



## RESOURCE MATERIALS

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# Working with Gay & Lesbian Youth

Lesbian, gay, bisexual, and transgender<sup>1</sup> youth as a population are often at greater risk for neglect and/or abuse, discrimination, and dependency problems due to prejudice based on a lack of understanding and acceptance by the dominant cultural group. Consider these statistics:

- Eleven and a half percent of gay and lesbian youth report being physically attacked by family members;
- Fifty percent of gay and lesbian youth are rejected by their parents due to their sexual orientation;
- It is estimated that twenty-six percent of gay and lesbian youth are forced to leave their homes because of conflict with their families over their sexual orientation;
- Gay, lesbian, bisexual, and transgender youth are two to three times more likely to attempt suicide than heterosexual youth; and
- Forty-two percent of homeless youth identify themselves as gay, lesbian, bisexual, or transgender.

The result of these alarming figures is that many youth feel very lonely and isolated. These young people need additional resources and advocacy that may not be available in certain communities due to discrimination and/or a lack of services. GAL volunteers can advocate for additional services and educate themselves about lesbian, gay, bisexual, and transgender youth.

To gain a better understanding, it helps to consider what it means to be lesbian, gay, bisexual, or transgender. Clinical psychologist Rob Eichberg describes homosexuality well when he says:

Some of us are heterosexual and others of us are homosexual and no one really knows why. Though many people might desire to do away with homosexuality in themselves or in others, there are now, have always been, and always will be lesbians and gay men. Being attracted to one's own sex is as natural for someone who is homosexual as being attracted to the opposite sex is for someone who is heterosexual. Much like the differences in the colors of our hair, eyes, or skin; the shape of our bodies; or being right- or left-handed; it is not good or bad, right or wrong, or better or worse to be homosexual or heterosexual—it just is.

From *Coming Out*, Rob Eichberg, New York: Plume, 1990.

<sup>1</sup> Definitions of these specific terms can be found in the Glossary of this manual.





*Difficulty forming loving, lasting, intimate relationships, due to a failure to attach, to bond, or to trust a primary caregiver during the first two years of life.*

## **Reactive Attachment Disorder**

### **What Causes Reactive Attachment Disorder (RAD)?**

Any of the following factors, especially occurring to a child during the first two years of life, puts a child at high risk of developing an attachment disorder:

- ✓ Maternal drug and/or alcohol use during pregnancy;
- ✓ Premature birth;
- ✓ Abuse (physical, emotional, sexual);
- ✓ Neglect;
- ✓ Sudden separation from primary caretaker (illness or death of mother, chronic illness or hospitalization of child);
- ✓ Undiagnosed and/or painful illness (colic, chronic ear infections);
- ✓ Frequent moves or placements;
- ✓ Inconsistent or inadequate daycare;
- ✓ Chronic maternal depression;
- ✓ Teenage mothers with poor parenting skills; and/or
- ✓ Drug-addicted infant.

### **What Are the Signs of Reactive Attachment Disorder?**

Although the following symptoms may be seen in many children, a child suffering from reactive attachment disorder will display all or most of them:

- ✓ Manipulative, superficially engaging, or charming;
- ✓ Abnormal eye contact;
- ✓ Indiscriminately affectionate with strangers;
- ✓ Lacking ability to give and receive affection;
- ✓ Extreme control battles often manifest in covert or “sneaky” ways;
- ✓ Destructive to self, others, animals, material things;
- ✓ Accident prone;

- ✓ Stealing;
- ✓ Hoarding or gorging food, abnormal eating patterns;
- ✓ Preoccupation with fire, blood, gore;
- ✓ Lack of impulse control and cause-and-effect thinking (frequently acts hyperactive);
- ✓ Learning lags and speech disorders, abnormal speech patterns;
- ✓ Lack of conscience;
- ✓ Crazy, chronic, obvious lying;
- ✓ Poor peer relationships;
- ✓ Persistent nonsense questions and incessant chatter; and/or
- ✓ Inappropriately demanding and clingy.

### **What Treatments Are Available?**

Children need extensive treatment to learn how to trust, thus enabling them to love. The most recent treatment of choice is attachment therapy. It uses a combination of therapeutic techniques, such as body therapies, psychodynamic techniques, holding techniques, and grief and loss work. The treatment of choice for RAD is a highly controversial issue. In any case, these children need extensive treatment at an early age in order to make up for the neglect they received in utero and as infants.

# Separation Anxiety Disorder



*Excessive anxiety about being away from home or separated from people to whom one is attached.*

## What Causes Separation Anxiety Disorder?

The disorder may be triggered by life stress, such as the death of a relative, friend, or pet; geographic move; or a change in schools.

## What Are the Signs of Separation Anxiety Disorder?

Separation anxiety disorder lasts at least a month, causing significant distress or impairment in functioning; the duration of the disorder reflects its severity.

### A child suffering from separation anxiety disorder may:

- ✓ Experience great distress (crying, clinging, panic) when separated from home or people to whom he/she is attached;
- ✓ Need to know the whereabouts of these people;
- ✓ Be preoccupied with fears that something terrible will happen to them;
- ✓ Be uncomfortable traveling alone;
- ✓ Refuse to attend school or camp or to visit a friend's house;
- ✓ Be unable to stay alone in a room;
- ✓ Cling to a parent or shadow the parent around the house;
- ✓ Have difficulty at bedtime;
- ✓ Be reluctant to sleep alone;
- ✓ Experience nightmares that reveal the anxiety; and/or
- ✓ Experience physical problems (nausea, stomachaches, dizziness).

## What Treatments Are Available?

The child should receive a thorough evaluation before treatment is started. For some children, medication can significantly reduce the anxiety and allow them to return to school. These medications may also reduce the physical symptoms. Generally, psychiatrists use medications as an addition to psychotherapy. Both psychodynamic play therapy and behavioral therapy have been found helpful in reducing anxiety disorders. In psychodynamic play therapy, the therapist helps the child work out the anxiety by expressing it through play. In behavioral therapy, the child learns to overcome fear through gradual exposure to separation from the parents.



