Developmentally-Sound Practice in Family and Juvenile Court

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Most children and adolescents in Family and Juvenile Court are affected by trauma, and at least half are struggling with learning disabilities, and all are limited by their childish thinking. Their relationships with family, their work with attorneys and other professionals, and their understanding of court proceedings are influenced by their reactions to maltreatment and loss, comprehension problems and immature thinking.

To represent a child in dependency hearings or a juvenile in delinquency hearings requires understanding how trauma, disabilities and immaturity are affecting that child's behavior. The lawyer will work with the child and family more successfully and encourage the provision of more effective services by understanding child and adolescent development: how separation from family, while done to protect the child, causes trauma that derails normal social, emotional and academic progress; how disabilities reduce a child's ability to digest what is happening to them and to communicate with others, which affects the child's adjustment in foster care and contributes to the adolescents' delinquent behavior; and how trauma, coupled with immature thinking, makes a teenager overreact in a threatening situation with tragic unintended consequences. The lawyer may not have clinical or special education training, but must know the effects of trauma, disabilities and immaturity in order, for example, to encourage positive visits with families in a dependency case or to recommend services that are likely to help keep a young person from re-offending.

Children and adolescents cannot be understood simplistically by their age or offense. Developmentally-sound practice in Family and Juvenile Court means seeing the complex and unique combination of trauma, disabilities and childish thinking behind the behavior of each child or adolescent. Court procedures and attorney-client relationships in dependency and delinquency hearings would be designed differently if we stood in the child's shoes: because of the effects of trauma, disabilities and childish thinking, children and teenagers are significantly compromised in the relationships that are crucial for them to develop normally. Families and foster parents should be informed about how children are traumatized by separation from family, which may compound the effects of maltreatment. Families and foster parents should be supported to work together to meet the child's need to feel safe, not just physically but from the sense of loss, fears and self-blame in his/her inner world. Some children require trauma treatment to recover from the trauma of separation from their families and of maltreatment. Without trauma-focused efforts of families, foster parents and therapists, children separated from the individuals they are attached to will be delayed, depressed, aggressive, limited in their academic progress, and affected in their relationships with adults and other children. Traumatized children--whether or not the loss and violence they have experienced has brought them to the attention of Child Protective Services—enter adolescence at risk of relationship and school problems that can lead to delinquency. The development of children and adolescents is further affected when they cannot comprehend like their agemates: children and adolescents who do not pick up on

cues correctly or are unable to sustain attention or organize themselves are at risk of behavior problems which contribute to multiple placements and arrest. Too often, trauma is viewed as the therapist's domain and disabilities as special education's responsibility, but these affect the thinking, behavior and relationships of children throughout every day.

Too often, courts apply a "typical child or adolescent standard," which does not give sufficient recognition to the substantial impairment of trauma and disabilities on youth in child welfare and juvenile justice. The normal thinking and behavior of most children/adolescents cannot be expected of the child who has been delayed by trauma and/or who has disabilities.

On the other hand, courts too often *fail* to apply a "typical child or adolescent standard," not recognizing that some behavior of children in foster care and delinquents is normal. For example, bedwetting by a child in foster care after a visit is common in children of the same age from divorced families after visits with their noncustodial parent. Another example is that a teenager's mistakes in thinking while with a group of inebriated friends involved in a fight where a victim is seriously injured could also be seen at high school parties where no arrests occur.

In this article, case examples are used to explain how trauma, disabilities and immaturity affect children and their families in dependency and delinquency cases. Familiarity with child and adolescent development research will help lawyers improve their relationships with children, adolescents and their families and recommend services that build on the strengths and meet the needs of traumatized, immature clients, many of whom have disabilities.

TRAUMA

To achieve developmentally-sound practice in Family and Juvenile Court requires recognizing that trauma in childhood causes disturbances of emotional regulation, social relationships, attachment, and communication. Trauma typically slows down development in children and can interfere with all aspects of the child's functioning. Traumatized children often have trouble concentrating in school, are fearful, and may seem emotionally detached. Children who have been abused or were not protected from violence often blame themselves and have trouble trusting others. "In the first years of life, the experience of trauma represents for children a loss of the developmentally appropriate expectation that their parents will protect them from harm. Young children rely on their parents for the consolidation of their sense of self, which is established through regulation of body rhythms, modulation of emotion, formation and socialization of interpersonal relationships, and learning from exploration of the environment. Each of these processes is disrupted when a child suffers a traumatic event or lives in chronic circumstances of traumatic stress."[1] Reactions to trauma may significantly interfere with the child's life, even in children whose symptoms do not meet the criteria for Post Traumatic Stress Disorder.

