

Spring/Summer '97  
Volume 2, No. 1

Giving kids  
confidence  
to overcome  
crisis



**KidsPeace**<sup>®</sup>  
The National Center for Kids Overcoming Crisis



KidsPeace National  
Centers for Kids in Crisis<sup>®</sup>



**National Hospital**  
for Kids in Crisis<sup>®</sup>

# Healing<sup>™</sup>

MAGAZINE

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HANNAH CHRISTINE BROUGH

AGE 6 MONTHS



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**About KidsPeace**

KidsPeace is a private not-for-profit organization dedicated to serving the critical needs of children and teens. Since 1882, KidsPeace has been helping kids develop the confidence and skills to overcome developmental and situational crises in their lives. Today, KidsPeace offers the nation's most comprehensive range of treatment programs, along with educational services to help families help kids anticipate and avoid crisis whenever possible. Long recognized for its exemplary work with children and families, KidsPeace is the recent recipient of "The Outstanding Organization Award" from the American Association of Psychiatric Services for Children and "Accreditation With Commendation" from the Joint Commission on Accreditation of Healthcare Organizations.



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How  
to reach



**KidsPeace®**  
The National Center for Kids Overcoming Crisis

**ADMISSIONS**

**National Hospital for Kids in Crisis**  
**KidsPeace National Centers for Kids in Crisis**  
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**KidsPeace National Centers for Kids in Crisis**  
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# KidsPeace: 115 years of *hope and healing*

*“See where we’ve gone.  
And where we’re going  
tomorrow.”*



**John P. Peter**  
*KidsPeace President  
and CEO*

**S**INCE THE DAY WE OPENED OUR DOORS IN 1882, KidsPeace has advanced greatly — both in our ability to serve children and in our quality of care. Today, we have beautiful, modern facilities in which our kids can grow and learn and heal. We have the very best therapeutic programs, professionally designed and creatively carried out, to help our kids. And, most important of all, we have an exceptionally supportive, caring staff of people who always go the “extra mile” to make sure our kids get every bit of help they need. It’s a healing combination, as our kids have shown us time and again.

In this issue of “Healing”, we highlight several facets of KidsPeace that demonstrate our commitment to excellence and innovation. Our Dual Diagnosis Program, a newly developed program that combines treatment for substance abuse and mental health issues, is recognized

for its comprehensive approach to helping adolescents overcome these challenges. And we also take a look around KidsPeace-New England, a unique residential treatment campus emphasizing experiential recreation therapy.

I am proud to introduce visitors to our campus – and readers of this magazine – to the many wonderful faces and features of KidsPeace in this, our 115th anniversary year. Come pay us a visit. See where we’ve gone. And where we’re going tomorrow.

For the kids,

**John P. Peter**  
President and CEO

# “We help kids face themselves.”

## *There's no way to dodge reality in the KidsPeace Dual Diagnosis Program*

***Adolescents facing personal or family problems sometimes take refuge in drugs or alcohol. But this escape quickly becomes a trap as dependency erodes both their physical health and emotional well-being. These addictive substances reach into every area of their lives, impairing their performance in school as well as their relationships with family and friends.***

**W**ith ever-increasing numbers of adolescents requiring treatment for both mental health and substance abuse problems, KidsPeace recently initiated a program that provides professional help for both diagnoses. A new residential program coordinates care for dual diagnosis clients by treating the presenting symptoms as well as the underlying causes of chemical dependence and emotional distress.

Carl Sever, supervisor of the Dual Diagnosis Program in Saylorsburg, Pennsylvania, describes the addition to the KidsPeace continuum of care as a “comprehensive inpatient program.” According to Sever, “It was

designed to help adolescents between the ages of 13 and 18 overcome drug or alcohol abuse and dependence while they learn to manage their personal problems in constructive ways.” Treatment focuses on the child’s behavioral and emotional difficulties, both individually and within the context of family and peer relationships.

### **But it doesn’t end there.**

“Families are encouraged to participate in therapeutic decisions and to take an active part in the treatment process,” says Sever. “Since substance abuse affects all members of a child’s family, the program includes support services and counseling for parents and their other children.” Drug and alcohol education, as well as ongoing emotional support, are an important part of this comprehensive plan.

### **Highly structured setting and curriculum**

Divided into four distinct components, the program includes individual and group therapy, educational testing and instruction, medical evaluation and treatment, and recreational activities.

“This population does well with a highly structured setting and curriculum,” Sever notes.

Admission begins with an initial assessment and orientation period, which lasts approximately two weeks. Extensive medical, psychological and educational testing is

included. Incorporating both group and individual counseling, this phase emphasizes the adolescent’s acknowledgment of the substance abuse problem and commitment to making necessary changes.

“This is, perhaps, the most significant part of their stay,” explains Sever. “Treatment won’t get very far without their admitting they need help.”

### **On to the next level**

What follows is a period of intensive treatment, which lasts approximately six weeks. This phase of the program provides a variety of therapies. It is also a time requiring participation in activities that focus on the needs of the group as well as those of the individual adolescent. Clinical modes include group therapy, assertiveness training, individual counseling, constructive confrontation and residential job assignments.

Says Sever, “In order to move on to the next level, specified program goals must be met during this therapeutic phase.”

Aftercare planning, begun during this period, centers on available clinical, educational, vocational and other supportive resources.

Individual education plans provide instruction and learning support services for each program participant. In accordance with state requirements, youngsters attend a full day of school on site.

Educational goals and achievements are an important part of each client's treatment, as well as a means of assessing the adolescent's therapeutic progress.

KidsPeace psychiatrists, pediatricians and nurses perform comprehensive medical evaluations, as well as provide routine and emergency care for adolescents in the program.

When the adolescent has accomplished specified treatment goals, a reentry period of two to three weeks provides preparation for returning to a community setting by reinforcing the positive, self-enhancing lifestyle begun during treatment. By the beginning of this transition period, adolescent and staff have jointly developed a comprehensive aftercare plan.

After successfully completing treatment, the adolescent is discharged to the family or placed in a setting that will provide the opportunity for continued care, growth and freedom from chemical influences. Comprehensive follow-up services are a crucial part of the aftercare program that tracks the adolescent's progress at regular intervals and provides for additional treatment, should that become necessary.

Sever says this program stands out from many others because of its emphasis on individual responsibility and participation in activities that benefit the entire group.

