



California Common Core Curricula for Child Welfare Workers

Trainer's Guide

Child and Youth Development in a Child Welfare Context

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



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>



CALIFORNIA COMMON CORE CURRICULA FOR CHILD WELFARE WORKERS



BACKGROUND AND CONTEXT

Curriculum Development

The Common Core Curricula is the result of a multi-year statewide collaborative effort to develop standardized curricula for California’s newly hired child welfare workers. Development and implementation of the Common Core Curricula was mandated by California’s Program Improvement Plan (PIP) as part of the 2003 federal Child and Family Services Review (CFSR). Although in-service core training had historically been provided by the Regional Training Academies (RTAs), the IUC and county staff development departments, the PIP stipulated that the California Department of Social Services (CDSS) “develop a common core curriculum for all new child welfare workers and supervisors that is delivered by all training entities statewide.”

The Statewide Training and Education Committee (STEC) developed the initial series of Common Core Curricula in FY2004/2005, marking the first implementation of new worker training that was *standardized* for the entire state. The purpose of statewide standardization is to achieve consistency and equity in the application of best and evidence-based practice in all 58 California counties. Each of the content areas of the Common Core has a set of measurable learning objectives for knowledge, skills and values essential to the provision of excellent service to families and children who participate in California’s county child welfare programs.

Contributors and Source Materials

The California Common Core Curricula for Child Welfare Workers is the culmination of a highly collaborative development process among California’s child welfare training institutions. The resulting curricula contains materials synthesized from curricula originated by the Northern California Training Academy at the University of California, Davis; the Bay Area Academy at San Francisco State University; the Public Child Welfare Training Academy at San Diego State University; the Central California Training Academy at California State University, Fresno; and the Inter-University Consortium Department of Child and Family Services for the County of Los Angeles. Additionally, portions of the curricula were

reproduced and adapted, with permission, from Rycus, J.S., Ginther, N.M., Maultsby, T., Houston, D., and Hughes, R.C. (1996) *Training for Child Welfare Caseworkers and Supervisors in Culture and Diversity. A Training Curriculum*. Institute for Human Services, Columbus, Ohio. Numerous curriculum developers also contributed content to the Common Core Curricula, under contract with CalSWEC.

Values Underlying the Development of Common Core Training

STEC used the following underlying values in developing recommendations for common core training:

- Common core training is grounded in social work values and ethics.¹
- Common core training builds upon, but is not limited to, new worker training currently underway in California, and utilizes existing training structures.
- Standards encourage flexibility in the way counties meet identified training needs.
- Standards encourage the application of best practices aimed at improving outcomes for children and families, by training strategies that progress from knowledge acquisition to building and demonstrating skills.
- Standards endorse training delivery methods for common core training that yield measurable learning objectives and that provide the basis for evaluation of knowledge, skills, and attitude acquisition in order to promote positive outcomes for children and families.
- Standards are consistent with those endorsed by California’s Title IV-E university programs for the bachelor’s and master’s degrees in social work.
- Common core training encourages inclusion of community partners, whenever possible, in order to share responsibility for child safety, permanency, and well-being.

Levels of Standardization

STEC determined that content areas of the Common Core would vary in their level of standardization:

¹ The National Association of Social Workers (NASW) Code of Ethics states, “Social work administrators and supervisors should take reasonable steps to provide or arrange for continuing education and staff development for all staff for whom they are responsible. Continuing education and staff development should address current knowledge and emerging developments related to social work practice and ethics...” (NASW Code of Ethics, 1996, revised 1999, Section 3.08).

CalSWEC’s Standards and Values support the use of ongoing training as a form of best practices: “Standards of practice are by their nature subject to change. In view of shifting societal standards, as well as advancing knowledge about children, human behavior, and human ills, standards must be subject to continuous reflection and review.” (CalSWEC Website)

http://calswec.berkeley.edu/CalSWEC/CalSWEC_Standards_Revised.html and
http://calswec.berkeley.edu/CalSWEC/CalSWEC_Values_Revised.html

Two content areas have **standardized information and standard delivery**, statewide:

- *Child Maltreatment Identification, Part 1: Neglect, Physical Abuse, and Emotional Abuse*
- *Child Maltreatment Identification, Part 2: Sexual Abuse and Exploitation*

Five other content areas have **standardized information**, with detailed instructions on delivery:

- *Framework for Child Welfare Practice in California*
- *Child and Youth Development in a Child Welfare Context*
- *Critical Thinking in Child Welfare Assessment: Safety, Risk, and Protective Capacity*
- *Family Engagement in Case Planning and Case Management*
- *Placement and Permanency*

Fourteen topics have **standardized competencies and learning objectives**:

- *Basic Interviewing*
- *Caregiver Substance Abuse and Child Welfare Practice*
- *Child Welfare Practice in a Multicultural Environment*
- *Court Procedures*
- *CWS Documentation for Use in the Legal System*
- *Domestic Violence*
- *Health Care Needs of Children and Youth in the Child Welfare System*
- *Indian Child Welfare Act (ICWA)*
- *Mental Health and Mental Disorders*
- *Multiethnic Placement Act (MEPA) / Interethnic Adoptions Provisions (IAP)*
- *Self-care for New Child Welfare Workers*
- *Statewide Automated Case Management System*
- *Supporting Educational Rights and Achievement*
- *Values and Ethics*

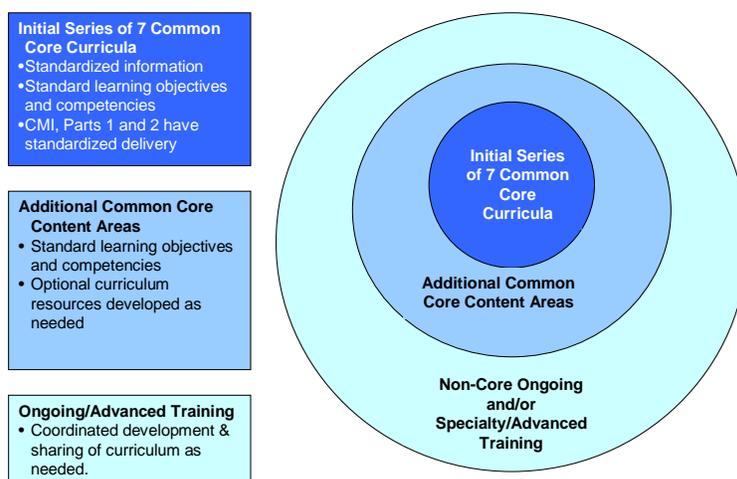
CalSWEC, the Regional Training Academies, counties, and the Inter-University Consortium serving Los Angeles County are currently developing, adapting, and sharing curriculum resources that address all of the learning objectives for these fourteen areas. CalSWEC is coordinating this effort by conducting statewide surveys of available curriculum resources that can be posted on the CalSWEC website beginning in 2008. Curriculum resources for many of these areas were developed previously by CalSWEC and its coordinating partners as

part of the Standardized Core Project (SCP) in 2001. Topic areas of the 2001 Standardized Core Project are available from CalSWEC upon request.

Completion of the Common Core

All fully standardized content areas of the Common Core must be completed within twelve months from the date of hire, with the exception of *Child Maltreatment Identification, Part 2*, which must be completed within twenty-four months from the date of hire. Of the fourteen topics that are standardized at the level of competencies and learning objectives, the *Statewide Automated Case Management System* must be completed by the end of the first year of service, and all other topics must be completed by the end of the second year of service.

Figure I: Conceptual Map of California's In-service Training Categories for New Child Welfare Workers



Foundational Themes to Guide Practice and Curricula

Five foundational themes were identified and interwoven in every content area of the Common Core Curriculum series. The curriculum *Framework for Child Welfare Practice in California* introduces new workers to these themes.

Working Definitions of the Foundational Themes:

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 & 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.

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.

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. These performance measures are referenced in the curricula where they apply. For more information on the performance measures in California, please refer to the website for the California Child Welfare Performance Indicators Project at the Center for Social Sciences Research (CSSR) at UC, Berkeley: http://cssr.berkeley.edu/ucb_childwelfare/.

Evidence-based Practice ("EBP")

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.

Training Evaluation

The evaluation components of the Common Core Curricula were developed concurrently with the creation of the curricula content. They are based on the [Training Evaluation Framework Report](#) developed by CalSWEC in FY 04/05 in response to the Program Improvement Plan (PIP). In addition to evaluating trainee satisfaction with the entire Common Core, four of the seven curricula in the initial series of the Common Core are evaluated by knowledge testing.² In this level of evaluation, trainees are tested on the knowledge that they acquired during the training in order to assure that the material is being presented effectively.

² *Framework for Child Welfare Practice in California and Child Maltreatment Identification, Parts 1 and 2* do not offer knowledge testing.

For *Child Maltreatment Identification, Parts 1 and 2*, embedded skill evaluations are employed. By this method of evaluation, trainees are evaluated on the skill of identifying child maltreatment when presented with case scenarios. Trainees practice the skill and are evaluated during the course of the training.

Analysis of the satisfaction, knowledge and skill evaluation data is used to assist training evaluation experts to improve the training. More information on the *Training Evaluation Framework*, as well as on training evaluation generally, can be found at: <http://calswec.berkeley.edu/CalSWEC/CWTraining.html>.