"Reactions [to trauma] vary at different ages because children understand and internalize the experience depending on their cognitive and emotional capacities…It is important to recognize that infants' and toddlers' reactions and behaviors resonate with

[1] Lieberman, Alicia and Patricia Van Horn, "Assessment and Treatment of Young Children Exposed to Traumatic Events" in Osofsky, Joy (ed). Young Children and Trauma. New York: Guilford, 2004, p. 112.

those of their caregivers. Even in the earliest phases of infant and toddler development, existing research as well as clinical reports indicate clear associations between exposure to violence and emotional and behavior problems…increased irritability, immature behavior, sleep disturbances, emotional distress and crying, fears of being alone, physical complaints, and loss of skills, such as regression in toileting and language. In addition, temper tantrums and clinging, manifested in inability to separate from parents or familiar caregivers, are common responses…Exposure to trauma, especially violence that impacts directly on the family, interferes with children's normal development of trust and later exploratory behaviors that lead to the development of autonomy."[2]

Recent research clarifies the connection among early trauma, attachment and the child's development of self-regulation: relationships mediate positive and negative feelings experienced by young children.[3] The child's "primary attachment relationship" models for the child how to regulate emotions, and when trauma affects the child's feelings, the attachment relationship is also altered.[4]

Over 500,000 children are in foster care in the U.S., nearly a third of whom are under 6. Since the reason they are placed in foster care is to protect them from maltreatment, the effects of loss on young children removed from home have been largely ignored. Children who are separated from their families are traumatized by disrupted attachments (removal from home); they may also have been affected by problems in the home prior to entering care. Children who are exposed to "disrupted caregiving" (separation from their families) are at risk for continued difficulty in emotional regulation and deficits in "social cognitive processing."[5] Disrupted attachments lead to irritability, protest, search for missing parents, clinginess to foster parents, anger when the parent returns, diminished appetite or food hoarding, disrupted sleep, and withdrawal in young children. Additionally, some children enter foster care with early attachment problems which make it difficult for them to accept comfort (and

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[2] Osofsky, Joy (ed). Young Children and Trauma. New York: Guilford, 2004, pp. 5-6

[3] Schore, Allan (2001) "The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health." Infant Mental Health Journal, 22, 201-269.

[4] Hinshaw-Fuselier, Sarah, Sherryl Scott Heller, Victoria T. Parton, Lara Robsinson, and Neil W. Boris, "Trauma and Attachment" in Osofsky, Joy (ed). Young Children and Trauma. New York: Guilford, 2004, p. 47. "…the impact of trauma on the developing child cannot be understood apart from the social and psychological resources available to buffer the effects of fearful arousal on the child's psychobiological functioning. In early childhood, the primary attachment relationship serves that function. Therefore, physiological and psychological responses to threatening events in early childhood can be understood fully only in reference to the quality of psychobiological regulation available within primary attachment relationships… New evidence suggests that the infant does not come equipped with a particular level of stress tolerance at birth that continues into the preschool and school years. Instead, the expression of the infant's general predisposition appears to be substantially under the influence of caregiver regulation. The sensitively attuned caregiver, able to navigate the pathway from heightened states of arousal to homeostatic recovery, shapes the infant's psychobiological response to environmental stressors, creating an infant who is able to tolerate challenges to his or her internal psychobiological milieu. Conversely, insensitive caregiver response to heightened infant arousal may promote dysregulated response to stress in the infant characterized by under- or overactivity in the stress response system. Sensitively attuned caregiver regulation effectively resets the infant's propensity to react to stressors with more enduring states of arousal. Therefore, these subtle regulatory events of early infancy shape the subsequent functioning of neuroendocrine stress response systems in enduring ways…the functioning of the attachment relationship over the first year…anticipates dual-level mechanisms embedded in the infant-caregiver relationship governing the regulation of fearful arousal in infancy, including both direct physiological mechanisms and intersubjective processes." Schuder, Michelle R., "'Hidden Trauma' in Infancy," in Osofsky, Joy (ed). Young Children and Trauma. New York: Guilford, 2004, p. 69-70.

[5] Price, J.M. & Landsverk, J. (1998). Social information-processing patters as predictors of social adaptation and behavior problems among maltreated children in foster care. Child Abuse and Neglect, 22(9), 845-858.

some show fearfulness, vigilance, and anxiety, which are symptoms of Post Traumatic Stress Disorder).

One of the reasons for the lack of consistent attention to the effects of trauma on children is that their reactions are so varied. A child's unique temperament frames his/her response to trauma: "...temperamentally reserved children may tend to respond to the trauma with internalizing behaviors such as affective numbing, social withdrawal, constricted exploration, separation anxiety and new fears. In contrast, very active and outgoing children may be more prone to respond with externalizing behaviors such as recklessness, temper tantrums, defiance and aggression. Young children are also likely to show a high co-occurrence of externalizing and internalizing symptoms, and may alternate periods of clingy and fearful behavior with episodes of anger and defiance. Young children's cognitive development is intricately connected with their social and emotional functioning. Traumatic experiences can derail the child's readiness to learn, either temporarily or for the long term, through such mechanisms as hypervigilance, constriction of exploration, aggression, generalized fears, and preoccupation with internal processes so that attention is deployed to the self rather than to the environment. The child's negative affect may in turn generate ambivalence, rejection, anger, and emotional withdrawal in the parents and caregivers, confirming the child's mistrust in others and reinforcing a psychological stance that interferes with the learning of healthier forms of adaptation."[6]

For too many children in foster care, it is assumed that placement in a loving foster home will be sufficiently therapeutic. Typically, unless they are diagnosed with acute Post-Traumatic Stress Disorder from sexual or severe physical abuse, they are not referred for trauma treatment. This ignores both the significant impact of disrupted attachment on most children placed in foster care, and the needs of families and foster families for guidance in responding to traumatized children. Many children require trauma treatment to support a return to normal development and reduce the likely continuing effects of trauma. Treatment should address withdrawal, aggression, increased arousal, numbness, anxiety, and attention problems that interfere with the child's ability to form satisfying relationships and make academic progress.[7]

Treatment should include guidance for families and foster parents. The therapist, the family and the foster parents work together to ensure the child's external and internal safety addressing fears of abandonment and problems with aggression in particular. It is not easy to care for the traumatized child in the foster home or during visits. Adults may minimize the child's feelings because they think the child is too young to be reacting to trauma or because their child's feelings of insecurity make them feel guilty or afraid

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[6] Lieberman, p. 115.

