SESSION VIII

UNDERSTANDING PRIMARY FAMILIES

Skill Set and Competencies

Skill set: Basic understanding of the kinds of problems in primary families that result in children being placed, and the importance of those families to children in care.

1. Aware of the possible reasons children need placement.
2. Aware of the emotional and social outcomes for children who do not have contact with their primary families. Aware of the importance of helping children have positive relationships with their primary families.
3. Familiar with the types of problems that can contribute to abuse and neglect of children and teens. Aware of the types of family resources and strengths that can reduce the likelihood of maltreatment.
4. Aware of the importance of supporting children’s positive feelings and memories about their primary family members.
5. Aware of the grief process parents experience when their children are placed in care. Aware of behaviors that indicate grieving.
6. Aware of the importance of involving primary families in case planning, daily decision-making, and other activities to help the child return home.

Agenda

I. Introduction
II. Exploring Our Own Issues
III. The Losses Experienced by Families with Children in Care
IV. Substance Abuse Issues Among Primary Parents
V. A Continuum of Contact
VI. Will the Real Birth Parent Please Stand Up?
Sources

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Handouts

#1 Benefits and Challenges
#2 Myths and Realities
#3 Guidelines to Produce Positive Outcomes for Children and Their Families
#4 Anticipated Behaviors of Parents Whose Children Come into Care
#5 Symptoms of Chemical Use Progression
#6 Chemical Abuse vs. Dependency
#7 Bridging the Gap

Section I. Introduction

5 Minutes

Trainer Instructions: The trainer should begin by collecting homework assignments and answering any questions posed by participants.

The trainer should stress that adoptive, foster, and kinship caregivers must acknowledge and fully understand the importance of birth families to children in care. The goal of this session is to help caregivers begin to understand placement from the birth family's point of view and to explore issues related to continuity and identity for the child. In addition, since birth families are part of the child welfare services team, particularly when the case goal is reunification, caregivers may have direct contact with birth family members in a variety of ways. We recognize that many adoptive and foster families may be ambivalent or unsure about having direct contact with birth families. The purpose of this session is to fully explore their concerns and feelings, and help them feel more comfortable, both in collaborating with birth family members and in communicating about them in a positive, constructive, and empathetic manner to the child.

Section II.

40 Minutes
Exploring Our Own Issues

Use:  Handout#1  
      Handout #2  
      Handout #3

Trainer Instructions: The trainer should set up a "Walk Around" exercise. The trainer should prepare flip charts and post them on the walls of the training room. Each flip chart should include one of the following statements written at the top.

- When caregivers have a positive relationship with birth family members, the best possible outcomes for the child are...
- The best possible outcomes for birth families are....
- The best possible outcomes for foster, adoptive, or kinship parents are...
- The worst possible outcomes (for all involved parties) are...
- My greatest concern about having direct contact with birth parents is...

On one flip chart, the trainer should draw a very large line figure of a person, with most of the white space on the flip chart contained within the outline. The figure should be labeled "Birth Parent." Trainees should be directed to write, within the figure, an adjective or descriptive phrase they have heard that describes attributes or qualities of birth parents, or that they themselves believe is true of birth parents. Trainees should be instructed to be honest about their own and other people's stereotypic perceptions of birth parents. The goal will be to sort out the stereotype and the reality.

Trainees should be given markers and instructed to walk around the room, read each statement, and write their own responses to the statements on the flip charts. At the completion of the walk around, the trainer should reconvene the group and generate discussion, making sure the following points are covered. The trainer should distribute Handout#1, Benefits and Challenges.

Potential Responses:

Child: Best Possible Outcomes

- Child's experience of loss is greatly reduced.
- Child's anxiety about separation is reduced.
- Continuity can be maintained for child.
- Problems with divided loyalties are reduced.
• Consistency in caregiving is encouraged, reducing stress for the child.
• Child is less confused about changes.
• Visitation is greatly facilitated.
• Child receives "permission" from birth family to succeed in placement.
• Much of the grieving process is prevented, since loss is minimized.
• Reunification and permanence for the child are facilitated.

Birth Family: Best Possible Outcomes

• Visitation and reunification are greatly facilitated.
• Total amount of time child spends in temporary care may be reduced.
• Birth parents feel trusted, empowered, and important in parenting role.
• Self-esteem is enhanced.
• Birth parents are less threatened by foster or adoptive parents, and less threatened by the unknown.
• Birth parents are less concerned about the care their child is receiving.
• Respective roles and responsibilities can be clearly defined and understood.
• Birth parents can learn constructive parenting and child care strategies from caregivers.
• Caregiving family may become support system for birth parent.

Foster or Kinship Family: Best Possible Outcomes

• Continuity is maintained in educational planning, medical treatment and care, discipline, and other child care needs; child's developmental needs are better met.
• Caregiving family is a full member of the services team.
• Caregiving family can get complete and accurate information about the child and his or her history and needs from the birth family.
• Stress is reduced for family; if child is less anxious and distressed, caregiving family is often less anxious and distressed.
• Caregiving family’s ability is increased to accurately and empathetically help child deal with issues and feelings about his or her birth family.
• Ease and effectiveness of foster-to-adopt or open adoption (where this is the most appropriate plan for the child) may be enhanced.
• Visitation planning is simplified.
• Caregiver can learn culturally specific child care strategies from birth family members and can enhance child's cultural identity.

Worst Possible Outcomes:

• Roles will not be clear; caregiver will be expected to serve as caseworker or therapist to birth family.
• Birth families will spend excessive time at the foster, adoptive, or kinship home.
• Child will never settle into care because of continual contact with birth family.
• Child will always be upset.
• Child will be abused again or neglected when in presence of birth family.
• Birth family will feel they can't compete, and will give up.