# “Permanent” Resolutions

The following “permanent” resolutions are most possible when the supporting questions can be answered and the underlying issues they suggest have been dealt with. There are only two truly permanent resolutions: return to parents and adoption.

## Return to Parents

- Have issues that brought the child into care been addressed by the agency?
- Have the parents made the changes that the child protective services agency requested?
- Has the DCF caseworker observed and documented a reduction of risk?
- What have the visits we observed told us about the parents’ ability to care for the child?
- Have we considered recommending a trial placement as a way to observe actual changes in child care?
- Have new issues that relate to risk been observed and addressed?
- Has DCF changed the rules or “raised the bar” in reference to expectations that are not related to risk?
- Would DCF remove this child today?
- Is this a multi-problem family that is likely to relapse?
- What services can be put in place to prevent relapse?
- Have the legal and/or biological fathers been identified?
- Have we recognized the child’s grief and need to reconnect to the family of origin?

## Adoption

- Are we ready to proceed with a termination of parental rights (TPR) case?
- Do legal grounds exist?
- Have we also considered the best interest issues that must be presented to the judge?
- How long will the court process take?
- Have the parents been asked to release the child for adoption?
- Is the child already living with caretakers who are willing and able to adopt?
- Are there relatives who are available to adopt?
- How soon can the child be placed?
- Who can help the child through the placement process?
- Have we assessed and evaluated the child’s particular needs and strengths?
- What is the child’s relationship with his/her siblings?
- Should the child be placed with siblings? Can the child be placed with siblings?
- Have we identified a placement option that will be able to meet the child’s needs?
- Have the child’s ethnic and cultural needs been considered and addressed?
- Are we holding up the child’s placement waiting for a specific type of family?
- Are the child’s needs so severe that finding appropriate parents is unlikely?
- Is the child able to accept “parenting”?

Materials created by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice. Used with permission.



# Placement with Relative or Kin

Living with someone the child already knows and feels safe with can mitigate the child's feelings of loss, which are part of any placement. The use of a relative or kin placement should be evaluated from the beginning of agency involvement. The following questions should serve as guidance in considering both the pitfalls and benefits involved with kin and relative placements:

- Have the relatives/kin been carefully evaluated? Is there a written home study?
- What are the parents' thoughts and wishes in reference to this relative?
- What will be the ongoing relationship with the parents?
- Will the parents create problems with the placement or compromise the child's safety?
- Will the relative be able to protect the child from hostile or inappropriate parental behavior?
- Will the relative be able to be positive about the parent to the child?
- Will there be an "unofficial" return to the biological parents?
- Will this relative support the present service plan?
- If the plan changes, will the relative support the change?
- How will visitation be accomplished?
- Are the relatives able to understand and cooperate with agency expectations?
- Have the relatives of both parents been considered, regardless of the removal home?
- Is placement with relatives a way we can protect the child's roots in his/her community?
- Will placement with a particular relative mean that the child must leave the community?
- Will placement with a particular relative mean that the child will lose other important relative or kinship ties?
- Will a relative placement mean that the child will have to endure another move?
- What losses will the child experience if another move is required?
- Have we considered sibling attachments, as well as any "toxic" sibling issues?
- Is this potential caretaker related to all the siblings?
- Is this relative able and willing to take all the siblings?
- Will placement with the siblings be positive for this child?
- Will this placement support the child's ethnic and cultural identity?
- Is this seen as permanent by the potential caretakers?
- Would this relative consider adoption?
- Are there the same issues in the extended family that existed with the parents?
- What preplacement relationship existed?
- Does the child have any attachment to these relatives?
- Have the child's wishes been considered?

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# Long-Term Foster Care: An Impermanent Solution

Despite the advocacy efforts of GAL volunteers and the hard work by caseworkers, many children remain in foster care and a family is not found for them. These children live in foster homes or group homes—or move from placement to placement during their time in care.

Long-term foster care becomes the plan for older or difficult children for whom there is no identified family. Sometimes these children are actually placed in a family setting but their caregivers do not want to adopt them. In any case, when the plan is permanent foster care, what the child protective services system is actually doing is planning for these children to belong to no one. Clearly this is unacceptable. When faced with this as the “only” alternative, it is our obligation to insist that this not be the end of the planning process, but rather the beginning of a new dialogue around how to make permanence a reality, even for the most difficult child. Begin this dialogue with these questions:

- What other options have been explored?
- Does the child need specialized care? Is it possible for him/her to have a legal and emotional attachment with a person with whom he/she does not live?
- Is there a significant role model or mentor involved with this child? What barriers exist to this person becoming the legal parent?
- What are the barriers to the caregiver adopting? How can these barriers be removed?
- Have all adoption subsidies, other financial resources, and continuing services been explored and offered?
- Who have been the child’s support and attachments in the past? Can any of them be involved now?
- Who are the child’s attachments and support in the present? What is their current involvement?
- What family or kin connections are available—especially with siblings?
- Can parents or other kin be involved anew in this stage of the child’s life?
- What does the child want?
- What resources and persons will be available when this child is an adult?
- Who will be this child’s family for the rest of his/her life?

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# Principles of Permanence

There are many principles that you can follow as the child’s advocate to ensure that the child in the system will not be forgotten. A number of these are listed below. Following them will ensure that your advocacy is focused on permanence for the child.

- **Constantly examine your own value system.**  
Understand the difference between poor parenting and abuse and neglect. Make sure that you can accept a variety of parenting styles, even those that include behavior of which you do not approve.
- **Carefully examine the DCF case record.**  
Understand the issues that brought the child into foster care. Ask agency staff about anything that does not make sense.
- **Ask the parents why they think they lost custody of their child.**  
Do not assume that they understand or agree with the agency’s reasons.
- **Recognize that the “system” should be operating on the child’s sense of time.**  
Help others to hear the clock that is ticking that childhood away.
- **Understand grief and the effects on children of moving and waiting.**  
Keep permanent resolution as the focus of your efforts.
- **Stay child-centered and family-focused.**  
Children need a permanent family—theirs, if possible—but not if it means the loss of their childhood.
- **Recognize parents’ strengths, but do not ignore their failings.**  
Advocate to return the child when the parents have “fixed” what brought their child into care. Advocate for termination of parental rights if the conditions persist.
- **Be a team player.**  
Attend reviews, continue to investigate and assess, and share with the caseworker and the court what you learn.
- **Aggravate the system if you have to—be a catalyst for change.**
- **Work for justice—act with mercy.**

Contributed by Jane Malpass, Consultant, NC Division of Social Services, and Jane Thompson, Attorney, NC Department of Justice.