[7] "Anger management alone does not reach the level of the complicated emotional process ..'anger management' as the term implies helps children to manage their anger—but it does little for the profound unmourned losses…" p. 186. Webb goes on to indicate that some approaches to trauma treatment require training beyond the usual preparation of masters-level clinicians. In addition, important tensions among clinicians impact on treatment selection: the tension between empirically supported treatment and other therapies; the polarization between supporters of psychotherapy and advocates of pharmacotherapy in the treatment of traumatized children. "Culturally diverse children and adolescents are frequently misdiagnosed and improperly treated because of a lack of understanding of cultural differences. Children in foster care constitute a substantial and underserved pool of child trauma cases and more than half these children are from minority groups." Webb, Nancy Boyd, Working with Traumatized Youth in Child Welfare. New York: Guilford, 2005

themselves.[8] Furthermore, many parents of children in foster care have themselves been maltreated, which affects their perceptions of their children's needs. "Frequently, when a young child is traumatized, the parent or caregiver is also traumatized. Parenting under 'normal' circumstances is a complex process. The added stress associated with parenting traumatized young children as well as coping with violence as an everyday event affects both the parent's and the child's capacity to form healthy attachment relationships. Parents living in such circumstances may become depressed and unable to provide for their young children's needs. Further, parents who witness violence or are themselves victims of violence are likely to have difficulty being emotionally available, sensitive and responsive to their children."[9]

The following example illustrates a parent's struggle to understand her children's needs after the trauma of separation (and possibly trauma from her substance abusing lifestyle):

> Ms. R is the mother of Julia, age 5, and Jesse, age 3, who came into care after a drug bust in their apartment. Ms. R and her boyfriend went to jail, and she was released into a residential drug treatment program with a rule prohibiting family contact for the first 30 days.[10] Throughout the first visit, Julia clung to her mother and her sobs could be heard throughout the agency when they had to leave. When Jesse came into the visit he did not look at his mother, sat in the corner holding a toy truck but not playing with it,, and did not say a word. Ms. R was trying to comfort Julia but it was evident how distraught she was by Jesse's "rejection" of her. It was a miserable visit that ended with Ms. R in tears wondering how she could return the following week. The caseworker worried that Ms. R would get high because of the pain of the visit. The foster mother reported that both children had troubling post-visit behaviors: Julia had angry temper tantrums and Jesse wet his pants and hardly talked for days after the visit. The foster mother told the caseworker she did not think continuing visits would be good for the children.

No one prepared either Ms. R or the foster parent for Julia's and Jesse's responses to separation from their mother, which could have been predicted given their ages and temperament. Julia was an outgoing child, so her behavior was more aggressive; at her age it was not surprising that she expressed her love for her mother and protested her mother's loss at the end of the visit and in the foster home. Jesse's withdrawal fit his temperament, and his detachment from his mother is not an unusual part of grieving at his age; his regression in speech and toileting is typical of 3-year olds separated from their families. Active assistance for their mother in helping Julia and Jesse with their different responses to being separated from her would have reduced the negative effects

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[8] Osofsky, p. 7-8.

[9] Ibid, p. 4.

[10] This is not developmentally-sound and the court should insist that programs agree to have children brought to visit their parents immediately and regularly because of the harm of separation for children; where staff of the drug treatment program are trained in visit coaching, the parent will make faster progress both in focusing on the needs of the children by parenting sober and in drug treatment. Beyer, Marty. Visit Coaching. A manual published by ACS, New York City, 2004. See also Beyer, Marty, "Visitation as a Powerful Child Welfare Service," The Prevention Report, Spring, 1999.

of removal from home on them.[11]

Instead of assuming that Julia's and Jesse's behavior in the visit was primarily the result of poor parenting prior to entering care, the case worker should be trained to actively prepare their mother and foster parent for the children's reactions to separation from their mother.[12] Even the most skilled parent would be upset by Julia's and Jesse's reactions and without guidance might not respond any more effectively than Ms. R or the foster mother did. But as the research cited above demonstrates, it is crucial that both the parent and the foster parent recognize in a child's aggressive protest and uncommunicative withdrawal that he/she is feeling confused, unprotected, and out-of-control and provide consistent, loving reassurance. With active support such as visit coaching before and after each visit, their mother would have been able to respond more effectively to their needs and manage her own feelings and the foster mother would have been able to understand their behaviors and help them get ready for the next visit.[13] If active coaching for their mother and foster parent did not result in happier visits, involving a therapist to guide the adults and treat the children's trauma reactions should be considered.