Revision Process

Major revisions to the Common Core Curricula are conducted every three years or sooner, based on developments critical to effective social work practice. Minor revisions occur systematically as needed, to reflect current practice and changes in policy and legislation. Each common core curriculum is numbered by version number (Version 1.0, 1.1, 1.2, etc.). The latest version of each curriculum is posted on the CalSWEC website.

Principles and Values of the Revision Process

The following principles and values are applied to the design of the revision process:

- Content will reflect “state of the art” knowledge and applications
- Content will apply transfer of learning principles and strategies
- Content will support and expand upon the competencies established in the Title IV-E bachelor’s- and master’s-level social work programs
- The revision process will draw upon the combined expertise of practitioners and university partners

Additionally, periodic revisions of the Common Core Curricula aim to advance fairness and equity principles throughout the child welfare system and expand support for improved outcomes for children and families.

CHILD AND YOUTH DEVELOPMENT

Trainer's Guide

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CALIFORNIA COMMON CORE CURRICULA FOR CHILD WELFARE WORKERS



HOW TO USE THE TRAINER'S AND TRAINEE'S GUIDES

Please read carefully as a first step in preparing to train this curriculum.

IMPORTANT NOTE: Each curriculum within the Common Core series is mandated and standardized for all new child welfare workers in the state of California. It is essential that all trainers who teach any of the Common Core Curricula in California instruct trainees using the standardized Training Content as provided. The training of standardized content also serves as the foundation for conducting standardized testing to evaluate and improve the effectiveness of new worker training statewide.

GENERAL INFORMATION

The Common Core Curricula model is designed to define clearly the content to be covered by the trainer. Each curriculum consists of a *Trainee's Guide* and a *Trainer's Guide*. Except where indicated, the curriculum components outlined below are identical in both the Trainee's and Trainer's Guides. The Trainee's Guide contains the standardized information which is to be conveyed to trainees.

The Trainer's Guide includes guidance to assist the trainer in presenting the standardized information. *Child Maltreatment Identification, Parts 1 and 2* each require a standardized delivery to support the embedded skill evaluations contained in these curricula, while the other five curricula in the Common Core series preserve some flexibility in the delivery of the content.

For an overview of the training, it is recommended that trainers first review the Background and Context, Agenda and Suggested Lesson Plan. After this overview, trainers can proceed to review the Trainer's Tips and Activities section in the Trainer's Guide and the Training Content in the Trainee's Guide in order to become thoroughly familiar with each topic and the suggested training activities. The components of the Trainer's and Trainee's Guides are described under the subheadings listed below.

The curricula are developed with public funds and intended for public use. For information on use and citation of the curricula, please refer to the Guidelines for Citation: http://calswec.berkeley.edu/CalSWEC/CCCCA_Citation_Guidelines.doc

Please note that each individual curriculum within the Common Core Curricula is subject to periodic revision. The curricula posted on the CalSWEC website are the most current versions available. For questions regarding the curricula, contact Melissa Connelly mconnelly@berkeley.edu or Phyllis Jeroslow pjero@berkeley.edu, or call CalSWEC at 510-642-9272.

COMPONENTS OF THE TRAINER’S AND TRAINEE’S GUIDES

Background and Context

The Background and Context describes how and why the Common Core was developed, as well as the values, levels of standardization, completion requirements, and revision process associated with the Common Core series. As an additional resource for trainers, the Background and Context also provides working definitions of the foundational themes that are interwoven throughout the Common Core, and basic information about the use of knowledge and embedded skill testing for evaluating the effectiveness of the training.

Table of Contents

The Trainer’s and Trainee’s Guides are divided into tabs according to the main headings of the Table of Contents. The pages within each tab are numbered, with each tab beginning with page 1. (For easy reference, there is also a separate Table of Contents for the Training Tips and Activities tab in the Trainer’s Guide.)

Competencies and Learning Objectives

The Competencies and Learning Objectives serve as the basis for the Training Content that is provided to both the trainer and trainees. All the Competencies and Learning Objectives for the curriculum are listed in a separate tab in both the Trainer’s and Trainee’s Guides. The Learning Objectives are subdivided into three categories: Knowledge, Skills, and Values. They are numbered in series beginning with K1 for knowledge, S1 for skills, and V1 for values. The Learning Objectives are also indicated in the suggested Lesson Plan for each segment of the curriculum.

Competencies are defined as broad indicators of essential and best practices. Typically, several *Learning Objectives* support the development of each *Competency*. The *Learning Objectives* are more specific than the *Competencies* and usually provide measurable indicators of learning.

Knowledge Learning Objectives entail the acquisition of new information and often require the ability to recognize or recall that information. *Skill Learning Objectives* involve the application of knowledge and frequently require the demonstration of such application. *Values Learning Objectives* describe attitudes, ethics, and desired goals and outcomes for

practice. Generally, *Values Learning Objectives* do not easily lend themselves to measurement, although values acquisition may sometimes be inferred through other responses elicited during the training process.

Agenda

The Agenda is a simple, sequential outline indicating the order of events in the training day, including the coverage of broad topic areas, pre-tests and/or post-tests, training activities, lunch, and break times. The Agenda for trainers differs slightly from the Agenda provided to trainees in that the trainer's agenda indicates duration; duration is not indicated on the agenda for trainees.

Suggested Lesson Plan (Trainer's Guide only)

The suggested Lesson Plan in the Trainer's Guide is a mapping of the structure and flow of the training. It presents each topic in the order recommended and indicates the duration of training time for each topic. The suggested Lesson Plan is offered as an aid for organizing the training.

The suggested Lesson Plan is divided into major sections by Day 1, Day 2, and Day 3 of the training, as applicable, and contains three column headings: Topic/Time, Learning Objectives, and Methodology. The Topic/Time column is divided into training Segments. The Learning Objectives column reflects the specific objectives that are covered in each Segment. The Methodology column indicates suggested training activities that may accompany each Segment. As applicable, each activity is numbered sequentially within a Segment, with activities for Segment 1 beginning with Activity 1A, Segment 2 beginning with Activity 2A, etc. The numbering schema of Day, Segment, Activity mirrors the labeling of materials in the Training Tips and Activities tab.

Evaluation Protocols

It is necessary to follow the step-by-step instructions detailed in this section concerning pre-tests, post-tests, and skill evaluation (as applicable to a particular curriculum) in order to preserve the integrity and consistency of the training evaluation process. Additionally, trainers should not allow trainees to take away or make copies of any test materials so that test security can be maintained.

Training Tips, Activities, & Transfer of Learning (TOL) Exercises (Trainer's Guide only)

The Training Tips section is the main component of the Trainer's Guide. It contains guidance and tips for the trainer to present the content and to conduct each *Training Activity*. *Training Activities* are labeled and numbered to match the titles, numbering, and lettering in the suggested Lesson Plan. *Training Activities* contain detailed descriptions of the activities as well as step-by-step tips for preparing, presenting, and processing the activities. The description also specifies the Training Content that accompanies the activity, and the time and materials required.

Trainers may prefer to insert corresponding pages of the Training Content at the end of each segment, as directed by placeholder pages that are provided. The style of the page numbering of the Training Tips and Activities tab is purposely altered to distinguish these pages easily from the insert pages of the Training Content. The Training Tips and Activities also reference accompanying PowerPoint slides and provide thumbnails of the slides, generally at the end of each *Training Activity*.

Occasionally, a *Trainer's Supplement* is provided that includes additional information or materials that the trainer needs. The *Trainer's Supplement* follows the *Training Activity* to which it applies.

Training Content (Trainee's Guide only; can be inserted into the Trainer's Guide)

The *Training Content* in the Trainee's Guide contains the standardized text of the curriculum and provides the basis for knowledge testing of the trainees. Training activities are labeled and numbered to match the titles and numbering in the suggested Lesson Plan.

Supplemental Handouts

Supplemental Handouts are clearly titled and appear in both the Trainer's and Trainee's Guides. Supplemental Handouts refer to additional handouts not included in the Training Content tab of the Trainee's Guide. For example, Supplemental Handouts include PowerPoint printouts that accompany in-class presentations or worksheets for training activities. Some documents in the Supplemental Handouts are placed there because their size or format requires that they be printed separately.

Background Information (Trainer's Guide only)

In certain curricula within the Common Core series, the Trainer's Guide contains an additional tab of general background information about the curriculum's content area for the trainer to read as preparation for **conducting the training. This information is not included in the Trainee's Guide.**

Master Glossary

A glossary shared by the Common Core series is provided in both the Trainer's Guide and the Trainee's Guide. The glossary defines words and acronyms commonly used in child welfare practice. Many of these terms appear in the content or supplemental information of one or more curricula in the series. The glossary is provided to help trainees learn language and terms specific to the field.

References and Bibliography

The Trainer's Guide and Trainee's Guide each contain the same References and Bibliography. The References and Bibliography tab indicates the sources that were reviewed by the curriculum designer(s) to prepare and to write the main, supplemental and background content information, training tips, training activities and any other information conveyed in the training materials. It also includes additional resources that apply to a particular content area. The References and Bibliography tab is divided into three sections:

- All-County Letters (ACLs) and All-County Information Notices (ACINs) issued by the California Department of Social Services (CDSS);
- Legal References (as applicable); and
- General References and Bibliography

In certain curricula within the Common Core series, the References and Bibliography may be further divided by topic area.

