

C. Placement Strategies to Prevent Trauma

Conceptual Framework

In previous sections, the potentially serious consequences of separation and placement to children and their families have been identified. However, when a child cannot be protected at home, even with intensive in-home service interventions, out-of-home placement may become necessary.

When out-of-home placement cannot be avoided, placement should be structured to minimize trauma to children and their families, to decrease the likelihood of crisis, and to reduce the long-term negative effects of separation. Strategies include careful preplacement planning; selection of the most appropriate caregivers; adequate preparation of children, their families, and caregivers; conducting placement activities in steps that promote a gradual adjustment to the change; involving family members in all aspects of the placement process; and intensive follow-up supportive services to the children, the caregivers, and the families.

The Decision to Place

There are two truisms in child placement. The first is that the only legitimate justification for out-of-home placement is that supportive family services and other interventions cannot assure protection of children in their own homes. The second is that children should never be left in a home when they cannot be protected from serious harm from maltreatment. In practice, however, many children have been removed unnecessarily, or they have been left in high-risk situations without sufficient protective interventions.

The following are some inappropriate reasons for decisions to place:

- Workers may assume too quickly that a situation is an emergency, without first completing a thorough assessment of risk and determining whether a child can be protected at home with intensive family services.
- Other community agencies and professionals may exert pressure to remove and place children. These placement recommendations may be based on insufficient or incorrect information, or they may reflect the personal values of persons who lack expertise in risk assessment.
- Conversely, the recent national emphasis on family preservation has been improperly interpreted by some to mean that no children should ever be placed out of home.
- In some cases, workers view placement in foster care or with relatives as a simpler, better, or less time-consuming way to assure children's safety than providing intensive in-home services and monitoring. In short, once children are in substitute care, their safety and well being can be assured, and busy staff can proceed with other activities. This practice is consistent with the attitude that "rescuing" children from "bad" environments, and placing them in better ones serves children's best interests.
- Agency and worker concerns about legal liability also can support a "better safe than sorry" attitude that promotes placement of children when the risk to them at home is equivocal.
- The rate of out-of-home placement is generally higher in communities that have few supportive service resources, such as homemakers, parent aides, protective day care, public health services, parenting classes, respite care, family support and counseling, or intensive in-home service programs. When foster care is the only resource available to protect children, it will be used. In these communities, a broad-based interagency and community effort must be undertaken to identify and strengthen family service resources.

- Research also suggests that the rate of out-of-home placements is disproportionately high for children of minority racial and cultural backgrounds [Stehno 1982; 1990]. This may be indicative of worker, agency, or community bias, and may also reflect our society's inability to provide many families with the resources necessary to assure basic survival and promote family integrity.
- When agencies lack standardized policies and procedures to guide risk assessment and placement decisions, and when workers and supervisors lack skill in risk and family assessment, placement practices are likely to be highly inconsistent. In some agencies, supervisors do not routinely review case decisions; workers may not receive regular consultative supervision; specialized training is not available; and staff make difficult and complex placement decisions without consultation and input from other professionals.

A broad-based agency approach is necessary to eliminate inappropriate placements. Placement decisions must always be based upon sound factual information about the child and family, gleaned from a thorough risk assessment. The effects of making placement decisions without first conducting a comprehensive risk assessment can be disastrous. Children not at high risk, as well as their families, may be unnecessarily subjected to placement trauma, while children at high risk of harm may be left unprotected in their homes. In addition, purported "emergencies" must be carefully assessed to determine the degree to which the child is truly endangered. Placement decisions are difficult and complex, and cases should generally be thoroughly discussed with other professionals before a plan to remove a child is formulated. Rarely should the decision to remove a child be made by any single individual.

Intake units must be staffed to permit thorough family assessments and a determination of risk before considering removal of children. When children are found to be at high risk, strategies to protect them in their own homes should be

considered before a decision is made to remove them. Agencies that can provide crisis intervention and intensive in-home services will be better able to prevent placement. Even if a child must eventually be removed, intensive in-home intervention provides workers with an opportunity to fully assess the family's strengths and needs, and to develop a placement plan that minimizes trauma.

Agencies must also develop consistent policies regarding risk and family assessment, service delivery, and out-of-home placement, and assure that managers and staff correctly understand and interpret them. Caseworkers and supervisors must be well trained in risk assessment, family assessment, and strategies that support and strengthen families. The skills needed to conduct an accurate and comprehensive risk assessment are quite complex; the agency's most experienced and skilled staff should be assigned this responsibility. Unfortunately, openings in intake units are frequently filled by inexperienced caseworkers. This greatly increases the likelihood of faulty decision making, with often destructive consequences.

Finally, all agency staff must guard against the effects of personal and institutional racial and cultural bias in determining the need for the placement of children. A thorough knowledge of cultural differences, community standards, and personal values and biases can prevent subjective assessments of families, and the inappropriate removal and placement of children.

Placement Strategies that Damage Children

For more than 75 years, child development specialists have stressed the inherent dangers of abrupt removal and placement of children and the long-standing trauma this creates, with consequences that can persist throughout life [Freud & Burlingham 1943; Littner 1956; Gerard & Dukette 1953; Bowlby 1973; Rycus, Hughes & Garrison 1989; Fahlberg 1979; 1991]. Yet, many child welfare agencies persist in abruptly taking children and their belongings from their homes and depositing them in new homes, often in the care of total strangers. The most

common justifications for this practice are, "We don't have time to do any more," or "The child had to be moved immediately to protect him; it was an emergency."

While there is some truth in both statements, our time pressures cannot justify the serious harm we have inflicted on hundreds of thousands of children and their families over the years, while ostensibly serving their best interests. While we cannot always prevent maltreatment of children, nor fully undo the damage related to such maltreatment, we certainly can control how we place them! This is particularly true when children are moved between foster homes, or to adoptive or other permanent families. Children in these situations are generally at no risk of imminent harm, and the agency can plan and schedule placement activities that meet the children's needs and that prevent unnecessary stress. Even in emergency situations, there are multiple options available before, during, and after the placement that can ease the transition and can prevent serious and long-term harm to children or their families.

Transitioning as a Placement Strategy

The fundamental principle of effective placement practice is, while a move cannot always be avoided, separation trauma can be prevented or minimized. "Transitioning" as a placement strategy to prevent emotional trauma from separation was introduced as early as 1943 by Anna Freud and Dorothy Burlingham, who suggested:

"If separation happened slowly, if people who are meant to substitute for the mother were known to the child beforehand, transition from one [caregiver] to the other would appear gradually... By the time the ... child had [to] let go of the mother, the new... [caregiver] would be well known and ready at hand. There would be no empty period in which feelings are turned completely inward... Regression occurs while the child is passing through the no-man's land of affection; i.e.,

during the time the old object has been given up before the new one has been found" [Freud & Burlingham 1943].

The goal of the transition method of placement is to "place the child in a new home only after he has developed some familiarity with it and gives evidence of a beginning affection for and dependence upon the new parents." [Gerard & Dukette 1953].

The placement strategies described below operationalize the concept of transitioning. They are designed to assure a sequence of activities that create a less stressful experience, and provide an emotionally supportive environment for children being placed, which helps prevent crisis and its debilitating effects. Specifically:

- 1) The degree of stress experienced by both children and their families during placement will be reduced. This is achieved by avoiding unnecessary changes, recognizing when children and families are experiencing excessive stress, and pacing the rate of placement to prevent children from becoming overwhelmed.
- 2) The children's and the families' ability to cope with placement will be strengthened by involving them in planning, preparing them for the placement, conducting placement activities in more easily managed steps, and by providing essential support before, during, and after the placement.
- 3) Families and children will be helped to achieve a realistic perception of the reasons for the placement, and will have opportunities to talk about their feelings and needs in a supportive environment.
- 4) The children's adjustment in the placement setting will be enhanced and supported by the caregiving families and caseworkers.

- 5) The substitute caregivers' ability to meet children's unique physical, emotional, and developmental needs will be strengthened.
- 6) When reunification is the case plan, families will be involved with their children in placement in a manner that reduces separation trauma, preserves and strengthens the parent-child relationship, and promotes prompt reunification.

Many workers believe they lack sufficient time to conduct placements in the manner described herein. However, we must seriously consider the negative consequences to children and families if we do not adhere to these principles, and we must prioritize our time to support as many of these placement practices as possible.

