

Families First

a newsletter for Nebraska Families

January/February 2019

N F A P A

Dark Enough: When Adoptive Families Struggle

July 3, 2018

By Minnette d'Ori

The relationship with Rebecca, my adopted 15-year-old daughter, is in a winter season. The terrain between us has changed from a safe testing ground into an icy, windswept tundra of distrust. It feels as though nothing can thaw the frozen caricature of our happy family picture.

Alone, I feel sadness for her; for us. She is a wounded little girl in a young woman's body. I feel tender and protective. When she's near, my skin wants to crawl off my body. My breaths get caught in my ribs. My face hardens and my muscles tense, ready for war. Sharp words cut deeply; I keep mine in a chokehold so only a few escape.

I have my faith, but Jesus is not what I reach for when fleeing is the only relief. Everything I do, think, feel or say is wrong when I'm with her. These captive words are knives tumbling inside my head and belly.

And then she walks out of the room.

I take a shuddering breath. The knives fall with a clatter inside me. Blood seeps from the interior cuts. Guilt rushes into the suddenly relaxed spaces in my body and vigorously rubs salt into those wounds. My heart weeps. I weakly vow to do better next time; vow to leave more room for grace.

How did we get here?

...

Paul and I married in 2006 and became foster parents in 2007. We strongly felt God's calling on us to provide sanctuary for children. In late 2009, Child Protective Services (CPS) placed 7-year-old Rebecca and her 15-month-old half-sister Alina with us as foster-to-adopt.

We officially became a family in March 2011. Ali was only 9 months old when she went into foster care, but Rebecca endured almost six years with her biological mother.

At 19 years old, their mother was pregnant with her first child, Rebecca. Street drugs only amplified her untreated depression and bipolar disorder, and her abusive boyfriend abandoned her shortly after Rebecca was born. She went on to have three more daughters with two other men in the next five years.

The girls were neglected in a home charged with static fear. Nothing was a given: meals, diaper changes, baths, a clear bit of floor on which to play. When a boyfriend was left in charge of the house, things got even scarier. The men were abusive in all ways.

When Rebecca was 6 years old, CPS had enough evidence to remove the children. Since Rebecca had a strong bond with her maternal grandmother, CPS initially tried placing the children with her. After a few months, it became clear that their grandmother was unable to meet the children's needs. CPS removed them again and divided them into three separate foster homes. Rebecca had multiple placements but eventually joined Ali and her foster family. A few months later, we got to meet them.

Rebecca stood close to her foster mom as we drove up to their house. Huge green eyes peered out from behind thick glasses, and a short bob made her head seem too big for her little stick body. Top teeth had gnawed her lower lip until it was raw and chapped. A too-wide smile stretched across her face. My throat instinctively tightened with fear; there was something wrong with her. Protective instincts roared up and smashed the thought. I introduced myself and invited her in for a gentle hug. She clung to me.

(Continued on page 3)



Nebraska Foster & Adoptive Parent Association

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Attention Foster Parents!

Earn Your In-Service Hours While Getting the Chance to Win a Great Prize!

Answer these 10 questions correctly and you will not only earn .5 credits toward your in-service hours, but your name will also be put in a drawing for a prize. For this issue we are offering a \$10 Walmart gift card.

There are a variety of ways to do this. You can email the information to Corinne@nfapa.org, send the questionnaire to the NFAPA office at 3601 N. 25th Street, Suite D, Lincoln, NE 68521 or you can complete the questionnaire online at <https://www.surveymonkey.com/r/JanuaryFebruary2019>. We will then enter your name in the drawing! We will also send you a certificate for training credit to turn in when it is time for relicensing. Good Luck!

The November/December 2018 newsletter had the wrong address listed for the in-service hour questions. The correct address for this issue is:

<https://www.surveymonkey.com/r/NovemberDecember2018>.

1. List 5 Things Most Parents of Kids Without Reactive Attachment Disorder Take For Granted
2. True or False. It was only through learning her diagnosis of RAD that I realized it wasn't about my parenting but about her trauma.
3. Fill In the Blanks. Recent studies show strong evidence of the connection between _____ later in life.
4. True or False. The National Institute of Health states that long-term psychotherapy has been shown to have less effect than medication.
5. Fill in the blanks. The turnover rate of foster parents ranges from _____ to _____%.
6. List the five stages of grief that you learned in class as well as discussed in this article.
7. True or False. Your response to your child's food insecurity can be the difference between a trigger or trust.
8. What can we do as foster parents to help our kids with food insecurities?
9. What are the four things doctors are looking for at an assessment in the emergency room?
10. If they still do not agree to hold your child, ask who is liable if your child makes a suicide attempt within the next 48 hours. You can also consider writing the words, _____ on the discharge papers before signing.

Name: _____

Address: _____

Email: _____

Phone #: _____

Families First Newsletter Issue: January/February 2019

Questions? Interested in becoming a member of the Board?

Call NFAPA at 877-257-0176 or 402-476-2273.

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(Continued from page 1)

Paul was immediately smitten with 15-month-old Ali, but she regarded us suspiciously. She protested when Paul took her from her foster mom's arms, but quieted quickly, studying his beard. She touched it and smiled, big hazel eyes meeting his deep brown gaze. Love at first tug.

...

Early on, the discord between Paul and Rebecca looked like shyness on Rebecca's part. Hoping therapy and love would change things over time, we kept her with the therapist CPS had chosen. Paul did everything he could to show her he loved her. Her gallant prince escorted her to the second, third and fourth grade father-daughter dances. He treated her to daddy-daughter dates at the State Fair, baseball games and chaperoned her field trips. He even volunteered to be the Girl Scout troop's cookie dad. Through it all she remained passive, never volunteering recognition, much less affection. Yet with me she was too clingy and dependent, always seeking my approval and attention.

When Rebecca was 8 years old and in second grade, she struggled so much with homework that we scheduled a neuropsychological evaluation. After a full day of testing, the results showed she had some lower scores in areas of logical problem solving but nothing alarming.

By the time Rebecca was 11 and in fifth grade, her avoidance and disinterest in Paul grew confrontational. At first it was small things; when reminded to do her chores, she reluctantly or partially did them. When Paul invited her along to the grocery store, where a treat was guaranteed, she declined. She also decided she didn't want to go to the father-daughter dance with him, which broke my heart.

As she entered sixth grade she began telling wildly improbable and easily disproved lies to everyone at the middle school, such as her classmate died of cancer yesterday. Or Rebecca herself has cancer. Or Rebecca missed school yesterday because she spent the night in the ER after stabbing herself in the stomach with a knife.

I quickly got on a first-name basis with the school counselor.

When I think back to my sixth and seventh-grade years, they were filled with exhilarating new freedoms; being allowed to ride my bike across town to a friend's house, or spending afternoons walking around our small downtown with a few friends. When we tried to allow Rebecca a few freedoms, she took advantage of our trust. Her lies caused such problems with her friends that we ended up apologizing to their parents. She fervently denied everything until cornered with the truth. Her world got smaller and smaller and damage control became our daily routine.

We held her accountable for her actions, and we never threatened consequences we wouldn't enact. She wasn't interested in striving for goals and rewards, even as she complained and blamed us for her restrictions. Frustrated, we found a new therapist, Theresa, who specialized in early

childhood trauma and its effects on brain development.

