desired results?" For example, if a fifteen month-old has started to tantrum when left at child care, parents and child care providers should discuss strategies for lessening the anxiety the child feels at separation. This might include a ritual of engaging the child with the provider before the parent leaves, keeping a photo of the parent at child care, and giving the child something of the parent's to keep as a transition object at child care, such as a scarf or glove.

Strategies to address other behaviors might be to change the timing of mealtime or naptime; decrease the number of transitions; prepare children in advance for changes; and/or engage children in calm activities prior to sleeping times. Changing the physical environment may also help (e.g., example, move nap space away from distractions, turn off the TV and radio during mealtime, provide separate play spaces for very young children).

Sometimes adult reactions to a child's behavior inadvertently reinforce the challenging behavior, rather than lessen it. In these situations, parents and/or caregivers will need extra support while they work on changing ineffective responses. For example, adults may be accustomed to giving a great deal of attention to a child who hits another child. The child may continue to use this behavior because of the attention it yields. It may take a few days for child care providers and/or parents to learn and practice a new response, such as shifting the focus of attention to the child who is hit.

Because infants and young children prefer what is familiar, they are likely to increase or intensify old behaviors during the first stage of adult response changes. A child who used to get a lot of attention for biting may actually intensify biting behavior for a period of time. This is normal, but frustrating for parents or caregivers who could interpret this increase of undesired behaviors as an indication that the new approach is not working. It is helpful to remember that this intensification of behavior is actually a sign of progress – like a wound that itches as it heals.

Whenever possible, it is advisable to start with the least intrusive strategies. Some of these strategies include:

- Ignore the behavior
- Distract and redirect the child's focus
- Reflect back to the child what is observed
- Give an empathic description of the child's feelings
- Present real choices (usually no more than two)
- Model desired behavior
- Reward desired behavior when it occurs
- Use humor and a light touch (without teasing, humiliation or shaming)
- Use clear language to describe what you expect from the child, coupling "don't do this" with desired replacement behavior
- Externalize the behavior so you can talk to them about it as something that can be changed, such as referring to a child's tantrums as "Mr. Dragon," or social avoidance/shyness as the turtle who is afraid to come out of its shell.

If these milder interventions are unsuccessful, the family and providers may choose to explore other options, including seeking outside help.

Seeking Additional Support

When parents seek outside help to address a challenging behavior, their greatest needs may be for encouragement, information, and guidance to help them get back on track with their child. Sometimes it is helpful to seek additional help from people who provide specific services. This may be an observation and feedback from a consultant, or interactions involving a consultant with child and parents and/or caregivers. Below are a few types of consultation that may be helpful.

Attachment Building

An infant's or young child's primary attachment can be disrupted or compromised through experiences such as early loss of a parent, severe neglect, or being raised in an environment where little individual attention is provided. In such cases, a program to help build healthy attachment with a primary caregiver (parent, foster parent, or other significant adult) may be needed. The lack of secure attachment can result in a number of challenging behaviors such as social avoidance, clinginess, provocative behaviors, indiscriminate affection toward others, poor impulse control, and aggression. Attachment building between the young child and parents can be coached by a specially trained counselor. Ideally, other family members and child care providers are included in this process so they can support the child and parents in this process.

Relationship Enhancement

Some parents and/or caregivers have a difficult time setting limits in a clear and compassionate way. Young children need to develop inner discipline and learn to manage their own behaviors. Adults may be too harsh, too permissive, or markedly inconsistent in their interactions with children. There may be frequent power struggles. Parents may feel as if things are out of control. Some parents end up not only exhausted, but dissatisfied and resentful in their parenting role. Some children and parents benefit from a program that helps parents learn to balance the joy of connecting and playing with their young child while setting necessary and reasonable limits in a calm, consistent, and compassionate way. This relationship support can be provided by parenting education classes, home visitors or by counselors trained in working with young children and their parents together.

Play Therapy

Because young children do not have well developed language skills to express their inner experiences, they use their behavior and play to express their thoughts and feelings. In some situations, it is helpful to both create a behavioral program to benefit the child and parents and to provide opportunities for the child to express herself through play materials. Sometimes this involves coaching parents and/or caregivers in how to provide expressive opportunities for the young child and encourage playtime for the child. If the child's challenging behaviors are a result of sexual abuse, physical abuse, witnessing violence, or other trauma, the child may benefit from guided play therapy which provides a safe outlet to express all that is trapped inside. Children who have experienced any significant loss, or whose parents are going through separation/divorce may also benefit from expressive therapy. This approach allows therapists to communicate with children through play and art materials, and helps them to metaphorically express their experiences.

Traditionally, family counseling is a verbal exchange among family members. In family play therapy, families are coached to play together in a way that includes young family members. Parents and siblings are encouraged to "listen" to what the young child is communicating. The counselor acts as a coach, guide and interpreter in a process of shared communication and interaction. This process can help family members to better understand each other, which promotes new solutions and strategies.

Referrals to Specialists

After the discovery process, parents and others involved with the child may try some new responses to affect the child's behavior. If these are unsuccessful, they may decide to seek more specialized help. This could involve a referral to a child and family counselor, medical practitioner, psychiatrist or psychologist, physical therapist, sensory integration specialist, or other service provider.

For example, the communication patterns and behaviors of a four-year-old might indicate the possibility of autism, and the team of supporters may seek a specialist in autism spectrum disorders. Or a two-year-old's tantrums may occur daily, last for over an hour, and cause harm to the child, leading to a referral to a psychologist who specializes in young children. Or a five-year-old, after successful toilet training, now wets and soils herself and refuses to use the toilet. The parents and family physician may decide to seek further evaluation from a medical specialist, psychiatrist, or psychologist.

Following is a list of mental health specialists and a brief description of each specialty:

- *Psychiatrists* are medical doctors who have gone on for further training in psychiatry, which is the study, diagnosis, treatment and prevention of mental or emotional illness. They evaluate and diagnose for such conditions as depression and anxiety, and can prescribe medication. Child psychiatrists receive further training in treating children with serious emotional disturbance.
- *Psychologists* are trained in using many different kinds of testing tools and can conduct formal evaluations. Schools often use psychologists for educational and psychosocial evaluations. Some psychologists also have psychotherapy practices.
- *Social Workers* are trained in helping families use various systems of support. Some social workers work within child and family agencies, hospitals, or schools. Clinical social workers are trained to practice psychotherapy with adults, children and families.
- *Mental Health Counselors* are trained to practice psychotherapy with individuals and families, but not to use psychological evaluation tools. Some specialize in working with children and families.
- *CUPS or Early Childhood Mental Health Consultants* focus on infants and young children and their families. They go to families' homes and child care locations to observe and offer suggestions to parents and child care providers. They actively collaborate with providers and services involved with young children and families.
- *School Guidance Counselors* are trained to help students and families within a school system. They meet with classrooms of students for guidance, facilitate small groups, and help individual children and families with issues related to school.

- *Case Managers* are trained to organize teams of people supporting a child and family. They facilitate meetings, coordinate and implement treatment plans and act as liaisons among different people such as parents and specialists.

Critical to successfully helping a child and family, especially when there are complex circumstances, is the coordination and collaboration of all those supporting the child and family. Sometimes families are confronted with conflicting messages from those that are helping them. These conflicts may be philosophical or based in different orientations, such as

- Family-centered vs. child-centered approaches
- Home-based services vs. center- or office-based services
- Homeopathic vs. traditional medical treatments
- Pharmacologic (medication) vs. behavioral interventions

Parents may hear conflicting evaluations or diagnoses and disagreements among service providers – all of which undermines their confidence in those from whom they seek support. A spirit of open-mindedness and inclusiveness among those helping the child and family is far more likely to inspire growth and change.

RESOURCES FOR MORE INFORMATION

WRITTEN MATERIALS FOR ADULTS (GENERAL)

Concept paper on the identification of and intervention with challenging behaviors, adopted 1999, by the Division for Early Childhood (DEC) of the Council for Exceptional Children.
www.dec-sped.org

Several books have been written by researchers and practitioners to help parents and others concerned with challenging behaviors. The language and content of these books is practical, straight-forward and reader-friendly:

Brazelton, B. Berry (1992). *Touchpoints: Your child's emotional and behavioral development birth to three.* New York; Perseus Publishers.

Greene, R. W. (1998). *The explosive child: A new approach for understanding and parenting easily frustrated, chronically inflexible children.* NY: HarperCollins.

Greenspan, S. & Salmon, J. (1996). *The challenging child: Understanding, raising and enjoying five difficult types of children.* Perseus Publishing.

Kucinka, M.S.(1991). *Raising your spirited child: A guide for parents whose child is more intense, sensitive, perceptive, persistent.* NY: HarperCollins.

ORGANIZATIONS AND WEBSITES (GENERAL)

The Division of Early Childhood of the Council for Exceptional Children is an international organization for individuals who work with or on behalf of children with special needs, birth through age eight, and their families.
www.dec-sped.org

Familyresource.com provides a wide array of articles and resources for parents and others supporting families.
www.familyresource.com

ORGANIZATIONS AND WEBSITES (GENERAL) *(CONTINUED)*

The National Network for Child Care provides "knowledge about children and child care from the vast resources of the landgrant universities (for) parents, professionals, practitioners, and the general public. We network with committed individuals around the country to bring you practical information and resources that will be useful to you in your every day work with children."
www.nncc.org

Spirited Kids, based in England, "(helps) parents and teachers cope with children with big personalities. Its work allows parents and teachers to share their experiences with each other and with experienced consultants and to identify the triggers that lead to challenging behaviors. Once this is done it is possible to develop strategies that reduce the conflict and struggles and help enhance the child's self-esteem and self-management skills."
www.spiritedkids.com

The Brazelton Touchpoints Center website offers parenting information as well as a "series of links to noteworthy sites which may provide helpful, professional assistance on child care and parenting questions."
www.touchpoints.org

Zero to Three "promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf." Their website contains many articles, tips for parents and providers, and links to other sites.
www.zerotothree.org

RESOURCES FOR SPECIFIC BEHAVIORAL CHALLENGES FOR CHILDREN AND ADULTS

SLEEP

Ferber, R. (1986). *Solve your child's sleep problems.* Fireside Publications.
Describes a specific program using a graduated or progressive approach to lessening an infant's or young child's dependence on adult involvement (rocking, sleeping with, holding) to fall asleep.

Sleepnet.com provides a variety of information and links related to infant and children's sleep.
www.sleepnet.com/children2000

EATING

Hirschmann, J. R. & Zaphiropoulos, L. (1993). *Preventing childhood eating problems: A practical, positive approach to raising children free of food and weight conflicts.* Gurze Books.

Satter, E. (2000). *Child of mine: Feeding with love and good sense and how to get your kid to eat...but not too much.* Bull Publishing Co.
Presents information about food and about emotional aspects of eating and how to make eating a healthy and pleasant experience for children.

TOILETING (INCLUDING ENURESIS, CONSTIPATION, AND ENCOPRESIS)

Schaefer, C. E. (1995*). Childhood encopresis and enuresis: Causes and therapy.* Jason Aronson.
Covers the physiology and treatment of encopresis and enuresis as well as toilet training practices.

There are many books for young children about toilet training. Some titles are:

- Galvin, M. R. & Ferraro, S. (2001). *Clouds and clocks: A story for children who soil.* American Psychological Assoc.
- Frankel, A. (1999). *Once upon a potty: Girl* and *Once upon a potty: Boy*. NY: HarperCollins.
- Borgardt, M. & Chambliss, M. (1994). *What do you do with a potty? An important pop-up book*. Intervisual Books,

TOILETING (INCLUDING ENURESIS, CONSTIPATION, AND ENCOPRESIS) *(CONTINUED)*

The National Kidney Foundation has a section on bedwetting.
www.kidney.org

The Enuresis Resource & Information Centre (ERIC) provides comprehensive information for parents, professionals, and kids.
www.enuresis.org

ATTENTION-SEEKING OR DEMANDING BEHAVIORS (INCLUDING TEMPER TANTRUMS AND POWER STRUGGLES)

Blumenthal, D. & Stevenson, H. (1996). *The chocolate covered cookie tantrum.* Clarion Books.

Faull, J. (2000). *Unplugging power struggles: Resolving emotional battles with your kids*. Parenting Press.
Practical advice for how to avoid, or at least endure, power struggles.

Kurcinka, M. S. (2001). *Kids, parents, and power struggles: Winning for a lifetime*. Quill Books.
Helps parents use power struggles as opportunities to teach children important life skills such as self-calming, how to be assertive and not aggressive, problem-solving, and working cooperatively with others.

ANXIETY (INCLUDING SEPARATION ANXIETY AND SPECIFIC FEARS)

The Child Anxiety Network is designed to provide "thorough, user-friendly information and direction for those who are not sure where to turn when they think their child or a child they know may need help to cope with anxiety."
www.childanxiety.net

Hanks, K. (2000). *Wimberley worried*. Green willow Books.
A mouse worries about everything: big things, like whether her parents might disappear in the middle of the night; little things, like whether she'll spill grape juice on her toy rabbit; and things in between, like whether she might shrink in the bathtub.

AGGRESSION (INCLUDING TEASING AND BULLYING)

Free Spirit Publishing, self-help resources for kids, teachers, and parents; includes questions by kids and answers by experts about issues such as privacy, teasing, and dealing with bullies.
www.freespirit.com

Parents, H. (1995*). Development of aggression in early childhood***.** Jason Aronson.
Focuses on the emergence of aggression in the first three years of life, the influences on aggression and what is, and is not, a healthy expression of it. Suggests preventive measures to modify hostility in children.

There are a number of picture books for young children about bullying and aggression. A few examples:

- Gassy, M. & Heinlein, M. (2000). *Hands are not for hitting*. Free Spirit Press.
- Bang, M. G. (1999). *When Sophie gets angry – really, really angry.* Blue Sky Press.
- Hayes, G. (2001). *Patrick and the big bully.* Hyperion Books for Children.

Also see books listed under General Resources in this chapter.

SOCIAL AVOIDANCE OR ISOLATION

Bechtold, L. (1999). *Buster: The very shy dog*. Houghton Mifflin Co.

Hood, S. & Clearwater, L. (2000). *Tyler is shy*. Mass Market Paperback.

SOCIAL AVOIDANCE OR ISOLATION *(CONTINUED)*

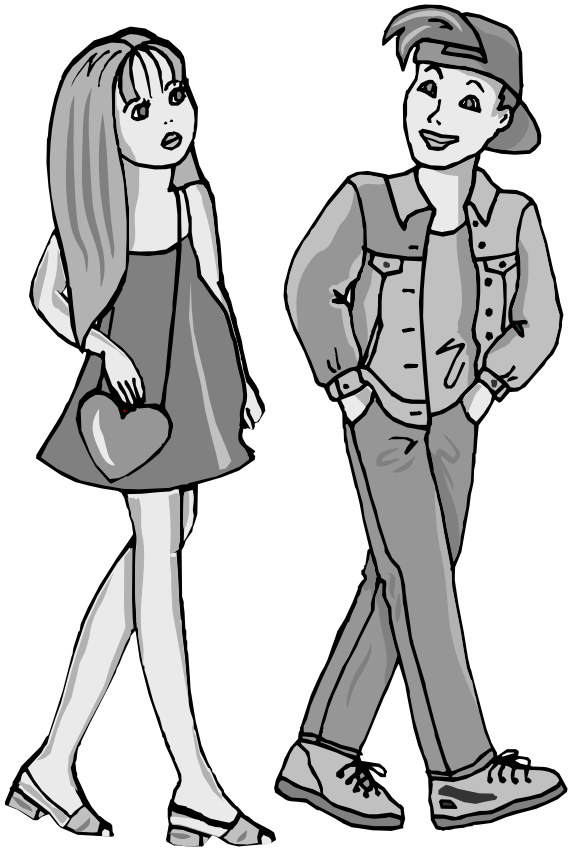
Nowicki, S. & Duke, M.P (1992*). Helping the child who doesn't fit in*. Atlanta: Peachtree Publishers.

Rubin, K. H. and Asendorpf, J. (1993). *Social withdrawal, inhibition, and shyness in childhood***.** Erlbaum, Lawrence Associates.

Zimbardo, P. G. and Radl. S.L. (1999). *The shy child: A parent's guide to preventing and overcoming shyness from infancy to adulthood.* Malor Books.

PART THREE

UNDERSTANDING AND RESPONDING TO DIFFICULT FAMILY CIRCUMSTANCES



CHAPTER 7
TEEN PARENTING

General Adolescent Development

Between the ages of 12 and 20, adolescents transition from childhood to adulthood, from dependency on their parents and other adults to increasing self-sufficiency. Each period of adolescence has its own distinct tasks and challenges. During these years, teenagers' cognitive scope transitions from relatively concrete, personal-experience-based conceptualizations to broader and more abstract ways of thinking. They are formulating their own self-identities, developing value systems and exploring lifestyles and career choices. It is a period of maturation in sexuality and intimacy.

Adolescence is often described as a "roller coaster" because of the intense emotional peaks and valleys many teens experience. Internally, adolescents must manage the physiological growth and hormonal changes that accompany sexual development, as well as the external stresses of peer pressure and societal expectations. Relationships between teens and parents can be rocky at times, as each is challenged to adjust and redefine the relationship over the years of adolescence.

Teens naturally engage in experiential learning and experimentation with "adult" behaviors. While adolescents naturally and increasingly assert their own control, they also want and need the guidance and support of adults who sincerely care about them. Teens respond to adults who listen to them respectfully, openly, and non-judgmentally. Building trust requires adults to connect with teens where they are - while also holding them accountable for their decisions and actions. This means making a long-term commitment to them that will continue regardless of their sometimes impulsive, argumentative or withdrawn behaviors. It is important to notice and enhance teens' accomplishments, strengths and ideas and to use affirmations and positive feedback. Both teenagers and adults benefit from focusing on teens' strengths and accomplishments, responding to their ideas, and helping them create a life that is healthy and satisfying.

Supporting Adolescents Through Pregnancy and Parenting

The adolescent years are challenging enough without significant stressors such as pregnancy and parenting, the demands of which can conflict with the normal course of adolescent growth and changes. A pregnant teen is suddenly thrown into having to think about new issues and make decisions that may change the direction of her life. One considerable decision concerns whether to terminate the pregnancy or give birth. If the teen chooses to give birth, she then needs to think about options for herself and her child such as whether to parent her child, or to release her child for adoption. All of these decisions contain their own stress and needs for special support. Furthermore, attending to these considerations may compete with other important developmental tasks of adolescence.

Over the course of several years, adolescents engage in a gradual process of learning and practicing many skills in preparation for becoming adults, such as finishing school, entering the world of employment, learning to live on their own, and planning for the future. When a teen is faced with becoming a parent, this course of learning and practicing is changed as the focus quickly shifts to the pregnancy, birth, and parenting. How this is played out depends on where a teen is in her own adolescent journey, her unique thoughts and feelings about pregnancy and parenting, and the degree of support available from family, friends and community.

Those who support pregnant and parenting teens have a valuable opportunity to share in a joint focus on the mother's pregnancy, both parents' preparation for parenting, and the infant or young child's development. Caring adults can explore with teen parents-to-be their thoughts, feelings, and expectations for their child, and then continue to provide support and guidance as the new parents learn to love and care for their infant and young child. As adult mentors provide nurturance, commitment, time, caring and genuine interest in adolescents, they are modeling for teen parents how to express these things to their child.

Helping adolescent mothers and fathers address their personal needs can be combined with promoting healthy development in their children. Those supporting teen parents and their children must maintain a balance between addressing the physical, emotional and social needs of pregnant or parenting teens and the developmental needs of their fetus, infant, or young child. Generally, supports fall under these categories:

- *Physical needs* such as housing, food, clothing, transportation, child care, and physical needs of the infant, such as clothing, furniture, car seat, diapers, etc.
- *Medical needs*, including prenatal care, life-style adjustments (e.g., healthy diet, exercise, cessation of tobacco, alcohol and other drug use), mother's and child's medical care, birth control, and supplemental food programs for pregnant women, infants and young children (WIC).
- *Household management skill development,* such as budgeting, economical shopping, nutrition and food preparation, tenant rights and responsibilities, and home maintenance.
- *Education and employment* (for the teen parent) including finishing high school, post-secondary education opportunities, job training, short and long-term employment potential and promoting a positive future outlook.
- *Parent education* about prenatal, infant and early childhood development, presented incrementally, one step ahead of the child's development (not all at once).
- *Emotional support* which conveys genuine interest in the teen's ideas, aspirations and abilities, and addresses issues with which the teen is struggling such as dating/relationship violence, possible history of abuse or neglect, and self-esteem.

- *Social opportunities* that are healthy for parent and fetus/infant/young child, that is, substance-free, respectful of all who participate, family-friendly, and appropriate for children who are present.
- *Community advocacy* about the needs of young parents; helping the community support positive social experiences for teens.

Some teen parents may choose adoption for their child-to-be or newborn. As the birth parents, teens who free their children for adoption need another kind of support that recognizes their feelings and losses. Those supporting pregnant teens who wish to explore adoption should help them consider specific adoption issues such as closed vs. open adoption, private vs. public agency adoption, and the degree of contact they would like with the adoptive parents and their birth child. There needs to be a plan for relinquishment of the infant, an opportunity for the birth parents to say goodbye to the child, and ongoing support, after relinquishment, to help manage possible feelings of guilt, depression, anger, shame, anxiety, etc. There are specially trained counselors, organizations, and support groups who help birth parents through the relinquishment process and accompanying feelings.

Another significant challenge can be the impact of pregnancy and parenting on teenagers' relationships with their own parents. In some cases, the impending birth of a grandchild may inspire a family to rally around the teen and strengthen family ties. In other cases, pregnant and parenting teens may experience disconnection from their families, leaving them feeling abandoned and rejected. In most cases, there is bound to be an upheaval of emotions as adolescents and their parents come to terms with how the pregnancy, birth and needs of their young child will change their lives and relationships. Sometimes it is helpful for a support person or counselor to talk with pregnant or parenting adolescents and their parents together, to explore how to best meet the needs of the infant or young child, what each expects of the other, and to plan for the future.

After the child is born, teen parents benefit from ongoing support through the ups and downs of parenting a newborn, infant, toddler and young child. It is important to think about how to:

> "When April was young, I really don't know if I was into her development and, you know, much about nurturing, or much about loving her, more than can I get her dressed, can I get her fed, can I get her back and forth to wherever she has to go so I can get to school."

- Promote attachment between teen parents and their infant or young child, through coaching in activities such as massage, gentle touch, eye contact, holding, rocking, singing, cooing, and playing with their newborn and infant.
- Explore with the teen parents their infant's or young child's abilities, temperament, communication patterns, and behaviors, including eating, sleeping, elimination, activity level and play behaviors, and how to interpret and respond to challenging behaviors.

- Enhance teen parents' pride and pleasure in parenting their infants and young children and encourage and reward positive parenting behaviors, (e.g., notice competent parenting practices, express delight in the child's accomplishments, notice the child's special responsiveness to his parent.)
- Help teen parents understand the normal stages and growth patterns of the fetus, newborn, infant and young child by using learning aids such as posters, pictures, videos, demonstrations.
- Present child development learning experiences that fit the learning style and timing of the teen parent, (e.g., focus mainly on the current stage and what is just around the corner in the child's development.)
- Help to prepare teen parents for the normal periods of disorganization or aggressions that naturally occur during an infant's and young child's development, and help teen parents obtain support during these times of vulnerability and uncertainty.
- Help teen parents determine if their child needs outside evaluation or specialized services (e.g., for a possible developmental challenge) and help them seek available resources.

Teen Pregnancy and Parenting: Risky Behaviors

A normal part of adolescence involves experimentation with new behaviors. This experimentation sometimes includes behaviors that are detrimental to a developing fetus, infant, or young child. While many teens do not engage in risky behaviors, those who are supporting teens during pregnancy and parenting need to be aware of and address these issues, which affect a substantial number of adolescents. These include smoking, use and abuse of alcohol and other drugs, sexual activity with different partners and unprotected sex, domestic or dating violence, and other impulsive, unsafe actions (e.g., hitchhiking, not wearing seat belts, etc.). These behaviors might lead to poor decision-making concerning the fetus or child, inadequate supervision of the child, or endangerment of the physical health and safety of the fetus or infant/young child.

Honest, direct, nonjudgmental and practical steps may help to assure the safety and healthy development of teen parents' babies during and after pregnancy and throughout their early years. Teens may benefit from interactions from adults who are willing to explore these safety concerns with them by:

- Talking candidly about tobacco, alcohol and other drug use and how their use affects a fetus, infant and young child.
- Presenting information about safe sex, complications of multiple sexual partners, and healthy sexual behaviors during pregnancy.
- Talking about sexual activity and the role of intimacy, answering questions, correcting misinformation, and advocating safe and healthy sexual practices.

- Talking with adolescent couples about positive and healthy relationship building.
- Talking about domestic and dating violence, “red flags” that signal a potentially abusive relationship, and the role of power and control in relationships, communication, and aggression.
- Talking with victims of dating and domestic violence about how to seek safety for themselves and their children, and use local resources such as safe homes, court orders and self-help groups.
- Connecting teen parents who are extremely angry, violent, or out-of-control with resources to help them gain control of their anger and violent behaviors.
- Talking about impulsive behaviors that can be harmful to the fetus, infant or young child and how to replace these with conscious, thoughtful, and healthy decisions.

Safety Concerns and Possible Risks to the Young Child

Adolescent parents, like older parents, may engage in neglectful or abusive behavior toward their children. Teens who are connected to supportive services such as a Parent Child Center, other child care environments, or a home visitor can be helped to learn how to avoid or change neglectful or abusive behavior and how to keep their children safe from harm. This may be particularly important for teens who have experienced abuse or neglect during their own childhoods. However, a number of other factors may contribute to neglectful, insensitive, or abusive parenting, including a lack of knowledge about the fetus, infant and young child's developmental needs, stress caused by inadequate physical, social, and emotional resources, substance abuse, relationship violence, low frustration tolerance, unrealistic expectations and impulsivity or poor decision making.

If adolescent parents are neglectful or abusive toward their children, support people need to be able to talk with them about what constitutes neglect and abuse to an infant and young child and what they need to do to improve their care. They need to explore whether the teen parent is willing and able to protect and nurture the child, or if alternative care for the child needs to be put into place. Child care providers and others who support infants and young children and their adolescent parents need to be able to recognize signs of neglect or abuse and report these, as mandated, to the child protective agency (in Vermont, Social and Rehabilitation Services). Child Protective Service, or SRS, can provide access to services for teen parents who want to change neglectful or abusive practices, and, when necessary, provide alternative homes for infants or young children, (e.g., foster, adoptive or kinship care.)

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Bell, R., co-authors and members of the Teen Book Project (1998). *Changing bodies, changing lives: A book for teens on sex and relationships, 3rd. edition.* NY: Random House.
This comprehensive manual for, about and, in part, by teens, covers the breadth of concerns teens (and adults who care about them) have about their ever-changing bodies, relationships, sexuality, physical and emotional health, and problems that can arise during these years of growth (e.g., eating disorders, substance abuse, violence, and sexually transmitted diseases.) Each chapter contains practical, user-friendly information as well as resources.

Injoy is a company dedicated to providing videos on topics of pregnancy, childbirth, postpartum care, baby care, parenting, teen pregnancy and teen parenting. A collection of videos specifically for teens includes such titles as

- *Healthy steps for teen parents* (3 volumes)
- *Sex smart for teens*
- *Teen breastfeeding*
- *The adoption option*
- *The stages of labor: A visual guide for teens*

1-800-326-2082

Leach, P. (1997). *Your baby and child: From birth to age five*, *revised edition.* NY: Knopf.
This comprehensive guide to infant and early child development is presented in easy to understand language and includes many photographs and drawings.

Morning Glory Press is dedicated to providing books for and about pregnant and parenting teens. A few of the many titles:

- *Teen moms: The pain and the promise*
- *Teen dads: Rights, responsibilities and joys*
- *Teenage couples: Caring, commitment and change*
- *Your baby's first year*
- *The challenge of toddlers*
- *Pregnant? Adoption is an option*

Toll free: 1-888-612-8254. www.morningglorypress.com

Simpson, C. (1995). *Everything you need to know about living with your baby and your parents under one roof.* NY: Rosen Publishing Group.
Explores key issues for teen parents living "at home;" strong inclusion of teen fathers.

Smith-Brassard, A., Keating, K., & Keleher, K. (2000). *Path to parenthood.* Barre, VT: L. Brown & Sons.
Covers physical development of the fetus, what to expect at the time of birth and what to expect after birth. Many topics are addressed, including pregnancy, baby supplies, signs and stages of labor, care of mother during pregnancy and after birth, Vermont resources and much more. Copies available from the Vermont Department of Health (see *Appendix I* for state and local offices) and home health agencies.

ORGANIZATIONS AND WEBSITES

Advocates for Youth is dedicated to promoting adolescent sexual health; comprehensive website includes publications, factsheets and web sites for teens.
www.advocatesforyouth.org

National Organization on Adolescent Pregnancy, Parenting and Prevention is a network of individuals and organizations committed to helping teens make responsible decisions about sexuality, pregnancy and parenting through sharing of information, resources, support and coalition building.
www.noappp.org

Vermont Parent Child Center Network consists of regional Parent Child Centers which offer a variety of supports to teen parents including pregnancy and birth support, help with housing and household management, employment preparation, fun and healthy social opportunities, child care for infants and young children, and other services. Below is a list of local Parent Child Centers (all area code 802):

Parent Child Center (PCC)	Address	Phone Numbers
Addison County PCC	126 Monroe Street, Middlebury	388-3171
Champlain Islands PCC	22 Lake Street, Alburg	796-3013
Early Education Services/Windham County	130 Birge Street, Brattleboro	254-3742 or 1-800-427-3730
The Family Center of Franklin County	27 Lower Newton St., St Albans	524-6574 ext 19
The Family Center of Washington County	32 Washington Street, Montpelier	828-8765
The Family Place PCC	319 US Route 5 South, Norwich	649-3268
Lamoille Family Center	480 Cady's Falls Road, Morrisville	888-5229
Lund Family Center	76 Glen Road, Burlington	864-7467
Milton Family Community Center	23 Villemarie Lane, Milton	893-1457
NEKCA/PCC North	32 Central Street, Newport	334-4072
NEKCA/PCC South	506 Portland Street, St Johnsbury	748-6040
Orange County PCC	35 Ayers Brook Road, Randolph	728-6155
Rutland County PCC	61 Pleasant Street, Rutland	775-9711
Springfield Area PCC	2 Main Street, North Springfield	886-5242
Sunrise Family Resource Center	238 Union Street, Bennington	442-6934
VNA/Maternal Child Health Services	1110 Prim Road, Colchester	860-4420

Planned Parenthood Regional Office	Address	Phone Numbers
Barre	90 Washington Street, Barre, VT 05641	(802) 476-6696
Bennington	140 Hospital Drive, Suite 307, Bennington, VT 05201	(802) 442-8166
Brattleboro	402 Canal Street, Brattleboro, VT 05301	(802) 257-0534
Burlington	23 Mansfield Avenue, Burlington, VT 05401	(802) 863-6326
	Vermont Women's Choice 23 Mansfield Avenue, Burlington, VT 05401	(802) 863-9001
Hyde Park	Page Building, Hyde Park, VT 05655	(802) 888-3077
Middlebury	102 Court Street, Middlebury, VT 05753	(802) 388-2765
Newport	79 Coventry Street, Newport, VT 05855	(802) 334-5822
Randolph	41 South Main Street, Randolph, VT 05060	(802) 476-6696 – On Thursdays, call (802) 728-9800
Rutland	6 Roberts North, Rutland, VT 05701	(802) 775-2333
Springfield	125 Park Street, Springfield, VT 05156	(802) 885-4701
St Albans	80 Fairfield Street, St. Albans, VT 05478	(802) 527-1727
St Johnsbury	357 Western Avenue, Ste 101, St. Johnsbury, VT 05819	(802) 748-8194
Waterbury	55 South Main Street, Waterbury, VT 05676	(802) 244-5651
Williston	183 Talcott Road, Ste 101, Williston, VT 05495	(802) 878-7232

See *Appendix I* for additional relevant Vermont organizations and websites.

CHAPTER 8
PARENT SUBSTANCE ABUSE

Alcohol and other drug use poses significant risks to families with infants and young children, both prenatally and during children's early years. At least 18% of pregnancies are exposed to alcohol, tobacco, and/or other drugs, and as many as twenty-four million children live in homes where substance abuse is present. Parents of infants and young children may use substances such as alcohol, tobacco and other drugs for a number of different reasons including recreation, escape, self-medication, and stress management. Substance abuse occurs in families regardless of age, education level, socioeconomic status, and gender.

Definitions

- *Substance Use* refers to drinking, smoking, inhaling, injecting, or swallowing a chemical substance, which could include alcohol, illicit drugs and prescription drugs. If one drinks a beer with dinner, one is using alcohol, but not necessarily abusing it.
- *Substance Abuse*, according to the American Psychiatric Association's *Diagnostic and Statistical Manual IV*, is "a maladaptive pattern of substance use leading to clinically significant impairment or distress." In other words, if the use of a drug or alcohol causes serious problems – at work, in school, within the family, with the law, or with physical or mental health – it is probably substance abuse.
- *Substance Addiction* refers to a lifestyle characterized by compulsive use and overwhelming involvement with alcohol or other drugs. There is usually continued use of substances despite adverse consequences.
- *Substance Dependence* involves two phenomena: tolerance and withdrawal.
  - *Tolerance* means that an increasingly greater amount of the substance is needed to achieve the same level of intoxication, or "high."
  - *Withdrawal* is the syndrome caused when a dependent person stops taking the drug to which he or she is addicted (including alcohol).
  - *Physical dependence* is a state of physiologic adaptation to alcohol or another drug accompanied by a withdrawal syndrome when there is an absence of the drug.
  - *Psychological dependence* is the feeling of satisfaction and a desire to repeat the alcohol or other drug experience to avoid the discontent of not having it.

