

GRANDPARENTS AND OTHER RELATIVES RAISING CHILDREN TRAINING PROJECT



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INTRODUCTION

This manual is designed as a resource for anyone wanting to start an educational/support group for grandparents and other relatives raising children or for anyone who is already leading such groups.

There are two primary sections:

- Content on how to go about establishing and maintaining support groups
- Topical resource content to assist the group leader in building agenda for group meetings.

This is not intended to be a “curriculum” but rather a resource from which group leaders can pull material in addressing some of the many issues faced by relatives raising children. The material can be used to supplement “packaged programs” or to help tailor a program for a specific group. Group leaders should feel free to pull material directly from the manual or to modify material to fit the needs of a particular group.

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Child Development*

<http://www.kidsgrowth.com/stages/guide/index.cfm>

Legal Options and Resources, Health, Mental Health, Financial and Social Service Resources**

2011 Relative Caregiver Resource Guide.pdf

HELP-A Handbook for Kentucky Grandparents.pdf

Both of these documents are available at **www.gapofky.org/handbook**

*(Growth Milestones – used with permission from KidsGrowth.com)

** HELP – A Handbook for Kentucky Grandparents and Other Relative Caregivers – used with permission from Access to Justice Foundation and Bluegrass Area Agency on Aging and Independent Living. Grandparents and Relative Caregiver Resource Guide - used with permission from Lexington Fayette – Urban County Government Department of Social Services and Office of Aging Services.

BUILDING AND MAINTAINING EDUCATION/SUPPORT GROUPS FOR GRANDPARENTS AND OTHER RELATIVES RAISING CHILDREN

A. Purpose Of Groups

These groups have two purposes: (1) To provide support and enrichment to grandparents and other relatives caring for children; (2) To assist grandparents and other relatives with information and practical skills that will help provide the best experience for grandchildren or other related children in their care. These purposes can be addressed simultaneously.

Support Enrichment Education

Within the context of these purposes, there is a running theme throughout the life of the group: Self-care. A sort of mantra might be:

“Taking care of myself is a gift to the children in my care.”

Although the topical content is important and helpful to the relative raising children, the emotional and social support gained from the group is the primary focus.

Group participants will probably gain some insight and therapeutic affect from the group experiences, this is not however, a therapy group. It does not take the place of individual or family counseling.

While group members will probably learn quite a lot about the functioning of the legal system as well as a host of other agencies and organizations, the group is no substitute for formal legal advice or the final word on law, regulations, and rules by which any agency or organization is run.

B. Method of Operation

1. Determining Needs and Interests

According to the Kentucky Cabinet for Families and Children, as of August 1, 2010, there are 10,548 children in the care of relatives who are receiving Kinship Care support. This is approximately 4,000 more children than those in the Foster Care system at the same time. The 10,548 number does not include those children in the care of relatives who are not receiving Kinship Care support. We do not know that number but indications are that it, at least, equals that number.

You might look to census numbers in your area to get a sense of the number of

children living in the care of family members. If you are in the school system, records might also give you a sense of that number.

There are certainly lots of care giving family members who have access to resources and support in assisting them in raising children. However, many of the families are struggling emotionally, socially, and financially. There is comfort in being able to communicate with people who are having similar experiences – simply to lighten the load.

Another way to determine need is to converse with educational, health care and social service organizations in your area.

2. Time and Place for Group Meetings

Most facilitators may have little choice about the location of the group meetings. Try to make sure the space is big enough for everyone to have some private space, but not so large that the group is engulfed in the coldness of unused space.

Facilitators can define the group space by arranging the seating to indicate the boundaries. It is generally best for the participants – including the facilitator(s) – to sit in a circle or square (tables may provided comfort but are not necessary). This allows for face to face interaction for all participants. Groups should not be set up in a traditional classroom style. That puts too much emphasis on the facilitator and promotes participant-to-facilitator interaction when it is more helpful to have participant-to- participant interaction.

Try to arrange meeting times in a way that would be most inclusive for potential participants. Lots of grandparents and other relatives who are caring for children have jobs and may only be able to meet at night or at the closing of a shift. Others might benefit more from morning or afternoon meetings. Facilitators will not be able to cover the time needs of everyone, but should be sensitive to the unique needs of the community.

Groups might meet once a week or once every other week or once a month, etc. It is helpful to have the meetings at a set time and day of the week, for example: every Wednesday from 6 p.m. to 8 p.m.. People are more likely to show up if it becomes a part of their routine. Having too much time between meetings can contribute to falling attendance.

There is a need to establish the length of time each meeting will run and determine a length for the life of the group. For example: a group might meet two hours, once a week, for twelve weeks. As the end of the group sessions approach, group members

might decide they would like to stay together for a while longer. If the facilitator is available and enough people want to continue, the number of extended group meetings should be determined by agreement between the participants and the facilitator(s). Groups should meet long enough for relationships to develop between participants.

If it is intended for the group to continue indefinitely, with new members entering at any time and more seasoned members possibly leaving, this should be made clear to the group members. This seems to be the way many grandparent and other relatives raising children groups work. Thus the composition and dynamics of the group are always changing.

Keep in mind that the meeting time may change once the group is formed and there is more information about the specific needs of group members.

3. Determining If the Group Will Be Open or Closed

Facilitators will need to determine if group membership will remain the same throughout the life of the group (closed groups), or if they will allow members to begin at any point in the life of the group (open groups). There are advantages to both methods of forming groups. If it is decided to have a closed group, the facilitator will need to advertise the formation of the group, recruit members, and stick with the same membership for the length of the group. Generally, this will allow greater potential for meaningful group interaction and, thus, support. Every time a new person is introduced into the group the group dynamics change. Participants are more likely to develop trust and comfort in disclosure if the membership remains consistent.

Open groups (inviting new members into the group at any point of the group's life) will probably meet the needs of most facilitators and participants. If someone is in need of support and they are told that the next group will begin in four months, they will probably be discouraged and feel their needs are unimportant. It may still be possible in open groups to create a sense of belonging and trust – it will just be more difficult and will require greater effort on the part of the facilitator. If a new group member attends his/her first group and feels a need to “tell their story” (and most do feel this need) the members who have been meeting with the group for some time may feel like: “We have heard all this before” or, it may come across as if the group is always starting over. This, in turn, contributes to some members losing interest and dropping out of the group. In open groups a new member may need information and discussion on a topic that was just covered. Repetition is not a bad thing in these groups but, the facilitator will need to make the topic relevant to the whole group – new members and old members. Open groups may also give a greater opportunity for new and fresh ideas.

For a number of reasons facilitators may feel like they have no choice but to have an open group. In this case you may have members dropping in and out of the group. The facilitator should not see this as negative. Most likely a core group will emerge and continue meeting over a long period. These are the people who will benefit from more intimate support. The in and out members will be able to take in as much support as they need or can tolerate.

4. Number of Facilitators

Groups may function with one or two facilitators. If the decision is made for two people to work as co-facilitators this means that preparation and planning will have to be conducted to assure “togetherness” of effort as well as compatibility of content and approach. It is probably not a good idea to have the two facilitators take turns with the group (one leading one week, the other leading the next week). This creates confusion for the participants and is disruptive to relationship development. Ideally, both leaders would be present at all meetings.

Here are a few examples of ways facilitators might work:

A group of Family Resource Youth Service Center (FRYSC) coordinators (and other facilitators) in a county may decide to lead groups, but at different times. Someone might hold a group in the morning, someone else in the afternoon - while school is still in session, someone else may lead an after school group, and someone may lead a group in the evening.

A group of FRYSC coordinators (and other community facilitators) in a county might decide to lead groups at different times during the year. When a group is not in operation at one site, potential group member might be referred to another group in the area.

Group facilitators might decide to split up the main responsibility for leading group sessions depending on expertise or level of comfort with the topic area.

Make sure the group participants understand how the two facilitators are going to function.

5. Recruiting Group Members

Once the time and place for group meetings have been established, information about the group should go out to the community. Some suggested places for publicizing the formation of the group are: Community Based Services offices, churches, Family Resource and Youth Service Centers, Cooperative Extension officers, schools, Head Start, family court, libraries, employee assistance program, doctor’s offices, health clinics, school counselors and principals, legal services offices, community aging programs, large plants or factories, local newspaper, TV, and radio,

community bulletin boards, as well as local and agency newsletters. Speaking at civic groups luncheons (they are always looking for speakers) might be another way of getting the word out.

Simply making the group available will not always attract potential participants. The group facilitator may find that they have to make phone calls or even home visits to recruit potential participants.

C. Facilitator Tasks

1. Create A Positive Atmosphere

The leader of the group acts as a facilitator. The facilitator will recognize that the best learning will come from the participant's interactions with each other. The grandparents and other relatives in the group are the experts. (Cox, 2002)

Every effort should be made to make the group a positive experience for the caregivers. Try to frame the work in positive terms and always celebrate group and individual achievements.

Hopefully, the participants in the group will come away with enhanced self-esteem, ideas for managing their stress, new methods of dealing with children in their care, workable strategies for advocating for their grandchild or relative, and a sense of purpose and pride in what they are doing. This means that the facilitator will want to build on the strengths of the relative care givers. Although there will certainly be a need and desire to discuss everything that goes wrong while providing care for children, the facilitator will want to realistically reframe some of these "wrongs" into more positive perspectives.

Statement by participant: "Everything in the book is wrong with this child."

Reframing statement by the facilitator: "This child has been through a lot and is still reacting to those experiences; however, he is coping and managing the best he can."

2. Providing Initial Structure (Around Topical Content)

Because groups function most effectively with some degree of structure, groups are encouraged to address a topic or set of topics at most gatherings (some gatherings will be, solely, for socialization and fun). At the end of each meeting the group can determine the agenda for the next meeting. The needs of the group, at any particular time, may dictate the focus for the meeting and, thus, over ride the agenda.

The materials provided with this program are to be used as content resources. Facilitators are not limited to these resources, and should feel free to research

other existing resource material. Materials are designed as “pull outs” – topical material that respond to various needs of relatives raising children. When the group determines the agenda for its next meeting, the facilitator can use the provided materials (and others) to help prepare for that meeting. When the group has difficulty coming up with topics for the next agenda the facilitator may introduce some on the topics for in the Resource Packet as possibilities. Facilitators may also choose to invite other experts to a meeting to assist in fulfilling the agenda. For example: The group might decide they need to learn more about guardianship or some other legal arrangement. There may be an expert in the community who could be called upon to assist in covering this topic. Although there are laws and administrative regulations that govern legal procedures, each local area has its own idiosyncratic methods and processes. Thus, someone in the local legal system may be best able to shed some light on these realities.

Group facilitators can use all or portions of this program content while working with grandparents and other relatives raising children. Group participants should provide the strongest lead in determining the information most needed, however, the facilitator might be helpful in putting their needs into brief terms and by providing options for discussion topics. If, through observation, the facilitator sees that the group might benefit from discussing a particular topic, the facilitator may point this out to the group as an option.

Group members may want to come up with a name for the group. This could help them identify with the group and, perhaps, feel a sense of belonging. This also gets away from calling this a “support group,” which may be off-putting for some caregivers. They can even create a mascot or banner or some other symbol that represents the group. Activities such as these help the participants feel like the group is “their group” – a sense of ownership. Facilitating support groups calls for flexibility and openness. The facilitator needs to be prepared with information about raising children in the care of relatives and skilled in helping group members remain connected and focused.

3. Providing Child Care

It is important for the facilitator or sponsoring organization to do their best to arrange child care during the group meetings. It might be possible to recruit volunteers to provide child care. However, it will be necessary to locate a space that is appropriate for children of all ages or let it be known the ages of children who can participate in child care. This might also be an ideal time to provide “homework” or “study” assistance to school age children. Some participants will continue attending the group, in part, because it gives them a couple of hours respite from the child or children. Legal liability is frequently a concern for programs or agencies sponsoring these groups and providing child care. This can be a stumbling block for some programs and organizations. Make sure the sponsoring agency understands the

issues around liability and help them make sure their interests are protected. Providing child care will go a long way in maintaining the group. Most relative care givers will not be able to attend support group meeting unless there is child care.

It should be noted that children will probably benefit from interaction with other children being cared for by relatives (“I am not the only one.”)

If child care is impossible to provide it might be best to offer the group during school hours. At least some caregivers would be able to attend if children are in school.

D. Facilitator Attitude

If someone chooses to facilitate an educational/support group for grandparents and other relatives raising children it is assumed they are doing so because they have evidence of a need. One of the main “hoped-for” goals of the facilitator is to make life a more positive and nurturing experience for children and families (what ever the make up of the family). This is a professional relationship that exists between the facilitator and the group.

One of the first things the facilitator will want to do is establish the purposes for the group – making sure everyone has the same understanding of why the group has formed and thus where the group is going. This will set the ground work for the group and give the facilitator and group members an anchor that will be the focus for all group activity and interaction.

As emphasized in the content of this program, gaining or increasing the capacity to empathize, is central to nurturing children. The facilitator will want to take care to model empathic feelings and expressions. Most people are not “taught” empathy, but rather, learn it or don’t learn it from day to day interaction with other people. Thus, it is helpful for the facilitator to understand, from the perspective of the participant, why a participant may be experiencing what they are experiencing and to normalize the participant’s reactions, feelings and thinking.

Putting yourself in someone else’s shoes and trying to see the world through their eyes is, perhaps, the most important element of healthy interaction. This also goes a long way in establishing trust between the group and the facilitator. Without this trust the group will not be able to give and take the kind of support they are seeking.

The facilitator will have to take care to attend to all group members and the group as a whole. This does not mean that the facilitator has to “like” every one equally. It does mean that the facilitator needs to have a good handle on any negative reactions they have to any group member – thus, able to purposefully interact with each member in ways that move the group toward its goals. This, alone, will help the facilitator remain grounded. Clarity of purpose helps moderate stress for the group and the facilitator. To avoid issues of transference the facilitators should utilize

supervised support systems to process their own reactions that may cause distress or interfere with the group process.

The facilitator should enjoy this experience. Yes, it is work, but interaction with any group of people has the potential to enrich everyone involved. If the group can see that the facilitator is enjoying meeting with the group they will also begin to relax and enjoy the experience.

The facilitator wants to take care to not over react to events that occur in the group. There may be times when the atmosphere in the group gets tense. The facilitator does not have to jump to the conclusion that this can not be allowed. Rather, the facilitator wants to verbalize what is going on in the group and get the members involved in how this is helping the group reach its stated goals. Most feelings and reactions are temporary. Thus there is no need to rush in and “fix” every incident. The facilitator need not over burden themselves with an attitude of “fixing.”

The facilitator wants the group and group members to see that he/she cares about them and is interested in their life and situation. If, in fact, the facilitator does care about the group and its members this will generally come across in the interaction between them in the group meetings.

The facilitator has to recognize that members of the group are going to be in different places – whether that has to do with understanding child behavior, how to best function in a group, motivation to learn, ability to appreciate other people’s efforts, or ability to manage and cope with difficult situations. To expect everyone to be at the same place is setting a stage for frustration and disappointment. This does not help the group accomplish its goals.

It is most likely that the facilitator will encounter grandparents and other relatives who are quite angry. They may be angry at parents, social service agencies, school personnel, etc. Or, they may be angry because of the cards they have been dealt – their personal situation. It is important that the facilitator not take this anger personally – even when it seems directed toward them. Sometimes the facilitator will need to help the participant recognize the anger and label it effectively.

Sometime the facilitator and group members may need to help the participant:

- find ways to effectively direct the anger;
- gain a new perspective about the anger;
- develop methods of coping with the anger;
- manage the anger in ways that keep it from harming the participant, the child, or other family members.

The facilitator might be able to help the participant reframe the anger in a way that makes it more manageable.

The anger should not be discounted or minimized by the facilitator. It is a valid response to some difficult situations. It is important to address the anger – thus, keeping it from adding to the already heavy stress load. Anger that is addressed in healthy ways can produce positive energy. Anger that is not addressed tends to fester and consume energy.

E. Forming and Maintaining Relationships (Campbell and Palm, Chapter Five. 2004)

All aspects of group functioning are dependent on the relationship that exist between the group participant and the facilitator as well as the relationship that emerges between participants. These relationships will be instrumental in the continuity of the group, the facilitator's ability to successfully deliver content, the investment participants are willing to make in the group, and the facilitator's ability to model behavioral and emotional expression. Basically, these relationships are the key to the success of the group.

The relationship between the facilitator and group participants is not easy to define. It is not a teacher/student relationship, it is not a friendship. It seems to have more to do with the facilitator establishing an atmosphere of mutual trust and respect. The facilitator has to genuinely care about the participants and their situations. This does not mean you have to like everyone but you do have to care about there success in caring for children and caring for themselves. If the facilitator can enjoy the group experience he/she will have an advantage in developing and maintaining the relationship.

The facilitator must be competent and genuine. The participants have to trust what they see. This requires open and honest interaction. Trust is not immediately established but is a continual process. Acceptance of group members is vital. They are who they are. It is not your desire to make them be the way you want them to be, but to appreciate what they have to offer and see into them deeply enough to feel connected. This requires empathy (which is also one of the keys to good parenting). Empathy - the ability to put yourself in their place as though you are they. This will come across to the participant as understanding and supportive while being non-judgmental. This is the same thing we want parents to do with children. It is why we want parents to know enough about child development to know how children at certain places in their growth journey think and express. The child development section of this packet will help in understanding age appropriate milestones.

To maintain this relationship the facilitator also has to be willing to examine their own irrationality (stereotypes, over-generalizations, biases). Perception is not always based on reality but is influenced by the lens through which we see the world. Lenses are clouded or spackled with our own generalizations and stereotypes as well as our understanding of the world based on our own experiences. Thus, there has to

be a continuous effort to know who we are and either love that or change that. We have to know, at least, some of the specks that influence how we see the world and other people. This is the only way you can have any control over your own irrational perceptive elements.

Grandparents and other relative caregivers are going to become empowered by the relationship that exists between them and the facilitator. They will be willing to try new things, see things in a different light, and think in terms of options and choices.

F. First Meeting

The first meeting of the group is an important time to set the tone for the group. The facilitator(s) need to arrive early at the meeting site to greet participants and check out the space. The space should be thoughtfully arranged to allow open conversation. It is a good idea to provide snacks (food is a good medium for discussion).

A few details that might be helpful:

- Name tags
- Enrollment sheets to capture basic contact information in case there is a need to contact the member
- Some agencies and grant-based groups may have required forms that members will need to fill out.

This is an opportunity for participants to meet each other and learn the purpose of the group. The facilitator should clearly explain the purpose of the group and why they decided to become a facilitator for such a group. Each participant should be given the opportunity to explain his/her situation: how they came to be caregivers for children of relatives; the circumstance that contributed to the child(ren) needing the care of relatives; a little about the children – age, gender, any specific physical, mental, and social strengths and limitations; what they see as the most positive thing about raising the children; what are some of the biggest challenges; and what they want to get out of this group experience. Not all members will want or need to explain details of their situation. They may not yet feel safe or secure with the group. The facilitator(s) will support efforts to explain their situation but should never force a participant to disclose more than they are ready to share.

The facilitator will want to protect the participants from over disclosing – disclosing too much too early. It is not unusual for those who spell their guts at the first meeting to not come back.

They may go away feeling too vulnerable, embarrassed, or over exposed to feel comfortable in coming back to the group. Because of this the facilitator will need to structure the discussion in such a way that people can get across the bases of their

realities and yet avoid over disclosing. It might be helpful to gently remind the group that they only need to share as much as feel comfortable doing.

Try to do something fun at the first meeting. This could be some sort of ice breaker activity, a door prize, game, etc.

G. Establishing Group Rules

The group rules should be developed by the participants and the facilitator(s). Rules might cover a number of topics, such as: level of confidentiality, respecting each other's perspective, giving everyone a chance to speak, what happens if someone arrives at a group meeting drunk or high, allowing the presence of children or not, etc.

These rules should be established during the first or second meeting, but can be revisited and modified at any point in the life of the group.

While establishing group rules would be a good time to disclose that the facilitator is obligated by law to report any suspected abuse or neglect.

The group rules should be developed in light of the purposes and goals of the group: support, enhancement, and education.

Following is a set of rules established by a group of adoptive parents:

- “Begin and end on time, but please do come even if you are going to be late! If you need additional time to talk to the leader, please feel free to do so after the meeting.
- Confidentiality – what is said in here, stays in here! (except in the event that someone is being hurt through child abuse, domestic violence, suicidal thoughts, or homicidal intentions)
- Always feel that your thoughts and opinions are valuable, share whenever you feel you can.
- Respect for everyone.
- Focus on our commonalities; accept our differences. We agree to disagree sometimes---it's okay to disagree and still be friends.
- Remember to respect others who are talking by only one person speaking at a time, listening to each other, and please not talking on the side.
- Give everyone a chance to share and talk, please do not dominate our shared time.

