A STUDY OF ROMANIAN FOSTER FAMILIES IN BISTRIȚA *JUDEȚ*

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PURPOSE OF STUDY

Romania has been notorious in the last decade of the 20th century for problems in its child welfare system. Child welfare problems and other social problems were exacerbated by the difficulties encountered in the transition to a market economy, including increased levels of poverty, unemployment, and child abandonment. While there still remain many difficulties, there also have been many social development innovations in Romania. In particular, nongovernmental agencies (the private, nonprofit sector) have been developing or assisting in the development of family preservation, family reunification, prevention of abandonment, foster care and adoption programs in Romanian.

Foster care is one of the newer innovations in child welfare. Before 1994, there were less than 10,000 foster or guardian families, even though over 100,000 children were in need of care, because they could not remain with their birth families. As of 2000, the media estimates the number of foster families was 29,000. By the end of 2002, with pressure and funding from the EU, the number of foster families was expected to increase to cover all infants and toddlers in out-of-home care.

Foster care in Bistrita is a public-private partnership between an NGO (Romanian Children's Relief/Fundatia Inocenti, abbreviated RCR/FI) and the local Romanian public child welfare agency (Bistrita Nasaud County Department of Child Protection, abbreviated BNCDCP). RCR/FI is a private, non-profit agency dedicated to improving the lives of children involved in Romania's medical and social welfare systems. RCR/FI began its work in 1991 and their mission is to support children and families during the transition from institution to family life. To serve this purpose, the program offers a number of services to children's, birth, adoptive, and foster families, staffed by a cross-disciplinary team comprised of social workers, psychologists, and educators.

The Department of Child Protection in Bistrita Nasaud (BNCDCP) was established in November, 1996. It was created as a Department of the County Council for the purpose of serving and protecting the rights of children in need.

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The Department has 29 employees, 22 of whom are professional staff. The majority of the staff has a four-year university degree (73%) and 18% are working on a four-year degree. Eighteen percent of the workforce has a graduate degree and another 18% are enrolled in a masters degree program in social work. Two social workers are assigned to foster care.

The foster care program began in March, 1998. The first step was to advertise, establish standards, and select the initial group of foster families. In October 1998, the first six foster mothers were licensed and children were placed. As of the fall of 2001, there were 60 foster families caring for 68 children. BCDCP is now planning to place special needs children in foster care.

This article evaluates one model of foster care located in Bistrita (Transylvania), Romania. To date, little but anecdotal information or media reports are available about the experiences of foster families and their foster children. The purpose of this study was to provide the NGO and the local Romanian public child welfare agency with empirical information on Romanian foster children in Romanian families.

STRUCTURE OF THE FOSTER CARE SYSTEM

Families are recruited to foster through the public agency (BNCDCP). A BNCDCP social worker studies each family and recommends those families that should be licensed to the County Commission for Child Protection (CCCP). The license is issued by the CCCP for a three-year period and then can be renewed. Social workers are obligated to visit foster families on a monthly basis.

At the time of the study, there were 75 children in the orphanage and 68 children in 60 foster families located throughout Bistrita County. Many more families had been licensed than had children placed with them because there were no funds to employ them. Staff for BCDCP indicated that there were about 120 approved foster families but funding was only available for about half of these families. There was indication that the number of foster families cited as existing in Romania is true of face value (29,000) but it is also very likely that less than half of them actually have children in placement. There are more than 210 potential foster families that are waiting for training and evaluation in Bistrita County.

The criteria for families to be licensed included the following: (a) a foster parent could not be older than 55, (b) must have another source of income, (c) must have suitable living arrangements, and (d) must be willing to participate in visitation and foster parent group meetings. Foster families earned salaries each month of 1,500,000 lei (about $50 USD). In addition, they are given two supplementary child allowances from the government: one of 500,000 lei ($17) for any child in placement and the other of 130,000 ($4) for any child under the age of seven or up to age 18, if the child is in school. Foster families also received some

food staples each month. As the position of foster mother is considered employment, time is credited towards government pensions.

Choosing a specific child for a specific family is the responsibility of the social worker from the BCDCP. Rejecting a child because of his or her skin color, ethnic or racial background, or religion is not allowed. Foster parents are given some choice as to the age and gender of the child placed in their family.

