



# California Common Core Curricula for Child Welfare Workers

## Trainee's Guide

# Child and Youth Development in a Child Welfare Context

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Version 1.2 | 2012

# Acknowledgments



California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), STEC has a wide membership that includes Regional Training Academy (RTA) representatives, county representatives, university-based Title IV-E Project Coordinators, the Inter-University Consortium in Los Angeles (IUC), the Administrative Office of the Courts (AOC) and other key stakeholders.

A subcommittee of STEC, the Content Development Oversight Group (CDOG), provided oversight and approval for the curriculum development process. A panel of experts also provided valuable feedback specific to this particular topic of the Common Core. As with many large curriculum projects in public child welfare, significant portions of the Common Core were adapted from existing curricula.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to:

[http://calswec.berkeley.edu/CalSWEC/Citation\\_Guidelines.doc](http://calswec.berkeley.edu/CalSWEC/Citation_Guidelines.doc)



**FOR MORE INFORMATION** on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: <http://calswec.berkeley.edu>

# Child and Youth Development (v1.2, 2012)

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## COMPETENCIES and LEARNING OBJECTIVES

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### CORE COMPETENCIES

The trainee understands how child/adolescent development is affected by multiple factors, including socioeconomic stressors and poverty in particular, ethno cultural background, parent-child interactions, child abuse and neglect, and delays and disorders common to children in the child welfare population.

The trainee understands children's developmental needs and how developmental level affects a child's perception of events, coping strategies, and physical and psychological responses to stress and trauma.

### LEARNING OBJECTIVES

#### Knowledge:

- K1.** The trainee will be able to explain and give examples of the processes and milestones of normal development of infants, toddlers, pre-schoolers, school-age children, adolescents, and emerging adults across the physical, cognitive, social, emotional, and sexual domains.
- K2.** The trainee will be able to provide examples of how cultural variations, such as parenting practices, can influence the manifestation and timing of developmental skills and stages.
- K3.** The trainee will be able to explain how parent-child interactions affect early brain development, and provide examples of parenting behaviors that stimulate optimal brain development.
- K4.** The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.
- K5.** The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.
- K6.** The trainee will be able to recognize the necessity of mental health collaboration when cognitive and behavioral symptoms of mental health needs are recognized in children, adolescents, and emerging adults and be able to articulate when a mental health referral is necessary.

- K7.** The trainee will be able to recognize possible adverse consequences of in utero drug and alcohol abuse on infant and child development, including fetal alcohol syndrome, mental retardation and developmental delays and identify appropriate interventions including early referral and collaboration with mental health providers.
- K8.** The trainee will be able to identify symptoms associated with failure to thrive and be able to articulate when a medical assessment is useful or necessary.
- K9.** The trainee will be able to recognize the principal characteristics of Attention Deficit Hyperactivity Disorder and the basic concepts underlying current methods of assessment and treatment including early referral and collaboration with mental health providers.
- K10.** The trainee will be able to identify the social, communication, and behavioral indicators associated with autism and other pervasive developmental disorders and explain why early intervention is and collaboration with service providers are important.

#### **Skills:**

- S1.** Given a case example, the trainee will be able to distinguish between normal and delayed developmental milestones and identify steps to take for collaborative early intervention.
- S2.** Given a case example, the trainee will be able to articulate, in terms a parent can understand, strength-based parenting strategies for children at different stages of development.
- S3.** Given a case example, the trainee will be able to analyze symptoms and possible causes of developmental delays and disorders and recommend appropriate referrals and interventions.

#### **Values:**

- V1.** The trainee will value an understanding of how poverty, lack of education, community distress and environmental stressors can impair a parent's ability to provide for a child's developmental needs.
- V2.** The trainee will value utilizing a strength-based perspective with families/caregivers when gathering information and assessing the child's developmental history.

- V3.** The trainee will value and respect cultural variations in child-rearing practices and beliefs when working with families from diverse ethnic, racial, and socio-economic backgrounds.
- V4.** The trainee will value keeping abreast of emerging research evidence regarding attachment, child development, and disorders of childhood, and applying current knowledge to child welfare practice.
- V5.** The trainee will value helping parents meet the challenges of providing nurturance and collaborative mental health and medical intervention to a child with a developmental delay, medical challenge, and/or mental or emotional concern.
- V6.** The trainee will value collaboration with mental health providers for early and appropriate interventions to assist children with disorders, delays and other challenges associated with prenatal exposure to alcohol and drugs, or resulting from other causes.

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# Child and Youth Development

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## AGENDA Day 1 of 2

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- I. Welcome and Introductions (15 min.)
- II. Knowledge Pre-Test (45 min.)
- III. Review Competencies and Learning Objectives (15 min.)
  - a. Icebreaker (10 min.)
  - b. Review Competencies and Learning Objectives (5 min.)

BREAK (15 min.)
- IV. A Framework for Understanding Child Development (90 min.)
  - a. Normal Development (30 min.)
  - b. Nature and Nurture (10 min.)
  - c. Brain Development (30 min.)
  - d. The Role of Culture (20 min.)

LUNCH (60 min.)
- V. Ages 0-2 (2 hours 35 min.)
  - a. Normal Development (15 min.)
  - b. Brain Development (20 min.)
  - c. Attachment (35 min.)
  - d. Grief and Loss (20 min.)

BREAK (15 min.)

  - e. Effects of Maltreatment (25 min.)
  - f. Effects of Maternal Substance Abuse (20 min.)
  - g. Red Flags and Implications for Practice (20 min.)
- VI. Summary of Day 1, Preparation for Day 2 (10 min.)

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**AGENDA**  
**Day 2 of 2**

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**I. Welcome, Review of Day 1**

**II. Ages 3-5**

- a. Normal Development
- b. Attachment
- c. Grief and Loss
- d. Red Flags
- e. Effects of Maltreatment
- f. Implications for Practice

**BREAK (15 min.)**

**III. Ages 6-12**

- a. Normal Development
- b. Grief and Loss
- c. Traumatic Experiences and PTSD
- d. Red Flags
- e. Effects of Maltreatment
- f. Implications for Practice

**LUNCH (60 min.)**

**IV. Adolescents and Emerging Adults**

- a. Normal Development
- b. Brain Development
- c. Grief and Loss
- d. Effects of Maltreatment
- e. Implications for Practice

**V. Case Application**

- a. Tammy and Marcus
- b. What Would You Do?

**BREAK (15 min.)**

**VI. The Child Development Game**

**VII. Post-test**

**VIII. Course Evaluation/Closure**

# Child and Youth Development in a Child Welfare Context

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## TRAINEE'S GUIDE

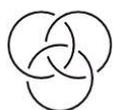
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This trainee content contains icons indicating content related to California's themes of practice:



Safety, Permanence, and Well-being



Engagement



Teaming



Fairness and Equity



Strength-based Practice



Evidence-based Practice



Outcomes-informed Practice

These themes are interwoven throughout the Common Core Curricula in California. Trainees are encouraged to pay special attention to the values and principles and make efforts to incorporate the concepts in their daily practice.

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## Introduction to Normal Development



There are many schools of developmental thought. Despite these differing conceptions, however, there are several principles upon which many developmental experts agree. They include the following:

### **Development Is an Ongoing, Dynamic Process**

Development begins with conception and does not end until death. Development involves continuous change.

### **Development Is Directional**

Most developmental processes evolve in predictable, defined directions. Development typically proceeds from **simple to complex**. A child must develop basic motor skills that will allow her to stand, walk, run, catch and throw a ball before she can maneuver through more complex activities such as playing basketball.

### **Development May Involve Stages**

At certain predictable times in the developmental process, new and different abilities emerge. These **predictable time frames** are often referred to as stages. After the emergence of a new skill or behavior in a stage, there is usually a period of leveling off, when the new skills are practiced, mastered, and integrated into the child's behavior. Early tasks and abilities that form the foundation for later development often become more complex behavior patterns.

An example is that of a 4-year-old who has well-developed language and social skills. A year earlier, this child may have responded to frustration by having a tantrum. However, with new language and social skills, the child can more effectively remove the source of frustration and negotiate a solution. Initially, this process may be somewhat difficult for the child, but with time and practice, it will become easier.

### **Development Is Cumulative**

A child who fails to master early foundational tasks will have more difficulty mastering the demands of later stages. Without remedial intervention, the child's development becomes more delayed, or may show increasingly abnormal patterns over time. The negative effects of early developmental deficits increase as the child grows and environmental demands become more complex.

Because early developmental tasks form the foundation for the development of later, more complicated tasks, understanding the stages of development are important for early detection of delays and timely intervention.

### **Development Occurs in Many Areas**

Human development is complex and proceeds simultaneously across many dimensions. One way to conceptualize the areas of development is to divide the developmental process into five domains: Social, Physical, Emotional, Cognitive, and Sexual. These domains can be easily remembered by the acronym *SPECS*. Each of these areas can be considered individually, or in conjunction, when evaluating a person's developmental progress.

It is important to note that until the late 20<sup>th</sup> century, much of the research conducted in child and family development focused primarily on European Americans (McLoyd, 2006). Any research that may have been conducted with members of ethnic or racial minority groups was often done from a deficit perspective, meaning that characteristics and outcomes of European Americans were considered to be the standard to which other groups should be compared (McLoyd, 2006). Fortunately, it is now recognized and acknowledged in research that heterogeneity among individuals and groups exists.

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## The Normal SPECS of Child Development

To facilitate the study of development, developmental tasks are typically divided into five primary domains, or **SPECS: social, physical, emotional, cognitive, and sexual**. While each of these developmental domains can be examined individually, it is misleading to suggest that development occurs separately in each domain. Development in any domain affects, and is affected by, development in all of the other domains.

### **Social Domain**

Social development includes the child's interactions with other people and the child's involvement in social groups. The earliest social task is attachment. The development of relationships with adults and peers, assumption of social roles, adoption of group values and norms, adoption of a moral system, and eventually assuming a productive role in society are all social tasks.

### **Physical Domain**

Physical development consists of the development of the body structure, including muscles, bones, and organ systems. Thus, physical development generally comprises **motor** development, dealing with the actions of the muscles; **sensory** development, which involves the organ systems underlying the senses and perception; and the **nervous system's** development, the coordination of both movement and perception.

1. Motor activity depends upon muscle strength and coordination. **Gross motor** includes activities such as standing, sitting, walking, and running, and involves the large muscles of the body. **Fine motor** activities include things such as speech, vision\*, and the use of hands and fingers, which involve the smaller muscles in of the body. Both large and small muscle activities are controlled and coordinated by the central nervous system.
2. Sensory development includes the development of vision\*, hearing, taste, touch, and smell, and the coordination and integration of perceptual input from these systems by the central nervous system.

*\* Note: Vision has both motor and sensory components. In the physical domain it is addressed because muscles regulate the physical structures of the eye to permit focusing; while in the sensory domain, it addresses the neurological pathways that transmit visual information to the brain.*

### **Emotional Domain**

Emotional development includes the development of personal traits and characteristics, including: the ability to enter into reciprocal emotional relationships; **mood and affect** (feelings and emotions); personal identity; and self-esteem as appropriate for one's age and the situation.

### **Cognitive Domain**

Cognitive development includes activities such as **thinking, perception, memory, reasoning, problem solving, and abstract thinking**. Language, which requires the use of symbolization and memory, is one of the most important and complicated cognitive activities.

*Note: It is important to differentiate language and speech as they are controlled by different parts of the brain. Speaking is a motor activity, while understanding and formulating language is a complex cognitive activity.*

### **Sexual Domain**

Sexual development includes the development of a person's **sexual identity** and **gender roles**. It includes engagement in sexual behavior and how a person relates to his/her physical maturation and adoption of gender roles.

### **Discussion Questions**

Thinking of the five developmental domains, answer the following questions:

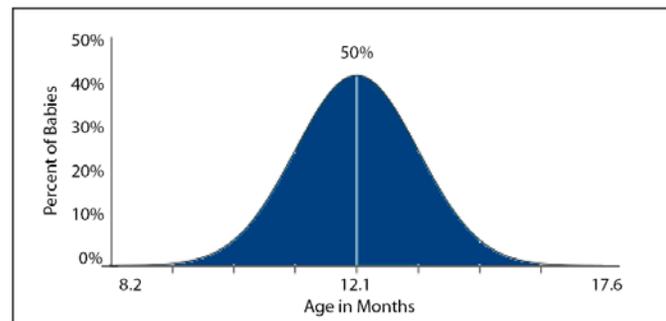
- How does a child learn to understand the concepts of near and far? Which of the four domains are utilized in understanding these concepts, and how?
- How is a child's concept of near and far altered from a developmental domain perspective if he or she is blind?
- How does a child learn and understand the complicated social cues that come from rules and roles in interpersonal relationships?
- How is a child's ability to develop social cues and understand social roles and rules affected if the child has a cognitive deficit such as intellectual delay?
- How does a child develop physical coordination and mastery of his or her own body and motor skills?
  - a. How is a child's ability to master his or her own body and motor skills affected if he or she has emotional problems that arouse fear and anxiety when trying new tasks and activities?

The term **normal** is a **statistical concept** that refers to a **trait**, not a child. The concept of normal represents what is typical or expected for the majority of members of a group. We must know what constitutes typical development in order to establish an accurate baseline from which to evaluate and understand the developmental progress of a child.

To label a child as delayed or abnormal simply on the basis of a statistical delay in performance is of little use. However, a statistically determined delay should be considered an indicator of potential developmental problems and should serve as an inducement to consider referral for developmental testing.

*Example: Domain—Physical (Normal age range for walking alone)*

For example, if we want to determine the normal age range for unassisted walking, we would observe and record the ages at which a group of children walked alone. Our study group should be representative, that is, randomly chosen and proportionately the same in composition as the entire population of children we are studying. If our study group is truly representative, we can assume that what we learn about the children in the sample is most likely true for all children. Once data are collected, we can record the information on a graph, such as the one illustrated below.



**Figure 1. Example of a normal distribution curve, N=794**

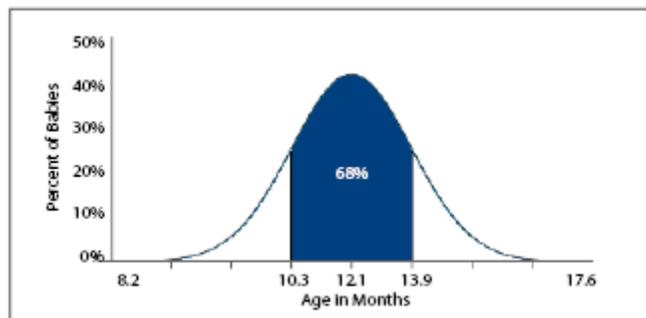
This type of graph, known as the normal distribution curve, can be used to depict the distribution of many typical traits in a population. In this sample, 794 children were observed (N=794). On this particular graph, the horizontal axis records the ages at which children were observed to walk alone, from the youngest at 8.2 months to the oldest at 17.6 months. The vertical axis records the percentages of children in the sample relative to when they were observed to walk alone.

The **mean** is calculated by adding all of the children’s ages when they walked alone and dividing by the number of children in the sample. In the example depicted in Figure 1, the mean is 12.1 months. The mean represents an *average* for the population.

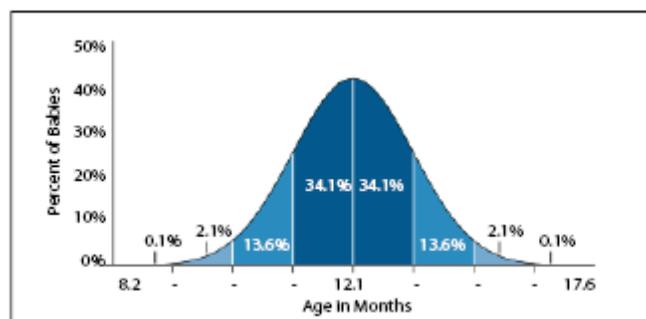
The **median** is another type of average that indicates the point at which 50% of the children are below, and 50% of the children are above. The median is also called the *midpoint*. In a normal bell-shaped distribution such as depicted in Figure 1, the mean and median are the same—12.1 months for this sample.

Another statistical measure, called a **standard deviation**, designates a fixed distance from the mean. One standard deviation by definition includes approximately 34% of the sample. The number of observations of children one standard deviation below the mean added to the number of observations of children one standard deviation above the mean therefore accounts for 68% of the sample.

In this study, one standard deviation is approximately 1.8 months. Therefore, Figure 2 below shows that 68% of children walk alone between the ages of 10.3 months to 13.9 months (34% below the mean and 34% above the mean). This is generally referred to as the average range.



**Figure 2. One standard deviation on either side of the mean**



**Figure 3. Two standard deviations on either side of the mean**

Two standard deviations on either side of the mean by definition include approximately 95% of the sample in a normal distribution as indicated in Figure 3. Figure 3 shows that 95% of the sample walked alone between approximately 8.5 months and 15.7 months of age.

The data discussed here were obtained from a study supported by the World Health Organization (WHO) that purposely focused on including data on individuals from diverse geographic and cultural backgrounds. Study participants were selected from Brazil, Ghana, India, Norway, Oman, and the U.S.A., and were mostly selected from privileged, healthy populations in an attempt to obtain information about children living under conditions unlikely to hinder normal growth and development (Martorell, de Onis, Martines, Black, Onyango, Dewey, & Siyam, 2006). At the time of collection, data from Brazil's study were unavailable and so are not included in the statistical analysis in this discussion.

However, Slater & Lewis (2007) note wide variation in the age of walking across cultures and relate the variation to cultural practices related to child rearing.

#### **Implications for Practice re: Determining Normal Development**

Mappings of behaviors onto a normal distribution curve are used for descriptive comparisons among populations to signal the need for appropriate screening when individual children appear to be late in achieving the milestones, and to raise awareness about the importance of overall development in child health (Martorell et. al, 2006).

Because development occurs on a continuum, it is not possible to use this statistical data to draw strict delineations of normal and abnormal. As the normal curve demonstrates, development occurs in a population **on a continuum**. However, statistically determined delays should be considered as indicators of potential developmental problems and should serve as an inducement to explore any problems and their origins.

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### Two basic constructs for developmental theories:

- *Stage theories*—focus on periods of acquisition of new skills that alternate with periods of consolidation of these newly acquired skills (examples: Piaget and Erikson).
- *Non-stage theories*—focus on the continuous process across numerous concepts of development forming a single blueprint (example: Gardner’s multiple intelligences and Coll’s Integrative Conceptual Model of Child Development).

### Social workers may use developmental theories to:

- Assess what might be expected of a “typical” child at a given age
- Understand the impact of critical events on development at different ages
- Understand a child’s view of the animate and inanimate world
- Know how to relate to children of different ages
- Assist caregivers to understand and work with children of different ages
- Identify children who need special assistance
- Identify appropriate resources

### Biological Development

Biological development describes development in terms of the changes in cells, organs, and body systems across the life span. Development occurs as:

- A sequential increase in the structural or functional complexity of a system
- A continuous, alternating process of differentiation and integration
- Unspecialized cells differentiate into several types of specialized cells, which integrate to form a system
- Behavior changes as new systems become fully developed

### Cognitive Theories

These theories describe and explain changes in the child’s mental representations of the physical and social world, including the self, from birth to maturity. These mental representations are the internalized frames of reference, which the child uses in his/her interactions with the external world. They represent both what is known and how it is known. Piaget’s theories of development are the best known examples. Others include theories of social cognition and information processing. In addition, Kohlberg used Piaget’s work as a starting point to propose three major stages of the development of moral judgment based on cognition.

## Psychoanalytic Theories

These theories focus on understanding the child's emotional life: the experiences of loving, hating, pain, pleasure, longing, guilt, etc. The emphases of child analysis are:

- The internal and private experiences of children
- The ways in which bodily and environmental processes influence the child's inner life and perception of the outer world
- The ways in which children represent their experiences and themselves
- The mutual interactions between reality and fantasy, inner and outer, adaptation to the shared world of reality and appreciation of personal desires and needs

Freud's stages of oral, anal, genital, oedipal, latency, and adolescence are the most frequently cited examples of these theories. Anna Freud and Melanie Klein also added to these theories. Erikson was also psychoanalytically based, but placed emphasis on ego rather than id, emphasizing socialization over instinct. For this reason, his theory is often placed among the social theories of development.

## Family Theories

These theories are based on family as a distinctive feature of human social organization. Families are viewed as a system. When change occurs in one aspect of the family it resonates through all the other members. Homeostasis is the way that families conserve their energy and socialize their young. Yet, the demands of rapidly maturing children offer continual threat to this homeostasis. Fleck suggests that there are five factors that contribute to the family's ability to support the development of its children, including: leadership, boundaries, emotional climate, communication, and the establishment and accomplishment of goals and tasks throughout the life cycle. These factors are defined as follows:

- **Leadership** is the decision-making, facilitating source of power and discipline within the biological, adoptive, or serial parents who lead the family. It is shaped by the presence or absence of mutual support and esteem and by the effectiveness of communication between the leaders of the family unit.
- **Boundaries** are the semi-permeable limits that differentiate individuals and the family as a whole from other members and the outside community. They define the self and the generations. Self and generational boundaries often remain relatively stable throughout the life cycle, while family/community boundaries must become increasingly permeable as children cross them more frequently to participate in community.
- **Emotional climate.** The affective environment within the family is the emotional glue, the lifeblood of the family's capacity to care for and support one another. Chronic scapegoating, child abuse, or child neglect are classic signs of failure in the family's emotional climate.
- **Communication** consists in the verbal and nonverbal messages between members of the family used for sharing experiences, feelings, values, and culture. It is the method by which other factors are conveyed.

- **Establishment and accomplishment of goals and tasks** assures that families will nurture and socialize their young so that they develop into contributory members of society.

### **Erikson’s Theory of Social-Emotional Development**

Erik Erikson’s theory states that each stage of life presents an emotional challenge that must be satisfactorily negotiated for healthy development to proceed. According to Erik Erikson, children develop in a predetermined order of eight distinct phases known as the “eight stages of man”. Each stage has two possible outcomes. According to the theory, successful completion of each stage results in a healthy personality and successful interactions with others. Failure to successfully complete a stage can result in reduced ability to complete further stages, a less healthy personality and a diminished sense of self. These stages, however, can be resolved successfully at a later time.

Each stage is regarded by Erikson as a “psychosocial crisis,” which arises and demands resolution before the next stage can be satisfactorily negotiated. These stages are conceived in an almost architectural sense: satisfactory learning and resolution of each crisis is necessary if the child is to manage the next and subsequent ones satisfactorily, just as the foundation of a house is essential to the first floor, which in turn must be structurally sound to support the second story, and so on.

#### *1. Trust vs. mistrust (hope)*

From birth to 1 year, children begin to learn the ability to trust others based upon the consistency of their caregiver(s). If trust develops successfully, the child gains confidence and security in the world around him/her and is able to feel secure even when threatened. Unsuccessful completion of this stage can result in an inability to trust, and fear about the inconsistent world. It may result in anxiety, heightened insecurities, and unwarranted mistrust of the world around them.

#### *2. Autonomy vs. shame and doubt (will)*

Between the ages of 1 and 3, children begin to assert their independence, by walking away from their mothers, picking which toys to play with, and making choices about what they like to wear, eat, etc. If children in this stage are encouraged and supported in their increased independence, they become more confident and secure in their own ability to survive in the world. If children are criticized, excessively controlled, or not given the opportunity to assert themselves, they may begin to feel inadequate in their capacity to survive. They may also become overly dependent upon others, experience shame or doubt in their abilities, and lack self-esteem.

#### *3. Initiative vs. guilt (purpose)*

From age 3 and continuing to age 6, children assert themselves more frequently. They begin to plan activities, make up games, and initiate activities with others. If given this opportunity, children develop a sense of initiative, and feel secure in their ability to lead others and make decisions. Conversely, if this tendency is squelched, either through criticism

or control, children develop a sense of guilt. They may feel like a nuisance to others and will therefore remain followers, lacking in self-initiative.

4. *Industry vs. inferiority (competence)*

From age 6 to puberty, children begin to develop a sense of pride in their accomplishments. They initiate projects, see them through to completion, and feel good about what they have achieved. During this time, teachers play an increased role in the child's development. If children are encouraged and reinforced for their achievements, they begin to feel industrious and confident in their ability to attain goals. However, if this initiative is not encouraged, for example, if it is restricted by parents or teachers, then the child may not reach his/her potential due to feelings of inferiority and self-doubt.

5. *Identity vs. role diffusion (fidelity)*

Adolescence marks the transition from childhood to adulthood. Children are becoming more independent, and begin to look at the future in terms of career, relationships, families, and housing, etc. During this period, they explore possibilities and begin to form their own identities based upon the outcomes of their explorations. If such identity development is hindered, an adolescent may experience confusion about him- or herself and his/her place in the world.

6. *Intimacy vs. isolation (love)*

In young adulthood, youth begin to share themselves more intimately with others. They explore relationships leading toward longer-term commitments with someone other than a family member. Successful completion of this stage can lead to comfortable relationships and a sense of safety, commitment, and care within a relationship. On the other hand, the avoidance of intimacy and fear of commitment and relationships can result in isolation, loneliness, and sometimes depression.

7. *Generativity vs. self-absorption (care)*

In middle adulthood, individuals establish their careers, settle down within a relationship, begin families, and develop a sense of being a part of a larger community. They give back to society through raising children, being productive at work, and becoming involved in community activities and organizations. Those who fail to achieve these objectives become stagnant and feel unproductive.

8. *Integrity vs. despair (wisdom)*

As people grow older and become senior citizens, they tend to slow their productivity, and explore life as a retired person. It is during this time that they contemplate their accomplishments and are able to develop integrity if they see themselves as leading a successful life. If they view their lives as unproductive, feel guilt about their pasts, or feel that they did not accomplish their life goals, they become dissatisfied with life and develop despair, often leading to depression and hopelessness.

## **Piaget's Stages of Intellectual Development**

Children are not little adults. Until they reach the age of 15 or so they are not capable of reasoning as an adult. Jean Piaget, a developmental biologist, devoted his life to closely observing and recording the intellectual abilities of infants, children, and adolescents. The stages of intellectual development formulated by Piaget appear to be related to major developments in brain growth.

### *Sensorimotor period (0-24 months)*

During this period, infants are busy discovering relationships between their bodies and the environment. Researchers have discovered that infants have relatively well-developed sensory abilities. Children rely on seeing, touching, sucking, feeling, and using their senses to learn things about themselves and the environment. Piaget calls this the sensorimotor stage because the early manifestations of intelligence appear from sensory perceptions and motor activities. Through countless informal experiments, infants develop the concept of separate selves, that is, the infant realizes that the external world is not an extension of themselves. Infants realize that an object can be moved by a hand (concept of causality), and develop notions of displacement and events. An important discovery during the latter part of the sensorimotor stage is the concept of "object permanence."

**Object permanence** is the awareness that an object continues to exist even when it is not in view. In young infants, when a toy is covered by a piece of paper, the infant immediately stops and appears to lose interest in the toy. In older infants, when a toy is covered, the child will actively search for the object, realizing that the object continues to exist.

After a child has mastered the concept of object permanence, the emergence of "directed groping" begins to take place. With directed groping, the child begins to perform motor experiments in order to see what will happen. During directed groping, a child will vary his movements to observe how the results will differ. The child learns to use new means to achieve an end. The child discovers that he can pull objects toward himself with the aid of a stick or string, or tilt objects to get them through the bars of his playpen.

### *The pre-operational period (2-7 years)*

Throughout most of the pre-operational stage, a child's thinking is self-centered, or egocentric. According to Piaget, during the pre-operational stage a child has difficulty understanding life from any perspective other than his own. In this stage, the child is oriented to "me, myself, and I."

**Egocentrism** is apparent in the relationship between two preschool children. Imagine two children are playing next to each other, one playing with a coloring book and the other with a doll. They are talking to each other in sequence, but each child is completely oblivious to what the other is saying.

Julie: "I love my dolly, her name is Tina."

Carol: "I'm going to color the sun yellow."

Julie: "She has long, curly hair like my auntie."  
Carol: "Maybe I'll color the trees yellow, too."  
Julie: "I wonder what Tina's eyes are made of?"  
Carol: "I lost my orange crayon."  
Julie: "I know her eyes are made of glass."

These types of exchanges are called "collective monologues." This type of monologue demonstrates the egocentrism of children's thinking in this stage.

Egocentrism of young children leads them to believe that everyone thinks as they do, and that the whole world shares their feelings and desires. This sense of oneness with the world leads to the child's assumptions of magic omnipotence. Not only is the world created for them, they can control it. This leads to the child believing that nature is alive, and controllable. This is a concept of egocentrism known as "animism," the most characteristic of egocentric thought.

Closely related to animism is artificialism, or the idea that natural phenomena are created by human beings, such as the sun is created by a man with a match. "Realism" is the child's notion that their own perspective is objective and absolute. The child thinks from one perspective and regards this reality as absolute. For example, names are real to the child. The child does not yet realize that names are only verbal labels, or conceive the idea that a name could have been different.

In the pre-operational stage, the child begins to develop the use of symbols (but cannot manipulate them), and the child is able to use language and words to represent things that are not visible. Also, the pre-operational child begins to master conservation problems. (See *Conservation below*.) Although the child is still unable to think in a truly logical fashion, the child may begin to treat objects as part of a group. The pre-operational child may have difficulty with classification.

In the latter part of the pre-operational stage, the child begins to have an understanding between reality and fantasy. The child also begins to understand sex roles in society.

#### *Period of concrete operations (7-11 years)*

During this stage, children begin to reason logically, and organize thoughts coherently. However, they can only think about actual physical objects, and cannot handle abstract reasoning. This stage is also characterized by a loss of egocentric thinking.

During this stage, the child has the ability to master most types of conservation experiments, and begins to understand reversibility. **Conservation** is the realization that quantity or amount does not change when nothing has been added or taken away from an object or a collection of objects, despite changes in form or spatial arrangement. The concrete operational stage is also characterized by the child's ability to coordinate two dimensions of an object simultaneously, arrange structures in sequence, and transpose

differences between items in a series. The child is capable of concrete problem-solving. Categorical labels such as “number” or “animal” are now available to the child.

#### *Period of formal operations (11-15 years)*

The formal operational stage is the fourth and final stage in Piaget’s theory. It begins at approximately 11 to 12 years of age and continues through adulthood, although Piaget does point out that some people may never reach this stage of cognitive development.

The formal operational stage is characterized by the ability to formulate hypotheses and systematically test them to arrive at an answer to a problem. The individual in the formal stage is also able to think abstractly and to understand the form or structure of a mathematical problem.

Another characteristic of formal operations is the ability to reason contrary to fact. That is, if given a statement and asked to use it as the basis of an argument, the individual is capable of accomplishing the task. For example, a person with formal operations can respond to the question, “*What would happen if snow were black?*”

#### **Stage Theories of Moral Development**

Historically, theories of morality (Piaget, Kohlberg) have proposed that morality develops in a progression of discrete stages following a specific hierarchy culminating in a final stage related to an understanding of absolute justice. These stages were seen as universal and outside the influence of socialization and culture (Harris and Graham, 2007).

As discussed in Harris and Graham (2007), other theorists have criticized traditional theories of moral development. Gilligan (1982) showed that women rely on a moral perspective that values interconnectedness and communication rather than an abstract notion of absolute justice. The Culture and Empathy Model (Humphries et al, 2000) relies on connections between gender, empathy and culture to explain moral development. They point out cultural differences in communalism and individualism and the impact those differences will have on moral development. Moreland and Leach (2001) explored the interconnections between the stages of ethnic identity development and the stages of moral development.

#### **Coll’s Integrative Conceptual Model of Child Development (1996)**

This theory focuses on the impact of racism, prejudice and segregation as the central force in development. As described in Harris and Graham (2007), the theory is based on several premises:

- a. the naivete of theorists and researchers has led to the misunderstanding of various ethnic groups;
- b. the buffering role that family and kin play in the developmental processes of children of color;
- c. the need to examine the roles of various contexts (outside the family) on the development of African American and other youth of color;

- d. the importance of examining health and education as outcomes in development rather than important contributors.

### **Bronfenbrenner's Bioecological Systems Theory (1986)**

This theory describes development as occurring within five systems:

- a. microsystem – the setting of the child's daily behavior (home, school, neighborhood)
- b. mesosystem – the connections and communication between the various microsystems
- c. exosystem – the environments that affect the child but which the child does not physically enter (media, parental workplace)
- d. macrosystem – the larger cultural context and the consistency of the lower systems within the larger culture
- e. chronosystem – patterns of stability and change in the child environment over time.

### **Gardner's Theory of Multiple Intelligences (1983)**

In *Frames of Mind: The Theory of Multiple Intelligences*, Howard Gardner proposed that there are seven main areas in which all people have special skills. He calls them intelligences. Gardner's research at Harvard University was in response to the work that Alfred Binet had done in France around 1900. Binet's work led to the formation of an intelligence test, and the familiar "intelligence quotient," or "IQ," the way that intelligence is measured on his test. Most intelligence tests measure verbal and math abilities. However, Gardner's Multiple Intelligences (MI) theory proposes that there are additional measures of intelligence, now totaling eight after he introduced another intelligence type in the mid '90s. While many teachers have some knowledge of MI theory, most schools are not fully equipped to use it to the advantage of all students. MI theory posits that each of us has all of these intelligences, to some degree or another. Some of them are simply more developed than others. Furthermore, we are all able to improve our ability in each of these areas. Gardner stresses that the intelligences are equal in their importance. Each intelligence area is described below.

#### *Bodily-kinesthetic*

This intelligence makes use of the body to solve problems and express ideas and feelings. Actors, athletes, and dancers use their whole bodies in this way, much the same way that craftspeople, sculptors, and mechanics use their hands. The following questions can help to determine if children are developing well in Bodily-kinesthetic intelligence.

Does the child:

- excel in more than one sport?
- move various body parts when required to sit still for long periods of time?
- have the ability to mimic others' body movements?
- enjoy taking things apart and putting them back together?
- have a hard time keeping hands off objects?

- enjoy running, jumping, or other physical activities?
- show skill in activities that require fine-motor coordination, such as origami, making paper airplanes, building models, finger-painting, clay, or knitting?
- use his or her body well to express himself or herself?

### *Interpersonal*

Interpersonal intelligence involves the perception of the moods, feelings, and needs of others. It is exemplified by salespeople, teachers, counselors, and people who work in the helping professions. Below are questions to help explore a child's Interpersonal intelligence.

Does the child:

- enjoy socializing with friends?
- seem to be a natural leader?
- empathize easily with others?
- give advice to friends who come to him or her with problems?
- seem to be street-smart?
- enjoy belonging to organizations?
- enjoy teaching other kids—either peers or younger ones?
- have two or more close friends?
- serve as a magnet for social activities with others?

### *Intrapersonal*

Intrapersonal intelligence is characterized by well-developed self-knowledge that is used to navigate successfully in the world. To learn more about a child's Intrapersonal intelligence, refer to the following questions.

Does the child:

- show a sense of independence or a strong will?
- have a realistic sense of her abilities and weaknesses?
- do well when left alone to play or study?
- “march to the beat of a different drummer” in living and learning?
- have a hobby or interest that he or she does not talk about much?
- have a good sense of self-direction?
- prefer working alone to working with others?
- accurately express how he or she is feeling?
- learn from failures and successes?
- have good self-esteem?

### *Linguistic*

People with Linguistic intelligence use words, either oral or written, in an effective manner. This intelligence is associated with storytellers, politicians, comedians, and writers. In order to explore a child's Linguistic intelligence, answer the following questions.

Does the child:

- write better than average for his or her age?
- enjoy telling stories and jokes?
- have a good memory for names, places, dates, and other information?
- enjoy word games, either visual or auditory?
- enjoy reading books?
- spell better than other children the same age?
- appreciate rhymes, puns, and tongue twisters?
- enjoy books on tape without needing to see the book itself?
- enjoy hearing stories without seeing the book?
- have an excellent vocabulary for his or her age?
- communicate thoughts, feelings, and ideas well?

### *Logical-mathematical*

Understanding and using numbers effectively, as well as having strong reasoning powers, are the earmarks of Logical-mathematical intelligence. Exemplars are mathematicians, scientists, computer programmers, and accountants. Below are some questions to determine if children are developing Logical-mathematical intelligence.

Does the child:

- demonstrate curiosity about how things work?
- have fun with numbers?
- enjoy math at school?
- enjoy math and/or computer games?
- play and enjoy strategy games, such as chess, checkers, brain teasers, or logic puzzles?
- easily put things into categories?
- like to do experiments, either at school when assigned or on his/her own?
- show an interest in visiting natural history or discovery-type museums and exhibits?

### *Musical*

Individuals with Musical intelligence relate to music in a wide range of ways. This can be embodied in performers, composers, music critics, and music-lovers. These are some questions to determine if children may be exhibiting a well-developing Musical intelligence.

Does the child:

- tell you when he or she recognizes that music is off-key?
- easily remember song melodies and sing them?
- have a pleasant singing voice, either alone or in a chorus?
- play a musical instrument?
- speak or move in a rhythmical way?
- hum or whistle to himself or herself?
- tap on the tabletop or desktop while working?
- show sensitivity to noises in the environment?
- respond emotionally to music he or she hears?

### *Spatial*

Individuals with this intelligence perceive the visual-spatial world in an accurate way, so as to be able to work in it effectively. The people who do this cover a wide range of fields that, upon first glance, do not seem to have much in common. Compare, for example, hunters, sailors, engineers, inventors, and surgeons to interior decorators, architects, painters, and sculptors. The questions below will help gauge Spatial intelligence in children.

Does the child:

- recall visual details in objects?
- have an easy time learning to read and understanding maps and charts in books?
- daydream a lot?
- enjoy the visual arts?
- demonstrate ability in using art materials and creating drawings, sculptures, or other three-dimensional objects?
- enjoy visual presentations such as videos, television, and movies?
- derive a lot of information from illustrations in books he or she reads?
- scribble, doodle, or draw on all available surfaces?

### *Naturalistic*

Individuals with a Naturalistic intelligence excel in distinguishing among members of different living species in the natural environment. They are able to recognize patterns and relationships, as well as draw upon resources and features of nature. Individuals who are chefs, botanists, farmers or biologists represent example of roles that utilize this sort of intelligence.

Does the child:

- Readily recognize patterns and categories with objects?
- Pay attention to relationships between living creatures (e.g.: prey/predator)
- Enjoy exploring nature and being outside?
- Have a curiosity in living creatures?
- Like caring for and interacting with animals or plants?

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There are many debates about whether people develop the way they do because of their biological predispositions, or because of the environment that they experience. This is often referred to as the *Nature vs. Nurture* debate.

### **What Is the Influence of Heredity?**

All human beings have a common genetic structure that determines the course of much of human development. This accounts for the basic similarities in the structure and functions of our bodies, and the differences between humans and other species. Many traits are inherited, including eye color, hair color, body type, height, and skin color. The expression of these traits is genetically determined.

### *Maturation*

When development results directly from the expression of genetic potential, it is called maturation. Genes regulate how fast and in what order maturation occurs, usually manifesting in predictable patterns regardless of environment or culture. Early infant motor skills such as grasping, sitting, crawling, standing, and walking result from maturation. Maturation is an underlying variable in all development. It creates a biological readiness for the child's encounters with the environment. The continuous interactions of the maturing child with the environment determine the final outcomes of development.

### *Physical Development*

The pattern of physical development during the first year of life, such as the pace at which a child's physical structure, bones, and muscles develop, is largely determined by genetics. The physical structure, bones, and muscles must all have developed sufficiently for a child to be able to support upright body posture and to bear weight in order to walk. Additionally, genetics can affect how and when a child experiences growth spurts, when teeth begin to erupt, and the age at which puberty occurs.

Although most infants in all cultures are biologically ready to walk sometime between the ages of 8 and 17 months, environment can influence when a child actually begins to walk. For example, a child who is carried on his/her mother's back for the first three years of life will not walk at 1 year.

### *Social and Emotional Development*

Genetics can also affect a person's social and emotional development. Some people are outgoing and sociable, while others are withdrawn and isolated. Some are high-spirited, while others often experience depression, and some are comfortable taking on new experiences, while others have high levels of anxiety. Research has found genetic links to each of these traits, as well as to some chronic mental illnesses such as schizophrenia.

A person's physical development may also affect his/her social and/or emotional development. For example, a newborn's brain is unable to organize the symbols necessary for speech. However, within the next 1-2 years, the baby's brain develops rapidly, and provides the tools to develop language. The ability to speak, in turn, increases the child's opportunities for more interactive social relations.

In summary, it could be said that heredity provides a person's genetic foundation. This foundation is then influenced by environment and culture in a variety of ways that shape development throughout a lifetime.

### ***What Is the Influence of Environment?***

Environment can be defined as the total complex of external influences that affect the survival and development of the child. There are many types of environments that influence the course of development:

- The *prenatal environment* includes the chemical balance of the mother's body and the presence of conditions or potentially toxic substances that can alter developmental processes.
- The *physical environment* in which the child grows includes the air the child breathes, the nutritional value of food the child eats, and exposure to conditions that can lead to disease, accident, or injury, including child abuse and neglect.
- The *social/cultural environment* consists of the norms, values, belief systems, morals, and standards of behavior that regulate life in the cultural group in which the child is raised and the possible interplay between the child's culture and the larger mainstream culture.
- The *learning environment* consists of the degree and type of stimulation available in the child's immediate environment. Sensory input promotes and shapes cognitive development. Stimulation, in adequate quantity and intensity, promotes the establishment and configuration of neural pathways in the brain.
- The *emotional environment* includes the nature of the child's interpersonal relationships and the degree of nurturance available to the child. The emotional environment shapes personality and affects the development of self-esteem, identity, trust, the ability to enter into intimate relationships, and personal resilience.

**Each of these environments can and will affect a person throughout his/her life. These factors can enhance a genetically predisposed trait while suppressing others. Combinations of these factors can create experiences that can traumatize an individual, resulting in arrested development. On the other hand, an optimal constellation of factors can promote extraordinary achievement and outcomes.**

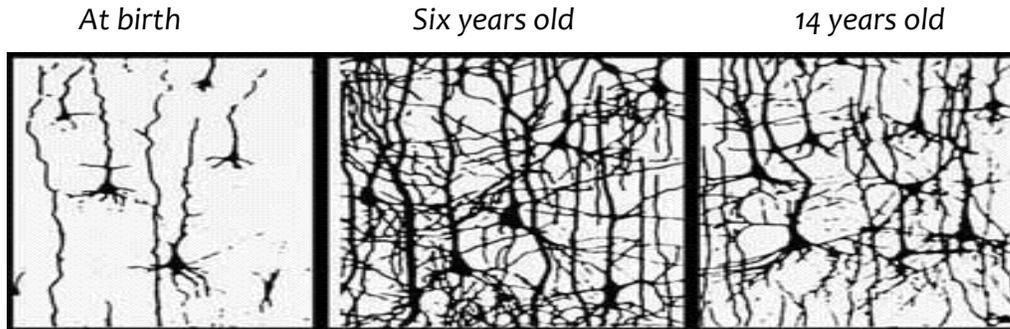
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## Principles of Neurodevelopment

1. **Neurodevelopment proceeds from genetic and environmental influences:** Genetics provide the blueprint, but the environment will shape how genes are expressed. When experiences are provided in a structured, patterned, and appropriately timed way, genetic potential can be expressed and neural systems which mediate various functions will develop.
2. **Neurodevelopment is sequential:** The brain develops in a sequential and hierarchical fashion, organizing itself from least (brainstem) to most complex (limbic, cortical area). These different areas develop, organize, and become fully functional at different times during childhood. The brainstem, which regulates cardiovascular and respiratory functions, is functional at birth, while cortical areas responsible for abstract cognition will not mature for years. Each brain area has its own timetable for development. The neurons for the brainstem have to migrate, differentiate, and connect before the neurons for the cortex. This has profound implications for maltreatment: for example, if nurturing is absent for the first three years of a child's life, the love and care that the child then receives when adopted may not be enough to overcome the malorganization of the neural systems that mediate socio-emotional functioning.
3. **Neurodevelopment is activity-dependent:** The brain organizes in a use-dependent way. Lack, or disruption, of critical cues can alter the neurodevelopmental processes of neurogenesis, migration, differentiation, and synaptogenesis—all of which can contribute to malorganization and diminished functional capabilities in the specific neural system where development has been disrupted. This can lead to compromised functioning throughout life.
4. **Neurodevelopment involves windows of opportunity and windows of vulnerability:** Sensitive periods for neural systems (and the functions they mediate) will be when that system is in the midst of organizing itself (the developmental 'hot zone'). Since the brainstem must organize key systems by birth, the sensitive period for those brainstem-mediated functions is during the prenatal period. The neocortex, in contrast, has systems and functions organizing throughout childhood and into adult life. The sensitive periods for these cortically-mediated functions are likely to be very long. Although the brain remains sensitive to experience throughout life, it is most receptive to environmental input (plastic) during early childhood. Different parts of the brain are more plastic (cortex) or less plastic (brainstem) than others.

“Experience can change the mature brain—but experience during the critical periods of early childhood organizes brain systems!”

**Illustration. Synaptic density in the human brain**



Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, 79-100, to supplement the screening of Dr. Perry's videotape and *Childhood Trauma, the Neurobiology of Adaptation and Use-Dependent Development of the Brain: How States Become Traits* by Bruce D. Perry M.D., Ph.D., et al.

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## Architecture and Functions of the Brain

The brain is the most complex part of the human body. Scientists have learned more about the brain in the last few years than in all previous centuries of study due to the accelerating pace of neurological and behavioral science, and the development of new research techniques, such as positron emission tomography (PET) scans and magnetic resonance imaging (MRI). An understanding of the brain's structure and function will help to create a framework for understanding the impact that maltreatment or trauma may have on the developing child.

### **Overview**

The brain's structures mirror evolutionary history through its organizational hierarchy from older to newer, lower (primitive) to higher (advanced), and in the positioning of the structures in the skull. (Siegel, 1999; Solms & Turnbull, 2002 in Applegate & Shapiro, 2005). There are three main interdependent brain systems: (1) the brainstem, (2) the limbic system, and (3) the cortex.

### **Brainstem**

*Location:* The base of the brain contains the lower structures, which include the neural circuits of the brainstem, a direct extension of the spinal cord.

*Functions:* The brain's oldest structure in evolutionary terms, the brainstem is responsible for monitoring and regulating basic physiological process such as heart rate, respiration, body temperature, and sleep cycles. (Siegel, 1999; Solms & Turnbull, 2002 in Applegate & Shapiro, 2005).

### **Cerebellum**

*Location:* The cerebellum is connected to the back, and slightly above, the brainstem.

*Function:* The cerebellum helps coordinate motor, social, emotional, and cognitive functioning. Collectively, the brainstem and cerebellum are referred to as the reptilian brain due to their resemblance to the brains of contemporary reptiles. (Stien & Kendall, 2004)

*Example of function:* When you play the piano or hit a tennis ball, you are activating the cerebellum.

### **Limbic System**

*Location:* The limbic system is located between the brainstem and the cerebral cortex and coordinates their activities. It forms a ring around the brainstem. Key regions of the limbic system include the orbitofrontal cortex, the anterior cingulate, and the amygdala. The limbic system also contains the hippocampus.

*Functions:* These regions perform the function of integrating and regulating a wide variety of mental and emotional processes, including attachment, and are believed to enhance the human capacity for assigning meaning to internal and external stimuli. The

hippocampus is a sub-system that mediates access to conscious forms of memory (Siegel, 1999 in Applegate & Shapiro, 2004). The limbic system is sometimes referred to as the mammalian brain since it first appeared in mammals. It is alternatively called the emotional brain, because it remains the source of our urges, appetites, and emotions. (Stien & Kendall, 2004). The most basic emotions of life, such as fear, activate the limbic system. Dysfunction in limbic structures underlies most psychiatric disorders, such as depression.

### **Cerebral Cortex**

*Location:* The newest and most advanced parts of the brain constitute the higher structures, principally the cerebral cortex found on the outer layer of the brain.

*Functions:* This area of the brain is responsible for the formation of ideas and mental representations of self, others, and the environment.

*Development:* The cerebral cortex is sculpted postnatally, in the context of positive and negative interactions with the social and physical environments. (Siegel, 1999; Solms & Turnbull, 2002 in Applegate & Shapiro, 2005).

*Other facts:* When people talk about gray matter in the brain, they are talking about the cerebral cortex. The cortex is gray because nerves in this area lack the insulation that makes most other parts of the brain appear to be white. The folds in the brain add to its surface area, and therefore increase the amount of gray matter and the quantity of information that can be processed.

### **Orbitofrontal Cortex**

*Location:* The orbitofrontal cortex lies just behind the orbit of the eye at the apex of the limbic system where the cortex and subcortical areas meet.

*Functions:* The orbitofrontal cortex is important in affect regulation and has been nicknamed the senior executive of the social-emotional brain. It contains neurons that process facial and vocal information and is believed to be critical in social adjustment, the control of mood, and the regulation and storage in memory of affective responses to events. It is expanded in the right hemisphere, and dominant for unconscious processes (Schore, 2003 in Applegate & Shapiro, 2005).

### **Left and Right Hemispheres**

*Location:* The cerebral cortex is made up of two large hemispheres that are connected by filaments of white matter, called the corpus callosum.

*Functions:* Although the two hemispheres appear identical, their functions are different.

*Left hemisphere:* The left hemisphere specializes in identifying and processing the details of a situation. Its specialty is processing the semantic aspects of language, making causal connections between phenomena, and coordinating fine motor movements (Pally, 2000; Siegel, 1998 in Applegate & Shapiro, 2005).

*Right hemisphere:* The right hemisphere specializes in processing global aspects of information: it gets the big picture of a situation, and is particularly adept at processing emotional experience, nonverbal communication such as gesture or tone of voice, and somatic sensations such as touch, pressure, and overall body positioning.

## **Functions and Characteristics Associated with the Right and Left Cerebral Hemispheres** (Courtesy of Haworth Press, <http://www.haworthpress.com>):

### **Left Hemisphere**

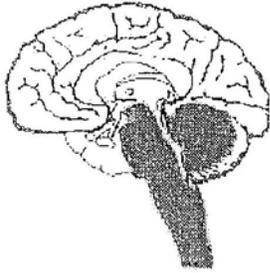
- Positive, optimistic emotions (e.g., happiness)
- Motivational tendency to approach, explore, and tack action
- Involved in the processing of verbal communication, words, and numbers
- Has the capacity to analyze, problem solve, and process information sequentially
- Allows for the elaboration and provides detailed perspective

### **Right Hemisphere**

- Negative, pessimistic emotions (e.g., fear or despair)
- Motivational tendency to withdraw and avoid
- Involved in the processing of nonverbal, emotional communication, imagery, and visual-spatial information
- Limited capacity to think analytically
- Provides global perspective

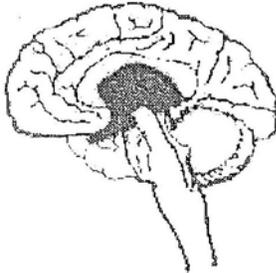
### **Triune Brain**

The image below depicts the evolutionary perspective of brain development, by Paul Maclean, which emphasizes that the human brain evolved from the bottom up. Each new layer added new functions that helped in the struggle to survive and dominate. As the fetal brain develops, it repeats the evolutionary development of the species- the primitive lower layers mature first and the cortex develops last. The cerebellum also evolved from an area that initially controlled movement to a structure that plays a significant role in thinking, emotional regulation, and communication. *Image and text provided courtesy of Haworth Press, <http://www.haworthpress.com>.*



Brainstem and Cerebellum

- Called reptilian brain; resembles the brain of modern reptiles.
- Regulates cardiovascular and respiratory functions.
- Contains some of the nuclei that regulate arousal.



Limbic System

- Considered our “emotional brain”; source of our urges, needs, and emotions.
- Plays the primary role in the functions necessary for self-preservation (fleeing, fighting, food, and reproduction).
- Evaluates experience for emotional significance.
- Is the hub of our memory system.



Cortex and Neocortex

- Referred to as our “thinking brain”; where conscious thinking, perception, planning, communication and voluntary motor action takes place.
- Inhibits lower, more reactive parts of the brain while figuring out socially adaptive ways to meet needs.

### **The Four Lobes of the Brain**

The cerebral cortex is divided into four lobes. Each has different functions and is represented in both hemispheres:

(1) the occipital lobes, involved in processing visual stimuli

Example of function: As you look at the words and pictures in the illustration, the occipital lobes are processing images from your eyes and linking that information with images stored in memory. Damage to the occipital lobes can cause blindness.

(2) the temporal lobes, which mediate auditory, language, and memory functions

Location: The temporal lobes lie in front of the visual areas and nest under the parietal and frontal lobes.

Examples of functions: Whether you appreciate symphonies or rock music, your brain responds through the activity of these lobes. At the top of each temporal lobe is an area responsible for receiving information from the ears. The underside of each temporal lobe plays a crucial role in forming and retrieving memories including those associated with music.

(3) the parietal lobes, which link sensory and motor functions and provide a sense of the spatial location of the body

Examples of functions: When you enjoy a good meal—the taste, aroma and texture of the food—the parietal lobes are at work. The forward parts of these lobes, just behind the motor areas, are the primary sensory areas. These areas receive information about temperature, taste, touch, and movement from the rest of the body. Reading and arithmetic are also functions in the repertoire of each parietal lobe.

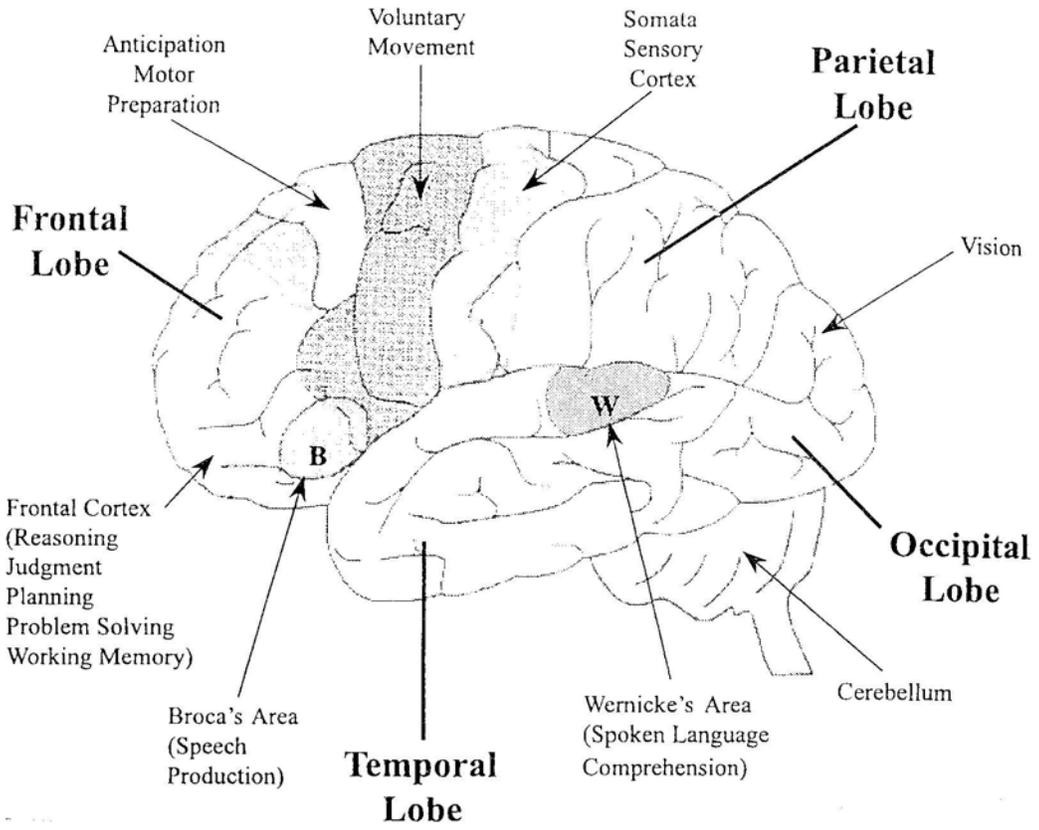
(4) the frontal lobes, sometimes called the executive center of the brain, which mediate motor behavior, language, abstract reasoning, and directed attention (Cozolino, 2002 in Applegate & Shapiro, 2005).

Location: The frontal lobes lie directly behind the forehead.

Examples of functions—Frontal lobes: When you plan a schedule, imagine the future, or use reasoned arguments, these two lobes are working. The frontal lobes appear to act as short-term storage sites allowing one idea to be kept in mind, while other ideas are considered.

### **Functional Areas**

The image below depicts contemporary mapping of the mind is based on two types of studies: those using functional imaging techniques that visually record neural activity as an individual is performing a mental and/or behavioral task, and those that show the effects of damage to particular areas of the brain and the effects of stimulating specific brain regions. The brain is a complex, interactive, and dynamic system. Remarkably, functional areas can change—given the right circumstances—and one are can take over the work of another. Image and text provided courtesy of Haworth Press, <http://www.haworthpress.com>.



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## The Role of Culture in Development

Culture can be viewed as a total system that regulates life within a particular group of people. It consists of values, beliefs, attitudes, traditions, and standards of behavior. The interplay and expression of these facets of culture exert a powerful influence on every domain of development. Consequently, child development cannot be assessed without a basic understanding of the cultural environment that surrounds and shapes a child's experiences.

In general:

- Culture may set parameters or limitations on aspects of an individual's development.
- Culture creates context and expectations for human development.
- Cultural preferences often result in some behaviors/traits being rewarded while others are ignored. Those behaviors that are rewarded flourish; those that are ignored often disappear.
- Cultural expectations for developmental milestones may create situations that compel the individual to meet the expectation, or restrain certain aspects of the individual's development.

The benefit of identifying cultural influences is to help determine when a child's developmental progress is considered normal or abnormal within the context of the family's culture. According to specific goals envisioned for children, different cultures provide a variety of child-rearing environments and obtain different behavioral outcomes. Because cultures have different socialization practices, the behavior of infants, young children, and adolescents varies across cultures. In addition, what is viewed in one culture as normal development, as well as the methods needed to achieve such development, may be seen by another culture as strange, deficient, or even pathological.

It is important to note that it is very easy to fall into the trap of ethnocentrism, i.e., judging other cultures' norms as strange or abnormal if they deviate from the norms of mainstream American culture, and workers should consider this when working with families. In fact, there is a history of ethnocentrism in social science research: early social thinkers used to categorize cultural evolution or level of civilization, according to how a society measured up to the standards of White Western industrialized nations (Small, 1988).

For example, the age at which a child learns to walk may depend on the parent's cultural beliefs about holding a child. If a child is constantly held or carried and not allowed to explore before the age of 2, the child may not learn to walk by the typical age of 12-13 months. Given the cultural context, this would not be considered as abnormal development. Another example could be with breast feeding practices. The decision to

breast feed or how long it is appropriate to breast feed for may be based on cultural norms of the family.