Finally, caseworkers cannot, by themselves, assure prudent child placement practices. A total agency commitment is necessary. Agency policies and procedures must be developed that support effective placement practices, and administrators and managers must facilitate such practice by providing flexible scheduling of case responsibility when a child needs to be placed; by mandating regular case review and consultation; by offering staff sufficient training in risk and family assessment; and by assuring opportunities for collaborative decision making.

Application

Choosing the Most Appropriate Placement Setting

The decision of where a child should be placed is as important as the decision to place. Placements that cannot meet a child's unique needs, or that subject the child to unnecessary stress, greatly increase both the trauma for the child and the likelihood of placement disruption.

A properly chosen placement will meet a child's physical, emotional and social needs, will strengthen and preserve the child's relationship with family members, and will minimize the changes to which the child must adapt. The following principles promote selection of the the most appropriate placement settings and caregivers.

- A child should be placed in the least restrictive, most home-like environment possible, and as close to the child's own home as possible. Relatives, family friends, and neighbors should be assessed to determine their willingness and ability to provide care and protection before considering a foster home placement. Family members can often participate in identifying potential placements for their child. This concept supports the widespread advocacy for kinship placements, which can reduce some of the traumatic effects of separation and placement.
- The child's development, needs, and anticipated behavior problems should be carefully assessed prior to choosing a placement. A caregiving family should be chosen based upon its capacity to meet the child's special needs. Unfortunately, many placements are made solely on the basis of available bed space. Failure to properly match a child to the most appropriate caregiving family greatly increases the likelihood that the placement will disrupt, resulting in another unnecessary separation and rejection.
- The number of nontherapeutic changes in lifestyle and environment should be minimized. Whenever possible, a caregiving family selected for a child should be of similar ethnic, cultural, and socioeconomic level as the child's own family. This reduces the number of cultural changes to which the child must adjust, thereby reducing stress, and also helps to preserve the child's cultural identity. Continuity can also be maintained by allowing the child to remain in the same school, church, and community.

- A child should never be placed in a group home, receiving center, or other institutional setting because an appropriate family setting is not available. Identification and support of kinship caregivers, and the recruitment and training of appropriate foster family and treatment homes, should be considered an agency priority. (See Section X-A, "The Components of an Effective Foster Care System.")

The success of a placement is also greatly increased when a child's family and the foster or kinship caregiver are involved in the planning and implementation of all aspects of the placement. (This will be discussed at greater length in Sections IX-B, "Empowering Parents to Participate in Placement Activities," and IX-C, "Promoting Reunification.")

Emergency Placements

All high risk situations do not automatically require the emergency placement of children. In some cases, the risk assessment will suggest safety factors in the family environment that can be strengthened to help protect children in their own homes. Intensive in-home supportive services may effectively reduce imminent risk, while simultaneously strengthening the family. Protective day care, homemaker services, and other in-home supportive services can sometimes assure that children are not left in the sole care of an alleged perpetrator while a more complete family assessment and case plan are being completed.

An emergency exists when a child is determined to be at imminent high risk of harm, and the child cannot be protected at home, even with intensive, in-home and supportive services. In these cases, placement may be necessary to assure the child's protection while the family situation is fully assessed and a case plan is developed. When the child needs emergency care, the worker should attempt to maintain the child in familiar surroundings, preferably with extended family members or close family friends, while a more comprehensive family assessment can be completed, and the determination can be made of the best intervention

plan for the family. This may include longer-term placement of the child in either a kinship or foster care setting. This also gives the caseworker time to become better acquainted with the child, to identify the most appropriate placement setting, and to move the child planfully, without subjecting the child to undue stress.

Preparing the Child, Family, and Caregivers

Preparation for change helps people cope. Fear of the unknown and feelings of anticipatory loss, common in any significant change, increase anxiety, depression, and vulnerability to crisis [Parad & Caplan 1965]. Preparation for change helps to reduce ambiguity and fear of the unknown, and provides much-needed support and reassurance.

The success of any placement is, therefore, greatly enhanced if all participants are properly prepared. The child, the family, and the caregivers should all be given thorough information about the placement plans, and should have the opportunity to fully discuss the placement with the caseworker.

Preparing and Involving the Child's Family

Preparing the child's family and involving them in placement planning has several goals:

- Assuring that family members understand why placement is necessary, including the specific conditions in the family that created a situation of high risk for the children;
- Helping the family become engaged as a partner in the placement process, to reduce the stress experienced by their children, and to participate in developing and implementing the reunification plan; and

- Enabling the family's continued involvement with their children while in placement, thereby enhancing the likelihood of successful reunification.

The reasons for removal of the children must be thoroughly explained and discussed with the family. The worker should help the family recognize the conditions that contributed to high risk, and explain that the agency intends to reunite the family as soon as the home can be made safe for the children. The worker should also make the commitment to work in partnership with the family to make this possible. Finally, the worker should request that the family participate in the placement process to reduce stress for themselves and their children.

Once parents understand the reasons for placement, they can often help the caseworker explain this to the children. This helps reassure the children that their parents will work with the caseworker, and will visit with the children while in placement. If parents cannot or will not participate, another person important to the child, such as an extended family member, can play this role. This can be illustrated by a case example.

Case Example: Alma Rogers

The child welfare agency responded to a neglect referral of two children, about ages seven and five, alone in their family's apartment. The neighbor who had made the referral had seen the children's mother leave the day before but had not seen her return. The neighbor said this wasn't the first time the children had been left alone, but this time the mother had been gone much longer than usual.

The worker called for law enforcement support, and together the worker and the officer entered the apartment. They found two little girls cowering in the bedroom. The house was in disarray, furniture had been overturned, and there were matches all over the kitchen floor. The seven year old tearfully said she

had been trying to light the stove to make her younger sister some soup, because she had been crying that she was hungry.

The neighbor gave the caseworker the name of the mother's sister, Elaine. The worker contacted her. Elaine told the worker that her sister, Alma, age 29, had become a frequent user of cocaine. Elaine told the worker that Alma had a long history of mental health problems, and that she had repeatedly left her children alone. Elaine said she would come to stay with the children until Alma returned.

When Alma returned several hours later, the caseworker and Elaine confronted her with the risk at which she had placed her children, and strongly suggested she needed help. When Alma realized her children could have set the apartment on fire, she broke into tears, confirmed she was depressed and had often contemplated suicide, and was "too far gone on drugs to be any good to anyone." She refused mental health treatment, suggesting, "I've been through all that, more times than I can count, and you can see all the good it's done me." She also said she was obviously a failure as a parent and didn't see any hope of change.

The worker stressed that Alma could not continue to parent in her condition, and that a safety plan would have to be made for her children. The worker told Alma she could help make the plan, or the worker would have no choice but to make it for her. Alma agreed to allow temporary placement of her children, saying, "I guess it's time I give up," but she would not agree to any more treatment. The worker suggested the first step was to assure the children's safety, and that she needed Alma's help to keep the placement from traumatizing the children. Her children needed her help and support, even if they couldn't live with her right now. The worker encouraged Alma to tell the children about the placement, and to help move the children. The worker also obtained a commitment from Alma that she would set up, and keep, regular visits with the children. The worker prompted Alma regarding what she should tell the children, and she supported Alma while Alma told the girls that she had some drug problems, and she wanted them to stay with Aunt Elaine for a while. She would take them to Aunt Elaine's herself, she would visit them as often as she could, and she hoped they

could come home again soon. The children were visibly upset, cried, and clung to her. Alma packed some of the children's clothes, and they all drove to Elaine's house. The children remained moody and sullen for several days, but their responses were more similar to those of children being left with a babysitter than children who had been traumatized by a forced separation and placement. They ultimately adjusted well, since they liked Aunt Elaine, and their mother had given them the necessary permission to stay with her. The children talked with their mother on the phone daily. The worker also made a commitment to the children that she would try to find the best help for their mom. She told Alma this, as well.

Whether a parent can be engaged to collaborate with the caseworker in planning and executing the placement is important diagnostic information. Parents who can support and reassure their children, and who will maintain contact with their children in placement, exhibit considerable strengths that work in favor of timely reunification. It is the caseworker's responsibility to encourage and empower the family to become involved in the placement, and to help eliminate barriers to such involvement. Providing transportation, asking parents to participate in preplacement visits, and preparing the foster caregiver to be supportive and receptive to the parent can increase the parent's comfort with the placement process.