After the presentation of the child to the foster parent, during which the child's characteristics are discussed, the foster parent meets the child. At that meeting the social worker goes into more details about the child and his or her needs. The foster parent visits the child one or more times to build a relationship. The number of times depends on the distance of the foster family to the institution, as visits are hosted at Romania Children Relief's Center, which is located in the orphanage. After the visits, and with final approval from CCCP, the child moves to the home of the foster parent.

Typically, children were available for foster care if they were born in Bistrita, abandoned (with or without legal paperwork completed), and with the parent's permission. At times, when parents directly contact the BNCDCP to abandon their child, they are given the option of having their child enter foster care. Priority is given to infants and toddlers.

This article reports on the evaluation of the foster care program. The purpose of this study, as we showed before, was to provide the NGO and the local Romanian public child welfare agency with empirical information on Romanian foster children in Romanian families.

METHODOLOGY

The protocol used in the foster care study had been used previously with adoptive families in Romania in 1999, and was modified for this study. Teams composed of one American and one Romanian, who conducted face-to-face structured interviews with foster families. The Romanian staff and American students received joint training on confidentiality, the safeguards for human subjects, and interviewing techinques. All families were interviewed in their home. The interviews were structured around the questions, but the teams were given the freedom to explore new lines of questioning as they came up. Each interview took from 60 minutes to two hours, depending on the number of children in the home. At the end of each day, we discussed results and any difficulties with the research instrument, translation, or protocol. Mistakes in translation were caught and corrected the first three days of interviews.

The questions probed in this study were: What problems/issues are families facing related to fostering or to the foster children? What post placement resources have they used? What post placement services would families like to have? What is

the stability of these placements? What are indicators of success/failure in these placements? How can the foster care program be improved?

Sample. As of summer 2001, there were 59 families providing foster care in Bistrita County. We conducted a census of all the families providing foster care in the county. All families were asked to participate to in-home interviews. A letter was sent to foster families by RCR staff the month before interviews were scheduled to begin. Two weeks after the letters were mailed, and about a week before the American team arrived, RCR staff contacted families to set up a date and time for interviews.

Measures. We used the Child Behavior Checklist for 4 to 16 year olds (CBC) and a version for children ages 2 to 3 (Achenbach & Edelbrock, 1983). The checklist has been extensively validated. The scales have been normed with two groups. The clinical group represents norms based on children referred for mental health services. The nonclinical group represents norms based on a general sample of children, akin to the typical child. Only the subscales are used in this analysis.

We included the Behavioral and Emotional Rating Scale (BERS) in the interviews. The Behavioral and Emotional Rating Scale (BERS) is a standardized scale designed to assess the behavioral and emotional strengths of children ages 5 to 18. It is a 52-item checklist normed on children not identified as having emotional and behavioral disorders and on children with emotional and behavioral disorders. It assesses five dimensions of childhood strengths: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning and Affective Strength. The BERS subscales have alphas ranging from .87 to .96; the scale has an overall reliability of .97 (see Epstein & Sharma, 1998).

A questionnaire used previously in research on adoption in the United States and Romania was modified for this project; it included questions about child and family demographic, child history prior to foster placement, measures of attachment, development, and sensory functioning, questions about service usage and service needs, and multiple indicators of outcomes.

All measures were translated into Romanian in the United States, and translation was verified in Romania. The CBC was translated by Adina Gabor, a former student in psychology and human development at Washington State University. The translated CBC scales were given to the project by Dr. Elizabeth Soliday, after securing permission to use it from Dr. Achenbach. Other translators included Simona (Monica) Stefanica, Margarita Protopopescu and Ludmila Neagu. Permission to translate and use the BERS without charge was given by Dr. Nils A. Pearson, Ph.D., Director of Research for PRO-ED (who distributes the BERS).

RESULTS

Response Rates. Of the 59 families contacted, all agreed to be interviewed, but 3 families were not at home at the time of the interview, for a response rate of 95%. The overall response rate was excellent by scientific standards. Eighty six

percent of the interviews were held with foster moms, 13% were held with both parents present, and in one case (2%) the interview was conducted with another family member, not the foster parent. Three (5%) of the 56 families were siblings placed together. The 56 families interviewed were caring for 68 children. Due to the small number of families involved in this project, only descriptive data are reported.

Demographic Description of Families. Most families (80%) had other children in the home. When there were other children, it was most often two other children. Most families (93%) had no other children join the family after the foster placement.

