TCJFS

KINSHIP

RESOURCE

HANDBOOK

KI 003 (04/14/2011/bg)

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
KINSHIP RESOURCE HANDBOOK
TABLE OF CONTENTS

Receipt of Kinship Resource Guide

By signing this receipt, I am acknowledging that I have received the Kinship Resource Guide from Tuscarawas County Job and Family Services. This guide contains Basic First Aid information, Medication Administration information, information regarding a child's grief process, information regarding child development, information on appropriate discipline, information on identifying and parenting sexually abused children, and a resource list of online and community services available to my family. By signing this receipt, I am acknowledging that it is my responsibility to read and learn this information as a kinship provider. I am acknowledging that an overview of this handbook was provided by agency staff.

Signature of Kinship Provider: _____
Date of Signature: _____

Witness of Kinship Signature: _____
Date of Witness: _____

Copy for Kinship Provider

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Copy for TCJFS File

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
KINSHIP CAREGIVER TRAINING AND SUPPORT

POLICY

Tuscarawas County Job & Family Services provides assistance to kinship caregivers to obtain training to help them meet the needs of children placed in their home.

PROCEDURE

1. All kinship caregivers are provided a copy of the TCJFS Kinship Handbook. This will be provided to all kinship families by either the Protective or Ongoing worker working with the family. Every effort will be made to provide the TCJFS Kinship Handbook as soon after the child or children are placed in the kinship home as is practical.

2. The TCJFS Kinship Handbook will contain resources and information on training and assistance available to kinship providers. In additional to community resources, the same will contain links to available on-line resources and training. In addition to being available in hard copy, the same will be posted to the agency's public web site. The TCJFS Kinship Handbook will be updated annually or as new information becomes available.

3. The case manager or investigator providing the TCJFS Kinship Handbook to the kinship family will provide an overview of the same at the time it is provided. Any questions the family has will be answered at that time. After doing the same, the case manager or investigator will obtain a written acknowledgement of receipt of the handbook. This documentation will be maintained in the case record of the children for whom kinship care is being provided.

4. Any kinship caregiver providing care to a child with exceptional medical needs will be required to complete CPR training. The same will be determined on a case-by-case basis by agency staff and management. When the same is necessary, the kinship care provider will be referred to a local resource to obtain the necessary training. If the same is cost prohibitive, the agency will pay the expense of the same if no other funding resources exist to cover the cost.

Lynn Angelozzi, Director

4-8-11
Effective Date

TUSCARAWAS COUNTY JOB & FAMILY SERVICES
FIRST AID INFORMATION

General Safety

BASIC FIRST AID PROCEDURES

INJURY		TREATMENT
NOSE BLEEDS	→	Pinch nose and tilt head forward.
ANIMAL BITES	→	Wash wound, identify animal, and report the bite.
SERIOUS FALLS	→	Do NOT remove the victim; call 9-1-1
SEVERE WOUNDS	→	Have the victim sit or lie down, apply direct pressure to stop the bleeding, call 9-1-1
SMALL WOUNDS	→	Wash the wound, apply dressing and bandage
BRUISES	→	Apply a cold compress
BURNS	→	**1st and 2nd degree**: Put burn in cold water, pat dry, and cover with clean bandage. Do not break blisters.
	→	**3rd degree**: Do not put water on an open wound, do not remove burned-on clothing. cover the burn lightly and get medical help!

- A **1st degree burn** is red, sore, and covers a small area
- A **2nd degree burn** is blistered and painful
- A **3rd degree burn** causes the skins to be white or charred and there is a loss of skin layers.

FOR ALL SEVERE WOUNDS AND BURNS, DIAL 911

FIRST AID KIT

Your basic First Aid Kit should contain the following items:

- An Antiseptic (e.g. Betadine)
- Antibiotic Spray or Ointment
- Adhesive Bandages (various sizes)
- Adhesive Tape (1 1/2" to 1" wide)
- Hydrocortisone Cream or Calamine Lotion (relieves minor itching)
- Ice Bag or Cold Pack
- Scissors with Rounded Ends
- Tweezers
- Thermometer
- Aspirin
- Syrup of Ipecac (for swallowed poisons; to use as directed by the **POISON CONTROL CENTER**

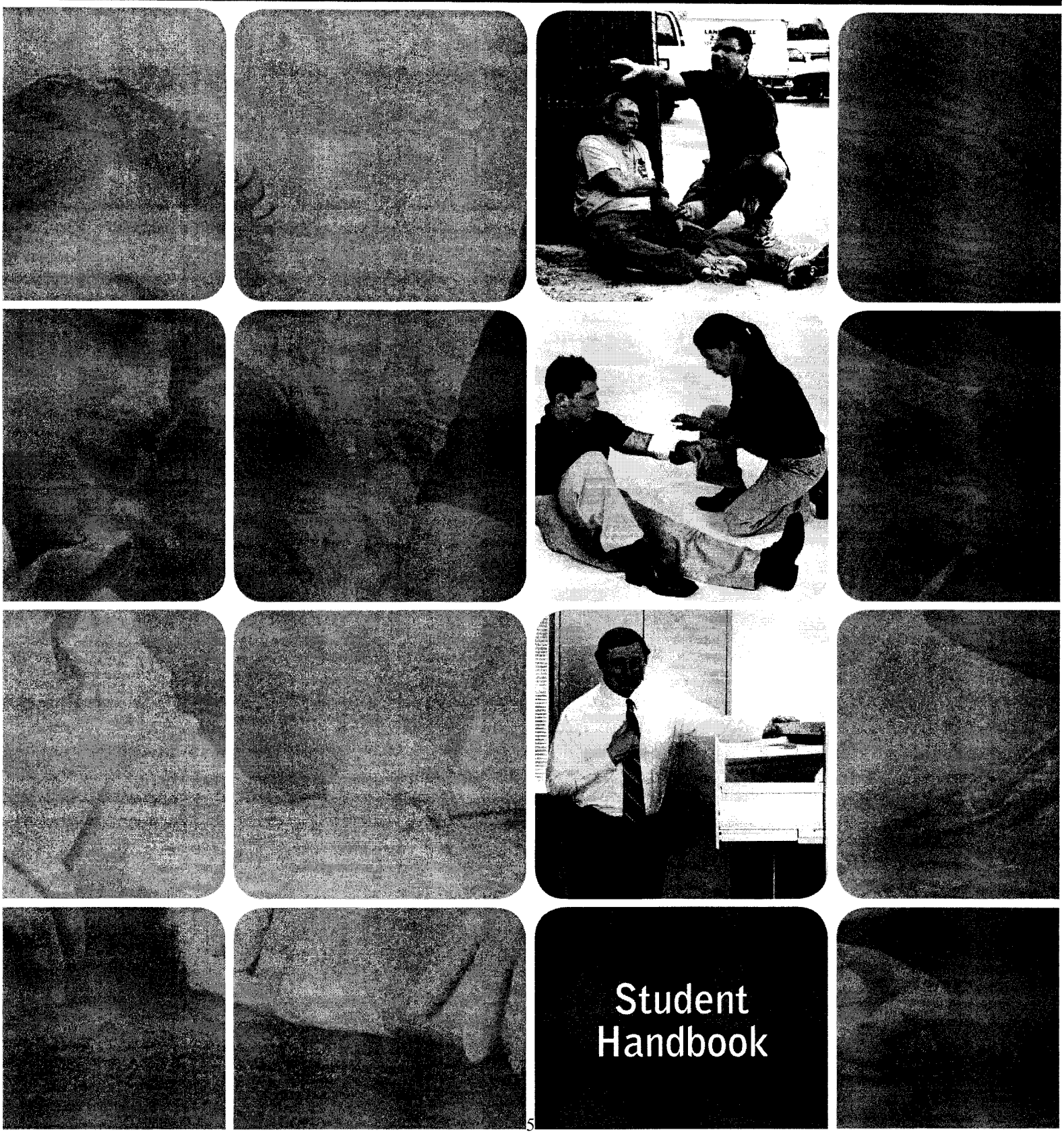
CAUTION

Be sure that all supplies are kept out of the reach of young children.

AMERICAN SAFETY & HEALTH INSTITUTE

Basic First Aid

for the Community and Workplace



Student Handbook

This handbook serves as a reference guide for basic first aid. For the purpose of this program, basic first aid is defined as assessments and interventions that can be performed with minimal or no medical equipment.[1] A first aid provider is defined as someone with formal training in first aid.

American Safety and Health Institute (ASHI) certification may only be issued when an ASHI-authorized Instructor verifies you have successfully completed and competently performed the required core knowledge and skill objectives of the program.

American Safety & Health Institute
1450 Westec Drive
Eugene, OR 97402 USA
800-246-5101
ashinstitute.org

Printed in the United States of America. BKBFA-08N (11/08)

Basic First Aid

Emergency scene.

At work, injuries and illnesses kill more than two million people in the world each year. That's one death every fifteen seconds... or six thousand people a day.

Safe practices and healthy choices at work, home, and play can prevent many injuries, illnesses, diseases, and deaths. However, once injury or sudden illness has occurred, providing effective first aid can make the difference between life and death; rapid versus prolonged recovery; and temporary versus permanent disability.

This program focuses on what you must know and do in order to provide confident, effective first aid care.

Legal Aspects of Providing First Aid

The Good Samaritan principle prevents someone who has voluntarily helped another in need from being sued for 'wrongdoing.' Since governments want to encourage people to help others, they pass specific "Good Samaritan" laws or apply the principle to common laws. You are generally protected from liability as long as:

- You are reasonably careful,
- You act in "good faith" (not for a reward),
- You do not provide care beyond your skill level.

If you decide to help an ill or injured person, you must not leave them until someone with equal or more emergency training takes over – unless of course, it becomes dangerous for you to stay.

Consent

Consent means permission. A responsive adult must agree to receive first aid care. "Expressed Consent" means the victim gives his or her permission to receive care. To get consent, first identify yourself. Then tell the victim your level of training and ask if it's okay to help. "Implied Consent" means that permission to perform first aid care on an unresponsive victim is assumed. This is based on the idea that a reasonable person would give their permission to receive lifesaving first aid if they were able.

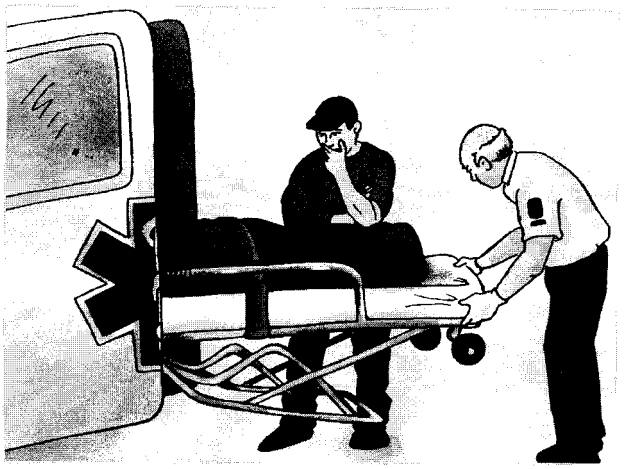
When Caring for Children
Consent must be gained from a parent or legal guardian. When life-threatening situations exist and the parent or legal guardian is not available, first aid care should be given based on implied consent.

When Caring for Older Persons
An elderly person suffering from a disturbance in normal mental functioning, like Alzheimer's disease, may not understand your request for consent. Consent must be gained from a family member or legal guardian. When life-threatening situations exist and a family member or legal guardian is not available for consent, first aid care should be given based on implied consent.

Use Common Sense

There is no evidence there has ever been a single successful lawsuit in the United States against a person providing first aid in good faith. Still, it is necessary to use common sense. Never attempt skills that exceed your training. Don't move a victim unless their life is in danger. Call for an ambulance immediately, even if you decide not to give first aid. Always ask a responsive victim for permission before giving care. Once you have started first aid, don't stop until qualified help arrives.

Emotional Aspects of Providing First Aid



Traumatic incidents cause emotional distress.

Both the first aid provider and the victim may suffer emotional distress during and/or following a traumatic incident.[2] The seriousness or horror of the incident will be a factor in determining the amount of emotional distress. It may be worse in human-made events; for example, a terrorist attack or mass shooting. Providing first aid care for a seriously injured or ill child is generally more emotionally difficult than caring for an adult.

Symptoms of a traumatic stress reaction include a pounding heartbeat and fast breathing which may begin during or within minutes of the traumatic event. Feelings of guilt for not having done more, worrying about the safety of loved ones, nightmares, and thinking about the event repeatedly may follow the incident.

Stress reactions are a normal, human response to a traumatic event and are usually temporary.[3] With the help of family and friends, most people gradually feel better as time goes by. If you feel you need extra help coping after a traumatic event, call your doctor or ask friends if they can recommend a mental-health professional. The organization you work for may have an Employee Assistance Program available to assist you.[4]

Infectious Diseases

The risk of getting exposed to a disease while giving first aid is extremely low. Even so, it is prudent to protect yourself from any exposure.

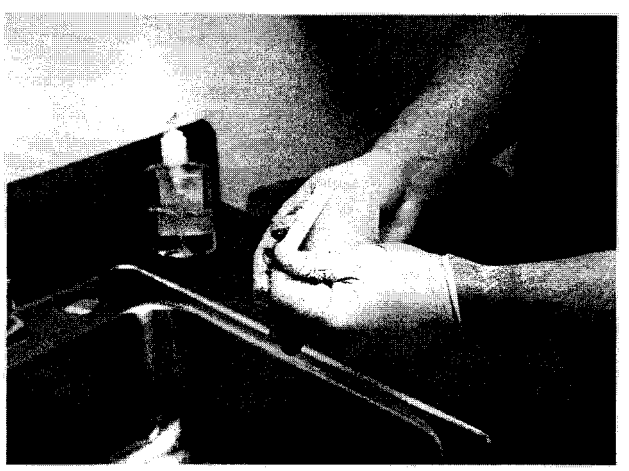
Bloodborne pathogens are viruses or bacteria that are carried in blood and can cause disease in people. There are many different bloodborne pathogens, but Hepatitis B (HBV) and the Human Immunodeficiency Virus (HIV) are the two diseases commonly addressed by health and safety standards.[5,6,7,8] "Universal Precautions" is a way to limit the spread of disease by preventing contact with blood and certain body fluids. To "observe Universal Precautions" means that whether or not you think the victim's blood or body fluid is infected, you act as if it is.

Blood

Personal Protective Equipment

Personal protective equipment provides a barrier between you and a victim's blood or body fluid. Disposable gloves are the most recognized barrier and should always be worn whenever blood or body fluids are or may become present.

Disposable Gloves



Remove gloves carefully.

When using gloves always quickly inspect them before putting them on. If a glove is damaged, don't use it! When taking contaminated gloves off, do it carefully. Don't snap them. This may cause blood to splatter. Never wash or reuse disposable gloves. If you find yourself in a first aid situation and you don't have any gloves handy, improvise. Use a towel, plastic bag, or some other barrier to help avoid direct contact. Make sure there is always a fresh supply of gloves in your first aid kit.

Eye Protection
Anytime there is a risk of splatter, goggles or safety glasses with side protection should also be used to help protect your eyes.

Prevention
To reduce the risk of infection, you should:

- Always wear personal protective equipment in first aid situations.
- Carefully remove gloves, clothing, and any other contaminated material. Place them in appropriately labeled bags or containers.

After providing first aid, wash your hands and other exposed skin thoroughly with an antibacterial soap and warm water. If soap and water are not available, use an alcohol-based hand rub.

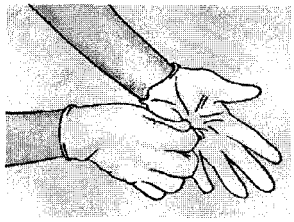
Decontaminate all surfaces, equipment, and other contaminated objects as soon as possible. Clean with a detergent and rinse with water. Use a bleach solution of one quarter cup (.06 liter) of household bleach per one gallon (3.79 liters) of water to sanitize the surface. Spray on the solution and leave it in place for at least 2 minutes before wiping.

DO NOT eat, drink, smoke, apply cosmetics, lip balm, or handle contact lenses until you have washed your hands after performing first aid.

Skill Guide #1

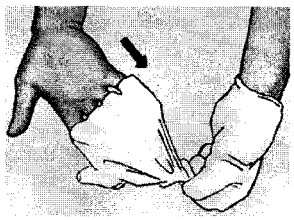
Proper Removal of Contaminated Gloves

1



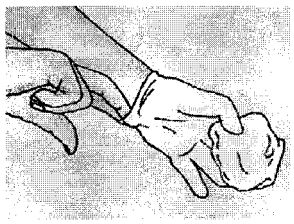
- Without touching the bare skin, grasp either palm with the fingers of the opposite hand.

2



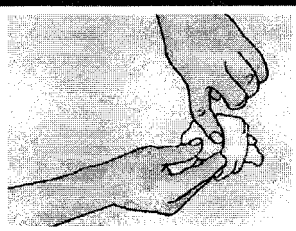
- Gently pull the glove away from the palm and toward the fingers, remove the glove inside out. Hold on to the glove removed with the fingers of the opposite hand.

3



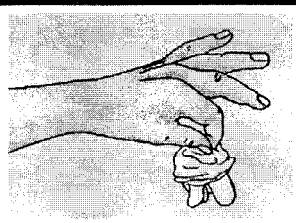
- Without touching the outside of the contaminated glove, carefully slide the ungloved index finger inside the wrist band of the gloved hand.

4



- Gently pulling outwards and down toward the fingers, removing the glove inside out.

5



- Throw away both gloves in an appropriate container.
- Wash your hands and other exposed skin thoroughly with an antibacterial soap and warm water. If soap and water are not available, use an alcohol-based hand rub.

Emergency Action Steps

Roles and Responsibilities of the First Aid Provider

Roles

The basic role of a first aid provider is to recognize a medical emergency and make a decision to help.

Your personal safety is your highest initial priority, followed by the safety of the victim and any bystanders.

Responsibilities

- Maintain composure.
- Maintain personal health and safety.
- Maintain caring attitude.
- Maintain up-to-date knowledge and skills.
- Without putting yourself in danger, make the victims' needs your main concern.
- Do no further harm.

Emergency Action Steps

The Emergency Action Steps are intended to help the first aid provider respond to an emergency and manage life-threatening problems of the airway, breathing, and circulation in a victim of any age.

Whenever you recognize and emergency, you should assess the scene for safety. Pause for a moment as you approach the victim. If the scene is not safe, or at any time becomes unsafe, GET OUT!

Assess the victim. What is your first impression? Is the victim responsive? If the victim is unresponsive, appears badly hurt, seriously ill, or quickly gets worse...

Alert EMS. Call 9-1-1 or activate your Emergency Action Plan.

Attend to the victim. Check the victim's airway, breathing, and circulation. Refer to the Universal First Aid Procedures.

Universal First Aid Procedures

Assess the Scene

- If it is not safe, or at any time becomes unsafe, GET OUT!
- Observe Universal Precautions. (Use Personal Protective Equipment!)
- If victim is awake and talking, identify yourself; ask if it is okay to help.
- If victim appears weak, seriously ill or injured, or is unresponsive...

Alert EMS

Call 9-1-1 or active your Emergency Action Plan.

Attend to the Victim

A = Airway — Open Airway.

- If unresponsive, tilt head — lift chin.

B = Breathing — Check Breathing.

- Look, listen, and feel for at least 5 seconds, but no more than 10.
  - **Unresponsive, not breathing** — Perform CPR.
  - **Unresponsive, breathing normally** — Place in recovery position. If injured, use HAINES position (page 9.)

C = Circulation

- Look for and control severe bleeding with direct pressure.
- Monitor tissue color and temperature.
- Help maintain normal body temperature.
- If it is available and you are properly trained, give emergency oxygen.

Provide First Aid Treatment

- **Suspected Spinal Injury** — Place your hands on both sides of victim's head to stabilize it.
- **Suspected Limb Injury** — Place your hands above and below the injury to stabilize it.
- Consider performing physical assessment (SAMPLE/DOTS — page 8.)

Skill Guide #2

Unresponsive Victim

Perform these steps quickly — in a minute or less!

Emergency Action steps

- Assess Scene. If the scene is not safe or at anytime becomes unsafe, GET OUT!
- Assess Victim. Victim is responsive? Identify yourself; ask if it's okay to help. If the victim appears weak, seriously ill, injured, or is unresponsive...
- Alert EMS. Call 911, activate Emergency Action Plan.
- Attend to the ABCs. Ensure an open airway, normal breathing, and control bleeding.

A

Airway. Open Airway

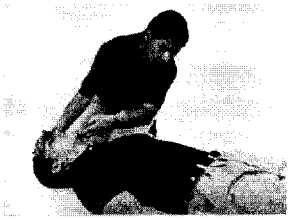
- Tilt the head - lift the chin.

B

Breathing. Check Breathing.

- Look, listen, and feel for 5, but no more than 10 sec.
- If the victim is not breathing normally or you are unsure, perform CPR.
- If the victim is breathing normally, assess circulation.

C



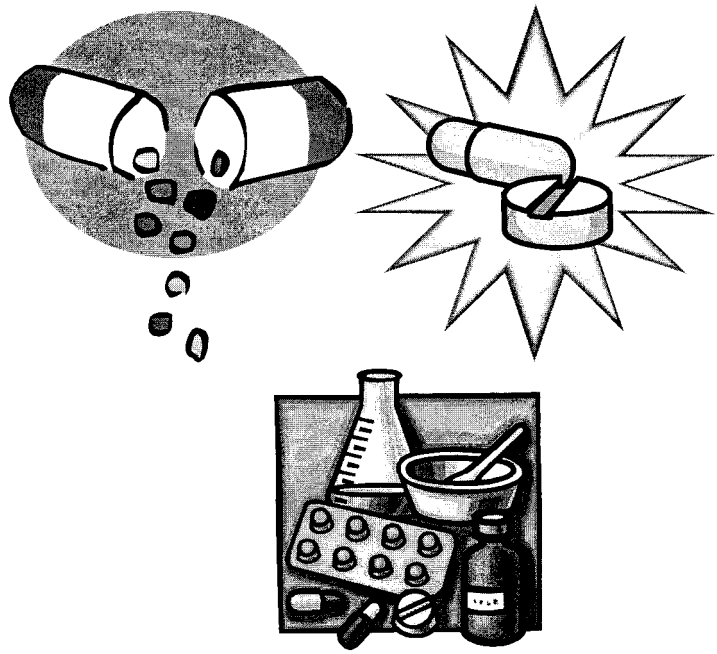
Circulation.

- Look for blood pumping or pouring out of a wound.
- Control blood flow with direct pressure.
- Look for normal tissue color.
- Use your exposed wrist to feel for body temperature.

Continue to Attend to the ABCs

- Keep the airway open.
- Ensure normal breathing.
- Control bleeding.
- Monitor tissue color and temperature.
- Help maintain normal body temperature.
- If it's available and you are properly trained, give emergency oxygen.

Medication Administration Video Handbook



Revised January 2010

Health Facilities and Emergency Medical Services Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver CO 80246-1530
(303) 692-2800 phone
www.HealthFacilities.info

PURPOSE AND OBJECTIVES

PURPOSE:

The purpose of the medication administration video and discussion manual is to review with staff how to safely administer medications authorized by law. It is not intended to replace a state approved Medication Administration Course. The video may be used as a refresher course for staff that are qualified medication administration persons. The manual highlights the areas covered in the video and provides hand-outs that can be used for additional training or for reviewing your facility policies and procedures related to medication administration practices.

OBJECTIVES:

- To administer medications according to written physician orders.
- To maintain proper documentation of the administration of both prescription and non-prescription drugs.
- To use the proper techniques when administering medications by the various routes.
- To safely and accurately fill and administer medications to and from medication reminder boxes with oversight from a licensed person or qualified manager.

LEGAL IMPLICATIONS

Successful completion of a state approved medication administration course does not lead to certification or a license. Upon completion of the medication administration training course, the individual is considered qualified to administer medications and is referred to as a Qualified Medication Administration Person, or QMAP.

Successful completion of a state approved medication course does not allow an individual to make any type of judgment, assessment or evaluation of a client.

Successful completion of a state approved medication course does **not** allow an individual to administer medication by injection or tube. QMAP's are **not** allowed to draw insulin or other medication into syringes.

> (*Note: there is a special exception in the law that authorizes individuals trained and employed in residential or day program services for person with developmental disabilities to administer medications through gastrostomy tubes or naso-gastric tubes. Such residential and day program services must be provided through service agencies approved by the Colorado Department of Human Services.*)

Giving medications to a client from a medication reminder box is considered administering medications, and therefore, can only be done upon successful completion of a state approved medication administration course.

If it is determined upon an inspection or complaint investigation that the QMAP is not administering medications according to the training regimen established in a state approved training course, retraining as a remedial measure may be required.

PERTINENT DEFINITIONS

MONITORING:
The law defines monitoring as "reminding the client to take medication at the time ordered by the physician or other authorized practitioner (dentist, physician assistant, nurse practitioner, podiatrist); handing a resident a container or package of medication lawfully labeled for the person by a licensed physician or other authorized licensed practitioner; visual observation of the client to ensure compliance; making a written record of the client's compliance with regard to each medication including the time taken, notification to the physician or other authorized practitioner if the client refuses to or is not able to comply with the physician's instructions."

ADMINISTRATION:
The law defines administration as "assisting a person in the ingestion, application, or using universal precautions, rectal or vaginal insertion of medication, includes prescription and non-prescription drugs, according to the written or printed directions of a licensed physician or other authorized practitioner, and making a written record thereof with regard to each medication administered, including the time and amount taken."

SELF-ADMINISTRATION:
The law defines self-administration as "the ability of a person to take medication independently without any assistance from another person. Such a person is personally responsible for medication administration."

MEDICATION REMINDER BOXES OR SYSTEMS:
A medication reminder box or system ("med minder") or customized patient medication package is a device that is compartmentalized and designed to house medications according to some time element (day or week or portions thereof).

QUALIFIED MANAGER:
A qualified manager is defined as a person who is the owner or operator of the facility or a supervisor designated by the owner or operator of the facility; and has completed training in the administration of medications (is a QMAP) or is a licensed nurse, licensed physician, or licensed pharmacist. This definition pertains to the facility/agency use of unlicensed staff filling medication reminder boxes. Qualified managers must complete a state approved medication administration competency test every four years.

AUTHORIZED SETTINGS

The law specifically identifies the settings under which a qualified medication administration staff person can administer medications. These settings are limited to the following.

1. The correctional facilities under the supervision of the executive director of the department of corrections including, but not limited to: those facilities provided for in article 20 of title 17, C.R.S.; minimum security facilities provided for in article 25 of title 17, C.R.S.; minimum security facilities provided for in article 25 of title 17, C.R.S.; jails provided for in article 26 of title 17, C.R.S.; community correctional facilities and programs provided for in article 27 of title 17, C.R.S.; the regimented inmate discipline and treatment program provided for in article 27.7 of title 17, C.R.S.; and the Denver regional diagnostic center provided for in article 40 of title 17, C.R.S.

2. Institutions for juveniles provided for in article 2 of title 19, C.R.S.

3. Assisted living residences.

4. Adult foster care facilities.

5. Alternative care facilities.

6. Residential childcare facilities for children.

7. Secure residential treatment centers.

8. Facilities that provide treatment for mentally ill persons, except for those facilities that are publicly or privately licensed hospitals.

9. Services funded through and regulated by the department of human services in support of persons with developmental disabilities.

10. State certified adult day programs.

SIX COMPONENTS OF A PHYSICIAN ORDER

There must be a written physician's order for prescription and non-prescription medications. To have a complete order, the following six items must be included:

1. The client's full name
2. The date of the order
3. Name of the medication
4. Dosage and administration information
5. Route of administration
6. Physician's signature

COMMON ABBREVIATIONS

ac	before meals
pc	after meals
bid	twice a day
tid	three times a day
qid	four times a day
HS	hour of sleep
po	by mouth
q	every
qd	every day
qh	every hour
q6h	every 6 hours
qod	every other day
DC	discontinue
ml	milliliter
Gm	gram
kg	kilogram
OU	both eyes
OS	left eye
OD	right eye
prn	as needed
tsp	teaspoon
Tbsp	tablespoon
oz	ounce
tab	tablet
cap	capsule
SL	sublingual
EC	enteric coated
meq	milliequivalent
otic	ear
oint	ointment
supp	suppository
sol	solution
s̄	without
p̄	post
c̄	with
x	times

COMMON DRUG MEASUREMENTS

METRIC - decimal system of weights and measures using the gram, meter and liter.

