



A SERVICE OF THE  
CHILDREN'S BUREAU

# The Source

■ **Newsletter of  
The National  
Abandoned Infants  
Assistance  
Resource Center**

VOLUME 13, NO. 2  
FALL 2004



## IN THIS ISSUE

- 1 Creating Threads of Continuity:  
Helping Infants and Toddlers  
Through Transitions in Foster Care
- 5 Helping Children Transition  
to New Caregivers
- 7 Making the Transition:  
Learning to Cope Through Art
- 9 Supporting the Transition of  
Infants with Prenatal Substance  
Exposure from Foster to  
Adoptive Homes
- 14 Congratulations!
- 17 Transition Issues for Children of  
Incarcerated Parents
- 25 Good Bets
- 29 Conference Listings

## CREATING THREADS OF CONTINUITY: HELPING INFANTS AND TODDLERS THROUGH TRANSITIONS IN FOSTER CARE

**T**wenty-month-old Sara had been living with her foster mother since birth. Her biological mother had a long history of substance abuse and was unable to stabilize her life. She had family reunification services but utilized them minimally. She was inconsistent in her visitation with Sara and expressed feelings of resentment and animosity toward the foster mother. Nonetheless, at the eighteen-month hearing, the judge determined that Sara should return to her biological mother that same day. Sara's things were packed, and her grieving foster mother tried hard to prepare her and to say goodbye. Her homeless biological mother, pleased but no doubt overwhelmed by the quickness of the return, took Sara to a shelter with her that night.

Despite concerted and thoughtful attempts on the part of the foster mother and child welfare worker to allow some transitional contact between Sara and her foster mother, her biological mother was unable and unwilling to allow this. By all appearances, she was just too angered by the system and focused on reclaiming her role as the mother of this child. She saw the foster mother as an interference and a threat, rather than an ally. Sara and her biological mother were offered



mental health services to assist with this transition, but the mother refused.

Several months later a chance encounter occurred at church one Sunday. The foster mother, looking across the room, saw two eyes intensely focused on her. They were Sara's eyes. The foster mother approached Sara and her mother with excited anticipation and with care and respect for Sara's mother's feelings. Sara's eyes lit up when she realized it truly was her foster mother. She immediately proceeded to reveal to her foster mother how she had held her in mind through the loss. Sara showed her a purse she had around her neck and the sole contents—lip balm—something that her foster mother had always carried in her purse especially for Sara.

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Sara's story movingly illustrates how important it is to very young children to maintain a connection to their primary caregiver. In this case, Sara, with no external help, ingeniously found a way to create a ready symbolic reminder of her foster mother as she grieved the loss of this first important relationship in her life. At 20 months, Sara created her own "thread of continuity" between caregivers by holding a symbol of her foster mother's love and care as she worked to develop a new relationship with her biological mother.



### Characteristics of the Typical Child Welfare Experience

Placement moves for children in the foster care system too often are inevitable. Even when all goes according to plan, a child may experience at least three placement changes and possibly more: the move from the biological home (where there may have been multiple caregivers already) to an assessment center and/or a temporary home, and then to a more permanent home. Difficulties regularly arise that can lead to additional moves. For example, foster caregivers may end a placement for a variety of reasons; potential relative caregivers may express interest after placements have already been made; or a relative may start caring for a child hoping that the child will reunify, without being prepared to provide a "forever home." The examples and the complex reasons are numerous and individual. The end result is the same—another move.

In any case, a central, though unfortunate, characteristic of relationships within the child welfare system is *discontinuity*. This includes not only

disrupted attachments between children and caregivers, but also the many changes in professional relationships with children in the foster care system. Just as children experience multiple caregivers, they also experience changes in child welfare workers, teachers, mental health providers, and peers, and therefore experience the loss of those important relationships as well. This discontinuity results in a fragmented and incomplete history, and a lack of knowledge about the child's experience by professionals and caregivers alike. The details of the child's internal experience and external reality, as well as their needs, wants, comforts, likes and dislikes, may be lost or obscured in a succession of placements, social workers, schools, daycares, and mental health professionals.

A second characteristic of the child welfare system experience is that it includes *dilemmas involving less-than-optimal choices*. Sometimes child welfare workers and other professionals are faced with decisions where none of the available options appears to provide the optimal life circumstances for a child. A child welfare worker may be faced with a choice between caregivers, neither of whom are a "good fit" for a particular child, or a worker may be required to suddenly move a child out of a long-term placement. In these situations, it can be extremely challenging to find ways of intervening that feel useful, and to maintain a sense of hopefulness.

Third, the experience of those involved with the child welfare system—children and professionals alike—is frequently characterized by *pervasive uncertainty about the future and feelings of helplessness to effect change*. Ambiguity about the future is often experienced by the child, his/her siblings, the birth parent(s), the foster and/or adoptive parents, the child

welfare worker, their supervisor and the attorneys involved. Though the judge has the power to make a decision, timetables, court processes and outcome are often unpredictable to all involved evoking feelings of helplessness or powerlessness. As a result, children's relationships invariably contain an element of anxiety that must be managed for them to feel safe and secure.



### Young Children's Experience of Disruption and Loss

Given that multiple placements often are a reality for young children in foster care, how do we protect their emotional experience and create threads of continuity for them? We know from burgeoning research that even very young infants experience and act on their world in multiple and rich ways. In fact, the period from age six months to four years has been identified as a particularly vulnerable time for separation from caregivers (Rutter, 1981 as cited in Fahlberg, 1991). This is the period where models or templates of attachment relationships and expectations of the world are formed. It is also the time in which caregiving relationships define one's sense of self, and one's confidence in moving autonomously into the environment. Loss and trauma during this time can have long term consequences for the child, including depression and anxiety (Bowlby, 1976, 1982; Carlson, 1998; Lyons-Ruth, Easterbrooks, & Cibelli, 1997).

John Bowlby (1976, 1982, 1989) and the Robertsons' (1989) seminal work clearly showed that toddlers with positive attachments have strong reactions to the loss of a caregiver. They

described an initial appearance of flattened affect and conformity, soon followed by a move to a “protest stage” involving anger, searching and acting out in an attempt to regain connection to the caregiver. Despair and depression may follow when the caregiver does not return, thus leading to detachment and a lack of connection to other adults. Children with more conflicted and negative attachments, characterized by abuse or neglect, will often still have strong emotional reactions when relationships to caregivers are disrupted. Providing emotional support with the grief process, help with a range of complicated feelings, and threads of continuity for the child’s experience, can facilitate the formation of new attachments and lessen the impact of a potentially traumatic event. For children who were drug-exposed and/or received inadequate nurturance due to a parent’s drug-using lifestyle, however, a combination of biological and environmental factors may have impaired their capacity to self-regulate, to manage novel stressors, and to make use of relational forms of soothing and comfort (Lester, Boukydis, & Twomey, 2000; Mayes, 1995). This both complicates and intensifies the need for caregivers and providers to actively help with the transition process.



### The Experience of Caregivers and Parents

Responding to the grief of infants and toddlers whose relationships are disrupted can be difficult. Among caregivers, parents, and professionals, there is a pervasive temptation to believe that children under one year of age are unaware of such changes and are “okay” when they cannot verbalize what they are feeling, or appear

passive or compliant. This wish is understandable, given the alternative of *feeling* the impact of relationship disruptions — as well as neglect, violence, and poverty—on the very young. To feel this impact may also remind us of our own painful experiences, or those of our children. Whatever the reason, we often are pulled to hope in our hearts that these children are being spared.

Further, young children in transition may demonstrate an array of behaviors that are open to misinterpretation. For example, a grieving child may withdraw or avoid interpersonal contact and thereby appear *not to need* special emotional care, or alternatively, indiscriminately climb into her new caregiver’s lap as if she has known her for years. Each set of behaviors represent a grieving child’s means of coping, which may be temporarily adaptive yet costly, in the long-term. For example, over time a child who avoids such interpersonal contact and soothing may not be able to enjoy the pleasure of close social relationships. Unfortunately, such behaviors draw upon the desires of well-meaning caregivers to believe that a child is adapting “fine.” This problem of misinterpretation can be compounded by a new caregiver’s lack of experience with the child. As a result, adults may respond in a number of ways including minimizing the child’s experience of grief, expressing anger at difficult behaviors, and misperceiving emotional withdrawal as rejection or a lack of need for comfort (Dozier, Migley, Albums, & Nutter, 2002).

Additionally confounding the process of caregiver-child relationship development may be the impact of prenatal drug-exposure. With problems of state regulation, and difficulty responding to stimuli and sustaining attention (Mayes, Bornstein, Chawarska &

Granger, 1995; Mayes, Grillon, Granger, & Schottenfeld, 1998), drug-exposed infants and toddlers can present severe challenges to a caregiver’s sense of competence, and their feelings of being able to connect with a child. For example, a drug-exposed child’s sensitivity to visual stimuli and subsequent gaze avoidance may lead a caregiver to feel inadequate or disconnected.

Other factors also may impede a caregiver’s ability to provide adequate emotional support for a grieving infant. There may be other children in the home, or a lack of time, energy and money. Relative caregivers may experience dramatic, unexpected life changes as they return to parenting. Kin and non-kin foster parents may have complicated feelings about the child and the biological parent. They may fall in love with or, at times, work to avoid falling in love with a child. They may struggle with a child welfare system that is not always supportive, that compensates poorly and too often seems to lack respect for their work. When a child leaves their home, their own grief and loss may impede their ability to help a child. Edelstein, Burge and Waterman (2001) refer to the grief of foster parents as “disenfranchised grief” as others and even the foster parents, themselves, have difficulty understanding and legitimizing their experience.

Biological parents have their own set of feelings that may affect their capacity to support their child. They may feel guilty or shameful about their child’s foster placement, and envious of others caring for their baby. For parents whose children were removed for reasons related to drug use, powerful feelings of guilt can be paralyzing and potentially interfere with their capacity to “see” their child’s needs. Parents who are actively using substances may be

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unable to effectively perceive, interpret and respond to their child's emotional signals. Parents in recovery may discover that in many ways they do not know their child and his/her cues, if their prior relationship occurred in the context of drug use. This experience of "starting from scratch" with parenting can generate insecurity and frustration that further complicates their responsiveness to their child.

Further, it is common for biological parents to feel marginalized or victimized by the child welfare system and to consequently feel angry and resentful. This anger and resentment may be directed toward foster parents, thereby creating a resistance to developing relationships on behalf of their child. A parent's view of foster parents as a threat may obscure their ability to understand the importance, to their child, of the foster parent-child relationship. All of these factors can contribute to making an already complex situation more difficult for children.



### Combining Theory and Practice: Creating "Threads of Continuity" for Children in Transition

Attending to the importance of relationships and a given child's unique characteristics and circumstances, it is possible to create *threads of continuity* even in circumstances where relationships must be disrupted. A process for planning and implementing a thoughtful transition, in which children and adults receive the necessary emotional and practical support to promote optimal well-being, is outlined in Box 1.

The first step in facilitating a transition is to consider important characteristics of the child and the caregivers involved. An individual child's special characteristics, developmental strengths, needs and preferences will affect his capacity to manage change. For example, an infant with a slow-to-warm temperament, or a child with regulatory problems may have a more difficult time managing placement changes than a child with an easy temperament or an ability to make use of adults to regulate her. It also is important to learn and/or imagine—even for very young infants—how a particular child will *feel* about a particular transition. Feelings will be affected by factors such as the child's quality of attachment to the prior caregiver(s), the number of placement moves she has already experienced, the length and quality of her relationship with the

current caregiver(s), whether or not she is familiar with the new caregivers and the way that previous placement changes were handled.

Additionally, it is important to identify the special strengths and needs of the caregivers, as well as the unique characteristics of the placements. It is essential to consider how the caregivers (both the "old" and the "new") will feel about this transition. Foster caregivers providing a potential adoptive placement may have very different feelings about a pending reunification, for example, than caregivers providing short-term foster care. Exploration with caregivers about their feelings, and acknowledgement and support for those feelings, are key to helping a child with a placement change.

