Self-Study Course

Fostering Children and Teens with Mental Health Problems

Revised 9/06

5 Hours Credit

Instructions: Read this self-study course. Complete the questionnaire at the back of the self-study. When you have completed it, return your questionnaire to the Alaska Center for Resource Families. You may keep this course for future reference.

This self-study course was developed by Aileen M. McInnis, Southcentral Training Coordinator, for the Alaska Center for Resource Families.

ALASKA *center for* RESOURCE FAMILIES

Return your questionnaire to:
Alaska Center for Resource Families
815 Second Avenue, Suite 202
Fairbanks, Alaska 99701

www.acrf.org

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Fostering Children and Teens with Mental Health Problems

Part One: Introduction to Mental Health Problems in Children

The terms *psychological disorders* and *mental illness* describe a broad range of mental or emotional problems that seriously interfere with a person's ability to live his or her life. Here are more than 200 classified forms of mental disorders. Some are easily managed; others are chronic and damaging. Many can be diagnosed in children.

Throughout history, mental illness was alternatingly seen as being possessed by God, or being possessed by the Devil. It was often interpreted as witchcraft or bad luck. More recently in this century, mental illness was seen as insanity or being mentally retarded or the result of poor parenting. Even today, mental illness is poorly understood and often feared. Nonetheless, advances in our understanding and the better availability of mental health services have made managing mental health problems more effective.

All of us feel fearful, confused or even a bit "crazy"' at times. That is normal. But when these feelings continue on a regular basis, take place in most contexts and interfere with everyday functioning, they may be considered disorders or mental illness. What is the difference between the two? The DSM IV Manual describes a *mental or psychological disorder* as a significant behavior or psychological pattern that occurs in an individual that is associated with present distress or increased risk of suffering pain, death or loss of freedom. *Mental illness* refers to the more serious and chronic forms of disorders of schizophrenia or chronic psychosis. Recent research is indicating strongly that many "mental illnesses" are biologically and chemically based. There is a trend toward classifying these disorders as "neuro-biological disorders" (NBD) and moving away from the label mental illness.

What causes psychological disorders or mental illness? Like many physical problems, we now understand that mental disorders and illnesses can result from any combination of factors including *psychological*, *biological* or *social* factors. (See **GRAPH 1**) These factors contribute to pattern of behavior that is seen as dysfunctional or getting in the way of a healthy, satisfying life.

Do Foster Children Have More Psychiatric Disorders Than The Rest Of The Population?

Most foster children who require psychological help are not mentally ill but may be suffering from a psychological disorder. Many of the children in our care have been victims of violence, suffered sexual abuse, and felt the pain of neglect and abandonment. When children experience maltreatment, observe violence, or suffer disruption in their family relationships, they are more at risk for trauma related effects. Not all children in foster care have psychological disorders, nor are all difficult behaviors in foster children related to mental disorders. But it makes sense that foster children are at higher risk for these difficulties.

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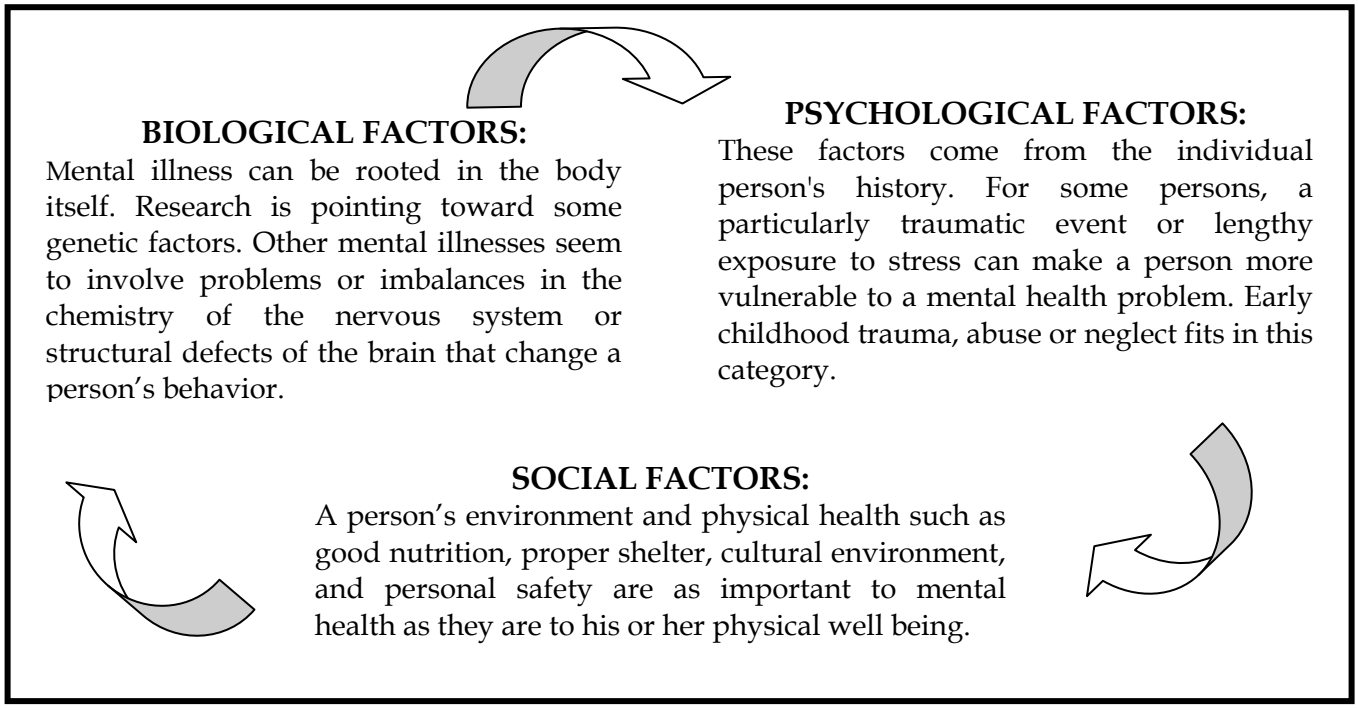

GRAPH 1: *The Causes of Mental Illness or Disorders*
From Evelyn McElroy Children and Adolescent with Mental Illness

The Difference Between Psychiatric Disorders And Severe Emotional Disturbance

Mental health clinicians rely on categories to understand a child's general patterns. It is important, however, to distinguish between a psychological diagnosis and other categories used to describe a child's behavior. A *psychiatric or psychological diagnosis* describes the terms we will discuss in this self-study. *Severely emotionally disturbed* is another descriptive term that is actually not a psychiatric category. Severely emotionally disturbed, or S.E.D., is a label that qualifies a child for certain services, such as Medicaid services, or eligibility for a specific clinic's services. Some psychiatric diagnoses may automatically qualify a child for S.E.D. services (such as schizophrenia or psychotic disorders) but not all of them do.

The educational system also has descriptions of conditions that qualify a child for special education supports. These include *learning disabled*, *emotionally disturbed* or *behaviorally disturbed*. These are not psychiatric diagnoses, but give a child access to services within the school system.

A psychiatric or psychological diagnosis does not describe a person, but describes his or her behavior or patterns. This is important to remember for those of us who care for these children. Each child is an individual with strengths, characteristics, likes and dislikes. Seeing past the label to the child helps us form the connection to a child that is so critical to his healing. Labels and diagnoses give us descriptions that help us be more effective in our interactions with a child. But children are people, too. Even a child with a psychological disorder or mental illness deserves our appreciation of his individual needs and gifts.