My Greatest Fears:

• Birth parents will be constantly calling and asking for rides, advice, money, or assistance.
• Birth parents will place my own family at risk of violence or harm.
• Birth parents will kidnap the child from my home or neighborhood.
• Birth parents will continue to perpetrate physical or sexual abuse on the child, if they have access to the child.
• Birth parents will be angry and resentful toward me and constantly engage me in confrontations.
• I will not be able to protect the child in my care.
• Birth parents will come to my home drunk or drugged.
• Birth parents will bring other people to my house uninvited.

Create a Stereotype of Birth Parents:

• Don't value their children
• Are selfish, meet own needs at the expense of the child
• Lack parenting skills
• Don't really love their children or they wouldn't treat them this way
• Can't control their own behavior
• Are promiscuous
• Are irresponsible
• Live in poverty
• Don't take advantage of services that are available
• Lack values
• Are lazy
• Have criminal records
• Exhibit violent behavior
• Are uncooperative

Trainer Instructions: The trainer should help the group examine the stereotypes and share experiences from professional practice that challenge these myths. During this discussion the trainer must be careful to avoid making judgments of
prospective caregivers who hold these stereotypes. They cannot be blamed for having these perceptions. The trainer should assure that the points covered in Handout #2, *Myths and Realities*, are fully discussed.

## Myths and Realities

<table>
<thead>
<tr>
<th>Myth</th>
<th>Reality</th>
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<tbody>
<tr>
<td>Birth parents who abuse, neglect, or relinquish their children do not care about them.</td>
<td>Birth parents do not plan to abuse or neglect children. Maltreatment of children usually occurs following times of overwhelming stress. Parents who maltreat their children may, in fact love their children dearly, but may not be able to cope with circumstances or may not know how to parent successfully. Furthermore, parents who voluntarily relinquish their children usually do so with tremendous ambivalence; they do not walk away from these relationships without significant, lifelong grief.</td>
</tr>
<tr>
<td>Most birth parents are violent, dangerous people who pose a threat to the foster families caring for their children.</td>
<td>Some birth parents have a history of violence or mental health problems that indicate risk for caregivers. Most birth parents, however, can build a collaborative relationship with foster or kinship parents that can be invaluable in the rapid reunification of the family. When the caseworker or foster parent is unsure about the level of risk posed by the birth family, relationships should be built with deliberate care along a continuum of openness, with the safety of the foster caregivers of paramount concern.</td>
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Foster families are expected to function as caseworkers or therapists for birth families. Foster families may serve in key roles as mentors with birth families. When foster and birth families develop a partnership, this will be part of a total intervention plan developed by the child welfare team. The intervention planning will involve the foster parent and will spell out the expectations for the foster parents, when those interventions will occur, and how they can improve the outcomes for the child.

The agency is "setting up" foster families to be hurt by dangerous birth parents. The agency will not expect foster families to place themselves at risk in working with birth families. The agency will always consider risks when developing a partnering plan for birth and foster families, and foster families will be involved in the development of the plan. Communication between foster and birth families may, at times, need to occur through an agency intermediary, usually the caseworker, to protect the safety of the child and the foster family.
Myth
Foster families are expected to work with all birth families of children who come into foster care.

Foster parents will be responsible for caring for the birth parents as well as the child.

Reality
Foster families are expected to communicate with the birth parents of all children. That communication may take many different forms, depending on the characteristics of the birth family, the wishes of the foster family, and the stage of the developing relationship between the foster and birth families. Relationships may begin with a journal of the child's progress, move into telephone calls between the birth and foster parents, meetings during supervised visits at the agency, and eventually evolving into unsupervised visits at the foster or birth home prior to reunification.

The role of the foster parent is to provide a safe, temporary home for children who are unable to remain in their birth homes. Foster parents are part of a team whose primary goal is reunification. Visitation and communication are essential to achieving that goal. However, caring for the birth parent is not an expectation of the foster parent; it would, in fact, be counterproductive to the development of adult, responsible behavior by the birth parent.

Trainer Instructions: At the conclusion of the discussion about myths and realities, the trainer should distribute Handout #3, Guidelines to Produce Positive Outcomes for Children and Their Families.
Section III. 35 minutes

The Losses Experienced by Families with Children in Care

A. Awareness of the Losses

Families typically experience extreme psychological distress or crisis when children are removed and placed.

Most families experience pervasive and painful feelings of loss when their children are removed. Parents may also experience psychological threats to their self-esteem and to their identity as competent parents. They may lose their sense of purpose and direction, particularly if they have been full-time parents whose daily activities have revolved around their children. Separation usually threatens the family’s identity, sense of belonging and togetherness, and feeling of security.

Parents whose children are removed are often subjected to criticism and blame from extended family members, neighbors, and friends. They may lose an acceptable social identity, and the respect and esteem of important others. Strong cultural values about family unity and competent parents may exacerbate this loss for many families, particularly if the child is placed with strangers outside the immediate community. The removal of the children may even threaten the esteem and respect children have for their parents, and birth families may feel judged and blamed, not only by the agency, courts, and community, but by the children, themselves.
Finally, removal of the children may reduce the family’s income and financial security. When a family’s primary source of income is public assistance, the removal of the children often results in a cut in their subsidy. They may have to move, and they may lose other supportive services, such as food stamps, medical care, and day care.