Encouragement and support for communication among caregivers is

*Continued on page 22 . . .*

## BOX 1

### Transition Checklist: 10 Steps in Facilitating a Transition

1. Consider unique characteristics of this transition and feelings of all involved.
2. Discuss transition with "old" and "new" caregivers, provide support.
3. Outline a tentative pre-placement visit plan in collaboration with "old" and "new" caregivers.
4. Identify important routines and transitional objects that are likely to help child adjust.
5. Encourage communication between "old" and "new" caregivers.
6. Enlist help of other support people in the transition process.
7. Communicate with the child, according to the appropriate developmental level, about transition.
8. Conduct pre-placement visits between the child and the "new" caregiver.
9. Identify key child behaviors and observe the child's response to transition process.
10. Revise the transition plan based on an assessment of the child's adaptation to the transition and the developing relationships.

*Source: SEED Early Childhood Mental Health Consultation and Training Project (March, 2003). Alameda County Social Services Agency/Children's Hospital and Research Center at Oakland.*

## HELPING CHILDREN TRANSITION TO NEW CAREGIVERS

Most young children leaving their biological families would choose to remain within the confines of those families, particularly with their parents. However, for a variety of reasons such as death, substance abuse, parental incarceration, and/or HIV, some children must transition to new temporary or permanent caregivers, which can be a painful and traumatic experience. According to Penzerro and Leinn (1995), when children are moved from place to place, “they may become incapable of forming lasting bonds.” When children must come into care, honesty, openness, and thoughtful preparation for both the children and caregivers can help to minimize the trauma for all parties. Following are some suggestions to assist in this process.



### Make Informed and Appropriate Placements

Staff involved with each transition should speak directly to the children’s current caregivers to gather as much information as possible about the children’s temperament, needs, and routines. This information is helpful in identifying and preparing new caregivers. When possible and appropriate, current caregivers may even be involved in identifying or determining new caregivers.

It is helpful to identify foster or adoptive parents that have experience and/or formal training in caring for children with specific needs (e.g., prenatal substance exposure, HIV).

Caregivers also need to be knowledgeable about the developmental status and needs of infants and young children, so that they have realistic expectations and respond appropriately. In addition, caregivers should be sensitive to a child’s cultural background.

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### Prepare the Children

Although it is not always possible, involving children in the early planning phases of a move may give them a sense of control over their situation. For instance, tell the child what the first meeting with the prospective family will be like, who will participate in the meeting, and where it will take place. It is helpful if biological parents communicate an attitude of trust of the new caregivers. A way for them to

do so is to be honest with their children about their lack of ability to care for them at the time, and to encourage the children to be respectful of their new caregivers.

Because abrupt moves tend to be more injurious than planned transitions, pre-placement visits between the children and the prospective caregivers can help to ease the transition by diminishing the children’s anxiety about the unknown and allowing them to begin the grieving process. Moreover, Fahlberg (1991) asserted that the trauma of parental separation or losses may be lessened if the child is prepared for the transition.



### Prepare the Caregivers

All adults involved in the move must be able to empathize with the children’s feelings, which might include anger, frustration, or even ambivalence. Additionally, caregivers must understand that issues of loyalty exist for children, and accept the fact that these children have or had a mother and father. Sometimes caregivers try to protect children from their biological parents and would rather they forget about them. Regardless of their views, however, foster parents need to support both the negative and positive feelings that children have of their parents, and they should not discourage children from speaking about their parents. As Littner (1975) emphasized, “For better or worse, they are his roots to the past,

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his support and foundation. When he is separated from them, he feels that he has lost a part of himself.”



## Prepare Other Children in the Home

When there are other children in the home where a new foster child is to be placed, caregivers should prepare those children for the new arrival. Advanced preparation might help the existing children to be more accepting of the new arrival. Sometimes children that are already in the home, especially foster children, feel as if they are being displaced when other children move into the home. Thus, it is important for the caregiver to reassure the current children of their love and commitment for them, and assure them that they are not being “re-placed.” Also, depending on the ages of the children, the foster parent can encourage them to create a work of art for the new arrival. Sometimes, a caregiver can initiate the process by providing children with the materials, e.g., paper, markers, paint, and picture frames. The completed artwork might serve as a welcoming gesture to the new child, which might hasten his or her adjustment to the home.



## Support Children through the Transition

Enabling children to keep some things the same can help them through the transition to a new caregiver. For instance, help them keep the same bedtimes, routines and rituals to which



they are accustomed. Also, allow children to hold onto their memories by not discarding their possessions without their permission. These items might be the only things the children have by which to remember their biological parents.

For older children, it also may be necessary to help them adjust to a new school and/or community. Caregivers can do this by having children participate in school orientation for new comers and/or participate in after school programs. In addition, children could join neighborhood clubs such as Girls & Boys Clubs, Girl Scouts/Boy Scouts, or other enrichment programs.

Finally, it is important for caregivers and other adults involved in the children's lives to look for warning signs that might indicate that children are not adjusting well. For example, sleep disruption, anxiety, poor appetite, inability to concentrate, and/or depression may all be important signs. When any of these signs is evident, caregivers should arrange for a physical examination to rule out any form of physical ailment. If the symptoms persist, a mental health evaluation should be pursued along with any necessary follow-up.



## Conclusion

There are no guarantees that the transitioning of children to new caregivers will work out positively all the time. However, we must continue to strive to adequately prepare caregivers and children for transitions to make them less traumatic, and support children throughout the process to encourage positive outcomes. We can do this by ensuring that children's physical and educational needs are met, and that their emotional/psychosocial issues are addressed.

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## REFERENCES

- Fahlberg, Vera (1991). *A Child's Journey through Placement*. Indianapolis: Perspective Press.
- Littner, N. (1975). The importance of the natural parents to the child in placement. *Child Welfare*, 54, 175-182.
- Penzerro, R. M., & Lein, L. (1995) Burning their Bridges: Disordered attachment and Foster care discharge. *Child Welfare*, 74, 351-366.

## MAKING THE TRANSITION: LEARNING TO COPE THROUGH ART

Transitions present challenges for each of us, but for children challenges can be daunting. When a child's transition is coupled with the loss of a parent or caretaker, the result is often overwhelming, provoking feelings of anxiety and threatening a child's sense of security and control.



### Use of Art Therapy

Art therapy provides opportunities for children to explore and anticipate the transition from one caregiver to another within the safe confines of a therapeutic environment. Because the child is in charge of his or her own exploration, a sense of control is heightened as are feelings of empowerment. Through creative arts modalities, children can use a range of expressive tools to explore their worlds. Common media utilized in art therapy sessions are drawing and painting supplies, collage, and clay. These conventional media can be combined with other modes of expression, such as play and sand tray therapy, wherein children can literally 'act out' the impending transition. Such dramatizations tend to diminish the anxiety and fear associated with impending changes, as scenarios have been imaginatively explored before they are lived experiences. Furthermore, the playful nature of art making, as well as the enticing range of media to choose from, enable children to feel safe enough to share their feelings of grief and anxiety. Moreover, the spontaneity of art-making challenges the child to cope with unknowns, and the ability to

"re-create" more than one piece of art provides the child with opportunities to do, undo, and test out new possibilities. Once learned and rehearsed, these skills can then be transferred to coping with the transition.



### The Art Therapist's Role

At Pediatric AIDS/HIV Care, in Washington, DC, a child is usually referred for individual art therapy services because of a loss or other extenuating life circumstance. A child's level of understanding and acceptance of that loss can vary widely depending on family disclosure, family stigma, acceptance level, and exposure to the ill caretaker's medical regime. During this often turbulent time, the art therapist maintains intimate and consistent contact with the family to better serve the child and facilitate the transition. Depending upon the level of openness versus resistance in exploring the transition, the art therapist may or may not give directives in session. Often times, anxiety will arise unconsciously through the artwork and the art therapist can then use the created image as a bridge to begin verbal processing.

In some cases, particularly with resistant or avoidant clients, the art therapist will provide a directive that is designed to elicit feelings related to the issue at hand. For example, one directive may be to fold a piece of paper in half and create a drawing of the house the child lived in with his or her mother on one side, and the house where he or she will soon be living on the other side.

Chosen colors, line quality, size of image, omitted or added figures, pencil pressure, balance, and the overall mood of artwork provide clues and starting points for further discussion. Each art therapist approaches sessions differently. In my sessions, the dialogue, art-making, and play co-exist, which in my experience invites a natural flow to emerge.

The following two artworks were created by Deonda (name has been changed to protect confidentiality), a 12 year-old African-American female who had witnessed her mother's substance abuse and her decline in health due to HIV/AIDS. Artwork #1 depicts her life with her mother. Artwork #2 depicts her life with her new caregiver. These artworks stand as the "before-and-after" house-tree-person drawings, a standard diagnostic drawing tool utilized by art therapists.



### Artwork #1

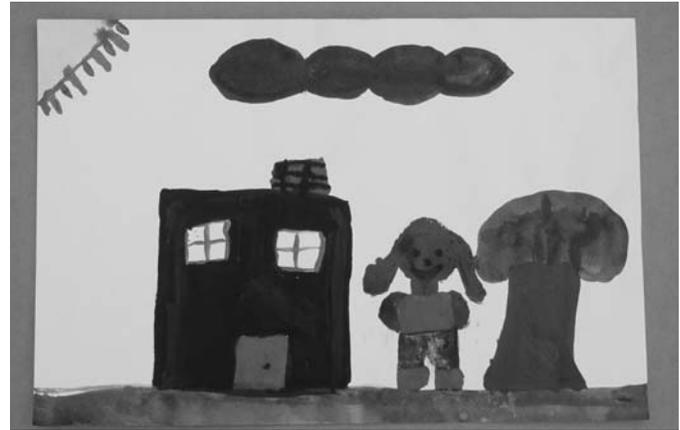
In this artwork, the figure identified as the client's mother is emaciated and washed out, as if she is disappearing right before your eyes. The mother figure lacks eyeballs, as if she is unable to see or has chosen not to witness her own self-destruction; a mood of "soullessness" is expressed. The client shared that this is a drawing of the crack house that she had frequented with her mother. A gloomy cloud hangs heavy above a transparent house that is plagued by harsh, angry marks of bold paint, lending a chaotic and intense feel to the

*Continued on page 8 . . .*

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ARTWORK #1



ARTWORK #2

piece. The door into the house is dark and uninviting with a red knob, potentially symbolizing the danger within. The tree has a large black hole in the trunk, which often represents trauma in art therapy work. Although the grass appears supple and healthy, the ground line is imbalanced and bumpy.

The overall mood of this artwork suggests panic, chaos, fear, and danger—all of which were felt by this client when she created this work and shared memories of trips to the crack house with her mother.



### Artwork #2

Although this artwork still makes use of some potentially troubling colors—red and black, which often symbolize anger—this piece is, nonetheless, a healthier depiction of this client’s emotional state. Here the client has transitioned to living with her maternal aunt and grandmother, subsequent to her mother’s death. The figure, which this client identifies as herself, stands tall and smiling—a much fuller, more robust figure than the one seen in the first artwork. The tree has shed its black hole and although the dark cloud still looms large, it is no longer threat-

ening to crush the house as it was drawn earlier; now it is floating. The house, although it appears more solid, looks to be filled with sadness and anger, most likely representing conflicted, unresolved, and complicated feelings of grief. However, the straight ground line of grass suggests a measure of stability.

The overall mood of this artwork appears happier and less frenzied than the first; gloom still lurks here, but no longer does it pervade this depiction. This work is an example of the complicated and often painful expressions of grief and anger that manifest after the death of a loved one about which one has conflicted feelings. This exercise (house-tree-person drawing) can be utilized at intervals of the treatment to track the grief process and new home environment.

However, judgments are not based on artwork alone; rather art therapists ask the child about his or her image and take the family context and current situation into account before drawing conclusions. It is problematic when someone attempts to “read” a client’s drawings without education in the field of art therapy, which is rooted in a very clinical approach taking the whole person—not simply the art—into account. Art therapy is not as

simple as reading images, as many people think. It is about using various medium and creativity to assist in the therapeutic process.



### Summary

Art therapy can be a powerful modality for tracking the emotional well-being of clients, particularly when the client has not yet found the words to express the intensity of feelings. In this case study, the client chose to use the art-making process to identify and express her internal feeling states. These works were then used in session to explore her unresolved feelings of grief and transition to a new home environment.