*Inability to acquire, retain, or broadly use specific skills or information, resulting from deficiencies in attention, memory, or reasoning, and affecting academic performance.*

## **Learning Disabilities**

### **What Causes Learning Disabilities (LD)?**

Many types of learning disabilities exist, and no single cause accounts for them. However, the basis of all learning disabilities is believed to be abnormal brain function. An estimated three to fifteen percent of school children in the United States may need special educational services to compensate for learning disabilities. Boys with learning disabilities outnumber girls five to one.

### **What Are the Symptoms of Learning Disabilities?**

A child suffering from a learning disability may:

- ✓ Have problems coordinating vision with movement;
- ✓ Be clumsy at physical tasks (cutting, coloring, buttoning, tying shoes, running);
- ✓ Have problems with visual perception;
- ✓ Have problems with phonologic processing (recognizing sequences or patterns and distinguishing among sounds);
- ✓ Have problems with memory, speech, reasoning, and listening;
- ✓ Have problems with reading, arithmetic, or writing (most learning disabilities are complex, with deficiencies in more than one area);
- ✓ Be slow to learn the names of colors or letters, to assign words to familiar objects, to count, and to progress in other early learning skills;
- ✓ Exhibit delayed learning to read and write;
- ✓ Have a short attention span and memory span;
- ✓ Have difficulty with printing and copying (activities that require fine motor coordination);
- ✓ Have difficulty communicating and controlling impulses;
- ✓ Have discipline problems; and/or
- ✓ Be easily distracted, hyperactive, withdrawn, shy, or aggressive.

## **How Is a Learning Disability Diagnosed & Treated?**

A doctor examines the child for any physical disorders. The child then takes a series of intelligence tests, both verbal and nonverbal, including testing for reading, writing, and arithmetic skills. Psychological testing is the final step of evaluation. No drug treatment has much effect on academic achievement, intelligence, and general learning ability. However, certain drugs, such as methylphenidate, may improve attention and concentration. The most useful treatment for a learning disability is an education that is carefully tailored to the individual child.



*Excessive, long-term, and pervasive behaviors, including distractibility (poor sustained attention to tasks), impulsivity (impaired impulse control and delay of gratification), or hyperactivity (excessive activity and physical restlessness).*

## **Attention-Deficit/Hyperactivity Disorder**

### **What Causes Attention-Deficit/Hyperactivity Disorder (AD/HD)?**

AD/HD is not caused by poor parenting, family problems, poor teachers or schools, too much TV, food allergies, or excess sugar. AD/HD is very likely caused by biological factors that influence neurotransmitter activity in certain parts of the brain and have a strong genetic basis. Approximately four to six percent of the U.S. population has AD/HD; however, if one person in a family is diagnosed with AD/HD, there is a twenty-five to thirty-five percent probability that another family member also has AD/HD.

### **What Are the Signs of AD/HD?**

The American Psychiatric Association's *Diagnostic and Statistical Manual* recently renamed the disorders formerly known as ADD and ADHD to be AD/HD.

#### **AD/HD includes three subtypes:**

1. A predominantly inattentive subtype (formerly ADD). Signs include:
  - Easily distracted by irrelevant sights and sounds;
  - Failing to pay attention to details and making careless mistakes;
  - Rarely following instructions carefully and completely; and
  - Losing or forgetting things like toys, pencils, books, and tools needed for a task.
2. A predominantly hyperactive-impulsive subtype (formerly ADHD). Signs include:
  - Feeling restless;
  - Fidgeting and squirming;
  - Running, climbing, leaving a seat in situations where sitting or quiet behavior is expected;
  - Blurting out answers before hearing the entire question; and
  - Having difficulty waiting in line or for a turn.
3. A combined subtype, which is the most common of the three.

AD/HD refers to all types of attention-deficit disorders, both with and without hyperactivity. To be considered for a diagnosis of AD/HD, these behaviors must appear before age seven and last for at least six months. The level of disturbance must occur more frequently and in a more severely pronounced manner than among other children in the same age group. And above all, these behaviors must create a real handicap in at least two areas of a child's life, such as school, home, or a social setting.

## **What Treatments Are Available?**

Clinical experience has shown that the most effective treatment for AD/HD is a combination of medication and therapy or counseling to learn coping skills and adaptive behaviors. The most well known treatments of AD/HD are psychostimulants, such as Ritalin and Dexedrine, and some antidepressants that affect the levels of dopamine, noradrenaline, and serotonin in the central nervous system. Taken in normal doses, stimulants can result in decreased appetite, stomachaches, agitation, irritability, and insomnia for some children. The long-term effects of taking these drugs are not yet known.

Medications can result in an improvement in core symptoms such as impulsive behavior and inattention as well as improved school and social performances. For that reason, treatment for AD/HD is more effective when regular use of drugs is combined with behavior treatment. Reward systems for appropriate behavior or performance, teaching parents child-management skills, and therapy that instructs parents and teachers in improved contingency management skills can help most children. Children who regularly take their medication and practice behavior techniques routinely do better than those who rely on stimulants alone.

## **When Should a Person Seek Help?**

Since many children exhibit occasional inappropriate or hyperactive behaviors, widespread confusion has arisen about the diagnosis and treatment of AD/HD. Due to those uncertainties, parents and guardians should not attempt to diagnose their children. Children who are responding to stressful family situations, are bored in the classroom, or are passing through certain stages of development may appear inattentive, hyperactive, or impulsive—yet they do not have AD/HD.

To determine whether a child needs to be examined by a physician, psychologist, or other medical specialist, you should consider several critical questions:

- ✓ Are the child's troublesome behaviors excessive, long-term, and pervasive?
- ✓ Do they occur more often than in his/her peers?
- ✓ Are his/her behaviors a continuous problem and not just a response to a temporary situation?
- ✓ Do his/her behaviors occur in several settings, or only in one specific place, such as the playground or school?