Fostering Children and Teens with Mental Health Problems

Part Two: Common Psychiatric Diagnoses In Children

When we care for a child who constantly fights, threatens to kill herself, or is in a perpetual daze, we want to know why the child acts that way. Determining the cause of behavior is often not easy. The first step in action is putting a name to what is going on. This is *called obtaining a diagnosis.*

Diagnosis And The DSM-IV

The *diagnosis* is an identification of the general pattern of dysfunction the child is experiencing. Unlike a broken leg or brain tumor that can be seen by an x-ray, there is no single test for psychological problems. A diagnosis is reached through consideration of tests, interviews and assessment of symptoms. The terms for diagnoses most often comes from the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. This is updated when needed. The edition we will refer to is the Fourth Edition, known as the DSM-IV. The diagnosis is the descriptive term used by mental health clinicians, insurance companies, Medicaid, schools and other service providers. It is good to be familiar with what the terms mean. Getting a diagnosis does not mean the illness goes away. In fact, a diagnosis doesn't change the child at all. But an accurate diagnosis helps the people around the child provide the kind of help he needs. Without a diagnosis, a child may not be eligible for services or it can be more difficult to find a way to pay for the treatment. Without an accurate diagnosis, we may actually be treating a child in a way that is harmful.

Major Psychological Disorders

With over 200 diagnoses, it is impossible to cover all the possible mental health diagnoses in children. We will look at the disorders most common to children in foster care. Mental disorders are grouped according to common characteristics. We will look at some of the more common diagnoses in the following categories:

Mood Disorders: *Disorders affecting emotion and feelings states*

Pervasive Developmental Disorders: *Disorders where information processing skills are affected*

Disruptive Behavior Disorders: *Disorders affecting behavior and how children function in the world and with others*

Anxiety Disorders: *Disorders involving abnormal patterns of fear and anxiousness*

Other Conditions That May Affect A Child Psychologically: *Includes severe emotional disturbance, attention deficit disorder, tic syndromes and fetal alcohol effects*

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MOOD DISORDERS

A mood disorder refers to a disturbance of mood and other symptoms that occur together for a minimal duration of time and are not due to other physical or mental illness. There is mounting evidence that many mood disorders have a physiological basis and that there is a genetic pre-disposition to mood disorders that runs in families. This self-study addresses two mood disorders: ***Major Depressive Disorder*** *and* ***Bipolar Affective Disorder.***

Major Depressive Disorder (*also known as childhood, chronic or clinical depression*)

Depression describes a normal emotion, but it can also refer to a psychiatric disorder. Children can get depressed as frequently and severely as adults can. Children often hide depression behind behavior problems. It is common for children to be treated initially for hyperactivity, learning disabilities, laziness, drug abuse, or destructive behavior while the primary problem is actually depression. Children with untreated clinical depression are at higher risk for suicide attempts. With younger children, these gestures may be more likely to appear as a child who constantly puts himself into situations that might cause him harm, such as running into the street or climbing into dangerous places or playing with firearms. To distinguish depression from normal sadness in response to an event, a child must have at least five of the following symptoms for at least two weeks:

- Depressed or irritable most of the time
- Pleasure in all, or almost all, normal activities has dropped significantly,
- Has lost or gained more than 5 percent of his body weight
- Has insomnia or sleeps too much
- Is either very restless or very slowed down
- Is tired most of the time
- Has feelings of worthlessness or excessive guilt feelings
- Finds it difficult to think, or concentrate or make a decision
- Has recurrent thoughts of death or suicide

> *"We had a little four year old girl in our home and we never once saw her smile or cry or laugh or show any emotion. She was just flat."*
>
> *- Foster Mother*

Very young children can also show signs of depression, including not wanting to eat, not making expected weight gains, listlessness, hyperactive or frantic behavior, flat affect or little emotion. Dysthymic Disorder is a chronic form of general depression where the symptoms are not as acute as those listed above, but are chronic. Dysthymia can be described as a general empty feeling or mild depression that is present more often than it is absent and has lasted at least two years.

TREATMENT GOALS FOR DEPRESSION: The goals of helping depressed children include: (1) help them identify and verbalize the origins of the depression; (2) help children elevate their mood so that they can return to normal functioning; and (3) come up with a safety plan for children who may consider self–induced injury or suicide.

Tools to achieve these goals often include a combination of therapy and medication. Occasionally, hospitalization is required. Some of the new psychiatric medicines can be quite effective in stabilizing brain function. Psychotherapy is aimed at treating emotional problems a child might have as well as help a child learn how to manage his disorder. Exercise, having fun and increasing social

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interaction are also important ways to regulate moods and are important additions to medication therapy.

Bipolar Affective Disorder: (also know as manic/depression)

Bipolar Affective Disorder is found much less frequently in children than in adults, but can occur in the late adolescent years. In this disorder, there is a distinct period during which the child's mood is elevated, his gestures and feelings become extreme, and the child may be extremely irritable, followed by a distinct major depressive episode. Manic episodes usually begin suddenly, with symptoms intensifying over a few days. Manic symptoms may include inflated self-esteem, decreased need for sleep, loud and rapid speech that is difficult to interrupt, continuous flow of speech with abrupt changes of topics, restlessness, increased sociability and flamboyant or bizarre activities. The manic episode may be described as euphoric, unusually cheerful or high, but those who know the person will recognize it as excessive. When the child moves into the depressed part of the cycle, he may be unable to function at all or moves slowly as if he has a heavy weight on him. His grades suffer, he ignores his friends, his self-esteem is poor, he may have trouble getting out of bed, and he may even be suicidal during these depressive states.

> *"Jerry is a classic case of bi-polar disorder. When he's up, he's flying. He doesn't sleep; he has pressured speech and talking a mile a minute. But when he is in the depressive part of the cycle, he can hardly drag himself out of bed."*
>
> -Therapist

TREATMENT GOALS FOR BIPOLAR AFFECTIVE DISORDER: Treatment should help a child increase control over impulses and reduce the mania while moving towards stabilizing his mood. Mood regulators such as lithium and supportive psychotherapy are treatments of choice. Teens with bi-polar affective disorder need to discuss with medical personnel the probability that this disorder may be a life-long condition. Adolescents need to explore the issues of self-care, stress management and a medication regime. These are difficult issues for an adolescent. Getting teens to stay with their medication and take care of themselves may be a challenge for foster parents.

IMPORTANT THINGS TO REMEMBER ABOUT MOOD DISORDERS:

1. Most mood disorders are thought to be biologically based, so often respond well to medication and antidepressants. Some of the newer medications (SSRIs) seem to be quite effective with adolescents.

2. Therapy should focus on managing the manic episodes and the depression, and help the child move toward stabilization of moods.

3. Learning patterns of self-care such as exercise, good nutrition, and regular sleep are important parts of managing the disease.