- Please share whatever frustrations you have, but be careful.....*about making the focus of the group a “grip session about the social service or court system.*
- Members may “pass” on hearing or engaging in an activity if they are not comfortable with it.
- Take care of yourself and your needs (freedom to go to rest room as needed, take a smoke break if needed, or to just leave the room if the discussion is too emotionally intense for you at this time.)
- Please feel free to leave cell phones on, but please speak out side the room.
- Leave the room as we found it.
- Call the leader or another group member anytime. We can always stop and just listen.”

These rules were written out and distributed to each member.

The group facilitator(s) also make a laminated copy of the rules and they were posted at each meeting.

The group may decide to add to or change the rules. These changes should always be a group decision.

H. Establishing Commonalities

Educational material might be better heard and utilized in an atmosphere that is supportive, where group participants can find some sense of commonality with other group members. The group facilitator will have to work toward identifying and re-enforcing these commonalities, as that will contribute to greater group cohesion. For example: All of the participants will, of course, be raising relative children. This will be the first established commonality. Wanting the best for the child they are raising may be another easily identifiable commonality. Hopefully the facilitator will be able to, rather quickly, establish another commonality, that being: Paying attention to self-care. Caregivers often forgo taking care of themselves and, thus, are at risk of burnout. The facilitator can point out that by coming to the group is a way to foster self care which in turn will benefit both them and the children.

Simple commonalities will be things like living in the same community or being from rural or small town areas. As the group progresses, other commonalities may be identified: Having some of the same concerns about children, running into the same parenting issues, having similar reactions to birth parents, recognizing the same or similar ambivalent feelings about raising the children, or having similar guilt feelings about “not having been a good enough parent” for the child’s parent.

Seek and welcome diversity in the group. There is much to be learned by familiarizing oneself with an array of different possibilities for solving problems. It is refreshing to gain new perspectives about old issues. Learning and using new parenting skills or perspective is not easy. People are usually drawn back to what they have learned from their own experience of being parented. Sometime this is good, sometimes it is not so good.

I. Managing Group Interactions

Remember the purpose of the group – support, enhancement and education. This helps the facilitators more clearly define their role and style. The facilitator’s role is to introduce content, keep the focus of the group, and facilitate supportive interactions.

The facilitator is not an interpreter of behavior, nor is the facilitator trying to discover or change what makes a person tick. This is not a therapy group. The emphasis is on social and emotional support. Also, throughout the group there is an emphasis on self care.

It is desirable for group members to evaluate their old ways of parenting and determine which ones they can keep and which one have to go. It is possible to build on some of the old skills while exploring options for new skills or ways of doing things.

1. Over talking and under talking group members

Most groups will have a few “over talkers” as well as “under talkers.” The facilitator will need to work toward managing these issues so that everyone has an opportunity to participate. There will never be equal verbal involvement by everyone. That is just one of our differences as people.

Under talkers can be encouraged (by the facilitator) to share more verbally, while over talkers can be encouraged to respect the need for all members to have a chance to speak. This issue can be partly addressed (early) in the “rules” of the group. The facilitator may also say things like: “Is anybody else experiencing what X is talking about? Please tell us about your experience.” The facilitator may directly ask questions of other people in the group to divert all the attention from the over talker. For example: “Y, X has just shared how hard it is for her/him to set rules and stick to them. What is your experience with rule setting?”

Here is another idea to address the over talker or verbal dominator:

“X, I am going to ask you to hold the rest of what you want to say so we can get some reaction from others about what you have already said.”

To get the under talker involved verbally in the group, the facilitator needs to pay close attention to the non-verbal cues given by the under talker and use those cues as a way to bring them more into the group. For example: The facilitator might see that Mr. P. is listening to what Miss E. is saying and seems to have a wrinkled brow and a look of doubt. The facilitator might say: “Mr. P. you look like you might have

a response to what Miss E. is saying. Would you share that with the group?” In other similar situations the facilitator might say: “Mrs. A, you seem to be a little uncomfortable with what is being said, are you?”

2. Maintaining the Focus of the Group

The focus of the group should center on the purposes for the group. It might be a good idea to post a written copy of the purposes at each meeting. This is a reminder to participants about the expected direction of the group. If the group gets too far astray from the purposes of the group the facilitator can point at the posted purposes and ask: “Is our present discussion contributing to the purpose of the group or helping us in reaching our goals?”

For example, if the group has determined that the topic for a particular group session will focus on “adolescence angst” the facilitator is responsible for directing discussion toward that issue. The facilitator can do this because he/she is a more objective voice in the group. Group members have a lot of emotional investment in their issues and concerns. In this instance, if someone begins talking about the frustrations with potty training, the facilitator may say: “W., I know that is an issue for you and I hope we will be able to address that; however, right now the focus is on adolescent angst. Do you have a perspective you want to share about managing this angst?” Or, “Remind me to come back to that topic once we have finished addressing the issue presently before the group.”

Certainly the group may, in the process of exploring a topic, decide that another topic is more helpful to them. The facilitator can remain flexible but needs to clarify with the group that they seem to be making a conscious decision to switch topics and ask if that is their intent.

If the facilitator observes that the group keeps coming back to a topic or particular situation, he/she can share that observation and make sure the group is making a decision and not drifting.

Some topics are more difficult to discuss than others. If it seems the group members are avoiding the topic (keep changing the topic or close up), the facilitator can interject comments about the level of discomfort or difficulty in talking about the topic. Sometimes, just recognizing that a topic is “hard” to talk about, eases the participants and makes them more comfortable. Even a brief discussion about “why” this topic is hard to talk about will allow participants to see that they are not the only one who is uncomfortable.

3. Directing the Conversation Between Participants

Group members may initially see the facilitator as the “expert.” Because of this they may direct all their questions and concerns to the facilitator. The facilitator, before

responding, will want to reflect the question or concern back to the group, asking group members to respond directly to the participant with the question or concern. The facilitator should make sure to do this kind of re-directing very early in the life of the group. Otherwise, the group sessions will become “Ann Landerish”, questions or comments from the participants to the facilitator and the facilitator responding back to the participant. This does not a group make. This kind of interaction defeats the purpose of “support.” On top of that, the facilitator does not want to set themselves up as knowing all the answers. They don’t. The facilitator may be able to share a number of perspectives on a topic, but every situation is different and the application of content will be handled differently by everyone.

Sometimes the energy of a group will drag. To pump up the energy a little the facilitator may ask the whole group a question. If that does not jump start interaction the facilitator may direct the question toward a specific person. If that doesn’t get things moving, the facilitator might introduce an exercise or activity that requires interaction.

It is part of the facilitator’s responsibility to maintain a logical flow in the group. Without someone to take this responsibility a group may become disjointed and redundant. The facilitator can redirect conversation to keep the focus on track. Or, the facilitator might point out common experiences or feelings between group members. The facilitator can also point out content and interaction from an earlier group meeting that is relevant to the present interaction – helping the participants feel connected to the entire group experience, rather than each meeting feeling like a re-beginning of the group.

4. Allow for Expression of Feelings

Although this is not a therapy group, it may be therapeutic. That is, the group experience may allow some participants an opportunity to talk, in a safe environment, about some of the emotionally laden issues that come up when caring for relative children. For some participants, these opportunities may not exist outside of the group. For example: Participants may need to talk about their anger and frustration with biological parents who have behaved irresponsible. They will probably learn that they are not alone in these feelings. Just that realization may ease some of the stress experienced by the care giver. Another example: Some participants may simply feel emotionally overwhelmed – angry, sad, hurt, lonely, etc. Being able to talk about that may be the first step in their getting more organized and specific about these feelings – find a targeted focus for some of the feelings. That, in turn, begins to allow the participant to feel a greater sense of control and ability to manage the feelings in ways that are constructive. Once someone starts experiencing strong feelings they tend to generalize the feeling – it then become the feeling about everything rather than a specific thing, person, situation, etc.. This is the kind of experience that contributes to depression.

Many family members who become care givers for children have a belly full of mixed feelings. They want to be available and helpful to the children and relatives in need, while at the same time feeling overworked, under appreciated, and taken for granted. The group is an ideal place for them to talk about such feelings, and to learn what other people are doing to cope with the same feelings.

The facilitator should not be afraid of these feelings and the expression of them, but welcome the opportunity to address them in the group. “Thanks Mr. H for bringing up your feelings in the group. Let’s spend some time and see if other people have ever had some of the same feeling and, if so, how have they learned to cope with or manage these feelings.”

On the other hand, the facilitator does not want to create a gripe group or a group where participants come in and simply spell their guts. Feelings need to be made as tangible as possible (not something floating around out there is space). To accomplish this, the facilitator will need to help the participant, through the group, learn some new ways of coping or new ways of looking at the problems to which they are responding. The facilitator may also help the participants determine what the feelings are really about. For example: Sometimes care takers may be expressing anger toward the birth parents but, they are really mad at their spouse for not being more involved (or supportive of their involvement) with the children.

Some participants may feel all sorts of guilt about having some of these feelings. The group is a good place for them to learn that these feelings are a pretty natural response to their situation. Guilt eats up a lot of energy. Learning that other people have some of the same feelings or that their experience is not very different from other’s experience, can begin to free up some of that energy, making it available for self care and/or caring for the children.

Speaking of guilt, it is pretty common for some participants to carry around some guilt about their own parenting. This is particularly true for grandparents. “If I had been a better parent when my son/daughter was growing up, we would not be in this present situation.” It may be helpful to go back to an old adage: “People do the best that can at the time and with the resources available to them.” Beating oneself up with all those “should’s” is pretty much a waste of time and energy. It is much more helpful to focus that energy on “what I can do now.” This may sound simple but it is sometimes very difficult to do. It is much easier to set around and talk about how awful things were than it is to talk about what I can now do. It will be the facilitator’s responsibility to assist participants in getting past the old wounds and help them focus on NOW.

5. Managing Aggressive or Confrontational Group Members

Every person in the group will bring their own personality, life experiences, values,

communication patterns, ways of coping with anxiety, and overall view of the world (the way things are and the way things should be). This is a part of what is fun about working with groups. This can also create some headaches for the facilitator.

One issue that can present a challenge for the facilitator and group is the presence of one or more verbally aggressive or confrontational members. At the same time, the presence of these folks can bring quite a lot of energy to the group. It is not the facilitator's responsibility to change personality or correct negative patterns of interactions. But it is the facilitator's responsibility to maintain a safe (emotionally and physically) atmosphere in the group.

Group rules can cover some of the potential issues in these instances. Rules that make it clear physical altercations will not be tolerated are usually a comfort to most group members. Rules about respect and allowing all group members an opportunity to participate may also rein in some of the negative confrontation.

Confrontation, when done in a thoughtful, respectful manner can be very helpful and motivating. Thus, there is no need to rid the group of all confrontation. However, the facilitator may help those who appear to be restricted to only confrontational interactions develop a broader repertoire of interactional skills. The facilitator may say for example: "Miss M I think you have a good point to make and I wonder if you can think of another way to present that point to Mrs. R. You just came across so strong that it may be hard for Mrs. R to really hear what you have to offer."

Confrontation can be limited when the facilitator models and directs participants to speak from the "I" position instead of the "you" position, for example: "You kids never help out you are lazy", can be rephrased to "I feel overwhelmed by all of the work around the house. I need your help to pick up the toys."

6. Summarizing

One of the techniques the facilitator can use to keep the group on track and to also prevent overload is to summarize the content covered in each group meeting. This, of course, takes place at the end of the meeting. This also gives the participants something manageable to take home. Here is an example: "The theme that seems to have emerged tonight is how to cope with and manage strong anger at the child's parents when they seem to continuously behave irresponsibly. There have been a few suggestions about how to better cope with this situation: try to focus on the needs of the children in your care while refusing to be drawn into a new problem or situation with your own child or relative – it was suggested that this might be a good time to call another group member and talk it out."

Another time that summarizing might be helpful is at the end of a long or rambling discussion. The facilitator might say something like: "Let me see if I understand

what the group is saying. What I hear is that you spend so much time dealing with the negative behavior of the children in your care that you miss or ignore the good behaviors. Is that right?" Sometimes members will not even realize that they have been saying something like that.

Summary may also be useful when one group member seems so overwhelmed that they can not verbally organize what they want to say or ask. The facilitator may say something like: "Do you mind if I attempt to summarize what you are saying." And then proceed to do so. If your summary is incorrect it gives the participant an opportunity to correct the summary. If you are expressing what the participant is trying so hard to get out, he/she may be grateful and relieved.

J. Building Group Member Capacity To Support (Campbell and Palm, 2004)

Some group members will be struggling with issues that other participants have learned to manage. Asking group members "If anyone else has struggled with this issue would you please share you experience, particularly how you have come to manage the issue." The sharing of the struggles and possible management efforts will become an important component of the group experience. This kind of interacting will build cohesion in the group and help people feel more comfortable talking about their struggles.

In situations such as the one above, try to get members interacting and sharing with each other rather than directing every thing toward the facilitator. Facilitators will need to get participants verbally interacting as soon as possible. Even if this interaction is not about content it will assist in establishing the intended pattern of interaction. Most people never tire of talking about themselves and their situation.

After the facilitator provides a very brief explanation of the purpose of the group it is good to put an emphasis on verbal interaction among participants. Having participants introduce themselves and "tell your story" may be a reasonable way to begin the first gathering. The facilitator can explain that it is their role to keep the group focused and moving toward the purposes of the group. The facilitator might be able to point out commonalities in the participants "stories," thus promoting a bond between members. Give the participant an opportunity to respond to someone else's story.

The first session should certainly introduce the concept of self care and explain that participation in the group might be one way participants can better manage the issues that come up for them and the children for whom they care, and thus taking better care of themselves. Some group members will be struggling with issues that other participants have learned to manage. Thus, the sharing of these struggles and possible solutions will be a valuable part of the group experience. Sometimes simply knowing that you are not alone with your struggles, or not the only one going through an experience, can be supportive and give emotional energy to "hang in".

We all love to get positive feedback. These caregivers also like and need positive strokes for the things they are doing and trying to do. When the facilitator gives this kind of feedback she/he is modeling a way to function in the group. Getting positive messages from other participants helps to create and maintain relationship between group members, thus contributing to group members feeling safe and comfortable in the group.

As the group goes along, the participants may take it upon themselves to bring snacks for everyone or even to organize a pot luck meal for the group. These activities usually help in building support among members and should be encouraged. Some or all of the group members might start meeting at a local restaurant (or some other place) after the meetings. For the members this might be a way of expanding their informal resources. Group members may begin calling each other to ask for support or advice. (Make sure you have the permission of group's members before distributing contact information.) There may be some potential problems with any of these outside activities, but they may be a natural result of support begun in the group. For a number of reasons the facilitator should avoid arranging any outside contacts between group members but should encourage such activities initiated by participants.

The group may benefit from some social activities. Usually these activities allow the members to interact in a "natural" environment. It may well be more comfortable for some participants to seek and gain support through these informal social opportunities.

Not all of the group meetings have to consist of sitting around talking about experiences. Having fun activities together builds bonds and contributes to the kind of environment that makes people want to continue coming. The group may have a pot luck supper once a month or so, creating an atmosphere where people can share informally. Other kinds of social activities that might be fun and helpful are things such as: meeting for supper (or any meal) at a local restaurant, going to a concert together, an evening of cards or dominos, etc. This can be a good way to enhance the quality of interactions in the group. These activities are usually more informal and, thus, more comfortable for some participants. This also gives the caregiver a little respite from the children. Some of the best support may come from these sorts of activities. Providing snacks, door prizes, food baskets, gift cards, tickets to family events (zoo, aquarium, theatre, theme parks, etc.), distributing items such as toys, socks, books, clothes, and school supplies, may reward participants for coming and influence further attendance

In most groups, transportation is an issue for someone. The facilitator might bring up or alert the group of a member's difficulty with transportation. It is common for some group members to begin traveling to the meeting together. The facilitator should not make these arrangements but, rather, create an opportunity for group members to offer assistance or ask for assistance.

The facilitator needs to have knowledge of all local programs that might assist in providing school supplies, clothing, and other resources. Sharing this knowledge can help the members connect with the facilitator as well as the group.

The major reason people continue in these kinds of groups is the relationships they establish with the group facilitator or other group members. Facilitators should take full advantage of this motivation. Creating a warm and accepting environment goes a long way. The facilitator(s) should constantly assess the relationships in the group and plan to build on or enhance these relationships as much as possible.

Sources:

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TOPICAL CONTENT

A. Adjusting To Changes And Transitions: Self Care

(This section of the packet stresses some things grandparents and other relatives can do to take care of themselves and respond lovingly to children during the changes and transitions that come with parenting grandchildren and other minor relatives.)

This *italicized* information is for facilitators.

Begin with a discussion that encourages participants to recognize the positive things about raising grandchildren – the things they enjoy or that give fulfillment. If they have a hard time getting started here are some possible items:

Children:

- *contribute to emotional fulfilling,*
- *add zest to life,*
- *give you purpose,*
- *define (or represent) what is important – and thus provide a lively perspective,*
- *contribute to vitality*
- *keep you focused on the now.*

Encourage as long a list as possible. If possible post the list on the wall. You might want to refer back to it.

Facilitate a general discussion with the participants on this topic: taking care of yourself while caring for children. They need a chance to talk. They may well bring up some of the issues listed below. If they do, go with it. If they do not bring up some of the issues below you can use this as a basis for presentation and discussion. Facilitator might need to help them stay focused on how they are taking care of themselves while managing some of the issues or problems listed below. It is easy for them to talk about all the problems, but harder to talk about self care. Some discussion of problems is helpful (for ventilating, clarifying, and gaining support) but an unstructured discussion of problems just seems to add to the anxiety they may already feel.

This session should be loosely structured, allowing the participants to choose the direction for the discussion. The facilitator's role is to maintain focus and manage group interactions.

Some of the following items may not come, readily, to mind when thinking about self care. However, these items – particularly the parenting items have long term effects on making life easier and much more pleasant for the caregiver and add enormously to the long term well being of the children.

“TAKING GOOD CARE OF YOURSELF IS A GIFT TO THE CHILDREN IN YOUR CARE”

As the group facilitator you will have to come back to this statement again and again during discussion of any of this program's content.. You might even try to make this a group motto or mantra. Try giving each of the participants a token (coin, poker chip, key chain bangle, a small card, etc) that they can carry with them as a reminder (each time they see it) that they need to take care of themselves.

1. Recognize and Accept Mixed and Ambivalent Feelings

Recognize and accept mixed and ambivalent feelings about assuming care of your grandchildren. You may also have to manage mixed feelings toward the parents of these children. At the same time you love your grandchildren, you might experience some feelings that you do not particularly like:

Mixed or ambivalent feelings are a normal part of day to day living. Generally, they only become problematic when you fail to recognize you have them or deny that you have them. You can still love someone and be angry at them or resent their behavior.

- *Anger and resentment* - You might resent having this parental responsibility thrust upon you. You might experience some anger about disrupted plans you have for yourself. Anger and/or resentment toward the child's parents seem to wane and flow while you care for the child. There is nothing wrong with having these feeling. You just want to be able to manage them in order to avoid letting them eat away at you and undermine your relationships with your grandchildren. Carrying around too much anger can be exhausting and contribute to health problems. You also have to manage these feeling so that they do not become transferred to the child.

You may find yourself still trying to parent your adult children while also parenting their children. It does not diminish your love for your child by insisting that they assume adult responsibility. You may even find yourself having to make a choice about where you are going to exert your parenting energy – toward the adult parent or the children. You simply may not have energy for both. If you have legal custody of the child or children, their needs and care always come before the birth parent's needs and wants.

- *Guilt* - Blaming yourself for the fact that your child can not take care of their children - "I must not have done a very good job as a parent or I wouldn't be in this situation." Beating yourself up only makes you bloody and doesn't change anything – wasted energy. Bury that old stuff and focus on the care of the child and care of your self. You can choose to learn new parenting skills and replace the worn out ones.

But, let's say that you have lots of clear evidence that you did not do a very good job parenting your own child(ren). And here you are trying to take care of

their child(ren). That does not mean that you can not be a good grandparent or primary care giver for these children. Maybe you have learned a lot since your kids were growing up. You may also be willing, now, to learn some new things about parenting.

Maybe you screwed-up. That was a long time ago and you are not able to go back and fix it. Forgive yourself, turn all that old stuff over to a higher being, and do your best with your present charges. If you let that old stuff go, you will be better able to have a warm, relaxed time with your grandchildren. You will be better able to take care of yourself and the children.

- *“It’s unfair”* – Rather than a social life, your time may be consumed with concern and care for you grandchildren. You may feel like other people do not understand what you are experiencing. You may feel that you have little in common with the parents whose children are the age of your grandchildren. This can lead to loneliness.

As difficult as it is to accept life may not be fair. Some people have to put up with and manage a lot more than others. However, the more you walk around saying to yourself that this responsibility of taking care of these related children is unfair, the more you will be anxious, tired, and even depressed.

Your body and mind respond more effectively when you focus on the good stuff. Unpleasant feelings may nag at you but allowing them to become the focus is self defeating.