Professionals working with children in foster care should insist that (a) the unique impact of the trauma on this child be understood and addressed; (b) the assumption that the child's poor adjustment is primarily the result of maltreatment be challenged; and (c) the child's reaction to separation from family be recognized.

The majority of delinquents have been traumatized, although frequently the juvenile justice system ignores the contribution of trauma to their behavior. Depression is a common reaction to trauma, but often is not diagnosed in delinquents: usually what is focused on in school and home is their problem behavior rather than their underlying sadness.[14] Aggression can be a defense against the helplessness common among traumatized children. Teenagers who have been abused often respond self-protectively like younger children when they feel threatened. They may have learned to rely on aggression for resolving disagreements. Traumatized children may not learn to soothe themselves and instead manage their anxiety with reflexive self-preservation.

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[11] "Trauma derails the child's developmental expectation that the parents will be effective protectors and may engender in the parents feelings of guilt and self-deprecation that interfere with their ability to help the child in the aftermath of the traumatic event…There is empirical evidence that the symptoms of preschoolers exposed to traumatic situations are predicted by their mothers' psychological functioning. It follows that enhancing mothers' ability to help their children cope with trauma should have a beneficial effect on the child's recovery." Lieberman, p. 123.

[12] Traditional supervised office-based visits common across the country are not developmentally-sound. Visit rooms are not homelike, toys are not age-appropriate, and families are angered by being under surveillance rather than encouraged to demonstrate their best parenting.

[13] See Visit Coaching by Marty Beyer for specific examples of how a visit coach would support Ms. R in seeing what Jesse and Julia needed from her and containing her sadness and guilt so she could respond patiently with the strong love she had for them.

[14] While moodiness and self-doubt are viewed as typical in teenagers, depression can be a serious, impairing disorder in adolescents. Cicchetti, D. and Toth, S.L. (1998). "The development of depression in children and adolescents." American Psychologist, 53, 221-241. Garber, J. and Horowitz, J.L. (2002). "Depression in children." In I.H. Gotlib and C.L. Hammen (Eds.), Handbook of depression (p. 510-540). New York: Guilford Press. An integrative model of adolescent depression incorporates the complex interplay among genetic, biological, cognitive, interpersonal, family and environmental factors and developmental challenges; family disruption contributes to negative self-image, poor relationships and maladaptive regulation of emotion and behavior. Hammen, C. and Rudolph, K.D. (2003), "Childhood mood disorders." In E.J. Mash and R.A. Barkley (Eds.). Child psychopathology (2nd ed., pp. 233-278). New York: Guilford Press.

Traumatized teenagers often abuse substances to numb painful feelings and memories. Even when they have been in the child welfare system prior to their arrest, typically delinquents have not received trauma treatment.

In one study, all but two of the 50 delinquents experienced severe trauma, including repeated abuse and/or death and/or abandonment since early childhood.[15] At least a third were physically abused (34%, 17 of 50) and a quarter were sexually abused (24%, 12 of 50). Ten of the 17 girls (59%) had been sexually and/or physically abused. Fifteen youth had been sexually or physically abused by parents/stepparents with substance abuse problems. The delayed development and depression associated with abuse and loss in these delinquents affected their relationships with peers and adults, lowered self-esteem, made some of them irritable and reactive, and contributed to substance abuse, which were factors in their offenses. Many of the youth had been depressed before the offense, and self-dislike, distorted thinking and unpopularity were associated with their depression. As Grisso noted, "chronic depression is frequently found in adolescents who murder. Yet clinicians often fail to identify depression in adolescents, partly because of the absence of classic signs seen in depressive conditions in adults. Depression in adolescents is more often represented by irritability, hypersensitivity to threat, and agitation--the very conditions that increase the likelihood of aggression (p. 237)."[16] One study found that 32% of delinquents had Post Traumatic Stress Disorder, in comparison to 3% or fewer in the overall child population.[17] Whether they meet the criteria for a diagnosis of Post Traumatic Stress Disorder or not, the experience of trauma affects the development of delinquents in many ways, including their fearfulness, feeling powerless, blaming themselves, functioning childishly and/or unpredictably, and using substances to numb painful feelings and memories.[18]

Because the majority of delinquents have been affected by loss and other trauma, usually without treatment, it is essential that courts understand how past trauma influenced the young person's behavior before and during the offense and how rehabilitative services can be designed to address the effects of trauma on him/her. When a delinquent has been abused, lost important individuals, experienced racism, been exposed to violence, and/or had a significant injury, we must ensure that their reactive responses, such as being flooded with anger from the past out of proportion to the present provocation, being self-protective when threatened, irritability, mistrusting others, perceiving others as hostile, and numbing feelings are not simplistically viewed as bad behaviors requiring punishment. The example of Daniel below illustrates how past trauma affected delinquent behavior and should be addressed with services, but because Daniel also had disabilities, his case study follows the next section.

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[15] Beyer, Marty, "Fifty Delinquents in Juvenile and Adult Court." In press, American Journal of Orthopsychiatry.

[16] Grisso, T. (1996). Society's retributive response to juvenile violence: A developmental perspective. *Law and Human Behavior, 20,* 229-248.