When possible, parents should be asked to recommend family members or friends as potential caregivers for their child. These caregivers should be evaluated for the degree of safety they can give the child. Both parents and caregivers must understand that the parents cannot interfere with the placement. The worker's ability to engage a parent to make an appropriate substitute care plan for a child is an essential step in developing the collaboration needed to reunify a family. When such a collaboration exists, and the family is fully involved, they are much less likely to engage in activities that sabotage the placement, or to emotionally withdraw from the child.

Parents should be asked to provide detailed information about their children's schedule, routines, likes and dislikes, and needs. This will greatly help the caregivers maintain continuity for the children, and also supports the parents' importance as caregivers to their children, as well. It is very helpful if parents can communicate this information directly to the caregivers.

The caseworker should acknowledge parents' anger and grief in response to the loss of their children, and should expect them to be initially resistant to talking with the worker or becoming involved in the placement. The caseworker should continue to be supportive, while firm, and continue to encourage and support parental involvement in all aspects of the planning and placement process. In the long run, most parents are more resistive to working with the agency and more likely to sabotage the placement when their children have been "whisked away to the unknown" by agency staff, while the family remains isolated and uninvolved in the process.

Preparing the Relative or Foster Caregiver

Caregivers need complete and accurate information about the children coming into their home. To assure confidentiality, parents should sign a release of information. Again, the transfer of information is considerably easier if parents can talk directly with the foster or relative caregivers. If a parent will not consent to a release of information, considerable data can still be shared without breaching confidentiality. As an example, the worker could communicate to the caregiver that "John has been hit with a belt by a man, and is very cautious around men."

If the caregiver has detailed information about a child, it increases the caregiver's ability to maintain continuity in the child's life, and helps to reduce stress. Information should include:

- The child's sleeping, bathing, and eating habits and schedules; food preferences, including culturally-specific dietary requirements and preferences; evidence of bed wetting, night terrors, or other sleep disturbances; whether the child sleeps with a light on, in a crib or bed, covered by a blanket or not covered, in pajamas or other apparel;
- The child's medical care needs, medications, special physical problems; the location of the child's medical records; the child's medical and inoculation history; the child's nontraditional medical experiences, and the family's expectations for medical care;
- How the child is accustomed to being comforted when upset;
- The child's interests, skills, and favorite activities;
- Behaviors and behavior problems that can be expected, and recommended methods of handling the child's problems; how the child has been disciplined in the past, and how the child should and should not be disciplined;
- The child's fears and anxieties, and how they are typically expressed;
- The child's school behavior, academic ability, extracurricular involvement, and special academic needs;
- The child's verbal ability and ability to communicate, and words that are important to the child that the caregivers may not understand;
- History of abuse, neglect, or sexual abuse, and how this may affect the child's development and response to the foster caregivers; and
- Culturally-specific caregiving practices should be stressed if the child and caregivers are of different cultural backgrounds. This includes strategies

to help children maintain their cultural identity and affiliations while in placement. Culturally-specific caregiving and hygiene practices should also be communicated.

The relative or foster caregiver must be encouraged to tell the caseworker if, at any time during the preplacement planning or visiting process, they realize they do not want to proceed with the placement. The caseworker should respect the family's decision, and seek another home for the child. If the placement is pursued despite the caregiving family's concerns, the risk of later disruption is greatly increased.

Preparing the Child

Adequately preparing a child for placement serves several important purposes. First, the caseworker can alleviate many of the child's anxieties and fears by providing detailed information regarding the need for placement, and by familiarizing the child with all aspects of the new home. This is, of course, less critical if the child knows the caregiving family and has stayed with them before. However, the child must still be helped to understand why a move is necessary, and his anxieties and fears related to separation must be acknowledged and addressed. Knowing what to expect can greatly lessen a child's fear of the unknown.

The preparation period also provides caseworkers with an opportunity to fully assess a child's individual development and needs. This information can also be communicated to the caregivers to help them in easing the children's transition into placement. Caseworkers should also use preparation as a means of establishing a supportive and trusting relationship with the child, which enables the caseworker to be more helpful and supportive to the child, both during and after the move.

While it may seem illogical that a child would trust the caseworker who moved him, a caring, concerned worker who is willing to stand by a child during a distressing time, can be an important source of comfort and strength to the child. Unfortunately, many well-meaning agencies or harried caseworkers send a case aide, a transportation aide, or other person to move children. The reasoning is that the caseworker will then be able to make a "fresh start" with children, once they are placed.

However, even if a person is angry with another person in a relationship, there is still a relationship, while an unfamiliar, "neutral" worker is still a stranger. If the caseworker properly and honestly prepares a child, the child's trust is likely to be greater, not less, even if the child is angry. A caseworker's relationship with the child can be strengthened by encouraging the child to express anger and fear, and validating those feelings. For example, the worker might say, "I know you're really mad at me for bringing you here, and upset about leaving Mom. It's okay to be mad, and I know you're scared too. Let's talk, again, about why I brought you here, and how I'm going to help Mom get better so you can go home." This will surface the child's fears and feelings about the placement, and the changes he is experiencing, ultimately easing the child's adjustment.

It is very important to most children that their caseworkers be a direct link to home and family. This assures them that they have not been set loose in the care of strangers who know nothing about their family or their past. Children are more likely to feel adrift, abandoned, and helpless without such a link. When distressed, children have been known to ask their caregivers to telephone their caseworker to find out what is happening, or how their family is doing.

The strategies used by the caseworker to prepare children for placement will vary, depending upon each child's age and level of developmental maturity.

Infants: Birth to 24 months

Many preparation strategies commonly used with older children are less effective with infants and toddlers because of their developmental limitations. In addition, infants are highly vulnerable to the effects of change in caregivers and environment, and they typically experience high levels of stress during placement. The goal of placement preparation, therefore, is to minimize the number of changes to which infants must adjust. Preparation incorporates strategies that maintain continuity and stability in the caregiving environment, that prevent abrupt losses of primary attachment figures, and that use sensory input to familiarize infants with their new environment.

Workers must help new caregivers understand the importance of maintaining consistency and stability in their caregiving activities. Caregivers should initially learn and follow an infant's typical routine and daily schedule as much as possible, including feeding familiar foods, maintaining familiar light levels, sounds, and smells, and giving baths and naps at the same time of day, and in the same manner to which the infant is accustomed. If previous care was harmful or intrinsically disruptive, or changes are necessary for other reasons, these should be introduced slowly.

Photographs, audio tapes, or videotapes can be used to familiarize infants with the faces and voices of the new caregiver(s). For infants who have developed rudimentary language skills, pairing words such as "mommy" or "daddy" with visual images can help reduce their strangeness. Workers and caregivers can also talk in simple language to infants about what is going to happen. Even preverbal children understand some language, particularly related to familiar persons, events, and objects. A caregiver might talk to an infant during routine caregiving, such as: "Andy's going to have lunch with the new mommy. See Andy's new mommy?" (Show photo.) "New mommy will give Andy cereal." "New mommy loves Andy." "New mommy gives Andy a bath." "Andy go night night in Andy's new bed." "We go bye-bye in the car after Andy's nap to visit Andy's new mommy."

Infants should also be allowed to acclimate to new caregivers prior to making the final move. When possible, a new caregiver should initially visit the infant in the infant's home and should provide as much direct care as possible, in the presence of the parent or current caregiver. This reduces the infant's stress, maintains the infant's current attachments, and allows the caregiver to learn caregiving routines to which the infant is accustomed.

Subsequent preplacement visits should occur in the new home, and should be scheduled on consecutive days, at different periods of the day. The infant's familiar caregiver and strongest attachment figure should be present, if at all possible, during the entire preplacement process. After placement, visits or phone contact with the previous caregiver should occur three to five times a week, until the infant has formed an attachment to the new caregiver. Frequent visits will maintain the parent-child relationship, which is essential for successful reunification. If termination of the parent-child relationship is the case goal, this should occur over a period of time. Such transitioning of infants into new families is critical, since traumatic separation during infancy is believed to contribute to attachment disorders [Bowlby 1973] and the failure to establish basic trust [Erikson 1963].