LIQUID: cubic centimeter (cc) = milliliter (ml)

SOLID: 1 gram (gm) = 1000 milligrams (mg)

HOUSEHOLD - system based on common, though not standard, measuring devices.

tsp. = teaspoon
Tbsp. = tablespoon
oz. = ounce

1 tsp. = 5 cc
3 tsp. = 1 Tbsp. = 15 cc
2 Tbsp. = 30 cc = 1 oz.

RULES FOR DOCUMENTATION - MEDICATION ADMINISTRATION RECORD

1. Chart after giving the medication; not before.

2. Only chart what you give - never document medications given by another person and never allow another person to document for you.

3. Chart as soon as possible after giving the medication.

4. Write your initials in the designated box on the MAR to initial the medications given.

5. Use ink, never pencil.

6. Never use white-out or erase.

7. If the medication cannot be given or a client refuses a medication then initial the appropriate box, circle initials, provide an explanation on the back of the MAR and notify the appropriate person as outlined in your facility procedures.

8. If a charting mistake occurs, draw a single line through the mistaken entry and initial and date error.

9. Transcribe new medications or order changes at the bottom of the MAR and draw X's through the dated boxes up to the start date.

10. Draw one line through discontinued medications and highlight with a transparent marker; then draw a line through the remaining boxes for the month.

11. When creating a new MAR, it is important to copy only from the current physician orders, and not from the old or previous month's MAR.

12. When documenting the administration of PRN medication, record the time given, the number of tablets, the reason for the medication, and then follow-up with an update of the results.

PROCEDURE FOR FILLING MEDICATION REMINDER BOXES (MRBs)

NOTE: **A licensed person or a qualified manger who is a QMAP must oversee a QMAP filling medication reminder boxes.**

1. MRB's should be filled in a safe, quiet, secured area, free from interruptions from staff, clients, and telephone.

2. Check all MRB's prior to filling for cleanliness and good repair. Make sure the tabs or lids on each slot close securely.

3. Wash hands before filling MRB's and between clients. Do not handle pills with fingers. You may use gloves or rounded nose tweezers to transfer medications from bottle lid to MRB.

4. Cross-checking the MRB label with the physician orders and the medication administration record (MAR).

   - The label on each MRB must be verified with the physician orders and the MAR.

   - Any discrepancies must be resolved prior to proceeding with filling.

   - The label on the MRB must reflect the information contained on the MAR and the number(s) of each medication to be place in the MRB so staff knows the number of medications that should be observed in each slot when administering from the MRB.

5. Fill the MRB one client at a time. The MRB's should not be filled for more than 1 week at a time to minimize mistakes. (Regulations prohibit filling of MRB's for more than 2 weeks at a time).

6. Using an organized system, each medication on the MRB label is filled, one at a time, until all medications for a client have been completed. Count the number of medications in the MRB and compare to the MRB's label.

7. Document the filling of the MRB on the MAR, including date, time, initials and signature.

8. ALWAYS ask for assistance when unsure of an order, a medication, a label or the procedure used in filling MRB's. You are responsible to know your facilities policies and procedures for filling and for administration of medications from MRB's.

9. The qualified manager should check the filling of the MRB's weekly during at least the first 2 times the MRB's are filled by a new QMAP, or a QMAP who is a new employee.

10. Periodic crosschecking of the MRB label and the contents to the MAR should be done for accuracy.

NOTES:

SOURCES OF INFORMATION ABOUT DRUGS

There are a variety of reference books available that provide information about specific medications, including the therapeutic effect, uses, side effects and special administration instructions. Each facility or program should have such a reference guide for use by staff.

Some examples of such reference books include:

Physician Desk Reference (PDR)
Mosby's Nursing Drug Reference

Other sources of drug information include:

Your local or consulting pharmacist
Medication inserts
Various Internet sites

CHECKLIST FOR COMPLETING PROPER STEPS IN THE ADMINISTRATION OF MEDICATIONS

- ❑ Washes hands using proper technique.
- ❑ Does not handle pills with bare hands.
- ❑ Checks the medication 3 times during preparation.
- ❑ Ensures they have identified the right client.
- ❑ Explains the administration procedure(s) to the client.
- ❑ Adheres to the 5 Rights of Medication Administration.
- ❑ Observes the client take the medication(s).
- ❑ Documents the administration of each medication on the MAR.
- ❑ Documents the administration of PRN medications including, time given, number of tablets, and effectiveness.
- ❑ Returns medications to locked storage area.

WHEN USING MRBs:

- ❑ Checks for cleanliness and good repair.
- ❑ Checks the medications in the MRB to ensure there are the correct number of tablets and the correct medications in the slot as consistent with the label on the MRB, the MAR and the physician orders.

FIVE RIGHTS OF MEDICATION

Knowledge and adherence to the FIVE RIGHTS of medication is the foundation to ensuring that medications are given safely. Breaking one or more of the five rights can easily result in a medication error.

The five rights of medication include:

The Right Client

The Right Time

The Right Medication

The Right Dose

The Right Route

Prior to the administration of any medication, the QMAP must take the time to ensure that they are giving the medication to the correct client at the correct time, that it is the correct medication in the correct dose and with the proper route, as prescribed in the physician order.

GENERAL PROCEDURES OF ADMINISTERING MEDICATIONS BY THE VARIOUS ROUTES

Preparation:

1. Compare the physician order with the MAR consistency. Resolve any discrepancy in accordance with facility/agency policies before proceeding with the administration of the medication(s).

2. Obtain the necessary supplies needed for the type of medication(s) to be administered such as medication cups, proper measuring devices, cotton balls, disposable gloves, tissues, crushing or splitting device, round nose tweezers.

Procedure:

1. Wash hands.

2. Obtain the ordered medication from the medication storage area.

3. Read the label 3 times as medications are prepared for administration as follows:

   When removing the container from the storage area (also check expiration date)
   When pouring the medication from the container
   When returning the medication to the storage area

4. Take the medication and supplies needed to administer the medication to the client.

5. Identify the client by verifying their name.

6. Explain the procedure to the client.

7. Administer the medication.

8. Document the administration of the medication by initializing the medication administration record in the designated box.

9. Dispose of supplies.

10. Wash hands.

MEDICATION ROUTES

There are various routes by which a QMAP is authorized to administer medications. The proper route for administration should be specified in the physician order. The authorized routes of administration are as follows:

- Oral = swallowed by mouth
- Sublingual = dissolved under the tongue
- Topical = applied to the skin
- Eye = drops or ointments applied to the eye
- Ear = drops placed in the ear
- Rectal = inserted in the rectum
- Vaginal = inserted in the vagina
- Inhalant = taken in through mouth or nose by breathing in or inhaling
- Transdermal = absorbed through skin through application of a patch

PROPER TECHNIQUE - ADMINISTERING MEDS BY THE VARIOUS ROUTES

ORAL MEDICATIONS

Oral medications are those medications that are taken by mouth.

1. When pouring tablets/capsules use the lid of the container to pour the medication, then drop the medication into a medicine cup. Do not handle medications with your fingers. Use a round nosed tweezer if necessary to move or touch medications.

2. For clients who have difficulty in swallowing medications, the following techniques may be helpful to gain cooperation, as well as assist the client to take all medications:

   - Have the client in a sitting position for easier swallowing.
   - Offer tablets/capsules one at a time. If necessary, place medication in the client's mouth toward the back of the tongue.
   - Offer a drink of liquid after each medication. Use a straw if necessary.
   - Allow the client to rest a short time after each medication is taken.
   - Allow enough time for the client to swallow each medication.
   - Tablets or capsules may be easier to swallow if given in a teaspoon of jelly or applesauce, if permitted on the client's diet. Be sure to tell the client that there is medication in the jelly or applesauce. Do not trick the client with disguising the medications.
   - Some clients request their medication to be crushed. Do not crush enteric coated tablets or open capsules.
   - If the client has continued difficulty taking oral medications, report this to the person in charge of client care. The physician may need to be consulted. Many medications are available in another form.

3. Remain with the client to be certain all oral medications have been swallowed. This also ensures that the medication is taken on time. In some instances, checking the client's mouth may be necessary to verify the client has swallowed the medication.

4. Troches or lozenges are not to be swallowed. Instruct the clients to allow the medication to dissolve in the mouth. Drinking liquids should be avoided until the medication has completely dissolved. These medications should be given last, after other oral medications.

SUBLINGUAL TABLETS

These are medications that are placed under the tongue.

1. Instruct client to place tablet under the tongue in the front part of the mouth. If several medications are being given, give the sublingual tablet last.

2. Advise the client not to swallow until the tablet is entirely dissolved.

3. For nitroglycerin tablets:

   - Instruct the client to sit down upon the first indication of chest pain.
   - Advise the client to relax for 15-20 minutes after taking the medication to prevent dizziness or fainting. Headaches are a side effect of the drug and should last no longer than 20 minutes. If headaches persist, notify the physician.
   - Follow written instructions from physician on additional administration of tablet.
   - If chest pain persists, follow the facility protocol that may include calling the physician or calling 911 for immediate assistance.
   - Stay with the client for reassurance and to calm anxiety.
   - Tightly close the medication container and store in a cool, dry place. The container may be kept in a pocket or purse for easy access to the client if the client can safely administer the medication.

ORAL LIQUIDS

These are medications that are poured, measured and swallowed.

1. Check to see that the cap of the bottle is on securely.

2. Read instructions to determine if contents are to be shaken as with a suspension. A rotating wrist movement will ensure a more thorough mixture.

3. Remove the cap and place it with the open side up.

4. Hold the bottle with the label toward the palm of the hand to avoid soiling the label.

5. Locate the marking on the medication cup for the amount to medication to be poured.

6. Pour the medication at eye level. Take care to not pour more than is needed.

7. Clean the lip of the bottle, if necessary, with a moist paper towel before recapping.

TOPICAL MEDICATIONS

These are medications that are applied to the skin.

Ointments, Lotions, Liniments, Aerosols, Gargles

1. Gloves should be worn whenever coming into contact with medication or a client's skin.

2. Directions for application of the mediation should be a part of the physician's order or included with the instructions accompanying the medication.

3. Ointments are applied directly to the skin or placed on a dressing that is then applied to the skin.

4. An applicator or tongue blade may be used to remove ointments from a jar or container.

5. Gloves should be worn to apply medicated creams/ointments to the client's skin.

6. Lotions are applied/swabbed on the skin for their antiseptic and/or astringent effects.

7. Liniments are rubbed into the skin quite vigorously to relieve soreness of the muscles and joints.

8. Aerosols are sprayed onto the skin. Not touching the skin has advantages when skin is irritated or burned.

9. Gargles are solutions that are bubbled in the throat by keeping the solution in the upper throat, tilting the head back and exhaling air to create bubbling. Check directions with gargles to know whether the medication should be diluted prior to administration.

Transdermal Patches: Medication is absorbed through the skin

1. A transdermal skin patch is impregnated with medication which, when applied to the skin, releases a continuous and controlled dosage over a specified time period.

2. Gloves should be worn to apply/remove transdermal patches.

3. Remove the old patch, if present.

4. Wash client's skin with soap and water (both new site and removal site).

5. Rotate application sites to avoid skin irritation.

6. Peel backing off the patch, press on skin and apply pressure to assure skin adherence.

7. Include the site of application with documentation.

Topical medications

APPLICATION OF EYE DROPS/OINTMENTS

1. Instruct the client about the procedure. Assist the client to sit or lie down with head tilted back.

2. Cleanse the eye(s) with a clean tissue, clean and wet washcloth or cotton ball. Always cleanse from the inside of the eye, near the nose, to the outside. Use a clean tissue or cotton ball for each wipe.

3. Remove cover of container, place lid with open side up.

4. Instruct client to look upward toward the top of their head.

   EYE OINTMENT: Retract lower lid. (Make a pocket.) Approach eye from out of field of vision. With due care to avoid contact with the eye, apply the ointment in a thin ribbon, into the lower lid pocket.

   EYE DROPS: Retract lower lid. (Make a pocket.) It may be necessary to separate the eyelids. Approach eye from out of field of vision. With due care to avoid contact with the eye, apply eye drop gently to the center of the lower lid. Do not allow the drop to fall more than one inch before it contacts the eye.

5. Following application, instruct client to look downward and then close eye(s) for a short time.

6. Wipe the excess ointment/drops with a clean tissue/cotton ball.

EAR DROPS

1. Position the client:

    - If lying in bed, have bed flat and turn head to opposite side.
    - If sitting up, tilt head sideways until ear is as horizontal as possible.

2. Clean external ear canal with a clean tissue or cotton ball.

3. Hold ear lobe in such a manner to allow visualization of the ear canal.

4. Instill ordered number of drops without touching dropper to the client=s external ear.

5. When instilling eardrops into both ears, place a cotton ball in the external portion of the first ear before turning the head to instill drops into the other ear.

6. Instruct client to lay quietly a short time to allow the medication to reach the eardrum.

NOSE DROPS/SPRAYS

1. For nose drops, instruct the client to lie down with their head extended over a pillow. The client may sit up for nasal sprays.

2. Avoid touching the dropper or spray nozzle to the client's nose.

    NOSE DROPS: Place the nose dropper just inside the nostril, and instill the correct number of drops. Instruct the client to remain with head back for a short time.

    NASAL SPRAYS: Instruct the client to sniff on the count of three as you squeeze the nasal spray. This will help to coordinate the client's sniffing with the application of the medication.

        Optional: Close one nostril while spray is applied to the other nostril.

INHALANTS

These medications are inhaled by the client using a dispenser commonly referred to as an inhaler.

1. The client should be in a sitting position.

2. Read instructions on the inhaler to determine if the medication is to be shaken.

3. Grasp the medication dispenser and remove the mouthpiece.

4. Hold the dispenser's mouthpiece approximately 1 inch from the client's mouth. If spacer is used, the spacer of the dispenser may be placed into the mouth between the teeth.

5. Instruct the client to exhale, and, on the count of three, to breathe in deeply as you dispense the medication, then hold their breath for 10 seconds, if possible, before exhaling.

6. Wipe off the mouthpiece or spacer before replacing the mouthpiece cover.

INSERTION OF VAGINAL AND/OR RECTAL MEDICATIONS

Rectal Suppositories

1. Provide privacy for the client.

2. Gloves are worn for the administration of suppositories.

3. Assist the client to lie down, preferably on their left side. (The colon is on the left side of the body and the suppository will enter the lower GI tract easier)

4. Remove protective covering of suppositories and place in a medicine cup.

5. Obtain lubricant for suppositories to apply before insertion.

6. Visualize the anal opening, lubricate and insert the suppository approximately 3 inches. The suppository should be inserted beyond the internal sphincter muscle of the rectum to prevent the suppository from being expelled.

7. Instruct the client to retain the suppository for as long as possible.

Vaginal Creams/Suppositories

1. Provide privacy for the client.

2. Put on disposable gloves.

3. Instruct the client to lie on her back in a frog leg position.

   Vaginal suppositories: Insert 2-3 inches into the vaginal orifice. Body temperature will melt the suppository to aid in the absorption of the medication.

   Vaginal cream: To insert, grasp the barrel of the applicator. Place the thumb on the plunger. Pointing the applicator slightly downward, insert the applicator into the vagina as far as it will comfortably go. Push the plunger with the thumb as the applicator is slowly removed from the vagina.

4. Instruct the client to remain lying down for 15-30 minutes for absorption of the medication. Vaginal creams/suppositories are best administered at bedtime.

APPENDIX

- Effective Hand Washing Tips
- Medication Administration Record (MAR) examples
- Chapter XXIV - Medication Administration Regulations. Also available on the Internet at http://www.cdphe.state.co.us/regulations/healthfacilities/index.html

Effective Hand Washing Tips to Prevent the Spread of Disease

Effective hand washing is one of the most important means of preventing infections that are spread through direct contact between people or between people and infected substances they might come in contact with, and for preventing contamination.

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Hand Washing Technique

1. Remove jewelry
2. Prepare paper towel before washing by pushing dispense handle for amount needed
3. Use warm running water
4. Wet hands – apply soap or anti-microbial agent with hands lower than elbows
5. Wash all surfaces of both hands – between the fingers, tops of the fingers and fingernails, and backs of the hands for a minimum of 10 seconds
6. Rinse under warm running water, letting water drip from fingers
7. Dry hands with paper towels
8. Use dry paper towel to turn off faucet
9. Apply hand lotion if necessary, but do not apply right after washing or before giving direct care. Hand lotion can interfere with the cleansing action or an anti-microbial agent

When to Hand Wash

1. When you arrive at or leave work
2. Between contacts with different residents
3. Before putting gloves on and after removing gloves – gloves do not replace hand washing
4. Before contact with people who may be susceptible to infections such as older people and babies
5. After coughing, sneezing or blowing your nose
6. After using the bathroom
7. After smoking cigarettes
8. Before and after food preparation
9. Before and after eating

Studies have shown that the best way to get others to wash their hands is to be a role model. When your residents and staff observe you washing your hands, they are more inclined to do the same.

Disinfect Other Common Surfaces in Your Facility

Throughout the day, people in your facility may come into contact with the telephone, door knobs, sink handles and toilet handles, countertops and appliances. Be sure to disinfect these surfaces on a regular basis by wiping them with anti-bacterial cleaners or common household products such as chlorine bleach.

A note of caution: Store disinfectants in safe areas that provide only limited access. You do not want your residents to be injured by the inappropriate use of such products. Also, state regulations prohibit the storage of disinfectants, bleach, household cleaning supplies, etc. with food products or medications.

CHILDREN'S GRIEF PROCESS

When a child is separated from his/her parents as a result of military service, divorce, abandonment, foster care, adoption, hospitalization, or incarceration, the child's responses are similar to those of an adult faced with death of a loved one. In fact, for children separation feels like death . . . it is mysterious and feels permanent.

Theorists such as John Bowlby, Vera Fahlberg, and Katherine Kubler-Ross have offered a model of the grief process which is applicable to children. They believe that there are 5 stages of grief. The order and duration of the stages may differ from person to person.

STAGE ONE: Shock/Denial

This is often called the "honeymoon period." The child is compliant and does not appear distressed. Seems to have adjusted well to the new home. In reality, the child's mind is given the perception that nothing's changed, there is no loss - so no pain is felt on the surface. Underlying problems may result such as sleeping problems, nightmares, appetite changes and illnesses (particularly upset stomach and colds).

STAGE TWO: Anger/Protest

Once the shock and denial has worn off, the child gives up the unconscious belief that he/she will return home soon. The child may be angry at themselves, angry at the caseworker, biological parents or you! The child may become mouthy, defiant, destructive or whinny and irritable. Lying and stealing may become a problem. This stage may last several months and you begin to wonder how the child became transformed from a sweet kid to a living terror!

STAGE THREE: Bargaining

The child realizes that the lost loved one is not coming back and begins to "wheel and deal" for their return. Children may be "good as gold" hoping that they'll be rewarded for their behavior and be sent home. Conversely, they may intensify their acting out in hope that they'll be thrown out of their foster and adoptive home and returned to previous caretakers. Children will use a variety of manipulative behaviors such as threats and promises to get what they want - to go home!

STAGE FOUR: Depression/Despair

Despite his/her best bargaining techniques, the child finds that he/she is not being reunited. The child now believes that he/she will never return home and enters the mourning stage of grief. The child withdraws, is unmotivated, may cease playing, cries, and has difficulty talking about their feelings. Eating and sleeping patterns change and there may be a preoccupation with death and suicide.

STAGE FIVE: Acceptance/Detachment

Little by little, the child begins to resume normal developmental tasks and activities. His/her mood slowly changes from sadness to a variety of emotions appropriate to the situation. The child can now seek out relationships and begin to make emotional investments in new people. He/she is much more realistic about the lost person(s), can talk about them, but not dwell on them constantly.

For the child who has suffered a loss the long term effects may be: an over-reaction to loss of any kind, avoidance of close relationships (to avoid vulnerability to future losses), dependency and clinging, extreme separation anxiety, and/or difficulty with transitions (such as moving or school changes). Because the child has diverted energy and attention to cope with difficult feelings and emotions, he/she may be developmentally delayed.

GOOD KID, BAD KID . . . THE SAME KID
"AFTER THE HONEYMOON"

by Ruth Siburt
American Foster Care Resources, Inc.

"You should have heard all the warnings our relatives gave us when we decided to become foster parents, but now that they've seen Danny they're singing a different tune. He's such a good boy, so helpful and polite. Best of all he's wondeful with our little Tanya. I've never known a ten year old who showed so much patience with a toddler. It's only been three weeks and already he seems like one of the family . . ."

Ahh, honeymoons, aren't they wonderful? In foster care, as well as in marriage they can have an almost magical shine about them. The relationship is brand new and everyone is doing his level best to be the perfect person he thinks he really *should* be. Some honeymoons last for months, others may barely make it through a weekend. Each experience will probably be as individual as the children involved. The two major traits honeymoons seem to hold in common are that they are temporary, and they make nice memories that sometimes help us through the less enchanted days ahead.

"Danny doesn't even seem like the same boy, he's so sassy and I hate to say it but sometimes he's downright mean to little Tanya. Now he's wetting the bed. I don't know how much more of this I can stand. Maybe I shouldn't have, but last night I told him unless the "Good Danny" can come back we won't be able to keep him . . ."

The jump from the honeymoon to testing stage can be quite a jolt. We may tend to feel we were tricked into believing that we agreed to take one child and ended up with someone startlingly different.

The first step in getting ourselves and the child through the initial testing phase is to remember that, even though all the evidence may seem to be to the contrary, the "good" child of the honeymoon and the "bad" child of the testing are only extremes of the *same* child. Our own "Danny" may never return to the darling we first met but neither is he likely to remain forever the "dragon" we're seeing now. The real child is somewhere in between the extremes and, like most of us, he will need to attain a certain measure of security and confidence before he will feel safe to show himself.

The second step is to realize that the testing phase is normal and necessary in the developing of the child's relationship with us. Biological children test limits, too. It seems to be a natural and continuing process in the childhood years. The tricky part is hanging in there until the worst of the testing is over and the good times start outnumbering the hard times again.

With an eye towards hanging in there, then, here are ten tips to help:

1. **Take It One Day At A Time.** Do your best to let go of what the child did yesterday and try not to fret about what new behavior tomorrow might present. If a day seems like too much to think about at once (and sometimes it may), then try it by the hour, letting go of the last, staying in the now, refusing to worry about what comes next.

2. **Pour On The Positives.** In the testing period your child will probably be attracting all kinds of negative attention without half-trying. The positives may be hard to come by but even if it is only for a good job of brushing his teeth, sincere appreciation can help the child in his struggle to feel better about himself.

3. **Forgive and Forget.** Sometimes forgetting is the hardest part of this little duo. What has passed need not leave your memory altogether but neither do past misbehaviors need to be revived and reviewed each time there is a problem. Forgiving means more than excusing, it means "Yes you did it all right and really you knew better. But it's the behavior that is disappointing, not you. Next time maybe you can choose to act differently."

4. **Have A Few Consistent Rules.** Experts suggest no more than five clearly defined rules for a child to keep in mind. The child will be more certain of what is expected of him and of what is most important to you. It may also be easier on you not to have to feel as if you must monitor every inch of the child's life.

5. **Keep Your Anger Out Of It.** Testing is some of the most frustrating behavior we are likely to meet and once in awhile it's bound to get the better of our normally sweet natures. When we can manage it, though, letting the child be angry all by himself tends to simplify matters.

6. **Try Laughing.** When you have a choice between laughing and screaming, try laughing. The testing child is taking himself very seriously. Sometimes it can be a great relief to him to find out that not every misstep he takes will lead to dire, earthshattering consequences. (Naturally, we're talking about laughing *with* here and not at).

7. **Use Your Agency.** Many foster care agencies offer services specifically designed to help foster parents and their kids to succeed. From support groups that can help you feel less alone with the unique problems fostering presents, to relief homes that can provide some time off from the twenty-four hour a day pressure, a good agency can help you through the toughest times. Find out what yours offers and use it, that's what they're there for. If they don't have what would help you most, ask for it.

8. **Give Yourself A Break.** Testing can just plain old wear a person out. Don't forget while you're busy nurturing your child that you are well worth nurturing, too. Walk, fish, swim, read, paint, . . . whatever is good for you to do for yourself, do it.

9. **Expect The Testing To Take Awhile.** We've all heard inspiring stories of lights suddenly dawning with a few well chosen words and a child's obnoxious behavior disappearing forever. Be happy for those who can manage it, but realize that most children don't come equipped with sudden change buttons. Most of them learn from boringly consistent repetitions of ideas and modeled behaviors. And most children learn to care for and value themselves only after they have been consistently valued and cared for.

10. **Expect It To Get Better.** Hour by hour, minute by minute--that's how most of the miracles in foster care occur. Sometimes they slip up on us so quietly and gradually, we hardly notice them, until one day, there they stand shining with a sort of magic all their own.

Hang In There.

CHILD DEVELOPMENT

NORMAL VS. DELAYED DEVELOPMENT

The most important thing to remember about normal child development is all children develop at different rates. Sometimes they may be ahead in some areas and behind in others. There is plenty of room for variation. All child development books or handouts are guidelines that tell you what changes and behaviors are exhibited by most children at specific ages. You should only be concerned if your child falls considerably behind his age level.

Many children who enter the foster care system will be "developmentally delayed". This means that even though a child is a certain age chronologically his behaviors and/or intellectual level are characteristic of a younger child. For example, you may have a 10-year old foster child who looks and acts more like a 7-8 year old. Often, but not always, foster children with developmental delays begin to "catch up" rapidly once they are placed in foster care.