Materials Checklist (Trainer's Guide only)

In order to facilitate the training preparation process, the Materials Checklist provides a complete listing of all the materials needed for the entire training. Multi-media materials include such items as videos, audio recordings, posters, and other audiovisual aids. Materials specific to each individual training activity are also noted in the Training Tips and Activities section of the Trainer's Guide.

Posters (Trainer's Guide only)

Some curricula feature materials in the Trainer's Guide that can be used as posters or wall art. Additionally, several of the handouts from the curriculum *Framework for Child Welfare Practice in California* can also be adapted for use as posters.

Child and Youth Development (v1.2, 2012)

COMPETENCIES and LEARNING OBJECTIVES

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.

Child and Youth Development

AGENDA Day 1 of 2

- 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.)

AGENDA

Day 2 of 2

- I. Welcome, Review of Day 1 (15 min.)**
- II. Ages 3-5 (60 min.)**
 - a. Normal Development (10 min.)**
 - b. Attachment (15 min.)**
 - c. Grief and Loss (5 min.)**
 - d. Red Flags (10 min.)**
 - e. Effects of Maltreatment (10 min.)**
 - f. Implications for Practice (10 min.)**

BREAK (15 min.)
- III. Ages 6-12 (90 min.)**
 - a. Normal Development (15 min.)**
 - b. Grief and Loss (10 min.)**
 - c. Traumatic Experiences and PTSD (20 min.)**
 - d. Red Flags (15 min.)**
 - e. Effects of Maltreatment (15 min.)**
 - f. Implications for Practice (15 min.)**

LUNCH (60 min.)
- IV. Adolescents and Emerging Adults (60 min.)**
 - a. Normal Development (15 min.)**
 - b. Brain Development (20 min.)**
 - c. Grief and Loss (5 min.)**
 - d. Effects of Maltreatment (10 min.)**
 - e. Implications for Practice (10 min.)**
- V. Case Application (50 min.)**
 - a. Tammy and Marcus (25 min.)**
 - b. What Would You Do? (25 min.)**

BREAK (15 min.)
- VI. The Child Development Game (20 min.)**
- VII. Post-test (30 min.)**
- VIII. Course Evaluation/Closure (5 min.)**

Child and Youth Development in a Child Welfare Context

SUGGESTED LESSON PLAN

DAY 1

Segment	Learning Objective	Methodology
<p>Day 1, Segment 1 15 min 9:00 – 9:15 am</p> <p>Welcome and Introductions</p>		<p>Activity 1A: Trainer’s introduction. Review goals, agenda and explain pre- & post-tests.</p> <p><i>PowerPoint slides: 1-5</i></p>
<p>Day 1, Segment 2 45 min 9:15 – 10:00 am</p> <p>Knowledge Pre-test</p>		<p>Activity 2A Knowledge pre-test.</p> <p><i>PowerPoint slide: 6</i></p>
<p>Day 1, Segment 3 15 min 10:00 – 10:15 am</p> <p>Review Competencies and Learning Objectives</p>	<p>Introduction to all competencies and learning objectives.</p>	<p>Activity 3A Icebreaker.</p> <p><i>PowerPoint slide: 7</i></p> <p>Activity 3B Review of competencies and learning objectives through a group exercise.</p> <p><i>PowerPoint slide: 8</i></p>
<p>10:15 – 10:30 am 15 min BREAK</p>		
<p>Day 1, Segment 4 90 min 10:30 am – 12:00 pm</p> <p>A Framework for Understanding Child Development</p>	<p>K1. The trainee will be able to explain and give examples of the processes and milestones of normal development of infants, toddlers, pre-schoolers,</p>	<p>Activity 4A: Lecture and discussion of normal development. Briefly discuss the five primary domains: Social, Physical, Emotional, Cognitive and Sexual.</p>

Segment	Learning Objective	Methodology
	<p>school-age children, adolescents, and emerging adults across the physical, cognitive, social, emotional, and sexual domains.</p> <p>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.</p> <p>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.</p> <p>K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.</p> <p>K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.</p> <p>V1. The trainee will value an understanding of how</p>	<p><i>PowerPoint slides: 9-12</i></p> <p>Activity 4B: Lecture and discussion on Nature and Nurture. Discuss Heredity and Environment.</p> <p><i>PowerPoint slides: 13-15</i></p> <p>Activity 4C: Lecture and discussion on brain development.</p> <p><i>PowerPoint slides: 16-20</i></p> <p>Activity 4D: Video clip from <i>Childhood: Louder than Words</i>. Discussion of the role of culture in normal development, variations among different cultures, and implications for child welfare practice.</p> <p><i>PowerPoint slides: 21-22</i></p>

Segment	Learning Objective	Methodology
	<p>poverty, lack of education, community distress and environmental stressors can impair a parent's ability to provide for a child's developmental needs.</p> <p>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.</p> <p>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.</p>	
	<p>12:00 – 1:00 pm 60 min LUNCH</p>	
<p>Day 1, Segment 5 90 min 1:00 – 2:30 pm</p> <p>Ages 0-2</p>	<p>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</p>	<p>Activity 5A: Lecture and discussion on the normal development, ages 0-2.</p> <p><i>PowerPoint slides: 23-26</i></p> <p>Activity 5B: Lecture and discussion on</p>

Segment	Learning Objective	Methodology
	<p>emerging adults across the physical, cognitive, social, emotional, and sexual domains.</p> <p>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.</p> <p>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.</p> <p>K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.</p>	<p>brain development.</p> <p><i>PowerPoint slides: 27-29</i></p> <p>Activity 5C: Video screening and discussion. Show video clip, <i>The First Years Last Forever</i>. Discuss the process of attachment and attunement. Complete case scenario exercise.</p> <p><i>PowerPoint slides: 30-39</i></p> <p>Activity 5D: Lecture concerning the child's experience of grief and loss, including separation resulting from out-of-home placement.</p> <p><i>PowerPoint slide: 40</i></p>
<p>2:50 – 3:05 pm 15 min BREAK</p>		
<p>Day 1, Segment 5 (Continued) 65 min 2:45 – 3:50 pm</p> <p>Ages 0-2</p>	<p>K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.</p> <p>K7. The trainee will be able</p>	<p>Activity 5E: Video clip from <i>Understanding Traumatized and Maltreated Children: The Core Concepts, Series 1. Tape 4: Neglect: How Poverty of Experience</i></p>

Segment	Learning Objective	Methodology
	<p>to recognize possible adverse consequences of in utero drug and alcohol abuse on infant and child development, including fetal alcohol syndrome, Intellectual Delay and developmental delays and identify appropriate interventions including early referral and collaboration with mental health providers.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p><i>Disrupts Development, on Self-Esteem.</i></p> <p>Discussion of failure to thrive causes, symptoms and treatment planning.</p> <p><i>PowerPoint slides: 41-44</i></p> <p>Activity 5F: Lecture and video screening. Introduce the effects on infant & child development of maternal substance abuse. Focus on Fetal Alcohol Syndrome. Screen the first 8 minutes of <i>The Listening Heart</i>.</p> <p><i>PowerPoint slide: 45</i></p> <p>Activity 5G: Lecture and group discussion on red flags and implications for practice.</p> <p><i>PowerPoint slide: 46</i></p>

Segment	Learning Objective	Methodology
	<p>V2. The trainee will value utilizing a strength-based perspective with families/caregivers when gathering information and assessing the child’s developmental history.</p> <p>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.</p> <p>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.</p>	
<p>Day 1, Segment 6 10 min 3:50 – 4:00 pm</p> <p>Summary of Day 1/ Prep for Day 2</p>		<p>Activity 6A: Group activity with trainees recounting selected learning points. Re-cap Day 1 agenda topics and provide preview of Day 2.</p> <p><i>PowerPoint slide: 47</i></p>

SUGGESTED LESSON PLAN
DAY 2

Segment	Learning Objective	Methodology
<p>Day 2, Segment 7 15 min 9:00 – 9:15 am</p> <p>Welcome and Review of Day 1</p>		<p>Activity 7A: Group activity: “<i>What do you remember?</i>”</p> <p><i>PowerPoint slides: 48-49</i></p>
<p>Day 2, Segment 8 60 min 9:15 – 10:15 am</p> <p>Ages 3-5</p>	<p>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.</p> <p>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.</p> <p>K3. The trainee will be able to explain how parent-child interactions affect early brain development, and provide examples of parenting behaviors that</p>	<p>Activity 8A Lecture and discussion on normal development and the SPECS of ages 3-5.</p> <p><i>PowerPoint slides: 50-51</i></p> <p>Activity 8B Lecture and discussion on attachment. Case scenario activity regarding attachment.</p> <p><i>PowerPoint slides: 52-54</i></p> <p>Activity 8C Lecture and discussion on grief and loss.</p> <p><i>PowerPoint slide: 55</i></p> <p>Activity 8D Lecture on the definition of developmental delays and disabilities, including Intellectual Delay, and autistic spectrum disorders.</p>

Segment	Learning Objective	Methodology
	<p>stimulate optimal brain development.</p> <p>K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.</p> <p>K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.</p> <p>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.</p> <p>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.</p> <p>S2. Given a case example,</p>	<p><i>PowerPoint slides: 56-57</i></p> <p>Activity 8E Lecture and discussion on the effects of child maltreatment.</p> <p><i>PowerPoint slide: 58</i></p> <p>Activity 8F Lecture and discussion of the implications for practice.</p> <p><i>PowerPoint slides: 59-60</i></p>