- *Overwhelmed* – It takes a lot of time and energy to raise a child. As the primary care provider you worry about their health, school functioning, legal issues, financial needs, emotional well-being, day to day hurts, etc. All of this can be stressful. This stress can contribute to some depression or physical illnesses. Keep a close check on how you are managing the stress. If you are exhausted all of the time, it is no good for you or the child. This is no time to be a martyr. Be a hero and exhibit good healthy habits for the children. They learn a lot more by what they see and experience than by what you tell them. (Fitzpartick, 2004) (AARP, 2006) (Kornhaber, 2002) Solicit support from other family members and caring adults. The adage that “it takes a village to raise a child” has great merit.

Ignoring these and other ambivalent feelings does not help. They will just come back to bite you in the butt. It might be better to go ahead and own them. That way you have some control over them and may be able to keep them in perspective.

They should know that these are “normal” feelings and that it is okay to have them. They are not bad people for having these feelings. Trying to deny that there are

ambivalent feelings associated with raising grandchildren only exacerbates the difficulties. Denial takes a lot of energy and also makes it hard for other people to provide support. However, they do need to take care that these feelings are not conveyed to the children. The grandparent group is an ideal place to talk about these feelings.

It is only through recognizing these feelings that they can exert any control over them and, thus, put them in perspective. If they deny some of these feelings they might find that the feelings start to control them or impact, negatively, their interactions with their children and grandchildren. Sharing these feelings might best be done with other grandparents, thus, one reason support groups are important.

2. Dilemma: Remain The Grandparent Or Become The Parent.

Children have parents (no matter how they are presently behaving or what they are presently experiencing). Whenever possible it is more helpful for the child to see their parents as parents and you as grandparents (or aunt or uncle or cousin or?). It is, of course, helpful for them to understand that they can depend on you when their parents are having tough times. “You can always count on me,” is very securing for the child.

If, however, the parents are not going to be involved in their life you can let the child (if they are old enough) make the choice of whether you are the grandparent acting like the parent or actually their parent. If it becomes clear that your grandchildren are not going to be returning to their parents it might be time to have this discussion with the grandchildren.

As the group facilitator you might encounter some relative care givers who are so angry at parents that they think the child should “disown” the parent. This anger is understandable but the relative has to take care not to pass it on to the child. As the facilitator you have to bring the discussion back to focus on the best interest of the child while showing empathy for the relative’s feelings.

3. Interaction Between Relative Care Giver And Biological Parent(S)

When possible it is best to maintain some sort of contact between the relative caregiver and the biological parent. Do your best to lovingly keep the parents informed about what is going on with the children. It may be hard to accept this, but -----Most parents love their children. They may not be able to provide for them, or express their love in a healthy manner, but they probably feel love for them. You want to do all you can to reinforce that love. This is a win – win – win situation for you, the child, and the parents.

There, of course, may be times when contact between the child and the biological parent is limited: when such interaction or contact is dangerous for the child; when biological parents are under the influence of drugs or alcohol; when children, after contact with their parents, repeatedly exhibit distress symptoms; when children verbally and emotionally indicate that they are frightened and do not want to visit. However, in general, it is a good idea for children to be able to make contact with their parents - even if their time together is under supervision.

If you are involved with the courts or the child welfare system you may not be able to keep children from having contact with their parents. There are sometimes court orders that require biological parents to have contact with their children at designated times. If you believe the contact is detrimental to the well-being of the child, you may talk to the social service worker or request a hearing with the court.

After contact (visits, phone calls, emails, etc.) children might exhibit some behaviors that are difficult. They may feel and exhibit sadness, anger, resentment, guilt, and a combination of all these. These feelings (particularly anger) may be expressed toward you. Actually, that is a pretty good thing. It means they feel safe enough with you that they can express these feelings. In their head, it would be a disloyalty to express such feeling to or about their parents. Do not take this personally. It really has nothing to do with you except that you are providing a safe and secure environment that tells them:

“it is okay to express myself and I will still be loved.”

4. Maintaining Relationship With Your Spouse Or Partner

It is easy for children to become the center of your world. Be careful. While you want to provide the very best of everything for the children in your care, you also have other realities and responsibilities. Children can learn to respect this. It is helpful for children to have boundaries that indicate your time and energy has to be shared. You do yourself, your partner, and the children a disservice by focusing all of your energy on the child (ren).

It is not unusual for partners who are involved in encore parenting to find that tending to children is much more shared than the first time around. Men may ease-up a little as they mature. They may have more patience or be more tolerant. If you have a partner, this venture has to be a joint endeavor.

If you and your partner are in conflict over how to parent these children seek professional help through family counseling or attending parenting classes together. Your partnering roles may be well established by this point. This does not mean modification is impossible. It is a good time to reach out to each other and find new connections and respect.

5. Maintaining Social Support

For goodness sake, do not cut yourself off from social contact with other adults. Kids are amazingly able to adjust. They do not need 100 percent of your time and energy. If you are accustomed to getting together with friends on a particular night, continue with that. You might have to modify timing a little but do not give it up all together. It is good for the children to see you have good, positive social opportunities and get some of your needs met.

If you belong to organizations or attend community and church events – continue doing that. Again, it may require some modification but do not give it up all together. Sometime the children will be able to participate in these occasions with you, other times you will need a child care provider or baby sitter.

Use every resource you can to get some time away from the children. You need that and they need that.

6. Helping Children Separate The Person From The Problem

Children need assistance in understanding that their parents are “good” people. They may be experiencing problems or behaving in harmful or destructive ways, but they are still good people. Separating the parent from the behavior might also help you manage some of your own ambivalent feelings.

Children may irrationally assume it is their fault when something goes wrong with their parents. They may see themselves as not being good children and that they have something to do with creating the problems that contribute to them being cared for by substitute parents. Young children are concrete thinkers. It is important to repeatedly remind them that they are not the cause of their parent’s situation or behavior.

The fact that their parents are not around may contribute to children idealizing their parents. This is a way children try to cope with loss. Fantasies play a major role in the child’s coping. This can be a difficult tight wire act for grandparents – letting the child cope through fantasy at the same time you resent the parents not doing their job. It is emotionally securing for the child for you to continue to reassure the child that it is not their fault that things are tough.

Having your grandchild grow up feeling loved by their parents will create better adjusted children, teens and adults. This, alone, will make your life much easier. Children need to know that they are loved by their parents. If they feel unloved by the parents they interpret this as: “For some reason I must not be lovable.” This presents life long issues for the child, particularly in terms of self image. The grandparent’s love and care can be an invaluable foundation to foster self love and

esteem. Developing and maintaining healthy relationships becomes a very difficult task.

Avoid degrading the parent to the child. The child will likely defend the parent out of a deep sense of loyalty. To see the parent as bad is often equated in the child's mind as "I must be bad."

It may help the caregiver to remember that love is a feeling, and that feelings and behaviors do not always match-up.

Some grandparents and other relatives may need some help here. They may think that the parents are really not "good" people. As the facilitator, you will need to let them express their true feelings and help them find ways to manage those feeling in order to keep them from negatively affecting the children. Children are children and not small adults. They think differently and perceive things differently. Adults too frequently think children see the world the same way they see the world. Wrong. Children are still developing lots of their cognitive capacity and may "think" more in terms of feelings than facts.

7. "Others Do Not Understand"

Grandparents and other relatives may feel like others do not understand what they are coping with. They may feel cut off from usual support systems – friends, neighbors, other relatives, etc. Social isolation can contribute to feelings of being overwhelmed. Grandparents may need a safe place to express their anger, resentment, frustration, and feelings of helplessness.

Finding support from the usual places may be more difficult now that you have the extra tasks of caring for children. The usual supports may really not understand what you are going through. You have to let them know. Tell them what you are experiencing – the good and not so good. Also, tell possible supporters specifically what they can do to help.

Supporters may be willing to baby sit; run errands; mow the yard; help furnish a bed room for the child; call on a regular basis and allow you to talk about your frustrations, ambivalent feelings, as well as your joys; help drive the child to activities or community functions; drop by for coffee; any other things that might make life a little easier and the child more comfortable.

Creating grandparent groups that offer training and support can be helpful. At the same time, making a commitment to attend group meetings and activities may be difficult for many. The benefit of such groups will not immediately be apparent. As the facilitator, you will probably have to make calls to check on folks. You might

even need to make a visit. Relatives will need lots of encouragement to continue attending. At the beginning, many of them may see this as “just one more thing I have to do.”

It might be a worthwhile idea, during the first couple of meetings, to bring in a relative who has been attending a support group and let them talk about their experiences and the need to continue attending.

It is not unusual for grandparents and other relatives to feel overwhelmed, frustrated, alone, and stressed. This set of responses may contribute to depression. According to a number of research reports, depression is an outcome for many grandparents who do not have adequate support in raising children.. Just being able to have contact with other people in a similar situation can lessen the degree of these feelings (another reason to continue to come to support groups).

8. Rest and Recuperation

Grandparents need time to get away. Grandparent’s may feel guilty and believe they should not leave the grandchildren with others. This may be a way grandparents try to make up for all the negative things that have happened. However, the grandchildren will benefit from a grandparents taking a break—having care givers who are rested and taking good care of themselves is a good thing for the children.

If you feel like you really can not get away, you need to reserve some time for yourself:

- Time to read or watch TV
- Time for exercise
- Time to make contact with friends and other family members
- Time to go to church or other community activities

The use of day care, pre school, after-school program, and other resources for children may be helpful in allowing the grandparents to have some child free time and rest.

Some grandparents will need a lot of support in this area. It may not feel “right” to them to have their grandchild in day care while they rest. To some grandparents this might make them seem lazy or unloving. Reassurance from the group leader will be most helpful in putting these feelings into perspective.

9. Holding A Job While Looking Out For Children

You need to keep an eye toward getting the most out of ypur work. When at work, be at work. Setting around worrying about the grandchildren is of no help to the

grandchildren. If you are a worrier, schedule three or four times during the day and let yourself focus on worrying for five minutes. Then stop and get back to work. This may seem overly simplistic but try it.

Although priorities may have been automatically re-ordered, they can not be forgotten. Make sure to have other things on the list – other than grandchildren. If you do not you stand a chance of, unknowingly, beginning to resent the grandchildren. A “grand parenting” couple should take care of each other. Make sure you leave some time to enjoy your partner.

It might be helpful to have a simple exercise about partners asking each other for what they need. Simple role play scenes might be useful. A lot of the people in your group will not think in terms of “taking care of their partner.” Many are just trying to make it through the day and expect their partner to tend to themselves. Well, that is just not the way it works. The exercise around this issue may be uncomfortable for many. They will need a lot of support and reassurance from the facilitator.

10. Children’s Concern About The Grandparents Dying

This will sometimes be verbalized and sometimes not. This fear a very common one for children between the ages of 6 and 10, but could be experienced by all ages.

Children will usually accept and do best with very straight forward and simple responses to questions about death. I would suggest that the grandparent be ready to verbally respond. Here are some possible responses:

- “I am going to be here for you.”
- “I am not sick and I think I will be here for a long time.” (If that is the truth)
- “I know you think I am pretty old, but I am not *that* old and I feel good and healthy”
- “Even if I get sick sometimes, I generally get well pretty quickly.”
- “I know you sometimes get worried about me not being here or me dying but I think I am going to be around a good long time.”

Grandparents and other caregivers can figure out who would be the guardian if something untimely were to happen to them. That way they can truthfully say:

- “If something happens to me Aunt Betty has agreed to take care of you.”

No need for a long discussion. It will generally only confuse the child and contribute to their worrying. If the child continues to ask questions, give short reassuring answers and divert the child's attention toward some activity – like helping you with a task.

11. Changes In Established Routine

Having children in the house full time will require major adjusting of your usual routine. That is an understatement. You will have to accommodate the child/ children but you should try to maintain some of your own lifestyle choices that have served you well.

Many grandparents hold full time jobs and the continuation of those jobs may be important, either for the income or because they meet other social/emotional needs.

With support and empathy most children can also adjust. You do not have to give up everything that makes your life easier and more secure. You can maintain much of your daily routine and expect the children to make reasonable changes.

It is okay for you to insist that you be able to watch your favorite TV shows. An over dose of Bob Sponge Pants might just send you right over the edge. You can still assume you have certain rights and privileges because you are the big person.

12. Postponing Your Own Plans

It is true that you will probably have to modify the plans you have made for yourself. Being responsible for raising children may not have been your goal during your aging years. Being involved in the lives of these children has probably been part of your plan, but not providing 24/7 care.

You and your partner will probably have to sit down and rethink the future. However, it is not advisable to give up all your plans. Modifications – yes. Dumping the whole thing – no. You deserve to have your chance to relax, take trips, get together with friends, go fishing, etc. Letting go of all that would probably create some resentment. And, with all your good intentions and work, this resentment will probably find its way into the relationship you have with the children and with each other.

Your grandchildren can profit from your insistence on maintaining some of you plans. If you follow through with a modified plan you will probably find yourself better able to enjoy the children and naturally give more to them when you are with them. They need to learn that adults can do some things without the children. They also need to do some things without adults. It is okay to have your own boundaries.

You might even involve the children in helping you plan some things for yourself. Children can get a kick out of this and it helps them to begin considering other

people's feelings and wants. They can even participate in selecting who will stay with them when you are away. Or, they can plan what activities they are going to be involved in while you are tending to your self-care.

It will be a real balancing act to honor your own aspirations and care of the children. In the end the balancing act will benefit everyone involved.

13. Dealing With A Plethora Of Confusing Agencies And Organizations

Child welfare agencies, juvenile or family courts, financial support services, medical facilities, mental health programs, school systems, insurance programs, all have their own languages as well as complex policies and rules. Grandparents have to learn how to negotiate these systems to maximize the benefits for their grandchildren. This can be exhausting and irritating. Many representatives from these units will extend themselves to help the grandparent. Others will have little empathy or respect for the grandparent or their situation. For some grandparents all of this will require a new set of skills (advocacy) and new ways of self-care.

This program includes a section on “advocating for your grandchild” but this might be a place to reinforce the idea that good advocacy is primarily based on building good relationships. Even though a good advocate can make demands and even threaten action, these are not the first strategies to employ. Always begin with the least offensive strategy first.

Some of the grandparents and other relatives in the group will be the best source for learning where to get services and how to go about getting them. As facilitator take full advantage of this. At the same time, keep in mind that some folks may have had a difficult interaction with a potential resource because they did not know how to get the most from the resource.

The group might decide to invite representatives from some programs, agencies, or services to the group meeting. This will give every one an opportunity to ask questions or simply make contact with a possible future resource.

14. Keeping Good Records

(Houtman, 1999, pp141 – 144)

Keep track of as much as possible without coming to feel like a scribe. No matter how good you are at this you will generally miss something – try not to worry about it too much. Here is a short list of some of the records that you want to try to keep:

- Health information – medicines (prescription and over the counter), medical appointments (office visits, clinics, emergency rooms visits, immunizations, names and contact information about care providers, bills, insurance

statements), medical histories – history of illness (type, time, recovery period, procedures).

The facilitator might introduce the relative to the Medical Portfolio

- School information – evaluations, grades, notes from school officials, school conferences, school visits, brief notes about children reaction to various aspects of school (Individual Education Plan, behavior issues, social interactions, transitions, school activities), a file of art work or other important projects, programs from school activity in which the child participates.
- DCBS (Department for Community Based Services) and other social service agencies – all contacts (date, purpose, outcome, names of person(s) with whom you had contact)
- Legal documents – Any reports or orders from court, information about guardianship, custody, or adoption. All police reports or calls you make to law enforcement – Date, purpose, outcomes, name of person(s) with whom you had contact.
- Financial support and expenditures – Kinship Care Payments and how they were used. Out of pocket expenses for child(ren)'s needs. Any other sources of financial support.
- Memorabilia – pictures, letters, notes, anything that will give the child a sense of history.

Most grandparents and relatives will not need all of this information but it can serve as a sort of check list to think about and determine which pieces you will need.

Having good records is one of the best tools for advocating for your grandchild and yourself.

15. Living With A Low-Grade, Gnawing Fear

Grandparents have to face their own developmental and aging issues at the same time they are caring for their grandchildren – What would happen if they get sick or die? What if the children's parents are never able to care for them? What if there is an attempt to reunite the children with their parents before the parents are ready to handle the responsibility?

These are all reasonable concerns that need to be addressed as straight forwardly as possible. It is best to take these issues one at a time and see what you can do. For example: What are your legal rights to make decisions about your grandchild in case you get ill, disabled, or die? You need to make sure what the legal implications are, get as much in writing as possible, get the written material reviewed by an attorney

and kept in a safe place. How permanent is the placement of your grandchild with you? You will probably have to live with some uncertainty about this, but you can discuss with the biological parents any plans that they have, or discuss with the placement agency their perspective on the permanency of placement – thus, allowing you to plan a little better. The point is to have a contingency plan for as many situations that present worries for you. This will probably help let go of some of the worrying – thus reducing anxiety and stress.

It is logical that grandparents and other relatives will worry about all sorts of things. Allowing some discussion of these worries is a good exercise. However, as the facilitator, you want to eventually bring the discussion to: “That is a worrisome thing, and what are you going to DO about it.” Allowing group members to just ventilate worries and concerns only increases anxiety. You want to move them toward “managing,” or “coping,” or “resolving.” Although we all enjoy a little drama in our life, you will have to help drama queens focus on “activity.”

16. Avoid Over-Indulgence And Over-Attentiveness

(McGinty, 2005)

When your grandchildren have been through difficult times or have to cope with the trauma of leaving their own home, your heart goes out to them. That is being a grandparent or loving caregiver. Now that you are standing in for the parents you have to be careful not to go overboard. The things that help children cope with loss and trauma are structure (including boundaries), a relaxed atmosphere, warmth and affection, an empathic listening ear, and reassurance. They do not need an abundance of new toys, clothes, the latest gadgets, designer shoes, or cell phones. They can survive and prosper quite well without 100% of your attention 100% of the time.

A simple life with routine, clarity of expectations, consistency, predictability, and positive messages will be more helpful to your grandchildren than all the stuff you can buy. It is perfectly okay to say “no” to them. Over-indulgence and over-attentiveness create unhappy and unhealthy children. These practices will not make up for what they have been through or are going through. Besides, too much attention focused on the child leaves little energy for focusing attention on yourself and your partner. Your grandchildren observing your loving and healthy interaction with your partner and other important people contributes to their feelings of security and comfort, and serves as a model for their own relationships.

Avoiding over-indulgence and over-attentiveness is a matter of self survival for the caregiver and a matter of discipline for children.

The above are only examples of some of the feelings, behaviors, and thinking that have to be managed. The facilitator needs to always bring the discussion back to self care, and emphasize that taking care of yourself contributes to the well-being of the grandchildren.

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B. Special Parenting Issues During The Transition (Moving In), And Long-Term

This *italicized* information is for facilitators.

Following is a list of some of the issues (and ideas about addressing them) that grandparents and other relatives have to face while children are moving in and settling in. At the same time much of this material is relevant to issues grandparents and relatives will confront at any point in the care of children. Facilitators can use this list as a sort of script to accompany a Power Point or they can use it to help develop specific trainings. It is also around some of these issues that grandparents can use support from the facilitator and other group participants.

It is not unusual for grandparents and other aging caregivers to experience a deterioration in both physical and emotional health when the full time care of children is thrust upon them. Depression seems to be a common response. Thus groups need to operate in such a manner that would empower the participants (Cox, 2002; Minkler, 1997; Smithgall, 2006)

This material is written as though talking to the relative caregiver. Please do not assume you have to use this material verbatim. This is intended to be a guide. The facilitator can add to the material, as well as emphasize or de-emphasize the material (depending on the needs of the group).

1. Life Needs To Be As Normal As Possible.

Try not to make a big deal of your grandchildren being in your care.

If the children are old enough, explain to them why they are living with you. Be honest and direct without demeaning the parents. Keep the explanation as short and simple as possible. Answer their questions as honestly as you can without flourishing the answer with long explanations.

Be clear with them that you are going to see that they are taken care of – you are there for them.

Let them know that you will, for the short term or long term, stand in for their parent(s). You will make sure they have clean clothes, a warm place, plenty of food, lots of love, etc. Get across the following messages: You will take them to the doctor if they get sick; you will interact with teachers or school personnel if there is a need for that; you will make sure they are safe; you will tend to them if they get scared; and you will listen to them when they need to talk.

Children will miss their usual routine (even as haphazard as it may be) and people. Try to keep children attached to parents, friends, and school as much as possible while keeping them safe.

If children are old enough, ask them what they want you to say to other people who ask why they are living with their grandparents. (This needs to be an honest response but it can lack detail: “Tammy is staying with us for a while because her parents are having a rough time.” “We are glad Tammy is living with us for a while.”)

ESTABLISH A ROUTINE (using already established routines if there are any) as soon as possible: Bedtime, nap times, meals, TV time, homework time, free play time, chores, etc. Nothing is more securing to children than structure and routine established in a loving and nurturing manner.