Preschool: Two to Five Years

Toddlers and young preschool children often have limited verbal ability, but they will probably be aware that something important is happening. They may become become frightened and anxious when they perceive that their parent is upset, or sense that a separation is imminent. When preparing preschoolers for a move, caseworkers must explain each step of a move in simple, concrete language that the children can understand. This explanation may need to be repeated several times during the course of the placement, both by caseworkers, and wherever possible, by parents. The explanation should be simple and direct, and should focus on the immediate future. Some examples are: "Today we're going in my car, and we're going to visit the Jones family. Mrs. Jones will make

you chicken soup for lunch. You can play with the children, Ben and Sally, and you'll take a nap in a new crib." "I'm going now, but I'll come back to get you after your nap, and you will go 'night night' in your own bed at Mommy's house." "Tomorrow after breakfast you'll go stay with Ben and Sally, and we'll help your mom so you can come home again." "I know you're very scared and maybe mad about leaving Mommy. But the Jones' will take very good care of you, and I'll be helping your mom while you're there. Your mommy will visit you lots of times, and you can talk to her on the phone."

Caseworkers can also use play techniques to communicate with toddlers and preschool children. This might include drawing pictures of the new family, the house, or the family dog; by telling stories; by acting out the move with dolls; and by showing photographs or videotapes of the new family members and their home.

During placement, many things are being done to children at an age when they need to be doing for themselves. Therefore, preschool children should be encouraged to make as many decisions for themselves as possible. These might include: what to take with them on visits; where they want to sit in the car; what they want the foster mother to make for lunch; where they want to take a nap, etc. They should also help pack their belongings and choose those items they want to take with them. Letting children leave important items at home can reassure them that they will be coming back.

Finally, during transitions, young children feel most secure when they can depend upon the people around them. Therefore, caseworkers should develop a strong relationship with children during the preparation period, which will enable them to be supportive and comforting throughout the placement process. This becomes less critical if children are to be cared for by people they know and trust, or if their primary caregiver participates in the placement, and can support and comfort them, both during and after the move.

School Age: Six to Nine Years

School-age children have well-developed language skills, and should be helped to talk about the placement and their experiences. Caseworkers can prepare children by describing the new home, the foster or caregiving family, and the neighborhood, and by answering children's questions. Children can also be debriefed after the move by being encouraged to talk about their experiences. Their responses can provide feedback regarding the degree of stress they are experiencing, and how well they are coping, which allows caseworkers to implement additional supportive measures as necessary.

Caseworkers should always explain to children why they must move. School-age children often believe placement is a punishment for something they did wrong. Caseworkers should reassure them and explain the reasons for placement in terms they can understand.

School-age children can also recognize and label some of their feelings, including being sad, scared, mad, lonesome, and worried. These feelings should be elicited and acknowledged by their caseworker and caregivers. Children should be encouraged to talk about their feelings, should be allowed to cry, and should be reassured that people know how hard it is and how badly they feel.

School-age children are less anxious if they clearly understand what is expected of them – that is, if they "know the rules." Caseworkers should insure that children are informed of the expectations in their new families, and help them understand that the caregiving family's rules might be different from those in their own families. Children should also be encouraged to talk with their caregivers, if they don't understand or like a rule. Caregivers should also learn each child's habits, likes and dislikes, and the rules to which they are accustomed. When feasible, some family rules can be modified to maintain continuity and consistency for the children.

When a child is placed in a family from a different cultural background, the caseworker should talk openly with the child about potentially feeling different, and the child's concerns about being accepted in the family and the new environment. The child should also be provided with opportunities to maintain culturally relevant activities and associations while in placement.

Preadolescent: 10-12 Years

Many preadolescents have begun to develop abstract reasoning, and their ability to view events from multiple perspectives has improved. As a result, they may be able to correctly identify the family and parental problems that resulted in a need for placement, thereby avoiding unnecessary self-blame. Caseworkers should help children fully explore the reasons for the placement, and stress that their need for safe care is paramount. Children will also need reassurance that their family is receiving help. They should be given considerable opportunity to ask questions, and workers should provide as much information as the children can handle. It is important that caseworkers be straightforward and realistic.

Preadolescent children should be encouraged to participate in placement planning, and to make as many decisions as possible about the placement process. They need to retain an appropriate level of control of their life.

Caseworkers should fully describe the placement setting prior to initiating preplacement visits. Preplacement visits will allow children to become accustomed to their new environment in stages. A trusting relationship with their caseworker is invaluable support, as it allows children to express their impressions, fears, and concerns before, during, and after placement. This is preferable to having to manage their feelings alone, and can prevent emotional turmoil or behavioral acting-out.

Many preadolescent children have concerns about loyalty. They need a consistent message that they do not have to choose between their own families and their new caregivers. They must understand they can be loyal to and love

their own families without risking censure from their caregivers. This will prevent them from having to reject their foster or caregiving family in order to reassure themselves of their own family identity, and will allow them to benefit from the placement without feeling disloyal.

When placed in a different cultural or socioeconomic environment, preadolescent children are often concerned about acceptance by peers and the community. They should be able to express these concerns with their caseworker and caregiving family. The caregiving family should intervene, when necessary, to protect a child from personal or community censure. Children should also have regular contact with their own community and cultural group. Placing children in homes in their own communities and cultural groups reduces this problem.

Early and Middle Adolescence: 13-17 years

Abused or neglected adolescents are often developmentally immature. Each youth's developmental level should be carefully assessed, and placement preparation strategies should generally be chosen that match each youth's developmental, rather than chronological age.

Typically, preparation of adolescents should focus on discussing the reasons for the move, and providing a detailed description of the placement setting. They should be involved as much as possible in choosing and planning the placement. They must know what their caseworkers are planning, and why, and must be given opportunity for input.

Some adolescents retain considerable loyalty to their primary families, and may be threatened if the placement is viewed as a new family. For this reason, foster or relative care may be presented as "a safe place to stay" until the family problems can be resolved, or until the youth can emancipate to independent living. However, we should recognize that adolescents without close family associations may desire and welcome integration into a new family.

Caseworkers should assess this with each youth individually and respond accordingly.

Adolescents may try to hide their anxiety and distress regarding a move. They may deny their concerns, and reject their caseworkers' attempts to provide support. Caseworkers should explain all aspects of placement anyway, "just in case any of this information might be of interest." Caseworkers should also prepare them for feelings of distress by saying, "Lots of kids in your situation are pretty angry about having to move," or, "Many kids don't like their new situation right away. If you don't, I'd like to hear about it. It's important that I help you feel comfortable."

If an adolescent must be placed in a culturally or racially different family or environment, the caregivers must understand the importance of maintaining cultural and ethnic identity while in placement. Adolescents are often very aware of personal, community, and institutional racism and bias. These need to be discussed, and they should be prepared with strategies to deal with them. They must be provided with opportunities for regular contact with their own community and cultural group. Again, as with younger children, developing placements for adolescents in their own communities and cultures greatly lessens this problem.

The preparation process is comparable when adolescents are to be placed in group or institutional care to meet special needs, or to provide opportunities for emancipation training. However, it becomes more important to identify a specific caregiver or caseworker who can establish a trusting relationship with a youth, and provide guidance and support during the adjustment period. This may be difficult when group homes or institutions are staffed on shifts. Without such a contact, however, adolescents are essentially left without situational support.

The Placement Process

Preplacement Visits and Activities

An effective strategy for reducing stress associated with change is to partialize the change into small, manageable increments, or steps. Smaller changes are less overwhelming, and can be more easily managed. Experiencing small successes also helps us feel in control, increases our confidence, and makes subsequent changes less threatening. Consider how often, in stressful and challenging situations, we say, "Well, I've gotten this far... I guess I can get through the rest." Preventing stress overload helps to prevent crisis and its resulting emotional turmoil and immobility.

Dividing placement activities among several preplacement visits allows children to become accustomed to their new caregivers and environment a little at a time. A sufficient number of steps should be planned to allow children to develop familiarity with and comfort in the new environment before they are placed there. In general, two or three preplacement visits in as many days can help ease the transition and remove some fear of the unknown. Some children will require additional time, and the placement plan should be individualized to meet each child's needs.