Effects of Alcohol and Other Drug Use During Pregnancy

It is strongly recommended that all pregnant women not use alcohol, illegal drugs, or tobacco. Although many women do protect their pregnancies from these health risks, some do not. Women who continue to use substances during pregnancy may do so for

a variety of different reasons. Those who are dependent on substances face the daunting challenge of trying to overcome their physical and psychological need for alcohol or other drugs. Some additional factors that may make it difficult to stop chemical use during pregnancy include

- Regular contact with people who use intoxicants a great deal and where there is an accepting attitude toward use
- Low self-esteem
- Depression, anxiety, or other emotional/social/physical distress
- Environmental stressors such as poverty, inadequate housing or violent neighborhoods
- Lack of social support during pregnancy and parenting

The use of alcohol and other drugs during pregnancy can result in spontaneous abortion, fetal distress, premature birth, physical and/or mental retardation, birth defects and withdrawal symptoms upon birth. The long-term effects to children born following *in utero* exposure to alcohol or other drugs include impulsivity, learning disabilities, antisocial behavior, neurological deficits and increased risk of Sudden Infant Death Syndrome (SIDS). The following details some of the risks associated with the most commonly used drugs.

- *Smoking:* Studies have found that there is a correlation between smoking and low birth weight, and it is believed that smoking plays a large role in the incidence of Sudden Infant Death Syndrome (SIDS) within the first 60 days of life. There are also higher rates of asthma and ear infections among children whose mothers smoked during pregnancy.
- *Alcohol:* Alcohol is one of the most dangerous drugs for pregnant women, especially in the early weeks. Heavy drinking during early pregnancy greatly increases the risk of a cluster of birth defects known as fetal alcohol syndrome. This includes a small skull (microcephaly), abnormal facial features, and heart defects, often accompanied by impeded growth and developmental delays. Heavy drinking in later stages of the pregnancy also affects growth of the fetus.
- *Cocaine:* When a pregnant woman uses cocaine, the fetus is affected directly by the cocaine itself and indirectly by a decrease in the mother's blood flow resulting from the cocaine use. Research suggests that there is an association between prenatal cocaine exposure and impaired fetal growth and a smaller head size at birth. There are higher risks of miscarriage, premature labor, and a condition called abruptio placentae (the partial separation of the placenta from the uterus wall, causing bleeding).
- *Heroin:* Babies of mothers who use heroin are often born underdeveloped. They suffer from breathing problems and infections in the first few weeks of life. Heroin can cause premature labor where the babies may be born so early that they need intensive care. Since heroin can cross the placenta, an unborn baby can become dependent on the drug. Babies of heroin-dependent mothers can suffer withdrawal symptoms after they are born and often need special care in the hospital. In addition, injecting heroin while pregnant increases the risk of HIV infection and other diseases for both mothers and babies.

- *Marijuana:* Studies of marijuana use by pregnant women are somewhat inconclusive because marijuana is used often with other drugs such as tobacco and alcohol. However, most studies have found that marijuana has a direct effect on the fetus through increased carbon monoxide levels in the mother and reduced oxygen passing into her bloodstream. Since marijuana crosses the placenta, it is suggested that marijuana use has an effect on the developing brain of the child, potentially resulting in significantly lower verbal skills and memory abilities in the first few years of life.

Growing Up in a Family with Substance Abuse: The Impact on Infants and Young Children

Children in homes where a parent or caregiver abuses substances may suffer from a variety of physical, mental, and emotional health problems. However, the substance abuse is rarely the only problem occurring in the home. Other problems may include, for example, domestic violence, mental illness, or poverty. While substance abuse does not directly cause domestic violence, a battering incident that is coupled with alcohol abuse may be more severe and result in greater injury. Substance abuse can tear families apart. When one or more people abuse substances in the family, there is often an increase in conflicts between parents, and general tension in the home. Substance abuse can cause pain and injury to family members and lead to an increase in domestic violence, failed marriages, and child maltreatment.

In their book, *The Ties That Bind* (2001), Weinstein, and Takas note that when parents are addicted to alcohol or other drugs:

> There are often no routines or patterns within the household. Children may have a bedtime of 8 PM one night, and midnight the next. Children may take on adult responsibilities such as cooking, cleaning, and helping younger siblings get ready for school. Youngsters may be neglected when the parent uses drugs. Children may be physically or sexually abused by either their intoxicated parents or their parents' drug-using friends. Children may have favorite possessions taken from them by the parents who need money to buy more drugs. Children generally live by the unspoken rule that the parent's addiction is a secret that cannot be discussed or shared with outsiders. At the same time, children have access to alcohol, drugs, and drug equipment (like needles) that can put them in danger. And because most of the family's energy is consumed by drug use, money may be a very real problem, and children may be hungry, and even homeless for periods of time.

Parents who struggle with substance abuse or addiction may not be able to provide for their children's physical, emotional and developmental needs. The substance abuse or addiction can severely compromise the ability of parents to provide a safe and nurturing home for a child. When the parent's primary activity is substance seeking, there is less time focused on the child. When parents abuse substances any of the following can occur:

- Disrupted bonding and attachment
- Chronic neglect of children's needs

- Lack of supervision and safeguarding
- Inconsistent parenting
- Tension and conflict among family members
- Less physical, language, social and emotional stimulation
- Isolation from healthy social experiences
- Few opportunities for age-appropriate play
- Reversal of roles, with children becoming caretakers of the emotional and physical needs of adults
- Secret-keeping patterns

The failure to provide the basic, age-appropriate needs for a child can lead to neglect - not providing for a child's basic needs of food, safety, clothing, shelter, medical and dental care. Neglect also includes lack of supervision, failure to provide for children's safety and inattention to children's emotional and developmental needs. Physical neglect can result in malnutrition, serious illness, compromised mental development, and/or low self-esteem. (See Chapter 14, *Child Neglect* for further information.)

During the first three years of life, infants and toddlers look to caregivers for answers to these questions:

- Do people respond to me?
- Can I depend on other people when I need them?
- Am I important to others?
- Am I competent?
- How should I behave?
- Do people enjoy being with me?
- What should I be afraid of?
- Is it safe for me to show how I feel?
- What things interest me?

In homes where substance abuse exists, these questions frequently go unanswered. Young children may not learn how to relax, play, laugh, and enjoy themselves. Sometimes young children assume aspects of the adult's responsibilities and roles. A "parentified child" may begin to take care of a parent's emotional and physical care.

Physical and Behavioral Indications of Substance Abuse in Families

The negative impact of alcohol and other drug abuse on families may become apparent through a variety of physical and behavioral indicators. The following may alert others to a possible substance abuse problem within a child's family.

Indications as seen in the parent:

- Inconsistent behaviors or notable changes in behavior
- Financial problems despite an adequate income, or sudden unexplained wealth (from selling drugs)
- Evidence of frequent accidents
- Missed appointments, absences from work, repeated lateness

Indications as seen in the child:

- Child, or clothing, is extremely dirty
- Often dressed inappropriately for the weather
- Child falls asleep during the day other than naptimes
- Frequent accidents resulting in physical injury
- Frequent absences or lateness
- Complaints of hunger and lack of developmentally expected weight gain
- Reports from the child that no caregiver is at home
- Emotional outbursts
- Very low self-esteem
- Limited or lack of trust of adults
- Inability to communicate own feelings or emotions

Addressing Substance Abuse in Families

Intervening with substance abuse for maternal health and in the young family is frequently hampered by the hidden nature of the problem. For many parents, the social disapproval and fear of losing their children are strong barriers to seeking help. Substance abuse can be passed from one generation to another. For some parents who abuse alcohol and other drugs, their childhoods offered no experience of families where alcohol and other drugs were a not part of everyday life. They, therefore, have no model for substance-free parenting and family life.

Those supporting families should be aware that chemical dependency is a serious health problem and that people who are addicted to substances suffer from a debilitating illness, not from a flaw in their character or a moral shortcoming. This does not mean they are not responsible for their actions, but they are deserving of respectful, compassionate, and helpful responses and services.

> "I was smoking marijuana at night to go to sleep, self-medicating because my brain wouldn't shut down. And I finally had Sharon [the CUPS Worker] say to me, 'Okay, I'm going to point out to you that every three weeks you come in here in crisis and want to give up, and it has something to do with substance abuse, right?'"

Child care centers and providers should have in place a protocol for responding to substance abuse when it interferes with a child's safety while in care. For example, providers should know what they will do if a parent arrives to pick up a child and is obviously intoxicated. Providers should have readily available lists of local resources for parents who ask for help, including phone numbers of crisis or help lines, Alcoholics Anonymous (AA) meeting schedules, and treatment providers in the community.

How to Have A "Caring Conversation"

Denial and shame may reinforce parents' belief that they should not talk about, trust or even experience their feelings. This, in turn, supports the practice of secrecy about the occurrence, role, and impact of substance abuse within the family. Because the person with whom you wish to talk is likely to be affected by these, it is helpful to prepare oneself for a "caring conversation."

Steps to consider are

- Make the first move – select an appropriate time and place, one that is private and free of distractions
- Ask permission to bring up a concern that may be a sensitive topic
- Be prepared – have resources ready to give the person
- Understand the fear and stigma involved with substance use
- Be aware of your own feelings and beliefs about substance use and abuse

A "caring conversation" includes the following four steps: Feelings, Fact, Feelings, Action.

- *Feelings*: Tell the person how you feel about him or her, regardless of the issue.
- *Facts*: Describe what you have observed, with specific dates, times, and places.
- *Feelings*: Share with the person how these facts make you feel; your concerns.
- *Action*: Tell the person what you know about where he or she might get information and help.

For example, a "caring conversation" by a child care provider might go as follows:

> "Mary, do I have permission to talk to you about something sensitive?
>
> [If "yes"]. I think you know that I care about you and Bobby. I've noticed lately that you have been dropping off Bobby later than usual, and you haven't looked or acted like yourself either. For instance, last Monday, you were an hour and a half late dropping off Bobby, and Tuesday, almost two hours late... Bobby is a wonderful little boy, and to see him appear so isolated from his friends lately makes me sad. This and some other things have made me concerned about Bobby and yourself, and I am wondering about stresses in your life right now. I do know that many families are affected by alcohol or other drugs and there are many places I know about that can help families get back on track."

If you are comfortable doing so, you might share personal experience; for example, "When I was growing up…" This may help the person feel more comfortable when talking with you. You might attribute bringing up this topic to your job, (e.g., "In my role, I often talk about these things with my families.")

You may not feel that you were helpful to the person during your conversation, but perhaps others will initiate similar conversations. Hopefully, over time, these multiple conversations will make a difference. A substance user may not pay attention when one person voices concern, or even when the second person does. However, by the time the sixth or tenth person has approached them, the person using substances may begin to become motivated to make a change.

Supporting Young Children

Often children of parents who abuse substances learn that their feelings don't matter and should be ignored or stuffed inside and not revealed. Children may need extra attention and help with identifying and expressing their feelings. Also, because of "magical thinking," young children are likely to believe they are responsible for whatever happens within their families and to blame themselves for bad things that might occur.

Young children benefit from regular contact with adults who care about and spend time with them. A caring, consistent child care provider or early education teacher can have a significant positive impact on a young child who lives in a family where substance abuse is an issue. Caregivers can support the emotional and social well-being of young children in many ways, such as

- Convey to children that they are important
- Help develop a sense of competency and worth
- Provide consistent nurturing and reasonable limits
- Provide opportunities for children to express their thoughts and feelings via play, art, music, etc.
- Assist in making satisfying contact with other children
- Help with learning about and expressing feelings
- Help with finding joy and optimism in the world

When opportunities arise for the child support person to talk with the child about the behavior of someone at home who abuses substances, the child will benefit from a nonjudgmental approach that allows the child to express whatever they are feeling and thinking. Important messages for the child to hear include

- You didn't cause it
- You can't cure it
- You can't control it
- You *can* learn to cope
- There are many people who care about you
- It's okay to be a small child, to play, and to be happy

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Hastings, J.M. & Typpo, M.H. (1984). *Elephant in the living room: A leader's guide for helping children of alcoholics.* Center City, MD: Hazelden Information and Educational Services.

Nelson, J., Intner, R. & Lott, L. (1996). *Positive discipline for parenting in recovery: A guide to help recovering parents (Developing capable people).* Prima Lifestyles.

Packer, A.J., Jr. (1999). *Parenting one day at a time: Using the tools of recovery to become better parents and raise better kids*. Dell Books.

Streissguth, A.P. (1997). *Fetal alcohol syndrome: A guide for families and communities.* Baltimore, MD: Paul H. Brookes Publishing Company.

Watkins, K.P. & Durant, L. (1996). *Working with children and families affected by substance abuse: A guide for early childhood education and human service staff*. Nyack, NY: Centre for Applied Research in Education.

Wood, B.L. (1992). *Raising healthy children in an alcoholic home.* Crossroad/Herder and Herder.

WRITTEN RESOURCES FOR CHILDREN

Black, C.A. (1997). *My dad loves me, my dad has a disease.* MAC Publishers.

Deaton, W. & Johnson, K. (2002). *Drinking and drugs in my family: A child's workbook about substance abuse in the family*. Alameda, CA: Hunter House.

Hastings, J.M. & Typpo, M.H. (1994). *Elephant in the living room: The children's book.* Center City, MD: Hazelden Information and Educational Services.

Sinberg, J. & Daley, D.C. (1989). *I can talk about what hurts: A book for kids in homes where there's chemical dependency.* Center City, MD: Hazelden Information and Educational Services.

Vigna, J. (1988). *I wish daddy didn't drink so much.* Morton Grove, IL: Albert Whitman and Co.

VERMONT ORGANIZATIONS AND WEBSITES

Alcohol & Drug Abuse Programs (Vermont Alcohol and Drug Abuse Programs (ADAP)) is a division of the Vermont Department of Health. An extensive Resource Library, with a wide range of educational materials, is available to anyone seeking information about substance use. Most of the brochures are free and there are a variety of materials to use as teaching support for young families. State office: 1-800-464-4343 or (802) 651-1550. www.state.vt.us/adap

Regional Offices	Phone Number
Addison Region	(802) 388-4678
Bennington Region	(802) 442-3929
Chittenden Region	(802) 863-7561
Franklin/Grand Isle Region	(802) 524-7918
Morrisville Region	(802) 888-2581
Northwest Kingdom Region	(802) 748-5550
Rutland Region	(802) 786-5876
Washington Region	(802) 479-4250
Windham Region	(802) 257-2885
Windsor Region	(802) 295-8835

VERMONT ORGANIZATIONS AND WEBSITES *(CONTINUED)*

Alcoholics Anonymous (AA) is a support group and 12-step program for recovering alcoholics. Meetings are held on a daily basis in dozens of location around the state. Membership is free, but members must have a desire to stop drinking. Regional Alcohol and Drug Abuse Programs (ADAP) offices publish locations of times of local meetings.
Hotline number: (802) 860-8382. www.alcoholics-anonymous.org

Vermont Parent Child Center Network provides a variety of parenting support and education services for parents of infants and young children through regional Parent Child Centers throughout Vermont. Call (802) 388-3711 for location of local Parent Child Centers or see list of Parent Child Centers in *Appendix I*.

NATIONAL ORGANIZATIONS AND WEBSITES

American Council on Alcoholism
Helpline: 1-800 527-5344. www.aca-usa.org

Hazelden Foundation, a major national provider of treatment, recovery, research and training services for alcoholism and drug addiction, offers programs, services and publications for individuals, families and communities affected by chemical dependency.
1-800-257-7810. www.hazelden.org

National Council on Alcoholism and Drug Dependence
Hopeline: 1-800-622-2255. www.health.org

National Clearinghouse for Alcohol and Drug Information
1-800-662-4357. www.drughelp.org

The National Women's Health Information Center
1-800-944-WOMAN (1-800-944-9662). www.4woman.gov

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

References

American Council for Drug Education. (1999). *Drugs and pregnancy*. www.acde.org/parent/Pregnant.htm

Department of Health and Human Services (1999). *Blending perspectives and building common ground: Report to congress on substance abuse and child protection.* Washington D.C.: Government Printing Office.

Diagnostic and Statistical Manual IV (1994). Alexandria, VA: American Psychiatric Association.

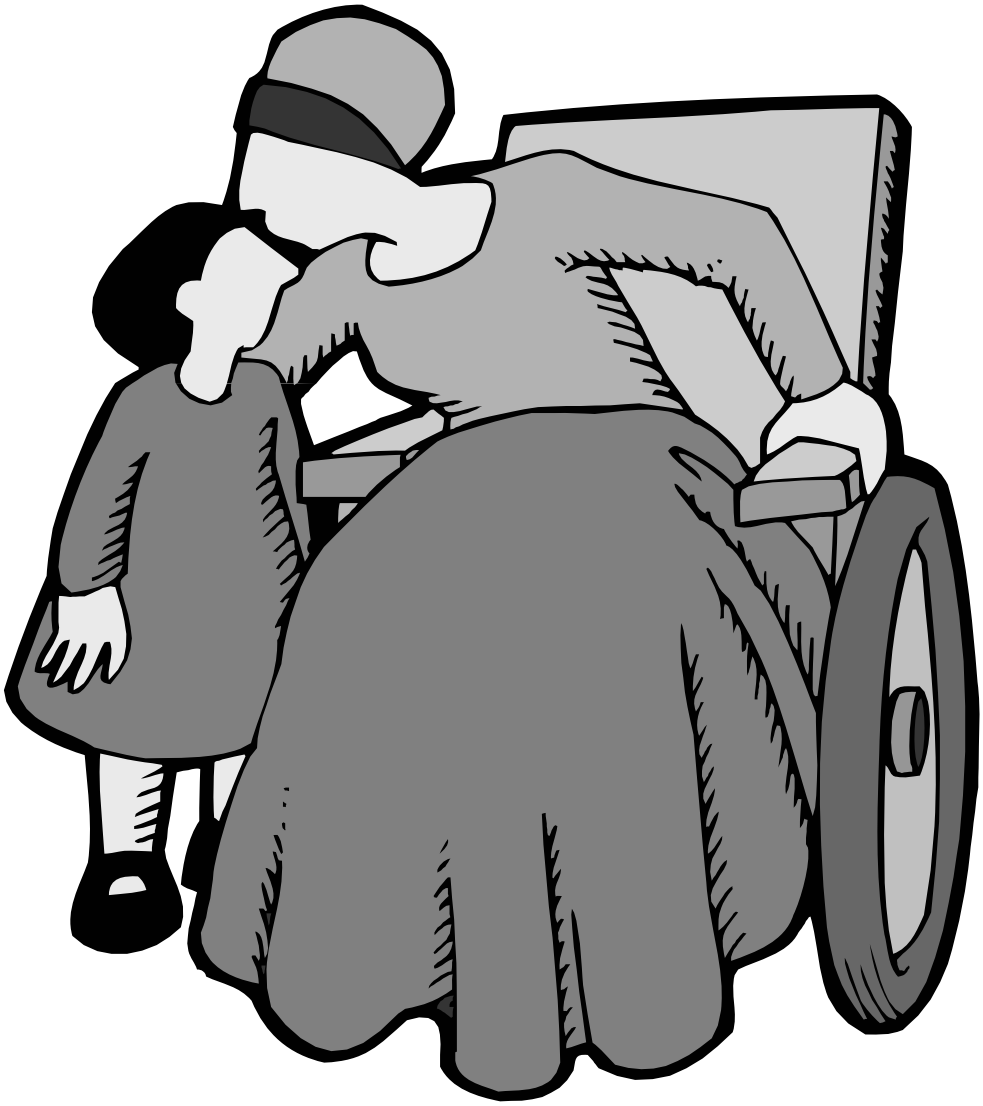
Dube, S.R., et al. (2001). *Growing up with parental alcohol abuse: Exposure to childhood abuse, neglect, and household dysfunction.* Child Abuse & Neglect, Volume 25, Number 12, 1627-40.

From Lullabies to Sneakers, training presented by Trudee Ettlinger, Montpelier, VT, April 11, 2003

Ministry of Children and Family Development (2001). *Community action guide: Working together for the prevention of fetal alcohol syndrome.* www.mcf.gov.bc.ca/child_protection/fas/misconceptions

U.S. Department of Health and Human Services. (2003, February). *The nature of substances of abuse*. www.calib.com/nccanch/pubs/usermanuals/subabuse/appen1.cfm

Weinstein, N. and Takas, M. (2001). *The ties that bind: Parental substance abuse and kinship care*. NY: Phoenix House.



CHAPTER 9
WHEN ILLNESS OR DISABILITY AFFECTS PARENTING

General Background

While raising children poses challenges for all parents, some parents face additional stress due to physical, medical, mental health, or developmental difficulties. Some parents facing these issues are connected to services and supports that help them address the challenges of parenting, but others are taking on their additional burdens all alone. Parents may not talk about their difficulties because they feel embarrassed, ashamed, fearful of criticism, or afraid of losing their children. Some parents might prefer not to share the presence of a disability or health issue with others out of a desire to normalize their role as parent, rather than focusing on their disability or medical condition. The presence of a disability can first come to others' attention during pregnancy or while the parent is caring for their infant/young child.

Parents who live with physical, emotional, or cognitive disabilities may be further challenged by the following factors:

- Social isolation due to inaccessibility of social gathering places; stigma, embarrassment or shame about their illness or disability; or prejudice and rejection from others.
- Vulnerability to mistreatment from those on whom the parent depends for assistance or others who take advantage of them.
- "Falling through the cracks" due to not meeting eligibility criteria, not knowing about or living too far from specialized services.
- Conflicting agendas or requirements of various support agencies.
- Environmental stressors, especially poverty, difficulties with employment, inadequate housing and accessible quality child care.
- Increased financial stress due to the added expenses of adaptive furniture and equipment, medical bills, loss of income, etc.

Those supporting families in which a parent has a disability or long-term illness should be guided by family-centered principles that increase the competency and independence of all families. Among these principles are

- Parents are respected and supported as heads of their families.
- Service providers sincerely value building a relationship with the parents.
- Parents are regarded as responsible adults, rather than through the lens of their diagnosis or disability; families are treated with respect, dignity, compassion and commitment.
- Service providers are willing to learn about the specific disability or illness as a way to better understand the unique challenges the family faces and to better help the parent(s) seek creative solutions.

- Parents and those supporting the family work together in a spirit of collaboration, stressing open communication and respecting confidentiality.
- Supporters may help parents assess their parenting needs, identify available resources, and access services, including child care, recreation, and social activities.
- In situations where the safety of the child is of concern, service providers work with the family and with Child Protective Services both to protect the child and to explore services that will help parents provide for their child's safety.

RESOURCES FOR MORE INFORMATION

ORGANIZATIONS AND WEBSITES

Through the Looking Glass provides services, information, referrals and support to families of adults with disabilities, including physical and visual disabilities, deafness, and parents with developmental disabilities. Through the Looking Glass consults with parents and professionals nationally.
1-800-644-2666. www.lookingglass.org

VERMONT RESOURCES

Supplemental Security Income: Aid to Aged, Blind or Disabled (AABD) is the monthly state supplement to federal supplemental security income (SSI) benefits, which provides a guaranteed minimum income to persons age 65 or older, or to persons determined to be blind or disabled. To learn more about eligibility for SSI contact the Vermont Department of Prevention, Assistance, Transition, and Health Access (PATH).
1-800-287-2800. www.path.state.vt.us

The Vermont Center for Independent Living advocates for disability rights, provides peer support and access to many resources for individuals with disabilities. Main office in Montpelier, Vermont.
1-800-639-1522. www.vcil.org

Postpartum Mood Reactions

There are many stresses associated with the arrival of a child, including changes in the mother's body, loss of sleep, changes in work status, changes in relationships with others (especially spouse/partner and other children in the family), increased financial demands, and loss of personal time and activities. Our society tends to focus on the joys and pleasures of having a baby with very little acknowledgement of the fears, worries, and losses that may accompany the birth of children. A significant number of mothers experience a range of mood reactions during pregnancy and after birth, which can present significant challenges to the mother, the infant and other family members.

Postpartum mood reactions cover a wide spectrum, from "baby blues" to postpartum psychosis. Baby blues occur within days after birth and, generally, last from a few days to a few weeks. Well over half of mothers experience postpartum blues to some extent, which usually resolve on their own. Postpartum psychosis, on the other hand, is much more severe and relatively rare.

Between these two extremes is a range of postpartum reactions, referred to as postpartum depression (PPD), that may appear within a few weeks of birth and persist for many months. Often anxiety accompanies the thoughts and feelings associated with depression. Signs of PPD include sadness, loss of interest in pleasurable activities, fatigue, changes in appetite/weight, changes in sleep, lack of pleasure in the role as mother, feeling worthless, hopeless and guilty, difficulty with concentrating, anxiety about the child's health, possible thoughts of death and/or suicide, thoughts of hurting the child, agitation and/or slowed movements, and strange or obsessive thoughts.

The cause of postpartum depression is unclear. Most likely, it is a combination of biological factors such as changes in hormone levels during and after birth, and psycho-social factors, including emotional or physical stress, insufficient family and social supports, ambivalence about mothering, or a history of abuse. There are a number of risk factors such as personal or family history of depression or anxiety, age (higher occurrence among teen mothers), history of substance abuse, history of pre-menstrual syndrome (PMS), poverty and other stressors such as single parenthood or a life crisis. Some mothers experience PPD as a result of a difficult birth, a physical or health problem in the infant, or death of an infant. Regardless of the cause, PPD can be a debilitating illness.

Infants parented by mothers experiencing depression and/or anxiety can be affected in a variety of ways. Most significant is the impact on attachment building. During the first year of life, the infant internalizes an idea of the caregiver and, by extension, the world. Critical to this development is the quality of responsiveness of the parent to the infant's signals (communications). When a parent is depressed, she may be distant and inconsistent in her availability to her infant. The desire to share time and pleasure with the infant and to respond to the child's needs may be diminished. Infants, in turn, may try harder to attract attention by becoming more demanding or may, conversely, withdraw and become distant toward others. Mothers experiencing depression or anxiety may also have increased difficulty dealing with their infant/young children's normally-occurring difficult behaviors, such as crying spells, night-waking, and varied eating schedules.

Those who support parents dealing with postpartum mood reactions can be helpful in several ways. They may gently explore with the new mother (and her partner) how she is feeling and let her know that many women experience sadness or moodiness after pregnancy. Talking openly and non-judgmentally about what might be regarded as forbidden thoughts and feelings may be a first step toward healing. Together, the support person and family can think about ways to decrease the depression and anxiety. Some possible strategies are to

- Strengthen social supports so the family is not isolated, (e.g., locate a play group for infants and their mothers.)
- Explore ways to reinforce the infant-parent bond, such as teaching infant massage techniques.
- Connect the mother with others dealing with PPD, perhaps through a support group.

- Help formulate realistic expectations for the family so the mother does not overestimate what she believes she should be doing.
- Encourage the mother to practice self-care strategies including good nutrition, exercise, and exposure to positive and inspiring thoughts through books, videos, tapes, and CDs.
- Identify others who can help with child care and household needs.
- Help the mother discover and participate in expressive outlets, for example writing, drawing, photography, clay, poetry.

Parents suffering from postpartum mood reactions may benefit from counseling. It is important to identify counselors who are experienced both in helping women who have depression and/or anxiety and in addressing parenting issues that the mother may want to explore. Sometimes medication can help with postpartum mood reactions. However, social supports and self-help groups may be the most effective because they address self-defeating thoughts, self-blame, isolation, and parenting issues. As depression and anxiety often interfere with a person's ability to take initiative, a family support person might help by taking concrete steps such as making phone calls or scheduling appointments and arranging child care, if the parent consents.

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Bennett, S. (2002). *Beyond the Blues: Prenatal and postpartum depression, a treatment manual.* San Jose, CA: Moodswings Press.
A concise manual about mood disorders seen in pregnancy and the postpartum period, including depression, anxiety, panic, obsessive-compulsive disorder, and psychosis; offers current information and recommendations about treatment from preconception to nursing mothers; includes an extensive list of resources.

Injoy Videos has an array of videos for parents, educators and health care providers on many topics about pregnancy and birth, including several on Postpartum: "Fragile Beginnings: Postpartum Mood and Anxiety Disorders," "Postpartum: A Bittersweet Experience," and "Healthy Steps for Teen Parents: Vol.3: Postpartum."
www.injoyvideos.com

Kleiman, K. (2001). *The postpartum husband*. Philadelphia, PA: Xlibris Corp.
Addresses the experiences of both the wife and husband dealing with postpartum depression.

Life after childbirth: Making it work for you (Revised, 2002). Vermont Postpartum Task Force.
A booklet to help families prepare for postpartum stress and care; practical descriptions of postpartum mood reactions, specific strategies for taking care of oneself and family, and resources. Available from local Department of Health offices. See *Appendix I* for locations of local offices.

ORGANIZATIONS AND WEBSITES

Depression After Delivery (D.A.D.) provides education, support and referrals for women and families coping with pre- and post-birth mental health issues.
1-800-944-4773. www.depressionafterdelivery.com

Postpartum Support International provides information about postpartum mood disorders, support group locator, resources, bookstore and research information.
(805) 944-4773. www.postpartum.net

VERMONT ORGANIZATIONS AND WEBSITES

The Vermont Department of Health has several programs for new mothers including *Healthy Babies, Kids, and Families* (a benefit of Medicaid and Dr. Dynasaur) and *Help Your Baby Help Yourself Helpline.* See *Appendix I* for location of local Department of Health offices.
1-800-649-HELP, (1-800-649-4357)

Vermont Parent Child Center Network supports regional Parent Child Centers. Each center offers a variety of supports for young mothers, which may include pregnancy and birth support, parent support groups, help with housing and household management, fun and healthy social opportunities, child care for infants and young children and other services.
See *Appendix I* for locations of regional Centers.

Mental Illness (Schizophrenia, Bipolar Disorder, Major Depression and Severe Anxiety)

Unlike some other disabilities, mental illness nearly always involves a high degree of societal misunderstanding, prejudice and stigma. Parents with mental illness must deal not only with the twin challenges of parenting and of their illness, but also with the erroneous beliefs and intolerance of many people, and even systems of care, around them. For this reason, some parents with mental illness choose to conceal their illness and to struggle alone. In many states the presence of mental illness in a parent constitutes grounds for termination of parental rights. The fear of losing their children is very real for parents with mental illness and causes some parents to avoid involvement with those who might help their family. Many parents with mental illness also struggle with poverty, isolation, other environmental stressors, increased vulnerability to victimization (past and current), dependence on substances and learning problems.

Children who have a parent living with a psychiatric illness may be affected by some of the following parental patterns or conditions:

- Inconsistent moods and unpredictable behavior
- Emotional unavailability
- Over-protectiveness or over-involvement
- Difficulty responding to the child's needs
- Lack of appropriate limits
- Inconsistent expectations and learning opportunities
- Failure to protect the child from unsafe situations
- Changes brought about by medication use or when a parent stops taking medication

These factors, in turn, may affect infants and young children in a number of ways, including the following:

- Difficulty building a secure attachment
- The development of undesirable coping strategies such as withdrawal or demanding behaviors
- Assuming a care-taking role
- Becoming accustomed to few or inconsistent limits which may lead to unsafe behaviors and difficulty learning self-control
- Exposure to unsafe conditions and potential for harm

Only recently have people begun to address the unique needs of parents with mental illness. Traditionally, services for parents with mental illness have focused on the illness and ignored, or minimized, issues involving parenting. Programs have tended to be problem-focused and based on deficits, rather than building on strengths.

At times, mental illness can significantly hinder parenting, such as when a parent is out of touch with reality or is severely depressed and unable to respond to a child's needs. In these cases, outside intervention may be needed to protect the child. Some parents may not be able to fulfill a parenting role for a period of time due to the severity of symptoms. However, service providers have recently come to appreciate the potential for parents with mental illness to parent well when they have compassionate and adequate support.

Specific circumstances may arise for parents with mental illness that need to be considered in helping them to parent effectively. For example, women who live with mental illness have a higher likelihood of previous or current victimization (physical, sexual, or emotional abuse). The history of abuse, or the occurrence of it in present life, may emerge as an issue during pregnancy or after childbirth. Those supporting the mother should be aware of signs of possible abuse and be prepared to help the mother consider its impact on providing for her child.

> "I was depressed all the time. It was a horrible, horrible time in my life. And I was suicidal because I couldn't feel like I was doing anything with my life. But Janice [the CUPS Worker] boosted my self-esteem and took the focus off the big, long-term goals so I was able to see what the short-term goals were and what I needed to do to feel better inside…Once I felt I was being a good mother and that I was doing everything in my power to help my children, then I was able to do the bigger things."

Sometimes it is necessary, in order to protect a child, to provide alternative care (foster, kinship or adoption). This would follow an assessment by a trained investigator of child neglect and abuse from Social and Rehabilitation Services (SRS).

Supporting Parents with Mental Illness

Those who support families in which a parent has a mental illness must develop a caring and nonjudgmental relationship with the parent, letting the parent know they are, first and foremost, recognized as a person and a parent – and not identified by their illness. By recognizing strengths and interests, hopes and dreams, frustrations and joys, those supporting the family can help the parent feel accepted and supported. There may be a need to assess parenting capacity (knowledge, skills, and understanding of the needs of infants and young children) and explore with parents their concerns about their ability to parent. This assessment will guide how to build in education and supports to sustain the parent-child relationship. In addition, family supporters must be willing to address social stigma, advocate for families, address custody concerns (if present), work collaboratively with families and others providing care, and educate others about parenting needs and concerns of families.