You should talk to the child's teacher to get a clearer reading on the child's daily behaviors. You should also seek a consultation with a health professional to rule out other possible psychological problems, such as depression or a learning disorder.

# Special Education Services

## The Individuals with Disabilities Education Act:

### What Is the Individuals with Disabilities Education Act (IDEA)?

The **Individuals with Disabilities Education Act (IDEA)**, a federal law originally passed in 1975 as PL 94-142 and amended in 1984, 1990, and 1997, mandates that all eligible children receive a free, appropriate public education regardless of the level or severity of their disability. It provides funds to assist states in the education of students with disabilities and requires that states make sure that these students receive an individualized education program based on their unique needs in the least restrictive environment appropriate. IDEA also provides guidelines for determining what related services are necessary and outlines a “due process” procedure to make sure needed services are provided.

### Who Is Eligible for Services Under IDEA?

Children ages three through twenty-one who need special education and related services because of a disabling condition are eligible. Eligibility for services is determined through “nondiscriminatory evaluation.” This requires that school districts use testing materials free from racial or cultural discrimination and presented in the child’s native language or means of communicating. Tests must be chosen that assess the child’s actual abilities if sensory, motor, or language impairments are present. Evaluations cannot be based solely on one general test, such as an intelligence test, and the child is to be assessed across all areas related to the disability by a “multidisciplinary team.”

An appropriate education may include an out-of-district or private school placement if the school district cannot provide appropriate services in the district. The courts have also ruled, however, that an “appropriate” education is not always the same as the “best” education as long as the education services adequately meet the child’s needs.

### What Is an IEP?

An IEP refers to the Individualized Education Program. This is a written, legal document that describes the specialized educational plan and related services to be provided to the student. It is developed in a team meeting in which all members of the IEP team decide what is an appropriate education for the child who needs services. The team can include the GAL volunteer, also acting as the education surrogate/surrogate parent. The main goal of the IEP meeting is to discuss the educational needs of the student and write a program that identifies goals and objectives and related services needed for the year.

### What Is the School’s Responsibility in Developing an IEP?

The local education agency is responsible for:

- ✓ Contacting parents about the need for an IEP;
- ✓ Setting a date, time, and location to meet that is convenient for everyone on the team, including the parent(s) or family member(s);

- ✓ Designating an official from the school district to be involved in and to conduct the meeting and ensure the team decisions are implemented;
- ✓ Inviting all members of the IEP team;
- ✓ Ensuring that the meeting is held, the IEP written, and placement decisions made; and
- ✓ Making sure that the IEP is reviewed at least annually and revised if necessary.

## **What Is the Parent’s Role in Developing the IEP?**

In IDEA, the term “parent” refers to the child’s biological parent, a guardian, a person acting as the parent of a child (such as the grandparents), or a surrogate parent appointed if the child is a ward of the state or the parent is unavailable.

IDEA ensures that parents are equal partners in the IEP process. School personnel and parents must work toward the common goal of developing an effective education program for the child.

Parents should prepare for the meeting by reviewing their child’s past education records. IDEA ensures that parents are permitted to inspect and review records in a timely manner. Parents should also have in mind goals or objectives based on what they see as needed, and they may want to talk with their child’s teacher before the meeting. The IEP should describe the student’s educational goals and objectives, related services needed, and the school placement decision. If parents are dissatisfied with any aspect of the IEP and are unable to resolve the problem, they may request mediation and, if necessary, pursue due process hearing options guaranteed by the law. Parents may obtain assistance in preparing for and/or attending IEP meetings from the local chapter of organizations, such as the Arc or LDA, for parents of children who have a disability. Many communities also have advocacy organizations specifically serving the disabled. Every state also has a protection and advocacy (P and A) agency.

## **Who Should Be Involved in IEP Meetings?**

IDEA requires that every IEP meeting, whether it is the initial meeting or a review, include:

- ✓ A person from the school district, other than the student’s teacher, who is qualified in special education or special education supervision;
- ✓ The student’s teacher;
- ✓ One or both of the student’s parents, family members, or guardians;
- ✓ The student, when appropriate;
- ✓ Someone qualified to interpret the instructional implications of evaluation (this may be one of the school personnel above); and
- ✓ Other people who are involved in the education of the student as identified by the school or the parent.

A meeting may be held without a parent attending if the parent is unable or unwilling to do so. The district must, however, invite the parents and document its attempts to set a time and place where all persons can attend. Parental absence from the meeting is not necessarily construed as reflecting dissatisfaction or disagreement, and IEP decisions, including school placement, will be made by the school in their absence.

## What Is Included in an IEP?

IDEA requires that the following items be included in the IEP:

- ✓ A statement of the student's present levels of educational performance;
- ✓ A statement of the yearly goals and the instructional objectives that need to be met to achieve these goals;
- ✓ A statement of the special education and related services that will be provided to the student as well as how much the student will participate in regular educational programs;
- ✓ The dates these services will begin and how long they will last;
- ✓ For each student age sixteen and over, transition services that will be provided; and
- ✓ What the school must do to enable the student to meet the objectives, how this is to be measured, and annually, whether the objectives from the previous year's IEP have been met.

## When Is It Appropriate for the Student to Participate?

Students need to participate in the IEP process as much as they can (some older children with mental handicaps may not have the intellectual ability to understand this process). Their opinions, preferences, and choices need to be part of the decision-making process. The chance to choose areas of instruction, based on their preferences, will help them develop skills that lead to independence and self-determination. Of course, there are several factors that limit how much students participate, including their age and their ability to make adequate decisions. However, almost all students can participate in some way in their IEP process.

## What Is to Be Reviewed at IEP Meetings?

Each student's progress related to his/her Individualized Education Program must be reviewed yearly to determine current progress and future needs. The review needs to consider the general progress of the student, staff and parental concerns about the student's progress, whether objectives are reached according to the measures described in the IEP, and what changes need to be made to meet the student's needs.