"Along with their therapy and education, we give kids daily assignments they are expected to perform," he says.

"We have created a community, and we are teaching them skills for living together as well as taking care of themselves.

"We also encourage them to join in making

decisions about activities and aspects of their lives where choices can be made. We do not coddle them or view them as helpless."

### **"We demand the best from our kids."**

Sever says what distinguishes the KidsPeace program is its emphasis on adolescents taking responsibility for their own behavior. There are no scapegoats, he says, and no way to dodge reality.

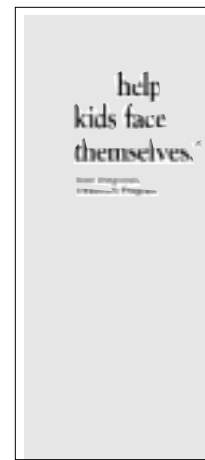
"We help kids face themselves," Sever says. "We will not accept their misbehavior. We make it difficult not to behave in a positive way, so that gradually good behavior feels right. It's positive peer pressure."

He also emphasizes the importance of helping adolescents think about the future, about what it will be like once they are discharged. They must make a conscious choice, he says, to plan their lives so that drugs or alcohol will not come creeping back in.

Most important, he insists, this program offers an atmosphere of caring and mutual respect.

"We demand the best from our kids, that they grow into their best selves. Because we care about them, we encourage them to turn self-destructive behavior into self-concern and healthy self-respect."

*To find out more about the KidsPeace Dual Diagnosis Program, please call Admissions at 1-800-8KID-123. Or call Carl Sever directly at (610) 381-3400.*



For a free brochure about the KidsPeace Dual Diagnosis Program, please call Director of Client Services David Dries at 1-800-25-PEACE, Ext. 8308.



# National Hospital for Kids in Crisis continuing education seminar examines how violence and trauma affect our children

By Jennifer Whitlock, MA

**STEVEN M. CRIMANDO, MA, A PRIVATE PRACTITIONER AND FORMER CLINICAL LIAISON FOR THE KIDSPACE NATIONAL HOSPITAL FOR KIDS IN CRISIS, HAS PROVIDED PSYCHOLOGICAL FIRST AID TO THE VICTIMS AND SURVIVORS OF DISASTER SCENES SUCH AS THE TWA FLIGHT 800 CRASH, THE WORLD TRADE CENTER BOMBING AND THE UNABOMBER STRIKES...**

**T**his may sound like territory that most therapists will never encounter. But in his two-part continuing education lecture, "Assisting Children Who Are the Victims and Witnesses of Violence and Trauma", Crimando says that lesser known events can traumatize children just as profoundly as the big news grabbers.

"There are a great number of traumatic incidents that happen in your communities, in your schools, in your neighborhood," said Crimando, who is also an Adjunct Professor of Psychology at Fairleigh Dickenson University in Madison, NJ, and an instructor at many police and EMS academies throughout the Northeast. "Some research indicates that in North America, four out of 10 people are exposed to major traumas in their lifetime. We're talking about TWA Flight 800, but we're also talking about the child who witnesses a parental suicide. And we're talking about other

occurrences such as earthquakes, floods, hurricanes, fire, car crashes, kidnapping and rape."

## Early intervention aids recovery

Crimando's talk concentrated on the most vulnerable population of victims: children. "Very often, we see after the trauma that the children are the forgotten victims because the parents are putting their life back together and rebuilding a home, or, in worst-case scenarios, making funeral arrangements. The children are not always able to talk to them about the event," said Crimando. "But young victims, for a number of reasons – such as less life experience, an underdeveloped neurology, and less ability to verbalize and express their response to the trauma – have a greater likelihood of later pathology."

Early intervention, however, gives kids a better shot at recovery. "There are brief, focused, structured interventions that have been very

effective in assisting individuals who have been exposed to violence and trauma," Crimando reported. "It has been at least anecdotally demonstrated that such methods help reduce the likelihood that those people will not go on to develop full-blown Post Traumatic Stress Disorder (PTSD)."

And kids are most likely to respond to therapy, if you reach them soon enough. "Dr. J.D. Lindy, head of trauma research at the University of Cincinnati, said that because a child's neurology is not fully mature, his or her cognitive understanding of a situation is like 'wet cement' within the first few days of exposure to a crisis," explained Crimando. "You can restructure it with a few tools – leave your hand print, write your initials. But as the days and weeks progress, the 'cement' begins to harden. Therapy is slow and arduous because you have to work with a 'hammer and a chisel' to chip away layers of trauma. So the message is, 'Do something quick.'"

Crimando shared specific methods of "sculpting wet cement" or "debriefing" that can be utilized immediately after a disaster. He also discussed "chiseling dry cement" – i.e., counseling victims who already had developed symptoms of PTSD.

## Traumatic Event Debriefing

Critical Incident Stress Debriefing, also called Traumatic Event Debriefing, was originally developed

to assist emergency personnel. Debriefing ideally occurs within three days of the event, but some research shows benefit up to 14 weeks after the event.

“The two central concepts of debriefing are ‘ventilate and validate,’” Crimando explained. “Tell the victim, ‘I hear you,’ and, ‘Those are real, normal responses to an abnormal event. You’re not going crazy.’ Instill hope that victims will return to normal functioning, and don’t expect pathology.”

Crimando says he usually conducts debriefing sessions in groups of no more than 20. “The sessions are not therapy,” he said. “It’s not about feeling better now. It’s meant to prevent long-term effects. Don’t confront their defense mechanisms, don’t discuss their personal lives. Focus on talking about what the events mean to them.”

To begin, “Start off by talking about facts because they’re easier to talk about than feelings,” advised Crimando. “What we want to know is: What did these kids do? What did they see? How much were they exposed to, and for how long? Start with the least threatening aspect: What were you feeling physically at the time of the event? Then inquire about physical reactions that surfaced in the ensuing hours and days. Move to what they were thinking, and then how they felt emotionally during the event and now. Then ask about their behavior at the scene and afterwards. Throughout, don’t pressure anyone to speak. The kids ventilate, and you validate.”

Continued Crimando, “Lastly, is what we’ll call the ‘Big Question’: ‘What is the worst part of the event for you?’ Even though they all shared the event, you will find it has a different meaning and impact on each person.

“Next, teach about the typical responses to trauma. (See sidebar on page 7: ‘Typical Responses to Trauma.’)”