Rebecca saw Theresa through eighth grade. Things got worse at home and school. She went through circle after circle of friends, dropping quickly through the social rungs. Her behavior toward Paul became confrontational rage; soon his attempts at communication came to all but a complete stop. He literally couldn't say a word to her without her turning on him. I was afraid to leave her alone with him.

By November 2016 she was in the middle of eighth grade. Her behavior was so unpredictable and vicious toward Paul that I began to suspect Reactive Attachment Disorder, or RAD. I contacted our former social worker's department supervisor, another woman we'd worked with during the adoption, and presented my reasoning and research.

She assured me it could not be RAD because Rebecca had a strong attachment with both me and her maternal grandmother, as well as her former foster mother. She strongly recommended that I get her tested for Fetal Alcohol Spectrum Disorders (FASD) since many of the symptoms overlap with those of RAD. I promptly scheduled Rebecca for an FASD evaluation. All of her test results were in the normal range.

I felt frustrated and defeated. Everyone was telling me my child was normal when I knew something was terribly wrong.

...

It was August 2017, the summer before Rebecca started high school as a freshman. I came home from work as Paul was taking out some recycling. He found some of Rebecca's old school papers, half-burned, in the bin. Alarmed, we confronted her.

Rebecca initially lied to us about when and where she'd burned the papers, but eventually we found that she'd lit them on fire on top of the dry wood mulch approximately six inches from both our house and our wooden deck.

I immediately sent an email off to Rebecca's therapist and our former social worker. I stated that I didn't feel safe with her in our house anymore, and I didn't know what to do. The following week we were assigned a social worker who opened a case for us. She found a psychiatrist who would be able to do a full mental health evaluation on Rebecca, and CPS covered the cost.

The results showed symptoms of PTSD, major depression and anxiety, as well as poor coping skills for stress. It also showed she couldn't process emotions, resulting in her bottling them all up. She also tested with clear symptoms of attachment disorder, specific to father figures. Wait a hot minute — attachment disorder specific to father figures? My understanding of attachment disorder was that it was all or nothing, either a child could attach to caregivers or they couldn't. Since Rebecca was attached to me, did all of the mental health and social services professionals around her also assume she could attach to Paul? How did everyone miss something so crucial?

In January 2018, Rebecca's new attachment therapist Cheri

diagnosed her with Borderline Personality Disorder (BPD). BPD is not curable, but it can be understood and managed. According to the National Institute of Mental Health, BPD sufferers have an unstable self-image and their actions display that uncertainty about how they see themselves. Unsure of their worth, they will go to extreme lengths to avoid real or imagined abandonment. They also feel victimized by the world and have great difficulty taking responsibility for their actions. Therefore, by the very nature of the disorder, BPD sufferers are blind to their role in the troubles surrounding them.

Recent studies show strong evidence of the connection between insecure parent-child attachment and the increased possibility of developing BPD later in life. Unfortunately, it is difficult to treat. The National Institute of Health states that long-term psychotherapy has been shown to have more effect than medication. However, there is a growing body of evidence that suggests targeting specific symptoms of BPD with medication may be helpful (such as those prescribed to treat depression or anxiety). Whether medication is prescribed or not, BPD sufferers must be willing to become more self-aware and learn to regulate their emotions through techniques learned in behavioral therapy.

Ideally, we would have gotten Rebecca and Paul working together in attachment therapy the day she came to us. I didn't know that a child's attachment-related behaviors may be very different with one caregiver than with another. I also had no idea that the disorder lies within the relationship and interactions between the child and the caregiver, as opposed to existing as an aspect of the child's personality.

Rather than dwelling on opportunities missed, I choose to focus on the joy in our house. Ali is 9 years old and thriving in fourth grade. She loves Rebecca deeply, but knows how to disengage from her when Rebecca starts throwing verbal daggers. Paul and Ali are buddies. Since her first day of kindergarten, he has waited with her at the end of the driveway for the school bus every single morning. She talks to him easily about anything on her mind. I love spending time with Ali. Her creative storytelling and sense of humor slay me.

I hope our family's journey into the "dark enough" is redeemed by many other puzzled parents learning from our story and providing attachment therapy as early as possible. Collectively, we continue to do the hard, good work of holding brokenness together.

Names have been changed to protect the privacy of the children and family.

Minnette d'Ori (whose name has been changed to protect the privacy of her family) is a happily married, full-time IT professional in the upper Midwest. Her passion for child advocacy led her to become a foster parent 10 years ago, and an adoptive parent eight years ago. She hopes sharing her experiences can help other foster and adoptive parents.

Reprinted with permission from:

<https://chronicleofsocialchange.org/adoption/dark-enough-adoptive-families-struggle>

Foster Parent Retention: What are the Foster Parents Saying?

by Dr. John N. DeGarmo, Ed.D.

With the increase in the number of children placed into foster care across the nation, there has been at the same time a tremendous challenge, nationwide, of retaining foster parents. Indeed, the turnover rate of foster parents ranges from 30% to 50%. Thus, 30% to 50% of foster parents make the decision to no longer be a foster parent home for children in need. As a result, with the increase in children in foster care paired with the decrease in number of foster parents, the end result is simply that there are not enough homes for children in need to be placed in, or a child is moved from one home to another, and so on and so forth.

Just why is there a problem with retaining good foster parents? Why do so many agencies across the nation, both state funded and private, struggle with the challenge of foster parent retention? Over 400 foster parents from across the nation in 2016 took part in a survey conducted by The Foster Care Institute. The makeup of survey participants included a wide range of experienced foster parents. 8% of those surveyed had only been foster parenting for one year or less. 34% of foster parents surveyed had been fostering between 1 and 5 years. 29% taking part in the survey had been foster parents between 6 and 10 years, and an additional 29% had been caring for children in foster care in their homes for over 10 years.

One factor that stood out in the survey was the issue of feelings of grief and loss for foster parents. Perhaps not surprisingly, 80% of foster parents taking place in the survey have experienced feelings of grief and loss after a child from foster care had transitioned out of their home, with another 5% indicating that they were currently experiencing such feelings. Yet, despite the large numbers of foster parents who have experienced feelings of grief and loss, only 33% felt that they have enough training in this area. The remaining 67% indicated that they sometimes, rarely, or never have enough training in this area. Furthermore, 50% stated that they take enough time between placements of children in their home in order to grieve when a child leaves, with the other 50% indicating that they do not.

A number of foster parents addressed this issue when given the opportunity to freely comment. Some of these comments are below.

- Participant #3: "More training in grief. This is so hard."
- Participant #7 "The hardest part of being a foster parent for me is when my kiddos leave my house."
- Participant #10: "I wish my caseworker would understand that my heart literally breaks in half when the kiddos leave my home."
- Participant #31: "Taking the time our family needs to

grieve when our kiddos go home”

- Participant #57 “More training in grief and loss”
- Participant #72 “We learned the hard way how to take care of ourselves.”
- Participant #108 : More information on grief and loss after a child has left the foster parents’ home.