Any significant changes in the student's program after the initial or annual IEP meeting necessitates another IEP meeting. IDEA requires that parents receive written notice whenever the district proposes or refuses to initiate or change anything related to the child's identification, evaluation, program, or placement.

Additionally, parents and educators should ensure that goals are functional and chronologically age appropriate, and that they prepare students for adulthood.

## What Is Meant by Placement in the Least Restrictive Educational Environment?

The decision to place a student with a disability in a particular education program must be based on the factors specified during the IEP process. This decision must be reviewed at least annually, and placement may change if the child's education program or needs change.

IDEA requires that students with disabilities be educated with students who do not have disabilities to the greatest extent appropriate. The law states that “unless a child’s individualized education program requires some other arrangement, the child is (to be) educated in the school which he/she would attend if not disabled” [Section 121a.522(c)]. It requires that removal of the child from the regular classroom occur only when education in regular classes “with the use of supplementary aids and services cannot be achieved satisfactorily” [Section 121a.550(2)].

The Arc and other organizations interpret “least restrictive” as representing instruction in the regular classroom to the greatest extent possible or appropriate. Families need, through the IEP process, to ensure that adequate accommodation and support are provided before alternative placement is considered and that time spent outside of the regular classroom is based upon functional considerations such as community integration and instruction. The Arc is opposed to student’s placement in segregated facilities, as they do not provide opportunities for learning from nondisabled role models, although the law and many other parents and professional organizations support a full continuum of placements being available.

Adapted from materials created by the Exceptional Children’s Assistance Center, 1998-99.

# Childhood Depression



*A feeling of intense sadness beyond an appropriate length of time.*

## What Causes Childhood Depression?

Children who develop major depression are likely to have a family history of the disorder, often a parent who experienced depression at an early age. Depression in children can be triggered by events or problems, such as the death of a parent, a friend moving away, difficulty in adjusting to school, difficulty making friends, or drug or alcohol abuse. However, some children become depressed without profoundly unhappy experiences.

## What Are the Symptoms of Childhood Depression?

The defining features of depression in children are the same as they are for adults. However, recognition and diagnosis of the disorder are more difficult in youth because expression of the symptoms varies with youth's developmental stage, and children may have difficulty properly identifying and describing their internal emotional or mood states. Therefore, symptoms of depression may manifest in children as the following:

- ✓ Frequent vague, nonspecific physical complaints, such as headaches, muscle aches, stomach-aches, or tiredness;
- ✓ Frequent absences from school or poor performance in school;
- ✓ Talk of or efforts to run away from home;
- ✓ Outbursts of shouting, complaining, unexplained irritability, or crying;
- ✓ Being bored;
- ✓ Lack of interest in playing with friends;
- ✓ Among older youth, alcohol or substance abuse;
- ✓ Social isolation, poor communication;
- ✓ Fear of death;
- ✓ Extreme sensitivity to rejection or failure;
- ✓ Increased irritability, anger, or hostility;
- ✓ Reckless behavior; and/or
- ✓ Difficulty with relationships.

Five or more of these symptoms must persist for two or more weeks before diagnosis of depression is indicated.

## **What Treatments Are Available?**

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. In order to prevent the recurrence of depression, it is recommended that treatment be continued for at least six months after the remission of symptoms.



*A repetitive and persistent pattern of behavior in which children or adolescents violate the rights of others or violate norms and rules appropriate to their age.*

## **Conduct Disorder**

### **What Causes Conduct Disorder?**

Researchers have not yet discovered what causes conduct disorders, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against anxiety, an attempt to recapture the mother-infant relationship, the result of maternal deprivation, or a failure to internalize controls. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment, to get material goods that come with living in an affluent society, or to gain social status among friends. Other sociologists say inconsistent parenting contributes to the development of the disorders. Finally, biological theories point to a number of studies that indicate children could inherit a vulnerability to the disorders. Children of criminal or antisocial parents tend to develop the same problem. Other biologists believe that male hormones or problems in the central nervous system could contribute to the erratic and antisocial behavior. None of these theories can fully explain why conduct disorders develop. Most likely, an inherited predisposition and environmental and parenting influences all play a part in the illness.

### **What Are the Signs of Conduct Disorder?**

Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- ✓ Steals, without confrontation (e.g., forgery) and/or by using physical force (e.g., muggings, armed robbery, purse-snatching, or extortion);
- ✓ Consistently lies (other than to avoid physical or sexual abuse);
- ✓ Deliberately sets fires;
- ✓ Is often truant from school or absent from work;
- ✓ Has broken into someone's home, office, or car;
- ✓ Deliberately destroys the property of others;
- ✓ Has been physically cruel to animals and/or to humans;
- ✓ Has forced someone into sexual activity with him/her;
- ✓ Has used a weapon in more than one fight; and
- ✓ Often starts fights.



## **What Treatments Are Available?**

Treatments, including behavior therapy and psychotherapy (either individual or group sessions), are aimed at helping young people realize and understand the effect their behavior has on others. Some children also suffer from depression or attention-deficit/hyperactivity disorder; use of medications as well as psychotherapy has helped lessen their symptoms of conduct disorder. Moralizing and threatening do not work. Often the most successful treatment is to separate the child from a damaging environment and to administer strict discipline.



*Re-experiencing a very distressing event that has overwhelmed a child's coping mechanism and has created intense feelings of fear and helplessness.*

## **Post-Traumatic Stress Disorder**

### **What Causes Post-Traumatic Stress Disorder (PTSD)?**

A child who experiences a catastrophic event may develop PTSD. A stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred, such as experiencing or witnessing one of the following:

- ✓ Physical or sexual assault or abuse;
- ✓ Family and community violence;
- ✓ Severe accidents;
- ✓ Life-threatening illnesses; or
- ✓ Natural disasters (flood, fire, earthquakes).

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

### **What Are the Signs of PTSD?**

PTSD affects how a child feels and acts. Signs of stress may include the following:

1. A child may re-experience the trauma by:
  - Talking about the trauma over and over again;
  - Including trauma-related events in play;
  - Dreaming about the trauma;
  - Feeling like the trauma is happening all over again; and/or
  - Becoming very distressed when reminded of the trauma.
2. A child might withdraw from the trauma experience by:
  - Avoiding thoughts or feelings about the trauma;
  - Avoiding activities associated with the trauma;
  - Forgetting parts of the trauma;
  - Losing skills such as toilet training or language skills;
  - Wanting to be alone more than usual;
  - Becoming less affectionate toward others; and/or

- Feeling like there is nothing to look forward to in the future.