Give the children names and phone numbers of resources in case they need further psychological help. And let the group know how to reach the debriefing team if they need more follow-up.”

### Treating Post Traumatic Stress Disorder

Unfortunately, many children don’t get the benefit of early intervention. About one fourth of those exposed to a traumatic situation may go on to develop PTSD symptoms such as persistent intrusive and distressing recollections of the event in dreams, nightmares and/or flashbacks; persistent avoidance of stimuli associated with the trauma; and persistent symptoms of increased arousal, in which the person is hypervigilant, has a heightened startle reflex, is jumpy and irritable, and sometimes aggressive.

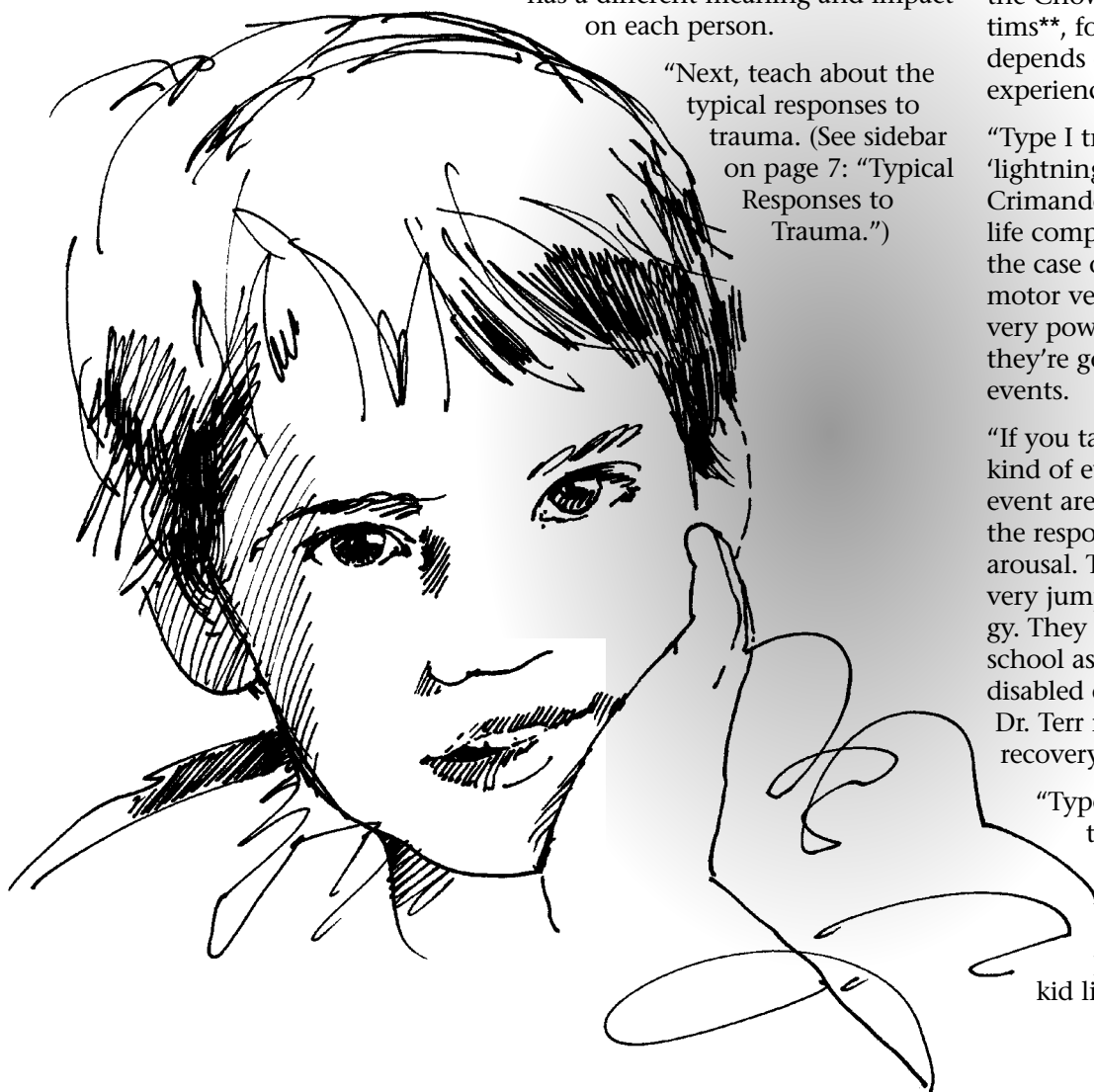
Dr. Terr, a researcher who studied the Chowchilla bus kidnapping victims\*\*, found that a child’s reaction depends on the type of trauma experienced.

“Type I traumas are what I call ‘lightning bolts,’” explained Crimando. “They come into your life completely unexpectedly – as in the case of kidnapping, a sniper, a motor vehicle accident. They’re very powerful, very brief. And then they’re gone. They’re extremely rare events.

“If you talk to children after this kind of event, their memories of the event are very sharp because part of the response pattern is hyperarousal. They become hypervigilant, very jumpy. And have a lot of energy. They may be misdiagnosed at school as hyperactive or learning disabled or conduct disorder.

Dr. Terr found that there’s a quicker recovery time in a Type I scenario.

“Type II traumas are more resistant to treatment. These are the chronic, long-standing repetitive situations – such as sexual abuse or physical abuse. Or when a kid lives in a battle area of the



inner city,” said Crimando. “These victims may have fuzzy memories of the event. It causes personality changes that are longer standing because the child had to develop a way of adapting to this stress. In extreme cases, there is disassociation, such as multiple personality disorder.”

Therapy may take longer, but can still produce positive changes. Crimando identified five phases of cognitive behavioral treatment for clients with PTSD: an introductory phase; addressing signs and symptoms; restructuring and transforming traumatic memory; reconnecting; and terminating.

**Introductory Phase.** “In the introductory phases, the first task is to establish rapport and a therapeutic alliance,” Crimando explained. “This may take a while. It’s particularly difficult to establish trust if the child was hurt badly by an adult.

Establishing trust takes a lot of compassion, empathy, consistency and time.”

Next, encourage your client to tell his story at his own pace, in his own language. “Ask him, ‘What was the worst part of this for you?’” advised Crimando. “It may not be what you’d expect. One of my clients said she came back from school one day and found her father had committed suicide in the bathtub. It was a very gory scene, but the worst part for her was that she didn’t want to have to tell her Mom all the details and she couldn’t go to the father-daughter dance at her school. It’s very important for her to tell the story in her own language, and to discuss what she’d seen, done and experienced – and have that validated.