The topic of grief and loss is examined in full in the book *The Foster Parenting Manual: A Practical Guide to Creating a Loving, Safe, and Stable Home* (DeGarmo, 2013). Grief can be expressed in variety of ways, depending upon the individual, as it is personal. Some will shed tears and cry while others will hold it inside. Some will busy themselves in a task, while other will seem detached and far away. The departure of your foster child from your home can be one that is devastating to you and your family. A brief look at the stages of grief, based upon Kubler-Ross’ well known stages of grief established in 1969, is important in order to fully understand the feelings that may come along with the removal of your foster child from your family. These same feelings may be felt by your foster child when he is removed from his own home, and first placed in yours.

Shock

The removal of the foster child may bring feelings of shock to the foster family. After a family member has formed an emotional attachment to the family, the sudden removal may cause deep shock and uncertainty, leaving the foster family confused.

Denial

With a sudden departure, some foster parents may deny that they ever formed a relationship with their foster child, or feel any sadness towards the removal. Even though they deny these feelings, they grieve believing that they were unable to provide the help the child needed.

Anger

A foster child’s removal from a foster parent home may bring feelings of anger and severe disappointment with the caseworker, as well as with the child welfare agency system. Foster parents may blame the system or caseworker for the

placement of their foster child into an environment they feel is not productive, or even harmful to the child.

Guilt

During this stage, foster parents may experience feelings of guilt, blaming themselves with the belief that they are at fault, and try to comprehend what they did “wrong” in the removal of the foster child. Still, other foster parents may experience guilt if they were the ones asking for the removal, as they were

unable to continue caring for the child.

Bargaining

Some foster parents will try to substitute the grief they have with helping others in need, in an attempt to justify the loss of their foster child. Other will try to substitute the loss with the placement of another foster child in their home, hoping that this new placement will help them



forget about the child that just left.

Depression

There are different components to depression brought on by grief. Some foster parents will become easily irritated; others will experience a constant state of feeling tired. Others will feel as if they can no longer continue with their day to day lives, and have a difficult time with the tasks associated with family, friends, work, and marriage.

Acceptance

After the passage of time, the grief from the loss of the foster child decreases, allowing the foster parent to accept the removal of the child, and move on. The emotional well being of the foster parent improves, and a sense of understanding of the child’s removal becomes clearer.

According to the survey many of these foster parents feel they do not receive enough access to the resources and training they need when they are experiencing feelings of grief and loss. While 33% responded that they do receive enough resources and training, another 32% indicated that they only sometimes receive such training and resources. 16% indicated that they rarely receive the training and resources they need, while 18% stated that they never receive the training and resources they need while grieving the loss of a child from foster care in their home.

To be sure, continuing education for foster parents is

essential. Making the decision to being a foster parent is a difficult one. It takes incredible commitment, unconditional love, and patience. After you determined that you are ready to begin, there are long hours of training ahead of you before your first foster child is placed in your home, and becomes part of your family. These hours of training will go a long way in helping you prepare for the many challenges that await you as a foster parent.

A lack of support from their caseworkers and agencies during times of burnout may point to another factor in retaining foster parents. According to the survey, 44% of those foster parents participating indicated that they did not receive the support that they felt they needed from their caseworker or agency during times of burnout and stress while caring for children from foster care in their homes. Only 36% stated that they received the support from their caseworkers and agencies that they needed during that time, while 18% indicated that they had never experienced burnout.

When given the opportunity to answer the question, “What would help you as a foster parent?” a number of foster parents focused on support issues. Here is a sampling.

- Participant #17: “The problems I’m having are that my child’s caseworker rarely answers my emails or voicemails. They expect me to be able to drop everything at a moments notice for them. And when the last child was moved from my home to be with family I was given 24 hours to get his things packed.
- Participant #18: “I also feel that it takes too long to receive feedback from the people in charge.”
- Participant #21: Taking the time our family needs to grieve when our kiddos go home. Sometimes it feels hard to step back in to the chaos after a break
- Participant #24: More support and help in a timely manner when we needed to have a child removed and placed elsewhere
- Participant #34: Having the agency support what I do as a foster parent and listen to me.
- Participant #36: More training. I love everything to learn
- Participant #39: Cpc caseworkers following up in things and answering there (sic) phone
- Participant #43: The workers didn’t offer any help and the only reason the kids left is because we were burned out and requested removal because we couldn’t handle 5 mentally challenged (ADHD, bi polar) kids plus raise our toddler and still be functional. It was horrible.
- Participant #49: More support from case workers
- Participant #51: More information on grief and loss after a child has left the foster parents’ home.
- Participant #78: more training and more support Grief and loss resources, training, and understanding, as

well as issues of support are key issues in regards to retaining foster parents. As more children enter into foster care from across the nation, it is even more important that foster parents receive the resources, training and support they need as they care for children suffering from trauma and abuse. Next month, the Foster Care Institute shall examine the results about how foster parents view their relationships with caseworkers, and how this may affect foster parent retention.

Reprinted with permission from:

<https://www.fosterfocusmag.com/articles/foster-parent-retention-what-are-foster-parents-saying>

5 Things Most Parents of Kids Without Reactive Attachment Disorder Take For Granted

by Anonymous



My husband and I adopted Payton* when she was three-years-old. She had alternated living with her birth mother and grandmother the first three years of her life. This switching back and forth between two environments—one of neglect and drug exposure and the other of overindulgence—led to her development of reactive attachment disorder (RAD).

There are many things I took for granted before having a child with RAD. I assumed my own childhood experiences, as well as those of raising my two other children, would be the same for Payton. Anything different didn’t occur to me.

Here are 5 things most parents of kids without RAD take for granted every day:

1. Most children understand love.

Children born into secure, loving environments get their basic needs taken care of from birth. They feel loved and valued. They feel safe and trust the adults in their lives to care for their basic needs. This paves the way for them to understand love.

We don't think to question love because it is such an inherent concept.

I learned in the first few years of raising Payton that she didn't have a foundation of trust and love to build on. Her foundation was cracked. "Kids with RAD have brains hard-wired to resist parenting and love due to abuse and neglect before age 3," said Institute for Attachment and Child Development Executive Director Forrest Lien. "It is their instinctive way to protect themselves from further harm." We not only had to build Payton's foundation from the ground up—we had to tear down the faulty one.

2. Love can conquer many hardships in family.

When my husband and I began the foster-adopt journey, we thought our love would heal any damage caused by our child's previous experiences. We have learned since then that true love does not and cannot conquer all. We have learned the most important thing to Payton is our commitment to meeting her needs. This includes a strict schedule, affection on her terms, and accepting she loves us as best she can.

Kids with RAD have brains hard-wired to resist parenting and love due to abuse and neglect before age 3," said Institute for Attachment and Child Development Executive Director Forrest Lien. "It is their instinctive way to protect themselves from further harm.

3. Most children grasp empathy.

Empathy is defined as "the ability to understand and share the feelings of another." Even if children don't understand empathy, they generally start to display it by the age of two. You've seen empathy in a child when s/he offers their favorite blanket to someone who is sad or sick. My younger daughter experiences night terrors wherein she turns beet red, cries, and shakes until the terror passes. When Payton hears the screaming, she doesn't offer a favorite blanket; she complains her sister is being too loud.

