DC:0–5™ Training Handout

CASE REPORT: TURNER

Turner, an 18-month-old Caucasian boy of European descent, was referred to the program by his child welfare worker. Turner, the only son of a single parent mother, was placed in foster care after the death of his mother due to drug overdose when he was 12 months old. Because none of the mother's family were able to care for him, and the father, who had been estranged, could not be located, this was an emergency placement to a temporary foster home for 4 weeks. Turner was then placed with a set of foster parents who were interested in longer placement and possible foster/adoption arrangements. Turner's new foster parents agreed to take Turner after observing him together with his first foster parents for 45 minutes at the child welfare visiting playroom and being told about the death of his mother. By report they felt an immediate chemistry with him and felt they could provide him with a loving, caring home. Turner went to live with the foster family 1 week after this meeting. There was no other transitional process for the new placement.

Reasons for referral were Turner's incessant crying, poor appetite, and his having little interest in his surroundings. When not crying, he often stared silently. He often cried for "Mama" and would go to the window or door looking out longingly. He seldom smiled and had very little speech for expressing himself. He showed little joy or interest in photos placed in a life book of himself with his mother.

The worker reported that this child's foster parents had been considering adoption when Turner was placed with them, but were expressing reservations as a result of Turner's emotional and behavioral patterns. The foster mother was especially concerned that Turner might be developmentally delayed or otherwise "damaged." They requested a thorough diagnostic assessment to rule out chronic disabilities which would preclude their adoption of Turner.

Assessment Process:
Assessment occurred over five sessions: (1) detailed interview with child welfare worker, (2) a review by the worker and the assessor of Turner's child welfare chart; (3&4) Two subsequent sessions involving home visits to observe Turner with foster parents and to elicit impressions and feeling toward him, and (5) administering the Bayley Scales of Infant Development.

Assessment Findings:
Turner had been exposed to cocaine prenatally and as a newborn had some tremors. He was difficult to console.

By 3 months old, he had become a quieter baby who smiled often and liked to be held. Turner's developmental milestones had been met on schedule. All descriptions of Turner's early life provided by physician records and extended family report indicated that Turner was developing along expectable lines even when placed in first foster home. There were signs of grief that were expressed when first placed, including calling for "Mama" and difficulty sleeping. However, the intense and prolonged behaviors began to emerge after the removal/transition to second foster family.

Cognitive Functioning:
Bayley Scales of Infant Development results reinforced finding of adequate developmental course (MDI+98, age appropriate distribution of items passed and failed.) Turner vocalized little, but receptive language appeared adequate. While performing adequately, Turner showed little pleasure in experimenting with the test items and expressed protest only when an object was removed.

His facial expression was attentive, but sober. Turner looked to the assessor to monitor her movements but with no sign of social engagement (detached). For a very young child, there was an oddly business-like quality to his behavior, he behaved as expected, but seemed emotionally detached from the experience.

Home Observations:
Turner's behavior at the foster home was quite different from his demeanor during the administration of the Bayley Scales. At home he seemed like a younger baby, prone to wailing at the slightest frustration. When the foster mother picked him up to soothe him, he held himself stiffly in her arms, arching

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away from her and avoiding eye contact. He cried inconsolably. Nothing seemed to help him (singing, rocking, patting, etc.). He had trouble falling asleep at night, and he vehemently protested bedtime rituals. The foster father appeared to have more patience and more success in calming Turner after bouts of crying or protest.

Frustrated and angry, his foster mother eventually resorted to leaving him alone in his crib to cry it out. Foster mother and child were quite detached from one another. The foster father had two grown children from a previous marriage, but the foster mother married later (late 30s) and had deeply wanted children. She sought spiritual meaning in the situation of foster/adoption and saw it as a duty to give love and economic resources to a child who did not have a home.

Unfortunately, Turner had not reciprocated the foster parents' eagerness to form an attachment. From the beginning, Turner's foster mother felt disappointed that Turner was not the cuddly responsive baby she had hoped for. She found herself irritated by his lack of joy and failure to respond to her positively. She often found herself suppressing the wish to shake him to make him stop crying.

Turner's foster father was affectionate and supportive and felt that Turner just needed time to get used to them and begin to love them. Turner's foster father was patient with him and able to use his sense of humor and empathic response to calm Turner's crying. Turner's responsiveness to his foster father made the foster mother feel patronized and angry with the foster father. She felt guilty about not being more patient with both Turner and her husband.

(Adapted from Lieberman, A. (1997). Mood disorder: Prolonged bereavement/grief reaction. In A. Lieberman, S. Wieder, & E. Fenichel (Eds.), *DC:0-3 casebook* (pp. 61–68). , Washington, DC: ZERO TO THREE.