[17] Steiner, H., Garcia, I.G., & Mathews, Z. (1997). Posttraumatic stress disorder in incarcerated delinquents, *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 3357-3365

[18] Giaconia, R. M., Reinherz, H. Z., Paradis, A. D., & Stashwick, C. K. (2003). Comorbidity of substance use disorders and posttraumatic stress disorder in adolescents. In P. Ouimette & P. J. Brown (Eds.), *Trauma and substance abuse* (pp. 227-242). Washington, DC: American Psychological Association.

DISABILITIES

As many as half of children in foster care and delinquents have learning disabilities, in comparison to less than 10% in the overall child population. Children and adolescents with learning disabilities are typically challenged by digesting information, comprehending, attending, and organizing. When a child or adolescent does not take in what is communicated by others or cannot concentrate or organize him/herself effectively, their relationships with family, peers, teachers and other professionals are different from those of children who do not have disabilities. Often they have normal intelligence and sometimes they cover up the reading, writing and arithmetic delays caused by their disabilities, but not comprehending and being unable to attend or organize are significant risk factors outside of school Below are the common disabilities that children in the juvenile justice and child welfare systems exhibit:

1. Problems Processing Information

Children with visual processing problems may not be able to comprehend what is written and have to rely instead on cues from what others say. Children with auditory processing problems may not be able to process what they hear; they learn primarily from what they read or observe.

2. Executive Function Deficits

Children with executive function deficits have problems with goal setting, self-regulation, and substituting more adaptive behavior for habitual negative actions.[19] Being unusually disorganized means that they have problems conceptualizing what is required to complete tasks, even those they have done before, including homework or chores. Not being able to "get their act together" causes peers to ostracize them; adults resent being relied on by a youngster who they think should be old enough to get ready for an activity with the right materials or equipment.

3. ADD & ADHD

Attention deficit disorder (ADD) and attention deficit hyperactivity disorder (ADHD) are the most frequently diagnosed behavior problem of childhood. Distractibility and impulsiveness are prominent characteristics of attention deficit disorders, making these children less able to stop behaviors that are difficult for themselves and others. Studies consistently find that medication can reduce distractibility, with little improvement in the social problems common among children with ADD and ADHD.

4. Language

Speech and language evaluation may uncover expressive and receptive language disorders in children and adolescents which contribute to relationship problems and academic failure. Frequently, children with behavior problems have never been assessed for expressive and receptive language disorders. Even less recognized are the

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[19] Pennington, B.F. & Ozonoff, S. (1996). Executive functions and developmental psychopathology, *Journal of Child Psychology & Psychiatry*, *37*:51-87.

comprehension struggles of children who live in homes where English is not spoken. They may receive ESL services if they enter school after immigrating, and some school systems offer bilingual special education. But it is not uncommon for bilingual services to end in the middle of elementary school, when reading and writing in English become increasingly demanding. High rates of elementary and middle school truancy among Latino delinquents is often blamed on their families not supporting educational achievement, when in reality this truancy may be caused by the stress of school failure because of an unrecognized language barrier.

By the time the learning problem is identified, many children are lacking in basic skills necessary to comprehend schoolwork. Learning problems also affect the child outside of school in significant ways. Often the learning disabled child gets into a negative cycle with self-dislike and attention-seeking behaviors which interfere with relationships at home and with peers.

The following example illustrates how trauma and disabilities can cause developmental delay and affect behavior:

Daniel says “everything changed” in his life when he was 6 and his mother died. He and his older brother were separated and lived with different relatives because their father traveled for work. Daniel was sexually abused by an older cousin with whom he lived (this abuse was not reported to Child Protective Services). He was also exposed to pornography in their home. At age 9, Daniel returned with his brother to their father, who had remarried. After his third change in schools, in fourth grade he was still reading at the first grade level and being teased by other kids for being a “retard.” His family did not recognize the severity of his disabilities and considered him “slow” and “childish.” His stepmother had not parented before and found his older brother’s high school acting out difficult to manage. When a new baby was born, Daniel was devoted to her but he received even less attention. He felt lonely after his older brother left home after conflict with their stepmother.

Daniel was arrested at age 13 for having sex with his 12-year old neighbor. To assess what services would help him requires understanding the complex weaving together of Daniel’s severe disabilities, his immaturity, and the effects of trauma. Daniel is a small, depressed youngster functioning below his chronological age. He is severely disabled by reading problems and an unusual limitation in his literal understanding which constricts what he comprehends, what he talks about, and how he approaches problem-solving. He is unaccustomed to labeling his feelings, which also compromises his communication. In detention, Daniel finally got an assessment of his learning disabilities. At age 13, he was reading and doing arithmetic at the third grade level and had severe information processing and attention problems. He had an IQ of 84 (verbal-78 performance-94), but he struggled to understand questions. He showed the uneven performance typical of children with attention deficits, with lapses of attention worsening during each task and an inability to slow down to reflect more carefully on difficult items. The evaluator concluded, "Learning and attentional deficits like these are not confined to the classroom as many people think, but spill over into all aspects of one's everyday life...attentional deficits interfere with the intake and processing of social information, causing confusion and disorganization in non-school contexts."