4. Affection is generally easy for many kids.

My son and younger daughter are always willing to give me a hug. We're an affectionate family. Despite living with us for eight years, Payton only initiates affection if it's part of a routine. When she hugs us, she is detached and becomes uncomfortable if the hug lasts longer than a brief embrace. She is never truly engaged nor does she ever spontaneously exhibit affection.

5. While nobody is perfect, many parents feel they do a decent job most of the time.

Although I made mistakes and knew I wasn't a perfect parent, I did feel confident in my parenting abilities with my other children. When we adopted Payton, however, I began to question every choice I made as a parent because she was always disobeying and acting disrespectful. I'd ask myself if our rules were unreasonable. I questioned if I was being too hard on her. I wondered if my telling her to pick up her room

was too difficult a chore. It was only through learning her diagnosis of RAD that I realized it wasn't about my parenting but about her trauma.

I have learned not to take anything for granted with Payton. When she spontaneously told me she loved me a couple summers ago, I rejoiced. While it has never happened again, I'll always cherish that moment. When she was able to identify her tantrum was triggered by sadness, I was proud of her maturity and willingness to share her feelings with me. When she cried the first day of kindergarten because she didn't want me and her father to leave, I felt hope that she was starting to heal.

And hope for my daughter is the one thing I will never take for granted.

*pseudonym to protect identity

Reprinted with permission from:

<https://www.instituteforattachment.org/5-things-most-parents-of-kids-without-reactive-attachment-disorder-take-for-granted-every-day>

Nebraska Child Safety Restraint Law Following Passage of LB 42

Current Law (effective through December 31, 2018)

All children up to age six must ride correctly secured in a federally-approved child safety seat.

Children ages six to eighteen must ride secured in a safety belt or child safety seat.

Childcare providers must transport all children securely in an appropriate child safety seat or safety belt.

Children up to age eighteen are prohibited from riding in cargo areas.

Violation carries a \$25 fine plus court costs and 1 point is assessed against the operator's driving record.

New Law Following Passage of LB42 (effective January 1, 2019)

All children up to age eight must ride correctly secured in a federally-approved child safety seat.

Children ride rear-facing until up to age two or until they reach the upper weight or height limit allowed by the car seat's manufacturer.

Children under age eight must ride in the back seat, as long as there is a back seat equipped with a seatbelt and is not already occupied by other children under eight years of age.

Children ages eight to eighteen must ride secured in a safety belt or child safety seat (booster seat).

Childcare providers must transport all children securely in an appropriate federally-approved child safety seat or safety belt.

Children up to age eighteen are prohibited from riding in cargo areas.

Violation carries a \$25 fine plus court costs and 1 point is assessed against the operator's driving record.

<https://dot.nebraska.gov/media/11226/child-safetyseat-law-2018-2019.pdf>

Waiting for a Forever HOME!

The following are children available on the Nebraska Heart Gallery.



Name: Sophia and Sonija

15 years old & 11 years old

Meet Sophia and Sonija!

Sophia, the oldest, is described as loyal and a good friend. She is caring and respects authority. Sophia adds that she is competitive, strong-willed and tough. She likes to participate in group activities and solving puzzles. She also enjoys volleyball and plays for her school's team. Sophia desires to travel in the future and would love to see California someday. Sophia likes to spend time with her friends and loves Harry Potter. She also has fun watching movies-her favorite genres are comedy and horror flicks. Sophia typically does well in school and likes her science class the most. Sophia has aspirations of attending college after graduating high school. Sophia is looking forward to becoming part of a Forever Family that will love her, listen to her, engage with her and laugh through difficult times with her.

Sonija, the younger sister, is creative, curious and inquisitive. She is talkative and enjoys making people laugh. Sonija describes herself as loving, trustworthy, confident, expressive and competitive. Sonija is great at establishing relationships and a skilled volleyball player. Sonija likes to spend time with her friends watching movies. Sonija also enjoys video games, dancing and socializing with peers. Sonija is looking forward to having a warm, caring Forever Family.

Connections

The girls will need support maintain a relationship with their aunt.

For more information on these children or others on the Heart Gallery please contact Sarah at:
Email: scaldararo@childsaving.org
Phone: 402-504-3673

Membership Drive

The Nebraska Foster & Adoptive Parent Association empowers, supports, and advocates for Nebraska families by promoting safety, permanency, and well-being of our children. Your membership supports the important mission of NFAPA. There are several membership levels to accommodate everyone in the foster care, adoptive care, and child welfare community.

NFAPA offers four annual membership levels; Single Family (\$25), Family (\$35), Supporting (\$75) and Organization (\$150). In order to enrich NFAPA's mission, we are offering a new membership program – Friends of NFAPA. This membership level is billed \$5 monthly.

To join, simply mail in the membership form included in this newsletter or visit

www.nfapa.org. Your membership will ensure that Nebraska's most vulnerable children will have their greatest chance at success!

How To Parent A Child With Food Insecurities

by Mike Berry

A common issue that children who have come from past trauma struggle with, are food insecurities. It can be frustrating, and sometimes, exhausting for parents who are ill-equipped. The big question is, how do you successfully parent a child who struggles with this?

It's an unseasonably cold and windy late May morning in the sleepy little Southern Wisconsin town of Lake Geneva. Like something out of a storybook, the streets are lined with vintage lamps, cobblestone sidewalks, and Victorian homes. It's almost too good to be true. The night before we piled all of our children into a rental car and made the 3 and half hour drive north from Indianapolis for Kristin to speak at a foster and adoptive moms retreat all weekend. Our stay at a comfortable hotel on the outskirts of town is made perfect by a hot (and free) breakfast before we start the day.

I can hear the panic in my son's voice as he wakes me up in the early morning hours. Question after question flows as I fumble to find my phone and shoes in the darkness of the room- "Hey dad, when are we gonna have breakfast?" "Hey dad, will they have waffles, and oatmeal, and toast?" "Hey dad, how long is breakfast open?" "Hey dad, we're not going to miss breakfast are we?" "Hey dad, what if they run out of food down there?"

Even in the darkness of the room, and in spite of my weariness, my heart fills with compassion for him. He doesn't even realize what he's doing, or what he's asking. The questions are coming from a distant, dark place, deep within him, that he doesn't even recall. It's a voice that continually prompts and pokes at him. As a baby, before he came into our care, he was hungry. And even when he was fed, it wasn't enough...it wasn't filling....so it left him insecure in a way that he may never be able to articulate. And although, for the past decade of being our son, he's never once gone hungry, or has never been in a situation where he

couldn't get enough food, the fear left from malnourishment remain, like a ghost dancing about in his mind.

When we arrive to the lobby of the hotel that morning, and find a table in the continental breakfast lounge our entire family can fit around, I begin gently reminding him. With a warm smile, I cheerfully say to him, "Hey buddy, remember, there will always be enough food this morning. Even if they run out of something, there are people in the back who are making more. And remember, you can go back up and get more if you feel hungry."

He nods and smiles. But the panic is still there. It's everlasting. It's a whisper deep within his psyche saying, "There's not going to be enough."

And that's the tragedy of trauma, of any kind, but particularly, malnourishment, or food scarcity. It's a panic that lives within our kiddos. It's a retreat to the brain stem (survival mode) because of an unmet need in the early stages of life. It's an all-too common theme amongst children in foster care, or children who have been adopted from trauma. And let's be honest- it can be frustrating! How do you respond? How do you handle the child who constantly asks or obsesses over food? How do you handle the child who hides food in his or her bedroom, or hoards food at school?