PATTERNS OF DEVELOPMENT FROM BIRTH THROUGH ADOLESCENCE

2 to 3 Months

2 Months:
Grasps at rattle
Smiles
Sees bright colored objects
Recognizes mother

3 Months:
Rolls and wiggles
Bats at dangling toys
Laughs

4 to 6 Months:

4 Months:
Rotates head
Holds head upright
Reaches for and touches objects

5 Months:
Grabs at feet
Uses arms to support upper body in prone position

6 Months:
Begins to hold cup
Rolls over
Grasps cube on sight
Feeds self crackers

7 to 9 Months

7 Months:
Sits up alone
Stands with assistance
Holds and examines objects

8 Months:
Rocking motion in crawl position
Begins crawling

9 Months:
Picks up items with thumb and forefinger
Initiates speech sounds

1 to 2 Years

15 Months:
Stoops and recovers
Walks
Puts ball in box
Builds tower of three blocks
Places three blocks in a row
Uses spoon

18 Months:
Climbs up stairs
Bumps down
Removes garments
Scribbles
Names pictures

2 to 3 Years

Runs
Climbs up and down stairs
Walks to ball and kicks it
Turns pages of book
Builds tower of six blocks
Strings beads
Places small boxes in larger boxes

3 Years

Opens door
Climbs stairs with alternating feet
Folds paper lengthwise
Builds tower of 9 to 10 blocks, bridges with 3 blocks
Colors

4 Years

Buttons clothes
Brushes teeth
Copies figures
Recognizes colors

6 MONTHS

Babies like to:
SHAKE, BANG, and THROW THINGS DOWN
GUM objects
RECOGNIZE familiar FACES

Give your baby:
Many HOUSEHOLD OBJECTS
Tin CUPS, SPOONS, and pot LIDS
Wire WHISKS
A CLUTCH BALL and SQUEAKY TOYS
A TEETHER and GUMMING TOYS

7 MONTHS

Babies like to:
SIT alone
USE their FINGERS and THUMB
NOTICE CAUSE and EFFECT
BITE on their FIRST TOOTH

Give your baby:
BATH TUB TOYS
More "THINGS"
STRING
More SQUEAKY TOYS

8 MONTHS

Babies like to:
PIVOT on their stomachs
THROW, WAVE and BANG toys together
LOOK for toys they have DROPPED
Make VOWEL SOUNDS

Give your baby:
SPACE to pivot and creep
2 TOYS at once to BANG together
Big SOFT BLOCKS
A JACK-IN-THE-BOX
NESTED plastic CUPS

9 MONTHS

Babies like to:
PULL THEMSELVES UP
CREEP
PLACE things generally
where they are wanted
SAY "DA-DA"
PLAY PAT-A-CAKE

Give your baby:
A SAFE CORNER of the room to EXPLORE
TOYS tied to his HIGH CHAIR
A metal MIRROR
A JACK-IN-THE-BOX

10 MONTHS

Babies like to:
POKE and PROD with their forefingers
PUT THINGS IN other things
IMITATE SOUNDS

Give your baby:
A big PEG BOARD
Some CLOTH BOOKS
MOTION TOYS

11 MONTHS TO 1 YEAR

Babies like to:
USE their FINGERS
LOWER THEMSELVES from standing
DRINK from a cup
MARK on a paper

Give your baby:
PYRAMID DISCS
A large CRAYON
A baking TIN with CLOTHES PINS
His own DRINKING CUP

1 YEAR TO 13 MONTHS

Babies like to:
CREEP
CRUISE
USE 1 or 2 WORDS
USE their FINGERS
Be HUGGED

Give your baby:
A BABYPROOF HOUSE
CUDDLING
A STACKING TOWER

13 MONTHS

Babies like to:
STAND UP, SIT DOWN
Try FEEDING themselves
RELEASE OBJECTS with more precision
IMITATE YOU
Play WHERE'S BABY

Give your baby:
His own DISH, CUP, SPOON
Your GAMES with him
FITTING TOYS

14 MONTHS

Babies like to:
- Put SOUNDS together
- Have an AUDIENCE
- SEARCH for hidden toys
- PILE 2 or 3 blocks

Give your baby:
- Your ATTENTION
- WOOD BLOCKS
- A CONTAINER TOY

15 MONTHS

Babies like to:
- WALK ALONE
- FLING objects
- FILL and EMPTY
- RESPOND to KEY WORDS
- Exercise HAND SKILLS

Give your baby:
- Big OUTDOOR TOYS
- Your CONVERSATION
- MANIPULATIVE TOYS

16 MONTHS

Babies like to:
- SQUAT DOWN
- Walk CARRYING things
- Use SAND
- ROUGH-HOUSE

Give your baby:
- PUSH and PULL TOYS
- Big SOFT TOYS
- Indoor or outdoor SANDBOX
- YOU on the FLOOR

17 MONTHS

Babies like to:
- LUG, TUG, DRAG things
- WAVE BYE-BYE
- Use WATER
- Get INTO EVERYTHING

Give your baby:
- WATER and POURING TOYS
- HAMMERING TOYS
- Your WATCHFULNESS
- Bigger PULL TOYS

18 MONTHS

Babies like to:
- OPPOSE YOU with "NO"
- GET what they want NOW
- Use WORDS with GESTURES
- CLIMB STAIRS

Give your baby:
- Your DIPLOMACY
- STAIRS
- A toy TELEPHONE
- Cloth PICTURE BOOKS

19 MONTHS

Babies like to:
- CLIMB UP onto everything
- MOVE to MUSIC
- IDENTIFY parts of themselves
- SORT OBJECTS and SHAPES

Give your baby:
- A SHAPE SORTING BOX
- A RECORD PLAYER out of reach

20 MONTHS

Babies like to:
- FETCH and CARRY
- DIG and MESS
- Have things THEIR WAY
- REMEMBER from yesterday
- TAKE things APART
- USE 15 to 20 WORDS

Give your baby:
- A carrying CASE
- Little CHORES
- Your PATIENCE
- THINGS to take apart

21 MONTHS

Babies like to:
- Claim "MINE"
- MARK on PAPER
- POINT to objects in BOOK
- TURN PAGES
- FIT things TOGETHER

Give your baby:
- A big CRAYON and PAPER
- PICTURE BOOKS
- A CONSTRUCTION SET

22 MONTHS

Babies like to:
FIT SHAPES
WATCH GROWNUPS
PUT things BACK
COME when CALLED
SCREW and UNSCREW

Give your baby:
SHELVES for his toys
HELP in putting things away
Simple PUZZLES
A plastic JAR with screw LID

23 MONTHS TO 2 YEARS

Babies like to:
Use 3 WORD SENTENCES
RUN
HELP with household tasks
Hear RHYMES
Work with their FINGERS

Give your baby:
A DOLL or TEDDY
A TOY to RIDE
A MOTHER GOOSE BOOK
FINGER manipulative toys

MILESTONES OF DEVELOPMENT

Age 1 - 2 Years

- Explores environment, gets into things
- Takes one long nap a day
- Plays alone for short periods of time
- Explores all his body

Age 2 - 3 Years

- Runs, climbs, pushes, pulls; is very active
- Legs appear knock-kneed
- Feeds himself with fingers, spoon, cup
- Can remove some clothing
- Explores private parts
- Sleeps less, wakes easily
- Is upset if mother leaves overnight
- Wants to do things himself
- Changes his mind
- Mood swings
- Imitates adults
- Plays, beside, but not with, other children
- Not yet able to share, wait, take turns, give in
- Likes water play
- Prolongs "good nights"
- Says "no"
- Understands more than he can say
- Runs, jumps, climbs
- Feeds himself
- Carries without spilling
- Can help dress/undress self
- May not take naps
- Wants approval
- Sensitive to signs of disapproval
- Wants to be included
- Likes to do simple tasks

Age 3 - 4 Years

- Is imaginative
- May fear dark and/or animals
- May have imaginary friend
- Is talkative
- Has some patience; can wait his turn
- Puts away toys
- Plays well alone, but groups are hard
- Is attached to parent of opposite sex
- Is jealous
- Releases insecurity by whining and/or crying
- Releases tension by thumbsucking, nail biting
- Is expressive
- Continues to gain weight and height
- Continues to gain coordination
- Good eating and sleeping habits
- Is bossy and boastful
- Very active
- Laughs and giggles
- Dawdles

Age 4 - 5 Years

- Uses "toilet words" (Ex.: poophead)
- Starts things but doesn't finish them
- Asks "how" and "why"
- Very active imagination
- Has short-lived fights
- Speaks clearly
- Tells stories and/or exaggerates
- Makes up meaningless words
- Dependent on peers
- Plays with others

CHILDREN'S NORMAL DEVELOPMENT, BEHAVIOR AND NEEDS, BY APPROXIMATE AGE

ABOUT SEVEN

Physical Development

- Annual expected growth in height: two or three inches. In weight: three to six pounds. Growth slow and steady.
- Losing teeth. Most seven year olds have their six molars.
- Better eye-hand coordination. Eyes not yet ready for much close work.
- Better use of small muscles.

Characteristic Behavior

- Sensitive to feelings and attitudes of both other children and adults. Especially dependent on approval of adults. Able to assume some responsibility.
- Interest of boys and girls diverging. Less play together.
- Full of energy but easily tired, restless and fidgety, often dreamy and absorbed.
- Little abstract thinking. Learns best in concrete terms and when he can be active while learning.
- Cautious and self-critical, anxious to do things well, likes to use hands.
- Enjoys songs, rhythms, fairy tales, myths, nature stories, comics, television, movies.
- Concerned about right and wrong, but sometimes prone to taking small things.
- Rudimentary understanding of time and monetary values.

Special Needs

- The right combination of independence and encouraging support. Acceptance at own level of development.
- Chances for active participation in learning situations with concrete objects.
- Adult help in adjusting to the rougher ways of the playground without becoming too crude or rough. Warm, encouraging, friendly relationships with adults.

ABOUT EIGHT

Physical Development

- Growth still slow and steady; arms lengthening, hands growing. Poor posture may develop.
- Eyes ready for both near and far vision. Nearsightedness may develop this year.
- Permanent teeth continuing to appear.
- Large muscles still developing. Small muscles better developed too. Manipulative skills are increasing. Attention span getting longer.

Characteristic Behavior

- Often careless, noisy, argumentative, but also alert, friendly, interested in people.
- More dependent on his mother again, less so on his teacher. Sensitive to criticism.
- New awareness of individual differences. Greater capacity for self-evaluation.
- Eager, more enthusiastic than cautious. Higher accident rate.
- Gangs beginning. Best friends of same sex. Allegiance to other children instead of an adult in case of conflict.
- Much spontaneous dramatization, ready for simple classroom dramatics.
- Understanding of time and use of money.
- Responsive to group activities, both spontaneous and adult-supervised.
- Fond of team games, comics, television, movies, adventure stories, collections.

Special Needs

- Praise and encouragement from adults. Reminders of his responsibilities.
- Wise guidance and channeling of his interests and enthusiasms, rather than domination or unreasonable standards.
- A best friend.
- Experience of belonging to peer group; opportunity to identify with others of same age and sex.
- Adult-supervised groups and planned after-school activities. Exercise of both large and small muscles.

ABOUT NINE OR TEN

Physical Development

- Slow, steady growth continues; girls forge further ahead. Some children reach the plateau preceding the pre-adolescent growth spurt.
- Lungs as well as digestive and circulatory systems almost mature. Heart especially subject to strain.
- Teeth may need straightening. First and second bicuspids appearing.
- Eye-hand coordination good. Ready for crafts and shop work. Eyes almost adult size. Ready for close work with less strain.

Characteristic Behavior

- Decisive, responsive, dependable, reasonable, strong sense of right and wrong.
- Individual differences are distinct, abilities now apparent.
- Capable of prolonged interest. Often makes plans and goes ahead on his own.
- Gangs strong and of one sex only, of short duration and changing membership.
- Perfectionistic; wants to do well, but loses interest if discouraged or pressured.
- Loyal to his country and proud of it.
- Spends a great deal of time in talk and discussion. Often outspoken and critical of adults, although still dependent on adult approval. Frequently argues over fairness in games.
- Wide discrepancies in reading ability.

Special Needs

- Active rough and tumble play. Friends and membership in a group.
- Training in skills, but without pressure. Books of many kinds, depending on individual reading level and interest.
- Reasonable explanations without talking down.
- Definite responsibility.
- Frank answers to questions about coming physiological changes.

THE ADOLESCENT

Physical Development

- Rapid weight gain at beginning of adolescence. Enormous appetite.
- Sexual maturity, with accompanying physical and emotional changes. Girls are usually about two years ahead of boys.
- Skeletal growth completed, adult height reached, muscular coordination improved.
- Heart growing rapidly at beginning of period. Sometimes a period of glandular imbalance.

Characteristic Behavior

- Going to extremes, emotional instability with "know-it-all" attitude.
- Return of habits of younger child; nail biting, tricks, impudence, day-dreaming.
- High interest in philosophical, ethical and religious problems. Search for ideals.
- Preoccupation with acceptance by the social group. Fear of ridicule and of being unpopular. Oversensitiveness and self-pity. High interests in physical attractiveness.
- Strong identification with an admired adult. Assertion of independence from family as a step toward adulthood.
- Responds well to group responsibility and group participation. Groups may form cliques.
- Girls usually more interested in boys than girls, resulting from earlier maturing of the girls.

Special Needs

- Acceptance by and conformity with others of own age.
- Adequate understanding of sexual relationships and attitudes.
- Kind, unobtrusive, adult guidance which does not threaten the adolescent's feelings of freedom. Assurance of security. Adolescents seek both dependence and independence.
- Opportunities to make decisions and to earn and save money.
- Provisions for constructive recreation. Some cause, idea or issue to work for.

THE EFFECTS OF CHILDREN'S DEVELOPMENTAL LEVEL ON THEIR EXPERIENCE DURING SEPARATION AND PLACEMENT

INFANCY (Birth to 18 months)

Cognitive Development

- The infant has **not developed object permanence.**
- Infants have **short attention span and memory.**
- They **do not understand change:** they only feel it.
- **Changes and unfamiliar sensory experiences frighten them.**
- They have little or no language ability and **cannot communicate,** except by crying.

Emotional Development

- Infants are emotionally **dependent upon others** to meet their basic needs.
- Infants generally form strong attachments to their primary caretaker and often **cannot be comforted by others when distressed.**
- After 5-6 months, the infant **displays anxiety in the presence of unknown persons.**
- Emotional stability depends upon continuity, and **stability in the environment** and the continued presence of their primary caretaker.

Social Development

- Infants have **few ways to communicate** their needs. If adults do not recognize their distress, their needs may remain unmet.
- **Social attachments are limited** to immediate caretakers and family members.
- Infants **do not easily engage into relationships** with unfamiliar persons.

Implications for Separation and Placement

- Infants' **cognitive limitations** greatly **increase their experience of stress.** Infants will be extremely **distressed** by changes in the environment and caretakers.
- Infants have **few internal coping skills.** Adults must "cope" for them.
- The infant experiences the absence of caretakers as **immediate, total** and **complete.** Infants **do not generally turn to others for help and support.**
- Separation during the first year can **interfere with the development of trust.**
- The child's **distress will be lessened** if his new environment can be made **very consistent** with his old one, and if the birth **parent can visit regularly.**

PRESCHOOL (Two to Five Years)

Cognitive Development

- Child has **limited vocabulary,** does not understand complex words or concepts.
- Child does not have a well developed **understanding of time.**
- Child has difficulty understanding **cause and effect** and how events relate.
- Child may display **magical thinking** and fantasy to explain events.
- Child displays **egocentric thinking;** The world <u>is</u> as he views it. He doesn't understand other's perspectives.
- The child **may not generalize** experiences from one situation to another.

Emotional Development

- The child is still **dependent on adults** to meet his emotional and physical needs. The loss of adult support leaves him feeling alone, vulnerable, and anxious.
- Development of **autonomy** and a need for self-assertion and control make it extremely difficult for a child this age to have things "**done to him**" by others.

PRESCHOOL (Continued)

Social Development

- The child is beginning to relate to peers in cooperative and **interactive play**.
- The child relates to adults in playful ways and is capable of forming **attachments with adults other than parents.**
- "Good" and "bad" acts are defined by their immediate, personal consequences. Children who are bad are punished; children who are good are rewarded.

Implications for Separation and Placement

- The child **needs dependable adults** to help him cope. Child can turn to substitute caregivers or a **known and trusted caseworker** for help and support during the placement process.
- The preschool child is likely to have an **inaccurate and distorted perception** of the placement experience.
  - Any placement of more than a few weeks is experienced as permanent. Without visitation, child may assume parents to be gone and not coming back.
  - The child will often view separation and placement as a **punishment** for **"bad" behavior** and will **cling to their own explanation** for the placement. Self-blame increases anxiety and lowers self-esteem.
- Because the child cannot **generalize experiences** from one situation to another, **all new situations are unknown** and therefore, more threatening.
  - The child will display considerable **anxiety about the new home.**
  - Most often, while verbal reassurances are helpful, the child needs to experience the environment to feel comfortable in it.
- Forced placement, without proper preparation, may generate **feelings of helplessness and loss of control**, which may interfere with the development of autonomous behavior.

SCHOOL AGE (Six to Nine Years)

Cognitive Development

- The child has developed **concrete operations** and better understands cause and effect.
- The child has **limited perspective taking ability.** She is beginning to understand that things happen to her **which are not her fault.**
- The world is experienced in **concrete** terms. The child is most comfortable if her environment is structured and she **understands the rules.**
- The child has a better perspective regarding **time**; can differentiate days and weeks, but cannot fully comprehend months or years.

Emotional Development

- **Self-esteem** is strongly affected by how well she **does** things in her daily activities, including academic performance and play activities.
- She is **anxious when she does not have structure**, and when she does not understand the "rules" or expectations of a new situation.
- The child's **primary identification is with her family** and her self-esteem is tied to people's perception of her family's worth.

Social Development

- The child **can form significant attachments** to adults and to peers.
- The child derives security from belonging to a **same-sex social group.**
- The child recognizes that **being a foster child is somehow "different"** from the other children.
- The child is **fiercely loyal and exclusive in her relationships.**
- Her value system has developed to include "right" and "wrong", and she **experiences guilt** when she has done something wrong.

Implications for Separation and Placement

- The child **can develop new attachments** and turn to adults to meet her needs, which **increases her ability to cope** in stressful situations.
- The child's perception of the **reason for the separation may be distorted**. In her cognitively concrete world, **someone must be blamed**, including caseworker, foster caregiver, agency or herself.
- The child will **compare foster caregivers to her parents**, and the caregivers will lose.
- **The loss of her peer group** and friends may be almost as traumatic as loss of her parents. Making new friends may be difficult. The child may be **embarrassed and self-conscious** about her "foster child" status, and she may feel isolated.
- The child will be very **confused if the "rules"** and expectations in the foster home **are different** from what she is used to.
- The child has a better understanding of time. **Placements of a few months can be tolerated, if the child understands she is eventually to go home**. Longer placements may be experienced as permanent.
- If the child was placed after some perceived misbehavior, she **may feel responsible and guilty**, and anxious about her parents accepting her back.

PREADOLESCENCE (Ten to Twelve Years)

Cognitive Development

- Some preadolescent children are beginning to **think and reason abstractly**, and to recognize complex causes of events.
- The child is able to **understand perspectives other than his own**. Some children have developed insight and may recognize that their **parents have problems** which contributed to the need for placement.
- The child's **time perspective** is more realistic.
- The child can **generalize experiences** from one setting to another.
- The child understands that rules often change depending upon the situation. The child can more easily **adapt his behavior** to meet the expectations of different situations.

Emotional Development

- **Self-esteem** and **identity** are still largely **tied to the family**. Negative comments regarding the family reflect upon him as well.
- The child has increased **ability to cope independently** for short periods of time. He still turns to significant adults for approval, support, and reassurance when things are difficult.
- He may be very **embarrassed and self-conscious by his foster child status**.

Social Development

- The child's **social world has expanded** to include many people outside the family.
- **Peers** are extremely important. Most peer relationships are of same-sex.
- **Opposite sex friendships** exist, but unless the child has been prematurely introduced to sexuality, these are of no special interest or concern.
- The child still **needs trusted adults** for leadership, support, nurturance, approval.
- They can begin to **understand that their parents have the capacity to do wrong**.

Implications for Separation and Placement

- The child has an increased ability to **understand the reasons for the separation.** With help, the child may be able to develop a **realistic perception of the situation** and avoid unnecessary self-blame.
- The child **can benefit from supportive adult intervention,** such as casework counseling, to help sort through his feelings about the situation.
- If given permission, the child may be able to **establish relationships with caregivers** without feeling disloyal to his parents.
- The child may be **embarrassed and self-conscious** regarding his family's problems and his foster care status, which may contribute to low self-esteem.
- The child may be **worried about his family** as a unit and may demonstrate considerable concern for siblings and parents.
- It may be difficult to replace "best friends" in the foster care setting. The child may be **lonely and isolated.**

EARLY ADOLESCENCE (13-14 Years)

Cognitive Development

- The child's emerging **ability to think abstractly** may make complicated explanations of reasons for placement more plausible.
- The child may have an increased **ability to identify her own feelings** and to communicate her concerns and distress verbally.

Emotional Development

- Preadolescence is a time of emotional **"ups and downs."** The child may experience daily (or hourly) mood swings and fluctuations.
- Physical and hormonal changes, including significant and rapid body changes, generate a beginning awareness of **sexuality.** The child experiences many new feelings, some of which are conflictual and contradictory.
- The child begins to feel a **desire to be "independent"** but is not ready for true independence. Independence is expressed rejecting parental values and rules, and adopting the values of her peers.
- The child experiences **anxiety when deprived of structure,** support and rules.

Social Development

- The child may be **embarrassed to admit her need for adult approval.**
- The child is **status conscious.** Much of the child's self-esteem is derived from peer group acceptance and from being in the "right" peer group.
- The child may feel a need to **keep up appearances** and may defend her family in public and to adults.
- The child is beginning to become aware of **social roles,** and she experiments with different roles and behaviors.
- Although many children will have developed a moral attitude with clearly defined `rights' and `wrongs,' **the values of the peer group often supercede their own.**

Implications for Separation and Placement

- Early adolescence is emotionally a chaotic period. **Any additional stress** has the potential of creating "stress overload" and **may precipitate crisis.**
- The child may **resist relationships with adults. Dependence upon adults threatens her "independence".** By rejecting adults, the child deprives herself of an important source of coping support.

Implications for Separation and Placement (Continued)

- The child may **deny** much of her discomfort and pain which prevents her from constructively coping with these feelings.
- Separation from parents, especially if the result of family conflict and unruly behavior on the part of the child, may generate **guilt** and **anxiety**.
- **Identity** is an emerging issue; dealing with her parents' shortcomings is difficult. Parents may be **idealized, shortcomings may be denied**; or, they may be **verbally criticized, and rejected.**

- Entry into **sexual relationships may be very frightening** without the support of a consistent, understanding adult.
- The child has the **capacity to participate in planning** and to make suggestions regarding her own life.
- **Persistent, repeated attempts to engage the child by a caseworker can have very positive results. The child may greatly benefit from the support and guidance of the worker.**

MIDDLE ADOLESCENCE (15-17 Years)

Cognitive Development

- The child has the cognitive ability to **understand complex reasons** for separation, placement, and family behavior.
- The ability to be **self-aware and insightful** may be of help in coping with the situation and his conflicting feelings about it.
- The child is more able to think hypothetically. He can use this ability to plan for the future and to **consider potential outcomes of different strategies.**

Emotional Development

- The child is developing greater **self-reliance**. He is more able to independently make, or contribute to making, many decisions about his life and activities.
- The development of positive **self-esteem** is as dependent upon acceptance by peers of the opposite sex as it is in being accepted by same-sex peers.
- **Identity** is being formulated. Many behaviors and ways of dealing with situations are tried, and adopted or discarded in an attempt to determine what feels right for him.

Social Development

- **Opposite-sex relationships** are as important as same-sex relationships. Individual relationships are becoming more important.
- The child is very **interested in adults as role models.**
- The child is beginning to **focus on future planning and emancipation.**
- Toward the end of middle adolescence, many children may begin to question previously held beliefs and ideas regarding `right' and `wrong,' and they may be less influenced by peer attitudes. An emergence of **independence ethical thinking** may be evident.

Implications for Separation and Placement

- The child will probably experience **ambivalence about his family.** With help and reassurance that ambivalence is normal, the child may be able to **accept his feelings** and be able to be angry at and love his family at the same time.
- The child's need for independence may **affect his response to placement in a family setting.** He may be unwilling to accept the substitute family as more than a place to stay. This may be perceived as the child's failure to "adjust" to the placement, **even though it is a healthy, and expectable, response.**
- The child **may not remain in a placement** if it does not meet his needs.
- The child may constructively use **casework counseling** to deal with the conflicts of separation and placement in a way that meets the child's needs without threatening his self-esteem and independence.

Infancy (0 - 12 Months)
Zero to Six Months

Primary Tasks:

During the first year the infant's development is so dramatic that parents often feel the baby "changes overnight." Physical development (which is an expression of underlying cognitive development) proceeds from head control to mobility. The primary psychosocial task for the baby is to build a sense of safety, security, and trust in other human beings — the parents and other caretakers. If this task is not accomplished, it will impact on related emotional development.

Physical Development

0-4 Weeks

- Proceeds from head to foot and central part to extremities
- Sucks reflexively
- Visually tracks to midline
- Lifts head when held upright

3-4 Months

- Prone — Lifts head momentarily
  — rolls from stomach to back
- Pulls to sit without head lag
- Grasps rattle

5-6 Months

- Reaches for objects
- Inspects objects with hands, eyes, and mouth

Cognitive/Language Development

0-4 Weeks

- Smiles selectively at mother's voice
- Startle reflex to sudden noise

3-6 Months

- Babbles and coos, squeals and gurgles (by 3 months)
- Anticipated food with vocalization
- Laughs

Psychosocial Development

0-8 Weeks

- Gazes at faces (birth)
- Smiles responsively
- Uses vocalization to interact socially

3-4 Months

- Distinguishes primary caretakers from others and will react if removed from home
- Smiles readily at most people
- Plays alone with contentment

Six to Twelve Months

Physical Development

Gross Motor

6-9 Months

- Creeps
- Sits without support
- Pulls to stand to cruise furniture

9-12 Months

- Crawls on all fours
- Attains sitting position unaided
- Stands momentarily
- First steps

Fine Motor

6-9 Months

- Transfers objects hand to hand
- Bangs with spoon
- Finger feeds part of meal
- Shakes bell

9-12 Months

- Holds, bites, and chews a cracker
- Grasps string with thumb and forefinger
- Beats two spoons together
- Begins to use index finger to point and poke

Cognitive/Language Development

6-9 Months

- Smiles and vocalizes to own mirror image (R,E)*
- Says "ma-ma," "da-da" (non-specific) (R,E)
- Shakes head "no-no" (R,E)
- Imitates playful sounds (R,E)
- Responds to name with head turn, eye contact, and smile

9-12 Months

- Recognizes voices of favorite people (R)
- Responds to verbal request such as wave bye-bye (R,E)
- Calls parent mama or dada (E)
- Repeats performances that are laughed at (R,E)
- Plays peek-a-boo (R,E)

Psychosocial Development

6-9 Months

- Discriminates strangers — i.e., frowns, stares, cries
- First stranger/separation anxiety begins
- Actively seeks adult attention; wants to be picked up and held
- Plays peek-a-boo
- Rarely lies down except to sleep
- Pats own mirror image
- Chews and bites on toys
- Beginning responsiveness to own name

9-12 Months

- Social with family, shy with strangers
- Beginning sense of humor
- Becoming aware of emotions of others

*R = Receptive
E = Expressive

Toddler Years (1 - 3)

Primary Tasks:

Separate emotionally from parents or primary caretakers. Self-confidence and self-esteem develops as toddlers make move towards greater autonomy — secure in their attachment to important adults. Key milestones include locomotion, toilet training, and verbal communication.

One Year (12 - 18 Months)

Physical Development

Gross Motor

12-18 Months

- Walks alone
- Stoops and stands up again
- Climbs up on furniture
- Walks up stairs with help

Fine Motor

12-18 Months

- Builds tower of 2 cubes
- Scribbles spontaneously or by imitation
- Hold cup
- Puts raisin or pellet in bottle
- Turns book pages, 2-3 at a time
- Holds spoon

Self-Help

12-15 Months

- Feeds self with fingers
- Removes hat, shoes, and socks
- Inhibits drooling

15-18 Months

- Chews most foods well
- Opens closed doors
- Holds cup and drinks with some spilling
- Imitates housework
- Will bring familiar object upon request

Cognitive/Language Development

12-15 Months

- Jabbers expressively (E)*
- Communicates by gesture (E)
- Vocalizes more than cries for attention (E)
- Understands word NO (R)
- Shakes head to indicate NO (E
- Says 2-3 "words" other than "ma-ma," or "da-da" (E)
- Looks in appropriate place when asked i.e., "Where is book?" (R)

15-18 Months

- Vocalizes NO (E)
- Vocabulary of 10-15 "words" (E)
- Fluent use of jargon (E)
- Points and vocalizes to indicate wants (E)

Psychosocial Development

12-15 Months

- Strong dependence on primary caretaker with increasing difficulty separating
- Difficulty quieting and relaxing into sleep
- Wants to have caretaker [illegible]by all the time
- Gives toy to adult on r
- Shows sense of me and mine

15-18 Months

- Follows simple requests
- Begins to distinguish you and me
- Imitates adult activities
- Interested in strangers, but wary
- Sharp discipline not helpful
- Verbal persuasion and scolding not useful
- Autonomy expressed as defiance
- Plays alone or beside other children — solitary or parallel play
- Strong claiming of mine

*R = Receptive
E = Expressive

One Year (18 - 24 Months)

Physical Development

Gross Motor

18-24 Months

- Runs stiffly
- Pushes and pulls large objects
- Carries large teddy bear while walking
- Comes down stairs on bottom or abdomen
- Seats self in small chair

Fine Motor

18-24 Months

- Builds tower of 4-6 cubes
- Tries to fold paper imitatively
- Can wiggle thumb
- Places rings on spindle toy
- Turns pages singly
- Turns knobs (television)

Self-Help

18-24 Months

- Helps dress and undress self
- May indicate wet or soiled diapers
- Pulls person to show
- Asks for food and drink by vocalizing and gesturing
- Uses spoon with little spilling
- Replaces some objects where they belong

Cognitive/Language Development

18-24 months

- Points to pictures in books (R)*
- Points to one body part on request
- Vocabulary of 20 words — mostly nouns (E)
- Understands yours vs. mine (R)
- Uses words me and mine (E)
- Starts to use "you" (E)
- Enjoys simple stories (R)
- Speaks in 2 word sentences — i.e., "juice gone"

Psychosocial Development

18-24 months

- Moves about house without constant supervision
- Parallel play predominates
- Temper tantrums are common in situations of frustration
- Conscious of family as a group
- Enjoys role playing
- Mimics real life situations during play
- Claims and defends ownership of own things
- Begins to call self by name
- Discriminates between edible and nonedible substances

*R = Receptive
E = Expressive

Two Years (24 - 30 Months)

Physical Development

Gross Motor

24-30 months

- Jumps in place
- Can walk on tiptoe (imitation)
- Walks up and down steps, both feet on each step
- Can walk backwards
- Runs headlong

Fine Motor

24-30 Months

- Holds pencil with thumb and forefingers
- Can zip and unzip
- Builds tower of 6-8 cubes

Self-Help

24-30 Months

- Learning to use buttons, zippers, and buckles
- Pulls on socks
- Pulls on pants or shorts
- Drinks from cup without spilling
- Helps put things away
- Toilet training in progress

Cognitive/Language Development

24-30 months

- Often calls self by first name
- Speaks 50 or more words; has vocabulary of 300 words
- Uses phrases and 3-4 word sentences
- Understands and asks for "another"
- Points to 4 body parts

Psychosocial Development

24-30 months

- Initiates own play activities
- Wants routines "just so"
- Does not like change in routine
- Cannot wait or delay gratification
- Does not share
- Identity in terms of sex and place in the family is well established
- Observes other children at play and joins in for a few minutes

Two Years (30 - 36 Months)

Physical Development

Gross Motor

30-36 Months

- Builds tower of 6-8 cubes
- Holds pencil with thumb and forefingers
- Can zip and unzip
- Completes 3 piece formboard
- Turns book pages singly

Fine Motor

30-36 Months

- Completes 3 piece formboard
- Turns book pages singly
- Builds tower of 6-8 cubes
- Holds pencil with thumb and forefingers
- Can zip and unzip

Self-Help

30-36 Months

- Toilet training in progress
- Can dress with supervision
- Eats with fork and spoon
- Pours from one container to another
- Gets drink unassisted
- Avoids simple hazards

Cognitive/Language Development

30-36 Months

- Verbalizes toilet needs
- Uses plural
- Increasing use of verbs
- Beginning use of adjectives and prepositions
- Vocabulary of 900 — 1000 words by 36 months
- Uses verbal commands
- Gives full name when asked
- Asks, "What's that?"