Preplacement visits should be a few hours in length, particularly for toddlers and preschool-age children. School-age children can tolerate visits of several hours. Visits should be scheduled to allow the child to experience the home at different times of day and under different circumstances, and to experience routine family activities. For younger children, visits should be scheduled to coincide with meals and nap times so they can experience these critical caregiving activities and feel more secure about them.

Early in the first visit, children should be given a tour of the home. Those areas which will be theirs (bed, closet, dresser drawers, toy box) should be pointed out,

and they should be encouraged to use them by putting their sweater in their drawer, putting their toy bear on their bed, hanging their coat in the closet, and taking a nap in their bed. Caregivers should point out where the food is, where the bathroom is, and otherwise help make children feel secure and comfortable.

Only one member of the caregiving family, usually a parent, should be identified to initially develop a relationship with a child who has been placed. No more than one or two family members should be home during preplacement visits. Children should never be greeted at the door by parents, a group of children, grandparents, dogs, and curious neighbors. Children need a single, trusting relationship with someone in the home to provide them with support and comfort during the early adjustment period. The preplacement visits should focus on developing this relationship. Other relationships can be developed as a child is ready. Some children are more comfortable with other children and less so with parent figures. In this case, older siblings can initially bond with placed children and "show them the ropes."

During preplacement visits, caregivers should try to maintain as much continuity for children as possible. They can adhere to children's familiar schedules and routines, feed them familiar foods, let them choose and wear their own clothing, and use gentle and nonintrusive guidance and discipline to help them learn new rules. After several weeks, when children are more settled, caregivers can gradually revise their schedule to better conform to the family's.

Ideally, children should be given periods of respite away from the new home during the placement. These can be in their own home, or in familiar and comfortable surroundings, where they can reflect on what is happening and freely express their concerns and feelings. Even in emergency placements, where children cannot return home, a relative's home, a friend's home, or even the caseworker's car can serve as such a respite. These respite periods allow children to recoup their strength and receive support from known and trusted persons.

Determining the Rate of the Placement

The rate of placement is the total length of time between the decision to place and the final placement. The shortest placement is to transport children and their belongings from one home to another and leave them. A more extended placement may include several preplacement visits over a period of several weeks, as might occur when a child is being placed from a foster home to the home of a previously noncustodial parent in another community.

The rate of placement should be determined by two factors: the degree of risk to children in their home environment, and their coping abilities. The rate should be individualized to prevent undue stress and anxiety, and to help children comfortably transition from one home to another, without leaving them unprotected in a high risk situation.

In situations where children are not at risk, as when being placed for adoption, moving between foster homes, or being reunited with family or relatives, the rate of placement should always be determined by their needs and ability to cope with change. If potential risk to children in their current placement is sufficiently high to warrant an emergency removal, placement should proceed without extended preparation. In these circumstances, however, we can increase the rate of placement by protecting children in familiar surroundings with a relative, friend or neighbor while we identify the most appropriate placement setting, prepare the children, and conduct preplacement activities.

Interim placements in emergency foster homes are not, however, the same as interim placements with a relative or friend. Children are comfortable with a relative or family friend. Staying there is, therefore, less stressful. In emergency shelter care, we place children in one strange and unknown situation, and then move them to another, just as they are becoming accustomed to the first. Such multiple moves greatly increase their stress.

When there are no options but to place children immediately in an unfamiliar setting without preparation or preplacement visits, caseworkers must be prepared to do intensive and extensive postplacement supportive work with them to prevent or deal with crisis. If, despite attempts by workers to avoid it, a child does experience clinical crisis, intensive casework activities should be provided during the crisis period. Without supportive counseling at the time of the crisis, children may suffer long-term negative consequences.

To determine a child's coping ability, the caseworker must recognize normal signs of stress in children, and must be familiar with a child's individual responses to stress. The worker must carefully monitor the rate of the placement to prevent the child from experiencing crisis. When the child shows signs of excessive stress, the caseworker should slow down the placement process and provide the child with considerable support. This may mean increasing the number of visits, and /or shortening the length of individual preplacement visits.

A placement without proper preparation can cause overwhelming stress and emotional crisis. However, at times, providing too long a preparation and preplacement period can also increase the child's anxiety. It is easy to overextend the preplacement process in relatively low risk situations, such as adoption. Once the child is told about the move, preparation activities should begin immediately. Under most circumstances, preplacement visits can be completed and the child can be moved within a few weeks. The child can generally be placed comfortably in the new home when she is familiar with the environment, and when she has identified the caregiver as a source of support and help, particularly if she is allowed frequent contact with her parent or other trusted caregiver.

The following case examples illustrate differences in coping ability of several children of the same age, but with different temperaments and histories. They also illustrate how their caseworker structured placements to meet the children's individual needs.

Marie Sullivan, age two

Marie was a failure-to-thrive infant. She was placed in foster care for a month during infancy and returned to her mother. She was again placed in foster care at age one and a half due to severe neglect. When Marie was two years old, the agency was awarded permanent custody, and an adoptive family was identified.

Marie was an engaging redhead who was well into the "me do it" stage. She related to people surprisingly well, considering her history, and she showed considerable interest in people, toys, and activities. Her foster parents were elderly and had chronic health problems, which greatly limited their activities. Marie had received good basic care and affection from them, but very little stimulation. Their home was dark and quiet; television was the only activity. Marie did not appear to be particularly attached to either foster parent.

Within the first few minutes of the caseworker's first home visit, Marie invited the worker to "play dolls" on the floor with her. The worker took advantage of Marie's attachment to her dolls, and used play strategies to engage Marie, and eventually to prepare her for the impending move. In subsequent home visits, Marie and the worker took turns acting out the placement steps with Marie's dolls.

The adoptive family had four children between the ages of four and ten. On the first preplacement visit, the children greeted Marie at the door and immediately took her to the playroom, where they stayed for the three hours until the visit was over. On the second visit, Marie brought some of her clothes and left them at the new house, and she protested when the worker told her it was time to go back to the foster home. On the third visit, Marie got out of the worker's car unassisted, walked alone up to the front door, knocked loudly, and when the door was opened, walked straight into the house. Her first stop was her new bedroom, where she opened a dresser drawer, put her favorite teddy bear inside, and slammed the drawer shut. She then stopped in the kitchen, asked for a

snack, and went off to find the kids. Essentially, Marie had moved herself in. The worker let her stay that night. Marie and the worker went back to the foster home the following day to say good-bye to the foster parents and to get the remainder of Marie's clothes.

The worker was initially concerned that Marie's behavior and apparent obliviousness to separation from her foster parents reflected an aloofness characteristic of attachment disorder, or reflected the "shock/denial" stage of grief. She prepared the adoptive parents for possible subsequent problems. However, Marie engaged quickly and appropriately with the parents and the children, and she never exhibited significant emotional distress or problems. She was doing very well six months later. The worker concluded that perhaps Marie had "gotten something good somewhere" in her chaotic early years, and had not lost her ability to engage in healthy relationships; or, that temperamentally, she was simply more resilient than other children.

David Vance, age two

David was a shy and retiring child. He was adopted during infancy, but was returned to the agency by the adoptive family at age one and a half, ostensibly because they "couldn't bond with him." He adjusted well to his foster home, but he exhibited excessive anxiety in response to new people and unfamiliar situations. He hid behind his foster mother and refused to look at the caseworker the first several times she visited. Eventually, the worker engaged him to play with her, but he began to cry each time the worker suggested they go for a ride in the car. It took many weeks of short walks in the yard and trips to the store in the worker's car, with the foster mother present, before David would go with the worker alone.

The adoptive family chosen for David was prepared for a lengthy preplacement process. The family initially met David at a park near his house. They talked with the worker while David played. David was curious, but unwilling to relate

directly to them. The adoptive family visited the foster home several times. Eventually, David went for walks with them in the yard, and then allowed them to take him to the park. After the third park outing, they took David to their house for ice cream. Subsequent visits were held in the adoptive family's home, gradually extended in length to entire days. When David was finally moved, the foster caregivers helped, and they visited him twice weekly in the adoptive home for the first two weeks of the placement. A month after placement, the adoptive family took David back to the foster home to visit. All in all, the placement process spanned about six weeks, with another two months of follow-up support. In spite of the careful preparation and slowed pace, David exhibited considerable stress, including crying at night and symptoms of physical illness. However, he did not experience crisis, and he allowed his adoptive parents to comfort him. Regular contact with his foster caregivers also helped him feel more secure.