Cultures typically have strong beliefs about male and female roles that significantly affect the social and emotional development of children. Girls that are taught to speak only when spoken to may learn not to initiate conversations with adults, and cultivate a shy interactional style. On the other hand, boys that are taught at a young age to be independent, and afforded opportunities to explore and interact with their environment, may develop greater ease in social interactions.

Cultural differences can also affect brain development. Tronick (2007) found that caregiver touch (a culturally defined norm related to parenting practices) was correlated with growth hormone production.

In addition, an activity otherwise considered to be appropriate may cause elevated stress for the child and/or parent, potentially leading to practices that are unacceptable to the child welfare system. For instance, toilet training is a common practice across many cultures though the age when it is introduced may vary. This developmental phase can also be one of the most stressful, especially for families who are already facing other, multiple stressors, during daily life (Schmitt, 1987). In fact, toilet training and colic are two developmental phases most frequently linked with fatal abuse, and have been associated with a variety of outcomes including delayed bladder and bowel control or bruises and burns to genital and other regions of the body (Schmitt, 1987).

## **Implications for Child Welfare Practice**

### **Key Points**

The purpose for understanding cultural influences is to help determine when different developmental outcomes constitute delays or abnormal patterns of development, thereby warranting casework intervention, and when cultural variations do not require intervention.

When working with parents, it is important to consider:

- In almost all cultures, the primary parental responsibilities are considered to be protection of the young and transmission of the culture to the offspring.
- Parents learn to parent as they were parented.
- Cultural mores set standards and expectations for parents and shape parent-child interactions.

### **How to Learn More about a Family's Culture**

Consider the following questions that would be appropriate to include in an ethnographic interview, and with each, consider the following:

- 1) How can this information help you understand the parent?
- 2) How can this information help you understand the child?
  
- 3) What is (are) the primary cultural group(s) with which the family identifies?
- 4) Does the family have strong social connections with other members of their culture?
- 5) What specific cultural values are important to the family?
- 6) Are there any cultural norms that may affect the children's development?
- 7) What characteristics of individual family members influence the family's functioning?
- 8) For how many generations has this family lived in the United States?
- 9) Are there generational conflicts between parents and children resulting from a clash between a family's traditional culture and contemporary U.S. culture?
- 10) How much do prejudice, stigma, or immigration laws play a role in how well the family is able to function?
- 11) How might services be tailored for this family to address their unique cultural needs?

Responses to these and other questions will help determine casework interventions and whether they are needed at all.

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## Newborns and the APGAR Test

The APGAR scoring system helps health care providers estimate a baby's general condition at birth. This score cannot predict how healthy the baby will be as he or she grows up or how he or she will develop, but it alerts health care providers that there may be an immediate problem.

The test is administered at 1 minute and 5 minutes after birth. If there are any problems with the infant, an additional score may be repeated at a 10-minute interval. Few babies have a perfect score due to the trauma of birth, but most are in the 8 to 10 range. If babies score lower than 5, they usually end up in the intensive care nursery.

<b>Score</b>	<b>0 Points</b>	<b>1 Point</b>	<b>2 Points</b>
<b>Activity (Muscle tone)</b>	Absent	Some flexing of arms and legs	Active motion
<b>Pulse (Heart rate)</b>	Absent	Less than 100 beats per minute	More than 100 beats per minute
<b>Grimace (response stimulation)</b>	No response	Facial grimace	Grimace and cough or sneeze
<b>Appearance (Skin color)</b>	Blue-gray, pale all over	Body pink; hands and feet blue	Completely pink
<b>Respiration (Breathing)</b>	Absent	Slow; irregular; weak cry	Good, strong cry

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## ***The Normal SPECS of Development for Infants and Toddlers***

### **Infants: Overview**

During the first 12 months of life, an infant's growth and development occur very rapidly. Much of what happens during this period lays the foundation for a person's ongoing development. Therefore, it is important to recognize normal development in order to be able to identify variations or delays that are cause for concern, so that early interventions can occur if necessary.

#### ***Social Development***

Bonding and attachment are processes that pervade the first year of life. Bonding is a biological process that occurs as a newborn child begins to find comfort in its world. If, as a result of this process, the child is able to find a specific person that they want to be close to and environmental conditions permit, the process of attachment begins. The most important social tasks are bonding and developing attachment to the primary caregiver, most often the child's mother.

Attachment is required for the later development of reciprocal connectedness during toddlerhood, and ultimately for the development of interpersonal skills, social integration, and empathy for others. Although developmentally sensitive, this process continues throughout infancy, childhood, and adolescence. The attachment process leads to the child's sense of trust in the world. Failure to form an attachment is likely to be more detrimental than suffering a disruption to an existing connection. Such failure may be the result of repeated changes in primary caregivers as may be the case for an infant who has multiple placements.

#### **Bonding:**

- ❑ the desire to have closeness
- ❑ can occur to something, or someone—blankets, toys, or people
- ❑ a biological and instinctive process that occurs naturally

#### **Attachment:**

- ❑ the desire to be close to a specific person or persons, usually the caregiver
- ❑ has another person as its object
- ❑ demonstrated by:
  - ⌘ responsiveness (smiling when someone is near; upset when they leave)
  - ⌘ seeking out physical closeness to someone

### ***Physical Development***

Prior to birth, the fetus experiences rapid brain growth, especially during the last trimester. When the infant is born, its head accounts for one-fourth of its body size. As the infant grows and develops, this ratio gradually reduces, and by adulthood, the head accounts for one-seventh of body size.

The infant is born with over 100 billion nerve cells, and these continue to multiply after birth, as the infant is stimulated physically and socially. Throughout the first year of life, the brain is the most rapidly developing organ in an infant's body. The brain's development lays the foundation and is the catalyst for further development in all five domain areas.

The beginnings of mastery over one's body is the infant's primary physical task. The emergence, refinement, and coordination of sensory and motor skills culminate in walking behavior about age one. Development progresses from the head down and from the inside out. The brain and central nervous systems are the first to begin to develop, and internal organs will develop before the extremities.

### ***Emotional Development***

The development of basic trust, a derivative of the attachment of the infant to the primary caregiver, occurs during the first year. This is a cornerstone of emotional development.

### ***Cognitive Development***

Cognition begins with alertness, awareness, recognition, and interest in visual, auditory, and tactile stimuli. We now know that some cognition begins in the womb; newborns are able to recognize their parents' voices. As motor development improves, the infant begins to explore and manipulate objects and develops a rudimentary understanding of their properties. Infants develop object permanence toward the end of the first year.

### ***Sexual Development***

As the infant develops the ability to control motor behavior, s/he begins to explore his or her body. Self-exploration begins most frequently with fingers, followed by toes. It progresses during the first year to include other body parts, including genitalia. This exploration is done voluntarily and can produce pleasurable sensations for the child.

A child's sexual development is shaped by its family's culture (Friedreich, 1998). The norms of what is acceptable and expected are molded by a parent's direct and indirect behaviors. During the first year, the infant learns by observing its parents and the surrounding observable world.

The child learns about gender roles from the way that parental tasks are divided and handled. The mother often responds directly to the cues of her child, who may be asking to be comforted, cuddled, talked to, fed, etc. Mothers are typically more concerned about how their children express their needs and ensuring that those needs are met. This is often in contrast to fathers, who respond more frequently to children by redirecting their children's cues to other activities. The role of the father may be more closely connected to play, and possibly discipline.

The child's early learning about gender roles becomes his/her understanding of what social rules and roles are for people in their culture, which helps to shape the child's future behaviors. The child learns from parental expectations what is, and what is not, acceptable behavior. This provides the foundation for their future sexual identity.

### **Cultural Note on Sexual Development**

In some cultures where male children are highly regarded, parents may touch the baby's genitals as an expression of pride in the fact that their child is a boy. In such cultures, this parenting behavior is viewed as a demonstration of adoration.

## **Birth to 3 Months**

### **Social Development**

During the first 3 months of life, much of the newborn's social development is dependent upon their state of *alertness*.

- ☼ In the *active alert* state, the newborn is very involved with its environment, often looking around, listening to various sounds, and responding to stimuli.
- ☼ In the *quiet alert* state, the newborn is aware of its environment, continuing to look and listen, but is usually quieter and less physically active.
- ☼ In the *drowsy* state, the newborn is usually very quiet and non-responsive to environmental stimuli; s/he is ready to fall asleep, but not yet sleeping (Rycus, 1998).

During this early time, the process of bonding begins. Bonding occurs as a child begins to learn about the unique features of its caregiver, and can occur with anyone or anything.

Creating a bond with the caregiver is unidirectional. It is a one-way relationship that the child creates. Bonding is a necessary foundation for the development of attachment and the achievement of reciprocal connectedness.

The process of bonding often occurs during the quiet alert state. Behaviors such as sucking, rooting, grasping, and cuddling allow the infant to begin this innate and instinctive process that is similar to the imprinting process in animals. Example:

*Two-week-old Michael lays in his mothers arms, swaddled tightly in his blankets. He is moving his head around and rooting, looking for his food. As he begins to nurse, his eyes remain open and he appears aware of his environment. His ability to see is approximately 8-10 inches away from his face, which allows him to visually understand the importance of his mother and to develop a bond.*

A good time to assess infants for their physical and social development is when they are in their active alert state. Many of the interactions that an infant experiences during this time leave a strong impression on the child. If an assessment is attempted during the quiet or drowsy state, the assessment may be inaccurate, as the infant is not functioning at his/her developmental peak. It is also important for parents to understand that an infant is not likely to be engaged when he or she is in the drowsy state.

### **Physical Development**

At birth, children often appear physically bent from being in their mother's womb. Their feet and legs may be bowed and turned inward, with their knees bent up toward their chest. Their limbs often appear to be skinny, and they may have a large rounded belly. This appearance lasts for the first several weeks of life (Rycus, 1998).

Most of the fetus' and infant's physical development progresses from the head down and the inside out. This means that a baby's brain and central nervous system develop before their internal organs and the upper body develops before the legs and feet (Rycus, 1998).

Newly born children can see approximately 8-10 inches away from their face, which allows them to see the person feeding them. This permits social interactions to begin with their caregivers. This distance increases gradually by the time the infant reaches 4-5 weeks of age.

Additionally, the newborn child can recognize voices of various people within a few days of birth, and will orient to sounds by turning its head in the direction of the sound.

*Ashley, a 7-week-old child, lies in her father's arms looking at his face as she drinks from a bottle. Her mother comes in from the laundry room and the door slams behind her. Her head immediately turns toward the direction of the door.*

During the first 3 months, the infant develops muscle control primarily in its head, neck and shoulders. Its hands are often found to be in fists.

There are several types of involuntary, reflexive movements that infants display. The first is a grasping reflex:

*Zachary, a 3-week-old boy lying on the floor, is handed a rattle by his grandmother, who places it in the palm of his hand. His hand immediately closes around the object in his palm and holds it tightly.*

Another is the sucking reflex:

*Maria, a 2-week-old, being held by her aunt, feels her aunt's fingers brush lightly across her cheek. Maria turns her head and begins making sucking movements with her mouth, as if she is ready to eat.*

The stepping reflex is also present, and the infant can appear to be attempting to walk at a very young age.

*Monique, a 5-week-old girl, cannot support her weight on her legs. When she is put in the standing position with someone holding her, and her feet touch the ground, she will pull one leg up and extend the other, as if walking in air.*

## **Emotional Development**

### *Temperament*

One of the most noticeable pieces of an infant's emotional state is its *temperament*, or the way a child responds to its environment. Debate continues about the extent to which our behavior and personality traits are genetic, biological, or a result of inborn temperament.

Levy & Orlans (1998) assessed temperament from infancy into adulthood and found that babies fit into one of the following four categories:

- Easy babies (40%) showed positive mood, regular body functions, adapted well, and approached rather than withdrew from new situations.
- Difficult babies (10%) displayed negative mood, were slow to adapt, withdrew in novel situations, and were irregular in biological functioning.
- Slow-to-warm babies (15%) were similar to the difficult babies, but reacted with less activity and intensity.
- Mixed babies (35%) displayed combinations of all of the traits.

The children with difficult temperaments developed the most emotional and behavioral problems over time. Researchers concluded that this was due to an interaction between nature and nurture.

Children with difficult temperaments were much more likely to experience negative responses from others as they developed. These children were more likely to trigger their parents, causing negative parental attitudes and reactions and provoking old, unfinished issues to surface. These reactions can amplify or diminish any inborn traits and qualities.

The study found two outcomes:

- Successful parenting of difficult children: Parents who were patient, consistent, firm and emotionally resolved, and not conflicted could manage these children well.
- Poor fit and unsuccessful parenting: Poor fit between parents and children's temperament accounted for difficulties in parenting.

### **Cognitive Development**

During the first 3 months of life, a significant change in a newborn's cognitive development can be noticed. At birth, infants' responses are often reflexive, or uncontrolled. Infants cry because they need something, but it is initially difficult to tell what they want or need. However, within a month, infants begin to be able to distinguish what they want and/or need, and in turn, make other sounds that serve as indicators. Some *differentiation* in their cries begins to appear and is identifiable to a caregiver. This further develops into squeals and cooing sounds, and eventually they will begin vocally interacting with their caregivers as if in conversations. By the age of 3 months, it is likely that one can easily identify feelings of pleasure and unhappiness in the infant.

## **3 to 6 Months**

### **Social Development**

By the age of 3 months, infants are visibly responsive to social stimuli, and will make eye contact, smile, laugh, vocalize sounds, and physically react in a voluntary way to other people. They have also moved from reflexive responses to more controlled movements and interactions. These movements become a child's way of playing, and also demonstrate how the child is moving from bonding to developing attachments.

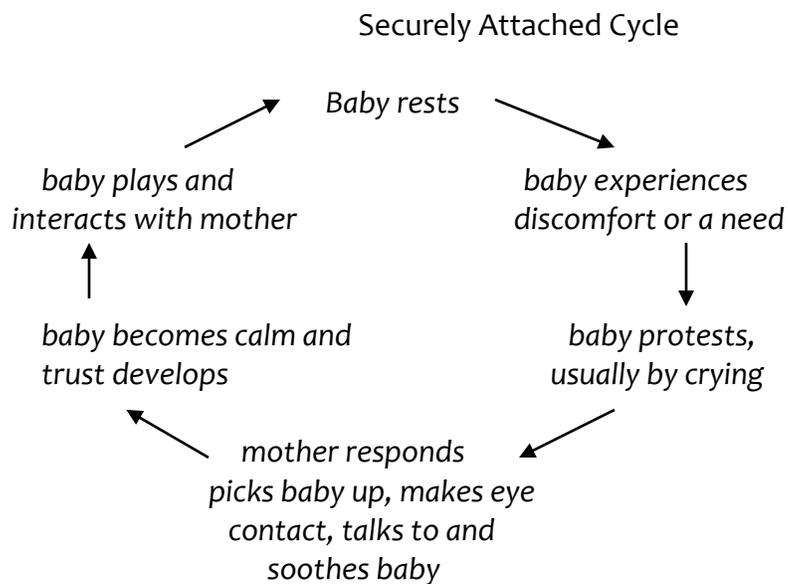
#### *Attachment*

According to Perry (2002), attachment is "a special enduring form of 'emotional' relationship with a specific person." Perry further postulates that since no human behavior is maintained without reward, attachment requires reward. Most often this reward comes in the form of soothing, comfort, and/or pleasure.

This movement toward developing an attachment becomes noticeable as the child begins to show preferential responses, such as a smile, to people that are

familiar. A child may show excitement at a person's arrival and, by the age of 6 months, may even show displeasure for the person's departure.

*Four-month-old Samantha is lying on a blanket, and squeals with a smile as the toy in her hand squeaks. She then re-focuses on the toy, and her face becomes more serious. Her mother enters the room after hearing the squeal. Samantha lifts her head, sees her mother and smiles.*



### **Physical Development**

As with social interactions, much of the infant's initially reflexive physical movement is now becoming quite controlled. Its head control is now excellent as the muscles in its upper body have strengthened, and its motor development begins to become focused on fine motor skills. If the infant grabs at an object, it is because s/he wants to hold it, and may show hand/eye coordination by putting the object in its mouth. Additionally, the infant may begin to develop hand-to-hand movements, although there will be no clear indication of a hand preference until the age of 12-18 months.

There is also a rapid expansion in gross motor development, and by the age of 5 months infants begin to develop lower body coordination. They begin to support weight on their legs, roll themselves over, and potentially even across the room.

### **Emotional Development**

During this 3-month period, an infant's temperament is clearly recognizable, as well as various emotional states that are readily apparent, including pleasure, anger, pain, fear, and protest. The infant's emotional regulation continues to develop through interactions between internal emotional states and the parent's responses to its behaviors.

### **Cognitive Development**

Object permanence is one of the most significant cognitive milestones, and it is not yet present during this period of growth and development in children. Object permanence is a process in which a child begins to understand that just because they do not see something (e.g., a toy), does not mean that it does not exist. Children in this age range do not yet have this understanding. If an object is out of their sight, it is considered out of mind, like it does not exist at all.

*Jennifer and her mother are in the family room playing with a ball. Jennifer's mother hides the ball behind a box next to her. Now, her mother sits with a blanket. Jennifer moves to her mother and picks up the blanket, which is something new that she had not played with before. It is in her field of vision, and she finds it interesting. She has forgotten the ball and now plays with the blanket instead by putting it in her mouth.*

Jennifer is too young to have developed object permanence, but she does have *attention to objects*, which is a critical component of cognitive development that will ultimately help lead to the development of object permanence.

### **7 to 12 Months**

#### **Social Development**

By the age of 7 months, children have developed a physical and cognitive level that motivates and supports exploration of their environment, which becomes the primary purpose of play for infants under the age of 18 months. They have the physical ability to move, and have cognitive skills that allow them to become goal directed.

*Seven-month-old Christopher sees some colorful building blocks across the room. He creeps with his arms and legs to pull himself across the room to reach the blocks. When he gets there, he uses his whole hand to grasp and grab the toy.*

Children also continue to be very interactive with people prominent in their lives. They make faces, laugh, and easily engage in play. They are now able to identify and discriminate people that they know from those they do not know, resulting in two new emotional responses in children, *stranger anxiety* and *separation anxiety*:

Stranger anxiety is an infant's feeling of discomfort or unhappiness around unfamiliar people that may occur during this time period. Often at this age, the infant seeks out the attention of people with whom they are attached,

and become uncomfortable around people they do not recognize. This can lead to various types of protest in response to the situation.

Separation anxiety is the infant's reaction to a parent's departure, often including a display of emotional distress. Separation anxiety usually begins around the age of 9 months.

Bowlby (1980) reviewed a great many studies describing children's responses to prolonged separation from the attachment figure (mother). There was remarkable uniformity among reported observations leading him to describe three stages of separation.

Responses may be divided into three major stages (which may overlap or merge, but are distinct in terms of the child's attitude toward its mother). The stages are:

- Protest—demonstrated by extreme distress (flailing, shaking, crying) and searching
- Despair—sense of hopelessness and withdrawal
- Detachment—renewed interest in environment, interest in exploring, and playing; affect is friendly and outgoing, unlike earlier stages; upon return of the mother, the child does not utilize efforts to regain proximity, and may fail to greet the mother, turn, and walk away

Detachment is seen as serving a defensive function against the intense negative emotions experienced during the separation and against the anxiety triggered by the expectation of losing the mother again.

Both stranger and separation anxiety are indications of the child's growing attachment to their caregiver. This attachment can be based on feelings of safety and comfort (secure attachment), or insecurity and fear (anxious attachment) if the attachment figure is not available. The attached person seeks the attachment figure for purposes of safety and protection, using behaviors that promote proximity and contact. According to Bowlby (1980), "the knowledge that an attachment figure is available and responsive provides a strong and pervasive feeling of security."

Between ages 9 and 12 months, children begin to experience a significant phase in their attachment. This occurs when the child is able to understand not only the unique features of its caregiver, but actually understands the attachment figure well enough to begin to formulate an idea about how their caregiver will respond to them.

*Eleven-month-old Kelly is attempting to pull herself up to a standing position on the coffee table in the living room of her house. As she does, she stumbles and hits her chin. She makes a frown on her face and appears as she may begin to*

*cry. She drops to the ground and begins crawling toward her mother, who is sitting on the floor nearby. Kelly reaches for her and her mother responds by picking her up and comforting her. Her mother's consistent and soothing response deepens Kelly's attachment to her mother.*

### **Physical Development**

By the age of 7 months, infants have developed upper body strength and coordinated leg movements that allow them to sit and begin crawling. Soon, they will have the ability to support weight on their legs without assistance, but will have little balance. They will work on increasing their leg strength and improving their balance by pulling up on objects that will help stabilize them, and some may even begin walking. Example:

*Nine-month-old Brooke crawls across the room to the couch and pulls herself up to a standing position. She can stand for a long period of time, as long as she is holding on to something. She may let go briefly, but will resume contact to keep her balance. This is how she practices increasing her strength and developing her balance.*

Infants will also work on their fine motor skills. Their hand-eye coordination is improving, but initially, they do not have the ability to use their thumb opposite their fingers to pick up or move objects. They often resort to raking their hands over something to grab onto it. However, during this 6-month period, they will develop the ability to put their hand over an object, pick it up and move it where they want it to go. Example:

*Ten-month-old Dominic is sitting in his high chair with cereal in front of him to eat. He picks up the pieces, one at a time, closing his thumb and forefinger around each piece. He then puts them into his mouth and eats them.*

### **Emotional Development**

Children at this age continue to display a range of emotions. They enjoy ongoing interactions with their caregivers that strengthen attachment and deepen their sense of trust in their world. With a positive attachment to their caregivers, they are more likely to explore their environment, but will return to their parents for reassurance or comfort after time, or when distressed. Issues around strangers and separation that may have arisen previously as part of the child's social development often continue to be present until the age of 1 year .

As a child reaches the age of 12 months, it begins to develop independence, or autonomy, from its primary caregiver. Autonomy is necessary for the healthy development of the personality. As children begin to develop autonomy, which is facilitated by their physical development, tantrums may begin to appear. The

generally placid, friendly, responsive, and cooperative child suddenly becomes willful, uncooperative, and stubborn. Example:

*After coming back into the house, Alana attempts to return to the porch. When her mother, who picked her up and told her she could not go outside, stops her, Alana begins to cry and squirm to express her displeasure.*

### **Cognitive Development**

Until this age, children functioned in an out of sight, out of mind perspective. They do not try to find an object they cannot see. As the child approaches 1 year, however, children begin to understand that just because they cannot see something, the object still exists. The development of this understanding is called object permanence (Newman & Newman (1995). Example:

*Junior, age 12 months, is playing with a football in the back yard with his uncle. His uncle takes the football while Tyrone is watching, and hides it under a towel. Tyrone goes to the towel and picks it up, and gets the football.*

Junior has developed an early stage of object permanence. He is able to search for the football because he watched his uncle hiding it. If he had not seen his uncle hide it, he would not have continued looking for it.

Object permanence is part of early problem solving. Infants develop the ability to move objects where they want them, and may even pull at things to see if they will come apart. They may do this over and over again, which builds mastery and lays a foundation for lengthening attention span. As children approach 1 year, the more goal-directed their behaviors become, and the more they engage in problem solving (Newman & Newman, 1995). Example:

*Eleven-month-old Louis sees his mother place a toy across the room, after having it taken away. He then crosses the room, pulls up on a coffee table and reaches for the toy so that he can take it apart.*

In this case, his behavior of moving across the room involved having a goal (getting the toy) and problem solving (pulling on the table to reach the toy).

### **Developmental Concerns**

Refer to pages 3, 6, and 9 of the “Milestones” Supplemental Handout to become familiar with signs of possible developmental delays at the end of ages 3-4 months, 7 months, and 1 year, respectively.

### **Toddlers: 1-3 years**

Between the ages of 1 and 3, a toddler's growth and development continue to occur quickly, although not quite as rapidly as during the first year of life. What a child has experienced during their first year, and whether they have developed attachments and a sense of trust in the world that they have begun to explore, will impact what occurs over the next two years. The time between 1 and three is an expansion of the child's need to develop autonomy and a mastery of their self and their environment that will lead to the development of will in a child.

### **Social Development**

As the child reaches the age of 1, he or she has typically developed affectionate and trusting relationships that are no longer just to a person (attachment), but with (reciprocal connectedness) other family members and adults outside the family. The child also begins to engage in simple games and play.

By the age of 1, the child usually has developed the ability not only to understand the unique features of its caregiver, but to understand the attachment figure well enough to begin to formulate an idea about how the caregiver will respond to them. S/he begins to develop the ability to understand another person's feelings, which is essential to developing empathy. This is a significant transformation in a child's social development and a deepening of reciprocal connectedness.

Reciprocal connectedness is a higher-level brain function that is required for normal emotional, cognitive, and social development. As this higher-level connection occurs with the caregiver, neuron pathways within the brain change accordingly, positively affecting a person's ability to develop interpersonal skills and empathy for others. During this time, children may continue to experience some stranger anxiety, although after a short time, they will usually venture out and become more interactive in a new setting. Example:

*J.M. hovers behind the door with just his nose and right eye poking out to see who is talking to his mother at the door. As his mother lets her friend into the house, he moves behind the staircase and continues watching. By the time his mother and her friend are seated on the couch, 15-month-old J.M. comes out from behind the staircase and crawls into his mother's lap.*

For the 2-year-old, imitation is the primary means of play and learning. Children will often imitate what their parents do around the house, and may indicate that helping mommy or helping daddy is their favorite thing to do. Example:

*Grabbing a nearby cloth of her own and a block she pretends is a spray bottle, 2-year-old Katie pretends to spray the coffee table and then dusts it with a cloth. She focuses on one particular spot, which she scrubs intently because there is a stubborn stain there. She then lifts up the book on the table and dusts under it.*

As the child approaches the age of 3, s/he will begin to focus on the behaviors of other children, and try imitating what they do. This determination to imitate another child is often an incentive to try new activities.

*After having watched 3-year-old Alathia slide down the slide, and being an autonomous and gutsy 2-year-old, Cameron decided he had to try it too. As he went down the slide himself and getting a surprising “thud” as he hit the bottom, he smiled and got up to do it again.*

When involved with other children, the 2-year-old may imitate activities of another child, but does not often interact with the child. Commonly, play between the age of 2 and 3 is considered parallel play, where children play side by side with each other. They may play with the same toys, but it is not a cooperative play. Children at this age are still very self-centered and they have not yet developed interactive skills with peers. Thus, they often do not know how to share, and do not understand another child’s needs or point of view.

Often children need structure to their social play and activities. They frequently engage in attention-seeking behavior for love and understanding aimed at the adults that are important to them. Their behavior can be guided into productive channels if they have established routines and consistent rules.

#### Attachment and Morality

Conscience development requires the internalization of a loving caregiver in whom the child is willing to place his/her trust. It is through this internalization process that the child incorporates another as part of himself/herself. Morality flows from the belief that hurting another is hurting oneself.

John Bowlby (1980) stated that in a child’s early years, the mother (primary caregiver) is both the child’s ego and superego.

“During this phase of life, the child is, therefore, dependent on his mother performing [them] for him. She orients him in space and time, provides his environment, permits the satisfaction of some impulses, and restricts others. She is his ego and his superego. Gradually, he learns these arts himself, and as he does the skilled parent transfers the roles to him. This is a slow, subtle, continuous process, beginning when he first learns to walk and feed himself and not ending completely until maturity is reached. Ego and super ego development are thus inextricably bound up with the child’s primary human relationships.”

### **Physical Development**

By the age of 1, the child's birth weight has tripled. The child becomes increasingly active as it perfects the gross and fine motor skills that emerged during the first year by further developing balance, coordination, stability, and an improved ability to manipulate objects.

Shortly after reaching 1 year of age, children have likely developed the ability to walk; a significant gross motor skill development. As children learn this skill, they will continually practice and refine their ability. This rapidly leads to the development of good balance and stability and the child will soon no longer have to think about what they need to do in order to walk somewhere; they will just do it. This is an example of achieving mastery and integration of their body.

After achieving mastery of walking, children become able to develop other complex motor skills, such as climbing—on furniture, or up the stairs, for example. These new skills allow them to do what they most often want to do—resolve their curiosity about their environment. Now that they are mobile, they can begin to explore, and get into everything.

For 2-year-olds, mastery of more complex activities is often connected to their social development and their desire to imitate behaviors of important adults in their lives. This need to imitate and master the skills required to complete a task are strong, no matter how complicated the task may be. A child will often insist, “Me do it!” even if it isn't realistically possible. To the child, it is important for them to struggle with the task, and as they imitate it more and more, they will develop the ability to complete the task.

*At age 2, Cameron would pick up a broom that was larger than she in an effort to help her mother sweep. Often she had difficulty maneuvering the broom, and her mother spent more time making sure the handle didn't knock over Cameron or something else than she did sweeping. But, by age 2½, Cameron had imitated the sweeping behavior enough that she was able to handle the broom like a pro, and she could actually help her mom.*

Additionally, children are developing and enhancing their fine motor skills. If given the opportunity, children can begin to draw and recognize shapes. Hand-eye coordination is also improving dramatically.

*Playing contently, Beau picks up a block and sets it on top of another. He does this again... and again... and again until he has a stack of five blocks before him.*

The child is developing increased strength and coordination. S/he is able to apply sensory and motor skills to challenges in the environment, such as stairs, balls, playground equipment, eating utensils, crayons and other objects. The child is developmentally ready to master toilet training.

### **Cultural Note on Toilet Training**

The age at which a child is toilet trained is often as much culturally as physically driven. In many cultures, a mother's status as a mother is in part defined by the age in which her child is toilet trained. In cultures such as these, children tend to be toilet trained at a younger age.

### **Emotional Development**

The primary task during this age is the development of autonomy, which includes mastery and control over one's self and one's environment. Children develop a basic concept of self, experiencing pride and pleasure at being good, and shame and distress at being bad.

At the age of 1, the nature of the attachment a child has to a caregiver can impact his/her emotional development. Also at this age, all of a child's development centers around two primary areas, mastery of his own body and understanding of objects. If allowed, the child will try to dress, wash, and feed himself. The desire is connected to the establishment of autonomy, while the accomplishment is often connected to physical development. This process is enhanced as a child's gross and fine motor skills develop.

*While trying to put on her clothes after waking up in the morning, Christina gets her foot stuck. She struggles, but gets one pant leg on before letting her mother help her. She then tries to put on her socks, and tells her mother, "I do it!" While hesitant, her mother lets her try. She gets the first sock on herself, and looks up at her mother with a smile.*

While letting children take on these tasks may not be an efficient use of time when in a hurry, letting children practice these skills allows them to perfect the task and gives them a sense of accomplishment.

Autonomy, while primarily an emotional developmental issue, is reflected in all aspects of what children do. The level of attachment and physical abilities sparks their desire to do more things on their own. Their willingness to jump into a pool, whether someone is there to catch them or not, reflects this. It can also be seen as a toddler trots off—out the door and down the street—with all the confidence in the world.

While Bowlby's (1980) work was the beginning of Attachment Theory, his work was furthered by Mary Ainsworth's (1978) research in the way attachment behavior becomes organized. A child's attachment status (whether secure or insecure) sets the stage for his/her development of autonomy.

### Securely Attached Children

- Secure attachment implies the ability of the child to tolerate some level of rage when the attachment figure is unavailable.
- When there are sufficient positive feelings toward the separated figure to balance the negative feelings that come as a result of loss, the child is able to separate.
- A child's ability to cope with the stress of separation depends significantly on the capacity to evoke the mental images of the person to whom the child attributes his/her sense of security and well-being.
- A securely attached child is able to internalize nurturance and self-soothes at separation.
- When love has been plentiful, non-conflictual, readily available, and dependable, it is easier to separate from attachments.
- A securely attached child will feel free to explore in a strange situation; will use mother as a secure home base; will not be unduly distressed by the appearance of a stranger; will show awareness of mother's absence, greet her on return, and then resume previous activities.

### Insecurely Attached Children

- Insecurely attached children may experience separation anxiety in new situations (i.e., school). The anxiety caused by the separation impairs concentration and learning.
- Children with attachment deficits are unable to meet age-appropriate developmental challenges.
- An insecurely attached child will not explore, even when mother is present.
- The child will get upset when a stranger appears, will appear helpless and in dire distress when mother temporarily leaves.
- When mother returns, the insecurely attached child appears incapable of making an organized attempt to reach her.
- An insecurely attached child re-experiences the rage from early losses over and over again in adult life.

### **Cognitive Development**

The emergence of symbolic thought is central to cognitive development and results in the ability to understand and produce language. Once developed, symbolic thought developed in the previous year allows a child between the ages of 2 and 3 to work on the perfection of their language skills to communicate with others, which becomes the principal cognitive task.

One of the most significant cognitive developments at the age of 1 is the ability to understand and process symbols that allow for receptive and expressive language development. While the ability to hear is present even before birth in children, it does not mean that a child can *recognize* what is heard. Receptive language becomes the ability to organize symbols and sounds into an understandable manner.

Words become symbols or signs that stand for things in an abstract way—there is no direct relationship between the word dog and the animal that it refers to, but the word stands for the objects. Adults naturally understand this concept, but for children, this is a change in thinking that emerges during this age. Expressive language becomes the ability to use the signs or symbols in a way that reflects what one wants to communicate to others.

During the first year of life, language for infants usually consists of cooing, and eventually babbling. Babbling actually begins between 10-12 months of age, and the sounds produced are sounds of their native language, unlike the earlier cooing that is representative of the full range of human language sounds. By the age of 13 months, children have receptive language abilities, and can understand a number of spoken words and phrases.

Expressive language often begins with words that are connected to the naming of objects and are usually one word sounds. Often the one word is not an actual word—*ba* may represent the word bottle to the child who is thirsty—but what is important is the shared meaning of the first word. Common first words include *mamma*, *dada*, sibling names, pets, body parts, clothes, and objects in their environment. By the end of the second year, the child’s vocabulary can include up to 300 words.

As the child’s vocabulary increases, its ability to utilize the words it knows also improves. Children begin to use telegraphic speech, or the formation of two-word sentences. Their receptive language, or their ability to understand other people’s spoken word, still far exceeds their expressive abilities, but they will experiment with combining words. Often these phrases include the essential words, but leave out others, such as verbs, pronouns and conjunctions. They may say things like:

- ❑ “more juice”
- ❑ “no go”
- ❑ “play outside”
- ❑ “dog big”

### **Sexual Development**

Toddlers are very curious about their bodily functions, especially those relating to elimination. Their curiosity helps facilitate progress in potty training and gaining control over their bodies. The toddler’s sexual development revolves around further exploration of various parts of its body, and may include behaviors such as masturbation (Newman & Newman, 1995).

Toddlers continue to watch and learn from their caregivers as they strive to develop their autonomy. As they become more and more capable of differentiating between people, they develop the ability to understand the difference between boys and girls

at some level, often associated with being a “mommy” or a “daddy.” This becomes a further step toward some rudimentary understanding of gender roles and identities (Newman & Newman, 1995).

***Developmental Concerns***

Refer to the Milestones Supplemental Handout, pages 12 & 16, to become familiar with possible indicators of developmental delay at the end of 2 years and 3 years, respectively.

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## The Concept of Attachment

Attachment refers to the social and emotional relationship children develop with the significant people in their lives. An infant's first attachment is usually formed with its mother. In some circumstances, someone other than the infant's mother can become the primary attachment figure for the infant. This may be a father, a grandparent, or an unrelated adult.

Attachment between a mother and her infant leads to reciprocal connectedness. The mother's care giving behaviors of feeding, holding, nurturing, smiling, cuddling, and talking to the infant reinforce the infant's attachment to the mother. The infant's responses to its mother's care—including cooing, smiling, cuddling, and becoming quiet when held—strengthen the mother's attachment to the infant. Research has demonstrated that two primary parenting behaviors are most important in developing an infant's attachment to a caregiver:

- The adult readily recognizes and responds to the infant's signals and cues and meets the infant's physical and emotional needs.
- The adult regularly engages the child in lively social interactions.

Studies of infants raised in institutional settings suggest that either behavior alone will probably not generate the development of reciprocal connectedness. Institutionalized infants failed to form strong attachments to caregivers who readily met their physical needs but did not engage them in social interaction. Infants often form social attachments to brothers, sisters, fathers, and grandparents who engage them in pleasurable social activity. Yet when they are tired, hungry, or distressed, they often cannot be comforted by anyone other than the caregiver who has historically recognized and responded to their signals of physical and emotional need.

### The Process of Attachment



Attachment serves the purpose of enhancing chances of survival. By keeping the child close, the caregiver reduces risks to the child's health and safety. The child, by remaining close to its caregiver, escapes normal dangers like the possible hazards of running into the street.

Attachment behavior is observable conduct that points to an underlying reciprocal connectedness between the child and his caregiver. Attachment behaviors appear normally in critical situations such as when the child is sick, injured, tired, or frightened. Again, note the survival value of attachment in keeping the child close to

her caregiver when the child is most vulnerable. The following are examples of attachment behaviors in infants and children:

- |              |                         |
|--------------|-------------------------|
| eye contact  | protesting separation   |
| smiling      | signaling or calling to |
| pouting      | holding or clinging     |
| following    | seeking to be picked up |
| searching    | reaching                |
| sitting with |                         |

Children who have insecure attachments do not behave as expected in critical situations. In fact, they often avoid caregivers at these times, preferring to handle the crisis by themselves. They have learned to fend for themselves.

Attachment is influenced by the caregiver’s roles of accessibility and responsiveness. Accessibility means that the caregiver is present and available, both physically and emotionally, to the child. Responsiveness refers to the caregiver’s ability and willingness to address the child’s needs sensitively, accurately, and directly. The caregiver can read the signals and anticipate the child’s needs based on past experience with the child. This responsiveness on the part of the caregiver, however, must endure over a period of the child’s first 3 to 5 years for attachment to mature and solidify.

The following stages of attachment follow sequentially if the reciprocal connectedness between child and caregiver remains unbroken, secure and healthy.

**Stages in attachment formation**

Age	Stage	Description
Birth to 3 months	Pre-attachment	<ul style="list-style-type: none"> <li>▪ Infant orients towards the sound of the caregiver’s voice; s/he tracks visually.</li> <li>▪ Infant smiles reflexively.</li> </ul>
3 to 8 months	Recognition/ Discrimination	<ul style="list-style-type: none"> <li>▪ Infant differentiates between primary caregiver and others.</li> <li>▪ Smiles are based on recognition.</li> <li>▪ Infant scans the caregiver’s face with excitement.</li> <li>▪ Infant greets caregiver and vocalizes differently to her.</li> </ul>
8 to 36 months	Active attachment	<ul style="list-style-type: none"> <li>▪ Stranger reaction emerges.</li> <li>▪ Infant shows clear preference for the chief caregiver.</li> </ul>

		<ul style="list-style-type: none"> <li>▪ S/he checks back to his caregiver’s face.</li> <li>▪ Child crawls or walks away from caregiver.</li> <li>▪ Child explores without anxiety.</li> <li>▪ Child acts intermittently in dependent and then in independent ways.</li> </ul>
36 months +	Partnership	<ul style="list-style-type: none"> <li>▪ Attachment solidifies.</li> <li>▪ Child shows increased ability to communicate needs verbally.</li> <li>▪ Child negotiates differences.</li> </ul>

***The positive working model***

The securely attached child has developed basic trust, an expectation that the world is primarily safe and that relationships will be satisfying.

About himself the child knows:

- I am worthwhile, wanted
- I am safe
- I am capable

About caregivers he knows:

- they are available
- they are responsive
- they meet my needs

Secure attachment influences and enhances many areas of a child’s development.

***The development of language and other communications***

Social interaction between infants and their caregivers stimulates the development of both verbal and nonverbal communication. Babbling, cooing, vocal interactions, and eye contact with caregivers are precursors to language development. Infants develop communication skills at an early age. Crying is an infant’s primary means of communicating distress or discomfort. Within a few months, the infant’s cries become more differentiated; most mothers can distinguish between tired cries, angry cries, frightened cries, or cries for attention. Timely nurturing responses by the caregiver to these and other cues from the infant further reinforce the infant’s attempts to communicate. Children who have been neglected, abused, or abandoned by caregivers are often delayed in their development of language.

***The development of trust and a positive world view***

According to Erikson, the primary developmental task of an infant during its first year of life is the development of basic trust. Trust, in Erikson’s view, refers to the infant’s perception of the environment as a positive, generally responsive, nurturing, and

dependable place. Trust also refers to the infant's sense of competence and confidence in her ability to act upon her environment to assure that her needs are met. The degree to which caregivers positively respond to the child's cues and meet her needs influences both aspects of trust.

For Erikson, the infant's early and continuous attachment to a primary caregiver is the single most important factor in the development of basic trust. Erikson also believes that the infant's experiences with attachment influence her world view (basic attitude toward the world), which sets the tone for all future interactions with her environment. If early attachments are absent, a source of pain, or unpredictable, the child will be less likely to approach others and will be more likely to avoid intimacy in relationships.

### ***The development of self-esteem***

Through her relationships with other important people in her life, a child learns that she is valued, worthwhile and wanted. She is positively reinforced by affection, caring and protection. These positive relationships are critical in establishing the foundations of the child's sense of self. Children who do not feel loved and important to their caregivers often develop low self-esteem and perceive themselves as inadequate in important ways.

### ***Anxiety reduction and a sense of security***

Infants and young children have few skills with which to cope with life stresses. As children grow, they develop more sophisticated coping strategies and greater self-reliance in mastering life's tasks and challenges. Infants and young children must rely on the adults in their lives to protect them and to remove stress. The child who has developed a reciprocal connection with a caregiver has a dependable source of security, which frees the child from excessive anxiety and fear. Children who are deprived of this security may develop strong anxiety reactions. If the anxiety state continues for a long period of time, it can interfere with the child's development in all domains.

### ***Learning through social interactions***

Play stimulates a child's cognitive, physical, and social development. Children develop social skills such as sharing, cooperation, and negotiation through play with parents and siblings. Children with attachment problems often have trouble controlling impulses. Children are also encouraged by parents to learn and to repeat new skills and activities. The child's trust in the parent and his wish to please the parent, both aspects of healthy attachment, are significant factors in the child's motivation to learn.

### ***Self-reliance***

Healthy attachment fosters the development of self-reliance in children. The secure emotional base provided through healthy, reciprocal relationships with important

adults promotes exploration, experimentation, and the development of self-confidence and self-reliance. Children whose attachments are insecure tend to be fearful, anxious, and dependent.

### ***Mary Ainsworth's classifications of attachment***

Mary Ainsworth (1978) enabled psychologists to look at the emotional development of children in a reliable, quantifiable way. Her work involved the systematic study and classification of children's responses to separation from the attachment figure.

#### ***Secure Attachment***

Securely attached children have an internal working model of caregivers as consistent, supportive in times of stress, sensitively attuned to their needs and signals, and reciprocal. As babies, they use their mothers as secure bases from which to explore the unfamiliar environment of a strange situation.

#### ***Insecure attachment***

Anxious avoidant children

- look away or ignore mother
- no proximity-seeking
- little effort to maintain contact

Caregivers of anxious avoidant children

- are rejecting
- appear uncomfortable with physical contact

Anxious resistant children

Appear ambivalent as evidenced by the following behaviors:

- intermingling of negative behaviors with attempt to gain proximity
- resisting and rejecting their mother upon reunion
- hitting, squirming, pushing away, throwing temper tantrums, rejecting toys

Caregivers of anxious resistant children are

- inept at handling
- less responsive to child's signals
- poor responders to child's needs
- generally unavailable

#### ***The Unattached Child***

Foster Cline added unattached to describe those children who truly are not reacting defensively and not hiding deep-seated ambivalence towards intimacy, but instead, "really don't care. They are simply and happily unattached: unwilling, uncaring, and unable to form intimate relationships with others."

### **Claiming**

Claiming is another way to build attachments and bonds. Claiming behaviors are those which separate the “we’s” and “they’s” of the world. When parents first hold their infant, usually they explore the child for physical abnormalities superficially. What follows is usually a detailed examination, scrutinizing the child to determine genetic resemblances among family members. The sense of interpersonal connection is enhanced by this claiming. Claiming behaviors can be either positive or negative. Positive response comments on the similarity to other members of the family. These responses continue through the child’s development as indicated by such responses as, “He’s just like Uncle Charlie.”

Disclaiming, a negative response, can also occur. This is especially common when the child has a physical abnormality. Special care must be given to help the parents grieve for the child and come to accept, cherish, and claim the infant as a full family member.

### **Disruptions in attachment**

Although minor disruptions in the child-caregiver relationship are usually harmless and to be expected, major separations and loss of a caregiver can disrupt the child’s attachment in very destructive ways. A distinct, three-stage cycle can be seen in the child’s response to disruptions in attachment. This cycle can be useful in understanding the responses of children in out-of-home placement to their removal.

<i>Stage in cycle</i>	<i>Response</i>
Protest	<ul style="list-style-type: none"><li>▪ crying</li><li>▪ distress</li><li>▪ pursuit of the mother</li><li>▪ searching after the mother</li><li>▪ temper tantrums</li></ul>
Despair	<ul style="list-style-type: none"><li>▪ depression</li><li>▪ quiet withdrawal</li><li>▪ refusal to be comforted by strangers</li><li>▪ disinterested in play or exploration</li></ul>
Detachment	<ul style="list-style-type: none"><li>▪ lack of interaction with the primary caregiver after reunion</li><li>▪ active avoidance of the caregiver</li><li>▪ failure to recognize the caregiver</li></ul>

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## Rasa (Case Scenario)

Read the following vignette with your table group. Discuss the questions below. Summarize your discussion with the larger group.

### Rasa's Story

You are the social worker for Rasa, a 4-month-old Persian girl. She tested positive for methamphetamine at birth, but did not have severe withdrawal symptoms. Her mother, Azar, is 23 years old. She was homeless at the time of Rasa's birth and acknowledged having a drug problem. Azar had one other child two years ago who was adopted as an infant through the child welfare system after Azar was unable to complete her case plan. Azar experienced physical abuse and neglect as a child and lived with several different relatives during adolescence.

Azar went right in to inpatient treatment when Rasa was born. The baby could not go with her to this program and was placed in foster care. Rasa has been doing well in her foster home and has been assessed to be on track developmentally. Azar's program is located out of county and visiting has been somewhat problematic. The program's schedule is very structured and transporting the baby the hours each way to visit with Azar has not always worked. Some visits have had to be rescheduled. You talk with Azar regularly. She is doing well in her program and loves to talk to you about wanting to have the baby in her care. You have spent some time discussing Azar's family of origin and her religion and culture as you plan for Azar's graduation from treatment and transition to aftercare. Azar does not have familial support and is worried about caring for Rasa as a single mother.

You decide to call the foster mother and ask her if you can pick up the baby and take her to see Azar. When you tell Azar that you are going to be there she sounds so excited that she can hardly speak.

When you arrive at the treatment center Azar looks well and healthy. You hand her the baby and she suddenly gets quiet. As you sit with Azar and Rasa, Azar wants to engage you in conversation. She is not focusing on Rasa. You notice Rasa gazing up at Azar but Azar will not look down at her.

### **Discussion Questions**

1. What do you think is happening between Azar and Rasa?
2. What do you think needs to happen between Azar and Rasa?
3. How would you talk with Azar to help her with parenting?

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## **Grief, Loss, and Separation in Infancy and Toddlerhood**

Separation from either or both parents due to out-of-home placement is a tremendous loss for a child. Grief is the natural response. Regardless of CPS involvement, a child may experience grief not only if a parent dies, but also if one becomes chronically or seriously ill, or if there is divorce or separation. Losing a parent through loss or separation is one of the most traumatic events that can happen to any child.

For a young child, losing a parent is an overwhelming crisis, impossible to understand. Bowlby (1980) describes three stages that well-attached children go through when they are separated from caregivers to whom they are attached. These are most evident in the child from ages 6 months to 4 years. The child:

- initially protests vigorously and makes attempts to recover his attachment object, such as going to the door and trying to find her.
- despairs of recovering the caregiver, but continues to be watchful. S/he appears to be preoccupied and depressed. When a car drives up or when there is a noise at the door, s/he becomes alert, hoping it is the caregiver returning.
- becomes emotionally detached and appears to lose interest in caregivers in general

### **Presentation and Experience of Grief and Loss Infancy**

Some indicators and characteristics of infant grief and loss are listed below. This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

- Children who have been separated from their mother (perhaps due to an out-of-home placement) may be sluggish, quiet, unresponsive to a smile or a coo, and may undergo physical changes (for example, weight loss), be less active, and sleep less.
- The infant has not yet developed object permanence; when things are out of sight, they are perceived as being gone. Even temporary losses of significant caregivers are experienced as total. Infants cannot comprehend that mother will be right back.
- Infants have short attention spans and memory. They do not understand change; they only feel it. Because they don't understand, changes and unfamiliar sensory experiences (sights, smells, noises, people) frighten them.

- Without language, infants have few ways to communicate their needs. Most communications are nonverbal. If adults are not familiar with their cues and do not recognize their distress, their needs may remain unmet.
- If separation occurs during the first year, it can interfere with the development of trust and reciprocal connectedness.
- Infants do not recognize death, but feelings of loss and separation are part of developing an awareness of death.

***Presentation and Experience of Grief and Loss in Toddlerhood***

Some indicators and characteristics of toddler grief and loss are listed below. This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

- Bowlby’s (1980) descriptions of three stages of separation apply here: (1) protest; (2) despair, preoccupation, and depression; and (3) emotional detachment.
- The child uses language to communicate but has a limited vocabulary and does not understand complex words or concepts. A child may stop talking and appear to feel overall distress.
- The child is still dependent upon adults to meet emotional and physical needs. The loss of adult support creates feelings of loneliness, vulnerability and anxiety.
- Children at this age often confuse death with sleep and may experience anxiety as early as age 3.

Failure to thrive (non-organic, NOFTT; also called psychosocial failure to thrive) is defined as decelerated or arrested physical growth (height and weight measurements fall below the fifth percentile, or a downward change in growth across two major growth percentiles) associated with poor developmental and emotional functioning. Organic failure to thrive is caused by medical complications of premature birth or other medical illnesses that interfere with feeding and normal bonding activities between parents and infants. Non-organic (psychosocial) failure to thrive occurs in a child who is usually younger than age 2 and has no known medical condition that causes poor growth.

### **What Causes Non-organic Failure to Thrive?**

Infants born into families with psychological, social, or economic problems are more at risk of developing non-organic failure to thrive. NOFTT occurs when maladaptive behaviors develop in both the infant and the primary caregiver. Maladaptive behaviors may develop around problems establishing regular, calm feeding routines, problems of attachment between the mother and the infant, and/or problems of separation. Other risk factors that put a child at risk for developing non-organic failure to thrive include mother or primary caregiver with any, or several, of the following conditions present:

- depression
- alcohol or drug abuse
- psychosocial stress
- lack of affection or warmth shown toward infant
- lack of knowledge about proper feeding
- lack of understanding of the infant's needs

### **Signs and symptoms**

The following are the most common symptoms of failure to thrive. However, each child may experience symptoms differently. Symptoms may include:

- lack of appropriate weight gain
- irritability
- easily fatigued
- excessive sleepiness
- lack of age-appropriate social response (i.e., smile)
- avoids eye contact
- lack of molding to the mother's body
- does not make vocal sounds
- delayed motor development

The symptoms of failure to thrive may resemble other conditions or medical problems. A doctor should always be consulted for a diagnosis. The individual issues involved in causing NOFTT are almost always complex. Treatment planning usually requires the involvement of a pediatrician, nutritionist, social worker, physical or occupational therapist, and a psychiatrist or other qualified mental health provider.

The first year of life is an important time for brain growth. Children with NOFTT that are not treated for an extended period of time may have difficulty catching up developmentally and socially. About 50% of children who experienced failure to thrive as an infant or young child continue to have social and emotional problems or eating problems later in life.

### ***Prevention of Failure to Thrive***

NOFTT occurs because of social, emotional, economic, and interpersonal problems. Community efforts to educate and encourage people to seek help for their problems may help to reduce the incidence of NOFTT. Encouraging parenting education courses in high school and educational and community programs may help new parents enter parenthood with an increased knowledge of an infant's needs. Early detection and intervention can reduce the severity of symptoms, enhance the process of normal growth and development, and improve the quality of life experienced by infants and children.

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## ***Risk Factors for Infants and Toddlers***

### ***Risk Factors for Abuse***

- Infants are demanding. They require constant attention and a great commitment of time. Infants often do not respect the parent's schedule. Sleep is frequently interrupted, and new parents are chronically tired. This is inherently stressful to even the most competent parent.
- A crying (screaming) infant can be extremely distressing to a parent, particularly if the parent is unable to quiet the infant. A crying infant who cannot be comforted is thought to be "ungrateful and unappreciative of my care." Infants cannot exhibit appreciation in the planful and reciprocating manner that is typical of adults.
- Newborns are often not very pretty. They are red, wrinkled, and may appear deformed to an uneducated parent. Their appearance may frighten a parent, or may stimulate a parent's feelings of poor self-esteem.
- They might have some kind of disorder like a gastroesophageal reflux disorder that causes them to vomit frequently when eating or drinking. This makes feeding exceedingly difficult and may frustrate parents leading to shaking or some other type of maltreatment.
- Newborns are not very social for the first 3 or 4 months. They demand a lot and give little back. The parent must derive any pleasure from providing care, rather than expecting expressions of gratitude or recognition from the infant.
- Infants who are premature, are sickly, have medical conditions, are irritable, are colicky, or otherwise require special care are most susceptible to abuse. Separations as a result of hospitalization or illness may prevent early attachment. Sickly or premature infants are more demanding in their care needs than healthy infants.
- The toddler is developing autonomy. "Me do it!" and "NO!" characterize the behaviors of this stage, which often includes stubbornness, rebelliousness, tantrums, angry outbursts, aggressiveness, obstinacy, and oppositional behavior. Struggles for power and control may develop. Oppositional behaviors can try the patience of even the most knowledgeable and understanding parent.
- Toilet training can be one of the most stressful developmental tasks for both children and parents. Trying to toilet train a child before he is ready can lead to extreme frustration and feelings of failure on the parent's part. The child experiences criticism, and often punishment, for reasons he does not understand. Toilet training can become a battleground between a parent who wants social compliance and a child whose major developmental task is to remain in control of his own body and his environment.
- A 2-year-old child who exercises autonomy by using the potty only when he wants to is seen by the parent as "plotting ways to get back at me." The 2-

year-old controls his own body functions as an expression of developing autonomy, and it is normal for children to be stubborn at age 2. The child is not capable of plotting in the manner the parent attributes to him.

### ***Vulnerability Factors***

- Infants and toddlers cannot protect themselves. They can't run, scream, or go for help. They are dependent and vulnerable. They will die if they are not properly cared for.
- Very rapid brain and body growth during the first two years makes the infant extremely susceptible to the effects of malnutrition. Intellectual delay and growth deficiencies can result.
- The infant's soft skull and unprotected body are very susceptible to injury. Head injuries easily lead to severe brain damage. The soft bones of the skull are more likely to fracture from a blow.
- Muscles are not developed adequately to protect the trunk and abdomen, and blows to this part of the body will cause serious internal injuries.
- Head and neck muscles are not strong enough to withstand even a mild shaking without potential brain and spinal cord injury.
- Infants are more susceptible to infection; they have not yet developed immunity to many environmental agents.
- Infants and toddlers use their bodies to explore their environments, manipulate objects, solve problems, and master many tasks. Physical injury, therefore, can have serious implications for cognitive development, in addition to physical development.
- Infants and toddlers are particularly vulnerable to the emotional effects of abuse and neglect. They likely experience abuse and neglect as raw, diffuse, pervasive, and incomprehensible pain. Abuse and neglect create barriers to attachment and the subsequent development of trust. This can permanently impair the child's relational abilities and create serious personality problems.

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## The Effects of Abuse and Neglect on Infants and Toddlers

### Social

- Maltreated infants may fail to form attachments to primary caregivers.
- Maltreated infants often do not appear to notice separation from the parent and may not develop separation or stranger anxiety. A lack of discrimination of significant people is one of the most striking characteristics of abused and neglected children.
- Maltreated infants are often passive, apathetic, and unresponsive to others. They may not maintain eye contact with others, may not become excited when talked to or approached, and often cannot be engaged into vocalizing (cooing or babbling) with an adult.
- Abused or neglected toddlers may not develop play skills, and often cannot be engaged into reciprocal, interactive play. Their play skills may be very immature and primitive.

### Behavioral Outcomes

Repeated exposure to traumatic or stressful situations leads to a *hyperarousal response*. In early childhood, those parts of the brain that respond to threat or trauma are those that control or regulate arousal, vigilance, locomotion, attention, and the startle response—the brainstem and midbrain. Use-dependent activation leads to malfunctioning in the normal activity regulated by these two areas; so a child exhibits motor hyperactivity, anxiety, behavioral impulsivity, sleep problems, hypertension. In addition, everyday stressors which may not elicit any response in a normal child elicit an exaggerated response in the sensitized child. The child is in a persisting state of fear and will move very easily from a state of being mildly anxious to feeling threatened to being terrorized. The child now has a set of maladaptive emotional, behavioral, and cognitive problems which are rooted in the original adaptive response. The hyperarousal response is most commonly exhibited by boys.

Girls (and very young children) are more likely to exhibit a dissociative response when confronted with the same set of traumatic experiences. When distressed, a young child will often cry. But when crying only elicits further discomfort, the child will abandon this response (a defeat or surrender response). In the face of continuing threat or trauma, the child may move into a freezing response—a normal response in the face of danger. However, this freezing mechanism can lead to children becoming labeled as oppositional-defiant because, when feeling anxious, they may act like they don't hear or are refusing to obey commands from teachers or other adults. This may force

the adult—teacher, parent, counselor— to give the child other directives which often involve a threat, “if you don’t do this, I will...” The more anxious the child becomes, the quicker s/he will move from being anxious to threatened, and from threatened to terrorized. The freezing can escalate into complete dissociation.

Dissociative behaviors include numbing, fantasy, daydreaming, and avoidance. Children report “going to another place,” “just floating,” assuming the persona of a hero or an animal. They are often described as robots or “acting as if they aren’t here” (Perry et al, 1995).

### **Physical**

- Chronic malnutrition of infants and toddlers results in slow growth, brain damage, and, potentially, intellectual delay.
- Head injury can result in severe brain damage, including brain stem compression and herniation, blindness, deafness, intellectual delay, epilepsy, cerebral palsy, skull fracture, paralysis, and coma or death.
- Injury to the hypothalamus and pituitary glands in the brain can result in growth impairment and inadequate sexual development.
- Less severe but repeated blows to the head can also result in equally serious brain damage. This type of injury may be detectable only with a CT scan and, in the absence of obvious signs of external trauma, may go unnoticed.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Shaking can result in brain injury, equal to that caused by a direct blow to the head, and spinal cord injuries, with subsequent paralysis.
- Symptoms of Shaken Baby Syndrome include lethargy, vomiting, coma, large head circumference, subdural hemorrhages, and, most commonly, retinal hemorrhages. Additionally, bones in the neck and spine can be injured, resulting in a collapse of the vertebrae. Spinal cord injury can result in paralysis.
- Internal injuries can lead to permanent physical disability or death.
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, vision problems from untreated strabismus (crossing of the eyes), respiratory damage from pneumonia or chronic bronchitis, etc.
- Neglected infants and toddlers have poor muscle tone, have poor motor control, exhibit delays in gross and fine motor development and coordination, and fail to develop and perfect basic motor skills.
- Since most of an infant’s cognitive development is facilitated by motor involvement with the environment, physical delays contribute to cognitive delays as well.