Psychosocial Development

30-36 Months

- Begins associative play activities
- Names or points to self in photos
- Joins in nursery rhymes and songs
- Likes praise
- Dawdles
- Auditory fears are prominent (noises)
- Shows sympathy, pity, modesty, and shame

Pre-School Years (3 - 5)

Primary Tasks:

Attains proficiency in simple self-care within the home and begins to form important relationships with peers and adults in nursery school or day-care setting. This is a period of continuing growth in individuation and independence. Identification and attachment to the family is strong. Children this age are egocentric, prone to magical thinking, and involved in Oedipal issues. Loss of or separation from parents during this phase of development may have a long-term impact on personal identity or the persistence of magical thinking.

Three Years

Physical Development

Gross Motor

- Gallops
- Balances on one foot (1-5 seconds)
- Catches large ball, arms flexed
- Hops on one foot (3 times)
- Turns somersaults
- At 3½ period of incoordination — stumbling, falling

Fine Motor

- Copies circle
- Imitates cross
- Builds with lego, bristleblocks, etc.
- Builds tower of 10 cubes
- Spontaneously draws
- Handedness may shift
- Imitates snipping with scissors

Cognitive/Language Development

Receptive Language

- Follows two unrelated commands
- Has concept of two or three
- Identifies same/different with pictures
- Responds to verbal limits and directions
- Identifies 2 or 3 colors
- Listens attentively to short story
- Choose objects that are hard/soft, heavy/light, big/little

Expressive Language

- Converses in sentences
- Speech is completely intelligible
- Answers simple yes/no questions
- Rote counts to 5
- Repeats nursery rhymes
- Counts 2-3 items
- Has 50-75% articulation of consonants
- Vocabulary of 1,500 words (by age 4)
- Tells age by holding up fingers

Psychosocial Development

- Outstanding characteristic is readiness to conform to spoken word
- Begins to take turns
- Plays simple group games
- Toilets self during the day
- Apt to be fearful — i.e., visual fears, heights, loss of parents, nightmares
- Uses language to resist
- Adults can bargain with child
- Tries to please
- May masturbate openly
- May have imaginary playmates
- Associative group play predominates
- Shares upon request

Pre-School Years (3 - 5)

Three Years - continued

Cognitive

- Uses words for ordering perceptions and experiences
- Show understanding of past versus present
- Great curiosity. Asks endless questions
- Matches colors (2 or 3)
- Completes 6-piece puzzle
- Can give sensible answer to "Why do we have stoves," etc.
- Tells a simple story

Four Years

Physical Development

Gross Motor

- Runs smoothly, varying speeds
- Hops on one foot (4-9 times)
- Balances on one foot (8-10 seconds)
- Bounces ball with beginning control
- Throws ball overhand
- Walks up and downstairs with alternating feet using rail

Fine Motor

- Copies cross and square
- Attempts to cut on straight line
- Hand dominance established
- "Writes" on page at random
- May try to print own name
- Draws person — arms and legs may come directly from head

Cognitive/Language Development

- Understands opposite analogies
- Follows 3-stage commands
- Listens eagerly to stories
- Follows directions with prepositions — on, under, in front of, behind

Expressive Language

- Uses all parts of speech correctly
- Vocabulary of 2,000 plus words
- Uses color names
- Defines words in terms of use (car, pencil)
- Asks many why, what, and how questions
- 100% production and use of consonants
- Corrects own errors in pronunciation of new words
- Loves new words
- Enjoys humor and self laughing
- Loves silly songs, names, etc.
- Increasing use of imagination
- Enjoys dress-up play
- Interest in time concepts — yesterday, hour, minute, etc.
- Identifies several capabilities
- Rote counts to 10
- Counts 4 items
- Categorizes animals, food, toys
- Matches geometric forms
- Identifies missing part

Psychosocial Development

- Dogmatic and dramatic
- Urge to conform/please is diminished
- Control issues prominent for many children
- May be physically aggressive
- Self-sufficient in own home
- Nightmares prominent
- May argue, boast, and make alibis
- Calls attention to own performance
- Tendency to boss and criticize others
- Rarely sleeps at nap time
- Separates from mother easily
- Often has "special" friend
- Prefers peers to adults
- Washes face, brushes teeth, and dresses self
- Uses bathroom unassisted

Five Years

Physical Development

Gross Motor

- Balances on one foot indefinitely
- Skips smoothly
- Uses roller skates
- Rides bicycle with training wheels
- Balances on tip toes

Fine Motor

- Handedness firmly established
- Colors within lines
- Can cut on line
- Copies circle, square, and triangle
- Not adept at pasting or gluing
- Draws within small areas
- Ties knot in string after demonstration

Cognitive/Language Development

Receptive Language

- Listens briefly to what others say
- Understands 6,000 words
- Categorizes words
- Guesses object by attribute and/or use clues, i.e., what bounces
- Points to first and last in a line up

Expressive Language

- Vocabulary of 2,500 plus words
- Repeats days of the week by rote
- Defines words and asks for word meanings
- Acts out stories
- Gives rhyming word after example

Cognitive

- Ready to enter kindergarten
- Appreciates past, present, and future
- Can count 6 objects when asked, "How many?"
- Begins to enjoy humorous stories and slap-stick humor
- States address, age, name, and ages of siblings
- Acts out stories
- Learns left from right
- Matches 10-12 colors
- Predicts what will happen next

Psychosocial Development

- Enjoys small group cooperative play — often noisy
- In 20-minute group activity, listens and participates
- Knows when certain events occur
- Accepts adult help and supervision
- Serious, business-like and self-assured
- Likes to complete tasks
- Wants to help and please adults
- Enjoys competitive exercise games
- Fears of parental loss, thunder, and scary animals
- More conscious of body, wants privacy
- Respects peers and their property
- Less hitting, more verbalizing
- Is capable of self-criticism and self-praise

Five Years - continued

School Milestones

- Prints first name and simple words
- Writing is mostly capitals — immature appearance
- Frequently copies left to right
- Reversals are common (b/d)
- Reads letters in sequence
- Recognizes first name
- Recognizes several or all numerals on clock, phone, calendar
- Counts and points to 13 objects
- Writes 1-10 poorly — many reversals
- Adds and subtracts using 5 fingers
- Is capable of self criticism

Elementary School Years (6 - 10)

Primary Tasks:
Successful mastery of the world outside their own family unit. Children this age are involved in academic learning, social interactions with same-sex peers, and developing motor skills. As they move into the latency years, there is a strong need for children to learn more about their early history and incorporate this knowledge in their growing sense of self-identity.

Six Years

Physical Development

Gross Motor

- Constant motion — very active
- Movement is smooth and coordinated
- Stands on one foot, eyes closed
- Balance and rhythm are good
- Bounces ball with good control
- Hops through hopscotch course

Fine Motor

- Ties own shoes
- Makes simple, recognizable drawings

Cognitive/Language Development

Receptive Language

- Uses picture dictionary
- Knows category labels
- Defines and explains words

Expressive Language

- Identifies likeness and differences between objects
- Identifies consonant sounds heard at beginning of words
- Gives category labels
- Likes to use big words
- Language becoming increasingly symbolic

Cognitive Development

- Names all colors
- Can tell what number comes after 8
- Understands quantity up to 10
- Can tell similarities and differences among pictures

Psychosocial Development

- Poor ability to modulate feelings
- Enjoys performing for others
- Difficulty making decisions
- Dawdles in daily routines — but will work beside adult to complete tasks
- Jealous of others; highly competitive
- Plays simple table games
- Often insists on having own way
- Easily excited and silly
- Persistent with chosen activities
- Goes to bed unassisted, but enjoys good night chat
- Frequently frustrated — may tantrum
- May return to thumb sucking, baby talk, etc.
- Praise of positive behaviors more effective than focus on negative behavior
- Often takes small things from others and claim them as found
- Begins to distinguish right and left on self
- Understands time interval differences including seasons

Elementary School Years (6 - 10)

Six Years (Continued)

School Milestones

- Begins to recognize words
- Matches words
- Identifies words by length or beginning sound/letter
- Rereads books many times
- Prints first and last name
- Invents spelling
- Reverses digits when writing teens (13/31)
- Rote counts to 30 or more
- Adds amounts to 6
- Subtracts amounts within 5
- Uses simple measurement
- Names coin, states, cents value of a penny, dime, and nickel
- Writing is slow and effortful with mixed capital and lower case letters

Seven Years

Physical Development

Gross Motor

- Activity level variable — calmer than 6 years
- Rides bicycle
- Runs smoothly on balls of feet

Fine Motor

- Small muscles are well developed
- Eye-hand coordination is well developed
- Draws triangle in good proportion
- Copies vertical and horizontal diamonds

Cognitive/Language Development

- Speaks fluently
- Uses slang and cliches
- Understands cause-effect relationships
- Recites days of week and month of year
- Can talk about own feelings in retrospect
- Often seems not to hear when absorbed in own activity
- Capable of concrete problem solving
- Can organize and classify information
- Learns best in concrete terms
- Interested in issues of luck and fairness
- Internal sense of time emerging

School Milestones

- Reading vocabulary increases
- Writing speed increases
- Reversal errors begin to be self-monitored (b/d)
- Learns to solve addition and subtraction combinations
- Learns to tell time

Psychosocial Development

- Independent in completion of routines
- Learning to screen out distractions and focus on one task at a time
- When angry becomes quiet and sullen
- Better control of voice and temper
- Sets high expectations for self; frequently disappointed by own performance
- Anxious to please others: sensitive to praise and blame
- Has not learned to lose games, will cheat or end game abruptly
- Little sense of humor — often thinks others are laughing at him
- Considerate of others
- Concerned about right and wrong

Eight Years

Physical Development

Gross Motor

- Movement is rhythmical and somewhat graceful
- Frequent accidents due to misjudging abilities e.g., broken arm
- Holds pencil, tooth brush, and tools less tensely
- Enjoys exercise of both large and small muscles

Cognitive/Language Development

- Ease in expression and communication
- Verbally is often out of bounds — i.e., boasting, exaggerating, sharing private information
- Likes to use big words

Reading

- Variable enjoyment of reading
- Likes humor in stories
- Reads new words through context and phonics
- Able to stop and talk about what he reads
- Omits words and reads out of order
- Prefers silent reading

Arithmetic

- Knows addition and subtraction combinations — some by heart
- Learning to carry in addition
- Learning to borrow in subtraction
- Knows a few multiplication facts
- Knows 1/2 and 1/4
- Interested in money

Written Language

- Can write sentences
- Begins cursive writing
- Few reversal errors
- Uses capital and lower case letter forms
- Tries to write neatly

Psychosocial Development

- May be selfish and demanding of attention
- May be cheerful
- Very curious about activity of others
- Learning to lose at games
- Sensitive to criticism, especially in front of others
- Strong interest in own past — e.g. stories, baby books, lifebooks
- Strong interest in own future — often plans to be famous
- Begins to have sense of humor e.g., original riddles and jokes
- May be snippy and impatient in talk with family members

Nine Years

Physical Development

Gross Motor

- Becomes interested in competitive sports — social aspects of the games are primary
- Apt to overdo physical activities
- Sitting posture often awkward — slouches, head close to work, etc.
- Works purposefully to improve physical skills
- May have somatic complaints — stomachache, dizziness, leg pains, etc.

Cognitive/Language Development

- Important year for gaining proficiency in reading, writing, and arithmetic
- Works hard and plays hard
- Frequently discusses reproduction with friends
- Associates scary daytime events with frightening dreams
- Enjoys school; wants to operate at optimal level, and may relate fears and failure more strongly to subject than to teacher
- Can describe preferred methods of learning
- Likes to read for facts and information — mysteries and biographies
- Enjoys keeping a diary and making lists
- Prefers to read silently
- Usually prefers written to mental computation
- Worries about doing well in school

Psychosocial Development

- Appears emotionally more stable
- Experiences quick, short-lived emotional extremes
- Mostly cooperative, responsible, and dependable
- Capable of concentrating for several hours
- Likes to plan ahead
- Peer pressure gains importance
- Begins to subordinate own interests to group purpose
- May take up collecting hobbies
- Learns to lose at games
- Beginning to be neater about own room
- Chooses member of own sex for special friend
- Overt criticism of opposite sex
- Makes decisions easily
- Relatively easy to discipline

Ten Years

Physical Development

- Girls and boys tend to be even in size and sexual maturity at tenth birthday
- Girls bodies undergo slight softening and rounding (10½)
- Somatic complaints decrease
- Increased fidgeting more common for girls than boys
- Little awareness of fatigue
- Bathing is strongly refused
- Loves outdoor exercise play — e.g., baseball, skating, jump rope, running

Cognitive Development

- Can participate in discussion of social and world problems
- Interest in reading varies greatly from child to child
- Humor is broad, labored, and usually not funny to adults
- Repeats "dirty" jokes to parent, but often does not understand
- Interested in own future parenthood and how they will treat own child
- Rarely interested in keeping a diary
- Wishes are mostly for material possessions, health and happiness for self and others, and personal improvement
- Enjoys memorizing
- Prefers oral to written work in school
- Interest span is short — needs frequent shift of activity in school
- Interest in movies and television diminishes

Psychosocial Development

- Seems relaxed and casual — describes self as "real happy"
- Boys show friendship with physical expression, i.e., punch, shove, wrestle
- Girls show friendship with note writing, gossip, and hand-holding
- Enjoys sharing secrets and discussing mysteries with friends
- Believes friends over parents
- Does not respond well when praised or reprimanded in front of friends
- Anger not frequent and is soon resolved
- Yells and calls names
- Little crying except with hurt feelings
- Relationship with mother tends to be sincere, trusting, and physically affectionate
- Relationship with father very positive, adoring, admiring

Adolescence

Primary Tasks:

The tasks of adolescence are similar for both boys and girls although boys tend to lag behind girls by one to two years, especially in physical maturation. Asymmetrical development e.g., cognitive development before physical growth, is common.
The primary tasks are:

- Exploring personal identity and roles
- Lessening dependence on family and renewed emphasis on separation and individuation
- Exploring relationships with peers
- Exploring sexuality
- Exploring ways to feel competent, important, and accomplished

Normal development often involves swings in mood and reliability, vacillation between dependence and independence, self-absorption, impulsivity, and control conflicts with adults.

Early Adolescence (Onset Age Varies from 11-13; Ends at Age 13-15)

Physical Development

Girls

- Pubic hair pigmented, curled
- Auxiliary hair begins after pubic hair
- Height growth spurt
- Breast development continues
- Labia enlarged
- Increase in subcutaneous fat
- Menarche (menstruation begins)

Boys

- Prepubescent physical development
- Beginning growth of testes, scrotum, and penis
- Downy pubic hair
- Consistent height growth

Cognitive Development

- Beginning to move from concrete toward abstract thinking (reasoning based on hypotheses or propositions rather than only on concrete objects or events)
- Increased interest in ideas, values, social issues; often narrow understanding and dogmatic
- Intense interest in music, clothes, hair, personal appearance — especially common for girls
- Although conflict with family increases, most express attitudes that place strong value on family and involved parents

Psychosocial Development

- Anxious about peer acceptance
- Concern with self-identity
- Still dependent on family but increased testing of limits
- Conflicts with peers and family are a means to establish independence
- Egocentric
- Abrupt mood and behavior swings
- Girls highly concerned with body image and physical changes
- Increased interest in peers and peer culture
- Changing friends is common
- Same sex relationships still most common, although concern, anxiety and experimentation with opposite sex — especially for girls
- Strong needs for achievement and recognition of accomplishment, although may be masked by feigned indifference.

Adolescence

Mid Adolescence (Onset Age Varies From 13-15; Ends at Age 16-17)

Physical Development

Girls

- Pubic hair fully developed
- Auxiliary hair in moderate quantity
- Continued breast growth
- Menstruation well established
- Decelerating height growth
- Ovulation (fertility)
- Moderate muscle growth and increase in motor skills

Boys

- Pubic hair pigmented, curled
- Auxiliary hair begins after pubic hair
- Penis, testes, and scrotum continue to grow
- Height growth spurt
- Seminal emissions but sterile
- Voice lowers as larynx enlarges
- Mustache hair

Cognitive Development

- When intelligence is normal, abstract thought is fully developed (usually by age 15) and can be applied in more situations
- Anxiety, major distractions interfere with abstract thinking
- Continued interest in ideas, ideals, values, social issues

Psychosocial Development

- Increased independence from family; less overt testing
- Girls are somewhat more comfortable with body image and changes
- Boys highly concerned with body image and changes as puberty begins
- Relationships with opposite sex increase; same sex relationship continues to dominate
- Reliance on and anxiety about peer relationships continues
- May experiment with drugs
- Concerned with achievement, experiences, feelings of accomplishment, receiving recognition
- Continued interest in appearance, music, and other elements of peer culture

Adolescence

Late Adolescence (Onset Age Varies from 15-16; Ends at Age 17-18)

Physical Development

Girls

- Full development of breasts and auxiliary hair
- Decelerated height growth (ceases at 16 ± 13 months)

Boys

- Facial and body hair
- Pubic and auxiliary hair denser
- Voice deepens
- Testes, penis, and scrotum continue to grow
- Emissions of motile spermatozoa (fertility)
- Graduated deceleration of height growth (ceases by 17 3/4 years ± 10 months)
- Muscle growth and increase in motor skills

Cognitive Development

- When intelligence is normal, abstract thinking is well established. Applications to own current and future situations and to broader issues (e.g., social concerns, academic studies)

Psychosocial Development

- As a major emancipation step becomes imminent, (e.g. graduation, moving out of the house, going to college, partial or total self-support), there may be marked increase in anxiety and avoidance behaviors
- Increasingly concerned and interested in movement towards independence. Generally not prepared emotionally or logistically for complete emancipation
- Can maintain more stable relationships with peers and adults
- Body image reasonably well established especially among girls
- More realistic and stable view of self and others, nature of problems, and better at problem solving
- Continued need for achievement and recognition for accomplishment

Adolescence

Post Adolescence (Onset Age Varies from 17-18; Ends at Age 20-21)

Physical Development

Girls

- Uterus develops fully by age 18-21
- Other physical maturation complete

Boys

- Full development of primary and secondary sex characteristics; muscle and hair development may continue

Cognitive Development

- Ability for abstract thinking and for practical problem-solving skills is increasingly tested by the demands associated with emancipation and/or higher education

Psychosocial Development

- Partial or full emancipation is accomplished, although commonly with difficulty
- Concerns about autonomy lessen and concerns about resources (money, car) increase
- Relationships with family tend to be somewhat less conflictual. Existing conflict tends to revolve around emancipation issues
- Attention still on peers and self-identity

DISCIPLINE

FOSTERING DISCIPLINE

by Patricia Ryan, Ph.D.

Many parents today have trouble in disciplining their children. They constantly ask themselves "Am I being too tough? Am I letting them get away with too much?" If this is true in general, it is even more true for foster parents. Having to care for children whom they have not raised makes it especially difficult to determine what are realistic expectations.

1. Discipline as Teaching

Many of us think of discipline as "punishment." This is only one meaning the dictionary gives us. Other meanings for discipline include "teaching," "self-control," and "control exerted externally" such as military discipline or religious discipline. If we accept this larger definition, we come to recognize discipline as "teaching children what they need to know if they are to become responsible adults, and setting limits for their safety and the comfort of others, until they are able to control their own behavior."

There are many ways to teach. These include:

- Modeling appropriate behavior
- Explaining why things work the way they do
- Providing negative consequences for inappropriate behavior
- Allowing children the opportunity to explore and learn from their mistakes

2. Why Foster Parents Can't Use Corporal Punishment

Many states, including Ohio, prohibit foster parents from spanking, hitting or using other forms of physical punishment. Foster parents express a great deal of concern over this prohibition. Some of the points they have raised and some answers follow:

"They Tell Me to Treat the Children Just Like My Own and I Spank My Own Children"

All children are different and therefore have different needs. We would not give a diabetic child sugar just because all the other children were enjoying it. Treating children fairly means meeting each of their needs to the same extent, not treating them just alike.

"Spanking Shows You Care and That You Love Them"

Many of the children in care have been physically battered by parents who purport to love them. They have learned that the only way you can get attention is to get someone to hurt you. This message is very confusing and leads children when they become adults to show their love by hurting their children and loved ones.

Further, many, if not most children in foster care, blame themselves for being in care and feel they are not very lovable. Since they don't feel they have any worth, it is difficult for them to believe that foster parents could love them.

"Some Children Ask for It"

Children who have been abused do attempt to recreate the situation with other adults. Expecting to be hurt sooner or later they will attempt to get adults to spank or beat them so that they can relax for awhile. This also gives them a measure of control and provides a form of attention. What we want to do with these children is teach them that there are other ways of getting attention and that adults will help them learn.

"Nothing Else Works"

Although many people say that nothing else works, if they find they have to spank very frequently, then spanking isn't working either. Even though most children come into care for neglect, we find that a significant portion have been physically or sexually abused. When children have been abused, they frequently have learned to screen out part of the pain.

Such children will not react to the mild forms of physical punishment most commonly used. Having been severely hurt in the past, these children often laugh at a spanking challenging the foster parent to hit harder.

Other children who have been abused will over-react to the slightest physical discomfort. These children do not need physical punishment and it may further traumatize them.

Since foster parents never know the entire past history of the children in their homes, they have to assume every child might have been abused. If spanking is dangerous for the emotional health and well being of such a child, they have to find something else that works.

GUIDELINES FOR DISCIPLINE
20 RULES FOR REARING CHILDREN

1. Don't disapprove of what a child is, disapprove of what he does.

2. Give attention and praise for good behavior, not bad behavior.

3. Encourage and allow discussion, but remember it's the parents who should make the final decision.

4. Punishment should be swift, reasonable, related to the offense and absolutely certain to occur.

5. Throw out all rules you are unwilling to enforce and be willing to change rules if you think it's reasonable to do so.

6. Don't lecture and don't warn--youngsters will remember what they think is important to remember.

7. Don't feel you have to justify rules, although you should try to explain them.

8. As your youngster grows older, many rules may be flexible and subject to discussion and compromise. However, on the few rules you really feel strongly about, enforce them no matter what rules other parents have.

9. Allow the child or youth to assume responsibility for his decisions as he shows the ability to do so. Remember the value of natural and logical consequences.

10. Don't expect children to show more self-control than you do as a parent.

11. Be honest with your youngster--hypocrisy shows.

12. The most important factor in your youngster's self-image is what he thinks you think of him, and his self-image is a major factor in how he acts and what he does.

13. Decide on a specific behavior you would like to change. Be specific. Don't just tell your child to be "neat." Tell him to pick up his blocks.

14. Tell your child exactly what you want him to do and show him how to do it--sometimes more than once.

15. Try to avoid power struggles with your child. No one wins.

16. Children need supervision.

17. Avoid being a historian. Don't keep bringing up bad behavior.

18. Not all tips work all the time.

19. Be aware that everyone has their own tolerance for misbehavior. Because of our own biases, needs, or rules, we may be willing to put up with or even find amusing some behaviors other parents find intolerable.

20. In order to adequately manage your child's behavior, you yourself need to become more disciplined. You need to change your behavior as a parent before your child's behavior will change (ex.: no empty threats; consistent, clear messages; offering praise; setting appropriate limits).

DISCIPLINARY TECHNIQUES

1. **Beat The Clock**

   Use a kitchen timer to set up a competition between a child and time. This usually works best for a child under age 8 years.

2. **Grandma's Rule**

   When you do "X", you can do "Y." Not "if" but "when." Always stated in a positive manner. When you put away your toys, you may go outside to play.

3. **Time Out**

   Is most effective when there are no toys and away from areas of activity. One (1) minute for each year up to age 5--should never be more than 5 minutes. It takes practice to become effective.

4. **Remove Privileges**

   Be fair and reasonable. Make the punishment fit the crime.

5. **Behavior Chart**

   Make a list of behaviors you would like your child to do. Lists are most effective when they are stated in a positive manner and you reward for a positive behavior rather than punish for a negative one.

Sometimes a star or sticker is enough of an incentive for a child to continue positive behavior. Other times you may decide that a specific number of stars may be worth something of value to your child. This would be a special treat, a new toy, or increased privileges. It is important not to set the goal too high or too low or a child may lose interest.

6. **Don't Set Your Child Up For Failure**

   This preventive technique is often overlooked. Don't leave money or valuables laying around. Put treasured objects away or out of reach so they can't be broken or lost.

7. **Extra Chores**

8. **Setting Consequences**

There are three types of consequences: **Natural, Logical, and Artifical Consequences**

NATURAL CONSEQUENCES ARE:
Those that occur without the parent's intervention.
EXAMPLE: *John refuses to take an umbrella when it rains;*
John and his belongings get wet!

LOGICAL CONSEQUENCES ARE:
Those that the parent sets and which are directly connected to the behavior.
EXAMPLE: *John spilled his glass of milk;*
John will clean up the mess.

ARTIFICIAL CONSEQUENCES ARE:
Those that the parent sets but which have no connection to the behavior.
EXAMPLE: *John won't do his homework;*
No allowance for one week!

PROBLEM-SOLVING AND PREVENTION

Problem #1: Resisting Bedtime

Prevention:

1. Share a special bedtime ritual. Example: read a story.
2. Make sure your child gets plenty of exercise so he will be tired.
3. Limit children's naps. Most toddlers give up naps at age 2.
4. Keep bedtime the same each night.

Solving the Problem:

1. Play beat-the-clock.
2. Use the same bedtime ritual regardless of time. If bedtime is delayed, go through the rituals anyway. It gives children a feeling of consistency.
3. Perform rituals in the same order every night.
4. Offer rewards for good behavior.
5. Let your child sleep in a "special place."

What NOT To Do:

1. Don't let your child control the bedtime. Pick a reasonable time and stick with it.
2. Don't keep reminding your child that he doesn't sleep well.
3. Don't expect children to need the same amount of sleep all the time.

Problem #2: Getting Out of Bed

Prevention:

1. Discuss bedtime rules at a non-bedtime time. Let your children know what to expect at bedtime.
2. Promise (and give) rewards for following the rules. Example: When you stay in bed all night, you can go to McDonald's for breakfast. Anything your child enjoys is okay.

Solving the Problem:

1. Follow through with promised rewards.
2. Stand firm with your rules.
3. If your child calls out to you and you aren't sure if you should check on him, go ahead. But if everything is okay, give a quick kiss and tell him it's time to sleep--not play.

What NOT To Do:

1. Don't give in to noise.
2. Don't scream up the stairs or down the hall for your child to be quiet. It teaches your child that you don't care enough to talk face-to-face.
3. Don't use threats or cause fears. (Example: If you get up, the boogey man will get you!) Unless you back up threats, they are only meaningless noise.
4. Don't change rules unless you explain why ahead of time. And if changes are temporary, explain when you go back to the rules.