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*This article was written in consultation with Emily Piccirillo, ATR, BC, Executive Director at Pediatric AIDS/HIV Care, Inc., which collaborates with the Family Ties Project in Washington, DC.*

## SUPPORTING THE TRANSITION OF INFANTS WITH PRENATAL SUBSTANCE EXPOSURE FROM FOSTER TO ADOPTIVE HOMES

Infants and toddlers are the most rapidly expanding age group in the child welfare system (Silver, Amster & Haecker, 1999). In the United States, approximately five percent of children now in foster care are under 12 months old, and 25% of children in foster care are less than five years of age (Children's Bureau, 2003). Similar trends are occurring with the child-in-care population in Canada (Foster & Wright, 2002). In British Columbia, 14% of the children in care in 2003 are three years of age or younger (British Columbia Ministry of Child and Family Development, 2003).

The Safe Babies project in British Columbia, Canada was initially developed in 1997 in response to the community's increasing awareness of the unique needs of infants with prenatal substance exposure and the birth, foster, and adoptive families that care for them. Of the 30 to 40 infants that require foster care services each year in the city of Victoria, where the project originated, approximately 40% proceed through to placement in adoptive homes. The majority of these infants have a history of prenatal alcohol and/or drug exposure. Consequently, public service agencies such as children's ministries are finding themselves supporting a waiting-for-adoption population that is primarily composed of hard-to-place or special needs infants and children. In fact, 93% of infants waiting for adoption in British Columbia in 2000/2001 were designated special needs (AFABC, 2004).

The complexity of providing daily care for many children with special needs calls for a gradual transition based on the needs and cues of the infant or child. Thus, the Ministry for Children and Family Development (MCFD) has developed a transition process for infants to address issues frequently seen in this population, e.g., difficulty managing change; issues with attachment following what has often been a prolonged placement in foster care; and daily care issues related to health, sleeping, feeding, and settling. This article will review components of the foster-to-adoptive home transition process developed specifically for infants and young toddlers with prenatal substance exposure from a collaborative interdisciplinary perspective.



### Attachment Theory and Drug Exposed Infants

A useful theoretical framework to underlie the process of transition from foster home to adoptive home is based on attachment and separation. John Bowlby (1907-1990), a child psychiatrist, proposed attachment and separation as the major conflict that needs to be resolved in order to produce healthy social and emotional developmental outcomes across the lifespan. A basic premise of the theory is that the quality of attachment relationships stems from interactions between infants and their caregivers (Bowlby, 1969). These

interactions reflect the degree to which infants can rely on their caregivers to provide proximity and companionship, safe haven in the face of threat or anxiety, and a secure base from which to explore. Failure to achieve secure attachment results in an inability to separate from caregivers and reconnect to new relationships (including work, friendship and intimate relationships) in a healthy way (Drummond & Marcellus, in press).

From an attachment theory perspective, infants placed into foster care are at risk for later difficulties for multiple reasons—they experience many disruptions in their relationships with primary caregivers, and they have histories of neglect, abuse, parental drug abuse, and/or family instability (Stovall & Dozier, 1998). Additionally, infants with prenatal substance exposure may have spent prolonged periods in a neonatal intensive care unit being cared for by multiple staff members, or they may have entered foster care from the home of the birth parents and may have experienced irregular and inconsistent daily care.

The behaviors and health and social issues that the infant brings to the interaction often may be considered challenging. Frequently noted health issues for drug exposed infants include risk of exposure to infectious diseases, failure to thrive, poor weight gain, prematurity, feeding problems, developmental delays, immunization

*Continued on page 10 . . .*

*Continued from page 9 . . .*

delays, upper respiratory illnesses, and skin conditions (Silver et al., 1999). Foster parents, professionals, and other caregivers also report specific challenges in caring for infants with prenatal substance exposure on a daily basis, including irritability, inconsolability, difficulty settling and being soothed, and sensitivity to change and stimulation.

Interventions to promote attachment may be designed to focus on the infant, the caregiver, the interaction, and/or the environment in which the interaction takes place. In fact, when discussing attachment theory, it is important to address the “other-than-mother” factors (Birns, 1999). Bowlby’s theory has been criticized for focusing on the mother as critical and minimizing discussion of other issues such as relationships with multiple caregivers and social and economic factors. Attachment theory is useful for practice when it moves away from a narrow maternal-infant focus to a model that focuses on relationships and attachment from broader perspectives, including the social support contexts within which relationships develop (Bliwise, 1999).

Levy and Orlans (1998) suggest that attachment is developed within the context of a relationship that includes factors such as nurturing touch, safe holding, eye contact, smile, positive affect, and need fulfillment. For infants with prenatal substance exposure, these factors may be difficult to achieve in the early neonatal period. The stress of withdrawal makes it difficult for the infant to manage the stimulation associated with touch and eye contact. Need fulfillment and engagement may be difficult to achieve with an infant that is experiencing the discomfort of withdrawal or gives ambiguous cues and has disorganized

behavior (Marcellus, in press). The caregivers’ guide developed for the Safe Babies project (*Baby Steps*) and other parent education resources provide suggestions for foster parents on how to promote a secure relationship with their infant. These suggestions are also useful to share with adoptive parents.



## Steps in the Transition Process

### IDENTIFYING AND EDUCATING POTENTIAL ADOPTIVE PARENTS

In 2002, MCFD launched a province wide adoption campaign, *Kids Can’t Wait to Have a Family*, to increase the awareness of the community about the number of children available for adoption within the child welfare system. Adoption education programs were developed and held in communities throughout the province. The key goals of the program were to inform potential parents about adoption in general, to educate them about characteristics and potentials of children available for adoption, and to inform them of the supports and services available to assist them in their parenting.

In some communities, one entire session with a representative from the Safe Babies program (a registered nurse, resource worker or experienced foster parent) was devoted to sharing current information within a lifespan approach about individuals with prenatal exposure to drugs and/or alcohol (Fetal Alcohol Spectrum Disorder, Neonatal Abstinence Syndrome). It has only been in the past thirty years that knowledge of the effects of alcohol and drugs on the developing fetus has become more widely available. Parents who adopted children twenty to thirty years ago report not receiving any birth

history information and having to gradually come to the awareness that their child has FASD, and to advocate for services and supports for them. Similarly, there has been a great deal of misinformation about the effects of illegal drugs (marijuana, cocaine, opioids). Now there are many sources of information for potential adoptive parents who are encouraged to read resources, meet other adoptive parents, attend workshops, and fully educate themselves about the long-term impact of prenatal alcohol and drug exposure on growth and development. To assist in this process, MCFD developed a video on adopting children with FAS, and provides potential adoptive parents with current information to help them make as informed a choice as possible. Educational materials include a handbook on providing daily care for infants with prenatal substance exposure.<sup>1</sup>

Information sharing may occur within the context of attachment therapy. Educating caregivers on the cues given by infants and about the specific needs of infants with prenatal substance exposure can help them develop the skill of accurately interpreting the infant’s needs and attending to them immediately. It is important not only to teach caregivers how to interpret their infants’ cues, but also to encourage caregivers to maintain self and family well-being and utilize support services such as respite as necessary so that they can maintain the high level of attentive care that their babies and young children need.

<sup>1</sup> This booklet is available electronically. To request a copy, email Lenora Marcellus at smarcellus@telus.net.

## THE MATCHING PROCESS

A move to placing the child's best interests above any others' inherent rights has opened up the potential for major changes in adoption practice (Sobol & Daly, 1995). One major change is related to the increasing contribution of birth and foster parents to choosing a family with "goodness of fit" for their infant or child. Foster parents are ideally situated to assist in the matching process. As the daily caregivers, they have the most intimate knowledge of the infants' characteristics, patterns of behavior, personality, temperament and needs. Many foster families are also adoptive families; because they had already been through the experience of adopting children, they have this additional perspective to bring to the process.

Sobol and Daly (1995) suggest that another change related to the matching process is that instead of parental characteristics being the leading criteria, it is becoming more important that the applicant possesses attributes necessary to meet the best interests of a specific child. This is particularly true for families who are considering adoption of a child with FASD. Effective environments for children with FASD are those that are highly structured, consistent and supportive. Families need to have the ability to provide this kind of environment for their child.

Another key strategy in enhancing the matching process in the Safe Babies project has been the development of specialized social worker roles. Within the project there are resource social workers (who facilitate and support the placement of children in foster homes) and adoptive social workers (who work with children and families throughout the adoption process) that have taken on specialized caseloads. Because of

their daily work with this specific population, they have developed a high level of expertise in the care of infants with special needs and the needs of the caregivers. An additional support within the program is that of the caregiver advisor. The caregiver advisor is a highly experienced foster parent who serves as a mentor to the group of foster families who work within the Safe Babies program. The caregiver is an invaluable resource not only for foster families, but also for birth and adoptive families.



## Pre-placement

The focus of pre-placement care is primarily on transferring attachment and empowering the new caregivers (Fahlberg, 1991). For older infants and toddlers, pre-placement preparation is crucial to reduce long-term anxiety and fear regarding separation, loss, and lack of safety with caregivers. Vera Fahlberg, a U.S. pediatrician and psychotherapist, provides suggestions in her book *A Child's Journey Through Placement* (1991) related to moving children of different age groups from foster care to adoption (Table 1). Infants and young children in the preverbal stage will most likely require an extended period of time to work through a gradual transition of caregivers.

Both foster and adoptive parents enter this process with a lot of similar emotions and fears. Experienced foster parents suggest that there is no right way or wrong way to facilitate this process, but have some further ideas that might make it a less intimidating experience. If possible, the foster parents need to arrange to meet the adopting parents without the baby in the social worker's office for the initial meeting. This prevents the baby from

*Continued on page 12 . . .*

### TABLE 1

## Strategies to support infants and young children in their transition from foster to adoptive home

- When moving preverbal children, workers and parents must pay close attention to the signals the children are sending us. She suggests that a child can sense a withholding of permission for the move. We all need to be supportive of everyone's feelings.
- Because small children usually feel most secure on their home ground, initial contacts with the adoptive families should take place in the foster home and in the presence of the foster parents.
- The child must be allowed to set the pace of the visits. In first visits, it may work to have the adoptive parents interact with the foster family and not center attention on the child, so that the child can see that the foster parents are comfortable.
- Contacts should occur more frequently with a shorter time span between the contacts, as infants and toddlers do not have a well-developed sense of time.
- Considerable time should be spent visiting, and at all times of the day, so that the adoptive parents may become familiar with the routines of their child.

*(Fahlberg, 1991)*

*Continued from page 11 . . .*

being involved in the early anxiety that adults will feel, and it allows adults to get the “housekeeping” out of the way. It may also be helpful for foster and adoptive parents to share their fears and set out a plan of visiting and expectations, keeping in mind that the baby will set the pace for the process.

The Adoption Branch of MCFD also has developed guidelines regarding the placement process. It is suggested that, if the child lives in a different community, the adoptive parents visit the child’s home. For these first visits, a worker and sometimes the child’s caregiver are present. Over time, as the relationship with the child grows, the adoptive parents will begin to spend time alone with the child and have visits at their home. Foster families within the program have been overwhelmingly generous in opening their homes and welcoming in the adoptive parents during this time.

## PLACEMENT TRANSITION

Within the Safe Babies project, over time, a more targeted transition process was designed and gradually implemented collaboratively with the foster families. The following strategies were developed by experienced foster parents and are shared with other foster and adoptive families and with the professionals who are supporting the infant and the families through the transition process (Hatch, 2002). Some of the information is general to infants, and some is specific to infants with prenatal drug and alcohol exposure.

- The transition may be stressful for the baby. The baby will let you know how she is managing. She may revert to some of the behaviors shown during the withdrawal period, such as agitation, difficulty with sleeping and feeding, even some vomiting and



diarrhea. She may reject the initial attempts of the adopting family to approach her or handle her. Some infants shut down and just eat and sleep, hoping to ignore the world until they can cope with such huge changes.

- Breaks for everyone will be important, so the foster family needs to feel comfortable letting the adoptive family know if it is time for a break. Similarly, the adoptive parents need to let the foster family know how the pace of the transition is working for them.
- Ensure transitional objects are packed, such as bedding, toys, and eating utensils.
- Encourage the new family to maintain the same familiar routine, continue with the same formula and diet, and slowly introduce new clothing, toys and bedding to provide reassurance to the baby.
- Include both sets of parents in the last of the packing together.
- At the final moment of the move, both families join together in loading the car. As an important gesture, on the final trip to the adoptive home, the foster family should place the baby in the car seat. This gives

the baby permission to love and accept her new family. It may seem that an infant is not able to comprehend such communication, but somehow it does place her at peace and allow her to move on to her new life.