4. If you care for a child who experiences major depression, you should have a well thought out plan of what to do if the child is suicidal or prone to other types of self-harm. **(See Page # 24.)**

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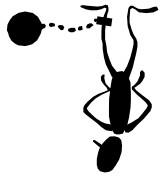
PERVASIVE DEVELOPMENTAL DISORDERS



With Pervasive Development Disorders, the brain has trouble correctly processing information. Thought to be the most severe of psychiatric disorders affecting children, Pervasive Developmental Disorders affect intellectual skills; responses to sights, sounds, smells and other senses; and, the ability to understand language or to talk. Children may assume strange postures or perform unusual movements. They may have bizarre patterns of eating, drinking or sleeping. **Pervasive Developmental Disorder** *also includes the diagnosis of* **Autism.**

As its name suggests, **Pervasive Developmental Disorder** describes a situation where a child is severally affected in multiple areas of development. These include motor skills, language, communication, and arithmetic and abstraction skills. Problems are experienced in the areas of communication, socialization, imagination, language, and motor skills. There may be a lack of interest in relationships (even with parent figures) and there is a pattern of blunted affect or emotion. Blunted affect means not showing any emotion or emotion appropriate to the situation.

Autism is the most severe of the Pervasive Developmental Disorders and starts before 3 years of age. As infants, autistic children don't cuddle and may even stiffen and resist affection. Many don't look at their caregivers and may react to all adults with the same indifference. On the other hand, some autistic children cling to a specific individual. In either case, children with autism fail to develop normal relationships with anyone, even their parents. Autistic children may not seek comfort even if they are hurt or ill, or they may seek comfort in a strange way. As they grow, these children also fail to develop friendships and generally they prefer to play alone. Even those who do want to make friends have trouble understanding normal social interaction.

Autistic children also go through repetitive body movements such as twisting or flicking their hands, flapping their arms or banging their heads. Some children become preoccupied with parts of objects, or they may become extremely attached to an unusual object such as a piece of string or a rubber band. They become distressed when any part of their environment is changed. For example, they may throw extreme tantrums when their place at the dinner table changes or magazines are not placed on the table in a precise order. Likewise, these children insist on following rigid routines in precise detail.

TREATMENT GOALS FOR P.D.D.: Pervasive Developmental Disorder and Autism affects many aspects of relating to the world. A child with either condition will need extensive help in the areas of developing basic language and communication skills, establishing bonds between parent and child and peers, and eliminating self-abusive behaviors. These goals are most attempted through rigorous behavior management and behavior modification programs that shape and reward appropriate behavior. New ways for treating Autism, however, are always being explored. The educational system becomes a critical partner in working with the child with PDD or Autism. Language and communication therapy and a well-thought out Individual Educational Plan are all critical for appropriate intervention.

DISRUPTIVE BEHAVIOR DISORDERS

*Children with Disruptive Behavior Disorders exhibit disruptive behavior that interferes with social situations such as the classroom, playground situations and family activities. In other words, these are the children who can't seem to stay out of trouble no matter where they are. This self-study deals with two common behavioral disorders***: <u>Oppositional Defiant Disorder</u>** *and* **<u>Conduct Disorder</u>**.

<u>Oppositional Defiant Disorder</u> Oppositional Defiant Disorder is a pattern of negative, hostile, and defiant behavior. A child with Oppositional Defiant Disorder shows four or more of the following on a chronic basis: often loses temper; is often touchy or easily annoyed; often argues with adults; deliberately annoys people; is often spiteful or vindictive; is often angry and resentful of others; blames other for his mistakes; and, actively defies or refuses to comply with requests or rules.

Oppositional Defiant Disorder differs from Conduct Disorder in that it is defiant behavior that does not regularly infringe on the rights or safety of others. Every child goes through periods of being defiant. The standard for ODD is that is lasts at least six months, often first appears in the pre-school ages, is present in most interactions with adults, and occurs more frequently than normally occurs for the child's developmental level. Oppositional Defiant Disorder rarely travels alone. It is almost always paired with another disorder such as Attention Deficit Disorder or Conduct Disorder.

TREATMENT GOALS FOR O.D.D.: With defiant and oppositional children, the goal of treatment should be to reduce the frequency and intensity of hostile and defiant behaviors, including extinguishing temper tantrums. Therapy that uses structure and predictability and is given by caring and sensitive adults is helpful. It is important to show the youngster how his behavior affects others. Children with Oppositional Defiant Disorder are more capable of empathy than children with Conduct Disorder. Establishing and setting limits is critical to the success of treatment. Reinforcing positive behavior is very important, because focusing solely on negative behavior often increases the oppositional behaviors. Some children benefit from medication, especially when ADHD is involved.

<u>Conduct Disorder</u> Conduct Disorder is used to refer to repetitive and persistent patterns of conduct that violate either the basic right of others or age appropriate social norms or rules. Children with *Unsocialized Conduct Disorders* are described as failing to establish a normal degree of affection, empathy or bond with others. They may have superficial peer relationships, be egocentric and manipulative, and lack concern for the welfare of others. The more socialized types of young persons with Conduct Disorders are described as being capable of attachment but they tend to be callous or manipulative toward persons they are not emotionally attached. Children with *Aggressive Conduct Disorders* are characterized by physical violence against others, including vandalism, firesetting, burglary, and assault. The non-aggressive child with a Conduct Disorder may break rules at home or at school and may be truant, abuse drugs or alcohol, or run away from home. Other symptoms of Conduct Disorder may include intimidating or threatening others, impairment in social, school or occupations function, staying out late at night despite parent prohibition (if under age 13),

cheating at games and or at school, physical cruelty to animals or people or forcing sexual acts on others.

Milder forms of conduct disorders tend to improve over time. More severe forms (those that require hospitalization or day hospital treatment) are more likely to be prolonged. Without treatment or intervention, the severe forms can lead to illegal or criminal activity and may be a precursor to anti-social activity in adults.

TREATMENT GOALS FOR CONDUCT DISORDER: A child with a Conduct Disorder needs to be educated about his condition and learn ways of stress management, taking time-outs, learning communication skills, and learning ways to calm himself. The day-to-day care of the child with Conduct Disorder should include firm and clear structure, limit setting, discipline, consistent rules, social skills training, behavior modification and identification with a positive role model. These are all elements that can be reinforced in a stable, structured foster home. Treatment often consists of therapy on an individual or group level and family therapy to help the family.

IMPORTANT THINGS TO REMEMBER ABOUT DISRUPTIVE BEHAVIORS DISORDERS

1. Children with disruptive behaviors need structure, routine, supervision, and guidance from adults. Firm day-to-day parenting and family life is critical in providing this structure.

2. Therapy needs to focus on understanding of self, self-control, stress and anger management, and focusing on self-responsibility.

3. If you care for a child with disruptive or aggressive behavior, you should have a plan of how to react when a child is violent or hostile and learn de-escalation skills to prevent situations from getting out of hand.

ANXIETY DISORDERS

Anxiety Disorders include excessive anxiety, worry, or fear that far exceed the expectation for the child's stage of development. Anxiety may involve physical tension in the body such as restlessness, fatigue, shakiness, muscle tension, rapid heartbeat, and shortness of breath or dizziness. Anxiety may be a generalized fear such as feeling constantly on edge, a general state of irritability or may include a specific fear. This self-study will look at Anxiety Disorders including **Post Traumatic Stress Disorder**, **Obsessive Compulsive Disorder** *and* **Separation Anxiety**.