**Implications for the Child Welfare System**

The multiple losses inherent in child placement can precipitate a crisis for families. When in crisis, family members are often immobilized and emotionally disabled by overwhelming distress. Families who have children removed may have difficulty just getting by, much less finding the stamina to make the changes necessary to have their children returned.

Some families served by child welfare agencies have a history of marginal adaptive behavior. They may have psychological and emotional problems, may be in dire poverty, may have substance abuse problems, and may have limited coping ability. Some parents have had consistently painful experiences in their interpersonal relationships, and in contacts with social institutions, and they may not trust the agency or the caseworker. They may have limited sources of emotional support. Negative life experiences may also contribute to a general perception of futility and helplessness, and some families may be without hope that their children will ever be returned. This is exacerbated by the serious, sometimes permanent damage that separation inflicts on parent-child attachment. Families may give up, withdraw from agency contact, grieve their loss, and resign themselves to life without their children. This seriously compromises the likelihood of successful reunification.

The degree of loss and threat experienced by family members can be minimized if the parents can be involved in planning for their children and be empowered during all phases of the placement process. Partnering between foster or kinship parents and the birth parents can achieve several objectives:

- Maintaining and strengthening the relationship between the parents and the child
- Developing and strengthening the parents’ parenting skills
- Helping the parents work to create a safe home environment for their children and, in doing the above…
- Reducing the traumatic effects of placement for children and families

This can promote reunification, or can provide the worker with essential information with which to conclude that the child cannot go home, thus enabling workers to direct their efforts toward placing the child in an alternative permanent family in a timely manner.

**B. The Grieving Parent: Typical Responses to Loss**
Use: Handout #4

Trainer Instructions: The trainer should encourage participants to remember the information they received in *Separation, Loss and Reunification*, Session IV. The trainer should briefly review the stages of grief and loss with the group. The trainer should ask the large group to brainstorm the typical behaviors of a parent who has children in care. The trainer should elaborate on the effects of grieving on birth families, the behaviors expected, and the impact of these behaviors on case planning and reunification.

At the conclusion of this discussion, the trainer should distribute Handout #4, *Anticipated Behaviors of Parents Whose Children Come into Care.*

Certain behaviors typify family members’ responses to the losses and threats experienced during placement. If a foster or kinship caregiver does not properly interpret the meaning of these behaviors and fails to recognize them as symptoms of grief and stress, the caregiver may respond in nonproductive and unsupportive ways. For example, the stunned immobilization of a parent in shock could be misinterpreted as a lack of motivation, or as being in agreement with the placement. Depressive withdrawal could be misinterpreted as a lack of desire to work with the agency toward reunification or as disinterest in the child.

There are many differences in people’s expressions of loss and grief. However, many behavioral responses to the placement of children are predictable, and can be interpreted as normal manifestations of the stages of grieving [Kubler-Ross, 1972; Fahlberg, 1979].

**Shock or Denial**

- Parents may exhibit a robot-like, stunned response at the move. They may be immobilized. A characteristic response of people in emotional shock is, “This can’t really be happening!”

- Parents may be very compliant and may express little emotion or affect. They may appear bland, uncaring, or uninvolved.

- Parents may deny that there is a problem or deny that the agency can remove the children. They may insist that the children will be home in a day or so, or that “No court will ever give you custody.”

- Parents may avoid the caseworker and deny the need to be involved with the agency.

**Anger or Protest**
Parents may threaten court action or may contact an attorney to fight the agency.

Parents may behave in a contrary and oppositional manner by refusing to let the caseworker visit the home or refusing to talk with the caseworker or kinship or foster caregiver.

Parents may refuse to participate in developing a case plan or in making decisions about the child’s welfare.

Parents may become demanding, sometimes making irrational demands on the worker or caregiver.

Parents may blame the agency, the worker, the caregivers, the court, the system, the complainant, or others, for the existence of the problem. They may vehemently reject any need to change.

**Bargaining**

Parents may become semi-responsive to the overtures of the caregivers or worker and may behave more compliantly.

Parents may make broad promises such as, “It will never happen again,” “I’ll ask my boyfriend to leave,” or “If I go to all my parenting classes, will I get my children back?”

**Depression**

Parents may forget or miss appointments, or may fail to attend scheduled visits with the children.

Parents may exhibit little initiative or follow-through in visitation, or in other activities designed to promote reunification.

Parents may display futility and a loss of hope that their children will ever be returned home. Some parents even move away or disappear, and the agency loses contact with them.

**Resolution**

Parents may emotionally begin to restructure their lives without their children.
Parents may move away without notifying the agency, may become involved in new relationships, may have other children, or otherwise “get on with life.”

Parents may not respond to agency efforts to work with them.

Parents may stop visiting their children.

Parents may not protest court action for permanent custody and may not attend permanent custody court hearings.

Implications for Child Welfare

Clearly, the child welfare goal is to support family members and employ strategies that maintain the family’s integrity while the child is in placement. This reduces the losses and threats experienced by the family and subsequently prevents the need to grieve. The extent to which family members experience placement as a loss depends largely on the agency’s ability to keep them actively involved with their child and involved in collaborative reunification planning while their child is in placement.

This also implies that caseworkers and caregivers must actively engage families of children currently in placement as quickly as possible. Caregivers will likely have to deal with anger and hostility, depression, and sorrow. This however, is preferable to allowing the grief to be fully resolved. Once parents have completed the grieving process, it becomes increasingly difficult to re-engage them.