## POST-PLACEMENT

The post-placement period of time is critical as infants and their new caregivers begin to get to know each other and develop relationships. Infants and children with FASD or drug exposure have been identified as a specific risk group for failed adoption because of issues such as challenging behaviors and difficulty with attachment (Levy & Orlans, 1998). Changes in attachment behavior must be considered within the context of each specific child’s health and social history. For example, attachment related behaviors such as lack of emotional responsiveness, resistance, avoidance of parents, indiscriminate sociability and inability to be soothed, can also be linked to prenatal substance exposure. Thus, in British Columbia, social workers continue to visit until the adoption is legal and

permanent. The social worker needs to make sure that the placement is feeling right for the adoptive parents and that the infant appears to be adapting to their new environment.

Additionally, families that are adopting a child with special needs may require extra support. In British Columbia, the MCFD Post-Adoption Assistance Program provides financial assistance for services related to the child's specific needs, such as counseling, therapy, or corrective dental or medical expenses, as well as maintenance in some cases. As well as MCFD programs, there are other agencies offering support services to parents of adopted children. The Society of Special Needs Adoptive Parents (SNAP) and the Adoptive Families Association (AFA) are two of these organizations. Both offer parent support groups, publish newsletters, and provide a lending library on adoption and related issues.

Post placement resources and support also need to be available for the foster family. The foster family has likely developed a loving relationship with the child and is now expected to relinquish this relationship to the adoptive parents. The experiences of grief and loss for foster families are often overlooked or minimized. Foster parents indicate that this is possibly one of the most difficult parts of fostering (Hatch, 2002). They suggest that besides helping the child transition to their new home, it is also important to be aware of how their own family is doing. Strategies for closure include: planning a special family celebration; giving themselves permission to talk about how they are feeling; allowing themselves to cry; or whatever it takes to acknowledge that it is difficult to lose a baby, even if it is in the best interests of the child. Each family responds differently to this event; some take a break and plan family time, while others are eager to care for another child.

Because of the intensity of the experience of transitioning, many foster and adoptive families develop close relationships. The adoptive families usually recognize that foster parents have played a critical role in their child's life and are interested in maintaining a relationship. Within the Safe Babies project, many wonderful relationships have continued, with foster parents becoming godparents or special aunts or uncles to the children as they begin to grow. One recommendation made by foster parents regarding continued contact is that immediately following placement it is usually beneficial for the transfer of attachment for the foster parents to wait a certain length of time (often dependent on the age of the child and how long they were in their home) before resuming contact.



## Conclusion

The Safe Babies project bases development of services and supports on the underlying philosophy of attachment. Movement of infants from foster to adoptive homes represents a significant transition in the lives of sensitive infants and young toddlers. This transition may be eased through incorporation of attachment-related strategies throughout the adoption process. By considering what will help the infant, the caregivers, the interaction between them, and the social context within which their relationship develops, professionals involved in the adoption process may increase the success of the transition.

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## REFERENCES

- Adoptive Families Association of British Columbia (2004). *BC's waiting children*. Retrieved June 20, 2004 from <http://www.neovox.net/~bcadoption/bcwc/statistics.htm>.
- Aitken, G. (1995). Changing adoption policy and practice to deal with children in limbo. *Child Welfare, 74*(3), 679-694.
- Birns, B. (1999). Attachment theory revisited: Challenging conceptual and methodological sacred cows. *Feminism and Psychology, 9*(1), 10-21.
- Bliwise, N. (1999). Securing attachment theory's potential. *Feminism and Psychology, 9*(1), 43-52.
- Bowlby, J. (1969). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.
- British Columbia Ministry of Child and Family Development (2003). *Adoption*. Retrieved June 20, 2004 from <http://www.cf.gov.bc.ca/adoption>.
- Children's Bureau (September 2003). The Adoption and Foster Care Analysis and Reporting System. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.
- Drummond, J., & Marcellus, L. (in press). Theories of growth and development. In J. Kerr Ross & M. Woods (Eds.), *Canadian Fundamental of Nursing* (3rd ed.). Toronto: Elsevier.
- Fahlberg, V. (1991). *A child's journey through placement*. Indianapolis, IN: Perspectives Press.
- Foster, L., & Wright, M. (2002). Patterns and trends in children in the care of the Province of British Columbia: Ecological, policy, and cultural perspectives. In M. Hayes & L. Foster (Eds.), *Too small to see, too big to ignore: Child health and well-being in British Columbia. Canadian Western Geographical Series Volume 35* (pp. 103-140).
- Groze, V., & Rosenthal, J. (1993). Attachment theory and the adoption of children with special needs. *Social Work Research and Abstracts, 29*(2), 5-13.
- Hatch, A. (2002). Helping infants move to their adoptive home. *Safe Babies Newsletter* (Fall), 1-2.
- Levy, T., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorder in children and families*. Washington, DC: CWLA Press.
- Marcellus, L. (in press). Foster parents who care for infants with prenatal drug exposure: Support during transition from NICU to home. *Neonatal Network*.
- Silver, J., Amster, B., & Haecker, T. (1999). *Young children and foster care: A guide for professionals*. New York: Brookes.
- Silver, J., DiLorenzo, P., Zukoski, M., Ross, P., Amster, B., & Schlegel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. *Child Welfare, 78*(1), 148-165.
- Sobol, M., & Daly, M. (1995). Adoption practice in Canada: Emerging trends and challenges. *Child Welfare, 74*(3), 655-678.
- Stovall, K., & Dozier, M. (1998). Infants in foster care: An attachment theory perspective. *Adoption Quarterly, 2*(1), 55-88.

## CONGRATULATIONS!

On October 1, 2004, the following programs were awarded four-year grants from the U.S. Department of Health and Human Services' Children's Bureau under the Abandoned Infants Assistance (AIA) legislation.

### COMPREHENSIVE SERVICE DEMONSTRATION PROJECTS

- ★ **Alianza Dominicana, Inc.'s** Best Beginnings Plus is a home visitation program serving at-risk pregnant and parenting families that are substance affected and/or HIV infected or affected.  
*New York, NY*
- ★ **Bienvenidos Children's Center** will provide home-based services, clinical interventions, family support services, substance abuse recovery, permanency planning, parenting and health education, and child focused services for Latina families who are at risk for abandoning their young children.  
*Los Angeles, CA*
- ★ **Children's Home Society of Florida's** Project SAFE is a child-centered, family-focused, peer facilitated program of home based and community services to prevent

abandonment of infants and young children perinatally exposed to dangerous drugs and/or HIV infection, and their siblings.

*Miami, FL*

- **Children's Hospital of Philadelphia** will provide training and education for child welfare agency supervisors, judges and attorneys about early childhood health, development and mental health; and establish an interdisciplinary pediatric developmental evaluation and referral clinic to identify service needs of infants with complex medical, developmental and behavioral conditions and link them to appropriate services.  
*Philadelphia, PA*
- ★ **The Children's Mercy Hospital's** Team for Infants Endangered by Substance Abuse (TIES) Program is a comprehensive, multi-agency program providing intensive, home-based services to pregnant and postpartum women and their families affected by substance abuse and/or HIV.  
*Kansas City, MO*
- **The Children's Place Association's** Lifelong Families Program will provide comprehensive permanency planning services to especially high risk HIV/AIDS-infected families in which the parent is ill or the caregiver is a teen, sibling or kin.  
*Chicago, IL*

- ★ **Consortium for Child Welfare's** Family Ties Project addresses the issues of children at risk of abandonment or orphaned by the HIV/AIDS epidemic by working with parents/caregivers to plan for the future care of their children.  
*Washington, DC*
- **Family-Children's AIDS Network's** Family Options program will provide comprehensive permanency planning and family support services for HIV-affected families.  
*Chicago, IL*
- **FamiliesFirst, Inc.'s** Shared Family Care Program will immerse families, with infants and young children who are impacted by substance abuse, in healthy family environments with community mentors, and provide comprehensive support services in order to stabilize families, prevent abandonment and promote permanency, well-being and safety for the children.  
*Concord, CA*
- **FamilyConnections'** Collaboration to Reduce Abandonment & Deliver Local Education and Support (CRADLES) Project will provide comprehensive services to infants who have been or are at risk of being abandoned by mothers who are HIV+ and/or have substance abuse and/or other serious physical, mental health or social problems.  
*Austin, TX*

★ **The University of Oklahoma's** Oklahoma Infants Assistance Program uses a team approach to provide comprehensive, coordinated services to families with prenatally drug-exposed infants.  
*Oklahoma City, OK*

■ **University of Colorado Health Sciences Center**, through a city-wide consortium of agencies, will provide an early intervention system of care for families of young infants who enter out-of-home placement.  
*Denver, CO*

★ **The Yale Coordinated Intervention for Women and Infants (CIWI) Program** and the Yale Positive Intervention for Families with HIV/AIDS (PIFA) will promote positive parent-child interactions through integrated, comprehensive, in-home programs.  
*New Haven, CT*

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**FAMILY SUPPORT SERVICES FOR GRANDPARENTS AND OTHER RELATIVES PROVIDING CAREGIVING FOR CHILDREN OF SUBSTANCE ABUSING AND HIV-POSITIVE WOMEN**

■ **Families & Children Together (FACT)** will partner with other community agencies to enhance the skills and knowledge of relative caregivers and professionals who are

caring for children who have been exposed to substance abuse and/or HIV, and to link families to resources necessary to increase family stability.  
*Bangor, ME*

★ **The Family Center, Inc.'s** Project Promise provides intensive, family-based interventions to grandparents and other family members who are caring for the children of HIV-positive and/or substance abusing women.  
*New York, NY*

■ **Families Resources, Inc.'s** Family Heritage Program will provide family preservation and supportive case management and counseling services to children who are affected by substance abuse and/or HIV/AIDS and their kinship caregivers in order to preserve their placements and prevent entry into foster care.  
*St. Petersburg, FL*

■ **Project Prevent's** Kin Care will provide comprehensive psychosocial support to relative caregivers and developmental follow-up for infants maternally exposed to substances and/or HIV/AIDS by using a holistic, community-based service approach.  
*Atlanta, GA*

**RECREATIONAL SERVICES FOR CHILDREN AFFECTED BY HIV/AIDS**

■ **Camp Heartland Project, Inc.** will enhance the lives of children infected with HIV/AIDS through year-round support, advocacy, recreational programs and community AIDS awareness efforts; evaluate the effect of recreational camping experiences on HIV/AIDS impacted youth; and develop and distribute model program materials to other recreational programs.  
*Milwaukee, WI*

■ **Pediatric AIDS/HIV Care, Inc.'s** Youth Space is a month-long summer day camp designed to preserve, assist and strengthen the well-being of urban minority youth (5-18) living with HIV/AIDS through a range of therapeutic, educational and cultural enrichment services, social and recreational activities, parent-caregiver counseling, and mentoring.  
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★ *These programs were existing AIA programs that received continuation grants.*

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## TRANSITION ISSUES FOR CHILDREN OF INCARCERATED PARENTS

There are more than 2 million children of currently incarcerated parents in the United States, and at least another 8 million children whose parents have been arrested and incarcerated during the children’s lifetime but are not in jail or prison today (Center for Children of Incarcerated Parents, 2004). Even though the majority of prisoners who are parents did not live with their children immediately before their incarceration (Mumola, 2000), these children have almost always experienced cycles of difficult transitions related to their parents’ instability, crime, arrest and incarceration. Some of these transitions are experienced by almost all children of prisoners, while others are experienced only by a minority.



### Early Parent-Child Separations

Research has found that the first parent-child separations experienced by children of prisoners are usually not due to parental incarceration. A significant number of children—about 40% of the children of male offenders and 20% of the children of female offenders—have never lived with those parents (Johnston, 2002).

While almost nothing is known about the effects of father-child separations that occur at and immediately after birth, such separations of mothers and infants have been of great interest. Although some authors have speculated about the risk this experience poses to the infant’s capacity for attachment,

infant development literature shows that babies are capable of forming attachments to any reasonable caregiver who appropriately meets their needs (Bowlby, 1969; 1982). Of greater concern is the effect of such separations on the mother’s ability to bond with her infant, which has significant implications for the subsequent mother-child relationship and quality of future maternal care.