If at all possible, children should be able to bring their own clothes, toys and other prized possessions with them.

2. Making Room (Adequate Space), Initial Finances, Initial Legal Arrangements

Living space needs will differ depending on the age of the children and the specific need of the child. Young children will generally adjust to whatever space is available, even sleeping in the living room floor or on the couch. Older children need a little more privacy in the long run. If privacy is not available let the older child know that you will work with him/her on meeting this need. Certainly, if you are lucky enough to have an extra room, most children will be able to share the space. Be careful not to adopt habits that you will have to undo, such as allowing the child to sleep with you because he/she is afraid.

Children who have been through difficult trauma – physical or sexual abuse, witness to spousal violence, abandonment, etc. – may be afraid of staying in a room by themselves. Talk about this with them and together reach a decision. Once they become more comfortable about their safety and the fact that you will not leave them, the fear will probably subside.

As much as possible, pay attention to your own needs for some space. For example, having children sleep in the living room may disrupt your routine so much that you feel a loss of control. Try to identify a specific space (a corner of the living room, the dining room, a hallway, etc.) that will allow you to proceed with your routines while giving the child a feeling of consistency and, at least, vague ownership.

Children may benefit from having some specific place to store the “stuff” (clothes, toys, games, books, CD’s, treasures, etc.) If you have a drawer that can be just for the child, that will work fine. Even a cardboard box will do. But it needs to be something that they can clearly identify as theirs.

The main idea is for the child to feel wanted, for him/her to have a sense that this is a place they “belong.” Space is only one way to help give the child a sense of belonging.

3. Pay Attention To Already Established Roles.

Some children have been assigned family roles or have assumed family roles. Some of these roles are effective and helpful to children. Others may be damaging. For example:

Some children may have assumed a role of caring for younger siblings. This is a reasonable role as long as it does not require a child to assume adult/parent responsibility. These “parental” children may be pretty invested in their role. Some of their identity may be tied to the role. Thus, it is not advisable to suddenly remove all these responsibilities from that child. This might be a slow process. It might work better for you and the child to assume this role together – invite them to participate or ask if they want to participate. Slowly the adult can begin to relieve the child of some of the responsibilities (particularly those that interfere with the child’s developmental needs).

Some children may have become the confidant of the parent(s) and accustomed to listening to adult problems and worries. Children need to slowly be relieved of this role. It will take some time to wean them of this role but they do not need to carry adult burdens.

Some children may have become the protector of the mother, particularly when domestic violence homes or situations. Reassure them that there is no need for the grandmother to have a protector. If there is domestic violence in your home this is not a safe place for the child. Another living arrangement must be made for the child.

Some children are accustomed to being the parent to their parents -- seeing that they eat, have clean clothes, are tucked in, (this may be particularly true if the parent is drug or alcohol addicted). Relieve them of these responsibilities but honor their feelings about the role.

Some children have had to assume the adult role of making sure that the bills are paid or dealing with individuals, agencies, or organizations concerning family finances. Be careful to recognize this as a strength but assure them that you will deal with those financial issues. (They may continue to question you about whether rent or mortgage is paid, etc., simply re assure them and go on). It may be helpful to the child if he/she is allowed (or invited) to watch as you pay bills. They can help you file receipts or take the stamped envelopes to the mail box.

4. Children Living In Chaotic Situations May, Initially, Have Lots Of Difficulty Following Routine Or Using Structure In A Beneficial Manner. (Cox, 2008)

Most of us are more comfortable with the familiar – no matter what that is. Adjusting to new ways of doing things takes some time. Some children might even

think it is disloyal to a beloved parent for them to conform to structure provided by adults in this new situation. This is one reason you should take caution in criticizing the child's parents and their way of doing things. If you can say ("oh, I see, that's how you do things at your house. While you are staying with grandma and grandpa, this is the way I want you to do things") in a non-scolding way, it might help avoid a struggle.

This will require some patience from the grandparents. In these situations it is best for the grandparents to be consistent and work as a team (supporting each other). Have some established rules and expectations – be explicit about these rules and expectations. If children are old enough, they may participate in the development of the rules and accompanying consequences if rules are broken (consequences should never be physical punishment). It is perfectly okay to have some rules that are not negotiable – just make sure children know that.

5. Some Children May Respond To The Change – Living With New People Or In A New Home – With Grief And Grief- Like Behaviors.

(Cox, 2000, pp. 63 -82) (Cox, 2008)

Children exposed to or affected by drugs and children who have been abused or neglected have usually experienced lots of loss. Some children have had frequent changes in living situations with different caregivers. Each time they experience loss. They may also have changed schools, left friends (and sometimes siblings), lost pets, given up favorite toys and clothes, and, of course, they have had to leave their parents. The caregiver will need to recognize and respect these losses.

They may be angry and that anger may come out in tantrums, pouting, withdrawal, withholding of affections, "mouthiness," etc. You can explain that you understand they are angry and that you would probably feel the same way, and that you hope the anger will pass quickly or that they can find some way of expressing it that is not so unpleasant (you can give them some examples of better ways of expressing that are okay with you).

Sometimes children will not express their grief directly for fear on upsetting the new caregiver. Usually these feeling will be turned inward or displaced. The children may act out and have problems at school or troubles with other children. At this point they may not look like they are grieving. Their behavior can get misinterpreted by the caregiver or other adults as defiance.

They may want to bargain with you about going back to stay with their parents or at their home. Explain that you also hope they will be able to do that when the situation permits such reunion. You can explain that your goal is to make sure they are safe and cared for and that home is not the best place for them at this time.

Younger children, 4 – 6 year olds, may talk about how they will be good (better behaved) if they can go home. You will need to explain that they are not responsible for what is going on at home – that what has happened at home is not their fault - that what is going on at home is the adults' responsibility.

Some children may experience real sadness about being away from their parents and home. Again, empathic responses are most helpful: "It is sad that you can not be home right now." "I would be sad too if I were you." Then express your love and care for them and explain that you want only the very best for them. Then try to get them involved in some physical or cognitive activity that will ameliorate the sadness. Children from around age 4 to 11 or so usually enjoy "helping" adults with "around the house" tasks – rearranging the cupboards, folding clothes, organizing canned goods, cleaning out the toy box, washing the car, and most any other household or repair activity. Children love to feel needed. Doing these kinds of activities with adults makes them feel important and is strength building. Even two year olds love to "help" adults with stuff around the house. Be prepared for the tasks to take longer than it would if you did it by yourself – time is not the point.

The child's feeling of loss can be complicated by parents who occasionally drop in, make promises, and are not heard from for another few weeks or months. The child gets their hope up that the parent has "reformed" and back in his/her life, only to be disappointed. This grief may often be expressed as anger which is most often directed at the grandparent or other adult care giver. (Cox, 2008)

This sadness that children experience should not be interpreted as "depression." It is sadness due to a particular situation. They are sad about something. This is a normal and healthy response to sad situations. Helping them manage the sadness will prevent it from moving toward depression. Having too much time to ruminate about the sadness will promote a generalization of sadness which can contribute to depression. If you are concerned about whether your child is clinically depressed, consult a mental health professional.

6. Rage

Some children may exhibit rage behavior, either as a part of the grieving process or simply because of an inability to verbally express the hurt and pain they are experiencing, or it might be a response to previous trauma (physical, emotional or sexual abuse). These behaviors may take the form of explosions at the slightest provocation, or they may seemingly come out of nowhere. They will sometimes take a physical form – striking out (hitting things or people), or they may be more verbal (calling people names, making threats, deliberately hurting feelings). Children should not, of course, be allowed to physically harm other people or property, but they may not be able to internally control such responses and will need you to impose restraint while soothingly explaining that you are sorry they are having such a hard time. They

may need some time to calm down – this may take the form of separating them from others or accompanying them on a walk or other physical activity. Whether the rage involves physical or verbal expression, the child needs to take responsibility for the behavior. This might take the form of apologizing (and they may need some adult help in figuring out how to apologize – verbal expression is best if possible but some children might write a note or do a “good deed” for the person harmed).

If the child is old enough – usually 5 or older – you can spend some time with them after the rage incident and give them some help in better ways to express “bad” feelings. For example, they might let you know that they are feeling like exploding before they actually explode – and you might help them defuse this feeling by getting them involved in a work or fun activity. Then you praise the hell out of them for being able to master such difficult situations. Older children (teens) might be able to verbalize such feelings (please recognize that not all teens are cognitively prepared to do this) and thus defuse some of the rage. You might be able to help them learn to talk it out rather than act it out.

Many children who have experienced difficult situations (trauma) have a very limited vocabulary for feelings, or difficulty in being able to distinguish degrees of feelings. They may only know how to label and express anger, happiness, or sadness. For them anger may not have degree – it is always at the far end of the scale. For example some frustrations may come out as anger at least partly because the child has no name for frustration and has no method of expressing frustration. They know anger and that is where they automatically go. Help children label emotions and identify ways of responding. For example: if a child is frustrated because they can not get their brother to stop picking at them, they might make a decision to leave the area where the picking is taking place as opposed to fighting with the brother. Also try to get them to come to you, not to tattle, but to verbally express the frustration. Listen very carefully to children. Stop what you are doing, get on their physical level, and look at them.

If they say something like: “I am so mad at my brother that I could kill him”, you might help them reframe that to a more realistic degree of anger and label it as frustration.

As with most everything else you need to role model the expression of feelings. Let children see that you have a wide range of emotions. Sometime you are angry, other times you are frustrated, hurt, scared, or bored. Sometimes you experience joy, delight, surprise, gratitude and are hopeful. As well as the physical expression of these motions, you want to label them verbally. Let the child see that lots of emotions are okay and come in degrees.

The rage reactions may seem totally irrational to you, but to the child they may make more sense.

7. Post Trauma Stress

(Here, we are not so concerned with a “Disorder” but with the fact that almost all children in out of home-care have had traumatic experiences. More information about trauma is presented in a separate section of this Packet.)

When children have been through highly traumatic situations, sets of behaviors (rage, fear, sadness, flashbacks, nightmares and other sleep disturbances, poor concentration, regressive behaviors, and suicidal thoughts) may be triggered by situations or thinking that relates to the previous trauma. To you these responses may look like they are coming out of the blue, but for the child they are connected to what they have experienced, even if the child can not understand and make the connection. It has also been found that trauma (physical abuse, sexual abuse, exposure to violence, severe emotional abuse, severe neglect, and, even, natural disasters) can have an effect on brain development. In some cases the part of the brain associated with anxiety and fear is overdeveloped and the part most closely related to learning is underdeveloped (National Clearinghouse on Child Abuse and Neglect Information 2001) (National Child Traumatic Stress Network 2005}. It also seems that traumatized children may develop health-related problems – particularly: allergies, asthma, and gastrointestinal problems {Graham-Bermann and Seng (2005) and Perry (2000)}. These children may find it harder to focus on school work in the classroom and harder to control their behavior (National Child Traumatic Stress Network (2004). They can learn to control the behaviors but it will take time and patience.

Recent studies using brain imaging technology have found that the trauma occurring during different developmental period effects the development of different parts of the brain. The consequences of trauma are long term and can have a significant impact of later mental and physical health. Trauma can also contribute to later learning difficulties and involvement in violence (Nageer et al. 2002).

When children’s brains have been trained to be hyper-vigilant (constantly on guard and trying to survive day by day) they may not, immediately, be able to respond to warm, giving, and caring environments in the way you might expect. They have become wired to be suspect of everyone. They know how to deal with difficult, threatening environments, but they have not developed the social and interactional skill to function well in a non-threatening world. This is just the way they “think.” The “on guard” part of the brain is highly developed, usually at the cost of development of other parts of the brain.

Helping children manage some of the consequences associated with trauma may mean that you need to provide some extra structure and lots of reassurance that you are “there,” and that you will look after them. Reasoning with children who

are in the throws of some of these behaviors may be like trying to reason with a drunk person. Diversion may be more successful, particularly with younger children. Affording them a structure where they can focus on something safe and tangible will be comforting – helping adults with tasks is a great activity. This may allow them to switch their thinking to the task at hand while being physically close to a safe and nurturing adult. Trying to verbally reason may not be as successful. Most adults talk too much.

Older children or teens may also respond well to the use of diversion, particularly something that requires physical activity. When the magnitude of the behavior has lessened, older children might be encouraged to write about those situations or thoughts that trigger their behaviors and then you might help them come up with ways they can respond that would be more helpful and acceptable in managing these difficult feelings.

You might feel a little crazy trying to figure out how to respond to some traumatized children. What seems like a rational response may not get the response you expected.. Staying calm and collected will help. The more the child escalates, the calmer you need to remain. Again, you need to be a little boring. “I am sorry you are having such a difficult time.” “I am not going to let you do anything crazy, and I am going to try not to be crazy.”

8. Challenges To Your Authority (“You Are Not My Mommy”) And Control (Cox, 2008)

Children at certain developmental stages have a strong need to assert themselves – including their “authority.” This may be particularly difficult for adults. Giving children space to assert themselves while maintaining structure and discipline is a challenge for any parent. With children who are perhaps feeling very little control over anything in their life – where they live, who they live with, what school they attend, which people they have contact with (parents and friends), etc. - this becomes an even more difficult situation. Children who lack any control over less tangible part of life may compensate for that by exerting extreme control over more tangible things. They may have an even greater need to assert themselves and establish personal authority. Letting them be as involved as much as possible in establishing rules and routines is only one example of letting them practice this important developmental tasks. Sometimes something as simple as letting a child assist in determining the supper menu will satisfy this authority need. Giving them choices about what clothes to wear – choose between two outfits (young children) or control over clothing selection (older children) is another way of helping them develop skills. Some other simple activities that allow the child to have a voice in decision making may be: selecting which TV shows the family will watch, where to go for dinner, which activities they want to be involved in, time limits on the computer, how to wear their hair (no matter how obnoxious it may be), how to decorate their

room (yes, this might be scary to you, but it is really rather harmless), access other people have to their private living space, etc,. Again, children who feel a total lack of control over anything will probably have a greater need to explore personal control in less pleasant ways.

Young children can usually respond rather well to: “No, I am not your mommy and I love you very much and want all sorts of good things for you. And, I want to help you understand how we do things in this house so everyone can feel as good a possible.”

Helping older children and adolescents master the development tasks associated with authority and control is trickier. One minute the adolescent may behave with great adult responsibility and the next minute it seems like they do not have the ability to even think clearly. And, guess what, that is just the case. The adolescent brain is still cooking. They are not done. They are, in fact, able at one minute to appear to be fully responsible, and the next minute unable to manage the thinking skills God gave a turnip. (In developmental terms the ability to think abstractly may not develop until they are as old as fifteen.) This may not be defiance; they are just incapable of holding it together for very long or have not learned to have much control over their impulses. (Cox, 2008) Now, it is true that some adolescents are much more capable than others. That does not say anything negative about those who are not. Kids are just at different places in development. This has nothing to do with things like ADHD, or other diagnosis, it is simply normal adolescent development. Your job is to continue to provide structure and support (nurturance), as you shake your head in dismay and wonder what alien has come down and taken over your beautiful grandchild. As children are learning to be more independent and to use good judgment, they might be allowed to help make some of the rules that will govern their behavior – time to be home, when to call for assistance, who to hang with, etc. They may not always be successful in following these rules but they are learning how to be more responsible. (Cox, 2008)

Cautionary note: particularly for grandfathers, uncles, brothers, and other males raising children: Adolescents, particularly boys, are experts at hooking your own “adolescence.” Yes, trust me; most adults (particularly males) still have some unresolved adolescent issues. That is not an awful thing. It just means you have to be aware of it. Adolescents are experts at honing in on those tender issues. It is a way of testing you, provoking you, questioning or challenging your role, or a way they try to make themselves feel better. Here is the key to remember: It has almost nothing to do with you. Do not take it personally. If they are able to “hook” your adolescents you will soon find yourself responding to them like you are their age. If you were outside yourself looking at this scene you would see exactly what is happening and you would probably feel pretty silly. However, it can be a powerful situation and it is easy to get caught up in it. The adolescent will have identified issues or situations about which you are passionate.

To avoid this: if you find yourself in an argument with an adolescent, take a minute – back off and, if possible, get in some quiet and alone space, try to put things in perspective, tell yourself this is minor – very minor, re-inform yourself about what is happening, take some deep breaths, and go back into the fray with a new realization of who you are and what is happening.

With children, the old adage, *choose your battles carefully*, make good sense. If you make everything a big issue, then nothing is a big issue. Children may be disrespectful out of habit. They have just not learned the essence of some of the results of their words and actions. When this occurs, it might help to let the child know that it is affecting you. “That hurt my feelings.” “That felt disrespectful.” “I really feel bad when you say things like that.” You will not always get the response you want but you are helping the child make the connection between their actions and the effect on other people.

Adolescence is a tough time. Most adolescents feel very vulnerable and spend lots of energy protecting themselves from hurt. And so many things hurt.

If you develop your sense of acceptability based on the adolescent’s reactions and responses, you are in for a world of hurt. Most of your goodies will have to come from adult relationships. Thus you have to make sure you have good adult relationships.

9. Feeling Uncertain About The Future

Some children we feel very uncertain about what will happen to them. They will need lots of reassurance that they will be taken care of. You can share the discomfort about what the future holds. “I do not know how long you will be staying with us, but we want you to be here as long as your need to. We want to make sure you are taken care of. We want this to be your home as long as you need it to be.” “I know you are concerned about your future, me too. But we will not let this concern get in the way of having a good time and creating a good life for as long as you are here.” You do not have to resolve everything. Children respond well to just knowing that you “get it” – that you understand what they are feeling. That is greatly reassuring to them.

Do not lie to the child. Do not say, “Don’t you worry, honey, you are going to stay right here with grandma for the rest of your life.” If this is not the case, don’t say it – no matter how tempting it is to say it. It is much better to say: “I don’t know how long you will be staying with grandma and I know that may make you feel a little unsettled, I will keep you up to date on any plans that are made. Together, we are going to enjoy the time you are here.”

The amount of detail about future plans that you share with the child will depend on the age and developmental needs of the child. Young children just need reassurance and empathy. Older children may drive to nuts in search of specific details. Just share what you know and don't worry about not knowing everything.

Some teenagers can be very dramatic about "the future." Don't become too worried about the drama, but do listen to them and do not make fun of their antics (no matter how tempting it may be). Try to avoid sarcasm with children of any age. Sarcasm takes on double meanings and can be confusing to younger children and can be used as drama material by older children.

10. Provocative Behavior

Children are very good at finding your points of vulnerability. They seem to know which buttons to push to get you going. They may use this ability in an effort to control you and situations, or to manipulate (get what they want). This can be a useful set of skills but when used to provoke responses and get into a battle of the wills it can be destructive. Some children adopt this as their primary way of surviving which may contribute to later problems and difficult mental health issues.

Children need to be confronted with these behaviors in a very matter-of-fact way and taught new ways of getting their needs met. Making a big deal of these behaviors will usually exacerbate them. They need to be nudged toward more acceptable ways to deal with you – ways to which you will respond favorably. Children who have experienced rejection and abandonment may expect you to also reject and abandon them. It is important that they understand you are rejecting a behavior and not them. That is why it is important for you to say things like "I don't like that behavior" rather than "you are a bad boy."

Your grandchildren may have lived in a home where limits were never clear and responses to misbehavior were inconsistent – punished one day and ignored the next. Thus, they assume that rules and boundaries are changeable. They will, initially, probably resent you for imposing boundaries on them. A part of their response will be based on operating outside their comfort zone. You are asking them to behave in ways that are less than comfortable (familiar). You are asking them to have a different perspective and that is just plan hard for them to do.

Children may have also learned to manipulate by "being pitiful." They may have learned that they can get whatever they want because they have had such an "unhappy existence" or "been through such a tough time." They can just about break your heart with their "pitifulness." There is no way for you to go back and fix what went wrong for your grandchildren (or their parents). Bending over backwards to make your grandchildren happy will not really make them happy – and it really hurts

your back. They want rules and boundaries – they just don't know how to ask for them. Even if they appear sad and hurt by rules and boundaries they will prosper and grow much more than if they do not have them.

Some children, who have experienced trauma, may be provocative in order to be in control of when trauma will happen. They may aggressively provoke adults because they “know” eventually the adult will strike out at them. Their thinking goes something like this: “I know I am going to get knocked around, it is better for me to be in control of when that will happen.” They make it predictable. As you know, children become masters at pushing your buttons, throwing you off base, and catching you off guard. Just recognize what is happening and it will allow you a bit more control over how you respond.

You need to be as predictable and transparent as possible. Kids need to know what to expect from you. Again, consistency is the key. Older children will call you an “old fuddy duddy” or worse. They will say “you are soooo boring.” You will be accused of “ruining their life.” This usually indicates that you are being consistent. You need to accept these responses from your grandchildren as compliments.

Some children who have been sexually abused by adults may come across in sexually provocative ways when interacting with adults. Be careful in responding to these children with harshness. They are doing what they have learned as a survival skill or, even, to be loved. Your harshness may serve as a blow to their self-esteem. Deal with these behaviors in a matter of fact manner, preserving the dignity of the child.