3. A child may experience restlessness and agitation, such as:
- Having difficulty falling asleep or staying asleep;
  - Becoming easily angered, irritable, or jumpy;
  - Having concentration problems;
  - Expressing fear (fear of being left alone or sleeping alone);
  - Becoming overly watchful and easily startled; and/or
  - Reporting physical complaints when reminded of the trauma.

### **What Treatments Are Available?**

Treatment of PTSD in children generally involves “talking therapies” (such as cognitive behavioral therapy, family therapy, or brief psychotherapy) and may include the prescription of medication by a psychiatrist.



*A combination of particular facial features, growth deficiency, and central nervous system damage resulting from alcohol exposure during pregnancy.*

## **Fetal Alcohol Syndrome**

### **What Causes Fetal Alcohol Syndrome (FAS)?**

A fetus exposed to any amount of alcohol may suffer from fetal alcohol syndrome. Alcohol causes physical damage to the central nervous system. The risk of severe birth defects increases with the amount of alcohol consumption. However, even small amounts of alcohol can be harmful; therefore, women are recommended to avoid alcohol during the entire pregnancy.

### **What Are the Symptoms of FAS?**

**A child with this condition will have one or more of these effects:**

- ✓ Poor sucking ability;
- ✓ Poor sleeping habits;
- ✓ Irritability from alcohol withdrawal;
- ✓ Unusually small body, head, eyes, or jaw;
- ✓ Cleft palate;
- ✓ Heart defects;
- ✓ Hip dislocation and other joint deformities;
- ✓ Mental retardation;
- ✓ Learning disabilities;
- ✓ Speech and language difficulties;
- ✓ Hyperactivity;
- ✓ Inappropriate emotional responses;
- ✓ Problems with fine and gross motor skills;
- ✓ Memory deficit or “quirky memory”;
- ✓ Inability to generalize from one situation to another;
- ✓ Easily stimulated or distracted;
- ✓ Difficulty with cause and effect;
- ✓ Seeming lack of remorse;
- ✓ Lack of boundaries;



- ✓ Overly affectionate;
- ✓ Hyper/under sensitivity to touch, sound, light, and textures; or
- ✓ Hygiene problems.

### **What Treatments Are Available?**

There is no cure for fetal alcohol syndrome. However, children with FAS can be helped. The treatment involves recognizing the symptoms and addressing the problems by providing medical and dental care or placing them in special school programs.

# Professional Assessment of Children

## Tools for Assessment

The selection of instruments (tests) to be administered to a child must be appropriate for the purpose of the evaluation and must take into consideration the child's age and any special handicaps such as sensory deficits, physical or motor impairments, or speech disorders. Tests should also be culturally appropriate or at least be free of cultural bias.

Other factors of importance in selecting tests for individual examination are determined by the attributes of the tests. Among those to be considered in choosing one test in preference to another are:

- **Validity**  
How well does the test measure what it is said to measure?
- **Reliability**  
How consistently are the test results reproduced when the same individual is re-tested? When the test is broken up via the split-half method and compared with itself, is it internally consistent?
- **Standardization**  
The test norms should be derived from a representative sample of the population to whom the test is to be applied.
- **Objectivity**  
An objective test involves specific responses to specific requests or situations. A standard set of directions is followed for administering and scoring the test. Any departures from these prescribed procedures must be reported.

*(Note: No single test score is conclusive; professionals look for several sources of data to support conclusions they draw from the tests.)*

## Brief Descriptions of Some Commonly Used Assessment Tools

The following list of assessment tools is in no way intended to be complete. It does, however, give some examples of the types of instruments that may be used. The GAL volunteer is not expected to have an expert's knowledge of the use of assessment instruments. However, some familiarity with the types of instruments being used may help guide research and further discovery on behalf of the child.

### Developmental Scales

#### **Denver Developmental Screening Test** *(1 month–6 years)*

Quick assessment of personal, social, fine motor, adaptive, language, and gross motor development.

**Gesell Developmental Schedules** (2 ½ years–6 years)

Thirteen tests assessing wide range of developmental factors in preschoolers. Assesses behavior and emotional and physical development. Used for screening, early intervention, or diagnosis.

**Bayley Scales of Infant Development** (2 months–30 months)

Two-scale test for infant mental and motor development and a behavior rating. Assesses early mental and psychomotor development. Used in the diagnosis of normal versus retarded development.

## Intelligence Tests

**Wechsler Intelligence Scale for Children–Revised (WISC-III)** (5 years–15 years)

Twelve subtests divided into two major divisions yielding a verbal IQ, performance IQ, and full scale IQ for children tested individually. Provides verbal and nonverbal scales.

**Wechsler Preschool & Primary Scale of Intelligence (WPPSI-II)** (2 years–6 ½ years)

Ten standardized subtests divided into verbal and nonverbal scales to assess cognitive and reasoning abilities. Scores converted to deviation quotient comparing subject to age peers.

**Stanford-Binet Intelligence Scale (SB-IV)** (2 years–Adult)

Measures overall cognitive abilities. Emphasis at lower ages on sensorimotor performance; at school age and above, highly dependent on verbal skills. Verbal and nonverbal tests assess verbal reasoning, abstract/visual reasoning, quantitative comprehension, and short-term memory. Can be used to substantiate scores from group tests, to provide more comprehensive assessment, and when a subject has physical, language, or personality disorders that prevent group testing. Results can help identify subjects who would benefit from specialized learning environments.

**Leiter International Performance Scale** (2 years–18 years)

Multiple-item nonverbal task assessment of intelligence. Individual performance scale. Covers range of functions, non-timed, nonverbal, assumed to be culture-free. Useful for children with speech or language difficulties.

**Wechsler Adult Intelligence Scale–Revised (WAIS-R)** (16 years–Adult)

Eleven subtests yielding verbal IQ, performance IQ, and full scale IQ. Verbal and nonverbal scales. Popular and well-standardized test but considered not useful for exceedingly superior or for retarded.