**THE GREAT MAJORITY OF INCARCERATED PARENTS ARE DRUG OFFENDERS AND, TYPICALLY, THEIR CHILDREN HAVE EXPERIENCED DRUG- AND CRIME-RELATED SEPARATIONS FROM THEIR PARENTS THAT PRECEDE PARENTAL INCARCERATIONS.**

Unlike newborns, older children who have formed an attachment to parents who provide them with daily care may be profoundly affected by the first extended parent-child separation. In families of criminal offenders, these separations are typically *not* due to parental incarceration, but rather to

parental substance dependency. The great majority of incarcerated parents are drug offenders and, typically, their children have experienced drug- and crime-related separations from their parents that precede parental incarceration.

There is little information available on the effects of these specific kinds of parent-child separations, but they share characteristics that make it likely they will be distressing transitions for children:

- They are often preceded by parental inaccessibility and disruptions in parental caregiving.
- They are often associated with ongoing family conflict.
- Information about the parents’ problems related to the separation is not usually shared with the children.

Children experiencing initial separations from a caregiving parent may show typical signs of emotional distress. If the parent-child relationship was substantial, children may move from initial distress to withdrawal or acting out. Severely affected children who do not receive assistance may eventually become detached and will have difficulty accommodating new caregivers and even the return of the separated parent (Bowlby, 1969 & 1982).



### Repeated Parent-Child Separations

Parental substance dependency is associated with inconsistent parenting,

*Continued on page 18 . . .*

*Continued from page 17 . . .*

chaotic households and family conflict, as well as recurring parent-child separations. The pattern of repeated separations is also seen to a lesser extent among criminal offenders involved in other types of compulsive behavior, such as gambling or theft. Regardless of the reason, criminal offenders typically move through a cycle of criminal behavior, arrest, incarceration and release from incarceration. The great majority of prisoners—including incarcerated parents—repeat this cycle over and over again. Nationally, about four in five imprisoned fathers and two out of three imprisoned mothers have served prior sentences (Mumola, 2000).

Children who are repeatedly separated from their parents in this way usually receive daily care from an “allo-parent” (e.g., a grandmother who lives in the children’s home) or are placed in a relative’s home and care (Johnston, 2002). A minority (about 10%-15%) of the children of women offenders, and a very small number (about 1%-2%) of the children of male offenders end up in foster care (Mumola, 2000); many of the children in this group have two criminal offender parents.

The effects of repeated parent-child separations, where the child initially had a substantial relationship with the parent, can be devastating. The child not only sustains emotional injury from the loss of the parent, but other consequences of parental absence—changes of caregiver and placement, loss of family income, a decreased level of physical and emotional support for the child—may cause even greater damage. Children’s ability to trust, and other aspects of their capacity for attachment, are undermined; developmental progress may be slowed; and reactive behaviors like aggression, attention/concentration problems, and depression may occur (Johnston & Carlin, 1996).



## Parental Arrest

About one in five children of criminal offenders have witnessed parental arrest (Johnston, 1991). Parental arrest is most commonly witnessed by young children because they are the most likely to be out of school and either in the home or accompanying the parent out of the home. It is also likely that the children who witness parental arrest are living with and receiving daily care from that parent.

This type of parent-child separation is specific to children of criminal offenders and is virtually always involuntary or “forced”. In addition, parental arrest is almost always abrupt and unexpected, and most families have not planned for the care of their children in these circumstances. As a result, children are doubly or triply traumatized, witnessing the forcible removal of a parent, losing a caregiver/protector, and often losing a familiar home as well. Thus, parental arrest may have profound short-term results, including traumatic stress reactions (Kampfner, 1995) and all their behavioral sequelae. In early childhood, kids have the cognitive capacity to understand concepts like “police” and “jail” but do not have the developmental skills necessary to process traumatic experiences without assistance, increasing the likelihood of negative outcomes following this type of trauma (Eth & Pynoos, 1984). Research suggests that the long-term effects of witnessing parental arrest may include a typical pattern of “legal socialization” (Stanton, 1980); for example, children who have seen their parents arrested have been found to be more likely to distrust police and the courts, and less likely to rely on law enforcement for protection.



## Separation Due to Parental Incarceration

Relatively few prisoners live together with their children prior to their first arrest (Mumola, 2000). Although most prisoners have not recently lived with their children, however, many of them have on-going contact with their children prior to their arrest. Incarceration may interrupt these parent-child relationships in several ways, including the following.

**Incarceration may prevent on-going parent-child contact due to travel-related barriers and costs.** Most state prisons are located in rural areas far from the cities where the majority of prisoners’ children live. Federal prisons are located in all parts of the U.S., and most federal prisoners are confined a long distance from their children’s homes. As a result, most incarcerated parents and their children do not visit (Bloom & Steinhart, 1993; Mumola, 2000).

**Incarceration prevents on-going parent-child contact when the custodial parent does not support visitation.** Even though a non-custodial parent is not in an active relationship with the child’s caregiver, parent-child contact often continues to occur because it is initiated by the non-custodial parent. When this parent becomes a prisoner, and parent-child prison visits are at the discretion of the caregiver, visits may not occur. Many mothers and fathers in prison want contact with their children but cannot achieve it for this reason (Carlin, 2000).

**Incarceration may prevent on-going parent-child contact when the custodial parent or child welfare authorities believe prison visiting is harmful**

**for children.** Although there is no research or other evidence that prison visiting has negative effects on children, parent-child visits in prison are often prohibited on that basis by custodial parents, other caregivers, social workers and Juvenile Dependency Court judges. In many cases, children become distressed after contact with their incarcerated parents by telephone or during/after a prison visit. This is a common reaction for children who have had a substantial relationship with the parent prior to the incarceration, and it usually reflects a reaction to parent-child separation rather than to the visiting environment (Johnston, 1995). Children who appear distressed following a prison visit should be managed in the same way as one would manage any child who becomes distressed after contact with a parent from whom they are separated.



### Parent-Child Reunification

Almost all prisoners are released from incarceration; the average sentence served by imprisoned fathers is 82 months<sup>1</sup> and by incarcerated mothers is 49 months<sup>2</sup> (Mumola, 2000). While many children of prisoners are aware of their parent’s release, the re-establishment of the parent-child relationship constitutes another transition in the children’s lives.

Only a minority of children of prisoners will fully reunify—in the sense of living together again—with their parents following the parents’ release from incarceration. Center for Children of Incarcerated Parents

<sup>1</sup> Incarcerated fathers in federal prisons serve an average of 105 months.

<sup>2</sup> Incarcerated mothers in federal prisons serve an average of 66 months.

research has found that only 13% of children will reside with their fathers following paternal incarceration, compared to 50% of children who will reside with their formerly incarcerated mothers (Johnston, 2002). One reason for this low level of father-child reunification is that the majority of male offenders have their children by two or more women (Hairston, 1995), so full reunification (i.e., living together) with all of their children is impossible.

**THE RETURN OF THE PARENT TO THE HOME SIGNIFIES A MAJOR TRANSITION FOR CHILDREN, WITH CHANGES IN HOUSEHOLD ARRANGEMENTS, POWER RELATIONSHIPS WITHIN THE FAMILY, PARENTAL AUTHORITY, FAMILY INCOME, AND/OR FAMILY RESOURCES.**

Many families that do reunify will reside together again immediately following the parent’s release; however, some will go through an extended process wherein the parent lives in a halfway house, participates in a residential treatment program, or otherwise establishes some stability before rejoining his/her children. The return of the parent to the home signifies a major transition for children, with changes in household arrangements, power relationships within the family, parental authority, family income,

and/or family resources. Children may experience a wide range of emotions in anticipation of, or reaction to, these changes, including happiness, excitement, anger, anxiety, sadness, shame, and fear. Acting out behaviors may increase, not only in response to these feelings but also as a reaction to changes in household routines and structure.

Other children will not have their formerly incarcerated parents return to their homes, but those parents will return to a more active role in the children’s lives. This circumstance may also be a transition for children, as parent and child relocate each other, establish contact and begin to rebuild their relationship. Although less intense than reactions to more traumatic experiences, children may also demonstrate emotional and behavioral reactions to these circumstances, often including anxiety and fear regarding the possibility of the parent’s return to prison.



### Intervening with Children of Prisoners

Children of prisoners typically go through cycles of transitions related to the cycles of criminal justice involvement in their parents’ lives. Depending upon the nature of their relationship with their parents, the transitions these children experience may be painful and even traumatic. Therefore, even if they have very limited relationships with their incarcerated parents, like other children who live apart from a birth parent, they may need support and reassurance. In addition, as they move through middle childhood and adolescence, children of criminal offenders need to receive information about parental intergenerational incarceration.

*Continued on page 20 . . .*

Continued from page 19 . . .

tion. Although they are at higher risk of criminal justice system involvement, this can be avoided by understanding and addressing the factors in children's lives that lead to juvenile and adult offending.

Children who have a substantial relationship with an incarcerated parent may have more concerns and fears about their parent and his/her criminal justice involvement. Thus, in addition to emotional support and information about the criminal justice and correctional systems, they may need information about the location, conditions and safety of their parents. There are some materials for children that address this issue. The Centerforce program in Northern California, for example, has a videotape entitled "What Does He Do in There?" that examines daily life in a men's prison with the intent of providing reassurance to children of prisoners.

The few children who lived with their parent in a caregiving relationship prior to the parent's incarceration are the most likely to have traumatic reactions to parental offending and imprisonment. Thus, a significant proportion of these children will need professional help to address the traumatic effects of these experiences. Others will need a higher level of emotional support, and attention to the structure and stability of their daily lives.

Regardless of a child's relationship to an incarcerated parent, however, most prisoners' children come from low-income families, live in high-crime communities, and face the daily hazards and risks of living in such communities. The core issues for these children are parent-child separation, single or no-parent family life, witnessed violence, and traumatic experiences—none of which is specific to parental incarceration. Like other children in their neighborhoods, they need the social supports and services that will minimize the effects of

poor schools, environmental hazards, dangerous neighborhoods, and overcrowded, deteriorating housing. Therefore, people who work with and know about children will need no special *skills* to help children of prisoners, but they will need additional *knowledge* about the criminal justice system and the effects of parental crime, arrest and incarceration in order to better identify and appropriately respond when children are distressed. Parents, caregivers, teachers, home visitors and others who work with children should be aware of the transitions in the lives of children of criminal offenders, and of the implications of those transitions for development. They should create and maintain a list of resources and referrals to services—including crisis intervention, therapeutic services and services for families involved in the criminal justice system—that will help children of prisoners adjust to the challenging conditions in their lives.

**Denise Johnston, M.D.**  
*Director, Center for Children of  
Incarcerated Parents*

#### REFERENCES

- Bloom, B. & Steinhart, D. (1993). *Why Punish the Children? A Reappraisal of Incarcerated Mothers in America*. San Francisco: National Council on Crime & Delinquency.
- Bowlby, J. (1969 & 1982). *Attachment & loss. Volume 1: Attachment*. New York: Basic Books.
- Carlin, M. (2000). Asserting parental rights from prison. *Family & Corrections Network Report*, 22:1-3.
- Center for Children of Incarcerated Parents (2004). How many are there? *CCIP Data Sheet No. 3*. Eagle Rock, CA: Authors.
- Eth, S. & Pynoos, R. Developmental perspectives on psychic trauma in childhood. In Figley, CR (Ed.), *Trauma and its wake*. New York: Bruner/Mazel, 1984
- Hairston, C. (1995). Imprisoned fathers. In K. Gabel & D. Johnston (Eds.), *Children of Incarcerated Parents*. New York: Lexington Books.
- Johnston, D. (2002). What works: Children of Prisoners. In V. Gadsden (Ed.), *Heading Home:*

*Offender Reintegration in the Family—What Works*. Lanham, MD: American Correctional Association.

Johnston, D. (1995). Parent-child visits in jails. *Children's Environments Quarterly*, 12(1): 25-38.

Johnston, D. (1991). *Jailed Mothers*. Pasadena, CA: Pacific Oaks College.

Johnston, D. & Carlin, M. (1996). Enduring trauma among children of criminal offenders. *Progress: Family Systems Research & Therapy*, 5(Summer): 9-36.

Kampfner, C. (1995). Posttraumatic stress reactions in children of imprisoned mothers. In K. Gabel & D. Johnston (Eds.), *Children of Incarcerated Parents*. New York: Lexington Books.

Mumola, C. (2000). *Incarcerated Parents & Their Children*. Publication NCJ 182335. Washington, D.C.: Bureau of Justice Statistics.