### **Emotional**

- Abused and neglected infants often fail to develop basic trust, which can impair the development of healthy relationships.
- Maltreated infants are often withdrawn, listless, apathetic, depressed, and unresponsive to the environment.
- Abused infants often exhibit a state of frozen watchfulness—that is, remaining passive and immobile, but intently observant of the environment. This appears to be a protective strategy in response to a fear of attack. It is as if the child were on guard.
- Abused toddlers may feel that they are bad children. This has a pervasive effect on the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of healthy personality. Children may become chronically dependent, subversive, or openly rebellious.
- Abused and neglected toddlers may be fearful and anxious, or depressed and withdrawn. They may also become aggressive and hurt others.

### **Cognitive**

- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or intellectual delay can result.
- Brain damage from injury or malnutrition can lead to intellectual delay.
- Abused and neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay that can also affect social development, including the development of peer relationships.
- Maltreated infants are often apathetic and listless, placid, or immobile. They often do not manipulate objects, or do so in repetitive, primitive ways. They are often inactive, lack curiosity, and do not explore their environments. This lack of interactive experience often restricts the opportunities for learning. Maltreated infants may not master even basic concepts, such as object permanence, and may not develop basic problem-solving skills.

### **Sexual**

- Children who have been sexually abused often have myriad long-term effects.
- Maltreated toddlers may exhibit sexualized play.
- Maltreated toddlers may have detailed and inappropriate knowledge of sexual activity.
- Maltreated toddlers may engage in excessive masturbation.

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## ***The Impact of Parental Substance Abuse on Children***

### ***Introduction***

The basic needs of children, including nutrition, supervision, and nurturing, often go unmet due to parental substance abuse. Additionally, families in which one or both parents abuse substances, and particularly families with an addicted parent, often experience a number of other problems including mental illness, unemployment, high levels of stress, and impaired family functioning, all of which can put children at risk for abuse. A report by the National Center on Child Abuse and Neglect states that 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of alcohol and other drug use by the child's parents.

Maltreated children of substance abusing parents are more likely to have poorer physical, intellectual, social, and emotional outcomes, and are at greater risk of developing substance abuse problems themselves (U.S. Department of Health and Human Services, 1999). Data indicate that abused or neglected children from substance abusing families are more likely to be placed in foster care and are more likely to remain there longer than maltreated children from non-substance abusing families (U.S. Department of Health and Human Services, 1999).

Because of the severity of problems experienced by maltreated children of substance abusing parents, and the fact that they are often in the foster care system longer than maltreated children from non-substance abusing families, expenditures related to substance abuse among families in the child welfare system are significant. One study estimates that of the more than \$24 billion that states spend to address different aspects of substance abuse, \$5.3 billion (slightly more than 20%) goes to child welfare costs related to substance abuse (National Center on Addiction and Substance Abuse at Columbia University, 2001).

### ***The impact of substance abuse on the fetus***

The use of alcohol, tobacco, and/or other drugs (ATOD) during pregnancy continues to be a leading preventable cause of mental, physical, and psychological impairments and problems in infants and children. The cost of ATOD use during pregnancy is high to society in both human and economic terms.

- Recent state surveys have shown that between 8% and 12% of women delivering in hospitals had used illegal drugs at some time during the pregnancy including just before delivery.
- According to a National Institute on Drug Abuse study (1995) on estimated use of selected substances during pregnancy, 5.5% of the women surveyed reported using illicit drugs while they were pregnant. Additionally, 18.8% reported using

alcohol, and 20.4% reported using tobacco.

- All illicit drugs reach the fetal circulation by crossing the placenta and can cause direct toxic effects on the fetus, as well as fetal and maternal dependency.
- Pregnant women who continue to take drugs against medical advice face increased risks of losing custody of their babies once they are born. In some states, they also risk criminal prosecution.
- Women who use intravenous drugs risk not only acquiring the HIV virus themselves, but also the double jeopardy of passing the virus and the drug to their fetuses. Additionally, HIV-positive women can pass the virus on to their babies through breast milk.

### ***Fetal Alcohol Spectrum Disorders***

Alcohol use during pregnancy results in a spectrum of adverse outcomes known as Fetal Alcohol Spectrum Disorders. This umbrella term includes Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorders (ARND), Partial FAS and Static Encephalopathy, Alcohol Exposed. Fetal alcohol spectrum disorders constitute a major public health problem with staggering economic costs. These disorders occur wherever pregnant women consume alcohol, and are not only a problem of a particular race or ethnic group, but an international concern.

FAS is characterized by specific facial abnormalities and significant impairments in neurodevelopment and physical growth. Developmental deficits in the brains of FAS/FAE children frequently produce negative behavioral outcomes that last throughout a lifetime. Early identification of children with FAS and other fetal alcohol spectrum disorders and stable family relationships have been shown to enhance their long-term outcomes.

### **Context**

- FAS and all other fetal alcohol spectrum disorders are entirely preventable through an alcohol-free pregnancy (Floyd et al, 2005).
- Prenatal alcohol exposure is regarded as a leading preventable cause of birth defects in developmental disabilities in the United States (Floyd et al, 2005).
- Estimates of prevalence rates of FAS in the United States range from .2 – 2 cases per 1,000 live births, translating to as many as 8,000 cases among the 4,019,280 births that occurred in 2002. Rates appear to be higher in several Native American populations (Riley & McGee, 2005).
- Children with fetal alcohol spectrum disorders are often not raised by their birth mothers, due to removal for abuse or neglect, or maternal death.
- In 2005, the U.S. Surgeon General issued an updated Advisory on Alcohol Use and

Pregnancy recommending that pregnant women should not drink alcohol, that a pregnant woman who had already consumed alcohol during her pregnancy should stop drinking to minimize further risk, and that a woman who is considering pregnancy or who might become pregnant should also abstain from alcohol (Floyd et al, 2005).

### ***Alcohol Use & Implications***

- 1 in 25 pregnant women in the United States report binge drinking (Floyd et al, 2005).
- Among nonpregnant women of childbearing age, 53% reported alcohol use and 23% reported binge drinking (Floyd et al, 2005).
- Half of all pregnancies are unplanned. Many women will not know they are pregnant during the early weeks of gestation and will continue to use alcohol at levels that cause fetal alcohol spectrum disorders (Floyd et al, 2005).
- As alcohol intake increases, there is a corresponding increase in the adverse effects observable in the fetus (Floyd et al, 2005).

### ***Effects on Neurodevelopment***

- The timing of prenatal alcohol exposure will determine which developing structures are affected and how severely they might be affected. Some children might be severely affected in multiple systems, whereas others may have no apparent effects. The age of the mother has also been identified as a risk factor for FAS (Riley & McGee, 2005).
- Prenatal exposure during the first trimester interferes with the migration, proliferation, and organization of brain cells. Exposure during the third trimester is highly related to damage to the cerebellum, hippocampus, and prefrontal cortex. The pattern of structural and functional abnormalities will vary, depending on how the exposure coincides with critical periods of development (Riley & McGee, 2005).
- Magnetic resonance imaging (MRI) of the brain has permitted advances in neurodevelopment research concerning fetal alcohol spectrum disorders. Findings include or suggest (Riley & McGee, 2005):
  - Detection of impairments in the following:
    - Overall IQ
    - Memory
    - Language
    - Attention
    - Reaction time
    - Visuospatial abilities
    - Executive functioning
    - Fine and gross motor skills
    - Social and adaptive functioning
  - Reduced brain growth in the frontal lobes, more prominent in the left

- hemisphere (suggesting difficulties with response inhibition, behavioral control and executive functions)
- Brain growth continues to be adversely affected long after prenatal exposure
  - Reductions in cerebellum volume
  - Reduced basal ganglia volume
  - Smaller and displaced corpus callosum

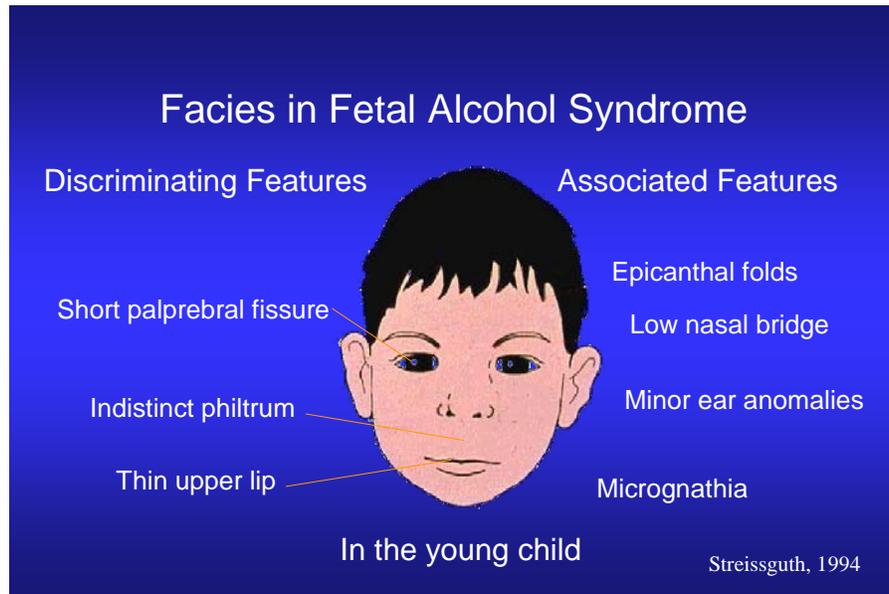
### **Negative Behavioral Outcomes**

- Outcomes for children with FAS include school failure, difficulties with peers, conduct problems, and mental health disorders (Floyd et al, 2005).
- A study assessing adverse life outcomes in 415 children, adolescents and adults with fetal alcohol syndrome and fetal alcohol effects found (Striessguth et al, 2004):
  - 80% were not raised by their biological mothers
  - 61% suffered major disruptions in schooling
  - 60% had experienced trouble with the law
  - 50% had been confined to a psychiatric or treatment facility, or incarcerated
  - 35% had experienced alcohol and drug problems
  - 49% had exhibited inappropriate sexual behavior
    - Almost all females in the study with inappropriate sexual behaviors had experienced sexual or physical abuse, or violence against themselves, and 7% also had alcohol or drug problems, making them vulnerable to having unplanned pregnancies, and giving birth to babies with fetal alcohol spectrum disorders.

### **Intervention**

- FAS in children with more subtle facial abnormalities or less obvious central nervous system deficits and FAE children may go undetected; physicians who are not specialists in this area need to be trained to assess more carefully for fetal alcohol spectrum disorders so that needed services can be obtained (Floyd et al, 2005).
- Since only 24% of children with FAS and 7% of children with FAE have an IQ below 70 (the traditional criterion for receiving services), they have difficulty getting appropriate services (Striessguth et al, 2004).
- Research indicates that early identification leads to interventions, services, and improved outcomes (Riley & McGee, 2005).
- Knowing which brain regions are affected may help target interventions more effectively (Riley & McGee, 2005).

## Schematic Picture Depicting Facial Abnormalities of an FAS Child



### **Specific Substances**

Caution re: the use of substances by nursing mothers

Although the incidence of breastfeeding by substance-abusing mothers is generally low, it is important to counsel nursing mothers that drugs of abuse are hazardous to them and their infants. Overall, studies demonstrate the need for close follow-up and early intervention for children born to substance-abusing women.

#### **Opiates**

Symptoms of neonatal opiate withdrawal are often present at birth but may not reach a peak until 3 to 4 days or as late as 10 to 14 days after birth. Evidence of withdrawal from opiates can persist in a sub-acute form for 4 to 6 months after birth. Common features of the neonatal abstinence syndrome mimic those of an adult's withdrawal from opiates. For example, the opiate-exposed fetus may experience withdrawal in utero when drugs are withdrawn from a dependent mother or after delivery when the mother's use no longer directly affects her newborn.

#### **Cocaine**

A major problem confronting pediatricians today arises from the consequences of maternal cocaine use during pregnancy. As in other substance-abusing populations, cocaine-dependent pregnant women have a high incidence of infectious diseases, especially hepatitis B, acquired immunodeficiency syndrome,

and other sexually transmitted diseases. Although women who use cocaine may be at increased risk of abruptio placentae, preterm labor and slow intrauterine growth, they usually experience an uncomplicated labor and delivery.

Cocaine-exposed infants have an increased incidence of premature birth, impaired fetal growth and neonatal seizures, and Sudden Infant Death Syndrome (SIDS). Although a specific cocaine withdrawal syndrome in neonates has not been defined, some show signs of irritability and tremulousness, lethargy, inability to respond appropriately to stimulation and abnormal cry patterns. Perinatal cerebral infarctions have occurred in infants whose mothers have used cocaine a few days before delivery. These perinatal cerebral infarctions exemplify the severe morbidity that may be associated with intrauterine exposure to cocaine.

**Marijuana**

Withdrawal from other substances such as marijuana does not seem to be as severe. Increased research is needed to define the degree of permanent residual effects in these infants. In addition, interpretation of clinical studies is complicated by the fact that abuse of multiple drugs often occurs.

However, several long-term studies have demonstrated that substance-exposed infants are at risk for developmental and learning problems. In a group of 3- and 4-year-old children exposed prenatally to marijuana, Fried and Watkinson found that, when controlling for alcohol and tobacco exposure, by 4 years of age marijuana exposure was associated with lower scores in the verbal and memory domains. The overall cognitive abilities of the children were normal.

***Effects of substance abuse on mother/baby/child***

<b>Alcohol</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Intellectual delay
Poor eating	Brain damage	Behavior problems
Tolerance	Heart problems	Learning problems
Intoxication	Kidney problems	Alcohol Related
CNS depression	Malformations	Neurological Disorder
	Changes in the face	(ARND)
		Fetal Alcohol Syndrome
		(FAS)

<b>Cigarettes</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Shortness of breath	Too small at birth	Hyperactivity
Heart problems	Heart problems	Asthma and breathing problems
Poor weight gain	Premature	
Stroke or heart attack	Breathing problems	
	Crib death	

<b>Cocaine, Crack Cocaine</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Slow development
Poor eating	Brain damage	Behavior problems
Accidents	Premature	Learning problems
HIV/AIDS risk	Seizures	
Heart attack or stroke	Drug withdrawal	
Hepatitis	Heart attack or stroke inside the womb	
	Kidney problems	
	Malformations	
	Crib death	

<b>Amphetamine, Stimulants</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Slow development
Poor eating	Brain damage	Behavior problems
Accidents	Premature	Learning problems
HIV/AIDS risk	Seizures	
Heart attack or stroke	Heart attack or stroke inside the womb	
Hepatitis	Kidney problems	
	Malformations	
	Crib death	

<b>Heroin, Opiates</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Slow development
Poor eating	Small brain	Behavior problems
Accidents	Premature	Learning problems
HIV/AIDS risk	Seizures	
	Drug withdrawal	
	Crib death	

<b>Oxycontin</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Slow development
Poor eating	Small brain	Behavior problems
Accidents	Premature	Learning problems
HIV/AIDS risk	Seizures	
	Drug withdrawal	

<b>PCP, Angel Dust</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Slow development
Poor eating	Brain damage	Behavior problems
Accidents	Premature	Learning problems
Disorientation	Seizures	Nervous system problems
	Shaky	

<b>Marijuana</b>		
<b>Effects on the mother</b>	<b>Effects on the baby</b>	<b>Effects on children</b>
Poor judgment	Too small at birth	Learning problems
Accidents	Unknown risks to fetus	Behavior problems
Poor eating		
Increased heart rate		
Toxic to respiratory system and immune system		

### **Signs and Symptoms of Withdrawal in Adults**

#### **Alcohol**

Early symptoms of alcohol withdrawal generally appear 6 to 48 hours after drinking has stopped but can occur up to 10 days after the last drink. Withdrawal symptoms may include:

- |                |                          |
|----------------|--------------------------|
| ▪ restlessness | ▪ vomiting               |
| ▪ tachycardia  | ▪ impaired concentration |
| ▪ irritability | ▪ sweating               |
| ▪ hypertension | ▪ impaired memory        |
| ▪ anorexia     | ▪ tremors                |
| ▪ insomnia     | ▪ elevated vital signs   |
| ▪ nausea       | ▪ nightmares             |

More severe symptoms of alcohol withdrawal may include:

- |  |  |
|--|--|
| ▪ increased tremulousness  | ▪ increased agitation                      |
| ▪ increased sweating   | ▪ delusions (usually paranoid)             |
| ▪ grand mal seizures   | ▪ Hallucinations-auditory, visual, tactile |
| ▪ delirium (with confusion, disorientation, impaired memory& judgment) |  |

*Note: Withdrawal symptoms do not necessarily progress from mild to severe. In some individuals, a grand mal seizure may be the first sign of withdrawal. Seizures usually occur 12 to 24 hours after cessation or reduction of drinking. One-third of all patients who have seizures develop delirium tremens.*

### **Cocaine**

Withdrawal from cocaine dependence is characterized by depression, anxiety and lethargy, which begin to resolve after approximately one week. Less common are signs of a paranoid psychosis during withdrawal from chronic use of high doses of cocaine. In cocaine withdrawal, medication is rarely needed for the serious sequelae that are associated with alcohol, barbiturate and opioid withdrawal.

### **Opioids**

Mild withdrawal signs and symptoms include:

- |   |                   |
|---|-------------------|
| ▪ generalized anxiety                         | ▪ restlessness    |
| ▪ opioid craving                              | ▪ lower back pain |
| ▪ slight aching of muscles, joints, and bones |                   |

Mild to moderate withdrawal signs and symptoms include:

- |                                      |                              |
|--------------------------------------|------------------------------|
| ▪ tension                            | ▪ lethargy                   |
| ▪ mild insomnia                      | ▪ mydriasis (pupils dilated) |
| ▪ diaphoresis (usually perspiration) |                              |

Moderate withdrawal signs and symptoms include:

- |   |                                     |
|---|-------------------------------------|
| ▪ anorexia  | ▪ rhinorrhea (runny nose)           |
| ▪ rhinorrhea (runny nose)                                     | ▪ nausea and/or stomach cramps      |
| ▪ lower back pain   | ▪ elevated pulse and blood pressure |
| ▪ lacrimation (tearing)                                       | ▪ aching of muscles, joints, bones  |
| ▪ goose flesh (earlier if client is in a cold, drafty room)   |                                     |
| ▪ chills alternating with flushing and diaphoresis (sweating) |                                     |

Moderate to severe withdrawal signs and symptoms include:

- |            |                                      |
|------------|--------------------------------------|
| ▪ diarrhea | ▪ tachycardia (pulse over 100BPM)    |
| ▪ vomiting | ▪ increased respiratory rate & depth |
| ▪ tremors  |                                      |

Severe withdrawal signs and symptoms include:

- |   |                                  |
|---|----------------------------------|
| ▪ kicking movements   | ▪ doubling over w/stomach cramps |
| ▪ elevated temperature (usually low grade, less than 100 degrees F) |                                  |

*Note: Withdrawal signs and symptoms differ in their order of appearance from one individual to another. Some individuals may not exhibit certain withdrawal signs and symptoms. Signs may also include uterine irritability, increased fetal activity, or rarely, hypotension.*

#### Barbiturates Abstinence Syndrome

The barbiturate abstinence syndrome begins 6 to 24 hours after the last dose, and symptoms are generally more severe with short-acting barbiturates. Signs and symptoms of barbiturate abstinence include:

- |  |                        |
|--|------------------------|
| ▪ tremulousness                                | ▪ diaphoresis          |
| ▪ anxiety                                      | ▪ postural hypotension |
| ▪ insomnia                                     | ▪ agitation            |
| ▪ anorexia                                     | ▪ nausea and vomiting  |
| ▪ delirium                                     | ▪ tendon hyperreflexia |
| ▪ grand mal convulsions (between days 3 and 7) |                        |

*Note: If untreated, withdrawal symptoms can progress to hyperpyrexia, electrolyte abnormalities, cardiovascular collapse and death.*

#### **Early interventions for infants**

Follow-up interventions include but are not limited to:

- nutrition
- psychomotor assessment/monitoring of development

- vision and hearing screening
- speech and language assessment/therapy
- emotional development assessments/therapy
- play therapy

Intervention strategies for drug-exposed infants should promote:

- self-regulation: the ability to regulate activity, attention, affect
- secure relationships with mother and significant caregivers:
- developmentally appropriate progress in motor skills, cognitive skills, speech, and language skills

### ***Early interventions for toddlers***

Follow-up interventions include but are not limited to:

- Early childhood education program
- Individual therapy

Strategies to support self-regulation:

- An orderly, consistent, child-appropriate environment
- Predictable routines and consistent schedules
- Clear expectations and rules
- Clear patterns for transitions
- Offering simple choices to children
- Praising a child's efforts, not just successes
- Using anticipatory guidance to avoid difficult situations
- Operate from their strengths

Strategies to support secure relationships with caregivers:

- Individual attention, celebration of each person
- Activities fostering positive self-esteem
- Labeling feelings to assist the child with identifying feelings
- Clear adult/child boundaries

### ***Transition to the preschool period***

Needed therapeutic services should be provided:

- speech and language
- physical therapy
- occupational therapy
- play therapy

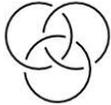
### ***Teacher training***

- understand general addiction issues
- understand women's addiction issues and family systems
- understand cultural/ethnic factors
- recognize behavioral cues to promote self-regulation

- provide consistency, predictability, structure
- plan for transitions
- address issues relating to addiction, abuse and violence

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## The Normal SPECS of Development for Preschoolers



By the age of 3, most children have developed a sense of self that allows them to feel confident in maneuvering around their environment, and eventually leads to the development of initiative in their activities. Their point of view continues to be self-centered, but over the next few years, they will begin to develop the ability not only to play with another child, but also to play cooperatively in groups of children. Physically, they continue to grow rapidly and continue to enhance mastery of their body and language.

### **Social Development**

Between the ages of 3 and 5, the child expands his/her social relationships with adults outside the family and develops interactive and cooperative play skills with peers. There are two principal tasks of social development for the preschool child: the development of interactive play skills, and learning social roles and rules.

- The child begins to understand, explore, imitate, and practice social roles.
- The child learns concepts of right and wrong and begins to understand the nature of rules. S/he experiences guilt when s/he has done something wrong.

Children move from imitating their adult caregivers to imitating other children. They may still involve themselves in parallel play, but the emergence of interactive play helps the child begin to understand, explore and learn about social roles and rules.

### **Interactive Play**

Children enter the preschool period with limited play skills. The development of language, with the subsequent ability to communicate better with others, promotes the development of play skills. Increasingly complex social interactions develop in stages throughout the preschool period.

For 3-year-olds, toys are the focus of most play. The preschool child must learn basic social rules, such as sharing and taking turns, before the child will be able to play cooperatively with other children. Frequent battles erupt while this is being learned. Few 3-year-olds can cooperate toward accomplishment of a common goal, particularly if it means compromising their own wants and needs (Rycus, 1998).

Between ages 4 and 5, children increasingly form friendships with other children and will ask to play with certain friends. Play is more cooperative and governed by rules.

Each child may imitate a specific role in imaginative play, and children may direct each other's activities. Joint involvement toward a common goal is more frequent.

*Tonya and Leticia were playing house under the dining room table. Tonya could be overheard directing Leticia, "Now you be the mommy. You have to hold the baby so she won't cry, because I'm working. I can't be disturbed."*

*Kelli, who understood the rules about taking turns, confronted Brian, who had been monopolizing the paints and easel: "Can't you see that I'm sad because you've been painting for too long!"*

Magical and imaginative thinking are frequently expressed in play. The preschool child will create fantasy characters and scenarios, including imaginary friends. Well-developed language allows them to talk to, and about, these friends. For example, they will weave elaborate scenarios about the life of a favorite stuffed animal and will explain the animal's needs, feelings, and thoughts in detail to anyone who is willing to listen. Children may be overheard making up and telling stories to themselves (Rycus, 1998).

### **Function of Play**

Children engage in play for its own sake because it is pleasurable. However, play is thought to serve several additional functions for the preschool child (Rycus, 1998).

- Play provides opportunities to practice and develop language skills by conversing with other children and with adults about the play activities. Stories, both those that are real and those that are made up, promote the development of language (Rycus, 1998).
- Through play, the child learns and practices basic social skills, such as sharing, taking turns, cooperating, and controlling his own impulses. Gross motor play and participating in activities and games that provide new challenges help to develop gross motor abilities and promote refinements in balance and coordination (Rycus, 1998).
- The child can discharge emotional tensions and anxieties through play. This affective function of play allows the child to safely express emotions that would be socially unacceptable or dangerous in most situations (Rycus, 1998).

*Michael was mad at his brother. While playing with his superheroes he created a battle in which the good guy beat up the bad guy.*

- Erikson views play as a constructive means of coping with stress. Through play, the child can rehearse coping strategies to help them deal with difficult situations (Rycus, 1998).

*Four-year-old Joseph was scheduled to see the doctor. He initiated playing doctor with his younger sister, pretended to give her a shot, told her it wouldn't hurt very much, and reassured her that she would be all better soon.*

- Children can experiment with social roles and differing perspectives through imitation and imaginative play. They pretend to be someone, assume the perceived characteristics of the role, and model the adult's behaviors (Rycus, 1998).

*Jenny announced to Laurie that she was going to be the teacher, and Laurie had to be the student and sit still. Jenny announced that she was going to write on the board and teach Laurie letters.*

- Play can help reduce fears. The imaginary companions of many children are wild animals who are made to be docile, friendly, and under the child's control (Rycus, 1998).

### **Cultural Note on the Role of Play**

Play is a universal activity. However, there are differences among cultures in how people play. For example, some cultures do not condone active physical play for girls, and thus parents may not allow their daughter to play tag in the yard.

It is important to take the time to understand culturally specific play patterns by talking with and observing families and asking them questions, as well as accessing community-based service providers who specialize with families of a particular group. Ethnographic interviewing techniques can be utilized to determine how children and adults interact playfully.

When teaching foster parents to play with children, the worker and foster parents should be familiar with culturally specific games, stories, activities, and play objects. This will prevent trying to teach play strategies that are not acceptable within a culture, and will also help to promote a positive cultural identity.

### **Physical Development**

The physical appearance of the child begins to change noticeably during this time as the infant/toddler begins to look more like a child. Children during these next few years before school will have weight and height gains that are fairly constant. The child gains weight at approximately 4 to 5 pounds per year and grows approximately 3 to 4 inches per year. Their physical growth continues, but the speed with which their brain is growing now begins to slow.

*A rule of thumb to help remember an average height and weight for a 3-year-old child is to think of threes: 3 years, 3 feet tall, 33 pounds!*<sup>1</sup>

By early preschool, the brain will have reached approximately four-fifths of adult size. This is significant when considering the impact of the environment. Positive, well-structured healthy environments are going to produce optimal brain growth, whereas environments where neglect and/or maltreatment have occurred may already have had irreversible effects (Rycus, 1998).

By age 3, most basic gross motor abilities have emerged. For the next few years, existing skills are practiced and perfected, and children develop mastery in applying motor skills to increasingly challenging and complex situations. They have not only developed the ability to walk and climb, but now they can run and jump and stand on one foot. They can use their hands and begin to have more control when they are coloring. They can feed themselves and usually have control of their bladder and bowel.

The preschooler loses the swayed back and protruding abdomen typical of the toddler and begins to stand more erect. By age 5, the preschooler will have good control over their muscles, but they will appear uneven and incomplete to the eye. The preschool child cannot sit still for long periods of time. Preschoolers prefer to be busy and active.

### **Cultural Note on Motor Development**

Motor abilities may differ between boys and girls. Different cultural expectations can affect the nature of motor development. In cultures that reinforce rough and tumble play for boys, boys will typically develop muscle strength and gross motor coordination. Quieter, more refined play, such as use of toys, crayons, and dolls, will generally promote the development of fine motor coordination (Rycus, 1998).

### **Emotional Development<sup>2</sup>**

As preschool children explore the world, their physical abilities and social desires affect their emotional development. Preschool children are very curious. They are often self-directed and willing to take charge, try new things, and manipulate the environment. Children who have earlier formed a secure attachment and a sense of autonomy now begin to pursue further emotional development in the areas of initiative, self-control, conscience, and self-esteem.

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<sup>1</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 485, Arlington, VA: CWLA.

<sup>2</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 491-493, Arlington, VA: CWLA.

### The Development of Initiative

Erikson describes the development of initiative as the preschool child's most important developmental task. A healthy child is self-directed and exuberant. He delights in orchestrating activities and being in charge. He takes pleasure in attack and conquest, and experiments with new roles and skills.

Initiative has its risks. Children must have a basic sense of trust in themselves and in their environment to feel confident enough to initiate new activities. They must also understand they are capable of autonomous behavior. The healthy development of trust and autonomy during the infant and toddler stages is a cornerstone of the preschool child's confidence and sense of competence.

### The Development of Self-Control

Before age 3, children react emotionally to frustrating situations. Infants cry when they are uncomfortable or unhappy. Toddlers have tantrums when they can't have their own way, or when they are confronted with a frustrating situation. Preschool children learn how to control their own emotions and behavior more effectively. Their improved cognitive ability, including greater mastery of language, helps them consider problems and solutions. Crying and temper tantrums in frustrating situations decrease during the preschool years as children develop better self-control. Improved coping abilities enable them to withstand some frustration and discomfort without becoming so emotionally aroused that their behavior becomes disorganized. Some parents notice that their preschool-age child can turn their tears on and off at will. This is another example of their increasing emotional control.

The preschool child is also better able to delay gratification. "You can have a cookie after dinner" does not lead to a tantrum. The child is able to wait a short time for a reward. The ability to delay gratification appears to be supported by prior predictable and consistent fulfillment of promises for rewards.

### The Development of Conscience

During the preschool period, the development of conscience coincides with the development of self-control. By age 5, most children understand the meaning of right and wrong. The child doesn't need the parent to say no to prevent her from touching the forbidden object. She will avoid it because she knows it is wrong to touch it, and that her parent will be angry with her if she does. The internalization of standards of right and wrong behavior forms the rudiments of moral behavior, or conscience.

The preschool child's understanding of right and wrong is fairly basic, however. The child cannot understand abstract moral principles. The concrete application of a moral principle is a rule. Preschool children do understand rules, but they

tend to view rules concretely. Thus, rules and consistency within the home environment become very important. Consistency allows children to begin understanding how rules work. Additionally, rules provide a dependable structure and a sense of security. Children who grow up in chaotic environments where the rules continually change or where no rules exist often show signs of anxiety and emotional disturbance.

#### The Development of Self-Esteem

By age 3, the child has a rudimentary sense of self. She understands “I” and “me” and knows she is different from other people. With the development of conscience, she will also begin to evaluate her own behavior as good or bad. She feels pride when she exhibits good behavior and guilt or shame when she exhibits bad behavior.

The preschool child’s self-esteem is largely dependent upon other people’s reactions to her. The normal drive toward initiative puts her in continual contact with other people. If these people respond to her with praise and support, she is likely to feel positive about herself, and her attempts at initiative will be reinforced. Conversely, if her initial attempts at initiative result in criticism or punishment, she is likely to perceive herself to be a bad child and may experience guilt and shame. Low self-esteem and lack of confidence result, and the child will be less likely to initiate or engage in new activities.

#### **Moral Development**

Moral development is an aspect of social development that deserves special attention. Lawrence Kohlberg has conducted much of the research that identifies predictable stages of moral development in youths.

- Preschool children and school-age children: The moral development of most children under age 11 is at the pre-conventional level. Preconventional morality is largely rules driven. For most preschool children, morality is based upon a punishment/obedience perspective. The child recognizes the superior power of an authority and conforms to rules simply to avoid punishment. Later in childhood, children begin to understand that rules can be useful in promoting self-interest exchanges.

#### **Cognitive Development**

Thinking is concrete and egocentric. Problem solving is illogical, and magical thinking and fantasy are prevalent. During the second year of life, children enter the stage of cognitive development known as pre-operations. According to Piaget’s theory, during the pre-operational stage, a child has difficulty understanding life from any perspective other than his own. In this stage, the child is very me-, myself-, and I-oriented.

### **Language Development**

The child's ability to understand and express symbols has provided a strong foundation by age 3. Now, language develops rapidly, with grammar and syntax becoming refined, and vocabulary increasing geometrically. The child uses language as a communication tool.

The child expands from two-word phrases into full sentences by adding linking words, including prepositions, conjunctions, and objects. The child's grammar improves. The child's spoken vocabulary increases exponentially. By age 4, children know approximately 1,500 words, and by age 5 that number increases to 2000.

The greater the child's vocabulary, the more likely the child will be able to express complete thoughts. Thought and understanding (receptive language) is generally more developed than spoken (expressive) language until the child is about 4. Preschool children will use and repeat new words, even when they do not fully understand their meaning. They also creatively make up words, with some amusing results.

Most preschool children talk nonstop. They enjoy using language to communicate with others and often talk just to talk. They are intrusive and will try to involve themselves in other people's conversations. It is also common for them to talk to themselves. They are adept at asking questions, particularly "Why?" They are not always interested in the answer. They often ask why just to keep the conversation going.

*Hilary, age 3½, ran to answer a knock at the door. Two minutes later she was back. Her father asked who it was, and Hilary answered, "It was a peep. But he's gone now." "A what?" asked her father. "A peep. But he went away." It was only after careful thought that her father realized "a peep" was Hilary's singular form of the word "people"—or "one peep" vs. "many people."*

Parents can promote their children's language development through conversation and reading. A parent can learn to direct comments and questions to their child throughout the day and engage them in conversation. Parents who cannot read can be encouraged to look through a magazine or book with the child, talk about the pictures, or make up stories. Fifteen to 20 minutes of concentrated conversation each day can greatly promote the child's language development.

### **Cultural Note on Language**

The development of language ability is universal. The nature of the language, the specific meanings of words, and rules for when and how people talk with one another are culturally determined. When assessing a child's language development, the assessment must be made within the child's cultural context. It is important not to confuse language delays or speech deficits with language or speech differences.

Words may have idiosyncratic meanings within cultures or subcultures, and the rules of grammar and syntax may not be the same as in Standard English. If a 4-year-old's language is not understandable, and if words are not used in context, the child may have speech and language delays. However, it should not automatically be assumed that this is the case. It may be that the worker is unfamiliar with the use of language in the family and the child's communication skills are appropriate within that cultural context.

Some cultures discourage children from approaching adults to begin conversations. These children are taught to remain silent in the presence of adults. The worker may need to observe the child in situations in which talking is encouraged, such as when playing with other children, to determine the child's language ability. Additional information may also need to be gathered from collateral sources.

### **Egocentric Thought**

Between ages 3 and 5, the way children think about the world is also changing. Preschool-age children have a thought process that is often referred to as egocentric. Egocentrism describes the nature of their thought processes and does not mean that they are selfish or thoughtless, per se. Their universe is circumscribed, with themselves, their family, and their homes at the center. The scope of their awareness and understanding is limited to their immediate experience. They view the world *only* from this perspective.

*Four-year-old Tara was explaining to her Dad where the sun went at night. She pointed toward the horizon and said, "Over there, just behind those trees. That's where the sun goes at night." When asked how it got to the other side of the sky, and where it came up in the morning, she replied, "That's easy, silly. You know the sun's hot, right?" "Right," said Dad. "Well, when the sun gets to the ground behind the trees, it burns a hole in the ground and goes under my house, and comes up on the other side."*

Preschool children do not realize that other people have perspectives that might be different from theirs. They view everything through their own eyes, and as a result, believe that their experiences are universal.

*Mike, age 4, could see that his Mom was upset because she was crying. He gave her his teddy bear to make her feel better.*

They also think that everyone has the same information they do. When they describe an event, preschoolers often leave out important and obvious facts. They assume that everyone already knows the details.

Egocentricity does not mean that preschool children are oblivious to other people's feelings. Even infants and toddlers become upset when other children cry. This is a precursor of empathy. Preschoolers often recognize visual cues of emotional states, and sometimes they can label them properly (mad, upset, happy, sad). They are, however, largely unaware of many feelings that generate visible behaviors in others.

*Kelli, at age 3½, was watching her aunt come up the front sidewalk. Aunt J. had just ended a long, tiring day and was probably frowning as she approached the door. Kelli greeted her at the door with a concerned question, "Aunt J., why is your face mad?"*

### **Animism**

Preschool-age children also attribute human characteristics to inanimate objects and animals. This is sometimes referred to as animism.

*Three-year-old Kristin put a doll blanket over a chicken that her mother was thawing out for dinner. When asked why, she said, "Because the chicken was cold, and I wanted to make it warm."*

*Leigh, age 4, had been very attached to a blanket since infancy. Leigh's Mom had to launder the blanket when Leigh was asleep, because Leigh was convinced that the blanket would drown in the washer and would get dizzy in the drier.*

*Sarah told her mother the wind was blowing because it was happy, and the flower opened its petals because it was getting a suntan.*

### **Illogical and Magical Thinking**

Preschool children have thought patterns, which may appear illogical because they draw conclusions from limited information. They have limited understanding of cause and effect. Usually, they derive their conclusions from *their* understanding of the world. If two events are linked sequentially, or two attributes of an object coexist, one is often thought to have caused the other.

While preschool children's reasoning may be faulty by adult standards, their conclusions make perfect sense to them, and they will stubbornly cling to them when presented with more complicated and more rational explanations. For example, it is not unusual for preschoolers to be afraid of being flushed down the toilet. In their experience, everything that gets thrown in the toilet disappears, never to be seen again. They cannot be talked out of their fear.

Likewise, they do not understand the abstract concept of value. A child may say, "Two pennies are better than a dime!" Preschool children consider attributes of the coins in concrete terms they can understand: size and number.

It is often difficult for preschool-age children to differentiate between fact and fantasy. Their imaginations are vivid and often display magical thinking. In describing an experience, the child will often embellish. This embellishment is not lying, but is how they use their imagination to explain the world. For example:

*Mikey, age 4, went to the circus and saw horses in the center ring jump over low hurdles. When he later told his dad about the circus, he described the “beautiful horses that were flying in the air all around the circus tent.”*

This should not be considered lying. It is imagination. The use of their imagination can also lead to the creation of fears when there is difficulty separating fact from fantasy.

*At age 4, Leigh fell and knocked out a front tooth. Mom told her to put the tooth under her pillow and the tooth fairy would come and bring her money. Leigh became hysterical, thinking a stranger would be sneaking into her bedroom in the middle of the night.*

*Kelli woke up crying in the middle of the night. “There’s something very strange going on here,” she told her dad. “There’s a doggy with something in his hair.” Dad found a doll in a chair casting a shadow on the wall. Turning on the light and explaining that it was only the doll’s shadow did nothing to calm Kelli’s fear. The doll had to be moved before Kelli was assured that she was safe.*

### **Inability to Sequence Events in Order**

Preschoolers also have difficulty relating events or ideas in their proper sequence. They do not have a well-developed understanding of time, particularly of long time periods. They may understand today, but yesterday and tomorrow are harder, and next week is incomprehensible. They confuse first, middle, and last, and cannot order events sequentially in time.

### **Sexual Development**

A question that often comes up around young children and their sexual development is, “What is normal for their age?” Preschool-age children often demonstrate a wide range of sexual behaviors that can include:

- ❑ Masturbation
- ❑ Sexual play with others—although play is usually with *same age* child
- ❑ Sexual talk
- ❑ A wide variety of sexual questions.

The behaviors of preschool-age children are culturally influenced. Most of their behaviors are driven by *curiosity*, and are done voluntarily. The behaviors can be hindered, shaped, or fully explored depending on the culture within the child’s family (Friedreich, 1998). Some family cultures will expect the behavior to stop while others will suggest the child engage in sexualized behaviors in private. Other cultures will

encourage activities such as masturbation as a way of helping the children calm themselves when they are anxious or worried about something. Whatever the direction, children at this age are very accepting of adult intervention.

Friedreich (1998) surveyed sexual behaviors of children and found that children exhibit a broad range of sexual behaviors. The most frequently reported behaviors were self-stimulating behaviors, exhibitionism, and behaviors related to personal boundaries. Intrusive sexual behaviors such as those involving direct sexual contact, oral/genital contact, or masturbation with objects were significantly less frequent. It is recommended that children exhibiting the more rare and intrusive sexualized behaviors receive further assessment.

The frequency of sexual behavior varied with age, increasing with age until age 5 for both boys and girls, and then becoming steadily less frequent until age 12.

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## ***Jazmine (Case Scenario)***

Read the following vignette with your table group. Discuss the questions below. Summarize your discussion with the larger group.

### ***Jazmine's Story***

You are the social worker for Jazmine, a 4-year-old Latina girl. She entered foster care 2 months ago following her mother's arrest. Her father's whereabouts is unknown and she has no other family in the area. Jazmine's mother, Marisol, moved here from out of state two years ago with Jazmine and Jazmine's father. Marisol has a criminal history involving petty theft and drug possession. She identifies herself as having a substance abuse problem.

Jazmine has been doing well in her foster home. She is passive and obedient. She is on track in her motor development. She is potty trained and can feed and dress herself. Jazmine speaks English, but her speech is delayed in that she only uses short phrases and is very difficult to understand. Jazmine has minimal interaction with other children. Her play is focused on interacting with toys and she does not seek out interaction with other children other than taking toys from them.

Upon her release from jail after 6 weeks, Marisol entered an in-patient substance abuse treatment program. Now stable in the program and testing clean, Marisol would like to have Jazmine join her in the program.

Marisol was unable to visit with Jazmine during the first six weeks in foster care due to the regulations of the jail. Since her release, she has had 2 supervised visits with Jazmine at the treatment program. The visits have been difficult for Jazmine and Marisol. They appear unsure how to interact in the artificial setting of the supervised visit. They start a lot of activities together, but Marisol is unable to sustain an interaction with Jazmine.

You decide to plan an activity for the next visit to encourage engagement between Marisol and Jazmine.

### ***Discussion Questions***

1. What do you do before the visit to help with your planning?
2. What kind of changes would you make to the timing and setting for the visit?
3. What kinds of suggestions would you make Marisol to help her engage with Jazmine?

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### ***The Experience of Grief, Loss, and Death for Children***

In the past, children were thought to be miniature adults and were expected to behave as adults. It is now understood that there are differences in the ways in which children and adults mourn.

Unlike adults, bereaved children do not experience continual and intense emotional and behavioral grief reactions. Children may seem to show grief only occasionally and briefly, but in reality a child's grief usually lasts longer than that of an adult. Mourning in children may need to be addressed again and again as the child gets older. As the child grows, he or she will think about the loss repeatedly, especially during important times in his or her life, such as going to camp, graduating from school, getting married, or giving birth to his or her own children. This longer period of grief is due to the fact that the child's ability to experience intense emotions is limited.

A child's grief may be influenced by his or her:

- age
- personality
- stage of development
- earlier experiences with death
- relationship with the lost person
- surroundings
- cause of death or separation
- family members' ability to communicate with one another and to continue as a family after the loss

The child's ongoing need for care, the child's opportunity to share his or her feelings and memories, the parent's ability to cope with stress, and the child's steady relationships with other adults are also other factors that may influence grief.

### ***Presentation and Experience of Grief and Loss in Children***

Some indicators and characteristics of grief and loss of preschool children are listed below. This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

- Grieving children under age 5 may have trouble eating, sleeping, and controlling bladder and bowel functions.
  
- At this age children see death as a kind of sleep that the person is alive, but only in a limited way. The child cannot fully separate death from life. Children

- may think that the person is still living, even though he or she might have been buried. Children of this age may ask questions about the deceased (for example, how does the deceased eat, go to the toilet, breathe, or play?).
- Young children know that death occurs physically, but think it is temporary, reversible, and not final.
  - The child’s concept of death may involve magical thinking and fantasy to explain how the loss occurred. For example, the child may think that his or her thoughts can cause another person to become sick or die, incorrectly assuming responsibility for the loss of the loved one.
  - The child uses language to communicate but has a limited vocabulary and does not understand complex words or concepts. The child may stop talking and appear to feel overall distress.
  - Children’s response to grief is affected by their relationships with the adults around them.
  - The preschool child is likely to have an inaccurate and distorted perception of the placement experience. Due to an immature conception of time, any placement of more than a few weeks is experienced as permanent. Without frequent contact with the parents, the child may assume that the parents are gone and are not coming back.
  - Due to egocentric thinking at this age, the preschool child may view separation and placement as punishment for bad behavior. Such thinking can increase anxiety.

### ***Helping Preschool Children to Grieve***

- Children need simple, honest explanations.
- Take full advantage of opportunities such as the death of a pet to teach preschool children about death.
- Assist in identifying and expressing their feelings. Angry thoughts and feelings can’t cause people to die.
- Respect the family’s religious beliefs.
- Avoid common mistakes in talking to children, e.g., “Mommy or Daddy has gone to sleep.”
- Clarify misconceptions that a child may have, such as sickness or going to the hospital always results in death.
- Children often benefit by participation in the funeral.
- Use metaphors and story-telling.
- Play and play therapy can assist a child to process grief.
- Model defenses.

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## ***Developmental Delays and Disorders of Childhood***

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment. According to the California State definition, which is also in line with the national view, the disability must begin before the 18th birthday, be expected to continue indefinitely and present a substantial disability. Also, the disability must be due to one of the following conditions:

- Intellectual delay
- Cerebral palsy
- Epilepsy
- Autism
- A disabling condition closely related to intellectual delay or requiring similar treatment

### ***Disability or delay within a cultural perspective***

Families of children of diverse cultures (and languages) may not identify a certain series of behaviors or symptoms as being descriptive of a delay or disability. Research indicates that many culturally diverse parents explain their child's condition as a combination of biomedical issues and sociocultural or folk beliefs. Families often see their child's condition as temporary or something that can be remedied. Therefore, it is not uncommon to see families following a combination of professional/medical prescriptions along with home remedies, folk, or alternative practices in order to help their child. It should be noted that families vary in how much weight they ascribe to professional, educational, or medical interventions as compared to alternative interventions.

Because families have different interpretations of what constitutes a delay or disability, even having their child labeled can lead to misunderstandings and mistrust between them and the professionals who are attempting to be helpful. For example, if everybody else in the family had followed similar developmental patterns, what would the label developmentally delayed given to the youngest child say about the rest of the family? If the child functions well in the life of the home and community and the concern only exists in the clinic, school, or agency, is the child truly delayed?

Instruction for children with developmental delays should reflect the goals identified and mutually agreed upon by the providers, educators, specialists, and, of course, the family. The learning objectives should include the child's strengths as the foundation. They should be aimed at bridging the gap between what the child is currently able to do in his or her environment and what he or she needs to learn to do in order to be optimally successful in the current or upcoming environments. For instructional

strategies and materials, professionals and families are encouraged to implement multicultural practices which honor and respect every child's culture and language.

### **Factors connected with the potential for abuse**

The literature presents contradictory findings regarding risk of abuse for children with developmental disabilities. They are at least as likely to be abused and neglected as the general population. There is some data to suggest that children with developmental disabilities have a higher risk of abuse. There are many reasons why children with disabilities may be more likely to be maltreated and less likely to disclose abuse.

#### *Limited communication abilities interfere with child/caregiver bonding:*

- Inability to use language to express self and/or respond to others
- Inability to produce strong, clear nonverbal signals as an infant and young child
- Inability to express needs clearly such as discomfort or hunger that may lead to caregiver frustration or feelings of inadequacy
- Inability or impaired ability to report maltreatment

#### *Judgment*

- Inability to distinguish appropriate from inappropriate treatment or behavior
- Inability to protect oneself, to tell when an environment is safe and when it isn't

#### *Social*

- Behavioral issues related to the disability which can increase the probability of maltreatment; for example, excessive crying, difficulty accepting comfort when upset, hyperactive, unmanageable or self-abusive, immobile, or unable to run away
- Require more extensive caretaking than typical children
- Decreased attractiveness
- Lack of awareness of increased unattractiveness, which may draw unwarranted attention
- Easier to ignore or neglect, such as a child who cannot see or hear
- Socialized to trust and obey adults
- Fear of physical abandonment as well as emotional abandonment

#### *Education*

- Lack of safety education
- Lack of social skills training
- Lack of sex education

#### **Discrimination**

- Less likely to be believed
- Less valued when believed

- Less able to negotiate the court system

### ***The Effect of Disability on the Presentation of Abuse<sup>3</sup>***

Many times, the developmental disability will affect the presentation of the abuse. Some of the reasons are:

- More difficult to see the typical signs and symptoms of maltreatment.
- Only indication may be a sudden change in behavior, which may only be detectable by people who know the child well.

Physical presentations of signs and symptoms of abuse must be very carefully evaluated and investigated. For example, children with cerebral palsy really do fall down a lot. Some children with disabling conditions show bruises much more easily to very slight stimuli. Thus bruising may not indicate physical abuse. On the other hand, in cases of sexual abuse, physical or medical evidence may be the only clear indication that abuse has occurred.

### ***Nonverbal children***

Traditional casework methods imply that clients will be able to communicate their experiences to another. This is usually a combination of verbal and nonverbal communication with the language of play included for young children. Traditional interviewing methods may not be appropriate for children with developmental disabilities who have limited or unusual use of verbal language, weak or idiosyncratic nonverbal cues, and/or atypical play. As one caseworker asked, “How do you interview a child who cannot talk?” The answer is you don’t interview that child using traditional methods.

Children who have limited or unusual uses of language represent a special challenge for child welfare caseworkers. In such cases, caseworkers will have to rely on:

- Information from as many people as possible who are regularly involved in the child’s life, and
- Consultation from an interdisciplinary team, including a physician with considerable experience in working with children with disabilities.



### ***Intellectual delay***

Intellectual delay is characterized by significantly sub-average general intellectual functioning (i.e., an IQ of approximately 70 or below) with concurrent deficits or impairments in adaptive functioning such as communication, self-care, and getting along in social situations and school activities. Intellectual delay is sometimes

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<sup>3</sup> Reproduced from: Cruz, V. *Working with Families with Children/Parents with Developmental Disabilities*, Metropolitan State College of Denver, date unknown.

referred to as a cognitive or intellectual disability. Intellectual delay is the most common developmental disability.

Children with intellectual delay can and do learn new skills, but they develop more slowly than children with average intelligence and adaptive skills. There are different degrees of intellectual delay, ranging from mild to profound. A person's level of intellectual delay can be defined by their intelligence quotient (IQ), or by the types and amount of support they need.

### **Degrees of Severity**

Mild intellectual delay Prevalence: about 85% of individuals with intellectual delay	IQ	55–69
Moderate intellectual delay Prevalence: about 10% of individuals with intellectual delay	IQ	40–54
Severe intellectual delay Prevalence: about 3-4% of individuals with intellectual delay	IQ	25–39
Profound intellectual delay Prevalence: about 1-2% of individuals with intellectual delay	IQ	24 or below

### **Causes of intellectual delay**

Intellectual delay can start any time before a child reaches age 18. It can be caused by injury, disease, or a brain abnormality. These causes can happen before a child is born or during childhood. For many children, the cause of their intellectual delay is not known. Some of the most common known causes of intellectual delay are Down Syndrome, Fetal Alcohol Syndrome, and Fragile X Syndrome, all of which occur before birth. Other causes that take place before a child is born include genetic conditions (such as Cri-du-chat Syndrome or Prader-Willi Syndrome), infections (such as congenital cytomegalovirus), or birth defects that affect the brain (such as hydrocephalus or cortical atrophy). Other causes of intellectual delay (such as asphyxia) happen while a baby is being born or soon after birth. Still other causes of intellectual delay do not happen until a child is older. These may include serious head injury, stroke, or certain infections such as meningitis.

#### **Genetic conditions**

More than 500 genetic diseases are associated with intellectual delay. These conditions can result from abnormality of genes inherited from parents, errors when genes combine or from other disorders of the genes caused during pregnancy by infections, overexposure to X-rays, and other factors. One example is PKU (phenylketonuria), a single gene disorder also referred to as an inborn error of metabolism because it is caused by a defective enzyme. Fragile X Syndrome is another single gene disorder located on the X chromosome and is

the leading inherited cause of intellectual delay. Down Syndrome is an example of a chromosomal disorder. Chromosomal disorders happen sporadically and are caused by too many or too few chromosomes or by a change in structure of a chromosome.

#### Problems during pregnancy

Use of alcohol or drugs by the pregnant mother can cause intellectual delay. Recent research has implicated smoking in increasing the risk of intellectual delay. Other risks include malnutrition, certain environmental contaminants, and illnesses of the mother during pregnancy, such as toxoplasmosis, cytomegalovirus, rubella and syphilis. Pregnant women who are infected with HIV may pass the virus to their child, leading to future neurological damage.

#### Problems at birth

Although any birth condition of unusual stress may injure the infant's brain, prematurity and low birth weight predict serious problems more often than any other conditions.

#### Problems after birth

Childhood diseases, such as whooping cough, chicken pox, measles, and HIV disease, which may lead to meningitis and encephalitis, can damage the brain as can accidents, such as a blow to the head or near drowning. Lead, mercury, and other environmental toxins can cause irreparable damage to the brain and nervous system.

#### Poverty and cultural deprivation

Children in poor families may become intellectually delayed because of malnutrition, disease-producing conditions, inadequate medical care, and environmental health hazards. Also, children in disadvantaged areas may be deprived of many common cultural and day-to-day experiences provided to other youngsters. Research suggests that such under-stimulation can result in irreversible damage and can serve as a cause of intellectual delay.

People with intellectual delay may have other disabilities as well. Examples of these coexisting conditions include cerebral palsy, seizure disorders, vision impairment, hearing loss, and attention-deficit/hyperactivity disorder (ADHD). Children with severe intellectual delay are more likely to have additional disabilities than are children with mild intellectual delay.

### **Cerebral Palsy**

Cerebral Palsy (CP) affects 2 out of every 1000 children born in the US each year. Usually caused by brain injury just before, during or immediately following birth, CP can affect muscle control resulting in fine and gross motor disability as well as

difficulty with speech. CP can also be caused by brain trauma from accidental or non-accidental injury (United Cerebral Palsy).

### ***Down Syndrome***

People with Down Syndrome have recognizable physical characteristics and limited intellectual endowment, which are due to the presence of an extra chromosome. The estimated incidence of Down Syndrome is between 1 in 1,000 to 1 in 1,100 live births. Each year approximately 3,000 to 5,000 children are born with this chromosome disorder.

### ***Causes of Down Syndrome***

Although many theories have been developed, it is not known what actually causes Down Syndrome. Some professionals believe that hormonal abnormalities, X-rays, viral infections, immunologic problems, or genetic predisposition may be the cause of the improper cell division resulting in Down Syndrome.

The risk of having a child with Down Syndrome increases with the advancing age of the mother; i.e., the older the mother, the greater the possibility that she may have a child with Down Syndrome. However, most babies with Down Syndrome (more than 85%) are born to mothers younger than age 35. Some investigators reported that older fathers may also be at an increased risk of having a child with Down Syndrome. It is well known that the extra chromosome could either originate in the mother or the father. Most often, however, the extra chromosome is coming from the mother.

### ***Development in Children with Down Syndrome***

Children with Down Syndrome are usually smaller, and their physical and mental developments are slower than other youngsters. There is a wide variation in mental abilities and developmental progress in children with Down Syndrome. The majority of children with Down Syndrome function in the mild to moderate range of intellectual delay. However, some children are not intellectually delayed at all, and others may be severely intellectually delayed.

Their motor development is slow. Instead of walking by 12 to 14 months as other children do, children with Down Syndrome usually learn to walk between 15 to 36 months. Language development is also markedly delayed. It is important to note that a caring and enriching home environment, early intervention, and integrated education efforts can have a positive influence on the child's development.

### ***Physical Features of Children with Down Syndrome***

Although individuals with Down Syndrome have distinct physical characteristics, generally they are more similar to the average person in the community than they are different. Not every child with Down Syndrome will have all the physical characteristics. Some children may only have a few, while others may show most of

the signs of Down Syndrome. Some of the physical features in children with Down Syndrome include:

- Flattening of the back of the head
- An upward angle of the eyelids
- Small skin folds at the inner corner of the eyes
- Depressed nasal bridge
- Slightly smaller ears
- Small mouth, hands and feet
- Gap between the first and second toes
- Decreased muscle tone
- Loose ligaments
- Approximately 50% of all children with Down Syndrome have one line across the palm

The physical features are important to the physician in making the clinical diagnosis, but no emphasis should be given to the characteristics otherwise. The physical features observed in children with Down Syndrome (and there are many more than described above) usually do not cause any disability in the child.

### ***Health Concerns People with Down Syndrome***

#### Hearing deficits

60 to 80% of children with Down Syndrome have hearing deficits. Therefore, audiologic assessments at an early age and follow-up hearing tests are indicated. If there is significant hearing loss, the child should be seen by an ear, nose and throat specialist.

#### Congenital heart disease

40 to 45% of children with Down Syndrome have congenital heart disease. Many of these children will have to undergo cardiac surgery and often will need long-term care by a pediatric cardiologist.

#### Intestinal abnormalities

Intestinal abnormalities also occur at a higher frequency in children with Down Syndrome. For example, a blockage of the food pipe (esophagus), small bowel (duodenum), or anus are not uncommon in infants with Down Syndrome. These may need to be surgically corrected immediately in order to have a normal functioning intestinal tract.

#### Eye problems

Children with Down Syndrome often have more eye problems than other children who do not have this chromosome disorder. For example, 3% of infants with Down Syndrome have cataracts. Other eye problems, such as cross-eye (strabismus), near-sightedness, far-sightedness, and other eye conditions, are frequently observed in children with Down Syndrome.

### Nutritional problems

Some children with Down Syndrome, in particular those with severe heart disease, often fail to thrive in infancy. On the other hand, obesity is often noted during adolescence and early adulthood. These conditions can be prevented by providing appropriate nutritional counseling and anticipatory dietary guidance.

### Thyroid dysfunctions

Between 15-20% of children with Down Syndrome have hypothyroidism. It is important to identify individuals with Down Syndrome who have thyroid disorders since hypothyroidism may compromise normal central nervous system functioning.

### Skeletal problems

Skeletal problems have also been noted at a higher frequency in children with Down Syndrome including kneecap subluxation (incomplete or partial dislocation), hip dislocation, and atlantoaxial instability. The latter condition occurs when the first two neck bones are not well aligned because of the presence of loose ligaments. Approximately 15% of people with Down Syndrome have atlantoaxial instability. Most of these individuals, however, do not have any symptoms, and only 1-2% of individuals with Down Syndrome have a serious neck problem that requires surgical intervention.