One other note: Some behaviors that may seem purposefully provocative may be quite normal for the child. Children learn to behave in ways that will get them what they want or that will please adults and bring them attention. Such behaviors should be addressed but not in a harsh manner. Re-direct the child to behaviors that are more acceptable and ultimately less harmful.

11. Guilt

Children may experience a lot of guilt about what has happened to their parents. Being self-centered (which is what they are supposed to be at certain developmental stages), children see themselves as having an impact on anything that happens around them. They are the center of the world. It would not be unusual for a child to assume that their behavior caused bad things to happen to their parents – “It is my fault that mommy and daddy are sick.” “If I had been better they would not have had to take drugs.”

This guilt can be a terrible burden for children and you need to help relieve it. If it goes unrelieved children will internalize the bad feelings they have about themselves. This will contribute to poor self-image and low self-esteem. They need to be reassured that they had nothing to do with what is happening to

Mommy and Daddy. Some children will experience this guilt but will be unable to verbalize it. They may act out in ways that will validate the bad feelings they have about themselves. When you come down too hard on them all it says to them is: "See I must be bad, see how bad I am, I have caused Grandpa to get really angry, I have to be punished because I am so bad." As much as possible ignore the bad behavior and really focus on rewarding the positive behaviors. Any validation, by important adults, of their "badness" only serves to reinforce their feeling about themselves.

"You are nothing but a brat." "You think you are really tough, don't you." "You enjoy hurting your grandma's feeling, right missy." "Stay away from me you little _____ (fill in the blank)." "I am fed up with you acting like a moron." All such comments indicate to the child that you (like they) think they are bad.

12. Shame or Embarrassment

Children may be embarrassed by living with their grandparents. Some children will be concerned about the age of the grandparents and think that other people will think it is "weird" to have such old "parents." Their friends might ask questions about their parents that they do not know how to answer or do not want to answer. In smaller communities it may be particularly difficult to hide information about their situation.

Children can be quite cruel. They may taunt your grandchild with names and stories, creating anger and hurt. Your grandchild may respond to this taunting by fighting, withdrawing, crying, running away, trying to joke it off, escaping into fantasy, try to ease the hurt by using drugs, etc. If they are able to say anything to you about these experiences the best you can do is listen and understand. Empathy goes a long way. They do not always expect you to DO anything, but they do need to KNOW that you get it.

Bullying, of course, should not be tolerated. If bullying is happening or present at school you have the right to know that it will be addressed by the school. If it takes place in organized clubs, centers, church groups, athletic teams, etc., you need to address it with leaders and expect them to deal with it.

13. Lying and Stealing

Lying by children is one of those things that seem to strongly disturb adult caregivers. Children may lie for many different reasons: to avoid punishment, to get what they want, to impress, and to feed a slumping self-esteem or self-image, or sometimes children's lies stem from fantasy and make-believe. Children might also lie because they have learned that parents do not really want to hear the truth. It is important for the adult caregiver to try to understand the "why" for the lie.

When children lie a lot (even about silly stuff), it is best for you to remember that the lying has nothing (or almost nothing) to do with you. Do not take it personally. It really has more to do with the child's early experiences and ways they have learned to survive. If children have been abused or neglected by adults, they really have little reason to trust adults – no matter how much love you give them. This is not about love or moral misconduct; it is about surviving the best way they know how.

It would not be unusual for children coming out of chaotic or abusive homes to have difficulty putting words to their emotions. This might, again, be a way of self-protection. If talking about the way you really feel gets you cursed at or hit, then just do not talk about it. This is the way some of the children in your care might think. You can help this a little by being open with your feelings and verbally labeling the emotions you are experiencing.

When you are trying to address the lying behaviors that concern you, you need to avoid asking children questions to which you already know the answer. Tricking children into lying can contribute to further lying or it might contribute to children not sharing what they really feel or think with the adult.

“Why” questions for children might also prompt lies. The concept of “why” is very difficult and requires a rather mature cognitive process. Young children may not have the capacity to answer the question. If you pressure them they might make up something to try to satisfy you. The question: “Why are you lying to me?” is not a fair question for most young children – they cannot answer it.

Adults frequently lie to avoid conflict, so do children, albeit usually with less sophistication or forethought.

Stealing is another behavior that really gets to adult caregivers. Again, the child might be stealing for any number of reasons. They may have learned that stealing is just a way to get what you want. They might see nothing “wrong” with taking other people's stuff. They may be validating that they are “bad.” (If you think you are a bad person, you do bad things, and it feels pretty good. In your own head it seems to make things consistent.) Stealing might be a way of trying to exert control. Also children might not understand the adult concept of boundaries. They need to be taught that stealing is “wrong.” It is not okay to take things from other people. With young children, a matter-of-fact statement about stealing being wrong may be all that is needed (you may have to repeat it several times). If children do steal they should have to replace what was taken or pay for it. It is also helpful to have them personally apologize to the person wronged. All of this can be done firmly, but without fire and brimstone.

14. ADHD-Like Behaviors – Not Able To Concentrate Or Remember, Easily Distracted, Can't Seem To Set Still, Have Poor Impulse Control, Seeming To Not Listen, Disruptive, Etc.

Hyperactivity or Attention Deficit Disorder involves a very complex set of behaviors and etiologies. If a child is really hyperactive or has ADHD they need the attention of medical and mental health specialist. Grandparents may need to learn some specific behavior management skills. Children who are suspected of being ADHD need to be evaluated and assessed.

Some children exhibit some or all of these behaviors for many reasons that have nothing to do with ADHD diagnosis. Children living in drug endangered environments may be responding to either the toxic effects of the drugs or to a chaotic life style. Children who have been abused or severely neglected may also exhibit some of these behaviors. It may be a way of attempting to cope or escape.

Be careful about, too quickly, accepting the diagnosis of ADHD without the person assigning the diagnosing doing a very comprehensive assessment (this involves more than a check list of symptoms). Exposure to trauma may produce behavior and characteristics that look a lot like ADHD. Children should not be placed on medication unless absolutely necessary (see "Traumatic Stress" above). Some children benefit greatly from medications for behavioral or cognitive difficulties. Just make sure the person prescribing the medication is well informed and conscientious. You probably know the children better than anyone else. Trust your observations and experiences. If an evaluator does not ask you for your input go to another evaluator. Evaluators have to understand the child's history and present situation in order to gain an accurate assessment.

15. Take Care When Using Mental Health Services – Ask For Assessment And Intervention Without A Diagnosis.

Many children coming out of abusive or neglectful situations can benefit from appropriate mental health intervention. However, grandparents need to be cautious about accepting diagnostic labels. All people seeking mental health services will be diagnosed. Insurance billing and reimbursement will be based on the diagnosis. Thus, a mental health professional may be forced into declaring a diagnosis in order to get reimbursed by insurance. When seeking mental health services for your grandchild ask for a complete assessment – psychological, social (particularly exposure to drugs, prenatal or environmental), cognitive, developmental, physical. A complete assessment will tell the professional all they need to know to determine if intervention is needed, as well as effective methods of intervention. A diagnosis may follow a child for a long time. Although the

label may be meaningful and helpful to some mental health professionals it can create obstacles for children in other venues.

Most diagnoses will tell you, the grandparent, very little about the child. You want a full explanation of what is going on and what you can do to help.

16. Verbally And Physically Aggressive Behaviors

Some children will push the limits and act in negative ways in order to validate how they see themselves – not worthy of love and positive attention. Initially they may not even be able to tolerate affection or kindness. They may respond in verbally abusive ways. Your kindness may not match their perception of themselves, and they have to prove to you that they are not “good.”

This is also a way some children maintain a distance from other people (particularly adults). They may fear that allowing themselves to get too close will be setting them up for disappointment and hurt. These children may be operating under the assumption that you will only abandon them or hurt them – like everyone else.

If children have been living in an environment where fighting and arguing are common and expected, they will, of course, adopt that behavior. You will have to work with them to find more acceptable ways to express what they are trying to express. More than anything, you and your partner will need to model how to deal with strong feelings.

Even when children come from community or familial culture where verbally and physically aggressive behavior is acceptable you can expect them to respect house rules: We do not use those words in this house. You cannot expect them to quit using the word immediately but you can keep reminding them and then move to consequences – removing privileges.

Children should not be allowed to be abusive to others. The house rules should address this behavior and the consequences for breaking the rules. This is definitely not a time to spank children. Spanking will only validate that hitting is a way to express anger, disappointment, frustrations, and other strong feelings.

17. The Overcompensating Child

Some children will exhibit “maturity” far beyond their years. They may be “very good” children, working very hard to never make a mistake, always getting good grades, being overly compliant, always trying to please. These “good” children may be

very worried that if they relax and let their guard down you will see that they are “bad” or that something is “wrong” with them. They may be attempting to overcompensate for the negative way they view themselves. Unfortunately, this “goodness” will ultimately backfire on them and they will be miserable people. Children need to be children – not little adults. They need opportunities to learn by mistakes, they need to play and have some rough and tumble times, they need to know that when they slip that they are still loved. They do not have to be perfect to get your attention and love. What these children are exhibiting is really a “false maturity.” This is very hard work and requires them to forego some of the healthy development that will serve them well as adults. It is literally a stressful burden. The saddest thing about overcompensation is that it does not work. All the attempts to feel better by doing all the right things just do not make them feel better. They probably still feel unworthy and can go through life trying to make up for it.

Please do not misunderstand, some children behave in ways that are pleasing because it does feel good and adds to their feelings of worthiness. But when “good” children do “all the right things” and still feel awful, they are not adding to their mental health reserve.

18. Helping The Child Separate The Parent And The Situation

No matter how you are feeling about the situation or behavior that brought your grandchild to live with you, you have to help your grandchild see that his/her parents love them. The behaviors of the parents may have been unhealthy or destructive for the child but it may not reflect the “feelings” of the parent. People get involved in situations and behave in certain ways for very complex reasons. They need to be held responsible for their behavior and choices but the children do not need to suffer because of it. Children need their parents to love them. It reflects tremendously on how they see themselves. Children who do not feel loved by their parents may come to see themselves as unlovable or unworthy of love. If this feeling gets internalized it can be crippling for a life time – affecting every future relationship in their life.

You can let the child know that you are unhappy or upset about the situation or the parents’ behavior, but you have to be very careful not to depict the parent as unloving. You can understand that the ability of young children to make this separation is limited. Thus, it is best for you not to even discuss your negative feelings about the parents with the child.

Do not be surprised if children idealize or romanticize their absent parents. This is a way they have of coping with loss. They need to do this. It may really piss you off that you are right there doing all the day to day hard work and getting very little in return while the parent who should be doing the hard work is not present. You need a place to vent those feelings and get some support for what you feel. However, it is not helpful to the children for you to vent these feelings with them.

Now we are getting down to the dirty stuff.

19. Peeing And Pooping

When Children are around 2 years old (earlier for some, later for others) they are very curious about their bodily functions – including “products” like poop. This is all developmentally normal. Some of these children – no matter how well adjusted – will take to being artist, using poop as the medium. They might smear poop everywhere. You might find this particularly with children who are “sort of” starting toilet training. Even though they may know poop is “nasty” they also find it fascinating. For most children this is a short phase. I mean the stuff stinks! DO NOT OVER REACT! You do not want this to become a weapon that can be used against you. Get the child cleaned up and do not let them back in the “affected area” until you have a chance to clean it. (Thank goodness for Clorox.) And, do not even think about repainting the wall until the kid is about 6.

Some children will arrive at you home needing toilet training. You might think that they should have already been trained. Children coming out of homes where they have been neglected or ignored may need a tender hand to help them learn bathroom stuff. Learning to pee and poop in the toilet is a process, and no matter how old the child is, if they have not been toilet trained they will need your patience. No matter how much they “look like” they should be able to tend to their own bathroom needs, if they don’t, they don’t. It is up to you to gently help them through this process.

You might also encounter children who have been toilet trained, but due to the trauma and chaos of leaving their home and parents, revert to infantile behavior – including wetting and soiling. Recognize this for what it is and help them manage the trauma (see above). You will have to address the wetting and soiling, but that will generally take care of itself once they are more comfortable and feel some control in their environment. Accidents will decrease and eventually disappear. Avoid, at all cost, making them feel shame or embarrassment. A matter-of-fact attitude can be helpful. Treat it as an accident and help them get cleaned up. If they are old enough they can help change the bed, put the bed clothes in the washer – along with any soiled or wet clothes. Be careful that you do not go overboard with sympathy. Remember – straight forward and matter of fact.

Fortunately this behavior may well be a sign of interest in potty training. Tell them they can poop in the toilet or their potty and look at what they have done. No touching. But looking is okay. Then wave it bye-bye and flush. Most kids will go through a normal phase of wanting to make messes. They can also be pretty good at helping clean up. This is all good. They learn it is okay to make a mess but it has to be cleaned up and they have to do it or, at least, help.

You might even encourage these children to make messes: play in the mud, help with food preparation (or let them mix all the left-over’s together (um, pretty), pull all the

Tupperware out of the cupboard and stack it, do finger painting, play with silly putty, let them mix water and corn starch together and play in it, etc. Sometime these rather time consuming and aggravating activities can satisfy the “messy” need and poop loses some of its interest.

If a child is older than 4, has been toilet trained, and still poops in their pants or in bed, there is cause for concern.

Don't panic!

With the assistance of a good doctor, you and the child can get through this. Remember this is not misbehavior on the part of the child. It is what might be called a non-medical medical condition. There is a very close relationship between constipation and “encopresis.” Children who have experienced trauma (abuse, neglect, changes in living arrangements, bullying, any other kind of maltreatment, divorce, loss of meaningful support, etc.) may develop chronic constipation. They hold their poop. Remember these are children who have lost control over most everything in their lives. Retaining poop is not a very conscious thing for the child. It just sort of happens. The encopresis occurs because the child holds the poop in their colon; it dries out, and becomes hard. When the child does go to the toilet, pooping may be painful, thus further reason to hold it. So the cycle starts.

DO NOT TRY TO TREAT THE CONSITPATION WITHOUT THE SUPERVION OF MEDICAL PERSONNEL.

The encopresis is usually the direct result of soft poop leaking about the solid retained poop. The child may not even be aware that they have pooped their pants. They may not have experienced the urge to go to the bathroom because the built-up of poop has stretched the colon and weakened the muscles, thus affecting the nerves that give the signal (urge) that it is time to hit the potty.

It is vital that children who experience encopresis not be humiliated or shamed. This will only make matters worse.

This needs medical treatment or else the soiling will become worse. The child may also lose their appetites and experience stomach pain.

20. Moodiness

This is the real dirty stuff.

Children of all ages are generally thought to be moody. What this usually means is that the child acts like they are, without reason, sad, angry, irritable, whiney, clingy, or generally out of sorts. Children can be very moody – meaning that their mood, disposition, behavior, and verbal and non-verbal responses can be sullen, energetic, sassy, bossy, giddy, aloof, silly, witty, responsible, dependable, snappy, feisty,

stubborn, totally unreasonable, etc., AND these can turn around on a dime. One minute they can be a delight to be around, the next minute you wonder what alien came down and took over the body of this child.

Adolescents are particularly prone to quick changes in mood or to become “moody.” A lot of this is simply biology. Teenagers’ brains are in almost constant flux. Their brain is not fully developed and is changing rather quickly and dramatically. The electrons seem to be moving so fast they are running into each other, or the glandular secretions are flowing so slow the kids seem like a sloth. On minute they are planning on being a brain surgeon, the next minute they are ready to drop out of high school. This can be a very bumpy ride for parents and other caregivers. You are just never quite sure where you stand with a teenager. One minute they are following you around, wanting your attention, being affectionate, and generally, acting like a very young child. Then whamo! They want nothing to do with you and can’t understand why you want to give them a hug.

Teens may, for unknown reasons (at least unknown to adults), become dramatic, march off to their room, hold up in there for hours, not wanting to talk with you – certainly not telling you what is going on. It is probably best to let them alone. They probably do not know, themselves, what is going on. They just experience a change in mood. You can say to them (through the door, sometimes), “If you decided you want to talk or can think of any way I can be helpful, let me know. Until then I am going to assume you just want some time to yourself.” Some statement like this gives the child an opportunity to save face, problem solve, rest, think, make decisions, etc. They need lots of practice with most of these things.

Caregivers can easily become frustrated with trying to address difficult behaviors of children. It helps to remember that some burdensome (for the child) and aggravating (for the caregiver) behaviors are deeply rooted and have a history. Thus, children will not be able to quickly conform to new expectations and new attitudes from caregivers. Caregivers will frequently have to work toward small goals and take small steps in trying to whittle away at problematic behavior (Cox, 2002)

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C. Some Potential Reactions Children Have To Various Traumas

This *italicized* information is for facilitators.

Group members need to understand that some of the behaviors they might encounter are related to difficult experiences children have had. Otherwise, some of these behaviors get misinterpreted as misbehavior or defiance.

Facilitators need to be a little careful not to over play trauma, but rather, make sure that relatives consider it as a contributing factor to some behaviors.

This does not mean that the behavior should be excused, but such knowledge may elicit greater empathy from the caregiver. Adults may be a little better at dealing with some difficult behaviors if they get a sense of where it is coming from. Lots of adults are quick to jump to the conclusion that a child's behavior is directed personally at them; most of the time this is not the case.

Facilitators need to allow time for "stories" from group members. These stories can usually be used to illustrate a point. If, however, someone is "over storying" the facilitator can deter them a little by asking other participants (very directly, and by name) to share one of their experiences. This will not stop the over talker but might slow them down a little. Usually people over talk in a group because they are feeling pretty needy, or they are trying to impress the leader or other group members, or they think that is what they are suppose to do. The facilitator will have to devise ways to make this person feel valued and important.

A good facilitator does not have all the answers but can lead the group in a discussion about possibilities, options, and potentials. The facilitator has to be careful about being caught in the "Ann Landers" role – here's the problem, here's the answer. Turning problems back to the group also contributes to a greater cohesiveness in the group – thus, greater support for the group members.

This material is written as though talking to the relative caregiver. Please do not assume that you will use the material verbatim. This is intended as a guide and to help answer some questions that might come up in group discussion.

1. Defining Trauma

Trauma can be defined in many ways. For the purposes of this project we will define trauma as any event or set of events that are more overwhelming than a child is ordinarily expected to encounter. Ordinarily no child should expect to be abused or neglected. Nor should they be exposed to domestic violence, parents being dragged off to jail, disturbing television shows, neighborhood brawls, and other kinds of violence (ACT Against Violence).

If you want a more formal definition of trauma, here goes: Trauma “involves direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates. ...The person’s response to the event must involve intense fear, helplessness or horror (or in children, the response must involve disorganized and agitated behavior.” (American Psychiatric Association, 2000)

2. Common Symptoms of Trauma

Most children experience some level of trauma. This might be particularly true for children who are not able, for whatever reason, to live with their parents. Most are resilient, absorb or manage the trauma, and move on without many consequences. Their ability to manage the trauma is usually due to the presence of an adult(s) they trust; they trust that someone will take care of them and protect them. If the trauma is a dramatic experience children (and this differs from child to child) may not be able to easily let it go. Children may re-experience the feelings associated with the trauma at any suggestion that reminds them of the original experience or set of experiences. For example: if they associate certain smells, or sounds with the trauma, these same smells or sounds may trigger feelings that re-traumatize the child. Because you can not get into the child’s head and may not have been around when the original trauma occurred, you might not know what the child is responding to. Their responsive behavior may even look like misbehavior or defiance. Children may not be able to explain what they are reacting to. They may not, themselves, be aware of what they are reacting to.

Children who experience dramatic trauma may exhibit physical and psychological symptoms such as:

- Hyper-arousal
- Difficulty breathing – like panting, shallowness, and rapid breathing)
- Increased heart rate,
- Cold sweats
- Muscular tension
- Tingling
- Racing thoughts
- Constriction
- Altered breathing
- Altered muscle tone and posture
- Constricted blood vessels in the skin, arms, legs, and internal organs
- Tense muscles
- Mind-body split (dissociation)

- The mind disconnects from the reality of the event
- May feel like losing time
- May involve memory loss
- Denial -acts as though what happened is unimportant

If a teenager experiences predominant hyper-arousal you might observe:

- Panic attacks
- Flashbacks
- Exaggerated startle response
- Extreme sensitivity to light or sound
- Hyperactivity, restlessness
- Nightmares and night terrors
- Avoidance behavior or clinging behavior
- Attraction to dangerous situations
- Frequent crying or irritability
- Rage reactions and abrupt mood changes
- Regressive behaviors
- Increased risk taking behaviors (Levine and Kline – 2007)

Teens who predominately respond to trauma by dissociating may exhibit all of some of the follow:

- Distractibility and inattentiveness
- Amnesia or forgetfulness
- Inability to organize and plan
- Feelings of isolation and detachment
- Muted emotional responses
- Easily and frequently “stressed out”
- Frequent day-dreaming
- Fear of “going crazy”
- Low energy and easily fatigued
- Excessive shyness – may live in an imaginary world (Levine and Kline – 2007)

Children who experience a lesser degree of trauma may present themselves as irritable, unable to concentrate, lacking self-control, and hyperactive. Because it is difficult to know the motivation for these behaviors they are sometimes, incorrectly, labeled as ADHD. Caution needs to be taken to make sure a thorough assessment (physical, psychological, social) is completed before treating a child for ADHD.