Segment	Learning Objective	Methodology
	<p>the trainee will be able to articulate, in terms a parent can understand, strength-based parenting strategies for children at different stages of development.</p> <p>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.</p> <p>V2. The trainee will value utilizing a strength-based perspective with families/caregivers when gathering information and assessing the child’s developmental history.</p> <p>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.</p> <p>V4. The trainee will value keeping abreast of emerging research evidence regarding attachment, child</p>	

Segment	Learning Objective	Methodology
	<p>development, and disorders of childhood, and applying current knowledge to child welfare practice.</p> <p>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.</p> <p>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.</p>	
10:15 – 10:30 am 15 min BREAK		
<p>Day 2, Segment 9 90 min 10:30 am – 12:00 pm</p> <p>Ages 6-12</p>	<p>K1. The trainee will be able to explain and give examples of the processes and milestones of normal development of infants, toddlers, pre-schoolers,</p>	<p>Activity 9A: Lecture, discussion and video screening on normal development and the SPECS of ages 6-12. Show 8 minutes of <i>Childhood: Life Lessons</i>.</p>

Segment	Learning Objective	Methodology
	<p>school-age children, adolescents, and emerging adults across the physical, cognitive, social, emotional, and sexual domains.</p> <p>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.</p> <p>K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.</p> <p>K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.</p> <p>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</p>	<p><i>PowerPoint slides: 61-63</i></p> <p>Activity 9B: Brief lecture on grief and loss in school-age children.</p> <p><i>PowerPoint slide: 64</i></p> <p>Activity 9C: Video screening and discussion of the definition of trauma, stressors, the stress response, how children respond to trauma, and characteristics of PTSD. Show 10 minutes of <i>Understanding Traumatized Children: The core Concepts: The Fear Response</i>.</p> <p><i>PowerPoint slides: 65-69</i></p> <p>Activity 9D: Lecture and discussion on red flags.</p> <p><i>PowerPoint slides: 70-73</i></p> <p>Activity 9E: Lecture and group activity on the effects of maltreatment.</p> <p><i>PowerPoint slide: 74</i></p> <p>Activity 9F: Activity and discussion on</p>

Segment	Learning Objective	Methodology
	<p>mental health referral is necessary.</p> <p>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.</p> <p>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.</p> <p>V2. The trainee will value utilizing a strength-based perspective with families/caregivers when gathering information and assessing the child's developmental history.</p> <p>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.</p>	<p>implications for practice. Case scenario exercise regarding ADHD and PTSD.</p> <p><i>PowerPoint slides: 75-77</i></p>

Segment	Learning Objective	Methodology
	<p>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.</p> <p>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.</p>	
	<p>12:00 – 1:00 pm 60 min LUNCH</p>	
<p>Day 2, Segment 10 60 min 1:00 – 2:00 pm</p> <p>Adolescence and Emerging Adulthood</p>	<p>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.</p>	<p>Activity 10A: Lecture and discussion on normal development and the SPECS of adolescence.</p> <p><i>PowerPoint slides: 78-80</i></p> <p>Activity 10B: Lecture, video screening and discussion on brain development. Show 6 minutes of <i>Frontline: Inside the Teenage Brain</i>.</p>

Segment	Learning Objective	Methodology
	<p>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.</p> <p>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.</p> <p>K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.</p> <p>K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.</p> <p>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</p>	<p><i>PowerPoint slides: 81-87</i></p> <p>Activity 10C: Brief lecture on grief and loss in adolescence.</p> <p><i>PowerPoint slides: 88-89</i></p> <p>Activity 10D: Lecture on the effects of maltreatment.</p> <p><i>PowerPoint slide: 90</i></p> <p>Activity 10E: Lecture and discussion of the implications for practice.</p> <p><i>PowerPoint slides: 91-93</i></p>

Segment	Learning Objective	Methodology
	<p>emerging adults and be able to articulate when a mental health referral is necessary.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
<p>Day 2, Segment 11 50 min 2:00 – 2:50 pm</p> <p>Case Application Activity</p>	<p>S1. Given a case example, the trainee will be able to distinguish between normal and delayed developmental milestones and identify steps to take for</p>	<p>Activity 11A: Case application activity with vignettes.</p> <p><i>PowerPoint slide: 94</i></p> <p>Activity 11B:</p>

Segment	Learning Objective	Methodology
	<p>collaborative early intervention.</p> <p>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.</p> <p>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.</p>	<p>Transfer of learning activity with short scenarios.</p> <p><i>PowerPoint slide: 95</i></p>
<p>2:50 – 3:05 pm 15 min BREAK</p>		
<p>Day 2, Segment 12 20 min 3:05 – 3:25 pm</p> <p>Child Development Review</p>	<p>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.</p>	<p>Activity 12A: Large group review activity.</p> <p><i>PowerPoint slide: 96</i></p>
<p>Day 2, Segment 13 30 min</p>		<p>Activity 13A: Knowledge post-test.</p>

Segment	Learning Objective	Methodology
<p>3:25 – 3:55 pm</p> <p>Knowledge post-test</p>		<p><i>PowerPoint slide: 97</i></p>
<p>Day 2, Segment 14</p> <p>5 min</p> <p>3:55 – 4:00 pm</p> <p>Summary and closure</p>		<p>Activity 14A: Closing activity and course evaluation.</p> <p><i>PowerPoint slide: 98</i></p>

CALIFORNIA COMMON CORE CURRICULA FOR CHILD WELFARE WORKERS - TRAINER'S GUIDE -

EVALUATION PROTOCOLS: OVERVIEW

Background and Purpose of Evaluations

The California Social Work Education Center (CalSWEC), along with California's four regional training academies (RTAs) and Los Angeles' Inter-University Consortium (IUC), has begun a process of evaluating common core training for new child welfare workers. In addition to the existing participant satisfaction evaluations, two types of evaluation will be used: knowledge testing and skills testing.

These evaluations have three main purposes:

1. To improve trainings' effectiveness in relation to trainees' needs in order to help them better serve children, youth, and families,
2. To see if the training has been effective in getting its points across, and
3. To establish a standard method of evaluating training effectiveness in response to federal requirements in the Program Improvement Plan (PIP) for California.

Thus, the evaluations are not meant to evaluate individuals. The purpose is to obtain feedback on course design and effectiveness.

Coding and Confidentiality

Participants will be asked to write an 8-digit ID code on their evaluation forms. These codes are critical for matching demographics with test scores to ensure fairness and equity, but will not be used for any other purpose. Codes will be generated by the participants from the first three letters of their mother's maiden name, the first three letters of their mother's first name, and the two digits for the day of their birth. Only aggregate results will be reported and only the participants themselves will know their code. The purpose of the evaluation and confidentiality are also explained in a cover letter for the trainees. A second trainee handout explains the process for generating an ID code.

Preparation by the Trainer

In most cases, trainers will administer the embedded skills evaluation and test administrators will conduct the knowledge tests. Instructions for the trainer are included

for both types of evaluations, and trainers should be thoroughly familiar with all evaluation procedures.

Trainers teaching the *Child Maltreatment Identification, Part 1* and/or *Child Maltreatment Identification, Part 2* content should read the embedded evaluation activity in its entirety well before attempting to facilitate the embedded evaluation process. This evaluation process consists of many steps and details; many trainers will be unfamiliar with this type of evaluation as it is new to California child welfare training. When facilitated well, this activity is an invaluable learning tool for trainees.

KNOWLEDGE EVALUATIONS

At various points during core trainings, in addition to the usual workshop evaluation forms, trainees will be asked to complete pre- and post-training knowledge evaluations (tests). At this time, pre- and post-evaluations will be done for three curricula: *Child & Youth Development in a Child Welfare Context*, *Family Engagement in Case Planning and Case Management*, and *Placement & Permanency*. In addition, there will be a post-test-only evaluation for the *Critical Thinking Skills in Child Welfare Assessment: Safety, Risk, and Protective Capacity* curriculum.

NOTE: Knowledge tests will typically be conducted by the test administrator from the RTA/IUC or county, *not* by the trainer.

Explicit instructions for facilitating knowledge testing can be found both directly after this document (still within the Evaluation Protocols section of the Trainer's Guide) and within the Training Activity Box in the appropriate segments of the Training Content & Tips section of the Trainer's Guide.

Trainees will be asked to answer approximately 30 multiple-choice questions for both pre- and post-tests. Each test takes approximately 30 minutes to administer. However, you will need to allow an extra 15 minutes for the introduction to the pre-test, which consists of the explanation of the evaluation, and completion of the demographics and ID code form. In the case of the *Critical Thinking Skills in Child Welfare Assessment: Safety, Risk, and Protective Capacity* curriculum, there is no pre-test; thus, trainers should allow an extra 15 minutes for the introduction to the post-test, which consists of the explanation of the evaluation, and completion of the demographics and ID code form. These time frames have been built into the curricula.

Test questions were developed specifically for the common core curriculum you are currently using. These test questions have been reviewed extensively by subject matter experts from the participating training agencies and consultants in test construction. The majority of questions have also been linked with supporting evidence from the child welfare literature or California law and policy documents.