### Other concerns that may require specialists:

- Immunologic dysfunction
- Leukemia
- Alzheimer disease
- Seizure disorders
- Sleep apnea and
- Skin disorders

### ***Pervasive Developmental Disorders/Autistic Spectrum Disorders***

Autistic spectrum disorders (ASDs) are a group of developmental disabilities that are related to brain function. People with ASDs tend to have difficulties with common culturally agreed upon social and communication skills. They also are likely to repeat certain behaviors and to not want change in their daily activities. Many people with ASDs also have unusual ways of learning, paying attention, or reacting to different sensations. ASDs begin during childhood and last throughout a person's life.

Experts have not identified a cause for autism and there is ongoing debate on the subject. While some people believe Autism is related to substances in vaccinations, the Centers for Disease Control and Prevention conclude that there is not a causal link between vaccinations and autism. Recent research (Losh et al, 2009) links autism to autism susceptibility genes and differences in neuroanatomical structures.

ASDs include autistic disorder, pervasive developmental disorder–not otherwise specified (PDD-NOS, including atypical autism), and Asperger’s disorder. These three conditions all have some of the same symptoms, but they differ in terms of when the symptoms start, how fast they appear, how severe they are, and their exact nature. These three conditions, along with Rhett Syndrome and childhood disintegrative disorder, make up the broad diagnosis category of pervasive developmental disorders.

### ***Pervasive Developmental Disorders***

Pervasive developmental disorders are characterized by a broad-based impairment or loss of the functions that would be expected for a child's age. These include three components:

- Impairment in social interactions;
- Impairment in communication; and
- Appearance of restricted, repetitive, and stereotyped patterns of behavior, interests and activities.

### ***Autistic disorders***

As the name Autistic Spectrum Disorder indicates, ASD covers a wide range of behaviors and abilities. No two people with an ASD will have the same symptoms. A symptom might be mild in one person and severe in another person. Some examples of the types of problems and behaviors a child or adult with an ASD might have are:

#### **Social skills**

People with ASD might not interact with others the way most people do, or they might not be interested in other people at all. People with ASD might not make eye contact and might just want to be alone. They might have trouble understanding other people’s feelings or talking about their own feelings. People with ASD might feel uncomfortable being held or cuddled. Some people with ASD might not seem to notice when other people try to talk to them. Others might be very interested in people, but not know how to talk, play, or relate to them. People with ASD tend to have difficulty interpreting facial expressions, and as such, can find common communication standards confusing. It is important to note that people with ASD are all different and one cannot assume likes and dislikes without actually learning about individual preferences. Some people with ASD like to have physical contact and seek out interpersonal interactions.

#### **Speech, language, and communication**

About 40% of children with ASDs do not talk at all. Others have echolalia, which consists in repeating back something that was said to them. The repeated words might be said right away or at a later time. For example, if you ask someone with an ASD, “Do you want some juice?” he or she will repeat “Do you want some juice?” instead of answering your question. Or a person might repeat a television

ad heard sometime in the past. People with ASDs might not understand gestures such as waving goodbye. They might say “I” when they mean “you”, or vice versa. Their voices might sound flat and it might seem like they cannot control how loudly or softly they talk. People with ASDs might stand too close to the people they are talking to, or might stick with one topic of conversation for too long. Some people with ASDs can speak well and know a lot of words, but have a hard time listening to what other people say. They might talk a lot about something they really like, rather than have a back-and-forth conversation with someone.

### **Repeated behaviors and routines**

People with ASDs might repeat actions over and over again. They might want to have routines where things stay the same so they know what to expect. They might have trouble if family routines change. For example, if a child is used to washing his or her face before dressing for bed, he or she might become very upset if asked to change the order and dress first and then wash.

Children with ASDs develop differently from other children. Children without ASDs develop at about the same rate in areas of development such as motor, language, cognitive, and social skills. Children with ASDs develop at different rates in different areas of growth. They might have large delays in language, social, and cognitive skills, while their motor skills might be about the same as other children their age. They might be adept at things like putting puzzles together or solving computer problems, but not skillful at some things most people think are easy, like talking or making friends. Children with ASDs might also learn a hard skill before they learn an easy one. For example, a child might be able to read long words, but not be able to tell you what sound a “b” makes. A child might also learn a skill and then lose it. For example, a child may be able to say many words, but later stop talking altogether.

### ***Asperger’s Disorder***

Fulfills Criteria A and B below, but lacks any clinically significant delay in language or cognitive development.

- A. Qualitative impairment in social interaction, as manifested by at least two of the following:
  - Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
  - Failure to develop peer relationships appropriate to developmental level
  - A lack of spontaneous seeking to share enjoyment, interests or achievements with other people
  - Lack of social or emotional reciprocity

- B. Restricted, repetitive, and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:
- Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  - Apparently inflexible adherence to specific, nonfunctional routines or rituals
  - Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
  - Persistent preoccupation with parts of objects

### ***Childhood Disintegrative Disorder***

Children with Childhood Disintegrative Disorder display normal development for the first 2 years followed by a significant loss of language, social skills, bowel or bladder control, play or motor skills. They also have abnormalities of functioning in two of the following: social interaction; communication; and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities such as those described in the criteria for Autistic Disorder.

Note: Due to the similarity of behaviors associated with Autism and other PDDs, use of the term pervasive developmental disorder has caused some confusion among parents and professionals. While distinguishing these groups may be helpful in research and in determining causation, at this point, the treatment and educational needs are similar for all of these diagnoses.

### ***Implications for Practice & Resources***

There is a growing autism rights movement (advocated by people with ASD and their supporters) that is based on the premise that autistic spectrum disorders result from neurological differences in humans, and are not the result of neurological abnormalities or damage. When working with children and families where ASDs might be an issue, it is advisable to first determine both the child's and family's perspectives on ASDs in order to provide the most salient and supportive services possible. A resource for further information is [www.autistics.org](http://www.autistics.org).

An online video, "In My Language" (8:36), artistically communicates the inner sensory and cognitive experience of the world of a person with autistic spectrum disorder, making a statement about personhood and human rights. It is available for viewing at:

<http://video.google.com/videoplay?docid=4998359028958016786&pr=goog-sl>

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### Information About Regional Centers

The Department of Developmental Services is responsible for designing and coordinating a wide array of services for California residents with developmental disabilities. These services are provided through a statewide system of 21 locally-based regional centers. Regional centers are nonprofit private corporations that have offices throughout California to provide a local resource to help find and access the many services available to individuals with developmental disabilities and their families. Both geographic accessibility and population density were considered when selecting locations for the 21 regional centers. The catchment area boundaries for the regional centers conform to county boundaries or groups of counties, except in Los Angeles County, which is divided into seven areas, each served by a regional center.

### Services Provided by Regional Centers

Regional centers provide or coordinate the following services for individuals with developmental disabilities and their families:

- Information and referral
- Assessment and diagnosis
- Counseling
- Lifelong individualized planning and service coordination
- Purchase of necessary services included in the individual program plan
- Assistance in finding and using community and other resources
- Advocacy for the protection of legal, civil and service rights
- Early intervention services for at risk infants and their families
- Genetic counseling
- Family support
- Planning, placement, and monitoring for 24-hour out-of-home care
- Training and educational opportunities for individuals and families
- Community education about developmental disabilities

### What Do Regional Center Services Cost?

There is no charge for diagnosis and assessment for eligibility. Once eligibility is determined, most services are free regardless of age or income. There is a requirement for parents to share the cost of 24-hour out-of-home placements for

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<sup>4</sup> Adapted from <http://www.cahf.org/public/dsc/regional.php> retrieved on April 10, 2009

children under age 18. This share depends on the parents' ability to pay. There may also be a co-payment requirement for other selected services.

Regional centers are required by law to provide services in the most cost-effective way possible. They must use all other resources, including generic resources, before using any regional center funds. A generic resource is a service provided by an agency which has a legal responsibility to provide services to the general public and receives public funds for providing those services. Some commonly used generic agencies are the local school district, county social services department, Medi-Cal, Social Security Administration, Department of Rehabilitation and others. Other resources may include natural supports. This is help that people get from family, friends or others at little or no cost.

### **What Can the Regional Center Do?**

Regional centers provide case management or service coordination. A case manager or service coordinator is assigned to help eligible individuals through development of a plan for services, service referrals and assistance accessing services.

### **What Services Will Be Provided?**

The regional center uses a planning process called an Individual Program Plan (IPP). For children age 0 to 36 months this process is called the Individual Family Service Plan (IFSP). The plan is prepared by regional center staff and the individual or the parents of a minor child, a guardian or conservator (if any), or anyone else the individual invites to participate.

The IPP (or IFSP) lists goals and the services needed to reach those goals. It lists who will provide the service and who will pay for it. All services listed in the IPP or IFSP will be provided either by a generic or natural resource, a regional center vendor (a business approved by the regional center) or directly by the regional center.

### **Where Can I Get More Information?**

To obtain more information about services available for individuals with developmental disabilities, contact your local regional center. [To find the Regional Center that serves your county, go to the California DDS website's Directory of Regional Centers at <http://www.dds.ca.gov/RegCtrs/main/rclist.cfm>.]

### **List of California Regional Centers**

- [Alta California Regional Center](#)
- [Central Valley Regional Center](#)
- [Regional Center of the East Bay](#)

- Eastern Los Angeles Regional Center
- Frank D. Lanterman Regional Center
- Far Northern Regional Center
- Golden Gate Regional Center
- Harbor Regional Center
- Inland Regional Center
- Kern Regional Center
- North Bay Regional Center
- North Los Angeles County Regional Center
- Regional Center of Orange County
- Redwood Coast Regional Center
- San Andreas Regional Center
- South Central Los Angeles Regional Center
- San Diego Regional Center
- San Gabriel/Pomona Regional Center
- Tri-Counties Regional Center
- Valley Mountain Regional Center
- Westside Regional Center

**Visit California DDS on the World Wide Web at**  
**<http://www.dds.cahwnet.gov/index.cfm>.**

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## **The Effects of Abuse and Neglect on Preschool Children<sup>5</sup>**

### **Social**

- The child may demonstrate insecure or absent attachment; attachments may be indiscriminate, superficial, or clingy. Child may show little distress, or may overreact, when separated from caregivers.
- The child may appear emotionally detached, isolated, and withdrawn from both adults and peers.
- The child may demonstrate social immaturity in peer relationships; may be unable to enter into reciprocal play relationships; may be unable to take turns, share, or negotiate with peers; may be overly aggressive, bossy, and competitive with peers.
- The child may prefer solitary or parallel play, or may lack age-appropriate play skills with objects and materials. Imaginative and fantasy play may be absent. The child may demonstrate an absence of normal interest and curiosity, and may not actively explore and experiment.

### **Physical**

- They may be small in stature, and show delayed physical growth.
- They may be sickly and susceptible to frequent illness, particularly upper respiratory illness (colds, flu) and digestive upset.
- They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, awkward gait, lack of muscle strength.
- Gross motor play skills may be delayed or absent.

### **Emotional**

- The child may be excessively fearful, easily traumatized, may have night terrors, and may seem to expect danger.
- The child may show signs of poor self-esteem and a lack of confidence.
- The child may lack impulse control and have little ability to delay gratification. The child may react to frustration with tantrums and/or aggression.
- The child may have a bland, flat affect and be emotionally passive and detached.
- The child may show an absence of healthy initiative and often must be drawn into activities; may emotionally withdraw and avoid activities.
- The child may show signs of emotional disturbance, including anxiety, depression, emotional volatility, self-stimulating behaviors such as rocking, or head banging, enuresis or encopresis, or thumb sucking.

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<sup>5</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 495-496, Arlington, VA: CWLA.

### **Cognitive**

- Speech may be absent, delayed, or hard to understand. The preschooler whose receptive language far exceeds expressive language may have speech delays. Some children do not talk, even though they are able.
- The child may have poor articulation and pronunciation, incomplete formation of sentences, and incorrect use of words.
- Cognitive skills may be at a level of a younger child.
- The child may have an unusually short attention span, a lack of interest in objects, and an inability to concentrate.

### **Sexual**

- Maltreated preschoolers may exhibit sexualized play.
- Maltreated preschoolers may have detailed and inappropriate knowledge of sexual activity.
- Maltreated preschoolers may engage in excessive masturbation.

### **The Effect of Maltreatment on Brain Development**

#### Neglect

- Emotional: leads to problems with attachment (limbic region); lacks experience-based capabilities to feel remorse, to be empathetic or sympathetic. Decreases the ability of the cortical regions to control impulsivity.
- Cognitive: leads to a deprivation of experience that inhibits the organization of the cortex. The cortex grows in size, develops complexity, makes synaptic connections, and modifies as a function of the quality and quantity of sensory experiences.

The ability of the brain to develop a healthy cortical modulation ratio (contrast the ratios for normal development with the ratios in neglect) is impaired when key experiences are minimal or absent. The cortical modulation ratio is the relative power of the maturing and mature brain to modulate the more primitive, reactive, reflexive output of the brainstem and midbrain. During infancy and childhood, the lower, more primitive portions of the brain develop first and, over time, the output of these areas is shaped, modulated, modified in more mature fashion as the higher brain areas develop. Any disruption of development which either overdevelops the midbrain and brainstem or under-develops the limbic and cortical areas will result in an imbalance in the Cortical Modulation ratio, predisposing to aggressive and violent behavior. This results in poor control of impulsivity, persisting immature emotional and behavioral functioning.

#### Neglect and Trauma

The combination of lack of critical emotional experiences and persisting traumatic stress leads to a dramatic alteration in the brain's modulation and regulation capacity. This is characterized by an overdevelopment of brainstem/midbrain

neurophysiology and functions, i.e., anxiety, impulsivity, poor affect regulation, motor hyperactivity, and an underdevelopment of limbic and cortical neurophysiology and function, i.e., empathy, problem-solving skills (Perry, 1997).

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## Ways to Help Maltreated Children

*The following material, adapted from the work of Bruce Perry, M.D., is directed at parents and caregivers. However, social workers will find it useful to use as a reference to assist parents and caregivers to understand and nurture the children in their care, and to apply in their own interactions with children.*



Please note that social workers will assess behavioral indicators and will include mental health providers early as partners to ensure that children receive timely mental health assessment and intervention.

The social worker, service provider, caregiver and parents will work as a team to identify the best interventions for the child. As part of this team, parents and caregivers make all the difference in the lives of maltreated children. This section suggests some different ways to help.

### **Nurturance**

Children need to be held and rocked and cuddled. Be appropriately physical, caring, and loving to children with attachment problems. Be aware that for many maltreated children, touch in the past has been associated with pain, torture, or sexual abuse. In these cases, make sure you carefully monitor how they react—be attuned to their responses to your nurturing and act accordingly. In many ways, you are providing replacement experiences that should have taken place during their infancy—but you are doing this when their brains are harder to modify and change. Therefore, they will need even more bonding experiences to help develop attachments.

### **Understand behavior**

The more you can learn about attachment problems, bonding, normal development, and abnormal development, the better you will be able to develop useful behavioral and social interventions. Information about these problems can prevent you from misunderstanding a child's behaviors. When children hoard food, for example, it should not be viewed as stealing but as a common and predictable result of being deprived during early childhood. A punitive approach to this problem (and many others) will not help the child mature. Indeed, punishment may actually increase the child's sense of insecurity, distress, and need to hoard food. Many of the behaviors seen in children who have been maltreated are confusing and disturbing to caregivers.

### **Parent children based on emotional age**

Abused and neglected children will often be emotionally and socially delayed. When they are frustrated or fearful, they will regress further. For example, this means that, at any given moment, a 10-year-old child may, emotionally, be a 2-year-old. Despite

our wishes that they would act their age and our insistence they do so, they are not capable of that. These are the times that we must interact with them at their emotional level. If they are tearful, frustrated, overwhelmed (emotionally age 2), parent them as if they were that age. Use soothing non-verbal interactions. Hold them. Rock them. Sing quietly. Breathe deeply. This is not the time to use complex verbal explanations about the consequences of inappropriate behavior. It is also important to note that, while a child may show a delay in one area, he or she may be on target in others. As stated above, stay in tune with the child—meet her where she is.

***Be consistent, predictable, and repetitive***

Maltreated children with attachment problems are very sensitive to transitions, surprises, chaotic social situations, changes in schedule, and, in general, any new situation. Busy and unique social situations will overwhelm them, even when they are pleasant! Birthday parties, sleepovers, holidays, family trips, the start and end of the school year—all can be disorganizing. Because of this, any efforts that can be made to be consistent, predictable, and repetitive will be very important in making these children feel safe and secure. When they feel safe and secure, they can benefit from the nurturing, enriching emotional and social experiences you provide them. If they are anxious and fearful, they cannot benefit from your nurturing in the same ways.

***Model and teach appropriate social behaviors***

Many abused and neglected children do not know how to interact with other people. One of the best ways to teach them is to model this in your own behaviors and then narrate for the child what you are doing and why. Become a play-by-play announcer: “I am going to the sink to wash my hands before dinner because...” or “I take the soap and get soapy here and...” Children see, hear, and imitate.

In addition to modeling, you can coach maltreated children as they play with other children. Use a similar play-by-play approach: “Well, when you take that from someone they probably feel pretty upset. If you want them to have fun when you play this game...” Positive play with other children can help increase self-esteem and confidence. Over time, success with other children will make the child less socially awkward and aggressive.

One area in which children who have been maltreated may have problems is modulating appropriate physical contact. Some of these behaviors are noticeable, while some are almost imperceptible. They don’t know when to hug, when to pick their nose or touch their genitals, how close to stand, or when to establish or break eye contact. In these cases, it is important to gently guide without shaming or embarrassing the child.

Children with attachment problems will often initiate physical contact (e.g., hugs, holding hands, crawling into laps) with strangers. Adults often misinterpret this as

affectionate behavior. It is not. It is best understood as supplication behavior and it is socially inappropriate. How adults handle this inappropriate physical contact is very important. We should not refuse to hug the child and lecture them about appropriate behavior. We can gently guide the child toward ways to interact differently with grown-ups and other children (e.g., “Why don’t you sit over here?”). It is important to make these lessons clear, using as few words as possible. They do not have to be directive—rely on nonverbal cues. It is equally important to guide in a way that does not make the child feel bad or guilty.

### ***Listen and play***

One of the most enjoyable ways to help is just stop, sit, listen, and play. When you are quiet and interactive, you find that they will begin to show you and tell you about what is really inside them. Yet, as simple as this sounds, it is one of the most difficult things for adults to do—to stop, quit worrying about the time, using the right words, your next task, and relax into the moment with a child. Practice this. You will be amazed at the results. Children will sense that you are there just for them—they will feel how you care.

It is during these quiet moments that you can best reach and coach children. This is a great time to begin teaching children about their different feelings. Regardless of the activity, the following principles are important to include:

1. Tell the child all feelings are okay to feel: sad, glad, or mad (more emotions for older children).
2. Teach the child healthy ways to act when sad, glad, or mad.
3. Begin to explore how other people may feel and how they show their feelings, e.g., “How do you think Bobby feels when you push him?”
4. When you sense that the child is clearly happy, sad, or mad, ask him how he is feeling; let him tell you.
5. Help the child begin to put words and labels to feelings; help him or her prepare alternate, healthy ways to respond to these feelings.
6. Have realistic expectations.

Abused and neglected children have so much to overcome. For some, they will not overcome all of their problems. For a Romanian orphan adopted at age five, after spending her early years without any emotional nurturing, the expectations should be limited. She was robbed of some, but not all, of her potential. We do not know how to predict potential in a vacuum, but we do know how to measure the emotional, behavioral, social and physical strengths and weaknesses of a child. A comprehensive evaluation by skilled clinicians can be very helpful in beginning to define the skill areas of a child and the areas where progress will be slower.

Be patient with the child’s progress and with yourself. Progress will be slow and can be frustrating. Many adoptive parents will feel inadequate because all of the love, time, and effort they offer their child may not seem to be having any effect. It does.

Don't be hard on yourself. Many loving, skilled, and competent parents have been swamped by the needs of a neglected and abused child that they have taken in.

Take advantage of other resources. Many communities have support groups for adoptive or foster families. Professionals with experience in attachment problems or maltreated children can be very helpful. You will need help. Remember, the earlier and more focused and structured the interventions, the better. Children are most malleable early in life and as they get older change is more difficult.

***Take care of yourself***

Caring for maltreated children can be exhausting and demoralizing. You cannot provide the consistent, predictable, enriching, and nurturing care children need if you are depleted. Make sure you get rest and support. Respite care can be crucial. Enlist help from friends, family and community resources. You will not be able to help your child if you are exhausted, depressed, angry, overwhelmed, and resentful.

Remember that what you are doing is enormously important. You may not feel as though you have made a difference; however, it is critical to remember that every positive experience a child has with a kind, attentive, respectful, adult - even when brief - can help refute what he or she has known in the past.

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## The Normal SPECS of Development for School Age Children



By age 6, the average child has developed the ability to maneuver in their world on their own initiative. They are comfortable trying out new things, and this gives them a sense of security as they enter school. Over the next six years, the influence of people other than their primary caregivers will strengthen as peers and teachers enter their world on a daily basis. Their sense of self becomes clearer, and they will begin to develop opinions of their own. They will also face new physical challenges and become more rational in their thought processes.

### **Social Development**

For children at age 6, relationships outside the family increase in importance. While the primary focus until this time has been on relationships with the primary caregiver and family, a shift now occurs as children begin to focus on friends and peer groups. While they have begun to understand what social roles and rules are by age 6, the next few years will be spent learning to use them to guide their interactions.

Children often become involved in a variety of new activities during this time, including school, sports, clubs, and other activities. As children enter these activities, the child imitates, learns, and adopts age-appropriate social roles, including those that are gender-specific. These help in the development of peer relationships. They also begin to develop a broader understanding of rules, which are relied upon to dictate proper social behavior and to govern social relationships and activities.

#### Peer Relationships

The social world of the school-age child, while still focused largely on home and family, expands to include teachers, peers, and schoolmates, as well as the larger world learned about in school and through books, movies, or television. The school-age child's more sophisticated cognitive abilities and better self-control affect both the quality of his interpersonal relationships and his behaviors in social settings.

The child develops meaningful and mutual friendships with peers. The child may have a best friend and also belong to a peer group. Children this age usually choose friends of the same sex. Many friendships develop between children because of common interests or proximity. For example, a child might have one playmate who lives next door, a different friend in his class, and yet another friend in his scout troop.

Because many friendships are situation-specific, they may also be transitory. A classic example is the behavior of children leaving friends they met at a two-week

summer camp. They promise faithfully to call or write, but they demonstrate little interest in the relationships once school activities resume.

### Function of Rules and Roles

Rules are important in guiding behavior. The child's ability to cope in a complex world depends upon how well he understands the rules. The child's understanding of the nature of rules, and their utility, becomes more sophisticated as the child gets older:

- Play is largely rule governed. Children engage in board games, sports, and group or team play, all of which require that rules be followed.
- Children age 5 or 6 believe rules can be changed to suit one's needs, and they will alter the rules of a game at whim to get what they want. This is a holdover from egocentric thinking, in which the self is at the center of the world.
- By age 7 or 8, the child is very conscious about obeying the rules. Rules are perceived as fixed, unchangeable, and handed down by an ultimate authority. This leads to strict interpretations of what is right and wrong. Issues of fairness are prevalent, and school-age children become angry, enter into arguments, and complain bitterly to adults if someone has broken a rule.
- By age 9 or 10, children begin to view rules as a useful means of regulating their activities, but they understand that not all rules are inflexible. Rules can be negotiated and constructed by equals to achieve an agreed-upon purpose.
- Rules provide the child with structure and security. Rules describe the laws of their world in concrete terms they can understand. In a new or strange situation, the first thing a school-age child will do is observe and ask questions to determine what is permitted and what is not. Children respond with anxiety to situations where rules are ambiguous or absent.
- The child begins to understand social roles. The behaviors that define a role are concrete and observable. However, the child's conception of roles is that they are fixed and inflexible. It is amusing to observe the disbelief on an 8-year-old's face when she sees her teacher at the grocery store. Mothers shop for groceries, not teachers.
- An understanding of roles does help the child adapt his behaviors to fit different situations. He may be a dominant leader and give orders to others on the school playground, sit quietly and be attentive in church, and be helpful to his mom by watching his younger brother.

- The child is beginning to understand sex role differentiation. She realizes that girls and boys are different and are expected to behave differently. Comments such as “Don’t be silly, boys don’t play with dolls” exemplifies the rigid role expectations of the child at this age. Children will emulate those qualities that are valued for their gender in their culture.

### ***Physical Development***

Children by the age of 6 continue to be very active, and will hardly ever sit still between ages 6 and 12. All of the activity allows them to move from a basic mastery of all fine and gross motor skills and move onward to mastery of more complex maneuvers, such as riding a bike with no hands.

Between the age of 6 and 12, the child’s physical growth is slow and steady. They will grow an average of 3 to 4 inches a year. Children’s appearance will change as their body proportions begin to look similar to that of adults, with their brain development being nearly complete. Puberty may begin in children as early as age 8 or 9, and more often by the age of 12 (Rycus, 1998).

Sports and activities are ways that children are able to do things that will enhance both their fine and gross motor skills, including their hand-eye coordination. It also is typically a means to connect with other peers. They may be involved in a variety of physical activities that can include formal and informal games. Often games such as soccer, basketball, softball, gymnastics, hopscotch, jumping rope, riding bikes, or turning cartwheels in the yard are appealing to children in this age range. Additionally, activities such as drawing and painting, woodworking, building models, and playing musical instruments allow children to further refine and practice fine motor skills.

### ***Cultural Note on Motor Skills and Play***

As noted previously, the development of motor skills may be influenced by cultural factors. This continues to be true for this age group. The specific physical play activities made available to children will vary by geographic location, and by class as well as culture. Cultures that value physical strength and skill tend to reinforce activities that involve gross motor abilities. In some cultures, girls are discouraged from engaging in active, rough and tumble physical play. Cultures that place greater value on cognitive and social, rather than physical, skills may tend to discourage active physical play (Rycus, 1998).

### ***Emotional Development***

Erikson defined this age range as a period of industry vs. inferiority where children are often purposeful and goal-directed in their behaviors and function. Erikson considered the ability to be self-directed, productive, and goal-oriented to be the most important developmental tasks of this age. Throughout the school years,

children become increasingly decisive, responsible, and dependable about making plans and following through with them. The child who fails at being industrious is likely to experience feelings of inferiority (Rycus, 1998).

The child at this age is particularly sensitive to criticism. In order to help develop positive self-esteem, it is important to recognize children for their efforts and commend them for their intent or attempt, rather than to base success solely on outcomes or final products. In part, this is because the child evaluates her worth on her ability to perform. Self-esteem is largely derived from one's perceived abilities (Rycus, 1998).

Children are becoming more aware of themselves as individuals and have clear likes, dislikes and opinions of their own. They begin to develop ways to handle difficulties and frustrations, and ways to make their own decisions that are based in their own moral development.

Children also develop different ways of making decisions that are rooted in their moral development. Children begin their own decision-making processes by making decisions based on the need to be obedient in an effort to avoid punishment. They then begin to test the boundaries, and will put their own needs and desires ahead of any potential consequences. Often, they do not like the displeasure this brings, and they will move on to decision making that is based on what their parents say and a desire to please others. By the age of 12, children also begin to have respect for the law and people in authority, and begin to understand the concept of duty and responsibility (Rycus, 1998).

Throughout the school years, children develop increasingly good self-control and frustration tolerance. They develop alternative strategies to deal with frustration and are better able to control their emotions. They have also learned to express their impulses and emotions in safe, socially appropriate ways. Emotional tension is often released through hard physical play. Older children are also better able to delay gratification.

### **Cognitive Development<sup>6</sup>**

Children's cognitive functioning becomes much more logical and rational as they enter this period. Children's memory improves during this time, and they begin to leave the egocentric thought process and become aware that other people have different perspectives. Language becomes a tool of communication that helps develop and enhance relationships with others. A dramatic change occurs between ages 5 and 7 in the school-age child. The changes are so predictable and prevalent

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<sup>6</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 507-510, Arlington, VA: CWLA.

that they have been acknowledged by nearly all developmental investigators, and collectively are called the five-to-seven shift.

Developmental theorists refer to the changes in the cognitive abilities of school-age children as constituting a *developmental leap*, in which new abilities emerge without obvious precursors. Many theorists suggest that significant changes in the organization of the child's brain permit the appearance of these new skills, specifically further development of the cerebral cortex, the portion of the brain that controls most of the higher cognitive functions. These qualitative changes occur in cultures that are markedly different from each other in terms of values, norms, and educational practices, suggesting a strong maturational component, and cannot be accounted for solely by increased experience.

### **Development of Concrete Operations**

Concrete operations is the name given by Piaget to the stage that marks the cognitive development characteristic of school-age children. The following abilities are typical of this stage:

- The child has a relatively accurate perception of objects, events, and relationships, as long as these are concrete, that is, observable or touchable.
  - For example, the child might observe that when a glass is dropped it usually breaks. When a plastic cup is dropped it bounces. The child would conclude that glass is more likely to break when dropped than plastic. The child can generalize his knowledge about the fragility of glass to other forms, such as vases, picture frames, and eyeglasses, and can adapt his behavior to prevent breakage.
- The school-age child's thinking is generally rational and logical. Magical and imaginative thinking are understood to be pretend and they are clearly differentiated in the child's mind from what is real. The child's imaginary friends disappear.
- The child can recognize similarities and differences between objects and people, as long as the attributes are visible and concrete.
  - For example, the child might say an apple and an orange are similar because they are both round, or that you eat them. A child at the stage of concrete operations would not understand that apples and oranges belong to an abstract class of objects called fruit.
- The child can consider and reflect upon herself and her attributes. She perceives herself in concrete terms, however, and would describe herself to others as, "I'm a girl, I have brown eyes, I play the piano, I like school." She is less likely to consider abstract qualities, such as "I'm friendly" or "I'm artistic."

- The child can consider two thoughts simultaneously. A preschool child might think, “I’m hungry” and would request something to eat. The school-age child might think “I’m hungry,” and at the same time think, “If I eat something now, Mom will be mad because I won’t eat dinner,” and consider both perspectives.
- The child has a good understanding of concepts of space, time, and dimension. School-age children understand how to sequence events in time, i.e., first, next, and last, and can therefore relate the events in a story in their logical order.
- The school-age child understands that the identity of an object or a person remains constant, regardless of outward changes. When mother puts on a mask, she is still mother.

### ***Memory Improves***

During this time, the child’s memory also improves. The school-age child can remember events that happened weeks, months, or even years earlier. The child’s short-term memory also continues to strengthen, which allows her to follow instructions, and once she learns them, to repeat complex activities on her own without assistance.

These increased cognitive abilities promote the development of more effective coping skills, including the ability to behave in planned ways and to control behavior.

- The child can now think about past actions or events and remember their consequences. He can use this information to plan strategies to solve problems.
- The child better understands how her activities and behaviors affect other people and events. She learns, through observation, “When I do this, then that happens.” She can repeat a behavior to achieve a desired effect or goal.
- The availability of multiple strategies to solve problems provides the child with greater control over his environment. He is less apt to respond to frustration with emotional outbursts because he can think through alternate strategies.
- Children’s aptitude with language increases their coping ability. They can think to themselves, and they can use language to communicate with other people, both of which assist them in solving problems and meeting their needs.

### ***The Emergence of Perspective Taking***

Preschool-age children do not recognize that other people have perspectives that might differ from their own. School-age children develop the ability to understand other people’s perspectives. This ability emerges in rudimentary form at the end of

the preschool years and develops in stages throughout childhood and into adolescence.

- A 7-year-old child in a transitional stage of perspective taking may be able to recognize and acknowledge that other people have opinions, but cannot yet mentally assume the role of the other person.
- Young school-age children can often understand how other people feel but will have difficulty if their perspective conflicts with those of another person. They cannot grasp that two contradictory perspectives can coexist.
- By ages 8 to 10, children can recognize the difference between behavior and intent. For example, if his father accidentally steps on 3-year-old Tyrone's hand, Tyrone will be angry with him for hurting him. When Tyrone is 8 or 9, he'll understand that his father didn't mean to hurt him.
- Throughout the school-age years, children become increasingly aware of the needs and feelings of others. By the age of 10 or 11, children have the ability to listen to each other's points of view, discuss them, and, when their views are in conflict, identify solutions that consider what both children want.

Having the ability to understand others' perspectives does not guarantee that children will act in unselfish ways. It simply means they have developed cognitively to a level where they can accurately recognize and consider other people's viewpoints.

### **Moral Development**

Moral development is an aspect of social development that deserves special attention. Lawrence Kohlberg has conducted much of the research that identifies predictable stages of moral development in youths. The moral development of most children under age 11 is at the pre-conventional level. Preconventional morality is largely rules driven. For most preschool children, morality is based upon a punishment/obedience perspective. The child recognizes the superior power of an authority and conforms to rules simply to avoid punishment. Later in childhood, children begin to understand that rules can be useful in promoting self-interest exchanges.

### **Language Development<sup>7</sup>**

During the five-to-seven shift, children enjoy learning, practicing, and perfecting words. They talk to themselves. They enter conversations with seemingly irrelevant or off the subject verbalizations and may ask questions to keep a conversation going without being particularly interested in the answer. School-age children use language

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<sup>7</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, p. 508, Arlington, VA: CWLA.

primarily as a communication tool to promote mutual understanding and to enhance relationships.

- They actively listen to what other people say and consider these communications carefully. They ask questions when they don't understand, and continue asking until they are satisfied with the answer.
- They can request instructions or directions, and they have the ability to carry them out precisely.
- They consider the needs of the listener in a conversation and will try to provide information the listener will find interesting or useful.
- They can describe events logically and sequentially.
- They can discriminate between relevant and irrelevant information in a conversation.
- Conversations are mutual. Both parties are invested in the communication, give and receive information, and exchange thoughts and opinions.

### ***Sexual Development***

School-age children continue to participate in natural and expected sexual exploration. The purpose of the exploration continues to be one of information gathering, and may now involve other children as part of the process in both a visual and a tactile manner as they attempt to further understand themselves and their own gender roles. How children play during this time is also a way that they further attempt to define their roles (e.g., playing house).

By age 6, children have explored their bodies to some extent, and have an understanding of who they are at an emotional level and at a physical level. As this happens, children may begin to show signs of modesty regarding their own body. They may begin to seek privacy when changing, and no longer be comfortable with someone checking in on them at bath time. Some sexualized behaviors, in the form of masturbation, may continue depending on the child's culture and the family norms. Additionally, body exploration with others of the same age may occur.

Most children have a clear understanding of gender and the roles people play in each group. Because outside influences are strong for the school-age child, the media and how it defines a positive self-image and gender roles can affect the child's concept of self and their roles.

### Normal Sexual Play

- Children may be involved in normal sex play with other children that are generally of similar age, size, and developmental status, and participate on a voluntary basis.
- While siblings may engage in mutual sexual exploration, most sex play is between children who have an ongoing, mutually enjoyable play and/or school friendship.
- The sexual behaviors of children are typically limited in type and frequency.
- The child's interest in sex and sexuality is balanced by curiosity about other aspects of their life.
- Normal sexual exploration may result in embarrassment, or guilty feelings, but does not usually leave children with deep feelings of anger, shame, fear, or anxiety.
- If children are discovered during sexual exploration and instructed to stop, adult observation indicates that the sexual behavior appears to diminish.
- The affect of the children regarding the sexual behavior is generally light-hearted and spontaneous.
- The types of behaviors engaged in may include: self-exploration and stimulation, kissing, hugging, peeking, touching and/or exposing of genitals, and perhaps pretending to simulate intercourse. Less than 4% of children engage in, or attempt to engage in oral sex, sodomy, or vaginal intercourse.

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## Grief and Loss in School Age Children

Children do not react to loss in the same ways as adults. Grieving children may not show their feelings as openly as adults. Grieving children may not withdraw and dwell on the person who died, but instead may throw themselves into activities (for example, they may be sad one minute and playful the next). Often families think the child doesn't really understand or has gotten over the loss. Neither is true; children's minds protect them from what is too powerful for them to handle. Children's grieving periods are shortened because they cannot think through their thoughts and feelings like adults.

Children at different stages of development have different understandings of separation, loss, death, and the events surrounding the loss. Also, children have trouble putting their feelings about grief into words. Instead, his or her behavior speaks for the child. Strong feelings of anger and fears of abandonment or death may show up in the behavior of grieving children. Children often play death games as a way of working out their feelings and anxieties. These games are familiar to the children and provide safe opportunities to express their feelings.

### **Common Questions of Children (note these questions may apply to children of all ages)**

Children's grief commonly expresses three issues:

1. *Did I cause the death (loss or separation) to happen?*  
Children often think that they have magical powers. If a mother says in irritation, "You'll be the death of me," and later dies, her child may wonder if he or she actually caused the mother's death. Also, when children argue, one may say (or think), "I wish you were dead." Should that child die, the surviving child may think that his or her thoughts actually caused the death.
2. *Is it going to happen to me?*  
The death of another child may be especially hard for a child. If the child thinks that the death may have been prevented (by either a parent or a doctor), the child may think that he or she could also die.
3. *Who is going to take care of me?*  
Since children depend on parents and other adults to take care of them, a grieving child may wonder who will care for him or her after the death of an important person.

### **Separation and Loss in Foster Care**

This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

One key to humanizing the process of moving a child from one family to another is to become sensitive to the ways that children perceive parental separations.

#### Being taken away

- Especially if there is no preparation, children are prone to chronic fears and anxiety. Some cope by withdrawing and always trying to please others.
- Some are constantly asserting themselves, trying to be in control of everything.
- In both reactions, there is a diminished trust for adults and self.

#### Being given away

- These youngsters feel that they have not measured up in some way.
- They are likely to hold themselves responsible for events leading up to the move, developing chronic guilt.
- They may have sadness and depression.
- If a child worked hard to change his behavior and measure up in his birth, foster, or adoptive home and still faces a move, he will probably express or act on anger.

#### Someone coming to take them away

- This is the most dangerous perception.
- The child may live in fear and constant anxiety; every knock at the door or visit by an acquaintance is traumatic.

#### They chose to move

- Some children feel they did something to consciously choose the move.
- This may occur by actual events (such as reporting the abuse) or magical thinking.

#### The least harmful perception

- For the child to see decision making as a shared responsibility.
- It is best if the child feels that along with others, he or she has input into the plan, but is not fully responsible.
- Talk about the move should be focused on helping the child grow and change in ways that are not being provided in the current living situation.

Unresolved separation and loss may interfere with new attachments.

### ***Interventions for Childhood Grief Due to Death***

A child's grieving process may be made easier by being open and honest with the child about death, using direct language, and incorporating the child into memorial ceremonies for the person who died.

#### *Explanation of death*

Not talking about death (which indicates that the subject is off limits) does not help children learn to cope with loss. When discussing death with children, explanations should be simple and direct. Each child should be told the truth using as much detail as he or she is able to understand. The child's questions should be answered honestly and directly. Children need to be reassured about their own security (they often worry that they will also die or that their surviving parent will go away). Children's questions should be answered, making sure that the child understands the answers.

#### *Correct language*

A discussion about death should include the proper words, such as "cancer," "died," and "death." Substitute words or phrases (for example, "passed away," "he is sleeping," or "we lost him") should never be used because they can confuse children and lead to misunderstandings.

#### *Planning memorial ceremonies*

When a death occurs, children can and should be included in the planning and participation of memorial ceremonies. These events help children (and adults) remember loved ones. Children should not be forced to be involved in these ceremonies, but they should be encouraged to take part in those portions of the events with which they feel most comfortable. If the child wants to attend the funeral, wake, or memorial service, he or she should be given in advance a full explanation of what to expect. The surviving parent may be too involved in his or her own grief to give their child full attention; therefore, it may be helpful to have a familiar adult or family member care for the grieving child.

### ***Presentation and Experience of Grief and Loss in School Age Children***

Some indicators and characteristics of grief and loss of school-age children are listed below.

#### *Children ages 6 to 9*

- For a child placed out-of-home, the loss of the child's peer group and friends may be almost as traumatic as the loss of the parents.
  
- Being out of the home can be tolerated if the child understands s/he will eventually return home. Because of concrete thinking, if the child cannot be told exactly when s/he will return home, anxiety may increase.

- Children at this age are commonly very curious about death and may ask questions about what happens to one's body when it dies. Death is thought of as a person or spirit separate from the person who was alive, such as a skeleton, ghost, angel of death, or "bogey man." They may see death as final and frightening but as something that happens mostly to old people (and not to themselves).
- Grieving children can become afraid of school, have learning problems, develop antisocial or aggressive behaviors, become overly concerned about their own health (for example, developing symptoms of imaginary illness), or withdraw from others. Or, children this age can become too attached and clinging. Boys usually become more aggressive and destructive (for example, acting out in school), instead of openly showing their sadness.
- Children may feel abandoned by both their deceased parent and their surviving parent because the surviving parent is grieving and is unable to support the child emotionally.
- Children begin to understand that events occur for which they are not at fault. Although, if the child was placed after some perceived misbehavior, this may cause feelings of responsibility, guilt and anxiety.

#### Children ages 9 and up

- If in out-of-home care, the child has an increased ability to understand the reasons for the separation. With help, the child may be able to identify the causes of the family disruption and realistically assess his role in the situation.
- The child is aware of the perceptions and opinions of other people. Children are embarrassed and self-conscious about their family's problems and may feel inadequate due to their foster care status.
- If separated, the child may be worried about his family as a unit and may demonstrate considerable concern for siblings and parents.
- The loss of best friends and peers may be particularly difficult for the child. The child may be lonely and isolated.
- By the time a child is 9, death is known to be unavoidable and is not seen as a punishment. By the time a child is 12, death is seen as final and something that happens to everyone.
- In American society, many grieving adults withdraw and do not talk to others. Children, however, often talk to the people around them (even strangers) to see the reactions of others and to get clues for their own responses.

- Children may ask confusing questions. For example, a child may ask, “I know grandpa died, but when will he come home?” This is a way of testing reality and making sure the story of the death has not changed.

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## Trauma and the Stress Response

Children respond to horrifying events with mental mechanisms that lead to acute and sometimes, chronic psychological disorders. Traumatic events are able to break past the child's ordinary coping and defensive mechanisms due to their:

- intensity
- threats to the child or to someone else
- unusual nature
- suddenness or quality of surprise

### **Definitions of Trauma**

A trauma is a psychologically distressing event that is outside the range of usual human experience. Trauma often involves a sense of intense fear, terror, and helplessness. Trauma should not be confused with stress. Trauma is an experience that induces an abnormally intense and prolonged stress response.

Type of Stressor	Examples
Child physical abuse or severe neglect	Beatings, burning, restraints, starvation
Child sexual abuse	Incest, rape, or sexual contact with an adult or much older child
Witnessing or learning about traumatic events	Witnessing a shooting or devastating accident, sudden unexpected death of a loved one
Serious accident	Car, plane, boating, or industrial accident
Natural disaster	Tornado, hurricane, flood, or earthquake
Criminal assault	Being physically attacked, mugged, shot, stabbed, or held at gunpoint
Sexual assault	Rape or attempted rape
Military	Serving in an active combat theater
Hostage-Imprisonment/Torture	Being kidnapped or taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, displacement as a refugee

### **Immediate Reactions to Trauma**

During the traumatic event, all aspects of the individual's functioning change, including feeling, thinking, and behaving. For instance, someone under direct assault abandons higher-level thinking in favor of survival responses. At that exact moment, all of the victim's thinking, behaving, and feeling is being directed by more primitive parts of the brain.

At the moment of trauma children usually retain full physical and emotional control, remaining silent during a traumatic event. Infants and toddlers may cry, but older children show few of the adult physiological disturbances.

A frightened child in a threatening situation does not focus on the words being spoken or yelled; instead, he or she is busy attending to the threat-related signals in the environment. The fearful child will selectively attend to nonverbal signs of communication, cues such as eye contact, facial expression, and body posture, or proximity to the threat. The internal state of the child also shifts with the level of perceived threat. With increased threat, a child moves along the arousal continuum from vigilance through terror.

### **The Stress Response**

#### The Neurobiology of Stress

The normal stress response is designed to help human beings cope with danger and to fight, flee, freeze, or submit. The processing of fear, as with all other emotional reactions, involves three steps: the unconscious evaluation of a stimulus, a bodily response, and conscious experience. Neuroscientists believe that most of our responses take place outside of our awareness. (Vasterling & Brewin, 2005)

#### The Arousal Continuum

The arousal continuum is characterized by many physiological changes. Under threat, sympathetic nervous system activity increases in a gradual fashion. Heart rate, blood pressure, and respiration are altered during the arousal response. Glucose stored in muscles is released to prepare the large skeletal muscles of your arms and legs for either fight or flight.

This total-body mobilization—the fight-or-flight response—has been well documented and described in great detail for adults. These responses are highly adaptive and involve many coordinated and integrated neurophysiological responses across multiple brain areas, including the brainstem nuclei responsible for autonomic nervous system regulation. They vary with the nature, intensity, and frequency of the event. Different children may have unique and individualized sets of responses to the same trauma.

These responses may include different survival strategies—ranging from fighting or fleeing to freezing or giving up or surrendering.

#### Hyperarousal and Dissociation

Two primary adaptive response patterns in the face of extreme threat are the hyperarousal continuum (defense—fight or flight) and the dissociation continuum (freeze and surrender response). Each of these response sets activates a unique combination of neural systems.

A hyperarousal response can result from repeated exposure to traumatic or stressful situations. In early childhood, those parts of the brain that respond to threat or trauma are those that control or regulate arousal, vigilance, locomotion, attention, and the startle response—the brainstem and midbrain. Use-dependent activation leads to malfunctioning in the normal activity regulated by these two areas; so a child exhibits motor hyperactivity, anxiety, behavioral impulsivity, sleep problems, hypertension. In addition, everyday stressors which may not elicit any response in a normal child, elicit an exaggerated response in the sensitized child. The child is in a persisting state of fear and will move very easily from a state of being mildly anxious to feeling threatened to being terrorized. The child now has a set of maladaptive emotional, behavioral, and cognitive problems which are rooted in the original adaptive response. The hyperarousal response is most commonly exhibited by boys (Perry et al, 1995)

Girls (and very young children) are more likely to exhibit a dissociative response when confronted with the same set of traumatic experiences. When distressed, a young child will often cry. But when crying only elicits further discomfort, the child will abandon this response (a defeat or surrender response). In the face of continuing threat or trauma, the child may move into a freezing response - a normal response in the face of danger. However, this freezing mechanism can lead to children becoming labeled as oppositional-defiant because, when feeling anxious, they may act like they don't hear or are refusing to obey commands from teachers or other adults. This may force the adult -- teacher, parent, counselor -- to give the child other directives which often involve a threat, "if you don't do this, I will..." The more anxious the child becomes, the quicker s/he will move from being anxious to threatened, and from threatened to terrorized. The freezing can escalate into complete dissociation (Perry et al, 1995)

Dissociative behaviors include numbing, fantasy, daydreaming, and avoidance. Children report "going to another place," "just floating," assuming the persona of a hero or an animal. They are often described as robots or "acting as if they aren't here" (Perry et al, 1995)

These response patterns are somewhat different in infants, children, and adults, though they share many similarities. In general, the predominant adaptive style of an individual in the acute traumatic situation will determine which posttraumatic symptoms will develop: hyperarousal or dissociative.

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## Post-traumatic Stress Disorder

### Features of Posttraumatic Stress Disorder (PTSD)

- The event involved actual or threatened death, serious injury, rape, or childhood sexual abuse. It was also out of the normal experience for that individual or may be cumulative or repeated.
- The stressor must be extreme, not just severe. It would not include many frequently encountered stressors that are severe but not extreme, such as failing in school or expected death of a relative.
- The stressor causes intense subjective responses, such as fear, helplessness or horror.

Key Symptoms	Examples
Re-experiencing the traumatic event	<ul style="list-style-type: none"> <li>▪ Intrusive, distressing recollections of the event</li> <li>▪ Flashbacks (feelings as if the event were recurring while awake)</li> <li>▪ Nightmares (can involve the event or other frightening images)</li> <li>▪ Exaggerated emotional and physical reactions to triggers that remind the person of the event</li> </ul>
Avoidance	<ul style="list-style-type: none"> <li>▪ Of activities, places, thoughts, feelings, or conversation related to the trauma</li> </ul>
Emotional numbing	<ul style="list-style-type: none"> <li>▪ Loss of interest</li> <li>▪ Feeling detached from others</li> <li>▪ Restricted emotions</li> </ul>
Increased arousal	<ul style="list-style-type: none"> <li>▪ Difficulty sleeping</li> <li>▪ Irritability or outbursts of anger</li> <li>▪ Difficulty concentrating</li> <li>▪ Hypervigilance</li> <li>▪ Exaggerated startle response</li> </ul>

### Duration of symptoms and related diagnoses

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing

		PTSD.
1-3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of co-morbid disorders.

**Neurobiology of PTSD**

Neuroimaging studies of PTSD have examined brain structure, neurochemistry, and function (Shin, Rauch, & Pitman, in Vasterling, & Brewin, 2005). Findings from basic science research have highlighted at least three brain regions that may play an important role in the etiology of PTSD: the amygdala (involved in assessment of threat-related stimuli), medial prefrontal cortex (underresponsive in PTSD events), and hippocampus (involved in memory processes).

LeDoux (1996 in Stien & Kendall, 2004) proposed that the brain uses two roads to process experience, the high road and the low road. The low road (from the thalamus directly to the amygdala) allows for instantaneous reaction. This is helpful in survival situations in which experiences are judged to be either threatening or not threatening. At the same time, the same sensory information is also delivered to the cortex where it undergoes more sophisticated analysis and comparisons with other similar experiences. This information is then communicated to the limbic (emotional) system. In the case of an adverse experience, the unconscious brain processes involved in the low and high roads eventually result in a bodily response, such as the release of hormones into the blood, alterations in heart rate, blood pressure, breathing, and the release of adrenaline by the kidneys, and a generalized activation of the entire body.

Prolonged or overwhelming stress endured at any age can impair the stress response, making it more reactive and less adaptive. The body begins to react as if danger is prevalent, even if this does not match reality. The threshold for reacting to stimuli may be lowered. Trauma may also change the brain’s preferred mode of processing stimuli, leading to a greater reliance on the low road, rather than the more discriminating high road to the cortex. Later exposure to stimuli that resembles the feared stimulus will provoke the same errant stress response.

Trauma also appears to alter brain chemistry, providing chemical markers for the presence of PTSD symptoms. When exposed to extreme stress, the body responds by releasing steroid hormones, particularly cortisol, from the adrenal glands. Research reveals that excessive chronic exposure to such stress hormones can

damage neurons, especially those comprising the hippocampus, the brain region involved in explicit memory (Schacter, 1996 in Applegate & Shapiro, 2005).

Different levels of stress and trauma appear to influence memory in different ways. Excessive amounts can cause significant memory impairment (Siegel, 1998 in Applegate & Shapiro, 2005).

Structural changes as well as chemical changes in the brain keep the stress response locked in overdrive. As a result, the brain enters a vicious cycle of escalating arousal and dysfunction of the stress response (Stien & Kendall, 2004).

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## **Children and Their Experience of Traumatic Events**

### **Children Re-experience Trauma**

For almost all children, a traumatic experience will play itself out repeatedly in their minds, after the event has ended. The thoughts, emotions, and feelings of being out of control and threatened will be re-experienced, as will the fear, anxiety, and pain associated with the event. Each time the child has a nightmare, an intrusive thought, or reenacts the event through play, the emotional or affective memory of being in the midst of the threatening event is evoked.

### **Memories**

Memories of single-episode traumatic events stay remarkably clear. They often recall these events in extraordinary detail, but details may become distorted through initial or ongoing misconceptions. For example, time and distance are often elongated or shortened.

Fuzzy or absent memory will occur if:

- the child was traumatized in a long-standing series of events
- the child was below age 28 to 36 months at the time of trauma and thus developmentally unable to create, store and/or retrieve verbal memories
- the child was unconscious or suffered a concussion during the events

### **Dreams**

Dreams tend to reenact the events, but even nonverbal children experience unremembered terror dreams. They may also sleep walk or sleep talk. The ability to dream with remembered content is a developmental step. Traumatic dreaming is, therefore, not a consistent finding in children.

### **Fears**

Fears arrive early and are late to go as opposed to sleep difficulties and attention problems, which are usually short-lived after a single, unrepeatable traumatic event. Fears come up almost immediately and generally occur as two types:

- Fear of repetition
- Fears of ordinary items, such as the dark, strangers, being separated from parents, being alone, and being outside

### **Play**

Children begin to play out, draw, dramatize or tell their stories of trauma within days to a few weeks of the event. Posttraumatic play is often grim, monotonous, and, at times, dangerous. Usually there is no obvious connection between the play and the trauma. For this reason, it often goes unnoticed as a symptom by caretakers. The need to play is so strong that it impels the child to play no matter what toys are

available. Even adolescents, well beyond the age-range of the usual pretend player, may play post-traumatically with sophisticated options such as tape-recorders, air brushes, poetry readings, or dramatic scenarios. For this reason, some acting out behavior in adolescents is actually posttraumatic play.

### **Symptoms**

Symptoms in adolescents may resemble more adult symptoms, but characteristics of younger children may remain. Adolescents may experience more sleeplessness, inattentiveness, and irritability than latency age children. Their responses are often quite uneven. Adolescent victims of physical and sexual abuse may be at even greater risk for behavioral and social difficulties than for PTSD symptoms.

### **Cultural Note**

Cultural influences form a context through which the traumatized individuals or communities view and judge their own responses to trauma. Culture influences what type of threat is perceived as traumatic and how we interpret the meaning of the traumatic event. Culture also influences how individuals and communities express traumatic reactions. While reactions to trauma seem to be common throughout all cultures and based in the physiology of human beings, manifestations of responses may differ significantly. If a society tends to stigmatize people suffering from a particular type of trauma, individuals who have experienced that kind of trauma may withdraw and remain silent. This tendency is a critical issue for many people who have endured certain kinds of traumatic experiences. If they are stigmatized, traumatized persons may experience additional injuries. On the other hand, cultures can also help define healthy pathways to new lives after trauma. Routines and traditions may aid survivors of a tragedy to re-orient themselves or return a measure of predictability to their lives.

Trauma and culture are particularly complicated today. Multiple identifications require complex reasoning for negotiating the environment. With an increase in life stress and a decrease in the capacity to screen and moderate the impact of a trauma, cultural traumas can be transmitted across time and generations as a bond for survival.

### ***After the Trauma: The Costs of Coping***

While the mental and physical adaptations used during a traumatic event will slowly subside, there will be residue from the experience. Indeed, for some children, this posttraumatic period is filled with more confusion, emotional pain, distress, and fear. Symptoms can become so severe that children may develop serious posttraumatic stress disorder.

Trauma creates feelings of anxiety that can last for years. Behavioral changes that accompany PTSD can lead to profound changes in the child's emotional constitution and personality. Overwhelming emotion may also cause changes in the child's

attitude toward life itself, and children can lose faith about their future (Stien & Kendall, 2004).

A classic set of predictable symptoms and physical changes is evident in the acute posttraumatic period through memory function. Not only can children remember the facts and narrative details of the event, they can recall and relive the emotional and physiological changes that were present in the alarm reaction. In effect, the child has both emotional and physiological state memories from the traumatic event, causing a state of hyperarousal. This hyperarousal may be characterized by a heightened startle response, increased muscle tone, a fast heart rate (tachycardia) and/or elevated blood pressure. Even at rest in the weeks following a traumatic event, children and adolescents often exhibit signs of physiological hyperarousal, such as tachycardia, despite outwardly normal behaviors. The inability to move back down the arousal continuum has profound implications for the child's long-term functioning. Persistent physiological and emotional distress is both physically exhausting and emotionally painful. Because of the pain, discomfort, and emotional and physiological memories associated with these recurring intrusive thoughts, a variety of protective avoidance mechanisms are used to escape reminders of the original trauma. These include active avoidance of any reminders of the trauma and the mental mechanisms of numbing and disassociation.

Children who survive a traumatic event with persistence of this low-level fear state may be impulsive, hypervigilant, hyperactive, withdrawn, or depressed, or have anxiety and sleep difficulties (including insomnia, restless sleep, and nightmares). In general, these children may show some loss of previous functioning or a slowed pace in acquiring new developmental tasks. Traumatized children may also seem to regress and retain persistent physiological hyperreactivity (such as fast heart rate or borderline high blood pressure).

### **Resiliency**

Resiliency may be defined as an individual's ability to positively adapt, thrive, and even excel despite experiencing detrimental circumstances, chronic stress, and/or prolonged or severe trauma (Cicchetti & Blender, 2006).

Though harsh and adverse conditions most often result in unfavorable consequences on a child's physical, intellectual, and emotional growth, resilient children seem able to overcome these conditions and continue the development process on track. The exact source or cause for the development of resilience in an individual is still not well known; however, it is determined that environmental, psychological, as well as biological (including neurological) factors are involved. For instance, studies have found that infants who are nurtured well at birth are more likely to be resilient than those with less nurturing (Leckman & Mayes, 2007). Scientists have also discovered the 5-HTT gene, which is found to play a role in the regulation of serotonin in the brain, and may be an influencing factor in why some children are able to cope and

adapt to experiences of abuse and neglect, seemingly overcoming extreme adverse circumstances (Bazelon, 2006).

**Introduction**

Many children have mental health problems that interfere with normal development and functioning. In the U.S., 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment. However, in any given year, it is estimated that less than 1 in 5 of these children receives needed treatment. Recent evidence compiled by the World Health Organization indicates that by the year 2020, childhood neuropsychiatric disorders will rise proportionately by over 50% internationally, to become one of the five most common causes of morbidity, mortality, and disability among children (U.S. Public Health Service, 2000).

**Attention Deficit Hyperactivity Disorder (ADHD)**

Attention Deficit Hyperactivity Disorder (ADHD) is a condition that becomes apparent in some children in the preschool and early school years. It is hard for these children to control their behavior and/or pay attention. It is estimated that between 3% and 5% of children have ADHD, or approximately 2 million children in the United States. This means that in a classroom of 25 to 30 children, it is likely that at least one will have ADHD (ADHD Basics, 2008).

**Symptoms and types**

The principal characteristics of ADHD are inattention, hyperactivity, and impulsivity. These symptoms appear early in a child's life. Many normal children may have mild levels of these symptoms, and the symptoms that resemble those of ADHD may be caused by another disorder. Therefore, it is important that the child receive a thorough examination and an appropriate differential diagnosis by a well-qualified professional.

There are three main types of ADHD. One type is characterized by inattentiveness; one type is characterized by hyperactive or impulsive behavior. The third type combines symptoms of both inattentiveness and hyperactivity.

Some signs of hyperactivity-impulsivity are:

- Fidgeting excessively
- Difficulty staying seated
- Running or climbing inappropriately
- Talking excessively
- Difficulty playing quietly
- Always seeming to be on the go
- Blurting out answers or frequently interrupting
- Having trouble waiting his or her turn
- Interrupting or intruding on others

Some signs of inattentive behavior are:

- Difficulty following instructions
- Difficulty focusing on tasks
- Losing things at school and at home
- Forgetting things often
- Becoming easily distracted or having difficulty listening
- Lacking attention to detail, making careless mistakes or being disorganized
- Failing to complete homework or tasks

The presence of some symptoms, however, does not confirm a diagnosis of ADHD. Just because a child has a lot of energy or difficulty paying attention in school does not mean the child has ADHD. An accurate diagnosis relies on the presence of a range of symptoms and difficulties that prevent the child from performing at an appropriate level for his or her age and intelligence level. Symptoms may go unnoticed until a child enters school. Teachers are often first to observe these issues, and their input should be considered seriously.