In detention, a meeting was convened with Daniel, his father, stepmother, and brother, the probation officer preparing a report for disposition, the educational evaluator and mental health staff from detention, and a community-based service provider. An important purpose of

the meeting was for Daniel to participate actively in identifying his strengths and needs, making it more likely that he will be committed to making improvements in his life. In this meeting, instead of getting stuck on his deficits, everyone worked together to look behind his behaviors to understand the unmet needs driving them:

DANIEL'S STRENGTHS

A good artist
A hard worker in school & chores
Takes care of his sister and is close to his brother

DANIEL'S NEEDS (age 13)

Daniel needs to do something good with his art work
Daniel needs to not feel stupid in school
Daniel needs to learn to pay more attention to cues from others
Daniel needs to make peace with the loss of his mother
Daniel needs to feel that he is not bad because of the abuse
Daniel needs to learn what to do with his sexual interests
Daniel needs to have friends who are doing positive things
Daniel needs to learn how to understand and follow directions
Daniel needs to learn how to express his feelings and thoughts
Daniel needs to learn techniques to lengthen his concentration

Like most first offender juveniles charged with sexual behavior, Daniel would be rehabilitated effectively in a program in the community.[20] In addition to understanding his sexual feelings and learning acceptable sexual behavior, Daniel's needs must be met through trauma treatment that includes his family so he can recover from his past losses and victimization. Moreover, he requires an improved special education program that teaches him how to compensate for his disabilities. His family requires coaching in how to parent him given his comprehension and attentional deficits. While his sexual behavior is likely to change in a treatment program, he will remain at risk of future non-sexual offending if he does not learn to comprehend more, pay attention better, feel successful in school and art, and have positive friends. These are achievable with services that are specifically tailored to meet his needs. To ensure that these services are provided, the court must be informed about two critical issues: 1) how the trauma of his mother's death, separation from his father, sexual abuse, and absence of his brother affected Daniel's behavior and what services would help him recover from that trauma and help his family support him and 2) how his difficulties with comprehension and concentration affected Daniel's behavior at home and with peers and what services would help him compensate for these disabilities and help his family support him.

IMMATURITY

While it is common knowledge that child development is a gradual process of expanding motor skills, speech, social abilities and academic skills, adults often expect more of a child based on his/her chronological age than is realistic given where he/she is

[20] Judith Becker and John Hunter, "Understanding and Treating Child and Adolescent Sexual Offenders," in Advances in Clinical Child Psychology (vol. 19), Ollendick and Prinz, ed., 1997.

developmentally. Especially for the child in foster care who is delayed because of trauma and who has disabilities, which affect comprehension, concentration, and social relationships, abilities typical of his/her chronological age cannot be expected. Early intervention for speech and motor delays is often provided for children in foster care. Far less common are services designed to enhance social skills, which are especially problematic for children in foster care who have withdrawn or aggressive reactions to trauma. Children of color are frequently negatively labeled as "behavior disordered" rather than provided with individual assistance to reduce their oversensitivity to perceived hostility.[21] Urging a trauma-informed response by teachers, families, foster parents and other professionals to the needs of the delayed, aggressive child in foster care could help reduce the disproportionate confinement of children of color in the juvenile justice system.

Families with children in foster care complain that parenting classes are pointless because they are too general and not practical—the parenting instructor does not see them with their children and in the class they do not learn about their own children's needs. Applying child development in a practical way with families as they get ready for visits with their children is not usually offered by the agency. Not only is the family unprepared for the children's reaction to separation described in the Julia and Jesse example above, but they are not helped with developmentally-sound planning for visits. For example, if the parent of a 4-year knew that children of that age may be very rigid about routines for no apparent reason, or that a 6-year old is just moving out of the hitting phase common in kindergarten, or that 8-year olds have the ability to "get" simple jokes and tell them endlessly, they could plan their visits accordingly by expecting those behaviors. The concepts that children love to show off their new skills and respond much more to praise than criticism could improve parent-child visits if families were helped with practical applications of such child development information. Visit coaching is a method of building on family strengths to support families in identifying what each of their children need from them and meeting those needs during visits; visit coaching also helps the parent containing their anger and sadness, which often compromise traditional supervised visits.

Families and foster parents are often not informed about remediation for the child's delay. Just as it is crucial to involve the family and foster family in trauma treatment, their inclusion in the early childhood intervention session or in observation in the classroom is essential to help them recognize their child's unique strengths and learn what they can do in the foster home and during visits to help the child catch up developmentally.

Applying adolescent development findings to teenagers in foster care or the juvenile justice system occurs surprisingly infrequently. Teenagers in these systems are often blamed for behaviors that are normative for middle school and high school students.[22] The immature thinking of adolescents was thoroughly presented in a

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[21] Dodge, K.A. (2003). Do social information processing patterns mediate aggressive behavior? In B. Lahey, T. Moffitt, & A. Caspi (Eds.), *Causes of conduct disorder and juvenile delinquency* (pp. 254-274). New York: Guilford Press.