## Vocabulary

**PPVT**

Point to response nonverbal multiple-choice selection of picture associated to word spoken by examiner. Measures receptive vocabulary for Standard American English, estimates verbal ability, and assesses academic aptitude. Also used with English as a Second Language (ESL) students, mentally retarded, and gifted students. Vulnerable to deficit in visual/perceptual functions. Scores converted to mental ages, deviation IQ.

**Full Range PVT**

Similar to Peabody. Assesses individual intelligence when scores are converted to mental age and tables are available for comparable Wechsler Verbal IQ. May be used in testing special populations such as physically handicapped, uncooperative, aphasic, or very young subjects.

## Perceptual- or Visual-Motor Integration Tests

### **Bender Visual-Motor Gestalt Test** (3 years–Adult)

A paper-pencil test, untimed. Assesses visual-motor functions. Evaluates developmental problems in children, learning disabilities, retardation, psychosis, and organic brain disorders. Visual-perception, visual-motor integration, motor skill, and organizational ability are tapped by copying figures. Also used as projective test.

### **Illinois Test of Psycholinguistic Abilities (ITPA)** (2 years–10 years)

Ten subtests evaluate child's cognitive and perceptual abilities in communication, auditory, psycholinguistic process of visual reception, levels of organization, sequential memory, association of symbols, ordering recall, discrimination and conceptualization of similarity, and closure.

### **Frostig Developmental Test of Visual Perception** (pre-kindergarten)

Forty-one-item paper-pencil test assessing eye-motor coordination, figure-ground, form constancy, discrimination of position in space, and reproduction of spatial relationships. Evaluates children referred for learning difficulties or neurological handicaps.

### **Goodenough-Harris Drawing Test** (3 years–15 years)

Assesses mental ability through nonverbal technique and drawing tasks. Revisualization, ability to reproduce representation of human figures. Developmental age scores. Also used as projective device.

### **Benton Revised Visual Retention Test** (8 years–Adult)

Measures visual memory. Utilizes ten cards depicting one or more geometric forms exposed ten seconds. Assesses revisualization, spatial perception, and perceptual-motor reproductions. Scored for number correct and number of errors. Used as supplement to visual mental examinations.

### **Memory for Designs (Graham-Kendall) Test** (8 ½ years–Adult)

Assesses revisualization and visual-motor coordination. Fifteen cards with simple geometric figures, each exposed five seconds, to be reproduced. Used to differentiate between functional behavior disorders and those associated with brain injury.

## Auditory Processing Tests

### **Illinois Test of Psycholinguistic Abilities (ITPA)** (2 years–10 years)

Assesses specific psycholinguistic abilities and disabilities in children. Facilitates assessment of child's abilities for remediation. Ten subtests of auditory-reception, association, sequential recall, grammatic closure, sound-blending, and verbal expressiveness. Assess decoding, ordering, memory, ability to analyze and synthesize parts-to-whole.

### **Goldman-Friscoe-Woodcock Test of Auditory Discrimination** (4 years–Adult)

Diagnoses an individual's ability to hear clearly under increasingly difficult listening conditions. Twelve subtests measure auditory election, attention, discrimination, memory, and sound-symbol skills. Intersensory integration is involved in multiple-choice response to pictures associated with recorded words. Used for instructional planning.

## **Kinesthesia & Tactile Perception**

### **Southern California Sensory Integration Tests** (4 years–10 years)

Measures an individual's ability to see, touch, and move in a coordinated manner. Seventeen-item paper-pencil and task assessment tests measuring visual, tactile, and kinesthetic perception, and different types of motor development. Used to identify the degree and type of disorder often associated with learning and emotional programs, minimal brain dysfunction, and cerebral palsy.

### **Reitan-Indiana Neuropsychological Battery for Children** (5 years–Adult)

Assesses brain-behavior functioning in children. Includes subtests of sensory perception, intersensory manual form perception, tactile localization, tactile-kinesthetic perception, learning, and recall. Used for clinical evaluations.

## **Motor Tests**

### **Southern California Sensory Integration Test** (4 years–10 years)

Five of six subtests require imitation of patterned movements, body positions, or response to verbal requests.

### **Southern California Motor Accuracy Tests** (4 years–8 years)

Measures degree of accuracy in drawing a pencil line over a printed line. Used in diagnosis of perceptual-motor dysfunction in atypical children. Used in clinical evaluations.

### **Lincoln Oseretsky Motor Development Scale** (6 years–14 years)

Measures motor development. Tests fine and gross motor skills. Used to supplement information obtained from other techniques concerning intellectual, social, emotional, and physical development.

### **Purdue Perceptual Motor Survey** (6 years–10 years)

Range of postural, motor, body image, and form perception measures.

### **Frostig Developmental Test of Visual Perception** (3 years–10 years)

Eye-motor coordination subtests measure skill of visually guided movements.

### **Bayley Scales of Infant Development, Motor Scale** (2 months–30 months)

Assesses developmental levels of motor patterns, including prehension and locomotion.

## **Academic Skills & School Achievement**

### **STANDARDIZED TESTS GIVEN BY SCHOOLS:**

All measure reading, math, and writing skills.

- **Iowa Test of Basic Skills (ITBS)**
- **Washington Assessment of Student Learning (WASL)**

### **TESTS GIVEN BY SPECIALISTS:**

#### **Woodcock-Johnson Psychoeducational Battery (W-JPEB)**

Twenty-seven-test battery. Evaluates individual cognitive ability, scholastic achievement, and interest level. Used to diagnose learning disabilities for instructional planning, vocational rehabilitation, and counseling.

### **Wide-Range Achievement Test–Revised (WRAT-R)**

Three paper-pencil subtests, which measure basic educational skills of word recognition, spelling, and arithmetic. Identifies individual learning difficulties. Used for educational placement, measuring school achievement, vocational assessment, and job placement and training.

### **Peabody Individual Achievement Test (PIAT)**

Four-hundred-item test of mathematics, reading, comprehension, and general information. Provides an overview of individual scholastic attainment. Used to screen for areas of weakness requiring more detailed diagnostic testing.