Section IV.  
20 minutes

Substance Abuse Issues Among Primary Parents

Use: Handout #5
Handout #6

Trainer Instructions: The trainer should acknowledge that many parents who maltreat their children do so because they are addicted to alcohol or other chemicals. The trainer should distribute Handouts #5, Symptoms of Chemical Use Progression, and #6, Chemical Abuse vs. Dependency, to reinforce learning.
Lecture

Disease Concept

The medical community defines chemical dependency as a disease based on the following characteristics:

- **Primary** - The chemical dependency is neither the result nor symptom of another illness; it stands alone and must be treated directly.
- **Chronic** - The disease is lifelong, and one can only hope to treat it through making different life choices. Physical tolerance increases, so it takes more of the substance to produce the desired effect.
- **Progressive** - The disease is continuously spreading or increasing in severity.
- **Fatal** - If there is no intervention, the disease may eventually result in death.
- **Developmental** – The emotional development stops at the point the addiction takes over. Therefore, if a 37-year-old parent became addicted at age 16, that would be the emotional age of that person, and any services given to that person would have to be structured with that developmental understanding.

For adolescents the disease concept might be more accurately defined as follows:

- **Primary** - The chemical use may begin as a secondary problem created by another issue, such as family dysfunction, low self-esteem, emotional or psychological problems, or abuse. However, now the chemical use, itself, is creating its own problems of greater significance than the original cause. Substance abuse also interferes with the normal mastery of psychosocial tasks (such as developing intimate relationships with friends). Therefore, substance-abusing adolescents and adults often do not have the foundational social and emotional skills to adequately function, emotionally and socially, in later stages of development.
- **Chronic** - When assessing duration, one needs to take into account the age of the individual. For example, a 14-year-old with a two-year history of extensive chemical use is significant.
- **Progressive** – There may be an appearance of controlled use because there may be periods of remission. Even when the adolescent is not using chemicals, the behavioral symptoms may continue.
- **Fatal** – Death is rarely caused by vital organ damage. Deaths are generally limited to acts of poor judgment, such as overdoses, car accidents, or fights.

The trainer should ask the group for some examples of similar medical diseases.

Possible answers: Diabetes
High blood pressure
Heart disease
Bipolar disorder or depression
Lecture

Progression and Compulsion:

In order to better understand a person’s preoccupation with chemicals, it can be described in the following way.

Trainer Instructions: The trainer should draw a continuum across a flip chart sheet. On the left-hand side should be written “depressed,” in the middle “normal,” and on the right-hand side “euphoria.” The trainer should use Handout #5, Symptoms of Chemical use Progression and Handout #6, Chemical Abuse vs. Dependency to further illustrate these points. This graphic will only work if the trainer draws the graph while talking about what it means. The trainer should not prepare this graph ahead of time. Substance abuse often progresses through predictable stages.

Experimentation Stage:

With a different color marker, the trainer should draw a line beginning at normal (going above the continuum line) and reaching euphoria and the returning to normal (going under the continuum line).

Lecture:

This depicts the users’ first experiences with chemicals (the learning phase).

- They learn that it makes them feel good.
- The degree of the “good feeling” is controlled by the amount of substance they consume.
- A “friendship” or “love relationship” is formed with the chemical.
Seeking the Mood Swing Stage:

The chemical users are starting to seek the mood swing.

- Overall, their behavior is still fairly appropriate.
- The users are beginning to anticipate the next time they can use (see their “friend”).
- They are paying a small price for their use, may experience a few hangovers or may have embarrassed themselves, but compared to the high, “it was worth it.”
- If a situation came up in which the chemical was not available, they would not be very upset.
- If someone raises concerns about their use, the users begin to rationalize them away and truly believe that they can correct the problem by changing themselves or the environment.
Trainer Instructions: Using a third color, the trainer should draw a line with a marker, beginning at slightly below Normal (going above the continuum line), ending just beyond Normal, then returning to below Normal (going under the continuum line).

Misuse or Abuse Stage:

- Their physical tolerance is increasing, and it takes more chemicals to get past normal and move toward the euphoric stage.
- The emotional price for chemical use is increasing.
- There is deterioration in many or all areas of their life (i.e. socially, physically, intellectually, and spiritually), although the user may not recognize the changes.
- They shift from anticipating the next chemical use to being preoccupied with it (more time may be spent obtaining, using, and maintaining chemical supply).
- They begin breaking promises and compromising morals; loss of control begins, and trouble often follows an episode of use.
- They may use chemical to relieve guilt, fears, and anxiety (all of which are increasing).
- They begin rationalizing use i.e., blaming others, having excuses and alibis, and being defensive about use.
- Users believe their own rationalizations that “next time it will be different.”
Addiction or Chronic Dependency Stage:

This is the chronic stage:

- The users are operating in the Depressed area on a daily basis, and chemicals only help them approach Normal.
- All of the symptoms and feelings in the harmful stage are intensified.
- They use in an effort to feel normal, trying in vain to recapture old highs, but also to avoid withdrawal.
- They may have physical problems.
- They are emotionally, physically, and spiritually sick; they may have faulty memory and impaired judgment.
- The urgency to use chemicals is increased.
- Chemical tolerance goes down (because of the condition of the body, it cannot handle large amounts).
- They experience paranoid thinking (high anxiety, hopelessness, isolation).
- They experience complete loss of control in all areas of their lives. They struggle with living day-to-day.
Section V.  

A Continuum of Contact

Use: Handout #7

Trainer Instructions: The trainer should deliver the following content in a mini-lecture. The trainer should distribute Handout #7, Bridging the Gap, and use the handout to demonstrate a continuum of contact to maintain attachment, speed reunification, reduce stress and anxiety, promote the development of a positive identity for the child, and, wherever appropriate, contribute to the growth and development of birth parents. The handout will give caregivers concrete suggestions on ways to partner with birth parents to achieve these many ends.