EMBEDDED SKILL EVALUATION

At this time, two curricula will incorporate an embedded skill assessment: *Child Maltreatment Identification, Part 1: Neglect, Emotional Abuse, and Physical Abuse (CMI 1)* and *Child Maltreatment Identification, Part 2: Sexual Abuse (CMI 2)*. The skill set that is evaluated involves the trainees' abilities to make a decision about whether child physical abuse (CMI 1) or child sexual abuse (CMI 2) has occurred in a given scenario, and to explain the rationale for the decision. The embedded skill assessment for CMI 1 will take approximately 90 minutes and for CMI 2 will take approximately 115 minutes each, respectively, in their entirety. This includes the trainer's explanation, passing out materials, completion of the demographics form, going through the sample scenario, administering the test for the four additional scenarios, processing the answers to the test, and collecting all test material.

As both the content and method of delivery are standardized for CMI, Parts 1 and 2, trainers should neither add to nor eliminate any of the content in this curriculum without first contacting their respective RTA/IUC. In addition, trainers should not change the order of the exercises/activities as they are set out in this curriculum, as this may affect the results of the embedded evaluations. The embedded evaluation is not only an evaluation, but is also a teaching tool that is part of a larger set of specific training activities built into the training days to support the trainees' learning process.

Specific instructions for facilitating embedded evaluations can be found directly after this document (still within the Evaluation Protocols section of the Trainer's Guide).

In the skills evaluation, trainees will review a set of case scenarios, decide whether or not certain elements of concern are present, and decide whether such elements suggest that child physical abuse (CMI 1) or child sexual abuse (CMI 2) occurred. In CMI 1 and the most current version of CMI 2, there are five scenarios in all, one of which is a sample and four of which comprise the test. Each scenario is followed by the same sets of questions.

In administering the skills evaluation, the trainer will first run through the sample scenario and the accompanying test questions. It is critical for the trainer to follow the instructions for the Embedded Evaluation in the Evaluation Protocols Tab of the Trainer's Guide, which describes step-by-step how to go through the example with the trainees so that they will understand how to take the test. Trainees will then be given the test, i.e., the remaining four scenarios and the questions that go with them.

About the Test Questions

For each scenario, trainees will be asked to consider the indicator elements (which were presented in the training). For each element, they will be asked to check "yes", "no", or "need more information" to indicate whether or not they believe the element was a

concern pointing to possible maltreatment in the scenario. Based on this assessment, trainees will then be asked to:

- ❑ Decide if they would conclude that physical (or sexual) abuse had or had not occurred,
- ❑ Identify the three elements that were most significant in making their decision, and
- ❑ Explain how these elements fit together to support their conclusions.

Finally, trainees will be asked to identify what further actions they would be most likely to take in this case scenario.

An important aspect to the embedded skills evaluation is to reinforce learning. Therefore, after the trainees have taken the test and passed their answer sheets to the trainer, the trainer will go over each question and the answers. The trainees will have a copy of their answers in order to help them participate in the discussion.

MAINTAINING SECURITY OF THE KNOWLEDGE AND SKILL EVALUATIONS

Trainers, RTCs, or others responsible for administering the tests should check for ID codes on all test forms. To maintain security of the knowledge and skill evaluations, all test materials should be collected at the end of the actual evaluation/test. Test administrators and trainers should not allow any trainees to leave the training room with any of the test questions or scenarios.

For the knowledge evaluations, test administrators and trainers **MUST** collect **ALL** test materials before participants leave the classroom. If the items leave the classroom and circulate, the validity of the tests will be compromised. At this time there is only a single form of the test that is used both pre and post training. Trainers, please:

- ❑ **Refrain from reviewing any of the specific test questions or answers in class,**
- ❑ **Refrain from distributing copies of the answer key to any trainees, and**
- ❑ **Refrain or prevent trainees from taking copies of the tests with them.**

Although we ask trainers to refrain from reviewing specific knowledge test questions or answers in class, trainers **CAN** debrief **general** areas of content with trainees (again, as long as specific test questions or answers are not reviewed).

For the embedded skill evaluations, trainers **MUST** collect **ALL** test materials, including the example scenario, the four test scenarios, and copies of answer sheets at the end of the test.

FEEDBACK ABOUT THE KNOWLEDGE AND SKILL EVALUATIONS

If you receive feedback from trainees about the knowledge or skill evaluation process, please feel free to forward a copy of the feedback to:

Leslie W. Zeitler, LCSW
Training & Evaluation Specialist
California Social Work Education Center (CalSWEC)
lzeitler@berkeley.edu

TRAINER INSTRUCTIONS FOR FACILITATION OF...

TRAINING ACTIVITY:

PRE-TEST

(usually Activity 2A of a given curriculum)

TRAINING ACTIVITY:

POST-TEST

(at the end of the 2nd day of training of a given curriculum, just before closing)

If RTA/IUC or county test administrators are not available, trainers should contact their RTA/IUC or county point-person for copies of actual pre- and post-tests for use during these segments.

General Tips:

RTA/IUC or county training evaluation administrators will typically be administering the pre- and post- knowledge tests to trainees for Common Core Curricula. Administration instructions are provided below for RTA/IUC and county test administrators. In the event that a test administrator is not available, the following instructions are provided within the Trainer's Content & Tips section to assist trainers with facilitating the testing process.

Test administrators and trainers should read the content contained within the *Evaluation Protocols* Tab of the Trainer's Guide prior to proceeding with any type of evaluation. More specifically, test administrators and trainers should be familiar with the sections of content labeled "Coding & Confidentiality" and "Maintaining Security of the Knowledge and Skill Evaluations."

In addition, when test administrators are not available, trainers should review this activity in its entirety prior to walking through it on the training day, as this evaluation process consists of many steps that may be unfamiliar to many trainers.

TRAINING ACTIVITY: TRAINER INSTRUCTIONS FOR KNOWLEDGE PRE-TESTS

Approximate time: 45-50 minutes

Materials:

- Pens for trainees to fill out test forms (*Please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. Please avoid the use of felt-tip pens for the answer sheets.*)
- Evaluation Packet #1: *Make sure there are enough copies for all trainees:*
 - Letter to the participant explaining the evaluation
 - Informed Consent Page
 - ID Code Assignment instruction sheet
 - Demographic Survey
 - Knowledge Pre-Test (*specific to curriculum topic; obtain from RTA/IUC or county point person*)
 - Answer Sheet for Knowledge Pre-Test (*Make sure the answer sheets are printed on WHITE PAPER ONLY; otherwise the scanner has difficulty capturing the test answers.*)
- Evaluation Packet #2: Post-test and Answer Sheets only (*Again, make sure the answer sheets are printed on WHITE PAPER ONLY; otherwise the scanner has difficulty capturing the test answers.*)
- Three 9x12 Envelopes:
 - 1 for trainer to collect ALL pre-tests
 - 1 for trainer to collect ALL post-tests
 - 1 for trainer to collect ALL blank tests (pre- and post-)

Introduce the evaluation component:

Discuss the use of pre-and post-tests according to the detailed instructions contained in the *Evaluation Protocols* tab in this Trainer's Guide. It is important that trainers follow these guidelines precisely in order to preserve the integrity of the testing process.

Training Activity:

Step #1. Distribute evaluation packet #1 to all trainees after you have convened the class. If the common content is inserted into a larger training module, you should pass them out before beginning coverage of the common core area to be evaluated.

Step #2. Introduce the knowledge evaluation:

- Explain for trainees that they will be asked to complete this test now and then another test at the end of the course. The purpose of the evaluation is not to

- evaluate them as individuals, but to get feedback on how well the training is doing in improving knowledge for trainees as a group. Future revisions to the training material will be based in part on overall test results.
- Emphasize that the feedback is important to us to help improve training. (*You can really help set the tone if you emphasize that getting this feedback is important and not just busywork or a chore to get through.*)

Step #3. Explain how to generate the ID code:

- Ask trainees to put an ID code on their evaluation form. They have directions in their packets, but again, it is best to go over the procedures on the *California Common Core Curriculum: Standardized ID Code* instruction sheet and answer their questions. As indicated in the instructions to the trainee, if they have completed a demographic form previously, they do not need to do so again—they just need to insert their ID code on the test.
- Explain to them that code numbers are needed because the statistics used to get the average improvement for the group are based on sets of linked pre and post assessments, but that their identities will not be known to anyone except themselves and individual scores will not be reported. (*This is in their letter but it doesn't hurt to go over it and answer questions. If they have any questions you can't answer or lingering concerns, encourage them to contact Leslie Zeitler at CalSWEC. Her contact information is in their introductory letter.*)
- Also explain to the trainees that code numbers are needed because evaluation results will be linked to demographic data to ensure that the training is working equally well for all participants [e.g., that the test is fair and that no bias exists in how different groups of people answer the questions (based not just on race, but gender, experience, education, or region, etc)]. Only aggregate results will be reported and only the trainees themselves will know their code. The purpose of the assessment and confidentiality are also explained in a cover letter for the trainees.
- Discuss that ID codes will be generated by the participants from the first three letters of their mother's maiden name, the first three letters of their mother's first name, and the two numerals for the day of their birth.