## **Adaptive Behavior Scales**

### **Vineland Social Maturity Scale–Revised**

One-hundred-seventeen-item interview covering eight categories of self-help in general, eating, dressing, communication, self-direction, socialization, and locomotion. Measures successive stages of social competence and adaptive behavior. Used to measure individual differences, which may be significant in cases of mental deficiencies and emotional disturbances, in order to plan therapy or individual education.

### **Woodcock-Johnson Scales of Independent Behavior (SIB) (2 years–Adult)**

Assesses functional behavior, self-help skills, and communication skills. Usually used with developmentally delayed individuals.

### **A.A.M.D. Adaptive Behavior Scale (3 years–6 years)**

Assesses social and daily living skills of children whose adaptive behavior indicates possible mental retardation, emotional disturbance, or other learning handicaps. Used for screening and instructional planning.

## **Personality & Social/Emotional Functioning**

A variety of tests can be used to examine various personality or emotional hypotheses about children. These tests include the following:

### **The Achenbach Child Behavior Checklist (CBCL) (2 years–16 years)**

Assesses behavioral problems and competencies of children and adolescents. Evaluates child behavioral problems from subject's perspective with Youth Self-Report (for ages 8–11 years), from parent's point of view with Child Behavior Checklist, and from teacher's perspective on classroom behavior with Teacher Report Form. Direct Observation Form used by experienced observer to rate on basis of a series of at least six ten-minute observation periods.

### **Behavioral Assessment Scale for Children (BASC) (2 ½ years–18 years)**

Assesses the range of behavior for typically developing children in order to look for areas of psychological damage.

### **Minnesota Multiphasic Personality Inventory–Adolescent Version (MMPI-A) (Adolescents–Adults)**

One-hundred-fifty-item true/false test of ten clinical variables or factors. Assesses individual personality. Used for clinical diagnosis and research on psychopathology.

**Children’s Depression Inventory (8 years–13 years)**

Twenty-seven-item pencil-paper inventory measuring overt symptoms of child depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Assesses severity of depression in children and adolescents. Also used to measure progress during treatment.

**Various Projective Tests****TAT, CAT, Robert’s Apperception Test for Children, Piers-Harris Children’s Self-Concept Scale, Sentence Completion Test**

Used with caution, as they are not standardized. They can be helpful when used with other sources and by a trained clinician.

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Adapted from *Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business*, second edition, Richard C. Sweetland, Ph.D., and Daniel J. Keyser, Ph.D., general editors. Kansas City, MO: Test Corporation of America, 1986. Updated for NCASAA by Peggy Tribble, Ph.D., May 2000.

# Resiliency: The 40 Developmental Assets

## The Search Institute's Framework for Looking at Protective Factors

In an effort to identify the elements of a strengths-based approach to healthy development, Search Institute developed the framework of developmental assets. This framework identifies forty critical factors for young people's growth and development. When drawn together, the assets offer a set of benchmarks for positive child and adolescent development. The assets clearly show important roles that families, schools, congregations, neighborhoods, youth organizations, and others in communities play in shaping young people's lives.

## External Assets

### SUPPORT:

1. **Family support:** Family life provides high levels of love and support.
2. **Positive family communication:** Young person and his/her parent(s) communicate positively and young person is willing to seek advice and counsel from parent(s).
3. **Other adult relationships:** Young person receives support from three or more non-parent adults.
4. **Caring neighborhood:** Young person experiences caring neighbors.
5. **Caring school climate:** School provides a caring, encouraging environment.
6. **Parent involvement in schooling:** Parent(s) are actively involved in helping young person succeed in school.

### EMPOWERMENT:

7. **Community values youth:** Young person perceives that adults in the community value youth.
8. **Youth as resources:** Young people are given useful roles in the community.
9. **Service to others:** Young person serves in the community one hour or more per week.
10. **Safety:** Young person feels safe at home, school, and in the neighborhood.

### BOUNDARIES & EXPECTATIONS:

11. **Family boundaries:** Family has clear rules and consequences, and monitors the young person's whereabouts.
12. **School boundaries:** School provides clear rules and consequences.
13. **Neighborhood boundaries:** Neighbors take responsibility for monitoring young people's behavior.
14. **Adult role models:** Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence:** Young person's best friends model responsible behavior.
16. **High expectations:** Both parent(s) and teachers encourage the young person to do well.

## CONSTRUCTIVE USE OF TIME:

17. **Creative activities:** Young person spends three or more hours per week in lessons or practice in music, theater, or the arts.
18. **Youth programs:** Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
19. **Religious community:** Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home:** Young person is out with friends, “with nothing special to do,” two or fewer nights per week.

## Internal Assets

### COMMITMENT TO LEARNING:

21. **Achievement motivation:** Young person is motivated to do well in school.
22. **School engagement:** Young person is actively engaged in learning.
23. **Homework:** Young person reports doing at least one hour of homework every school day.
24. **Bonding to school:** Young person cares about his/her school.
25. **Reading for pleasure:** Young person reads for pleasure three or more hours per week.

### POSITIVE VALUES:

26. **Caring:** Young person places high value on helping other people.
27. **Equality and social justice:** Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity:** Young person acts on convictions and stands up for his/her beliefs.
29. **Honesty:** Young person “tells the truth even when it is not easy.”
30. **Responsibility:** Young person accepts and takes personal responsibility.
31. **Restraint:** Young person believes it is important not to be sexually active or to use alcohol or other drugs.

### SOCIAL COMPETENCIES:

32. **Planning & decision-making:** Young person knows how to plan ahead and make choices.
33. **Interpersonal competence:** Young person has empathy, sensitivity, and friendship skills.
34. **Cultural competence:** Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills:** Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution:** Young person seeks to resolve conflict nonviolently.

## **POSITIVE IDENTITY:**

- 37. Personal power:** Young person feels he/she has control over “things that happen to me.”
- 38. Self-esteem:** Young person reports having high self-esteem.
- 39. Sense of purpose:** Young person reports that “my life has a purpose.”
- 40. Positive view of personal future:** Young person is optimistic about his/her personal future.

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