Support for families in which a parent has a mental illness should focus on strengthening and maintaining the relationship between parents and their infant or young child. By building and maintaining a strong, nurturing attachment, both parent and child will experience long-term benefits. This might be accomplished by a comprehensive program of in-home visits during which a mentor coaches and models care of the infant or young child. Classes in child development with a focus on the special needs of infants and young children at different stages in their development, encouragement of mutual play between parent and child, and opportunities to participate in family-friendly events in the community can also be helpful. Play groups, regular child care, and periodic respite may lessen the possibility of feeling overwhelmed by the demands of 24-hour care of a totally dependent young child.

The mental health recovery movement can be an important source of hope and support for parents who have mental illnesses. One of the strongest advocates and teachers in this growing movement is Vermonter Mary Ellen Copeland, who shares a wealth of strategies to help people with mental illness feel better and work toward recovery through her books, seminars, and other resources.

Those who support the family should be aware of other stressors that may impact on parenting, such as financial worries, employment, housing, shopping, meal planning and preparation, household management, and making and getting to appointments. While these concerns are not directly related to parenting, they are part of the overall family picture and influence how parents feel about themselves and their ability to nurture their children.

Sometimes a parent with mental illness may need to be hospitalized. It is especially helpful to have a backup plan in place. By having a plan for extended family, regular child care provider, or friends to assume care of the infant or young child, the parent's anxiety will be eased, and the child's stress reduced.

While parenting an infant or young child can be an additional stressor in the parent's life, it can also be incentive for seeking out healthy choices and working toward wellness. Many parents with mental illness are resilient and can be loving, positive parents when they have support systems in place. The challenge is to provide comprehensive and long-term family-centered programs rooted in the belief that parents with mental illness *can* be good parents.

RESOURCES FOR MORE INFORMATION

RESOURCES FOR ADULTS

Copeland, Mary Ellen, whose website *Wellness Recovery* provides information and articles about mental health self-help and recovery written by her, as well as links to her books and training opportunities.
(802) 254-2092. www.mentalhealthrecovery.com

Marsh, D.T., Dickens, R.M., & Torrey, E.F. (1998). *How to cope with mental illness in your family: A self-care guide for siblings, offspring, and parents*. NY: J.P. Tarcher/Putnam.
Explores the nature of mental illnesses such as schizophrenia, major depression, and manic depression; offers tools for family members; includes a comprehensive list of books, organizations, self-help groups, and mental-health services.

Mueser, K.T. (1994). *Coping with schizophrenia: A guide for families*. Oakland, CA: New Harbinger Publications.
Offers information, research, and strategies for coping with schizophrenia in the family.

Nothing to hide: Mental illness in the family (2002). New York, NY: New Press
A photo-text exhibit that presents photographs and interviews with twenty families whose lives are affected by schizophrenia, bipolar disorder, obsessive compulsive disorder, major depression, anxiety disorders, and other brain disorders.
www.familydiv.org

Torrey, E.F. & Knable, M.B. (2002). *Surviving manic depression: A manual on bipolar disorder for patients, families, and providers*. NY: Basic Books.
A guide to every aspect of living with Bipolar Disorder, including symptoms, treatment and advocacy; written for both those who suffer from Bipolar Disorder and their loved ones.

RESOURCES FOR CHILDREN

McNicholas, J., Carroll, J., Erickson, K. & Reed, R. (1991). *My mom still loves me* and *Good weather or not*. Produced by Turtle Creek Valley MH/MR, Inc. of Pittsburgh, PA, in cooperation with Family Communications, Inc., producers of Mister Rogers' Neighborhood.
A video and story book to help young children understand mental illness; also materials to assist professionals in explaining mental illness to children.

VERMONT RESOURCES

NAMI Vermont (National Alliance for the Mentally Ill) provides support, education and advocacy to families coping with mental illness; 11 affiliate groups throughout the state.
1-800-639-6480 or (802) 244-1396. www.namivt.org

See *Appendix I* for regional *Community Mental Health Center* locations. Each center has programs and support for adults dealing with mental illness.

Cognitive Limitations

Parents with cognitive limitations, or developmental delays, experience the same joys and challenges as all parents. They feel anticipation, excitement, and fears about having a child and they are just as emotionally attached to their infants as other new parents.

Parents with cognitive delays often experience other stressors which impact on parenting. Indeed, these other factors may be more significant than the cognitive delay. Many have genetically-related physical disabilities. Many developmentally delayed adults live in or close to poverty. They often have histories of sexual, physical and emotional abuse and neglect. Nearly all have experienced rejection, taunting, and social prejudice – all of which contribute to low self-regard and feelings of inadequacy and unworthiness.

Cognitive limitations affect how a person learns. Although some adults with cognitive delays have received good schooling while growing up, many have not. Those who support parents with cognitive limitations should explore what learning approaches work best for each individual, and use these approaches to help the parent care for their infant and young child. Usually concrete, hands-on, frequently repeated and reinforced techniques demonstrated within the home are very helpful.

The degree of cognitive disability will naturally guide the extent to which supports are needed for the family. For example, if the parent is able to read fairly well, they are more likely to read to their young child, be able to follow written instructions and, when the child begins elementary school, be able to help with schoolwork. Other parents may require a great deal more assistance with parenting matters.

Some possible concerns for children of parents with cognitive delays are adequate supervision and protection, meeting basic needs such as sleep, nutrition and hygiene, and ensuring sufficient attention, interaction and stimulation. Some parents with cognitive delays may have difficulty with problem-solving, remembering specific instructions such as giving medicine, or making judgments based on what is best for the child.

Supported Parenting is a comprehensive approach in which parents with cognitive delays are viewed as capable of parenting their children when consistent, long-term, respectful, individualized, multi-faceted supports are in place, based on the parent's learning style and the specific needs of the family at any given time. This often requires a team approach with multiple providers. A comprehensive program of support should include the following:

- In-home, concrete, hands-on practice of infant/child care routines.
- Community-based activities and classes which provide opportunities for social interactions and activities with other families.

- Meeting the additional needs of the parents, including employment, medical, dental, mental health and educational services.
- Mentoring programs in which an adult takes particular interest in the family, with regular visits, as well as involving the family in social and recreational activities.

Because infants and young children are constantly growing and changing, supports need to be flexible and adaptable. Sometimes a parent with cognitive limitations and their child(ren) may live with another family who provides support to both parent and child. In some cases, if a child is neglected, abused, or at risk of harm, the child may be taken into state protective custody and placed with a foster family. Sometimes the child can later be reunited with the parent once adequate parenting and safety are ensured.

If the parent cannot adequately meet the child's needs for nurturance, guidance and affection, then the Court may deem it necessary to terminate parental rights so that the child can be adopted. In such cases, it is sometimes possible for the birth parent(s) to continue to have some contact with their child, even though parental rights have been legally transferred to the adoptive parent(s).

One of the most challenging aspects of providing Supported Parenting is the involvement of several sources of support and the potential for conflict among different service providers. For example, a child care provider or early childhood teacher might be primarily focused on the needs of the child and have concerns about the child's growth and development. At the same time, the parent might have support providers whose efforts are aimed at the parent's needs, such as finding and maintaining employment, learning how to read, and becoming integrated into the community, rather than prioritizing the child's needs. By adopting a family-centered perspective, the focus is no longer on just the child or just the parent but on the family as a whole and on supporting the relationships within the family.

There are several avenues for arranging supports for parents with cognitive limitations and their children. Community mental health centers have staff trained to provide support to adults with cognitive delays and to address the unique needs of parenting. In Vermont, the Nurturing Program for Parents with Special Learning Needs is available in several communities. Local health department office or special education coordinators within local school districts can help identify and access community resources.

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Booth, T. & W. (1998). *Growing up with parents who have learning difficulties*. NY: Routledge. Compilation of interviews with 30 adults who were parented by someone with cognitive limitations; advocates long-term, family-centered support.
1-800-634-7064. www.routledge.com

Institute on Community Integration, University of Minnesota
Publishes *Impact,* a periodic newsletter dedicated to improving community services and social supports for persons with disabilities and their families. Vol. 11, No. 1 (Spring, 1998). Focuses on supporting parents who have cognitive limitations.
(612) 624-4512

The Wisconsin Council on Developmental Disabilities has a number of helpful resources. Booklets include:

- Heighway, S. (1992). *Helping parents parent: A practical guide for supporting families headed by parents with cognitive limitations.*

  Covers assumptions about parenting, meeting children's needs, successful supportive relationships, assessment principles, interventions, abuse and neglect.

- Sweet, M. (1990). *Discovering the parent's language of learning: An educational approach to supporting parents with cognitive disabilities***.**
  A guidebook for helpers for understanding a person's individual learning style and how to use this when supporting parents with cognitive limitations.
  (608) 266-7826. www.wcdd.org

ORGANIZATIONS AND WEBSITES

Supported parenting for mothers and fathers with learning difficulties. Describes the principles and models of supported parenting.
www.supported-parenting.com

Through the Looking Glass (TLG) offers a prevention-oriented program for parents with cognitive disabilities as well as on-going research into programs which provide support to parents with cognitive limitations.
1-800-644-2666. www.lookingglass.org

VERMONT RESOURCES

ARC (Advocacy, Resources and Community for Persons with Disabilities and Their Families), a national organization with state and local chapters providing support, information, and resources for people with developmental disabilities and their families.

- Champlain ARC and ARC of Vermont: (802) 846-7295 extension 91.
- ARC of Northwestern Vermont: (802) 524-5197. www.arcvermont.org
- ARC-Rutland Area: (802) 775-1370

The University of Vermont Center on Disability and Community Inclusion in Burlington is part of a national network of developmental disabilities programs established to support individuals with disabilities and their families, including *Green Mountain Family Network,* which provides services to families in which a parent has a cognitive delay.
(802) 656-4031. www.uvm.edu/~cdci/

Division of Developmental Services, within the Vermont Department of Health, Division of Mental Health, state office that oversees programs for people with developmental disabilities.
Toll free in VT: 1-888-268-4860, or (802) 241-2614. www.ddmhs.state.vt.us

LONG-TERM ILLNESS, SEVERE INJURY, RECENT PHYSICAL DISABILITY OR HOSPITALIZATION OF A PARENT

Young children assume that their parents are strong and invincible. Parents provide for all the needs of their children and handle any problems that arise. From the perspective of the young child, parents never get sick or become incapacitated. So when a parent becomes seriously ill, injured, hospitalized, or disabled, the child's illusion of omniscient care is threatened, precipitating a complex array of emotions and behaviors.

The child may feel angry at the parent for getting sick or hurt and either express these feelings overtly or keep them hidden inside. The child may worry about the parent's welfare and their own care, especially if the parent who is injured or ill is her primary caregiver. Some children might express anger at the healthy parent for letting bad things happen, while some avoid dealing with worries by acting as if nothing is wrong. Others show pseudo maturity by acting older than their years. A young child might withdraw and become sullen, or become more testy and boisterous. Young children may also express remarkable sympathy toward the ill, injured, or disabled parent. Young children benefit from knowing what is going on and being involved, in small ways, with the care of the parent.

When a mother or father is injured or becomes ill, the other parent may be overwhelmed by the task of caring for the disabled parent on top of the needs of the children and the house. Roles within the family may change. An older sibling may be expected to take on more household tasks and care of younger children. A stay-at-home parent may now need to work outside the home. The caregiving parent may become overextended and exhausted. Changes (e.g., more irritable, worried, distracted and less available) in the caregiving parent's usual way of being can be disorienting to the child. When other people such as relatives, friends and neighbors assume care of the child, this can be both reassuring and unsettling.

Exposure to any changes in the injured or ill parent might be stressful for the child, but should not be avoided. If the parent is disfigured or looks or sounds different, the child may react with curiosity and/or distress, but these reactions may be offset by the assurance that the parent has not disappeared. Sometimes an ill or injured parent may experience a change in personality, becoming, for example, less responsive, more sullen, or agitated, which can be confusing to a young child. The presence and stability of other caring adults will help offset the distress of such changes. How a child reacts to physical changes due to illness or injury is influenced by the attitude and behaviors of those closest to the child.

Most importantly, children need honest, clearly stated and appropriate explanations for why Mommy or Daddy is different. They should be encouraged to ask questions, to talk about what they think and feel, and even allowed to have a sense of humor about what is happening. They should not be entirely shielded from the realities of the illness or injury, but should be exposed to them in developmentally appropriate ways with sensitive adults present to help them understand and answer their questions.

When a parent is in the hospital, visiting children should be accompanied by trusted adults, who can help them make sense of the strange sights, sounds, smells, machinery, instruments and personnel. Young children need help understanding various treatments and medical procedures and how their parent may respond to them. Visits should be of a length appropriate for the child, and there should be someone available to talk with the child about what they experience. If the parent is not conscious, a child should be given thoughtful explanations as to why his parent doesn't respond. After surgery, children should be helped to understand the healing process and what to expect. When a parent's mobility or movements are compromised there are adaptations that can be made to promote regular and satisfying contact between the parent and young child.

Those who are in a position to support families with a seriously injured, ill, hospitalized or disabled family member can provide information to family members about how children are affected by these conditions. They can help the adults find developmentally appropriate language for describing to the child what is happening and answer her questions.

It is especially helpful for young children to be able to express what they experience through words, drawing and expressive play. Providing baby dolls and medical supplies such as bandages, stethoscopes, empty medication bottles and opportunities for the child to play out what they see and feel can help them work through and gain mastery of their experiences. Young children can be encouraged to draw pictures of what they see, hear, think about and feel. There are many children's picture books available about hospitals and medical conditions, and these can help adults explain medical situations to children. Larger hospitals have a Child Life Specialist or other specially trained professional who can provide information, guidance, and opportunities for helping young children. There are professional and self-help organizations for nearly all medical conditions; these groups provide a fount of information and ideas for helping family members.

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES

Harphan, W.S. (1997). *When a parent has cancer: A guide to caring for your children.* NY: HarperCollins.
Focuses on being a parent, and not just a parent with cancer, based on the author's personal experiences.

McCue, K. & Bonn, R. (3rd Edition, 1996). *Helping children through a parent's serious illness.* NY: St. Martin's Press.
A comprehensive manual for helping children of all ages when a parent has a chronic and/or serious illness. Explains the importance of giving honest information, the kinds of emotional experiences children go through and practical information such as visiting the hospital and preparing for the parent's return home.

WRITTEN AND VIDEO RESOURCES *(CONTINUED)*

Tannen, N. (1998). *The impact of parental illness on the child and family: Implications for system change.* Georgetown University Press Monograph, National Technical Assistance Center for Children's Mental Health, 3307 M St. NW, Suite 401, Washington, DC 20007, (202) 687-5000. Covers economic, psychosocial and medical impacts of a parent's serious illness on families with young children and adolescents. Includes families coping with HIV/AIDS, cancer, multiple sclerosis, and depression.

ORGANIZATIONS AND WEBSITES

The American Association for Marriage and Family Therapy (AAMFT) has a section under "Consumer Updates on Chronic Illness" plus links to many different organizations and websites covering areas such as AIDS, Alzheimer's Disease, Arthritis, Epilepsy, Anorexia/Bulimia, Cancer, traumatic head injury, diabetes, chronic pain, lupus, stroke, muscular dystrophy, etc.
www.aamft.org

Kidskonnected is a website listing books, with short annotations, for parents and children dealing with cancer in the family.
www.kidskonnected.org

CHAPTER 10
FAMILIES IN CRISIS OR EXPERIENCING SEVERE STRESS

There are many ways in which the stability of a family can be stressed and the care of young children affected for a period of time. In this chapter, we look at several life changes that generally have strong impacts on families and involve special considerations. A family may experience severe stress when dealing with the following circumstances:

- Death of a family member (including infant/young child), loved one, or pet
- Disaster (e.g., flood, fire, earthquake, war)
- Incarceration of a parent
- Homelessness

A number of other circumstances commonly create severe family stress or crisis, including parent separation and divorce, child abuse, domestic violence, and parent substance abuse. Each of these is discussed in chapters focused on these issues.

Death of a Family Member, Loved One or Pet

The permanent loss of a loved one for infants and young children is particularly challenging because they do not yet have the cognitive ability to grasp the permanency of death. In the magical thinking of young children, they believe the person will reappear. With each passing day, the very young child feels more deeply the absence of the person or pet. Eventually they will exhibit signs of grieving. During the days and weeks after the death, a young child may show one or more of the following:

- Magical thinking: "I caused this to happen." Or "_____ will come back."
- Disinterest, lethargy and denial.
- Avoidance of feeling: lots of activity or talk but not about the loss.
- Regression: clinging, bedwetting, thumb sucking, baby-talk.
- Confusion and cognitive discrepancies, (e.g., "Only very old people die, so my friend Timmy didn't really die").
- Fears that were not present before the death, (e.g., the dark, insects, or strangers).
- Mirroring the behaviors of the one who died, (e.g., eating only foods the deceased person liked to eat).
- Sleep, eating and/or elimination difficulties.
- Anger that the deceased person or pet has not come back; anger that other people say the person or pet is dead.

While the death of a parent or sibling is the most serious loss for a young child, children also can feel deeply the loss of a grandparent, friend, caregiver, pet, or anyone else who has been a significant part of their young lives. The death of a pet may be the first grieving experience for a young child and, as such, provides an opportunity to model how to talk about death, how to plan and carry out a ritual of remembrance and burial, and how to talk about memories and feelings for as long as they persist.

Loss precipitates some of the most intense feelings human beings ever have. Young children should be helped to recognize, identify, and express whatever they are feeling. Whatever the young child expresses should be accepted, never judged or punished. Because the natural language of young children is play, it is helpful to provide opportunities for the grieving child to express their feelings through play materials, art, music, etc. If the child exhibits a recurring and disturbing pattern of play, it might be helpful to consult with someone experienced in working with grieving children.

When a parent dies, children worry about who will care for them and about the possible loss of the next parent or caregiver. They need reassurance of stability and increased attention from the remaining caregiver(s). Not only is the infant or young child experiencing a grief reaction, so, too, are other significant adults in the child's life. When a parent dies, there may be a period of time during which the surviving parent is less physically and emotionally available to his or her children. Children will be confused by this change and may try to engage adults by clinging, being aggressive or acting helpless. Those supporting grieving families should provide support to both the children and the adults responsible for caring for the children.

Even very young children need to talk about the deceased and how he or she died. They need clear, truthful information delivered in simple, concrete, and developmentally appropriate language by adults who are prepared to follow the child's lead. It is important not to shield children from death through silence or ambiguous references. Children need explanations of what happened to the person or pet that died, including what has happened to the body. When explaining death to young children, it is helpful to focus on the physical realities of death - the heart stopped beating and the person or animal can no longer breath, eat, sleep, see, hear or feel anything. Avoid any description of death as going to sleep.

Children also need to hear how the family makes sense of death. Those supporting the child and family should be aware of the family's cultural, religious and ethnic beliefs about death and use the language and concepts of the family when talking with the young child. When these concepts or beliefs are different from those of the support person, this provides an opportunity to learn more about the family and honor their traditions. It is imperative that support people take care not to impose their own religious, cultural or ethnic beliefs onto families.

There are many ways that others can be helpful to an infant or young child and their family in the event of a death:

- Help family members plan for consistent care of the young child when a parent or primary caregiver has died.
- Help families and caregivers understand the ways young children process the death of a beloved person or pet, and how they grieve.
- Provide developmentally appropriate opportunities for young children to express their feelings about the death by using dramatic play props, puppets, dolls, play figures, and art materials.
- Listen closely to the child's verbal and nonverbal expressions; convey acceptance of whatever is expressed, gently correcting misinformation; expect repetition of questions and concerns; avoid lecturing.
- Talk with adults in the family about developmentally natural ways the child may become fascinated by death, such as asking many questions, pondering their own deaths, and perhaps experimenting with how things die (e.g., killing bugs).
- Help family members appreciate the child's need to remember the deceased person or pet through photographs, hearing and telling stories about the deceased, and keeping treasured possessions, such as an article of clothing.
- Help others understand the need for the child to express a range of feelings about the deceased, including sadness, confusion, anger, fear, regret, and hope.
- Use all the senses to help the young child remember the deceased, to express grief, and to heal:
  - *Visual* - photos, videos, drawings; looking at anything reminiscent of the deceased
  - *Auditory* - audio tapes of the deceased person's voice, listening to music and singing songs associated with the deceased, repeating the person's unique phrases and expressions
  - *Olfactory* - scents associated with the deceased, (e.g., clothing, cologne, after-shave, candles, room freshener)
  - *Taste* - foods associated with the deceased
  - *Touch* - physical touch sensations associated with the deceased, (e.g., fabric)

When an Infant or Young Child Dies

One of the most devastating experiences for parents is the death of their infant or young child. It is important that those around them respond quickly and with compassion. Relatives, friends and caregivers supporting the family should avoid messages such as "You can always have another baby" or "This was meant to be; we just don't understand why." Grieving parents, grandparents, siblings and other family members need to be able to talk about their loss and to be listened to openly, with compassion and without judgment.

If there are older siblings, they will need developmentally appropriate explanations for the death of their brother or sister. Sometimes, young siblings may believe that they caused the death, or may fear the same thing will happen to them. The remaining child(ren) will naturally be upset by watching their parents' grief. The sibling may try to take care of a grieving parent, physically and emotionally, or may use behaviors to distract the parents from their grief.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Dougy Center staff (1999). *35 ways to help a grieving child.* Portland, OR: Dougy Center for Grieving Children.
The collective wisdom of many children, families, and staff who have learned about grieving and healing.

Fry, V. (1995). *A part of me died, too: Stories of creative survival among bereaved children and teenagers*. NY: Dutton Children's Books.
Covers a variety of death experiences (parent, grandparent, sibling, friend, pet) in different circumstances (chronic illness, accident, suicide, murder); tells stories of children who have experienced death and been helped through the healing process.

Trozzi, M. (1999). *Talking with children about loss*. NY: Penguin Putnam, Inc.
Author describes the many lessons she has learned from children dealing with loss and grief; goal is to increase adults' understanding, caring, and support for grieving children.

WRITTEN RESOURCES FOR CHILDREN

Johnson, J. (1982). *Where's Jess*? Omaha, NE: Centering Corporation.
A young boy's sister dies and his parents help him as he tries to understand.

Palmer, P. (1994). *"I wish I could hold your hand": A child's guide to grief and loss.* Atascadero, CA: Impact Publishers.
Helps children understand the feelings of grief when someone leaves or dies.

Silverman, J. (1999). *Help me say goodbye: Activities for helping kids cope when a special person dies*. Minneapolis, MN: Fairview Press.
Art activity book which encourages children to express in drawing what they cannot say in words.

There are many fine picture books for young children about death. Libraries and bookstores will all have a selection. Some classic books about death for young children include:

- Brown, M.W. *The Dead Bird*
- Paola, T. *Nana Upstairs and Nana Downstairs*
- Varley, S. *Badger's Parting Gifts*
- Viorst, J. *The Tenth Good Thing About Barney*

ORGANIZATIONS AND WEBSITES

Centering Corporation is dedicated to providing education and resources to the bereaved, including books, videos, dolls, and cards, as well as training opportunities for caregivers and families. (402) 553-1200. www.centering.org

Compassionate Friends (Vermont chapter) assists families "toward the positive resolution of grief following the death of a child of any age and to provide information to help others be supportive." www.vtcompassionatefriends.org connects to state and national resources including local groups.

Good Grief Program (Boston University Children's Hospital) provides training, consultation, and supports for adults who help children through grief experiences, "based on the premise that in the crisis of loss lies a unique opportunity for children to develop, strengthen, and master coping skills." (617) 414-4005. www.bostonchildhealth.org/special/goodgrief

National Center for Grieving Children and Families offers trainings, information, and support to those helping children as they move through their healing process
www.dougy.org

Disasters Such as Flood, Fire, Earthquake and War

A disaster is a sudden misfortune that catches people off guard and causes disruptions in daily life, destruction or loss of property, and sometimes loss of lives. It is followed by an immediate sense of vulnerability and fearfulness for safety. A disaster can be an occurrence in nature such as a flood, earthquake, tornado, or hurricane, or caused by human behaviors such as war, fire, terrorism, or shootings.

While Americans are accustomed to experiencing and responding to natural disasters such as floods and hurricanes, only recently have we experienced a rise in human-precipitated disasters close to home. In addition to drive-by and school shootings, bomb threats, and drug wars, the unprecedented terror and destruction of the September 11, 2001 attack has further awakened us to the possibilities of new and unimagined disasters. Today, children hear about bio-terrorism, which increases anxiety about the safety of our everyday environments including food, water, and pieces of mail.

The rise of media coverage of disasters around the world poses a particular challenge for those caring for young children. Exposure to disasters via television can cause trauma to even far distant viewers. After the World Trade Center attack, many young children were traumatized by watching, often over and over again, the scene of airplanes crashing into buildings, often believing that a new disaster was occurring each time.

Infants and young children are sensitive to the emotions and moods of those who care for them. They not only sense, but also tend to absorb, their caregivers' feelings, whether these are feelings of sadness, fear, confusion, frustration, anger, surprise or joy. In the face of disaster, adults experience intense emotions and are in a heightened state of alert. These feelings, more so than the disaster itself, can cause distress to infants and toddlers, who are often too young to comprehend the actual crisis.

Preschoolers' reactions to disaster vary a great deal, from “shutting down” and even dissociating from the confusion around them, to becoming anxious, clingy, and hypervigilant. Young children naturally engage in magical thinking. A four year-old may believe that his thoughts caused the disaster to happen, and may also presume that his parent or caregiver can make everything better. This can be useful for those who are helping young children because their reassurance and words of comfort can go a long way. Young children usually feel comforted just hearing adults say that they will keep them safe and knowing that caring adults are "in charge."

Beyond absorbing and expressing the emotions of the adults around them, young children’s reactions to disasters will differ based on several factors:

- Degree of exposure and proximity to the disaster
- Personal injury to the child or to others close to the child
- Protection felt by the child during the disaster (e.g., presence of a parent or other trusted adult, response of rescue personnel)
- Child's developmental grasp of the world and how things come to happen
- Child's ability to manage inner feeling states

Responses to infants and young children need to meet the specific ways each child has been affected by the disaster. Some children show signs of stress later on, rather that at the peak of the crisis. A young child who appears to be handling the aftermath of a disaster well may have a delayed reaction of trauma days, weeks or even months later.

In the aftermath of disaster the following responses can be helpful to infants and young children:

- Have the child stay close to a parent, relative or close friend who can devote their attention to helping the child.
- Listen carefully and calmly to whatever children have to say about the disaster; allow them to talk freely without interruption.
- Give honest, factual, and developmentally appropriate information about the disaster; correct misinformation.
- Maintain as much routine, familiarity and predictability as possible.
- Provide relaxing and soothing communications with the child, and activities such as singing quietly, looking at picture books, talking calmly, gentle touch, tending to a favorite stuffed animal or doll, and guided visualizations of serene images.
- Eliminate or minimize exposure to media coverage which is designed to inform adult viewers or listeners and may be disturbing to young children.
- Provide opportunities for children to play out what they have seen and heard. Helpful props might include paper and crayons, improvised play figures, puppets, toy rescue vehicles, medical play props, and dramatic play with other children.

Young children do not understand the future implications of a specific disaster. They focus on the immediate and the personal. For example, a young child might worry about grandparents far away from the disaster because they assume everyone they know is experiencing the same disaster. Or a young child might express what appear to be inappropriate emotions such as giggling or acting silly. Often, in the face of trauma, young children regress. These changes in behavior are natural responses when the child's neurological, emotional, and physical systems are overly stressed. In addition to soothing and comforting the young child, it is important not to judge their responses and to accept whatever they feel, say, and do, while ensuring that they do not act out the disaster in unsafe ways (e.g., experimenting with fire-starting).

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES FOR ADULTS

Bromfield, R. (2002). *Living with the bogeyman: Helping your child understand fear, terrorism, and living a full life in a world of uncertainty*. NY: Random House.
Addresses how the events since September 11, 2001 add a dimension of disturbing reality to children's monster and bogeymen fears. Offers strategies for coping with fears, dealing with feelings, and fostering resilience in the face of danger.

Greenman, J. (2001). *What happened to the world? Helping children cope in turbulent times.* Watertown, MA: Bright Horizons Family Solutions.
This pamphlet was prompted by the events of September 11, 2001 and provides guidance for how to respond to children based on their developmental ability; includes a list of websites and other resources on;

- Children & Stress
- War and Terrorism, and
- Tolerance and Respect for Diversity.

www.brighthorizons.com

RESOURCES FOR CHILDREN

Holmes, M.M., Mudlaff, S.J., & Pillo, C. (2000). *A terrible thing happened: A story for children who have witnessed violence or trauma.* Washington, D.C: Imagination Press.
A child finally talks to someone about terrible things he's seen and starts to feel better. Written for children who have witnessed any kind of violence, including natural disasters and community violence. Ends with suggestions for adults helping traumatized children.

Layton, A, B, & M. (1997). *I'll know what to do: A kid's guide to natural disasters.* Washington, DC: Magination Press.
A book for school-aged kids that could possibly be used with younger children. This book provides facts about earthquakes, hurricanes, tornadoes, floods, and mud slides and discusses how to deal with and survive a natural disaster.

ORGANIZATIONS AND WEBSITES

The National Association for the Education of Young Children website provides resources and links for parents and those who work with young children under the heading, Helping Children Cope with Disaster. Some helpful titles: "Helping Children Cope with Violence," "Helping Children Cope with Disaster," "Remote Control Childhood? Combating the Hazards of Media Culture," and "Helping Young Children in Frightening Times."
www.naeyc.org/resources

ORGANIZATIONS AND WEBSITES *(CONTINUED)*

American Red Cross
Red Cross disaster relief focuses on meeting people's immediate emergency disaster-caused needs. When a disaster threatens or strikes, the Red Cross provides shelter, food, as well as health and mental health services to address basic human needs. In addition to these services, the core of Red Cross disaster relief is the assistance given to individuals and families affected by disaster to enable them to resume their normal daily activities independently.

- Northern VT Chapter: 1-800-462-9400 or (802) 660-9130. www.nvtredcross.org
- Central VT/NH Valley Chapter: (802) 773-9159

Incarceration of a Parent

The incarceration of a parent creates immense stress for all family members, including financial, social and other hardships. When mothers are incarcerated, children often also lose their primary attachment figure. Young children, who naturally worry about who will take care of them, may fear further abandonment, feel guilty that they did not prevent the incarceration, be angry at the police for taking the parent away, or shame about the parent's "bad" behavior.

When a parent is imprisoned or jailed, young children are often placed with other family members or in foster care. Even if relatives or foster parents are caring and attentive, most children nevertheless experience a tremendous sense of loss, and often abandonment, when they are no longer living with a parent. Some relatives or guardians may harbor angry feelings toward the parent who is incarcerated, leading them to create physical barriers to visitation and phone calls, or emotional barriers, such as forbidding mention of the parent’s name, or speaking disparagingly about the incarcerated parent, which confuses children and their feelings about their parent.

Many children with an incarcerated parent live in poverty because the adults caring for the children may be financially stretched. Furthermore, adults may be less physically and emotionally available, thereby placing the children at risk of inadequate care. The social stigma of incarceration impacts the child in both subtle and direct ways. There may have been publicity about the incarcerated parent in newspapers and on television, thereby exposing the family to public scrutiny. Families with incarcerated members may experience harsh judgment and even ostracism. By association, young children may come to believe that they, too, are "bad.” As a way of identifying with the incarcerated parent, the child may engage in, and be punished for, more "bad" behaviors than before.

A particular challenge with helping children who have an incarcerated parent is giving them developmentally appropriate information about the parent's crime. Understanding adult behaviors that lead to arrest and incarceration, as well as the justice/corrections system, is difficult for young children. In an attempt to grasp what is confusing and incomprehensible, young children are likely to construct a story about what happened which may be full of inaccuracies. It is important to clear up misunderstandings using simple, straightforward language. Adults should provide honest explanations while also being sensitive to how much information children are ready to handle.

Children who witness the arrest of a parent can suffer trauma related to this experience. The arrest may have involved sirens, police cars, handcuffs, shouting, aggressive behaviors, and weapons. Because infants and young children tend to absorb emotions around them and because they have only a few coping mechanisms, the intense emotions surrounding an arrest can overwhelm the child's neurological system. The sights, sounds, confusion and feelings of helplessness accompanying the arrest may present themselves in subsequent behaviors such as developmental regressions, aggressive behaviors, sleep/eating/speech difficulties, emotional withdrawal, avoidance of certain stimuli, or other changes in mood and behaviors.

Young children should be encouraged to express their feelings about the arrest through play materials, drawings and conversations with caring adults. Caregivers and relatives should be prepared to field questions that may be asked over and over again, as it takes time for young children to process what has happened. It is important that adults be willing to explain what has happened as many times as young children ask, always in language that they can understand and follow.

Visitation to the incarcerated parent presents another set of challenges. Children need to be prepared for, and their needs considered, during visits. Visits to prison are unsettling because of the noise, security checks, many rules, and non-child-oriented environment. Yet visits are important to maintain the child-parent connection, as this helps children understand that their parent is not permanently gone and still does care for them. Parents in prison can use visits as opportunities to assure their children that they are not to blame for the incarceration, to respond to their children's natural anger and concern over being left, and to reassure the children that they still have a role in the child's life.

Before a child's first visit to a correctional facility, the person who will accompany the child should visit the prison in order help prepare the child for what to expect. The adults should be sensitive to the child's physical and emotional comfort, such as being willing to end the visit when the child shows signs of wanting to leave. Following prison visits, it is important for young children to process these experiences through play and conversation.

Those in a position to help children with an incarcerated parent may do so in a variety of ways:

- Help the remaining parent and other caregivers to connect with support groups and community resources (e.g., transportation to the prison.)
- Help parents and other caregivers to access formal supports such as family assistance programs (housing, food, employment, child care) and counseling.
- Help others (parents, caregivers, extended family, etc.) understand the impact to the young child of having an incarcerated parent.
- Help those involved to think about and prepare the child for visits to the prison.
- Provide developmentally appropriate opportunities for the young child to express his or her understanding and feelings about the incarceration by using dramatic play, puppets, doll houses, play figures, and art materials.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES FOR ADULTS

Wright, L.E. & Seymour, C.B. (2000). *Working with children and families separated by incarceration: A handbook for child welfare agencies* . Washington, DC: Child Welfare League of America Press.
Addresses the special needs of children whose parents are in prison, outlines child welfare practices, and provides practical suggestions in areas such as child protection, temporary care in out-of-home placement, permanency planning, and family reunification.