Here are some thoughts...

1. **Remember.** Before we talk about your child, let's talk about you for a moment. You must remember where your child has come from, what they went through before they came into your care, and how that all plays out in their life (and behavior) today. A child who was malnourished, starving, or constantly worried about food source in their younger years, will carry that fear into their older years. It will affect their behavior, the way they eat, and the way they respond to meal times. Simply remember this will give you a compassionate outlook, and will help you respond calmly.
2. **Respond.** It's crucial that you respond with compassion, gentleness, and kindness. I know this can be frustrating to deal with. And I know you have been over the food hoarding deal time and time again. But remember what we just talked about. What he or she is doing is a trauma response. And they might not even know they are doing it. Your response to their food insecurity can be the difference between a trigger or trust. Remember that and respond with compassion.
3. **Permission.** We don't ever tell our children "no" to food. Especially those of our children who went through malnourishment and starvation in their infant years. Instead, we grant permission to get food when they feel worried. However, this is not a full-blown meal. We keep healthy snacks on hand (fruit, veggies, etc) that are always accessible (more on this in a minute). Grant your child permission

to get food when he or she feels insecure.

4. **Remind.** In the same spirit, when you are getting close to a meal time, remind them that it is almost meal time. Remind them that there will always be enough food. Remind them that if they feel they need more after their first helping, they are welcome to get seconds, or thirds. If you're away from home, remind them that you will be stopping at _____ time to eat. You may even pull up a map on your phone and show them how far you have to travel until you arrive at the restaurant.
5. **Show.** I mentioned a moment ago, that we keep healthy snacks on hand that are always accessible. But we actively show our children who deal with insecurities, where this food is located. The only thing we ask them to do is ask us before opening up the cabinet. This is an important boundary in helping them regulate through this. For the child who hoards food at night, keep a special stash that is designated "their's only" on hand in your kitchen or pantry for when they feel hungry. Set the boundary that they must have the snack in the kitchen (or you'll provide plenty of feasting for mice or bugs :-)), but make sure they understand where the food is, and that there is enough. Same is true for school. If your child is hoarding food at school or panicking that lunch is too far away, coordinate special snack time with your child's teacher or aid.

Food insecurities, and food worries are really a tension to manage, they may not be a problem you can solve. We know adults who were malnourished as children, some 30 to 40 years in the past, and they still live with the affects of food scarcity. Some of them don't even realize they reacting out of this past trauma. Stay consistent with your child and make sure you respond with compassion and kindness. In time, your child will trust that there is enough, and you will never let go hungry.

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<https://confessionsofanaadoptiveparent.com/how-to-parent-a-child-with-food-insecurities/>



After passage of the Strengthening Families Act, the Nebraska Legislature passed a law – Nebraska Revised Statute 43-4713 – stipulating that a child must receive a document explaining his or her rights related to education, health, visitation and court participation. A sub-committee of the Nebraska Strengthening Families Committee provided feedback from youth on what they would like to see in the Youth Care Bill of Rights. Upon receipt of the feedback, the Division of Children and Family Services (CFS) modified the Youth Care Bill of Rights.

A youth is to receive a copy of the Youth Care Bill of Rights within the first 72 hours of being placed in foster care and, again, prior to every court hearing. CFS recognizes the importance of making youth aware of their rights when placed in foster care and would like to partner with foster care agencies and parents to ensure and support the rights outlined in the Youth Care Bill of Rights.



Nebraska Department of Health and Human Services FOSTER YOUTH RIGHTS

- To have my basic needs met.
- To have my voice heard.
- To have honest and clear communication.
- To live in the most family-like setting that is safe, healthy, and comfortable and meets my needs.
- To maintain family connections.
- To safely visit my family including my siblings unless the Department of Health and Human Services provides myself and the court reasons why such visitation or ongoing interaction would be unsafe.
- To participate in age or developmentally appropriate extracurricular, enrichment, and social activities and to have my caseworker and judge consult with and talk to me about my opportunities to participate in activities.
- To understand the system or systems in which I am involved.
- To access my personal information including but not limited to: my certified birth certificate, social security card, proof of Medicaid enrollment, health care card, immunizations, medical and educational records, and medical power of attorney.
- To receive a copy of my consumer credit report on an annual basis and help to correct any inaccuracies on the report.
- To be provided with the opportunity to learn life skills needed to successfully transition into adulthood.
- To an education.
- To be provided necessary medical care, including dental, mental health, behavioral health and substance abuse.
- To be notified of court hearings in my court case and to attend court hearings.
- To stay safe and avoid exploitation.

Next Court Hearing:

I have been provided with and understand my rights.

Youth Signature:

Date:

Children and Family Service Specialist:

Date

Youth refused or was unable to sign:

Substitute Caregiver Signature:

Date

Keeper of the Spoons

by Anonymous

There are rules when it comes to raising children from hard places. It has taken me some time to understand them, and so I thought I would share what I have learned from my son and his spoons. I once heard of a spoon analogy with chronic illness, but it wasn't until Israel, that I realized parts of it related to kids from hard places.

For the first few months, Israel demanded to carry a spoon all day, and at night he fell asleep with one clutched in his tiny fingers. The moment he awoke he would cry out "poon?" and we would quickly find it beneath the covers or grab a new one from the drawer. Every moment of every day was a little boy who held a spoon that was never used to eat. The spoon represented every moment he went without food, every minute he sat without company, every damn day that he spent sitting alone in a metal crib.

We thought the spoon represented a tenuous promise of future meals, but I've come to understand that it was so much bigger than that.

Perhaps one of the most difficult moments to witness when I first met Israel, was mealtime and my first introduction to his 'spoons'. It was determined that the orphanage staff show me how well he could eat. Here was a 4 year-old child who was encouraged to use a spoon, when he had never held one before. His hand shook as he worked to use the spoon and tried not to spill. It was finally taken from him in frustration and the soup was shoveled in and the meal finished within three minutes.

I remember thinking how sad it was that a four year old had never fed himself or held a spoon before. So, we naively walked up the orphanage steps thinking we had already finished the hard work of adoption, only to find ourselves hunkering down into the trenches of healing a post-orphanage child; a post-institutionalized boy with a heart and mind that did not understand how to live a day that lacked in total and complete structure. Because what we didn't understand in the beginning, was the rules of holding on to spoons.

We learned that he always needed to have a spoon in hand to ward off the fear and the darkness. We started stashing extras in the diaper bag, in the car and in our back pockets. I didn't understand that family can't fix trauma and love doesn't erase bad experiences. Instead I came to realize the body keeps score and keeps record of all the hurts and pain. My son carried these in the form of a spoon. The spoon represented emotional investment. It soon became evident that every single moment he was in our family, we were requesting that he give up his spoon.

All my children carry spoons, but they have grown to understand that as their mother, I carry extras. They look to me in stressful and scary situations, and I hold out a spoon and say, "It's okay we got this together, I will keep you safe." Emotional investment is scary when you have been hurt by the

very cure for childhood trauma: relationship. It takes a huge amount of effort to free yourself from the memory of trauma, and fear holds strong to our little ones. In order to help our children, we must first seek to understand them and the rules.