David and Marie represent two ends of the continuum of children's responses to placement-induced stress. Marie's placement went easily, largely because of her comfort with new people and new situations, and the absence of strong attachment to her foster parents. David, by contrast, was exceptionally vulnerable, probably due to his temperament and his previous separation experiences. The rate and length of each placement were determined by the child's needs and stress level. The worker was able to adjust placement activities to prevent crisis, while encouraging the child to form attachments to new caregivers, and a new home before the final move.

A third example demonstrates how a natural progression from one family to another resulted in a creative placement that met the child's needs. This case example also illustrates how a child's current caregivers can facilitate a move.

Darren Thomas, age two

Darren was removed from his teenage mother when he was one year old. Considerable work had been done with the mother to help her keep Darren, but he continued to be subjected to serious neglect because of his mother's chronic use of drugs and alcohol. There were no relatives to care for him, and he was placed in foster care. The agency filed for permanent custody, and an adoptive family was identified.

Darren was two when adoptive planning began. The worker prepared Darren to move using dolls and photographs, and began preplacement visits with the adoptive family. Darren knew his caseworker well, and went willingly with her to the new home. However, upon entering the home and meeting the new family, he became uncharacteristically cautious, and clung to the worker. The family tried repeatedly to engage Darren and entice him away from the worker; the harder they tried, the more frightened Darren became, and the more he clung to the worker. The family suggested the worker leave so they could better focus Darren's attention on them. Despite her concern about leaving him, she complied. When she returned an hour later, Darren was distraught; he had cried continuously, and the adoptive family had decided this was not the "right child" for them. When the worker entered the house, Darren ran to her and promptly curled into her lap sobbing, and eventually fell asleep.

About a month later, adoption planning was resumed with a second adoptive family. This time the worker began placement activities on a Friday by having the adoptive family meet Darren in his foster home. They visited for three hours, talked with the foster parents, played with Darren, and expressed strong commitment to continue the adoption.

The caseworker had arranged to pick Darren up early Monday morning to transport him to visit in the adoptive home. When she arrived at the foster home on Monday, Darren wasn't there. The foster mother sheepishly explained that

they had seen the adoptive family at their church on Sunday, and the adoptive family had invited the entire foster family to Sunday dinner. They had visited well into the evening. Darren had played with his new brother, and they both fell asleep in the bedroom they were to share. Rather than disturb Darren, the foster family let him sleep, and asked the adoptive family to call them if Darren awoke and was at all distressed. The foster mother acknowledged to the worker that she had wondered if this was permitted, but only after she had returned home. She had called and left a message at the agency early that morning, and apologized if she had erred in her judgment.

When the worker arrived at the adoptive home, Darren was contentedly having breakfast. The remaining placement steps went as planned, with Darren returning intermittently to the foster home to pack and move his belongings. The two families planned to visit often after church.

Darren was a friendly, adaptable child, who nonetheless reacted strongly to an unfamiliar and stressful situation. With the validation given to the adoptive family by his trusted foster family, he was able to easily engage and stay with them without distress. The ability to maintain contact with his foster parents after placement also helped to prevent a traumatic separation.

Rochelle Carter, age 10

Rochelle's case illustrates how a worker can prevent trauma when a child must be moved without preparation or preplacement visits.

Rochelle had lived with her grandmother intermittently for most of her life. Her mother was mentally ill and hospitalized periodically. Currently, the mother's whereabouts were unknown. Rochelle's biological father had died in a car accident shortly after her birth.

The child welfare agency became involved after a referral from a neighbor. Rochelle's grandmother had been taken to the hospital by the emergency squad, and it was believed she had suffered a heart attack. Rochelle was due home from school, and there was no one to care for her. The neighbor, also elderly and ill, knew of no other family or relatives in the area, and could not care for Rochelle herself. The intake worker arranged for the neighbor to meet Rochelle after school, and she began arranging an emergency foster placement for Rochelle.

The worker arrived at the home shortly after Rochelle returned from school. Rochelle was visibly upset, and very worried that her grandmother was going to die. She did not want to move; she wanted to stay alone in the house, or go to the hospital and stay with her grandmother. The worker explained how this was not possible, and began talking about going to a foster home. Rochelle protested strongly and said she would not go. The worker was very supportive and assured Rochelle that everything possible was being done to help her grandmother, but that it was important that an adult be there to care for Rochelle.

In spite of Rochelle's refusal to go, the worker began preparing Rochelle. She talked about the foster mother, Audrey, described her interests, told Rochelle that Audrey was very concerned about her grandmother and really wanted to help Rochelle. Audrey had a daughter who was grown, and she had lots of time to spend with Rochelle. The worker then asked Rochelle if she would be willing to talk to Audrey on the phone before they went to the house; Rochelle grudgingly agreed, and the worker placed the call. Audrey, who had been prepared by the worker, told Rochelle how much she wanted her to come stay for as long as she needed to, and that the first thing they would do when she got there was to call the hospital and check on Rochelle's grandmother. Rochelle agreed to stay with Audrey, but "just for now." She packed the bare essentials in an overnight bag, and the worker transported Rochelle to Audrey's.

The worker made daily follow-up visits to the foster home for the first week. Rochelle and Audrey called the hospital several times a day to check on

Rochelle's grandmother, who remained in intensive care, but was stable. When Rochelle needed additional clothes, the worker transported her and Audrey to the grandmother's house, and together they decided what to take and what to leave. Eventually, most of Rochelle's belongings were moved to Audrey's.

Her grandmother's illness and the placement together precipitated an emotional crisis for Rochelle. She had long crying bouts, and she awoke most nights with nightmares. Audrey was up with her for many hours. They drank hot chocolate and just sat together until Rochelle fell asleep again. Rochelle could not concentrate in school and could not sit still in class. The caseworker talked with the teacher, who intervened gently and did not punish Rochelle. The worker and Audrey considered supportive counseling, but decided to wait a while longer to see if Rochelle settled in.

The grandmother was eventually discharged from the hospital to a nursing home. Audrey, who had lost her own mother recently, helped Rochelle deal with the loss, and took Rochelle to visit her grandmother frequently.

Eventually, Rochelle was placed for adoption with an aunt she didn't know she had – her biological father's sister. This time, the placement occurred only after extended preparation and preplacement visits. Audrey felt herself too old to adopt, but she remained close to Rochelle, and was accepted by the adoptive family as Aunt Audrey.

While Rochelle had to be placed with little preparation in a precipitous situation, the caseworker and the caregiver together provided sufficient situational and emotional support to prevent permanent negative outcomes from the crisis.

Providing Children with Opportunities to Talk about Placement and Their Feelings

Separation and placement are universally painful. Children typically experience feelings of loss, abandonment, fear, anxiety, confusion, isolation, anger, guilt, rejection, and depression as a result of separation. A child's expressions of emotional pain may elicit feelings of guilt from adults for having caused the pain, or feelings of helplessness at being unable to alleviate the pain. For these reasons, children are often not permitted by parents or other adults to express or dwell on painful feelings. Adults may subtly encourage a child to stop crying, or may try to redirect him to think about other things, or to become involved in distracting activities. However, as with any victim of trauma, the child needs to talk about his experiences, perhaps many times during a period of weeks or months, with a supportive and caring listener.

Unresolved painful feelings, and misunderstood experiences, will continue to cause fear and confusion for a child. The emotional energy expended in trying to cope with these feelings can reduce the child's ability to concentrate, interfere with school work, prevent him from dealing with fears about attachments, and keep him preoccupied with his own needs. The painful feelings may be manifested in unacceptable behaviors for which the child may be punished. This only increases the child's anxiety and depression, and may complicate his situation.

The caseworker should develop a supportive, nurturing relationship with the child that allows the child to communicate his painful feelings, either in words; through drawings, stories, or play; or through appropriate behaviors such as crying; by verbally and emotively discharging tension or anger; or choosing not to talk or play for a while. The caseworker should educate the caregivers to support the child in a similar manner. If the child can deal with negative feelings by expressing them in a supportive environment, these feelings are less likely to cause lasting harm. For less verbal children, the caseworker may need initially to

label the child's feelings, such as, "You look like you're ready to cry. You probably feel really sad right now. You can cry if you like. I have lots of tissues;" or, "I know how mad you are about having to move. It's a hard time, and it's Okay to be mad. You can tell me about it, if you like."