Step #4. Trainees complete the knowledge evaluations/tests:

- Explain that there are approximately 25-30 multiple-choice questions on the test, and that trainees have approximately 30 minutes to complete the evaluation/test.
- Tell trainees to please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. (Please avoid the use of felt-tip pens for the answer sheets, as they bleed through to the other side of the answer sheets and can negatively affect the scanning/data capture process.)
- Tell trainees that they should completely fill in the bubble indicating “pre test.”
- Tell trainees that they should completely fill in the bubble next to the letter of the choice (A, B, C, or D) on the answer sheet that best answers each test question.
- Ask trainees to work carefully and thoughtfully—trainees should try to answer each question and give only one answer—whichever they think is the best choice.

- If trainees make a mistake or want to change their answer, instruct them to cross out the mistake with a clear, well-defined “X” and then completely fill in the bubble of the answer they would like credit for.
- Tell trainees not to worry if they don’t know all the answers on the pre-test. They’re not supposed to know all the answers. Tell the trainees to just make their best guess.
- Upon finishing the test, trainees should review it once more to see if they may have accidentally missed any questions.

Step #5. Collect the test forms when the group has finished:

- Remind trainees to put their 8-digit ID codes at the top of each page of their respective test answer sheets.
- **As you collect them, please check for missing, or incorrectly generated ID codes, and encourage people to fill them in or correct them.** Any missing codes mean we can’t use the data.
- Test administrators should place all completed pre-tests in an envelope labeled “PRE-TEST”. After gathering completed pre- and post-tests, test administrators should make 1 copy of the completed tests for their RTA/IUC/County (in the event that the tests get lost in the mail). Test administrators should send the original copies of the completed tests to Leslie Zeitler at CalSWEC.
- **Reminders: Trainers, please:**
 - ⇒ **Do NOT provide specific questions or answers from the test.** At this time there is only a single form of the test that is used both pre and post training.
 - ⇒ **Refrain from distributing copies of the answer key to any trainees.**
 - ⇒ **Prevent trainees from taking copies of the tests with them.**

Note: Trainers *can* debrief general areas of content with trainees, as long as specific test questions or answers are not reviewed.

End of Activity

TRAINING ACTIVITY: TRAINER INSTRUCTIONS FOR KNOWLEDGE POST-TESTS

Approximate time: 30 minutes (or 45 minutes for post-test only curriculum)

Materials:

- Pens for trainees to fill out test forms (*Please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. Please avoid the use of felt-tip pens for the answer sheets.*)
- Evaluation Packet #2: Post-test and Answer Sheets only (*Trainer: Obtain from RTA/IUC or county point-person. Also, please make sure the answer sheets are printed on white paper only; otherwise the scanner has difficulty capturing the test answers.*)
- Three 9x12 Envelopes: (from pre-test instructions)
 - 1 for trainer to collect ALL pre-tests
 - 1 for trainer to collect ALL post-tests
 - 1 for trainer to collect ALL blank tests (pre and post)

Training Activity:

Step #1. Distribute evaluation packet #2 to all trainees as the last activity before the end of the class. Note: Evaluation packet #2 consists of only the post-test.

Step #2. Introduce the knowledge evaluation:

- Explain for trainees that this is the follow-up to the pre-test. Remind the trainees that the purpose of the evaluation is not to evaluate them as individuals, but to get feedback on how well the training is doing in improving knowledge for participants as a group. Future revisions to the training material will be based in part on overall test results.
- Emphasize that the feedback is important to us to help improve training. (*You can really help set the tone if you emphasize that getting this feedback is important and not just busywork or a chore to get through.*)

Step #3. Ask trainees to put their ID code on the post-test.

- Remind trainees that code numbers are needed because evaluation results will be linked to demographics they provide to ensure that the training is working equally well for all participants [e.g., that the test is fair and that no bias exists in how different groups of people answer the questions (based not just on race, but gender, experience, education, or region, etc)]. Only aggregate results will be reported and only the participants themselves will know their code. The purpose of the assessment and confidentiality are also explained in a cover letter for the trainees.

- Discuss that ID codes will be generated by the participants from the first three letters of their mother’s maiden name, the first three letters of their mother’s first name, and the two numerals for the day of their birth.

Step #4. Trainees complete the knowledge evaluations/tests:

- Explain that there are approximately 25-30 multiple-choice questions on the test, and that trainees have approximately 30 minutes to complete the evaluation/test.
- Tell trainees to please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. (Please avoid the use of felt-tip pens for the answer sheets, as they bleed through to the other side of the answer sheets and can negatively affect the scanning/data capture process.)
- Tell trainees that they should completely fill in the bubble indicating “post test.”
- Tell trainees that they should completely fill in the bubble next to the letter of the choice (A, B, C, or D) on the answer sheet that best answers each test question.
- Ask trainees to work carefully and thoughtfully - trainees should try to answer each question and give only one answer - whichever they think is the best choice.
- If trainees make a mistake or want to change their answer, instruct them to cross out the mistake with a clear, well-defined “X” and then completely fill in the bubble of the answer they would like credit for.
- Upon finishing the test, trainees should review it once more to see if they may have accidentally missed any questions.

Step #5. Collect the test forms when the group has finished:

- Remind trainees to put their 8-digit ID codes at the top of each assessment form.
- **As you collect them, please check for missing, or incorrectly generated ID codes, and encourage people to fill them in or correct them.** Any missing codes mean we can’t use the data.
- Test administrators and trainers should place all completed post-tests in an envelope labeled “POST-TEST”. After gathering completed pre- and post-tests, test administrators should make 1 copy of the completed tests for their RTA/IUC/County (in the event that the tests get lost in the mail). Test administrators should send the original copies of the completed tests to Leslie Zeitler at CalSWEC.
- **Reminders - Trainers, please:**
 - ⇒ **Do NOT provide specific questions or answers from the test.** At this time there is only a single form of the test that is used both pre and post training.
 - ⇒ **Refrain from distributing copies of the answer key to any trainees.**
 - ⇒ **Prevent trainees from taking copies of the tests with them.**

Note: Trainers *can* debrief general areas of content with trainees, as long as specific test questions or answers are not reviewed

End of Activity

EVALUATION PROTOCOLS APPENDIX: TRAINEE EVALUATION PACKETS

Following is a list of the documents that form Trainee Evaluation Packet #1. This packet is used to administer the pre-tests for curriculum that has both a pre-test and a post-test.

Please note:

- For the curriculum with a post-test only, Trainee Packet #1 is used at the end of the training, for the post-test. Hence, there is no Trainee Packet #2 for one-day curricula.
- The packet does not include the demographic survey, because it is in a special PDF format for data capture purposes and the format could not be integrated into this Word document. Please ask your RTA/IUC or county point-person for the copy of this document.
- The packet does not include the actual tests, which will only be provided on the day of the training by the test administrator.
- The instructions also refer to Trainee Packet #2. This packet is not included here, since it consists only of the post-test.

TRAINEE EVALUATION PACKET #1

Includes:

- Letter to participant explaining the evaluation
- Informed Consent page
- ID Code Assignment Instructions
- Demographic Survey
- Knowledge Pre-Test (or Post-Test, as applicable)

Child and Youth Development in a Child Welfare Context

TRAINER'S GUIDE

Training Tips, Activities, & Transfer of Learning (TOL) Exercises

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General Training Tips

- The *Trainee Content* contains the information to be used by the trainer to present the topics. Please read the *Trainee Content* carefully.
- Trainers must be thoroughly familiar with the Evaluation Protocols in the Evaluation tab in order to conduct the pre- and post-tests properly.
- The following icons indicate content related to the primary themes of child welfare practice in California:



Safety, Permanence, and Well-being



Engagement



Teaming



Fairness and Equity



Strength-based Practice



Evidence-based Practice



Outcomes-informed Practice

- Information related to these themes should be emphasized.
- Bold italic text indicates expected trainee responses. Encourage trainees to provide the expected content.
- The curriculum contains content related to the two types of formal assessment in use in California: Structured Decision Making (SDM) and Comprehensive Assessment (CAT). Content specific to a particular assessment system is designated using the icons below.

SDM

Indicates content to be covered only in those counties using the Structured Decision Making assessment tools.

CAT

Indicates content to be covered only in those counties using the Comprehensive Assessment Tools.

If you are training a group of SDM users, refer only to the SDM list. If you are training a group of CAT users, refer only to the CAT list. If your group includes both SDM and CAT users, highlight several items from each list.

- Content related to specific legal and policy requirements for case planning is designated with the icon below. Emphasize this content.



Rules and Regulations

SEGMENT 1

Welcome and Introductions

Total Segment Time: 15 min

TRAINING ACTIVITY 1A

ACTIVITY: Welcome and Introductions

Activity Time: 15 min

Materials:

- Trainer's & Trainee's Content: Agenda
- PowerPoint Slides: 1-5

Training Tips and Discussion Points:

■ **Step #1.** Introduce yourself and establish your background and experience as related to child and youth development (three minutes maximum).

■ **Step #2.** Review the goals presented in PowerPoint slide 2:

- 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

■ **Step #3.** Display PowerPoint slide 3. Explain that following the pre-test activity, Day 1 will focus on the foundations of child development including nature and nurture, the role of culture, brain development, attachment, and the SPECS domains: social, physical, emotional, cognitive, and sexual. Later in the day, we will focus on infant and toddler development and tomorrow we will explore child development in the preschool, elementary, and adolescent stages.