### **Identifying ADHD**

The child's pattern of behavior is compared against a set of criteria and characteristics of the disorder as listed in the DSM-IV-R. To be diagnosed with ADHD, a child must show symptoms in at least two settings, such as home and school, and the symptoms must interfere with the child's ability to function at home or school for at least six months. Critical questions include: Are these behaviors excessive, long-term, and pervasive? That is, do they occur more often than in other children the same age? Are they a continuous problem, not just a response to a temporary situation? Specialists have agreed that at least six symptoms from the previous lists must be present for an accurate diagnosis, and symptoms must begin by age 7.

### **Seeking help**

Parents and other caregivers play a crucial role in ensuring that children receive the care that they need. Children with symptoms of ADHD should be referred to and evaluated by a mental health professional that specializes in treating children, or a primary care doctor who has experience in treating this disorder. The diagnostic evaluation should include behavioral observation in the classroom and at home. A comprehensive treatment plan should be developed with the family, and, whenever possible, the child should be involved in making treatment decisions. Educational testing should be performed when learning disabilities are present.

A variety of professionals may be helpful:

Specialty	Can diagnose ADHD	Can prescribe medication, if needed	Can provide counseling or training
Psychiatrists	Yes	Yes	Yes

Psychologists	Yes	No	Yes
Pediatricians or Family Physicians	Yes	Yes	No
Neurologists	Yes	Yes	No
Clinical Social Workers	Yes	No	Yes
Licensed Marriage and Family Therapists	Yes	No	Yes

### **ADHD Causes**

ADHD is nobody’s fault. Researchers believe that biology plays a large role in the development of ADHD. Thirty to 40% of children diagnosed with ADHD have relatives with the same disorder, suggesting that genes are at least partly responsible. Brain scans reveal that the brains of children with ADHD differ from those of children without the disorder. Children with ADHD are thought to have problems with the part of the brain that controls the organization and direction of thought and behavior (ADHD Basics, 2008).

### **The Affect of ADHD on School and Social Life**

Symptoms of ADHD such as trouble sitting still, paying attention to details, and listening can make school difficult for a child with ADHD. Although most children with ADHD have normal or above-normal intelligence, 40 to 60% have serious learning difficulties. Many others have specific problems with schoolwork or maintaining good grades, and face particular challenges with assignments and tests that require focused attention, lengthy writing, or have time limits. On a social level, children with ADHD often have trouble developing meaningful relationships with peers and family members. Other children may find it frustrating to play with a child who has ADHD, because of classic symptoms such as difficulty following rules, waiting one’s turn, or excessive talking (ADHD Basics, 2008).

### **Disorders that sometimes accompany ADHD**

Children and adolescents with ADHD are more likely than children without the disorder to suffer from other mental disorders. Up to one-half of all young people with ADHD have oppositional defiant disorder; about one-third has an anxiety disorder; and up to one-fifth has a mood disorder (<http://www.idonline.org/adhdbasics/adhdbasics>, Retrieved September 9, 2008). Adolescents with untreated ADHD are at risk for substance abuse disorders. Research shows that young people treated for ADHD have lower rates of substance abuse than children who go untreated. Refer to the Trainee Content on ADHD for additional information as needed.

### Learning disabilities

Many children with ADHD, approximately 20 to 30%, also have a specific learning disability. In preschool years, these disabilities include difficulty in understanding certain sounds or words and/or difficulty in expressing oneself in words. In school-age children, reading or spelling disabilities, writing disorders, and arithmetic disorders may appear. Dyslexia, a reading disorder, is quite widespread. Reading disabilities affect up to 5% of elementary school children (ADHD Basics, 2008).

### Tourette Syndrome

A very small proportion of people with ADHD have a neurological disorder called Tourette Syndrome. People with Tourette Syndrome have various nervous tics and repetitive mannerisms, such as eye blinks, facial twitches, or grimacing. Others may clear their throats frequently, snort, sniff, or bark out words. These behaviors can be controlled with medication. While very few children have this syndrome, many cases of Tourette Syndrome have been associated ADHD (ADHD Basics, 2008).

### Oppositional defiant disorder

As many as one-third to one-half of all children with ADHD, mostly boys, have another condition, known as oppositional defiant disorder (ODD). These children are often defiant, stubborn, and non-compliant. They are likely to have outbursts of temper, or become belligerent. They argue with adults and refuse to obey (ADHD Basics, 2008).

### Conduct disorder

About 20% to 40% of ADHD children may eventually develop a more serious pattern of antisocial behavior known as a conduct disorder (CD). These children frequently lie or steal, fight with or bully others. They are at risk of getting into trouble at school or with the police. They are aggressive toward people and/or animals, destroy property, commit thefts, carry or use weapons, or engage in vandalism. These children or teens are at greater risk for substance use experimentation, and later dependence and abuse. They need immediate help (ADHD Basics, 2008).

### Anxiety and depression

Some children with ADHD have co-occurring anxiety or depression. If the anxiety or depression is recognized and treated, the child will be better able to handle the problems that accompany ADHD. Conversely, effective treatment of ADHD can have a positive impact on anxiety as the child is better able to master academic tasks.

## Bipolar disorder

There are no accurate statistics on how many children with ADHD also have bipolar disorder. Differentiating between ADHD and bipolar disorder in childhood can be difficult. In its classic form, bipolar disorder is characterized by mood cycling between periods of intense highs and lows. But in children, bipolar disorder often seems to be a rather chronic mood dysregulation with a mixture of elation, depression, and irritability. There are some symptoms that can be present both in ADHD and bipolar disorder, such as a high level of energy and a reduced need for sleep. For differentiating children with ADHD from those with bipolar disorder, elated mood and grandiosity are distinguishing characteristics for bipolar disorder.

## **ADHD Treatment**

Early identification, diagnosis and treatment help children reach their full potential. The most effective treatments for ADHD include a combination of medication, behavioral therapy, and parental support and education. Nine out of ten children respond to medication, and 50% of children who do not respond to an initial medication will respond to a second. When ADHD co-occurs with another disorder, such as depression or anxiety, a combination of medication and psychotherapy is shown to be particularly effective (ADHD Basics, 2008).

## Medications

For decades, medications have been used to treat the symptoms of ADHD. The medications that seem to be the most effective are a class of drugs known as stimulants. Following is a list of the stimulants indicating their generic names, their trade (or brand) names, and approved age. Approved age means that the drug has been tested and found safe and effective in children of that age.

<u>Generic name</u>	<u>Trade name</u>	<u>Approved age</u>
Amphetamine	Adderall	3 and older
Dextroamphetamine	Dextrostat, Dexedrine	3 and older
Dexmethylphenidate	Focalin	6 and older
Methylphenidate	Ritalin	6 and older
Methylphenidate (extended release)	Metadate ER, Metadate CD, Ritalin SR	6 and older
Methylphenidate (long acting)	Ritalin LA, Concerta	6 and older
Pemoline	Cylert*	6 and older

*\*Because of its potential for serious side effects affecting the liver, Cylert should*

*not ordinarily be considered as first-line drug therapy for ADHD.*  
(ADHD Basics, 2008).

The U.S. Food and Drug Administration (FDA) recently approved a medication for ADHD that is not a stimulant. The medication, Strattera®, or atomoxetine, works on the neurotransmitter norepinephrine, whereas the stimulants primarily work on dopamine. Both of these neurotransmitters are believed to play a role in ADHD. More studies will need to be done to contrast Strattera with the medications already available, but the evidence to date indicates that over 70% of ADHD children given Strattera manifest significant improvement in their symptoms.

The stimulant drugs come in long- and short-term forms. The newer sustained-release stimulants can be taken before school and are long-lasting so that the child does not need to go to the school nurse every day for a pill. Doctors can discuss with parents the child's needs, decide which preparation to use, and whether the child needs to take the medicine during school hours only or in the evening and on weekends too (ADHD Basics, 2008).

#### Side effects of the medications

Most side effects of the stimulant medications are minor and are usually related to the dosage of the medication being taken. Higher doses produce more side effects. The most common side effects are decreased appetite, insomnia, increased anxiety, and/or irritability. Some children report mild stomachaches or headaches.

The stimulant drugs, when used with medical supervision, are usually considered quite safe. Stimulants do not make the child feel high, although some children say they feel different or funny. Such changes are usually minor. Although some parents worry that their child may become addicted to the medication, to date there is no convincing evidence that stimulant medications used for treatment of ADHD cause drug abuse or dependence. A review of all long-term studies on stimulant medication and substance abuse, conducted by researchers at Massachusetts General Hospital and Harvard Medical School, found that teenagers with ADHD who remained on their medication during the teen years had a lower likelihood of substance use or abuse than did ADHD adolescents who were not taking medications.

#### Facts to remember about medication for ADHD

- Medications for ADHD help many children focus and be more successful at school, home, and play. Avoiding negative experiences now may actually help prevent addictions and other emotional problems later.

- About 80% of children who need medication for ADHD still need it as teenagers. Over 50% need medication as adults (ADHD Basics, 2008).

As with other mental health issues, it is important that practitioners keep abreast of current research on ADHD.

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### **Introduction**

No one thing causes depression. Children who develop depression may have a family history of the disorder. Family history, stressful life events such as losing a parent, divorce, or discrimination, and other physical or psychological problems are all factors that contribute to the onset of the disorder. Children who experience abuse, neglect, or other trauma or who have a chronic illness are at a higher risk for depression. Depression in children often occurs along with other mental health problems such as anxiety, bipolar, or disruptive behavior disorders.

Depression can lead to academic underachievement, social isolation, and create difficult relationships with family and friends. Depression in children is also associated with an increased risk for suicide. Shaffer et al (1996) found a strong correlation between adolescent suicide and diagnosed mood or affective disorders, with 61% of adolescent suicide victims having a mood or affective disorder diagnosis. When working with depressed youth, it is essential that a suicide assessment be conducted by a trained professional to ascertain the status of any ideation, intent, suicide plan, or means. According to the Center for Disease Control and Prevention, suicide is the third leading cause of death for adolescents.

Adolescents who become clinically depressed are also at a higher risk for substance abuse problems. They will use alcohol and drugs as a way to numb or manage their pain. Any child or adolescent who abuses substances should be evaluated for depression. If an addiction develops, it is essential to treat both the mental health disorder and the substance abuse problem at the same time.

Once a young person has experienced an episode of depression, he or she is at an increased risk for having another episode of depression within the next five years. Children who experience a depressive episode are five times more likely to have depression as an adult (Mental Health America, 2008).

### **Signs and Symptoms**

The list below outlines possible signs of depression. If a child is struggling with any combination of these symptoms for more than two weeks, a doctor or mental health professional should be consulted.

- Frequent sadness, tearfulness, or crying
- Feelings of hopelessness
- Withdrawal from friends and activities
- Lack of enthusiasm or motivation
- Decreased energy level

- Major changes in eating or sleeping habits
- Increased irritability, agitation, anger, or hostility
- Frequent physical complaints such as headaches and stomachaches
- Indecision or inability to concentrate
- Feelings of worthlessness or excessive guilt
- Extreme sensitivity to rejection or failure
- Pattern of dark images in drawings or paintings
- Play that involves excessive aggression directed toward oneself or others, or involves persistently sad themes
- Recurring thoughts or talk of death, suicide, or self-destructive behavior

### ***Risk factors***

In childhood, boys and girls appear to be at equal risk for depressive disorders, but during adolescence, girls are twice as likely as boys to develop depression. Children who develop major depression are more likely than patients with adolescent- or adult-onset depression to have a family history of the disorder, often a parent who experienced depression at an early age. Adolescents with depression are also likely to have a family history of depression though the correlation is not as high as it is for children.

Other risk factors include:

- Stress
- Cigarette smoking
- A loss of a parent or loved one
- Break-up of a romantic relationship
- Attention, conduct or learning disorders
- Chronic illnesses, such as diabetes
- Abuse or neglect
- Other trauma including natural disasters

### ***The Depressed Child***

The first step in helping the depressed child is to recognize the depression. This can be challenging. It is difficult for adults to accept that young children, even infants, can suffer from depression. Childhood is supposed to be a happy, carefree time of life. Only in recent years has scientific evidence convinced most mental health specialists that childhood depression exists.

Recognizing the symptoms of childhood depression can also be difficult. While some children display the classic symptoms (sadness, anxiety, restlessness, eating and sleeping problems), others express their depression through physical problems (various aches and pains) that do not respond to treatment. Still others hide their feelings of hopelessness and worthlessness under a cover of irritability, aggression, hyperactivity, and misbehavior.

Complicating the recognition of depression are the developmental stages that children pass through on the way to adulthood. Negativism, clinginess, or rebellion may be normal and temporary expressions of a particular stage. In addition, children go through temporary depressed moods just as adults do. Careful observation of a child for several weeks may be required to determine if there is a problem. When symptoms of possible depression seem severe or continue for more than a few weeks, an evaluation by the child's pediatrician to rule out a physical illness would be a good first step. A next step, if deemed necessary, would be consultation with a mental health professional that specializes in treating children. While parents typically assume prime responsibility for getting treatment for their depressed child, other people such as relatives, teachers, and friends can play a role.

### **Treatment**

Treatment intervention can significantly reduce future episodes of depression in at-risk teens. A recent study found that at-risk teens who participated in 8 weekly group sessions of cognitive behavioral therapy followed by 6 monthly follow up sessions had significantly fewer episodes of depressions than similar teens who did not receive the treatment (Garber et al, 2009).

An evaluation for depression may include consultation with a child psychiatrist, psychological testing, and medical tests to rule out an underlying physical condition that might explain the child's symptoms. A comprehensive treatment plan should include psychotherapy and, in some cases, medication. Selective Serotonin Reuptake Inhibitors (SSRIs) such as Prozac, Paxil, and Zoloft have been shown to be effective with children. Studies do not support the use of tricyclic antidepressants (Elavil, Imipramine, etc.) in youth. However, Imipramine is sometimes used to treat enuresis (bed-wetting) because it improves the functioning of the smooth muscle of the bladder. A plan to treat depression should be developed with the family, and, whenever possible, the child should be involved in making treatment decisions.

The United States Food and Drug Administration issued a warning in 2004 because certain types of antidepressant medication have been linked to a 3-5% increase in suicidality among teens. Social workers should share this information with parents and foster parents and discuss this risk with doctors prescribing antidepressant medication to teens.

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## Other Mental Health Disorders of Children



In addition to having a basic understanding of the mental health issues below, the social worker plays a vital role in getting children the services they need through early referral and intervention. The social worker is often the person making the initial referral for assessment and the social worker's role continues as he or she facilitates the intervention by ensuring that each child has a team that includes school personnel, service providers, parents and substitute caregivers.

### **Anxiety Disorders**

An anxiety disorder is a mental health problem that can affect people of all ages, including children. Anxiety disorders are the most common type of mental health disorder in children, affecting as many as 10% of young people.

All children experience some anxiety; this is normal and expected. For example, when left alone at preschool for the first time, many children will show distress; a young child with his or her own room may develop a fear of the dark. Such anxiety becomes a problem when it interrupts a child's normal activities, like attending school and making friends or sleeping. Persistent and intense anxiety that disrupts daily routine is a mental health problem that requires intervention.

#### *Generalized Anxiety Disorder*

Children with generalized anxiety disorder (GAD) have recurring fears and worries that they find difficult to control. They worry about almost everything—school, sports, being on time, even natural disasters. They may be restless, irritable, tense, or easily tired, and they may have trouble concentrating or sleeping. Children with GAD are usually eager to please others and may be perfectionists, dissatisfied with their own less-than-perfect performance.

#### *Separation Anxiety Disorder*

Children with separation anxiety disorder have intense anxiety about being away from home or caregivers that affects their ability to function socially and in school. Children with this disorder may worry excessively about their parents when they are apart from them. When they are together, the child may cling to parents, refuse to go to school, or be afraid to sleep alone. Repeated nightmares about separation and physical symptoms such as stomachaches and headaches are also common in children with separation anxiety disorder.

### *Social Phobia*

Social phobia usually emerges in the mid-teens and typically does not affect young children. Young people with this disorder have a constant fear of social or performance situations such as speaking in class or eating in public. This fear is often accompanied by physical symptoms such as sweating, blushing, heart palpitations, shortness of breath, or muscle tenseness. Young people with this disorder typically respond to these feelings by avoiding the feared situation.

### **Obsessive-Compulsive Disorder**

Obsessive-compulsive disorder (OCD) typically begins in early childhood or adolescence. Children with OCD have frequent and uncontrollable thoughts (called obsessions) and may perform routines or rituals (called compulsions) in an attempt to eliminate the thoughts. Those with the disorder often repeat behaviors to avoid some imagined consequence. For example, a compulsion common to people with OCD is excessive hand washing due to a fear of germs. Other common compulsions include counting, repeating words silently, and rechecking completed tasks.

### **Posttraumatic Stress Disorder**

Children who experience a physical or emotional trauma may develop posttraumatic stress disorder (PTSD). Children are more easily traumatized than adults. A child may re-experience the trauma through nightmares, constant thoughts about what happened, or reenacting the event while playing. A child with PTSD will experience symptoms of general anxiety, including irritability or trouble sleeping and eating. Children may exhibit other symptoms such as being easily startled.

### **Bipolar disorder and children**

Many children and especially adolescents experience mood swings as a normal part of growing up, but when these feelings persist and begin to interfere with a child's ability to function in daily life, bipolar disorder could be the cause. Bipolar disorder, also known as manic-depression, is a type of mood disorder marked by extreme changes in mood, energy levels, and behavior.

Symptoms can begin in early childhood but more typically emerge in adolescence or adulthood. Until recently, young people were rarely diagnosed with this disorder. Yet up to one-third of the 3.4 million children and adolescents with depression in the United States may actually be experiencing the early onset of bipolar disorder (American Academy of Child and Adolescent Psychiatry).

Children with bipolar disorder usually alternate rapidly between extremely high moods (mania) and low moods (depression). These rapid mood shifts can produce irritability with periods of wellness between episodes, or the young person may feel both extremes at the same time. Parents who have children with the disorder often describe them as unpredictable, alternating between aggressive or silly or withdrawn. Children with bipolar disorder are at a greater risk for anxiety disorders

and Attention-Deficit Hyperactivity Disorder (ADHD). These co-occurring disorders complicate diagnosis of bipolar disorder and contribute to the lack of recognition of the illness in children.

Bipolar disorder begins with either manic or depressive symptoms. The lists below provide possible signs and symptoms. Not all children with bipolar disorder have all symptoms. Like children with depression, children with bipolar disorder are likely to have a family history of the illness.

#### Manic symptoms

- Severe changes in mood—from unusually happy or silly to irritable, angry, or aggressive.
- Unrealistic highs in self-esteem. May feel indestructible or believe he or she can fly, for example.
- Great increase in energy level. Sleeps little without being tired.
- Excessive involvement in multiple projects and activities. May move from one thing to the next and become easily distracted.
- Increase in talking. Talks too much, too fast, changes topics too quickly, and cannot be interrupted. This may be accompanied by racing thoughts or feeling pressure to keep talking.
- Risk-taking behavior such as abusing drugs and alcohol, attempting daredevil stunts, or being sexually active or having unprotected sex.

#### Depressive symptoms

- Frequent sadness or crying
- Withdrawal from friends and activities
- Decreased energy level, lack of enthusiasm or motivation
- Feelings of worthlessness or excessive guilt
- Extreme sensitivity to rejection or failure
- Major changes in habits such as over-sleeping or over-eating
- Frequent physical complaints such as headaches and stomachaches
- Recurring thoughts of death, suicide, or self-destructive behavior

#### Concurrent Substance Abuse

Many teens with bipolar disorder abuse alcohol and drugs as a way to feel better and escape. Any child or adolescent who abuses substances should be evaluated for a mental health disorder. If an addiction develops, it is essential to treat both the mental health disorder and the substance abuse problem at the same time.

#### Treatment

Various treatments known to be effective in adults with manic-depressive illness also may help relieve the symptoms in young people. The essential treatment for this disorder is the use of appropriate doses of mood stabilizing medications. The most typical is lithium, known to be very effective in adults for controlling mania

and preventing recurrences of manic and depressive episodes. Research on the effectiveness of this and other medications in children and adolescents with manic-depressive illness is ongoing. In addition, studies are investigating various forms of psychotherapy to complement medication treatment for this illness in young people.

### ***Schizophrenia***

Schizophrenia is a chronic, severe, and disabling brain disorder that affects about 1% of the population during their lifetime. Symptoms include hallucinations, delusions, disordered thinking, and social withdrawal. Schizophrenia appears to be extremely rare in children. Typically, the illness emerges in late adolescence or early adulthood. However, research studies are revealing that various cognitive and social impairments may be evident early in children who later develop schizophrenia. These and other findings may lead to the development of preventive interventions.

Only in this decade have researchers begun to make significant headway in understanding the origins of schizophrenia. In the emerging picture, genetic factors which confer susceptibility to schizophrenia appear to combine with other factors early in life to interfere with normal brain development. These developmental disturbances eventually appear as symptoms of schizophrenia, typically during adolescence or young adulthood. A number of new, effective medications for schizophrenia have been introduced during the past decade.

### ***Tourette Syndrome***

Tourette Syndrome (TS) is characterized by repeated, involuntary movements, and uncontrollable vocal sounds known as tics. Affecting approximately 100,000 Americans in its full-blown form, TS generally emerges during childhood or early adolescence.

Although the basic cause of TS is unknown, current research suggests there is a genetic abnormality affecting certain neurotransmitters in the brain, and that varying environmental factors, possibly including infections, modify the clinical expression of the disorder. Symptoms of TS are seen in association with some other neurological disorders, particularly Obsessive Compulsive Disorder (OCD). Researchers are investigating the neurological similarities between OCD and TS to determine whether a genetic relationship exists.

In most cases, Tourette Syndrome is not disabling. The symptoms do not impair patients, development proceeds normally, and there is no need for treatment. However, some effective medications are available in the rare instances when symptoms interfere with functioning. Children with TS can generally function well at home and in the regular classroom. If they have an accompanying learning disability or other disorder, such as ADHD or OCD, they may require tutoring, special classes, psychotherapy and/or medication.

**Bullying**

Foster children may be especially vulnerable to bullying related to weight, gender identity, sexual identify formation or other issues that may begin to affect children in this age range. Social workers should assess for this possibility and enlist help from the school, service providers, parents and caregivers. The California Department of Education provides resources related to bullying:

<http://www.cde.ca.gov/ls/ss/se/bullyres.asp>.

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## **The Effects of Abuse and Neglect on School Age Children<sup>8</sup>**

### **Social**

- The child may be suspicious and mistrustful of adults, or overly solicitous, agreeable, and manipulative, and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms about her family; may exhibit role reversal and assume a parenting role with the parent.
- The child may not respond to positive praise and attention, or may excessively seek adult approval and attention.

### **Physical**

- The child may show generalized physical developmental delays.
- The child may lack the skills and coordination for activities that require perceptual motor coordination.
- The child may be sickly or chronically ill.

### **Emotional**

- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by peer expectations for performance, and may withdraw from social contact; may be scapegoated by peers.
- The child may experience severe damage to self-esteem from the denigrating and punitive messages received from the abusive parent, or from the lack of positive attention in a neglectful environment.
- The child may behave impulsively, may have frequent emotional outbursts, and may not be able to delay gratification.
- The child may not develop coping strategies to manage stressful situations effectively and master the environment.
- The child may exhibit generalized anxiety, depression, and behavioral signs of emotional distress; may act out feelings of helplessness and lack of control by being bossy, aggressive, destructive, or by trying to control or manipulate other people.
- The child who is punished for autonomous behavior may learn that self-assertion is dangerous and may assume a more dependent posture. He may exhibit few opinions, show no strong likes or dislikes, may not be engaged into productive, goal-directed activity. The child may lack initiative, give up quickly, and withdraw from challenges.

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<sup>8</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 515-516, Arlington, VA: CWLA.

**Cognitive**

- The child may display thinking patterns that are typical of a younger child, including egocentric perspectives, lack of problem solving ability, and inability to organize and structure his thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on schoolwork, and may not be able to conform to the structure of the school setting. The child may not have developed basic problem solving or attack skills, and may have considerable difficulty in academics.

**Sexual**

- The child may engage in developmentally inappropriate sexual play with other children.

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## ***Sexual Behaviors that are Cause for Concern***

- Sexual behavior that is engaged in by children of different ages or developmental levels. The wider the age difference, the greater the concern.
- When the children involved in the sexual behaviors together do not have an ongoing mutual play relationship.
- The children's sexual behaviors are out of balance with other aspects of the child's life and interests, or the sexualized behavior becomes a primary focus for the child.
- The children seem to have too much knowledge about sexuality and behave in ways more consistent with adult sexual expression.
- The behaviors being exhibited are significantly different than those of other children.
- The sexual behavior continues even after many consistent requests to stop.
- The child's behavior occurs in public or other places where the child has been told they are not acceptable.
- Other children complain about the child's sexual behavior or are adversely affected by it.
- The child's sexual behaviors are directed at adults.
- The children do not understand their rights or the rights of others in relation to sexual contact.
- The behavior appears to progress in frequency, intensity or intrusiveness over time.
- The child experiences fear, anxiety, deep shame or intense guilt in connection to the behavior.
- The behaviors cause physical or emotional pain or discomfort to self or others.
- Anger precedes, accompanies or follows the sexual behavior.

- Verbal or physical aggression precedes, accompanies or follows the sexual behavior.
- Coercion, force, bribery, manipulation or threats are involved in the sexual interactions.

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## Erik (Case Scenario)

Read the following vignette with your table group. Discuss the questions below. Summarize your discussion with the larger group.

### **Erik's Story**

You are the social worker for Erik, a 9-year-old Caucasian boy. He entered foster care 8 months ago due to physical abuse and neglect. Erik's mother hit Erik with a piece of a broken bookcase because he would not listen to her. Erik suffered a deep laceration to his face and his parents did not provide medical treatment for the injury. Their home was in significant disarray and did not have running water at the time Erik was removed. Erik is living with his maternal grandmother. His parents visit sporadically, dropping in at the grandmother's home to play with Erik, but not providing any parenting. His parents have acknowledged a history of substance abuse and domestic violence.

Erik is behaviorally challenging to his grandmother. He has been diagnosed with ADHD and takes medication every day. He has moments of close attachment to his grandmother and the two share a loving relationship, but he is defiant of her efforts to ensure he completes homework or chores. Erik is on track in his motor development and speech. He has cognitive, social and emotional delays. He has been held back at school and is repeating the third grade. He has difficulty forming friendships and has been in two physical altercations at school.

You arrive at the school at 10:30 am for a face to face contact visit with Erik. He is called out of class and brought to the office to meet with you. There is no meeting space available, so you are left to meet with Erik in the teacher break room. Erik immediately finds a stapler and begins pushing staples into the bulletin board. After repeated requests from you and several minutes of chasing him around, he finally gives you the stapler, but he then picks up your keys and will not return them.

### **Discussion Questions**

- What can you do engage Erik during this meeting?
- What could you do differently to plan the next meeting?
- What could you do during the next meeting to make it easier to interact with Erik?

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## The Normal SPECS of Development for Adolescents



Adolescence is a period of significant transition. Behaviors that were previously permitted or otherwise positively reinforced are no longer allowed. Other behaviors that were once prohibited are not only permitted, but expected. In order to adopt new behaviors, the old patterns must be changed or relinquished. This is not an easy passage for the child.

Because adolescence is a period of extremely rapid change that covers approximately nine years of the child's life, adolescence is usually subdivided into stages called early, middle, and late adolescence. While the exact age at which individual children proceed through these changes may differ, the stages are fairly consistent in normally developing adolescents.

- *Early adolescence* refers to the period between ages 12 and 14. In American culture, the 13-year-old eighth-grader epitomizes this group of children.
- *Middle adolescence* includes youths between ages 14 and 17. Most high school students, grades 9 through 12, fall into this category.
- *Late adolescence* refers to youths between ages 18 and 21 and represents the final developmental step into adulthood. Recently graduated high school students and college students would be included in this category.

### **Social Development**

Adolescent social development occurs in conjunction with their cognitive and emotional development. The youth's improved insight and perspective taking ability lead to changed expectations for interpersonal relationships and an increased ability for self-disclosure and intimacy. The development of identity and independence also strongly influences how youth relate to other people.

#### Stages in Social Development:

1. The first step in the development of an independent self is to try to psychologically distance oneself from one's family, and particularly one's parents. In early adolescence, parents' attitudes are often summarily rejected, and parents are accused of being out of touch, old-fashioned, and of not understanding.
2. At the same time, youths establish a strong identification with their peers. The peer group provides teens with strong support and clear standards of behavior. Young adolescents form many kinds of peer groups, usually

composed of same-sex youths. Members conform to the group's standards of conduct, dress, language, and demeanor.

3. The next step centers on achieving social status, which is largely related to group membership. Youth who belong to groups with high social status are popular and may be envied by youths who are not part of the group. The standards that determine status may be different in different environments, but they are fairly rigidly applied within a group.
4. Once a youth has identified a group to associate with, they look for social acceptance, which is usually dependent upon conformity to observable traits or roles that group members value. The social worth of other people is rarely based upon an insightful assessment of their personal attributes. Youth may compromise their beliefs or values and even reject childhood friends to gain acceptance into the clique or group that provides them the most social status.
5. The young adolescent's need to be independent from parents is generalized to adults outside the family, particularly adults in authority positions. Yet, these same youths may develop crushes on adults or older youths, and they may try to emulate these adults' mannerisms, dress, or behavior.
6. Young adolescents are typically ambivalent about sexual relationships. They are often shy, embarrassed, and self-conscious. Early relationships usually involve group dating and activities or just hanging out. Thus youths can test out their social skills within the security and support of their same-sex peer group.
7. During middle adolescence, youths continue to associate with their peer groups; however, one-on-one friendships with same and opposite sex peers become increasingly important. These relationships are often based upon criteria absent from their previous relationships, including mutual understanding, loyalty, and intimacy. Increased insight and perspective taking ability enables youths to understand that others have feelings and experiences both similar to, and different from, their own.
8. During middle and late adolescence, values become individualized and internalized after careful consideration and independent thought. The peer group declines in importance, individual friendships are strengthened, and more youths date in one-on-one relationships.
9. Self-revelation is a first step toward the development of interpersonal intimacy. The development of intimacy is a difficult and gradual process and is partly dependent upon the youth's experiences with intimacy within the family. Youths who are raised in families where intimacy is absent or where

interpersonal relationships are distorted may have considerable difficulty learning and becoming comfortable with self-disclosure and self-expression.

10. Intimacy has its risks. As a result, youths develop expectations within their relationships for **loyalty, confidence, and trust**. Good friends are expected not to disclose personal information to others and to remain loyal and understanding, regardless of the information that is shared.
11. Youths develop similar expectations for relationships with adults. During middle adolescence, many youths are intensely curious about how adults feel, think, and perceive the world. They see adults as possibly having answers to some of their questions and concerns. Middle to late adolescents are less likely to think that no adult can be trusted.
12. Youths who are capable of self-disclosure also begin to expect the same from adults. They respect honesty and straightforwardness and are quick to point out hypocrisy and dishonesty in adults.

### **Physical Development**

As children enter adolescence, they embark upon significant physical changes. Most youth experience a significant growth spurt during this time, and will experience the onset of **puberty**. Additionally, their brain development is re-energized. Puberty and the youth's brain development affect their physical, social, emotional and sexual development.

The physiological changes of puberty promote development in two critical areas:

- There is rapid physical growth of bones, muscles, and other body tissues. Much of the physical growth takes place during a *growth spurt* in which the child grows several inches and gains considerable weight in a relatively short period of time. Metabolic efficiency reaches its lifetime high. Muscle mass is adequate for adult tasks, and will continue to increase into the 20's.
- There are significant changes in both the sex organs and **secondary sex characteristics**.
  - Girls mature physically on the average two years earlier than boys. Most girls experience their growth spurts between the ages of 11 and 14. Hormonal changes promote breast development, pubic hair, maturation of the uterus and ovaries, and menstruation. The average age range for the onset of menstruation is between ages 11 and 14.
  - Boys mature physically on average between the ages of 13 and 17. For boys, their sex organs grow in size, and the testicles begin to produce

semen. Erections, which first occur in the infant, become more frequent, and ejaculations are now possible. The onset of puberty in boys ranges from about ages 12 to 15.

### **Brain Development**

While researchers previously thought that brain development had stopped by adolescence, it has now been established that brain development continues during this time and affects adolescent youth in a variety of ways. The following are some behaviors often found in adolescents that may be attributed to the brain's development during this time:

- Adolescents often experience strong waves of rapidly changing emotions, which can influence decision making.
- They can often be perceived as acting out or moody. The rational mediation of their emotions slowly increases throughout adolescence, and reaches adult-like levels over the next 10–20 years.
- Adolescents often have difficulty handling multiple tasks simultaneously. They may have questions about what to do first and often forget commitments
- While some abstract thinking ability may be present, it is still difficult for the adolescent to grasp. It can be hard to determine what they will and will not understand.
- Adolescents are less able to read subtle social cues such as facial expressions and body language, although others may expect adolescents to do so because they can look much older than their years.
- Youth will have strong sexual feelings, but have little rational perspective for decision making.
- Critical memories may be difficult to access under stress.
- Youth often fail to see patterns or learn quickly from experience.
- Youth may have difficulty maintaining normal sleep patterns. Adolescent youth are often tired during the day and have difficulty falling asleep at night.

### **Emotional Development**

The primary task of the adolescent's emotional development is to establish a unique personal identity, building upon—but separate from—the childhood personality. To do this, the youth will often participate in experimental activities, which allow them to try out different ways of behaving, thinking, etc., in order to discover who he or she wants to be.

Early adolescence is an emotionally chaotic period, and the young adolescent is more emotionally labile than at any other time during development. The early adolescent period is inherently stressful because of rapid changes and difficult challenges. Youths are also more aware of their feelings and emotional states, and they recognize their feelings to be an inherent part of themselves.

Young adolescents often engage in activities that promote intense emotional experience. Listening to loud rock music, attending concerts and other group activities where emotions are at a peak, going to horror movies, riding amusement park rides, and reading about intimate interpersonal or sexual experiences all serve to activate new and intense feelings.

For some youths, experimentation with drugs and alcohol are attempts to magnify emotional experiences, as are driving at excessive speeds, performing daredevil stunts, or otherwise taking risks. The combination of volatile emotion, experiential innocence, lack of judgment, and dangerous activity, however, can have devastating and even life-threatening consequences.

Youth will also pull away from parents in order to become their own person. Adolescents will participate in activities that tend to reject parental norms, values, and lifestyle in order to discover their own. Youth will come to recognize parents as people, accepting mixed feelings toward them without feeling disloyal or guilt-ridden.

For successful emotional development adolescents will also:

- Learn to face and deal with problems.
- Prove one's adequacy and ability to function independently.
- Find a philosophy of life; develop an idealism/spirituality, while learning to cope with disillusionment.
- Understand sexuality and make decisions about how to express it and come to terms with one's masculinity/femininity.
- Learn a positive use of leisure time.
- Pursue interests and skills toward developing a life's work.

Additionally, adolescent youth are forming their identities, solidifying their moral decision making process, and coping with the experiences of puberty.

### **Identity Formation**

While development of an individual identity is a principal task during adolescence, identity formation may continue well into early adulthood. Adolescence, however, is the first time in the life cycle that the developmental task of identity is of central importance. According to Erikson, identity formation includes both cognitive and affective (feeling) aspects.

Self is an abstract cognitive concept. The ability to objectively view the components of one's self requires perspective taking ability and insight. The development of identity includes organizing one's perceptions of one's own attitudes, values, behaviors, and beliefs into a coherent whole. The affective component of self refers to feelings of self-worth and self-esteem.

**Cultural Note: Identity**

The struggle for identity formation can be compounded for minority adolescents and for children raised in families with an ethnicity different from their own. These youth have the doubly difficult task of establishing an identity, cultural and otherwise, which may be at odds with their own families or that of the dominant culture. The dissonance that this creates can be a barrier to achieving an integrated sense of identity.

Prior to adolescence, children's attitudes and behaviors were largely determined by the values and expectations of the family and culture in which they are raised. The adolescent's transition from being a member of a family to being independent challenges the youth to develop a sense of self that is more individualized. Blatant rejections of parental standards by young adolescents can be seen as primitive attempts to individualize themselves. Youths this age lack both the cognitive ability and the experience to evaluate parental values and standards on their own merit.

The young teen substitutes the structure of the peer group for the structure of the family. Youths consider themselves independent because they are behaving differently from their family. They typically fail to recognize that their excessive conformity to group standards does not reflect greater independence; it simply reflects dependence on a different group of people. The peer group encourages youths to try out different ideas and behaviors, in a generally accepting setting.

Identity confusion is the negative outcome of failure to develop a positive identity. Erikson suggests "identity-related psychopathology is the most common clinical disturbance in the first two decades of life." Some degree of identity confusion is a normal developmental problem and should be expected. According to Erikson (1959), identity confusion can manifest itself in a number of ways and can be affected by the lack of resolution of earlier developmental tasks. For example:

- Failure to achieve basic trust can have the most severe consequences on the development of identity. These youths exhibit what Erikson (1959) calls an almost "catatonic immobility." They fail to understand that changes in their lives are possible, much less understand their own role in promoting these changes. They have no confidence that the passage of time will provide a remedy. They feel impotent to change things, and cannot look with any confidence toward the future.

- Similarly, failure to achieve autonomy, initiative, and industry during earlier developmental stages can affect the adolescent’s ability to develop a stable, positive identity. Youths who have not positively resolved the earlier stages may exhibit feelings of self-doubt and shame, pervasive guilt, self-criticism, poor perceptions of self-worth, and overly rigid expectations for their own behavior, and a sense of inadequacy concerning task related competence.
- Youths may try to deal with these negative outcomes by overcompensating, including becoming narcissistic and unrealistically self-complimentary. Alternatively, they may harbor grandiose ideas of their capability and have high expectations for their performance in the future. They can also give in and behave in self-defeating ways, or fail to even try to master the challenges of developing an independent self. These youth appear to be lost and without direction.
- The failure to achieve identity can interfere with development in the next of Erikson’s stages—the development of mature intimacy. According to Erikson, in order to be comfortable in intimate relationships, one must have a well-developed and positive sense of self. The experience of emotional and sexual intimacy can be threatening to persons without a strong identity.

By the end of middle adolescence, most youths have developed a concept of themselves that offers enough structure and stability to allow them to pursue new activities, such as entering the work force, continuing their education, or starting their own family.

Perspective-taking ability during middle adolescence permits the child to recognize differences in people’s values and beliefs, which stimulates more intensive examination of other people’s values. The youth begins to wonder about the validity of teachings that were previously accepted without question. The awareness of inconsistencies in values creates ambiguity and may be threatening.

A primary impetus for identity formation is the need for youths to separate from their parents and to prepare to live independently. To do this, they must develop a set of standards, values, beliefs, and rules that can provide them with the structure and guidance previously provided by the family.

### **Lawrence Kohlberg’s Stages of Moral Development<sup>9</sup>**

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<sup>9</sup> Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare*, pp. 531-532, Arlington, VA: CWLA.

Advancements in abstract thinking, perspective taking, and insight produce significant changes in the moral thought of adolescents. Adolescents are often able to understand that moral principles have social utility; rules exist for the betterment of society and the benefit of its members. This perspective is called conventional morality.

There are two stages in conventional moral thought:

1. The first is epitomized by the Golden Rule. Ethical behavior is behaving in ways that benefit, and do not harm, other people.
2. A second level of conventional morality is called the “law and order” perspective, which holds that rules exist for the good of society, and citizens must uphold the law because the system could not function otherwise.

The standards of conventional morality, whether they are interpersonal or legalistic in origin, are internalized during adolescence. Youth who have developed conventional morality experience shame, guilt, and other self-blame when they fail to live up to internalized moral standards or the expectations of important others.

In assessing the moral development of youths, it is important to differentiate between moral thought and moral behavior. Young adolescents, particularly, may espouse certain moral principles but behave in ways that are in contradiction to their expressed values. Lack of self-control or strong positive reinforcement are powerful stimuli to act in ways that are not consistent with espoused values.

### ***Emotional Responses to Puberty***

At the same time adolescent youth are working toward developing their own sense of identity and creating a moral value base from which to operate, they are experiencing significant physical changes. Adolescents’ emotional responses to puberty vary. Many adolescents are somewhat ambivalent about the physical changes. They may be concurrently proud, embarrassed and self-conscious. At times, adolescents worry about whether they are normal.

Most teens exhibit anxiety about their physical appearance and are likely to be very self-conscious of the changes. Minor physical features assume enormous significance, and considerable emotional energy is spent scrutinizing oneself in the mirror and trying to hide, or otherwise change, perceived flaws.

It takes time to re-acclimate to rapid changes in body size and appearance. Boys who grow several inches in as many months are often awkward and clumsy until they re-learn coordination. The changing voice is unpredictable for a period of time; the youth sounds like someone else to himself.

A girl's attitude about menstruation is largely determined by the attitude of family and friends. It may be experienced with pleasure and pride, and considered a rite of passage. It may also be perceived as an annoyance. The onset of menstruation can be very traumatic for girls who have not been prepared, and who neither expect nor understand the changes in their bodies. The bleeding may be thought to be a sign of internal injury. It is particularly traumatic for a girl who has been sexually abused and may believe that she has been physically harmed.

Unexpected and unexplained erections in adolescent boys can be the source of extreme embarrassment. To be called on in class to stand up or go to the board at the time of an erection is a typical fear of many adolescent boys.

An early or late onset of puberty can have emotional and social significance for some youths. Research suggests that boys who mature early tend to be more self-confident and socially appropriate in their behavior than boys who mature late. Differences in girls are similar but less marked.

*During junior high school, Bill had been a popular, active, and verbal student. He was 15 when he entered high school, and he was still very thin and very short. Many of the other boys in his class were tall, strong, muscular, and in Bill's eyes, considerably more attractive than he. They were athletic; Bill was repeatedly bowled over by heavier boys during football practice in gym class. He was interested in girls, but he felt that they weren't that interested in him. Other boys seemed to talk to girls with ease. He felt inadequate.*

*Marjorie was an extremely pretty child. She was 11 when she began her menstrual periods, and she had fully developed breasts and body curves by the time she was 13. Marjorie was initially thrilled by all the attention and pleased that she was so popular. She begged her mother to let her date one of the high school boys, and then became very frightened when she was alone with him in the car and he tried to kiss and fondle her. She also became increasingly embarrassed by all the attention she received from adult men, and felt increasingly alienated from her girlfriends. She eventually began to wear sloppy sweatshirts and baggy jeans to hide her body.*

In both situations, a gap exists between the child's emotional and physical development. Bill, at 15, is emotionally ready for more mature relationships, but his body is still that of a pre-adolescent. Marjorie, at 13, is psychologically a very young adolescent with the body of an adult woman. The greater the discrepancy between physical and emotional maturity, the more conflict the youth experiences.

### **Cognitive Development**

As children enter adolescence, they enter the stage of cognitive development that Piaget referred to as formal operations. Not all people achieve this state of cognitive development. Research suggests that a combination of factors, including cultural

influences, level of education, the presence of emotional problems, and intelligence may affect the emergence and the ultimate degree of sophistication of these cognitive skills.

During early adolescence, precursors to formal operational thinking appear, including a limited ability to think hypothetically and to take multiple perspectives. During middle and late adolescence formal operational thinking becomes well developed and integrated in a significant percentage of adolescents.

Although the ability for formal operational thought has a maturational component, these cognitive skills can be greatly improved by the formal education found in a college or advanced technical school setting. Formal operational cognition includes the following:

- *The Ability to Think Hypothetically:* The youth is able to calculate the consequences of thoughts, actions, events, or behaviors, without ever actually performing them. Hypothetical reasoning is often referred to as if-then reasoning. For example, “If I were to do X, then Y would probably happen.” It allows the youth to consider a large number of possibilities and plan behavior accordingly.
- *The Ability to Think Logically:* Youth are better able to think in logical terms and can use logic in abstract thought. They can identify and reject hypotheses or possible outcomes based upon their logic.
- *The Ability to Think About Thought:* Preoccupation with thought, and especially with thoughts about oneself, is characteristic of adolescent cognition. Introspection and self-analysis are common.
- *The Development of Insight:* Perspective-taking assumes its most advanced form during late adolescence. The youth is able to understand and consider not only the perspectives and views of other people, but the perspectives of entire social systems (such as America’s attitude toward communism or mainstream culture’s attitude toward a subculture). The youth is able to consider how his behaviors affect other people, and how other people’s behaviors affect him.
- *The Emergence of Systematic Problem Solving:* The youth can attack a problem and think about it in detail, weighing all possibilities in order to think of, and choose, a solution. The youth can also evaluate the success or failure of his solution and make adaptations as needed.

### **Sexual Development**

Adolescence is a time that is filled with a variety of physical changes and social expectations that impact a youth's sexual development. Hormone levels are changing that create physical interests in self and sexual identities. Sexuality is part of the youth's struggle to find out who s/he is as a person. Peer relationships change in a way that move a youth toward having more adult-like relationships. As a result, a youth may experiment in relationships with others from the same sex, opposite sex or both. As a youth begins to develop his/her sexual identity, the significance of gender and sexual roles and rules begin to take new shape. These issues are largely shaped by a person's cultural expectations.

There are significant differences among youth in their expression of sexual behavior. These differences are influenced by several factors:

- personal readiness,
- family values and standards,
- peer pressure,
- religious affiliation,
- internalized moral standards, and
- opportunity.

Motivation to engage in sexual behavior may include biological and hormonal pressure, curiosity, a desire for social acceptance, and an attempt to increase self-esteem. Being pushed into sexual activity before one is emotionally ready, due to pressure or a need for acceptance, can contribute to emotional distress.

### **Identity**

The adolescent youth must elaborate upon and revise his/her understanding of gender roles, as they affect his/her identity. While gender is a biologically based and socially defined category, it has a psychological component to it as well. As adolescent youth are exploring and redefining their sense of individuality, they must also explore and redefine their role in connection to their gender.

### **Relationships**

Early in adolescence, youth become interested in sexual relationships. Because most of their contact with people is through groups, they often are not sexually active. In middle to late adolescence, as relationships begin to move to more one-on-one connections, sexual exploration may begin. In part, this move toward sexual relationships stems from social expectations of their peer group, as well as the physical and sexual maturation of the adolescent. As youth begin to formulate ideas about their own interest in sexuality, part of that process includes the creation of their own sexual identity.

### **Cultural Note on Sexuality**

Culture influences the adolescent's decisions about his sexual activity in a multitude of ways:

- whom an adolescent finds attractive
- the age at which a youth begins dating
- how likely a teen is to practice safe sex
- how much they share with others about their sexual endeavors
- what a teen defines as sex
- whether or not they masturbate
- how they define sexual satisfaction, competence and mastery
- whether youth will come out as gay or lesbian

### **Lesbian, Gay, Bisexual, and Transgendered Youth**

For lesbian, gay, bisexual and transgendered (LGBT) youth, finding their sexual identity can be experienced as a difficult process because such relationships may violate religious and cultural values, and disapproving parents can respond harshly. There is now research dedicated to further understanding this process for youth, and a model of Sexual Identity Development is discussed below. This model, based on the work of Eli Coleman (1981–1982), suggests five stages of development in individuals with a predominantly same-sex orientation. This model contends that identity integration depends on completion of tasks at earlier stages.

#### Stage One: Pre-Encounter

This is often referred to as the *baseline stage*, or the *pre-coming out stage*, because it occurs prior to the youth having any understanding of his or her own sexual orientation. Individuals during this stage are not conscious of same-sex feelings, but they may experience feelings of conflict.

#### Stage Two: Encounter

This stage often referred to as the *coming-out stage*, includes the initial exposure to various terms, feelings, or people who may be gay, lesbian, bisexual or transgendered. During this time, individuals acknowledge their homosexual feelings and begin to tell others.

#### Stage Three: Immersion

This stage is often referred to as the *exploration stage*. During this time, the person explores their physical, sexual, intellectual, or emotional feelings about their sexual identity. It is the most dangerous time for youth because it can involve tremendous risk-taking, both in the relationships and in the acknowledgement of their sexual identity. It also potentially exposes the individual to loss of family, friends, and support groups. Individuals have their first major experiences of sexual and social activity with others. Their tasks at this stage include developing interpersonal skills, a sense of personal attractiveness, and a sense of sexual competence.

#### Stage Four: Internalization

This stage allows the individual to integrate information related to self-identity. The development of stable committed relationships occurs, but is accompanied by a period of grief and loss as they deal with the effects of the previous stage. Depression can become quite acute during this period.

#### Stage Five: Synthesis/Commitment

This is also known as a stage of *integration*. The individual becomes comfortable with his/her sexual identity, and sexual identity now becomes only one factor in defining who the individual is. Individuals incorporate their public and private identities into one self-image.

The process of moving through the five stages of sexual development can be very difficult for LGBT adolescent youth, who are already struggling with the complex issues of identity development common to all adolescents. Due to the increased challenges faced by LGBT youth, usually in the form of familial and societal pressures, these youth encounter a variety of vulnerabilities that include:

- Depression/Suicide—Youth questioning their sexual identity are three times more likely to attempt suicide than other youth.
- Homelessness—In several recent studies, over 35% of homeless youth acknowledged being gay or lesbian or questioning their sexual orientation.
- Throwaway Youth—According to Appleby and Anastas (1998), 26% of queer youth are forced to leave home because of conflicts with their families over their sexual identities.
- Sexual Abuse—With a lack of available information and support, gay and lesbian youth are often vulnerable to sexual perpetrators who offer to help them explore their sexuality. Often gay and lesbian youth have indicated a reluctance to report being sexually abused for fear that they will be blamed.
- HIV and Other Sexually Transmitted Diseases—Information related to sexually transmitted diseases is still not disseminated in a way that speaks directly to gay and lesbian youth. The rate of HIV continues to rise in people under the age of 25.

#### ***Institutional Barriers***

When youth are struggling to develop their sense of identity and facing the variety of concerns mentioned above, they might turn to a variety of community-based resources. However, for gay and lesbian youth, this is not always possible. Many of

the traditional resources available for youth are not designed to accommodate LGBT kids.

- School systems—Gay and lesbian youth often report school to be the most unsafe place for them.
- Church/spiritual community—Oftentimes these communities are integral to an individual’s cultural or family identity and yet they are often very unwelcoming places for discussions about sexual identity.
- Media/entertainment—While some strides have been made in this area, gay and lesbian youth still do not see themselves modeled in an esteem-enhancing way.
- Child Protective Services—This system is often unaware of resources to provide for gay and lesbian adolescents and often employs terms and phrases that imply a heterosexual bias.

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## The Normal SPECS of Development for Emerging Adults<sup>10</sup>



*Emerging Adulthood* refers to young adults between ages 18 and 21 and represents the final developmental step into adulthood. Recently graduated high school students and college students would be included in this category.

### **Social Development**

As with adolescent development, emerging adulthood social development occurs in conjunction with cognitive and emotional development. The youth's improved insight and perspective taking ability lead to changed expectations for interpersonal relationships and an increased ability for self-disclosure and intimacy. The development of identity and independence also strongly influences how youth relate to other people.

During emerging adulthood, the young adult's peer groups are fairly well established and there may be increased conflict between peers and parents regarding values. The importance of peer groups increases as they look more to peers than family for affection and approval. Young adults experiment with social roles as they continue the development of personal identity.

### **Stages in Social Development**

1. During emerging adulthood, values become individualized and internalized after careful consideration and independent thought. The peer group declines in importance, individual friendships are strengthened, and more youths date in one-on-one relationships.
2. Youths who are capable of self-disclosure also begin to expect the same from adults. They respect honesty and straightforwardness and are quick to point out hypocrisy and dishonesty in adults.

### **Physical Development**

For young adults, physical development continues, but at a reduced pace. For some emerging adults there are continuing weight and height changes. Ongoing physical development leads to improved development or refinement of skills in sports.

The physiological changes of puberty continue in two critical areas:

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<sup>10</sup> Adapted from The Supporting Youth to Successful Transitions from Foster Care curriculum prepared by Debbie Lowery of the Resource Center for Family Focused Practice

- There is continued physical growth of bones, muscles, and other body tissues. Muscle mass will continue to increase into the 20's.
- There are continued changes in both the sex organs and **secondary sex characteristics**.

### **Brain Development**

The brain continues to develop during this time. Young adults are about halfway through the brain development process that started at the onset of puberty. Of particular note is the ongoing development of the prefrontal cortex, the part of the brain that allows for impulse control, planning, and goal setting (Aamodt & Wang, 2011).

A key stage of development at this age is the brain's heightened reward of risk taking behavior. During this stage, young adults may over value potential rewards and underestimate negative consequences, making them more likely to engage in risky behavior (Aamodt & Wang, 2011). Some consider this risk taking to be adaptive for young adults as they are expected to take on new challenges by trying new things, being open to new environments, and filling new roles (Dobbs, 2011).

Extended foster care can provide a valuable support network for young adults who are taking on new challenges and may be especially important for youth who have experienced trauma. Young adults who have experienced trauma may have more difficulty with planning and organizing behavior and with inhibiting impulses (Aamodt & Wang, 2011).

Some key aspects of brain development for young adults:

- Synaptic growth and pruning allowing for neuroplasticity, growth and development of new thinking and behavior
- Increasing myelination leading to enhanced speed and efficiency of information processing
- Dopamine neurotransmission in striatal and cortical systems peaks during adolescence leading to heightened but temporary sensitivity to rewards (especially pertinent to ADHD)
- "Under" activity in areas of the brain responsible for anticipatory processing means that reward cue detection is less sensitive when reward is offered and more distal (delayed gratification)
- "Under" activity during probabilistic decision making in orbitofrontal cortex and medial prefrontal cortex leads to difficulty accurately determining possible negative consequences

- “Over” activity in brain during reward receipt makes the young adult hypersensitive to immediate rewards and behaviors leading to immediate reward are enhanced at expense of longer-term reward
- Amygdala hyperactivity results in limitations to harm avoidant behavior

### ***Emotional Development***

Young adults are continuing the key emotional development task of adolescence: establishing a unique personal identity. As part of this development, young adults are likely to show a more positive commitment to membership in an ethnic or racial group and accept positive and negative aspects of both his and her own and other groups.

In addition, young adults explore the new rights they are afforded as they turn 18. This leads to explorations of conscience and continued development of standards, values, beliefs, and rules that can provide them with the structure and guidance previously provided by the family.

### ***Cognitive Development***

Through the emerging adulthood period young adults gain skills in hypothetical thinking, logical thinking, introspection, self analysis and problem solving. This gains in cognitive abilities lead to more generating and testing of hypotheses, more serious consideration of vocational interests and goals, and development of insight.

### ***Sexual Development***

Pubertal changes that started in puberty continue into young adulthood. Emerging adults will likely have an increased interest in sexuality. They may also be exploring birth control decisions and parenting.

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## Adolescence and Brain Development

Adolescence is a time of transition, both in biology and in behavior. During adolescence, the greatest changes in brain development occur in the parts of the brain that control self-control, judgment, emotions, and organization. These changes occur in the frontal and parietal lobes in particular and also in portions of the limbic system.

### **Brain Changes**

What scientists know is that the amygdala (limbic region) which is closely linked to emotionally laden responses, is particularly active during adolescence. The amygdala appears to undergo a growth spurt during adolescence that is more pronounced in males.

These changes in the limbic system influence the intensity of emotional reactions. Research indicates that the brain reaches maturity around age 21 or 22 especially in those parts of the brain that govern control of impulsivity, judgment, planning for the future, foresight of consequences, and other characteristics that make people morally culpable. One researcher puts the age of full maturity at 25 or 26 ([http://www.phschool.com/science/science\\_news/articles/teen\\_brains\\_trial.html](http://www.phschool.com/science/science_news/articles/teen_brains_trial.html), Retrieved September 9, 2008).

Because the frontal lobe is still maturing, teens cannot react efficiently in situations of high emotional content. Adolescence often presents life circumstances that overwhelm the capacity of the brain to appraise situations, make good decisions quickly, or to react appropriately.

Significant changes in the sleep/arousal patterns of adolescent can compound emotional instability in complex social situations.

### **Behavioral Impact**

Changes in brain development most effect motivation and emotion (Dahl, 2003). Teens typically exhibit mood swings, increased conflict with parents, a greater tendency for risk-taking and rule-breaking, alterations in sleep/arousal regulation, an increased risk of emotional disorders, and an increase in romantic and sexual interest.

While this biological component is strong, Alan Booth (Pennsylvania State University) found that the influence of environment trumped the influence of biology. Looking at 400 stable middle-class families, he found that when parent-teenager relationships were poor, high-testosterone sons were more likely to engage in high-risk behaviors, such as skipping school, sex, lying, drinking, and stealing. Low-testosterone sons

were more likely to be depressed. High-testosterone daughters with poor relationships with their mother were also more likely to engage in risky behaviors; low-testosterone daughters also reported feeling depressed. However, if parent-child relationships were healthy, testosterone levels didn't seem to matter at all (Cheng, 1998).

Adolescents appear to need more sleep than previously thought. Teens may exhibit greater daytime sleepiness (increased need for sleep) even if they obtain as much night sleep as prepubertal children. “In a controlled lab setting, Carskadon found that teenagers happily slept on and on, a bit over nine hours. And even then, they were sleepy in the middle of the day.” They also had a propensity to grab real nap opportunities (Strauch, 2003).

Research indicates that REM sleep is critical to the consolidation of learning and memory. A study indicated that rats who learned to navigate a maze in order to reach a reward, rehearsed the same maze in their dreams. Researchers found the area of the brain that the rats used to learn the maze. The same area lit up when the rats were sleeping. During REM sleep, the brain appears to integrate old memories with new learning to forge deeper, broader conceptualizations through new patterns of neural pathways.

Some developmental changes in sleep regulation are biologic and linked to puberty. Melatonin and other sleep-inducing hormones are released two hours later in an adolescent compared to a child (10 o’clock vs. 8 o’clock). Therefore, natural feelings of drowsiness are delayed. At the same time that there is the biologic shift toward a preference for going to sleep later, there is also a physiological need for more sleep during puberty. In a sleep lab, adolescents sleep 9.5 hours/night.

Some changes in sleep regulation are linked to social influences, habits, and patterns. Technology (TV, computers, video games, music gadgets, etc.), peer interactions (cars, phones, significant others), school schedules (homework, extracurricular activities), and work obligations—all push in the direction of delayed sleep.

Interactions between these domains can lead to a negative spiral of consequences. Since adolescents have been demonstrated to need about nine hours of sleep, the consequences of less sleep can have dramatic consequences—as seen on later slides.