Post Traumatic Stress Disorder (PTSD)

Post Traumatic Stress Disorder is usually associated with victims of traumatic events such as plane crashes or war experiences. But newer evidence supports the theory that PTSD can also occur in children when he or she experiences a shocking, unexpected event. The trauma is usually so extreme that it overwhelms a child's coping mechanisms and creates intense feelings of fear and helplessness. The traumatic event may be experienced by the individual directly (such as physical or sexual abuse, assault, rape, kidnapping, threatened death) or by observation (witness of trauma to another person) or by learning about a trauma affecting a close relative or friend. Ongoing child abuse and sexual abuse of a child is considered extremely stressful to children, second only to early loss of a parent or a natural catastrophe.

Symptoms of PTSD in children include: recurrent intrusive and distressing memories of the event; recurrent distressing dreams of the event; feeling as if the traumatic event is recurring; intense psychological distress when exposed to reminders of the traumatic event; numbing of general responsiveness (detachment, estrangement from others, decreased interest in significant activities); and persistent symptoms of increased arousal, (irritability, sleep disturbance, poor concentration, hypervigelance, and anxiety).

In children, stress often shows up at bedtime, and at points of separation from parent figures. Separation points include a parent leaving the house, going to school, turning off lights, or a change in the household. Re-experiencing the traumatic event is common. Young children may repeat the event in their play. Symptoms may also include avoiding thoughts or feelings about the event and avoiding activities or situations that remind them of the event. They may feel detached from other people, take less pleasure in previously enjoyed activities, have trouble sleeping, have nightmares, and have difficulty concentrating. They may have various physical symptoms such as stomachaches and headaches. Young children may lose recently acquired developmental skills such as toilet training or language skills.

What Is a " Psychotic Episode?"

A psychotic episode usually refers to either the sudden presentation of psychotic feature in an individual who has been functioning normally or the decompensation of a patient with a chronic mental illness. Symptoms of acute psychotic episodes may include disorganized thinking, paranoid or other delusions, auditory hallucinations, aggression, agitation, decreased sleep, confusion and emotional outbursts.

Psychotic episodes are most often seen in schizophrenia, but can also occur during extreme depression, anxiety or stress. They may be caused may be a medical condition or an alcohol or drug induced reaction. Some episodes are responses to early trauma, such as in the case of flashbacks. A psychotic episode may happen just once under extreme stress or can be chronic, such as in the case of schizophrenia.

During an episode, it is important that a caregiver provide protection from self-harm or danger and to seek medical and psychiatric evaluation.

TREATMENT GOALS: Supportive, insight oriented therapy with a cognitive or behavioral component to address disruptive symptoms seems most effective for children and adolescents. Play therapy may be used for very young or nonverbal children.

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Obsessive Compulsive Disorder (OCD)

Teenagers with Obsessive Compulsive Disorder have obsessions or compulsions. An *obsession* refers to recurrent and persistent thoughts, impulses or images that are intrusive and cause severe anxiety or distress. A *compulsion* refers to repetitive behaviors and rituals (like handwashing, hoarding, ordering, checking) or mental acts (like counting, repeating words silently, avoiding). Other compulsive behaviors include counting while performing another compulsive action such as handwashing or endlessly rearranging objects in an effort to keep them in perfect alignment or symmetry with each other. Performing these rituals may give the person with OCD some relief from anxiety, but it is only temporary. The obsessions and compulsions also significantly interfere with the teen's normal routine, academic functions, social activities or relationships. A person is not considered to have Obsessive Compulsive Disorder unless the obsessive or compulsive behaviors are extreme enough to interfere with everyday life. The fact that OCD patients respond well to specific medications suggests the disorder has a neuro-biological basis.

TREATMENT GOALS FOR OCD: The goal of treatment is to help the child regain control over his or her actions and thoughts to the point where they do not interfere with daily living. Some medications are quite helpful in relieving the symptoms of OCD in many people. Traditional psychotherapy aimed at helping the patient develop insights into his problem, is generally not effective against OCD. However, behavior therapy that involves exposing a person to the object and helping them learn to modify their response combined with medication seems to be fairly effective.

Separation Anxiety Disorder

Separation Anxiety Disorder is diagnosed when children develop intense anxiety to the point of panic as a result of being separated from a parent figure. This differs from the stranger and separation anxiety experienced by most children between 8 and 15 months and different than the normal anxiousness children feel when separated from parents for a short time. This anxiety is so intense it interferes with children's normal activities. They refuse to leave the house alone or visit or sleep at a friend's house. At home, they may cling to parent figure or complain of stomachaches, headaches, nausea and vomiting. Many children with this disorder have trouble falling asleep and may try to sleep in their parents' bed. When separated from a parent, they become preoccupied with morbid fears that harm will come to their parent. This anxiety may include school phobia where children refuse to attend school because they fear separation from a parent, not because they fear the academic environment.

TREATMENT GOALS FOR SEPARATION ANXIETY DISORDER: Goals include eliminating the intense anxiety for the child and increase the child's ability for separation from parent figures to developmentally appropriate levels. For young children, managing nighttime fears and physical complaints (such as tummy aches) is also important. For some children with acute anxiety, medications may significantly reduce the anxiety and allow them to return to the classroom. Therapy may help the child work out the anxiety by expressing it through play. Or, as in behavior therapy, a child may learn to overcome fear through gradual exposure to separation from the parental figure or by learning methods or rituals to help deal with separation.

Other Disorders of Infancy or Adolescence

Reactive Attachment Disorder

Reactive Attachment Disorder is a markedly disturbed and developmentally inappropriate social related ness in most contexts that begin before 5 years and is associated with grossly pathological care. It is considered a disorder that is first identified in infancy, childhood, or adolescence. All children in foster care run the risk of attachment difficulties, but most children in foster care do not have Reactive Attachment Disorder. Children who are removed from a parent in the first three years of life and experiences multiple placements or who never forms a healthy attachment with a parental figure in the first years of life runs a high risk of attachment difficulties.

Some children may show their attachment difficulties by being *inhibited* or withdrawing from social interactions. Or they may show attachment difficulties of the *disinhibited* type, which includes children who will attach to any adult around them or not show any restraint in getting close to others. Some of the symptoms include: intense control battles, superficially engaging and charming, indiscriminately seems to attach to stranger, incredible hostility toward mother figure, appearing to have little affect or conscience, cruelty to animals, self or others, and parental figures who feel like giving up or hostile toward the child. The single factor, which differentiates Reactive Attachment Disorder from other disorders, is a history of attachment disruptions and early abuse or neglect.

TREATMENT GOALS FOR ATTACHMENT DISORDER: The goals of treatment will focus assisting the child to bond with caregivers. Involvement of the adoptive or birth family in treatment is critical, for these are the people who the child needs to form long-term attachments. Some therapists believe that traditional intervention does not work with attachment-disordered children and recommend more intrusive therapies such as holding therapy or rage reduction. For long term foster care, the foster family may be involved in family therapy and intensive home intervention. Interventions may include increasing expression of feelings, increasing positive incidents between parent and child, decreasing the child's negative feelings toward all caretakers, and increasing situations where a child feels as if he belongs in a family.

Other Conditions that May Affect a Child Psychologically

Children with mental health problems may have several conditions intensify each other. The following conditions are often accompanied by other difficulties that may land a child in a mental health center.