Explain how the very large topic of child development will be approached during this training. Explain that we will cover each age range sequentially. Display the corresponding PowerPoint slides: Age Range (4) and Topics of Each Age Range (5). Over the next two days, we will cover the following age ranges:

- 0–2, Infants and toddlers
- 3–5, Preschool children
- 6–12, School-age children
- 13+, Adolescents

For each age range, we will address topics applicable to that age, including:

- Normal development
- Brain development
- Attachment
- Grief and loss
- Effects of maltreatment
- Red flags
- Implications for practice

Not every topic is specifically relevant to each domain, e.g., brain development is critical for the 0–2 age range and the adolescent age range, so it will be addressed primarily within these developmental stages.

■ **Step #4.** Ponder the following questions with the trainees: “So why offer child development training? Of all the subjects that are taught, why spend more time on this topic when you may have already had education, training and experience in child development?”

Comment as follows, or with other similar examples:

- Can trainees observe a 4-year-old and know what the development tasks are for his/her age?
- Do trainees know how developed 4-year-olds should be cognitively, emotionally, socially, physically, and sexually?
- Trainer may have other specific professional experience to mention here.

Explain that knowing the answers to these questions for each developmental stage is critical to child welfare practice. In fact, there is a big push to teach child development.

Why?



- So that we know what is normal and abnormal at each developmental stage;
- So that we know when a child is behind developmentally and can intervene to assist the child as early as possible;
- So that we understand how child development interacts with safety, permanency, and well-being in order to maintain a focus on these outcomes;
- So that we can help parents and foster parents understand child development and the harmful effects of maltreatment on development;
- So that parents and foster parents can know how to provide for the well-being of children in their care in a manner appropriate to their developmental stages; and

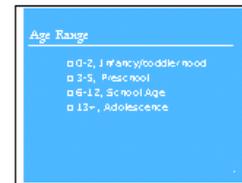
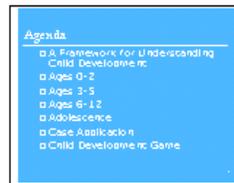
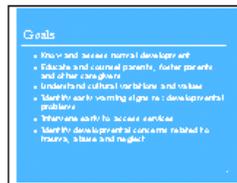


- So that we understand how safety, permanency, and well-being interact with child development.

Note that these reasons reiterate the goals of the training.

End of Activity

PowerPoint Slide, Activity 1A: Slides 1-5



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SEGMENT 2

Evaluation

Total Segment Time: 45 min

TRAINING ACTIVITY 2A

ACTIVITY: Knowledge Pre-Test

Activity Time: 45 min

General Tips:

RTA/IUC or county training evaluation administrators will typically be administering the pre- and post- knowledge tests to trainees for Common Core Curricula. Administration instructions are provided in the Evaluation Protocols Tab for RTA/IUC and county test administrators. In the event that a test administrator is not available, the instructions in the Evaluation Protocols Tab are provided to assist trainers with facilitating the testing process.

Test administrators and trainers should read the content contained with the Evaluation Protocols Tab of the Trainer's Guide prior to proceeding with any type of evaluation. More specifically, test administrators and trainers should be familiar with the sections of content labeled *Coding & Confidentiality* and *Maintaining Security of the Knowledge and Skill Evaluations*.

In addition, when test administrators are not available, trainers should review this activity in its entirety prior to walking through it on the training day, as this evaluation process consists of many steps that may be unfamiliar to many trainers.

Training Activity:

Note to Trainers: As new versions of curricula are edited and released, CalSWEC will remove the following evaluation-related documents from within the curriculum sections of a given Trainer's Guide with respect to knowledge tests and embedded evaluations (and from given Trainee's Guides for curricula with embedded evaluations):

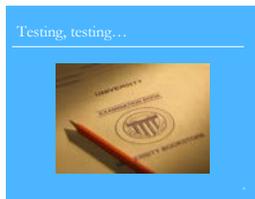
- *Trainer Content/Tips*: remove instructions for facilitating the embedded evaluation process (both for the sample scenario and for the test scenarios) and instructions for facilitating the knowledge test process for applicable curricula and place such instructions solely in the Evaluation Protocols Tab (*and/or on the secure section of the CalSWEC website*).

The rationale for removing evaluation-related content from the respective sections of the Trainer’s Guides is that when changes are made to the instructions for the evaluations, or to the sample/test answer sheets, we can avoid re-numbering the entire curriculum and just re-number the evaluation documents.

Please refer to the Evaluation Protocols Tab in your Trainer’s Guide for a full copy of the instructions for facilitating the knowledge test process.

End of Activity

PowerPoint Slide, Activity 2A: Slide 6



For security purposes, the pre-tests, post-tests, and answer sheets are not posted in the same area as the curriculum on the CalSWEC website.

Pre-tests, post-tests, and answer sheets can be found in the Evaluation Protocols Tab of the Trainer's Binder. If you don't have these documents in your binder, please contact:

1. California-based trainers: Please contact your RTA/IUC training evaluation personnel for copies of the scenarios and answer keys.

2. Outside of California: Please contact Leslie Zeitler lzeitler@berkeley.edu at CalSWEC for copies of the scenarios and answer keys.

Please do not allow trainees to leave the training room with any test materials.

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SEGMENT 3

Review Competencies and Learning Objectives

Total Segment Time: 30 min

TRAINING ACTIVITY 3A

ACTIVITY: Icebreaker

Activity Time: 10 min

Materials:

- Name tents
- Markers
- PowerPoint Slide: 7

Purpose:

This activity is designed to be a warm up activity and a chance to recognize child development experience and expertise among the trainees.

Training Activity:

- **Step #1.** In table groups, ask the trainees to discuss a small success each trainee has recently experienced at work, preferably one that is related to working with, or on behalf of, a child or youth.
- **Step #2.** Ask trainees to make name tags/table tents listing their names and the ages of any children they are caring for at home.
- **Step #3.** Ask trainees to introduce themselves, mentioning any relevant child development experience, the ages of their children, and a brief (1 or 2 sentence) description of their recent success.
- **Step #4.** Acknowledge the hands on experience of trainees. If trainees do not have children, validate that they have had experience with children in one capacity or another.

End of Activity

PowerPoint Slide, Activity 3A: Slide 7

What about you?



What small success have you had in your work recently that you are proud of?

Discuss in your groups.

ACTIVITY: Review of Competencies and Learning Objectives

Activity Time: 5 min

Materials:

- Trainer’s and Trainee’s Guides: Competencies and Learning Objectives
- Flip chart
- Markers
- PowerPoint Slide: 8

Purpose:

This activity is designed to help participants understand why this training is relevant to child welfare practice through a review of the learning objectives.

Training Activity:

■ **Step #1.** Begin by asking the group to refer to the Competencies and Learning Objectives in their Trainee’s Guides. Ask the trainees to read them and check the ones that interest them the most. Ask trainees to call out their top choices and write these on chart paper. Post the chart paper on the wall in the training room and refer back to it as needed to reinforce the learning objectives.

■ **Step #2.** As trainees call out their interests, use their comments to enhance the introduction to the topics that will be covered in the class. Use their interests to review the training content. This should be a quick walk-through of the major objectives for the training.

Enhance the discussion with the following information.



- Through recent scientific and technical advances, we have vastly increased our knowledge of the brain and how it affects all areas of development.
- We continue to develop throughout our lives, progressing through the developmental stages. We grow sequentially from the simple to the complex, and we leave undone developmental tasks behind.
 - Adolescence offers a time to “catch up” developmentally. During adolescence, youth have a chance to move up and down the developmental ladder, a process that can be challenging for parents.
 - Adolescence is unique to Western culture. In some cultures, one may marry at 12 years of age and begin working much earlier. Developmental adolescence may extend beyond the teen years into the early 20s.

End of Activity

PowerPoint Slide, Activity 3B: Slide 8



Day 1, SEGMENT 4

A Framework for Understanding Child Development

Total Segment Time: 90 min

TRAINING ACTIVITY 4A

ACTIVITY: Normal Development

Activity Time: 30 min

Materials:

- Trainee Content: Introduction to Normal Development (page 5 of Trainee's Guide)
- Trainee Content: The Normal SPECS of Child & Youth Development (page 7 of Trainee's Guide)
- Trainee Content: What is Normal? (page 9 of Trainee's Guide)
- Trainee Content: Developmental Theories (page 13 of Trainee's Guide)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- PowerPoint Slides: 9-12

Training Activity:

■ **Step #1.** Refer to the *Trainee Content: Introduction to Normal Development* and display the corresponding PowerPoint slide (9). Discuss the following key points about development:

- It is an ongoing, dynamic process
- It is directional
- It involves stages
- It is cumulative
- It occurs across many areas

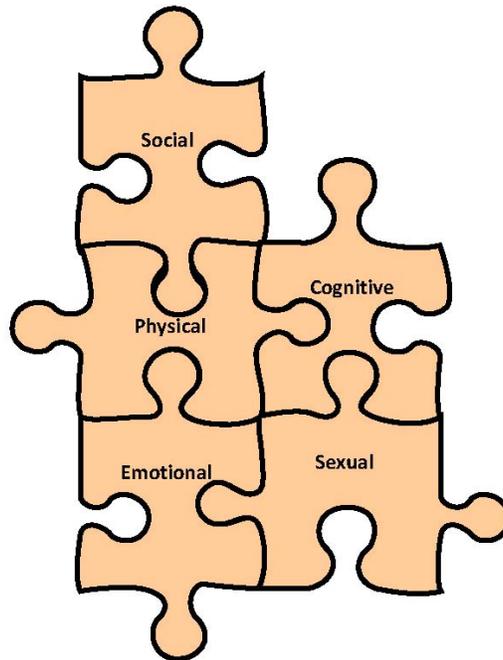
■ **Step #2.** Provide an introduction to developmental domains for understanding child development. Refer trainees to *Trainee Content: The Normal SPECS of Child & Youth Development*. Display the corresponding PowerPoint slide (10). Cover the following information:

To facilitate the study of development, developmental tasks are typically divided into five primary domains. Refer to the acronym SPECS to name the 5 domains:

- Social
- Physical

- Emotional
- Cognitive
- Sexual

Write the acronym vertically on chart paper, then write out each word. (Optional: draw a puzzle with 5 interlocking pieces, labeling each piece with one of the SPECS domains. See example below. This reinforces the concept that while development can differ in each domain, the domains fit together and are interconnected.)