Content

Relationships between members of the child's immediate and extended birth families and foster, adoptive, or kinship families includes a wide range of activities. These may be placed on a continuum, with, at one end, very limited, highly structured or supervised contact (such as anonymous letters, or contact only with the agency or caseworker as an intermediary) and, at the other end, regular, frequent, and unsupervised face-to-face contacts between birth and caregiving family members for a variety of purposes.

It is important to understand that both the nature and the intensity of the family-to-family relationship will differ from case to case, depending upon:

- The needs of the child
- The degree to which the birth parents can be engaged as constructive collaborators in the case plan
- The goal of casework--that is, reunification, open adoption, or other permanent alternative
- The nature of the parent-child relationship at the time of placement
- The degree to which the safety of all parties can be assured
- The training and skill of the caregiving family

In many situations, foster, adoptive, or kinship care families can become an important support system for members of the child's family. When such relationships exist, birth parents are empowered and helped to maintain active and constructive involvement in their children's lives, while they are resolving the problems or issues that led to placement. Foster and kinship caregivers can also serve as mentors to birth families, which promotes the development of the birth parents' personal and parenting skills.
Collaborative relationships help strengthen and maintain children's attachments. In open adoptions or adoptions by foster caregivers, members of the child's birth family may continue to have contact with the child and family after the adoption has been finalized. When children in care are reunified with their families, they can often maintain their attachments to their foster or kinship caregivers, preventing separation trauma. Prior caregivers can also provide respite care when needed, thus continuing in a supportive role to the birth family.

While such collaborative family relationships can have many benefits for all parties, they must be developed over time. Trust and confidence can only evolve through positive interactions. As in any new relationship, there will be periods of testing, disagreement, tension, and skepticism, as well as periods of success and collaboration. All parties must expect this developmental process, recognize it as normal, and be able to work through it, with the help of the agency, the worker, or other caregivers, when needed.

There are several potential barriers to the beginning of a relationship between birth families and caregivers:

- The families may know little to nothing about each other at the beginning; they may lack information on which to even begin a relationship.

- They may have significant misinformation about each other or hold stereotypes of each other, which will interfere with their ability to get to know one another as individuals.

- Birth and caregiving families may feel threatened by one another. Birth parents may be threatened by the child's affection for the caregiving family, the socioeconomic status of the caregiving family, or their success in parenting and in managing their lives. Caregiving families may feel threatened by the child's loyalty to the birth family, by the birth family's behavior, or by the birth family's expressed anger and dislike of them.

- Significant cultural differences and misinformation between birth and caregiving families may lead to misassumptions and poor communication.

Caregivers who will work directly with birth family members should be trained in strategies for engaging birth parents, to help them work through these issues and to help promote their personal development and parenting skills. These special skills make caregivers highly valued contributors to the child welfare service team.
**Section VI.**

60 minutes

**Will the Real Birth Parent Please Stand Up?**

 Trainer Instructions: A personal presentation by one or two birth parents, reflective of the population served by the agency, should complete the session. The purpose of the presentation is to “de-villainize” birth parents by giving them an opportunity to present themselves as real people with feelings, strengths, and challenges. An alternative panel that includes a birth parent and a foster parent, who have worked well together, may present their experiences and talk about how they worked together to meet the needs of children and to work toward reunification. It is not necessary to have model birth parents; however, highly dysfunctional birth parents may serve to strengthen rather than contradict trainees’ stereotypes. It is appropriate to pay the families for their time and travel. A suggested rate is $25.00 to $50.00 per session per family.

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<tr>
<th>Each panel will be different, depending on the individuals who are presenting. Some suggested guidelines to provide structure and assure success include:</th>
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<tbody>
<tr>
<td>1. The trainer should schedule a practice session with the panel members prior to the actual training and give them sample questions. This will increase panel members’ comfort with the situation.</td>
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<tr>
<td>2. The trainer should set the ground rules with the group and introduce the panel members, using first names only. It may be difficult for some families to share their personal stories. This is a teaching and learning environment; information shared in this session should be kept confidential.</td>
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<tr>
<td>3. The panel members may pass if they do not want to answer a question. The trainer may also pass for the panel member if he or she feels that a question is too intrusive or inappropriate.</td>
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<td>4. The trainer should stress that this is information from the perspective of the family that had children in care.</td>
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**Trainer Instructions:** The trainer should conduct a brief introduction of each panel member, followed by a brief interview of the family members. Sample interview questions are listed below.

Tell us how your children came into care. What was your life like at the time?
What were your feelings at the time your children came into care? How did you react during the first days and weeks after removal?

What was it like to tell your family, friends, and others that your children no longer lived with you?

What contact did you have with the foster families caring for your children? What things were helpful? What was not helpful? What was the most difficult thing you experienced involving a foster parent? The best thing?

What was the resolution of your case? How are you dealing with parenting your children on an ongoing basis? How are you dealing with your losses? What times of the year are particularly difficult for you? What makes things better or worse? Do you have any contact with your children now? Do you get information? How?

What is your community’s perception of the children’s services agency?

**Trainer Instructions:** The trainer should conclude the session by thanking the participants for coming to the session and inviting everyone to remain for refreshments. It is important that this be done, so participants can process their emotions and feelings about the presentation. This will also give participants an opportunity to interact with the presenters on a different level and deepen the learning process. The trainer should remind all involved that they are still under the same ground rules during the informal processing time. The trainer should monitor the conversations to assure everyone’s comfort.