Stanton, A. (1980). *When Mothers Go To Jail*. New York: Lexington Books.

## NATIONAL RESOURCES

- **The Center for Children of Incarcerated Parents**  
Box 41-286  
Eagle Rock, CA 90041  
Ph: 626-449-2470  
Fax: 626-449-4537  
Email: ccip@earthlink.net  
Website: e-ccip.org
- **The Family & Corrections Network**  
32 Oak Grove Rd.  
Palmyra, VA 22963  
Ph: 434-589-3036  
Fax: 434-589-6520  
Email: fcn@fcnnetwork.org  
Website: fcnetwork.org
- **The National Resource Center on Children of Prisoners**  
Child Welfare League of America  
440 First St. NW, Third Floor  
Washington, DC 20001  
Ph: 202-638-2952  
Fax: 202-638-4004  
Website: cwla.org

## THE GUARDIAN ANGEL...

When a mother is incarcerated and leaves her children, someone who genuinely cares for the children must step up to the plate and care for them. I chose to be that person and became the caregiver for my daughter's three children while she was away. Assuming the responsibilities of caregiver for my grandchildren brought forth many challenges.

At times, it was difficult to provide for their material and financial needs. They needed food, clothing, shelter, nurturing . . . There were some resources available to help support the children, but they could be somewhat elusive. In addition, to be eligible for some of these resources, I had to navigate a sometimes unfriendly administrative system. For instance, when a mother is absent, food stamps are allocated on the basis of the income of the children's caregivers, which may make them more difficult to obtain. TANF is also available, although the monthly payments are less for a relative than they would be for a non-related caregiver.

When I took in my grandchildren, my hope was to give them an opportunity to be successful in their own lives by teaching them that they could make better choices for themselves. The children and I set up rules and boundaries that they were to abide by. We decided together how we would handle other family members, church members and school personnel finding out about our situation. We shared their mother's incarceration with select persons and chose not to make the school aware of the problem, unless it was absolutely necessary. We were very fortunate in that we made it through without hav-

ing to share that information with the school. Therefore, the children were never teased.

When an incarcerated mother returns home, new concerns arise. She is usually coming back to the same situation she left. She does not have a job unless she was in a halfway house. Even though she may have received training, she will most likely only be able to secure a minimum wage job. If she is a felon, she will not qualify for subsidized housing. She will have to reapply to receive TANF. She will strive to regain control of her children. She usually feels guilty about her absence and tends to be very lenient. Often, her leniency brings about conflicts with the caregiver provoking tensions in the household.

We could not have survived without the help of AIM, Inc., which provided the children with monthly outings, visits with their mother, and other cultural functions. AIM also provided a support group for the caregivers, the *Guardian Angels*, of which I am a member. The *Guardian Angels* is a safe space for caregivers to come together and share their struggles with raising the children or with a mother's re-entry into the children's lives.

Today, my heart leaps with joy when I receive a card, letter, or picture from one of my grandchildren thanking me for keeping our home together. I am just glad to see them accomplish the goals that they have set up for themselves... and it makes it all worth it.

By Frances L. Springer

### Aid to Children of Imprisoned Mothers, Inc. (AIM)

Aid to Children of Imprisoned Mothers, Inc. (AIM) is a non-profit, community-based organization that assists inmate mothers, their children and other family members in maintaining critically important family ties during the mother's incarceration. Created in 1987 in Atlanta, GA, AIM seeks to diminish the impact of the mother's incarceration on family relationships through a variety of support services to the children and other family members. These include: after school programming, summer camp, and Saturday programs for the children; transportation of children for prison visits; emergency aid for families; and information and referral for mothers and caregivers. They also provide consultation to legislators, judges and other professionals on child custody issues.

AIM's mission is "To inspire hope in children of imprisoned mothers and their families by providing programs and services that lessen the impact of the mother's incarceration."

AIM, Inc.  
906 Ralph David Abernathy Blvd  
Atlanta, GA 30310  
Ph: 404-755-3262  
Fax: 404-755-3294  
Website: [www.takingaim.net](http://www.takingaim.net)

*Continued from page 4 . . .*

another important part of a well-planned transition for a child. The development of a positive relationship between caregivers prior to a child's placement change can assist tremendously in facilitating threads of continuity. Even without a prior relationship, when caregivers can be encouraged to communicate with one another at the point of transition (if necessary, with a professional acting as mediator), children are likely to benefit. In our experience, in-person contact between "new" and "old" caregivers can relieve tension borne of jealousy and negative fantasies that each may hold about the other. This often translates into smoother transitions for children—who then sense that "things are okay" rather than "something is wrong here."

When possible, the endorsement of a "new" caregiver by the "old" one also can soothe children's anxieties about the transition. Further, caregivers can share important information about a child's preferences, strengths and special needs. Information about the child's routines and transitional objects is particularly important, as these details are often central to helping a young child adjust to change. Box 2 outlines some examples of routines and transitional objects that may assist in a transition.

Working with "old and "new" caregivers to develop a tentative plan for a pre-placement visit can help to alleviate anxiety about the unknown for all involved. Plans should be flexible and responsive to the child's needs, as often reflected by his behavior. For example, there should be a plan for a

transition from a foster home to an adoptive home with gradually increasing visitation between the child and the adoptive family, and ongoing contact between caregivers that includes monitoring of the child's behavior and reactions, and modifications of the plan as required. The help of other support people (e.g., relatives, therapists, teachers) can be enlisted to assist in a transition process, and where continuity of existing services (e.g., early intervention, day care) is possible, a transition can go more smoothly. These approaches provide "threads of continuity" in a variety of ways.

Finally, it is essential to communicate with very young children about their placement changes and emotional experiences, according to their developmental level. Even older infants and toddlers need a supportive, clear explanation of events. Professionals and caregivers may have difficulty "finding the words" to talk with a child, as they grapple with their own feelings of sadness, anger, helplessness and uncertainty. Guidelines to help with this dilemma are included in Box 3.

## BOX 2

### Routines and Transitional Objects: Questions to Consider About a Child in Transition

- What are the child's familiar sleeping arrangements (where, with whom) and sleeping hours (naps, nighttime)?
- What are the child's familiar feeding and eating arrangements (where, with whom) and times?
- Does the child have food likes and dislikes, "comfort" foods, foods associated with special people, events and routines (e.g., milk at bedtime)?
- Does the child have familiar routines or approaches to bathing, getting dressed; familiar routines for awakening, going to sleep (e.g., sing a particular song, read a book)?
- Transitional objects are those important items chosen by the child to keep and could include a blanket, stuffed animal, item of clothing or other idiosyncratic object; perhaps a tape of the caregiver's voice singing; or special items that could remind the child of former caregivers and familiar environments (e.g., clothing, toy or gift from caregiver; things with familiar scents attached; the laundry soap used).
- Photographs of previous caregivers, birth and foster siblings, pets, places the child has lived can be very helpful in providing "threads of continuity" for children, offering visual representation of people who have "gone away."

*Source: SEED Early Childhood Mental Health Consultation and Training Project (March, 2003). Alameda County Social Services Agency/Children's Hospital and Research Center at Oakland.*



### Summary and Conclusions

Disruptions of relationships and multiple transitions are an unfortunate but regular occurrence for young children in the child welfare system. There is an invisibility that accompanies the loss and grief that infants and toddlers experience as they endure these multiple moves. In this article, we have described a number of factors that may contribute to this invisibility and a number of approaches to create "threads of continuity" for children in foster care, which consider emotions such as grief, confusion and anxiety. Creating "threads of continuity" will ensure less painful transitions, promote more positive relationships, and

preserve a child’s history and experience. At the core of these recommendations is the need to attend to the unique circumstances of each child, including the emotions of caregivers and professionals that can impact the child’s experience. Recognizing and confronting the emotional consequences of placement changes in foster care can provide opportunities for clinical intervention that are both preventive and protective of the social-emotional health of young children and their families.

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**REFERENCES**

Bowlby, J. (1982). *Loss: Sadness and Depression*. New York: Perseus Publishing.

Bowlby, J. (1989). *Attachment*. New York: Perseus Publishing.

Bowlby, J. (1976). *Separation: Anxiety and Anger*. New York: Basic Books.

Carlson, E. (1998). A prospective longitudinal study of attachment disorganization/ disorientation. *Child Development*, 69, 1107-1128.

Dozier, M., Higley, E., Albus, K., & Nutter, A. (2002). Intervening with foster infants’ caregivers: Targeting three critical needs. *Infant mental health journal. Special Issue: Infants in foster and kinship care*, 23 (5), 541-554.

Edelstein, S., Burge, D., & Waterman, J. (2001). *Helping foster parents cope with separation, loss, and grief*. Child welfare, 80 (1), 5-25.

Fahlberg, V. (1991). *A child’s journey through placement*. Indianapolis, IN: Perspectives Press.

Lester, B.M., Boukydis, C.F.Z., & Twomey, J.E. (2000). Maternal substance abuse and child outcome. In C.H. Zeanah (Ed), *Handbook of infant*

*mental health* (2nd ed., pp. 161-175). New York: Guilford Press.

Lyons-Ruth, K., Easterbrooks, M., & Cibelli, C. (1997). Infant attachment strategies, infant mental lag, and maternal depressive symptoms: Predictors or internalizing and externalizing problems at age 7. *Developmental Psychology*, 33, 681-692.

Mayes, L.C. (1995). Substance abuse and parenting. In M. Bornstein (Ed), *Handbook of parenting: Volume 4. Applied and practical parenting* (pp. 101-126). Mahwah, NJ: Lawrence Erlbaum Associates.

Mayes, L.C., Bornstein, M.H., Chawarska, K., & Granger, R.H. (1995). Information processing and development at assessments in three month olds prenatally exposed to cocaine. *Pediatrics*, 95 (4), 539-545.

Mayes, L.C., Grillon, C., Granger, R., & Schottenfeld, R. (1998). Regulation of arousal and attention in preschool children exposed to cocaine prenatally. *Annals of the New York Academy of Sciences*, 846, 126-143.

Robertson, J. and Robertson, J. (1989). *Separation and the Very Young*. London: Free Association Books.

Rutter, M. (1981). *Maternal deprivation reassessed*. London: Penguin Books.

**BOX 3**

**Guidelines for Discussing Transitions with Children**

GUIDELINES	EXAMPLES
1. Find out what, if anything, has been told to a child about their impending move.	<ul style="list-style-type: none"> <li>■ Talk with the child (if he is verbal), as well as caregivers and others to determine whether any distortions are present (e.g., “I have to leave because I’m a bad kid”) that need to be corrected.</li> </ul>
2. When talking to children, say what is known to be true, without making promises that cannot be kept.	<ul style="list-style-type: none"> <li>■ For very young children, it is most useful to offer an explanation of events that is simple and truthful (e.g., “Daddy is in jail so you can’t stay with him right now.”).</li> <li>■ When the outcome is uncertain or unknown, it is important not to provide false reassurance. Indeed, it can be helpful to address the emotional impact of uncertainty itself (“I’m sorry. I don’t know what will happen yet, and I know that’s scary for you.”). Realistic reassurance can be provided, however, through clear statements about what can be predicted, and what is likely to promote feelings of relative safety (“Although you can’t stay with Mommy tonight, you and your brother will be staying together.”).</li> </ul>
3. Name and validate the child’s feelings to help them manage them.	<ul style="list-style-type: none"> <li>■ This may involve interpreting a child’s behavior, because they are unlikely to articulate their feelings in words (e.g., “You look like you feel mad. I understand why you feel mad about this.”).</li> <li>■ A child should be allowed many options about their feelings. Adults need to resist the temptation to talk children out of feelings such as sadness or anger, despite how painful it may be to address those feelings directly.</li> </ul>



## CALL FOR ARTICLES

**T**he National AIA Resource Center is soliciting articles for the fall 2005 issue of *The Source*. This bi-annual newsletter is distributed to administrators, researchers, policy makers, and direct line staff throughout the country, and is also available on-line at <http://aia.berkeley.edu/publications/source.html>.

The fall 2005 issue will focus on **substance using parents with cognitive limitations**. Specifically, we are looking for articles that discuss:

- the etiology and prevalence of co-occurring developmental disabilities and substance abuse;
- strategies for identifying parents with cognitive limitations and substance abuse problems;
- challenges to meeting the needs of parents with co-existing disabilities and their children; and
- innovative and collaborative approaches to working with this population to address their substance use, parenting, and other related issues.