Postplacement Services to Children

Once a child is moved, casework intervention can ease the child's adjustment, and help prevent subsequent trauma.

Assure that the Caregiver Receives Adequate Support

Postplacement support can greatly increase the likelihood of a successful adjustment by the child and the caregiving family, which helps to prevent placement disruption. Postplacement support can be provided in a number of ways. The caregiving family can be referred to appropriate community services that address the child's special needs. This may include medical services, special education programs, mental health counseling services, recreational opportunities, and developmental services. The caseworker, as a case manager, can help to arrange and access needed services. When a child is from a different cultural background than the caregiving family, the caregivers should be helped to locate culturally relevant service providers, particularly for developmental and recreational services.

Emotional support for caregivers is also important. The caseworker should be available to help the caregiving family identify and discuss issues and resolve problems. Respite services should be made available to caregivers who are caring for challenging children. Respite services are designed to offer short-term, out-of-home care for children to allow caregivers a reprieve from the stresses of foster care. This allows families to renew their strength, and to focus time exclusively on their own needs. Finally, invaluable support can be provided by the caseworker and by other caregiving families who have had similar

experiences. The opportunity to talk with others allows caregivers to exchange ideas, vent their frustration, and receive encouragement and support.

(Strategies to support caregivers is more fully discussed in Section X-C, "Working with Foster and Other Caregivers.")

Help Children Develop a Story to Explain the Reasons for Placement

Many children have difficulty responding to questions from friends, neighbors, teachers, and other curious adults about why they are living in a foster home. Children are often embarrassed and self-conscious. They may fabricate reasons for their placement, or they may avoid discussing it.

The caseworker can help a child deal with this situation by helping her prepare and practice an honest, simple, but nonjudgmental explanation of why the child cannot live at home. Confidential information can remain confidential. Such a "cover story" can prevent embarrassment for the child. An example of an appropriate explanation might be: "I'm staying with my aunt till my mom feels better and can take care of me." "My mom is getting counseling, and she can't take care of me until she's better. When she is, I'll go back home." The foster family, including all children in the family, should be included in this activity, and all family members should use the same explanation when asked about the child. The foster family should offer the explanation to interested neighbors, other children, teachers, and others to reduce the number of persons who will ask the child directly about her status.

Help Children Maintain Continuity and Identity: The Lifebook and "A Story about You"

Children in placement are at a significant disadvantage. Each time they move to another home, a part of their past is lost. Most of us remember our pasts through photographs and anecdotes that we've heard from our families. Ironically, while

fun for most people, these stories are not critical to identity development, since we learn who we are and understand our histories by growing up with our parents and extended families, and by sharing in their customs and traditions.

Many children in placement have neither memory nor knowledge of their early lives. Many children doubt they have a history. For example, a five year old solemnly told his caseworker that he had never been a baby... he had always looked just like he did now. If a child has correct information, supported by visual representations of his early life, he can be helped to construct a positive and realistic sense of self, along with a history. This helps children retain ties to their past, which is critical if a child is to be reunified with his family. It will also enable the child to integrate elements of his past and his future if placed into an adoptive or other permanent home.

Each child in lengthy out-of-home placement should have her own Lifebook to document her history. Lifebooks are scrapbooks that contain photographs, drawings, anecdotes, stories about the child, her family and her friends, and other memorabilia. The child can participate in developing the Lifebook, and in dictating or writing her own contributions to the history.

The Lifebook provides continuity, helps establish a positive identity, and allows the child to share her past life with others. Lifebooks are also an excellent tool for caseworkers in helping children understand the reasons for placement. The Lifebook can also help children from ethnically and culturally diverse backgrounds maintain a positive cultural identity and self-esteem.

Case Example: Lisa, age seven

Lisa's biological mother had left her with a neighbor in a laundromat "for a couple of hours" when Lisa was two. She never returned. Lisa lived with this woman and her husband, Jack, for several years. The woman subsequently divorced Jack, and left Lisa in his care. At age seven, Lisa was living with Jack,

whom she called "Daddy," and his new girlfriend when, during an episode of domestic violence, a neighbor called the police. Lisa was placed into foster care to assure her safety. Further assessment revealed that Jack had been engaging Lisa in fondling and sexual play for many months.

The worker could find no historical information about Lisa, except for her mother's name on Lisa's birth certificate. The father was listed as "unknown." The mother could not be located, permanent custody was filed, and an adoptive home was sought for Lisa.

The worker began to prepare Lisa for adoption. Lisa was very confused about why she couldn't live with Jack, and didn't understand that he wasn't really her father. The worker developed a Lifebook with Lisa to help her better understand her situation and to reconstruct her early history.

The worker wrote, "A Story About Lisa," and read it to Lisa during visits. When the worker read parts that Lisa remembered, Lisa embellished the story from her own point of view, and her contributions were added to the story. The worker and foster mother also took pictures of Lisa for the Lifebook. The worker reconstructed what she could of Lisa's early life by photographing her old school, her teacher, and the home and neighborhood where she had lived prior to placement. A photograph of Jack was obtained and also put into the Lifebook. Lisa dictated what should be written about each picture.

One day, the worker brought Lisa a footprint and a picture taken immediately after she was born, obtained from hospital files. When presented with the photo, Lisa stared at it for long moments, then asked, "Are you sure this is really me?" Lisa pasted the picture on the first page of her Lifebook and told the worker to write, "This is Lisa when she was a very teeny, tiny, little baby."

There are many ways caseworkers can gather information for a Lifebook. Foster caregivers or relatives are often eager to help, and can assume most of the

responsibility for gathering contents and compiling the scrapbook. There are many sources of valuable information:

- The worker can approach biological parents and other relatives and request pictures of the child. Families are often willing to provide pictures, if the purpose is explained, and if they are assured that the pictures will always be in the child's possession. If they have only original prints, photo shops can make copies, and the originals can then be returned to the family members.
- Family members can contribute pictures of themselves. This should include parents, siblings, extended family, family friends, and others who have been important to the child. This is particularly important if the child's biological parents are, or have been, absent.
- The worker can approach previous foster parents or caregivers; they may have many pictures of the child in their own family albums. They can provide negatives or extra photos, or copies can be made from prints or slides. Workers may find photos documenting a child's first tooth, first steps, birthday parties, and other family events. Photos of previous caregiving families should also be obtained.
- The worker can return with the child to her previous schools, neighborhoods, and communities, and together they can photograph people and places familiar to the child. The worker can also obtain class pictures from the school, and school pictures from the school photographer.
- The worker can call the hospital where the child was born, inquire whether infant photos were taken, and contact the photography department to obtain the negative or a reprint. Footprints and other documentation may also be available. The hospital building can be photographed, also.

- The worker can ask relatives and previous caregivers for examples of the child's drawings and artwork.
- The worker can ask key informants to tell their "cutest story" about the child, and then write these up into a narrative, identifying each storyteller and his or her relationship with the child.
- Workers can encourage current caregivers to document what appear to be unimportant daily events. These current events will one day be the child's history, and this documentation will be of particular importance if the child leaves their home.

Developing the Child's Story

Writing a story that presents the child's history and the reasons for placement requires both honesty and sensitivity. It is a difficult undertaking, since information about the child's early life may not be immediately available. However, workers can construct a history for most children that provides continuity and strengthens identity, and that can also help to explain the reasons for placement, even from limited information.

The story should begin with the child's birth information. Basic facts are essential, including the date of birth, the time, the child's weight and length, the place of birth, and the name of the hospital. If this information is not in the case record, it can be obtained by asking the parents or other family members, by checking the birth certificate, and by accessing the records at the hospital. A release of information may be necessary.