Gabel, K. & Johnston, D. (editors) (1995). *Children of incarcerated parents.* San Fransisco, CA: Jossey-Bass, Inc.
A book for social workers, psychologists, and others who work with children whose parents are incarcerated; examines the impact of parental incarceration on children, their care and possible placement, legal and policy issues, and intervention programs.

Enos, S. (2001). *Mothering from the inside: Parenting in a women's prison*. Albany, NY: SUNY Press: Series on Women, Crime & Criminology.
Explores how women in prison manage parenting from behind bars, including finding places for their children to live, managing relationships with caregivers, demonstrating their ability to parent, and negotiating rights for their children. Also highlights issues of race, ethnicity and marginality of women in prison.

Special issue of *Child Welfare* (Vol. 77: 5, September/October 1998) devoted to children with parents in prison.

WRITTEN RESOURCES FOR CHILDREN

Hodgkins, K. & Bergen, S. (1997). *My mom went to jail.* Madison, WI: The Rainbow Project.
Told from the child's point of view; covers foster care, feelings of abandonment, and what incarceration is like.

Testa, M. & Schaffer, A. (1996). *Nine candles.* Minneapolis, MN: Carolrhoda Books.
A boy visits his mother in prison.

Wittbold, M. (2003). *Let's talk about when your parent is in jail.* NY: PowerKids Press.
Takes the reader through all the stages of incarceration.

Woodson, J. (2002). *Visiting day.* Danbury, CT: Scholastic Books.
A girl excitedly anticipates and prepares to go with her grandmother to visit her father, while her father, in his cell, prepares for her visit.

ORGANIZATIONS AND WEBSITES

Child Welfare League of America See *Working with children and families separated by incarceration* above.
www.cwla.org

Family and Corrections Network (FCN). Dedicated to providing information, training and technical assistance about children of prisoners, parenting programs for prisoners, prison visiting, incarcerated fathers and mothers, hospitality programs.
www.fenetwork.org

ORGANIZATIONS AND WEBSITES *(CONTINUED)*

Vermont Department of Corrections (DOC) works in partnership with Prevent Child Abuse Vermont (PCAVT) to provide parenting programs in Vermont prisons, including informal support groups (Parents Together), Nurturing Fathers/Mothers Program, a Head Start teacher at the woman's prison, and visitation programs for mothers and children to spend child-friendly time together. Contact:

- DOC Coordinator of Recreation Services, (802) 241-1329
- PCAVT, Montpelier office, 1-800-244-5373.

Homelessness

The common image of those who are homeless has long been single males, living on city streets or sleeping in emergency shelters. In fact, since the 1980's, single mothers with one or more young children are one of the largest growing populations of homeless people. The two common denominators of homelessness are poverty and lack of affordable housing. A large proportion of homeless women with children are victims of sexual and/or physical abuse, and many have substance abuse or mental health problems. A growing number of homeless families have employed parent(s), but their incomes, usually well below poverty levels, do not cover the cost of adequate housing.

Rural homelessness is often a hidden problem. It presents a different set of factors and challenges than urban homelessness. In Vermont, homelessness has a distinctly rural cast. Rural locations offer few shelters and other resources and supports for homeless persons. Feelings of shame and pride often preclude rural homeless people from seeking public resources. Homeless rural families are more likely to live in their car or camper, at a campground, in an abandoned cabin, or temporarily move in with friends or relatives, often in overcrowded situations.

Several factors exacerbate rural homelessness:

- Lack of public awareness (out of sight, out of mind)
- Isolation (distance from services, where they do exist, and lack of public transportation)
- Lack of resources, such as emergency shelters and transitional and permanent housing options, mental health and substance abuse treatment, and supports for children who are homeless
- Stigma (association by some in society of homelessness with laziness, immorality, lack of willpower, and lack of caring for one's children)

Children who are homeless are clearly children at risk. Much of what we believe is key to healthy child development is simply not available to children who lack a stable residence. Some of the common problems homeless children share are very basic: lack of adequate sleep, nutrition, and dependable daily routines, all of which harm their physical, emotional, social, and cognitive development. Homeless children are continually uprooted and are faced with constant uncertainty at best, and with serious threats to their safety and well-being at worst. Stressed by their homelessness, parents may quite understandably become depressed, anxious and emotionally unavailable to their children.

Some necessary "ingredients" for healthy development are often severely limited when a family is homeless, including:

- Consistent caregiving and attachment formation
- Language and cognitive stimulation
- Organized and supervised group experiences with other children
- Regular medical and dental care

Young children thrive on routine and predictability, yet these are almost impossible to create when the family has no home. Infants and young children who are homeless are likely to exhibit social withdrawal, aggression, and/or attention problems. They may not develop at expected rates, which undermines school readiness, creating further problems down the road.

As with other forms of stress, there is great individual variation in how homeless children fare. Some show remarkable resiliency and are able to soak up any positive influences in their lives. They go on to do well in school and develop unique skills and talents. Even interactions with one caring and consistent adult who spends time with, plays with, and listens to a young child who is currently homeless can have a significant impact.

> "I went to a Community Action Program when I got here, and they had this woman work with me. She gave me a place to stay at like a shelter and asked me what my goals were. My goals at the time were to get my son caught up on his immunizations, and maybe enroll in college, and get my license…So people started to keep me sort of focused on how I was gonna get my life on track 'cause I had this child now…and in the programs that I'm connected with now [including CUPS], people help me stay on track…Today I have a home, I have a job, and Colin [my son] is unbelievably better."

Many homeless children and their families need a great deal of support, beginning with adequate housing and financial security, as well as emotional and social interventions. Like all young children, those who are homeless need calm places to sleep, adequate food, safe environments in which to play, and caring adults and older children who show pleasure in their company.

Because they feel ashamed, embarrassed and guilty, or fear removal of their children from their care, many homeless families hide their homelessness, and do not seek help for themselves and their children. Sensitive observation and sympathetic inquiry may enable an outreach worker, child care provider or other helper to offer assistance locating resources for the family. This might include tapping into community housing options, entitlements and Medicaid resources, medical clinics, food shelves, subsidized child care, and counseling.

Navigating through the often-confusing tangle of housing, social welfare, health and other agencies can be overwhelming for parents who are homeless and without resources. A designated case manager or other advocate who works closely with homeless parents in overcoming the barriers to housing, financial support and services, while also providing emotional support, is often key to achieving residential stability. Especially in rural areas where resources are few and far between, active outreach and ongoing support of homeless families needs to be a high priority. With the primary goal of establishing a stable living environment for young children, parents and family support people can work together to identify goals to end homelessness and take steps towards meeting these goals.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Kozol, J. (reprinted 1989). *Rachel and her children: Homeless families in America.* NY: Random House.
Captures the voices of adults and children and their relentless struggle to survive homelessness in America.

Visser, Y. (1996). *Out of sight, out of mind: Homeless children and families in small-town America*. Lexington, KY: University Press of Kentucky.
Provides background information for understanding the causes, needs and responses to homelessness in rural areas.

ORGANIZATIONS AND WEBSITES

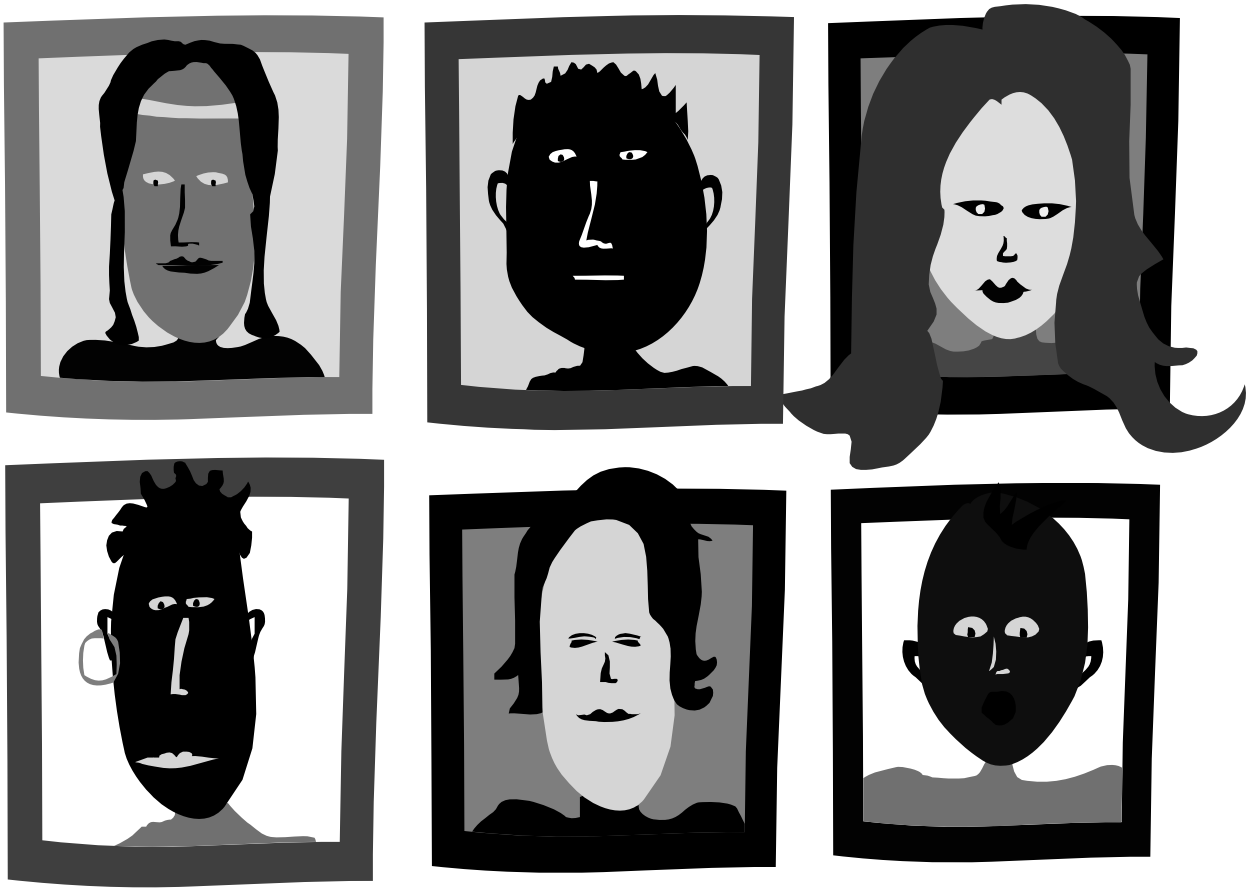
National Center on Family Homelessness works to end family homelessness through long-term solutions. The NCFH designs, pilots and evaluates programs and services, and shares knowledge with service providers, policy makers and the public.
www.familyhomelessness.org

National Coalition for the Homeless is dedicated to ending homelessness through education, program development and policy making. They publish a number of Fact Sheets including: "Rural Homelessness" and "Homeless Families with Children."
www.nch.ari.net

Homeless Information in Vermont provided by the U.S. Department of Housing and Urban Development, comprehensive website with information and access to services
www.ezrc.hud.gov/local/index.cfm?state=vt&topic=homeless

Vermont Association of Child Care Resource and Referral Agencies can help locate early child care and education programs, some of which are specifically designed for children who are homeless. Toll free: 1-877-822-2772, www.vaccrra.org, or see *Appendix I* for list of member agencies.

Vermont Department of Education oversees the federal Education for Homeless Children and Youth Program which ensures that homeless children have access to free, appropriate public education, including public preschool.
(802) 828-5148



CHAPTER 11
REFUGEE AND IMMIGRANT FAMILIES

Background

For immigrant families, the act of leaving their home countries for relocation in the United States is often fraught with a complex mixture of feelings including anticipation, sorrow, relief, excitement, loss, and fear. Some immigrant families are refugees who have had to leave their native countries because of political strife. Some have left their homelands because of war, persecution, famine, or the inability to sustain themselves. Some have come to this country seeking religious or ethnic freedom or a better life for their families. Some have come to join family members who preceded them.

Regardless of the parents' reasons for immigrating, young children's experience of relocation may be distressing due to their lack of coping skills with handling so much loss at one time. There is the loss of one's native language, of relationships (relatives, neighbors, caregivers, community), of customs and rituals and familiar cultural symbols, of social/economic place within the home community, and of familiar sensory experiences.

Immigration may trigger anxiety, depression and an inability to progress developmentally for some children. These reactions may be further exacerbated if children or other family members have been the victims of persecution, violence, severe poverty, homelessness, exile, or have witnessed violence, death and destruction. Some young children may arrive in the U.S. with symptoms of post-traumatic stress, such as regressive behaviors, clinging or avoidant behaviors, excessive fearfulness, compulsive behaviors, sleep, eating or toileting difficulties, and trouble progressing to new developmental stages.

Immigrant families go through multiple adjustments as they settle into their lives in the United States. Many must learn a new language, as well as adapt to unfamiliar foods, different housing options, medical care, educational systems, transportation, currency, climate, clothing, social rules, media exposure, child-rearing practices and many more subtle differences.

In addition to the tremendous change of living in an entirely new culture, families may come with issues that might never be revealed but which affect adjustment, including family literacy, learning disabilities before immigration, medical and/or mental health issues, coping strategies and strengths, social connectedness and social skills, and the expectations of family members about immigration to the United States. The ease with which young children adjust is closely related to how well their parent(s) adapt to their new life circumstances.

Changes in Family Dynamics and Parent Roles

Settling into a new country and culture may involve shifts in family dynamics. Adults who were middle class or community leaders at home, for example, may lose their professional and community identities and find themselves working in low-paying, low-status jobs, or even unemployable – especially if their English is poor.

An older child who quickly learns English may begin to take over managing the affairs of the family vis-à-vis the community and negotiating various decisions that need to be made. With this shift in power some children may come to view their parents as weak and vulnerable, which can be frightening, especially to young children. The parents' loss of status, authority, and sense of competency may result in secondary problems such as depression, irritability, anxiety, use of substances, and emotional detachment. Often these reactions are temporary, but they can stress the family for a period of time.

Immigrant and refugee parents may find themselves pulled in many directions as different helpers provide guidance. Extended family, their homeland community, service providers and neighbors – all may see things differently and provide conflicting advice which can be confusing to parents. Those supporting immigrant and refugee families can be most helpful by assisting parents to identify their own family's needs and make decisions that will best meet these needs, thereby supporting and enhancing their role as parents. It is usually helpful at first for parents to use their native language with their children, as this reinforces their competency, confidence, and authority as parents.

When recently-immigrated children begin preschool or child care they and their families may be confronted with new child-rearing practices which may cause them concern. For example, in the native culture infants may always be held by an adult or older child. At child care centers in our country, it is common for infants to be put on the floor with a variety of toys and the expectation that they will play and explore independently. Among the many other potential cultural differences in child-rearing practices are feeding, toileting, sleeping, medical care, handling aggressive behaviors, manners, discipline and interactions between children and their elders.

Such differences can readily result in misunderstandings and conflicts between parents and caregivers, which are significantly exacerbated by language barriers. This is a time when a translator may be helpful as well as visits by the provider to the child's home and the parents to the child care home or center.

Second Language Acquisition

The acquisition of the language of one's new community is critical to successful adjustment and, especially for young children, to their ability to progress in new learning environments. The child's first language should be the foundation for learning a second language, which is added to the first language rather than replacing it.

While young children typically become facile in their new language much more quickly than adults and even older children, learning a new language is a complex process that takes time and a great deal of practice. Young children move through several stages of learning English (R. Holmes, personal communication, June 3, 2003):

- Listening to new sounds, watching how these sounds are used and attaching meaning to them. During this stage, children may become nearly silent, as all of their concentration and energy is focused on listening and watching.
- Imitation of sounds and experimentation, usually to oneself, but not yet in a social setting.
- Behavioral responses to receptive (spoken) English, such as following directions given by others, which indicates understanding of the new language.
- After a time of listening and building receptive language, the child begins to use words and phrases in the new language to communicate with others.

Family and cultural beliefs about learning English will influence what parents convey to their children about living in the United States and learning English. Some parents feel strongly that in order for their children to be successful in American culture they must speak only English. Other parents believe it is more important to preserve their original ethnic and cultural identity, customs and language. Those who support immigrant families need to be sensitive to these beliefs – as well as their own beliefs and experiences with language, culture, immigration and identity.

Despite the complexities involved in learning English, most refugee and immigrant young children do so without major difficulties and readily enter the English-speaking culture that surrounds them.

Medical Care

Immigrant and refugee parents may have different beliefs from our Western views about the causes of and cures for medical conditions and illness. When their children are ill or in need of medical help, some immigrant parents may engage in practices that are unfamiliar and cause concern among American helpers. It is important to explore these differences and to learn about the parents' beliefs, experiences and practices regarding health-related issues. This may necessitate using a professional translator.

The American medical system can be confusing and frustrating. Immigrant and refugee families will need extra support learning how to navigate gaining access to health care, including who to contact and when. The U.S. health insurance system, with its paperwork and specific requirements, adds to the confusion. Family supporters can help by locating community clinics, medical providers who speak other languages or are receptive to patients from other cultures, accessing health and dental care for low-income children such as Doctor Dynasaur in Vermont, and guiding families through the sometimes complex system of referrals, paperwork and making appointments.

Women supporting immigrant families may be able to provide guidance and support for mothers regarding obstetric or gynecologic care. This specific area of medical care can be particularly challenging for some immigrant and refugee women and requires a high level of sensitivity and understanding.

Starting Preschool or Child Care

As with American-born young children, starting preschool, child care or other early education program evokes strong feelings in immigrant children and their parents. This may be the first experience of separation and of entrusting the child to the care of people outside the family. It is helpful to learn about the practices in the family's homeland related to out-of-home care and education and how the parents feel about it.

This may be an infant's or young child's first exposure to new and different experiences without the presence of a family member to guide, intercede and comfort him. He will hear a new language, be surrounded by strange adults and children, and experience unfamiliar smells, tastes, sounds and sights. Ideally, a single caregiver should be designated to help a child through the first several weeks, thereby lessening the pressure to make connections with many new people. This first out-of-home relationship will become the child's security base for moving out into the world away from home.

The parents, too, experience many losses:

- Loss of closeness to their child
- Loss of ability to communicate as the child learns English and has an ever-expanding life based on this new language
- Loss of influence in the child's life and control over what he is exposed to

Some immigrant and refugee parents will gladly welcome their child's widening world and find pleasure in learning about their new country through their child. Other parents may need extra support and attention to help them manage these layers of losses.

A new phenomenon for many families will be their child's exposure to popular culture via television and movies. These media will be viewed by children as models of how to behave in the United States. Young children are not able to discriminate what is acceptable and what is not, and their parents may not know how to screen our media for appropriateness. Some refugee and immigrant families may need help learning about specific television programs for young children and a general understanding of American media, as well as the importance of limiting young children's exposure to television and other media. While age-appropriate television and movies might be helpful aids in learning about cultural behaviors, they are not effective teachers of language. This is best done through person-to-person interaction.

How Supporters Can Be Helpful to Immigrant and Refugee Families

- Convey compassion, interest in, and respect for immigrants' stories, culture and encourage them to tell you about these, with the help of a translator if necessary.
- Learn about the role of extended family and be welcoming to all family members who are instrumental in providing for the needs of young children.
- Advocate for immigrant families, based on their expressed wishes for help, so they can meet the needs of their children, such as locating a translator, social services, language classes, pediatric medical and dental care, food and housing supports, child care, and social experiences within the community.
- Provide developmentally appropriate opportunities for young children to express their feelings about their immigration experience by using meaningful play props including dolls and play figures that have physical characteristics similar to the child, culturally sensitive story books, and art materials.
- Welcome parents and encourage their participation when their child starts an out-of-home experience (child care, play group, preschool).
- Seek to understand parents' beliefs about child development and how children learn, their feelings/hopes/fears about out-of-home experiences for their child, their understanding of how American child care and education systems work, and their beliefs and desires about learning English for themselves and for their children.
- Create opportunities for immigrant young children to play with a playmate or a small group of children so they can practice language, learn social skills and feel secure in developing relationships with peers.
- Show interest in the family's native foods and help them find food sources in the community. Out-of-home care and education environments can use familiar, ethnic foods to help the child feel secure and as a way to connect with the family and young child.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. NY: Farrar, Strauss & Giroux
Follows the first years of life of a Hmong child who is frequently brought to the Emergency Department of her local American hospital. Without judgment, the writer presents the dilemmas and frustrations for the medical personnel as they attempt to treat the child and the confusion and distrust of the family whose cultural beliefs and practices are very different from the Americans around them.

Lynch, E.W. & Hanson, M.J. Editors (2nd Edition, 1998). *Developing cross-cultural competence: A guide for working with children and their families.* Baltimore, MD: Paul H. Brookes Publishing Co.
Provides hard-to-find information and practical advice to those who work with children and families from diverse cultural and linguistic backgrounds.

WRITTEN RESOURCES *(CONTINUED)*

McAdoo, H.P. Editor (1999). *Family ethnicity: Strength in diversity*. Carthage, IL: Corwin Press. Descriptions of family customs, proverbs, and stories from various cultural groups in the US today, including Native American Indians, Native Hawaiians, Mexican-American and Spanish, African-American, Muslim American and Asian-American.

Responding to linguistic and cultural diversity: Recommendations for effective early childhood education. (Position Paper) and *Health care for children of immigrant families* (Policy Statement) from National Association for the Education of Young Children.
www.naeyc.org/resources/position statements/positions intro.asp

WRITTEN RESOURCES FOR CHILDREN

There are many helpful books to read with immigrant/refugee children. Look for books that have illustrations of children and environments that are similar to the child's ethnic experience.

Shapiro, N. & Adelson-Goldstein, J. (1998). *The oxford picture dictionary - monolingual.* NY: Oxford University Press.
A workbook with pictures to help identify specific words, phrases and concepts, grouped under such headings as: Everyday Language, People, Housing, Food, Clothing, Health, Community, Transportation, Plants and Animals, Work, Recreation. It can be used with children and their parents when needing a quick reference to show something.

ORGANIZATIONS AND WEBSITES

Center for Multilingual/Multicultural Research has many links to other websites.
www.bcf.usc.edu/~cmmr/

UN High Commission for Refugees provides information and resources related to refugees from all over the world.
www.unhcr.org

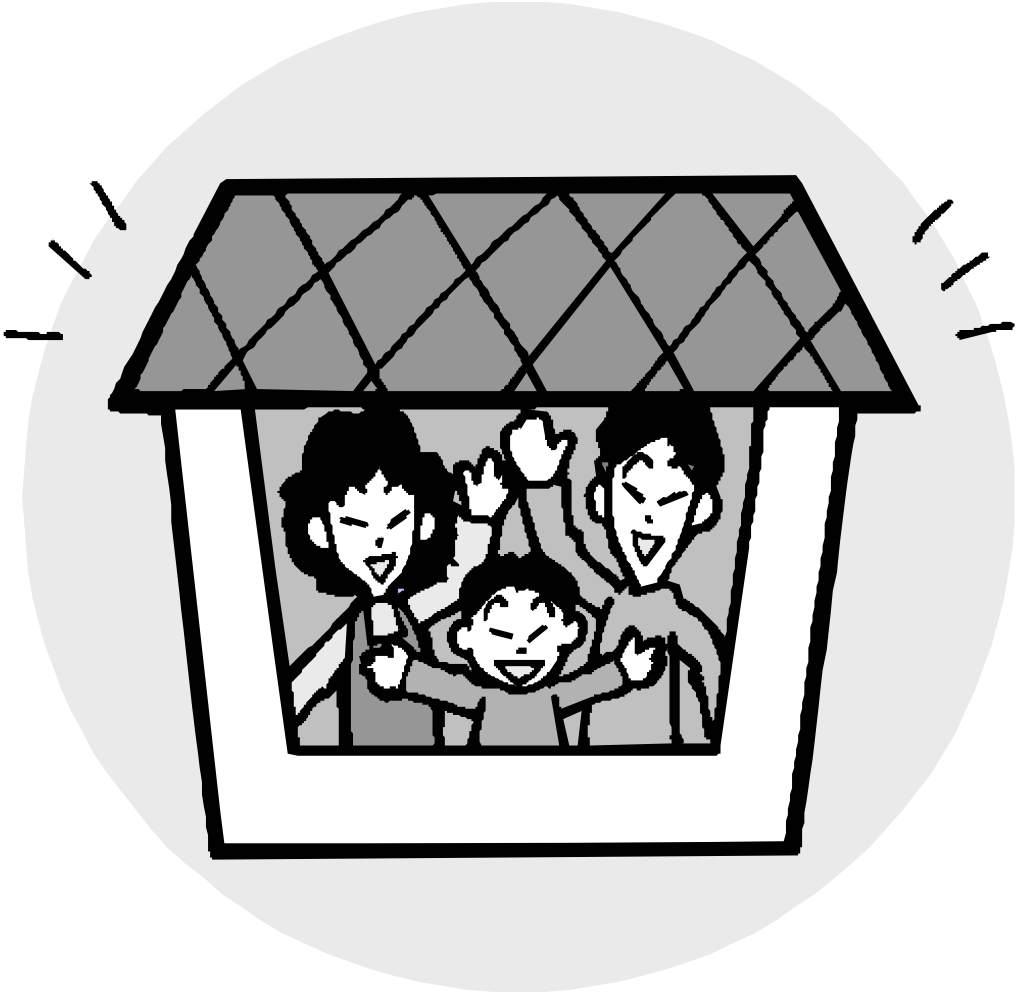
VERMONT ORGANIZATIONS AND AGENCIES

Child Care Resource and Referral, Head Start, Parent Child Centers, Migrant Educators and school districts offices provide information about local child care programs and resources for young children, their parents and families.
For location of local Migrant Educator, call 1-800-234-8848. See *Appendix I* for location of local offices of other agencies.

Prevention, Assistance, Transition, and Health Access (PATH) offices provide access to financial support programs, employment, housing, translators and local bilingual service providers.
1-800-287-2800. www.path.state.vt.us See *Appendix I* for location of local offices.

Project HEAL at the Howard Center for Human Services in Burlington "addresses the mental health and severe social adjustment needs of refugees… (and) provides education to refugees about cross-cultural differences, and the responses to those differences within the context of American societies, including those pertaining to the issues of child-rearing practices, domestic relationships, and interpersonal relationships."
(802) 859-1212

Vermont Refugee Resettlement Program offers multiple services for refugees who settle in Vermont, including translators, help with housing, social services and financial support.
(802) 655-1963. www.vrrp.org



PART FOUR

UNDERSTANDING AND RESPONDING TO YOUNG CHILDREN IN TRAUMATIC CIRCUMSTANCES

CHAPTER 12
TRAUMA AND BRAIN DEVELOPMENT IN YOUNG CHILDREN

The Importance of Understanding the Impact of Trauma on Young Children

Trauma, when experienced by infants and young children, is defined as a physical or psychological threat or assault to a child's physical integrity, sense of self, safety or survival or to the physical safety of another person significant to the child. Children may experience trauma as a result of a number of different circumstances, such as:

- Abuse, including sexual, physical, emotional
- Exposure to domestic violence
- Severe natural disasters, such as flood, fire, earthquake, and tornado
- War or other military actions
- Abandonment
- Witness to violence in the neighborhood or elsewhere, including fights, drive-by shootings, and law enforcement actions
- Personal attack by another person or an animal
- Kidnapping
- Severe bullying
- Medical procedure, accident, or serious illness

During the last decade a great deal has been learned about how the brain continues to develop after birth, and is shaped over the first few years of life. We now understand that infants' and young children's brain development is directly impacted by experiences, by relationships and by the emotional tone of their environments.

How the brain develops is critical to how children grow, change, and react to their experiences. It is important to understand what occurs in the brain when a child is traumatized. This chapter lays the groundwork for the following three chapters on child abuse, child neglect and children exposed to domestic violence. Those chapters provide specific strategies for caregivers, parents and other helpers supporting infants, young children and their families in responding to traumatic experiences and protecting young children from further harm. Here we offer an overview of the tremendous toll that trauma exacts on infants' and young children's development from a neurobiological perspective, and describe how this harms emotional and social development and affects children's approaches to dealing with life's stresses.

With this background, parents and those supporting young children and their families can better understand the need to provide young children with safe, stimulating, and nurturing relationships and environments, to protect young children from trauma, and, when traumatic events occur, to respond quickly and in ways that will decrease the adverse effects of trauma.

The brain mediates threats with a set of predictable neurobiological responses. Two predominant adaptive response patterns to extreme threat occur along 1) the hyperarousal continuum (fight or flee) and 2) the dissociative continuum (freeze, numb and surrender). Dissociation is a defense against fear or pain. It allows the child to escape mentally from the frightening or painful things that are happening to them. Each of these response patterns activates a unique combination of neural systems.

The neurophysiological activation seen during an acute stress response in a child is usually immediate and reversible. However, this response pattern tends to occur again and again at increasingly low thresholds of stimulation, and the more the pattern is activated, the more it tends to be re-activated. In this way, an acute stress response can become a long lasting, posttraumatic pattern of responding to stress.

Posttraumatic stress is traumatic stress that persists after a traumatic incident has ended and continues to affect a child's capacity to function. If posttraumatic stress continues and the child's neurophysiological responses remain chronically aroused, even though the threat has ended and the child has survived, then the term *post-traumatic stress disorder (PTSD)* is used to describe the child's enduring symptoms. Because trauma affects the child's ability to self-regulate, both physically and emotionally, post-traumatic symptoms in infants and young children may encompass one or more of a broad range of behaviors, including the following:

- Difficulty sleeping, eating, digesting, eliminating, breathing, or focusing
- A heightened startle response
- Agitation and over-arousal, or withdrawal and under-arousal
- Avoidance of eye contact
- Pulling away from physical contact with another person
- Terrified responses to sights or sounds that remind the child of the traumatic experience(s), (e.g., a dog, police siren or the smell of alcohol on a person's breath)

Adults should be concerned about possible trauma if a young child who *was* developing at a steady pace suddenly begins to show signs of distress or begins to lose previously gained skills or abilities. Children under extreme stress may begin fighting with other children, withdrawing from people and activities they previously enjoyed or show signs of fearfulness and general anxiety, including trouble getting to sleep, nightmares, or extreme distress upon separation from the parent(s). Many factors, including the age of the child and whether they have at least one protective, sensitive caregiver to help them cope with the trauma, will lessen or exacerbate each child's experience of trauma.

Effects of Trauma on the Developing Child's Brain

The brain and central nervous systems of infants and young children are still developing and being shaped by their experiences. Trauma that occurs in infancy and early childhood is especially concerning because it can adversely affect brain development long after the traumatic experience.

Infants and young children will draw upon all their resources to manage a traumatic situation, but, in reality, they have relatively few options to draw upon when their safety or survival is threatened. They cannot predict the occurrence of a traumatic event, and are completely dependent upon other people for their survival and well-being. They are generally unable to defend themselves or others or even escape a frightening experience by running away. They may not yet have language skills or capacity to organize their thinking or talk through a traumatic event.

In response to a major threat, the sympathetic branch of the nervous system switches on organs and glands such as the adrenals, thyroid, and pituitary that are involved in taking quick action in response to a threat to survival. When aroused, the sympathetic system dilates pupils, increases heart rate, raises blood sugar, decreases digestive activity and constricts bladder and rectal sphincters. These responses prepare the body to fight or flee from an immediate threat. Long-term overuse of these responses creates an imbalance in a child's capacity to draw upon other ways of responding to routine, day-to-day stress and may actually undermine the child's ability to respond quickly to a subsequent real threat.

The neurophysiological activation occurring during a single acute stress response (e.g., a house fire) is usually rapid and reversible. However, prolonged stress increases the levels of stress hormones in the brain over time. If the stressful events are of sufficient duration, intensity or frequency, or occur during a particularly critical period of neurological development, trauma can permanently alter young children's developing brains and central nervous systems. In such cases, a child's experience of being in the world is permeated by fear. The accompanying stress response becomes the traumatized child's template for brain organization and functioning.

Signs of Trauma in Infants and Young Children: How Infants and Young Children Cope with Trauma

Children draw upon a limited range of adaptive responses to cope with the shock and fear associated with a traumatic experience, and they tend to continue to use these same responses, even after the threat is gone. Over time, these children begin to function as though their survival is *always* at stake. Thus they are nearly always either attempting to fight or flee from perceived threats to their survival. Adaptive responses may include some or all of the following:

Persistent Fear States

Freeze, fight, and flight responses are immediate and automatic survival responses to acute trauma that serve to protect a person from harm. They mobilize a total body response to fear, mediated in large part by the brain stem and the autonomic nervous system.

- A frightened child may "freeze" in his tracks. This response may provide camouflage and give the child a few moments to process and evaluate the situation. Children who function in a persistent fear state startle easily and may react violently to physical touch or being caught off guard.

- Physical flight usually is not possible for infants and young children. The most common equivalent to actual flight is psychological removal by way of dissociation. Children who have had to use dissociation in order to endure an extreme threat or painful experience tend to use it again and again anytime they feel excited or scared.
- The fight response involves the mobilization of energy to do battle against the threat of harm, but because children are small and relatively powerless to take on grownups, the fight response generally involves acute alertness, vigilance, frantic movement, crying out for help, or tantrumming.

Anxious Responses

Responses to fear are typically outside the child's conscious control. They can be re-stimulated internally by memories, by arousal of any kind, or by external reminders of the traumatizing event. Anxious children may bite their fingernails, wet the bed, pick at their skin, pull out their scalp hair, eyebrows, or eye lashes, stammer or stutter, tear apart their clothes or show other habitual signs of fearfulness. They may not be able to relax or allow themselves to be in any situation where they feel out of control.