If it is not possible to conduct the presentation, an alternative activity should be provided. However, alternatives which do not require a birth parent presentation are less valuable in providing insight and empathy for prospective foster and adoptive parents.

**Alternative Activities (Only if Birth Parent Presentation Cannot Be Done)**

**Trainer Instructions:** The trainer should lead the group in a large-group brainstorm or in three small groups (depending on time frames) addressing the question, "What could you do to work with the child's family in this stage of the case plan?" The trainer should ensure that the following points are covered in the discussion.

**Preplacement**

- Meet the child's family (or previous foster family if adoptive placement) prior to the placement.
• Ask the parent for information regarding the child's schedule, food likes, activities
  the child enjoys, and allergies or other medical concerns. This helps maintain
  continuity for the child, and is reassuring to the birth parent.

• Invite the child's family to come to your home for a preplacement tour. While
  there will be a few birth families for whom this is not appropriate, in general there
  are significant benefits to both the child and the birth family in reducing anxiety
  and preventing separation trauma.

• Assure the parents that you will support and help them in any way you can to
  achieve the case plan.

**During Placement**

• Encourage the children to call their birth parents "Mom" or "Dad" and adopt
  another name or title for yourself ("Aunt Jean," "Grandma Lee," etc.).

• Assure the parents that their feelings associated with grief and loss are normal and
  expectable, and that you understand how they feel. Provide reassurance and
  empathy. Do not lash back when they demonstrate anger or forget an
  appointment.

• Call the parents as soon as the children are settled in to reassure them that the
  children are safe.

• Let the parent help the child unpack. Encourage the parent to give the child an
  article of clothing that the parent has worn. Having the parent's smell on the
  clothing can be reassuring to the child.

• Ask the parent to accompany you to enroll the child in school, to go to doctor's
  and counseling appointments, and to go to the child's school or sports events.

• Save the child's report card to be opened at the next visit. Collect a file of
  schoolwork, pictures, and cards that the child has made. Share them at the visit.

• Ask the school to let the child make two Mother’s or Father’s Day cards.

• Encourage children to talk about their family. Show respect when you talk about
  them.

• Work on the Life Book with the child and involve parents in making the Life
  Book during family visits.
• Provide transportation to and from visits.

• As you develop a relationship with the parents, invite them to call their children on the phone. With agency permission, you can also encourage parents to pick up the children at your home for visits or hold the visits in your home.

• Provide modeling of child care and child management techniques during visits. Facilitate visits! If a goal is that the mother will play and appropriately interact with her nine-month-old, get down on the floor, play peek-a-boo, patty cake, and build towers together with the mom and baby.

• Keep parents informed about the child's development.

• Solicit the parents’ input and opinions regarding decisions about the child. For example, ask the parent what kind of clothing to buy for the child, or when possible, take the parent with you and shop together with the child.

• Arrange alternate holiday celebrations with the child's family if the child cannot go home for special occasions.

• Jointly plan and host a birthday party for the child.

• Let the birth mother have the center seat at "Parents Night" activities.

**Post-Reunification or Post-Adoption**

• Help the child move. Be supportive and encouraging.

• Let the child know that you will continue to be a part of his or her life, and make plans for contact. Give the child preaddressed and stamped note cards to send to family and friends.

• Plan a “Moving On” party. Invite the child's family or foster family.

• Help the child say good-bye to friends at school. Make a photo address book.

• Visit the child, especially for the few weeks immediately after the move.

• Encourage the parents. Assure the parents that you will be available to talk with them and, where appropriate, to help them if they need it.
Pre-Training Handout

Skill Sets and Competencies

Skill set: Basic understanding of the kinds of problems in primary families that result in children being placed, and the importance of those families to children in care.

- Aware of the possible reasons children need placement.

- Aware of the emotional and social outcomes for children who do not have contact with their primary families. Aware of the importance of helping children have positive relationships with their primary families.

- Familiar with the types of problems that can contribute to abuse and neglect of children and teens. Aware of the types of family resources and strengths that can reduce the likelihood of maltreatment.

- Aware of the importance of supporting children’s positive feelings and memories about their primary family members.

- Aware of the grief process parents experience when their children are placed in care. Aware of behaviors that indicate grieving.

- Aware of the importance of involving primary families in case planning, daily decision-making, and other activities to help the child return home.
Benefits and Challenges

Benefits that are likely to result when birth families and foster, adoptive, or kinship families work together in a collaborative manner:

- Separation trauma and anxiety are greatly reduced.
- Continuity of care and attachments are maintained for the child in care.
- Planning and implementing visits are simplified, making it possible to visit more frequently, and helping to assure more productive visits.
- Reunification can occur more quickly, or an alternative plan for permanence can be made in a timelier manner.
- The birth family can use the caregiving family as a role model and can be mentored to make changes that enhance their personal development and parenting skills.
- When the two families work collaboratively, loyalty issues for the child are reduced, and the child is less likely to create divisiveness and resentment between the two families.
- Caregiving families can maintain contact with the child after reunification, which prevents additional separation trauma.
- Caregivers can become a permanent support system for the child and family.

Challenges that are likely to result when birth families and foster, adoptive, or kinship families work together in a collaborative manner.

- Families may have different values, backgrounds, cultures, parenting styles, beliefs, knowledge, and skills. This may create disagreements, particularly on the best means of caring for the child. These disagreements may need to be negotiated before the families can work together successfully.
● The families may not like one another. This may interfere with the establishment of a relationship. In some cases, unresolved disagreements may lead to distance in the relationship.