### **Consequences**

- Consequences of too little sleep are: tiredness and decreased motivation, involuntary napping, inability to do tasks that are not exciting or competitive, irritability, lack of emotional control, inability to concentrate or remember simple information.
- Difficulties with focused attention: “... Too little sleep can, in particular, impair a teenager’s ability to do two important things at once, such as

thinking and curbing emotions. ... The sleep-deprived teenagers could no longer process emotion and think effectively at the same time, which means either activity, controlling emotions or remembering, could be impaired” (Dahl, 2001).

- Irritability, emotional lability: Sleepy teenagers don’t have different emotions from others, they just have less control of those emotions and the emotions tend to be more exaggerated—both negative moods and silliness. “Feelings are more raw. If they’re frustrated, they are more likely to show anger; if they are sad, they are more likely to cry.” (Dahl, 2001). Affect regulation and cognitive emotional integration are more difficult when there is less control.
- Negative effects on learning, memory consolidation: REM sleep is critical to the consolidation of what we learn today into what we remember tomorrow (Graham, 2000).

### **Vicious Cycle**

- Teens’ inability to fall asleep early due to delayed melatonin secretion makes it harder for them to wake up early for school. Then, catch-up sleep on weekends pushes the circadian system to delay further.
- Adolescents often use stimulants in an effort to avoid sleepiness during the day that results from sleep deprivation. Use of stimulants (caffeine and nicotine) can exacerbate difficulties in falling asleep.
- Full-time students working more than 20 hours/week often compound problems associated with sleep deprivation when work demands make it necessary for the adolescent to stay up late at night to meet homework and study demands.
- Other factors affecting sleep are social, familial and environmental. Emotional arousal, conflict, stress, or distress may interfere with sleep, setting up a vicious cycle in which emotions cause lack of sleep and lack of sleep exacerbates emotions.

Adapted from: *Sleep Needs, Patterns, and Difficulties of Adolescents*, National Academy Press, 2000, and *Cerebrum*, Strauch, 2003.

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## Grief and Loss in Adolescents

Some indicators and characteristics of grief and loss in adolescents are listed below. This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

### **Early Adolescence (13 to 14 years)**

- Adolescents have an increased ability to identify their feelings and to communicate their concerns.
- Adolescents are emotionally labile, and loss and separation may exacerbate emotional fluctuations.
- The additional stress of loss or separation may compromise the teen's coping ability and precipitate a crisis.
- Adolescents may not be able to admit a need for support, nurturance, and structure from adults. Without these, however, the adolescent may flounder and experience considerable anxiety. By rejecting adults, the teen is deprived of an important source of coping support.
- Separation from parents, especially if the result of family conflict and unruly behavior on the part of the adolescent, may generate guilt and anxiety.
- Young adolescents may feel they are unable to fit in to their new social environments, especially if there are significant cultural differences between the foster child and his/her peers. This can result in considerable anxiety, and at times depression. These issues also affect the late stages of adolescent development.

### **Middle Adolescence (15 to 17 years)**

- The middle adolescent may have the cognitive ability to understand complex reasons for separation, placement, and family behavior. S/he may understand that things happen for many reasons, that no one person may be at fault. The ability to be self-aware may be of help in coping with the situation and conflicting feelings about it.
- Adolescents who are placed out-of-home are denied the opportunity to work out their quest for independence and age-appropriate ambivalence within the family setting. The adolescent may be confused by simultaneous feelings of anger and love for his/her family of origin. With help and reassurance that

ambivalence is normal, the adolescent may be able to accept his/her internal feelings.

### ***Helping Adolescents to Grieve***

- Teens need to be given permission to grieve or not to grieve.
- Do nothing to interfere with the natural outpouring of acute pain, sadness, anger, and guilt in the immediate aftermath of the loss.
- Encourage adolescents to express their longing, yearning, and sadness.
- Help them to understand normal grief.
- Stress the unique form grief will take for each person.
- Address the anxiety that personal death awareness evokes in adolescents.
- Be sensitive to the sex roles difference in adolescent bereavement.
- Be sensitive to the increased guilt associated with the de-idealization process in early adolescence.
- Respond empathetically to the vulnerable sense of self of adolescents.
- Support the developmentally critical process of individuation in bereaved adolescents.
- Recognize the critical importance that same sex friendships have for early adolescents in terms of identity formation.
- Be alert to the fantasized ideal family as another source of guilt.
- Recognize the many forms of adolescent rebellion and its implications for bereaved adolescents.
- Reach out to shy and inhibited teens to facilitate their grieving.
- Be prepared to tolerate anger and hostility in dealing with adolescents with acute grief reactions.

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## ***The Effects of Abuse and Neglect on Adolescents***

### ***Social***

- The youth may have difficulty maintaining relationships with peers. They may withdraw from social interactions, display a generalized dependency on peers, adopt group norms or behaviors in order to gain acceptance, or demonstrate ambivalence about relationships.
- Maltreated youth may display limited concern for other people, may not conform to socially acceptable norms, and may otherwise demonstrate delayed moral development.
- Maltreated youth may not be able to engage in appropriate social or vocational roles. They may have difficulty conforming to social rules.

### ***Physical***

- The youth may be sickly or have chronic illnesses.
- Sensory, motor, and perceptual motor skills may be delayed and coordination may be poor.
- The onset of puberty may be affected by malnutrition and other consequences of serious neglect.

### ***Emotional***

- The youth is likely to mistrust adults and may avoid entering into relationships with adults.
- Maltreated youth may display a variety of emotional and behavioral problems, including anxiety, depression, withdrawal, aggression, impulsive behavior, anti-social behavior, and conduct disorders.
- Maltreated adolescents may lack the internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent and sometimes volatile mood swings.
- Abused and neglected youth may demonstrate considerable problems in formulating a positive identity. Identity confusion and poor self-image are common. The youth may appear to be immobilized and without direction.
- The youth may have no trust in the future and may fail to plan for the future. The youth may verbalize grandiose and unrealistic goals, but may not be able to identify the steps necessary to achieve the goals. These youth often expect failure.

### ***Cognitive***

- The youth may not develop formal operational thinking; may show deficiencies in the ability to think hypothetically or logically and to problem solve systematically.

- The youth's thinking processes may be typical of much younger children; the youth may lack insight and the ability to understand other people's perspectives.
- The youth may be academically delayed and may have significant problems keeping up with the demands of school. School performance may be poor.

### **Sexual**

- Maltreated youth, particularly those who have been sexually abused, often have considerable difficulty in sexual relationships. Intense guilt, shame, poor body image, lack of self-esteem, and a lack of trust can pose serious barriers to a youth's ability to enter into mutually satisfying and intimate sexual relationships.
- Girls who experience sexual abuse are more likely to develop eating disorders, especially if the girl started her period before age 12 and if the abuse started before age 11 (Romans, 2000).
- A significant percentage of teenagers, both boys and girls, who become truant or who develop unruly or acting-out behaviors, are *reacting to sexual abuse* (Garnefski, 1998).
- Teens who experience sexual abuse may become more isolated and exhibit symptoms of anxiety and insomnia.

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## ***Elements of Positive Youth Development***

The following was developed by youth as part of the Y.O.U.T.H. Training Project to give voice to what youth need during adolescence.

**Bonding:** When a youth has a chance to develop a deep connected relationship with another person.

**Resilience:** When a youth learns to persevere over obstacles (and understands and can identify the strategies s/he used to keep on keeping on).

**Social Skills:** When a youth knows how to act and feel comfortable in groups, with individual friends, etc.

**Emotional Competence:** When a youth knows how to act and feel comfortable in groups, with individual friends, etc.

**Cognitive Ability:** When a youth can plan a party, pass a class, get an A on a test, think through a problem.

**Principles and Values:** When a youth can identify right and wrong, can act accordingly, and communicate her/his beliefs to others.

**Self-determination:** When the youth has the ability to live and grow by self-developed, internal standards and values.

**Spirituality:** When a youth develops a sense or belief in a higher power, internal reflection, or mediation.

**Opportunity:** When a youth gets a chance to master a skill, earn a paycheck, and generally excel at something.

**Appreciation:** When a youth is told that s/he is valued, regarded, have strengths.

**Youth engagement:** When a youth has meaningful participation in a critical decision in her/his life, or in the development of case planning, service or legislation.

### **Honoring the Voices of the Y.O.U.T.H. Project**

As a caseworker, how can you help to facilitate these elements? Please discuss in your table groups and develop a list of strategies.



# Child & Youth Development in a Child Welfare Context

Version 1.2, 2012



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## Goals

- Know and assess normal development
- Educate and counsel parents, foster parents and other caregivers
- Understand cultural variations and values
- Identify early warning signs re: developmental problems
- Intervene early to access services
- Identify developmental concerns related to trauma, abuse and neglect

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## Agenda

- A Framework for Understanding Child Development
- Ages 0-2
- Ages 3-5
- Ages 6-12
- Adolescence
- Case Application
- Child Development Game

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## Age Range

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- ❑ 0-2, Infancy/toddlerhood
- ❑ 3-5, Preschool
- ❑ 6-12, School Age
- ❑ 13+, Adolescence

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## Topics of Each Age Range

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- ❑ Normal Development
- ❑ Brain Development
- ❑ Attachment
- ❑ Grief & Loss
- ❑ Red Flags
- ❑ Implications for Practice

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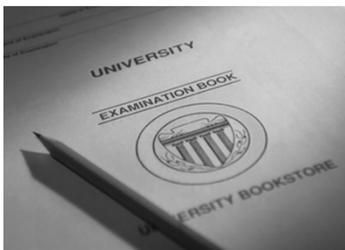
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## Testing, testing...

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What about you?

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**What small success have you had in your work recently that you are proud of?**

**Discuss in your groups.**

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What about you?

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**Core Competencies & Learning Objectives**

- What will make this day worth your time?
- Any other areas you would like to discuss?

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Understanding Development

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- Dynamic and ongoing
- Directional
- May involve stages
- Cumulative
- Occurs across many domains

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## Developmental Domains: **SPECS**

*put on your glasses!*

- Social**
- Physical**
- Emotional**
- Cognitive**
- Sexual**



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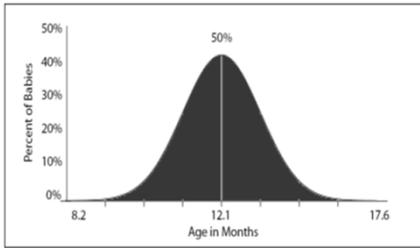
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## Normal Distribution Curve



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## Theories

- Biological**
- Cognitive**
- Psychoanalytic**
- Family**
- Non-stage constructs**

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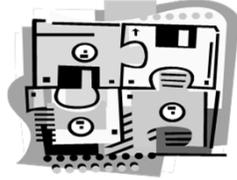
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What Genetic & Environmental  
Factors Determine the  
Final Outcome?



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## Heredity



Genetic potential  
+ development  
= maturation

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## Environment

- ▣ Prenatal
- ▣ Physical
- ▣ Social/Cultural
- ▣ Learning
- ▣ Emotional



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## The Brain

- ❑ Most complex organ in the human body
- ❑ 100 billion neurons
- ❑ Trillions of synapses
- ❑ Prime mandate is survival
- ❑ Creation of social relationships is the primary survival strategy

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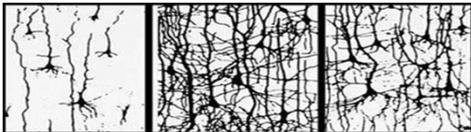
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## Synaptic Density\*

- ❑ Born with 100 million neurons
- ❑ Brain develops more rapidly and extensively during the first year than previously thought
- ❑ Significant influence of environment & experience
- ❑ Synaptic Pruning: "Use it or lose it"

\* (Perry 2002)



Birth          Six years old          14 years old

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## Principles of Brain Development

- ❑ Genetics provide blueprint; environment shapes expression of genes
- ❑ Sequential development is use-dependent
- ❑ Healthy growth needs specific repetitive patterns of activity
- ❑ Experience during critical periods of childhood organizes the brain

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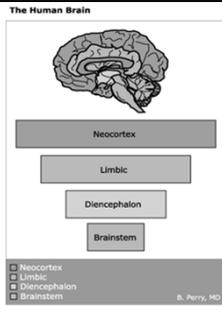
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## Brain Functions

- ❑ Brain Stem: regulation & control of body
- ❑ Limbic system, cortex & neocortex: reception & interpretation of sensory data
- ❑ Cortex & neocortex: conscious thought, memory, & emotions



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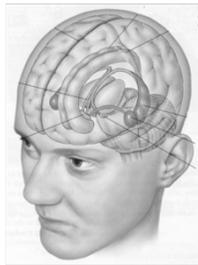
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## Brain Function and Trauma

- ❑ Brain Stem
- ❑ Reticular Formation
- ❑ Cerebral Cortex
- ❑ Limbic System



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## What is normal within a cultural frame?



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Video Clip

***Childhood: Louder Than Words***



The role of culture  
in child  
development

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Infants

□ *I am what I am given*



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Infants

- S – Attachment, smiles
- P – Mastery over body, alertness
- E – Basic trust, sings, plays
- C – Object permanency, peek-a-boo
- S – Sensual creatures: everything in the mouth, explores body parts, bats eyes

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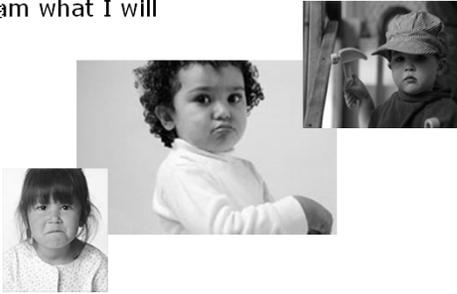
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## Toddlers

- I am what I will



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## Toddlers Age 1 - 2

- S – Relationships with family (Age 1 – 2)  
Relationships with peers (Age 2 – 3)
- P – Fine & gross motor skills (Age 1 – 2)  
Challenges motor skills (Age 2 – 3)
- E – Autonomy (Age 2 – 3)
- C – Language (Age 2 -3)
- S – Interested in body parts, curious

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## Infant Brain Development

Critical Windows of Opportunity:

Vision - Birth to 6 months

Speech - Birth to 3 years

Emotional Development - Birth to  
18 months

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## Infant Brain Development

### Effects of Child Maltreatment

- ❑ Limited Environmental Stimulation
  - Synaptic connections (flow of brain signals) may be eliminated or fail to develop
  - May result in deficits in cognitive abilities
- ❑ Acute Stress
  - Causes a physiological coping response
  - Alters development of neurotransmitters
  - Promotes structural and functional alterations in areas of the brain

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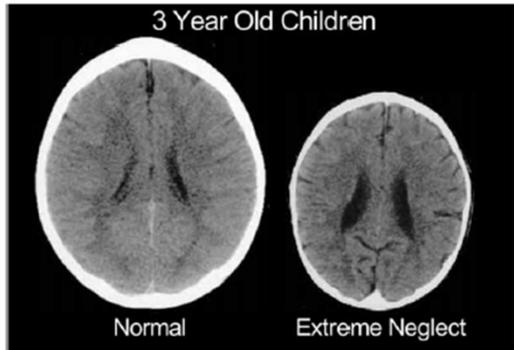
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## Video Clip

### *-The First Years Last Forever-*



**The dance of attunement**

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## Video Concept Review

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### □ Rhythm, Repetition, & Consistency

- Assists brain organization
- Foundation for current and later learning

### □ Reciprocal Communication

- Parents are more engaged with Child
- Parents meet the child's needs more effectively

### □ Enjoying Parenting

- Parents are less inclined to harm their child

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## Infant Brain Development

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### Attachment & Attunement:

- Attachment refers to the social and emotional relationships children develop with the significant people in their lives.
- Attunement is being aware of, and responsive to, another person.

"Just as the brain allows us to see, smell, taste, think, talk and move, it is the organ that allows us to love...or not."  
*Bruce Perry*

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## Infant Brain Development

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### Attachment Plays a Role

- Development of:
  - Language
  - Trust and positive world view
  - Self-esteem
- Anxiety reduction/sense of security
- Learning through social interactions
- Self-reliance

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## Stages of Attachment Formation

- **Birth to 3 months**
  - Pre-attachment
- **3-8 months**
  - Recognition/discrimination
- **8-36 months**
  - Active attachment
- **3 years on...**
  - Partnership



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## Key Factors for Attachment

- Claiming
- Attunement
- Physical Contact

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## Responses to Disruptions in Attachment

- **Protest**
- **Despair**
- **Detachment**

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## Application to Practice

- ❑ Read the case scenario "Rasa" with your table group.
- ❑ Discuss the following questions:
  - What is happening between Azar & Rasa?
  - What needs to happen between Azar & Rasa?
  - How would you help Azar with her parenting?
  - How can you address the role of culture in your interactions with Azar & Rasa?

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## Infant Brain Development

### Attachment Templates

- ❑ First relationship with primary caregiver builds template for future relationships
- ❑ Secure attachment builds neural connections
- ❑ Childhood experiences are the foundation for the brain's capabilities later in life

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## Implications for Practice

- ❑ How do our systems and practices reinforce the negative developmental templates that abused and neglected children and parents have?

HOW DO OUR KIDS  
GET LEFT BEHIND?



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## Grief & Loss in Children Ages 0-2

- ❑ Infants Experience Acute Stress and Fear
  - May present as
    - ❑ Decreased activity level
    - ❑ Sleep disturbance
    - ❑ Weight loss
- ❑ Toddlers Experience Overwhelming Crisis
  - May present as
    - ❑ Protest
    - ❑ Vigilance
    - ❑ Emotional detachment

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## Video Clip

### *-Understanding Traumatized Children: The Core Concepts-*



**How poverty of experience disrupts development**

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## Maltreatment & Brain Development

- ❑ Neglect means that there was an absence of appropriate stimulation at the right time of development.
- ❑ Trauma means that there was an over stimulation at the wrong time and perhaps for a prolonged period of time.

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## Dysfunction Resulting from Maltreatment

Depends on the insults:

-*Timing*

-*Nature*

-*Pattern*

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## Failure to Thrive

- Decelerated or arrested growth
- Weight for age falls below the 5<sup>th</sup> percentile (corrected for prematurity)
- Organic (explained by physical condition)
- Nonorganic (not explained by physical condition)

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## Video Clip

### ***-The Listening Heart-***



Fetal alcohol syndrome  
identification and  
intervention

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## Implications for Practice

- ▣ What can we do to address red flags for delayed development in the children we serve?

How can we  
Best Intervene?



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## Taking It Home

- ▣ What was the most important thing you learned today?



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## Welcome Back!



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## What about you?

- ❑ How is your memory?
- ❑ Let's test your brain!
- ❑ Write down what you remember & win a prize!



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## Pre-School

- ❑ I am what I can Imagine



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## Pre-school

- ❑ S – interactive play, social roles
- ❑ P – gross and fine motor skill mastery
- ❑ E – initiative, self-esteem
- ❑ C – increased vocabulary, concrete & egocentric thought
- ❑ S – curiosity, masturbation

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## Stages of attachment

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### 3 years on...

- Partnership
  - Attachment solidifies
  - Increased verbal communication of needs
  - Negotiation of differences

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## Interrupted Attachment

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### Developmental Effects:

- Low self-esteem
- General distrust of others
- Mood disorders
- Inadequate social skills
- Generalized cognitive and language delays

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## Application to Practice

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- Read the case scenario "Jazmine" with your table group
- Discuss the following questions
  - What do you do before the visit to help with your planning?
  - What kind of changes would you make to the timing and setting for the visit?
  - What kinds of suggestions would you make to Marisol to help her engage with Jazmine?

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## Grief & Loss in Children Ages 3-5

- May view separation as punishment
- May have trouble eating and sleeping
- May regress in bowel and bladder control
- May think death is temporary, reversible
- May use magical thinking to explain loss
- If loss is due to separation (placement), may think parents and siblings are gone forever

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## Developmental Disability Definition

- Begins before 18 and continues indefinitely
- Presents a substantial disability
- Must be due to:
  - Intellectual Delay
  - Cerebral Palsy
  - Epilepsy
  - Autism
  - Other closely related disabling conditions

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## Autism

- Presents with varying impact
- Affects 1 in 150 children (1 in 94 males)
- Affects social interactions and communication
- Appears in the first 3 years
- Responds to early intervention
- Lasts throughout life

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## Effects of Maltreatment Ages 3-5

Varies based on

- developmental stage of child
- nature of maltreatment
  - neglect, abuse or trauma
- frequency and duration of maltreatment
- severity of maltreatment

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## Implications for Practice

- Establish a collaborative treatment team
  - Build a team early to provide assessment and intervention for behavioral and mental health needs
  - Help caregivers and parents work within the team model
- Help caregivers use positive discipline
  - Natural and logical consequences
  - Choices within limits
  - Engagement through games and play

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## Implications for Practice

- What can we do to address delayed development associated with maltreatment in the children we serve?



**How can we  
Best Intervene?**

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## School Age

□ I am what I learn



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## Video Clip

*-Life's Lessons-*

The 5-7 shift



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## School Age

- S – Same sex friends, rules guide behavior
- P – Improved complex gross motor skills, perpetual motion, naturally physical
- E – Industry, mastery, self-control, needs recognition
- C – Logical and sequential, concrete operations
- S – Increased modesty

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## Grief & Loss in School Age Children

- Children age 6-9
  - May be curious and ask many questions
  - May become fearful and anxious
  - May withdraw from others
  - May feel abandoned by both parents
- Children over age 9
  - Have increased ability to understand reason for separation
  - May worry about family more than about self

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## Trauma

- Trauma results from the over-activation of the stress network
- Repeated activation of traumatic experiences increases the severity of traumatic effects and makes them less amenable to treatment

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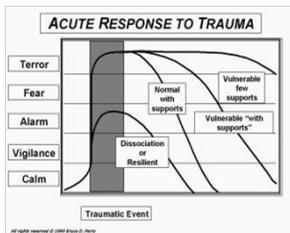
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## Video Clip

### *-Understanding Traumatized Children: The Core Concepts-*

The fear response and the impact of child trauma



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## Brain Development

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### The Stress Response

- ❑ Survival strategies involve more primitive brain functions
- ❑ Primary adaptive responses to threat exist on two continuums:
  - Hyperarousal (fight or flight)
  - Dissociative (surrender)
- ❑ Different people may have different responses to the same trauma

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## Posttraumatic Stress Disorder

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- ❑ Extreme stressor, intense fear, helplessness or disorganized behavior
- ❑ Persistent reliving of the traumatic event
- ❑ Emotional numbing, flat affect, depression
- ❑ Persistent psychological hyper-reactivity
- ❑ For children:
  - a loss of previous functioning
  - an inability to master new developmental stages

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## Co-Morbidity with PTSD

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- ❑ For children:
  - Major depression
  - Panic disorder
  - Anxiety disorder
  - ADHD, ODD, & conduct disorder
- ❑ For adolescents:
  - All of the above
  - Substance abuse
- ❑ For adolescent girls:
  - All of the above
  - Increased likelihood of health problems

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## Mental Health Concerns

- ❑ 1 in 10 U.S. children and adolescents suffers from mental illness severe enough to cause some level of impairment
- ❑ Fewer than 1 in 5 of these children receives needed treatment
- ❑ Common disorders include anxiety disorders (OCD, PTSD), depression, bipolar disorder and conduct disorders.
- ❑ Social workers play a vital role in meeting children's needs with **early assessment and intervention**

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## Attention Deficit/Hyperactivity Disorder

- ❑ The most common psychiatric disorder treated in children (3-5% of school age children)
- ❑ It is an emotional, cognitive, and behavioral disorder
- ❑ Symptoms include
  - Impulsivity
  - Hyperactivity
  - Inattentiveness
  - Low tolerance for frustration

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## Co-Morbidity with ADHD

Co-occurs with other psychiatric disorders

- ❑ Oppositional defiant disorder 33-50%
- ❑ Conduct disorder 20-40%
- ❑ Mood disorders 10-20%
- ❑ Anxiety disorders 35%
- ❑ Learning disability 20-30%

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## Depression in Children

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- May appear as sad or irritable
- Symptoms include
  - School difficulties, refusal to attend
  - Withdrawal, isolation
  - Physical complaints
  - Negative attitude
  - Aggressive or antisocial behavior

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## Effects of Maltreatment Ages 6-12

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- Effects of an unpredictable environment
  - anxiety and an inability to perform
  - inability to learn coping strategies to manage the environment
  - impulsivity and inability to delay gratification

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## Implications for Practice

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- What can we do to improve our interactions with traumatized children?

**How can we  
Best Intervene?**



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## Resiliency

- Ability to overcome adversity
  - Individual factors – cognitive and social skills, self-esteem, help-seeking
  - Environmental factors – support, stability, community connection
  - Genetic factors – associated with gene regulating serotonin levels

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## Application to Practice

- Read the case scenario “Erik” with your table group
- Discuss the following questions
  - What can you do to engage Erik during this meeting?
  - What could you do differently to plan the next meeting?
  - What could you do differently during the next meeting to make it easier to interact with Erik?

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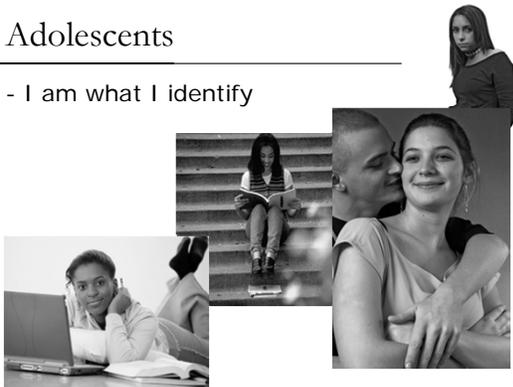
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## Adolescents

- I am what I identify



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## Adolescents

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- ❑ S – Peer identification, social acceptance
- ❑ P – Growth, brain development, puberty
- ❑ E – Individual identity, labile, likes intense emotion, moral development
- ❑ C – Formal operations
- ❑ S – Physical relationships, sexual identity, gender identity

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## Emerging Adults

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- ❑ Ages 18-25
- ❑ Continued development of the prefrontal cortex
  - improving impulse control, planning, and goal setting
- ❑ Age of risk taking
- ❑ Emerging adults may over-value potential rewards and underestimate negative consequences

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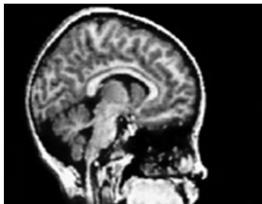
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## Video Clip

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### *-Inside the Teenage Brain-*



Brain development during adolescence

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## Adolescence

### The Last "Best" Chance

- ▣ Transition in biology and behavior
- ▣ Transition to adult roles, responsibilities
- ▣ Most significant time of brain development after infancy

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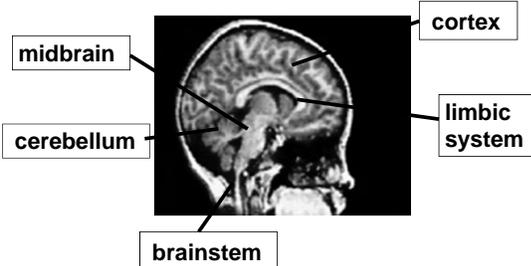
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## Adolescent Brain Development



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## Behavioral Impact: Puberty

Highly active limbic system  
(emotions and sexual behavior)  
+  
Underdeveloped prefrontal cortex  
(Poor decision making under pressure)  
=  
Risk taking, mood swings,  
conflict with authority

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## Behavioral Impact: Age-Related

- Adolescents need practice to learn
  - How to weigh long-term consequences of behavior
  - How to regulate their affect for better self-control and planning
  - How to navigate complex social situations in the face of strong emotions and/or conflicting feelings

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## Sleep and Adolescents

- Changes
  - Changes in circadian rhythm
  - Increased need for sleep (9+ hours)
- Confounding Factors
  - Teens daily activities don't leave enough time for sleep



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## Consequences

- Decreased motivation
- Impaired ability to process emotion and think effectively at the same time
- Difficulty learning
- Delayed reaction time

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## Grief & Loss in Adolescence

- Indicators & Characteristics
  - May feel guilt about the separation or loss
  - Loss may exacerbate emotional fluctuation
  - Stress overload may occur
  - May not admit need for support and therefore experience anxiety

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## Implications for Practice

- How can we help teens process feelings of grief?

How can we  
Best Intervene?



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## Effects of Maltreatment

- Maladaptive behaviors:
  - Truancy, unruly acting out behavior, or depression
  - Lack of confidence about the future
  - Feelings of guilt, shame, self-doubt, and lack of self-worth
  - Avoidance of intimacy
  - Mental health diagnoses

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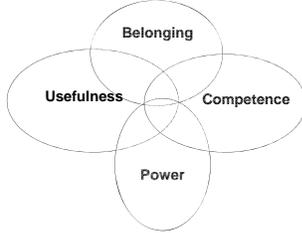
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## Youth Development for Success



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## What Makes a Difference

- Reflectiveness
  - curiosity about one's thoughts, feelings, & motivations
  - willingness to try to make sense of emotions
- Agency
  - conviction that what one does matters
  - belief one can intervene effectively in one's own life
- Relatedness
  - engagement & interactions w/others
  - Willingness to use connections when available

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## Implications for Practice

- How can you help facilitate Positive Youth Development?

**How can we Best Intervene?**



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## Application to Practice

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- Tammy and Marcus
- Vignettes pages
- What chronological age are they?
  - How would you expect them to act?
- What developmental age are they?
  - How would you respond?

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## What Would You Do?

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## Lets Play A Game

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Testing, testing...

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Thank You & Evaluations

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# **Supplemental Handout: The SPECS of Normal Development**

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Birth to One Year						
Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
Birth	<p>Prefers female voice</p> <p>Can identify mother figure through auditory and olfactory senses within 48 hours of birth</p> <p>Bonding process initiated</p>	<p>Weight range for full-term: 5 ½ - 10 ½ lbs. Average wt.: Boys 7 ½ lbs. Girls 7 lbs</p> <p>Length range for full term: 18 - 22 inches</p> <p>Head is large (¼ of total body size)</p> <p>Rapid brain development</p> <p>Abdomen is large Arms and legs thin</p> <p>Fontanels open</p> <p>Small for Gestational Age (SGA) if full-term weight is less than 5 lbs.</p> <p>Premature if less than 37weeks, gestation</p>	<p>Sees well at 8 - 12 inches</p> <p>Sense of taste, smell, touch, and hearing well-developed</p> <p>Reflexes include: sucking fencing posture grasping startling</p> <p>Hands kept fistled</p> <p>Movement is active, random, flailing and uncontrolled</p> <p>Lifts head</p>	<p>Consciousness of self begins with the early mental representation of a special person created by the child.</p> <p>Learns about love and trust through touching and holding</p>	<p>Alertness states: active alert quiet alert drowsy</p> <p>Responds to bell</p> <p>Undifferentiated cry for needs</p> <p>Responses to surroundings are very reflexive</p>	<p>The full range of sexual behaviors includes penile erection, vaginal lubrication or orgasm</p>

## Birth to One Year, Continued

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
1-3 Months	<p>Spontaneous smile develops</p> <p>Begins to smile responsively</p> <p>Alert to presence of people</p> <p>Makes eye contact</p> <p>Vocalizes sounds</p> <p>Bonding process continues as child is able to identify caretaker</p>	<p>Average weight gain is about 1 ounce per day</p> <p>By three months, will grow about 2 inches in length from birth</p> <p>Rapid brain development continues</p>	<p>Will visually track objects to midline at one month</p> <p>Can lift head to 45° by one month</p> <p>By two months:</p> <ul style="list-style-type: none"> <li>- can visually track objects past midline</li> <li>- can lift head to 90°</li> </ul> <p>By three months:</p> <ul style="list-style-type: none"> <li>- can visually track objects 180°</li> <li>- can put hands together</li> <li>- muscle control in upper body is good</li> <li>- can lift chest up with arm support</li> <li>- can be held in sitting position and hold head steady</li> <li>- beginning to develop hand-eye coordination</li> <li>- rolls over</li> </ul>	<p>Continued development of sense of trust in the world through interactions with the primary caretaker</p> <p>Temperament is present and clear to caregivers</p> <p>Feelings of pleasure and unhappiness present by 3 months</p>	<p>Will begin to vocalize in ways other than crying</p> <p>Differentiated types of crying develops</p> <p>Gurgling, squealing and cooing occur</p> <p>Interactive vocalization begins, and child initiates babbling</p> <p>Laughter</p>	<p>Parental roles of caregiving are being defined that will assist the child in learning social rules, roles, expectations and gender identity later</p>

## Birth to One Year, Continued

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
4 – 6 months	<p>Will begin to resist if a toy is pulled away from them</p> <p>Will actively engage with adult in interaction</p> <p>Ability to feed self crackers or other items</p> <p>Vocalization used to interrupt others/gain attention</p> <p>Will begin to initiate social contact</p> <p>Imitates facial expressions</p> <p>Works to get a toy that is visible, but out of reach</p> <p>Wants to form an attachment to a specific person(s), often his/her caregiver</p>	<p>Will gain 5 – 6 ounces per week</p> <p>Birth weight often doubled by 5 months of age</p> <p>By six months of age, 2-3 more inches in length will be added to length at 3 months of age</p> <p>Rapid brain development continues</p>	<p>Movements are controlled and purposeful – no longer reflexive</p> <p>Can grasp rattle purposefully</p> <p>Able to bear some weight on legs</p> <p>If put in sitting position, there is no head lag</p> <p>Child uses hands to rake for objects s/he wants to pick up</p> <p>By 5-6 months, may be able to sit and pull self to sitting</p> <p>Moves objects from hand to hand</p> <p>Stands if holding on to something</p>	<p>Emotions present and visible to others include:</p> <ul style="list-style-type: none"> <li>- happy</li> <li>- sad</li> <li>- angry</li> <li>- pain</li> <li>- fear</li> <li>- protest</li> </ul>	<p>Is aware of the presence of objects</p> <p>Attention to objects begins as a critical component of cognitive development</p> <p>Able to laugh as a response</p> <p>Vocalizes desires and eagerness through a range of sounds</p> <p>Will look for objects</p> <p>Initiates own noises, and imitates speech sounds</p> <p>Will turn toward voices</p>	<p>Exploration of body may now include fingers and toes, arms and legs</p> <p>Parental roles of caregiving continue to be defined that will assist the child in learning social rules, roles, expectations and gender identity later</p>

## Birth to One Year, Continued

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
7 – 12 months	<p>Development of attachment to caregiver continues to strengthen</p> <p>Interactive play begins</p> <p>Can play peek-a-boo</p> <p>Will initiate interactions</p> <p>May shout or use other sounds for attention</p> <p>Shyness or anxiety around strangers may occur</p> <p>Separation anxiety</p> <p>Stranger anxiety</p> <p>By 12 months, will play ball with other people beside caregiver</p> <p>Demonstrates clear wants</p>	<p>Gains 2 – 3 ounces per week</p> <p>Birth weight triples by the age of one year</p> <p>Adds 3 – 4 inches from 6-month height by the age of one year</p> <p>Rapid brain development continues</p>	<p>May pull to standing position</p> <p>Can support weight on legs</p> <p>Cruising walk while holding on to something for balance may begin</p> <p>Thumb-finger grasp develops</p> <p>By the age of one year, will stand alone well and begin to walk</p> <p>By the age of one year, is starting to drink from a cup</p>	<p>Ability to explore environment and play leads to continued understanding of and trust in environment</p> <p>Attachment to caregiver strengthens</p> <p>Enjoys interactions with caregiver</p> <p>By the age of 1 year, beginning to become curious about environment and willing to explore</p> <p>Begins to move towards developing autonomy</p>	<p>Can imitate sound sequences</p> <p>May use “mama” or “dada” indiscriminately at 7 months, but will be used properly by 10 months of age</p> <p>By 10 months, may begin to label specific objects with sounds</p> <p>By 12 months</p> <ul style="list-style-type: none"> <li>- may use 3 or more words other than mama and dada</li> <li>- object permanence beginning to develop</li> <li>- early problem solving skills arise</li> <li>- mastery of task is important</li> <li>- foundation for attention span laid</li> <li>- shakes head “no”</li> </ul>	<p>When unclothed, may begin to explore body and handle genitals</p> <p>Becomes clear on differentiating between people, and begins to make observations about these people, laying a foundation for gender roles and identity development</p>

## One to Two Years

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
13 – 18 months	<p>Interactions with others will expand</p> <p>Has good understanding of caregiver, and will begin to have expectations of how their caregiver responds</p> <p>Reciprocal connectedness forms</p> <p>Has desires to obtain objects or toys to play with</p> <p>Begins to imitate behaviors of caregivers</p> <p>Will grab others hand to get attention</p> <p>Curiosity arises, may ask “what’s that?”</p> <p>Hand toy to adult if unable to operate it</p>	<p>By 18 months,</p> <p>Height: 29 – 32 inches</p> <p>Weight 21 – 29 pounds</p>	<p>Able to walk backwards</p> <p>Enhancement of balance and stability</p> <p>Mastery and integration of body</p> <p>Feeds self, able to use utensils</p> <p>Can take off clothing on their own</p> <p>Walks up steps</p> <p>Throws a ball</p>	<p>Attachment to the caregiver lays the foundation for conscience development</p> <p>Internalization of caregiver, who becomes part of oneself</p> <p>Belief that if I hurt another, I hurt myself begins to develop</p>	<p>May scribble</p> <p>Vocabulary develops</p> <p>Increase in number of words in vocabulary and reaches up to 20 words by 18 months</p> <p>Begins using double-syllable words by 15 months</p> <p>Receptive and expressive language abilities develop</p> <p>Pulls at a wet diaper</p> <p>Can name objects and body parts</p> <p>Tries to sing</p> <p>Able to follow simple instructions</p>	<p>Continued exploration of body, grounded in curiosity</p> <p>Interactions with others lead to further understanding of behaviors and social rules and roles for gender</p>

## One to Two Years

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
19 - 24 months	Imitation of household behaviors in play becomes helpful	By the age of 2 years:  Height: 32 – 36 inches  Weight: 22 – 31 pounds	Puts on clothing  Able to wash hands  Develops more complex motor skills such as: - able to climb - able to throw ball overhand - kicks ball forward - jumps in place - can pedal tricycle  Gains muscle control for toilet training	Develops sense of autonomy, or willingness and ability to move around and explore world  Types of attachment visible - secure - insecure	Can combine 2 different words  Follows 2 – 3 step directions  Can recognize pictures  Understanding of symbols allows for child to use phrases and short sentences.  Will add “ing”, plurals, and possessives to words	Sense of curiosity leads to early understanding of the body and bodily functions

## Two to Three Years

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
2 – 3 Years	<p>Imitation becomes primary means of play</p> <ul style="list-style-type: none"> <li>- early imitation of parent/ caregiver behaviors</li> <li>- later, as child approaches 3 years of age, will begin to imitate other children</li> </ul> <p>Play is often parallel play, done near, but not with, other children</p> <p>Behavior is easily guided</p> <p>Strives to understand social and gender related rules and roles</p> <p>Has difficulty sharing</p>	<p>By the age of 3:</p> <p>Height: 33 – 42 inches</p> <p>Weight: 24 – 42 pounds</p>	<p>Focuses on mastery of more complex activities</p> <ul style="list-style-type: none"> <li>- standing on one foot</li> <li>- running</li> <li>- jumping</li> <li>- climbing</li> <li>- more skillful use of one hand</li> <li>- balancing on toes</li> </ul> <p>Shows a strong desire to continue to attempt to accomplish tasks, even if they aren't realistically possible – this helps develop the skills to achieve the tasks</p> <p>Fine motor skills are enhanced</p> <ul style="list-style-type: none"> <li>- can draw specific shapes</li> <li>- controls movement of pencil or crayon</li> </ul> <p>More control over bladder and sphincter muscles</p> <p>Can button clothes</p>	<p>Children strive for a sense of autonomy.</p> <p>Emotional reactions may be strong as child struggles with need for independence</p> <p>Has a desire to be seen and accepted as an individual</p> <p>Identifies preferences</p>	<p>By the age of 3, has a vocabulary of up to 300 words</p> <p>At age 3, can now carry on a conversation</p> <p>May have a short attention span</p> <p>Displays curiosity and will ask questions such as</p> <ul style="list-style-type: none"> <li>- what</li> <li>- where</li> <li>- who</li> </ul> <p>Develops a basic sense of time</p> <p>Uses past tense</p>	<p>Behaviors continue to reflect self-exploration and masturbation</p> <p>Easily re-directed by parents based on culturally accepted standards</p> <p>Begins understanding of gender roles</p> <p>Interest in watching others when undressing or using the bathroom</p> <p>Will ask caregivers questions about sexual body parts, especially breasts and penis</p>

### Three to Five Years

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
3-5 Years	<p>Play moves from parallel to more interactive with other children</p> <p>Toys are often the focus of play</p> <p>Play helps teach social rules</p> <p>Cooperative play can occur</p> <p>By the age of 5, play becomes more cooperative and is clearly governed by rules</p> <p>Improved ability to share</p>	<p>At age 3, average is 3 feet tall and 33 pounds</p> <p>Gains of about 4 – 5 pounds a year and 3 – 4 inches a year</p> <p>Brain growth slows considerably, with the brain having reached 4/5ths of its adult size</p>	<p>Has good sense of balance and can easily complete a variety of tasks including:</p> <ul style="list-style-type: none"> <li>- running</li> <li>- balancing on toes</li> <li>- jumping</li> <li>- catching and throwing</li> </ul> <p>Good hand-eye and hand-finger control</p> <p>Has control of bladder and bowel</p> <p>May appear uncoordinated at times of rapid growth</p> <p>Fine motor skills improve including:</p> <ul style="list-style-type: none"> <li>- cutting with scissors</li> <li>- drawing</li> <li>- writing</li> </ul>	<p>Development of initiative occurs</p> <p>Child is often self-directed and confident</p> <p>Learning how to control emotions and behavior</p> <p>Crying and temper tantrums decrease</p> <p>Tears may turn on and off at will</p> <p>Better able to delay gratification</p> <p>Conscience development occurs as child begins to understand right and wrong</p> <p>Self esteem is dependent upon other people's reactions to them</p>	<p>By the age of 4 ½, knows approximately 1500 words</p> <p>Recognizes colors</p> <p>Can name coins such as penny, nickel and dime</p> <p>By the age of 5, vocabulary is approximately 2,000 words</p> <p>“WHY” is a common question</p> <p>Thought is very egocentric</p> <p>Does not realize other people have their own perspectives</p> <p>Thinking may be illogical or magical</p> <p>Draws figures with 6 parts</p> <p>Short and long term memory improve</p> <p>Learning letters and numbers</p>	<p>Sexual behaviors include masturbation, and may include sexual play with other, same age children</p> <p>Vocabulary may include sexual words, or foul language</p> <p>May have questions about body parts or behaviors</p> <p>Behaviors and questions are based in curiosity</p> <p>May pretend to be of opposite sex in play</p> <p>May try to compare body parts with other children</p> <p>Seeking to understand gender roles and identity</p>

### School Age Years (6-11)

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
6 – 11 Years	<p>Relationships with people and peers outside the family become very important</p> <p>Friends often of the same gender, based on common interests or proximity</p> <p>Sports become a good way to relate to other children and play</p> <p>Other interests also of importance:</p> <ul style="list-style-type: none"> <li>- school</li> <li>- clubs</li> <li>- activities</li> </ul> <p>Rules and roles become very important in guiding behavior</p> <p>Needs affection and affirmation from adults</p> <p>Conflict may arise when peer group values differ from parent values</p>	<p>Growth during this time is slow and steady – approximately 3 - 4 inches per year</p> <p>Height: 42 - 52 inches</p> <p>Weight: 40 - 79 pounds</p> <p>Body proportions are similar to adult</p> <p>Girls may experience a growth spurt</p>	<p>Fine and gross motor coordination increasingly better, and children enjoy doing activities that allow them to use these skills, such as art, music or athletics</p> <p>Strength and coordination increase in activities such as</p> <ul style="list-style-type: none"> <li>- riding a bicycle</li> <li>- skating</li> <li>- swimming</li> </ul> <p>May begin puberty</p>	<p>Children seek to become industrious, or self-directive, productive and goal oriented</p> <p>Self-awareness improves</p> <p>Introspection becomes possible</p> <p>Children can understand that other people have thoughts, opinions and feelings</p> <p>Sensitive to criticism</p>	<p>Can consider two thoughts simultaneously</p> <p>Improved concept of time</p> <p>Problem solving skills enhance and allow for understanding of cause and effect</p> <p>Become qualitative</p> <p>Concrete thinking</p> <p>A strong sense of fairness</p> <p>Can understand similarities and differences</p> <p>Memory improves</p> <p>Reading and math skills grow</p> <p>Able to take other's perspectives</p> <p>Language enhances relationships</p> <ul style="list-style-type: none"> <li>- active listening</li> <li>- asking questions</li> </ul>	<p>Sex play with other same age children may occur and can include:</p> <ul style="list-style-type: none"> <li>- self-exploration</li> <li>- simulation</li> <li>- kissing</li> <li>- hugging</li> <li>- peeking</li> <li>- touching</li> <li>- exposure of genitals</li> </ul> <p>Behaviors are usually limited in type and frequency</p> <p>Behaviors are based on curiosity</p> <p>Easily redirected to stop</p> <p>Gender identity clear, often tied to social rules and roles</p> <p>Media and peers can influence identity and roles</p>

Adolescents (12 – 21 Years)						
Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
12 – 15 Years (Early)	<p>Social relationships important - centered in peer group</p> <p>Strong identification with peer group</p> <p>Social status &amp; acceptance are important</p> <p>Move toward independence from parents</p>	<p>By the age of 15:</p> <p>Height: 5' 4 "</p> <p>Weight: 65 + pounds</p> <p>Growth spurts common:</p> <ul style="list-style-type: none"> <li>- Boys: 12-15 years of age</li> <li>- Girls: 11-14 years of age</li> </ul>	<p>Puberty occurs</p> <p>Rapid physical growth of bones and muscles</p> <p>Menstruation begins for girls (11 – 14 years of age)</p> <p>Male sex organs grow in size, testicles begin to produce semen</p> <p>Brain development increases</p> <p>Sleep is important, and may occur at different times than adults</p>	<p>Primary focus is on identity formation</p> <p>Attitudes and behaviors becoming individualized, no longer based on values and expectations of the family and culture</p> <p>Peer group strong influence on identity and esteem</p> <p>Emotionally labile in early adolescence</p> <p>Emotional response to puberty also occurs</p>	<p>Formal operations may be reached – but not everyone achieves this level of cognitive development. It includes:</p> <ul style="list-style-type: none"> <li>- Able to think hypothetically</li> <li>- Logical thinking</li> <li>- Ability to think about thought</li> <li>- Development of insight</li> <li>- Systematic problem solving</li> </ul>	<p>Often, the early adolescent is ambivalent about sexual relationships</p> <p>Often are shy, embarrassed and self-conscious</p> <p>May develop one on one friendships with person of opposite sex</p> <p>Interest in sexual relationships increases</p> <p>Masturbation may occur</p> <p>Attractions may arise to people of same, opposite or both genders</p>

### Adolescents (12 – 21 years cont'd)

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
16 - 21 years (Middle & Late)	<p>Peer group's importance declines, and individual friendships strengthen</p> <p>Dating and one-on-one relationships become more significant</p> <p>Relationships often based on mutual understanding, loyalty and intimacy</p> <p>Youth allowed to have their own feelings and experiences that can differ from others</p> <p>Self-revelation occurs</p> <p>Intimacy is important</p> <p>Begin to develop expectations about their relationships with adults</p> <p>Conflicts with parents grow</p>	<p>Girl's adult stature is achieved</p> <p>Boys continue to grow</p>	<p>Puberty and physical maturation continue</p> <p>Bone and muscle growth continue</p>	<p>Sense of self, apart from peers and family stabilizes</p> <p>Self esteem based on youth's ability to live up to their own standards of behavior</p> <p>Individual identity forms</p> <p>Perspective taking abilities improve</p> <p>Examination of other people's values and beliefs may occur</p> <p>Identity confusion may occur</p> <p>Morality issues occur</p>	<p>Emergence of formal operations continues</p>	<p>Pubertal changes continue</p> <p>Greater interest in sexuality</p> <p>Attraction to others of same, opposite, or both genders</p> <p>Sexual intimacy, intercourse</p> <p>Decisions about sexual orientation, birth control, parenting and partners arise</p>

## “SPECS” of Normal Development

### Adulthood (21 and on... )

Age	Social Development	Physical Growth	Physical Development	Emotional Development	Cognitive Development	Sexual Development
1-30 (early)	<p>Commitment to relationships may occur</p> <p>Decisions about parenting and family arise</p> <p>Family stages of development impact personal relationships with others outside of home</p>		Peak of physical ability about age 25	<p>In early adulthood, Intimacy is a key developmental issue.</p> <p>Seek an open, supportive relationship</p>	<p>Formalization of education or training</p> <p>Work becomes an essential outlet for cognitive development</p> <p>Exploration of interest</p>	<p>Strong need for sexual experimentation and intimacy</p> <p>Physical responses peak, and may then slow as pregnancy and family roles appear</p>
30-65 (middle)	<p>Ageing of one’s own parents becomes an issue</p> <p>Changing roles may occur as parents allow for adolescent child’s independence</p> <p>As children age, refocus on personal relationship may occur</p>		<p>Vision changes may occur</p> <p>Hand-eye coordination may slow</p> <p>Decrease in muscle mass</p>	In middle adulthood, generativity, or what one does to make things better for future generations is important.	<p>Maximum involvement in career occurs during middle adulthood</p> <p>Work impacts financial and social aspects of one’s identity</p> <p>Later adulthood: Looking to have less critical role in work</p>	<p>In middle adulthood, relationships outside of commitments may be explored</p> <p>Renegotiation of sexual relationships occurs later in adulthood as a result of physical changes and emotional needs</p>

65+ (later)	<p>Roles may change as enter grand parenting roles</p> <p>May develop adult relationships with children</p> <p>Deal with concepts and issues around death and dying</p>		<p>Chronic or degenerative illnesses</p> <p>Senses become less acute</p>	<p>In later adulthood, a sense of integrity is sought</p> <p>Seeking an understanding of one's life</p> <p>Ability to face death without fear</p>	<p>Concerns about leaving the workforce and how that impacts relationships</p>	<p>Sexualized behaviors may cease</p>
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## **Behavioral Impact of Maltreatment: A Reference to Use with Caregivers and Parents<sup>1</sup>**

The following material is adapted from the work of Bruce Perry, M.D. Social workers will find it useful to use as a reference to assist parents and caregivers to understand and nurture the children in their care, and to apply in their own interactions with children. This supplemental handout contains information relevant to all developmental levels.

### **What specific problems can I expect to see in maltreated children with attachment problems?**

The specific problems that you may see will vary depending upon the nature, intensity, duration and timing of the neglect and/or abuse. They may also differ from child to child. Some children will have profound and obvious problems, while some will have very subtle problems that you may not realize are related to early life neglect. Sometimes, these children do not appear to have been affected by their experiences. However, it is important to remember the reason you are working with the children and that they have been exposed to terrible things. Below are some clues that experienced clinicians consider when working with these children:

**Developmental delays:** Children experiencing emotional neglect in early childhood often have developmental delay in other domains. The bond between the young child and caregivers provides the major vehicle for a child's development. It is in this primary context that children learn language, social behaviors, and a host of other key behaviors and skills required for healthy development. Lack of consistent and enriched experiences in early childhood can result in delays in motor, language, emotional, social, and cognitive development.

**Eating:** Atypical eating behaviors are common, especially in children with severe neglect and attachment problems. They will hoard food, hide food in their rooms, or eat as if there will be no more meals even if they have had years of consistent available foods. They may have failure to thrive, rumination (throwing up food), swallowing problems and, later in life, unusual eating behaviors that are often misdiagnosed as anorexia nervosa.

**Soothing behavior:** These children will use very primitive, immature and seemingly bizarre soothing behaviors. They may bite themselves, head bang, rock, chant,

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<sup>1</sup> Adapted in part from: Perry, B. (2007). *Maltreated children: Experience, brain development and the next generation*. (New York: W.W. Norton & Company) and Bruce Perry, M.D. *Bonding and Attachment in Maltreated Children*, on-line curriculum.

scratch, or cut themselves. These symptoms will increase during times of distress or threat.

**Emotional functioning:** A range of emotional problems is common in maltreated children, including depressive and anxiety symptoms. One common behavior is “indiscriminant” attachment. All children seek safety. Keeping in mind that attachment is important for survival, children may seek attachments – any attachments – for their safety. Non-clinicians may notice abused and neglected children are “loving” and hug virtual strangers. Children do not develop a deep emotional bond with relatively unknown people; rather, these “affectionate” behaviors are actually safety-seeking behaviors. Clinicians are concerned because these behaviors contribute to the abused child’s confusion about intimacy, and are not consistent with normal social interactions. Furthermore, although the child seeks safety, these inappropriately affectionate behaviors can, ironically, put the child in very dangerous situations.

**Inappropriate modeling:** Children model adult behavior – even if it is abusive. Maltreated children learn that abusive behavior is the “right” way to interact with others. As you can see, this can cause problems in their social interactions with adults and other children. Children that have been sexually abused may become more at-risk for future victimization. Boys that have been sexually abused may become sexual offenders.

**Aggression:** One of the major problems with neglected, poorly attached children is aggression and cruelty. This is related to two primary problems in neglected children: (1) lack of empathy and (2) poor impulse control. The ability to emotionally “understand” the impact of your behavior on others is impaired in these children. They do not understand or feel what it is like for others when they do or say something hurtful. Indeed, these children often feel compelled to lash out and hurt others. They will hurt those less powerful than they, such as animals, smaller children, peers and siblings. One of the most disturbing elements of this aggression is that it is often accompanied by a detached, cold lack of empathy. They may show regret (an intellectual response) but not remorse (an emotional response) when confronted about their aggressive or cruel behaviors.

# Guidelines for Managing Information Related to the Sexual Orientation & Gender Identity and Expression of Children in Child Welfare Systems

JANUARY 2013



NATIONAL CENTER FOR LESBIAN RIGHTS



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## **I. INTRODUCTION**

In the last decade, the child welfare profession has made significant progress toward the goal of developing competence to serve children whose actual or perceived sexual orientation is other than heterosexual, and children whose gender identity or expression is incongruent with their biological sex or with cultural expectations related to gender presentation. Practitioners, advocates, researchers and public policymakers have contributed to a growing field of knowledge and accepted best practice. (Child Welfare League of America, 2012) (Wilber, Ryan, & Marksamer, 2006) (Mallon, 1999) Although there is a continuing need for written policies, training and technical assistance, as well as organizational culture change, child welfare professionals have made impressive strides toward achieving a better understanding of the relevance of sexual orientation and gender identity and expression to child protection and well-being.

Despite this commendable progress, however, the field has not arrived at consensus about how and when to elicit or collect information related to young people's sexual orientation, gender identity or gender expression. Similarly, there are no clear guidelines navigating the tension between the need to disclose the information to appropriately serve children, and the need to guard their privacy. Although the field increasingly recognizes the need for better data to measure outcomes and develop interventions, most systems still do not systematically collect, track or report this information. The lack of clarity on these complex issues hinders the efforts made toward increasing positive outcomes for children across the spectrum of sexual orientation and gender identity and expression. This publication will begin to bridge the gap by proposing standards governing the management of information related to sexual orientation and gender identity and expression.

This publication was developed in conjunction with the Putting Pride into Practice Project ("P4"), a three-year effort undertaken by Family Builders by Adoption, in partnership with the California Department of Social Services, to implement CWLA's Best Practice Guidelines for Serving LGBT Youth in Out of Home Care in several county child welfare systems in California. P4's objective is to increase the competence of child welfare professionals to serve children whose actual or perceived sexual orientation is other than heterosexual, and children whose gender identity or expression is incongruent with their biological sex or with cultural expectations related to gender presentation. The project provides training and technical assistance to build agency capacity and improve

organizational competency through leadership and policy development, community and constituency engagement, and recruitment, training and support of placement resources. In 2012, the P4 project engaged The Center for the Study of Social Policy (CSSP) both to provide additional support to the work and leadership in developing the strategy for introducing the guidelines to the field.

In November 2011, the P4 staff at Family Builders joined with Legal Services for Children to convene a two-day meeting of 25 individuals with broad child welfare experience to examine three questions:

- Under what circumstances should child welfare personnel seek information about a child's sexual orientation or gender identity if it is not otherwise disclosed?
- Under what circumstances should child welfare personnel record information about a child's sexual orientation or gender identity?
- Under what circumstances should child welfare personnel disclose information about a child's sexual orientation or gender identity?

The objective of the convening was to gather expert opinions that would guide the formulation of a set of professional guidelines. This document represents the culmination of those efforts. The Center for the Study of Social Policy (CSSP) will be taking the lead on field testing these guidelines. CSSP is in the process of securing funding and working with up to three child welfare jurisdictions to field test the guidelines. Based upon the experiences and input in the field sites, project staff will refine the guidelines, if necessary, and develop a final version for national dissemination. The field testing will also inform us what is needed in terms of tools, policies, training, and technical assistance to effectively implement the guidelines.

## II. GUIDING PRINCIPLES

The following principles provide the theoretical and philosophical underpinnings for the professional guidelines contained in this publication. When confronted with a situation not directly addressed by the guidelines, professionals should rely on these principles to guide their decisions.

1. All children deserve safety and acceptance in their homes and communities.
2. All children need support and nurturance to develop and embrace all aspects of their evolving identities, including their sexual orientation and gender identity and expression.
3. Children thrive when their caregivers affirm and respect their sexual orientation and gender identity and expression, and family acceptance both protects against health risks and promotes overall health. Conversely, children experience negative health and mental health outcomes when their caregivers reject or fail to support their sexual orientation and gender identity or expression.
4. Children perceived by others to be lesbian, gay, bisexual or gender nonconforming are exposed to the same risks as children who openly identify as lesbian, gay, bisexual or transgender.

### III. LAYING THE GROUNDWORK FOR IMPLEMENTATION

Child welfare professionals routinely collect and analyze information about the children in their care for the purposes of creating individualized case plans, monitoring agency trends and performance, guiding strategic planning, and reporting to government agencies and funders. Standard demographic data fields include gender, race, ethnicity, and age, among others. However, most assessment protocols and case management systems do not require or accommodate collection of data related to children's sexual orientation, gender identity or gender expression. In addition to these structural and procedural barriers, many professionals are reluctant to collect, record or disclose this information and may express a range of concerns about any requirement to do so. Common reservations include:

- The private and sensitive nature of information related to sexual orientation and gender identity may make workers feel that is inappropriate to directly ask about these issues. (*"It's none of our business."*)
- A young person's sexual orientation or gender identity or expression may seem unrelated to the reasons that he or she is in protective custody. (*"What does this have to do with abuse or neglect?"*)
- Many professionals feel uncomfortable talking about sexual orientation and gender identity. (*"What if I say the wrong thing?"*)
- Workers may feel that children are too young to have considered these issues or to understand or discuss them. (*"I'm supposed to ask a 5-year-old whether he likes boys or girls?"*)
- Requiring collection or documentation of this data imposes unnecessary burdens on overworked and under-resourced personnel. (*"This is just one more mandate . . ."*)
- Collecting the information poses the risk of inappropriate disclosure. (*"Don't ask, don't tell. What we don't know cannot be repeated."*)

Child welfare managers should be prepared to respond to these issues in order to ensure broad buy-in prior to implementation of the guidelines. The most important message to convey is that the information guidelines are essential to advancing the core objectives of child safety, permanency and well-being. The field must adapt to society's

evolving understanding of the relationship between children's actual or perceived sexual orientation or gender identity and expression, and their health, social and educational outcomes. Research has established that lesbian, gay, bisexual and gender nonconforming children confront significant external threats to their health and well-being. Research has also informed the development of interventions that support children in overcoming these challenges. Child welfare leadership must give workers the tools to understand this research and its application to contemporary social work practice. Once child welfare personnel understand that the guidelines are consistent with good social work practice, their initial objections may prove less daunting.