Some children who have been traumatized may suddenly become overwhelmed with fear and express their anxiety by freezing, crying, running, or screaming. These panic attacks may occur for no apparent reason. For example, a child may respond with terror to the color of a visitor's lipstick, seeing a pair of scissors on a table, or hearing a certain tone of voice. The child may be completely unable to move through or get beyond her fear without help from a caring adult.

Memory Problems, Flashbacks and Dissociation

Severely traumatic experiences are not processed and stored in memory in the same manner as other day-to-day events. Instead of being integrated with past experiences, they appear to remain separate and held partly or fully out of conscious awareness. Intense recollections can intrude into waking and sleeping awareness and be experienced as if they are occurring in the moment. Traumatic experiences appear to be encoded in the parts of the brain that ensure survival through the regulation of heart rate, respiration and body temperature. They are stored in memory much like a hologram, complete with emotional and sensory information, such as smells, sounds, images and tastes but *without* a narrative link to the context and sequence of events. This may explain why an extreme fright may literally render a child speechless.

Flashbacks in young children are reported by observers as sudden, out-of-context, intense emotional-behavioral episodes that the child does not remember having. The driven, repetitive reenactments of trauma observed in the play behavior of traumatized children may actually represent what are referred to as flashbacks in adult trauma victims.

Protective dissociation represents another disturbance of memory in that it protects trauma survivors from overwhelming emotions, thoughts, and sensations at the time of the trauma and afterwards. Repeated use of protective dissociation is an automatic, unconscious, habitual response to any and all stressors. Children who often dissociate are not fully present for much of their daily interactions and activities. They often end up with odd gaps in the knowledge and understanding of what is going on around them. In this way, the over-generalized use of dissociation undermines a child's functioning and development.

Agitation, Arousal and Problems with Regulation

Children who re-experience extreme agitation and anxiety, but who do not readily gain relief through dissociation or protective numbing may increase their arousal, by running, flailing, crying, or screaming to the point of being out of control. Such escalation may increase their physiological arousal state to the point that a self-protective numbing response eventually occurs and enables them to gain relief from their extreme anxiety.

Traumatized children experience significant problems with modulation of affect. They often have intrusive, spontaneous, affective recollections of trauma that they attempt to control or prevent by numbing, dissociation or avoidance of feelings. Sometimes the play of traumatized children may be repetitive, driven, severely constricted in affect (verbalizations, movement, and fantasy productions) and interspersed with out-of-control bursts of anger and aggression that may appear unrelated to the actual play.

Traumatized children are generally not aware of the physiological aspects of their own arousal such as increased heart rate, perspiration, and dry mouth. They may also have difficulty identifying or describing their own feelings. Excitement and fear both feel the same. Arousal of any kind, whether the feelings are positive or negative, may easily trigger the body's freeze-fight-flight response associated with trauma and re-kindle the child’s original feelings.

Aggression and Rage

One way a child can cope with a perceived threat of harm is to lash out at anyone or anything that challenges their sense of control. Aggression may take the form of breaking toys and other objects, hitting, biting, scratching other children, hurting animals or using threatening words or gestures to control other people.

Extreme anger is a survival response generated by the brain’s limbic system. Rage may find expression in thoughts or threats of harming oneself or others, explosive temper tantrums, or physical or verbal aggression. A child's angry response may be completely out of proportion to the events that lead up to it and may even be triggered by a benign attempt to approach or physically comfort a child.

Depression

Children who have been hurt and frightened may come to believe they are responsible for what happened to them. They may feel sad, angry, ashamed and guilty. Children who are depressed may cry or look sad and dejected. They may become irritable, lack the energy to do things, and attempt to avoid feelings by watching television or flitting from one activity to another. They may withdraw from friends and activities and complain of various physical ailments. Feelings of hopelessness and despair may lead children to fantasize about dying or harming themselves.

Avoidance

Many children who have experienced something very frightening or painful tend to avoid circumstances where they might have the same experience again. While this is a self-protective mechanism, it often means that such children avoid closeness or vulnerability in relationships and restrict the activities they take part in. Avoidance can be obvious, such as a refusal to go to certain places or participate in specific activities, or it can include more subtle and generalized shying away from any situation that might make them feel unsafe, helpless, or out of control. Avoidance can be expressed quietly, by simply not doing something, or actively and loudly as when a child talks incessantly or makes a lot of noise; banging things around, yelling, or singing.

As with any phobic response, the challenge with avoidance is to encourage children to try the things that are scary to them while making sure they have plenty of reassurance and support. Through these corrective or desensitizing experiences, children discover that they not only survive but can manage these experiences and even enjoy them.

> "Michael was referred [to CUPS] by his pre-school teacher. [He had been] sexually abused. When I began to work with him he [typically] did not want to talk about what had happened. His play was rather scattered. He would move from one thing to another without letting themes develop. The one theme that did repeat itself over and over was that of getting away from danger…After a summer of sessions, Michael began to undress [the dolls], pull their pants down and have them engage with each other sexually, with violent and cruel overtones. While at first he would not allow any discussion about this play, after a while it was okay to refer to it and ask questions about it. This went on for several more months [until] his teacher was reporting that he was demonstrating noticeable calm and resilience in the classroom and seemed to be getting more from the program."

Children traumatized by abuse may avoid intimacy, because emotional closeness leads to intolerable feelings of vulnerability and loss of control. Intimacy for these children represents a threat, not safety. Agitation, avoidance of eye contact, withdrawal, oppositional behavior, poor hygiene or personal habits that repel others, or any number of other behaviors can all be used to keep people at arms length so that the child does not have to deal with the possibility of being hurt again.

Distrust and Pessimism

Children who have been abused and betrayed by other people, as well as children who have been victims of natural disasters, accidents, injuries or serious illnesses, may come to approach every situation from a position of basic distrust and pessimism. They anticipate being hurt, frightened and out of control, so they may try to manipulate situations preemptively so that the trouble they expect actually occurs. Even when they have learned to feel relatively safe again, they often hold a part of themselves in reserve, not able to give themselves over fully to the comfort or sheer joy of any close relationship or carefree playfulness.

High-Risk Behaviors

Facing overwhelming fear produces an arousal response that mobilizes the entire organism to flee or fight. Some children whose arousal systems have been repeatedly jolted into action by trauma will seek out experiences that retrigger this hyper-arousal response. (This phenomenon is sometimes also seen with combat veterans who return home to find safe, everyday life boring and depressing). These children may appear to be fearless in the face of real dangers, pushing the envelope of experience to see what they can survive. They want to get on the scariest rides, see the most frightening movies, move at the fastest speeds, climb to the highest places, all without taking safety precautions. These high-risk behaviors are likely to eventually confirm the child's basic belief that bad things will happen to him again as they have in the past.

Obsessive-Compulsive Responses

In an attempt to gain mastery over their anxiety and assert control over what seems to be an uncontrollably dangerous world, some children rely on excessive attention to orderliness, schedules and rules. Everything must be in its place; everything must be checked and rechecked to make sure it is where it is supposed to be. Children who hoard food may be obsessively attempting to fend off the possibility of re-experiencing hunger and deprivation they experienced before. Other children may become rigid and inflexible about any changes in the order of events or of their possessions. Getting ready for a new experience, an unexpected change in schedule or even transitions from one activity to another may trigger extreme anxiety and agitation and a need to check all the details over and over.

Somatic Responses and Control

Being "revved up" all the time, as though one's life depended on always being ready for another traumatic event, can take a toll on children's immune systems. Sometimes, traumatized children may experience more infections or accidents than their peers. They are often out of touch with their own body sensations, so early signals of illness may go unnoticed and therefore untreated. Anxiety may be expressed through the body in the form of rashes, stomachaches, loss of appetite or overeating, headaches, dizziness or other physical complaints.

Difficulties with eating, elimination or sleeping may communicate children's fearfulness or attempts to gain some control over themselves. Some children may hoard food, overeat certain foods (typically fats and carbohydrates, especially sweets) or eat only a very limited number of foods. Other children may have difficulties with wetting or soiling, especially at times when they are re-experiencing the fear, anger and hurt of being traumatized in the past. Other children, out of extreme anxiety, may avoid toileting and become ill due to constipation or bladder irritation.

Sexualized Behaviors

Overt, compulsive and unusual sexual behaviors in children can be conditioned responses to previous sexual abuse or self-soothing behaviors they have developed in response to extreme anxiety. Some of these behaviors may include masturbating in public places, cajoling or bullying other children into sexual activities, using objects for sexual stimulation, sexual play with animals or exhibiting adult-like erotic or sexually provocative behaviors. When children are sexually abused, they may experience pleasurable feelings of sexual arousal and affection in combination with rage, pain, terror and shame. These children will need to be given explicit privacy rules and the expectation that they will follow them in all settings. They will also need very close supervision, so that they are not re-victimized and/or end up victimizing other children.

Supporting Caregivers

Adults who regularly work with children with a history of trauma may find themselves secondarily traumatized. It is important for them to find ways to take care of themselves that provide respite from the stress of giving of themselves to children whose needs are great and whose histories can be heartbreaking.

The priority for caring adults who work or have regular contact with a young child who has been traumatized is to establish safety for the child, and help her to learn to feel and act safe. Several other chapters in this handbook look more closely at specific ways a child might be traumatized and describe how caring adults can best support them, including

- Chapter 8, *Parent Substance Abuse*
- Chapter 10, *Families in Crisis or Experiencing Severe Stress*
- Chapter 13, *Child Abuse: Physical, Sexual and Emotional*
- Chapter 14, *Child Neglect*
- Chapter 15, *Children Exposed to Domestic Violence*

RESOURCES FOR MORE INFORMATION

WRITTEN AND VIDEO RESOURCES FOR ADULTS

Alexander, D. (1999). *Children changed by trauma: A healing guide.* Oakland, CA: New Harbinger. When children encounter violence, disaster, divorce, or the death of a loved one, they experience a wide range of feelings. Suggests ways to help them cope with these emotions, learn to talk about what happened, and begin to feel safe again.

Brohl, K. (1996). *Working with traumatized children.* Washington, DC: CWLA Press.
Discusses the mind-body connection between a terrifying experience and a child's adaptive coping mechanisms. Details the trauma recovery process and offers specific treatment intervention techniques. Readers will especially appreciate in-depth discussion of PTSD in children who are abused or neglected.

James, B. (1989). *Treating traumatized children: New insights and creative interventions.* Boston, MA: Books/Macmillan
Provides specific guidance and tools for treating children who have been traumatized by physical and sexual abuse, disaster, divorce, or witnessing violent events. Provides helping professionals with a clear blueprint for assessing the impact of trauma and developing specific interventions to help children recover.

Koplow, L. (Ed.). (1996). *Unsmiling faces: How preschools can heal*. New York, NY: Teachers College, Columbia University Press.
Offers specific tools to help early childhood educators recognize and respond therapeutically to children who have been abused or neglected.

Monahon, C., (1997). *Children and trauma: A guide for parents and professionals.* San Francisco, CA: Jossey-Bass.
Teaches parents and professionals about the effects of trauma on children and offers a blueprint for restoring a child's sense of safety and balance. Describes in detail the warning signs that indicate a child is in need of professional help and offers hope and reassurance for parents by suggesting straightforward ways to help kids through tough times.

Perry, B. (videos by Bruce Perry, MD). Magna Systems, Inc.

- *Understanding childhood trauma: The brain: Effects of childhood trauma, MOD 503.*
- *Understanding childhood trauma: Identifying and responding to trauma in ages 0 to 5 years old, MOD 504.*
- *Understanding childhood trauma: Trauma and healing, MOD 607.*

These three videotapes provide a complete overview of the effects of trauma on young children and ways to respond to help children recover from traumatic experiences.
www.magnasystemsvideos.com

WRITTEN AND VIDEO RESOURCES FOR ADULTS *(CONTINUED)*

Terr, L. (1990). *Too scared to cry: Psychic trauma in childhood.* New York, NY: Harper and Row. Based on research following the traumatic experience of a group of children trapped in a school bus for a lengthy period. Provides examples of how children cope with overwhelming trauma, and particularly how their play is affected; useful to parents and helping professionals.

WRITTEN RESOURCES FOR CHILDREN

Galvin, M. (1991). *Ignatius finds help: A story about psychotherapy for children.* NY: Magination Press. Ignatius.
This is a story of a bear who has trouble getting along with others at home and in school, visits a psychotherapist, Dr. Pelican, whose innovative techniques help Ignatius solve his problems.

Holmes, M. (2000). *A terrible thing happened: A story for children who have witnessed violence or trauma.* Washington, DC: Magination Press.
This gently told and tenderly illustrated story is for children who have witnessed any kind of violent or traumatic episode, including physical abuse, school or gang violence, accidents, homicide, suicide, and natural disasters such as a flood or fire.

Mayer, M. (1992). *There's a nightmare in my closet.* NY: Penguin books.
At bedtime a boy confronts the nightmare in his closet and finds the nightmare not so terrifying after all.

Moser, M. (1991). *Don't feed the monster on Tuesday: The children's self-esteem book.* Kansas City, MO: Landmark Editions (Grades K-6).
Dr. Moser presents valuable information to children that will help them understand the importance of self-worth and practical approaches to strengthen their self-esteem.

UNICEF. (2000). *For every child: The rights of the child in words and pictures.* New York, NY: Phyllis Fogelman Books.
A beautifully illustrated book for young children that makes clear the basic human rights of all children.

WEBSITES AND ORGANIZATIONS

The Child Trauma Academy, directed by Bruce Perry, is dedicated to improving the lives of children who have been traumatized and their families. Full text articles about many kinds of trauma are found under "CTA Materials."
www.childtrauma.org

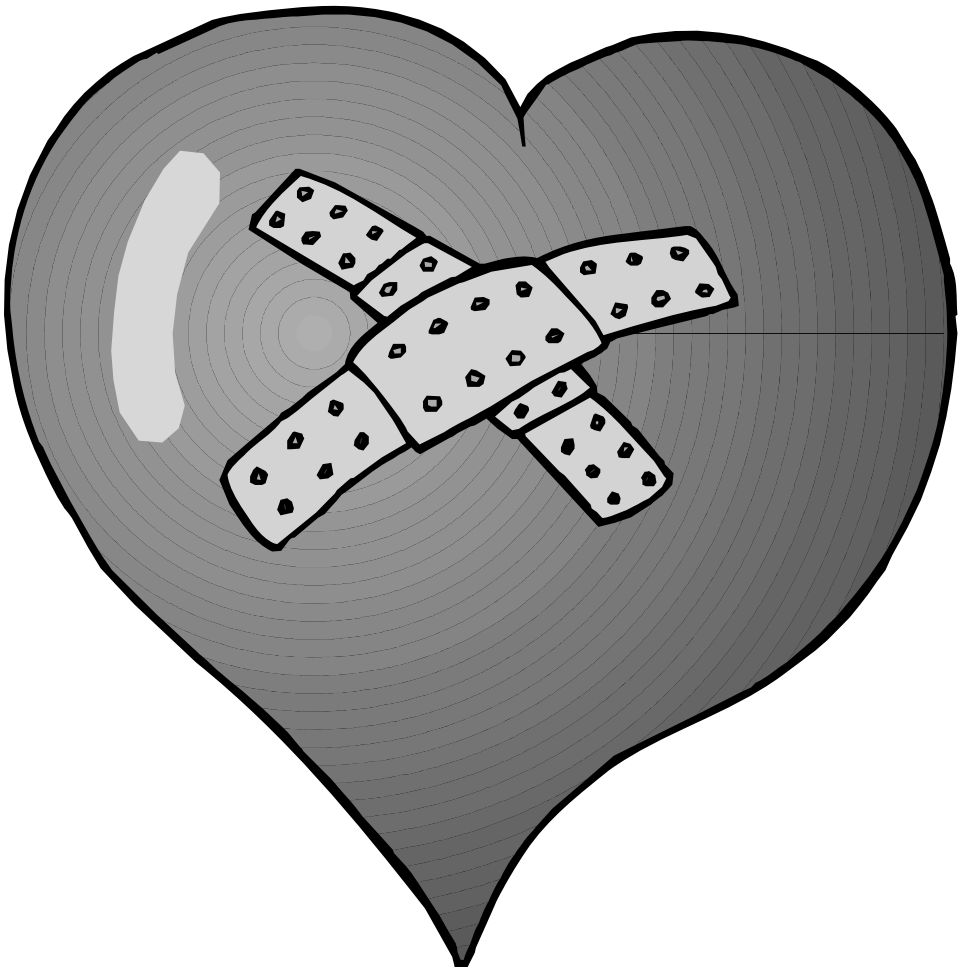
David Baldwin's Trauma Information Pages is designed for parents, caregivers and others concerned with disasters, accidents and other injuries; provides full text articles about trauma and related topics.
www.trauma-pages.com

The Guidance Channel is an educational publishing and media company that provides a variety of healing resources/tools including videos, books, curricula, information handouts, videos and therapeutic games.
1-800-99-YOUTH (1-800-999-6884). www.guidancechannel.com

VERMONT RESOURCES

Victims Compensation Program, Vermont Center for Crime Victim Services
103 South Main Street,
Waterbury, Vermont 05671-2001

The Victims Compensation program offers assistance in identifying treatment providers and paying for treatment of children who have been victimized.
1-800-750-1213 or (802) 241-1250. www.ccvs.state.vt.us/



CHAPTER 13
CHILD ABUSE: PHYSICAL, SEXUAL AND EMOTIONAL

Child abuse, whether physical, sexual or emotional, can have long-lasting effects on children's emotional well-being and how they view themselves and others. Child abuse usually occurs at the hands of someone known to the child and likely to be in a care-giving role. Children who experience sexual, physical, or emotional abuse may have been exposed repeatedly to maltreatment by the time they come to the attention of protective caregivers. This is because it is so often perpetrated by family members or other trusted individuals.

Children who have been physically, sexually, or emotionally abused will likely experience trauma, which may cause intense fear that mobilizes their arousal response to fight, flee or surrender to a perceived threat. (See Chapter 12, *Trauma and Brain Development in Young Children*). It is difficult, and sometimes impossible, to know the specific nature of the traumatic events these children have experienced.

The Relationship between Trauma, Child Abuse, and Attachment

Abuse alters children's attachment behaviors and belief that others can be trusted to offer them safety and comfort. When abuse is caused by the very person or persons the child most relies on for security and nurturing, the impact is most severe, as children's experiences are mediated through their attachment relationships with their primary caregivers. The person the child would normally turn to for comfort and reassurance is the same one who frightens, threatens, hurts or fails to protect them. In such situations, infants and young children may have no one to turn to.

> "I didn't wake up one day and decide, 'I think I want to be a loser today.' I got that way over the course of my life…I didn't purposely have the issues that I have. They came through a life of abuse, and all kinds of things that happened to me, and I didn't just wake up one day and say, 'I don't want to function like the rest of you.'…because I do."

The immediate and ongoing responses by the child's primary caregivers regarding the abuse can exacerbate or ameliorate the child's experience. Children respond to the actual traumatic experience as well as to cues from significant adults about what they have experienced, why it happened to them, and how they are expected to cope with it.

It is critical that significant adults in the child's life respond actively and quickly to protect the child. If they show compassion and exonerate him from blame or shame, and if they express anger toward and distance themselves from the perpetrator, the child will experience the protection he needs and will most likely recover. If, however, a child's caregivers ignore the abuse or blame her for causing problems in the family, the child may come to believe that she is the cause of bad things that happen to her, and that adults cannot be counted on for help. The dynamics of child abuse are complex; even caring adults can sometimes react to abuse in ways that increase a child's fears and sense of shame.

Physical Abuse

Physical abuse of an infant or young child is defined as physical injury inflicted by another person by shaking, punching, beating, throwing, kicking, biting, burning or any other physically harmful action. Physical abuse can result from inappropriate attempts to discipline or punish a child. Shaking an infant or toddler can cause serious harm and may result in Shaken Baby Syndrome, which is characterized by whiplash-induced intracranial and intraocular bleeding, but with no external signs of head trauma.

Infants and young children who have been physically abused may be frightened and in physical pain, fussy and difficult to comfort, agitated and restless or withdrawn, unresponsive and dissociative. Dissociation is a coping mechanism which allows the child to escape mentally from the pain and fear of the abuse. When children dissociate, they may stare into space for long periods of time as if cut off from reality. Frightened children may startle at sudden movements or sounds. Young children who have been physically abused may be angry, defiant and aggressive toward other children and adults. In preschool or daycare, they may cling to a caring child care provider or teacher. They may have difficulty focusing on activities or completing tasks. These children may be preoccupied and unable to listen or participate in regular activities.

Signs of physical abuse may be visible, such as broken bones, slap marks on the face or body, or marks left on the buttocks from a beating with a belt, cigarette burns, cuts, bruises, scratches, or bite marks. Sometimes there may be no external signs of abuse, but the child may show signs of shock or distress and be suffering from internal injuries to the head or body.

Not all injuries are indicators that the child has been abused. Even infants may be hurt accidentally. Toddlers and preschoolers are likely to get bumps and bruises as they go about their usual daily activities. It is important to observe carefully to differentiate indications of actual abuse from accidental injuries.

Sexual Abuse

Sexual abuse is most often perpetrated by a parent, step-parent, other relative or someone else close to the family who has ready access to the child. Stranger sexual abuse of young child does occur, but is less common.

Any of the following behaviors constitute sexual abuse of a child:

- Intrusion in which there is evidence of a child's mouth, anus or genitals being penetrated by the abuser's penis, finger or an object.
- Molestation with genital contact, (i.e., any act where some form of contact with a child's genitals occurs, without intrusion or penetration.)

- Other forms of sexual abuse that may not involve actual genital contact such as the abuser:
  - fondling the child's breasts or buttocks
  - exposing his genitals for the child to see
  - arranging for the child to witness to adult sexual activity or explicit video sex

Infants and young children who have been sexually abused show symptoms similar to those of physically abused children: they may be frightened and in pain, fussy and difficult to comfort, agitated and restless or withdrawn, unresponsive and dissociative (meaning detached from the feelings, thoughts and memories of the abusive experience). They may be alarmed by loud noises, sudden movements or anything that reminds them of the abuse (for example, certain smells, clothing of a certain texture or color, or music associated with the abuse). Signs of sexual abuse may include any kind of persistent preoccupation with the mouth, genitals or rectum, such as rubbing, holding or scratching.

Signs of injury from sexual abuse may include oral, rectal or vaginal bruising, redness, soreness or bleeding, or infection in the genital area, rectum or mouth. Less obvious, but no less damaging, are signs of sexual abuse that can be observed in children's behaviors. These may include preoccupation with their own or others' genitals (including excessive masturbation), placing objects in the vagina or rectum, demonstrating knowledge of adult sexual activities in play with dolls or toys, or attempting to engage other children or adults in sexual activities. Normal, innocent curiosity about their own and other children's bodies may be replaced by the often driven, repetitive or secretive nature of sexualized behavior in children who have been sexually abused.

It is natural for infants and young children to express curiosity about their own and others' bodies. Infants discover pleasant sensations from touching themselves, toddlers explore their bodies with great interest, and preschoolers may play "doctor" with peers as they master their knowledge of the human body – and the differences between boys and girls. These activities tend to be carried out openly, in a spirit of curiosity, and without distress or intensity. Parents and early care providers will want to be aware of typical sexual development in infants and young children so they can distinguish between what is developmentally normal interest and exploration versus behaviors which may signal that a child has been sexually abused.

Emotional or Psychological Abuse

Emotional or psychological abuse is more difficult to define and identify because this form of abuse does not leave physical evidence. In addition, psychological or emotional abuse often takes place in conjunction with other types of child maltreatment. Emotional or psychological abuse is characterized by *a sustained pattern* of hostile, rejecting, threatening, terrorizing, demeaning, or shaming words and actions by an adult or youth toward a child - rather than a single mean-spirited remark or action.

Emotional or psychological abuse includes the following behaviors:

- A pattern of belittling, denigrating, blaming, making fun of, teasing, or other nonphysical forms of hostile or rejecting treatment, or threatening a child with physical or sexual abuse or abandonment.
- Close confinement by tying or binding a child's hands, arms or legs, tying a child to a chair or bed, or locking a child in an enclosed area such as a closet or basement as a means of punishment.
- Deliberate withholding of food, shelter, sleep, or other necessities as a form of punishment.

Emotional or psychological abuse erodes the child's developing sense of self, self-esteem, social competence, and self-efficacy. Young children who have been emotionally abused may let caregivers know what someone else has said or done to them by saying or doing the same thing to another child or adult. Additional indicators of emotional or psychological abuse include poor self-regard, anxiety, a negative view of the world (pessimism), destructive behaviors, depression, withdrawal, apathy and learning difficulties.

Responding to and Reporting Abuse

When an infant or young child is abused, it is difficult for those who did not take part in, or witness the abuse to determine the actual sequence of events and the child's immediate or subsequent responses to them. However, children who have been physically or sexually abused show signs of abuse or exhibit behaviors in their day-to-day interactions at home or in child care that should raise concern.

If a parent, care provider, or other person working with children has any reason to suspect a child has been, or is currently being, physically, sexually or emotionally abused, a report of suspected child abuse must be made immediately to the child protection agency (the Vermont Department of Social and Rehabilitation Services - SRS) so that an investigation can be conducted and appropriate steps taken to ensure the abuse stops and the child is safe.

Children seek to please the adults they rely on, and they readily pick up on cues from adults about who did what to whom. Adults who suspect abuse should *not* interrogate the child, but should immediately report their concerns to SRS so that an expert investigator can talk to the child right away.

Vermont State Law mandates that professionals in education, child care, mental health, social services, health care and law enforcement, corrections, recreational programs and camps and any other concerned person must report all suspected cases of child abuse and neglect to Social and Rehabilitation Services (SRS) within 24 hours. The law now mandates that clergy are also required reporters (excepting information given them in the confessional or the equivalent).

Any person who in good faith makes a report of abuse will be immune from liability that may occur or be imposed as a result of making a report. Local Social and Rehabilitation Services (SRS) offices are listed in *Appendix I*.

There are times when it is safe and appropriate to discuss concerns about abuse or neglect with parents and involve them in making a report to SRS. For example, a child may disclose to a care provider that a babysitter who is not a family member or a neighbor has sexually abused her. In this case, it would be appropriate to speak with the parent(s) and involve them in making the SRS report.

There are other times when discussing concerns about abuse or neglect with a parent may further endanger the child. For example, if a child has visible signs of abuse and discloses in child care that his father or mother beat him, the first priority must be protecting the child from further abuse. A report to SRS should be made immediately without first alerting the parents.

Concerned adults should contact SRS and describe as clearly and accurately as possible the specific nature of what they have seen and heard that leads them to suspect child abuse or neglect. Based on the nature of the concerns, an SRS intake worker will discuss the information with her supervisor, who then determines if the report warrants an investigation, and if it is safe and appropriate for the caller to talk directly with a parent about the report to SRS.

Parents who suspect abuse or neglect, by a child care provider or anyone else, should immediately contact SRS. A special SRS investigative unit handles all reports of suspected abuse or neglect by licensed child care providers or other licensed professionals (including, among others, teachers, members of the clergy and health or mental health professionals).

Finding Help for Children and Their Families

First and foremost, if abuse or neglect is suspected, the child must be kept safe and free from threat of harm or abuse. Once an investigation has been conducted by SRS, the abuser has been identified and appropriate steps have been taken to ensure that there will be no contact between the abuser and the child, the focus needs to be on helping the child and family recover from this traumatic experience.

It is important to remember that discovering and reporting abuse is highly upsetting and unsettling to a family. Even if the abuse or neglect is not substantiated, the parents, child and extended family members will need time to recover from the intrusive experience of being investigated. When abuse or neglect *is* substantiated, family members may feel relieved to no longer be keeping a secret and to get help, but they are likely to feel anger, betrayal, conflict and sadness as well. In addition to feeling scrutinized and judged, parents may also be exhausted from dealing with a variety of professionals from child protection, legal, health and mental health agencies. If the abuse leads to a civil or criminal court case, the child and family will need special support to prepare for the emotional and financial toll this often takes.

Children who have been abused or neglected and who cannot safely stay with their parents) will be taken into protective custody. Law enforcement officers, either local or state police, will take physical custody of the child and a Family Court Judge will rule to place the child in the care and custody of SRS. In these circumstances, every effort will be made to place the child with a safe family member or a safe caregiver in the child's home community. When these options are not possible, the child will be placed with a licensed foster parent while SRS case planning as well as court and legal proceedings continue.

When abuse or neglect is substantiated, SRS "opens" a case, and a child protection worker is assigned to the child. The worker creates a case plan that includes regular, supervised visits with parents and various services, including health and mental health care for the child. Children who have been abused or neglected are often eligible for crime victim's assistance that can pay for individual therapy to help them recover from the trauma of abuse or neglect and the subsequent separation from their birth parents.

Removal from his home can be very confusing to a young child, who could interpret this move as punishment rather than protection. Furthermore, moving to a stranger's home, even temporarily, can cause further harm to a child whose greatest need is for consistent care from a loving, trustworthy adult. Child care providers and other service providers can serve an important role by providing continuity for a child who is moved into a new environment. During this transition, it is very helpful to maintain as much consistency and familiarity as possible for the child. Caregivers who can create surroundings and schedules that decrease the intensity and duration of the acute response (alarm and/or dissociation) for the child will decrease the probability of persisting post-traumatic stress symptoms. Key elements to successful early intervention include safety, structure, predictability and sensitive nurturing by individuals attuned to a child's possible reactions. The child may test every limit set to make sure it is firm, to ensure he is being protected.

In conjunction with therapy, medication may be necessary to provide children relief from the extreme fearfulness, hyper-arousal, anger and depression associated with abuse. Medication may make it possible for children to calm down, focus and engage in prosocial behaviors that enable them to be socially successful with other children in child care or preschool settings. Medication should be used as an adjunct to a comprehensive treatment approach that offers the child relief from the traumatizing events of the past and greater self-regulation to help them cope with stress in the present and future.

Services may involve attachment and/or relationship enhancement counseling with both child and primary care person (often the mother or foster mother). Some young children benefit from expressive therapy with a counselor trained in working with young children who have experienced abuse. By using art and play materials, the child is helped to express perceptions and feelings about what was experienced, learn and practice personal safety skills, and build a personal sense of worth, competency, efficacy and pleasure. Counseling should address such issues as how the child and his or her caregivers can manage the child's anxiety, depression, sexualized behaviors, and aggression.

Parents of children who have been sexually abused may need special support as they come to terms with the reality that their child has been violated. Parents may carry prolonged and intense anger at the perpetrator, along with guilt that they did not protect their child, or they may believe that their child has been permanently damaged by the abuse. Many communities have groups for parents of children who have been abused, offering education and support in a protected environment so parents can express their anger, grief and other feelings. To learn about these groups, parents can contact their local community mental health center, SRS office, State's Attorney's Office Victim's Advocate, Prevent Child Abuse Vermont (see *Appendix I* for locations of these resources) or any child and family counselor.

If there is concern that a child and his parent are both being abused, as in the case of domestic violence, great care must be taken to ensure that both parent and child are protected and that nothing is done that could inadvertently increase the danger to either of them. Chapter 15, *Children Exposed to Domestic Violence,* provides guidance and resources for supporting families in which both mother and child(ren) are victimized.

Because young children tend to be resilient and to respond to good, ongoing, consistent and nurturing care, early assessment and intervention can help prevent a prolonged trauma response in young children who have been abused. With support and understanding, they and their families can heal and grow stronger.

RESOURCES FOR FURTHER INFORMATION

WRITTEN RESOURCES

Cyprian, J. (1998). *Teaching human sexuality: A guide for parents and other caregivers.* Washington, DC: CWLA.
An illustrated human sexuality glossary that clearly explains reproductive anatomy and physiology; sexual expression and orientation; gender issues; and sexual abuse. Appendices provide additional information on sexually transmitted infections, national hot lines, and other sexuality education resources for parents and children.

Giardino, A.P. and Giardino, E.R. (2001). *Recognition of child abuse for the mandated reporter, third edition.* Brandon, VT: Safer Society Press.
Completely updated, widely acclaimed practical text/reference that helps professionals fulfill their legal and ethical responsibility to report child abuse with a high level of confidence and effectiveness. Also serves as a textbook for students in medicine, nursing, social services, and law enforcement who are preparing for work with children.

Garbarino, J., Guttman, E., & Seeley, J., (1986). *The psychologically battered child: Strategies for identification, assessment and intervention.* San Francisco: Jossey-Bass Publishers.
Provides guidelines for those who are investigating, identifying, preventing, and treating the psychological maltreatment of children and adolescents. It also offers a comprehensive explanation of psychological child abuse and clearly defines different types of psychological maltreatment.

Garbarino, J. (1999). *Lost boys: Why our sons turn violent and how we can save them*. NY: The Free Press.
Responds to the increase of youth violence in America. James Garbarino demonstrates that, in spite of hazards posed by the family, societal neglect, and easy access to firearms, there is reason for hope as long as parents and teachers are able to recognize and respond to warning signs that a child is in trouble.

WRITTEN RESOURCES *(CONTINUED)*

Gil, E. (1991). *The healing power of play: Working with abused children*. NY: Guilford Press.
Describes how therapists can both facilitate constructive play therapy and intervene in posttraumatic play to help children traumatized by abuse or neglect achieve positive resolution.

Hoyle, S. G. (2000). *The Sexualized child in foster care*: *A guide for foster parents and other professionals*. Washington, DC: CWLA.
A practical guide, written for foster parents and other child welfare professionals, that gives information and a wide range of resources for supporting children in foster care who have been sexually abused.