3. The Child’s Attempt to Manage Trauma

When traumatized children re-experience trauma they go into survival mode. This might mean they are ready to fight (to protect themselves), or they may hide and

get out of the way, or run to some assumed safe place, or they may try to make themselves invisible – become very quiet and still. At this point the child may close down emotionally. They pull inward. For them, this is a logical way of protecting themselves. Many children are feeling vulnerable on lots of levels – physically, emotionally, and socially. This constant vigil of being on-guard is exhausting, using up lots of energy that could be put to better use, but they do not yet feel safe and have not incorporated the trauma in a way that it is minimized. The longer a child stays in this survival mode the more difficulty he/she will have with thinking, remembering, and problem-solving.

Young children are not very good at moderating feelings or expression of feelings. They sort of have an “off” and “on” switch. They are either off or on – no dimmer on that switch. This is also true of older children who have not, for what ever reason, developmentally conquered the skills needed to moderate – that is, they may not be able to read cues and interpret what will be acceptable. You may well see these responses in children who have lived in extreme drug environments.

Some children who have experienced repeated trauma will express themselves through rage. This rage may be directed inwardly – suicide attempts, cutting and other self destructive behaviors – or outwardly with aggression toward other people, particularly other children. On the other hand, some children may associate aggression with danger and become extremely passive - making themselves vulnerable to victimization.

Children may use a number of defense mechanisms such as denial and numbness to ward off the pain of the trauma. Some children may participate in magical thinking – if I do this or that I will be safe and protected. Some children will have sleep disturbances and night terrors. Some children will have difficulty with quiet times because their idle thinking goes back to something associated with the trauma or sets of traumatic events.

Children may, at the same time they are re-experiencing trauma, blame themselves for whatever happened around the traumatic experience. Remember, children tend to see themselves as the center of the world, thus, over estimate their impact on what happens around them. This self-blame combined with the actual trauma can create a heavy burden for the child.

Seeking safety, some children may return to infantile behaviors – wetting or soiling themselves, sucking their thumbs, being overly clingy, using “baby talk,” returning to temper tantrums, etc.

Some children will have their trust (so vital for healthy development) shattered and develop a pessimistic perspective of the world and life in general. This will likely interfere with their ability to develop and maintain relationships and impact most

of their daily social interactions. These children may experience depression or depressive symptoms.

4. What You Can Do to Help

Children express themselves the best way they know how. Children too young to use words certainly find ways of letting us know they are happy or upset. Even older children still may not have developed the cognitive abilities to express themselves completely in words. Yet, they will display certain behaviors that let us know something is not right. This is originally what we referred to as “acting out.” Children differ in how and what they express. As the grandparent or relative you need to give yourself time to learn the nuances of the child’s behaviors. The child also needs time to learn your limits and expectations. Try not to jump to any conclusions about motivations for behavior until you have gotten to really know the child. Take great care to not overreact to expressions of feeling. A “matter-of-fact” response will usually be more helpful to the child and end up causing you less misery. EMPATHY is the key. Try to understand situations and circumstance from the child’s perspective and respond with that understanding.

Help the child transition out of the survival mode by letting them know they are safe and that you will take good care of them. These statements will, at first, probably have little effect on the child. But, through the caregiver’s consistent actions of providing safety, trust begins to develop. At this point they may be able to hear reassuring statements from the caregiver.

Let them know that the danger has passed and that they are okay.

Depending on the developmental age of the child, help them talk about the feelings they are experiencing. Giving words to feelings is a rather sophisticated cognitive ability. Children can use some help in describing their feelings. Posted pictures depicting different emotions can help the child put words to feelings. It is a worthwhile exercise to look at a book or magazine with a child and have him/her label some of the feelings being expressed or felt by people in the pictures.

Make sure that other potentially supportive adults in the child’s life know about the trauma, resulting behaviors, and how to respond to the child. Teachers, day care workers, as well as school and day care administrators might be able to respond more effectively and emphatically if they are aware of the needs of the child.

When children seem to be re-experiencing trauma, involve them in some easy activity that will divert the thoughts and feeling associated with the trauma. It is best if you can be involved in the activity with them. Remain close by them. Your physical presence can contribute to them feeling safe.

These children may need lots of reassurance that you will protect them, that you will not abandon them, and that you will love them unconditionally. Some children who have been through lots of trauma will not respond as you might expect to physical comfort and gentle verbal interaction. These expressions may interfere with their perception of how they should be treated. Some of these children have internalized a negative self-image and believe they are unlovable. Your physical affection and gentle manner may be terribly uncomfortable for them. Be patient. Continue to offer them as much positive physical affection and gentle interaction as they can tolerate. You may not feel good when a child rejects your affection. So, remember the rejection is not personal and may be the only way the child can manage intimacy at this time.

Discipline (structure, rules, consequences) and follow through help develop trust. This is a part of the predictability that children need and love.

Seek professional assistance for the child and yourself.

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D. What You Can Do To Help Children From Substance Abusing Environments

1. Children Who Come From Substance Abuse Environments

This *italicized* information is for facilitators.

Unfortunately, many children who come to live with grandparents do so, at least in part, because of the parents' involvement in substance abuse. A large number of parents who have a history of substance abuse also maltreat their children. The Child Welfare League of America (2009) estimated that 60% to 80% of the children entering out-of-home placements not only experience maltreatment (neglect as well as physical, emotional and sexual abuse) but also come from homes where biological parents abuse drugs or alcohol. This means that many of these children have experienced chaos, neglect, abuse, health problems, physical and emotional distress, endangerment, and burdensome concerns for the safety and well being of their parents. These children experience complex trauma which means that they are exposed repeatedly to traumatic events over many months or years and this exposure has a negative effect on developmental outcomes (Blaustein, Kinniburgh -2007) (University of Wisconsin Extension, 2007)

Children may be exposed to or affected by substance abuse. The impact of prenatal exposure will vary depending on the substance, the extent the substance was used, and, according to recent research, the trimester in which the substance was abused. Children exposed environmentally will be affected differently based on the substance, form or method of exposure, age of exposure, length of exposure, pre-existing physical health of the child, forms of outside support available to the child and family, idiosyncratic characteristics of the child, and the extent to which maltreatment had already disrupted developmental success.

Grandparents might need some assistance with identifying possible signs and symptoms exhibited by these children as well as some help in managing associated behaviors, health problems, and emotional trauma.

Grandparents might also need some assistance and support in responding to, and interacting with, substance abusing parents. Many relatives may not know how to support the substance abusing parent while refusing to enable the substance abuse and addiction. Most grandparents could also use some help in exploring ways to explain, to children, the parent's substance abuse.

Facilitators should always present cautions about interpreting the signs and symptoms of children who are exposed or affected by substance abuse. Many of these signs and symptoms are very similar to signs and symptoms of children who have been maltreated (neglected and/or abused). Because parents who abuse one substance

may also abuse other substances, it is difficult to determine which substance is the cause of the child's suffering..

Thus far, research is inconclusive about immediate and long term effects children who are exposed or affected by substance abuse will experience. Children, who are known or suspected to have been exposed or affected by substance abuse, need on going evaluation and assessment. There is a need to evaluate neurodevelopment as well as psychosocial functioning. It is development over-time that needs to be understood. For example: Speech and language development may be on target at one benchmark but behind if evaluated at another point in development. This will, of course, have an impact on the child's educational and social (interactional) successes, and may, thus, impact self- image and self- esteem.

It is very difficult to determine if some of the problems experienced by drug exposed or affected children are primarily the results of substance abuse or/and other environmental factors. In many instances the response from the caregiver will not be all that different – what ever the etiology. However, some neuropsychological and physiological issues will need targeted interventions.

a. Defining “Drug Endangered Child”

There continues to be some debate on what constitutes a drug endangered child. The legal definition of “endangered child” differs from state to state and may or may not include children who are exposed to drugs and alcohol. The definition that was developed by the National Alliance for Drug Endangered Children in 2010 will serve as the definition for this project: “...children who are at risk of suffering physical or emotional harm as a result of illegal drug use,, possession, manufacturing, cultivation, or distribution. They may also be children whose caretaker’s substance misuse interferes with the caretaker’s ability to parent and provide a safe and nurturing environment.”

b. Exposed and Affected

For the purposes of this resource packet we will differentiate between Exposed and Affected children. Children who are exposed to drugs and/or alcohol have experienced an intake of substance, whether that is prenatal exposure or exposure due to presents in a toxic environment (for example: presence in a home where methamphetamine is produced or smoked). Children who are affected by drugs and/or alcohol are those who have lived in environments where substances are abused but the children have not had any direct intake of the substances (for example: presence in a home where prescription medication is taken illegally).

It is estimated that between 60 and 80 percent of all children in out-of-home placements are there, at least in part, because their parents abused drugs or/and alcohol. (CWLA, 2009)

As grandparents and other relatives taking care of children you are probably most concerned about how these children have been impacted by substance abuse, and what you can do to make sure the children get what they need. To that end, this section of the project will focus on the following:

- Caring for the child who has been prenatally exposed to drugs and/or alcohol
- Caring for the child who has been environmentally exposed to drugs
- Caring for the child who has been environmentally affected by drugs and/or alcohol
- Relating to the substance abusing parent

2. Caring For The Child Who Has Been Prenatally Exposed To Drug And/Or Alcohol.

Prenatally exposed children will have different experiences based on:

- The substance(s) to which they were exposed
- The trimester(s) in which the exposure occurred
- The extent of the exposure – frequency and amount of substance abused
- The general health of the mother
- Resources available to the family (particularly the mother) – health care, nutrition, emotional and social support, etc.
- The parental and home environment of the baby/child
- The speed and accuracy of assessments and evaluations on the new born
- Treatment available to the infant or child
- Whether the child has also experienced maltreatment

When alcohol or most narcotic drugs are used during pregnancy they pass through the placenta and enter the blood stream of the fetus. These substances may impact the developing central nervous system and most other biological systems

a. Alcohol During Pregnancy

We have long known that if expectant mothers use or abuse alcohol during pregnancy they are risking exposing the fetus to alcohol. This could result in *fetal alcohol spectrum disorder (FASD)*. According to the US Department of Health and Human Services (2006) FASD consist of a spectrum of disorders:

- *Fetal Alcohol Syndrome (FAS)* – characterized by growth deficiencies, particular facial features, and developmental disorders
- *Alcohol-Related Neurodevelopment Disorder (ARND)* – characterized by significant delays or disorders in a number of developmental domains, but

without the accompanying facial features. Although IQ may be depressed it tends to be higher in these children than in children diagnosed with FAS.

Some of the most severe and dramatic birth defects are association with alcohol abuse by the mother. Many women who abuse alcohol also abuse other drugs and use tobacco.

Children exposed in-utero to alcohol may experience: (Coggins, Timler, Olswang, 2007)

- communication disorders (Baron-Cohen, 2000)
- language delays
- learning problems
- mental retardation
- difficulty in understanding and expressing emotions
- interpersonal interaction problems
- memory problems
- attention deficits
- poor problem-solving skills
- an array of behavior disorders (Charnoff, 1998) (Astley,2004)

Some children exposed in utero to alcohol will have a smaller head size and delayed growth (height and weight). The combination of these two characteristics is strongly associated with neuron-developmental functioning. (Astley, 2004)

In these children you might also see some combination of the following cranial and facial features:

- *Microcephaly* –an abnormally small head due to failure of brain growth. This may be noticed at birth (by simply measuring circumference of the baby’s head or it may not be noticed until later (first few years) when the head does not grow to match the development of the facial growth. This is often associated with mental retardation but that is not always the case. It is most frequently associated with delays in speech and motor skills.
- *Epicanthal folds* – A fold in the upper eyelid reaching from the nose to the end of the eyelid. These folds will appear in a large number of newborns but as their nasal bridge elevates it will disappear.
- *Short palpebral fissures* – small eye openings
- *Flat nasal bridge* – flat and smooth bridge across the upper nose, between the eyes
- Low set ears

- *Receding jaw*
- *Flattened mid-face*
- *Short, upturned nose*
- *Flat philtrum* –space between the nose and upper lip
- *Thin upper lip*(Astley and Clarren, 2000) (Astley, 2004)

Please do not try to diagnosis based on these features. If you observe a combination of these features or a prominence of one take the child to a reliable physician and ask for an evaluation. If you know or suspect that the child has been exposed to drugs or alcohol during pregnancy, explain that to the physician. Along with these conditions some children prenatally exposed to alcohol also experience cardiac hemangiomas (benign tumors) and liver defects (American Academy of Pediatrics Committee on Substance Abuse and Committee on Children with Disabilities (2000).

As children age some of the facial features may become less noticeable. However, long term outcomes may include diminished IQ and academic functioning as well as maladaptive behavior, easy distractibility, and difficulty in perceiving social cues (Clarren, 200) (Henry, Slone and Balck-Pond, 2007).

Prenatal alcohol exposure is also associated with increased irritability and fussiness during infancy. Unfortunately, this can contribute to decreased maternal attachment which has long-term consequences. When interacting with other children (particularly in developmental and educational settings) these children may be less socially competent and more aggressive. They may exhibit some antisocial behavior: lack of consideration of the rights and feelings of other children and respond negatively to limits and request by authority figures.

b. Cocaine or Crack Cocaine

Children exposed prenatally to cocaine or crack cocaine experience a number of difficulties at birth and during early development. It is unclear whether this is based purely on the abuse of substance or if it also relates to a number of social situations – poverty, violence, lack of prenatal care – plus the use of crack and other substances. Low birth weight and premature births have been associated with the abuse of crack and other drugs. However, many crack addicted mothers are also living in poverty, violent relationships, and do not seek and use adequate prenatal care. (Turner, S. J., 2008)

Some studies have found that babies born to crack using mothers (even having received free prenatal care) appear to be jitterier, had more muscle tension and were more difficult to move because they were stiff. These babies may cry and

fuss more. We are left with the question of whether the child's developmental and cognitive difficulties arose from the abuse of drugs or the lack of effective parenting. (Chasnoff I, J., Schnoll S.H., Burns, W.J., Burns, K.A., 1985).

It should be noted that many of the early studies in this area have been questioned in terms of methodology and later studies indicate less association between cocaine use and some of the earlier described outward characteristics. (Chazotte C., Youchah J., Freda M. C., 1995: Drug Policy Alliance, 2008, Napiorkowski, B., 1996)

Certainly, babies born to crack abusing mothers need special attention, assessment and early intervention. However, there seems to be some evidence that these babies can have better developmental outcomes if the mother receives good prenatal care and uses good parenting skills in raising the baby. This is significant because it means that you, as the relative caregiver, can have an extremely important impact on the outcomes for these babies.

Dr. Ira Chasnoff and his colleagues at Northwestern University Medical School (who have been in the forefront of research in this area) report the following characteristics of cocaine exposed infants: (Chasnoff, et al., 1998)

- Prematurity
- Lower birth-weight, and shorter
- Smaller head circumference (highly correlated with neurodevelopmental problems)
- Piercing crying
- Irritability and hypersensitivity – newborns may move quickly from sleeping to screaming and are inconsolable
- Poor feeding
- High respiratory and heart rates
- Tremulousness
- Poor sleep patterns – apnea and deep sleep
- Increased risk of malformations of the urinary track
- If cocaine is used shortly before birth the fetus may experience a stroke
- Retinopathy or damage to the iris
- Some babies may exhibit a lack of coordination, early motor delays, and difficulty tracking visual stimuli (these babies, however, seem to catch up later.)

The behavioral issues associated with children exposed to cocaine prenatally will probably not show up significantly until they are in an educational setting.

Some of the behaviors that seem to register as significant in research are:

(Delaney-Black, V., Covington, C., Templin, T., Ager, J., Martler, S., Sokol, R., 1998)

- Hyperactivity
- Lack of organization
- Distractibility
- Unpredictability
- Difficulty dealing with transitions
- A deficit of social or interactional skills

One can see how school might be a challenge for some of these children and their teachers. There does not seem to be an intelligence difference between cocaine exposed children and non-exposed children. However some of the difficulties listed above can certainly get in the way of learning and in establishing and maintaining friends.

These infants may require a lot of attention from caregivers. Using parents may not be well equipped to provide the quality and quantity of parenting needed by these babies. The best of parents will need lots of emotional and social support.

Following are some suggested ways of managing the needs of these children:
(Schneider, J.W., Chasnoff, I.J., 1987; Schaffer, J., 2000)

- Intervene before the child becomes frantic. These babies are easily over-stimulated. Some early signs of agitation are: yawning, sneezing, exaggerated motor movements, color changes, eye aversions.
- Some experts suggest that when a baby becomes frantic swaddling or holding the baby close, keeping the body vertical, and rocking sided to side provides some comfort. When the baby is no longer showing pre-frantic signs, remove the swaddling so they can learn to control motor skills.
- These infants usually do not need medication but do need a peaceful environment. They may respond well to the tenderness provided by rocking and swaddling. If a baby is living in chaos it would be very difficult to provide this care.
- Because these babies are usually stiff with an extended posture it is difficult for them to bring their hands together or lift their legs while lying on their backs, it might be best to prop them on their side.
- These babies should not be placed in walkers or “jumpers.”

c. Methamphetamine Using Mothers

- Babies born to methamphetamine using mothers also seem to experience a number of early nervous system problems.

- During the *first four weeks of life* these babies seem to experience dopamine depletion that can lead to: (Shah, 2006)
 - Lethargy – excessive sleep periods (“good baby”)
 - Poor sucking and swallowing coordination (contributing to weight loss)
 - Periods of sleep apnea
 - Slowness in developing habits or the same behavior to a given stimulus

- From four weeks to four months of age these children might exhibit:
 - Symptoms of central nervous system immaturity – poor motor development
 - Sensory integration problems – tactile defensive, texture issues (These children might not respond positively to being cuddled, held, or bathed. They may also have adverse responses to certain materials and textures. As an example: a baby might start crying the minute you put it in a pair of soft flannel pajamas.)
 - Neurobehavioral symptoms – these babies may not give back very much in response to interaction (this can contribute to a lack of maternal attachment.)

- From six months to 18 months:
 - This is the honeymoon period during which the infant appears to be symptom free.
 - After this time (particularly when children enter a learning environment) you might begin to notice some of the following: (All of the following information also applies to children who are environmentally exposed – particularly those children exposed to the toxic effects of methamphetamine production and smoking.)

- Cognitive Development
 - Language delays and deficiencies
 - Poor visual scanning/visual motor skills
 - Working memory problems – difficult with remembering a sequence
 - Doing several things or one thing with several steps. Need to be assigned one task at a time – short clear directions.
 - Decreased learning by trial and error – may continue to make the same mistake over and over. This may look like defiance but may actually be an inability, at this time, to learn by repeatedly doing.
 - Problems with incidental learning – As opposed to direct learning, incidental learning is self-directed and, therefore, tied to self-esteem.

Incidental learning is learning by picking up on information in the environment – like language. Drug exposed children may not, easily, pick up on cues – such as parental facial expressions. They need direct information. Again, some of these children may appear to be misbehaving or defiant. In fact, they are just having difficulty learning. Many of these children will, as they get a little older, need help in building their emotional repertoire. You might find, as with other children who have experienced trauma, that their emotional expressions are a bit more extreme than other children. They need some help in learning and verbally labeling an array of emotional expressions (Frier, 2005).

You can expect some of these issues with any young child, but as they mature difficulties in these areas may diminish. Meth exposed and affected children might be slower to develop some important cognitive skills.

If you, the caregiver, know that the child's mother was using drugs or alcohol during her pregnancy you need to make sure that the child is seen by health care professionals who can perform effective assessments. You need to share information you have concerning their prenatal history with the health care professional.

d. Children Born To Mothers Addicted To Prescription Painkillers

Although this is not a new situation, recently the number of children born to mothers addicted to prescription painkillers has increased. There seems to be little data about exact numbers of newborns addicted but review of some local hospital discharge records seem to tell the story. For example, at Lee Memorial Health System in Lee County, Florida, the number of neonatal abstinence syndrome (NAS - infant drug exposure and withdrawal) cases has increased 657 percent since 2005. This spike is largely attributed to pregnant women using such medications as OxyContin and Percocet, or using methadone to treat a drug problem. Most recently Dr. Karen Buchi and other researchers at the University of Utah tested umbilical cord samples from 850 deliveries and found that 4.7 percent tested positive for narcotics. It is unknown whether the narcotics were legitimately prescribed medications for pregnancy pain or if they were illegally acquired medications. For the infant the results are usually the same. (Gluck, 2010)

At birth and for weeks after, these babies will experience withdrawal from these substances. As the painkillers taken by the mother begin to wane in the infant's blood system they go through withdrawal which usually includes severe tremors, high pitched crying, stiffness, quickened breath and heart rate, diarrhea, weight loss and sleeplessness. Some of these infants are treated with methadone and or morphine to help them through the pain of withdrawal. The long term implications of this experience are yet unknown.