“When they tell their stories, avoid being shocked or repulsed,” added Crimando. “Show them that you can tolerate listening to what happened to them. Sometimes watch-

ing an adult respond with horror to their story can re-traumatize a kid.”

Psychoeducation is another key feature of the introductory phase. “Unless they’re having an acute reaction, teach children that what they’re experiencing is a normal reaction to an abnormal event,” Crimando emphasized. “The event temporarily overwhelmed their ability to cope. If, for instance, they have trouble concentrating, or they want to play alone for a while, that’s a normal reaction.”

**Addressing Signs and Symptoms.** Teach clients the signs and symptoms of trauma, as well as possible coping mechanisms – such as relaxation and guided imagery. Discourage maladaptive coping mechanisms such as substance abuse, which is often used to reduce the hyperarousal response.

“Explore issues of re-victimization,” Crimando advised. “Victims sometimes have to testify in court over and over, which may be a form of revictimization. Observers’ reactions to their plight may be distressing. Address their concerns. Talk in a very safe manner. Allow ventilation – them telling the story – and validate their feelings. Let them know they’re not crazy on top of this horrible thing that happened to them.”

**Restructuring and Transforming Traumatic Memory.** “Help the child make the shift from being a victim to being a survivor – from, ‘What happened to me prevents me from succeeding,’ to, ‘If I can get over what happened to me, I can get over anything,’” Crimando said.



You may need to identify and correct their misconceptions. For example, a child may believe that the trauma happened because she did something wrong. Put the blame back where it should belong. The child did not invite the event.

“The Chinese character for crisis has two parts: danger and opportunity,” Crimando pointed out. “Help kids see where the opportunity for personal growth is. Help them rework the story. Help them master it. Help them master the experience so they can start thinking about it when they like, then stop thinking about it when they like.”

**Reconnecting.** Help children who have experienced trauma to develop a sense that it's safe to go back into the world. They might not feel safe walking out their door if something happened to them nearby. You may do exposure therapy: take them to the place where the event happened, and show them that they can master the situation.

**Terminating.** “Termination may be sensitive because it may re-stimulate feelings of loss and abandonment,” Crimando warned. “Let your client know that PTSD does not go away. One of the hallmark features is re-experiencing the trauma. There may be anniversary reactions and reminders. Every time kids go through the next developmental stage, they will have a new way of thinking about the world. At those times, they may reprocess the experience.”

Warning children that symptoms will return will not scare them off. To the contrary, preparing them for the inevitable relapse helps them cope with the episodes. If the client is not prepared, she may feel as though she went back to zero when it happens.

“I let clients know that over time, the feelings they have will be less intense,” Crimando said. “What we are looking for as the net result of treatment is that the child can turn on and off the recollection. It does not come to him with such

emotional power that it knocks him on his tail and causes behavior problems. Instead, the child will decide when to talk about the situation, and, when he's done, turn it off. If feelings are re-stimulated in the future, they are always welcome to come back.”

When children do come back, Crimando doesn't consider it a failure. “PTSD may not require long-term treatment every week,” he said. “Instead, the child may receive a pulse of treatment, and then stabilize. When the child experiences the event in different ways as she ages, she may receive another pulse of treatment.

“The first line in any treatment plan for somebody with PTSD should be to engender hope,” Crimando asserted. The client needs to know that, no matter how difficult the situation was and how intense the initial reaction was, he or she can cope.

*Address questions to Steve Crimando at 7 Serviss Road, Hopatcong, NJ, 07843, or call (201) 398-4646.*

\* Taken from “The Trauma Membrane and Other Clinical Concepts Derived From Psychotherapeutic Work With Survivors of Natural Disasters”, *Psychiatric Annual* (1985, volume 15).

\*\* In the mid 1970s, three teenaged boys in Chowchilla, California, kidnapped a bus full of toddlers, forced them into a tractor trailer that was buried in a quarry, and kept them there for a prolonged period of time. Eventually, the children found a way to escape. Dr. Lenore Terr, a psychiatrist from UCLA, conducted a 20-year study of the victims.

# Typical Responses to Trauma

## Physical

Insomnia  
Loss of Appetite  
Headaches  
Muscle Weakness  
Poor Coordination

## Affective

Depressed, anxious  
Numbing  
Constricted Affect  
Fear of Repeated Trauma  
Guilt and Shame  
Intolerance of Fear Response  
Pessimistic About Future

## Cognitive

Distractibility  
Duration/Sequence Distortions  
Declining School Performance  
Recurrent Intrusive Recollections  
Flashbacks, Nightmares

## Behavior

Clinging, Regression  
Isolation, Distancing  
Thrill seeking, Counterphobic  
Reenactments of the Scene  
Unsatisfying Traumatic Play  
Increased Substance Abuse  
Hypervigilance,  
High Startle Reflex

A deep concern for special children is evidenced in Dr. Bill Breton's extracurricular activities. He is founding president of the Maine Association of Directors of Services for Exceptional Children, founding director of the Maine Special Education Director's Academy, former president of the Maine chapter of the Council for Exceptional Children and member of the Governor's Advisory Panel on the Education of Exceptional Children.

# Quote Dr. B



**"I do not**  
*Governor's Advisory*  
*member Dr. Bill Bre*  
*at KidsPeace-New E*

**B**ILL BRETON WALKED INTO A CLASSROOM 30 years ago, eager to introduce his students to Chaucer and Shakespeare. A recent college graduate, he was excited by the prospect of opening up new worlds of great literature to his students. But it didn't take long before Breton realized his students weren't ready for such demanding work. In fact, most could barely read or write.

Breton remembers feeling initially overwhelmed, then inspired by the enormous challenge he faced. His students could learn as well as other students, he reasoned, as long as their teacher taught them well.

"Brains don't sit at desks," he thought. "Kids do!"

But he also knew that in order to teach them, he would have to understand what they were up against – not just in school, but also socially,



# believe that children fail.”

*anel on the Education of Exceptional Children  
n develops educational program for special kids  
gland*

emotionally, spiritually. These kids needed all the guidance, creativity and understanding their brand-new teacher and part-time basketball coach could muster.