Osmond, M. , Durhan, D., Leggett, A., & Keating, J. (1998). *Treating the aftermath of sexual abuse: A handbook for working with children in care.* Washington, DC: CWLA.
Reviews the impact of sexual abuse on a child's physical and emotional development and describes the effect of abuse on basic life experiences. Guides caregivers and other professionals to recognize and understand the child's story in signs, signals and behaviors. Through careful and thoughtful listening, helping professionals can help children tell their stories and find pathways to healing.

Reppucci, D., Britner, P., Woolard, J., Sarason, S., (1997). *Preventing child abuse and neglect through parent education.* Baltimore: Brookes Publishing Co.
Outlines an empowering approach to service delivery in child abuse prevention programs. Using knowledge from research on 25 distinct parenting programs, provides detailed case studies and dozens of practical suggestions for planning, evaluating, and strengthening parent education programming.

Silver, J.A., Amster, B. J., & Haecker, T. (1999). *Young children and foster care: A guide for professionals*. Baltimore: Brookes Publishing Co.
Offers a multidisciplinary discussion of the needs of children and families involved with the child protection system, focusing on infants and young children from birth to 5. Features information on child development, highlights key concerns and issues for children in foster care, and presents expert advice on important aspects of care that may be overlooked.

UNICEF (2000). *For every child: The rights of the child in words and pictures*. New York: Phyllis Fogelman Books.
A beautifully illustrated book featuring 14 of the most pertinent rights of the child, carefully chosen and retold in simple, evocative text that can be easily understood by every child and parent.

RESOURCES FOR CHILDREN

Brown, L. K. & Brown, M. (1997). *What's the big secret? Talking about sex with girls and boys*. Boston, NY: Little, Brown & Co.
Introduces children to the differences and similarities between girls and boys. Provides answers to questions such as "Are girls and boys different on the inside?", "How do you tell girls and boys apart?", and "Is sex a dirty word?".

Girard, L. W. (1992). *My body is private.* Morton Grove, IL: Albert Whitman & Co.
A mother-child conversation introduces the topic of sexual abuse and ways to keep one's body private and safe.

Hindman, J. and Novak, T. (1983). *A very touching book…for little people and for big people.* Alexandria Assoc.
Written by a pioneer in the field of sexual abuse, this introductory book helps children understand touch and their feelings about touching and being touched.

Kehoe, P. (1988). *Helping abused children: A book for those who work with sexually abused children.* Seattle, WA: Parenting Press, Inc.
A tool to assist the counselor, teacher, or caregiver with practical, helpful information and activities for use with children ages 3-12.

RESOURCES FOR CHILDREN *(CONTINUED)*

Klassen, H. (1999). *I don't want to go to Justin's house anymore.* Washington, DC: Child & Family Press.
A book for young and school-aged children about a friend who is being physically and emotionally abused. Mom doesn't understand why Collin is reluctant to go to his best friend's house. Once Collin's mom realizes that Justin is being abused, she and Collin decide to help his friend.

Kleven, S. (1998). *The right touch: A read-aloud story to help prevent child sexual abuse.* Bellevue, WA: Illumination Arts.
Reaches far beyond the usual scope of a children's picture book; introduces a very difficult topic-the sexual abuse of young children. A gentle, thoughtful story, meant to be read aloud by a trusted caregiver.

Ostis, C. (2002). *What's happening in our family: Understanding sexual abuse through metaphors*. Brandon, VT: Safer Society Press.
Stories have the power to hurt and to heal. This book provides stories to help therapist and families take apart the tangled stories that shape how children who have been abused feel about themselves and what happened to them.

Sherman, J. (2002). *Because it's my body.* Brandon, VT: Safer Society Press.
Provides children with a powerful and empowering phrase to use when they no longer feel like being touched (whether it be kissing, hugging, or a piggyback ride). One child narrates as she and her four friends play out different wanted and unwanted interactions.

Wachter, O. (1983). *No more secrets for me: A book for adults to share with children.* NY: Little, Brown.
Sexual abuse is a secret no child should have to keep. The essential book for everyone concerned about protecting young children from sexual abuse.

VERMONT RESOURCES

Social and Rehabilitation Services (Vermont SRS) Division of Social Services is designated by Vermont statute to evaluate and investigate reports of suspected child abuse and neglect. SRS child protection workers conduct investigations, assess families' needs, and make recommendations for services to alleviate family stress and improve parenting skills. When someone calls to report possible abuse or neglect, an intake worker will take information and make a determination about the need to conduct an investigation. If there is information to indicate that the child may have been abused or neglected, as defined by state law, the referral will be accepted as a report. If a caller is unsure whether a situation will be considered abuse or neglect, call the nearest SRS district office to talk with an SRS investigator. See *Appendix I* for a listing of SRS District Offices.

To Report Child Abuse in Vermont call your local SRS office, or (802) 479-4260 between 7:45 am and 4:30PM. After regular business hours, weekends and holidays, call 1-800-649-5258 or 1-800-228-7395. See *Appendix I* for a listing of SRS District Offices.

To find out about the Vermont Department of Social and Rehabilitation Services policies, services and relevant Vermont statutes, use the SRS website. www.state.vt.us/srs/

Community Mental Health Centers provide support and counseling for children and families in which child abuse has occurred. See *Appendix I* for a directory of community mental health centers in Vermont.

Chittenden Unit for Special Investigation – Sexual Assault/Abuse Assistance (CUSI)
CUSI is a law enforcement unit that investigates sexual crimes and other serious cases of child abuse or neglect that have occurred in Chittenden County. Specially trained professionals provide for the emotional needs of young victims and families and help them through the ongoing process of investigation and legal actions. CUSI is a prototype for other units organized elsewhere in Vermont. (802) 652-6800. www.vtspecialcrimes.org/CUSI

VERMONT RESOURCES *(CONTINUED)*

Network for Children, Youth, and Families: Child Protection/Sexual Abuse - composed of professionals representing various disciplines and agencies, provides consultation for case assessment and treatment planning. The Network provides clarification of provider roles and coordination among providers to improve service delivery. Available for children, prenatal to 18 years old, where there is a risk, suspicion, or substantiation of abuse or exploitation. The Network works closely with the Department of Social and Rehabilitation Services (SRS) in identifying and treating child abuse and neglect cases.
(802) 863-9626

Prevent Child Abuse Vermont (PCAVT) - Provides several statewide programs for families including:

- Parent's Stress Line, a toll-free number to call for help when parents are feeling angry, stressed and/or in need of support, resources and referrals
  Parents' Stress Line: 1-800-CHILDREN (1-800-244-5373). www.pcavt.org
- Shaken Baby Syndrome Prevention Program
- Understanding and Responding to Sexual Behavior of Children (URSBC)
- Care for Kids (community-based sexual abuse prevention)
- The Nurturing Program (family-oriented education for both kids and parents)
- Parents Together™(self-help support groups for parents)
- Vermont Parents' Home Companion and Resource Directory (annual publication listing many family resources throughout the state as well as helpful tips for parents, kids, and providers)

Vermont Center for the Prevention and Treatment of Sexual Abuse (VCPTSA) provides information and referrals to victims, therapists, and other concerned citizens; assistance with the legal process; help with accessing compensation for services; advocacy for the victim when necessary; training for law enforcement and nurses; and a lending library. VCPTSA has developed a network of therapists with expertise in working with sexual abuse, including child victims.
(802) 651-1663

ORGANIZATIONS AND WEBSITES

Childhelp USA® National Child Abuse Hotline is available to anyone needing help or who suspects abuse. Professional counselors are available 24 hours a day, 7 days a week. "The goal of Childhelp USA® is to meet the physical, emotional, educational, and spiritual needs of abused and neglected children by focusing on treatment, prevention, and research."
1-800-4-A-Child (1-800-422-4453). www.childhelpusa.org

Children's Rights, Inc. is devoted to helping abused and neglected children who are failing in the foster care system.
(212) 683-2210. www.childrensrights.org

National Center for Missing and Exploited Children provides services to families and professionals on prevention and interventions with abducted, endangered, and sexually exploited children. Website provides tips and articles.
24 Hour Hotline: 1-800-THE-LOST (1-800-843-5678). www.missingkids.org

American Professional Society on the Abuse of Children (APSAC) seeks to improve the quality of service provided by professionals who work in child abuse and neglect; promotes effective, culturally sensitive, and interdisciplinary approaches to the identification, intervention, treatment, and prevention of child maltreatment.
(405) 271-8202. www.apsac.org

CHAPTER 14
CHILD NEGLECT

Definition

The maltreatment of children falls into two general categories: abuse and neglect. Although these two types of maltreatment are often mentioned together, we have chosen to present them separately. It is not unusual for both neglect and abuse to co-exist. However, because abuse typically is more obvious (e.g., physical or medical evidence) there is a tendency to focus one's response on the abuse, and ignore the neglect which the child also may have suffered.

Abuse to an infant or young child often occurs out of adult frustration or anger. Neglect tends to occur more out of lack of emotional connection and responsiveness to the child. Abuse interventions involve assuring the child's safety and helping adults learn non-hurtful ways to interact with their child. Neglect requires inspiring within the parents the will and understanding to emotionally bond with their child and to meet the child's developmental needs.

Child neglect refers to an act of omission, which may or may not be intentional by the parent(s), related to their failure to meet basic and necessary needs of the child. These needs include several categories:

- *Physical needs,* such as adequate and safe housing, appropriate clothing and personal hygiene, and appropriate nutrition.
- *Medical, dental and mental health needs,* such as seeking medical, dental and mental health attention when needed and following through on recommendations and prescriptions.
- *Protection from physical harm,* such as developmentally appropriate supervision and protection from unsafe situations.
- *Protection from emotional harm,* such as abandonment, lack of emotional availability, minimal parent-child interactions, and inconsistent parental responsiveness to the child.
- *Protection from exploitation,* such as an excessive requirement to care for younger siblings or an incapacitated parent.

Child neglect can be blatant, as in abandonment, or subtle, such as an emotionally unavailable parent. There are many factors that might prompt parental neglect of an infant or young child, such as

- Parent depression or other psychiatric or developmental disability
- Parent drug/alcohol involvement
- Domestic violence
- Parent history of childhood neglect and poor attachment
- Lack of knowledge and understanding of infant and early childhood needs, nutrition, medical problems, and/or household management

- Environmental stressors such as poverty, poor housing, lack of access to resources
- Social and physical isolation
- Large number of children close in age
- Parent physical illness or disability
- A disability or difference in the child
- Parent disappointment regarding their child or their role as parent

Responding to Child Neglect

There are many possible indications of child neglect that should prompt adults to take notice. Some examples of these red flags include:

- Lack of expected physical growth
- Malnutrition
- Persistent illness
- Flat emotional responses
- Turning away from eye contact, or making eye contact only on child's terms
- Social development delays
- Cognitive or language development delays
- Inability to manage frustration
- Aggressive behaviors
- Poor impulse control
- Chaotic home environment
- Absence of adequate food, clothing, housing, clean diapers, etc.

Service providers need to be acquainted with state laws that define child neglect, as well as procedures for reporting neglect to Vermont Department of Social and Rehabilitation Services (SRS). Suspicion of neglect should be reported SRS so that investigators can assess for the presence of and type(s) of neglect. For a list of district SRS offices, see *Appendix I.*

The SRS assessment will help guide those supporting the family in planning for ways to address the neglect. SRS has access to specific services as well as funding sources for those services. Support services may be provided by SRS, a local Parent Child Center or other early care center, the Department of Health or other family support providers. In many cases services may be put into place to support the parents and child together, (e.g., home visits to model nurturing parenting, classes to help parents learn about the developmental needs of children at different ages, addressing economic stressors, or counseling to help promote attachment.)

Sometimes it becomes necessary to place the child with another family (through kinship or foster care or adoption). When a child who has been neglected joins an adopted or foster family one of the most significant challenges may be to help the child and parent(s) build a healthy attachment. They can be supported in doing this by working with a counselor specially trained in attachment building. The VT Adoption Consortium and SRS are available to provide general supports to the family, and Casey Family Services can help with locating therapists trained in attachment building. *See this Chapter's Resources for More Information section.*

The goal of ameliorating child neglect is to assure that the child's basic physical, medical, and emotional needs are adequately met. In addition to meeting the child's needs for food, shelter, clothing and basic requirements for health and safety, the focus of intervention should be on promoting a positive and responsive parent-child relationship. To this end, an approach that is family-centered, multi-faceted, long-term and individualized is recommended.

The nature of the neglect will have direct bearing on what kinds of help should be provided. Assessment of the issues or needs of the parent(s) that contribute to neglect of the child is an important early step in determining intervention strategies. If, for example, a mother is distant and unavailable to her child due to depression, then those supporting the family will want to assist the mother in recognizing that she needs treatment and help her obtain the appropriate treatment. The mother will also need guidance and support in parent-child interactions.

> "They gave me these phrases and all these things to do, and I call it 'Fake it till You Make it.' So I did what they asked me to do and a couple of months later, I was doing it on my own. It wasn't fake. I was feeling it, and it helped me to develop attachment to my children, because it was finally coming from within…It was about my finally caring more about raising my children than I cared about education, money, pleasing people. I finally care about being a parent."

If the primary issue is a parent's lack of knowledge and understanding of the developmental needs of infants and young children, then a different helping response is called for. The focus should be on assisting the parent to recognize the importance of attending to her child's social, emotional and cognitive development, along with guidance regarding developmentally appropriate activities and strategies for engaging her child.

Building a trusting relationship between the parent and support persons is critical and may take many months. Hands-on approaches are most likely to be successful. Interventions need to be assertive and direct, not ambiguous or uncertain. Family support people must become active demonstrators, working alongside parents in the natural milieus of the family.

For example, to help a parent understand the importance of eye contact with her baby, a home visitor should model how to do this, coach the parent in looking at her baby and reinforce each time this is observed. Rather than tell a parent to take her toddler to a playgroup, the in-home visitor should accompany the parent and child, help facilitate introductions, and engage the parent and child, together, in activities. When addressing food buying and preparation, the support person should go with the parent to the store or food shelf, and prepare meals with the parent in the family kitchen

Specific actions to help a family where neglect occurs might include some of the following:

- Help parents identify their family's needs and whatever challenges effect their ability to parent; explore resources that would be helpful to address these needs.
- Discover, reinforce and augment strengths within parent(s) and use these as cornerstones as they learn to meet their children's needs.
- Help parents access personal supports, such as counseling, drug and alcohol treatment, self-help groups, and psychiatric consultation, and safe homes for victims of violence.
- Help parents connect with informal resources, (e.g., community activities, neighbors and extended family.)
- Locate resources that teach parenting, household management and nutrition skills, ideally in the home, provided frequently (at least weekly), and over an extended period of time.
- Help isolated parents build social networks for interacting with other adults and children, (e.g., through child care, play groups, community gatherings, and other informal and formal programs.)
- Help parents gain access to professionals and other helpers who work with parents to strengthen their parenting skills and knowledge, rather than taking over parenting responsibilities.
- Advocate with social, political, and community systems for services that are needed.

The Importance of Attachment

A strong, healthy attachment is necessary for children to develop emotional regulation, behavioral control, and social adjustment. Common to all forms of neglect is the injury to attachment formation between infant/young child and their primary caregivers. Because of the importance of attachment building between children and their primary caregivers (which are usually the parents), those supporting the family will want to do all they can to promote positive, consistent and nurturing interactions between parent and child.

In some cases, an experienced “attachment therapist” should be included in the support plan to help the family. The therapist will, over time, guide parents through the process of building a strong and positive relationship with their infant or young child by using such activities as holding, rocking, eye contact, smiling, talking softly, singing, physical touch, infant massage and cuddling. All those supporting the family can model and promote the use of such relationship-building activities as peek-a-boo, counting fingers and toes, nursery rhymes, finger plays, and dancing and movement games.

Young children naturally go through periods of rejecting parental limits and correction. They must learn to manage their intense feelings of rage and frustration. The once cute and cuddly infant becomes a force with whom to reckon. In order to sustain the ongoing process of attachment building, parents often need additional support through their child's challenging developmental periods, such as "the terrible two's,” a colicky stage or a period of intense testiness. Those supporting the family can help to prepare parents for these important, and sometimes challenging, stages in their infant's and young child's development and provide guidance on how best to supervise and support their son or daughter through these stages.

Cultural Factors

Practices that many caregivers might see as evidence of neglect may instead simply be manifestations of cultural differences. Parents’ beliefs, customs, traditions, and practices regarding appropriate infant and child care are shaped by their ethnic, cultural, religious and socioeconomic background. Those in a position to support families must be aware of and respect such differences, when exploring parenting practices with families. Decisions may need to be made regarding whether particular practices based on cultural differences have an impact on the safety and wellbeing of the child.

The following are some examples of cultural variations that might be observed:

- A religious group celebrates holidays that require fasting and the parents withhold food from a young child.
- Starting at the age of seven or eight, older siblings are left in charge of younger children.
- Parents’ pride and the high value they place on independence causes them to refuse help, including food, clothing and subsidized housing for their family.
- Medical issues are treated with non-medical, culturally different practices.
- Parents choose a lifestyle that is not in the mainstream, (e.g., live in a remote area without running water, electricity and telephone.)
- It is the practice within an ethnic group to favor boys over girls, so that males in the family are fed first, and male infants are held and played with more than female infants; or female young children are encouraged to be dependent while male young children are encouraged to fend for themselves.
- Parents believe that immunizations are more harmful than helpful, and choose not to have their infant or young child immunized.

- Poverty can define the kinds of food a family purchases, the clothes family members wear and where they live, creating a negative first impression on the support person.

It is sometimes difficult to know where to draw the line between culturally different child-rearing behaviors and practices that place children at risk of harm. Treating boys and girls differently may not place the child in harm's way, whereas leaving an infant or young child in the care of a seven or eight year-old may pose a threat to the child's safety. Whenever possible, those supporting the family should explore beliefs and practices that affect the child's well-being. There may be a middle ground that does not contradict a family's belief system and also keeps the child safe. If uncertain about the occurrence of neglect, a service provider can contact the local SRS office, explain the situation without revealing names, and discuss whether or not a report is necessary or advisable.

RESOURCES FOR MORE INFORMATION

WRITTEN RESOURCES

Attachment theory and research: A framework for practice with infants, toddlers and families. Special Issue of Zero to Three, Vol. 20, No. 2 (Oct./Nov. 1999*).*
Discusses current research on infant and young children's development in the context of their environments; application of research-based knowledge to practice; training practitioners using research and clinical knowledge; and reaching out to parents, policymakers and others who care about healthy infant and young child development.

Hershfield, B. *The role of child day care in strengthening and supporting vulnerable and at-risk families and children.* Child Welfare League of America.
www.cwla.org/programs/daycare/atrisk/

Hughes, D. A. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children.* Northvale, NJ: Jason Aronson.
Overview for understanding and helping children who suffer from attachment problems. The background information about theories of attachment, therapeutic interventions and principles of parenting are clearly outlined and presented in user-friendly language. Case examples enliven the theoretical principles.

Hughes, D. A. (1998). *Building the bonds of attachment: Awakening love in deeply troubled children.* Northvale, NJ: Jason Aronson.
The story of "Katie" and how she and her foster-mother work to build attachment; describes the inner life of the child, the joys and struggles of the committed foster-mother, and the process of providing therapeutic guidance and support; a valuable tool for therapists, parents/caregivers and others seeking to understand how to help a child suffering from poor attachment.

U.S. Department of Health and Human Services (1993). *Child neglect: A guide for intervention*. Washington, DC: U.S. Government Printing Office.
Offers guidance for people working to reduce the incidence and developmental effects of child neglect; the *Intervention* section stresses the need for family-centered, multi-service approaches. Several specific intervention programs are outlined and reviewed. Available free from the National Clearinghouse on Child Abuse and Neglect Information: 330 C St. SW, Washington, DC 20447. 1-800-FYI-3366 (1-800-394-3366). www.calib.com/nccanch

VERMONT ORGANIZATIONS

Social and Rehabilitation Services (SRS) - Vermont's Child Protection Service agency investigates reports of child abuse and/or neglect, including a 24 hotline; also child care subsidization, foster care recruitment and training, and adoption services and support.

Central Office:

103 South Main Street
Waterbury, VT 05671-2401
(802) 241-2131
www.state.vt.us/srs

For location of District Offices, see *Appendix I*
24 Hour Abuse and Neglect Report Hotline: 1-800-649-5285

The Vermont Adoption Consortium is a group of agencies working together to improve access to services and supports for all adoptive families in Vermont. Services include counseling, information and referral, advocacy, support, discussion groups, educational resources, linkage to respite services, and intensive supports where needed.

- Adoption Advocates, Shelburne: (802) 985-8289
- Casey Family Services
  White River Junction: 1-800-607-1400
  Waterbury: 1-800-244-1408
- Easter Seals of Vermont, Berlin, Toll free: 1-888-372-2636
- Northeast Kingdom Human Service - Futures Unlimited, St. Johnsbury and Newport: 1-800-649-0118
- Vermont Children's Aid Society
  Winooski: 1-800-479-0015
  Woodstock: (802) 457-3084
- Vermont Department of Social and Rehabilitation Services (SRS) Adoption Coordinator, Waterbury: 802-241-2131

CHAPTER 15
CHILDREN EXPOSED TO DOMESTIC VIOLENCE

Definition and Scope of the Problem

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual and psychological tactics as well as economic coercion that adults or adolescents use against their intimate partners. Domestic violence happens when one partner uses these tactics to gain and maintain power and control over the other partner. Domestic Violence can occur in heterosexual and same-gender relationships and, although domestic violence can be perpetrated by men or women, an overwhelming majority is perpetrated by males against female partners. Domestic Violence crosses all socio-economic, class, cultural, and racial boundaries. By definition, domestic violence does not include child abuse, child to parent violence or sibling violence.

Domestic Violence is a learned behavior. It is learned through observation, through experience and reinforcement, in families, in the community and in our culture. It is not caused by genetics, mental illness, alcohol or drugs, anger, stress or the victim's behavior. Because domestic violence involves one person exerting power and control over another, the situation can never be looked at as a "relationship problem." The responsibility for the violence lies solely with the abuser.

A question that people often ask about domestic violence is "Why don't women leave?" Actually, statistics show that battered women do leave. And, a woman might leave a battering relationship many times before leaving for the last time. The main reason that women give for leaving abusive relationships is "*concern for their children."* Concern for children is also the main reason given for going *back* to an abusive relationship. *Why do women go back?* In addition to a the impact on their children and a host of reasons including economic, homelessness, displacement and isolation, victims of domestic violence are at much greater risk for experiencing violence once they have left their relationship. More than half of all domestic violence related homicides are committed by men *after* a separation or divorce.

The statistics on the extent of domestic violence in this country, and on its impact on children, are frightening indeed.

- 95% of domestic violence perpetrators are male.
- One out of every three American women (31%) reports being physically or sexually abused by a husband or boyfriend at some point in her life.
- Pregnant women are at twice the risk of battery by their male partners; 40% of assaults on women by male partners begin during their first pregnancy.
- Children witness 68-80% of domestic assaults.
- Children who witness woman abuse exhibit symptoms similar to children who have been physically, sexually or emotionally abused.

- In homes where domestic violence occurs, there is a 45-60% chance of co-occurring child abuse.

(National Institute of Justice & U.S. Department of Health and Human Services, 1995; Commonwealth Fund, 1999; Martins, R., Holzapfel, S., & Baker, P., 1992, and Child Witness to Violence Project, 2000).

The Impact of Domestic Violence on Young Children

Domestic violence is not just an issue for the perpetrator and the victim; it can have tremendous consequences as well for any children living in the home. Sadly, children in homes where domestic violence occurs are very often witnesses to incidents of their mothers being beaten or otherwise physically abused.

Young children are exposed to domestic violence at rates that are disproportionately higher than older children. Between 1993 and 1998, children under the age of 12 resided in 43% of the households where intimate partner violence occurred (compared to the 27% of households in the U.S. that were home to children under the age of 12) (Rennison, C. & Welchans, S., 2000). Because young children are the most vulnerable to exposure to domestic violence, professionals who work with young children and their families must become familiar with the issue, recognize the warning signs, understand the ways that children can be exposed to and are impacted by domestic violence, and understand effective ways to support families.

Children may be exposed to domestic violence in many different ways:

- *Exposure to, or witnessing, domestic violence* may include seeing or hearing an incident, or seeing the aftermath of a violent episode.
- *Forced witnessing* occurs when the batterer forces the child to witness the assault or participate in the abuse.
- *Direct involvement in domestic violence* occurs when the child actively tries to intervene in or stop the abuse or calls 911 for help.
- *Inadvertent injury to the child* may occur when the batterer throws something at the adult victim, but hits the child instead.
- *Involvement in parental dynamics* happens when the child attempts to intervene or when the cause of the domestic violence is attributed to the child.

It is important for service providers who work with young children exposed to domestic violence to be aware that if a child and adult witness the same traumatic event, a child under the age of 11 is three times more likely than an adult to develop symptoms of *Post Traumatic Stress Disorder* (PTSD). Adults have defense mechanisms to “explain” the violence. Children, however, believe they cause the domestic violence or should be able to stop it. They often feel utterly helpless.

Witnessing domestic violence affects how young children view the world. For instance, children may learn to attribute specific behaviors and characteristics with specific genders: men are powerful and scary; women are weak and need to be controlled. Children may also learn that it is okay for men to hurt women in order to get what they want, that women deserve to be hurt, that anger justifies violence, and that there is no consistent and safe system for communicating feelings. Children often feel as though the violence is their fault. Batterers also may undermine the mother-child relationship in a variety of ways, such as forbidding a mother to comfort or see to the needs of her crying baby.

For many of these children, the world is hostile and unpredictable. One night mom gets hurt because there is chicken for dinner. The next night mom gets hurt because there *isn't* chicken for dinner. The next night everyone goes out for pizza and has a great time.

The effects of witnessing domestic violence can exact a tremendous toll on young children. There are physical, social, emotional, behavioral and cognitive effects. Children may show some effects in one or more of the categories listed below.

- *Physical effects*: eating and sleeping problems (including fear of falling asleep); developmental delays (sometimes due to battering that has occurred during pregnancy); bed-wetting and other regressive behaviors; psychosomatic disorders (stomachaches, headaches, tics, etc.); physical injuries (which may occur while trying to intervene or escape).
- *Social/Emotional effects*: extreme fear (especially of males), insecurity, anxiety, and anger; constant fear about possible danger; lack of confidence; withdrawal; inability to be comforted; difficulty trusting; emotional disconnectedness; conflicted loyalties to parents; depression; difficulty relating to other children; social isolation; feeling responsible for the abuse; shame and guilt; post-traumatic stress; suicidal feelings.
- *Behavioral effects:* poor impulse control; acting out violently; behavioral problems in school or child care; difficulty concentrating; easily distracted; unusually high activity levels; acting as a caretaker of siblings as well as parents; extreme passivity or listlessness; an extreme need to overachieve.

"Cindy [the CUPS Worker] went to court with me when I had to get a restraining order for my children's father…We came up with goals, like what I want, what are the successes going to be for me and my sons. My youngest son has some issues around aggression and definitely has some anxiety issues, because before my oldest son received services, he was very aggressive. He would swear a lot and he overturned coffee tables and made holes in the wall, and the little one grew up seeing all these things happen."

- *Cognitive effects*: learning difficulties; difficulty with problem-solving skills; developmental delays (such as delayed language development); loss of previously-learned skills; beliefs shaped by their experience that hitting to gain control is okay; equating love with abuse; confusion about gender roles; confusion about cause and effect relationships; expectation of violence and unpredictable behavior from others; learning disrespect for mother; blaming others for one's own actions; difficulty recognizing manipulation.

The extent to which exposure to domestic violence affects a particular child depends on a number of variables. These include:

- *Age of the child:* usually the younger the child, the more vulnerable he or she is and the fewer coping skills available.
- *Familiarity or closeness* of the child to the victim and the perpetrator: generally, the closer the emotional relationship of the child to the victim and/or the perpetrator, the stronger the impact.
- *Frequency* of domestic violence episodes: ongoing exposure has a more traumatic effect than witnessing a single violent episode.
- *Severity* of the domestic violence: the more severe the violence the more likely the child will be traumatized by the event.
- *Proximity* to the violence: the closer physically the child is to the violence and the more profound the sensory impact, the greater the likelihood of trauma.

There are mediating factors that influence how children may be affected by exposure to domestic violence. Though some children are traumatized by witnessing, many children suffer lesser or no serious impact due to protective factors, such as a strong, positive relationship with the non-offending parent or other family members as well as community supports the child may have.

Creating a Safe Environment for Children

There are general strategies those working with children can use to support all children around issues of violence and abuse. General safety planning is a way to help children who may be in unsafe situations at home, at school or in the community. Safety plans help children strategize how to deal with strangers or bullies and how to call for help in emergencies.

Many children will not share the fact that they live in a home where domestic abuse is occurring, as they have been warned that it is "private family business" or they are frightened of the consequences of telling someone. However, chances are that caregivers and others serving young children will have among their charges some who have witnessed their mother being physically or sexually abused. Providing general information about domestic violence may lead some children to talk about the violence they have experienced at home.

The following approaches help ameliorate the impact of domestic violence for those children for whom it is a reality. Furthermore, they provide lessons and build strengths that support non-violence and promote equal power in relationships for all children.

- Remind children that they are never to blame for another person's actions and that any abuse that they witness and experience is never their fault.
- Have patience and understand that children's feelings and behaviors are a direct result of their experience. Set clear limits on behaviors, but always express your acceptance of feelings.
- Ensure that children have the opportunity to form secure, trusting relationships with adults.
- Be aware that children may identify you as a safe person with whom to share their experiences of violence in the home.
- Help children know what to expect by providing a highly structured and predictable environment that includes preparing children for transitions and addresses changes in routines.
- Provide positive and structured opportunities for children to be assertive and powerful in pro-social ways, such as serving as line leaders or calendar helpers and playing non-competitive games.
- Practice a "Zero Tolerance for Violence" philosophy in all aspects of your work with children, including discipline, communication, conflict resolution, media, toys, and books.
- Encourage and guide dramatic play to help children practice feelings, expression and non-violent problem-solving through their play experiences.
- Support children who experience developmental challenges by providing them with developmentally appropriate materials.
- Model positive touch and non-violent, healthy expression of feelings, especially anger.
- Teach problem-solving and coping strategies to all children.
- Should you believe that a child under your care is in a home where domestic abuse is occurring, contact the non-abusive parent, encourage her to seek help, and provide information about resources available (see Chapter 15, *Children Exposed to Domestic Violence, Resources for More Information)*.

Responding to Children Who Experience Domestic Violence

If an adult learns from a child that he or she has witnessed domestic violence, the adult should maintain a supportive and caring attitude, without over-reacting. Children need to feel that it is safe to tell an adult, and that they can trust someone with what even young children realize is information that their parents might not want them to share with others. When dealing with a young child who starts talking about domestic violence:

- *Allow the child to tell his/her story.* Practice active listening. Do not pressure the child to talk. Remember that your role is not to gather information or to investigate the situation.
- *Reassure the child by validating his/her feelings.* Acknowledge the child's feelings. Depending on the situation, it may be helpful to let the child know you are glad that he told you, that the violence is not his fault, and that it is not right for adults to hurt others. An older child may ask you to keep this a secret. It is important to let children know that you may need to tell others about the abuse at home.
- *Do not criticize or speak negatively about the abusive parent.* A child may have confused or mixed feelings about the abusive parent. She may dislike the abuse, but love the abusive parent. If you criticize the abusive parent, the child's feelings of loyalty toward that parent may cause her to feel inhibited about talking to you about the situation.
- *Tell the child you believe that violent behavior towards others is wrong.* Let her know that you will support the abused parent in seeking support, without getting the child in trouble.
- *Do not make promises you cannot keep.* Be careful to reassure the child in ways that are realistic. Promises such as: "I'll always keep you safe" or "I won't let anything happen to your mom" are impossible to guarantee, and may eventually lead the child to distrust you.
- *Follow the child's lead.* Young children have short attention spans and typically do not spend much time on one topic, especially if it is a distressing one. It is important to allow the child to say as little or as much as she wants to and then move on to another activity when the child is ready.

Supporting Parents Who are Victims of Domestic Violence

One of the most important ways to assist children in families where there is domestic abuse is to be supportive if a parent tells you that she is a victim. If an abused parent tells you about violence occurring in the family, listen and believe her. This may be the first time she has told anyone about the violence. The act of reaching out for help by a woman who has been battered is extremely difficult and may even be dangerous for the woman. Support from a trustworthy person is extremely important at this time. Talk with her privately about your concerns; never in the presence of others, including her children.

It is important to speak from a caring place. Women sharing experiences of abuse need support and a kind, listening ear. Be mindful of your language and be careful not to blame her for her situation. Don't pretend you understand her situation; be willing to say, "I don't know" and offer to find the information she requests, or that you may need to support her. Speak from your own experience. If you have specific concerns, talk about what you saw, heard, or felt from her or her children without projecting reasons for the behavior.

Battered women are often afraid to talk about their situations. They may not feel comfortable talking at length about the abuse, and may be concerned about whether they can trust you. Validate parents' feelings and experiences and avoid judging. In some cases, you may be able to help facilitate a dialogue between the parent and the child about the violence. However, first make certain that this is what the mother wishes to do.

Women make choices for their families based on their experience and assessment of their safety. They are the best judges of their and their children's safety. Be ready with information about domestic violence programs and supportive resources and offer assistance in making a connection to these resources. Have posters, brochures, and cards in a visible and accessible location, so that domestic violence victims can take them without identifying themselves.

It is important for care providers to realize that even when battered mothers leave the batterer, the violence may not end. Often the severity of the physical and sexual violence escalates after separation. Just because a batterer is out of the home, the risk is not necessarily gone.

Extreme caution should be used when sharing any information disclosed by a battered woman. It is especially important to keep confidential any information regarding her safety plan or plans to flee. Perpetrators may go to great lengths to find out where a woman is hiding. When documenting information about a family in agency records, keep in mind who has access to the information, and where it might be shared.