Family income ranged from 2,000,000 lei per month to 20,000,000 lei per month ($71 USD to $714 USD); the salary of 200,000,000 was very unusual with only one family reporting such income from the father working out of the country. Twenty five percent of the families made $107 USD or less per month and 75% of families made $183 USD or less per month. Average salary was $184 USD per month ($2 208 per year).

Foster mothers were 42.9 years old, on average. If they had a spouse, on average he was 46.0 years old. Most families were two parent households (88%) with the vast majority being first time marriages (77%).

Demographic Description of Children and Their History. Over half the children were male (57%). At the time of the study, children ranged in ages from 1 to 11 and were 4.0 years of age, on average. They had been placed from infancy to age 10; average age at placement was 2.8 years. About 48% were placed at the age of 1 year or under, 64% at the age of 2 or under, and 71% at the age of 3 or under. About 22% were placed at school age (5 or older). Most (57%) children were described as Romanian and 24% of the children were described as Roma/Gypsy. About 8% of the children had been in foster placement for less than a year; the vast majority (75%) had been in placement a year. About 13% of the children had been in placement 2 years and 2 (3%) were in placement 3 years.

Most foster parents did not know or could not recall the length of time the child had been in earlier placements. For those who could recall placement history, most of the children (90%) had been in an orphanage or institution before placement, for an average of 29 months. Length of time in an institution or orphanage for these children ranged from 13 months to 108 months; about 10% of the children had spent a year or less in an institution or orphanage, 56% had spent about 2 years in an institution or orphanage, and about 19% had spent more than 3 years in an orphanage or institution. The majority (67%) had been in a maternity hospital before placement, for an average of 2.9 months. Like the data on the length of time in an institution or orphanage, most foster parents did not know or could not recall the length of time the child had been in placement. Length of time in a maternity hospital ranged from less than a month to 15 months; about 50% of the children had spent 1 month or less in a maternity hospital. Almost one third of

the children had been in a family before placement. Only 2 foster parents could report length of time in a family, so this data is not reported.

Families were asked to evaluate the quality of the placements before the child entered foster care. For the most part, the institutions were well rated, most families knew nothing about maternity hospitals, and previous family placements were evaluated negatively. It is interesting that most families had some experience with visiting the local orphanage from which most of these children came. Our own observations about this facility were that it was clean, the children were well cared for, and there were many programs for children. In the weeks we were there, we saw many international visitors to the facility. RCR has most of its program activities at this facility, attesting to the many resources at the local orphanage in Bistrita.

Child Health and Functioning. For the most part, health problems, disabilities and other difficulties were not reported for the children. Only 3 (4%) children had vision impairment, only 2 (3%) were reported to have physical disabilities, and 7 (10%) children were reported to be retarded. Overall, the majority of the foster children do not have special physical or health needs.

Parents were asked to evaluate lags in developmental skills for their children at foster placement and at the time of the study. For the majority of children, foster parents reported no developmental delays at placement or at the time of the study. For the children entering the family with some delays, most of these children had improved. When delays were identified, language skills were the most prevalent delay. The families who had children with continued language delays identified the lack of speech therapy services as problematic and expressed a desire for in-home speech therapy services.

Parents were asked to evaluate sensory information for their children at placement and at the time of the study. In previous research, sensory problems had been identified in many Romanian children who had been adopted from institutions (see Cermak & Groza, 1998; Groza, Ileana & Irwin, 1999). For the most part, there were no reports of sensory difficulties at placement or at the time of the study. For children entering families with some difficulties, most of them had improved. Still, sensory problems were more apparent at foster placement compared to reports from Romanian families who had adopted Romanian children (see Groza and the Bucharest Research Team, 1999). The difference between foster and adopted children is that the adopted children were placed much younger, after spending less time in institutions or orphanages.

Most families were not knowledgeable or skilled in the assessment or treatment of sensory problems. Still, families identified sensory problems in 10% or more of their children after placement; this is likely a low estimate of the incidence of sensory problems and suggests that a number of children would benefit from occupational therapy/sensory integration services well after placement.

Families were also asked to evaluate the "how well prepared they were for their foster child's problems, handicaps, or health difficulties". The only caveat with this data is that most families felt that the children had no problems, handicaps or health difficulties, so they did not answer these questions. Overall, families reported that their foster children's difficulties, if any, were adequately presented to them. Still, 25% of families reported that their foster children had more serious problems and handicaps than described, and 14% reported that their foster children had more serious health problems.