Severely Emotionally Disturbed

Severely Emotionally Disturbed is a label given to children that is not a psychiatric diagnosis but a label that is commonly used in mental health and in the educational system. Severely Emotionally Disturbed generally describes a child who is suffering from severe disturbance of the emotional processes that occur over a long period of time and interferes with a child's ability to function in social and educational systems. A child who is severely emotionally disturbed may also have a diagnosed psychiatric problem. It generally includes one or more of the following characteristics:

- An inability to learn which cannot be explained by intellectual, sensory or health factors
- An inability to build or maintain satisfactory interpersonal relationship with peers and teachers
- Inappropriate types of behavior or feelings under normal circumstances
- A general pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder is a condition characterized by a failure to remain attentive in various situations, especially in the school and home. Current thinking emphasizes that the causes of ADHD are likely to be biological, based on how the brain processes information. Characteristics include short attention span, easily distracted, doesn't seem to listen, impulsive behavior, failure to follow through on instructions, poor organizational skills, high energy level, restless and disruptive behavior. Often children's behaviors may get them in trouble at school or may be very difficult for parents to manage at home, so if ADHD is not diagnosed, a child's problems may be seen as behavior problems. ADHD often accompanies other psychological diagnoses such as conduct disorders or oppositional defiant disorder. The most effective treatment for ADHD appears to be work with parents, school and child to learn coping strategies and set up environments and self monitoring skills to help children cope. Many children with ADHD have also found success with medications such as Ritalin or Cylert. The most effective and long lasting treatment is a carefully monitored plan combining both behavioral assistance and medication.

Tic Disorders

The most well know tic disorder is Tourette's syndrome; a neurological disorder characterized by *tics*—involuntary, rapid, sudden movement or vocalization that occur repeatedly in the same way. Tourette's occurs at a much higher percentage in children with severe developmental disorders. Tics can be mild or can be severe. They can be motor tic such as eyeblinking, head jerking, jumping or twirling or they can be vocal, such as throat clearing, tongue clicking, uttering words that are out of context with what is happening. Some persons with Tourette's do not need medication; others find medication helpful in controlling symptoms. Sometime tic disorders might also have obsessive-compulsive behavior or ADHD or sleep disorders.

Fetal Alcohol Syndrome or Fetal Alcohol Effects

FAS and FAE are physical conditions describe a condition that are caused when a woman drinks alcohol during pregnancy and the fetus is exposed to alcohol. Exposure to alcohol can cause damage to developing brain cells, the nervous systems, and to skin and bones. The child may be affected mildly or severely. Fetal Alcohol Syndrome includes pre- and post-natal growth retardation, central nervous system and distinctive facial characteristics. Fetal Alcohol Effects include some but not all of those effects. Children with FAS or FAE may also have a behavioral problem such as impulsiveness, lying that doesn't make sense, perseveration (gets stuck on doing one thing over and over again) and social immaturity for the child's age. FAS/FAE may accompany other diagnosis such as ADHD, attachment disorder; conduct disorder or behavior such as sexually acting out. It is important that these children be accurately identified because FAS/FAE may demand a different intervention than traditional mental health intervention.

IMPORTANT THINGS TO REMEMBER ABOUT THE DIAGNOSIS OF A MENTAL DISORDER

1. Children should have a thorough physical exam and family history completed as part of any evaluation. Physical causes of problems need to be ruled out before a psychological diagnosis is made. Conditions like allergies and disabilities such as a hearing loss, suggest a medical treatment rather than a psychological one.

2. Without a complete history, diagnosis may be faulty or be incomplete. For example Fetal Alcohol Effects mimics many of the symptoms of conduct disorder, attachment disorder, and attention deficit disorder. Yet the goals of treatment vary widely for the different conditions.

3. Psychological disorders are patterns that interfere with a child's ability to function normally. The severity and intensity of the behaviors and the length of time a child has exhibited the behaviors is important. Just because a child has difficulty with relationships does not mean he has attachment disorder. It is important not to get into the habit of "diagnosing" children in your care based on your past experience. A good diagnosis includes a thorough and complete evaluation by people specifically trained to do it.

Fostering Children and Teens with Mental Health Problems

Part Three: Evaluation and Treatment of Mental Health Problems in Children

This section explores what treatment is available to children and teens with mental health problems and who can provide that treatment. In Alaska, where you live may limit what is available. Many communities experience the frustrations of having to send a child to a larger community for treatment or settle for what is available. The treatment continuum will be further discussed in Part Two of this series.

What Is the Role of Treatment?

Treating psychological problems is different than treating a physical injury. Psychological treatment is a process of helping a person overcome, understand, manage or lessen the effects of whatever the disorder presents. Short-term counseling focuses on problem solving and working through immediate crisis. Longer-term counseling can be designed to help a person make large steps or changes in their ability to function in the world. Types of treatment used will have different effects. Talking therapy helps a person understand what his problems or challenges are. Behavioral therapy assists a person in functioning in the world or consciously trying to change behavior. Medication therapy will help manage the physical aspects of a disorder.

Treatment does not "fix" people. Treatment and therapy helps a person manage, understand, lessen the effects, and live with the challenges he may be facing. Just because a child is in treatment, doesn't mean that he will get better! A good therapist can work with a resistant child, but no therapist can make someone change. Sometimes the type of therapy used may not be effective with the type of disorder the child has. A child's treatment should be planned according to the child's needs. For example, a child with social problems may benefit best by group activities, while a seriously disturbed suicidal child may benefit from hospitalization. It may take several tries to find the right fit between treatment and child. Finding this right fit between child and treatment often depends on a good evaluation of a child's condition.

What Is A Psychiatric Evaluation And How Are They Done?

The evaluation is a tool to determine a child's strengths and functioning abilities and to identify disturbing patterns of behavior. A **psychiatric evaluation** is conducted by a psychiatrist, who is also a medical doctor. A psychiatrist can explore any physical causes of the behavior and assess the possibilities of major psychiatric illness and the possible appropriateness of medication. A **psychological evaluation** is conducted by a psychologist who uses a combination of tests to clarify a diagnosis by checking cognitive functioning, social relationships, strengths and weakness of the child's functioning. He or she will also test a child's information processing skills, expressive language and motor skills. This evaluation will include a family and social history. Some families may be asked to observe behavior or fill out checklist of behaviors the parent has observed. A **family** or **individual assessment** is a less rigorous assessment that usually involves a social and family history and an inventory of behaviors.

This information is examined and may result in a diagnosis. When a treatable problem is identified, recommendations are provided and a specific treatment plan may be developed by the treatment

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team or between the therapist and family. When working with children's behavior problems, it is important to include a full physical exam to determine if behavior has a biological base or to rule out allergies, internal injuries, reactions to medications, or nutritional deficiencies.

Who Are the People Involved With Providing Mental Health Services?

The foremost people involved with a child's mental health care are the foster parent and the social worker. In addition, the traditional mental health system in Alaska has a continuum of different services available depending on where you live in the state. Let's identify some of the players you are apt to work with.

Psychiatrists are physicians who hold a medical degree and spend four years or more in approved residency training in psychiatry. A psychiatrist's role in treatment is primarily to do complete evaluations, prescribe medications and monitor extreme behaviors in patients.

Psychologists hold a degree in psychology from an accredited program. Many providers of clinical psychological services are licensed under state law. Licensed psychologists generally hold a doctorate (Ph.D. or Ed.D.) in psychology and have two years of supervised work experience. They, too, have the title of Doctor, but cannot prescribed medication. Many psychologists specialize in testing and psychological evaluations.