The rules of holding spoons.

1. A child with a background of trauma cannot afford to give up their spoons, it is a matter of survival.
2. You cannot simply just get up and go in the morning. It takes a spoon just to get moving. Remember that I often revisit traumatic events in my dreams.
3. The tasks of my day, including the most simple; each one costs a spoon and this terrifies me. Every new or novel event is filtered through prior history.
4. When I have given away all my spoons, I have lost my ability to survive. In my mind, the worst thing that ever happened to me, is about to happen again.
5. Holding spoons is my strategy to stay safe. When you make me give up a spoon, a little bit of fear becomes terror; a little bit of anger becomes rage; and a little bit of sadness becomes desolation.
6. Remember I must live life reserving spoons to survive. I am always prepared and on high alert. I live each day with the looming thought that this may be the day that something very dangerous and bad will happen. This is because bad things have happened before.
7. I am always conscious of how many spoons I have, and I hold them close because my body will never forget I have experienced scary things.
8. When I carry spoons, I don't own myself anymore. Any loud sound, a bump from someone on the playground, or a worksheet in class that I don't understand, can hijack me away.
9. I will carry spoons my whole life. Trauma is stored on a cellular level.

And if trauma is not expressed, it will be stored deep within the mind to fester like a wound. So what we have learned is that what makes you resilient to trauma is to own yourself fully. Bessel van der Kolk

It has been two long years of carrying spoons. Every day is a new day to teach trust and love. A connected child will see you as the keeper of the spoons. My children have days they trust me with their spoons and they have days that they are clutched tightly in their fists. I have learned that being a keeper of the spoons is the greatest honor that we can ever hold. When my child looks to me for security and safety, this is what I live for. The moment when he cries out from his bed "Mommy", instead of lying silently in bed clutching a spoon while tears slip down his cheeks. The day when instead of rocking with his inner pain in a corner, he seeks me out for comfort. The day I noticed my silverware drawer was full of spoons, these are the moments when I know that I am the keeper of spoons. I cannot take away his spoons, but I can teach him that a

mommy is strong enough to help hold them safe.

As we raise children from hard places, as we work with children who have experienced trauma, let us always recognize the cost of spoons. And may we all be adults who can be strong and wise enough to be Keeper of the Spoons. The ones who recognize that the very cure for childhood trauma lies in the origin of pain. Relationships are scary and they cost a lot of spoons, but thank God we are strong enough to sit in the dark moments and help carry spoons.

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Taking a Child to the Emergency Room

An open letter about what the ER can (and can't) do for your child in a psychiatric emergency

by Julia Johnson Attaway

Dear Parent,

You are not a failure because you have taken your child to the ER. You may feel terrified and ashamed, but you are not a failure.

You are, in fact, a hero. You have done the brave thing, the hard thing, the only thing you knew to do to keep your child safe. That is honorable. So if anyone — relative, friend or acquaintance — tells you in the next few days that you overreacted, or that your child simply needs more discipline, or that it's all in your kid's head, you have the right to say, gently and firmly, "Please don't be critical. It's not like I wanted to go. I am scared and I really need your support." If that person can't be helpful to you in this strange new world, find someone else who can.

Since you're here, and heaven knows you have time, it might help to have a few pointers so you know what to expect. You see, an emergency room visit for psychiatric issues works a bit differently than one for a physical problem.

First — and this is hard — you need to know that they are

not going to fix anything. There's no psychiatric equivalent of setting a broken leg or removing a ruptured appendix. There are no blood tests or lab results to tell you what's wrong (though they may take blood to check for physical problems that could be contributing to your child's difficulty). You're probably going to walk out of here without having a diagnosis, and even without medication. You will have a better understanding of how dangerous your child's situation is, and what the best course of action is going forward.

Assessing safety

The primary thing the doctors do here is assess the safety of your child. The key question they will be trying to answer is whether or not your child is an imminent danger to herself or others. This assessment centers on three main issues: thoughts, plans and intent.

- **If your child has intrusive thoughts** about dying or about doing harm and is upset but doesn't intend to do anything, he requires ongoing care, probably on an outpatient basis. Many teens who cut themselves fall in this category (cutting, while a profoundly disturbing behavior, is not necessarily an indicator of suicidal intent). Kids who are depressed but not actively suicidal, and those who are verbally explosive, often fall in this category as well. Weird as it may seem, this is relatively good news. You will most likely be going home with a recommendation for follow-up care with a therapist.
- **If your child wants to harm herself or others yet doesn't have a plan**, that's a step higher on the worry scale. Risk factors that doctors consider in gauging the best course of action include how impulsive your child is, her recent pattern of behavior, and any known triggers in the home or school environment that could lead to a crisis.
- **If your child has ideas about how to harm himself or others but no firm plans to put those plans into action**, this is more concerning. If you are sent home, be sure you ask what kinds of methods are lurking in your child's mind so that you know how to minimize the risks of action.
- **If your child has a plan** for suicide or harm to others, **has made an attempt or is acting in a highly impulsive manner that makes an attempt likely**, hospitalization is almost always required. This is because everyone's No. 1 priority is to keep your child safe and alive.

The doctors will make this safety assessment by talking with you and your child. At some point you will be asked to step out of the room so that the doctors can speak privately with your son or daughter. That's okay. Doctors do this because it is not uncommon for a child to reveal a suicide plan to doctors that the parent knew nothing about. Do not feel guilty if your child tells a stranger things you didn't know. Kids love their parents and often fear hurting them, so they don't want to tell you about their deepest pains because they want to "protect" you from the truth.

If you are told your child has a suicide plan

Allow yourself time and space to grieve. To avoid distressing your child with your tears, you can excuse yourself to get a cup of coffee, pick up something to eat or call your significant other. Ask a nurse for tissues and a place you can cry. Your child will be safe while you are gone. It's okay to leave for a while. Just remember to bring back the coffee or whatever it was you said you'd gone to get! And remember to be thankful that you brought your child to the hospital: You did the right thing.

After you have fallen apart and pulled yourself more-or-less together again, go back in to your child and say, very gently, "The doctors told me you have a suicide plan. I am so, so sorry you are hurting that much. I love you, and even if you can't see how life is worth living right now, I can see many beautiful things still inside you. I love you very much. I am so glad we came to get help." And then you can cry, together. Or not.

Make sure you write down the names of all the doctors who speak to your child. Take notes of everything they say. Your emotions are running too high to process everything — or even anything — that's coming at you right now, so write it all down.

If outpatient treatment is recommended

If you are advised to seek outpatient treatment, you probably won't be given advice on how to manage life at home better between when you leave the hospital and when you walk into your child's first therapy appointment.

It is appropriate to ask if there are books you should read or websites to explore that would help you handle your situation better. If the doctor doesn't have suggestions, look at some of the free booklets online at SAMSHA.gov, and explore childmind.org and NAMI.org for helpful information.