## **Dr. B: “first and foremost, a wonderful teacher”**

Three decades later, Bill Breton – affectionately known as “Dr. B” around campus – continues to teach and guide and care for kids who need some extra help. Now Supervisor of Special Education at KidsPeace National Centers for Kids in Crisis-New England, he is exceptionally qualified to fill this important role. Along with a doctorate in educational leadership from the



With KidsPeace-New England’s strong emphasis on kinetic learning, therapeutic recreational activities expand the arena in which kids can feel successful. They climb, swim, fish, sail, sled, trek, hike and study – all in the beautiful, peaceful and protective environment of the Ellsworth, Maine, campus.





Dog-sled treks? Lama-pack expeditions?

At KidsPeace-New England, almost anything is possible. George Russell, Executive Director, finds his therapeutic recreation team seeking out new opportunities to help children take “down the psychic walls” – even if that means some unusual challenges for both kids and staff!

University of Maine, Breton holds three state certifications: special education services director, school superintendent and teacher of exceptional children.

As founding president of the Maine Association of Directors of Services for Exceptional Children, founding director of the Maine Special Education Director’s Academy and a former president of the Maine chapter of the Council for Exceptional Children, Breton keeps a finger on the pulse of special education issues. He has been a member of the Governor’s Advisory Panel on the

Education of Exceptional Children since 1985.

KidsPeace-New England’s Executive Director **George Russell** says Breton’s broad experience and comprehensive knowledge of special education has helped the center better serve its children.

“Still,” he confides, “Dr. Breton is, first and foremost, a wonderful teacher.”

Breton came to the Ellsworth, Maine, campus two years ago to work with the staff and 45 children in residence. He liked the interdisciplinary treatment approach he found there – therapists, educators, social workers and childcare counselors all equally involved in treatment and committed to restoring the child.

At KidsPeace, a seamless service plan is built on an understanding of the whole child. This emphasis on understanding the child from the perspective of each discipline makes the program unique, says Breton.

Under his leadership, the clinical component of care and the educational program have become fully integrated, ensuring full cooperation and coordination between educators and clinicians. This alliance allows staff members to work with the children to develop their own individualized education and treatment plans.

“It’s a team process,” says Breton. “And each member of the team presents us with a unique and valuable insight into the child.”

### **Not just another special ed program**

Russell credits Breton with developing a program that is both unique and progressive in its approach to treatment.

“Bill has succeeded in creating an educational program for special kids, as opposed to just another special ed program,” he says. “It has been an exciting process to watch.”

Today that process includes top-quality clinical and educational services for behaviorally and emotionally challenged children ages 11-17. Since many of the youngsters have never been successful in traditional

school settings, the instructional curriculum includes basic life skills training in addition to academic course work. The program also capitalizes on the extraordinary natural resources and beauty of the campus – a vast evergreen forest, majestic mountains and a pristine lake bounded by sandy shores.

With a strong emphasis on kinetic learning, therapeutic recreational activities expand the arena in which kids can feel successful. They climb, swim, fish, sail, sled, trek, hike and study – all this in a beautiful, peaceful and protective environment. Staff members work hard to foster an atmosphere of self-reliance so, although there is a high degree of supervision, it doesn't feel intense or "suffocating" to the children.

### Putting the child first

"We offer the children experiences which impart confidence and self-esteem," says Russell. "These experiences also help the kids begin to overcome feelings of inferiority or a perception of themselves as 'damaged goods.' It's a way of taking down the psychic walls they've built around themselves just to survive. We do this brick by brick.

"We get the kids to focus on skills development, to experience successes and to take control of their lives. KidsPeace offers kids a safe environment where they can explore their feelings, recover from trauma and



Meet the KidsPeace-New England team (clockwise from left): Rick Miller, supervisor of therapeutic recreation; Judith Bragar, social worker, girls residential; Kristie Wood, senior child care worker, boys residential; Theresa Lewis, intake caseworker, and Edward J. McSweeney, intake/managed care coordinator; Theresa Gallant, program supervisor; and R. Hawk Henries, counselor.

begin the journey to becoming a healthy adult."

Breton believes caregivers should work hard to gain a better understanding of children with emotional challenges. A better understanding, he believes, "will enable us to develop better methods, programs and opportunities to assist them in being as successful as they can be."

Describing him as an outstanding role model who is "consistently there" for the youngsters, Russell says there are many Sunday mornings when he finds Breton at breakfast with his young charges.

"He is always putting the child first," says Russell.

By their sincere commitment, he says, KidsPeace teachers and caregivers like Breton give children a leg up on developing a more positive world view.

"I do not believe that children fail," says Breton. "If they do, it's because we haven't figured out how to reach them. It's because we have not yet found the key to unlock the door."

Despite all his accomplishments, Dr. Breton hasn't completely abandoned his first loves. While there are many aspects of his job that Dr. B finds rewarding, he doesn't hesitate when asked what he likes best.

"Shooting hoops with the kids," he says. "And teaching Shakespeare."

*KidsPeace-New England recently received accreditation with commendation from the Joint Commission on Accreditation of Healthcare Organizations. This honor represents the organization's "outstanding level of achievement" in providing care of the highest quality to the*



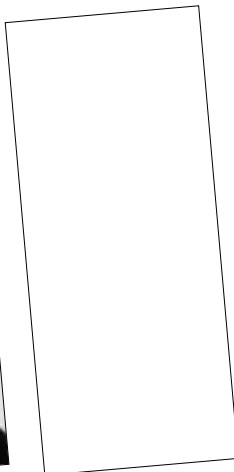
KidsPeace-New England capitalizes on the extraordinary natural resources and beauty of the campus – a vast evergreen forest, majestic mountains and a pristine lake bounded by sandy shores. This healing environment offers children experiences – for example, backpacking with a lama team! – that help to impart confidence and self-esteem.