The failure to give foster families adequate and complete information caused great stress for the family. Families need this information in order to maximize their success in parenting children who enter families after experiencing neglect, trauma and difficulties. The failure to adequately prepare families places these families at-risk of ending the placement or not being able to sufficiently meet the foster child's needs.

Attachment Relations. Families were asked to report on a series of indicators of the parent and child relationship. The manner in which parents were relating to the foster children was a concern for many practitioners and policy makers who were skeptical of foster care. Some believe that since families were being paid to care for children, they would have little investment in the relationship.

Overall, attachment relationships were very positive. The majority of parents reported getting along well with their children, spending time together they enjoy every day, good communications with their children, trusting their children, feeling respected by their children and feeling close to their children. It was obvious from our observations of the family and daily debriefings that the families were very invested in and attached to the foster children and that the majority of the children were attached to their foster families.

Behavior Concerns. Families were asked to report on a series of behaviors that were a concern to American and Romanian families who adopted Romanian children. There were few behavior concerns at placement or at the time of the study. Still, about one third of the children engaged in the self stimulating behavior of rocking at placement and 10% continued to do so, even though it was a year or longer after foster placement. Children who entered families with behavioral issues had, for the most part, improved by the time of the study.

The Child Behavior Checklist (CBC) subscales for children 2 to 3 years of age (n=17) assessed withdrawal, depression, sleep problems, somatic complaints, aggressiveness and destructiveness. For this analysis, we looked only at the percent of children scoring in the clinical range of each of these scales. The clinical range is those scores indicative of severe emotional and behavioral disorders. For the withdrawal subscale, only 1 child (6%) scored in the clinical range; this was also true for the depression and destructive subscales. For all three scales, it was the same child. No children scored in the clinical range for

sleep problems, somatic complaints, or aggressiveness. This means that most children 2 to 3 years of age do not have scores high enough to be indicative of severe emotional and behavioral problems.

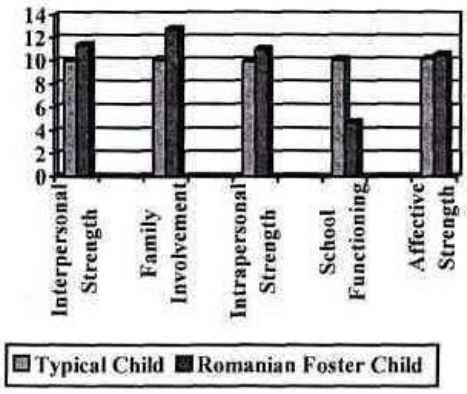
The CBC subscales for children 4 to 11 years of age (n=21) assessed withdrawal, anxiety/depression, somatic complaints, social problems, thought problems, attention problems, delinquency, and aggressiveness. Similar to above, for this analysis, we looked only at the percent of children scoring in the clinical range of each of these scales. One boy (5%) scored in the clinical range on the withdrawal scale, 2 children (10%, one boy and one girl) scored in the clinical range on the anxiety/depression scale, 2 children (10%, one boy and one girl) scored in the clinical range on the social problem scale, 2 children (10%, one boy and one girl) scored in the clinical range on the thought problem scale, 5 children (24%, three boys and two girls) scored in the clinical range on the attention problem scale, 2 children (10%, one boy and one girl) scored in the clinical range on the delinquency scale, and 2 children (10%, one boy and one girl) scored in the clinical range on the aggressiveness scale. For most of the scales, it was the same two children (one boy and one girl) who had all the difficulties. This means that most children 4 to 11 years of age do not have high enough scores that would be indicative of severe emotional and behavioral problems. However, almost one-fourth evidence attention problems.

Strengths. Social work has become increasingly oriented in the 1990s towards working from a strengths perspective. The works of Saleebey (1992), Cowger (1994), and DeJong and Miller (1995) have contributed to helping social workers understand and practice from this perspective. All too often, either implicitly or explicitly, research on family life and children in the child welfare system has been more oriented to deficits, problems, and pathology, rather than strengths, resources and appropriateness. As Saleebey (1992) writes, "The language of pathology and deficit gives voice to particular assumptions and leads to certain ends." (p. 3). In addition, focusing on the problems creates a web of negative expectations about the child and the child's capacity to deal with demands on him or her (see Saleebey, 1992). Even in the face of profound disabilities, by focusing on strengths we give hope – hope has become devalued in the helping relationship when sometimes it is one of the few things we can concretely give. Sometimes the hope is not for the child, but for the parents who must care for the child.