● The caregiving family may be fearful of birth family members. Some families who have had their children removed may behave in a hostile, sometimes irrational manner. Birth parents may at times have substance abuse problems or mental illness, which may make it difficult to predict their behavior. Parents may have been convicted of serious offenses or crimes. It may be difficult for caregivers to discern when birth parents are simply acting out their anger or frustration, or are dangerous. This must be fully discussed with the caseworker.

● The birth family's presence may, at times, interfere with the caregiving family's schedule, habits, traditions, or decisions. This may increase the difficulty of caregiving and contribute to disruption.

● The birth family may be jealous of the foster family and may believe the foster family can offer their child more than they can. The family may feel embarrassed and ashamed, and may worry that the children may not want to return home. They may respond by competing with the foster caregivers for the children's attention and affection.
### Handout #2

#### Myths and Realities

<table>
<thead>
<tr>
<th>Myth</th>
<th>Reality</th>
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<tbody>
<tr>
<td>Birth parents who abuse, neglect, or relinquish their children do not care about them.</td>
<td>Birth parents do not plan to abuse or neglect children. Maltreatment of children usually occurs following overwhelming stress. Parents who maltreat their children may, in fact, love their children dearly, but may not be able to cope with circumstances or may not know how to parent successfully. Furthermore, parents who voluntarily relinquish their children usually do so with tremendous ambivalence; they do not walk away from these relationships without significant, lifelong grief.</td>
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<tr>
<td>Most birth parents are violent, dangerous people who pose a threat to the foster families caring for their children.</td>
<td>Some birth parents have a history of violence or mental health problems that indicate risk for caregivers. Most birth parents, however, can build a collaborative relationship with foster or kinship parents that can be invaluable in the rapid reunification of the family. When the caseworker or foster parent is unsure about the level of risk posed by a birth family, relationships should be built with deliberate care along a continuum of openness, with the safety of the foster caregivers of paramount concern.</td>
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<tr>
<td>Foster families are expected to function as caseworkers or therapists for birth families.</td>
<td>Foster families may serve in key roles as mentors with birth families. When foster and birth families develop a partnership, this will be part of a total intervention plan developed by the child welfare team. The intervention planning will involve the foster parent and will spell out the expectations for the foster parents, when those interventions will occur, and why they are planned to improve the outcomes for the child.</td>
</tr>
<tr>
<td>Myth</td>
<td>Reality</td>
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<tr>
<td>The agency is &quot;setting up&quot; foster families to be hurt by dangerous</td>
<td>The agency will not expect foster families to place themselves at risk in working with birth families. The agency will always consider risks when developing a partnering plan for birth and foster families, and foster families will be involved in the development of the plan. Communication between foster and birth families may, at times, need to occur through an agency intermediary, usually the caseworker, to protect the safety of the child and the foster family.</td>
</tr>
<tr>
<td>birth parents.</td>
<td></td>
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<tr>
<td>Foster families are expected to work with all birth families of</td>
<td>Foster families are expected to communicate with the birth parents of all children. That communication may take many forms, depending on the characteristics of the birth family, the wishes of the foster family, and the stage of the developing relationship between the foster and birth families. Relationships may begin with a journal of the child's progress, move into telephone calls between the birth and foster parents, meetings during supervised visits at the agency, and eventually evolve into unsupervised visits at the foster or birth home prior to reunification.</td>
</tr>
<tr>
<td>children who come into foster care.</td>
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<td>Foster parents will be responsible for caring for the birth</td>
<td>The role of the foster parent is to provide a safe, temporary home for children who are unable to remain in their birth homes. Foster parents are part of a team whose primary goal is reunification. Visitation and communication are essential to achieving that goal. However, caring for the birth parent is not an expectation of the foster parent; it would actually be counterproductive to the development of adult, responsible behavior by the birth parent.</td>
</tr>
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<td>parents as well as the child.</td>
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Guidelines to Produce Positive Outcomes for Children and Their Families

Respect for one another--The primary team members must recognize that each member brings individual viewpoints, values, and culture to the team process. The primary care team should seek to utilize diversity to achieve benefits for the child.

Seek conflict resolution--The primary care team must be committed to resolving differences of opinion regarding the case plan or intervention strategies. Differences of opinion that do not affect the case plan are irrelevant to the case planning process.

Permission for honesty--The primary care team needs to set an atmosphere of honesty with one another regarding case goals and planning. Each member needs to be honest regarding the actual agenda for the case process. There must be freedom for members to explore the meaning of behaviors and words with one another.

Focus on the best interests of the child--The primary care team must agree to act in a manner that helps children. The primary care team must keep revisiting what is best for the children.

Communication--The primary care team must have established channels of communication that provide information in a timely and efficient manner.

The primary care team should:

- Be committed to using effective methods of communication
- Communicate their expectations through a well-written case plan
- Communicate clearly and document progress through the use of monthly reports
- Use journals that can be passed between the foster parent and the primary family to prevent miscommunication (these journals need to have some structure so they can be useful--materials concerning journaling are available at your local Regional Training Center).

Should the goal of the case plan change, the primary care team continues to plan for the best interest of the child. The actual caregiver may change as in situations of adoption and kinship care, but the primary family can remain involved in the planning process.
Handout #4

Anticipated Behaviors of Parents Whose Children Come Into Care

Shock or Denial

- The parent acts in a robot-like fashion, and does not display feelings.
- The parent agrees with the agency.
- The parent denies the need for services or evaluations.
- The parent avoids the agency professional or caseworker.
- The parent believes the paramour over the child’s allegations of abuse.