*children and families it serves. To learn more about learning at KidsPeace National Centers for Kids in Crisis-New England, please call 1-800-992-9KID.*

*Or write for your free information kit, pictured below, which includes brochures on the school and residential programs as well as a video (shipped under separate cover) about the campus: KidsPeace Fulfillment, 5100 Tilghman Street,*

*Suite 028, Allentown, PA 18104. FAX requests accepted at (610)706-0124. For FAX requests, please be sure to write legibly, and include your daytime phone number.*





## Especially for parents

# Let's talk... about your child's *medication*

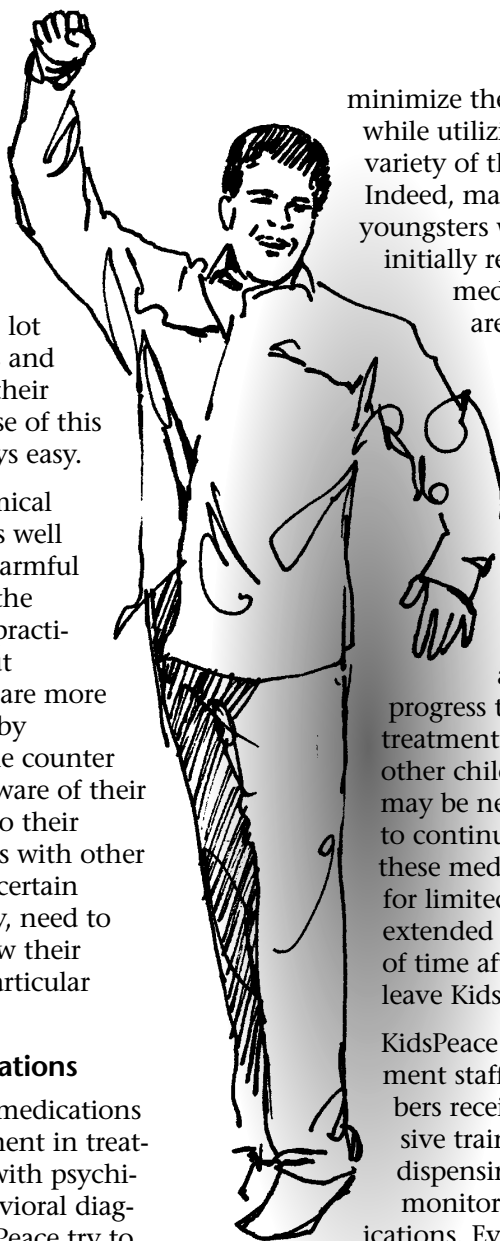
*At KidsPeace, our clients' concerns are our concerns. Like most children's mental health professionals, we believe that helping parents understand the unique circumstances surrounding their child's critical issues will give the entire family a better chance at working together to address and resolve crisis. Here are some tips for the parents of children who have been prescribed psychotropic drugs. You're invited to copy and pass them along, courtesy of KidsPeace.*

If you're the parent of a child who is taking psychotropic medication such as Prozac, Ritalin or any of the many lesser known prescriptions, you've probably heard a lot about their effectiveness and the long-term safety of their use. Trying to make sense of this information is not always easy.

Understanding the chemical makeup of medicines, as well as their beneficial and harmful effects, was once solely the domain of the medical practitioner or pharmacist. But because all medications are more readily available – both by prescription and over the counter – it is important to be aware of their side effects in addition to their potential for interactions with other medicines, alcohol and certain foods. Parents, especially, need to know both why and how their children should use a particular medicine.

### Understanding medications

Although psychotropic medications are often a vital component in treating children and teens with psychiatric, emotional or behavioral diagnoses, clinicians at KidsPeace try to



minimize their use while utilizing a variety of therapies. Indeed, many of the youngsters who initially receive medication are able to reduce and sometimes eliminate their need for medicine as they progress through treatment. For other children, it may be necessary to continue taking these medications for limited or extended periods of time after they leave KidsPeace.

KidsPeace treatment staff members receive extensive training in dispensing and monitoring medications. Everyone

who works directly with the children attends in-service training. They are also required to have a thorough understanding of medications, including the wide range of possible reactions and interactions with other substances.

**David Post**, RPh, DMD, KidsPeace dentist and consulting pharmacist, is a member of the organization's Pharmacy and Therapeutics Committee. He says prescribing medication for children is a matter of balancing risks and benefits.

"There is some degree of risk in giving any kind of medication, even aspirin," Dr. Post says. "The determining factor is always its potential to help the child achieve stability and regain the ability to function in ways that are helpful – weighed against any possible side effects. We are conservative in prescribing, and always hope that medication can gradually be reduced or eliminated. But, initially, medication can be quite helpful in easing children into the therapeutic situation and allowing them to respond to more personal types of therapy."

### What to watch for

Dr. Post describes some of the unexpected reactions that can occur with these medicines, especially if they are inadvertently combined with

other substances: "Some drugs, particularly tranquilizers and some antibiotics, can produce sensitivity to sunlight, which could be harmful to a person who does not take proper precautions when going outdoors. And other types of medicine react adversely with certain foods, so absolute dietary vigilance is required."

The more common side effects, Dr. Post says, are drowsiness, headaches, rashes or gastrointestinal disturbance. These usually can be eliminated or reduced by modifying dosages or changing medications. But, he cautions, it is important to watch for physical or psychological changes in the person who is ingesting any chemical substance – whether it is a potent anti-psychotic prescription, mild over-the-counter analgesic or anything in between.

**Debbie Pianowski, RN,** KidsPeace nursing supervisor and Pharmacy and Therapeutics Committee member, says it is critical for a consumer to take medicine as prescribed.

"To be effective, medication needs to be taken in the correct dosage for the length of time prescribed by your physician," she says. "It's not helpful – and can be harmful – to skip doses or to discontinue a prescription before a doctor permits you to do so.

"And remember, pharmacists are a good source of information if you have any questions about the side effects of your medications and their possible interactions with other drugs."

### Frequently asked questions

Both Post and Pianowski are available to answer questions about medications that are prescribed for KidsPeace clients. Below are some of the more common questions kids ask, along with the responses:

#### "I don't want side effects."

You can't tell ahead of time whether you will experience side effects. They are possible, but they may be quite mild. Many people, includ-

ing children and teenagers, take psychiatric medications without problems. Sometimes, having side effects will still be better than feeling bad, getting into trouble or not being able to enjoy things.

#### "This medication will damage my body."

Most psychiatric medications have been taken by millions of people. Many children and teens have been treated with these medications over the last decades. There is no evidence that these medications generally have bad effects on your body, your growth or your intelligence. If you have concerns about your medication, be sure to discuss them with your doctor.

#### "I won't be able to stop my medication. I'll get hooked on it."

Psychiatric medications are not addictive when taken as prescribed by your doctor.