Drawing from this perspective and to give balance to the project, we asked families about the strengths of their foster children. All families easily identified strengths when prompted to do so. Figure 1 shows the strength of the foster children in comparison to the norms for the typical child group. While it may graphically appear different, overall there are no statistical differences between Romanain foster children and children serving as the referenced norm,

with the exception of school functioning. School was identified by several foster families as a major source of stress. However, overall, the data indicate that Romanian foster children have as many strengths as typical children in the United States.

Figure 1
Strengths of Romanian Foster Children



Placement Stability. Several items were used to assess the stability of the foster placement. Families were asked to evaluate the impact of the placement, the smoothness of the placement over the last year, and how often they think of ending the foster placement. Approximately 98% of respondents rated their foster placement as having positive effects on their families. There were variances in the smoothness of the placement: 58% reported the placement was smoother than expected, 29% reported the experience to be about what they had expected, and 13% reported more ups and downs than expected. While the majority of families never or seldom think of ending their foster placements, 4% have had some thoughts of ending their placements.

Overall, these results are very postive about placement stability. This is remarkable, given that 25% of parents also reported that they were not given complete or accurate information about the child. Families survived the stressors of parenting foster children and even rose above the gaps in information to present themselves and their children in a very positive framework.

SUMMARY

It is clear that excellent progress is being made with regard to foster care in Romania. There are several indicators of success. Parent – child relations are

extremely positive. Families evaluated the impact of foster placement on the family in very positive terms. All the foster families enjoyed talking about their children and could easily find strengths in their children. Most of the children are developmentally appropriate and have no health problems or sensory difficulties. Parents report good parent – child relations, few have behavior concerns, and the foster placements are very stable.

Problems or issues were not pronounced. However, some families may not have been well prepared for foster parenting or the foster care experience. As such, a few families had entertained thoughts of ending their foster care placements. Overall, these placements are quite stable and successful. One stressor identified by several families is school. A way to improve the system would be to assign a social worker to work with the rural school and advocate for the child.

One area of services where we identified need for improvement is permanency planning. It is important to create a system of permanency planning and adoption that is followed by social workers and agencies. Each child needs a permanency plan, and foster parents must be aware of the plan and their role in supporting it. We discovered that many families had no knowledge about the plans for the children or, in the case of adoption, the practices were poorly executed. The major issue facing families during the time of the study was that they had not been paid and there was no information about when they would be paid. Several weeks after we returned we were told that the families had finally been paid but that there was concern about future payments. Families rely on foster care payments to meet expenses. The surest way of undermining the foster care program is to fail to pay the families on time. Families should be paid before social workers or administrators, in the event that there is a delay.

In summer 2002, families were being forced to take additional children into their home under veiled threats of loosing their license if they refused. Families reported that they were not prepared to parent two children, nor was the child subsidy sufficient to meet all the children's needs.

To improve foster care, more families need to be funded and recruited to meet the demands for placement of children who cannot reside with their birth families. In addition, recruitment and family preparation activities need to be oriented towards assisting families in making social connections with each other and building networks of informal social support. While not all families want social contact with other foster families, a substantial percent of families either had social contact – which they evaluated as helpful – or wanted social contact with other foster families, particularly those that lived close to them.

On an administrative level, there is need for improvement in the documentation of visits and records about monitoring of families after the placement. Many families

reported infrequent visits, and in one case a family had not been visited by a social worker for five months. The lack of visits places children who are already vulnerable more at-risk, if the placement is not going well.

We suggest that a foster parent advisory board may be helpful for several reasons. Families need a voice and they can be helpful. Parents can assist in recruiting and marketing foster care to other Romanian families. Foster parents have a different type of credibility in the community than do social workers. They can be a great asset in locating other families to foster children. In addition, families know their own service needs as well as the service needs of other families in their communities – they can advise the agency on developing programs that will strengthen and support families.