The Psychiatric Nurse is a licensed, professional, registered nurse who has expertise in psychiatric and mental health nursing. In a hospital setting, the nurse will have more day-to-day contact with your child than the physician or psychiatrist

The Advanced Nurse Practitioner may also be eligible to do psychiatric evaluations and prescribe medication. The Advanced Nurse Practitioner is a more common figure these days in mental health.

Mental Health Clinician/ Clinical Social Worker/ Psychotherapist: A clinician or therapist's background will vary widely. Many therapists or clinicians hold a Masters Degree in Psychology, Social Work or Counseling and have worked under the supervision of another clinician.

Counselors: In some nonprofit social service agencies, helpers may be peer counselors or bachelor level providers with experience. Some therapists and counselors have background and experience in religious or spiritual counseling. Other counselors may have certifications in specialties such as hypnosis, substance abuse counseling, or anger management.

Activity Therapist is paraprofessionals who work on specific activities with children to increase social skills or emotional skills. The qualifications of an Activity Therapist or Aide varies, though usually they will have a college degree in social work or psychology or several years of schooling with practical experience in dealing with children.

Treatment Teams: Some agencies and organizations use a treatment team approach meaning that a team of people involved with the child share their information and resources to most effectively work with the child. The parent or the foster parent should be part of this team.

Other Forms of Therapy

There are many approaches to mental health not addressed in this short self-study. Each community has different forms of healing for children and adults alike. These forms may include:

Spiritual or Church Counselors	*Native Alaskan healing rituals*
Bio Feedback	*Nutritional Counselors*
Guided Imagery	*Play Therapy*
Art Therapy	*Body Work*

What is most important for foster parents to know is that the caseworker is an important part of your team. Whatever therapy is determined best for the child needs to be determined by the caseplan. You can and should give your input based on what you know about the child, but you must have the agreement of the caseworker before you pull a child out or place a child in any kind of therapy. Never cut back on medication or stop therapy without consulting the child's caseworker.

Don't Forget the Other Important Supports in the Your Community! There are many supports in community outside of the mental health system, including: *School counselors, clergy and religious people, support groups, elders, mentors, Big Brothers/Big Sisters, community health aides, cultural supports, physicians, occupational therapist, art therapist, nutritionists and other parents and kids going through the same things.* Healers take many forms. Use everyone you can to build a good system around your family and your child.

What Is The Role Of Medication When Treating Children?

For some of the more serious and persistent disorders, medication can be immensely helpful. Medication works on brain function and the central nervous system to help a child stabilize. It is most helpful when used in conjunction with psychotherapy. Therapy treats the causes and the roots of the disorder, while medication treats some of the physical symptoms and help children stabilize and function. Medication with children and adolescents, however, is tricky. Children and adolescents are in a rapid growing state so it may be difficult to determine correct dosage. In teens, with their fluctuating hormone levels, it is essential that if a child is on medication, that he is regularly evaluated for dosage and evidence of serious side effects. The most common psychiatric drug prescribed for children is Ritalin for symptoms of Attention Deficit Hyperactivity Disorder. Other disorders that seem to respond well to medication include depression, bi-polar disorder, obsessive-compulsive disorder, anxiety disorders and schizophrenia.

"Psychotherapy treats the causes and the roots of the disorder, while medication treats some of the physical symptoms and help children stabilize and function."

Because we are often dealing with teenagers who may not be disciplined and motivated to take medication, it is important to both educate and engage the adolescent in her own drug management. Some side effects are so unpleasant that teens may "tongue their meds" or pretend to take it but hide the pill under their tongue instead. Traditional antidepressant drugs are generally poorly tolerated by teenagers because of common side effects such as sleepiness. Some recent developments in medication have proved to be more tolerable with adolescents. Drugs called selective serotonin reuptake inhibitors (SSRIs) tend to be tolerated well by teenagers because of their rapid action and low tendency to cause side effects. These brand names include Prozac, Zoloft and Paxil. It is important than an adequate time period be given to allow the medication to work (4 to 6 weeks) and that adequate doses are used. For older children, it is important to educate them about their medication and why they are taking them.

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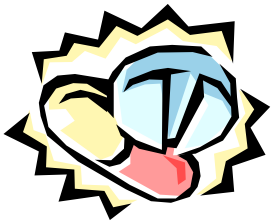

If Your foster child is taking medication, You should know the following things:

1. Psychiatric drugs need birth parent or guardian's permission because most are considered voluntary treatment. Do not administer any drugs to a child before checking with the caseworker.

2. Learn about the medication your child is taking. Ask the physician for what signs of problems you should watch for and who to call if something unusual happens that you think is linked to the medication. Make sure you understand all instructions about the medications, including when it should be taken and how, what activities should be avoided while on the medication and what foods or drinks should be avoided. Ask what happens if a dosage is missed. Know the possible side effects to the medication.

3. Be observant when medication or dosage changes or if the child goes through a growth spurt. Keep a written record of a child's behavior. Dosages often need to be adjusted. Some medications also require that a child have his blood tested regularly. A child under medication should have ongoing supervision by a medical professional and should be evaluated on a regular basis.

4. Keep your doctor's phone number available and report any action you think may be a side effect. Trust your instinct if you think something is wrong.

5. Adults should supervise children's medication. Work with the school if a child needs to take medication during the school day. Some drugs that adolescents take may be considered controlled substances, so make sure you carefully supervise where the medication is going.

6. Each doctor should be informed about all medications the child is taking. Some drugs may have a bad reaction when taken with others. Follow directions. Don't skip medication or double up on dosages. Do not take a child off medication suddenly unless instructed by a doctor.

7. Children should receive other behavioral and emotional support while on medication. Medication is not a cure on its own. Be supportive and advocate if necessary if your foster child needs something he is not getting.

8. Take the same precautions in storing and disposing of psychiatric medications that you do with any other medications. Be especially mindful of medications around young children who often think the pills are candy, or around depressed and potentially suicidal children who may use drugs to overdose.

> *"Don't forget medication is not a cure all. Medication is plowing the field, then we plant, cultivate and reap the harvest."*
> *- Foster Mother*

9. If the foster child is leaving your home, make sure that all medical records and written instructions regarding medication goes to the next caregiver or to the caseworker. Keep medications in their original containers and always throw unused or old medications away.

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Fostering Children and Teens with Mental Health Problems

Part Four: Role of the Foster Home with the Child with Mental Health Problems

In Children and Adolescents With Mental Illness, Evelyn McElroy suggests parents use the P.L.A.N. approach when incorporating a child with mental health problems into the family. P.L.A.N. Stands for **Plan**, **Learn**, **Anticipate** and **Negotiate**. This chapter will use the P.L.A.N. strategy to discuss the role of the foster home in caring for a child with a mental health problem. These same strategies will also work for children with special needs or an emotional disturbance.

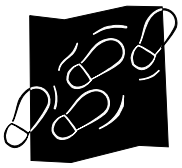
PLAN. Structure your household so children will be more likely to succeed.

LEARN. Find out as much as you can about a child's condition.

ANTICIPATE. Adapt your parenting to this child's needs.