You will probably be told to bring your child back to the hospital if she exhibits dangerous behavior. Ask the doctor to explain exactly what that means, and for rules of thumb so that you know the difference between what feels dangerous to you and what merits a return visit. The doctor may not be particularly helpful with this. Few medical professionals have ever parented a mentally ill child, and they may not know the reality of what your life at home is like. At a minimum, if your child has violent rages, ask to be shown how to hold her in a way that minimizes your risk of getting hurt.

You may (or may not) be told to lock up sharps and medications when you go home, or to remove things that can be used to hang or suffocate oneself. When you go home you should quietly do this anyway: Making it less easy to commit suicide reduces the likelihood of disaster arising from impulsive behavior. You might also want to block how-to sites on suicide from your kid's computer and phone. The internet has a lot of good information, but it's also full of bad ideas.

Plans for follow-up care

If your child doesn't already have an outpatient team, try to have the hospital set up a followup appointment with a provider before you leave. The wait list at most clinics can be several months long, and one huge advantage of an Emergency Room visit is that it can bump you up on the priority list. A phone call from a hospital to a clinic will be returned much, much faster than any call you make personally.

If you are in the ER in the evening or on a weekend, ask for the name of the social worker at the hospital who will be arranging the follow-up appointment, and get his or her direct phone number. Call the social worker first thing the next business day. Call again two hours later. Call however often you need to call until you get the appointment set. If you are not getting a response, consider contacting the patient advocate at the hospital.

If the hospital says they don't have enough staff to arrange an appointment, ask to speak to a patient advocate. You may not win the battle, and if you don't (or simply don't have the energy to fight), ask a good friend or close relative to make the appointment for you. Make sure that the clinic takes your insurance. Make sure that you can actually get there; in some parts of the country services are few and far between.

If you want to use a therapist in private practice, you will have to find one yourself and make your own arrangements. Before you go this route, you need to know that many private therapists do not accept insurance. They will provide receipts so you can seek out-of-network reimbursement, but that only helps if your plan allows out-of-network costs and you have enough cash flow to wait for reimbursement. The cost, depending on where you live and what kind of professional you need, can be anywhere from \$100 to \$400 a week. If medication is also required, you will need to find and pay for a pediatric psychiatrist, too. You may find it wise to take whatever clinic appointment the hospital offers even if you plan to go private, so you are getting some sort of help while you get your longer-term plan in order.

If you disagree with the doctor's safety assessment

If you feel your child is a suicide risk or may hurt others, make your opinion known loud and clear. Be specific about your concerns: Cite information your child may have confided to you, and note recent patterns of behavior that indicate things are getting worse. If your child sees a therapist regularly and the therapist can visit you in the ER, ask the doctors doing the hospital evaluation to speak with that therapist (you will have to sign a release so they can share information). If they still do not agree to hold your child, ask who is liable if your child makes a suicide attempt within the next 48 hours. You can also consider writing the words, "Parent has communicated to medical staff that she feels child is not safe to return home" on the discharge papers before signing.

About short-term observation

Some hospitals have a short-term observation unit where a child can be held for up to 72 hours. In some places this is called a Comprehensive Psychiatric Emergency Program (CPEP). When a child is at high risk yet it's not clear if inpatient treatment is needed, a couple of days in a low-stress environment like this (almost no activities, no therapy, 24-hour observation and a lot of television) may be a viable option.

If inpatient treatment is recommended

If your child is admitted for inpatient care, at some point you will want to excuse yourself to "get a cup of coffee" and cry. If you break down in front of your child, she is likely to feel guilty and at fault for hurting you. Right now your kid needs you to be brave, because if there's one thing scarier than being the parent of a kid going into the psych ward, it's being the kid who will actually be there.

It may take a day or two or even more for a bed to open up (especially if you arrived late in the day, on a Friday, or near a holiday). This means your kid may be in the ER for a long time. You can use this interlude to organize your thoughts, scribble down notes about the sequence of events in recent months and to remember that Uncle Harry was depressed for many years and depression can be hereditary.

In most cases, the bed will be in a different facility. Before the social work team starts looking for a spot, ask what the options are. In some cases, one facility may be far away while another is closer, or one may have 12 beds (presumably less chaotic) instead of 24. It's fair to ask which units have the best reputation. This is because the doctor in the ER may never have been to any of the facilities, and may never have treated someone released from there.

Older teens may be eligible for either adolescent or adult units. When possible, opt for adolescent. The severity of illnesses on an adult ward is likely to be more extreme.

If you have a long wait until a bed is found, do not feel that you have to stay in the ER with your child the whole time. Pop out for dinner and trade off with other family members. Allow your child some space. Your kid is probably going to watch television most of the time, anyway, and you need to take care of yourself. Go home and pick up your child's toothbrush, toiletries (nothing in glass bottles), pj's (no drawstrings), underclothes, slippers or socks or shoes without laces and a couple of days' worth of clothes. Don't bring your son's favorite sweater or your daughter's beloved jeans; you don't want to taint them by association with the hospital. Besides, things do sometimes get lost or stolen. Bring magazines, puzzle books or other forms of entertainment; electronics will not be permitted on the unit. You might want to bring some food for your child, too, since hospital grub isn't the best. And be kind to yourself.

Remember, you are not a failure. What you are doing is heroic.

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<https://childmind.org/article/taking-a-child-to-the-emergency-room/#.XAqUeIX0qYE.email>

NFAPA Support Groups

Have you ever thought about attending a support group? NFAPA offers support groups to foster, adoptive and kinship families! This is your chance to gain understanding and parenting tips through trainings, discussions and networking with fellow foster families.

This is a great way to meet other foster/adoptive families in your area! In-service training is offered at most support groups for those needing credit hours for relicensing. Up to date information with each support group location will be on the calendar page on our website at www.nfapa.org. Support Groups will be cancelled for inclement weather.

Contact a Resource Family Consultant for more information:

Jolie Camden (Panhandle Area): 308-672-3658

Tammy Welker (Columbus): 402-989-2197

Terry Robinson (Central/Southwest Area): 402-460-7296

Robbi Blume (FACES): 402-853-1091

NFAPA Office: 877-257-0176

IN-PERSON SUPPORT GROUPS

- Alliance Support Group:** Meets the third Thursday of the month. Registration is required.
Contact Jolie Camden to register: 308-672-3658
Box Butte General Hospital, Alliance Room, 2101 Box Butte Ave.
6:00-7:30 p.m.
January 17, February 21, and March 7 2019
- Scottsbluff Support Group:** Meets the second Tuesday of the month. Registration is required.
Contact Jolie Camden to register: 308-672-3658
Sugar Factory Road-*please do not bring in Pepsi products.*
6:00-7:30 p.m.
January 8, February 12, March 12, April 9, May 14 and June 11 2019
- Chadron Support Group:** Registration is required.
Contact Jolie Camden to register: 308-672-3658
CHA Daycare and Home School, 237 Morehead
6:00-7:30 p.m.
January 7, February 4, March 4, April 1, May 6, and June 3 2019
- Columbus Support Group:** Meets the second Tuesday of the month (except July and December). Childcare available.
Contact Tammy Welker at: 402-989-2197
(Thank you Building Blocks and Behavioral Health Specialists for providing childcare!).
Peace Lutheran Church, 2720 28th St.
7:00-8:30 p.m.
January 8, February 12, and March 12 2019
- Broken Bow Support Group:** Registration is required.
Childcare is provided. Must register to attend and have child care.
Contact Terry Robinson to register: 402-460-7296
Evangelical Free Church, 2079 Memorial Drive. 6:30-8:30 p.m.
March 14, 2019

ONLINE SUPPORT GROUP

- FACES:** Online Support Group: Every Tuesday 9:00-10:00 p.m. CT Contact Felicia at Felicia@nfapa.org to become a member of this closed group. Meets weekly to discuss issues foster parents are facing. Support only.