Some medications can be stopped abruptly, if decided by you and your doctor to do so. Others have to be stopped over time to avoid unpleasant reactions. Your doctor can advise you on when and how to stop the medication.

#### "I don't want to take medication for the rest of my life."

Since problems with behavior, mood and thinking often have been present for a long time, they usually cannot be treated quickly or briefly. You may have to take your medication for several months or even longer. People with other medical



problems, such as allergies or heart problems, may have to take their medication every day for many years. Only in rare instances do people take psychiatric medication for their entire life.

**“I’m not going to take drugs.”**

These medications are sometimes called “drugs”. You buy them at a “drugstore”. However, they are not like street drugs (e.g., marijuana, cocaine or heroin), even though street drugs can change behavior, mood and thinking, too. There are many differences between medications and street drugs. Medications are prescribed by your doctor to help treat a medical problem. Street drugs or alcohol create medical problems, both physical and emotional, and they can make medical problems worse. When taken as prescribed, medications will not lead to addiction. Even though street drugs may make some people feel better for a short period of time, they are addictive and harmful. They are also expensive and illegal. It is smart to take medications when recommended and under the care of a doctor. It is not smart to take street drugs. Using street drugs is not taking care of yourself.

**“Taking medication proves that I’m crazy.”**

Some people think that taking medication is a sign of weakness. But, in fact, taking medication shows that you understand how to take care of a medical problem. Almost all people have to take medication at some time to stay healthy. So you are certainly not alone or crazy. Taking medication proves that you are dealing with your problem in a responsible way and that you take your well-being seriously.

**“I’m afraid that I will not be able to learn in school any more.”**

Without medication treatment, many young people who are depressed or anxious have difficulty performing well in school. Psychiatric medications usually help you do a better job at school or on

the job. Medication may improve concentration, decrease tired feelings, increase mood. These medications should make it easier, not harder, for you to learn in school. If you think they are interfering, discuss this with your doctor.

**“Medications might turn me into a whole different person.”**

Psychiatric medications do not change your personality. You will still have your normal feelings of happiness and sadness. Medications only help change those feelings, thoughts or behaviors that are a problem.

**“Taking medication is all I have to do to get better.”**

It would be nice to think that psychiatric medications can act like magic, but they don’t. Psychiatric symptoms are often the result of a combination of stress and some medical problem in the brain. Pills can help with the medical problem, but do not help you deal with stress in your life. To cope better with stress, other therapies are recommended.

**“I just don’t want to take it!”**

Many children and teenagers are worried about what may happen to them when they take medications. Sometimes, they and their family members are not used to taking medications. Discuss your thoughts and feelings with your parents, your doctor and your therapist. Many kids are helped by medications. Even if they don’t like taking them, they realize that they are doing better and feeling better.

It’s wise to learn as much as you can about your child’s prescriptions. And it’s helpful to seek objective information. But, remember, medications are a very individual matter; there is no single answer to questions about them and no substitute for a physician’s personal assessment.

**IN THE NEWS**

**KidsPeace congratulates**

**Mike Hopkins**, Director of the KidsPeace Intensive Treatment Family Program, on his recent election to President of the Foster Family-Based Treatment Association (FFTA). Established formally in 1988, the FFTA is North America’s premiere professional organization dedicated to the specific issues concerning foster family-based treatment. Currently boasting 340 member agencies throughout the United States and Canada, the FFTA mission is “to promote, develop, improve and support the quality of treatment foster care.”

# “Parents and educators can avert crisis by tuning in to kids.”



## *Preventing and managing violence in our schools*

By Dr. Herbert E. Mandell, Medical Director, KidsPeace National Hospital for Kids in Crisis

### **A VARIETY OF SOCIAL AND ECONOMIC FACTORS ACCOUNT FOR THE DRAMATIC RISE IN SCHOOL VIOLENCE.**

Some of the principal causes are disintegrating nuclear families, child abuse and neglect, substance abuse, poverty, media violence, hunger for peer approval, lack of constructive values, short life expectation and learning disabilities, including attention deficit hyperactivity disorder (ADHD).

Educators have a unique challenge and a unique opportunity to effect some meaningful changes. Since schools are being pushed to function ‘in loco parentis’, teachers, guidance counselors and administrative personnel have to assume additional responsibilities. At times it seems as if they have been asked to become surrogate parents, healthcare providers, therapists, nutritionists and social workers.

Teachers and school districts deserve high marks for modifying teaching techniques and adopting new methods of communicating with students. They are taking a proactive approach to identifying difficulties and intervening in situations that have the potential for harm.

Many situations put kids at risk. For instance, the death – particularly a violent one – of someone close to a child will have a serious emotional impact on that youngster. Children react differently from adults, so even if they don’t show their emotions openly, you can be sure that a lot is going on inside.

Children may mask their emotional pain in stomach pains, headaches, nightmares or learning problems. Teachers and other responsible adults need to be aware of these signs and be prepared to help.

The cut-back in community social services has placed a lot more responsibility on school personnel. But schools have moved into the breach by creating student assistance and crisis intervention teams.

It’s important to assess at-risk kids and decide who needs intervention. If a child has been exposed to violence, or has lost someone close, it is necessary for the child to grieve and resolve any feelings of anger or guilt. And there must be follow-up with counseling or support groups for as long as it takes.

As for prevention, teachers and other school officials should “follow their gut” and move to head off problems they feel developing. Instead of waiting for a crisis to erupt, they should pay attention to their sixth sense – their intuition – and act immediately to head off a crisis. It’s crucial to confer with other staff members and shut

down classes if necessary. Most of all, moving quickly will help contain any potential problem.

But before schools get to this point, there are many community and educational resources that can be utilized. Despite the cut-backs in funding, there are still excellent sources of help.

The Prothro-Stith curriculum for conflict resolution is a cognitive approach to addressing anger and preventing violence. It is invaluable for high school teachers, counselors, coaches and others who work with kids in a school setting.

In addition, there are many religious and community organizations that sponsor parenting skills classes, and social service agencies that offer counseling for children and families.