If you are compelled by agency policy to disclose any information regarding a victim, *you must notify her first* so that she can plan adequately for her own and her child's safety. Be clear and honest about your responsibilities as a mandated reporter of child abuse and understand that this may inhibit her from telling you her story. Guidelines include:

- Keep information that she gives you confidential. Telling others of her situation could be life threatening for her and her children.
- Honor your commitment to protect the victim's confidentiality by never talking to other providers without the permission of the adult victim.
- If you are required to make a child abuse report, be sure to include only pertinent information relating to the child abuse and not other information that might compromise the family's safety.

In the State of Vermont, child witnessing in and of itself is not considered child abuse under Vermont Statutes or SRS policy. However, Social and Rehabilitation Services (SRS) may get involved in extreme situations where the child or children may be at risk of physical harm due to their physical proximity to the violent incident. SRS has an internal Domestic Violence Unit that can offer support and information to both service providers and families about the overlap of child abuse, child witnessing and domestic violence (see Chapter 15, *Children Exposed to Domestic Violence, Resources for More Information.)*

The Vermont Network Against Domestic Violence and Sexual Assault

A key resource in Vermont is the Vermont Network Against Domestic Violence and Sexual Assault. This is a statewide coalition of 16 domestic and sexual violence programs throughout Vermont, with a statewide coalition office located in Montpelier (see Chapter 15, *Children Exposed to Domestic Violence, Resources for More Information* for contact information on this and other services.) The Network Statewide Office provides consultation on statewide and national initiatives around domestic and sexual violence, acts as a statewide resource and clearinghouse for information, and provides technical support to member programs.

The Network's 16 direct service programs provide comprehensive domestic violence and sexual assault services to adult and child/youth victims in each county in Vermont (see *Appendix I* for a complete listing). These services include 24-hour emergency hotlines, emergency shelters and safe homes, court advocacy and support in obtaining Relief From Abuse Orders, support groups, community and school outreach, and prevention education.

Because of the Network's empowerment-based philosophy, making referrals to Network Programs will be different from making referrals to other human service agencies. For the most part, Network programs will not initiate contact with a victim, but rather, will wait to provide support and resources to a victim when she requests them herself. Confidentiality agreements between programs and victims generally prohibit sharing any information about the victim, her situation, or her use of services to anyone without the victim's advanced permission.

When people working with young children and their families are making referrals to Network Programs, it is most helpful to provide adult victims with information and hotline numbers and recognize that they will reach out when and if they feel ready. However well-intentioned the motive, others should not take the initiative on behalf of a woman without the victim's knowledge.

Offer to stay in the room when a victim calls a hotline or offer to place the call and hand the phone to the victim after you have reached an advocate. If mothers wish to have help with safety planning, this must be done with the involvement of an individual with specialized training in domestic violence, such as a Network Program staff person.
Remember, though, that there should be no pressure or judgment about whether or not a woman seeks support about her situation.

Contact with the Battering Parent

There may be times when a caregiver or other service provider has contact with a batterer. It may be that a mother has taken you into her confidence but is still with her battering partner. Even if there has been a separation, the battering parent may be authorized to pick up his children from a child care setting. If you are in a position to come into contact with the battering parent:

- Keep yourself safe. Don't confront a batterer about his abusive behaviors.
- Be aware that the batterer may try to engage you in conspiring conversations and strategies. He may try to take you into his confidence and minimize his behaviors or blame his partner for his abuse.
- Anticipate that a batterer may try to get information about his current or former partner's activities and whereabouts.
- In a child-care setting, have a written plan regarding who may pick up a child and what you will do if you have concerns about a child's safety (e.g., if a parent arrives under the influence, angry and upset, or threatening).
- Check with the non-offending parent to decide whether to write a plan regarding parent-attended events. In an effort to create safety and follow Relief From Abuse Order requirements, some plans may include parents taking turns attending events or conducting two separate events.

Additional Service Considerations For Children and Families

Couples counseling or family therapy is *not* recommended when domestic violence is present. In fact, couples counseling can actually put the victim at greater risk for abuse by mistakenly focusing on the couple taking "mutual responsibility" for the violence.

Visitation with the abusive parent must be approached with great care. Children who have witnessed domestic violence may not be emotionally ready to visit with the parent who has perpetrated abuse in the family. If a child exhibits symptoms such as violent play, significant aggression, devaluation of the victimized parent, self-abusive behavior, or peer and school related problems, he or she may be further harmed by contact with the abusive parent (Dowling, C. & Ferrato, D., 1998).

RESOURCES FOR MORE INFORMATION

VERMONT ORGANIZATIONS

Vermont Network Against Domestic Violence and Sexual Assault state office and 16 member agencies provide education, advocacy, support and services to victims of domestic violence.
State Office: 1-800-489-7273. www.vtnetwork.org
See *Appendix I* for location of local network member programs

Social and Rehabilitation Services (SRS), Domestic Violence Unit
Provides statewide case consultation, training and assessment services to SRS staff as well as direct services and advocacy for families on cases where domestic violence and child abuse co-exist. The purpose of the DV Unit is to enhance the safety of abused children, youth and battered women and to hold batterers accountable.

- Coordinator, Central Office: (802) 241-1206
- Middlebury, Burlington, Rutland, Bennington Office: (802) 388-5395
- Morrisville, St. Albans, Newport, Brattleboro Office: (802) 888-1369
- St. Johnsbury, Barre, Hartford, Springfield Office: (802) 479-4479

VERMONT ORGANIZATIONS *(CONTINUED)*

Domestic and Sexual Violence Statewide Hotlines and Resources

- Vermont Domestic Violence Hotline: 1-800-228-7395
- Vermont Sexual Violence Hotline: 1-800-489-7273
- SafeSpace (for LGBTQQ survivors of violence); Toll free: 1-866-869-7341
- Deaf Victim Advocacy Services-TTY Warm Line: 1-800-303-3827

Vermont Center for Crime Victim Services and Vermont Victims' Compensation Program
1-800-750-1213. www.ccvs.state.vt.us

Additional local supports:

- Each Vermont county has a local multidisciplinary *Domestic Violence Task Force* made up of representatives from local organizations. Contact local Vermont Network Program (see above) for more information.
- Each county's *State's Attorney's Office* has a victim advocate who can assist women who are involved with the criminal court system. Find office location in local phone book under Vermont, State's Attorney
- The Department of Corrections has victim advocates working in the local *Probation and Parole* offices who can support women with current or former partners involved in the correctional system. Find office location in local phone book under Vermont, Corrections Department, Probation and Parole.

WRITTEN MATERIALS, VIDEOS AND WEBSITES FOR ADULTS

Bancroft, L. & Silverman, J.G. (2000). *The batterer as parent* (2000). Thousand Oaks, CA: Sage Publications.
Takes the reader inside homes affected by domestic violence, imparting an understanding of the atmosphere that battering men create for the children who live with them. Shows how partner abuse affects each relationship in a family and how children's recovery is inextricably linked to the healing and empowerment of their mothers.

Breaking peaces (2002). 17-minute video produced by the Infant Parent Institute (Michael Trout, director).
What prenates, infants, and toddlers would say, if they could speak, about their experience of witnessing domestic violence in their families.
(217) 352-4060. www.infant-parent.com

Child witness to violence project 20/20. 12 minutes, ABC News.
Focuses on the impact of domestic violence on children and features interviews with children, parents, and staff from the Child Witness to Violence Project in Boston Mass.
www.bostonchildhealth.org/childwitnesstoviolence.

Groves, B. (2001). *Children who see too much: Lessons from the child witness to violence project*. Child Witness To Violence Project, Boston Medical Center, Boston, MA 02118.
www.bostonchildhealth.org/childwitnesstoviolence

Levin, Diane, E. (1994). *Teaching young children in violent times: A preschool-grade 3 violence prevention and conflict resolution guide.* Educators For Social Responsibility, Cambridge, MA.

Osofsky, J.D., and Fenichel, E. (Eds.). (1994). *Hurt, healing, hope: Caring for infants and toddlers in violent environments.* Arlington, VA: Zero to Three/National Center for Clinical Infant Programs.

WRITTEN MATERIALS, VIDEOS AND WEBSITES FOR ADULTS *(CONTINUED)*

Safe havens project curriculum: A curriculum for early childhood educators. Child Witness to Violence Project in cooperation with Mister Roger's Neighborhood.
Specifically geared for early childhood through 3rd grade. Three modules:

1) Violence that Children Can See,
2) Using the Classroom to Help Kids Affected by Community Violence,
3) How Does this Affect Us as Educators? Includes videos, overheads, scripts and structured activities. Cost is $203.50, and can be ordered through Child Witness To Violence Project, Boston Medical Center, MAT 5, 1 Boston Medical Center Place, Boston, MA 02118.

(617) 414-4244. www.bostonchildhealth.org/childwitnesstoviolence.

We can't play at my house: Children and family violence. Book II. Handbook for teachers. From Boulder County Safehouse, Inc., 835, North Street, Boulder, CO 80304.
www.bouldercountysafehouse.org

WRITTEN MATERIALS AND VIDEOS FOR CHILDREN

Bernstein, S. (1991). *A family that fights*. Morton Grove, IL: Albert Whitman & Co.
An 8 year-old boy and his two younger siblings live in a home where the father abuses the mother. Picture book with illustrations in pencil, 4-12 years.

Davis, D. (1984). *Something is wrong at my house.* Seattle, WA: Parenting Press
A boy tells about the violence in his home and how it affects him. Advice for children on coping.
It's not always happy at my house.

Minnesota Coalition for Battered Women.
A film about three children's experience of their father's violence toward their mother.
(612) 646-6177. www.mcbw.org

Kids' stuff. National Film Board of Canada.
A 6-minute video animation about a child who hears his mother being beaten.
1-800-542-2164

Lee, I. & Sylvester, K. (1993). *When mommy got hurt: A story for young children about domestic violence.* Charlotte, NC: KIDSRIGHTS
A young child tells this story about the parents' fight, how the mother & child leave to live somewhere safe, and the conversations the mother has with this child afterward. Focuses on four points: Violence is wrong, it is not the child's fault, it happens in many families and it's OK to talk about it. Black and white drawings suitable for coloring.

Paris, S. & Labinski, G. (1986). *Mommy and daddy are fighting***.**
Three young sisters build a fort of blankets and huddle together to cope with their father's abuse against their mother.

Trottier, M. & Friedman, J. (1997). *A safe place*. Morton Grove, IL: Albert Whitman & Co.
A mother escapes to a domestic violence shelter with her young daughter, where she builds up her strength and gains the courage to begin a new life. As they leave, the little girl gives hope to a frightened boy just entering the shelter.

Tulip doesn't feel safe. Johnson Institute, 7205 Ohms Lane, Minneapolis, MN 55439.
A video for young children on safety planning.
1-800-231-5165.

References

Baker, L, Jaffe, P, Ashbourne, L, and Carter, J. (2000). *Children exposed to domestic violence: An early childhood educator's handbook to increase understanding and improve community responses.* London, England: Centre for Children & Families in the Justice System.

Child Witness To Violence Project at Boston Medical Center (2000). *Shelter from the storm: Clinical interventions with children affected by domestic violence.* A Curriculum for Mental Health Clinicians. Child Witness To Violence Project, Boston Medical Center, Boston, MA 02118. www.bostonchildhealth.org/childwitnesstoviolence.

Commonwealth Fund. (May 1999*). Health concerns across a woman's lifespan*: Survey of Women's Health.

Dowling, C. and Ferrato, D. (July/Aug. 1998). *At risk: At first children fear violence, then they use it.* Mother Jones.

Ganley, A. and Schecter, S. (1996*). Domestic violence: A national curriculum for child protective services*. San Francisco, CA: Family Violence Prevention Fund.

Haertl, J. *Understanding domestic violence: What you don't know can hurt everyone*. Municipal Advocate, Vol. 16, No. 3 (Spring, 1997).

Jaffe, P.G., Wolfe, D.A., Wilson, S. & Zak, L. (1986). Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *American Journal of Orthopsychiatry* ,56 , 142-146.

Martins, R, Holzapfel, S, and Baker, P. (1992). Wife abuse: Are we detecting it? *Journal of Women's Health* 1(1):77-80.

McAlister Groves, B. and Mazure, S. (1995). *Shelter from the storm*; *Using the classroom to help children cope with violence.* Child Witness To Violence Project, Boston Medical Center, MAT 5, 1 Boston Medical Center Place, Boston, MA 02118. www.bostonchildhealth.org/childwitnesstoviolence.

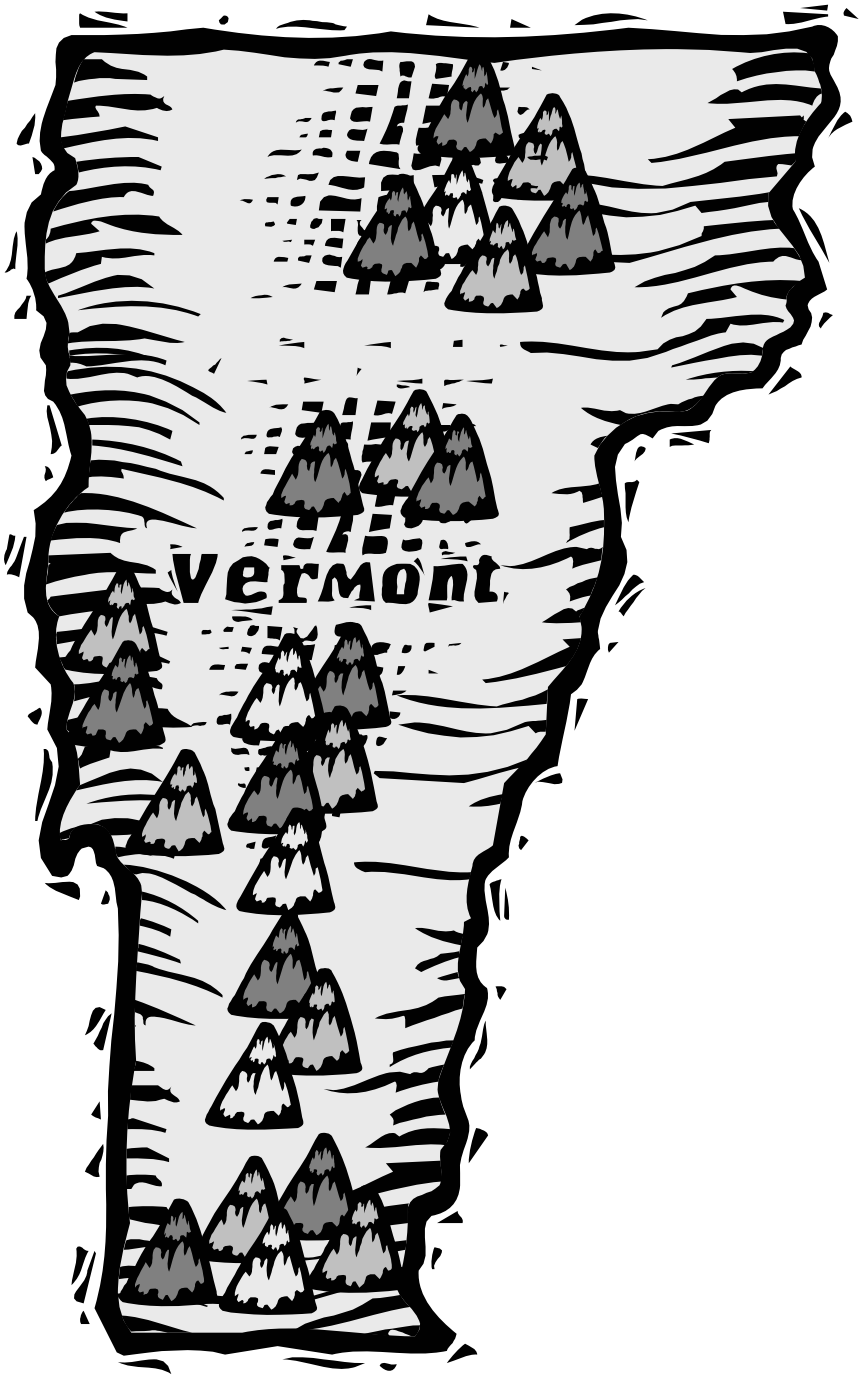
Osofsky, J.D., and Fenichel, E. (Eds.). (1994). *Hurt, healing, hope: Caring for infants and toddlers in violent environments.* Arlington, VA: ZERO TO THREE/National Center for Clinical Infant Programs.

Rennison, C. M., and Welchans, S. (2000). *The bureau of justice statistics special report: Intimate partner violence*. www.ojp.usdoj.gov/bjs/abastract/ipv

State of Vermont, Social and Rehabilitation Services (2001). *Final report of the domestic violence workgroup: Policy recommendations for domestic violence response in child protection.* Waterbury, VT: Vermont Department of Social and Rehabilitation Services.

Violence against women research strategic planning workshop report (1995). Washington, D.C.: National Institute of Justice in cooperation with the U.S. Department of Health and Human Services.

Appendices


Vermont

APPENDIX I
VERMONT GENERAL RESOURCES

Publicly Funded Agencies

Listed below are local or regional offices of several publicly funded agencies that have programs for supporting families with infants and young children. They are listed in alphabetical order by town in which they are located. They include

- Community Mental Health Centers (CMHCs)
- Office of Economic Opportunity (OEO)
- Parent Child Centers (PCCs)
- Prevention, Assistance, Transition and Health Access (PATH)
- Social and Rehabilitation Services (SRS)
- Vermont Department of Health (DOH)

Community Mental Health Centers (CMHCs)

Community Mental Health Centers (CMHCs) provide supports for children and families dealing with serious social, emotional and behavioral challenges.

Central Office

Vermont Department of Health, Division of Mental Health (DDMHS)
Division of Mental Health, Child, Adolescent, and Family Unit
103 South Main Street
Waterbury, VT 05671-1601
(802) 241-2650
www.ddmhs.state.vt.us

Regional Community Mental Health Centers:

They are listed in alphabetical order by town in which they are located.

Town	Community Mental Health Center	Phone Number(s)
Barre	Washington County Mental Health Services 260 Beckley Hill Barre, VT 05641	(802) 476-1480
Bennington/ Manchester	United Counseling Service of Bennington County 100 Ledge Hill Drive (PO Box 588) Bennington, VT 05201	Bennington (802) 442-5491, Manchester (802) 362-3950
Brattleboro	Health Care & Rehabilitation Services of Southeastern VT 51 Fairview Street Brattleboro, VT 05301	(802) 254-7500 or Crisis Team Hotline: 1-800-622-4235
Burlington	Howard Center for Human Services Baird Center for Children and Families 1110 Pine Street Burlington, VT 05401	(802) 863-1326

Regional Community Mental Health Centers: ***(Continued)***

They are listed in alphabetical order by town in which they are located.

Town	Community Mental Health Center	Phone Number(s)
Middlebury	Counseling Service of Addison County 89 Main Street Middlebury, VT 05753	(802) 388-6751
Montpelier	Washington County Mental Health 56 State Street Montpelier, VT 05602	(802) 229-0591
Morrisville	Lamoille County Mental Health Services 520 Washington Highway Morrisville, VT 05661	(802) 888-5026
Newport	Northeast Kingdom Human Services 154 Duchess Avenue (PO Box 724) Newport, VT 05855	(802) 334-6744
Randolph	Clara Martin Center 11 Main Street (PO Box G) Randolph, VT 05060	(802) 728-4466
Rutland	Rutland Mental Health Services 78 South Main Street (PO Box 222) Rutland, VT 05701	(802) 775-2381 or Toll free: 1-877-430-2273
Springfield	Health Care & Rehabilitation Services of Southeastern VT 107 Park Street Springfield, VT 05156	(802) 885-5781 or Crisis Team Hotline: 1-800-622-4235
St Albans	Northwestern Counseling and Support Services 107 Fisher Pond Road St. Albans, VT 05478	(802) 524-6554 or 1-800-834-7793
St Johnsbury	Northeast Kingdom Human Services 560 Railroad Street (PO Box 368) St. Johnsbury, VT 05819	(802) 748-3181
White River Junction	Health Care & Rehabilitation Services of Southeastern VT 195 North Main Street White River Junction, VT 05001	(802) 472-1053 or Crisis Team Hotline: 1-800-622-4235

Office of Economic Opportunity (OEO) and Community Action Agencies

Provide funding and assistance to low-income Vermonters through food, shelter, and other services aimed at alleviating poverty. These include housing assistance, emergency fuel and utility assistance, food and nutrition education, emergency food shelves, case management, transportation assistance, and other services. OEO also funds homeless shelters and other homeless service providers through a combination of federal and state funding.

Central Office

Office of Economic Opportunity (OEO)
103 South Main St.
Waterbury, VT 05671-1801
(802) 241-2454
www.ahs.state.vt.us/oeo/

Regional Offices

Regional Offices of the 5 Community Action Agencies in Vermont. There are also satellite offices in many smaller communities.

Serving Bennington and Rutland Counties

Bennington-Rutland Opportunity Council (BROC)
60 Center Street
Rutland, VT 05701
1-800-717-BROC (1-800-717-2762) or (802) 775-0878
www.broc.org/

332 Orchard Road
Bennington, VT 05201
(802) 447-7515

Serving Orange, Lamoille and Washington Counties

Central Vermont Community Action Council (CVCAC)
195 US Route 302-Berlin
Barre, VT 05641
1-800-639-1053 or (802) 479-1053
www.cvcac.org/

Serving Chittenden, Addison, Franklin and Grand Isle Counties

Champlain Valley Office of Economic Opportunity (CVOEO)
191 North Street (PO Box 1603)
Burlington, VT 05401
1-800-287-7971 or (802) 479-1053
www.cvoeo.org

Addison County Action (ACA)
PO Box 82
Middlebury, VT 05753
1-800-639-2318 or (802) 888-5229
www.cvoeo.org/AddisonCommAct

Addison County Community Action Group (ACCAG)
(not an OEO office, but provides similar services)
282 Boardman Street
Middlebury, VT 05753
(802) 388-3608

Chittenden County Action (CCA)
191 North Street
Burlington, VT 05401
1-800-287-7971 or (802) 479-1053
www.cvoeo.org/ChittendenCommAct

Franklin/Grand Isle Community Action (FGICA)
86 North Main St.
St. Albans, VT 05478
1-800-300-7392 or (802) 527-7392
www.cvoeo.org/FranklinGrandIsleCommAct

Serving Caledonia, Essex and Orleans Counties

Northeast Kingdom Community Action (NEKCA)
70 Main Street (PO Box 346)
Newport, VT 05885
1-800-639-4065 or (802) 649-3268
www.nekca.org

108 Cherry Street
St. Johnsbury, VT 05819
(802) 748-8997

Serving Windsor and Windham Counties

Southeastern Vermont Community Action (SEVCA)
91 Buck Drive
Westminster, VT 05158
1-800-464-9951 or (802) 722-4575
Brattleboro Outreach: (802) 254-2795

Gilman Office Center #4
Holiday Inn Drive
White River Junction, VT 05001
(802) 295-5215
www.sevca.org

Parent Child Centers (PCCs*)*

Parent Child Centers (PCCs) provide a variety of services for young pregnant and parenting Vermonters including prenatal support, outreach services, playgroups and early care programs, educational and social opportunities for young parents, and coordination with other service providers. Some Parent Child Centers (or Family Centers) also house other early childhood programs such as Success by Six, Early Education Initiative (EEI), and Family, Infant and Toddler Program (FITP).

State Contact

Located at:

Addison County Parent Child Center
(802) 388-3171
www.vermontfamilyresource.org/PCCNetwork

Regional Parent Child Centers

They are listed in alphabetical order by town in which they are located.

Town	Parent Child Center	Phone Number(s)
Alburg	Champlain Island Parent Child Center 22 Lake Street Alburg, VT 05440	(802) 796-3013
Bennington	Sunrise Family Resource Center 238 Union Street (PO Box 1517) Bennington, VT 05201	(802) 442-6934
Brattleboro	Early Education Services of Windham County 130 Birge Street Brattleboro, VT 05301	(802) 254-3761 or 1-800-427-3730

Regional Parent Child Centers ***(Continued)***

They are listed in alphabetical order by town in which they are located.

Town	Parent Child Center	Phone Number(s)
Burlington	Lund Family Center 76 Glen Road (PO Box 4009) Burlington, VT 05406	(802) 864-7467
Colchester	VNA/Maternal Child Health Services 1110 Prim Road Colchester, VT 05446	(802) 860-4420
Middlebury	Addison County Parent/Child Center 126 Monroe Street (PO Box 646) Middlebury, VT 05753	(802) 388-3171
Milton	Milton Family Community Center 23 Villemarie Lane Milton, VT 05468	(802) 649-3268
Montpelier	The Family Center of Washington County 32 College Street, #100 Montpelier, VT 05602	(802) 828-8765
Morrisville	Lamoille Family Center 480 Cady's Falls Road Morrisville, VT 05661	(802) 888-5229
Newport	NEKCA/Parent Child Center North 32 Central Street Newport, VT 05855	(802) 334-4072 or 1-800-639-4065
Norwich	The Family Place 319 US Route 5 South Norwich, VT 05055	(802) 649-3268
Randolph	Orange County Parent Child Center 35 Ayers Brook Road Randolph, VT 05060	(802) 728-6155
Rutland	Rutland County Parent Child Center 61 Pleasant Street Rutland, VT 05701	(802) 775-9711
North Springfield	Springfield Area Parent Child Center 2 Main Street North Springfield, VT 05150	(802) 886-5242
St Albans	Family Center of Northwestern Vermont 27 Lower Newton Street St. Albans, VT 05478	(802) 524-6574
St Johnsbury	NEKCA/Parent Child Center South 506 Portland Street St. Johnsbury, VT 05819	(802) 748-6040

Prevention, Assistance, Transition and Health Access (PATH)

Prevention, Assistance, Transition and Health Access (PATH) (formerly the Department of Social Welfare) administers state and federal programs such as Medicaid, Food Stamps, and Reach Up to eligible Vermonters in need. "Our mission is to help Vermonters find a path to a better life. To this end we take on many roles: employment coach, health insurance provider, crisis manager, career planner, champion of families, and promoter of human potential."

Central Office

Department of Prevention, Assistance, Transition and Health Access (PATH)
103 South Main Street
Waterbury, VT 05676-1201
(802) 524-7900 or (802) 287-0589
www.dsw.state.vt.us/

District Offices

They are listed in alphabetical order by town in which they are located.

Town	PATH District Offices	Phone Number(s)
Barre	McFarland Office Bldg. #150 5 Perry Street Barre, VT 05641	(802) 479-1041 or 1-800-499-0113
Bennington	200 Veterans Memorial Drive, #6 Bennington, VT 05201	(802) 422-8541 o 1-800-775-0527
Brattleboro	232 Main Street (PO Box 70) Brattleboro, VT 05302	(802) 257-2820 or 1-800-775-0515
Burlington	1193 North Avenue, #5 Burlington, VT 05401	(802) 863-7365 or 1-800-775-0506
Middlebury	700 Exchange Street, #103 Middlebury, VT 05753	(802) 388-3146 or 1-800-244-2035
Morrisville	63 Professional Drive Morrisville, VT 05661	(802) 888-4291 or 1-800-775-0525
Newport	100 Main Street, #240 Newport, VT 05855	(802) 334-6504 or 1-800-775-0526
Rutland	320 Asa Bloomer Building 88 Merchants Row Rutland, VT 05701	(802) 786-5800 or 1-800-775-0516
Springfield	100 Mineral Street, #201 Springfield, VT 05156	(802) 885-8856 or 1-800-589-5775
St Albans	20 Houghton Street, #313 St. Albans, VT 05478	(802) 524-7900 or 1-800-660-4513
St Johnsbury	67 Eastern Avenue, #7 St. Johnsbury, VT 05819	(802) 748-5193 or 1-800-775-0514
White River Junction	224 Holiday Drive, #A White River Junction, VT 05001	(802) 295-4148 or 1-800-775-0507

Social and Rehabilitation Services (SRS)

Social and Rehabilitation Services (SRS), Vermont's Child Protection Service agency, investigates reports of child abuse and/or neglect, including a 24 hotline; also child care subsidies, foster care recruitment and training, and adoption services and support.

Central Offices

Social and Rehabilitation Services
103 South Main Street
Waterbury, VT 05671-2401
(802) 241-2131
www.state.vt.us/srs

Child Care Services Division (including Child Care Subsidy)
(802) 241-3110

24 Hour Abuse and Neglect Report Hotline
1-800-649-5285

District Offices

They are listed in alphabetical order by town in which they are located.

Town	SRS District Offices	Phone Number(s)
Barre	225 North Main Street Barre, VT 05641	(802) 479-4260
Bennington	200 Veterans Memorial Drive Bennington, VT 05201	(802) 442-8138
Brattleboro	232 Main Street Brattleboro, VT 05301	(802) 257-2888
Burlington	1193 North Avenue Burlington, VT 05401	(802) 863-7370
Middlebury	700 Exchange Street Middlebury, VT 05753	(802) 388-4660
Morrisville	63 Professional Drive Morrisville, VT 05661	(802) 888-4576
Newport	100 Main Street Newport, VT 05855	(802) 334-6723
Rutland	220 Asa Bloomer Boulevard Rutland, VT 05701	(802) 786-5817
Springfield	100 Mineral Street Springfield, VT 05156	(802) 885-8900
St Albans	20 Houghton Street St. Albans, VT 05478	(802) 527-7741
St Johnsbury	67 Eastern Avenue St. Johnsbury, VT 05819	(802) 748-8374
White River Junction	226 Holiday Drive White River Junction, VT 05001	(802) 295-8840

Vermont Department of Health (DOH)

Vermont Department of Health (DOH) oversees a number of programs to support infants, young children and their parents (see below for descriptions of three key programs). Other programs include Dental Health Services, Lead Poisoning Prevention, Children with Special Health Needs and Child Development Clinics (see description in *Assessment Services* below. Contact district offices for access to all DOH programs.

Central Office

Vermont Department of Health
108 Cherry Street (PO Box 70)
Burlington, VT 05402
1-800-464-4343 or (802) 863-7200
www.healthyvermonters.info

District Offices

They are listed in alphabetical order by town in which they are located.

Town	DOH District Offices	Phone Number(s)
Barre	5 Perry Street Barre, VT 05641	(802) 479-4220 or Toll free: 1-888-253-8786
Bennington	200 Veterans Memorial Drive, #1 Bennington, VT 05201	(802) 447-3531 or 1-800-637-7347
Brattleboro	232 Main Street, #3 Brattleboro, VT 05301	(802) 257-2880 or Toll free: 1-888-253-8805
Burlington	1193 North Avenue, #1 Burlington, VT 05401	(802) 863-7323 or Toll free: 1-888-253-8803
Middlebury	700 Exchange Street Middlebury, VT 05753	(802) 388-4644 or Toll free: 1-888-253-8804
Morrisville	63 Professional Drive Morrisville, VT 05661	(802) 888-7447 or Toll free: 1-888-253-8798
Newport	100 Main Street, #220 Newport, VT 05855	(802) 334-6707 or 1-800-952-2945
Rutland	300 Asa Bloomer State Office Building 88 Merchants Row Rutland, VT 05701	(802) 786-5811 or Toll free: 1-888-253-8802
Springfield	100 Mineral Street, #104 Springfield, VT 05156	(802) 885-5778 or Toll free: 1-888-296-8151

District Offices *(Continued)*

They are listed in alphabetical order by town in which they are located.

Town	DOH District Offices	Phone Number(s)
St Albans	20 Houghton Street, #312 St. Albans, VT 05478	(802) 524-7970 or Toll free: 1-888-253-8801
St Johnsbury	67 Eastern Avenue St. Johnsbury, VT 05819	(802) 748-5151 or 1-800-952-2936
White River Junction	266 Holiday Drive, #22 White River Junction, VT 5001	(802) 479-1053 or Toll free: 1-888-253-8799

Healthy Babies, Kids and Families

Healthy Babies, Kids and Families is a benefit program of Medicaid and Dr. Dynasaur to help families find services within their communities. The Healthy Babies nurse or family support person can help with planning for pregnancy, delivery, and becoming a parent; locating medical and dental care during pregnancy and for children until age six; finding parent-child education, and child care and early education opportunities; and advocating for other needs as they arise. Contact a local DOH office or call 1-800-649-4357 or (802) 863-7333 or

Women, Infants and Children (WIC)

Women, Infants and Children *(WIC)* is a nutrition program for women, infants and children which provides health education, nutrition counseling and food for infants, young children up to age 5, pregnant women and nursing mothers. To learn more about WIC contact your local DOH office or call 1-800-464-4343 or (802) 863-7333.

Family, Infant, Toddler Program (FITP)

The *Family, Infant, Toddler Program (FITP)* of Vermont is a family-centered coordinated system of early intervention services for infants and toddlers (under age 3) who have a delay in their development, or a health condition which may lead to a delay in development, and their families. A core team, including the family, an early interventionist and a local school district representative, a social worker, and a community resource parent plans evaluation activities and determines eligibility for services, and assists families in the coordination of available services. To learn more about FITP contact a local host agency (listed below), or call 1-800-660-4427 or (802) 863-7338 or www.healthyvermonters.info (search: FITP)

FITP Host Agencies

They are listed in alphabetical order by town in which they are located.