Child welfare managers and supervisors should support workers by reminding them that they routinely discuss sensitive issues with their clients. Learning how to perform this core function is an integral part of clinical training. The skills and knowledge necessary to sensitively and appropriately explore the issues of sexual orientation and gender identity and expression can and should be taught and integrated into existing training, policies and procedures. Protecting the confidentiality of sensitive client information is also a hallmark of good social work practice with which workers will be fully familiar. The guidelines reflect this same protection by limiting disclosure and emphasizing the importance of written policies, and ongoing training supported by skilled supervision.

That child welfare personnel confront serious workload challenges cannot be denied. However, by providing clear standards and promoting sound practices and professional support, the guidelines may prevent the types of crises that exacerbate workload issues. Again, workers are more likely to embrace the guidelines if child welfare directors and managers communicate the ways in which the guidelines promote the well-being of *all* children in the agency's care and custody.

With appropriate policies, training and support, the perceived obstacles to obtaining information related to children's sexual orientation and gender identity and expression can be addressed. More importantly, the benefits of obtaining the information outweigh the risks – especially if child welfare agencies adopt and scrupulously adhere to procedural safeguards. Information about the sexual orientation and gender identity and expression of children in care is essential to the agency's core function of developing and implementing individual case plans. Disaggregated data is also essential to adequately assess the agency's competence in serving children of all sexual orientations and gender identities, and to guide strategic planning and reform efforts.

### III. INFORMATION GUIDELINES

The child welfare profession is increasingly focused on outcomes and accountability as the framework for reforming systems nationally. The federal government routinely reviews states on a set of outcomes through the Child and Family Services Review. States are required to develop Program Improvement Plans based on these reviews and to engage in ongoing quality improvement. The field is moving toward measuring well-being through the use of evidence-based strategies and interventions. States and counties are implementing new practice models based on implementation science. All of these reform efforts hinge on the collection and analysis of client data.

At the same time, the field is increasingly aware of the correlation between children's actual or perceived sexual orientation, gender identity or gender expression and their overall well-being. Thus, the Administration of Children and Families recently issued an information memorandum emphasizing the importance of supporting and affirming LGBT children and families. It is both timely and essential that the child welfare profession create the infrastructure and policy framework for meeting this obligation, including the collection, analysis and integration of accurate data.

These guidelines are divided into five sections:

- Collecting information for individual case planning
- Collecting information for agency planning and assessment
- Recording information
- Disclosing information
- Institutionalizing practice

The guidelines provide the framework for utilizing client data to ensure the safety, permanency and well-being of children across the spectrum of sexual orientation and gender identity and expression. The commentary following the guidelines provides background information and the rationale for each standard. Prior to implementing the guidelines, agencies should develop practice tools designed to provide more detailed instruction to personnel charged with implementing the guidelines. Along with ongoing

training and supervision, these tools should provide guidance to workers on how to talk to youth about sexual orientation, gender identity and gender expression, what specific questions to ask and at what intervals, and how to record the information in the appropriate paper or digital file.

#### **A. COLLECTING INFORMATION FOR INDIVIDUAL CASE PLANNING**

Child welfare professionals cannot adequately serve the children in their care unless they understand the strengths, needs, experiences and characteristics of each unique child. Possession of information about the child's age, development, temperament, academic achievement, physical and mental health, and many other individual characteristics is essential in assessing the child's current circumstances and developing a case plan. The child's sexual orientation, gender identity and gender expression are integral and defining aspects of his or her identity and experience, and are essential to understanding the whole child.

The child welfare profession is chiefly concerned with child safety, permanency and well-being. These outcomes are supported or undermined by the reactions of adults to the sexual orientation and gender identity or expression of the children in their care. Research conducted by the Family Acceptance Project has established the critical role that caregiver acceptance of young people's sexual orientation and gender identity in promoting health and well-being and protecting against risk. Conversely, caregiver rejection based on these aspects of a child's identity is highly correlated with serious health problems. (Ryan, Huebner, Diaz, & Sanchez, 2009) Recent research has also established a clear link between gender nonconformity and childhood abuse and post-traumatic stress disorder in youth. (Roberts, Rosario, Corliss, Koenen, & Austin, 2012) Thus, a child's perceived or declared sexual orientation or gender identity may be directly relevant to the alleged abuse or neglect, whether or not the connection has been expressly identified.

Even if a child's sexual orientation or gender identity or expression is not directly related to the alleged abuse or neglect, these aspects of the child's identity may have some bearing on the child's safety, permanency and well-being. A growing body of research demonstrates that sexual orientation and gender identity are important predictors of the health and social outcomes of youth due to the distinct challenges lesbian, gay, bisexual and transgender individuals confront. As such, understanding these aspects of the child's identity is essential. Conversely, failure to understand the whole child can lead to poor decisions that seriously undermine the chief aims of permanency, safety and well-being.

**1. Intake forms and protocol should require child welfare personnel to document each child's biological sex, gender identity, and gender expression.**

*Commentary: Biological sex, gender identity and gender expression are three distinct aspects of every person's identity. Biological sex refers to a person's physical anatomy and is used to assign gender at birth. In the majority of cases, a child's biological sex is either clearly male or clearly female. However, there is a range of possible variations in human anatomy and chromosomal makeup (Brill & Pepper, 2008), necessitating a separate classification for the small percentage of children who are not clearly biologically male or female. Some individuals have medical conditions known as "differences of sex development" (DSD) in which their biological attributes (chromosomes, gonads, reproductive anatomy or genitalia) differ from what is associated with male or female biology. (Malouf & Baratz, 2012) These individuals are sometimes referred to as "intersex." Child welfare personnel are not qualified to determine whether or not a child is intersex, and should not attempt to make this determination independently. However, if the child or family offers the information or it is otherwise acquired through medical screening, child welfare personnel should document the information and its source. In documenting a child's biological sex, commonly used terms include male, female or intersex.*

*Gender identity refers to a person's deeply felt sense of being male, female, both or neither. An individual's gender identity may or may not be congruent with that person's biological sex. Terms for identifying a person's gender identity may include male, female, unsure, neither or both.*

*Gender expression refers to the manner in which a child expresses or externalizes gender, through dress, mannerisms and behavior. Again, an individual's gender expression may or may not be congruent with that person's biological sex. Terms used to describe a person's gender expression may include masculine, feminine, androgynous, or both masculine and feminine.*

**2. Child welfare personnel should assess the extent to which each child's expression of gender matches or diverges from cultural and social expectations in the child's family and community.**

*Commentary: Gender expression is not exact or objective. It is a relative concept based on an individual or community's subjective perception of gender roles and expectations, which is influenced by beliefs, culture, experiences and frame of reference. For these purposes, the perception or beliefs of the child welfare worker are not as important as the child's experience and the perception and reaction of important people in the child's life. Children may be subjected to ridicule, rejection or humiliation based upon other people's perception that their mannerisms, behavior or dress diverge from that which is expected of their gender (gender variant). Child welfare personnel should not classify or evaluate any child's gender expression for the purposes of redirecting or changing the child, but to explore the child's need for support and to monitor the child's adjustment. Gender variant expression, by itself, is not problematic nor cause for concern. However, gender nonconforming children may need support to form and integrate a healthy identity. To explore the child's gender expression, child welfare personnel may rely on information from the child, family and reliable third parties, such as school and medical personnel. Child welfare personnel may also rely on personal observation supported by objective information.*

**3. Child welfare workers should document the gender identity of every child three years of age or older.**

*Commentary: Gender identity is formed at very early age, often emerging around the same time that a child learns to speak. (Brill & Pepper, 2008) Everyone has a gender identity, which is internal and personally defined. Most people's gender identity is congruent with their biological sex, in which case there is little need to consciously define one's gender identity as distinct from one's gender. When a child's biological sex and gender identity are not congruent, the child often begins voicing this discrepancy between ages 2 and 4. (For example, a young boy may consistently report that when he grows up, he's going to be a woman.) It is important to identify children who experience this incongruity – children who describe or manifest a gender identity that differs from their biological sex. The purpose is not to categorize or diagnose the child, but to ensure that the child's family or caregivers have the information and support necessary to better understand and support the child's healthy development.*

- 4. Child welfare personnel should determine the most appropriate time and manner of identifying each child's gender identity and expression, based upon the child's age, stage of development, cognitive abilities and personality, as well as the level of trust developed between the worker and the child.**

*Commentary: Child welfare personnel should directly engage children who are developmentally and cognitively capable of understanding and discussing gender, in age-appropriate discussion of their preferred gender expression and the gender with which they identify. Children and youth who openly identify as transgender or use other words to indicate that they are gender nonconforming may be willing and able to discuss how they express and identify their gender. Language and conventions related to discussing gender roles may vary in different cultures. Child welfare personnel should rely on visual observation and reliable third party reports of young or incompetent children's choice of interests, activities, mannerisms and clothing, as well as any disclosures by the child about the child's gender. Family members, as well as medical and mental health professionals may provide important insights.*

- 5. Child welfare workers should document the sexual orientation of every child 10 years or older who can understand and discuss these issues.**

*Commentary: Every person has a sexual orientation that exists somewhere along a continuum ranging from exclusive attraction to the same sex to exclusive attraction to the opposite sex and every variation in between. Although the development of each person's sexual orientation is unique, studies show that children become aware of sexual attraction at about age 10. (Ryan, LGBT Youth: Health concerns, services and care, 2003) Compared to children of earlier generations, today's young people are self-identifying as lesbian, gay or bisexual at increasingly younger ages. (Ryan, LGBT Youth: Health concerns, services and care, 2003) Children may be aware of same-sex attraction long before they engage in any sexual behavior and sometimes before they know the language or concepts to describe their feelings. Nonheterosexual youth may use words other than lesbian, gay, or bisexual to describe their sexual orientation. Terminology may differ across cultures or geographic locations. Youth may engage in heterosexual sex even if they identify as LGB or experience same-sex attraction. The best source of information about a child's sexual orientation is the child. Thus, it is critical for workers to develop competency to skillfully and sensitively engage children and youth in these discussions.*

*Understanding a child's sexual orientation, at every stage of development, helps child welfare professionals create and implement appropriate case plans. Competent services ensure that all children are safe and supported, and that caregivers have the tools to embrace and guide all children -- including lesbian, gay and bisexual children, and children who are perceived by others to be nonheterosexual. Child welfare professionals, along with families and peers, can provide critical support to young people during the development and integration of their sexual orientation. Acceptance and support bolster resilience and counteract the health risks associated with harassment and rejection. Engaging young people in supportive discussions about their sexual orientation provides an opportunity for youth to come out, a process that boosts self-esteem and decreases health risks. (Wilber, Ryan, & Marksamer, 2006)*

- 6. Child welfare personnel should identify the most appropriate time and manner of documenting the child's sexual orientation, based upon the child's age, stage of development, cognitive abilities, personality, and readiness to discuss the issue.**

*Commentary: Children are at various stages of awareness and comfort with their sexual orientation. Some children may not have consciously experienced same-sex attraction or become aware that they are not heterosexual. Others may be aware of attraction and emotional connection to people of the same gender and may identify as lesbian, gay or bisexual, whether or not they have had any type of sexual experience. Children and youth who internally identify as lesbian, gay or bisexual may not be comfortable discussing these issues – especially before they know it is safe to do so. Cultural and religious norms also influence children's willingness to talk about sexual orientation or gender identity. Child welfare personnel should signal their openness and acceptance in order to encourage disclosure and normalize discussion of these issues. Using language which is inclusive, age appropriate, culturally accepted and understandable helps to create an environment in which children can disclose information about themselves at their own pace and on their own terms. Conveying inclusive and affirming messages in posters and other materials or images also helps to create a safe environment.*

- 7. Child welfare personnel should ensure that their understanding, and any documentation, of the child's sexual orientation and gender identity and expression remains current.**

*Commentary: Gaining an understanding of a child's gender identity and sexual orientation and the impact of these issues in the child's life cannot occur in a single encounter or interview, but necessarily occurs over time. Sexual orientation and gender*

*identity are immutable characteristics that cannot be changed. However, awareness and integration of one's sexual orientation and gender identity is an evolving process, as is one's ability and readiness to discuss these issues. Some children may enter care at a very young age, and begin understanding their sexual orientation many years later. Some young people may deny or repress their sexuality or gender nonconformity. Others may feel uncertain because of a lack of contextual information or role models – while others may know that they are gay or lesbian at early ages. A child's understanding of her sexual orientation or gender identity may also shift over time. A child who initially identifies as bisexual may ultimately determine that she is a lesbian. A child who initially demonstrates gender nonconforming behavior or expression may discover that he is gay.*

*Just as a child's understanding of her identity develops over time, her external circumstances may also change. A school or home environment that that was once stable and supportive may become unsafe for a child who openly identifies as gay, or insists upon wearing gender nonconforming clothing in middle school. Child welfare workers cannot expect to "check a box" or definitively address these issues in one meeting. The objective is not to simply repeat the same questions at preset intervals, but to stay connected, pay attention, and create opportunities to discuss all aspects of the child's experience. It is particularly important to be alert to any indication that the child is experiencing distress, lack of support or external pressure related to developing or integrating a positive gender identity and sexual orientation.*

## **B. COLLECTING INFORMATION FOR AGENCY ASSESSMENT AND PLANNING**

Like all publicly funded services, child welfare agencies are under increasing pressure to demonstrate that their programs are effective and efficient. Shrinking public dollars have increased the demand for accountability, prompting public agencies to collect data to support program assessment and planning. Child welfare agencies collect and report client data to track demographic trends, identify gaps in programming, assess the effectiveness of specific interventions and programs, and measure progress toward system objectives. (Child Welfare League of America and Juvenile Law Center, 2008) Client data can also be used to measure the outcomes of targeted populations of children and youth.

A growing body of research has demonstrated that lesbian, gay, bisexual and transgender youth are at increased risk for homelessness (Quintana, 2010), substance abuse , suicide, school bullying (Gay Lesbian and Straight Education Network, 2010) and family rejection. Informed by these findings, the child welfare profession is obliged to

monitor and protect the safety and well-being of children who may face enhanced risks based upon their actual or perceived sexual orientation or gender identity or expression. In order to meet this obligation, child welfare personnel must collect data – on an individual and aggregate level. Simply put, the agency cannot determine whether it is meeting its obligation to LGBT youth unless it makes an authentic effort to identify the sexual orientation and gender identity of the children in its care. In the absence of such data, child welfare agencies cannot accurately assess their services to LGBT children or youth, track the outcomes of these young people, or create services that respond to the needs of this population.

Fortunately, the child welfare profession can follow the lead of other public agencies that are successfully collecting this information. For example, sexual orientation questions have been included on school-based surveys of adolescents since the mid 1980's through versions of the Youth Risk Behavioral Survey. Researchers have drawn from the experience of these surveys to distill best practices for asking questions related to sexual orientation and gender identity and expression. (Badgett & Goldberg, 1998) Researchers have also successfully surveyed LGBT youth in the juvenile justice system, significantly increasing the profession's understanding of the disproportionate numbers of LGBT youth in detention, as well as their experiences and offenses. (Irvine, 2010)

**1. Child welfare agencies should include sexual orientation and gender identity in the demographic data collected for each child.**

*Commentary: Including data fields for sexual orientation, gender identity and gender expression is important for several reasons. Absent this data, agencies can only guess about the prevalence of LGBT youth in their care. Client specific data is also necessary to track permanency, well-being and safety outcomes for LGBT youth, and the extent to which these outcomes differ from those of heterosexual and gender conforming children and youth. The data is essential to assessing the agency's success in recruiting and supporting affirming, competent caregivers.*

**2. Child welfare agencies should provide all youth in protective custody with the opportunity to complete an annual confidential survey evaluating the services they have received.**

*Commentary: Supplementing intake questions with a self-administered survey increases the validity of the agency's data by providing youth with an opportunity to identify themselves confidentially. Anonymous surveys permit youth to be more candid, increasing the reliability of the data and potentially providing more accurate data on the*

*quality of services and the needs of youth. In their report on “Best Practices for Asking Questions about Sexual Orientation on Surveys,” Badgett and Goldberg provide several recommendations for maximizing the accuracy and validity of survey data. Survey drafters should give careful consideration to the framing of the questions used to elicit the data, as well as their placement on the survey. Questions designed to elicit data on sexual orientation should address one or more dimensions, such as self-identification, sexual behavior, sexual attraction or romantic relationships. These questions should not immediately precede or follow questions about sexual abuse or assault. Questions eliciting information about gender identity or expression should define the relevant terms in simple, direct language. In general, the language used in the survey should be “culturally appropriate, relevant, acceptable, and compatible with the respondent’s understanding of the construct that the question is intended to measure.” (Badgett & Goldberg, 1998)*

### **C. RECORDING INFORMATION**

Clinical education and training emphasizes the critical importance of accurate, timely case notes. The case file documents all aspects of the child welfare worker’s investigation, assessment and case plan. Caseworkers must capture each child’s story and summarize the actions undertaken by the agency to strengthen the family and keep the child safe. The importance of this function cannot be overstated. Documentation is an important tool for improving outcomes for children, and protecting both children and caseworkers. Lack of timely and accurate documentation can undermine the effectiveness of all other priorities and tasks undertaken by the caseworker. (Stephenson-Valcourt, 2009-2010)

The case file provides a comprehensive record for the current caseworker and a case history for subsequent workers. Information from the case file is used to develop court reports and recommendations. Generally, clients are also entitled to copies of all or part of their case files when they reach the age of majority. Caseworkers should anticipate the multiple functions of a case file when making the inevitable judgment calls about what to include and what to exclude.

- 1. Child welfare personnel should record relevant and reliable information related to the child’s sexual orientation, gender expression or gender identity in the case file.**

*Commentary: As part of the process of documenting the information they have gathered through interviews and observations, child welfare personnel should record information related to the child's sexual orientation, gender identity and gender expression. Workers should carefully identify the source of the information in the case file, and limit the information recorded to that which is relevant to furthering the goals of permanence, well-being and safety. For example, while it is important to document that a young person in care has recently disclosed that he is gay, it is not necessary to divulge every aspect of his personal life and relationships. It may be most important to document efforts to ensure that the youth is in a safe and supportive environment at home, at school and in the community. Consistent with sound social work practice and professional guidelines, child welfare agencies should adopt and implement policies that protect the confidentiality of information in the case file.*

- 2. Child welfare personnel should record information related to a child's sexual orientation or gender identity or expression in a court report only when the information is directly relevant to the issue to be decided by the court, the worker preparing the court report has discussed the matter with the child and obtained his or her authorization, and the worker has taken precautions to minimize unnecessary disclosure of the information to third parties.**

*Commentary: There may be circumstances under which it is essential for the court to understand how the child's sexual orientation or gender identity or expression is related to the issue to be decided at a hearing or other proceeding. For example, in a hearing at which a change in placement is considered, the court may need to understand the need for a safe and accepting caregiver. However, court proceedings are often attended by many individuals – including parents, siblings, caretakers, providers, guardians ad litem and attorneys. These individuals may or may not be aware of the child's sexual orientation or gender identity. Moreover, despite policies and statutes that require the confidentiality of court reports, their contents are often disclosed outside of court proceedings. Thus, workers should exercise caution and should only include this information in court reports when they can articulate a specific rationale for doing so, and have worked with the child to minimize any potential negative ramifications that may stem from disclosure. Agency policy may provide that, even when disclosure to the court is necessary, workers must prepare a supplemental report containing the information and request an in camera discussion of the matter and/or a protective order prohibiting redisclosure of the information.*

## **D. DISCLOSING INFORMATION**

Children served by the child welfare system interact with many other systems and individuals, including service providers, courts, schools, caregivers and others. Disclosing personally identifiable information across these systems may help children achieve better safety, permanency and well-being. With appropriate safeguards, sharing information can reduce duplication of effort and enhance coordination of services, all toward the goal of improving outcomes for children. Child welfare agencies may share information internally, with other agency employees, without violating confidentiality provisions. However, information contained in child welfare agency files is protected by federal and state confidentiality provisions, and generally may not be disclosed outside the agency without proper consent or a court order. (Social Security Act) Child welfare agencies must carefully reconcile these potentially countervailing interests in order to appropriately serve the children in their care. (Child Welfare League of America and Juvenile Law Center, 2008)

- 1. Child welfare professionals should regard children as the principle owners of information related to their sexual orientation and gender identity and expression, and should actively involve them in decisions related to any disclosure of this information.**

*Commentary: The consequences that flow from disclosure of personal information are primarily borne by the individual who is the subject of the information. For this reason, ethical and legal standards generally require the subject's consent or authorization prior to disclosure of confidential or sensitive information.*

*Young people are uniquely qualified to anticipate the positive and negative consequences that may result from disclosure of information related to their sexual orientation or gender identity and expression. At a minimum, child welfare professionals should engage youth in a discussion prior to disclosure in which the young people have an opportunity to ask questions, assert their wishes and problem-solve to minimize potential negative consequences or amend the information to be disclosed. This discussion also provides an opportunity for the professional to clearly identify the objective of the contemplated disclosure. Meaningful engagement with young people conveys respect, and builds trust.*

*Child welfare professionals should obtain the child's consent prior to disclosure whenever possible. In rare circumstances, child welfare professionals may determine that they are legally or ethically obligated to disclose this information against the child's wishes. For example, the child's sexual orientation may be directly tied to abuse or self-harm that the professional is mandated to report. In this situation, the professional should carefully explain the reason for disclosure, and should limit the disclosure to that information necessary to protect the child's safety and well-being.*

- 2. Child welfare professionals should identify and document a specific rationale related to the child's interests for every decision to disclose information related to the child's sexual orientation or gender identity.**

*Commentary: In an ideal world, children and youth would feel secure in all aspects of their identities, and coming out as gay, lesbian, bisexual or transgender would engender support and affirmation. In such a world, information related to a child's sexual orientation or gender identity might not warrant such stringent protections. Unfortunately, we are far from achieving these aspirational conditions. In fact, unwarranted disclosure of this information may subject a child to a range of physical and emotional harm. Under these circumstances, information related to a child's sexual orientation or gender identity must be considered both private and sensitive.*

*At the same time, there are circumstances under which disclosure of this information may be necessary to promote a child's welfare. Child welfare professionals should be thoughtful and cautious about any decision to disclose this information in verbal, written or digital communications. Prior to any disclosure, professionals should identify the rationale for disclosure, specifically ascertaining how the child will benefit from disclosure. Professionals should document this decision and the rationale in the case file.*

*Disclosure of information increases the likelihood that it will be redisclosed beyond the intended recipient. While the nature of this risk can differ, all modes of disclosure (verbal, written, digital) necessarily involve risk of re-disclosure and potential negative collateral consequences. Child welfare professionals should limit disclosure of the information to recipients who need it to support or serve the child. Professionals should also consider the risk of re-disclosure and take measures to minimize this risk.*

**3. Policies governing the management of information related to the sexual orientation or gender identity of children should be consistent with state and federal confidentiality laws, as well as agency policy and rules of court.**

*Commentary: State and federal laws govern the management of client information held by public child welfare agencies, including the circumstances under which personally identifiable information may be shared. Different laws govern what information may be shared with whom, often depending upon the original source of the information. For example, information obtained from health records is governed by different laws than information obtained from education or mental health records.*

*Confidentiality laws may differ from relevant professional standards. For example, the regulations governing the Health Insurance Portability and Accountability Act (HIPAA) of 1996 permit disclosure of health information for routine purposes of treatment, payment or health care operations without specific consent of the client. This regulation conflicts with the Privacy and Confidentiality standards of the NASW Code of Ethics, which provide, "Social workers may disclose confidential information when appropriate with valid consent from a client or person legally authorized to consent on behalf of a client." (Polowy, Morgan, Khan, & Gorenberg, 1997) The HIPAA provision authorizes disclosure for some purposes without consent, whereas the NASW provision requires consent for any disclosure.*

*Child welfare agencies should consult their legal counsel to ensure that agency policies comply with all relevant legal standards and requirements.*

**4. Child welfare agencies should consider adopting additional measures to prevent inappropriate or harmful disclosure of information related to children's sexual orientation, gender identity or gender expression.**

*Commentary: Because of the unique sensitivity of this information, child welfare agencies may determine that additional layers of protection are appropriate. Agencies may decide to add one or more of the following protections: a requirement for supervisory approval prior to disclosure, a requirement that child welfare personnel obtain a signed consent prior to disclosure, or a requirement that child welfare personnel obtain a court order authorizing disclosure and/or prohibiting redisclosure of the*

*information. Child welfare agencies may also consider entering into a Memorandum of Understanding with local child welfare system stakeholders that specifies the limited circumstances under which information related to children's sexual orientation, gender identity or gender expression may be disclosed.*

## **E. INSTITUTIONALIZING PRACTICE**

Competent child welfare practice is informed by a constantly evolving body of research and accepted best practice. Child welfare agencies also experience frequent turnover of personnel. Combined with daily workload challenges, competing reform initiatives and shrinking budgets, these realities threaten the sustainability of new policies and procedures.

Meaningful integration of these guidelines will require several key structural elements. At the outset, agency leadership is crucial. The Director of the child welfare agency, and other key managers, must fully understand and embrace these guidelines. Leadership is essential to conveying the importance of the guidelines and their connection to the agency's mission and values, as well as responding to any initial resistance. Agency management must be visibly involved in the introduction of the guidelines, as well as their implementation over time.

Child welfare agencies must also commit sufficient resources to ensure the viability and sustainability of the guidelines in daily practice. At the outset, resources are necessary to adequately communicate the change in policy to all of the important internal and external stakeholders, including agency managers, supervisors, line workers, families, children, judges and attorneys. Agencies should ensure that all personnel receive training and ongoing supervision geared toward consistent implementation of the policy in daily practice. Agencies must also build internal competence across all levels of the organization to decrease the agency's dependence on outside consultants and resources.

**1. Agency policies, practices, training and supervision related to children’s sexual orientation, gender identity and gender expression should be explicitly grounded in credible social science research and the foundational objectives of safety, permanency and well-being.**

*Commentary: Policies and practices related to sexual orientation, gender identity and gender expression often engender controversy due to their association with entrenched religious and political points of view. Agencies cannot expect to prevent resistance or debate, and should instead invite constructive engagement as an opportunity to convey a consistent and thoughtful rationale. Internal and external messaging related to these issues must emphasize their connection to the child welfare objectives of safety, permanency and well-being. All communications should cite peer reviewed, published social science research, as well as emerging professional standards, that support the objectives and content of the policies and training.*

**2. Child welfare agencies should have written policies and procedures governing the management of information related to the sexual orientation, gender identity and gender expression of children and youth under their care.**

*Commentary: Written policies and procedures provide the roadmap for consistent and competent practice, as well as professional accountability. Thoughtful development and revision of agency policy provides an opportunity to engage and educate agency employees and external stakeholders about the agency’s mission and values, and permits personnel and providers to reflect on their own experiences and points of view. Development of written policy should be as inclusive as practicable to incorporate the perspectives of important child welfare stakeholders, including managers, supervisors, line workers, court officers, families, children, guardians ad litem, judges and attorneys. Policies should be specific enough to provide meaningful guidance, and general enough to permit trained professionals to exercise reasoned judgment and discretion. When questions arise about the management of information related to children’s sexual orientation, gender identity or gender expression, professionals should refer to written policy for guidance. Agency policy should also form the backbone of all training and supervision. Child welfare agencies should institutionalize the practice of regular review and revisions of policies to ensure that they remain consistent with emerging research and understanding of children and families.*

**3. Child welfare agencies should provide pre-service and ongoing training to all child welfare personnel regarding the agency's policies governing the management of information related to children's sexual orientation, gender identity and gender expression.**

*Commentary: Under Title IV-E of the Social Security Act, the federal government underwrites 75% of the cost of training employees of state and local child welfare agencies, as well as foster and adoptive parents and child care institutions staff. The Children's Bureau has clarified that matching federal funds are available to support training that addresses "How to assess and serve the needs of children without bias and ensure their safety, including how to parent youth struggling with issues related to sexual orientation, gender identity and/or gender expression." (Children's Bureau, 2012) Child welfare agencies should include these topics in their existing training programs, including training of child welfare workers on the practice issues covered by these guidelines. The training should be tailored to respond to the agency's current level of competence and familiarity with serving children whose actual or perceived sexual orientation is other than heterosexual, and children whose gender identity or expression is incongruent with their biological sex or with cultural expectations related to gender expression. A series of trainings dedicated to implementation of the guidelines may be appropriate to introduce new policies and procedures. Agencies may also determine that initial trainings are best delivered by outside consultants, or some combination of internal and external trainers. As personnel become more familiar with the guidelines and agencies more fully integrate these practices, it is important to build internal capacity to conduct the training. Integrating these issues into broader training programs may also assist in institutionalizing these guidelines.*

**4. Child welfare agencies should ensure that all staff receive ongoing supervision and technical assistance on the management of information related to the sexual orientation, gender identity and gender expression of children and youth under the agency's care.**

*Commentary: Particularly in the early stages of implementation, child welfare workers will likely have questions about how to apply the guidelines in specific situations. Agencies must provide some accessible mechanism for exploring solutions to such questions. Options include assignment of a specific person or persons to whom such questions are directed, a means of convening a group of personnel to "staff" a specific case to brainstorm potential solutions, or a contract with an external expert to provide coaching and technical assistance. Although the number of questions is likely to diminish over time, it is still a good practice to ensure some means of providing guidance in*

*individual cases. In addition to case specific technical assistance, agencies should ensure that supervisors regularly monitor practice through the supervision process. This may involve case file reviews to ensure compliance with the guidelines, or simply inviting questions about implementation.*

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# CALIFORNIA COMMON CORE CURRICULA FOR CHILD WELFARE WORKERS



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## MASTER GLOSSARY

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### **366.26**

The legal process by which the court determines the most appropriate permanent living arrangement for the child, either through adoption, legal guardianship, or a planned permanent living arrangement.

### **387 petition**

A petition filed under Welfare & Institutions Code Sec. 387, requesting a child's removal to a more restrictive placement. 387 petitions must be filed to request removal from a parent on a Family Maintenance plan, removal from a relative to foster care, and removal to a higher level of foster care.

### **388 petition**

A petition filed under Welfare & Institutions Code Sec. 388, requesting a change of a court order. Any interested party can file a 388 petition.

### **AB 458**

The California Foster Care Non-Discrimination Act (AB 458) went into effect in 2004 and prohibits discrimination in the California foster system on the basis of "actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status." [California Welfare & Institutions Code Sec. 16013(a) and 16001.9(a)(23)]. AB 458 also mandates initial and ongoing anti-discriminatory training for group home administrators, child welfare workers, foster parents, relative caregivers and foster family agency staff.

### **AB 490**

The Ensuring Educational Rights and Stability for Foster Youth (AB 490, Steinberg, 2003) legislation expands and stipulates authority for school records of foster, homeless, and incarcerated youth. It also establishes legislative intent that foster youth are ensured access to the same opportunities to meet academic achievement standards to which all students are held; maintain stable school placements; be placed in the least restrictive educational placement; and have access to the same

academic resources, services, and extracurricular and enrichment activities as all other children. The law makes clear that education and school placement decisions are to be dictated by the best interest of the child.

### **AB 636**

The Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg) establishes a system whereby counties identify and replicate best practices to improve child welfare service outcomes through county-level review processes. It is also referred to as the California–Child and Family Service Review (C-CFSR).

### **AB 3632**

The Special Education Pupils Program (AB 3632) was passed in 1984 and assigns responsibility to state agencies and counties for meeting the goals of an Individualized Educational Plan (IEP). This legislation assigns schools the responsibility to educate, the state Department of Mental Health (DMH) the responsibility to provide mental health services, and the state Department of Social Services the responsibility to provide out-of-home care.

### **Ability to Locate**

This term from the California Standardized Safety Assessment Matrix refers to the ability of the social worker to determine where the children and/or family are located. [This includes information gathered as part of the hotline information gathering process and that is essential to facilitate the ability of the responding ER social worker to locate the child. Specifics regarding hard-to-find locations should be gathered as part of this assessment.] (*#12 in the Standard Areas for Review*)

### **Ability to Meet Child’s Needs**

This term from the California Standardized Safety Assessment matrix refers to the ability of the caregiver to provide a safe, stable home and meet the basic needs of children in their care. [This includes the ability to respond to a child’s age and condition by providing care in a way that supports the child’s health, mental health, education, development, and physical and emotional well-being.] (*#10 in the Standard Areas for Review*)

### **Addiction**

Dependence on a chemical substance to the extent that a physiological and/or psychological need is established. This may be manifested by any combination of the following symptoms: tolerance; preoccupation with obtaining and using a substance; use of the substance despite anticipation of probable adverse consequences; repeated efforts to cut down or control substance use; and withdrawal symptoms when the substance is unavailable or not used.

## **Adoption**

Occurs when the court terminates the rights of the legal parent, usually the biological parent, and orders that another person is now the legal parent of the child.

## **Adoption & Safe Families Act (ASFA)**

The National Child Welfare Act of 1997 which set performance goals, outcomes, and indicators for social work system practice.

## **Alternative Dispute Resolution**

Various processes by which legal disputes are settled without going to trial.

## **Alternative Permanency**

Arrangements whereby youth for whom family restoration is not possible or appropriate establish enduring emotional ties with unrelated adult caregivers who are willing and able to offer a stable and supportive continuing relationship whether within or outside of the legal channels of adoption or guardianship.

## **APGAR Test**

A test administered at one minute and five minutes (and may be repeated at a 10-minute interval) after birth to help health care providers assess critical aspects of a baby's health at birth.

## **AOD (Alcohol and Other Drugs) Abuse**

A pattern of substance use that threatens one's health or impairs one's social or economic functioning.

## **Attention Deficit Hyperactivity Disorder (ADHD)**

ADHD is characterized and diagnosed by three types of behavior: (1) inattentiveness; (2) hyperactivity or impulsivity; or (3) combined (inattentiveness and hyperactivity). ADHD typically manifests initially in childhood.

## **Autistic Spectrum Disorder (ASD)**

A group of developmental disabilities that are related to brain function including autistic disorder, pervasive developmental disorder—not otherwise specified (PDD-NOS, including atypical autism), and Asperger's disorder. People with ASD tend to have difficulties with common culturally agreed upon social and communication skills and are likely to repeat certain behaviors and resist change in their daily activities. Many people with ASD also have unusual ways of learning, paying attention, or reacting to different sensations. ASD begins during childhood and lasts throughout a person's life however, early intervention can be critical in improving prognosis.

## **Basic Needs**

This term from the California Standardized Safety Assessment Matrix refers to the fundamental needs of a child and family for food, shelter, clothing, medical care, and

the child's need for supervision. (#26 in the Standard Areas for Review)

### **Batterer Intervention**

Intervention focused on helping the batterer learn to be non-violent.

### **Bias-Free Written Language**

Communication that makes a conscious effort to avoid perpetuating biases in language that emerge as a result of assumptions or attitudes on the basis of race, gender, religion, or nationality. This includes rephrasing for gender neutrality, use of inclusive terminology, appropriate forms of address and titles, and avoiding stereotypes. (<http://www2.state.ga.us/Courts/supreme/biasfree.htm>)

### **Bench Officer**

Judges, Referees, or Commissioners who hear the evidence presented and make decisions about the families who come before the court.

### **Best Interest of the Child**

One of the fundamental tenets of the dependency system for achieving the best outcomes for each individual child.

### **Burden of Proof**

A party's responsibility to prove something in dispute.

### **Bottle Rot**

Severe dental decay which appears as blackened baby teeth, caused by improper feeding, including allowing milk or other liquid to pool in the baby's mouth during sleep. Bottle rot can cause damage to permanent teeth and gums if not treated properly by a dentist.

### **Bruise**

Bleeding under the skin which results in discoloration. A bruise may take on the pattern of the object which caused the injury.

### **California Child and Family Services Review (C-CFSR)**

Authorized by the Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg), this county-level review process encompasses a system of continuous quality improvement which seeks to identify and replicate best practices to improve child welfare service outcomes.

### **California Child Welfare Outcomes and Accountability System**

California's accountability mechanism that tracks and monitors child welfare outcomes, measures performance on a county and statewide basis, and enforces continuous quality improvement by requiring counties to set and meet improvement goals.

## Caregiver

Parent(s), guardian(s), or other adult(s) fulfilling the parental role and entrusted with the responsibility to care for the child(ren).

## Caregiver-Child Interaction

This term from the California Standardized Safety Assessment Matrix refers to the verbal and non-verbal communication and behavior between a caregiver and child, which reflects the quality of the relationship and the degree to which it is reciprocal. [This includes behaviors that demonstrate a caregiver's awareness of the child's emotional state, the caregiver's capacity for empathy and bonding, and the caregiver's ability to respond appropriately to the child, including responses associated with child discipline.] (#11 in the Standard Areas for Review)

## Caregiver's Compliance/Progress toward Case Plan Objectives

This term from the California Standardized Safety Assessment Matrix refers to the progress of the parent(s) in achieving the objectives of the change-oriented interventions specified in the case plan. [This includes the frequency and extent of the parent's participation in case plan activities, and the degree to which the parent demonstrates that these activities have resulted in change consistent with case plan objectives. Compliance is not the sole basis for considering preservation/restoration, but is one element in assessing the parent's success in achieving the objectives of the case plan and preparation to act as a responsible parent.] (#37 in the Standard Areas for Review)

## Caregiver's Personal History of Abuse

The information gathered and utilized by the social worker in the assessment process to determine whether the caregiver has ever been a victim of child abuse or neglect him/herself, and whether that history affects the caregiver's protective capacity.

## Caregiver Protective Capacity

This term from the California Standardized Safety Assessment Matrix refers to the ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns, and to support the ongoing safety of the child. [Such capacities include, but are not limited to, attachment to the child, parental caregiving skills, awareness of and ability to interpret the child's needs, positive motivation to nurture or meet the child's needs, willingness to seek and use help, and willingness/ability to act protectively when the child is threatened with harm. Protective capacity elements are the focus of both safety plans and case plans for change-oriented intervention. They point to the inherent capacities of the family or the resources that could be mobilized to contribute to the ongoing protection of the child as well as to the ability or motivation of the parents to change.] (#8 in the Standard Areas for Review)

### **Caregiver Willingness to Change**

This term from the California Standardized Safety Assessment Matrix refers to the caregiver's motivation to change those conditions that threaten child safety and/or those ineffective/inappropriate behaviors that were identified in the initial assessment. (*#22 in the Standard Areas for Review*)

### **Case Plan**

The written document which is developed based on an assessment of the circumstances which required child welfare services intervention, and in which the social worker identifies a case plan goal, objectives to be achieved, specific services to be provided, and case management activities to be performed. [Div 31-002(c)(2)]

### **Change-Oriented Services**

Child Welfare Services interventions that increase protective capacities of the caregivers by modifying conditions or ineffective/inappropriate behaviors that threaten child safety, reconciling the competing demands of urgency and the gradual nature of meaningful change processes.

### **Child and Family Services Review (CFSR)**

Authorized by the 2000 Federal Rule pursuant to ASFA, this formal review of state child welfare programs is conducted every three years by the federal government using specific benchmarks designed to assess achievement of child safety, permanency, and well-being outcomes and to identify the state's strengths, needs, and requirements for technical assistance.

### **Child and Family Support Assessment (CAFSA)**

The Child and Family Support Assessment is comprised of an initial face-to-face assessment of child safety, risk for maltreatment, and parental protective capacity followed by a more comprehensive child and family assessment.

### **Child Development**

This term from the California Standardized Safety Assessment Matrix refers to the child's language, cognitive, social/emotional, sensory, and motor development. [The social worker will note any diagnosed developmental problems or apparent need for developmental testing.] (*#29 in the Standard Areas for Review*)

### **Child Neglect**

Acts of omission or commission which result in minimal standards of care not being met.

### **Child Strengths and Vulnerability**

This term from the California Standardized Safety Assessment Matrix refers to behavioral and attitudinal strengths of the child that support the child's safety, permanency, and well-being, including health, education, and social development.

The child's vulnerability refers to the child's susceptibility to suffer abuse or neglect based on age, health, size, mobility, social/emotional state, and the ability of the caregiver to provide protection. [Key characteristics indicating increased child vulnerability include developmental disability, mental illness (including withdrawn, fearful, or anxious behavior), and lack of self protection skills; children with substance-abusing parents; homeless children; and children experiencing chronic neglect.] (#3 in the Standard Areas for Review)

### **Child Welfare High Risk Response (see also Differential Response)**

Intervention in situations in which children are at moderate to high risk for continued child abuse/neglect, and actions have to be taken to protect the child with or without the family's agreement. May involve the filing of criminal charges against the adult(s) who caused harm.

### **Child Well-Being**

A primary outcome goal for child welfare services focused on how effectively the developmental, behavioral, cultural, and physical needs of children are met.

### **Child's Attorney**

An attorney that represents the child in court and informs the court of the child's wishes and the child's best interests.

### **Child's Immediate and Ongoing Needs**

This term from the California Standardized Safety Assessment Matrix refers to the identified developmental, behavioral, cultural, and physical needs of a child including immediate and ongoing needs for safety and security/permanency. [This includes ensuring that children and families receive sufficient support and services when and where they need them in order to maintain all aspects of their functioning that may be compromised by risk factors associated with abuse and neglect. Immediate and ongoing safety, permanency, and well-being needs include medical, dental, mental health, and developmental needs; housing, food, clothing, education, and emotional support (i.e., healthy family and peer relationships).] (#15 in the Standard Areas for Review)

### **Child's Permanency Needs**

This term from the California Standardized Safety Assessment Matrix refers to the maintenance and/or establishment of enduring family attachments. This includes a broad array of individualized permanency options, including Reunification, Adoption, Legal Guardianship, and alternative permanent living arrangements for all children and youth to promote their safety, permanence, and well-being. [Permanency is both a process and a result that includes involvement of the child/youth as a participant or leader (when possible) in finding a permanent connection with at least one committed adult, who provides:

- a safe, stable and secure parenting relationship,
- love,
- unconditional commitment,
- lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons, including brothers and sisters.

A broad array of individualized permanency options exist for all children and youth to promote their safety, permanence, and well-being. Reunification and adoption are two important ones among many that may be appropriate. California Permanency for Youth Task Force.] (#20 in the Standard Areas for Review)

### **Child’s Relationship with Peers and Adults**

This term from the California Standardized Safety Assessment Matrix refers to the quality of connectedness (defined as close and positive attachment) experienced by the child toward significant adults or peers in his or her life. [This quality is measured by the degree to which these relationships meet or enhance the child’s emotional, developmental, social, mental, and/or educational needs. These significant relationships may include immediate family, friends, professionals, or extended family, and also can include anyone who has an impact on the child’s life. Significant relationships are not solely measured by frequency of contact with the child.] (#32 in the Standard Areas for Review)

### **Collateral Contacts**

Persons from whom pertinent information is gathered to make a decision regarding the allegations of child maltreatment and the potential risk of abuse in the future. [The child welfare worker contacts persons who may have knowledge about the family for the express purpose of obtaining pertinent information regarding the risk and safety of the child. Applicable policies and regulations must be followed regarding the release of confidential information obtained from collateral contacts.]

### **Common Continuum of Alcohol and Drug Dependency & Response (see also Cycle of Addiction)**

Describes the pattern of use that can lead to dependency: non-use/selective abstinence; experimental use/initial use; response use, “at risk” use; situational/crises, or binge use/abuse; unhealthy use, chronic abuse; chemical dependency/addiction; recovery and relapse; and “in recovery.”

### **Community Response (see also Differential Response)**

A proactive response to, and assessment of, situations involving families under stress who come to the attention of the Child Welfare System but who do not

present an immediate risk for child maltreatment. Provides families with access to services to address identified issues without formal entry into the system.

### **Component**

In the CFSR review, a component comprises part of a composite.

### **Composite**

Reflects the general domain assessed by data. In the CFSR review, each composite comprises one or more weighted components. The individual measures in a composite are weighted using a technique known as principal components analysis.

### **Concurrent Planning**

The process of coupling aggressive efforts to restore the family with careful planning for the possibility of adoption or other permanency options should circumstances prevent the child from returning to her/his family of origin.

### **Confidentiality**

The protection of information from release to organizations or individuals not entitled by law to such information.

### **Contributing Factors Requiring Intervention**

This term from the California Standardized Safety Assessment Matrix refers to the circumstances that require child welfare services intervention (WIC 16501.1(f)(1). (#23 in the Standard Areas for Review)

### **County Counsel**

An attorney that represents the child welfare agency in court. (The child welfare agency, not the individual child welfare worker, is the client.)

### **Court Appointed Special Advocate (CASA)**

CASA is a program designated by the local presiding juvenile court judge to recruit, screen, select, train, supervise, and support lay volunteers to be appointed by the court to help define the best interest of the child. CASA volunteers visit the child regularly and write reports for the court.

### **Cultural and Language Considerations**

This term from the California Standardized Safety Assessment Matrix refers to the consideration and exploration of the family's cultural framework in the assessment and the development of safety plans and case plans. [This includes social work intervention, services, and assessments that are culturally competent and linguistically sensitive, including the provision of services in the language of the client population served.] (#4 in the Standard Areas for Review)

### **Current and Previous Social Services**

This term from the California Standardized Safety Assessment Matrix refers to any social services currently or previously provided by a public child welfare agency or any social services agency. [These services may include CalWORKS, mental health services, counseling services, family resource services, etc. This information is used by the social worker to determine the response type, conduct safety assessments, perform case management, and make decisions regarding service interventions, placement, permanency goals, and readiness for case closure.] (#24 in the Standard Areas for Review)

### **Current and Prior CWS History**

This term from the California Standardized Safety Assessment Matrix refers to the information gathered by the social worker from reviews of the CWS/CMS and other available documentation to determine whether or not the child and family have current or past involvement with the public child welfare agency. (#2 in the Standard Areas for Review)

### **Current and Prior Maltreatment**

This term from the California Standardized Safety Assessment Matrix refers to a current or prior act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which has resulted in, or has placed the child at risk of, developmental, physical, or psychological harm. [The child welfare worker will gather information provided by reporting parties and collateral contacts (when appropriate) about that person's knowledge of current maltreatment of a child. The child welfare worker will also gather information about any previous incidents of child maltreatment involving the child or family.] (#1 in the Standard Areas for Review)

### **CWS Response (see also Differential Response)**

A proactive response to, and assessment of, situations involving families with low to moderate risk of child maltreatment. CWS response includes the engagement of families, voluntarily whenever possible, in the development and implementation of a service plan directed at the protection of the child.

### **CWS Stakeholders**

More than 60 invited representatives from many sectors of the child welfare community who met monthly over the course of three years to identify and recommend changes in California's Child Welfare Services, leading to better outcomes for children and their families.

### **Cycle of Addiction (see also Common Continuum of Alcohol and Drug Dependency & Response)**

Describes the pattern of use that can lead to dependency: non-use/selective abstinence; experimental use/initial use; response use, "at risk" use;

situational/crises, or binge use/abuse; unhealthy use, chronic abuse; chemical dependency/addiction; recovery and relapse; and, “in recovery.”

### **Decision Making Model**

A general model adapted from Stein and Rzepnicki to assist new workers in the process of decision making (Miller, 2005). This general model includes the following steps:

- Step 1: Information Gathering
- Step 2: Application of Rules of Criteria
- Step 3: Discussion/Feedback
- Step 4: Decision/Professional Judgment
- Step 5: Reassessment

### **Defacto Parent**

A person who has been found by the court to have assumed the day-to-day role of parent for a substantial period of time, fulfilling the child’s physical and psychological needs for care and affection. (2009 California Rules of Court, Rule 5.502(10))

### **Definitions of Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and/or Exploitation**

Penal Code 11165 et seq.

### **Delinquency Proceeding**

A juvenile court hearing in which the court is asked to declare a minor a ward of the court for behavior that would be considered criminal if the minor were an adult. (Welfare and Institutions Code Sec. 602.)

### **Delinquent Behavior**

This term from the California Standardized Safety Assessment Matrix refers to behavior by a person under the age of 18 that is persistently or habitually in conflict with the reasonable orders of his guardians and/or is in violation of any laws of this state or the United States. (Welfare & Institutions Code Sec. 601, 602) (#35 in the *Standard Areas for Review*)

### **Dental/Medical Care**

Dental and medical care (including routine examinations, diagnoses, treatment, or hospital care under general or special supervision) are to be rendered by licensed dental and medical professionals, respectively. [This term is from the California Standardized Safety Assessment Matrix (#27 in the *Standard Areas for Review*).]

### **Dependency Proceeding**

A juvenile court hearing in which the court makes a determination as to whether or not a minor will be declared a dependent of the court. The determination is based on establishing that child abuse or neglect has occurred, as defined by one or more of the grounds specified in Welfare and Institutions Code Sec. 300.

### **Detention Hearing**

The first judicial proceeding in a dependency case wherein the judge decides whether the child should remain in protective custody, away from his or her parents, while an investigation into the reasons for the removal is conducted. At this hearing, the court will appoint counsel, advise parents of their rights, explain the court process, order visitation when appropriate, inquire about possible relative caregivers, inquire into the child's paternity and determine whether the Indian Child Welfare Act might apply. This hearing must be held within three days of the physical removal of the child.

### **Differential Response (see also Child Welfare High Risk Response, Community Response, and CWS Response)**

A system for triaging referrals received by the Child Abuse Hotline/Intake that provides a broader range of responses by the Child Welfare System to assure child safety and family maintenance that includes partnerships with community based agencies and consults with families to identify community supports and strength-based solutions appropriate to their circumstances.

### **Differentiation**

The process by which neurons become specialized in response to neurochemical and micro environmental cues. These cues tell each neuron which combination of genes to activate in expressing a “unique neurochemistry, neuroarchitecture and functional capability...Each neuron undergoes a series of ‘decisions’ to determine its final location and specialization”. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, p. 83.]

### **Dismissal**

The court dismisses the dependency petition indicating the termination of legal proceedings. This can happen because a child is returned home and supervision is no longer necessary, or because a child has reached the age of majority and the agency has met all the dismissal requirements in WIC Sec. 391.

### **Disparity**

Disparity refers to inequities based on a child's or family's minority racial or ethnic status in access to, or the quality of, treatment, services, or resources available through involvement in the child welfare system. “Research shows that children of color in foster care and their families are treated differently from—and often not as well as—white children and their families in the system” [Hill, R.B. (2006). *Synthesis*

of *Research on Disproportionality in Child Welfare: An Update*. Casey Family Programs, p. 3]. Decision points in case management (e.g., reporting, investigation, substantiation, foster care placement, adoption, and exit) are often used to analyze the presence of disparities.

### **Disposition**

At this hearing, the court considers what it should do to protect and help the child and his or her family. The court decides whether to dismiss the case, order informal services for the family without making the child a dependent, appoint a guardian with the consent of the parents, declare the child a dependent of the court and leave the child in the home of the parents with family maintenance services, remove the child from the home and order reunification services for the parents, or remove the child from the home and not order reunification services for one of the reasons in WIC Sec. 361.5(b). The court also approves the case plan submitted to the court which outlines the services to be provided to the child and family. This hearing can occur at the same time as the jurisdiction hearing and must occur within 10 court days of the jurisdiction hearing for detained children and within 30 court days for a non-detained child.

### **Disproportionality**

Disproportionality refers to the differences in the percentage of children of a certain racial or ethnic group in the population as compared to the percentage of the children of the same group in the Child Welfare System. “For example, in 2000 Black children made up 15.1% of the children in this country but 36.6% of the children in the Child Welfare System” [Hill, R.B. (2006). *Synthesis of Research on Disproportionality in Child Welfare: An Update*. Casey Family Programs, p. 3].

### **Division 31**

The State of California’s regulations that provide policy and procedures on the delivery of child welfare services. These regulations are reflected in programs that are funded by Title IV-E federal funds. Each county develops more specific policy and procedures from these state regulations.

### **Domestic Violence**

This term from the California Standardized Safety Assessment Matrix refers to a pattern of assaultive and coercive behaviors used against intimate partners (including physical, sexual, and psychological attacks, as well as economic coercion). [Refer to the legal definitions in Family Code Sec. 6211. Also recommend using the National Council of Juvenile and Family Court Judges’ *Effective Interventions in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice* (Greenbook Project).] (#34 in the Standard Areas for Review)

### **Due Process**

The conduct of legal proceedings according to rules and principles to protect private

rights, including notice and the right to a fair hearing.

### **Early Reunification**

Efforts directed at enhancing parental protective capacity in order to permit the child to return to his or her family within 30 to 60 days of placement.

### **Educational Needs**

This term from the California Standardized Safety Assessment Matrix refers to the level of the child's academic performance which takes into account the child's age relative to assigned grade level, the child's performance as recorded, monitored, and measured by the child's educational institution, and any barriers that are identified that may interfere with the child's successful academic performance. (*#30 in the Standard Areas for Review*)

### **Educational Surrogate**

The responsible adult appointed to represent the rights of a child with exceptional educational needs in all educational matters related to the provision of a free appropriate public education if the educational rights of the child's parents have been limited. (Education Code Section 56050)

### **Ethnographic Interviewing**

A skillful and engaging method of interviewing designed to elicit comprehensive information about a person's life experience in terms of values, beliefs, customs, history, and family composition, etc., often relying on open-ended questions.

### **Evidence-based Practice**

The application to service delivery of research evidence related to child welfare, integrated with clinical expertise and client values. The existing body of research reflects varying levels of methodological rigor and efficacy, and differences in applicability to child welfare practice. Where available, research on child welfare practice is integrated into the common core.

### **External Resources**

The formal or informal resources outside the individual or the family, (i.e., community connections, support of friends, church, or community organizations, etc.) that strengthen their capacity to mitigate risk and to support the ongoing safety of a child. (See also Protective Capacity.)

### **Factitious Disorder by Proxy**

Commonly referred to as Munchausen Syndrome by Proxy, this DSM IV-TR recognized disorder is manifested when a caregiver deliberately induces illness in another person (usually a child).

### **Failure to Thrive (FTT)**

Condition that exists when a child under age 2 is below the fifth percentile on normal growth charts for height, weight, and head circumference. Organic causes should be ruled out. Non-organic failure to thrive is a result of caloric deprivation and there is often a corresponding lack of bonding between the primary caregiver and the baby.

### **Fairness and Equity**

A principle of best practice that promotes policies, procedures, practices, and service arrays that support all children and families in obtaining similar benefit from child welfare interventions and equal opportunity to attain positive outcomes. The concept 'fairness and equity' embodies the ideals of social justice and cultural competency, and the reduction of disproportionality and disparities in the child welfare system.

### **Family and Household Relationships**

Refers to the interactions between persons who are related by blood, marriage, or adoption, and/or who reside together in the same dwelling.

### **Family and Youth Engagement**

Practices and strategies congruent with relevant sociocultural dynamics that effectively engage parents, youth, and extended family members in a respectful and collaborative manner in the assessment, intervention and case planning processes.

### **Family to Family**

An initiative designed in 1992 and field tested in communities across the country that effectively incorporates a number of strategies consistent with the values and objectives of the California Child Welfare Redesign, including comprehensive assessment, family team decision-making, neighborhood placement in families, and concurrent planning to assure children permanent families in a timely manner.

### **Family Well-Being**

A primary outcome goal for California's child welfare services whereby families demonstrate self-sufficiency and the ability to adequately meet basic family needs (e.g., safety, food, clothing, housing, health care, financial, emotional, and social support) and provide age-appropriate supervision and nurturing of their children.

### **Fetal Alcohol Spectrum Disorders**

An umbrella term referring to all disorders occurring due to an alcohol exposed fetus including Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorders (ARND), Partial FAS and Static Encephalopathy, Alcohol Exposed.

### **Folk Treatments**

Cultural practices and natural healing methods which are used to treat illnesses and

injuries.

### **Fontanel**

Any of the soft membranous gaps between the incompletely formed cranial bones of a fetus or an infant.

### **Fracture**

Broken bone. Knowing the type of fracture may help to determine if it was caused accidentally or non-accidentally.

### **Guardian Ad Litem**

A person appointed by the court after a hearing to make decisions about case strategy for an incompetent parent.

### **History of Child Abuse and Neglect**

Refers to caregiver's identification as a perpetrator of substantiated child abuse or neglect as defined by a child protection agency.

### **History of Criminal Behavior**

This term from the California Standardized Safety Assessment Matrix refers to a caregiver's previous or current illegal activity as defined by federal and state law that may affect the caregiver's protective capacity. [Typical sources include self-report, drug test results, and law enforcement records.] (#25 in the Standard Areas for Review)

### **Home Environment**

This term from the California Standardized Safety Assessment Matrix refers to the physical condition of the home including safety hazards and health concerns. (#9 in the Standard Areas for Review)

### **Inclusive Governance**

A characteristic of effective community partnerships that ensures that the diverse perspectives of the people affected by a decision, especially groups currently and historically under-represented, are taken into account in making and shaping decisions.

### **Independent Living Skills Program (ILSP)**

A program for children age 16 through 21 that provides services to help youth become self-sufficient by the time they leave the foster care system. Dependent children who are or have been in placement after the age of 16 must be offered enrollment in this program.

### **Indian Child Welfare Act (ICWA)**

Congress passed these laws in 1978 to protect the best interests of Indian children

and to promote the stability and security of Indian tribes and families by establishing specific standards that must be met before an Indian child can be removed from his or her family and placed in an adoptive or foster care placement. Congress was concerned about the high rate of Indian children being removed from their homes and placed with non-Indian families and the negative consequences this has had on Indian children, families, and tribes. This federal law is codified in California statute and rule of court.

### **Individualized Educational Program (IEP)**

A written document developed for each public school child who is eligible for special education services. The IEP is created by a team that includes educators, caregivers, and other child specialists (including a child welfare representative, if applicable) and is reviewed at least once a year.

### **Initial Safety Determination**

The [California child welfare improvement] intake function, utilized to ensure the immediate safety of the child and the identification of risk factors.

### **Internal Resources**

Resources that exist within each individual in the family and in the family as a whole (i.e., emotional and psychological strengths, etc.) that strengthen the capacity to mitigate risk and to support the ongoing safety of a child. (See also Protective Capacity.)