Problem #3: Overusing "No"

Prevention:

1. Think before saying no. Avoid saying no when you really don't care.
2. Limit "yes/no" questions.
3. Try to use "no" less yourself. Example: If your child is throwing sand, instead of saying "no," try saying "We throw balls, not sand."

Solving the Problem:

1. Understand that many children say "no" to assert their independence. Let them say "no" occasionally.
2. For toddlers, ignore the "no." If you ask if they want juice, and they say "no," give it anyway. Between 1 and 3 years of age, children often say "no" even if they mean "yes."
3. Don't set yourself up for arguments.

What NOT To Do:

1. Don't get angry.
2. Don't offer a choice when the only answer you will accept is "yes."

Problem #4: Temper Tantrums

Prevention:

1. If you see trouble coming, don't let it build up. Say, "I bet this puzzle piece goes here."
2. Make sure your child has plenty of exercise.
3. Make sure your child gets plenty of sleep.
4. Make sure you don't take a child into the store when he's sick, tired, or fussy.
5. Offer interesting toys.
6. Have at least a small space where your child can play freely.

Solving the Problem:

1. Ignore the tantrum. If you're home, walk out of the room. Give your child no attention during the tantrum. If he is destructive to himself, others, or property, put him in a confined safe place. In public, go back to the car.
2. REMAIN CALM. Say to yourself, "I can best teach my child to control himself by controlling myself."
3. Stand firm. You have good reasons for your rules.
4. Explain any changes in rules. Example: Today mommy has money for a new toy. You didn't change your mind because your child had a tantrum.

What NOT To Do:

1. Don't try to reason with a child DURING a tantrum.
2. Don't throw a fit yourself. Say to yourself, "Why do I need to act crazy? I said "no" for a good reason."
3. Don't belittle your child.
4. Don't be a historian.
5. Don't make your child pay for the tantrum by having nothing to do with him later in the day. Don't make him feel unwanted just because his behavior was.

Problem #5: Name Calling/Talking Back

Prevention:

1. Talk to your child the way you want to be talked to.
2. You need to decide if what your child says is back talk or simply how he says words. "Do I have to?" or "I don't want to" aren't really examples of back talk.
3. Avoid calling your child nicknames that you wouldn't want him to call other people.
4. Teach your child that she doesn't have to put up with abusive language.
5. Keep tabs on what words your child hears--from you, friends, or television.

Solving the Problem:

1. Put your child in "time-out."
2. Wear out the name. (One (1) minute for each year)
3. Refuse to listen to back talk or being called names.

What NOT To Do:

1. Don't use back talk yourself.
2. It's hard not to yell when you're being yelled at, but shouting answers only teaches your child how to back talk. Say "I want to help you, but I don't feel like being helpful when you call me names."
3. Don't label your children. Example: "You dummy . . ."

Problem #6: Interrupting

Prevention:

1. Limit the length of conversations.
2. Make phone calls during nap time or when the children are in school.
3. Keep special toys that children play with only when you are on the phone or have company.

Solving the Problem:

1. Give attention to your child, if possible, when you're on the phone. You can rock or cuddle.
2. Use Grandma's Rule. When you play two minutes with toys, I'll be finished.
3. Give your child his own phone to talk on.
4. If people call when your child needs your attention, tell them to call back.
5. Have "mommy time" and "together time."

What NOT To Do:

1. Don't interrupt people yourself.
2. Don't give attention for and encourage interrupting.

Problem #7: Aggressive Behavior

Prevention:

1. Supervise play closely.
2. Don't teach aggressive behavior. If you hit or throw things when you're angry, your child thinks this is okay.
3. Children bite when they are in a situation they cannot handle. Limit overwhelming activities.

Problem Solving:

1. Biting:
   a. Pinch the child's nose shut to help them release the victim.
   b. Give your child something they can bite.
   c. Hold the child's jaw shut and firmly say "No biting."
2. Teach your child things he can do instead of hitting.
3. Forget the incident when it's over.
4. Remove the child immediately. Try time-out.

What NOT To Do:

1. Don't hit a child to stop him from hitting others.

Problem #8: Getting into Things

Prevention:

1. Childproof your house.
2. Decide what can and cannot be touched. "You can play here but not in mommy's room."
3. Put away breakables that cannot be replaced. Why tempt fate?
4. Explain ways for your child to go in off-limit areas. Example: "You can cross the street if you are with an adult."

Problem Solving:

1. Use distraction for children under age 2.
2. Teach your child to "touch" with his eyes, not his hands.
3. Be consistent.
4. Have things your child can touch and handle.

What NOT To Do:

1. Don't be upset if your child does touch off-limit items. Curiosity is normal.

Problem #9: Destroying Toys

Prevention:

1. Provide toys that are sturdy.
2. Provide age-appropriate toys. Many young children get frustrated by toys too advanced for them and they break the toys.
3. Give your kids things they can tear or cut or paint.
4. Share specific rules about caring for and playing with toys. Example: "Your coloring book is the only thing you can color with your crayons."
5. Supervise your child's play.

Problem Solving:

1. If they make a mess, teach a child over age two they need to help clean up.
2. Don't replace broken toys.
3. Take away toys when your child abuses them.

What NOT To Do:

1. Accidents happen. When a child breaks something, even on purpose, don't throw a tantrum yourself. It teaches your child you care more for things than for your child.
2. Don't punish too harshly. Loss of the toy may be punishment enough.

Problem #10: Child Won't Share

Prevention:

1. Let some toys belong only to your child. A toy he never has to share.
2. Let your child know he is not the only person in the universe who has to share.
3. Put labels on identical toys.
4. Understand that children do not really understand the reasons for sharing until they are 3 to 4 years old.
5. Set up sharing rules. Example: If you have it in your hands, it's yours until you put it down.
6. Your child may share better when he's not at home.
7. Sharing takes time to learn.

Problem Solving:

1. Supervise your child's play.
2. Set the timer.
3. Put a toy in "time-out."

What NOT To Do:

1. You cannot force a child to want to share.
2. Don't punish for occasionally not sharing. Just remove the toy.

Problem #11: Fighting Clean-up Time

Prevention:

1. Clean up as you go along.
2. Show your child how to clean up the mess and provide proper clean-up materials (soap, towels, etc.)
3. Be specific. Example: "Put the blocks in the bucket."
4. Let your child play "messy" games in "safe" areas--not on your new carpet.

Problem Solving:

1. Help your child clean up. Sometimes the mess is too big for your child alone.
2. Use Grandma's Rule.
3. Provide containers that make clean-up easy.

What NOT To Do:

1. Don't expect perfection.
2. Don't punish messiness.
3. Don't expect children to prepare ahead for messes. Young children don't know the value of new clothing. Provide old ones for messy games.

Problem #12: Sibling Rivalry

Prevention:

1. Don't compare.
2. Don't get involved in fights when possible.
3. Give individual attention to each child.
4. Intervene only when one child is hurting another.
5. Understand that fighting among brothers and sisters is normal.

Problem Solving:

1. Separate fighting children.
2. Use a bookcase or toy box to divide a bedroom shared by your kids. Everyone needs to have their own space.
3. Suggest a new activity. Boredom often leads to fighting.

What Not To Do:

1. Don't point out the fact that they hated each other five minutes ago when you seem them playing nicely.
2. Don't encourage competitiveness. Let each child develop their own talents.
3. Don't worry if your kids don't get along all the time.

Problem #13: Potty Training

Prevention:

1. Look for signals that your child has to go to the bathroom.
2. Put the potty in a handy place.
3. Don't start training too early (between 18 and 28 months).
4. Don't expect immediate control. There will be many accidents.

Solving the Problem:

1. React calmly to accidents.
2. Praise your child for staying dry as well as for correct toileting.
3. Take your child's potty with you. Many children won't "go" on a strange potty.

What NOT To Do:

1. NEVER punish for toileting accidents.
2. Don't make a big production out of accidents.
3. Don't ask a child if he has to go. Tell him when it's time to try.

Problem #14: Wanting Their Own Way

Prevention:

1. Provide a variety of things your child can do.
2. Say "yes" sometimes.
3. Understand that wanting things our way is normal.

Problem Solving:

1. Reward even the slightest sign of patience.
2. Avoid saying a flat-out "no." Tell your child how he can get what he wants. Example: "When you wash your hands, you can have some M & M's."

What NOT To Do:

1. Don't give in just because your child will make a scene if you don't.
2. Don't demand that your child does everything now. It makes them believe that they, too, can demand things instantly.
3. Make certain your child knows that misbehavior did not get him what he wanted. You are leaving now because you are ready, not because your child complained.

Problem #15: Dawdling

Prevention:

1. Allow yourself plenty of time.
2. Maintain a routine. Kids dawdle more when their routine is broken.
3. Don't dawdle yourself. Don't announce it's time to go when you aren't ready yet.

Problem Solving:

1. Make it easy for your child to hurry. Example: Run into mommy's arms.
2. Play beat-the-clock.
3. You may need to physically guide your child through the task (dressing or getting into the car).

What NOT To Do:

1. Don't lose control. If you're in a hurry, but your child isn't, don't slow yourself down more by yelling. It only makes him slower.
2. Don't punish for dawdling. Time has no meaning to a child under 6 years of age and hurrying has no advantages.

Problem #16: Not Following Directions

Prevention:

1. Learn how many directions your child can follow at once.
2. Let your child do as many things by herself as possible.
3. Limit number of rules. Be consistent with important rules like safety.

Problem Solving:

1. Give simple, clear directions.
2. Praise following directions.
3. Use a countdown. Example: "You have until I count to five."
4. Comment on any progress, not just when the job is done.
5. Use Grandma's Rule.
6. Walk your child through what you want him to do.

What NOT To Do:

1. Don't back down if your child resists. Tell yourself "I know my child doesn't want to do as I say, but I'm more experienced and I know what's best for him."
2. Don't expect too much of your child.

Problem #17: Clinging and Whining

Prevention:

1. Practice leaving your child for short periods at an early age.
2. Tell your child what you'll both be doing while you're gone.
3. Tell your child when you will be back.
4. Play peek-a-boo. It teaches a young child that you can go away but will still be back.
5. Reassure your child you will be coming back.
6. Provide toys your child only can play with when you are gone.
7. Make sure your child's basic needs are met--enough sleep, food, baths, and plenty of hugs so they will be less cranky.

Problem Solving:

1. Teach your child what whining is. Show your child how to ask for things without whining.
2. Ignore the whining. Use time-out when the whining is excessive.
3. Prepare yourself for a scene when you leave.
4. Understand that your child needs time with you and without you.
5. Try to start out with brief separations at first.

What Not To Do:

1. Don't give in to a whining child.
2. Don't whine yourself.
3. Don't let whining make you crazy. It won't last forever.
4. Don't become upset when your child clings. The world is a big, scary place. He is more comfortable with you.
5. Don't send mixed messages.
6. Don't belittle your child.

WHAT TO DO IF . . .
(BEHAVIORS OF THE NEW CHILD)

(Reprinted from F.A.I.R. Newsletter - Spaulding for Children)

YOUR CHILD STARTS LYING:

- Stop asking if he's done it when you know he has.
- Stop giving attention for lying.
- Don't ask "WHY?" questions.
- Realize he's afraid he may be sent away if he tells the truth about something he did wrong.
- Don't give a lecture on right and wrong.

YOUR CHILD IS QUIET AND SAD:

- Say, "You seem sad to me."
- Let him know it's okay to be sad.
- Ask him if he wants to talk about it.
- Ask if you can sit and be sad with him for awhile.
- Ask if he wants to help you make up a story about a child who was sad one day.
- Ask if he is thinking about someone from his past.
- Know that you don't have the responsibility for your child's being happy at all times. Grieving is a natural part of the healing process and is not to be avoided.

YOUR CHILD SAYS, "YOU ARE NOT MY REAL PARENTS!":

- Say, "No, but you are going to stay here and we are going to work out our problems."
- Don't let it show that it hurts.
- Don't ask if he wants to go back to his "real" mother.
- Realize that what he is saying is, "Are you going to keep me?"
- Don't deny that there is a biological parent by saying, "Yes, I am." You might say that you are not the parent he was born to, but that you will be his parent now.

YOUR CHILD WETS THE BED FREQUENTLY:

- Buy yellow sheets.
- Help him change the sheets and give him a big hug.
- Don't be angry or punish him.
- Don't talk about it to other people in his presence.
- Don't worry about it unless you have to sleep with him.
- Be sure it's not a medical problem.

YOUR CHILD TALKS ABOUT THE PAST:

- Talk about yours so he will know he isn't the only one that bad things have happened to.
- Be glad that he has enough faith in you to tell you.
- Help him to understand that he isn't to blame for what happened to him.
- Remember that a child can never give up the past until he is allowed to have it.
- Listen and encourage him to talk.

YOUR CHILD DOESN'T TALK ABOUT THE PAST:

- Talk about yours so he will know that it's okay to talk about his.
- Ask the caseworker to help him do a scrapbook.
- If he has a lifebook, show an interest in it.
- Leave items that he brought from previous homes sitting out.
- At appropriate times, make casual references to things that happened before he came.
- Listen and look for clues that he wants to talk about the past.
- Don't assume that because he isn't talking, he isn't thinking.

YOUR CHILD MISBEHAVES IN SCHOOL:

- Have regular conferences with the teacher and the child present.
- Don't try to explain that if he flunks second grade he won't get into Harvard.
- Expect his school adjustment to take at least a year.
- Don't put pressure on him to achieve in school.
- Don't compare him with other children.
- Have a sense of humor.
- Don't automatically side with the teacher.
- Remember that repeating a grade is not the worst thing that can happen.

YOUR CHILD TAKES TWO HOURS TO EAT:

- After letting him know that he must finish by the time everyone else does, clear away his plate when you're done; let him go hungry.
- Do not feed him before the next meal if he didn't eat, and don't feel guilty about it. It is his choice.
- Don't be constantly reminding the child during the meal to hurry up as this gives him attention.
- Let him sit at a different table for slow eaters and take as long as he wants.
- Remember that very few children, if any, starve to death if they have food on hand.

Some Additional Behavioral Signs in Children Who Have Been Ritualistically/Satanically Abused

- Bizarre nightmares
- Sadistic play (for example, mutilation of dolls or small animals)
- Self-mutilation
- Pre-occupation with death
- Increased agitation on certain dates which represent satanic high holy days
- A constant fear of harm and extreme fear of being alone

ARE ALL CHILDREN AFFECTED EQUALLY BY CHILD SEXUAL ABUSE?

There is a myth that all children who have been sexually abused are "damaged goods" and that the damage is for life. In fact, with guidance and support a child who has experienced sexual abuse can certainly recover and go on to live a happy, successful life with loving and trusting relationships. However, there are many factors which influence the extent of the child's trauma and subsequent healing process. Some of these are:

- **The age of the child when the abuse began.** Children abused very early in life may carry body or sensory memories of the abuse but will not have the words to express their rage. One adult survivor of sexual abuse figured out, with the help of therapy, that the reason she became sexually stimulated when she heard and felt a room fan was because a fan had always been on when she was molested as a child. Children who are abused pre-pubescently, during the time when their sexuality is emerging, may carry greater effects of the abuse.

- **The relationship of the primary perpetrator to the child.** A child's trust of his/her primary caretaker is central to their relationship. Therefore, when abuse occurs in this context, the betrayal is intensified.

- **How long the abuse occurred.** The longer the abuse occurred, the more likely the victim is to feel that he/she should have been able to stop it and thus he or she feels more "guilty."

- **Whether there was violence involved.** In most cases where the abuse included violence or potential violence (that is, the victim was made to understand that without cooperation there would be violence) the child will have experienced additional trauma and therefore damage to his/her development.

- **The social system available to the child at the time of abuse.** The child who had someone to tell about the abuse will suffer less than the child who had no one to tell. And even in some cases where the support system is available, the child may choose not to tell for fear of the consequences. For example, the child may think, "If I tell my father that my brother is abusing me and he believes me, then my father may do something drastic like hurt my brother or send me to jail."

  When children reveal their secrets, the response of adults will vary. It is important to stay as calm as possible so as not to further traumatize the child. The rage you may feel is natural, but the child may perceive that it is directed at him or her. The child needs a safe, supportive atmosphere in which to talk. Children also benefit enormously from hearing that this has happened to other children, male and female.

- **Ego development of the child at the time of the abuse.** If the child has a firmly established concept of his or her sexual identity, the abuse will have less impact. Children who are abused by a same sex perpetrator often have deeply felt fears about whether this means they are homosexual. One way in which parents can help allay this fear is to explain that our bodies have many nerve endings. If these nerve endings are stimulated, they will react. For example, if a bright light hits your eyes, your first response will be to blink or to shade them from the light. A simple concept to use with children is that of tickling. If a child is ticklish, he or she will laugh when tickled. It does not matter whether the person tickling is male or female; the child is reacting to the experience.

  If the perpetrator is of the opposite sex, questions of identity may also come into play. For example a boy who is abused by a woman and is not aroused, may doubt his masculinity. If he is aroused physically, but not emotionally, he may equally doubt his masculinity. The same identity issues for girls may hold true.

  If the child has a positive self-concept, that is, if he or she feels valued at the time the abuse occurred, there will be fewer repercussions. In fact, children with good self-esteem are more likely to feel they can say no and/or tell someone about the abuse.

DO BOYS WHO ARE ABUSED HAVE SPECIAL ISSUES?

Boys who are sexually abused face some additional problems because of persistent myths in our society. Males are rarely viewed as fitting the victim role. When boys get hurt, they are often told "act like a man," "don't be a sissy," "control your emotions." The message to boys is to stand on their own two feet and to take care of themselves. Under these circumstances, a male victim is less likely to tell and therefore cannot begin a healing process. This increases the chances that he may take on the role of the victimizer in an attempt to master his own experience.

A further complication for boys is that the media portray boys who have sexual experiences with older women as going through a "rite of passage" rather than as victims of sexual exploitation. Movies such as "Summer of 42" and "Get Out Your Handkerchiefs" are prime examples of this.

WHAT ABOUT JUVENILE SEX OFFENDERS?

Some children who have been sexually abused go on to abuse other children. While this is a serious problem, the exact percentage of sexual abuse victims who become abusers is not known.

It is important to realize that these children are victims as well as offenders and need to receive counseling from qualified therapists who understand both aspects of the problem. The therapist must be able to be empathic and understanding of the "victim" but confrontational with the "victimizer."

Victimizers have triggers that precede their behavior. For example, a child may abuse another child when he or she finds him or herself in a vulnerable or stressful situation. Sometimes this is because he or she lacks control or power. This may be when the child gets called a name at school or believes he or she is being punished unfairly. The therapist must help the child to not only recognize his/her own individual triggers but also, to understand the consequences of acting out these impulses.

In other instances, past experiences have left the child overly sexually stimulated. The child needs education and suggestions of alternative positive behaviors to replace the sexually victimizing behavior.

WHAT DO PARENTS NEED TO KNOW WHEN PARENTING A CHILD WHO HAS EXPERIENCED SEXUAL ABUSE?

Parents who foster or adopt children who have experienced sexual abuse need the wisdom of Solomon, the strength of Hercules and the patience of Mother Theresa. If you fall short in any of these areas, do not despair. You are in good company. Perhaps, more important is your desire to help a young person grow into a healthy, trusting adult. This is a privilege and one which brings real satisfaction to those who have provided foster care or adopted.

WHAT DO PARENTS NEED TO BE AWARE OF ABOUT THEMSELVES?

It is very important for you as prospective foster or adoptive parents to be honest with yourselves and with your foster and adoption worker about a number of things:

- Is there a history of sexual abuse in either the mother or father's past? If there is, how were those experiences resolved? Did you decide to "just forget about it" and chalk it up as one of those things that just happened? Or did you get help, from your parents, a teacher, a minister, a therapist or someone who could help you work through your feelings about having been abused? Parents with unresolved abuse experiences in their history may be at greater risk for either abusing the child again, or for keeping too much physical and emotional distance, for fear of abusing the child. Parent/Survivors in local support groups regularly address these phenomena.

- How comfortable are you as prospective parents, with your own sexuality and with your sexual relationship(s)? Can you talk comfortably about sex? Do you give yourselves permission to acknowledge your own sexual feelings, thoughts, fantasies and fears? Do you have a well-established relationship which allows for direct and open communication? A child who has been sexually abused may need to talk about what happened to him or her. The child's behavior may be seductive or blatantly sexual at times. A parent must be able to deal with this.

In addition, there are some other issues that are important for foster and adoptive parents to consider. They are:

- **A willingness to "be different," or experience embarrassing situations, at least for a while.** Children who have been sexually abused may behave toward their adoptive parents in ways which are different than non-abused children. For example, Lisa, age 8, began shouting loudly, in public places like the supermarket, that her father had abused her. In fact, it was her biological father and not her adoptive father who had abused her, but the strangers in the supermarket obviously did not make the distinction.

- **An ability to wait for the child's commitment while not putting off making your own.** An abused child is often untrusting and tied to the past. A child may repeatedly test your commitment to him or her. She or he may feel that if you really and truly saw her or him as they are, with all the scars, that you would not really want him or her.

- Many parents have the hope that their love will immediately ease the mistrust their child has of the world and all its adults. What one adoptive parent learned was "love has a different meaning for my daughter. To her, it's simply a deal: You do this for me and I'll do that for you . . . What a shock to discover that love is not enough." A true, trusting love based on more than just bargaining can come to pass with a sexually abused child, but it will take time, consistency and patience.

- **A sense of humor.** As with most situations in life, a good hearty laugh helps.

WHAT DO PARENTS NEED TO BE AWARE OF ABOUT THEIR CHILD WHO HAS BEEN SEXUALLY ABUSED?

Children who have experienced sexual abuse will probably need help in learning new behaviors and ways of relating. Some of the behaviors and emotions you may see expressed by your child are:

- **Withdrawal** - Overwhelmed by the feelings she or he has experienced, the child may retreat physically or emotionally. As a parent, you may feel confused or resentful. It can be very isolating to have someone close to you tune you out. Unless you think there is danger of physical harm to the child or others, the best course of action is to reassure the child that you care and that you will provide the limits and boundaries that your child needs.

- **Mood Swings** - A moment's tenderness can quickly explode into anger. The child may be full of confidence one day, only to sink into despair the next. It is difficult to see someone you care about in pain, but you cannot control the feelings of someone else. Point out that these mood swings are occurring. Do not allow yourself to be unfairly blamed. Try to stay calm and accepting that sometimes the child does not even know when or why his/her mood swings are occurring. Crying jags can be part of these mood swings. Accept that it is beyond your power to make it all better. Sometimes when a parent tries to rescue a child from his or her pain, he or she ends up feeling guilty, resentful and frustrated when it does not work. When a caterpillar is emerging from the cocoon, it must have a period of time to build strength in its wings. If the butterfly is released from its cocoon before its time, its strength will be diminished and it will not be able to survive on its own.

- **Anger** - The first target for the child's angry feelings may be the person he or she has come to feel the safest with - you. When a person's angry feelings are completely out of proportion to what is going on, it probably has nothing to do with the present situation. Something in the present is triggering and re-stimulating old memories and feelings. The safety of the current situation allows these feelings to be expressed. Recognize that this is actually a sign of health, but do not accept unacceptable behavior, and never expose yourself to physical violence.

You can assure your child that you are willing to work out the problem at hand, but in a safe and supportive manner. For example, a child may be offered a pillow to beat on in order to vent his or her anger.

- **Unreasonable Demands** - Some children learn the survival skills of manipulation and control. They may feel entitled to make unreasonable demands for time, money or material goods. It is important not to play into or get trapped by these demands. You need to maintain a healthy relationship with your child. This will help the child reduce these demands.

- **Sexual Behaviors** - Since the abuse was acted out sexually, the child needs help in sorting out the meaning of abuse, sex, love, caring and intimacy. Some children may try to demand sexual activity, while others may lose interest in any form of closeness. Think of all the needs that are met through sex: intimacy, touch, validation, companionship, affection, love, release, nurturance. Children need to be re-taught ways that these needs can be met that are not sexual.

A child who has been sexually abused may feel:

- I am worthless and bad

- No person could care for me without a sexual relationship

- I am "damaged goods" (no one will want me again)

- I must have been responsible for the sexual abuse because

    * it sometimes felt good physically
    * it went on so long
    * I never said "no"
    * I really wasn't forced into it
    * I never told anyone

- I hate my body

- I am uncomfortable with being touched because it reminds me of the abuse

- I think I was abused but sometimes I think I must have imagined it

- I blame my (biological) mother or father for not protecting me but I can't talk about it; I don't want to hurt him/her.

A child who has been sexually abused will benefit from clear guidelines that set the rules both in the home and outside. These kinds of rules will help provide the structure, comfort and security which all children need to grow into healthy adults. Experts in the field of adoption and child sexual abuse believe these guidelines are particularly important during the first year after placement, when the child is working hard to establish new relationships with his/her adoptive family and to build trust.

The following guidelines address topics with specific reference to children who have been sexually abused.

- **Privacy**: Everyone has a right to privacy. Children should be taught to knock when a door is closed and adults need to role model the same behavior.

- **Bedrooms and Bathrooms**: These two locations are often prime stimuli for children who have been sexually abused, since abuse commonly occurs in these rooms.

  By the time children enter first grade, caution should be used about children of the opposite sex sharing bedrooms or bath times.

  It is not advisable to bring a child who has been sexually abused into your bed. Cuddling may be overstimulating and misinterpreted. A safer place to cuddle may be the living room couch.

- **Touching**: No one should touch another person without permission. A person's private parts (the area covered by a bathing suit) should not be touched except during a medical examination or, in the case of young children, if they need help with bathing or toileting.

- **Clothing**: It is a good idea for family members to be conscious of what they wear outside of the bedroom. Seeing others in their underclothes or pajamas may be overstimulating to a child who has been sexually abused.

- **Saying "No"**: Children need to learn that it is their right to assertively say "no" when someone touches them in a way they do not like. Help them to practice this.

- **Sex Education**: All children, including the child who has been sexually abused, need basic information about how they develop sexually. They also will benefit from an atmosphere in which it is OK to talk about sex. Appropriate words for body parts, such as penis, vagina, breasts and buttocks, will give the child the words to describe what happened to him or her. Suggestive or obscene language is sometimes a trigger for old feelings for a child who was sexually abused, and should not be allowed.

- **No "Secrets"**: Make it clear that no secret games, particularly with adults, are allowed. Tell children if an adult suggests such a game, they should tell you immediately.

- **Being Alone With One Other Person**: If your child is behaving seductively, aggressively or in a sexually acting out manner, these are high risk situations. During those times, it is advisable not to put yourself in the vulnerable position of being accused of abuse. In addition, other children may be in jeopardy of being abused. Therefore, whenever possible during these high risk situations, try not to be alone with your child or allow him/her to be alone with only one other child.

- **Wrestling and Tickling**: As common and normal as these childhood behaviors are, they are often tinged with sexual overtones. They can put the weaker child in an overpowered and uncomfortable or humiliating position. Keep tickling and wrestling to a minimum.

- **Behaviors and Feelings**: Help children differentiate between feelings and behaviors. It is normal to have all kinds of feelings, including sexual feelings. However, everyone does not always act on all the feelings he or she has. Everyone has choices about which feelings he or she acts on, and everyone (except very young children) must take responsibility for his or her own behavior.

WILL OUR CHILD AND FAMILY NEED PROFESSIONAL HELP?

It is very likely that at some time or other parents of a child who was sexually abused will need professional help and support for themselves and their child. The type of therapy that will be the most helpful, that is, individual, couple or family therapy, will depend on a family's particular situation. When a child is being seen in individual therapy, it is important that the parents, who have the primary responsibility for the child, be in close contact with the therapist, or included in the therapy. Try to choose a therapist who is knowledgeable about both sexual abuse and adoption issues and with whom you feel comfortable.

Support groups for foster or adoptive parents or sexually abused children and support groups for victims/survivors are another helpful resource. Foster and adoptive parents who have had a chance to talk with others who understand the experience of parenting a sexually abused child say that this kind of sharing is very useful. Dr. Nicholas Groth, a leading psychologist in the field of sexual abuse, along with many children and adult victims/survivors, say that groups for children can be most effective in the healing process. The opportunity to talk and share with other children who have also experienced sexual abuse reduces a child's sense of isolation and belief that he/she is the only one to whom this has ever happened.

IS THE HEALING EVER COMPLETED?