Town	FITP Host Agencies	Phone Number(s)
Barre	The Family Center of Washington County 104 North Main Street, Suite 2 Barre, VT 05641	(802) 476-8757 or 1-800-270-4231
Bennington	Southwest Vermont Medical Center Family, Infant & Toddler Program 100 Hospital Drive East Bennington, VT 05201	(802) 447-2768 or 1-800-750-6975
Brattleboro	Winston Prouty Center 10 Oak Street Brattleboro, VT 05301	(802) 258-2414 or 1-800-281-7852
Middlebury	Addison County Parent Child Center 126 Monroe Street (PO Box 646) Middlebury, VT 05753	(802) 388-1437 or 1-800-639-1577
Morrisville	Lamoille Family Center 480 Cady's Falls Road Morrisville, VT 05661-9222	(802) 888-5229 or 1-800-639-1932
Newport	Orleans Essex North Supervisory Union 471 Sias Avenue Newport, VT 05855	(802) 334-3324 or 1-800-253-6621
North Springfield	Springfield Area Parent Child Center 2 Main Street North Springfield, VT 05150	(802) 886-5242 or 1-800-808-4442
Norwich	The Family Place 319 US Route 5 South Norwich, VT 05055	(802) 649-3268 or 1-800-639-0039
Rutland	Rutland County Parent Child Center 61 Pleasant Street Rutland, VT 05701	(802) 747-5039 or 1-800-974-2034
St Albans	Family Center of Franklin County 27 Lower Newton Street St. Albans, VT 05478	(802) 524-6574, (802) 524-7959 or 1-800-870-6720
St Johnsbury	Northeast Kingdom Human Services, Inc 560 Railroad Street (PO Box 368) St. Johnsbury, VT 05819	(802) 748-6609, (802) 748-0213 or 1-800-299-6609
Williston	Parent to Parent of Vermont 600 Blair Park Road, Suite 240 Williston, VT 05495	(802)764-5294 or 1-800-870-6758

Department of Health Publications

Smith-Brassard, A., Keating, K., & Keleher, K. (2000). *Path to parenthood.* Barre, VT: L. Brown & Sons.

Covers physical development of the fetus, what to expect at the time of birth and what to expect after birth. Many topics are addressed, including pregnancy, baby supplies, signs and stages of labor, care of mother during pregnancy and after birth, Vermont resources and much more.

Copies available from the Vermont Department of Health and home health agencies.

Vermont Department of Health. (2003). *Growing up healthy: a guidebook for new families, 2nd Edition.* Burlington, VT: Vermont Department of Health.
A resource for parents of children that covers developmental stages from birth to age five and includes information on caring for sick children, keeping young children safe and healthy eating.
Copies can be obtained from local DOH offices (listed above).

Adoption And Foster Care Organizations

Casey Family Services

Casey Family Services provides long-term foster care placement services, advocacy and support to families and service providers, and post-adoption services.

60 South Main Street
Waterbury, VT 05676
1-800-244-1408 or (802) 244-1400
www.caseyfamilyservices.org

Department of Social and Rehabilitation Services (SRS) Adoption Unit

Department of Social and Rehabilitation Services (SRS) Adoption Unit provides information about adoption in Vermont, and a website with numerous links to adoption resources.

103 South Main Street
Waterbury, VT 05671
(802) 241-2131
www.state.vt.us/srs/adoption

Foster and Adoptive Parent Training Partnership

Foster and Adoptive Parent Training Partnership, between the Department of Social and Rehabilitation Services (SRS) and the University of Vermont Department of Social Work, provides training to Vermont's foster and adoptive parents.

7 Kilburn Avenue, Suite 9
Burlington, VT 05401
(802) 657-3301
www.uvm.edu/~socwork/childwelfare/foster

Friends in Adoption

Friends in Adoption provides adoption information and support for prospective parents and pregnant women considering adoption.

44 South Street (PO Box 1228)
Middletown Springs, VT 05757
(802) 235-2373
www.friendsinadoption.com

Lund Family Center

Lund Family Center residential program for pregnant and parenting young women, adoption services for all members of the adoption triad, parenting workshops, peer support, and childcare and play groups.

76 Glen Road
Burlington, VT 05401
1-800-639-1741 or (802) 864-7467
www.lundfamilycenter.org

Project Family

Project Family is a partnership between the Department of Social and Rehabilitation Services (SRS) and the Lund Family Center (see above) to find adoptive families for children in foster care. Also supports trainings, conferences and workshops.

76 Glen Road (PO Box 4009)
Burlington, VT 05406
1-800-639-1741 or (802) 864-7467
www.projectfamily.state.vt.us/

The Vermont Adoption Consortium

The Vermont Adoption Consortium is a group of agencies working together to improve access to services and supports for all adoptive families in Vermont. Services include counseling, information and referral, advocacy, support, discussion groups, educational resources, linkage to respite services, and intensive supports where needed.

- Adoption Advocates, Shelburne: (802) 985-8289
- Casey Family Services,
  White River Junction: 1-800-607-1400,
  Waterbury, 1-800-244-1408
- Easter Seals of Vermont, Berlin, Toll free: 1-888-372-2636
- Northeast Kingdom Human Service - Futures Unlimited,
  St. Johnsbury & Newport: 1-800-649-0118
- Vermont Children's Aid Society,
  Winooski: 1-800-479-0015,
  Woodstock: (802) 457-3084
- Vermont Department of Social and Rehabilitation Services (SRS) Adoption Coordinator, Waterbury: (802) 241-2131

Vermont Children's Aid Society

Vermont Children's Aid Society provides pregnancy and birthparent counseling, adoption placement services, and lifetime post-adoption services at four regional offices:

Main office

79 Weaver Street (PO Box 127)
Winooski, VT 05404
(802) 655-0006

Satellite offices

- Woodstock: (802) 457-3084
- Rutland: (802) 744-8555
- Bennington: (802) 442-7901

www.vtcas.org

Vermont Foster/Adoptive Family Association

Vermont Foster/Adoptive Family Association is a volunteer parent organization dedicated to strengthening foster and adoptive families through training, peer support, information, referrals, advocacy, newsletters, and networking. There are twelve local associations. 1-800-746-7000

Assessment Services For Young Children

If parents are worried about their child's development, they should first talk to their pediatrician. Every pediatrician is trained to do developmental screening. If the pediatrician suspects a developmental delay or disability, he or she might refer the child to the Vermont's Child Development Clinic, to the Child Development Clinic at Dartmouth Hitchcock Medical Center, or to the Family Infant and Toddler Program for further developmental assessments and intervention. Although it is preferable for parents to contact their pediatrician first, children can be directly referred to the Child Development Clinic in Vermont or at Dartmouth. Parents can also contact their local Family, Infant and Toddler Program directly for a developmental evaluation if the child is under 3, or their local Essential Early Education (EEE) program if the child is over 3. Contact information for all of these is included below.

Child Development Clinic (CDC)

Child Development Clinic (CDC) is for children (generally under age 8) who may have a developmental delay or disability. The CDC is part of the Vermont Department of Health's Division for Children with Special Health Needs (CSHN) and provides developmental evaluation services, follow-up and referral to community services. This clinic is offered in Barre, Bennington, Brattleboro, Burlington, Middlebury, Newport, Rutland, St. Johnsbury, and White River.

Child Development Clinic, CSHN
Vermont Department of Health
108 Cherry Street
Burlington, VT 05401
1-800-464-4343 or (802) 863-7200
www.healthyvermonters.info/hi/cshn/cshn.shtml

Child Development Program

The *Child Development Program* at Dartmouth-Hitchcock Medical Center provides developmental evaluation services, follow-up and referral to community services.

Child Development Program, DHMC
Rubin Building, Level 5
1 Medical Center Drive
Lebanon, NH 03756
(603) 653-6060

Family, Infant, Toddler Program (FITP)

The *Family, Infant, Toddler Program (FITP)* of Vermont is a family-centered coordinated system of early intervention services for infants and toddlers (under age 3) who have a delay in their development, or a health condition which may lead to a delay in development, and their families. A core team, including the family, an early interventionist and a local school district representative, a social worker, and a community resource parent plans evaluation activities and determines eligibility for services, and assists families in the coordination of available services. FITP is a program of the Vermont Department of Health's Division of Children with Special Health Needs. (CSHN) 1-800-660-4427 or (802) 863-7338, www.healthyvermonters.info (search: FITP)

FITP are listed above, under Department of Health.

Essential Early Education (EEE)

Essential Early Education (EEE) provides special education and related services for children three to five years old through local school districts at no cost to parents. Special education is specialized instruction that meets a child's special needs. Related services are services a child needs in order to benefit from special education such as physical or speech therapy, transportation or counseling. Parents should speak with their school district's EEE coordinator or special education administrator by contacting the superintendent's office. For a list of superintendents, see www.state.vt.us/educ/new/html/directories/su_sd.html or, contact the *Essential Early Education Consultant*, at the Vermont Department of Education, (802) 828-5115.

Kids on the Move

Kids on the Move, located at the Vermont Achievement Center, provides physical and occupational and speech therapy evaluation, along with child development clinics. Services are available to pediatric clients with a wide range of diagnoses, including cerebral palsy, myelomeningocele, autism and pervasive development disorders, genetic disorders, joint diseases, speech and language disorders, feeding difficulties and developmental delays.

88 Park Street (PO Box 871)
Rutland, VT 05702
(802) 775-7612

Early Child Care And Education Programs

Child Care Services Division (CCSD)

Child Care Services Division (CCSD), at the Vermont Department of Social & Rehabilitation Services (SRS), works to assure a statewide system that promotes and supports safe, accessible, quality childcare for Vermont families. Included in the division is the Child Care Subsidy Program, which helps low-income working families pay for needed child care. There are over 6,000 Vermont children served by the Child Care Subsidy Program at any time. For more information about eligibility and access to subsidized child care, contact a local SRS office or call (802) 241-3110.

Early Childhood-Vermont

Early Childhood-Vermont provides a website which is intended to provide a central resource for early learning issues for professionals, programs, organizations, parents and children. Included are many links and information in such areas as Professional Development, Vermont Publications and Reports, Curriculum Ideas, The Parent Place, and Business Resources. For more information see website: www.ahs.state.vt.us/EarlyChildhood

Essential Early Education (EEE) and Early Education Initiative (EEI)

Essential Early Education (EEE) is special education and related services for children three through five years old provided by local school districts and funded by the Vermont Department of Education through the Individuals with Disabilities Education Act (IDEA). To be eligible for EEE services, the child must be screened or evaluated for a developmental delay or medical condition that may significantly impact the child's ability to be successful upon entering elementary school. Services may be provided in the child's home and/or within preschool classrooms.

The Early Education Initiative Grant Program (EEI) also funded by the Vermont Department of Education provides collaborative, community-based early childhood services to three- and four-year old children at risk of school failure due to a number of factors including significant developmental delay, living in poverty, at risk of abuse or neglect, limited English proficiency, or other identified concerns. These services are administered by local school districts and supervisory unions, Parent-Child Centers, Head Start, and other community-based early childhood programs/centers. Children receive EEI services in a variety of settings including center-based programs, in the home, and/or in community playgroups (Vermont Department of Education (2002). Vermont Early Education Initiative Status Report 2001-2002. Montpelier: Author.)

Contact your local school district office or the Vermont Department of Education EEI Program Specialist at (802) 828-3892 or the EEE Consultant at (802) 828-5115, www.state.vt.us/educ./new/html/pgm_earlyed

Head Start and Early Head Start

Head Start and *Early Head Start* are comprehensive child and family development programs available to income eligible families. Head Start serves families with preschool children age three to five. Early Head Start serves pregnant women and families with children from birth to three years. Contact regional offices about local programs (home-based and/or center-based) in communities throughout their area.

State Office

Agency of Human Services
103 South Main Street
Waterbury, VT 05671
(802) 241-2705
www.ahs.state.vt.us

Regional Sponsors of Head Start Programs

Counties	Regional Sponsors	Phone Number(s)
Lamoille Orange Washington	Central Vermont Community Action Council (CVCAC) Main Office - Barre	(802) 479-1053 or 1-800-639-1053
Windham Windsor	Consumer Controlled Community Child Care (5-C) Main Office - Bellows Falls	(802) 463-3737
Bennington	United Counseling Service/Bennington Head Start Plus Main Office - Bennington	Agency: (802) 442-5491 or Center: (802) 442-3686
Addison Chittenden Franklin Grand Isle	Champlain Valley Office of Economic Opportunity (CVOEO) Main Office - Burlington	(802) 658-0983
Caledonia Essex Orleans	Northeast Kingdom Community Action (NEKCA) Main Office - Newport	(802) 334-7316 or 1-800-639-4065
Rutland	Rutland County Head Start Main Office - Rutland	(802) 775-8225

Parent Child Center Network

Parent Child Center Network is a statewide network of 16 regional centers providing assistance and education to young families at low or no cost. Services include home visiting, early childhood programs, parent education, parent support, playgroups, information and referral, and community development. Look under Publicly Funded Agencies, above, for location of local Parent Child Centers, phone (802) 388-3171 or visit www.vermontfamilyresource.org/PCCNetwork

Success By Six Program

Success By Six Program is a comprehensive early childhood initiative to support local agencies throughout Vermont to enhance the ability of families to protect, nurture, educate, and support the development of their children so they will start school ready to learn. Success by Six Community Projects are guided by local Early Childhood Councils.

State Office

Agency of Human Services
103 South Main Street
Waterbury, VT 05671
(802) 241-2928
www.ahs.state.vt.us

Regional Programs

They are listed in alphabetical order by the county in which they are located.

Counties	Regional Programs	Phone Number(s)
Addison	Mary Johnson Children's Center (Middlebury)	(802) 388-4304
Bennington	Department of Health	(802) 447-3531
Caledonia	St. Johnsbury Success by Six	(802) 748-6040
Chittenden	Early Childhood Connection (Burlington)	(802) 652-5138
Franklin	Success by Six (St. Albans) Early Childhood Programs (Swanton)	St Albans: (802) 527-5426 Swanton: (802) 868-4457
Grand Isle	Champlain Islands PCC (Alburg)	(802) 796-3013
Lamoille	Morrisville Elementary School	(802) 888-1400
Orange	Parent Child Center (Randolph)	(802) 728-6155
Orleans	Northeast Kingdom Human Services (Derby)	(802) 766-5331
Rutland	Rutland County Parent Child Center	(802) 755-9711
Washington	Washington County Success by Six (Barre)	(802) 476-2136
Windham	A.B.C. Success by Six (E. Dummerston)	(802) 254-9469
Windsor	Springfield Area Parent Child Center (North Springfield) The Family Place (Norwich)	North Springfield: (802) 886-5242 Norwich: (802) 649-3268

Vermont Association for the Education of Young Children (VAEYC)

Vermont Association for the Education of Young Children (VAEYC) is an affiliate of the National Association for the Education of Young Children (NAEYC) and works to promote the professional development of all who care for and educate young children. VAEYC sponsors an annual conference, a day at the legislature, and other trainings.

Vermont Association for the Education of Young Children
PO Box 5656
Burlington, VT 05402
(802) 657-2535
www.vaeyc.org

Vermont Association of Child Care Resource and Referral Agencies (VACCRRA)

Vermont Association of Child Care Resource and Referral Agencies (VACCRRA) is a statewide network of non-profit agencies who are committed to the development and support of quality child care options for Vermont children and families. They provide guidance for parents seeking child care, resources and technical assistance for child care providers, and assistance to employers to promote child care options for Vermont workers.

Main office

Child Care Resource
181 Commerce Street
Williston, VT 05495
1-800-339-3367 or (802) 863-3367
www.vermontchildcare.org

VACCRRA Member Agencies

They are listed in alphabetical order by town in which they are located.

Town	VACCRRA Member Agencies	Phone Number(s)
Bennington	Bennington County Child Care Association	(802) 447-6936
Brattleboro	Windham Child Care Association	(802) 254-5332
Middlebury	Mary Johnson Children's Center	(802) 388-4304
Montpelier	The Family Center of Washington County	(802) 828-8771
Morrisville	Lamoille Family Center	(802) 888-5229
Newport	NEKCA/Parent Child Center	(802) 334-4072
Rutland	Vermont Achievement Center	(802) 747-0033
Springfield	Springfield Area Parent Child Center	(802) 886-5242 or 1-800-808-4442
St Albans	The Family Center	(802) 524-6574 or 1-800-427-6574
St Johnsbury	Umbrella	(802) 748-8645
Williston	Child Care Resource	(802) 479-1053 or 1-800-339-3367

Vermont Child Care Providers' Association

Vermont Child Care Providers' Association offers peer support, access to resources and information, and advocates for the needs of child care professionals. "We believe that meeting providers' needs leads to a more stable child care system and higher quality care for children." Open to all child care providers in the state.

(802) 657-2529
www.geocities.com/vccpa

Family Support Organizations

Alliance for the Mentally Ill in Vermont

Alliance for the Mentally Ill in Vermont provides public education on serious mental illness, advocacy and support by and for mental health consumers, families of those with serious mental illness, and practitioners. It offers helpline assistance, legislative and system advocacy, and support groups for consumers and family members.

1-800-639-6480 or (802) 244-1396
www.namivt.org

ARC of Vermont

ARC of Vermont offers support, resources, and community involvement opportunities for people with disabilities, their families and friends. This includes training, personal advocacy, legislative advocacy, policy development, information, referral services and family support activities.

ARC Offices

ARC Offices	Phone Number(s)
ARC of Vermont	(802) 846-7291
Champlain ARC	(802) 846-7295
ARC of Northwestern Vermont	(802) 524-5197
Central Vermont ARC	(802) 223-6149
Rutland Area ARC	(802) 775-1370

www.arcvermont.org

Center on Disability and Community Inclusion

Center on Disability and Community Inclusion, located at the University of Vermont, supports individuals with disabilities and their families through a wide range of programs and projects. The Center promotes opportunities for individuals with disabilities of all ages and in all facets of community life: meaningful relationships, personal choice and control, meaningful activities, safety and health, and living in a home and community.

101 Cherry Street, Suite 450
Burlington, VT 05401
(802) 656-4031
www.uvm.edu/~cdci/

Parent-to-Parent of Vermont

Parent-to-Parent of Vermont is an organization of parents in the state, offering support and information to parents of children diagnosed as having a disability or special health care need. Parents who have had a similar experience with their own child extend support by sharing feelings and experiences. Parent-to-Parent also provides health care financing information and referral for services such as respite and other support needs. For more information and a list of local support groups call or visit the Parent to Parent website.

600 Blair Park Road, #240
Williston, VT 05495
1-800-800-4005 or (802) 764-5290
www.partoparvt.org

Prevent Child Abuse Vermont (PCAV)

Prevent Child Abuse Vermont (PCAV) provides support, education and training programs for parents and caregivers on parenting children who have been physically or sexually abused or neglected. They host self-help groups (call about location of local groups), offer parent education programs, provide a parents Stress Line (1-800-CHILDREN [1-800-244-5373]), and publish the “Vermont Parents’ Home Companion & Resource Directory.”

PO Box 829
Montpelier, VT 05601
1-800-CHILDREN (1-800-244-5373) or (802) 299-5724
www.pcavt.org

The Vermont Family Consortium

The Vermont Family Consortium consists of agencies and organizations that provide support, training, advocacy, information, and resources for people with disabilities, their families, and providers. A brochure is available through the Center on Disability and Community Inclusion, University of Vermont: (802) 656-4031.

- Center on Disability and Community Inclusion: (802) 656-4031. www.uvm.edu/~cdci/
- Autism Society of Vermont & Autism Information Center: 1-800-559-7398. www.autism-info.org
- National Alliance for the Mentally Ill – VT: 1-800-639-6480 or (802) 244-1396. www.namivt
- Vermont Coalition for Disability Rights: (802) 223-6140
- Parent to Parent of Vermont: 1-800-800-4008 or (802) 764-5290. www.partoparvt.org.
- Vermont Parent Child Center Network: (802) 388-3171. www.vermontfamilyresource.org/PCCNetwork
- Vermont Parent Information Center: 1-800-639-7170 or (802) 658-5315. www.vtpic.com.
- Vermont I-Team: (802) 656-4031. www.uvm.edu/~cdci/programs/iteam
- Prevent Child Abuse Vermont: 1-800-CHILDREN (1-800-244-5373) or (802) 229-5724. www.pcavt.org
- ARC of Vermont: (802) 846-7291. www.arcvermont.org.
- Vermont Foster/Adoptive Family Association: 1-800-746-7000
- Family, Infant and Toddler Project of Vermont (FITP): 1-800-660-4427 or (802) 863-7338. www.healthyvermonters/info (search FITP)
- Vermont Federation of Families for Children's Mental Health: Office: (802) 223-4917, Parents Hotline: 1-800-639-6071

Vermont Federation of Families for Children's Mental Health

Vermont Federation of Families for Children's Mental Health provides training and support to families who have children experiencing or at risk to experience emotional, behavioral, or mental health challenges.

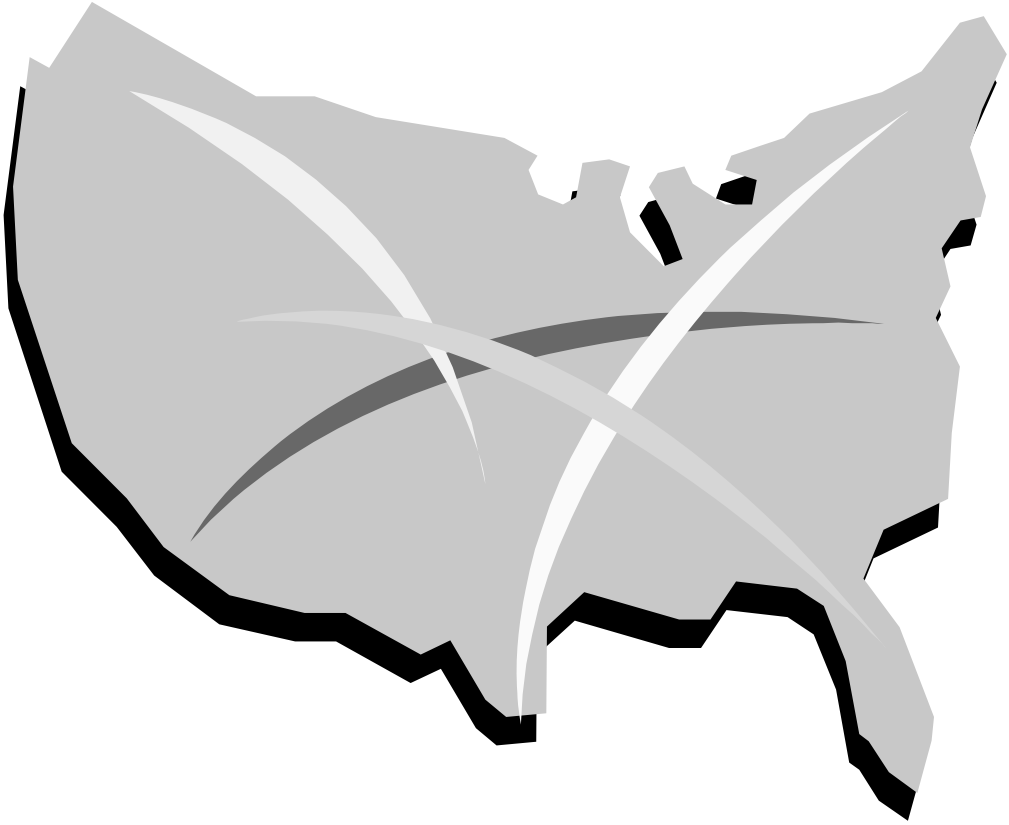
PO Box 607
Montpelier, VT 05601
1-800-639-6071 or (802) 223-4917

Vermont Parent Information Center (VPIC)

Vermont Parent Information Center (VPIC) helps parents of children with special needs to identify, access and advocate for community resources and to understand how to navigate various systems. Programs include workshops, publications, lending library, and assistive technology.

1 Mill Street, Suite A7
Burlington, VT 05401
www.vtpic.com

- Chittenden County: (802) 658-5315
- Rutland Office: (802) 773-2023
- Rest of Vermont: 1-800-639-7170



APPENDIX II
NATIONAL ORGANIZATIONS AND WEBSITES

Bright Futures

Bright Futures, a national initiative to promote and improve the health and well-being of infants, children and adolescents, offers publications and materials geared toward health professionals and educators to promote partnerships between health professionals, families and members of the community. *Bright Futures in Practice: Mental Health* presents information on early recognition and intervention for specific mental health challenges and provides hands-on tools for health professionals and families for use in screening, care management, and education.

Bright Futures Project
Georgetown University
2115 Wisconsin Avenue NW #601 (PO Box 571272)
Washington, DC 20057
(202) 784-9556
www.brightfutures.org

Center on the Social and Emotional Foundations for Early Learning

Center on the Social and Emotional Foundations for Early Learning supports early childhood programs as they address the social and emotional development of young children by disseminating evidence-based, user-friendly information about how best to help children with challenging behaviors and mental health challenges. The Center offers a set of practical briefs, with strategies for promoting social skills and emotional development, positive parenting practices, classroom practices, and more. See *What Works Briefs: Summaries of Effective Practices for Supporting Children's Social-Emotional Development and Preventing Challenging Behaviors.* Order hard copies by mail, or download from the website.

61 Children's Research Center
51 Gerty Drive
University of Illinois at Urbana-Champaign
Champaign, IL 61820
www.csefel.uiuc.edu/briefs

Child Welfare League of America (CWLA)

Child Welfare League of America (CWLA) is the largest national child welfare organization, providing support to agencies serving children and their families, along with advocacy, research and training. The many CWLA publications cover all aspects of child protection, as well as support to all who work to prevent and heal child abuse and neglect.

440 First Street NW, Third Floor
Washington, DC 20001-2085
(202) 638-2952
www.cwla.org

Children's Defense Fund (CDF)

Children's Defense Fund (CDF) provides "a voice of advocacy for all children in America who cannot vote, lobby, or speak for themselves [and] pays particular attention to the needs of poor and minority children and those with disabilities." The Parent Resource Network (PRN) is designed to help parents (and others) find information on such topics as Children With Disabilities, Adoption and Foster Care, Child Care and Early Education, Black Families and Parenting Education and Skills.

25 E Street NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org/parentresnet.php

Child Development Media, Inc

Child Development Media, Inc. offers an extensive collection of video tapes and training materials that cover such topics as Assessment and Planning, Diversity and Culture, Development, Health and Disability, Home Visiting, Language and Communication, Parenting, Parents with Special Needs, Partnerships and Teams, Play, and Working Families.

5632 Van Nuys Boulevard #286
Van Nuys, CA 91401
1-800-405-8942 or (818) 994-0933
www.childdevelopmentmedia.com

Childswork/Childsplay

Childswork/Childsplay offers a variety of products to promote the social and emotional development of children, including play therapy and other materials appropriate for young and older children.

135 Dupont Street (PO Box 760)
Plainview, NY 11803-0760
1-800-962-1141
www.childswork.com

Devereux Early Childhood Initiative (DECI)

Devereux Early Childhood Initiative (DECI) provides articles, a newsletter, a listserve, web links and access to training and other resources aimed at creating working partnerships among early childhood educators, families and behavioral health professionals to promote young children's social and emotional development, and related to the Devereux Early Childhood Assessment (DECA) program.

www.devereuxearlychildhood.org

Early Head Start National Resource Center (EHS NRC)

Early Head Start National Resource Center (EHS NRC) provides articles, chapters, annotated reviews of print and video material, research abstracts and internet links about child development, child health and safety, and children with disabilities under the heading *Information Resources*.

www.ehsnrc.org/InformationResources

Family Village: A Global Community of Disability-Related Resources

Family Village: A Global Community of Disability-Related Resources integrates information, resources, and communication opportunities on the Internet for persons with cognitive and other disabilities, for their families, and for those that provide them services and supports.

The Family Village @ Waisman Center
University of Wisconsin-Madison
1500 Highland Avenue
Madison, WI 53705-2280
www.familyvillage.wisc.edu

Federation of Families for Children's Mental Health (FFCMH)

Federation of Families for Children's Mental Health (FFCMH) is a national parent-run, non-profit organization focused on the needs of children with emotional, behavioral or mental health challenges and their families. The organization supports many local chapters, advocates for the rights of children and families and shares the latest information and technologies with all interested groups and individuals.

1101 King Street, #420
Alexandria, VA 22314
(703) 684-7710
www.ffcmhy.org

Head Start Information and Publication Center

Head Start Information and Publication Center provides a Mental Health Toolkit comprised of Head Start publications, articles and links to major clearinghouses on children's mental health and family support as well as information about and links to federal agencies addressing mental health, organizations for mental health professionals, and promising practices for early childhood mental health.

www.headstartinfo.org/infocenter/mentalhealth/mh_tkbok

National Association for the Education of Young Children (NEAYC)

National Association for the Education of Young Children (NEAYC) is devoted to helping provide high quality early childhood education programs for young children. NEAYC produces and disseminates resources for parents, early care and education providers and communities. The organization's website provides information for parents and professionals in the fields of early care and education.

1509 16th Street, NW
Washington, DC 20036
1-800-424-2460
www.naeyc.org

National Black Child Development Institute (NBCDI)

National Black Child Development Institute (NBCDI) provides and supports programs, workshops, and resources for African American children, their parents and communities in early childhood health and education, child welfare and other relevant topics. NBCDI supports services, community outreach, training and research and works to inform the public about local and national issues affecting African American children.

1101 15th Street, NW
Washington, DC 20005
(202) 833-2220
www.nbcdi.org

National Child Care Information Center (NCCIC)

National Child Care Information Center (NCCIC) is a national, federally-funded resource whose purpose is to provide information and linkages to complement, enhance and promote the child care delivery system. NCCIC provides child care information, outreach, linkages, technical assistance to states, national leadership forums and publication of the *Child Care Bulletin*.

243 Church Street, NW 2nd Floor
Vienna, VA 22180
1-800-616-2242
www.nccic.org

National Institute of Mental Health (NIMH)

National Institute of Mental Health (NIMH): On the NIMH website, go to "For the Public" and "For Practitioners" for information and links to information about such topics as Child and Adolescent Mental Health and topics relevant to parents in need of mental health services.

NIMH Office of Communications
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Toll Free 1-866-615-NIMH (1-866-615-6464) or (301) 443-4513
www.nimh.nih.gov

National Parent Information Network (NPIN)

National Parent Information Network (NPIN) provides access to research-based information about parenting and about family involvement in education. NPIN is a project of the ERIC clearinghouse system. It consists of a virtual library containing hundreds of resources (books, articles, pamphlets) covering the full spectrum of parenting and child development issues, as well as links to many other resources.

www.npin.org

The National Resource Center for Family Centered Practice

The National Resource Center for Family Centered Practice provides technical assistance, staff training, research and evaluation, and library research on family-based programs and issues to public and private human services agencies in states, counties, and communities across the United States. The Center has worked in child welfare, mental health, juvenile justice, community action, county extension, Head Start and job training programs.

University of Iowa School of Social Work
National Resource Center for Family Centered Practice
100 Oakdale Hall Iowa City, IA 52242
www.uiowa.ed/~nrcfcp

Research and Training Center on Family Support and Children's Mental Health

Research and Training Center on Family Support and Children's Mental Health provides an array of research information, trainings, and articles about childhood mental health issues. The semi-annual bulletin, *Focal Point,* is mailed free of charge upon request. The website has step-by-step instructions for how to use their research base and links for in-depth information about young and older children with emotional and behavioral challenges.

Research and Training Center on Family Support and Children's Mental Health
Portland State University
PO Box 751, Portland, OR 97207-0751
(503) 725-4180
www.rtc.pdx.edu

World Association for Infant Mental Health (WAIMH)

World Association for Infant Mental Health (WAIMH) provides access to information (research, articles, videos, conferences) from around the world, including links to international websites concerning infant mental health. Their website includes a resource library for accessing written information.

WAIMH c/o Institute for Children, Youth & Families
Kellogg Center #27
Michigan State University
East Lansing, MI 48824
(517) 432-3793
www.msu.edu/user/waimh

ZERO TO THREE

ZERO TO THREE provides the latest research, resources, information, technical assistance and training for parents and professionals working with infants and toddlers. Publications cover a wide range of relevant topics including developmental assessment, cultural awareness, attachment, pediatric medical care, parenting, quality early care, relationship-based practices, and special needs.

2000 M Street, NW, Suite 200
Washington, DC 20036-3307
1-800-899-4301 or (802) 479-1053
www.zerotothree.org

Vermont
CUPS
Children's UPstream Services

APPENDIX III
ABOUT THE CUPS LEARNING TEAM

Background

Over the past five years of the CUPS grant, the interdisciplinary CUPS Learning Team has worked to develop learning opportunities in the area of early childhood mental health for the CUPS Regional Teams, parents, and others who support children and families in Vermont. The Team has produced many statewide conferences and workshops regarding systems development, foundation skills (including assessment) for relating to families and treatment teams, and also special topics like trauma and attachment, domestic violence, substance abuse, and social skills training for children. It has facilitated a Reflective Supervision Network for family advocates and professionals, supported a Consortium of family advocacy organizations, and collaborated with higher education to expand the learning available for people caring for children.

To guide workers in an ongoing way, the Learning Team has produced two documents:

Knowledge and Practices to Promote the Emotional and Social Development of Young Children (2001, DDMHS, Waterbury, VT); and

Finding Help for Young Children with Social-Emotional-Behavioral Challenges and Their Families: the Vermont Children's UPstream Services (CUPS) Handbook (2003, DDMHS, Waterbury, VT).

A third white paper from the "CUPS Documentation Project" will soon supplement these other two books.

MANY THANKS

to the

CUPS Learning Team Members,

Past and Present.

CUPS Learning Team Members

Priscilla Baker, *Retired Early Childhood Teacher and Child/Family Counselor*

Brenda Bean, *Division of Mental Health*

Ellie Breitmaier, *Domestic Violence Unit, Department of Social and Rehabilitation Services*

Annamarie Cioffari, *Program in Community Mental Health, Southern NH University*

Anne-Marie Darsney, *The Family Place Parent Child Center*

Sherry DeGray, *Addison County Parent Child Center*

Pam Doyle, *Family Representative, formerly VT Head Start Parents Association*

Marisa Edwards, *Winston Prouty Center*

Meg Ellis, *Family Representative*

Julie Finkle, *Vermont Federation of Families for Children's Mental Health*

Bev Heise, *Department of Education; formerly UVM Center on Disability and Community Inclusion*

Helen Keith, *Family, Infant and Toddler Project, VT Department of Health*

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