Most of these babies will have to remain in hospital care for several weeks resulting in an enormous drain on resources – both financial and physical space in neonatal units. These babies will usually require 13 days of hospitalization as compared to 3 days for healthy babies. (May, 2011 and Gluck, 2010)

Discovering that a pregnant woman is addicted to pain relieving medication poses a dilemma for physicians and medical personnel. While the use of narcotics is addicting the fetus, cold turkey withdrawal by the mother could contribute to miscarriage or preterm labor. If these women go into treatment for addiction they may be prescribed methadone which is also addictive for the mother and the fetus.

At this point there is no standardized treatment for NAS.

Relatives raising children who are born addicted to narcotics will need to establish a relationship with an informed pediatrician and insist that these babies be closely monitored. These are not easy babies and require lots of extra attention and care. The immediate and long term implications for infant withdrawal are unclear, but this factor should be considered when treating these children for any medical or developmental problem.

e. Any Drugs Or Alcohol - Some General Effects

Following are some general effects children may experience if they have been exposed or affected by substance abuse (any drugs or alcohol):

- Emotional Development (Frier, 2005)
 - Attachment difficulties – trust issues, relationship issues, adaptation problems, placed a later risk of criminal behavior and substance abuse
 - Poor self-concept – based on perceived response from others
 - Mood swings
 - Mistrust and fear – afraid that the abusing parent will become ill or die. Afraid that the parent will be placed in jail or that financial problems will interrupt the “normal”
 - Guilt and self-blame – They perceive that they are, to some degree, responsible for anything that happens in their world – including the parents abuse of drugs and alcohol
 - Anger – Probably becomes generalized over time. It would not be unusual for them to be angry at the non-abusing parent or caregivers.
 - Shame
 - Post-traumatic stress (see project material on trauma)
 - Hopelessness and helplessness
 - Appear detached and unemotional
 - Act out – consequences do not matter

- Future Substance Abuses - UCLA Integrated Substance Abuse Program findings: (O'Brian, 2009)
 - 84 percent of women in Treatment for meth abuse were emotionally abused
 - 63 percent were physically abused
 - 29 percent were sexually abused
 - Men report 36 percent were physically abused and
 - 7 percent were sexually abused

- Children exposed in-uteri

Children exposed in-uteri may experience some of the following cognitive and developmental difficulties: (Frier, 2005) (Hyter, 2007)

- Communication disorders
- Language delays
- Learning problems
- Mental retardation
- Difficulty in understanding and expressing emotions
- Interpersonal interaction problems
- Memory difficulty
- Attention deficits
- Poor problem solving skills
- Behavior disorders

Because the exposure has affected the central nervous system development, many of these children also experience secondary symptoms or clinical issues such as:

- Oppositional or hyperactive (impulsive) behaviors
- Withdrawal
- Depression
- Other mental health problems

It should be noted that one of the major frustrations for Drug Endangered Children centers on language difficulties. This frustration (and anger) can contribute to behavior problems. Relative caregivers should be cautious about children that they know have been drug exposed being diagnosed with behavior disorders without a full assessment of language functioning. This lack of complete assessment can lead to intervening in the wrong realm of developmental functioning.

Without early and effective intervention these children will probably have significant difficulty navigating social and academic environments.

The environment in which these children live is an important part of their being able to manage the difficulties and delays they experience. Many children exposed in-uteri (particularly to alcohol) are also exposed to living environments that include maltreatment. Grandparents knowing that the child has been exposed to drugs and/or alcohol, and maltreatment can begin to understand some of the motivation for the child's behavior. Understanding the origins of the behavior can help grandparents respond in ways that are most nurturing to the child (empathy).

Such understanding might also help the grandparents deal with their frustrations (stress) in trying to manage difficult behaviors. What might look like defiance may really be a failure to remember, or an inability to generalize from one situation to another, or a misinterpretation of the meaning of social situations or emotional expressions. It may be a response to emotional distress or frustrations the child experiences trying to master skills that are expected of him/her at the same time they are lacking the ability to respond in socially pleasing ways. (Cicchetti, Rogosch, Maughan, Toth, and Bruce, 2003) (Cicchetti, 2004)

Misinterpretation of the behavior can contribute to further difficulties for the child. Learning to respond to these difficult behaviors empathically is essential. Grandparents are also left with the responsibility of locating, navigating, and making use of professional services needed by these children, particularly the need for comprehensive assessments including: speech and language development, psychological functioning, physical well-being, and the impact of social/emotional environments.

Children exposed to alcohol and most narcotic drugs frequently exhibit limited processing abilities and some learning difficulties, but usually have normal range of intelligence. *Social Communication** (the developmental process of language, social cognition, and higher order executive functions – decision making and strategic planning) seems to be one of those areas affected by prenatal alcohol exposure, narcotics exposure, as well as maltreatment. These children may not be as quick as other children to: (Coggins, Timler, and Olswang, 2007)

- learn language
- know how to interpret social situations and the interactions between people in their environment
- integrate and accumulate language and cognitive abilities as they relate to a particular situation

****Development and use of language – These children have not been given the opportunity to develop basic communication because of their parents' impairment or failure to nurture. Concurrently brain development has been affected by the lack of early interaction and the experiences associated with trauma.***

Social Cognition – Children may not understand what is going on in social situations and how they should behave in different situations. This may come across as a lack of empathy and difficulty in anticipating consequences of the actions in social situations. These children may have difficulty making inferences about what other people in social situations believe, intend, or think – for them there is a lack of predictability (not able to predict other people’s intentions, moods or behaviors). They may have trouble picking up on social cues and “read” a situation “wrong.” Thus, they often respond in ways that seem weird and socially awkward.

Executive order functioning – Children may not be able to process large amounts of information, apply it to particular complex situations, and figure out how to respond. (Coggins et al., 2007) (Singer and Bashir, 1999)

Because many children who are exposed prenatally to drugs and alcohol are also exposed to a social environment that is violent and chaotic they may exhibit some of the same reactions and behaviors as other maltreated children. This environment impacts the child’s ability to develop language, develop social cognitive skills, and use executive order functioning. Thus, the environmental situations in which many exposed children exist exacerbate the difficulty in developing these vital skills and abilities. (Cicchetti, 2004)

Ideally all children would develop *emotional competence* *– able to “respond emotionally, yet simultaneously and strategically apply their knowledge about emotions and their expression to relationship with others, so that they can negotiate interpersonal exchanges and regulate their emotional expression” (Saarni, 1999): p166.

****Emotional Competence includes the mastery of: (Denham, 1998)***

- a. emotional understanding – able to identify the emotions of one’s self and others, plus the development of a vocabulary to describe these emotions.***
- b. emotional expression – able to verbally and nonverbally express emotions***
- c. emotional regulation – ability to understand emotions as well as manage both negative and positive emotions.***

“The ability to understand and express emotions is important for managing one’s own emotions, understanding the feelings of others, getting along with others, and early learning.” (Way, Yelsma, VanMeter, and Black-Pond, 2007). This involves understanding, interpreting, and expressing a range of feelings and is critical to language development, which, in turn, will affect academic achievement (Thompson, 2002).

What happens to and around the child during the first year of life is key to the development of emotional competency. Of course, there are inherent factors that also play a role. The interaction between the caregivers and child – the emotional

expression and language assigned emotions (facial expressions and affective vocalizations) – will promote the development and maintenance of synaptic connections during development of functional brain circuits. (Ovtscharoff and Braun, 2001).

Around the age of 2 most children, not exposed to maltreatment and physical trauma, will develop “single” representation for separate emotions – sad, happy, mad, scared, surprised, etc. Early elementary aged children begin to understand and express a “sequence” of two emotions – scared and then mad. This will follow closely with them being able to experience and express a mixture of emotions – scared and mad at the same time. They will also begin to recognize the mixture of feeling in others. (Bretherton and Beeghly, 1982; Hater and Whitesall, 1989: Dunn, Brown and Beardsall, 1991: Salovey and Sluyter 1997; Harter, 1999)

The child’s exposure, in uteri or environmentally, to substance abuse or maltreatment may interfere with their ability to master the knowledge and skills needed for emotional competency. Children who have experienced trauma and maltreatment early in their lives might have underdeveloped left-hemisphere brains. This part of the brain is responsible for the child being able to perceive and express language. These children may attempt to compensate through patterns of behavior that they think will help them survive. However, these behaviors may interfere in the social emotional learning (empathy, self-awareness, identification with others) that is fundamental to right brain development. (Tiecher, 200; Schore, 2001; Decety and Chaminade, 2003).

The upshot of this is: Grandparents may feel like they cannot do anything to help their grandchildren because the child was affected during a time they did not have them. It is true that they cannot go back and fix the things that happened to a child. However, once the grandparents have the child living with them, they will most likely have more control over the social and emotional environment than any other areas that impact the child’s well being. Thus, what can they do to provide the best care for children exposed (prenatally or environmentally) to alcohol or narcotics and children who are maltreated?

Following are some ways that grandparents might be able to help children (even adolescents) develop greater emotional competence if they have been exposed, prenatally or environmentally, to alcohol or narcotics and children who are maltreated:

Verbally identifying the feelings being exhibited by the child:

Examples:

- “All that yelling seems to mean you are mad.”
- “Frowning like that tells me you are worried.”
- “All that smiling shows me you are a happy girl.”

- “Those little squeals tell me you are excited.”
- “That crying sound must mean you are sad.”

Model your own expression of feelings by giving them a name.

Drawing pictures about what they feel and helping them name the emotion
Positive reinforcement: “I like it when you tell me how you are feeling even if it is hard for you to find the right word.”

Put a number of pictures on the refrigerator that are examples of feelings and when the child is obviously having an emotional experience (positive or negative), ask him/her to show you the picture that matches how they are feeling.

Do the same with colored circles (red = mad; blue = sad; green = happy; orange = excited; purple = thinking about mommy; pink = scared).

An occupational therapist or resource teacher can assist you in obtaining pictorial representations of emotions for the home setting.

3. Caring For Children Who Have Been Environmentally *Exposed* To Substance Abuse

This usually refers to those children exposed to the toxic environment associated with the production of methamphetamine or the smoking of methamphetamine. (Again, many of these children experience maltreatment: Their physical, social, and emotional needs may be neglected because the caregiver is physically not available, emotionally detached, and too impaired to address the needs of children; some children will experience physical abuse because the caregiver is more prone to irrational violence at certain times in the substance abuse cycle, or children may be seen as “other people” because of the psychotic effects of meth; some children are sexually abused because of unsupervised “visitors” in and out of the home, or because the drug heightens sexual responses at certain points in the abuse cycle.)

The way children respond to environmental exposure of methamphetamine will differ based on the degree of exposure, the age at exposure, the frequency of exposure, and a number of social characteristics of the family. It is unknown how long children will experience the cognitive and physical responses to exposure, but there is evidence that children who are environmentally exposed can improve the longer they are out of the toxic environment.

Some of the symptoms of environmental exposure are very similar to the symptoms of exposure in-uteri. However environmentally exposed children may recover more quickly and respond to nurturing parenting more immediately than children exposed

in-uteri.

Initially, environmentally exposed children may exhibit some of the same cognitive and behavioral symptoms described in the section above. Again, the age of the child will make a significant difference. These children may appear lethargic and may sleep many hours. At other times they may not be able to sleep at all. These children may: (Ellis, Sturgis, and Wright, 2008)

- appear to be less attentive
- fail to pick up on cues (like facial expressions)
- have memory problems
- have periods of exaggerated activity

4. Caring For Children Who Are Environmentally *Affected* By Substance Abuse

These are children who live in environments where caregivers abuse drugs and/or alcohol or in communities and neighborhoods where substance abuse is the norm.

These children may lack the resources and support needed for healthy physical, emotional, social, and spiritual development. The environment will affect:

- Self-perception and the perception of others
- The development of social values and norms
- Ability to gain from educational experiences
- Ability to develop and maintain a sense of hope
- The development of a sense of belonging and connectedness
- The development of a sense of safety and protection
- Vulnerability to future substance abuse and criminal behavior
- Ability to effectively develop and maintain interpersonal relationships
- Ability to maximize their own intellectual and emotional abilities

Many of these children will suffer from neglect. Their parents may not be physically available. If the parents are addicted, the number one priority is the next high. Everything else, including the well-being of children is down the priority list. Children learn that they can not count on their parents being there for them. Children will respond differently to this lack of availability. Children might find and use other people they can count on (children can be pretty resourceful). Some children will not develop a sense of safety. This will affect these children for the rest of their lives.

Because children who live in difficult and chaotic environments have been traumatized, they may be hyper vigilant. They have learned the need to be aware of everything and to constantly monitor the environment for safety. These children may appear to have attention problems but they may simply be doing what is

necessary for survival. (Brooks, Zuckerman, Bamforth, Cole, and Kaplan-Sanoff, 1994)

5. Responding To And Interacting With The Substance Abusing Parent.

This might be a difficult discussion for some kinfolks. The discussion can get emotional. Some caregivers might be very angry at the parent(s). Other may over identify with the parent(s). One way of approaching this topic is to talk about "How to show love to someone who is abusing drugs or alcohol." This puts it into a perspective that might make it a more tolerable topic for discussion.

Communicating with substance abusing relatives is very difficult. In communication we expect folks to be rational – well, the substance abuser is usually not very rational (particularly while they are using). Remember, their priority: where and how do I get my next high. Because this is the over riding priority most of their interaction with you will be based on:

- Distortions
- Lies
- Manipulation

You can remain more rational with them if you do not take any of their distortions, lies and manipulations personally. They really have little to do with you. They have everything to do with getting high.

We have about three ways of responding to a loved one who is abusing substances:

- Support them
- Enable the addiction
- Cut off all contact with them.

Supporting the person who is abusing drugs means that you refuse to become involved in behaviors that will contribute to unhealthy and destructive life choices.

It is supportive when you and other family members refuse to condone irrational and irresponsible behavior by the substance abuser. It is also supportive to impose limits on the level of emotional energy you will invest in the day to day life of the substance abuser. You can not fix it. The substance abuser has to be the one to invest energy in their recovery. Sometimes the more energy you and other family members invest means the less the substance abuser feels he/she has to invest.

So, what can you do to be supportive (loving) toward the substance abusing family member (the parent or parents of the children from whom you are providing care)? Here are some suggestions: ***(some of these suggestions may not, initially, seem very loving. But, they are, in fact, the height of love.)***

Supportive Behaviors: (Nolan, 2001; SAMHSA, 2001)

- Be willing to struggle with what is supportive and what is enabling
- Keep the children in your care safe
- Verbally express your love and concern while refusing to enable the addiction
- Avoid character attacks – if you want to discuss your concerns with the abuser when he/she are sober and you are in a safe situation, talk with him/her about observable behavior. Things like: “You are a sorry so and so.” “You are just a mess.” “You are a poor excuse for a human being.” “You do not love your children and you are a lousy parent.” are too all consuming and vague. Saying these sorts of things may make YOU feel a little better at the moment, but they just feed into the abuser’s self-pity and validate that they are awful people.
- Demand responsible behavior from the loved one who is abusing – but don’t get too emotionally invested in his/her failed attempts at being responsible.
- Refuse to lie for the abuser
- Refuse to make excuses
- Refuse to bail them out of jail
- Refuse to get drawn into arguments. There is no way to rationally appeal to a drug-induced, irrational person.
- Do not pay bills for which you are not responsible and do not affect safety and well-being. In emergency situations when children are still in the home: Do pay phone, electric, and water bills if you can scrape it together. If you buy food or other products for the abuser, retain the sales slip, open the product if practical, do what you can reasonably do to keep the abuser from returning or reselling the product for cash.
- Focus on yourself, the children in your care, and other non-using family members.
- Be vigilant about your self care:
 - Eat healthy food
 - Stay physically active
 - Get adequate rest and sleep
 - Pay attention to your own positive qualities
 - Develop and use a positive support system
 - Try to get some “alone” time – allowing you to stay focused
 - Be prepared for harsh criticism from some other family members
 - Keep reminding yourself that you are doing the best thing for your loved one
 - Take part in Al-non or other support programs
 - Attend to your spiritual needs
 - Seek professional assistance for yourself
- Direct the substance abuser to professional treatment
- Provide support for the loved one while they are in treatment:
 - Stay informed about the treatment plan
 - Remain consistent with the treatment plan

- Visit if the loved one is in residential care (if consistent with treatment plan)
- Provide encouragement and reassurance of love
- Provide practical services for the loved one who is in residential treatment: mow lawn, keep an eye on house or apartment, look after animals, etc.
- When it does not take you away from the children, help the person in treatment (or post treatment) stay active. They may not do well with a lot of down time.
- Refuse to put yourself in legal jeopardy
- Do not make threats that you are not willing or able to back up:
 - “I will call the police if you come over here, one more time, when you are drunk or high”
 - “I will not let the children visit with you if you are high”

Maintain an expectation of personal responsibility, and refuse to excuse behaviors that are self-destructive or destructive to others.

If you are a parent or close family member of a substance abuser it is easy to fall, unintentionally, into contributing to the continued abuse. This is what we call enabling.

Here are some examples of enabling behaviors: (Nolan, 2001; SAMHSA, 2001)

- Ignoring the signs of use and abuse
- Tiptoeing around the issue and refusing to confront or even ask questions
- Explaining away situations that seem too hard to believe
- Making excuses for the using family member
- Defending the users irresponsible behaviors and protecting them from consequences
- Giving or loaning money to the abusing family member
- Allowing yourself to be manipulated into assuming responsibilities for the user’s duties
- Blaming yourself for the substance abuse
- Allowing the user to steal from you or be abusive toward you and/or the children in your care
- Allowing your life to revolve around the needs of the user
- Getting caught up in the user’s drama. Substance abusers can be very “pitiful” and will try to pull you into their self-pity.

When it comes to family we are more likely to respond from the heart –what we feel, and less from the brain – what we think. This serves most of us well as long as we are dealing with rational people, whose brain is not completely rewired by drugs and alcohol. It can be very difficult for family members to enforce boundaries and provide the kind of love described, above, as supportive because it FEELS like it goes against deeply rooted values – values centered around “taking care of our own.”

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E. Grandparents and Other Relatives Caring for Children of Incarcerated Parents

One reason grandparents and other relatives assume the care of children is due to the incarceration of biological parents or parent. This situation can present several challenges for the relative care giver, including: having to interact with the court system and child welfare agencies, questions of continued contact between the child and parent, difficult discussions with the child, and helping children express and cope with mixed emotions. It also calls for the relative caregiver to be extra attentive to the child's developing self-image.

1. The Trauma of being separated from parents due to incarceration

It is always a traumatic event for a child to be separated from a parent, whether that is because of death, divorce, court mandated removal of the child, or incarceration of parent. Children are affected differently depending on age and circumstance leading to the separation. Such traumatic events can contribute to the child's inability to attach to others, emotional numbing, anger, depression, regression, and various antisocial behaviors. Rather than their energy going toward mastering various age specific developmental tasks, their capacity to cope is overwhelmed and emotional survival begins to take precedence over developmental tasks. This then contributes to delayed development, regression, and other maladaptive coping strategies. These children also have to cope with a lot of uncertainties, such as: where and with whom they will live, the length and stability of these living arrangements, what really happened to their parent or parents, how their peers or other adults will respond to them, and questions about their own role in the loss of the parent. Grandparents and other relative caregivers can help clarify some of these uncertainties and, thus, reduce some of the negative effects of the trauma (Wright and Seymore, 2000).

There seems to be some research evidence that children who experience childhood trauma (neglect and abuse) including the imprisonment of parents are more likely than their peers to commit delinquent acts and be incarcerated in their lifetime (Dallay, 2002; Johnson, 1995; Kampfiner, 1995; Myers, Smarsh, Amulund-Hagen and Kennon, 1999; Phillips and Haarm, 1997; Reed and Reed, 1997). The trauma of having a parent incarcerated can disrupt important developmentally related attachment, self-control, and moral and social judgment (Dally, 2002; Eddy and Reid, 2003; Johnston, 1995; Wolfe and Jeffe, 1001). These children may also be at higher risk and greater vulnerability for physical, academic, and social/emotional problems (Connors, 2003). At the same time, there are indications that children of incarcerated parents who are cared for by a relative with whom they already have a nurturing relationship will suffer less disruption and trauma (Bloom and Steinhart, 1993; LaPoint, Pickett and Harris, 1985; Hanlon, 2005).

Two studies, Hanlon, O'Grady, Bennett-Sears and Calaman (2004); Smith, Krisman, Strozier, and Marley (2004) seem to indicate that children of substance abusing incarcerated parents who were already living in households that included grandparent(s) were less likely to participate in deviant behaviors than those children who were living in households that did not include grandparent(s) prior to incarceration.