Only abstracts that address issues for parents with these co-existing conditions and their children will be considered for publication. Research findings in this area also are welcome.

To be considered for publication, please email a brief (150-200 words) abstract of your proposed article to Amy Price at [amyprice@berkeley.edu](mailto:amyprice@berkeley.edu).

**ABSTRACTS ARE DUE FRIDAY, JANUARY 14, 2005.**

*For questions, contact Amy Price at 510-643-8383 or [amyprice@berkeley.edu](mailto:amyprice@berkeley.edu)*



## GOOD BETS



### Rebuilding Attachments with Traumatized Children

This book uses attachment theory and research to frame a discussion of how to work with traumatized children to rebuild their self-esteem and hope for the future. Along with a discussion of how trauma impacts the development of positive attachments, the author includes case examples, strategies, and tips for therapists to use in their work. A workbook, *Real Life Heroes*, complements the text by providing a tool for professionals and other caring adults to use with traumatized children. Designed for children ages 6 to 12, the workbook helps children develop confidence and self-respect by honoring their past and preparing for their future. Cost: \$39.95.

*R. Kagan, 2004. 335 pages. Available from The Haworth Press, Inc., 10 Alice St., Binghamton, NY 13904. Ph: (800) HAWORTH (429-6784). Fax: (800) 895-0582. www.haworthpress.com*

### The Adventures of NanaCat and Her Children series

This 2-book series was created to help children ages 3 – 8 adapt to living with and being raised by a relative caregiver. The books speak to the need for security that is often present when a child is taken from their parents and introduced to a new home. Cost: \$6.95 each plus shipping (discounts available for multiple copies).

*M. Catherine, 2003-2004. Available from Florida Kinship Center. Ph: (813) 974-6444. Fax: (813) 974-4675. Email: kinfo@flkin.org. www.flkin.org.*

### Creative Strategies for Financing Post-Adoption Services and Promising Practices in Adoption-Competent Mental Health Services

These two papers published by The Casey Center for Effective Child Welfare Practice are the latest additions to the *Strengthening Children and Families* series. They describe post-adoption policy and practice, and they offer suggestions for financing adoption-related services at the state level. Executive Summaries are also available. Cost: Free.

*Casey Family Services, the Casey Center for Effective Child Welfare Practice. 127 Church Street, New Haven, CT 06510. Ph: (203) 401-6900. Fax: (203) 401-6901. www.caseyfamilyservices.org.*

### Roadblocks in Cognitive-Behavioral Therapy: Transforming Challenges into Opportunities for Change

This book brings together writings from leading practitioners to discuss obstacles that arise during therapy but are not widely discussed in the literature. Suggestions for overcoming some of these obstacles are given. Cost: \$40.00.

*R.L. Leahy (Ed.), 2003. 364 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com*

### Treating Parent-Infant Relationship Problems: Strategies for Intervention

Leaders in the field describe interventions for infant-caregiver relationship strengthening. Recognizing that some children are more difficult than others to care for, and that some parents are less prepared to cope with the difficulties inherent in raising a child, this book describes a number of therapeutic techniques. Cost: \$40.00.

*A.J. Sameroff, S.C. McDonough, & K.L. Rosenblum, 2004. 304 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com*

### Treating Attachment Disorders: From Theory to Therapy

Dr. Brisch outlines an attachment-oriented framework for working with clients of all ages. Extensive case examples serve as the base of the book. The author illustrates how attachment-oriented interventions can successfully treat clients with a wide range of difficulties. Cost: \$24.00.

*K.H. Brisch, 2002. 294 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com.*

### Losing a Parent to Death in the Early Years: Guidelines for the Treatment of Traumatic Bereavement in Infancy and Early Childhood

This book offers clinicians, counselors, educators, child-care professionals, and others a compassionate yet practical guide to the assessment and treatment of young children who have experienced the death of a parent or primary caregiver. The authors describe how babies, toddlers, and preschool-age children typically respond to overwhelming loss, explain complications in the grieving process that are associated with the sudden or violent death of a parent, and offer vignettes that illustrate therapeutic interventions with traumatically bereaved young children and their families. Cost: \$39.95.

*A. F. Lieberman, N. C. Compton, P. Van Horn, and C. Ghosh Ippen, 2003. 160 pages. Available from Zero to Three Press, P. O. Box 960, Herndon, VA 20172. Ph: (800) 899-4301. Fax: (703) 661-1501 attn: ZERO TO THREE Bookstore. Email: Oto3@presswarehouse.com. www.zerotothree.org.*

*Continued on page 26 . . .*

Continued from page 25 . . .

### Emotional Connections: How Relationships Guide Early Learning

This book translates new research on cognitive, social, and emotional development in the early years into the language of daily caregiving and teaching. The authors give trainers the information and tools they need to teach infant-toddler caregivers how to build responsive relationships with very young children and their families. The authors show how positive relationships are the context for helping babies and toddlers learn, communicate, and regulate behavior. An accompanying *Instructor's Manual* includes teaching strategies; activities; times required for each lesson; and a CD-ROM with printable handouts, worksheets, and overheads. Cost: \$29.95 (book); 202 Pages, \$44.95 (instructor's manual).

*P. McArthur Butterfield, C.A. Martin, & A. Pratt Prairie, 2004. 208 Pages. Available from Zero to Three Press, P. O. Box 960, Herndon, VA 20172. Ph: (800) 899-4301. Fax: (703) 661-1501 attn: ZERO TO THREE Bookstore. Email: Oto3@presswarehouse.com. www.zerotothree.org.*

### Young Children and Trauma: Intervention and Treatment

This book fills a crucial gap in the literature of mental health professionals and child welfare advocates by presenting valuable knowledge and treatment techniques for working with young children affected by traumatic experiences. Particular attention is paid to the needs of children suffering from the effects of abuse and neglect, but other forms of trauma, such as illness, injury, and exposure to violence, are also explored. Cost: \$42.00.

*J.D. Osofsky (Ed.), 2004. 360 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com.*

### Real Belonging: Give Siblings Their Right to Reunite

Lynn Price describes the importance of maintaining a bond between siblings in foster care. Cost: \$19.95.

*L.S. Price, 2004. Available from Inkwater Press. Ph (303) 791-0915 or (888) 723-5664. Email: lynn@camptobelong.org. www.lynnprice.com.*

### Posttraumatic Stress Disorders in Children and Adolescents: Handbook

A rich mix of research and clinical experience with PTSD, stress, and trauma are presented in this book. This book is different from many others concerning these disorders in children in that, rather than basing work with children and adolescents on work with adults, the editor has requested that the contributors write specifically about their work with younger populations. Cost: \$22.95.

*R. R. Silva (Ed.), 2004. 384 pages. Available from Norton Professional Books, W.W. Norton & Company, 500 Fifth Avenue, New York, NY 10110. Ph: (800) 233-4830. Fax: (212) 869-0856. www.npbcatalog.com.*

### Emotional Beginning and Partners in Parenting Education (PIPE)

*Emotional Beginnings* is a curriculum and on-site training process used by childcare professionals to increase the emotional availability and relationship building skills of infant and toddler caregivers. The entire package includes: a Site Coordinator's Guide, 46 Presentation Posters, a CD-ROM of handouts for Caregivers, an Instructional Video, and a Caregiver Handbook. The *PIPE* model is a preventive intervention for parenting educators that is designed to increase the emotional availability and relationship building skills of parents with their babies and toddlers. The package includes an Educator's Guide, Parent Handouts, and Activity Cards. Cost: \$135 (*Emotional Beginnings*) and \$420 (*PIPE*) plus shipping and handling.

*Available from How to Read Your Baby, 280 Columbine, Suite 311, Denver, CO 80206. Ph: (303) 377-4584. Fax: (303) 355-5749. www.howtoreadyourbaby.com.*

### Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates, and Child Welfare Professionals

This report encourages powerful child-welfare decision makers, such as judges, to stay informed about early childhood development in order to make sound decisions and use important resources for children. Cost: Free.

*S. Dicker & E. Gordon, 2004. Available from: Zero to Three Press, P. O. Box 960, Herndon, VA 20172. Ph: (800) 899-4301. Fax: (703) 661-1501 attn: ZERO TO THREE Bookstore. www.zerotothree.org/policy/.*





### The Importance of Caregiver-Child Interactions for the Survival and Healthy Development of Young Children: A Review

This review brings together current theory as well as empirical evidence from an array of disciplines including neurophysiology, psycholinguistics, behavioral embryology and developmental psychology on the importance of caregiver-child relationships for the survival and healthy development of children. The authors discuss the importance of culture on development, as well as the role of the caregiver in the development of children, the importance of stable care, research findings, the effect of caregiver-child relationships on the health and development of children, and implications for practice. Cost: Free on-line.

*World Health Organization's (WHO) Department of Child and Adolescent Health and Development. Available on-line at [www.who.int/child-adolescent-health/publications](http://www.who.int/child-adolescent-health/publications), or contact [cah@who.int](mailto:cah@who.int).*

### The Complexity of Connection: Writings from the Stone Center's Jean Baker Miller Training Institute

The Stone Center embraces the theory of connection as vital to human growth and development. The book provides an examination of connection and disconnection at the individual and societal levels. Cost: \$18.95 (paper), \$40.00 (hard)

*J.V. Jordan, M. Walker, L.M. Hartling (Eds.), 2004. 308 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. [www.guilford.com](http://www.guilford.com).*

### How Connections Heal: Stories from Relational-Cultural Therapy

Professionals affiliated with the Stone Center's Jean Baker Miller Training Institute wrote this practice-oriented casebook, and they show how RCT is used in practice with individuals, couples, families, groups, and in an institutional setting. They stress that relationships are the foundation of therapy. Cost: \$23.00 (paper), \$45.00 (hard).

*M. Walker & W.B. Rosen, 2004. 258 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. [www.guilford.com](http://www.guilford.com).*

### Black Families in Therapy: Understanding the African American Experience (2nd edition)

Nancy Boyd-Franklin expands her previous edition and further discusses some of the issues inherent in working with African American families. Included are issues facing communities of differing socio-economic levels, expansions of therapeutic concepts for more relevance to African American families, and an empowerment approach to help individuals realize change. Cost: \$38.00.

*N. Boyd-Franklin, 2003. 368 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. [www.guilford.com](http://www.guilford.com).*

### Understanding Families: Approaches to Diversity, Disability, and Risk

This book provides a comprehensive mix of information on research and practice to use in working with families of varying compositions. Readers will learn how to develop effective partnerships with families, especially those with at-risk children or children with disabilities. Cost: \$32.00.

*M.J. Hanson & E.W. Lynch, 2003. 208 pages. Available from Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285-0624. Ph: (800) 638-3775. Fax (410) 337-8539. [www.brookespublishing.com](http://www.brookespublishing.com).*

### Culturally Competent Practice with Immigrant and Refugee Children and Families

Experts discuss key issues facing families and the histories of immigration of 14 immigrant groups, whose populations are growing in the United States. Topics include cultural conflicts, trauma associated with refugee experiences, and effects of poverty and discrimination. Recommendations for assessments and interventions are presented throughout the book. Cost: \$38.00.

*R. Fong (Ed.), 2003. 320 pages. Available from The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. [www.guilford.com](http://www.guilford.com).*

### The Lobbying and Advocacy Handbook: Shaping Public Policy at the State and Local Level

This book provides guidance for those in the nonprofit sector who may be new to the lobbying process at the state and local levels. It provides a road map of the steps to take in the process, including where to begin. Cost: \$37.95.

*M. Avner, 2003. 240 pages. Available from Wilder Publishing Center, 919 Lafond Ave., St. Paul, MN 55104. Ph: (800) 274-6024. Fax: (651) 642-2061. Email: [books@wilder.org](mailto:books@wilder.org). [www.wilder.org/pubs](http://www.wilder.org/pubs).*

### The State of America's Children Yearbook 2004

State data of child care, child health, education, family income, juvenile justice, mental health, and nutrition are presented in this all-inclusive resource. This yearbook is essential for discussion with community leaders, policy makers, and the media. Cost: \$15.95.

*Children's Defense Fund, 2004. Available from Children's Defense Fund, Fulfillment Division, P. O. Box 90500, Washington, D.C. 20090-0500. Ph: (202) 662-3652. Fax: (202) 628-8333. [www.childrensdefense.org](http://www.childrensdefense.org).*

*Continued on page 28 . . .*

Continued from page 27. . .