[22] Beyer, Marty. "What's Behind Behavior Matters: The Effects of Disabilities, Trauma and Immaturity on Juvenile Intent and Ability to Assist Counsel," Guild Practitioner, 58:2, Spring, 2001.

persuasive brief to the Supreme Court in *Roper v. Simmons (*the 2005 opinion against the death penalty for juveniles) by the American Medical Association and the American Academy of Child and Adolescent Psychiatry, along with other organizations:

> "Older adolescents behave differently than adults because their minds operate differently, their emotions are more volatile and their brains are anatomically immature...These behavioral differences are pervasive and scientifically documented… Their judgments, thought patterns, and emotions are different from adults, and their brains are physiologically underdeveloped in the areas that control impulses, foresee consequences, and temper emotions. They handle information processing and the management of emotions differently from adults."

The AMA brief went on to summarize how brain development explains immature thinking in teenagers:

> "Brain studies establish an anatomical basis for adolescent behavior. Adolescents' behavioral immaturity mirrors the anatomical immaturity of their brains. To a degree never before understood, scientists can now demonstrate that adolescents are immature, not only to the observer's naked eyes, but in the very fibers of their brains…First, adolescents rely for certain tasks, more than adults, on the amygdala, the area of the brain associated with primitive impulses of aggression, anger, and fear. Adults, on the other hand, tend to process similar information through the frontal cortex, a cerebral area associated with impulse control and good judgment. Second, the regions of the brain associated with impulse control, risk assessment, and moral reasoning develop last, after late adolescence…as teenagers grow into adults, they increasingly shift the overall focus of brain activity to the frontal lobes…[which are responsible for] decision making, risk assessment, ability to judge future consequences, behavioral inhibition, impulse control…and making moral judgments. Adolescents are inherently more prone to risk-taking behavior and less capable of resisting impulses…Adolescents as a group are risk takers [and]… exhibit a disproportionate amount of reckless behavior, sensation seeking and risk taking…it is statistically aberrant to refrain from such [risk-taking] behavior during adolescence. In short, teenagers are prone to making bad judgments. Cognitive experts have shown that the difference between teenage and adult behavior is not the adolescent's inability to distinguish right from wrong…Rather, the difference lies in what scientists have characterized as deficiencies in the way adolescents think, an inability to perceive and weigh risks and benefits accurately…"

The delinquent offenses of many teenagers demonstrate the inadequate risk analysis skills and poor judgment described in the AMA brief.

The AMA brief went on: "Adolescents score lower on measures of self-reliance and other aspects of personal responsibility, they have more difficulty seeing things in

long-term perspective, they are less likely to look at things from the perspective of others, and they have more difficulty restraining their aggressive impulses." This immature thinking affects many juvenile offenses because teenagers do not anticipate the consequences of their actions and have difficulty weighing choices in a rational decision-making process. In situations where adults see several choices, teenagers may believe they have only one option. Often adolescents are incapable, because of immaturity, to see any way out except a desperate action that shows poor judgment and violates their moral values. Furthermore, most teenagers' decision-making is compromised when they are scared (especially if they were previously traumatized). They typically react to threat that adults consider exaggerated. Their fear has to be evaluated from the child's perspective at the time, not an outsider's assessment afterwards.

The AMA brief continued: "Researchers have found that the deficiencies in the adolescent mind and emotional and social development are especially pronounced when other factors—such as stress, emotions and peer pressure—enter the equation. These factors affect everyone's cognitive functioning, but they operate on the adolescent differently and with special force. The interplay among stress, emotions and cognition in teenagers is particularly complex—and different from adults. Stress affects cognitive abilities, including the ability to weigh costs and benefits and override impulses with rational thought. But adolescents are more susceptible to stress from daily events than adults, which translates into further distortions of the already skewed cost-benefit analysis." Many teenagers experience overwhelming pressure in school, at home, and with peers before their offenses which further compromised their decision-making.

The AMA brief went on: "The typical adolescent is also more vulnerable to peer pressure than an adult…Adolescents spend twice as much time with peers as with adults. The pronounced importance of approval and acceptance by friends will make an already risk-prone or impulsive adolescent even more so. Adolescents not only are more susceptible to peer pressure, but they gravitate toward peers who reinforce their own predilections…an adolescent who spends time with risk-prone friends is more likely to engage in risky behavior." Many male delinquents' offenses are committed in groups, typically under the influence of alcohol or drugs. Often girls are charged for offenses older males involved them in, which is not surprising given the worries about abandonment and disconnection that dominate adolescent girls' thinking.[23]

The AMA brief described how trauma further impairs teen functioning: "Normal adolescents cannot be expected to operate with the level of maturity, judgment, risk aversion or impulse control of an adult… an adolescent who has suffered brain trauma, a dysfunctional family life, violence, or abuse cannot be presumed to operate even at standard levels for adolescents."

The following example of a delinquent reflects aspects of poor risk analysis, reactivity to fear, overwhelming stress, and peer influence described by the AMA and

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[23] Brown, L. and Gilligan, C., Meeting at the Crossroads. Ballantine: New York, 1992. Girls are especially at risk during physical maturation and school transitions and may develop enduring negative self-evaluation.

demonstrates the combination of trauma, immaturity, and disabilities that help us understand her behavior:

"Marissa" is an outspoken, poised 16-year old born in Puerto Rico. Her mother, who had been sexually abused by her father and was battered by her husband, left her children to work on the mainland. When she and her older siblings were sent to their mother, Marissa adjusted poorly. She did not have an attachment to her mother; she was not placed in a bilingual program in school. Marissa and her sister were physically abused by their mother and sexually abused by their brother and their mother's boyfriend. By age 9, Marissa had her first in a series of suspensions from school for fighting; her mother said she could not control the children, all of whom were prescribed Ritalin. Her mother worked evenings and sent the children to their aunt, but Marissa felt picked on by her aunt.

