CASE 1.

Jeremy is a 4 year old child who has been in foster care for 4 months with a seasoned foster parent. She called because his behavior is out of control and she is considering asking the caseworker to remove him.

History: When he entered the home, he was relatively quiet the first few days. After the first visit, he threw a tantrum that started at the end of the visit and lasted for over an hour. He does not sleep much. Foster mother has trouble getting him to go to bed, stay in bed and stay asleep once he falls asleep. She keeps a baby monitor in his room so she can hear him in case he starts wandering at night. He shares a room, and often arouses the 6 year old he shares the room with, so now that child is always tired. Jeremy throws things, breaks them, is aggressive toward the foster parent, the 6 year old, children in his childcare setting, and the adults there. He purposely breaks things. The foster parent notes that he has several tantrums a day, especially when he cannot have his way. He has been suspended from two childcare settings and foster mother, who works, cannot stay home with him. He is very hyperactive and has no sense of danger so she has to watch him every minute. He does not think before he acts—is very impulsive. He is very easily frustrated. Some of the other kids at childcare are afraid of him. Sometimes he seems spacey but other times he just goes off with no provocation.

What else do we want to know?

Past medical history: full term, maternal THC, cocaine abuse during pregnancy, no prenatal care, did well in newborn nursery, went home with mom from nursery, hit and miss f/u with pediatrician; history of elevated lead at age 2 yrs; history of iron deficiency anemia as toddler.

Development: behind in all but gross motor on ASQ

Psychosocial history: maternal substance abuse, domestic violence, father now in jail, multiple caregivers prior to foster care, home unsafe, mother left unattended on several occasions per neighbors. Two older siblings live with grandmother who just could not manage his behavior. He lived with his grandmother and two siblings on and off over the last year but grandmother often had to give him to another caregiver for a time because he was so out of control. Everyone denies physical abuse and sexual abuse, but domestic violence has been a major issue with multiple police calls to mother's home.

Visitation: twice a week supervised for one hour. Mom shows up most of the time, but sometimes says hurtful things. Last week, she told him that it is " his fault that he is in foster care". Gets picked up at childcare by medical motors and dropped back after the visit. Mom often cuts visits short or spends significant time discussing issues with child welfare. His mother brings lots of junk food to visits. He does not visit with siblings or grandmother. The judge has now ordered visits with dad at the jail even though dad has not seen him in 3 years. The first one was yesterday. The caseworker took him and said it did not go well.

Allergies: None

Medications: Started on Benadryl to help with sleep but does not help. Former doctor thought he had ADHD.

Discipline: Puts on time out when has tantrums or becomes aggressive. He won't stay there so becomes a battle. Uses a lot of video time because it is the only time he will sit for a few minutes.

Child's strengths: He seems pretty bright to the foster mother, and he can be very loving when he is in a good mood. He is pretty mechanical. He likes to pretend sometimes.

What are we going to do? HEALTH ASSESSMENT

Issues contributing to his behavioral issues: multiple losses, adverse childhood experiences, developmental delays, insomnia.

Trauma: ACE questions—what is his trauma score? Assume that he has a pretty significant history of chronic neglect and attachment disorder based on his behaviors. We may never know the full extent of his issues because the adults in his life may not disclose. DV, caregiver MH problems, dad in jail, caregiver losses, neglect, unknown if physical abuse or sexual abuse, but probably emotional abuse. (ACE>4).

Physical health: growth parameters, lead, hemoglobin, check hearing and vision and any sign or symptoms of chronic illness. Consider a sleep study although probably will not be of much help

Developmental assessment: Global delays except for gross motor so expectations might exceed his capacity; if he is bright but lacks the language, he may in fact be very frustrated.

Mental health: Needs assessment for PTSD (insomnia, impulsive, hyperactive, spacey, goes off without provocation, prolonged tantrums) by trained mental health professional although ADHD, anxiety, depression, ODD, Disruptive behavior disorder of childhood are all on the differential diagnosis list. What is probably not on the list are bipolar disorder and conduct disorder—he's too young to diagnose.

Plan: Reminder: Children are doing the best they can.

Obtain as much information as possible: talk with childcare providers, mother, grandmother, and foster mother.

Childcare: He may need to be with younger kids in a small group in childcare/educationally based program.

Visitation: Assumes you have child-friendly visitation space. Move to a coaching or PCIT/CPP model. Have mother call ahead/arrive and then transport him ideally by foster parent, caseworker or same mm driver every time. Schedule during his good times (avoid nap-time, before lunch etc.). Practice positive parenting with parent during visits. Praise the parent when they are doing well. Teach parent how to play with or read to their child. Plan a fun outing even if just to the playground.

Positive parenting strategies for caregivers, caseworkers, childcare providers:
Time in, reading, child-directed play, one on one. Distraction. Catch him being good and be specific about what that behavior is. Ignore negative behavior unless it is unsafe. ROUTINES.

Prepare him for transitions (such as visits): send a healthy snack, have him draw a picture for mom or caseworker, send a transitional object (blanket, stuffed animal or toy), tell him you will see him when he gets back. Re-entry: ideally in foster home but if returns to childcare, someone should greet him and spend some one-on-one fun but quiet time with him. If very motoric, may want to take him out to playground for about 15 minutes and then transition in. Have clear but reasonable limits. Family time. Do fun things like cook together—make some cookies or cupcakes. Teach about everything. Time-put is the last resort for a traumatized child and you might better want to sit with the child without words but with empathy. If caregiver is getting upset, should take their own "time out" or call someone.

Developmental: if behind, needs a CPSE referral and an education program. Talk with providers re trauma history, behaviors and strategies use to help this child.

Sleep:. Own room ideally. Quiet, dark spot, can use a night-light if scared. Have a bedtime routine that is quiet and predictable—triggers the body to be tired—(could lay out clothes for next day) bath, pajamas, brush teeth, read a book, quiet chat, tucking in time, reassure child they are safe and you will see them in the morning, a hug to last the night. If gets up, take back to bed without a word. A special blanket or toy to sleep with. If ineffective after 2 weeks, try melatonin or Benadryl for sleep. Consider a sleep study. Speak with therapist re suggestions or whether possibly PTSD related.

Health: treat anemia, elevated lead or any other health issues.

Consider: genetics if syndrome appearance. Behavior management specialist. Trauma specific therapy. Developmental-behavioral pediatrics evaluation.