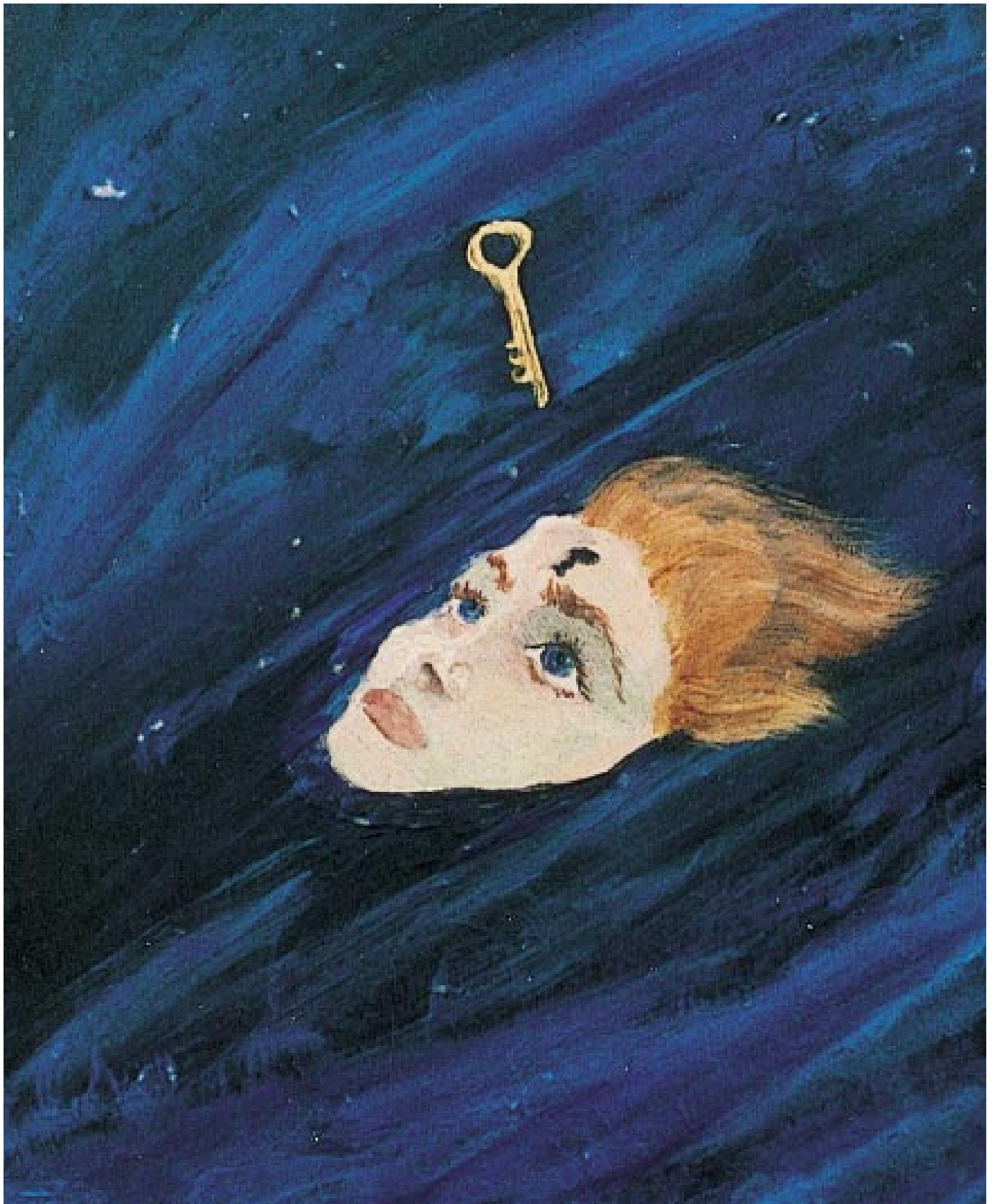
KidsPeace provides its HelpLine, a toll-free phone service available daily, round-the-clock. Trained counselors offer a friendly ear to anyone who calls, and provide referrals for professional help if it is needed.

But the best way parents and educators can avert crisis is by tuning in to kids. The most important thing is to plug in to youngsters on a frequency they operate on. And offer guidelines and models of behavior to help during the tough times.

**Questions about this article? Call Dr. Mandell at (610) 799-8877.**

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The art of kids. The art of healing at KidsPeace.





# The Family Resource File



## Are you a resource for children and families?

If your organization offers helpful information or other assistance to children and families, KidsPeace will be happy to consider including a description of such services in "The Family Resource File". To be listed in a future issue of "Healing Magazine", please call Janice Curran, Editor, at (610) 799-8338, or write KidsPeace Creative Services, 5100 Tilghman Street, Suite 010, Allentown, PA 18104.



## "We want very much to find permanent homes for these deserving children"

### How New Jersey helps bring children and adoptive families together

A nice home. A loving parent. A permanent family. It's every child's dream.

Unfortunately for too many children, it will remain just that – a dream.

They are youngsters whose birth families, for a variety of reasons, can no longer take responsibility for them. Until they find an adoptive family, they remain in foster care. But as the list of waiting children grows longer, the list of waiting parents trails far behind.

**Elizabeth McGinnis**, family recruitment coordinator for the **New Jersey Human Services Department's Division of Youth and Family Services**, says there are scores of wonderful children who are legally free and available for adoption.

"We want very much to find permanent homes for these deserving children," McGinnis says. "We make every effort to link prospective parents with information about kids who can be adopted. And we make it easy to get profiles of kids who are available – to see pictures and receive descriptions of these children."

New Jersey also participates in a nationwide entry registry of children awaiting adoptive families that places information about them on an Internet website called "Faces of Adoption." People can view these prospective adoptees and review a brief write-up on each child. This registry is sponsored and maintained by the **National Adoption Center**, which provides detailed information about adoption resources in each state through its "Adoption Quest."

"There are so many children who need a home and a family who will love and care for them," says McGinnis. "Foster care, no matter how loving, can never substitute for belonging to a permanent family - for being a chosen child."

Prospective parents or childcare professionals who want more information about children waiting to be adopted can visit the National Adoption Center's website at <http://www.adopt.org/adopt> or call **800-99-ADOPT**.

"Love from a family is what is important," says McGinnis. "I have seen the tremendous difference a permanent family can make in the life of a child who is chosen."

To find out more about the KidsPeace therapeutic foster care program, visit our website: [www.fostercare.com](http://www.fostercare.com)

This information is provided solely as a resource for families and professionals who may be interested in learning more about adoption. This listing is not a referral by KidsPeace, nor an endorsement or recommendation of any organization or its services. KidsPeace has no affiliation with and receives no funding from any listed organization, nor has it conducted a review of any organization or its services.



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