This project offers pilot data that can be used in the design of other efforts to evaluate foster care in Romania. The measures used here were helpful in understanding some of the child developmental and behavioral issues. Better measures for development need to be employed in future projects. We also recommend measures about birth family and birth family history, foster family functioning and foster family support networks be incorporated in future projects.

This project was a good pilot study of the issues in Romania's new foster care system. We learned a great deal from the families, but there is still much to learn.

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Appendices

Directions: Behavioral and Emotional Evaluation Scale (BERS) contains a series of statements used in order to evaluate child's behavior and emotions in a positive way. Please read each sentence and circle the number that coresponds best to the state of the child during the past 3 months. According to the points from 3 to 0, try to evaluate the child as objectively as you can.		Very much like a child	Like a child	Not too much like a child	Not at all like a child
1.	Demonstrates a sense of belonging to family	3	2	1	0
2.	Trusts a significant person with his or her life	3	2	1	0
3.	Accepts a hug	3	2	1	0
4.	Participates in community activities	3	2	1	0
5.	Is self confident	3	2	1	0
6.	Acknowledges painful feelings	3	2	1	0
7.	Maintains positive family realtionships	3	2	1	0
8.	Demonstrates a sense of humor	3	2	1	0
9.	Asks for help	3	2	1	0
10.	Uses anger management skills	3	2	1	0
11.	Communicates with parents about behavior at home	3	2	1	0
12.	Expresses remorse for behavior that hurts or upsets others	3	2	1	0
13.	Shows concern for the feelings of others	3	2	1	0
14.	Completes a task on first request	3	2	1	0
15.	Interacts positively with parents	3	2	1	0
16.	Reacts to disappointments in a calm manner	3	2	1	0
17.	Considers consequences of own behavior	3	2	1	0
18.	Accepts criticism	3	2	1	0
19.	Participates in church activities	3	2	1	0
20.	Demonstrates age-appropriate hygiene skills	3	2	1	0
21.	Requests support from peers and friends	3	2	1	0
22.	Enjoys a hobby	3	2	1	0
23.	Discusses problems with other	3	2	1	0
24.	Completes school tasks on time	3	2	1	0
25.	Accepts the closeness and intimacy of others	3	2	1	0
26.	Identifies own feelings	3	2	1	0
27.	Identifies personal strengths	3	2	1	0
28.	Accepts responsibility for own actions	3	2	1	0
29.	Interacts positively with siblings	3	2	1	0
30.	Loses a game gracefully	3	2	1	0
31.	Completes homework regularly	3	2	1	0
32.	Is popular with peers	3	2	1	0
33.	Listens to others	3	2	1	0
34.	Expresses affection for others	3	2	1	0
35.	Admits mistakes	3	2	1	0
36.	Participates in family activities	3	2	1	0
37.	Accepts "no" for an answer	3	2	1	0
38.	Smiles often	3	2	1	0

39.	Pays attention in class	3	2	1	0
40.	Computes math problems at or above grade level	3	2	1	0
41.	Reads at or above grade level	3	2	1	0
42.	Is enthusiastic about life	3	2	1	0
43.	Respects the rights of others	3	2	1	0
44.	Shares with others	3	2	1	0
45.	Complies with rules at home	3	2	1	0
46.	Apologizes to others when wrong	3	2	1	0
47.	Studies for tests	3	2	1	0
48.	Talks about the positive aspects of life	3	2	1	0
49.	Is kind toward others	3	2	1	0
50.	Uses appropriate language	3	2	1	0
51.	Attends school regularly	3	2	1	0
52.	Uses note-taking and listening skills in schools	3	2	1	0

Key Questions

1. What are the child's favorite hobbies or activities? What does the child like to do?
2. What is the child's favorite sport(s)?
3. In what school subject(s) does the child do best?
4. Who is the child's best friend?
5. Who is the child's favorite teacher?
6. What job(s) or responsibilities has this child held in the community or in the home?
7. At a time of need, to whom (e.g., parent, teacher, friend, relative) would this child turn for support?
8. Describe the best things about this child.

Below is a list of items that describe children and youth. For each item that describes your child **now or within the past 6 months,** please circle the **2** if the item is **very true** or **often true of your child.** Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0** . Please answer all items as well as your can, even if some do not seem to apply to your child.