Recovery from child sexual abuse is an ongoing process. As this process unfolds, the child will ideally move from victim to survivor to thriver. Developmental stages, particularly adolescence and young adulthood, may trigger old feelings about the abuse. For example, the time when an adolescent's body begins to develop physically, or when he or she marries, or becomes a parent may restimulate old feelings and memories.

As discussed earlier, so many factors can influence the extent of the damage to the abused child. While foster and adoptive parents cannot erase what happened to their child earlier in his/her life, you have a wonderful opportunity to provide your child with new, healthier experiences. Those who have made the commitment to parenting a sexually abused child say that the rewards of helping a child grow into a healthy, vibrant adult are very satisfying indeed.

This paper was written for the National Adoption Information Clearinghouse by Rosemary Narimanian of Philly Kids Play It Safe and Julie Rosenzweig of the National Adoption Center.

SITUATIONS THAT PRECEDE OR "SET UP" INCEST

(From the book One in Four by Victoria Kepler,
Pages 138-143, Social Interest Press, Inc. 1984)

Each of these cues viewed singly means little and could be indicative of a normal, stable family, but, several cues together could be symptomatic of serious dysfunction within the family unit.

To understand why incest occurs consider:

1. personalities of the individuals involved
2. situation, setting, and circumstances
3. the changes or crises recently occurring in the family structure

Changes occurring in a family which may increase risk of incest:

1. Father and mother experience extreme marital problems in that they have stopped having sex with each other
2. Parent of the same sex as child becomes incapacitated or is frequently absent from home
3. Parent of opposite sex suffers a crisis such as father becomes unemployed or mother becomes widowed
4. Daughter is beginning to mature physically
5. Overcrowding in the home, especially in sleeping arrangements
6. Social and geographical isolation of family
7. Sex climate of family becomes lax, loose, or repressive
8. Alcoholism
9. Pattern develops of rigid, restrictive control by father of the social activities of one or more of the children

Characteristics of Incestuous Daughters:

1. Poor relationship with mother; mother may be gone, hospitalized or at home but does not like or want the daughter; mother may be jealous and reject the daughter
2. Daughter has a low self-esteem, feels unattractive, unloved, inadequate
3. Daughter looks for attention and affection; wants friendship of peers but is afraid of rejection so isolates herself; easily falls in love with father who bestows gifts and attention on her
4. May develop a seductive manner, look, or behavior to attract attention
5. She may be stuck on father - making her very vulnerable to advances (Electra complex), does not identify with her mother and wants to possess father for herself (if she did identify with mother, she could give up her wish for her father and devote her energies to other concerns)
6. May act as "rescuer" of father - sensing he is unhappy, may try to "rescue" whole family - believes she is the only one who can hold things together - rescuing may extend to sex with father to calm him down or to keep him from fighting with the mother or the other children in the family (daughters of "tyrants" often adopt this role)

Characteristics of Incestuous Fathers:

1. He never got over a fixation with his own mother
2. Never identified with his father
3. Was encouraged to be the "little man" of the house or take care of his parent's emotional needs
4. Inadequate coping skills
5. Lack of proper nurturance in own childhood
6. Clings to fantasy of an all-loving mother and sees in daughter a chance to finally obtain it

Characteristics of nonparticipant mother (in father-daughter incest):

1. Seeks role reversal - this basic symbiotic quality is reflected in nearly all the traits of mothers whose husbands and daughters engage in incest
2. Is frigid or wants no sex with husband - feels relief when daughter substitutes
3. Keeps herself tired and worn out
4. Weak and submissive, overly dependent on husband
5. Becomes "mom" to her husband
6. She becomes indifferent, absent or promiscuous
7. Lack of proper nurturance in own childhood
8. Inadequate coping skills

There are no conclusive signs or symptoms that incest is occurring in a family. But, when several cues are forming a pattern or are found in a combination with one another, incest may be considered as a distinct possibility.

Cues in Father-Daughter Incest:

Blurring of generational lines:

Father and/or mother takes "child" position
Daughter takes role of "mother" and "wife" in family
Father acts as suitor to daughter
Mother acts as rival to daughter

Father:

Jealous of daughter's being with peers and dating
Over-possessive of daughter
Often alone with daughter
Shows favoritism toward daughter over other siblings

Siblings:

Jealous of daughter chosen by father
Rejection of sister due to their resentment of her being "special"

Daughter:

Depressed
Withdrawn
Secretive
Excessively seductive (Lolita Syndrome)
Delinquent behavior
Suicide attempts or threats
Regressive behavior (may even appear mentally retarded)
Poor self-image
Promiscuity, and/or prostitution
Isolation from peers
Uninvolved in school activities
Grades fall
Truancy from school
Running away from home
Use of drugs and/or alcohol

Physical cues:

Pregnancy
Venereal disease
Stomachache
Genital infection
Painful discharge of urine
Lacerations, abrasions, bleeding, discharge
In some cases it has been found that extreme overweight or extreme underweight (anorexia nervosa) may be cues
Paralysis (particularly from the waist down) for which no physical cause can be found (usually comes on suddenly) - psychosomatic

Cues in younger children:

Since they have difficulty verbalizing their fears, the signs of incest in young children are likely to be physical and behavioral.
Bedwetting
Encopresis (fecal soiling)
Altered sleep patterns
Severe nightmares
Overly compulsive behavior
Excessive curiosity about sex
Seductiveness
Clinging/whining to a particular parent (nonabusive)
Hyperactivity
Difficulty in walking or sitting
Fears of phobias
Learning problems
Precocious sex plan
Explicit knowledge of sexual parts
Regression in developmental milestones
Separation anxiety
Taking excessive number of baths

Cues in Brother-Sister Incest:

Brother and sister act like boy and girl friend
Sister fearful of being alone with brother
Brother and sister embarrassed when found together
Sister antagonizing brother with no retaliation

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TALKING STRAIGHT WITH CHILDREN

GUIDELINES TO EFFECTIVE COMMUNICATION:

1. Have good eye contact and body proximity.
   When you have something important to say to a child, words alone are not enough. The proximity of the adult allows the message to be even clearer than if spoken from across the room.

2. Be observant of nonverbal communication.
   When the words say one thing and the body posture says another, a mixed message is sent. Reflect on this with your child and try to glean the real message.

3. Be "clean" in your communication with children.
   When you know the facts, don't ask for them. This is manipulative and traps the child in a lie.

4. When correcting a child's behavior, begin with the "I" word instead of "you".
   "I" sentences can help us make statements. "You" sentences often cast blame.

5. Use positive language when setting a limit.
   With a little practice, it is as easy as using negatives and comes off as more respectful and clarifying. It also reinforces the expected appropriate behavior (i.e. "walk" instead of "don't run").

6. Speak respectfully.
   Be courteous to your child. Modeling is the best teacher.

7. Be direct and specific in your observations to children.
   This kind of feedback is far more effective because it helps children believe you are attentive and observant. This is especially critical when you praise or criticize your child. Sort out the behavior from the child.

8. Offer children opportunities to practice choice-making.
   This communicates the belief that you see them as capable and independent thinkers. You begin offering choices as soon as they understand spoken language.

9. Offer children opportunities to be their own problem-solvers.
   Do this as often as possible in situations that do not affect the child's welfare.

10. Understand what a child is asking for before you respond.
    Children's words may not be reflecting the source of their questions. Ask questions of them that clarify.

11. Let children know the consequences of behavior without threatening them.
    We can discipline children effectively without manipulating them. Make consequences logical/natural instead of punitive.

12. Express your expectations of behavior when children misbehave without shaming them.
    A message can be strong without being degrading.

EFFECTIVE DISCIPLINE TECHNIQUES

Clearly identify the child's age stage
of development and temperament before reacting.

Distracting the Child

Ignoring Misbehavior When Possible

Structuring the Environment

Behavior Penalty

Avoid/Control the Situation; Not the Child

Involving the Child through Choices and Consequences

Planning Time for Loving

Letting Go

Teach New Skills

Increasing Your Consistency

Start Slow with Targeting Behavior For Change

Recognizing Positive Behavior

Acknowledge Feelings

Excluding the Child with time-out

Make Agreement

Define Expectation

9 Things to do Instead of Spanking

By Kathryn Kvols

Research confirms what many parents instinctively feel when they don't like to spank their child, but they don't know what else to do. The latest research from Dr. Murray Strauss at the Family Research Laboratory affirms that spanking teaches children to use acts of aggression and violence to solve their problems. It only teaches and perpetuates more violence, the very thing our society is so concerned about. This research further shows that children who have been spanked are more prone to low self-esteem, depression and accept lower paying jobs as adults. So, what do you do instead?

1 - Get Calm

First, if you feel angry and out of control and you want to spank or slap your child, leave the situation if you can. Calm down and get quiet. In that quiet time you will often find an alternative or solution to the problem. Sometimes parents lose it because they are under a lot of stress. Dinner is boiling over, the kids are fighting, the phone is ringing and your child drops the can of peas and you lose it. If you can't leave the situation, then mentally step back and count to ten.

2 - Take Time for Yourself

Parents are more prone to use spanking when they haven't had any time to themselves and they feel depleted and hurried. So, it is important for parents to take some time for themselves to exercise, read, take a walk or pray.

3 - Be Kind but Firm

Another frustrating situation where parents tend to spank is when your child hasn't listened to your repeated requests to behave. Finally, you spank to get your child to act appropriately. Another solution in these situations is to get down on your child's level, make eye contact, touch him gently and tell him, in a short, kind but firm phrase, what it is you want him to do. For example, "I want you to play quietly.

4 - Give Choices

Giving your child a choice is an effective alternative to spanking. If she is playing with her food at the table ask, Would you like to stop playing with your food or would you like to leave the table?" If the child continues to play with her food, you use kind but firm action by helping her down from the table. Then tell her that she can return to the table when she is ready to eat her food without playing in it.

5 - Use Logical Consequences

Consequences that are logically related to the behavior help teach children responsibility. For example, your child breaks a neighbor's window and you punish him by spanking him. What does he learn about the situation? He may learn to never do that again, but he also learns that he needs to hide his mistakes, blame it on someone else, lie, or simply not get caught. He may decide that he is bad or feel anger and revenge toward the parent who spanked him. When you spank a child, he may behave because he is afraid to get hit again. However, do you want your child to behave because he is afraid of you or because he respects you?

Compare that situation to a child who breaks a neighbor's window and his parent says, "I see you've broken the window, what will you do to repair it?" using a kind but firm tone of voice. The child decides to mow the neighbor's lawn and wash his car several times to repay the cost of breaking the window. What does the child learn in this situation? That mistakes are an inevitable part of life and it isn't so important that he made the mistake but that he takes responsibilty to repair the mistake. The focus is taken off the mistake and put on taking responsibility for repairing it. The child feels no anger or revenge toward his parent. And most importantly the child's self-esteem is not damaged.

6 - Do Make Ups

When children break agreements, parents tend to want to punish them An alternative is to have your child do a make-up. A make-up is something that people do to put themselves back into integrity with the person they broke the agreement with. For example, several boys were at a sleep-over at Larry's home. His father requested that they not leave the house after midnight. The boys broke their agreement. The father was angry and punished them by telling them they couldn't have a sleep-over for two months. Larry and his friends became angry, sullen and uncooperative as a result of the punishment. The father realized what he had done. He apologized for punishing them and told them how betrayed he felt and discussed the importance of keeping their word. He then asked the boys for a make-up. They decided to cut the lumber that the father needed to have cut in their backyard. The boys became excited and enthusiastic about the project and later kept their word on future sleep-overs.

7 - Withdraw from Conflict

Children who sass back at parents may provoke a parent to slap. In this situation, it is best if you withdraw from the situation immediately. Do not leave the room in anger or defeat. Calmly say, "I'll be in the next room when you want to talk more respectfully.

8 - Use kind but firm action

Instead of smacking an infant's hand or bottom when she touches something she isn't supposed to, kindly but firmly pick her up and take her to the next room. Offer her a toy or another item to distract her and say, "You can try again later." You may have to take her out several times if she is persistent.

9 - Inform Children Ahead of Time

A child's temper tantrum can easily set a parent off. Children frequently throw tantrums when they feel uninformed or powerless in a situation. Instead of telling your child he has to leave his friend's house at a moment's notice, tell him that you will be leaving in five minutes. This allows the child to complete what he was in the process of doing.

Aggression is an obvious form of perpetuating violence in society. A more subtle form of this is spanking because it takes it's toll on a child's self-esteem, dampening his enthusiasm and causing him to be rebellious and uncooperative. Consider for a moment the vision of a family that knows how to win cooperation and creatively solve their problems without using force or violence. The alternatives are limitless and the results are calmer parents who feel more supported.

Kathryn Kvols is the president of the International Network for Children and Families and the author of Redirecting Children's Behavior. She is also a national speaker and workshop leader.

INCAF Certified Instructors teach the *Redirecting Children's Behavior* course year-round at schools, churches, and community centers *throughout the United States and the world.* If you or your organization are interested in scheduling a class, talk, or training session, you can contact your local *certified Instructor* , fill out our handy on-line *Information Request Form*, or call toll free **1-800-257-9002**.

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Set firm limits when your child's actions interfere with your rights or dignity or are concerned with health and safety.

Otherwise, let your child go about the things that are his. Give no anxious warnings, urging, scolding, lectures or criticism.

W. Hugh Missildine, M.D.

THE DIFFERENCE BETWEEN PUNISHMENT AND DISCIPLINE

Both punishment and discipline are forms of behavior management. However, there is a big difference between the two concepts. Discipline is the rules and expectations parents have for their children's behaviors. Punishment is the actions taken by parents when rules or expectations have been purposefully broken.

Let's use an example to illustrate the difference. In sports, players have to follow certain rules or standards. Let's call these rules "discipline." The rules are necessary for the game to be played in the expected manner. When a rule is broken, the player or team is administered a penalty by the referee. The hockey player who picks a fight with another player receives a punishment. Fighting is not allowed. The referee tells the player he has to sit in the penalty box for five minutes. At home when children fight, they too are given a penalty or punishment. Fighting at home is against family rules. The referee in this instance is the mother or father who tells the child he too, has to sit for five minutes in the penalty box. At home, we call this penalty box time-out. Remember, for the punishment to have meaning, the rules must be clear, consistent, and fair.

Children's Behavior:
Why won't my child behave?

Questions to ask yourself:

- Am I expecting too much for my child's age?
- Do I always say no?
- Do I tend to scream?
- Am I too strict?
- Have there been major changes in our home or lives?
- Am I under a lot of stress?

What you can do:

- Praise behavior you want to encourage
- Make sure your child understands your rules
- Limit "No's"
- Look for the *reason* for the behavior
- Listen to your child
- Try to understand your child's feelings
- Find out about stages children go through
- Give your child individual attention every day
- Take care of your own needs, too.

The **TLC's** of parenting:

Teach
All children need guidance

Listen
Encourage your child to express feelings

Care
Your child needs your love and support

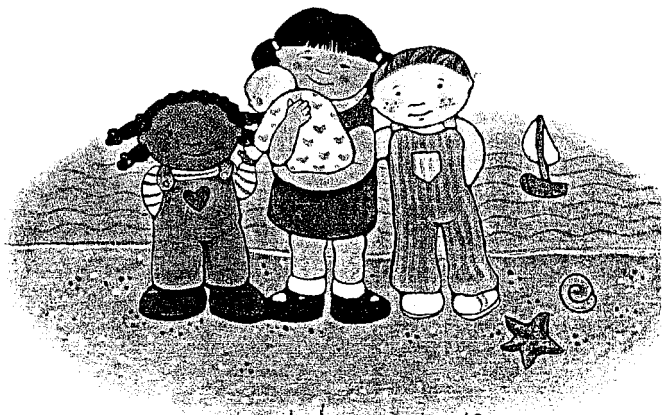
For more help, look in the first few pages of your local phone book for "Community Services" listings. There might be several organizations to call for parenting advice or help. Look under headings like Children's Services, Counseling Services, Human Services, United Way First Call for Help, etc. If you're afraid you might hurt your child, call the National Child Abuse Hotline at: 1-800-4A-CHILD (1-800-422-4453).

Written with the help of Bellflower Center for Prevention of Child Abuse, Cleveland, Ohio.

Ten things to do instead of yelling or hitting

It's hard to raise a kid!
You don't have to lift a hand to hurt your child. Words hit just as hard. The next time everyday pressures build up to the point that you might lash out, stop!
Try any of these simple alternatives:

1. Put your hands over your mouth. Count to 10. Or better yet, 20.
2. Stop in your tracks. Press your lips together and breathe deeply.
3. Phone a friend or phone the weather.
4. Say the alphabet out loud.
5. If someone can watch the children, go out and take a walk.
6. Take a hot bath or splash cold water on your face.
7. Pick up a pencil and write down your thoughts.
8. Put your child in a "time-out" for a few minutes.
9. Turn on the radio or TV.
10. Hug a pillow.



Watch over us,
The sea is so wide
and our boat is so small.

Dealing with problems at this age

Watch what you say
If you yell, threaten and put down your children, you turn yourself into the enemy. For example, don't say, "You never do any chores! Why should I let you do anything after supper?" Instead, try saying, "When you clear the dishes, you can go outside." This approach works much better.

Avoid arguments
When your child misbehaves, try to avoid arguments and say as little as possible. Don't say things like "How many times do I have to tell you to wipe your feet when you come in?" or, "What's wrong with you, do you think I'm the maid?" Instead, make your child take responsibility and nicely say: "You tracked in dirt. The rag is under the sink." If your child protests or refuses, handle it calmly.

When children lash out
Do not allow yourself to get into a never-ending argument and let your children manipulate you into getting what they want. If your child says, "I hate you! You never let me do anything!" respond by saying "I'm sorry you feel that way, and **walk away**, even if it's into a locked bathroom! Eventually, children will find a more positive way to get your attention. Remember to give them praise and attention when they do.

Praise does work wonders
School-aged kids need just as much praise as toddlers. Catch them at being good. Say things like, "Super fantastic! You did a great job!" Or, just a simple," You did good, kid."

Asking for help
Sometimes kids need more help than you alone can handle. You need extra help if you have kids who hit you, try to seriously hurt their siblings, drink or take drugs, fail in school, get involved with sex or run with gangs.

It can be frustrating at first to find help for serious problems. Be persistent. Call your child's health provider, the school principal, your religious leader, community mental health or children's service agencies until you get the help you need.

Written with the help of Kelly Gruner, MSW, CSW
*First lesson of love is to listen by Paul Tillich

Discipline for school-age children

The first lesson of love is to listen

School-aged kids have a lot to say, so be patient and listen. Sometimes just answering, "I see," and "What a bummer!," or, "No wonder you're in a bad mood," helps their problems and let's them know you care.

Make your rules clear

Kids will test your limits. Often, kids will forget what they are supposed to do, so be specific about your rules and chores. If you ask for their input on the rules, your kids may cooperate better. Write them down and hang them up where kids can see them.

When a rule is broken, you can take away privileges (video games, TV, bike riding, etc.) or use a time-out. Whatever you do, you need to be ready, willing and able to **enforce the rule** or it won't be effective. Try to make the consequence fit the situation.

Children lie to avoid being punished or criticized. They are still learning the benefits of telling the truth and of being trusted. Don't blame or put down your kids because it makes them sneakier. Deal with lying calmly and don't take it personally.

Parenting is hard work! Let your children's school help you. Get to know their teachers and stay in touch with them. Go to your library and find parenting books.

More on back

Watch over us,
The sea is so wide
and our boat is so small.

Help your child be good!

Learn what is normal and what to expect from your child at each age and stage. Maybe you are expecting too much too soon. Join a parent's group, read articles in parenting magazines or check out videos from your library on child development.

- **Try not to yell** or say "No" or the time. A child learns from having the freedom to explore. Make your home toddler-proof, and allow your child learn in a safe and stimulating place.
- **Praise** behavior you want to encourage.
- **Keep your rules simple** and consistent. Don't overwhelm a young child with too many rules.
- A child's memory is poor and learns best by repetition. **Be patient** and know you will have to repeat yourself a lot.
- If your child is doing something wrong, **show him the right way** to do it, like: pet the dog, not pull its tail.
- If possible, encourage your children to **"use their words."** Children who express themselves with words will *tell* you how they feel, not show you.
- Give your child **lots of individual attention and love** every day. Children often misbehave if they are feeling lonely or neglected.
- **Listen** to your children and make them feel important. Again, they often they misbehave to get attention.
- **Give choices rather than commands** to get your child to cooperate. For example, if your child is avoiding brushing his teeth at bedtime, ask him if he wants to do it before or after putting on his pajamas.
- **Plan ahead.** If your child is going to get restless in the car or store, bring along a favorite toy.
- **Distract** your child if he's doing something you don't like. Take him away from the scene, or give him something else he likes. Remember, very young children don't understand right or wrong.
- **When you get angry** at your child, take a break for yourself. Call a friend, cry, take a shower - whatever helps you. Remember, never shake a baby! Shaking can cause severe brain damage and even death.
- **Teach, don't punish.** Before you yell at your child, imagine someone yelling it at you. Cruel words hurt as bad as spanking.
- **If you are under a lot of stress,** your child knows it. Look for help. United Way First Call For Help can guide you to some places that can help you cope with difficult situations.

Written with the help of Bellflower Center for Prevention of Child Abuse, Cleveland, Ohio

Discipline for your child

It's hard to raise a kid!

- Discipline means to **teach**, not punish
- Discipline is good for your child. It makes him* feel safe.
- You must teach a toddler what he can and cannot do. This is sometimes called "setting limits."
- Provide a safe place for your toddler to explore and learn. Remove anything you don't want him to get into.
- Toddlers want to be good, but often don't know how. Stop oncoming bad behavior by saying, "Let's do this instead." Show him how.

When your child acts up:

- Stop him and remove him from the scene.
- Don't hit, don't spank.
- Put him in a "time-out" for 2-3 minutes, using a chair or stair. Use the same spot each time. Time-outs give both of you a chance to cool off. Your child can join you when he can control himself.
- Correct him with short, simple sentences.
- When he's upset, help him tell you why.
- Don't say No! too often. If you do, your child won't listen. Save NO for when he could hurt himself or someone else.
- Set up routines and rules, then be consistent. Let your child know you mean what you say.
- Spend as much time as you can with your child.
- Praise your child for good behavior.

*All tips apply to both boys and girls.

Watch over us
The sea is so wide
and our boat is so small.

Tips for quieting a crying baby

Try and stay calm. Babies can sense tension.

- Gently walk, dance or rock with the baby.
- Hold the baby close to you and breathe slowly and calmly.
- Check for fever or swollen gums. If the baby is sick, call the baby's health provider.
- Check the baby's clothing. Make sure it's loose enough and that fingers and toes are not bent.
- Take the baby for a ride in the stroller or in a car seat in the car.
- Wrap the baby in a soft, warm blanket.
- Rock the baby in a carriage while you watch TV or read.
- Carry the baby in a soft, front carrier.
- Turn on music, run the vacuum, dryer, dishwasher or run the water in the tub. Babies like consistent, rhythmic noise.
- Sing or talk in a quiet, sing-song way.
- Offer the baby a noisy toy. Shake or rattle it.
- Lay the baby tummy down on your lap. Gently rub or tap the baby's back.
- Massage the baby's body and limbs gently.
- Put the baby in a wind-up swing.
- Swaddle the baby tightly.
- Offer a pacifier.
- Cross the baby's arms across the chest, and gently hold them. Talk in a calm and soothing voice the whole time.
- If nothing else works, put the baby in the crib and close the door for a few minutes. Go to another room and calm down. Turn up the radio or TV. Check on the baby every 10-15 minutes. The baby may just fall asleep.
- Ask for help. Have someone you trust come over and care for the baby while you take a break.

Remember:

- Babies don't always follow your schedule.
- What works one day to comfort your baby may not work the next time.
- The baby is not *trying* to be difficult.

Never shake the baby!

Shaken Baby Syndrome

Coping with a baby's non-stop crying **is** very frustrating. However, do not allow yourself or anyone to shake the baby! Shaking does not stop the crying. The baby is too young to understand that the crying makes you upset and angry.

An injury caused by shaking a baby or toddler is called "Shaken Baby Syndrome." Shaking can cause blindness, brain damage, cerebral palsy or even death.

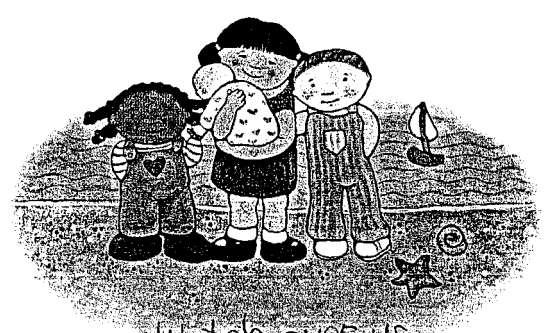
Being too playful with babies can also cause damage. Do not toss them on your knee or foot, or spin them around. Anything that causes the baby's head to flop back and forth can cause damage.

Try your best to comfort the baby

The best way to cope with the crying, is to learn what to *do* for it. The first thing to do is to make sure all the baby's basic needs are met:

- Does the diaper need changing?
- Is the baby hungry or thirsty?
- Is the baby too warm or too cold?
- Is the baby bored or lonesome?
- Is the baby sick or have a fever?

If the baby continues to cry, use the list of tips on the other side.



What to do for your child during a tantrum

Be alert to signs that your child is building up to one. Try to interest him with a new activity or toy. If the tantrum does happen:

- Remove him from the scene and go to a quiet spot.
- Don't offer a reward for stopping the tantrum.
- Watch him, especially if he's in the bathroom or kitchen. He can hurt himself easily when he's out of control.
- It's very important to be polite to him and not embarrass him about it in front of others.
- If the tantrum happens in a public place, never threaten to leave him. Stay with him and help him calm down. It might be best to go home.
- Discuss it once he quiets down. Or review what happened later when your child is happy again.

It can be ok to ignore certain behavior like:

- crying and screaming for attention
- slamming doors, sticking out his tongue
- pounding or kicking the floor (without hurting anyone or anything)

Don't ignore it when your child:

- tries to hurt himself, hurt you or others
- throws things or damages your home
- has tantrums in public places

What to do for yourself

- Don't punish, yell or spank. Keep your cool.
- Be loving and firm. You are helping your child learn self-control. Remind him: "use your words."
- Set the rules for your household and stick to them. Make sure other adults follow the same rules in your home.
- Be clear and consistent about your rules.
- Provide simple reasons for your rules.
- If *you* get too frustrated, go somewhere quiet and take a time-out for yourself for 5 minutes.

Try not to be embarrassed when tantrums occur. They are *normal* and not wrong. Over time they will diminish. Let your children express themselves. It's normal for them to test your rules and limits.

Temper Tantrums

Temper tantrums are a normal part of your toddler's development. They usually occur between the ages of 1 and 3, and lessen by age 4.

A tantrum is one way a child can express himself. He is not being bad.*

Why do tantrums occur?

They usually happen because a child is frustrated, angry or frightened:

- he's unable to explain his needs or feelings (he doesn't know how to *say* it yet)
- he's not getting his way
- he can't fully understand what a grown-up is trying to say

Certain conditions can lead to tantrums:

- if he is hungry, tired or uncomfortable
- if he is anxious, frustrated or sick

Preventing tantrums from happening

- Avoid things that will frustrate him.
- Don't have him do stressful things when he is tired.
- Don't let him get too hungry. Serve healthy snacks if needed.
- Pick your No's. Don't say no to everything or he will have more tantrums.
- *Let* him say what he's feeling if he's able. Help him with the words. Give him your full attention.
- Don't make too many plans for your toddler. Set up some quiet time every day where you give him your undivided attention.