Anger or Protest

- The parent is verbally aggressive to agency caseworker, foster parents, or related professionals, and appears irritable when dealing with the system.
- The parent writes letters to the editor complaining about Children’s Services.
- The parent gets an attorney.
- The parent threatens to sue the agency caseworker or foster parent.
- The parents threaten to hurt the agency caseworker or foster parent.
- The parent tries to get the child to recant, sometimes using threats to the child or others in the primary family.
- The parent tells the child the placement is his or her fault.
- The parent criticizes the way the child is dressed.
- The parent destroys property of the child, foster parent, or agency.
- The parents tell the child not to listen to the foster parent.
- The parent complains about the agency.

Bargaining

- The parent promises to do anything necessary to get the children back.
- The parent promises to stop drinking or using drugs, or to get rid of a perpetrator in order to have the children returned.
- The parent is basically compliant.
- The parent requests more visits in exchange for completing part of the case plan.
- The parent calls the foster home at 2 a.m. to ask the foster parent the time of the visit the following day.
- The parent tells the child that he has to get better grades and do his chores before he can come home.
• The parent buys the child elaborate gifts.
• The parent promises unrealistic things to the child upon returning home.
• The parent compares himself to other parents to prove that they are not as bad as the other parents, or makes statements that the foster family does improper things and that they get paid to take care of the children.

**Depression**
(The following are symptoms of depression, whether the depression is caused by grief or other sources, such as chemical imbalances in the brain.)

• The parent forgets appointments or visits.
• The parent acts whiney or helpless.
• The parent exhibits little initiative or ambition.
• The parent sees everything as futile.
• The parent resumes or begins using alcohol or drugs (note: this behavior could appear at other stages).
• The parent seems to have unresolved or undiagnosed “somatic” complaints.
• The parent seems to take unnecessary risks or reverts to earlier harmful patterns of behavior, such as prostitution.
• The parent spends much energy that is misdirected or diffused.
• The parent begins steps to complete tasks but does not complete them.
• The parent seems irritable and may make suicidal gestures.

**Resolution and Acceptance**

• The parent fails to respond to the team after a period of apparent cooperation.
• The parent stops visiting.
• The parent does not show up for court or does not offer defense in court.
• The parent voluntarily moves to a home with too few bedrooms for the children.
• The parent sells the children’s beds or possessions.
• The parent gets pregnant.
• The parent marries someone with children.
• The parent makes statements such as “The children would be better off without me,” or “Look what an adoptive family can offer her.”
Handout #5

Symptoms of Chemical Use Progression

1. Experimentation
   - Users learn that chemicals make them feel good.
   - The degree of the good feeling is controlled by the amount of substance the users consume.
   - Users form “friendships” or “love relationships” with the chemical.

2. Seeking the Mood Swing
   - Users begin to look forward to the next time they can use.
   - Overall, users’ behavior is still appropriate; there are embarrassing moments but, compared to the high, “it was worth it.”
   - Users may experience a few hangovers.
   - Users would not be overly disappointed if a situation arose in which chemicals were unavailable.
   - If anyone raises concerns about their use, users rationalize the concerns away.

3. Misuse and Abuse
   - Users’ tolerance increases (more chemical is needed to feel any positive effects).
   - The emotional price for chemical use is increasing.
   - Users often use to relieve feelings of guilt, fear, and anxiety (originally brought on by chemical use).
   - External consequences often follow an episode of using.
   - Deterioration in many areas of life (socially, physically, intellectually, and spiritually) although the users may not recognize the changes.
   - Users are preoccupied with the next chemical use (may spend more time obtaining, using, and maintaining supply).
   - Users begin to break promises and compromise morals (loss of control begins).
   - Users rationalize use by blaming others, having excuses and alibis, and by being defensive about use.
   - Users believe own excuses “next time will be different.”

4. Addiction and Chronic Dependency Stage
   - Users are depressed nearly every day, chemical use no longer makes them feel high.
   - All of the symptoms and feelings in the harmful stage are intensified.
   - Use is necessary to feel normal.
   - Users may have physical problems related to chemical use.
   - Users are emotionally, physically, and spiritually sick (may have faulty memory and impaired judgment).
   - Urgency to use chemicals is increased.
   - Chemical tolerance may go down (due to deterioration of the body).
   - Users often have paranoid thinking (high anxiety, feels hopeless, isolated).
   - Users experience a complete loss of control.
Chemical Abuse vs. Dependency

social use – The use of any drug or combination of drugs in social situations, or for social reasons. If such social use causes harm, physical or otherwise, to the user or others, it is also considered abuse.

Binge drinking – Periodic heavy use of alcohol (five or more drinks consumed on the same occasion, at least one day in the past 30).

Substance abuse – The characteristic feature of abuse is the presence of dysfunction related to the person’s use of alcohol or other drugs. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association for diagnosing substance abuse and mental health disorders, substance abuse is a “maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of a variety of possible symptoms or impairment, including failure to fulfill major role obligations, recurrent use in physically hazardous situations, substance related legal problems, continued substance use despite having persistent or recurring social or interpersonal problems related to substance abuse.” (DHHS 1999, pp. 11-12, DSMIV pp. 182-183).

Addiction or chemical dependency – A disease in which the substances have caused changes in the person’s body, mind, and behavior. The DSM-IV distinguishes dependence from abuse primarily by the presence of more abuse symptoms (three or more, rather than at least one), and the possible presence of tolerance (needing more of the substance for the same intoxicating effect) or withdrawal (physical symptoms when the substance is not used) (DHHS 1999, p. 12).