The child's history should include the ages at which he first sat up, cut teeth, crawled, walked, uttered his first words, started preschool, and other milestones. Information on developmental milestones can be gleaned from family members,

or can be inferred from case dictation or photographs. For example, one worker found a family case dictation which noted that when the child was nine months old, he was "dressed inappropriately in only a wet diaper, and was crawling around on a filthy floor." It can be inferred that at nine months, the child had learned to crawl. Many developmental stages can be determined from this kind of description, and can be written in the child's story. For example, "When you were four you liked to ride your cousin's tricycle;" "Your grandma said even when you were very little, you loved chocolate ice cream;" "When you were two, you liked to play outside, and once you played in the mud and got it all over yourself;" "You were a quiet baby; you didn't cry very often;" "When you were three, you went to the zoo with your brother, and you really liked the elephants;" "By the time you were 15 months, you were toddling all over the house." While these do not state precisely when the events occurred, they do document the events. It is most important to provide the child with validation that he has a history; that he was once a tiny baby, then a young child, that he developed skills like all children, and that he did cute and unique things.

Factual and descriptive information about the child's parents and extended family are essential. This is made more difficult when biological parents have been absent and cannot be found. However, information can again be obtained from extended family members, and from the case record. Children will want to know not only what their parents looked like, but their interests, likes and dislikes, and accomplishments. This makes them real to the child. For example, a description of a child's parents could read as follows:

"Your mother had green eyes and dark blonde hair. She was of medium height and build. Her background was Irish, French, and Cherokee and Choctaw Indian. She was of the Protestant religion. She had a ninth grade education and worked as a waitress. Your mother was musical and artistic; she loved to draw, and she liked to play the piano. She also loved sports, especially swimming and softball. Your father had dark hair and eyes, and he was about six feet tall. He was a very skilled mechanic, who particularly liked riding and working on

motorcycles. He traveled all over the county on his bike with a group of other bikers. He met your mother on one of his trips."

It is important to present inherently negative information in a matter-of-fact and nonjudgmental way. We know that children need positive facts about themselves and their families to develop healthy self-esteem and identity. Yet, we cannot fabricate a story, nor hide important facts that will help a child better understand his history. Workers are confronted with the dilemma of how to tell a child that she didn't sit up until she was 11 months old because her mother never fed her; that a child was born prematurely because of her mother's drug addiction; or that her mother left her with a stranger at the laundromat and never returned. We must look for the strengths in the child's history, and interpret this information in a positive light.

An early case dictation by a child welfare caseworker describes Jenny, 11 months old, sitting on a filthy blanket in a ragged playpen, with a ball and two blocks. She had poor color and was very underweight for her age. Jenny was dirty, underfed, and wobbly, but she was sitting up by herself, and her mother provided her with a playpen and a few toys. The history might read:

"You lived with your mother in a small apartment until you were 12 months old. Your mother was very young when you were born, only 15, and she didn't understand how to feed and care for babies. Sometimes she forgot to feed you, or change your diaper. Still, she did what she could for you. She got a playpen and she put toys in it. When you were 11 months old you were sitting up all by yourself, and the first time the caseworker saw you, you were in your playpen batting around a pink rubber ball your mother had given to you."

Events like prematurity can be explained in general terms. Most children are not concerned with the medical reasons for their prematurity. A simple explanation will suffice, such as:

"Sometimes babies surprise everybody by being born sooner than expected! You were born two months early, and this is the reason you were so very tiny when you were born. Because you were so little, you got very special care in the hospital, sleeping in a bed that kept you warm and comfortable until you grew big enough to go home."

Stories from family members, albeit brief, can be embellished to create a picture of the child and her environment.

"Your grandma told me you were a pretty baby with white-blonde hair and blue eyes. She said your blue eyes were a family trait – your grandmother's eyes were blue, and so were your mother's. Your grandma called you "Sweet Pea" because when you crawled around on the floor in your flannel sleepers, you looked like Sweet Pea from the Popeye comic strips."

By describing parents' attempts to provide care for the child, we can help dispel the child's fear that they were blithely abandoned by selfish parents who didn't care whether or not they existed.

You lived with your mom at your grandma's house for four years. Your mom tried very hard to take care of you and your brother. It was not easy, because two children, age four and six, can be quite a handful. Sometimes your mom wanted to be independent, and she and your grandma had fights. Sometimes the pressures got too great, and your mom took you and your brother to her girlfriend Sylvia's, and Sylvia cared for you while your mom tried to find a job. Some days there was nobody at home to take care of you. That was when you got your first caseworker, Sally, who wanted to be very sure that you and your brother were cared for. Sally moved you to a foster home, at least for a while, until she could find your mother and try to help her care for you herself."

In the story, the worker can acknowledge the child's feelings about loss and multiple placements. Children may have no memory of these feelings, or may believe negative feelings should not be expressed. Validating the child's negative feelings is an important part of the therapeutic process.

"During the summer, Mrs. McGraw learned she had to have a major operation. She didn't want to tell you, because she was afraid you would worry. It would take her many months in bed to recover, and she would have to go to the doctor often for treatments. She felt it would be better if you were in a family where the mom could be at home. So we moved you to the Andersons.

"This was your third foster home, and by this time, you were pretty confused, tired of moving around, and angry. You worried about how long you would stay with the Andersons, and whether you would move again. You wondered when you could go home, or when you would get a family you could stay with forever. It was really hard for you. Your caseworker kept working to help your mom solve her problems and take you home, or else find you a family of your very own to live with forever.

"After we moved you to the Andersons' house, you helped us to understand how very angry you were. You had lots of tantrums. You kicked and screamed, and sometimes you broke things. It was hard for the Andersons at first, and harder for you. But we talked about how bad you felt, how worried you were, and how mad you were that you had to move again, and the Andersons finally understood what you were feeling. They helped you learn to tell them when you were mad, so you didn't hurt yourself or other people. Every day you and Mrs. Anderson would have "mad story time" where you could tell her every single thing that you were feeling mad about that day."

Workers have little trouble describing well-meaning and sincere parents who just don't have the capacity to care for their children. Quoting or paraphrasing parents' reasons for allowing their children to be placed can help those children understand that their parents had their best interests at heart, and their parents didn't give them away because they were bad. While some children may believe their parents to have been weak or irresponsible, this is better than believing that their own inherent badness prompted their parents to abandon them.

"Your mom came to the agency and asked us to find you a permanent family where you would be loved and cared for. Your grandma had died, and your mom was alone. She had been on drugs for a long time, and she was struggling to get better. She knew that when she was on drugs she didn't give you very good care. She explained to me why she wanted us to find you a family to live with. She said, "I suppose this sounds very cold and unloving, but I've been doing a lot of thinking about this, and I cried most of last night. But I'm doing this for Danielle. I was raised on the streets, and not in the schools, and I don't want Danielle to have the sort of life I had. It's a hard life. Danielle deserves better than that. I'll always love her, but I want her to have a future, and I can't give it to her. If she stays with me, she'll always be hurt."

It is considerably more difficult to help children deal with serious parental problems or behaviors, such as drug addiction, criminal activity, abuse or neglect, sexual abuse, or violence. Older children may have some memory of these activities, and other family members may continue to reinforce their parents' "badness."

"Life was not very happy for your mother when she was growing up. When she was very little, your Grandpa Tom left your grandma alone with three little children. Your grandma had never worked before. She did laundry and cleaning to support her family. She didn't have much time to spend with her children. Your mother was always a strong-

willed girl, and when she became a teenager, she became very rebellious. She dropped out of school, ran away from home, and lived with her friends. She took drugs from time to time. Most teenagers are rebellious, and it can be a hard time. But it was especially hard for your mother, because she was stubborn and wouldn't let anyone help her. She wanted to be independent, but she made some bad choices. Her relationship with your grandma was pretty stormy, and made things hard for both of them, even though your grandma always loved your mom. You were born while your mom was on the run, and your grandma took you to live with her, hoping that one day your mom would grow up enough to become a loving and responsible parent."

Helping children understand their history is much like providing sex education; we must give children enough information to answer their questions, but not more than they are ready for, or are able to comprehend. Adoption workers should consider writing each child's life story in two or three versions, covering the information at varying levels of depth for use at different stages of development. When children reach adolescence, they will need more in-depth information, and they are more capable of understanding complex explanations. Information can be given to permanent families to be shared with children as they grow.

While young children may have difficulty understanding abstract reasons for behavior, older children may, in time, be able to understand that their parents were products of their own environments, and may be able to develop empathy for them, if not acceptance of their behavior. As Fahlberg [1991] states, an important goal of the life story is to eventually help adolescents and young adults understand the complex events that led to their placements, to perhaps understand, and possibly to forgive their parents for their actions.