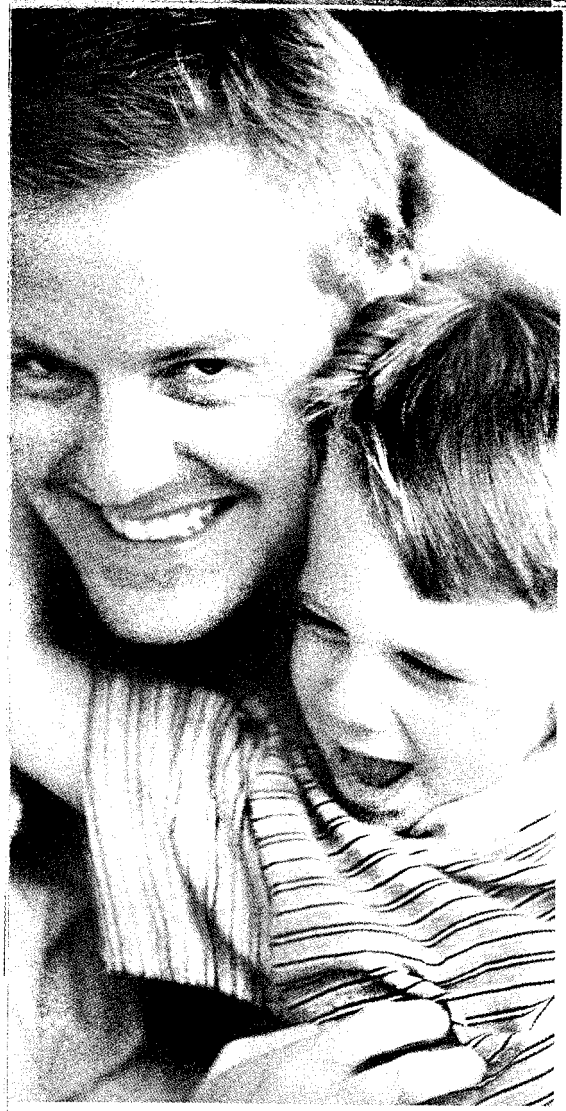
*All tips apply to both boys and girls.

More on back

Watch over us,
The sea is so wide
and our boat is so small.

A Parent's Handbook

Loving Discipline for Children Ages 1 through 5



You may find it helpful to keep important names and numbers handy.

Write them below:

My child's health care provider(s)

Name _____

Phone number _____

Name _____

Phone number _____

Caregiver(s)

Name _____

Phone number _____

Name _____

Phone number _____

Name _____

Phone number _____

School(s)

Teacher's name _____

School phone number _____

Teacher's name _____

School phone number _____

Local emergency number

Name _____

Phone number _____

An emergency contact

Name _____

Phone number _____

Please read:

Talk to your health-care provider! This handbook is not a substitute for the advice of a qualified health-care provider. • The photos in this handbook are of models. The models have no relation to the issues presented. • The trademarks, including registered trademarks, in this handbook are the property of the respective trademark owners.

If you are a parent* of a child age 1 through 5,

this handbook is for you. You can use it to help you:

Learn what behaviors to expect for your child's age.

What may look like misbehavior is often a normal part of learning and growing. Knowing what to expect at each age can help you:

- encourage your child's desire to learn
- guide your child toward safe and appropriate behavior.

Understand the difference between discipline and punishment.

Discipline is more than reacting to misbehavior. It includes everything you do to teach your child good behavior.

Learn how to teach good behavior in a loving way.

Your child needs to be sure of your love. Feeling loved can make it much easier for him or her to make good choices.

Help your child learn good discipline at every age. Give him or her a gift for life!

*In this handbook, "parent" also refers to guardians, grandparents and other primary caregivers.

Note: This handbook describes general patterns of growth and development. All children grow and develop in their own unique way. Your child may not exactly follow the patterns described in this handbook. Consult your child's health-care provider if you have questions.

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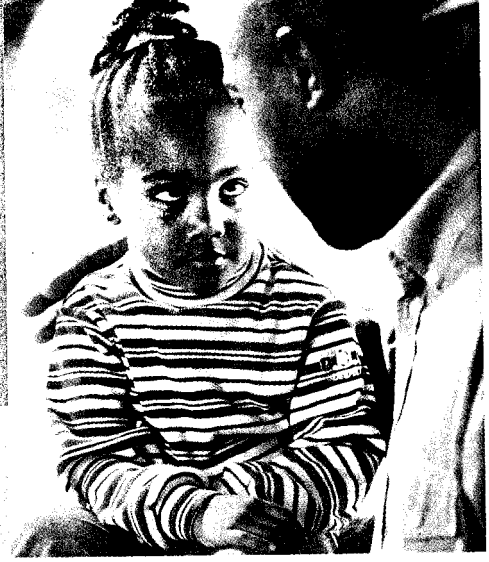
Discipline is not the same as punishment



There's a lot more to discipline than stepping in when a child misbehaves. When you discipline with love, you keep guiding your child's actions as he or she grows up. You:

Help your child stay safe

In the youngest years, discipline is mainly about keeping your child safe. As he or she gets older, you can start teaching your child ways to protect him- or herself.

Teach your child right from wrong

Your very young child relies on you to say and show what's right and what's wrong. Over time, you help him or her learn how to tell right from wrong.

Think about the cause of a behavior

For example, your child may:

- not know the behavior is wrong
- be trying to test your limits
- be tired, sick, hungry, angry, bored, frustrated, etc.

Avoid shaming your child

- Yelling, insults or name-calling only make a child feel bad. They don't teach better behavior.
- Focus on the behavior, not the child. For example, say that hitting is wrong, not that the child is bad.

Don't spank or use other physical punishment.

Doing this may stop an unwanted behavior. But it also:

- does not give any guidance for a child to learn from
- could injure a child
- teaches that hitting is an OK way to solve problems or express anger.

Help your child feel loved and secure

Teaching good behavior involves:

- providing routines, structure, and safe, stable surroundings
- being consistent in how you act with your child.

Give your child a role model

At all ages, children learn from watching parents. You can teach your child a lot through your own good example!

Help your child develop important values and qualities

Some of these are:

- self-control and self-discipline
- confidence and self-esteem
- self-respect and respect for others
- responsibility.

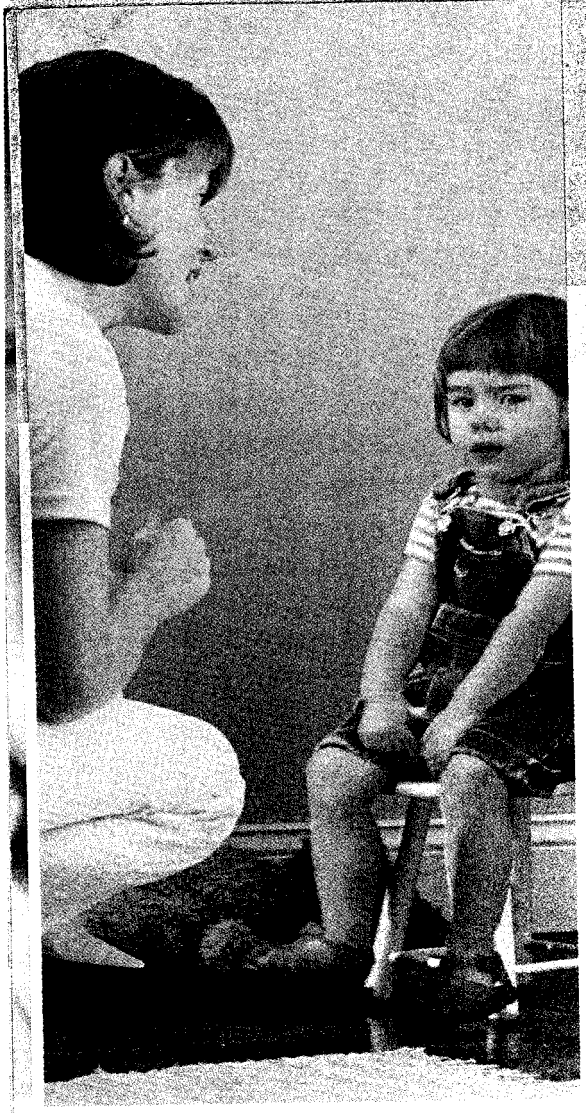
Think about the values and qualities you would like your child to have as an adult.

For example, you may want him or her to:

- be able to make good decisions
- be kind to others.

Try sharing your thoughts with another parent. Keep thinking about this as you read this handbook. Think about how you can raise your child to be that kind of adult one day. Write your thoughts below.

Values and qualities I want my child to have as an adult:	How I can help my child develop these values and qualities:



Know the basics of loving discipline

It's important to:

Keep a loving relationship

Here are some tips:

- Give your time and attention. Show your child affection. Play together.
- Give your child chances to express thoughts and feelings. Talk about your own thoughts and feelings.
- Let your child see that you are listening. Stop what you are doing. Get at eye level with your child. Look at him or her. Use body language, such as nodding and eye contact. Try not to interrupt.

Use praise to encourage good behavior

Your child wants to please you—your praise shows that he or she has. Praise also teaches your child what's right to do—so he or she can keep on doing it in the future. Try to:

- Praise specific good behaviors (saying "thank you for picking up your toys," for example) instead of just saying "good girl" or "good boy."
- Give praise when your child stops or admits to inappropriate behavior.
- Catch your child being good!

Set fair expectations and limits

All children need these to grow more independent but still feel secure.

- Make sure expectations and limits are clear and right for your child's age and ability.
- Slowly give more choices, freedom and responsibility as your child grows up.
- Pick your battles. Stick to important matters, such as safety and good manners.
- Expect not to be liked at times. Parenting involves making some decisions your child won't agree with.
- Be sure that other caregivers and family members know—and follow—the expectations and limits.

Teach your child better ways to act

At different ages, this may involve:

- distracting your child from unsafe activities
- teaching your child what he or she can do, not just what he or she should not do
- helping your child solve conflicts.

Use fair consequences for inappropriate behavior

Talk to your child about the consequences in terms he or she can understand. In general:

- Respond right away. But always remember to think before you act!
- Fit the consequence to the action. Avoid consequences that are too harsh.
- Be consistent. Always follow through if you say a behavior will have a certain consequence. This helps teach that the behavior really is not OK.

Encourage good behavior as much as possible, to keep from using consequences too often. Encouragement works better in the long run!

Use methods that fit your child

If you have more than one child, be sure to do this for each one. It's important to:

- Keep your child's age in mind. Discipline needs to change as a child grows up.
- Consider your child's personality. For example, some children are more active or outgoing. Others are more quiet or shy.

Limits that are fair for one child may be too hard for another to follow. For example, a younger or more active child may not be able to stay in a store for too long without touching things.

What is your child's personality?

Keep it in mind as you read this handbook. Are there others who know your child well? You may also want to ask for their insight.

Think about where your ideas about discipline come from. This can help you decide how you want to teach good discipline. Writing your answers may help you think about them. Or try talking about the questions with someone.

How would you describe the discipline you had as a child?

- ☐ very strict—I was given little or no say
- ☐ firm but fair
- ☐ permissive—I could have used more guidance
- ☐ mixed (different styles were used at different times)
- ☐ other: _____

How did this kind of discipline make you feel? If discipline was mixed, did it seem right for each situation? Or did you feel confused by it?

_____

_____

Do you remember any specific times (or ways) that your parent or guardian taught you discipline?

How did you feel at the time (for example: loved, angry, secure, unsure)?

_____

_____

Do you wish anything had been different?

_____

_____

What does "discipline" mean to you?

What words first come to mind when you hear the word "discipline"?

_____

What do you think discipline should do—for your child and you?

_____

How happy are you with your answers? Are there things you would like to learn or change?

_____

How has discipline been going so far?

Think about times you have tried to teach your child good discipline. (Remember times when your child was behaving well, too.) Write down your thoughts. Or talk about them with someone. Keep them in mind as you read this handbook.

My child's action(s)	My action(s)	How well my action(s) worked	Things to change, try or learn
EXAMPLES: *Pushed her sister.*	*Said "No pushing."*	*OK at first. But she pushed again later.*	*Remind her when she starts to play. Tell her how to say what she feels instead.*
Said "thank-you" when Grandma gave him a cookie.	*Told him that was very polite.*	*Seemed helpful. He smiled and said he's a big boy now!*	*Keep noticing other polite actions.*

Development and behavior of children ages 1 and 2

Children these ages generally:

Are very curious and love to explore

They may do this by:

- touching and tasting
- "experimenting" (for example, dropping an object over and over to see what happens).

Wanting to explore is natural and healthy. But your child is too young to know what's safe. Your job is to encourage curiosity—while keeping your child safe.

Move around more and more

1- and 2-year-olds are eager to practice new and exciting skills! These include:

- walking
- running
- jumping
- climbing.

Your child can get to all kinds of things that catch his or her eye. But knowing which ones to stay away from only comes later!

Get better at grasping, picking up and holding things

Eager hands want to try things such as:

- holding spoons and cups
- turning doorknobs and book pages
- working switches
- squeezing toothpaste tubes.

But your child does not yet understand how to use all these things. For example, he or she may squeeze the tube of toothpaste just to see all the toothpaste come out!

Use the space below for notes about your child's development and behavior:

Copy what you do

Your child will copy actions before knowing what they're really for. For example, if you hammer something, your child may try pounding a toy on a table.

Use words and then simple sentences

- "No!" may be a favorite. This is a normal way to learn to be independent. Your child is not trying to misbehave. He or she may even say no, then do what you ask!
- Your child may also use other words to show independence. For example, he or she may say, "I do it."

Express feelings in physical ways

Your child may show anger, frustration and other feelings through actions such as:

- yelling or crying
- temper tantrums
- biting
- pushing or shoving.

Act on impulse

You may see this in different ways. Your child will:

- often not think before acting—or not think about how actions affect others
- use new skills in some inappropriate ways—to touch unsafe things, climb on furniture, pull the cat's tail, etc.

Only see their own point of view

For example:

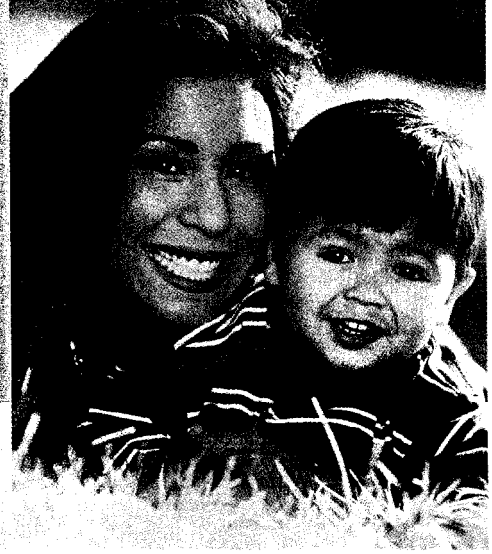
- When you stop your child from trying to do something unsafe, he or she does not understand why you are stopping him or her.
- Your child does not understand that hitting or kicking hurts a person.

Cannot understand or remember rules

- Your child may follow a simple direction at the time you give it (not to pull the cat's tail, for example). But he or she probably won't remember it the next time.
- He or she won't understand that the direction always applies (to all cats, for example).

1- and 2-year-olds need lots of reminders!

Teaching good discipline to children ages 1 and 2



Children these ages generally cannot control their own actions. Your little explorer needs you to take charge! Here are some tips:

Keep your child safe.

- Take all steps needed to make your home childproof. For example, remove or lock up objects that your child should not touch (such as breakable or poisonous items). Put plants out of reach. (Some plants are poisonous.) Ask your child's health-care provider for more advice.
- Distract or redirect your child. For example, offer a safe toy when you take away an unsafe object. If your child heads toward something unsafe, bring him or her to a safer spot to play.

Set limits to protect property and other people.

- Stop your child if he or she hits, bites, etc. Try holding him or her and saying "No hitting." Watch play closely. Remove your child, if needed. Never hit or bite back!
- Offer substitutes. For example, give paper if your child starts to draw on a wall.
- Create a safe area to play. Try to have a spot where it's OK to be messy!

Encourage and praise good behavior.

- Give your child a hug and say what he or she did well. For example, thank him or her for coloring on the paper, not the wall.
- Try to keep your child from getting frustrated. Show the right way to do a task, such as getting dressed.
- Follow routines for meals, bedtime and other regular activities. Knowing what to expect helps your child work with you.

Send clear messages.

- Keep explanations short and simple. For example, if your child goes toward the stove, say, "Don't touch. Ouch. Hot."
- Use body language and tone of voice. For example, if your child hits you, show a sad face. Look him or her in the eyes and say, "Hitting hurts." Then ask for a hug. Smile and say, "Hugs feel good."

Consider timeouts for a 2-year-old.

A timeout gives your child a chance to calm down when needed. A 1-year-old is too young to understand what a timeout is for. (See page 19 for tips on using timeouts.)

Be ready for temper tantrums.

Your child may start having tantrums after about age 2. To help you manage:

- Remind yourself that tantrums are a normal way to express frustration. They can happen when a child tries to be independent but fails.
- Ignore the tantrum if it's safe to. Your child wants an audience. Taking that away may stop the tantrum sooner. Also, don't make a big deal of it once it's over.
- Don't give in. Don't say yes to something you already said no to. Giving in tells your child that tantrums work. If you asked your child to do something before the tantrum, calmly repeat it after.

Set an example.

Your child can't yet copy all that you say or do. But he or she is not too young to learn from you. Here are some things you can do:

- Use good manners with your child and others. For example, say "please" and "thank you."
- Show affection to your child and others.
- Show correct actions—for example, how to touch a flower gently.

Discipline diary

Keep track of your efforts to teach your 1- or 2-year-old good discipline.

Encourage appropriate behavior as often as you can—check the box under the happy face (☺) each time you do this. Check the box under the sad face (☹) each time you have to stop inappropriate behavior. Try to have more checks in the ☺ column.

Date	My child's action(s)	My action(s)	Notes	☺	☹
10/6	Touched my face gently.	Smiled and said, "Nice, gentle touch."	She did it again and smiled.	✓	
10/7	Pulled my hair.	Made sad face. Said, "Ouch. No pulling."	Next time he reaches for my hair, show him how to touch it.		✓

Read these examples of common discipline issues for children ages 1 and 2. Think about possible ways to handle each case. Review pages 10-13, if needed. You may want to write your answers or talk about them with someone else.

Case 1

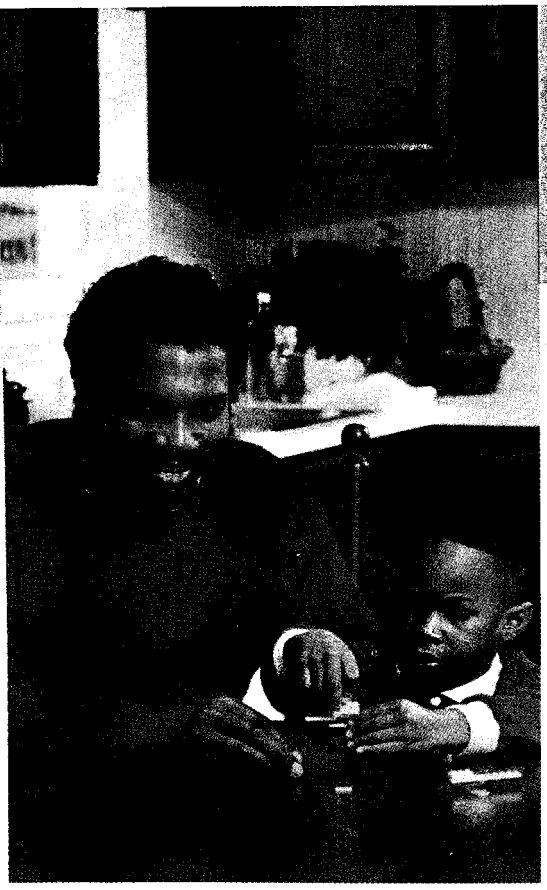
Your 18-month-old was tearing up pages from your newspaper one morning. You told her to stop and showed her how to turn pages. She followed your example. But later, she tore a page again. (HINT: 1- and 2-year-olds need lots of reminders.)

Case 2

You are reading while your 1-year-old is across the room. He has been touching the lampshade and you have told him no twice. Both times, he looked at you and stopped briefly. Now he is touching it again. And he doesn't stop when you say no. (HINT: Body language and tone of voice can help 1- and 2-year-olds understand.)

Case 3

You are in the grocery store with your 2-year-old. Several times, after you have put an item in the cart, your child has grabbed something and put it in. Each time, you have said not to do that. But your child keeps putting something into the cart every time you do. (HINT: 1- and 2-year-olds spend a lot of time copying adults.)



Development and behavior of children ages 3 and 4

Children these ages generally:

Enjoy being active

They:

- gain new skills, such as climbing stairs while holding on, hopping on one foot, catching a ball and driving a tricycle
- may do risky things to try them out
- have lots of energy—they may tire themselves out from playing so hard, then get cranky!

Become more and more independent

3- and 4-year-olds:

- are eager to try new activities—but still don't always know which ones are safe
- want more freedom and control over what they do
- become toilet trained—but may still have accidents sometimes (such as at night).

Use the space below for notes about your child's development and behavior:

Use language better and better

These little talkers:

- use complete sentences and can repeat rules back to you
- may start talking back or using bad words
- use words to express some feelings, such as anger or sadness—and may start to talk about your feelings, too
- enjoy telling stories and sharing their ideas—they need your time and patience while they try to get all their words out!

Have active imaginations

3- and 4-year-olds cannot always tell the difference between fantasy and reality. They:

- enjoy pretend play—and may do what you ask more easily if it involves "make-believe"
- may have an imaginary friend
- like to tell fantasy stories—keep in mind that these are not meant as lies.

Enjoy playing with other children

Play helps children of these ages learn to get along with others. They learn skills such as:

- sharing
- taking turns
- solving conflicts without fighting.

Your child may also learn some unwanted behaviors during group play. You'll need to keep a close watch!

Still act on impulses and express some feelings in physical ways

Learning to think before acting and to have self-control takes time. Be proud that your child is trying. But also expect him or her to sometimes use behaviors such as:

- pushing
- shoving
- temper tantrums.

Start to understand and remember rules

You'll see 3- and 4-year-olds get better at:

- remembering a rule for longer
- understanding that a rule always applies (for example, it's not OK to pull <u>any</u> cat's tail)
- following simple rules in games.

Teaching good discipline to children ages 3 and 4

Here are some things to try:

Explain limits, expectations and consequences in simple ways.

Ask your child to repeat them. Your child:

- still needs limits for his or her own safety and others'
- can start to understand what you expect—and what will happen if he or she breaks rules.

For example, say, "If you push anyone when you play today, then you'll have to stop playing, like you had to yesterday. Remember, we don't push." Be sure to follow through!

Keep encouraging and praising good behavior.

For example:

- Praise your child for trying out a better way to act (such as being patient while you talk to someone, or asking for something instead of grabbing it).
- Mention it when your child behaves well. For example, say, "I like how you are sharing and waiting your turn."

Teach words to express feelings.

You can:

- Help your child learn names of feelings. For example, say, "It seems that you are angry. Please tell me why."
- Help your child figure out what he or she feels. For example, say, "When I see you hit the baby, I wonder if you are jealous. Do you get mad when I spend time with him?"

Teach peaceful ways to solve conflicts.

For example:

- Teach your child to say "No hitting" if another child hits him or her.
- Suggest taking turns instead of fighting over a toy. Suggest a different toy to play with while waiting.

Supervise play.

You no longer need to take charge of every move. But be ready to step in when needed. Watch for:

- behaviors that you must stop right away (pushing and shoving, for example)
- chances to guide your child toward better ways to act.

Use timeouts when appropriate.

It's best to save timeouts for behavior that is out of control. To give a timeout:

- Tell your child he or she needs a timeout. Say why (to help him or her calm down and stop hitting, for example).
- Have him or her sit with no distractions—in a corner chair, for example.
- Tell your child to sit quietly until you say it's OK to get up—or until a timer you set (such as a stove timer) goes off. Try about 1 minute for each year of age.
- Afterward, calmly say what you expect. For example, say, "We don't hit." Or, "Now that you are calm, you can play again."

Be consistent in handling temper tantrums.

Tantrums can still be common during these years. Help keep your child from using tantrums to get what he or she wants. (Follow the tips on page 13.) And keep in mind that you'll see fewer and fewer tantrums as your child learns to express feelings with words.

Setting an example

Copying you is one way your child tries to please you. Make it a point to:

- Be polite and kind to others, including your child. Use words and phrases such as "please," "thank you" and "excuse me."
- When you share something with someone, point it out to your child.
- Show self-control. For example, express anger in quiet ways. Solve conflicts by calmly discussing them.

Discipline diary

Keep track of your efforts to teach your 3-or 4-year-old good discipline.

Encourage appropriate behavior as often as you can—check the box under the happy face (☺) each time you do this. Check the box under the sad face (☹) each time you have to stop inappropriate behavior. Try to have more checks in the ☺ column.

Date	My child's action(s)	My action(s)	Notes	☺	☹
10/6	Shared a toy in play group.	Told him that was nice to do.	He kept sharing nicely.	✓	
10/7	Grabbed a toy from another child.	Told her, "Grabbing is not polite." Had her give it back and choose another toy.	Watch more closely. Say what to do instead, if she starts to grab.		✓

Read these examples of common discipline issues for children ages 3 and 4. Think about possible ways to handle each case. Review pages 16-19, if needed. You may want to write your answers or talk about them with someone else.

Case 1

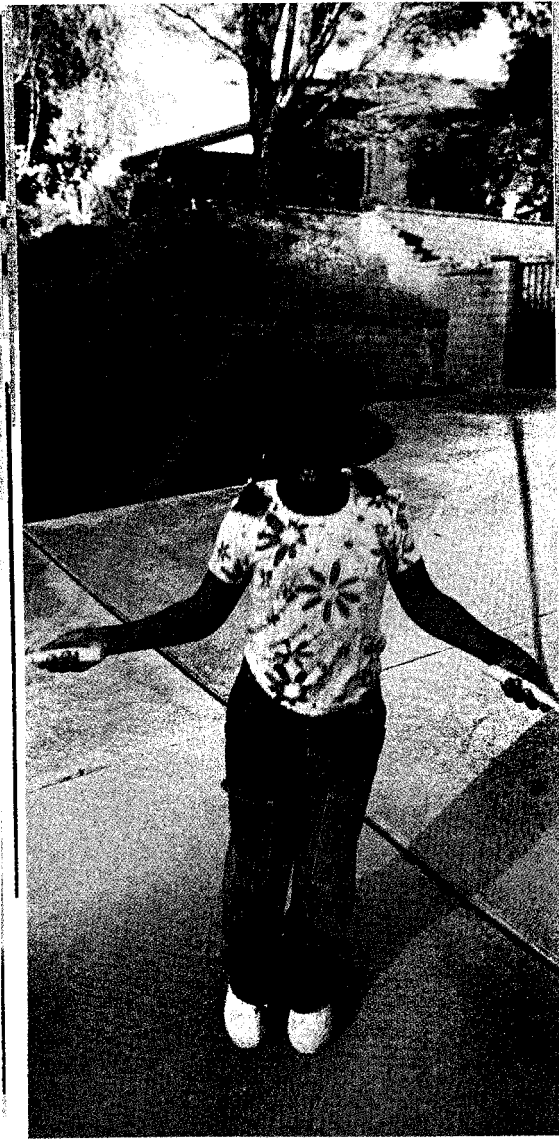
Your 4-year-old loves to talk and learn new words. At the park one day, a group of older children run by. One yells a bad word. Your child repeats it to you proudly, with a big smile. (HINT: 3- and 4-year-olds are learning more and more words—and want to say them all!)

Case 2

Your 3-year-old has just joined a play group. He brought 2 toys with him. Another child picks one up. Your son takes it back and holds onto it. The other child grabs it back. (HINT: Sharing is a skill that children have to learn—it doesn't happen on its own.)

Case 3

Your 3½-year-old has had a busy day learning to drive her new tricycle. She is proud and excited! After supper, she starts driving it around the living room. She screams with delight, "I go! I go!" (HINT: 3- and 4-year-olds may try out new skills without thinking about rules or risks.)



Development and behavior of 5-year-olds

Children this age generally:

Get better at many physical skills

5-year-olds can:

- climb stairs without holding on
- skip, jump rope, jump off things and run on tiptoe
- play on playground equipment
- start learning to drive a bike with training wheels
- bounce and throw a ball
- use scissors and tools
- use a fork and knife.

5-year-olds love to try new skills at every chance! They need to know what the limits are—to prevent injury and stay safe.

Have very active minds

Children this age enjoy using their growing language and thinking skills. They:

- speak well, so that even strangers can understand—safety around strangers becomes a concern because your child may be eager to talk to anyone
- talk about how to do things with their playmates—for example, who will do what in a game
- enjoy rhymes and words that sound silly
- may use bad words to shock you
- enjoy stories and fantasy play—but get better at seeing the difference between pretend thoughts and real actions
- can pay attention better (to you, teachers, etc.)—but this is still hard at times
- ask lots of questions! Instead of just accepting what they hear, 5-year-olds want to understand their world better. It may seem like they are always asking "Why?"

Start gaining self-control

5-year-olds want to be more in charge of their own behavior. Adult guidance has been sinking in! These children can:

- repeat safety rules during play
- use words more often than actions to express feelings
- sometimes calm themselves when anxious or upset.

Your child may still act on impulse at times. For example, he or she may have temper outbursts or hit when angry.