NEGOTIATE. Develop skills as a team member and learn to negotiate with social workers and therapists about what the child needs.

GRAPH 2: *The P.L.A.N. Approach of Incorporating A Child with Mental Illness into Your Home*
Based on the Work of Evelyn McElroy,
Children and Adolescents With Mental Illness



STEP ONE:
MAKE A <u>PLAN</u> FOR A CHILD TO BE IN YOUR HOME.

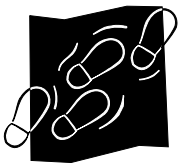
Experienced foster parents know the keys to success are consistency and structure. If a child does not feel he can control himself, he depends on his environment (and parent) to provide control for him. *MAKE THIS PRINCIPLE WORK FOR YOU!*

PLAN #1: ***Provide Structure And Consistency In Your Home So Children Know What To Expect.***
This is especially important for children with emotional problems. They must have predictability and structure in their lives. Predictability comes in a household with structure. Structure means having a rhythm of how things get done in your house. Set up routines in your home. Designate specific areas in the house for specific activities. Have a schedule. It is also helpful to establish a few simple house rules. These may include such rules as: *hitting is not allowed*; *everyone is expected to do at least one chore*; no *name-calling is allowed*; you *must always let a parent know where you are.* House rules and structure keep your home from feeling unstable and chaotic. Make your environment as uncomplicated and predictable as possible. Provide food that children can easily prepare for themselves.

PLAN #2: ***Meet A Variety Of A Child's Needs Every Day.***
These include the need to be recognized and encouraged, the need for food and sleep, the need for relaxation and fun, the need for physical activity, and the need for socialization and touch. When foster children get regular, consistent care, they can learn to relax and be secure that someone is taking care of them. They, then, can put more of their mental energy in confronting other problems. Don't underestimate the power of simple rituals that let children know you care. Talk with your child everyday. Say hello and goodbye. Celebrate birthdays, holidays and achievements. Plan a day that includes interesting things for children to do. Provide your child with lots of positive feedback.

PLAN #3: ***Have A Consistent Behavior Plan.***
Structure also means a consistent behavior program. You may use a series of point systems, or chore charts or routines. You may use time out or consequences. You may post house rules or allow children to earn tokens to trade in for rewards. Like other foster parents, you will have to find out what works with the child in your care. Whatever your system is, make sure it is consistent. When a child knows a certain behavior will always get a certain response, he learns to modify his behavior. Work with your treatment team or therapist to find a behavior plan that will best work with the child in your care.

PLAN #4: ***Take Care Of Yourself!***
If you are exhausted, frustrated and physically sick, you won't be very effective when parenting a child with mental health difficulties. And these kids can drive you to it! Get enough rest and good nutrition. Find a way to get a regular break. Make this a priority for yourself—*no one else will if you don't.*



STEP TWO:
LEARN AS MUCH AS YOU CAN ABOUT A CHILD'S CONDITION

Ask your counselor for information, go to the library, call the Alaska Center for Resource Families or if you have access to a computer, search the Internet. The more you know, the better you equipped you are to do well. You need to learn about medication the child might be taking. And you may have to learn from the therapist or previous foster parents how to manage behavioral problems that may occur as a result of the illness.

OTHER RESOURCES THAT COULD HELP YOU INCLUDE:

Mental Health Organizations:

ALASKA MENTAL HEALTH ASSOCIATION: 907-563-088, FAX 907-563-0881
4050 Lake Otis Parkway, Suite 202, Anchorage, AK 99508

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
There are mental health center in many communities throughout Alaska. To find the one nearest you, contact the in your region.

ANCHORAGE OFFICE: 269-2600 or (800) 770-3930
701 E. Tudor Road, Suite 260, Anchorage, AK 99503

NORTHERN REGIONAL OFFICE: 451-6884 or 1-800-770-1672
751 Old Richardson Hwy, Suite 350, Fairbanks, AK 99701

SOUTHCENTRAL REGIONAL OFFICE: 352-6301 or 1-800-755-0712
851 West Point Drive, Suite 310, Wasilla, Alaska 99654

SOUTHEASTERN REGIONAL OFFICE: 465-3370 or 1-800-465-4828
350 Main Street, PO Box 110620, Juneau, AK 99811

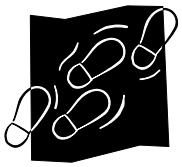
General Resources:

PARENTS, INC. (SUPPORT GROUPS AND INFORMATION) 337 7678 or 1-800-478-7678
4743 Northern Lights Blvd, Anchorage, AK 99508.
(PARENTS, Inc has centers throughout the state, call for the one nearest you.)

Website Addresses:

The following general pages have multiple links to a wealth of mental health information on the Internet:

Mental Health Net:..... http://mentalhelp.net/
Links to Sites Regarding Depression:.....www.depression.com
National Alliance for the Mentally Ill: .....www.schizophrenia.com
National Institute of Mental Health: .....www.nimh.nih.gov/home.cfm
Internet Mental Health:.....www.mentalhealth.com
National Foster Parent Association:.....www.kidsource.com/NFPA



STEP THREE:
ANTICIPATE POTENTIAL CHALLENGES AND MAKE A PLAN

In knowing about a child's disorder, you can anticipate and adapt your parenting to this child's needs. Anticipating what will help a child do well will help your entire household. Here are suggestions for children and adolescents with some of the disorders discussed in this self-study.

When Parenting A Child or Teen With Conduct Disorder…

1. Establish and maintain appropriate parent child boundaries. Don't let the child bully his way into power.

2. Set firm and consistent limits and enforce them when child rebels or is aggressive. Establish clear consequences. Put your house rules in writing and review them often.

3. When a child messes up, let him experience consequences. Point out the connection between what he did and the consequence. Emphasize accepting personal responsibility and point out how his actions affect others. But avoid lectures. Get in often, make the point and get out quickly!

4. Work on substitute skills. Help a child "stop, look, listen and think." Reinforce work in therapy at home in how to handle stress, how to deal with conflicts, and curb impulsive behavior.

5. Use a point system where teen earn points for positive behavior and exchange the points for some reward or special privilege. This both rewards a child for positive behavior and gives the child experience in delaying gratification, which is an important for children who are impulsive.

6. For the teen with angry, aggressive outbursts, a foster parent should learn de-escalation skills and have a safety plan in place in case a child gets violent. Talk to your teen about your expectations of conduct beforehand and of consequences. When things can't be de-escalated, it is important to keep family members safe.

Ideas for De-escalating Potentially Angry and Violent Situations

Lower your voice and talk slower. Be gentle. Back away. Don't move in or put your hands on a child. This often increases the energy and escalates the situation

Find something to agree with the child. Try to listen to the feelings behind the words. Don't defend or justify your actions at this point. That can come later. Ask the child what he wants to see happen.

Break the interaction by saying you need a break. Offer to come back in 30 minutes to talk more about the situation. Change the situation by offering to go for a walk or a drive after a short break.

Don't get hooked into an argument. If things are escalating, just focus on bringing the energy level back by keeping calm and slowing down the pace.

Clear the room of others so the child does not have an audience and others will not be in harm's way. If there is another adult in the house, ask them to join you.

Don't talk too much! Talk can be stimulating. Give the child some time to regain composure and respond to your request. Get yourself back in control before you try to get the child back in control.