0 = Not True (as far as you know), 1 = Somewhat or Sometimes True, 2 = Very true or Often True

1. Acts too young for his/her age.
2. Allergy (describe): _____
3. Argues a lot.
4. Astma.
5. Behaves like opposite sex.
6. Bowel movements outside toilet.
7. Bragging, boasting.
8. Can't concentrate, can't pay attention for long.
9. Can't get his/her mind off certain thoughts; obsessions. _____
10. Can't sit still, restless, or hyperactive.
11. Clings to adults or too dependent.
12. Complains of loneliness.
13. Confused or seems to be in a fog.
14. Cries a lot.
15. Cruel to animals.

16. Curelty, bullying, or meanness to others.
17. Day-dreams or gets lost in his/her thoughts.
18. Deliberately harms self or attempts suicide.
19. Demands a lot of attention.
20. Destroys his/her own things.
21. Destroys things belonging to his/her family or others.
22. Disobedient at home.
23. Disobedient at school.
24. Doesn't eat well.
25. Doesn't get along with other kids.
26. Doesn't seem to feel guilty after misbehaving.
27. Easily jealous.
28. Eats or drinks things that are not food -- **don't** include sweets. _____
29. Fears certain animals, situations, or places, other than school (describe): _____
30. Fears going to school.
31. Fears he/she might think or do something bad.
32. Feels he/she has to be perfect.
33. Feels or complains that no one loves him/her.
34. Feels others are out to get him/her.
35. Feels worthless or inferior.
36. Gets hurt a lot, accident-prone.
37. Gets in many fights.
38. Gets teased a lot.
39. Hangs around others who get in trouble.
40. Hears sounds or voices that aren't there (describe): _____
41. Impulsive or acts without thinking.
42. Would rather be alone than with others.
43. Lying or cheating.
44. Bites fingernails.
45. Nervous, highstrung, or tense.
46. Nervous movements or twitching (describe): _____
47. Nightmares.
48. Not liked by other kids.
49. Constipated.
50. Too fearful or anxious.
51. Feels dizzy.
52. Feels too guilty.
53. Overeating.
54. Overtired
55. Overweight.
56. Physical problems without known medical cause:
    a. aches or pains (not headaches)
    b. headaches
    c. nausea, feels sick
    d. problems with eyes (describe): _____
    e. rashes or other skin problems
    f. stomachaches or cramps.
    g. vomiting, throwing up
    h. other (describe): _____
57. Physically attacks people.
58. Picks nose, skin, or other parts of body (describe): _____
59. Plays with own sex parts in public.
60. Plays with own sex parts too much.

61. Poor school work.
62. Poorly coordinated or clumsy.
63. Prefers being with older kids.
64. Prefers being with younger kids.
65. Refuses to talk.
66. Repeats certain acts over and over; compulsions (describe): _____
67. Runs away from home.
68. Screams a lot.
69. Secretive, keeps things to self.
70. Sees things that aren't there (describe): _____
71. Self-conscious, or easily embarrassed.
72. Sets fires.
73. Sexual problems (describe): _____
74. Showing off or clowning.
75. Shy or timid.
76. Sleeps less than most kids.
77. Sleeps more than most kids during day/night (describe): _____
78. Smears or plays with bowel movements
79. Speech problems (describe): _____
80. Stares blankly.
81. Steals at home.
82. Steals outside the home.
83. Stores up things he/she does not need (describe): _____
84. Strange behavior (describe): _____
85. Strange ideeas (describe): _____
86. Stubborn, sullen, or irritable.
87. Sudden changes in mood or feelings.
88. Sulks a lot.
89. Suspicious.
90. Swearing or obscene language.
91. Talks about killing self.
92. Talks or walks in sleep (describe): _____
93. Talks too much.
94. Teases a lot.
95. Temper tantrums or hot temper.
96. Thinks about sex too much.
97. Threatens people.
98. Thumb-sucking.
99. Too concerned with neatness or cleanliness.
100. Trouble sleeping. (describe): _____
101. Truancy, skips school
102. Underactive, slow moving, or lacks energy.
103. Unhappy, sad, or depressed.
104. Unusually loud.
105. Uses alcohol or drugs for nonmedical pruposes (describe): _____
106. Vandalism.
107. Wets self during the day.
108. Wets the bed.
109. Whining.
110. Wishes to be of opposite sex.
111. Withdrawn, doesn't get involved with others.
112. Worries.
113. Please write in any problems your child has that were not listed above.