At age 12, Marissa began associating with older males in the neighborhood, sleeping until noon, and getting high. She failed 5th grade and was expelled in 6th grade for having marijuana in school. A psychological evaluation reported that Marissa had an IQ of 64 (testing was done in English only) and recommended special education for learning disabilities and residential placement: "She is anxious, insecure, and socially immature. She adopts a streetwise demeanor to fit in and be accepted. She is extremely needy for emotional nurturance and is vulnerable to being taken advantage of." Marissa was put on probation for truancy and was placed in a program after violating probation by being truant again and staying out after curfew. At age 14, she was reading and doing math at the 7th grade level but did not understand her learning disabilities. Marissa was prescribed Depakote for Bipolar Disorder and Adderall for ADHD. After six months she was returned to her mother and soon ran away because of conflicts at home and went off her medication. She was incarcerated and was moved after fighting with a peer. In her next program, when she was physically restrained while being taken to the time-out room, Marissa hit a staff person so hard she required medical treatment.

Charged with assault at 16, she ended up in a therapeutic group home where the director wrote, "the changes in Marissa's behaviors are amazing. She has been compliant with directions. She has been participating appropriately in groups. She has been a positive leader on many occasions. Marissa's behaviors have changed so much that she was Citizen of the Week this past week. We're not sure she's bipolar or ADD after all." Her therapist concluded that Marissa's reflexive reaction when she felt threatened came from anxiety from early attachment problems and abuse. Marissa said, "Now I'm really working on my problems. A person has to decide to change. I used to be the ringleader of negativity. Now other girls look up to me. My anger was my big problem. I used to let small stuff get to me. Anger can take over you. I had to learn to walk away if something makes me angry. I don't have to be the center of attention like before, but I still really like having one person to talk to. My relationship to my mother is a lot better." She said having a family therapist who drove her home and talked with her and her mother in their home made a big difference. Now school, friends, and not getting high are what she is focusing on. "I smoked weed to get away from problems, but it just makes your problems worse." She worries that she does know how to make positive friends. She wants a weekend job that she could start when she is on weekend home visits, and she hopes she will meet positive friends at work. Marissa wants to

finish high school and go to college, but she is afraid to go to regular school: "I'm too nervous to go to a big school. I have real problems in concentration. I'm getting all As in the small class here at the group home."

At age 16 in her state, Marissa is at risk of being prosecuted as an adult and going to adult prison if she is released without sufficient support and again reacts reflexively to threat with aggression. Her lawyer asked the family therapist at the group home to convene a meeting with Marissa, her mother, group home staff and teacher, her probation officer, and a girls' program in the community. They encouraged Marissa to speak up about what she wants for herself, and as a team they came up with the following:

MARISSA'S STRENGTHS

Articulate
Acts self-confident
Likes talking to people and helping others

MARISSA'S NEEDS (age 16)	SERVICES TO MEET HER NEEDS
• To continue to say when she is angry and think before acting	One-on-one encouragement to walk away before she explodes and to write in her journal Continued family therapy in her mother's home
• To learn how to soothe herself before her anxiety builds up	Trauma treatment to understand how loss and abuse in the past still affect her One-on-one instruction in relaxation techniques
• To have individual instruction to continue to overcome her reading problems	Continue in the group home class for the rest of the year while applying to another school Help to start a book group with a goal of reading one book a week
• To build on her personal skills and bilingual abilities for future job goals	One-on-one help to interview for a part-time job at a travel agency or a social service agency
• To find a friend at work to do positive activities with	One-on-one encouragement to avoid getting high, to improve her give-and-take in a friendship and to find other relaxing activities

Marissa's unique combination of trauma, disabilities and immaturity are addressed in this strengths/needs-based plan. The intensive home-based services designed to support Marissa in school, work and in making positive friends will include a trained one-on-one person working with her daily in conjunction with her therapist who will continue family therapy and begin trauma treatment. The group decided that a treatment foster home with one of the group home staff members would allow Marissa to continue at the group home school and start working. Her therapist will guide the foster parent and prepare her mother for Marissa's return in the future.[24]

[24] Burns, B.J., & Hoagwood, K. (2002). *Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders*. New York, NY: Oxford University Press. See also Chamberlain, P., & Mihalic, S.F. (1998). Multidimensional treatment foster care. In. D.S. Elliott (Ed.), *Book eight: Blueprints for violence*

In conclusion, developmentally-sound practice in Family and Juvenile Court requires that any professional working with a child in foster care or a delinquent considers how disabilities, trauma and immaturity are affecting the child's behavior and their relationships. By reaching agreement about the underlying needs driving the child's behavior, we can tailor supports for them in their families, foster families, schools and programs that will allow the child or adolescent to get back on a path of positive development.

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