### **Intimate Partner Violence (IPV) (see Domestic Violence)**

### **Jurisdiction Hearing**

At this hearing, the court takes jurisdiction of the case if it determines that the allegations in the petition filed by the child welfare agency have merit, and that the child has been abused or neglected as defined in Welfare and Institutions Code Sec. 300. Jurisdiction grants the court authority to make orders regarding disposition. The jurisdiction hearing must be held within 15 days of the detention hearing.

### **Juvenile Dependency**

A legal system that designates children under age 18 as dependents of the court if a judicial determination of parental abuse or neglect is made. California's system simultaneously strives to preserve the family unit, while obtaining permanency for children.

### **Kin**

Includes relatives in a nuclear or extended family, members of a child's clan or tribe, stepparents, or any other adults who share a fictive kinship bond with a child (e.g., godparents).

### **Kinship Care**

Kinship care is the full time care, nurturing, and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child.

### **Legal Guardianship**

Occurs when the court suspends, but does not terminate, parental rights, and another adult is appointed to be responsible for the child.

### **Level of Care to Meet Child's Needs**

This term from the California Standardized Safety Assessment Matrix refers to the assessment and determination of the appropriate services and placement type that best meets the child's physical and emotional needs. [This includes considerations of placing the child in the least restrictive, most family-like setting; addressing the child's personal characteristics and cultural background; maintaining the child's connections to family and siblings whenever possible; allowing the child to remain in his/her current school if possible; allowing for reasonable visitation, reunification, and permanency planning; and providing for any special needs of the child. Based on Div 31-400 in general.] (#16 in the Standard Areas for Review)

### **Maltreatment (see Current and Prior Maltreatment)**

#### **Measure**

An actual indicator of performance.

#### **Mediation**

A discussion facilitated by a trained mediator concerning a court case that provides a problem-solving forum as an adjunct to formal court proceedings for all interested persons to develop a plan in the best interests of the child. Family preservation and family strengthening are emphasized.

#### **Mediator**

A trained professional who guides the discussion at mediation in a neutral manner with the aim of bringing the parties to consensus.

### **Medical/Dental Care**

Medical and dental care (including routine examinations, diagnoses, treatment, or hospital care under general or special supervision) are to be rendered by licensed medical and dental professionals, respectively. [This term is from the California Standardized Safety Assessment Matrix (#27 in the Standard Areas for Review).]

### **Mental Health/Coping Skills**

This term from the California Standardized Safety Assessment Matrix refers to emotional and psychological well-being, including the ability of an individual to use

his or her cognitive and emotional capabilities to handle day-to-day life stressors and function effectively in society. (#28 in the Standard Areas for Review)

### **Minimum Sufficient Level of Care (MSLC)**

The social standard for the minimum of caregiver behavior below which a home is inadequate for the care of a child. Factors to consider in establishing what the MSLC is for a particular child include those that relate to:

- the child’s needs,
- contemporary social standards, and
- community standards.

### **Mongolian Spots (see Slate Gray Patches)**

### **Multi-Disciplinary Teams**

A group of professionals and paraprofessionals representing an array of disciplines (e.g., resource families, service providers, law enforcement, juvenile courts, and other community organizations) who interact and coordinate efforts with parents and families, pooling their skills to offer comprehensive, coordinated services.

### **Munchausen Syndrome by Proxy (see Factitious Disorder by Proxy)**

### **Mutual Combatants**

Two persons, equally involved in the commission of a crime against the other person with neither person acting in self-defense.

### **Neurogenesis**

The process by which new nerve cells and the network of branched cells and fibers that supports the tissue of the central nervous system (“neuroglia”) are generated. This “birth” of neurons occurs primarily during the second and third trimesters of pregnancy. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3.]

### **Neuronal Migration**

The process by which neurons “cluster, sort, move and settle into their final ‘resting’ place.” Primarily guided by neuroglial cells, neurons migrate out from where they are produced in the center of the developing brain to where they will eventually settle (i.e. the brainstem, cortex, etc.). Although most neuronal migration takes place in utero and during in the perinatal period, it continues to occur throughout childhood. Environmental factors and “intrauterine and perinatal insults” can affect the migration of neurons, thus influencing the formation as well as the function of the developing neural network. [Adapted from: Perry, B.P. (2002). Childhood Experience

and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, p. 83.]

### **Non-Adversarial Approaches**

Practices, including dependency mediation, family group conferencing, or decision-making and settlement conferences, designed to engage family members as respected participants in the search for viable solutions to issues that brought them into contact with the child welfare system.

### **Non-Minor Dependent Youth**

As defined by the Fostering Connections to Success and Increasing Adoptions Act of 2008, a non-minor dependent youth is a current or former dependent child or ward of the juvenile court who

- has attained 18 years of age but is less than 21 years of age;
- is in foster care under the responsibility of the county welfare department, county probation department, or Indian tribe; and
- is participating in a transitional independent living case plan.

### **Noticing**

Formal provision of the date, time, location, and purpose of the hearing.

### **Overrepresentation**

Overrepresentation refers to the current situation in which particular racial/ethnic groups of children are represented in foster care (or in the child welfare system as a whole) at a higher or lower percentage than their representation in the general population. [Adapted from McRoy, R. (2005). *Moving from Disproportionality to Fairness and Equity*. Lecture presentation, The Symposium on Fairness and Equity in Child Welfare Training and Education, 2005.]

### **Outcomes-Informed Practice**

Practice that supports and is informed by federal and state outcomes. All training in California supports the federal outcomes of Safety, Permanency and Well-Being. California also has developed state-specific performance measures. [For more information on the performance measures in California, refer to the website for the Child Welfare Dynamic Report System at the Center for Social Sciences Research (CSSR) at UC, Berkeley: [http://cssr.berkeley.edu/ucb\\_childwelfare/](http://cssr.berkeley.edu/ucb_childwelfare/)]

### **Parenting Skills**

This term from the California Standardized Safety Assessment Matrix refers to the skills a parent demonstrates regarding the capacity to effectively care for, guide, and discipline the child(ren) in the parent's custody. (#31 in the Standard Areas for Review)

### **Participatory Case Planning**

A strategy encompassing several formal models and informal philosophies aimed at working together with the family and others (such as relatives, service providers and community members) to develop strength-based case plans that are tailored to meet the specific needs of the family.

### **Party**

A participant in the case who has the right to receive notice and to present evidence to the court.

### **Peer Quality Case Reviews**

A key component of the C-CFSR designed to enrich and deepen understanding of a county's actual practices in the field by bringing experienced peers from neighboring counties to assess and identify the subject county's strengths and areas needing improvement within the child welfare services delivery system and social work practice.

### **Performance Indicators**

Specific, measurable data points used in combination to gauge progress in relation to established outcomes.

### **Permanence**

A primary outcome goal for child welfare services whereby all children and youth have stable and nurturing legal relationships with adult caregivers that create a shared sense of belonging and emotional security that endures over time.

### **Permanency Hearing**

The hearing where the court determines the most appropriate permanent plan for the child. This can occur at the disposition hearing if the court does not order reunification services under WIC Sec. 361.5(b) or at a hearing wherein the court terminates reunification services. The permanent plans in California in order of preference are: return home, adoption, legal guardianship, permanent placement with a relative, or permanent placement with an identified placement and a specific goal. If the court chooses adoption or legal guardianship, it must set a hearing under WIC 366.26 which is referred to as a .26 hearing or a selection and implementation hearing.

### **Perpetrator**

The person who has committed the abuse against the child.

### **Perpetrator Access**

This term from the California Standardized Safety Assessment Matrix refers to the perpetrator's relationship to the child; and the frequency and intimacy of the perpetrator's contact with the child. (*#5 in the Standard Areas for Review*)

### **Pediatric Radiologist**

A medical expert who interprets X-rays regarding fractures and internal injuries in children.

### **Petechiae**

Pinpoint hemorrhages often associated with suffocation.

### **Physical Abuse**

Non-accidental, inflicted injury/trauma to a child.

### **Positive Toxicology Screen (pos tox)**

A screening test (usually referring to a test of newborn urine) which demonstrates that a substance has been ingested by indicating positive results for a drug. Mothers who test positive for drugs upon delivery will have infants who also have ingested the same substance. Generally these results indicate usage by the mother within the past 72 hours.

### **Post Permanency Hearing**

Review hearings after the development of a permanent plan for the child during which the court reviews the case and case plan. Must be held no less than every six months.

### **Posttraumatic Stress Disorder (PTSD)**

As defined by the DSM IV-TR, PTSD refers to an emotional illness that develops as a result of an event involving actual or threatened death, serious injury, rape, or childhood sexual abuse and is out of the normal experience for that individual (or may be accumulative or repeated). The stressor must be extreme, not just severe, and cause intense subjective responses, such as fear, helplessness or horror. Key symptoms include:

- Re-experiencing the event
- Avoidance
- Emotional numbing
- Increased arousal

### **Pre-Placement Preventative Services**

This term from the California Standardized Safety Assessment Matrix refers to services designed to help children remain with their families by preventing or eliminating the need for removing the child from the home. [These services are emergency response services and family maintenance services. Div 31-002 (p) (8).] (#14 in the Standard Areas for Review)

### **Prevention**

Service delivery and family engagement processes designed to mitigate the circumstances leading to child maltreatment before it occurs.

### **Program Improvement Plan (PIP)**

A comprehensive response to findings of the CFSR establishing specific strategies and benchmarks for upgrading performance in all areas of nonconformity with established indicators.

### **Protective Capacity**

Refers to the ability and willingness to utilize *internal* and *external* resources to mitigate risk and to support the ongoing safety of a child.

### **Reasonable Efforts**

A legal determination as to whether or not the child welfare agency has provided the family with adequate services, which can include visitation, referrals, and other case management. Reasonable efforts must be made to reunify the family or to finalize a permanent plan for the child.

### **Recovery**

Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection—and external conditions that facilitate recovery—implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services.  
<http://www.psychservices.psychiatryonline.org/cgi/content/full/52/4/482> .

### **Relapse**

The recurrence of symptoms (usually referring to substance abuse) after a period of successful recovery. Relapse is common in recovery from addiction and not considered a treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

### **Relapse Prevention**

Relapse prevention efforts in drug treatment require the development of a plan tailored to maintaining new behavior in an effort to avoid renewed substance abuse. The plan involves integrating behavior diversion activities, coping skills, and emotional support.

### **Resource Families**

Relative caregivers, licensed foster parents, and adoptive parents who meet the needs of children who cannot safely remain at home. Resource families participate as members of the multidisciplinary team.

### **Restraining Order [Protection Order]**

A restraining order is a [court order](#) intended to protect victims of domestic violence from being physically abused, threatened, stalked, or harassed by the person who previously perpetrated abuse.

### **Reunification**

Occurs when the court determines there is no longer a substantial danger to the child and returns the child to the physical custody of the parent or caregiver who participated in child welfare services.

### **Risk**

The likelihood that a child will be abused, neglected, or exploited.

### **Risk Assessment**

The process utilized by a child welfare worker to determine the likelihood that a child will be abused, neglected, or exploited. [This could include the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to:

- facilitate the interviewing of children, families, and community members;
- gather and evaluate information from collateral contacts;
- gather and evaluate psycho-social information regarding the parent;
- review and evaluate past history (including use of CWS/CMS data).

Risk elements are the focus of the case plan for change-oriented interventions—they indicate what has to be addressed as the child protection system works with the family to change the conditions that put the child at risk, as well as potential future safety challenges. The assessment of risk also incorporates the elements of protective capacity.]

### **Safety**

A primary outcome for child welfare services whereby all children are, first and foremost, protected from abuse and neglect.

### **Safety Assessment**

The process utilized by a county child welfare worker to determine if a child is currently safe from physical abuse, sexual abuse, emotional abuse, neglect, and/or exploitation. [This could include the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to make that determination. The safety assessment is conducted as part of the initial CPS intervention and continues throughout the life of the case. *A safety assessment is not the same thing as a risk assessment.*]

### **Safety Interventions**

This term from the California Standardized Safety Assessment Matrix refers to the actions, services, arrangements, and circumstances intended to mitigate the threat of, repeat abuse of, or maltreatment of the child. [This includes the development of a safety plan for providing services to promote the health and safety of the children in the family. The safety plan addresses what threats of severe harm exist; how they will be managed, including by whom, under what circumstances, with what specified time requirements, etc.] (#13 in the Standard Areas for Review)

### **Safety Threshold**

The point when family conditions, in the form of behaviors, emotions, intent, situations, etc., are manifested in such a way that they exceed risk factors and threaten the child's safety.

### **School Attendance Review Board (SARB)**

School Attendance Review Boards handle most attendance issues for school jurisdictions without the involvement of Child Protective Services.

### **Secondary Trauma**

Secondary, or vicarious trauma, refers to the effect of trauma on those people who care for, or are involved with, those who have been directly traumatized.

### **Shaken Infant Syndrome**

Severe trauma to a child under age 5, and generally under age 1, as a result of severe shaking that results in a whiplash-type of injury. Retinal hemorrhages are symptomatic. A significant amount of force is required.

### **Shared Family Care**

Temporary placement of children and parents in the homes of trained community members who, with the support of professional teams, mentor the families to develop the necessary skills, supports, and protective capacity to care for their children independently.

### **Shared Responsibility**

This concept encourages community residents to get involved in child protection. It offers opportunities for participation and stresses the importance of community responsibility for child safety and well being. This does not negate the ultimate accountability of the child welfare agency for child protection. Rather, it engenders a community mindset to develop capacity to protect children and to strengthen and preserve families.

### **Sibling Placement**

This term from the California Standardized Safety Assessment Matrix refers to the efforts made in all out-of-home placements, including those with relatives, to place siblings together in order to maintain the continuity of the family unit. [Sibling is defined as a person related to the child by blood, adoption, or affinity through a common legal or biological parent. Welfare & Institutions Code Sec. 16002(a)(b)] (#19 in the Standard Areas for Review)

### **SIDS**

Sudden Infant Death Syndrome is the unexplained, unexpected death of an otherwise healthy child up to age 1. There is an absence of an explanation of the cause of death via autopsy, and a death scene investigation should be conducted to rule out other causes of death.

### **Skeletal Survey**

A body X-ray to determine if there are fractures or internal injuries. Usually ordered for children age 2 or under when the physician suspects abuse.

### **Slate Gray Patches (formerly known as Mongolian Spots)**

A birth mark which resembles a bruise in appearance. May be colored brown or greenish-purple and is often located on the lower back/buttocks, although it can occur anywhere on the body. More common on children of color, this condition is often mistaken for child abuse.

### **Social Environment**

This term from the California Standardized Safety Assessment Matrix refers to the social interactions of those living in or having significant contact in the home that support or compromise the child's health and safety. [This includes the degree to which communications, interactions, and relational networks within the home or surrounding the child support or compromise the child's health and safety. Also included are the current and historical conditions within the home which are associated with the caregiver's capability to rely on an appropriate social network, ability to solve problems, and ability to communicate effectively. Positive aspects of the social environment may mitigate risk to the child.] (#7 in the Standard Areas for Review)

### **Stages of Change**

The five stages of change are: pre-contemplation, contemplation, preparation, action, and maintenance.

### **Standardized Safety Approach**

A uniform approach to the safety, risk, and protective capacity of the adult caregiver to assure basic statewide levels of protective responses and to assure that fairness and equity are embedded in criteria used for case decisions.

### **Status Offender Proceeding**

Occurs when the court is asked to declare a minor a ward of the court based on the minor's refusal to obey reasonable orders of the minor's parents. (Welfare and Institutions Code Sec. 601.)

### **Status Review Hearing**

At this juvenile court hearing, held every six months after disposition, the judge reviews the case and the case plan. In family maintenance cases, the judge must decide if the conditions that brought the family within the court's jurisdiction still exist or if such conditions are likely to exist if supervision is withdrawn. In family reunification cases, during the period in which reunification services are being provided, the court must return the child home unless the agency can show that return of the child to the home would create a substantial risk of detriment to the child's safety, protection, or physical or emotional well-being.

### **Strength-based Practice**

Practice that identifies strengths in an individual, family, or system, and the formulation of service arrays and interventions that acknowledge and build on those strengths. A strength-based approach honors and respects the dignity of family members and incorporates the family's collective knowledge about the resources and strengths in their family system. Strength-based practice involves joining with the family to reach goals for improvement in family functioning. It includes:

- Using language that focuses on strengths
- Specific interviewing skills
- Specific assessment criteria
- Specific model practices
- Specific casework practices
- Engagement of the neighborhood and the community
- Agency practices with staff and the community

### **Subsequent Referrals**

This term from the California Standardized Safety Assessment Matrix refers to reports received by the child welfare agency regarding new allegations made after the initial report of child maltreatment. (*#36 in the Standard Areas for Review*)

### **Substance Abuse**

This term from the California Standardized Safety Assessment Matrix refers to the abuse of alcohol and other drugs (AOD) by the parent, caregiver, or the child. [Considering substance abuse in making safety assessments will include the severity and impact of the AOD use on each member of the family. Some cases will require

differentiating between substance use, abuse, or dependence for the adult or adolescent family members.] (#33 in the Standard Areas for Review)

### **Substance Abuse Assessment**

Screening and/or assessment to determine the presence of an AOD abuse disorder. This assessment process should: employ cultural sensitivity; use a standardized tool such as the Addiction Severity Index (ASI); use Standardized Placement Criteria such as the American Society of Addiction Medicine (ASAM) Placement Criteria; and ensure that re-assessments occur with concomitant case plan adjustment.

### **Substitute Care Provider**

A foster parent or relative/non-relative extended family member who is responsible for a child's care during his or her placement in out-of-home care. [The non-relative extended family member may be a person who has an established familial or mentoring relationship with the child.]

### **Substitute Care Provider's Strength and Willingness to Support the Child's Case Plan**

This term from the California Standardized Safety Assessment Matrix refers to the active participation of the caregiver in activities that promote and support the child's safety, permanency, and well-being, including health, education, and social development. (#18 in the Standard Areas for Review)

### **Substitute Care Provider's Willingness/Ability to Provide Care, Ensure Safety**

This term from the California Standardized Safety Assessment Matrix refers to the substitute care provider's ability and commitment to the care and safety of the child. [This includes the willingness to accept the child into the caregiver's home and provide for the child's daily care and maintenance.] (#17 in the Standard Areas for Review)

### **Successful Youth Transition**

The desired outcome for youth who experience extended stays in foster care, achieved by the effective provision of a variety of services (e.g., health and mental health, education, employment, housing, etc.), continuing through early adulthood, while simultaneously helping youth to maintain, establish or re-establish strong and enduring ties to one or more nurturing adults.

### **Support System**

Refers to an informal network of people, resources, and/or organizations whose assistance and encouragement strengthen an individual's or family's functioning.

### **System Improvement Plan (SIP)**

A key component of the C-CFSR, this operational agreement between the county and the state outlines a county's strategy and actions to improve outcomes for children and families.

### **Uniform Practice Framework**

A fully articulated approach to all aspects of child welfare practice that:

- Uses evidence-based guidelines for the start-up phase and ongoing incorporation of known “best” or “promising” practices
- Aligns with sound child and family policy
- Is responsive to unique needs of diverse California counties
- Can be integrated with a Differential Response system
- Addresses shared responsibility with the community
- Emphasizes non-adversarial engagement with caregivers
- Integrates practice work products from the Full Stakeholders Group and the Statewide Regional Workgroups.

### **Violence Propensity/Capability**

This term from the California Standardized Safety Assessment Matrix refers to a pattern of aggressive, coercive, threatening, or potentially harmful behavior or history on the part of a parent or household member. [The presence of family violence in the home, social isolation, and prior criminal convictions may indicate safety and/or risk concerns for the child. These include concerns about the child witnessing domestic violence.] (*#6 in the Standard Areas for Review*)

### **Visitation**

This term from the California Standardized Safety Assessment Matrix refers to the formalized face-to-face contact between a child and a parent(s)/guardian, siblings, grandparents, or others deemed appropriate by the county or juvenile court to promote the continuity of parent-child relationships and permanency. (Div 31-002 (v)(1)(B)) [The duration, frequency, location, and supervision of the contacts will be based on the safety goals of the case plan, the child's developmental needs, and the parents' strengths and needs. Regular and frequent contacts between parent and child and/or between the child and his or her siblings help to maintain family relationships, empower parents, minimize children's separation trauma, and provide an opportunity for family members to learn and practice new skills and interactive behaviors.] (*#21 in the Standard Areas for Review*)

### **Voluntary Relinquishment**

Process by which parents voluntarily surrender their parental rights and allow their child to be adopted.

**Vulnerable Families**

Families who face challenges in providing safe, nurturing environments for their children, including families demonstrating patterns of chronic neglect; families with young children (ages 0-5); families affected by alcohol and drug abuse; families experiencing poverty or homelessness; family victims of domestic violence; and family members whose mental health is compromised.

**Welfare and Institutions Code**

A series of laws that govern California's dependency system.

# Child and Youth Development in a Child Welfare Context

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# Child Developmental Milestones



## Normal physical development: Approximately birth to 3 months

**Birth to 3 months:** Gains about 1 oz. per day after initial weight loss in first week

### Birth

- ✓ Reflexes (e.g., sucking, grasping, hands fisted, random movement, etc.)
- ✓ Vision at 8-12 inches and can lift head

### 1 month

- ✓ Can lift head to 45-degree angle
- ✓ Vocalizes and gurgles

### 2 months

- ✓ Alert to people

### 3 months

- ✓ Chuckles
- ✓ Smiles
- ✓ Whines and vocalizes
- ✓ Rolls over

## Activities that promote healthy growth: Approximately birth to 3 months

- ✓ Offer me a finger to hold. Listen to me and learn my responses. Smile and touch me when you talk to me. Tell me I am wonderful.
- ✓ Help me to develop trust. Gently hold me while talking in sweet encouraging tones. Call me by name and make eye contact.
- ✓ Pick me up when I cry and reassure me. Don't leave me alone crying and give me the impression that no one cares for me.
- ✓ Learn how to soothe me and meet my needs before I cry.
- ✓ Gently rub my back, sing to me, play music for me or bounce me gently to music. I am sensitive to sound so keep music low.
- ✓ Hold me securely in new places and protect me.
- ✓ Keep me clean, well fed and clothed appropriately for the temperature.
- ✓ Give me colorful toys that make interesting sounds.
- ✓ Sucking calms me so let me suck my fingers or a pacifier. Be gentle and don't interrupt my sucking by pulling or jiggling something I'm sucking on.

## Developmental Concerns: By the end of 3-4 months

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Does not seem to respond to loud noises
- ✓ Does not notice hands by 2 months
- ✓ Does not follow moving objects with eyes by 2 to 3 months
- ✓ Does not grasp and hold objects by 3 months
- ✓ Does not smile at people by 3 months
- ✓ Cannot support head well by 3 months
- ✓ Does not reach for and grasp toys by 3 to 4 months
- ✓ Does not babble by 3 to 4 months
- ✓ Does not bring objects to mouth by 4 months
- ✓ Begins babbling, but does not try to imitate any of your sounds by 4 months
- ✓ Does not push down with legs when feet are placed on a firm surface by 4 months
- ✓ Has trouble moving one or both eyes in all directions
- ✓ Crosses eyes most of the time (occasional crossing of the eyes is normal in these first months)
- ✓ Does not pay attention to new faces or seems very frightened by new faces or surroundings
- ✓ Experiences a dramatic loss of skills he or she once had

### Normal physical development: Approximately 4-6 months

**4-6 months:** Gains 5-6 oz. per week

#### 4 months

- ✓ Grasps rattle
- ✓ Pulls to sit up
- ✓ Can bear some weight on legs
- ✓ Laughs and smiles

#### 5 months

- ✓ Birth weight doubles
- ✓ Sits without support
- ✓ Feeds self cracker
- ✓ Turns toward voice

#### 6 months

- ✓ Adds 2-3 inches to height
- ✓ Sits up
- ✓ Holds 2 cubes and works to reach for desired toy
- ✓ Imitates speech sounds

4

### Activities that promote healthy growth: Approximately 4-6 months

- ✓ During bath time, try washing me in a sitting position. I may also want to sit up and play. Help me sit up for 5-10 minutes and help me keep my back straight.
- ✓ Give me safe healthy finger foods at 5-6 months. (e.g., crackers)
- ✓ Lay me on a blanket on the floor and let me roll and reach.
- ✓ Spend time with me - play, smile, nod, talk and laugh with me. Give me toys or attention when I need a distraction.
- ✓ Respond to my fears and cries by holding, talking to and reassuring me. Talk to me about what I'm feeling and tell me that it's OK.
- ✓ Talk to me, sing to me or give me my favorite toy at diaper changing time. Don't scold, make loud noises or frowning faces.
- ✓ Keep me in my car seat even if I complain. Distract me with songs or toys and reassure me. Put my seat where I can see outside.
- ✓ Avoid separating me from you for days. I need consistent, reliable relationships so if you leave me for long periods expect me to be more clingy for awhile and need more reassurance.

5

### Developmental Concerns: By the end of 7 months

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Seems very stiff, with tight muscles
- ✓ Seems very floppy, like a rag doll
- ✓ Head still flops back when body is pulled to a sitting position
- ✓ Reaches with one hand only
- ✓ Refuses to cuddle
- ✓ Shows no affection for the person who cares for him or her
- ✓ Doesn't seem to enjoy being around people
- ✓ One or both eyes consistently turn in or out
- ✓ Persistent tearing, eye drainage, or sensitivity to light
- ✓ Does not respond to sounds around him or her
- ✓ Has difficulty getting objects to mouth
- ✓ Does not turn head to locate sounds by 4 months
- ✓ Does not roll over in either direction (front to back or back to front) by 5 months
- ✓ Seems impossible to comfort at night after 5 months
- ✓ Does not smile on his or her own by 5 months
- ✓ Cannot sit with help by 6 months
- ✓ Does not laugh or make squealing sounds by 6 months
- ✓ Does not actively reach for objects by 6 to 7 months
- ✓ Does not follow objects with both eyes at near (1 foot) and far (6 feet) ranges by 7 months
- ✓ Does not bear weight on legs by 7 months
- ✓ Does not try to attract attention through actions by 7 months
- ✓ Does not babble by 8 months
- ✓ Shows no interest in games of peek-a-boo by 8 months
- ✓ Experiences a dramatic loss of skills he or she once had.

6

### Normal physical development: Approximately 7-11 months

**7-11 months:** Gains 2-3 oz. per week

#### 7 months

- ✓ Plays peek-a-boo, pulls to stand, gets to sitting position
- ✓ Nonspecific "dada" or "mama"

#### 8 months

- ✓ Thumb-finger grasp is weak
- ✓ Shakes head "no" and shouts for attention

#### 9 months

- ✓ Walks holding onto furniture and plays pat-a-cake
- ✓ Shy with strangers

#### 10 months

- ✓ Stands momentarily
- ✓ Specific "dada" or "mama" and can put 2 words together

#### 11 months

- ✓ Stands alone well
- ✓ Plays ball with strangers
- ✓ May recognize words as symbols

7

**Activities that promote healthy growth: Approximately 7-11 months**

- ✓ Play peek-a-boo, puppets, wave bye-bye, and teach me words and colors even if I can't repeat the words right now.
- ✓ Have a regular bedtime routine. Slow my activity an hour before bedtime, rock me, pat my back and bring my favorite blanket. Once dry, fed and well prepared for bed, leave me with a kiss. Ignore my cries for a few minutes until I am asleep.
- ✓ Encourage physical exploration within your eyesight. Keep dangerous objects away from me and baby-proof my environment. Be there to comfort me when I get hurt.
- ✓ Help me stand by holding my hands. Make sure my heels are flat.
- ✓ I may purposefully drop and throw things as an experiment. Give me safe things to drop and throw.
- ✓ Open a cupboard in the kitchen kept safe for my exploration. Keep only non-breakable objects that are baby-friendly.
- ✓ Give me something interesting on my tray to explore at mealtime. (e.g., cooked spaghetti, spoons)
- ✓ Do not force me to eat and understand that I am learning and will be messy with my food.

8

**Development Concerns: By the end of one year**

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range.

- ✓ Does not crawl
- ✓ Drags on side of body while crawling (for over one month)
- ✓ Cannot stand when supported
- ✓ Does not search for objects that are hidden while he or she watches
- ✓ Says no single words ("mama" or "dada")
- ✓ Does not learn to use gestures, such as waving or shaking head
- ✓ Does not point to objects or pictures
- ✓ Experiences a dramatic loss of skills he or she once had

9

**Normal physical development: Approximately 12-23 months**

**1 year**

- ✓ Birth weight triples
- ✓ Stoops and recovers, learning to drink from cup, pulls up to a standing position, walks holding on to furniture
- ✓ Knows 3 words other than "mama" or "dada"

**13-14 months**

- ✓ Scribbles, 6+ word vocabulary, tries to sing, points
- ✓ Walks backwards. Better cup control, spilling less
- ✓ Towers 2 cubes and begins using a spoon

**15-16 months**

- ✓ Begins using double syllable words and asks "What's that?" Learns names of body parts, objects, colors
- ✓ Removes clothes, pulls adult hand to show something

**17-19 months**

- ✓ Walks up steps, towers 4 cubes, asks for "more," 20 word vocabulary, hands toy to adult if unable to operate
- ✓ Throws ball, follows directions, helps in simple tasks

**20-23 months**

- ✓ Kicks ball forward, jumps in place, puts on clothes
- ✓ Plays with 2 toys, pedals tricycle, towers 8 cubes, washes and dries hands

10

**Activities that promote healthy growth: Approximately 12-23 months**

- ✓ Learning to walk takes time. Hold my hand and encourage me to take steps when I'm ready, don't rush me.
- ✓ If I grab, hit or bite when I'm mad, don't scold me or hit me. Teach me words to use instead of hurting others.
- ✓ It will take time before I'm able to do many things. Set limits, but I will break rules many times before I learn. "No!" is not enough, please explain why. (e.g., "The stove is too HOT!" Move me and show me a safe place to play.)
- ✓ Give me choices whenever possible. Don't say "no" too often and distract me if I am refusing something. Reward me for good behavior. Ignore my "no" if I do not get a choice.
- ✓ Let me scribble with thick washable crayons or felt markers, tape a paper to the table so it doesn't slip.
- ✓ Compare colors and sizes with me (big spoon, red balloon).
- ✓ Tell me about the story, let me pat the pages and make noises, help me learn to turn pages by half lifting one.
- ✓ Building blocks, sandboxes, ride and pull toys, jack-in-the-box, music toys and balls are very important learning tools.
- ✓ Understand that me and mine are important before I can learn about you and yours. Set up a box that is mine.
- ✓ Teach me about not hurting others and sharing, but don't shame me. Be patient and encourage my empathy for others.

11

### Developmental Concerns: By the end of 2 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Cannot walk by 18 months
- ✓ Fails to develop a mature heel-toe walking pattern after several months of walking, or walks only on his toes
- ✓ Does not speak at least 15 words
- ✓ Does not use two-word sentences by age 2
- ✓ By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- ✓ Does not imitate actions or words by the end of this period
- ✓ Does not follow simple instructions by age 2
- ✓ Cannot push a wheeled toy by age 2
- ✓ Experiences a dramatic loss of skills he or she once had

12

### Normal physical development: Approximately 2-4 years

#### 2 years

- ✓ Average height: 32-36", weight: 22-31 lbs
- ✓ Uses short sentences and adds "ing" and plurals

#### 2 ½ years

- ✓ Average height: 33-38", weight: 24-34 lbs
- ✓ Gains muscle control for toilet training
- ✓ Asks "what, where, who" questions
- ✓ Shows interest in peers, has difficulty sharing
- ✓ Displays some self-control

#### 3 years

- ✓ Average height: 33-42", weight: 24-42 lbs
- ✓ Buttons clothes, walks downstairs and uses the toilet
- ✓ Increased vocabulary and uses past tense, asks "why"
- ✓ Has difficulty sharing and develops a basic sense of time
- ✓ Identifies preferences and increased sense of self
- ✓ Loses sway back and large abdomen of the toddler at 3 ½ years old
- ✓ Can balance on one foot briefly and walks heel to toe

#### 4 years

- ✓ Catches a ball 2 out of 3 times and cuts with scissors
- ✓ Talks to self and can share better

13

### Activities that promote healthy growth: Approximately 2-4 years

- ✓ Let me do it myself when possible. Let me feed myself even if I'm messy. Give me 2 choices when you can.
- ✓ Let me make choices about the food I eat and let me refuse food. Reduce in-between snacks so I will be hungry at mealtimes. Don't use food as a reward or punishment.
- ✓ Teach me about dangerous things (matches, knives, strangers, stray animals, cars, etc.). Significant consequences should be given for dangerous behavior after giving warnings.
- ✓ Naps are still important to reduce cranky and moody behavior.
- ✓ Give me a warning that it will soon be time to move along.
- ✓ Don't hurry me too much, I need patience and time to learn.
- ✓ Read to me, color with me, teach me games.
- ✓ If there is a new baby, remember I **will** be jealous. Assure me of your love, give me special time and let me help with the baby.
- ✓ Talk to me about what I'm feeling - comfort me and don't scold me.
- ✓ Offer a hand when I'm in a new situation as a substitute for picking me up. Don't insist I have to grow up.
- ✓ Blow bubbles for me. Teach me to catch and throw a ball.
- ✓ Respect my fears and do not force me into fearful situations. Comfort me and encourage me that there is nothing to fear.

14

### Strategies for potty training and tantrums: Approximately 2-4 years

#### Potty training tips

- ✓ No age is exact for toilet training. Watch for me to grimace at dirty diapers, show you my wet pants and stay dry for up to 2 hours. I need to be verbal enough to understand toilet training.
- ✓ Change me as soon as possible, tell me it's nice to be clean
- ✓ Let me have a toy to keep me happy and busy on the potty-chair. Put me on the potty briefly at first (up to 5 minutes).
- ✓ Praise my efforts and encourage me to let you know when I need to go potty. Teach me the family words for toilet training.
- ✓ Dress me in easy to remove clothing, be patient, never scold me, visit the potty before going somewhere, help me wipe, teach me to wash my hands and show me how to flush.

#### Tantrums

- ✓ Make sure I get enough sleep, eat healthy and keep a regular routine. I need physical activity during the day. Teach me to ride a tricycle, encourage running, dancing and jumping.
- ✓ Learn warning signs and distract me. Don't expect too much.
- ✓ Since tantrums are a release of frustrated feelings and a way to get attention, ignore me if I'm in a safe place. Don't reward tantrums. Stay calm and leave me reassuring me you will be back when I'm quiet. When I stop, talk to me, tell me what I'm feeling. Help me express my frustration in words.

15

### Development Concerns: By the end of 3 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Frequent falling and difficulty with stairs
- ✓ Persistent drooling or very unclear speech
- ✓ Cannot build a tower of more than four blocks
- ✓ Difficulty manipulating small objects
- ✓ Cannot copy a circle by age 3
- ✓ Cannot communicate in short phrases
- ✓ No involvement in "pretend" play
- ✓ Does not understand simple instructions
- ✓ Little interest in other children
- ✓ Extreme difficulty separating from mother or primary caregiver
- ✓ Poor eye contact
- ✓ Limited interest in toys
- ✓ Experiences a dramatic loss of skills he or she once had

16

### Development Concerns: By the end of 4 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Cannot throw a ball overhand
- ✓ Cannot jump in place
- ✓ Cannot ride a tricycle
- ✓ Cannot grasp a crayon between thumb and fingers
- ✓ Has difficulty scribbling
- ✓ Cannot stack four blocks
- ✓ Still clings or cries whenever parents leave
- ✓ Shows no interest in interactive games
- ✓ Ignores other children
- ✓ Doesn't respond to people outside the family
- ✓ Doesn't engage in fantasy play
- ✓ Resists dressing, sleeping, using the toilet
- ✓ Lashes out without any self-control when angry or upset
- ✓ Cannot copy a circle
- ✓ Doesn't use sentences of more than three words
- ✓ Doesn't use "me" and "you" correctly
- ✓ Experiences a dramatic loss of skills he or she once had

17

### Normal physical development: Approximately 5-7 years

Average height: 40-50", weight: 34-55 lbs.

#### 4-5 years

- ✓ Paints and colors, draws figures in 6 parts, learning shapes and colors
- ✓ Climbs, runs, bike or trike riding
- ✓ Broad vocabulary, listens carefully, asks questions
- ✓ Learning letters, numbers and written name
- ✓ Recognizes differences and similarities
- ✓ Short and long term memory improves
- ✓ Develops friendships with peers, recognizes gender
- ✓ Believes rules can change to suit their own needs

#### 6-7 years

- ✓ Body proportions are similar to that of an adult
- ✓ Imagination is an important part of development
- ✓ Enjoys achieving in sports, rides a bike without training wheels and learns to skate
- ✓ Can learn to swim, swing, climb on jungle gyms and other more complex physical tasks
- ✓ Learning to read and do simple math
- ✓ Understands concepts of first, next, last, large, larger, etc.
- ✓ Understands time concepts of yesterday, today, tomorrow
- ✓ Looks forward to holidays, birthdays and annual events

18

### Activities that promote healthy growth: Approximately 5-7 years

- ✓ Discuss physical gender differences with me. Teach me the proper names for body parts without shame. If I am old enough to ask the question, I am old enough to understand the answer. Don't give me more information than I ask for.
- ✓ Create a home library with interesting books about heroines and heroes, fables and fun stories. Read to me every day and let me read a part of each book, discuss the ideas in the book.
- ✓ Remember rewards works better than punishment. Have a sticker chart, give balloons, pennies for the bank, etc.
- ✓ Play children's music, sing, clap and dance with me.
- ✓ Encourage physical involvement and imaginative expression. (e.g., "Itsy-Bitsy Spider" and "I'm a Little Teapot")
- ✓ Teach me to count, sing my ABC's and write my name with lots of patience. This will take time and repetition.
- ✓ I need a bike or trike, balls, clay and play space with toys.
- ✓ Plant a garden or a pot from seed. Help me water it and watch it grow. Pick flowers for my table and let me eat the vegetables.
- ✓ Follow a routine at bedtime. Show me the clock and tell me it's time for bed. Let me pick out my bath toys, choose my pajamas, read me a story, etc. Spend time with me. Sing me a song, rub my back. Kiss me, say goodnight, I love you.
- ✓ Give me permission to say no to adults that make me feel uncomfortable. Talk with me and get to know how I'm feeling.

19

### Developmental Concerns: By the end of 5 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Acts extremely fearful or timid
- ✓ Acts extremely aggressively
- ✓ Is unable to separate from parents without major protest
- ✓ Is easily distracted and unable to concentrate on any single activity for more than five minutes
- ✓ Shows little interest in playing with other children
- ✓ Refuses to respond to people in general, or responds only superficially
- ✓ Rarely uses fantasy or imitation in play
- ✓ Seems unhappy or sad much of the time
- ✓ Doesn't engage in a variety of activities
- ✓ Avoids or seems aloof with other children and adults
- ✓ Doesn't express a wide range of emotions
- ✓ Has trouble eating, sleeping or using the toilet
- ✓ Can't tell the difference between fantasy and reality
- ✓ Seems unusually passive
- ✓ Cannot understand two-part commands using prepositions ("Put the doll on the bed, and get the ball under the couch.")
- ✓ Can't correctly give her first and last name
- ✓ Doesn't use plurals or past tense properly when speaking
- ✓ Doesn't talk about her daily activities and experiences
- ✓ Cannot build a tower of six to eight blocks
- ✓ Seems uncomfortable holding a crayon
- ✓ Has trouble taking off clothing
- ✓ Cannot brush her teeth efficiently
- ✓ Cannot wash and dry her hands
- ✓ Experiences a dramatic loss of skills he or she once had

20

### Normal physical development: Approximately 8-12 years

Average height: 45-58", weight: 45-85 lbs.

#### 8-9 years

- ✓ Play and imagination are still important developmental tools
- ✓ May enter puberty early
- ✓ Very verbal and asks factual questions, may request instruction
- ✓ Social roles are better understood
- ✓ School and neighborhood are important arenas for growth

#### 10-11 years

- ✓ Girls may experience a growth spurt
- ✓ Tolerates frustration better, good with time concepts, can plan and understands cause and effect, more rational and logical
- ✓ Needs affection and affirmation from adults
- ✓ Concrete thinking with a strong sense of fairness
- ✓ Begin to see conflicts between peers and parent values

21

### Activities that promote healthy growth: Approximately 8-12 years

- ✓ Turn off the TV and play a game with me or talk things over. Don't let me watch PG-13 or R-rated movies.
- ✓ Bake cookies with me. We can wear aprons and don't get too upset about how messy the kitchen becomes.
- ✓ Teach me cards and board games I can play with my friends.
- ✓ Encourage outside play. (e.g., jump rope, skates, balls, etc.) Draw a hopscotch grid on the sidewalk with chalk.
- ✓ Teach me about nurturing by giving me responsibility for a family pet. Understand I may forget and remind me.
- ✓ I need to know how to swim to stay safe in water.
- ✓ Teach me about nature through camping, hiking and going to the zoo.
- ✓ Let me organize a water fight with the hose and balloons.
- ✓ Establish family traditions. Remind me about what we did last year. Tell me why it is important.

22

### Strategies for child safety: Approximately 8-12 years

- ✓ Know where I am at all times. Teach me to check in and give me timelines. Provide clear instructions to me about what you believe is safe and supervise my activities.
- ✓ Make my house safe, friendly and child centered. Children can visit under your watchful eye.
- ✓ Get to know the parents in my neighborhood and my friend's parents. Teach me to keep away from places that are unsafe.
- ✓ Give me permission to say "my mom or dad wants me home" or "my mom won't let me" if they need to make an excuse to get out of an uncomfortable or pressure situation.
- ✓ Teach me about drugs, alcohol, smoking and teen pregnancy. Let me tell you how I feel about these things.
- ✓ Value me and teach me how to value and care for myself.
- ✓ Teach me to be cautious of overly friendly adults or strangers.
- ✓ Ask me how I'm feeling. Listen and keep communication open.
- ✓ Be reliable and predictable and create a safe place for me to put my trust. Forgive me when I fail and apologize when you have let me down. Teach me about respect by modeling it.
- ✓ Teach me about my bright future and celebrate each accomplishment along the way. Give me vision.

23

### Normal physical development: Approximately 13-18 years

#### 13-14 years

- ✓ Challenges limit setting and parent's judgment
- ✓ Wants to be with peers more often
- ✓ Puberty has begun or been achieved
- ✓ Awkwardness and self-doubt may occur with new growth

#### 15-16 years

- ✓ Girls full stature is achieved, boys may continue some growth until age 18
- ✓ Skills are developed and refined
- ✓ Introspection and intense self-analysis
- ✓ Conflict between parents grows, will push you away as he or she attempts to take on more autonomy
- ✓ Peers values become more important
- ✓ Experimentation with social roles is expected
- ✓ Boys may experience a growth spurt.

#### 17-18 years

- ✓ Hormonal and brain development continues
- ✓ Interest in school increases or decreases
- ✓ Youth relies more on peers for affection and approval
- ✓ Individual identity forms, seeks independence
- ✓ Parents and family are still important and necessary
- ✓ Vision for the future and belief in self is essential

24

### Activities that promote healthy growth: Approximately 13-18 years

- ✓ Be clear about what you expect of me. Set curfews and know where I am at all times. Make sure I check in frequently.
- ✓ Start with small freedoms, assuring me that larger freedoms will be allowed once I've proven myself capable of the smaller ones.
- ✓ Allow me to have my own music in my room.
- ✓ Encourage me to express my feelings in writing and verbally. It's OK to be angry, not mean.
- ✓ When I speak, listen to the feeling underneath along with the words. Am I scared? Or hurting?
- ✓ Peers are very important for me. Allow me to talk on the phone and have friends over.
- ✓ As much as you can, let me wear what I like as part of self-expression.
- ✓ Encourage volunteer or paid work. Instill responsibility and polite public behaviors.
- ✓ Support and encourage me to gain a special talent early in my teen years (dance, music, drama, sports, art, etc.).

25

### Strategies for dealing with conflict: Approximately 13-18 years

- ✓ Understand my need for developing a separate self and do not take my struggles to gain independence personally.
- ✓ Understand that I still need supervision, guidance and protection even if I push you away or am critical of you. Troubled children often report a parent doesn't "love them enough" to wonder where they are or what they do.
- ✓ Acknowledge my feelings and maintain consistent consequences for my disobedience of clear limits you set.
- ✓ Consequences should always be related to my disobedience. (e.g., If an hour late, set the next curfew time an hour earlier.)
- ✓ Don't give up - when I make mistakes, disobey or lose my temper when you set limits, know that this is normal. Reassure me that you still care and won't give up on me.
- ✓ Give me another chance. I want your love and approval and will keep trying. Reassure me that you are still proud of me.
- ✓ Give me a vision for who I can become. Give me a reason why I should make healthy positive choices.
- ✓ Maintain communication and physical affection.

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### At Risk Adolescents

- ✓ Typical adolescent behavior taken to the extreme -- more moody, more hostile.
- ✓ Defiance. Ignoring the rules. Violating curfew.
- ✓ Totally uncommunicative to you or teachers. Only talks to peers.
- ✓ Sense of complete aimlessness or alienation.
- ✓ Destructive eating habits. Eating disorders can be life-threatening.
- ✓ Missing money or greater expenditures.
- ✓ Greater secrecy.
- ✓ Drinking or other substance abuse

### Factors that can increase risk

- ✓ Undiagnosed learning disability. This child is subject to constant personal frustration and criticism from others. Discouragement and disaffection soon follow. It's never too late for educational/psychological testing.
- ✓ Unhappy family life
- ✓ Family size
- ✓ Traumatic illness in the family
- ✓ Severe moodiness or depression
- ✓ Isolated family
- ✓ Friends that have destructive characters and behaviors

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### **Symptoms of PTSD (Post Traumatic Stress Disorder)**

#### **Play**

- ✓ Children begin to play out, draw, dramatize or tell their stories of trauma.
- ✓ Post-traumatic play is often grim, monotonous, and, at times, dangerous. Connection between the play and the trauma is usually not obvious.
- ✓ For this reason, it often goes unnoticed as a symptom by caretakers. The power to play is so strong that it impels the child to play.
- ✓ Even adolescents, well beyond the age-range of the usual "pretend" player, may play post-traumatically with art or music.
- ✓ For this reason, some "acting out" behavior in adolescents is actually post-traumatic play.

#### **Symptoms in very young children**

- ✓ Ego-centric
- ✓ Time Skew – Mis-sequencing trauma
- ✓ Omen Formation – should have seen it coming
- ✓ Bids for control

#### **Symptoms in elementary school-aged children**

- ✓ Generalized fear – stranger or separation anxiety, avoidance of situations or people associated with trauma
- ✓ Sleep disturbance
- ✓ Preoccupation with words
- ✓ Post-traumatic play
- ✓ Lost developmental skills

#### **PTSD in Adolescents**

- ✓ May begin to look like adults
- ✓ Traumatic reenactment

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## **Case Application Activity: Tammy**

### **Tammy**

Tammy is 4 years old and of appropriate weight and height for her age. She is Caucasian and currently lives in a foster home. Tammy has been in child protective custody for one month, since she was found wandering on a busy street by herself. Tammy was removed from her birth mother, Sue and her adoptive mother Jeannie (Sue's partner). After Tammy was found alone on the street, Sue admitted to using drugs and often sleeping until 11 or 12, leaving Tammy to get herself up in the morning when Jeannie is not home. Jeannie's job requires frequent travel and Jeannie notes that Sue has been the primary caregiver. Jeannie states that she was aware that Sue was drinking a lot, but she was not aware of the full extent of the problem. The team explored options with Jeannie including Jeannie taking a leave of absence to stay home with Tammy. Jeannie does not feel able to make that change. Jeannie noted she has a substance abuse history as well and is not clean and sober herself.

Tammy has been doing well since she has been in foster care. She goes to preschool in the mornings, three days a week. The foster mother, Mary, tells you that Tammy loves to play with the family dog and can dress herself now with minimal help, something that she could not do when she arrived.

At school, Tammy struggles with expressing herself. Her feelings are easily hurt by the other children. The teacher says that more than any other child in the class Tammy will find an isolated corner and stay there introspectively playing by herself. She is not easily comforted by the teacher and does not show a preference for one teacher over another, like most of the other children. She can follow simple two-step directions and likes books with colorful pictures. On the playground, Tammy likes to climb the stairs to the slide and to go down. She is learning to ride a tricycle and can now pedal by herself. She was not potty trained when she moved to the foster home but now she is and rarely has an accident. This is a source of pride for Tammy. She is curious about her body and understands now about where potty comes out and can recognize the sensations associated with simple body functioning. When the foster mother comes to pick her up from her school, Tammy does not run to her and sometimes does not even seem to recognize her. The transition from school to home is often emotional with Tammy refusing to talk or react to the foster mother for a couple of hours afterwards.

Tammy has been referred for developmental assessment and therapeutic play. The process for beginning this assessment and treatment has been underway for about three weeks and as the social worker you are building Tammy's treatment team.

Sue has started drug treatment and has been doing well. Jeannie has participated in outpatient treatment. Both Jeannie and Sue have begun learning new ways of interacting with Tammy and learning about child development. They are eager to see Tammy and try out their new parenting skills. As the social worker, you attend the next supervised visit. When you arrive you notice Tammy and Mary sitting, reading a book. Tammy is smiling and appears relaxed. Sue and Jeannie arrive and you go with them and Tammy into the play room for the visit.

Tammy immediately becomes quiet, goes to the far end of the room, and sits down facing away from Sue and Jeannie. Tammy begins sucking her thumb and holding a book very tightly. Sue asks how Tammy is doing. Tammy just looks at her, vacantly. Sue looks hurt, gets angry, and tells Tammy that she is not her friend. Sue goes and sits on the opposite side of the room and begins to play with a puzzle refusing to look at Tammy or at you. Jeannie looks to you to take action and does not make any effort to engage Tammy.

1. Assess Tammy across the SPECS of normal development.
2. How does Tammy's behavior reflect developmental delays or unresolved developmental issues?
3. If Tammy's issues are not attended to what will be her SPECS as a school-age child? What about an adolescent?
4. How might this behavior, if untreated affect her school life and school progress?
5. How does the mother's behavior suggest developmental issues?
6. What, if any are the cultural issues in this case?
7. What would you say to Sue and Jeannie to help them with Tammy during this visit?

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## **Case Application Activity: Marcus**

### **Marcus**

You are the social worker for Marcus. Marcus is 11 years old and of normal height and weight for his age range. He is Latino and lives with his maternal grandparents, who also care for his older brother and younger sister. Marcus has another brother who has a different father and the brother lives with that paternal grandmother. Marcus' mother, Carmen is in prison on drug related charges. She is serving a three-year sentence; however, for the past six years Carmen has been incarcerated for most of the time. When Carmen is released she quickly gets strung out on drugs and then gets picked up again. Marcus tells you that this is the only reason that she is still alive. Marcus and his siblings lived with their mother for the first two years of their life and then for short periods when she was not incarcerated. During that early period the case file suggests that Carmen led a transient lifestyle with many people coming in and out of the home and her focus was on obtaining drugs and partying. Marcus' father, Miguel was incarcerated during Marcus' early years. When he was released from prison 2 years ago Miguel tried to re-establish contact with Marcus, but Marcus' maternal grandparents were very opposed to any contact and Miguel became discouraged. Miguel has recently resumed efforts to build a relationship with Marcus, but the situation is challenging because the grandparents do not trust Miguel and have not allowed him to be in touch with Marcus.

Marcus talks lovingly about his mother and of wanting to take care of her when she comes out of jail. His grandparents regularly tell him that his mother needs to clean up, grow up, and come take care of her children as they are getting old and will not be around for very much longer. They are angry and heartbroken about their daughter.

Marcus' grandparents own a modest home in a part of the community that used to be well respected. As the community has moved on to attract affluent people from surrounding cities this part of town is no longer looked upon with as much respect as it once was. Marcus' grandparents are proud people who believe that they should be able to take care of their own and to keep their own business private. It is very difficult for them to have child protective services in their life and they wonder what they did to Carmen to make her lead this lifestyle. They do not believe in allowing outside people into their family to help them and resist any type of therapy for the children or themselves. When the Department insists, they reluctantly take the children to their appointments, but it has been difficult to engage them with a therapeutic team for Marcus. Their life has not turned out as they had imagined and

they cycle from lovingly talking about taking care of the children to being resentful that they are forced to care for them.

Marcus is a handsome boy with a quick wit and a quick smile. He is mischievous and loves to go get lunch with you whenever you pick him up. Marcus is in special education and has a therapist, psychiatrist and behavior specialist on his treatment team. Marcus' grandparent's have been asked to meet with the behavior specialist in their home weekly, but they have not been keeping these meetings.

Marcus has a teacher's aide that follows Marcus wherever he goes at school. Marcus is embarrassed by this. You notice that when you visit him at school that the other children look at him and look away. He does not seem to have many friends, but really wants them, and the opinions of the other children seem extremely important to him. Marcus directs a lot of anger at his shadow. Marcus can sit with you and read a book and work on his homework if you sit quietly next to him. He will not sit for very long and do his work on his own. Marcus does not do extracurricular activities, like sports, etc.... He was sent home last week for getting into a fight during a basketball game with the other children because someone went over the line with his feet and the point was still good. The other children told him that there had been agreement before they started that it was allowed to go over the line but Marcus apparently did not understand that. He was suspended from play with the other children for a week.

Marcus' grandmother says that he leaves the home each afternoon when he gets home from school and roams the neighborhood getting into trouble. When you have suggested that Marcus get involved in an after school activity the grandparents looked alarmed and overwhelmed. The grandmother says that he just needs the good love of his family and he will be all right. Marcus will not actively engage on his own with other children when they are playing a game. Marcus does not seem confident in his skills.

At grandmother's house, if you speak to the grandmother without him being the focus of attention, he will act out by knocking something off of the coffee table or irritating the other children. If the conversation is about Marcus, he will get very red in the face, scream a profanity, and storm out of the house. At your last visit, the grandmother said that she was fearful that Marcus was a "pervert" as he talks about his "dick" and girls all of the time and she caught him masturbating in his bedroom the other morning.

Your office is very close to the school and on most days for the past two weeks you have been called to the school to come pick up Marcus in the middle of the day as the office tells you that he has had a blow-out. When you get to his classroom Marcus is usually sitting in a chair with his arms crossed, his face flushed, looking down at the floor with an angry stare. When you ask what happened the teacher tells you that

she asked Marcus to go get his homework out of his backpack in the coat room and Marcus jumped up and looked confused. She insisted that he go get it and he jumped on the table and started kicking books off of it with his feet. The shadow had to step in.

The teacher says that the ADHD medication that Marcus is on is not working and that he needs to be seen by the psychiatrist again to increase his medication. Marcus says that he does not like the medication. It does not help him and it makes his mouth dry.

1. Assess Marcus across the SPECS of normal development.
2. How does Marcus' behavior reflect developmental delays or unresolved developmental issues?
3. What developmental age is Marcus in the different areas?
4. Why do you think so?
5. What are the cultural issues in this case?
6. Does the system contribute to the developmental issues at all? If so how?
7. What would you say to Marcus' grandparents in order to help them understand and parent Marcus?
8. What could you do to facilitate more interaction between Marcus and his father?
9. What could you do to better engage Marcus' grandparents in the team working to help Marcus with his behavior?

# It's time to change how we view a child's growth.

As they grow, children are always learning new things. Below are just some of the things you should look for as your child grows. Use this as a guide, and if you have any concerns, talk with your child's doctor and call **1-800-CDC-INFO** to get connected with your community's early childhood intervention system.

## At 6 months, many children

- respond to own name
- respond to other people's emotions and often seem happy
- copy sounds
- like to play with others, especially parents

## At 1 year (12 months), many children

- use simple gestures, like shaking head "no" or waving "bye-bye"
- say "mama" and "dada" and exclamations like "uh-oh!"
- copy gestures
- respond to simple spoken requests

## At 1 ½ years (18 months), many children

- play simple pretend, such as feeding a doll
- point to show others something interesting
- show a full range of emotions, such as happy, sad, angry
- say several single words

## At 2 years (24 months), many children

- say sentences with 2 to 4 words
- follow simple instructions
- get excited when with other children
- point to things or pictures when they are named

## At 3 years (36 months), many children

- show affection for friends without prompting
- carry on a conversation using 2 to 3 sentences
- copy adults and friends
- play make-believe with dolls, animals, and people

## At 4 years (48 months), many children

- tell stories
- would rather play with other children than by themselves
- play cooperatively with others

## Questions to ask your child's doctor:

- Is my child's development on track for his or her age?
- How can I track my child's development?
- What should I do if I'm worried about my child's progress?
- Where can I get more information?

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[www.cdc.gov/actearly](http://www.cdc.gov/actearly)

1-800-CDC-INFO



Learn the Signs. Act Early.

# Es tiempo de ver el crecimiento de los niños de manera diferente.

A medida que crecen, los niños siempre están aprendiendo cosas nuevas. Los siguientes son solo algunos de los aspectos del crecimiento de su hijo en los que usted debe fijarse. Use esta lista como una guía y, si algo le preocupa, consulte con el médico de su hijo y llame al **1-800-CDC-INFO** para recibir información acerca del sistema de ayuda para la intervención infantil temprana de su comunidad.

## A los 6 meses, la mayoría de los niños

- responden cuando se les llama por su nombre
- reaccionan ante las emociones de otras personas y por lo general parecen felices
- imitan sonidos
- disfrutan jugando con otras personas, especialmente con sus padres

## Al año (12 meses), la mayoría de los niños

- usan gestos simples, como mover la cabeza de lado a lado para decir “no” o despedirse con la mano
- dicen “mamá” y “papá” y exclamaciones como “¡oh-oh!”
- imitan gestos
- responden a pedidos sencillos

## Al año y medio (18 meses), la mayoría de los niños

- juegan a imitar cosas sencillas, como alimentar a una muñeca
- señalan para mostrar algo que les llama la atención
- expresan una gran variedad de emociones como felicidad, tristeza o enojo
- pueden decir varias palabras sueltas

## A los 2 años (24 meses), la mayoría de los niños

- dicen frases de 2 a 4 palabras
- siguen instrucciones sencillas
- se entusiasman cuando están con otros niños
- señalan objetos o imágenes cuando se los nombra

## A los 3 años (36 meses), la mayoría de los niños

- demuestran afecto espontáneo por sus amigos
- pueden conversar usando 2 o 3 frases
- imitan a adultos y compañeros
- juegan imaginativamente con muñecas, animales y personas

## A los 4 años (48 meses), la mayoría de los niños

- pueden contar cuentos
- prefieren jugar con otros niños que jugar solos
- juegan con los demás de manera cooperativa

## Preguntas para hacerle al médico de su hijo:

- ¿Está bien el desarrollo de mi hijo para la edad que tiene?
- ¿Cómo puedo seguir el desarrollo de mi hijo?
- ¿Qué debo hacer si me preocupa el progreso de mi hijo?
- ¿Dónde puedo obtener más información?

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[www.cdc.gov/pronto](http://www.cdc.gov/pronto)

1-800-CDC-INFO



**Aprenda los signos. Reaccione pronto.**