### A Closer Look: Lessons from Local Initiatives for Children

A follow-up to *Bringing It Together*, a 2002 Children's Defense Fund report, this report looks at communities' responses to the needs of children and families. Included in the discussions are child care, early education, and health care. Cost: \$12.95.

*Children's Defense Fund, 2004. Available from Children's Defense Fund, Fulfillment Division, P. O. Box 90500, Washington, D.C. 20090-0500. Ph: (202) 662-3652. Fax: (202) 628-8333. www.childrensdefense.org.*

### Early Intervention for Trauma and Traumatic Loss

Which interventions are most helpful in facilitating recovery from the effects of stress and trauma is a matter open to question. This book describes current knowledge and a range of interventions for PTSD, acute stress disorder, and traumatic grief for people across the life span. Evidence-based clinical recommendations are made, and discussions of special groups, including 9/11 survivors, veterans, and victims of sexual abuse, are presented. Cost: \$40.00.

*B.T. Litz (Ed.), 2003. 354 pages. The Guilford Press, 72 Spring Street, New York, NY 10012. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com.*

### A Family's Guide to the Child Welfare System

This resource answers questions asked by many families when they enter the child welfare system. Organized by section tabs and written in a question and answer format, this guide can also be used by professionals to increase family participation in service planning. Cost: \$10.00.

*J. McCarthy, A. Marshall, J. Collins, G. Arganza, K. Deserby, & J. Milon, 2003, December. 128 pages. Available from National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Suite 401, Washington, DC 20007. Ph: (202) 687-5000. Fax: (202) 687-1954. Email: Mary Moreland, deaconm@georgetown.edu. www.gucchd.georgetown.edu.*



## VIDEOS

### When the Bough Breaks—Children of Mothers in Prison

This documentary is an up-close look at children coping with their mother's incarcerations. Their stories illustrate policy gaps between the judicial and social service systems. Cost: \$350 (sale); \$75 (rent).

*J.E. Petzall & D. Rogers, 2001. 58 minutes. Available from Filmmakers Library, 124 East 40th Street, New York, NY 10016. Ph: (212) 808-4980. Fax: (212) 808-4983. Email: info@filmmakers.com. www.filmmakers.com.*

### Gentle Transitions: A Newborn Baby's Point of View About Adoption and Is Anyone in There? Adopting a Wounded Child

Presented from an infant's point-of-view, the *Gentle Transitions* video suggests what adults should think about and do to make the transition from one family to another and the adoption experience work best for a baby. Designed for foster and adoptive parents, as well as child welfare professionals, a companion video, *Is Anyone in There?* acknowledges the challenges of adopting a traumatized child. The latter video comes with a booklet that briefly looks at attachment disorders and lists references and available resources. Cost: \$70.00 each.

*Gentle Transitions 16 minutes; Is Anyone in There? 11 minutes. Available from Infant-Parent Institute, 328 North Neil Street, Champaign, IL 61820. Ph: (217) 352-4060. www.infant-parent.com/videos.*

### Multiple Transitions: A Young Child's Point of View on Foster Care and Adoption

This video attempts to distill what children would say about what it feels like to be moved around, how and why their behavior begins to change, and what happens to their availability for new attachment. It also includes suggestions for how the system could do a better job. Cost: \$70.00.

*12 minutes. Available from Infant-Parent Institute, 328 North Neil Street, Champaign, IL 61820. Ph: (217) 352-4060. www.infant-parent.com/videos.*

## ON-LINE RESOURCE

### Dialogue with the Experts: Hearts and Minds - The State of America's Babies and Toddlers

In April of 2003 in Washington, D.C., ZERO TO THREE held a forum of leaders in the field of infant-family. Virtually attend the five presentations on important issues affecting babies, toddlers, and their families.

Visit <http://www.zerotothree.org/aboutus/dialogue.html>



## CONFERENCE LISTINGS



### Roundtable on Religion and Social Welfare Policy Fall Conference

This annual conference will comprehensively examine the status of faith-based social services in the United States, and the outlook for the future following the fall elections.

**DATE:** December 9, 2004

**LOCATION:** Washington, DC

**SPONSORING AGENCY:** The Roundtable on Religion and Social Welfare Policy

**CONTACT:** Ph: (518) 443-5014. Fax: (518) 443-5705. [www.religionandsocialpolicy.org](http://www.religionandsocialpolicy.org)

### Resiliency: Hope, Choice and Self Determination for Children, Families and Communities

The 16th annual conference of the Federation of Families for Children's Mental Health will focus on practical strategies that actively promote resiliency for children with emotional, behavioral or mental health needs and their families.

**DATE:** December 9-12, 2004

**LOCATION:** Washington, DC

**SPONSORING AGENCY:** Federation of Families for Children's Mental Health

**CONTACT:** Ph: (703) 684-7710. [ffcmhconference@earthlink.net](mailto:ffcmhconference@earthlink.net). [www.ffcmh.org](http://www.ffcmh.org)

### 2005 National Girls Initiative/Florence Crittenton Roundtable: Growing Girls for Greatness

This year's roundtable will bring together professionals and other interested parties working to help girls and young women achieve their "greatness." The conference will stress relevant issues and highlight evidence-based practice and promising strategies to promote the well-being of girls and young women.

**DATE:** January 5-7, 2005

**LOCATION:** Scottsdale, AZ

**SPONSORING AGENCY:** Child Welfare League of America

**CONTACT:** Ph: (202) 639-4911. [roundtable@cwla.org](http://roundtable@cwla.org). [www.cwla.org/conferences](http://www.cwla.org/conferences)

### The Knowledge-Implementation Nexus: Addressing Critical Issues in Public Mental Health

The 15th annual conference on state mental health agency services research, program evaluation, and policy, this conference will concentrate on three main areas of focus and how they affect system transformation: recovery/resiliency, co-occurring disorders (mental health/substance abuse), and evidence-based practices.

**DATE:** February 6-8, 2005

**LOCATION:** Baltimore, MD

**SPONSORING AGENCY:** National Association of State Mental Health Program Directors Research Institute, Inc.

**CONTACT:** Vera Hollen, Conference Manager. Ph: (703) 739-9333, ext. 116. Fax: (703) 548-9517. [vera.hollen@nri-inc.org](mailto:vera.hollen@nri-inc.org). [www.nri-inc.org/Conference/Conf05/05Papers.pdf](http://www.nri-inc.org/Conference/Conf05/05Papers.pdf)

### The 2nd International Conference on Patient- and Family-Centered Care: Partnerships for Enhancing Quality of Care

Innovative health care programs dedicated to collaborative efforts with patients and families will be showcased.

**DATE:** February 21-23, 2005

**LOCATION:** San Francisco, CA

**SPONSORING AGENCY:** Institute for Family-Centered Care

**CONTACT:** Ph: (301) 652-0281. [institute@iffcc.org](mailto:institute@iffcc.org)

### Children 2005: Crossing the Cultural Divide

Children living in conditions ranging from extreme poverty and violence to material luxury share common universal needs, including shelter, health care, nurturing relationships, protection from harm, and help dealing with harm. At this conference more than 2000 individuals committed to the well being of children will gather to share stories and develop strategies to promote equal opportunity for all children.

**DATE:** March 9-11, 2005

**LOCATION:** Washington, D.C.

**SPONSORING AGENCY:** Child Welfare League of America

**CONTACT:** [www.cwla.org/conferences/2005nationalrpf.htm](http://www.cwla.org/conferences/2005nationalrpf.htm)

### Supporting Promising Practices and Positive Outcomes: A Shared Responsibility

The goal of this conference is to promote interagency and interdisciplinary collaboration to optimize services for children and their families. The conference will support prevention-focused, evidence-based practice and the application of research. Discussions, workshops, and poster sessions will be included.

**DATE:** April 18 - 23, 2005

**LOCATION:** Boston, MA

**SPONSORING AGENCY:** The Children's Bureau

**CONTACT:** Ph: (703) 528-0435. [15thconf@pal-tech.com](mailto:15thconf@pal-tech.com). <http://nccanch.acf.hhs.gov/profess/conferences/cbconference/index.cfm>

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## COMING IN 2005

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### TWO NATIONAL AIA TRAINING EVENTS!!!

Washington, DC  
SPRING 2005

#### **Sustaining your Child and Family Services Organization in Lean Times**

Designed for community-based organizations serving families with young children affected by substance abuse, child welfare and/or HIV, this one-day training institute will provide information about strategic planning and capacity building, collaboration, advocacy, and accessing financial support as mechanisms for program sustainability.

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Washington, DC  
FALL 2005

#### **Addressing the Needs of Substance Exposed Newborns and their Families: Effective Policy and Practice**

Bringing together professionals from hospitals, child welfare agencies, public health agencies and substance abuse treatment programs, this two-day national symposium will provide program administrators, practitioners, policy makers, and advocates with information about state and local policies and exemplary practices in addressing the needs of substance exposed newborns and their families.

**For more information about these events, or to receive registration materials, contact the Resource Center at 510-643-8390 or [aia@berkeley.edu](mailto:aia@berkeley.edu).**



## RESOURCES AND PUBLICATIONS AVAILABLE FROM THE NATIONAL AIA RESOURCE CENTER

Title of Publication	Unit Price	No. of Copies	Total Price
■ AIA Fact Sheets			
— Kinship Care (May 2004) .....	FREE*	_____	_____
— Family Planning with Substance-Using Women (April 2004) .....	FREE*	_____	_____
— Perinatal substance exposure (February 2004) .....	FREE*	_____	_____
— Recreational programs for HIV-affected children and families (September 2003) .....	FREE*	_____	_____
— Standby guardianship (August 2003) .....	FREE*	_____	_____
— Subsidized guardianship (July 2003) .....	FREE*	_____	_____
— Women and children with HIV/AIDS (May 2003) .....	FREE*	_____	_____
— Shared family care (December 2002) .....	FREE*	_____	_____
— Boarder babies, abandoned infants, and discarded infants (July 2002) .....	FREE*	_____	_____
■ Directory of AIA Programs (2004) .....	5.00	_____	_____
■ Focusing on the needs of youth in kinship care (September 2004) .....	5.00	_____	_____
■ Discarded Infants and Neonatacide: A review of the literature (September 2004) .....	5.00	_____	_____
■ AIA Best Practices: Lessons Learned from a Decade of Service to Children and Families Affected by HIV and Substance Abuse (2003) .....	12.00	_____	_____
■ Shared Family Care: Restoring Families Through Community Partnerships (2003) in VHS or CD-ROM (please circle one) .....	10.00	_____	_____
■ Annual Report on Shared Family Care: Progress and Lessons Learned (2002) .....	10.00	_____	_____
■ Expediting Permanency for Abandoned Infants: Guidelines for State Policies and Procedures (2002) .....	10.00	_____	_____
■ Partners' Influence on Women's Addiction and Recovery (2002) .....	10.00	_____	_____
■ Bay Area Shared Family Care: Whole Family Mentoring/Bridging Communities (Video 2000) .....	10.00	_____	_____
■ Voluntary Relinquishment of Parental Rights: Considerations and Practices (1999) .....	10.00	_____	_____
■ Integrating Services & Permanent Housing for Families Affected by Alcohol and Other Drugs (1997) .....	10.00	_____	_____
■ Delivering Culturally Competent Services to Women & Children Who Are Drug-Affected (1997) .....	10.00	_____	_____
■ Service Outcomes for Drug- and HIV-Affected Families (1997) .....	10.00	_____	_____
■ Family Planning & Child Welfare: Making The Connection (Video/Guide 1997) .....	25.00	_____	_____
■ Shared Family Care Program Guidelines (1996) .....	10.00	_____	_____
* One copy free. For price of multiple copies, please contact the Resource Center.			
		<b>Total Amount Enclosed</b>	_____

Look on-line (<http://aia.berkeley.edu>) for these and other publications

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**PRINTING:** Autumn Press

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*The Source* is published by the National AIA Resource Center through a grant from the U.S. DHHS/ACF Children's Bureau (#90-CB-0126). The contents of this publication do not necessarily reflect the views or policies of the Center or its funders, nor does mention of trade names, commercial products, or organizations imply endorsement. Readers are encouraged to copy and share articles and information from *The Source*, but please credit the AIA Resource Center. *The Source* is printed on recycled paper.

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1-24175-14185-44-CSAIA3  
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