TRANSRACIAL SUPPORT GROUP

- Parenting Across Color Lines:** This group supports and strengthens racial identity in transracial families. Support only. Meets the fourth Monday of the month.
Children welcome to attend with parents.
Newman United Methodist Church, 2242 R Street, Lincoln. 6:15-8:00 pm
Contact the NFAPA office to register for Family Events or any questions.
402-476-2273
For more information or to RSVP, contact Laurie Miller at Laurie@nfapa.org

Be sure to mark your calendars! If you have a topic you want discussed, please contact the Resource Family Consultant for that group.

How Gratitude Can Help You Better Care For You!

by Mike Berry

Over the years we've learned what it means to take care of ourselves as parents. But nothing we do, in terms of self-care, happens apart from being hands on as parents. We've learned that simple things, in the middle of parenting demands, make a big difference...

It's the dead of winter out on the farm we just moved to north on Indianapolis, Indiana where we live. The wind is blowing so hard it sounds we fear the gigantic oak trees in our front yard are going to come crashing through our roof at any moment. It's early March and this should not be! But this is Indiana. I'm huddled under a blanket in our front room watching a show on Hulu with all of the kids. Even though our thermostat is set to 70, I can't get warm...not even close. Haven't been able to in months.

We laugh...we giggle...we recite quotes from Black-ish, one of our favorite shows to watch together as a family, but I just can't get warm. And I'm not simply talking about physical warmth. Yes, I'm cold...but I feel like the past few months have been emotionally, spiritually, and mentally cold for me. It began in January. The coldest month in all eternity. Or at least it felt that way. My schedule was slammed, I was jumping on a plane every weekend, and trying to finish my next book.

February wasn't any better. Cold, cold and then more cold. And just when we thought it was about to warm up, it snowed blizzard-like conditions on the same weekend that spring was supposed to begin!

I had never in my life suffered through seasonal depression. I was always a fan of winter, even the boring months after Christmas but before spring. And here I was, every single day, feeling lost...depressed...lonely. Add to that, one of my kids was in residential treatment and not doing well at all.

It's easy to allow seasons like this to consume you. It's easy to believe that nothing is going to get any better than it presently is. It's easy to muddle through a winter and feel like all hope is lost, and you'll never feel warmth again in the depths of your soul. Add to that, parenting kiddos from trauma and the hopelessness feels even deeper. Mind you, I'm not saying that my children have caused me to feel despair in the past. Nope. I love them deeply. But the battles we face as a result of past trauma (which is not their fault) can be exhausting.

Yes, last winter was cold. But then one afternoon a good friend reminded me of something that I had failed to see through that season: "You have so much to be thankful for Mike. You're just looking at the wrong things."

So true. As I reflect back on that season of my life last year, I realize something- I was focused on everything I thought I didn't have, but needed. I was staring at everything going wrong, so much so, that I forgot about everything going right! When I simply stopped and began to give thanks for what I had, and what was right, my spirit lifted and my perspective changed. Not only that, but I began to better take care of me because I realized I had so much to live for, and so much to be thankful for!

Your level of gratitude has nothing to do with how much

stuff you have, the bottom line in your bank account, or even whether or not you get to do all the things you want to do!

Gratitude is not dependent on what you have. Gratitude is dependent on what you believe about

So what do you believe about your life? Are you focused on what you don't have, or can you stop and begin to give thanks for what you do have? What I've found is simply stopping and expressing gratitude every now and then, can change my entire attitude on life. And it's the simply everyday things that we often overlook....

I'm thankful that the sun came up today.

I'm thankful for the beautiful family I have.

I'm thankful for the house I have.

I'm thankful that I have a car to drive.

I'm thankful for breath in my lungs (what a gift!).

I'm thankful that I get to be daddy to these amazing kids!

I'm thankful that I get to be a husband.

I'm thankful for life.

Simple stuff. When I stopped focusing on what I didn't have and began giving thanks for what I do have, I began taking better care of me! My health improved. My energy level returned. And my perspective on life transformed!

Choose gratitude my friend.

Reprinted with permission from:

<https://confessionsofadoptivemom.com/how-gratitude-can-help-you-better-care-for-you/>

Upcoming Training

Facilitated by the Nebraska Foster & Adoptive Parent Association

Sponsored by Nebraska Department of Health and Human Services

The Kinship Connection

This six hour training will provide Relative & Kinship families with training on the following topics:

- The Legal Process
- RPPS/Respite
- Trauma & Attachment
- Safety
- Behavior Management
- Redefined Roles
- Loss & Grief
- Permanency Options for Children & Youth

Sunday, February 17, 2019

from 9 am – 4 pm: Scottsbluff

Monday, February 18, 2019

from 9 am – 4 pm: Lincoln

Sunday, June 9, 2019

from 9 am – 4 pm: Scottsbluff

Sunday, October 13, 2019

from 9 am – 4 pm: Scottsbluff

**Registration is required.*

Register online:

<https://www.surveymonkey.com/r/KinshipRegistration2019>

These informational classes are for Relative & Kinship families who have not taken pre-service classes to be licensed foster parents.

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JOIN NFAPAyour support will enable NFAPA to continue supporting foster parents state-wide!

Benefits

- Ongoing trainings/conferences at local and state level
- Networking opportunities with other foster families, adoptive families, and relative caregivers
- Opportunity for all foster families, adoptive families and relative caregivers to be actively involved in an association by serving on committees and/or on the Executive Board
- Working to instigate changes by alertness to legislation affecting the child welfare system
- An advocate on your behalf at local, state and national levels
- 25% of membership dues goes toward an NFAPA Scholarship

Thank you for your support!

Please mail membership form to:
NFAPA, 3601 N. 25th Street, Suite D
Lincoln, NE 68521.

Questions? Please call us at 877-257-0176.

NFAPA is a 501c3 non-profit organization comprised of a volunteer Board of Directors and Mentors.

Name(s): _____

Organization: _____

Address: _____

City: _____ County: _____

State: _____ Zip: _____ Phone: _____

Email: _____

I am a Foster/Adoptive Parent. I have fostered for _____ years.
(circle one)

I am with _____ agency.

I wish to join the effort:

- ☐ **Single Family Membership** (a single foster or adoptive parent), \$25
- ☐ **Family Membership** (married foster or adoptive parents), \$35
- ☐ **Supporting Membership** (individuals wishing to support our efforts), \$75
- ☐ **Organization Membership**
(organizations wishing to support our efforts), \$150
- ☐ **Friends of NFAPA**, \$5 billed Monthly

My donation will be acknowledged through Families First newsletters.

- ☐ Gold Donation, \$1,000
- ☐ Silver Donation, \$750
- ☐ Platinum Donation, \$500
- ☐ Bronze Donation, \$250
- ☐ Other, \$ _____