When Parenting A Child or Teen with Oppositional Defiant Disorder…

1. Many of the suggestions from parenting a child with conduct disorder will be helpful.

2. With the oppositional child, a parent has to take special care not to get "hooked" into arguing, reasoning or threatening. For your own mental health, work on modifying your own behavior as well as the child's. Learn to keep in control and to take time outs when needed.

3. Give the child choices and control over minor decisions when you can. Avoid threats and avoid saying, "Do it or else!" The child who is oppositional always chooses the "or else!" Because the child get so much power and attention for being negative and defiant, this child needs lots of rewards and praise for appropriate and compliant behavior.

When Parenting A Child or Teen with Attachment Difficulties…

1. Help children learn to put their feeling into words, so that feelings don't turn into undesirable behaviors. Promote interactions with family members that give positive feelings such as fun, laughter, caring, and being proud of oneself.

2. Promote attachment in children by provide comfort and basic care to a child. Show the child you care, do things for and with the child, give lots of eye contact and verbal praise, take time to talk with a child. Simple things like this show that someone really cares about your wellbeing. Use rituals at bedtime and mealtime that increase togetherness and positive encounters.

3. Avoid time out for children that shun attachments. Children who are uncomfortable with intimate relationships often do things to propel them out of situations. If you use time out for calming down, keep the timeout chair in the same room with you, or sit quietly with a child.

4. Don't force too much too soon. Remember a foster home provides a safe place for a child to be – your relationship with the child will be different and less intimate than with your own birth children. A child with a history of poor attachment fears rejection and abandonment, but often times seem to initiate it. If you start feeling inadequate in your parenting or feel resentful toward the child or feel angry, abusive feelings, you are not alone! Make sure you have someone you can talk this out with. Separate your worth out from the effects on the child. Be realistic of how close you may get to these children.

When Parenting A Child or Teen With Depression…

1. Encourage a healthy sharing of feelings that help children become more assertive with dealing with their needs.

2. Don't nag a child to snap out of it or cheer up. Don't make the child a victim or treat him like a fragile doll. But don't minimize the child's feelings either.

3. Monitor a child's self-care including sleep, food, exercise and hygiene. Physical health is critical in dealing with depression. If a child is taking medication, monitor it carefully.

4. Have a plan in place for if a child becomes suicidal. Use the suggestions below to help you think about what you could do.

What to do when your child is suicidal

Prevent: Remove a child's access to dangerous objects. This includes firearms, medications, knives, alcohol, or drugs. Keep control over vehicle keys as well.

Know The Signs: These include deepening depression, managing final arrangements, giving away possessions, risk taking or self destructive behavior, indirect or direct statements about suicide, sudden elevated mood or feeling free, and heavy alcohol and drug use.

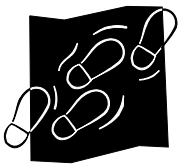
Ask and Listen: Don't be afraid to ask if someone is contemplating suicide. Always take these threats seriously. To help you gauge the severity of the threat, ask the person if they have a plan. If it is well thought out and the child has access to the means, this is a serious threat. Often the ability to talk about it with someone who is concerned offers a release for the child. *Listen*, don't give advice. Don't challenge or call the child's bluff. Sometimes just being able to talk at length makes a child too tired to do anything to hurt himself.

Persuade: Offer hope. The next step is to offer hope in the form of help. With your words, let them know you care.

"I love you and I don't want to see you hurt yourself."
"I can tell you're really hurting. Tell me what you are going through so I can understand."
"I care too much to sit by and ignore what's happening to you. Its time we found someone to give you're the help you need."
"I have heard you mentioning suicide lately. I am very concerned. Are you feeling so bad that you are thinking of killing yourself?"

Point out the good work the child has done. Get the child in touch with the therapist, For extremely suicidal children, there may need to be a regular "check-in" to monitor feelings.

Refer: Contact therapist or caseworker. If child is in immediate danger, he may need to be hospitalized. Call 911, or take the person to a hospital emergency room. **DO NOT LEAVE THE PERSON ALONE!**



STEP FOUR:
LEARN TO WORK WITH AND NEGOTIATE WITH TEAM MEMBERS

It is critical that the different members of the team – foster parent, social worker and therapist—all work together. Rarely does a team just "click." You have to work hard to keep the lines of communication open. Negotiating means being assertive for what's best for your foster child, but also what works for your family. If a behavior modification plan is too time consuming, **SAY SO**. But be prepared to offer other ideas of what your family is willing to do. Remember, you are supposed to be working together! Here are some ideas of how to support a child's efforts in therapy:

Get the child to and from appointments. Support the idea of the value of therapy.

You can either help therapy or sabotage it. Let the child know you support therapy and believe it is important. Make sure the child gets to his appointments and project a positive attitude towards it. One foster family participates as a family with the activity therapy provided their children so that the whole family reinforces the skills being learned.

Expect a roller coaster, not a steady improvement.

When a child is going through counseling, his behavior will sometimes be better and sometimes be worse. Often, when painful issues and feelings are being dealt with in therapy, the child's behavior will appear worse at home. That doesn't mean therapy is making the child worse. In order for some issues not to plague the child into adulthood, they need to go through the painful process of confronting and dealing with issues. You as a foster parent may see lots of up and down behavior in your foster child. If you are prepared for it and know it is normal, it may be easier to hang on until things settle down.

Watch for changes in behavior.

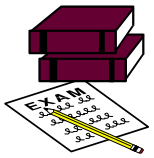
If a child is on medication or is showing suicidal or self-destructive tendencies, it is very important that foster parents be the "eyes and ears" on the child. If a child is showing side effects or reactions to medication, contact the doctor or therapist. Keeping a journal of what you are seeing when a child first starts medication will help you track changes or reactions.

Maintain communication with the therapist

Check in regularly to communicate with therapist about home issues or ask questions. Pick up the phone or schedule a few minutes before appointments. When therapist and foster parent are communicating with each other, valuable information is shared. Children are also less likely to be successful in manipulating therapist against the foster parent. Keeping a log of behaviors and being specific about behaviors. (For example, instead of "Joe is acting out again," tell the therapist, "Joe has been disciplined three times at school this week for tardiness.") Specific language is much more effective than general conclusions.

Be the best parent you know how to be.

Families can be very therapeutic for a traumatized child. But a parent is not a therapist. A child may need a non-parent figure to scream at, cry with, question, and push against. He also needs a safe place in his family. One therapist wrote, "Parents must remain the gatekeeper of safety—the ones who nurture and protect while we, the therapist, open the wounds." Don't pressure a child to open up and tell you everything. It might place him in too vulnerable a position, which may cause other problems in the parent child relationship. He needs a parent, and that is a role you can fill very well. Provide guidance, nurture and comfort and child, and set the limits he needs.



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"Child and Adolescent Obsessive Compulsive Disorder": www.ocdresource.com

"Conduct Disorder" www.noah.cuny.edu:8080/illness/mentalhealth/cornell/conditions/conductd.htlml

"Facts for Families: Comprehensive Psychiatric Evaluation": www.aacap.org/web/aacap/factsFam/eval.htm

"Facts for Families: The Continuum of Care For Children and Adolescents": www.aacap.org/factsFam/continum.htm

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"What Do I Say To My Child If I Think He/She Is Thinking Of Committing Suicide?": www.syz.com/spsrd/child.html

Test