Understand and remember rules better

5-year-olds are starting to learn right from wrong. They:

- follow rules in games and have a sense of fair play
- follow family rules—about bedtime, watching TV and doing chores, for example
- remember instructions longer (from earlier the same day, for example)
- can use more complex rules (for example, saying "thank-you" at the right times)
- may ask permission before doing something
- feel guilty about breaking a rule they know.

Start to see other points of view

They:

- put themselves in other people's places through pretend play
- notice other people's feelings, such as anger or sadness
- think about what others want and need.

Use the space below for notes about your child's development and behavior:

Teaching good discipline to 5-year-olds

Here are some things to try:

Be very specific with praise.

This helps your child learn more about appropriate behavior. It also helps him or her feel proud—and want to please you again next time! For example, say:

- "I like how you put your toys away without being asked."
- "You worked very hard at cutting out those shapes so neatly!"

Help your child accept responsibility for his or her behavior.

You can:

- Allow more independence. For example, give chores that fit your child's age (such as picking up toys). Give chances to play alone. Always keep an eye out for safety!
- Teach ways to make up for inappropriate behavior. For example, have your child apologize if he or she hurts someone.

Give chances for group play.

This is very important at this age. Playing with other children helps a child learn about:

- the importance of rules
- getting along with others.

Keep groups small if your child prefers it.

Keep helping your child express feelings with words.

5-year-olds have lots of strong feelings, such as anger, pride, happiness and fear. You can:

- Give your child chances to talk about his or her feelings. For example, ask, "Are you excited about going to school?"
- Keep helping your child figure out his or her feelings. For example, say, "It seems like you may be jealous because your friend got a new bike."

Talk more about limits and behaviors.

Take advantage of your child's growing language and thinking skills. He or she can understand more now. You can:

- Give more reasons. For example, say, "Don't chase your ball into the street. A car could hurt you. Ask me to get it." Or say, "We say 'please' when we ask for something. It shows respect."
- Avoid saying "Because I said so," if your child asks why he or she has to do something. It doesn't teach what to do in similar cases.
- Talk about behaviors to help your child stay safe—around strangers, for example.

Help your child understand consequences.

Talk about the consequences ahead of time. Help your child see how they relate to the behavior. For example, say:

- "Remember what will happen if you throw your ball in the house. You won't get to play with it for the rest of the day."
- "It's your job to put your toys away. If you don't do it, then you don't get to watch your TV show."

Setting an example

Showing good behavior is effective with children this age. For example:

- Listen patiently when your child talks. This teaches respect. It also shows how to value what others think and say.
- Help other family members with tasks.
- Play with your child. Make a point of sharing, taking turns and not arguing.

Discipline diary

Keep track of your efforts to teach your 5-year-old good discipline.

Encourage appropriate behavior as often as you can—check the box under the happy face (☺) each time you do this. Check the box under the sad face (☹) each time you have to stop inappropriate behavior. Try to have more checks in the ☺ column.

Date	My child's action(s)	My action(s)	Notes	☺	☹
10/6	Put her bears away after playing house.	Told her I was proud that she remembered to pick up.	She said, "I told Baby Bear we have to pick up our toys!"	✓	
10/7	Left his game on the floor.	I told him he could not use it again today, because he didn't take care of it.	He seems so grown-up in some ways. Maybe he needs more reminders.		✓

What would you try in these cases?

Read these examples of common discipline issues for 5-year-olds. Think about possible ways to handle each case. Review pages 22-25, if needed. You may want to write your answers or talk about them with someone else.

Case 1

Your child and a friend have been saying rhymes, telling jokes and singing silly songs. They keep getting sillier and sillier. Soon, they are doing silly dances on tiptoe and collapsing in giggles. One of them climbs onto a chair and starts dancing up there. (HINT: 5-year-olds love being silly. They can also start to think about what others want and need—such as reasonable noise levels or to have belongings treated with respect.)

Case 2

Your child has been making up a story about life in a pretend place all morning. He has been having a great time. He has brought many of his toys into the living room to act it out. You told him to pick up before lunch. Now he has come to the kitchen for lunch. All the toys are still out.
(HINT: 5-year-olds can remember rules and consequences better.)

Case 3

Your child is trying a new game with her play group. They have been talking about the rules and who will go first. You are proud of how well they have been working things out. Then you notice that your child is starting to sound upset. You see her push another child.
(HINT: 5-year-olds start gaining self-control, but still act on impulse at times.)

Parents often wonder about certain behaviors.

Some behaviors can be normal but still upsetting. Try to figure out why your child behaved in a certain way (review the possible causes on page 4, if needed). It can help you find the best way to handle it. Here are some things to consider for:

Tantrums

- What did he or she want to do (or get) just before?
- Was he or she very tired or frustrated? Would a nap or distraction have helped?
- Did I see any signs that it was coming?
- Were we somewhere that tends to upset him or her (the grocery store, for example)?

Hitting, yelling, biting, and so forth

- What was going on beforehand and right at the time? Was there enough supervision?
- Was he or she tired? Angry? Does he or she know how to express anger in words?
- How often has he or she done this? Does he or she understand that it's wrong? Have I been consistent in responding to it?
- Has he or she seen me or another family member do this?

Lying

- Is he or she truly lying? Or just telling a story or imagining something?
- Has he or she ever heard me or another family member tell a lie—even a "small" one?
- Has he or she lied before? Is there a reason he or she may fear telling the truth?
- Have I ever praised him or her for being honest, to help teach the value of honesty?

Sometimes, professional help is needed.

For example, seek help if the behavior:

- happens often or continues past the expected age
- seems too extreme to be normal (for example, if the behavior causes injury)
- affects your child's ability to function at home or school.

If you have any questions or concerns, talk with a professional such as your child's health-care provider, school counselor or teacher.

Keep notes if a behavior concerns you.

This can help you think of ways to prevent or stop the behavior. You may want to share this sheet with your child's health-care provider.

Date/child's age	Behavior just before	When	Where	What happened	Notes

Keep anger out of discipline.

As a parent, you can expect to feel angry at times. And it's OK to admit it—in healthy ways—when you are. But always remember to stop and think before acting. Never discipline your child in anger.

Letting anger control your actions can lead to actions you could regret.

It could cause you to hurt your child:

- physically
- emotionally.

It could also mean legal problems.

Try these ways to manage anger.

If you feel anger getting the best of you, it may help to:

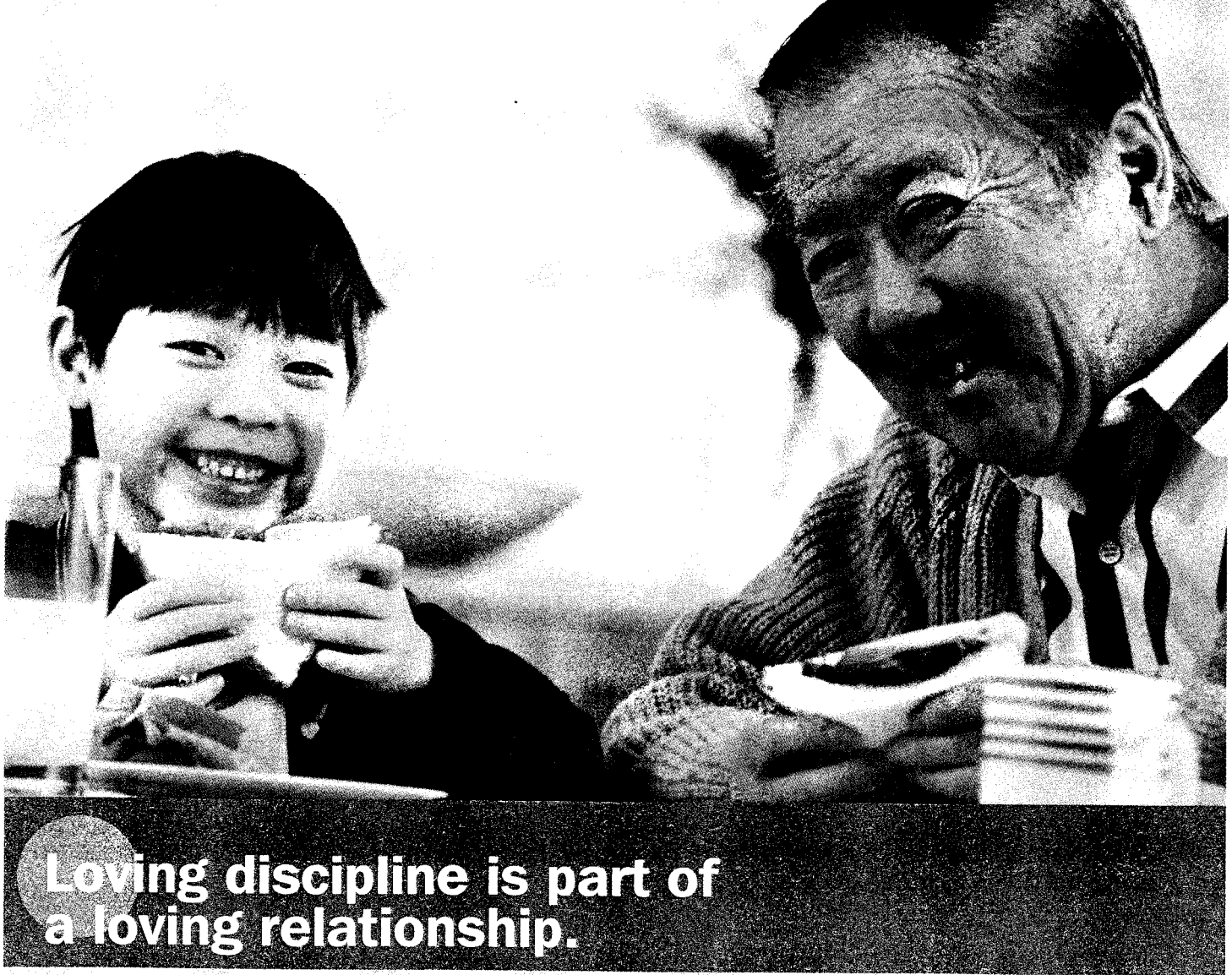
- Stop. Take some slow, deep breaths.
- Slowly count to 10—or higher, if it helps.
- Take a break. Call a friend or leave for a short time. Make sure your child has proper supervision.
- Keep a journal. Writing about your feelings can be a great release.
- Remind yourself about what is normal for your child's age. Think about why he or she may be acting a certain way.

Consider learning ways to relax. Some examples are progressive muscle relaxation and visualization. These can help keep anger from getting the best of you.

Seek help if you think you may lose control.

It can help keep you from taking things out on your child. To find help, look in the community service section in the front of your phone book. You can also contact:

- your child's health-care provider (ask about parent support groups or parenting classes)
- Childhelp USA® National Child Abuse Hotline 1-800-4-A-CHILD® (1-800-422-4453).



Know what behaviors to expect for your child's age.

Keep in mind that very young children really can't "misbehave."

Encourage good behavior.

Give ongoing guidance and appropriate praise.

Respond to inappropriate behavior in helpful ways.

Be consistent with consequences. Also teach your child what he or she can do—help him or her learn better ways to act.

Make loving discipline part of your child's memories!

IDENTIFYING AND PARENTING SEXUALLY ABUSED CHILDREN

BEHAVIORS RELATED TO SEX AND SEXUALITY IN PRESCHOOL CHILDREN

by Toni Cavanagh Johnson, Ph.D. (Licensed Clinical Psychologist)

The following chart attempts to describe behaviors which relate to sex and sexuality of preschool children of normal intelligence. Available literature and empirical data on child sexuality have been studied and consultation with hundreds of professionals, parents and child care providers has been sought to prepare this chart. It is a first step in defining behaviors related to sex and sexuality which are within the normal range, behaviors which raise concern and behaviors which require immediate assessment and intervention. This chart is not meant for use in the assessment of child sexual abuse. Comments and suggestions are invited by the author.

The behaviors in the first column are those which are in the normal range. This range is wide and not all children will engage in all of the behaviors, some children may engage in none while some may only do one or two. There will be differences due to the child's interest and the amount of exposure the child has had to adult sexuality, nudity, explicit television, videos and pictures. The child's parent's attitudes and values will influence the child's behaviors.

The second column describes behaviors which are seen in some children who are overly concerned about sexuality, children who lack adequate supervision and other children who have been, or are currently being, sexually molested or maltreated.

When a child shows several of these behaviors, a consultation with a professional is advised.

The third column describes behaviors which are often indicative of a child who is experiencing deep confusion in the area of sexuality. This child may or may not have been sexually abused or maltreated. It may be that the level of sex and/or aggression in the environment in which the child has lived overwhelmed the child's ability to integrate it and the child is acting out the confusion. Consultation with a professional who specializes in child sexuality or child sexual abuse should be sought.

Sex Play is Within Normal Range of Childhood Behavior

All aspects of normal sex and sexuality for preschool children are related to curiosity and exploration. Preschoolers are trying to find out about the world, how it smells, tastes, works, sounds and feels. Everything related to the genitals, breasts, differences between males and females, and procreation are subjects of preschoolers exploration and curiosity. This interest comes and goes.

Areas of Concern

Concern arises when the child focuses on sexuality to a greater extent than 1) other areas of the child's environment or, 2) other developmentally matched peers. Interest in sex and sexuality should be in balance with the curiosity and exploration of all other aspects of the child's life. When a child is admonished about certain sexual behaviors yet continues, this raises concern. When a child does not seem to understand that the overt display of sexual behaviors is uncommon.

If a child shows several behaviors which are of concern, professional advice is recommended.

When to Seek Professional Help

When there is secrecy, anger, anxiety, tension, fear, coercion, force or compulsive interest and activity related to sex and sexuality, professional advice should be sought.

BEHAVIORS RELATED TO SEX AND SEXUALITY IN PRESCHOOL CHILDREN

Normal Range	Of Concern	Seek Professional Help
Touches/rubs own genitals when diapers are being changed, when going to sleep, when tense, excited or afraid.	Continues to touch/rub genitals in public after being told many times not to do this.	Touches/rubs self in public or in private to the exclusion of normal childhood activities.
Explores differences between males and females, boys and girls.	Continuous questions about genital differences after all questions have been answered.	Plays male or female roles in an angry, sad or aggressive manner. Hates own/other sex.
Touches the genitals, breasts of familiar adults and children.	Touches the genitals, breasts of adults not in family. Asks to be touched himself/herself.	Sneakily touches adults. Makes others allow touching, demands touching of self.
Takes advantage of opportunity to look at nude persons.	Stares at nude persons even after having seen many persons nude.	Asks people to take off their clothes. Tries to forcibly undress people.
Asks about the genitals, breasts, intercourse, babies.	Keeps asking people even after parent has answered questions at age appropriate level.	Asks strangers after parent has answered. Sexual knowledge too great for age.
Erections	Continuous erections	Painful erections
Likes to be nude. May show others his/her genitals.	Wants to be nude in public after the parent says "no".	Refuses to put on clothes. Secretly shows self in public after many scoldings.
Interested in watching people doing bathroom functions.	Interest in watching bathroom functions does not wane in days/weeks.	Refuses to leave people alone in bathroom, forces way into bathroom.
Interested in having/birthing a baby.	Boys interest does not wane after several days/weeks of play about babies.	Displays fear or anger about babies, birthing or intercourse.
Uses "dirty" words for bathroom and sexual functions.	Continues to use "dirty" words at home after parent says "no".	Uses "dirty" words in public and at home after many scoldings.
Interested in own feces.	Smears feces on walls or floor more than one time.	Repeatedly plays with or smears feces after scolding.
Plays doctor inspecting others' bodies.	Frequently plays doctor after being told "no".	Forces child to play doctor, to take off clothes.
Puts something in the genitals or rectum of self or other due to curiosity or exploration.	Puts something in genitals or rectum of self or other child after being told "no".	Any coercion or force in putting something in genitals or rectum of other child.
Plays house, acts out roles of mommy and daddy.	Humping other children with clothes on.	Simulated or real intercourse without clothes, oral sex.

SEPARATING FALLACY AND FACT

One of the reasons that sexual abuse has not been considered to be a major social problem and has been greatly under reported to child protective services is that there are a great many misconceptions which prevail.

FALLACY One of the biggest problems in dealing with sexual abuse is that children are often lying about the activity or just "making up a story" to gain attention or get their parents in trouble.

FACT Children almost never lie about having been sexually abused. In a seven year study done in California based on more than 600 families involved in a sexual abuse treatment program, FEWER THAN ONE PERCENT OF THE CASES WERE SHOWN TO BE BASED ON LIES OR FALSE ALLEGATIONS OF SEXUAL ABUSE OR INCEST BY THE CHILD.

FALLACY In most sexual abuse cases, the abuser is a stranger to the child.

FACT In the vast majority of cases, the perpetrator is well known to the child - usually a relative such as a father, step-father, uncle, or boyfriend of the mother. In fact, research shows that father-daughter incest accounts for approximately 75 percent of the cases.

FALLACY Sexual abuse is more likely to occur in homes where only one parent is present.

FACT Both mother AND father figures (or substitutes) are living in the home in over 90 percent of reported sexual abuse cases.

FALLACY The lower the family income and social and educational status, the higher is the likelihood of sexual abuse of children.

FACT Eighty percent of sexually abusive fathers are employed, revealing a higher income and education level than physically abusive families in general. In addition, the victim's family usually is well respected in the community and often demonstrates involvement in church and civic affairs.

FALLACY Most father-daughter incest can be explained as caused by a provocative or seductive child.

FACT A promiscuous or seductive child is often the result, but never the cause of incest.

FALLACY In father-daughter sexual involvement, the mother is usually unaware of the occurrence of sexual abuse.

FACT While the mother nearly always denies knowledge of the incestuous affair, in some cases, she has good grounds to suspect the abuse. In therapy, the mother will often admit to knowing of the abuse or relate that she "felt uncomfortable" or "suspicious" about the behavior of the father and daughter.

FALLACY Sexual abuse is usually characterized by a violent or forcible attack or aggression on the child which often leaves physical signs such as vaginal tearing or bruising about the pubic area.

FACT Oftentimes, a father-daughter incestuous affair is characterized by warmth, gentleness, and affection with no violence involved. The father may use his position of power to persuade/coerce his daughter without ever resorting to physical violence.

FALLACY The child victim's reaction to the disclosure that sexual abuse has been occurring is always negative and usually has extremely traumatic effects on the child.

FACT The child's reaction to the disclosure of sexual abuse can range from extremely negative to neutral to positive depending on several variables. The identity of the perpetrator and the number of incidents occurring are important to gauging the child's reaction. Evidence indicates the greater the emotional bond between the perpetrator and victim and the longer the situation has existed results in greater trauma for the child. The traumatic effects are also dependent on the degree of force, violence or shame invoked on the child. In many cases, the child experiences gratification or secondary gain from the relationship, resulting in a positive or at least neutral experience for the victim. Termination of this "special relationship" can result in a "sense of loss" for the child, especially if the offender was a parent. It has often been mistakenly concluded that the accusation is false because the child doesn't exhibit severe or mild trauma to the situation. It is important not to overreact on the basis of one's own personal biases (i.e. the belief that it must have been traumatic) in assessing the situation.

FALLACY Psychologically, the sexually abused child has probably been permanently damaged by the sexual relationship that occurred.

FACT This need not be true. The degree of long range emotional problems for the victim is dependent on many of the variables listed above. Another variable is the reaction of the adults and professionals involved. Don't re-define the situation as more/less alarming than the child sees it by imposing <u>your</u> personal biases.

FALLACY Family sexual abuse is an isolated one-time incident.

FACT For most victims the abuse continues for years and may involve siblings sequentially. <u>In most cases, the offender will not stop until there is intervention</u>.

PARENTING THE SEXUALLY ABUSED CHILD

As a prospective foster or adoptive parent, you may have some valid concerns about sexual abuse. You may wonder what the special needs are of children who have been sexually abused and whether you will be able to meet those needs. By acquiring more knowledge, you will feel more confident in taking on the challenges and rewards of parenting a child with special needs.

Many parents who have fostered or adopted sexually abused children feel that their greatest obstacle was lack of information about sexual abuse in general; about their particular child's history; and about helpful resources such as support groups, skilled therapists and sensitive reading materials. This article will provide you with some basic information about child sexual abuse as well as some special considerations for parents who foster or adopt these children.

WHAT IS CHILD SEXUAL ABUSE?

Child sexual abuse is any forced or tricked sexual contact by an adult or older child with a child. Usually the adult or older child is in a position of power or authority over the child. Physical force is generally not used, since there is usually a trusting relationship between the adult or older child and the child who is abused.

There are various types of sexual activity which may take place. It can include open mouth kissing, touching, fondling, manipulation of the genitals, anus or breasts with fingers, lips, tongue or with an object. It may include intercourse. Children may not have been touched themselves but may have been forced to perform sexual acts on an adult or older child. Sometimes children are forced or tricked into disrobing for photography or are made to have sexual contact with other children while adults watch.

Child sexual abuse does not always involve physical touching. It can include any experience or attitude imposed on a child that gets in the way of the development of healthy sexual responses or behaviors. For example, a child may be a victim of "emotional incest." If a mother tells her son, in great detail, about her sexual exploits, or if a father promises his daughter that she will be his life partner when she turns 18, these would be scenarios in which the child could be considered sexually abused. Siblings who are aware of a brother or sister's victimization, but are not actually abused themselves, may also suffer many of the same effects as an abused child.

In addition, some children experience ritualistic and/or satanic abuse. Ken Wooden, founder of the National Coalition for Children's Justice, defines ritualistic abuse as a bizarre, systematic continuing abuse which is mentally, physically, and sexually abusive of children, and for the purpose of implanting evil.

HOW OFTEN DOES CHILD SEXUAL ABUSE OCCUR?

Estimates are that approximately 1 in 4 girls and 1 in 8 boys experience sexual abuse in some way before they are 18. Data on how many of these children live in foster or adoptive homes are not available. Foster care and adoption social workers are now saying they believe the percentages of boys and girls in foster care who have been sexually abused are much higher than in the general population, perhaps as high as 75%. Many came into foster care initially because of sexual abuse and others are children who were re-victimized while in foster care, either by an older foster child or by an adult.

WHAT BEHAVIORS OR SIGNS MIGHT YOU SEE IN A CHILD WHO HAS BEEN SEXUALLY ABUSED?

While no one sign or behavior can be considered absolute proof that sexual abuse has occurred, you should consider the possibility of sexual abuse when one or several of these signs or behaviors are present.

Physical Signs

- Scratches, bruises, itching, rashes, cuts or injuries, especially in the genital area
- Venereal disease

- Pregnancy in (young) adolescents

- Blood or discharge in bedding or clothes, especially underwear

Behavioral Signs

- Aggressive behavior towards younger children

- Advanced sexual knowledge for the child's age

- Seductive or "sexy" behavior towards adults or peers

- Pseudo-mature behavior (for instance, a girl who is eight and dresses like a 16-year old, wears makeup and generally acts "too old for her age," or a young boy who attempts to be his mother's "man" in every sense of the word)

- Regressed behavior (for example, the child who has been toilet trained starts wetting the bed)

- Excessive masturbation, masturbation in public places, difficulty with being re-focused to another behavior

- Poor relationships with peers

- Fear of a particular person, place or thing (for example, if the abuse occurred in the bathroom, the child may show fear in that room)

- Sudden or extreme changes in behavior (for instance, a previously good student starts having trouble with schoolwork, a child who was not sad before starts crying frequently or acting sad, or a formerly cooperative child acts defiantly or is uncooperative or unusually overly cooperative)

- Eating disorders (overeats, undereats)

Additional Behavioral Signs in Pre-teens and Adolescents

- Self-mutilation (the child may repeatedly pick at scabs, cut him/herself with a razor blade, bite his/her finger or arm, burn him/herself with a cigarette)

- Threatening or attempting suicide

- Using drugs or alcohol

- Becoming promiscuous (a child is sexually active without discrimination, or just has that reputation)

- Being prudish (the child avoids any sexuality, does not see him/herself as a sexual being in any way)

- Prostitution

- Fire-setting

- Lying, stealing

- Running away

- Isolating self or dropping friends

- Pre-occupation with death (the child may write poems about death, may ask a lot of questions about death, such as "What does it feel like and where do people go?")

KINSHIP RESOURCE GUIDE

ADAMHS Board http://www.adamhtc.org/index.htm
1260 Monroe Street NW, Suite 27N
New Philadelphia, OH 44663
330-364-6488

1. Tuscarawas County Family and Children First Council – Service Coordination
    a. Focuses on multi-need children up to the age of 21. The goal is to build upon family strengths, utilize and coordinate existing services and resources, strengthen and increase access to formal and informal supports, and strategize to address a child and family's unmet needs.
    b. Contact Rindy Brace
        i. 330-364-3307
        ii. rindy@adamhtc.org
2. NAMI – National Alliance on Mental Illness http://www.nami.org
3. FACT Team

Personal and Family Counseling Services http://www.personal-family-counseling.com
1433 5th Street NW
New Philadelphia, OH 44663
330-343-8171

1. Kinship Care Program
    a. Designed to support both caregivers and children who are in this situation, and connects families with other families in similar situations. The Kinship Navigator is available to listen to your concerns in the comfort of your own home, and will help you get answers to your questions, obtain needed services, and help you navigate the legal, school, health or human service systems. The bi-monthly support group provides education, discussion and family activities, individual support for each family's specific needs and provides advocacy for children and caregivers.
2. Early Childhood Mental Health Consultation
    a. Provides a skill-building curriculum that is incorporated into existing early childhood programs to enhance healthy, social and emotional development of children ages 0 to 6. Clinical consultation, assessment, training and education are also offered through this service.

The Village Network Uhrichsville Office
117 E. 3rd Street
Uhrichsville, OH 44683
740-922-2144

1. Day Treatment Program
    a. Day Treatment programs at The Village Network are for **youth ages 10 to 18-years-old** that need intensive mental health services in coordination with academic instruction. It is also available for youth stepping down from residential treatment and those suited to remain in a community-based setting.
    b. Treatment services may include diagnostic assessment, psychological and/or psychiatric evaluation, individual, group and family therapy, academic instruction, expressive arts, art and recreational therapy, and after-care with community follow-up.

Community Mental Healthcare http://www.cmhdover.org
201 Hospital Drive
Dover, OH 44622
330-343-6631

1. Kids' Program – Rosie Das 330-343-3050
    a. Children must be potty trained
    b. For primarily ages 3-6 – children who are having behavioral and social issues

Northeast Ohio Behavioral Health http://www.neobh.com

4510 Dressler Rd. NW	**213 Market Avenue North, Suite 200**
North Canton, OH 44718	**Canton, OH 44702**
330-494-5155	**330-451-1701**

1. Individual and Family Therapy
    a. Children with Developmental Disabilities
    b. Children and Adolescents in specialized placements
    c. Child and Adolescent victims of sexual abuse
    d. Child/Adolescent Survivors of Trauma and loss
2. ADHD Assessment and Consultation

Dr. Gregory Keck

1. Attachment and Bonding Center of Ohio http://abcofohio.net

First Aid 101 http://firstaid.about.com/c/ed9.htm

1. Email course provides weekly lessons in first aid concepts, including legal aspects, basic first aid, and specific injuries/illnesses.
2. Website also has a free first aid newsletter

Online Job and Family Services application for Benefits http://ODJFSBenefits.ohio.gov

1. Tuscarawas County Job and Family Services www.tcjfs.org
    a. Food Stamps, Cash Assistance, Medical Card
    b. Daycare Assistance

Conference of Promoting Healthy Attachments

1. Contact Michele Santin
    a. msantin@diosteub.org
    b. 740-282-3631 ext. 122
2. Held in Oglebay, WVA

Annual Foster Parent Conference

1. Contact East Central Ohio Regional Training Center
    a. 247 Highland Avenue Cambridge, OH 43725
    b. 740-432-2355
2. Held in Sugarcreek, OH

Tuscarawas County Board of DD www.tuscbdd.com
1260 Monroe Street NW
New Philadelphia, OH 44663
330-339-5145

www.kinshipohio.org

1. This website provides information about resources and services for kinship caregivers in Ohio.

How You Can Reach Us for Services . . .

Address

Tuscarawas County Job & Family Services

389 16th Street, SW

New Philadelphia, Ohio 44663

Phone

(330) 339-7791 OR 1-800-431-2347

Fax

(330) 339-6388

TTY/TTD Ohio Relay Service

1-800-750-0750

Website

www.tcjfs.org

E-Mail

help@tcjfs.org

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