2. Common needs of children and caregivers

There are many variables that affect the developmental outcome for children. Thus, grandparents and other relatives raising children do not have to accept the above evidence as a certainty. Given our understanding of child development, it is not a surprise that children (of all ages) of incarcerated parents tend to fair better if they have a close, positive relationship with an adult caregiver who is willing to help children cope with an array of mixed emotions (Turner, 1995; Rutter , 1987; Werner (1989). Good parenting skills along with a loving relationship with the relative caregiver are key to the outcome for these children.

Although every child and family is different the Children of Prisoners Library has identified some common needs of children of prisoners as well as needs of the caregiver:

a. "Most Children of Prisoners Need:

- consistent caring adults who understand that, in general, children love their parents, even when they have committed a crime
- people who will not condemn the incarcerated parents as worthless
- people who will understand that children of prisoners feel angry, sad, confused, and worried.
- a chance to express these feelings and learn to cope with them
- a chance to learn and practice skills and keep busy with positive activities
- faith or affiliation with a community that can provide meaning for the child beyond their own crisis
- people who can help them maintain contact with their incarcerated parent or parents or explain to them why they cannot maintain contact

b. Most Caregivers Need:

- Support and understanding from friends, family, clergy and the community
- Emotional support, such as counseling or group activities
- Information about children of incarcerated parents as well as about services in the community
- Guidance about what is generally best for children and how to answer their questions
- Rules, boundaries, and space in the home: for the children, for the family and for the caregiver
- Opportunities for respite care and relief from the duties of care giving
- Help with managing the needs and services that are all too often fragmented, unavailable or costly.” Adalist-Estrin, A.

This *italicized* information is for facilitators.

Recent federal legislation such as the Improved Adoption Incentives and Relative Guardianship Support Act of 2008, has attempted to address the importance of children remaining in close contact with kin. For children entering the formal child welfare system this means that the first option for placement of children who are unable to remain in the care of their parents is placement with relatives. This legislation also makes provisions for some services to these relatives and the children placed in their care.

However, most children living with grandparents and other relatives do not seek assistance from formal agencies. African American families in particular are reluctant to seek formal arrangements when taking on the responsibility of caring for children. Particularly, grandparents caring for children of incarcerated parents are reluctant to seek out services from formal agencies. It has been found that interaction with other caregivers in similar situations can be helpful (Dressel and Barnhill, 1994; Kessler, Price and Wortman, 1985). Faith based agencies may appeal to some of these caregivers, particularly the African American caregivers (Hanlon, Carswell and Rose, 2007).

Some census data cited in research indicates that at least 25% of children living in homes headed by grandparents live in poverty and the 33% of these households have no health insurance (Dressel and Barnhill, 1994).

3. Some things to consider when providing a home for children of incarcerated parents

Tell children the truth about what has happened to their parent(s). How much you tell children will depend on their ability to understand. Usually a simple straight forward explanation will work best for all concerned.

Deciding if and how much contact children will have with parents while they are incarcerated will depend on a number of factors:

- safety of the child
- stipulations of court order concerning visitation
- parent's compliance with service agreement if there is one
- extent and quality of the relationship prior to incarceration
- child's desire for contact
- child's response to contact, or the affect expressed after contact
- parents ability to be nurturing and supportive during contact

In general, it is best for the child to have some kind of contact with parents while they are incarcerated. Visits may be arranged except in the most severe situations. However, the parent(s) may be in prisons far from home, it may be costly to get there, and some prisons or jails may not be very child friendly. It is helpful to grandparents and other relative caring for children to talk with others who have had to make the decision about if and how much contact should be encouraged. Children who can not visit their parents can make phone calls and write letters. Caregivers can help children write letters if the child is not able. Caregivers can also help children make list of things to talk about during phone calls. Children may want to send parents small gifts, cards, report cards, drawings, etc. (AARP).

Be mindful that children may have a loyalty to their parents (even if they do not know them well or if the parent has abused or neglected the child) and that displaying affection toward other caregivers may seem disloyal. Do not take this personally.

Structure and routine are a comfort to children of all ages – even if they respond to it in difficult ways.

Children do not have to feel the same way you feel about their parents. Listen when children want to talk about their parents. Make every effort to respond to the child in non-judgmental ways.

It is important for children with incarcerated parents to talk about their parents and ask questions about their well being. This should be encouraged. Help children express their emotions about the situation.

A few helpful resources for helping children with their questions and also helping them express emotions which are frequently mixed (I love my mommy but I am mad at her for not being here with me.) are:

How to Talk About Jails and Prisons with Children: A Caregivers Guide published by Oregon Department of Corrections – access at <http://www.childrensjusticealliance.org> and How to Explain Jails and Prisons to Children: A Caregiver's Guide published by California Department of Corrections and Rehabilitation and Friends Outside – access at www.friendsoutside.org. How to Explain Jails and Prisons to Children: A Caregivers Guide by Initiative Foundation access at: http://www.ifound.org/doc/files/IOC_CaregiversGuide_Dec09.pdf

Children need to be reassured that they did not play a role in what has happened to their parents. It is not their fault. This is a fear that frequently lurks in the child mind, leading to the guilt and sadness (or even depression).

Children who are separated from their mother due to incarceration (as opposed to separation for other reasons) are more likely to recall trauma and experience greater absence of emotional rapport with their new caregiver. Kampfiner (1995). The caregiver might help build stronger rapport by providing reassurance of their on-going presence for the child and by having a good understanding of how children experience and express trauma.

Adolescence is generally a challenge in the best of situations, but may be particularly fraught with potential difficulties if parents are incarcerated.

This is a developmental period when there is a significant struggle between allegiances to family and peers. If the parent is absent the allegiance to peers may become particularly strong and if the absent parent is incarcerated the shift may be more toward antisocial peers. (Hirschi, 1969; McLanahan and Bumpass, 1988). This could, without strong and supportive caregivers, increase the vulnerability to the development of deviant activity. Consistent parenting and interaction with positive peers could help prevent this unhealthy shift.

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F. Advocacy

This *italicized* information is for facilitators.

Generally, you can think of advocacy in two ways: 1) Individual Advocacy – when a grandparent acts as a spokesperson for his/her grandchild; and 2) Issue Advocacy – when grandparents (usually along with others) try to make changes on an administrative, legislative or institutional level that would benefit grandparents and grandchildren being raised by grandparents.

Even though this is a serious issue, please do not be afraid to have some fun with the participants around some of this.

1. Defining Advocacy

For this project, we will focus on you being an individual advocate: you acting as a spokesperson for your grandchild in order to gain resources, services, perspectives, and attitudes needed for their overall well being. As an advocate you may, at some point, have to bare you teeth and extend your claws, but in most instances you will not have to act like the mama bear protecting her cubs.

At some point your group may decided to take on some issue advocacy, such as addressing legislative changes. This is up to the group and assistance from the project will be provided at the time, if desired.

As a good advocate you will have to use a range of strategies and skills. Most of the time the strategies will be rather straight forward and simple: presenting your perspective and asking for what you need. Other times you will have to buck up and be rather firm about your grandchild's needs.

Here are a few examples when you might find yourself acting as an advocate:

- Requesting assistance from school to meet the special needs of your grandchild or relative
- seeking financial assistance for medical care
- gaining access to developmental assessments and evaluations
- informing health or mental health care providers of the kinds of issues that need attention and obtaining the necessary treatment
- Involving yourself in the school's IEP (individual educational plan) process
- keeping the courts and child welfare agencies informed about the interaction between the child in your care and his/her parents

- Insisting that visits with parents be evaluated and monitored
- Obtaining the information (from social services, mental health and health providers, school personnel) you need to best provide care for your grandchild or relative
- insisting that social services, mental health, health care providers, school personnel and other support services, work collaboratively for the benefit of your grandchild or relative obtaining financial payments to which you are entitled as a caregiver for your grandchild or relative

2. Purposeful Use of Relationship

Probably the most important element of good advocacy is *relationship*. That is, figuring out what kind of relationship you need in order to get what you want for your grandchild. These relationship strategies will have to be used with any number of agencies, organizations, programs, and individuals. When it comes right down to it remember: relationships are most frequently between you and one or a few individuals. You really can not have a relationship with and organization or agency. It also helps if you remind yourself that these individuals with whom you want this relationship are just folks. Generally they respond well to the things to which you would respond well: friendly attitude, calmness, request (as opposed to demands), being allowed a quantum of control, plain old politeness, etc.

3. Continuum of Relationship

You might think of relationships on a continuum. Running from:

- collaboration (everyone working in harmony to achieve the same goal)
- to cooperation (everyone communicating and working together to achieve the goal)
- to coordination (people taking different roles and working on different tasks, with open communication, in order to reach the goal)
- to bargaining (people trying to gain consensus, but clearly everyone has something to gain or lose – communication is guarded until you can work out the differences)
- to conflict (everyone recognizes that there is disagreement about the goal – communication is secretive and competitive).

The facilitator might use a board or flip chart to depict this continuum.

As much as possible, you want the relationship to be *collaborative* or, at least, *cooperative* (both of you agreeing to pull together to meet the needs of your grandchild). Granted, sometimes you have to use *bargaining* or *conflict* strategies to get to collaboration or cooperation, but only when necessary. A general rule of thumb is: When advocating, use the least offensive strategy first, and if necessary advance to what might be considered more offensive (or demanding).

Too often people trying to advocate for a child start out by developing conflict relationships, thinking that is what you have to do to get anywhere. This is simply not the case. It is true that you might get attention and you might even get what you intended to get, but, what will happen the next time you need something from that same person? It will require lots of repair work to move you toward collaboration. Burning bridges is not a good idea, swimming back across that river is just plain hard work and, it can take a long time. If you are going to have to use conflict strategies make sure it's worth it. You just will not have the energy to fight all the time.

4. Skills In Advocating For The Children In Your Care

Along with relationship building, as an advocate, you need to *know* as much as you can about:

- What it is that you want – this needs to be as specific as possible and not encumbered with unnecessary detail or clouded by unrelated issues
- The system(s) with whom you have to negotiate (for example; what are their options and limitations)
- The processes used by the system (how does it work - how do decisions get made, and who makes them)
- The people in the system (for example; what might they respond to most favorably, or what kinds of stress are they under)
- Your own rights and responsibilities

Making demands that are outside the possibilities of the organization or people with whom you are dealing, only wears you down and angers everyone (including you). This means you have to do your homework. I know you feel like you do not have the time for homework – but, in the long run, it will save you time (and grief).

One thing that most of us find maddening is trying to deal with an organization that we do not understand and people in the organization acting like we are stupid for not knowing how everything works. Sometimes organizations even speak a

special language – might as well be Greek to us. The people in the organization make assumptions that everyone knows everything they know. Not. It is perfectly okay to ask people in an organization to educate you about the structure, policies, and procedures of the organization. Better yet, try to gain that understanding prior to making contact with the organization. Look up the organization “on-line,” find written materials, or talk to people who have had dealings with the organization.

Good advocates need to be *organized* and they need to *keep good records*. Presenting request in writing is frequently helpful – it lets the other person or organization know that your request is recorded and can be used later, if necessary. Even if you make the request in person (verbally) it is a good idea to leave a written copy of the request.

Here is partial list of some records you may want to keep:

Keep track of all appointments you have concerning your grandchild – With whom did you meet? When? Where? What was discussed? What did they agree to?

Keep records of any visits or interactions between your grandchild and their parents: When did they visit? For how long? Were they alone or with other people? Where was the visit? What were the child’s reactions and behaviors after contact with parents?

Keep all medical records, dates, diagnosis, treatment, names of providers of services (yes, you can ask the physician for a copy of the records). It might be a good idea to create a notebook or file on each child that contains all medical information. Broward County, Florida, has created a form that might be useful for such purposes. The form can be found at: http://www.sheriff.org/about_bso/dfres/becca/becca-form.pdf

Keep track of contact with child protective service personnel.

If lawyers are involved, make sure to keep all written legal documents (and, ask the lawyer to explain them in plain English or Spanish or whatever your native tongue).

Keep track of any money you receive for tending to your grandchild, and a record of how that money is spent. These records may serve you well when you need something for your grandchild. Also, if organizations know that you are keeping careful records they will be more likely to pay attention to your request. The written word can be pretty powerful.

With all your best effort you might still run into organization, agencies, or individuals who (for whatever reason – and don’t even try to figure that out) are barriers to you

getting what you need for you grandchild. *Persistence* is the strategy that might serve you best. When the organization or individual realizes that you are not going to give up or shut up they might begin to wear down. Continue to call, make appointments, drop in, or write letters.

If that doesn't work you may need to move to *confrontation*. That is, confronting the person with the fact that you have noticed that he/she is resistant to helping you meet the needs of your grandchild. Example: "Mr. X, I have been trying for several days (weeks, months) to enlist your help in filing the necessary paperwork to get a comprehensive assessment of my grandchild's medical needs. You seem to either ignore my request or you seem uninterested in helping us." You deliver this in a firm but calm manner. This will sometimes be enough to jar the person into action.

A few notes about confronting:

- Use confrontation only when other relationship strategies don't work.
- Use confrontation to move the negotiations toward collaboration, that is what you really want anyway.
- If you are going to confront someone, you want to be in *emotional* control. Therefore, the confrontation needs to be planned and purposeful. If you go in all hot and bothered you stand a good chance of burning bridges; that, you do not want to do.
- Gentle confrontation is helpful when no one is taking action on your request. It pushes them along a little. This is sometimes what happens when you follow up – ask for an update. You can express disappointment in the lack of activity and remind them you will be in touch again tomorrow.
- Keep your goal in the forefront; this will keep you from getting too caught up in the confrontation itself (otherwise you become more interested in winning the confrontation than in achieving the goal).
- If, with your best effort, you are not getting anywhere with the person in negotiation, go to the next person in the chain of command.
- Threat is one way of confronting, but be sure that you can carry out the threat. And, by threats I do not mean "if you do not get on this request right away I am going to slap you upside the head." and, certainly do not carry out the threat – this stuff will just get you arrested and maybe sued. Not worth it no matter how good it might feel. A threat might be: "If action is not taken on this request by the end of the month, I will be back with ten other grandparents and we will sit here until action has begun."

If that doesn't work you can employ a couple different strategies: One, you can *go above the person* to the next level in the organization – supervisor, director, etc. – and make your request (taking with you all your records of the times you have attempted to get assistance). Or Two, you can use a simple but *honest threat*: “Mr. X, I do not know what else to do you get your help. So, I am telling you that if you do not have the necessary paper work done by tomorrow morning at 10am I am going to proceed to the head of the agency with my request.” Then, if nothing happens, you *carry out the threat*.

If that threat does not get Mr. X moving you can make another threat: “Mr. X, I am going to get as many grandparents raising grandchildren as I can and we are all coming down here and set in you office until you complete the paper work I need.”

In these examples you have moved from collaboration to bargaining to conflict. As you move into conflict relationship strategies you must remember that you are doing so purposefully - in order to move back toward collaboration. (Anger and frustration may be motivation for using conflict strategies, but do not deliver the strategy in anger.) So, if Mr. X, at any point along this continuum of relationship strategies, takes action to assist you, praise the hell out of him. Verbally tell him how helpful he has been. Send a little thank you note. Email his supervisor telling him/her how grateful you are to have had Mr. X's help. Why do this? Because you just looove Mr. X? I really doubt it. But you are doing it because you want to lay the ground work for any other possible time you might need his help or some other grandparent might need his help.

As an advocate you have to follow up your request with more calls or visits. You can never assume that just because someone said they would do something – that they will do it. You have to keep a little fire lit until your request is actually honored.

School requires special attention when we are talking about advocacy. As we know, school can be the best of places or the worst of places when it comes to nurturance. Some children, and unfortunately, some teachers can be insensitive or down right cruel. Children who have experienced trauma – particularly maltreatment or exposure to substance abuse environments – may experience learning difficulties as well as difficulties with interpersonal interaction. These children may exhibit a lot of behavior or present cognitive responses that look a great deal like ADHD or hyperactivity. But, they may well be responses to the trauma of maltreatment or reactions to toxins from drugs and/or alcohol. These problems may not show up until the children enter school or other learning environments.

Grandparents may have to serve as advocates for grandchildren who need special attention with learning. You may find that you have to request (or insist upon)

evaluations and assessments to determine specific learning issues and appropriate interventions. Here is a place you need to know your rights. All children have a right to an education – not matter what special accommodations or programming may be required. However, some school systems are stretched to the limit in providing such services. You might find yourself in a situation where you are insisting that the school act as an advocate for your child. The school may have to demand resources from within its own system. This is tricky and they will need your help. You might be more able, as an outsider, to exert pressure, since school personnel have a vested interest in not upsetting the leaders in the education system. This is where you have to practice persistence.

You might also find yourself in the uncomfortable position of - once having accomplished your goal of getting evaluations and assessments – insisting that no diagnostic label be place on the child. You will want records to record learning issues and methods of addressing these issues but it might not be in the best interest of your grandchild to have records indicating a diagnosis. Unfortunately, diagnosis tend to follow a child from classroom to classroom and can, in many cases carry a stigma, even with professional educators. A diagnosis is not needed in order to provide good intervention. It may, instead, be needed by insurance companies or by the school in order to get reimbursed by insurance companies or programs.

It should be noted that children experiencing learning difficulties and who are under the age of 9 will be in a catch all category of “developmentally delayed.” After age 9 the child would have to have a diagnosis in order to qualify for exceptional educational services. We would all like to trust that professionals would follow the ethics of confidentiality, but that is not always the case. You also want to question the use of medication for learning difficulties. Sometimes they are necessary and helpful, but we have a history of jumping to medication before trying other interventions. Some research would indicate that this is one of the contributing factors that has lead to our drug abuse epidemic. Question, question, question. How will the medication affect the child? What parts of the body are affected? How does it work in the body – including the brain? How does the medication interact with other medications and foods? What is the intent of the medication? What other interventions will accompany medications? What are the long-term effects? Is there a research based safety record? What should you expect to see in terms of behavior changes, habits, personality, physical functioning? You need a lot of information before agreeing to a regiment of medication.

If your grandchildren are having visits with their parents, they are probably having some behavioral or attitudinal responses. Depending on how these visits are handled by the parents, the child, and you, these responses may be positive or negative for the over all well being of the child. Teachers probably need to be informed about these visits and usual reactions. They can play a key role in assisting children with

these transitions. You will want to monitor the effectiveness of the teacher who is assisting. You may find yourself having to educate them, or giving them suggestions about how to handle behaviors and attitudes. You may have to (as gently as possible) insist that they not exacerbate the difficulties the child is having with these transitions.

Use Grandparent Raising Grandchildren education/support groups to help you with advocacy strategies. The experience found in such groups can be a major source of ideas, support, and inspiration.

5. Common Traps In Advocating

Remember there are several traps you want to avoid when acting as an advocate for your grandchild:

- It is tempting to go into the fray with all guns loaded, cocked and ready to shoot. Back off, cowboy. In advocacy work you do not want to create conflict unless you have to.
- When you are trying to get services or resources for your grandchild you will probably have to deal with people who are in authority positions – directors, supervisors, owners, leaders, teachers, doctors, and a host of people who want you to THINK they are the authority. These are, ultimately, just people. If they start talking in words or language you do not understand, stop them and ask them to come back down to earth. Be confident that you are in charge of your effort and have every right to make a reasonable request.
- You really need to notice that most everyone will respond to kindness, reasonableness, and politeness. Remember: no bull in a china shop techniques. Leave the bulldozer at home.
- You will have to guard against smooth talk and manipulation. Expect that people are going to be honest and straight forward (just as you are going to be) and if they are not then you confront, as specifically as possible, that they are off base. Make sure you understand what they are saying: “So, you are saying.....”
- Sometimes, for a whole lot of reasons, some people try to make you think that either you really do not want what you really do want (a little tricky there) or that they are with you on every count (and take no action to follow through with what you are requesting). This might be slick but don’t let it get by you. Stick to your goal and make sure that if they agree to help you, they follow through.
- You have to hang in there. Persistence pays off. Some folks will try to wear you down and get rid of you. Nope, ain’t gonna happen. You come right back and soon.

- When someone agrees with your goal and agrees to help you get your request, make sure you follow through: check on the progress of things (you may feel like you are a nuisance – and you probably are) and be persistent until you get the request granted.
- Be very careful about making assumptions. If you are not sure about something - check it out, ask questions, look it up, ask for clarification. You also have to be careful about the attitude with which you enter negotiations. Initially every relationship is a bargaining relationship. Everybody is still checking out everybody else. So, go into the process with confidence, stay your course, enjoy the journey, and show respect for those involved.

Working through the organizational maze associated with raising grandchildren and other relatives requires patience and fortitude. This is a part of being well *organized* and might require some file folders. Make a folder for each organization or services.

A lot of the work in teaching grandparents good advocacy skills can be done through role-play. If you use role-play, you have to warm the participant to the activity. Most people are, initially, rather uncomfortable with role-play. Try to make the warm up fun.

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