Tell trainees that this training will explore each age range using the SPECS domains.

Social

Ask the group to give you an example of the social domain. Friendships would be an example. Attachment is also in the social domain.



The trainer can ask the group, “*When do we usually assess children in the social domain?*” Answer: School age. When children go to school, their deficits or other difficulties in the social domain are easier to see. But waiting until school age to perform an assessment can be too late or decrease the effectiveness of a needed intervention. Researchers are now learning that the earlier children with autism and attachment disorders are assessed and treated, the higher the level of functioning the children can attain (Lake, 2005; Matson, 2007). Since abuse, neglect, and out-of-home placement can cause attachment deficits in children, it is also important for social workers to refer children for an assessment when an attachment disorder is suspected.

Physical

The physical domain is about physical growth and maturation, and sensory, motor, and nervous system development. Doctors refer to the “percentile” of the child’s growth relative to a child population. Motor activity is divided into gross motor and fine motor skills.

Emotional

The emotional domain is about feelings and self-regulation. It also includes the development of empathy, personal traits, personal identity, and self-esteem.

Cognitive

The cognitive domain is about language development, thinking, and problem solving. Our brains develop in a use dependent way, i.e., “use it or lose it”.

Sexual

Ask the group, at what age do humans develop sexuality? *Answer:* From birth. The infant’s sexual development includes self-exploration through fingers and toes, and later expands to other body parts, including genitalia. Preschool age children often demonstrate a wide range of sexual behaviors that can include masturbation, sexual play with other children (usually of the **same age**), sexual talk, and a wide variety of sexual questions (Friedreich, 1998).

The sexual domain includes the development of gender roles and identity. By 18 months of age, toddlers can self-identify as a boy or a girl.

■ **Step #3.** Emphasize that the developmental domains interact across categories and are not discrete.

As time permits, engage the class as a large group using the following questions which are also included in the trainee content *Questions for Discussion* at the end of the *Trainee Content: The Normal SPECS of Child & Youth Development*.

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 five domains are utilized in understanding these concepts, and how? (**Encourage responses linking the physical domain and the cognitive domain to this concept**).
- How is a child’s concept of “near” and “far” altered from a developmental domain perspective if he or she is blind? (**Note that this cognitive concept can be enhanced through physical exploration rather than visual**).
- How does a child learn and understand the complicated social cues that come from rules and roles in interpersonal relationships? (**Encourage responses**

related to observing rules and roles and practicing rules and roles in play or through interactions with adults).

- 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? **(Encourage responses related to additional time needed as well as more explicit instruction and cueing).**
- How does a child develop physical coordination and mastery of his or her own body and motor skills? **(Encourage responses related to repeated efforts over time as muscle control and muscle strength improve).**
- 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? **(Note that anxiety may limit the child’s willingness to repeatedly fail at tasks in order to build competency).**

■ **Step #4.** Introduce the concept of normal development. Note that normal development can be defined based on statistical or theoretical models, but that historically these models have been biased by their reliance on a white, middle class conceptualization of normal and their use of predominantly white, middle class, male subjects for research.



Refer trainees to the *Trainee Content: What is Normal?* and display the corresponding PowerPoint slide (11) to describe a normal distribution of the behavioral marker for the age at which walking is first observed in a hypothetical population. Emphasize that “normal development” is a statistical concept. Statistics in and of themselves do not necessarily determine what is normal for a specific child; however, statistically determined delays should be considered an indicator of potential developmental problems. Possible causes of developmental delays should be explored through referrals to medical and/or behavioral professionals, and early interventions provided, if needed. Note that more information about referrals and treatment for children with developmental delays will be covered in day 2.

Cover the following points:



- The “normal distribution curve” is used to depict the distribution of many typical traits in a population. The horizontal axis records children’s ages from birth to 2 years. The vertical axis records numbers of children displaying a particular behavior. (The graph is also referred to as a bell-shaped curve.)
- The highest point in a normal distribution curve is the mean, representing the average for the population for that particular trait. In this example, the highest point is age 12 months, as this is the mean age at which children in this culture walk. This statistical analysis provides a baseline for what is typical or expected for the majority of members in a group.

- With basic statistical measures, researchers often determine typical as a designated range below and above the mean age at which a behavior in a population of children was observed.
- Using all of the observations of a particular behavior for a population of children, the developmental milestones of an individual child may be seen to fall within the statistically designated typical range, or perhaps at the extreme ends of the data distribution.
- A statistical measure called a *standard deviation* designates a fixed distance from the mean. One standard deviation on either side of the mean includes approximately 34% of the population.
- Relative to ages at which children walk, one standard deviation is approximately 2 months. Therefore, 68% of children walk between the ages of 10 to 14 months. This is generally referred to as the average, normal, or typical range. Walking before 10 months or after 14 is statistically uncommon.
- Development occurs on a continuum. It is not possible to use statistical data to draw strict delineations about “abnormal” development for any given child.
- Development is a *process*, not an event occurring at a fixed point in time. Thus, the term “typical” is more fitting than the term “normal.”
- The term typical most appropriately *refers to the trait, not the child*, and the rate and progress of a child’s development must be evaluated individually for each developmental domain.
- It would be inappropriate and unprofessional to label a child delayed or atypical simply on the basis of a statistical delay in performance; however, *statistically determined delays should be considered an indicator of potential developmental problems and should serve as a prompt for further assessment.*
- Note that the rate of a child’s development may also vary among traits. For example, a child may develop physical skills earlier and language skills later than average, but still be within typical limits. Earlier development may, at times, be genetically determined; or, it may be promoted in traits or skill areas that are favored and reinforced by the child’s culture and environment. For example, in Uganda, the typical age for walking is 10 months; in the U.S. it is 12 months and in France it is 15 months. This variation is related to culturally determined childcare practices including time spent holding and carrying the

child and time spent stimulating muscles used for walking (Slater and Lewis, 2007).

■ **Step #5.** Display PowerPoint slide 12 and briefly discuss the role of child development theories as they apply to the concept of normal development.

Refer trainees to their Supplemental Handout, and tell them that they can refer to this later if they want more information on the theories that inform our approach to child development. Although we will not review these theories during our limited class time, explain that developmental theories may help social workers in the following ways:

- 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

Explain that most developmental theories are based on the stages of development and acknowledge that trainees have probably studied these theories in the past.

Mention the following different types of stage theories and the most well-known theorists associated with each of the theories.

- Biological
- Cognitive (Piaget)
- Psychoanalytic (Freud)
- Family (Fleck)
- Social/emotional (Erikson)
- Moral (Gilligan, Humphries, Kohlberg)

Note that developmental theorists are increasingly aware of the limitations of Kohlberg and Piaget as their work sought to ignore culture and view development as universal.

Briefly add that some theories are based on concepts rather than stages such as:

- Gardner’s theory of multiple intelligences (Gardner 1983) which includes the concept that a person with strong bodily-kinesthetic intelligence is person who makes use of the body to solve problems and express ideas. Athletes, dancers, and actors all rely heavily on the use of their bodies to express themselves.
- Bronfenbrenner’s Bioecological Systems Theory (1986) which includes the concept that development occurs through exposure to five systems or

ecological contexts including individual interactions and cultural interactions (Harris & Graham, 2007).



- The Integrative Conceptual Model of Child Development (Coll et al, 1996) identifies social class and ethnicity as central to child development (Harris & Graham, 2007).

Transition to the next foundational topic, Nature and Nurture by noting it is important to remember there are multiple influences on development: genetics and environment are the main categories we use to describe hereditary developmental differences and developmental differences that are related to positive or negative experiences.

End of Activity

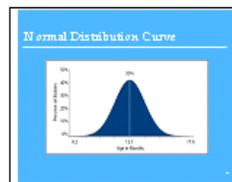
PowerPoint Slide, Activity 4A: Slides 9-12

Understanding Development

- aDynamic and ongoing
- aDirectional
- aMay involve stages
- aCumulative
- aOccurs across many domains

Developmental Domains: SPECS

- aSocial
- aPhysical
- aEmotional
- aCognitive
- aSexual

A cartoon character with a large head, wearing glasses and a starburst around its head, representing a developmental domain.

The sides

- Biological
- Cognitive
- Psychosocial
- Family
- Home large to small

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ACTIVITY: Nature and Nurture

Activity Time: 10 min

Materials:

- Trainee Content: *Nature and Nurture* (page 25 of Trainee’s Guide)
- PowerPoint Slides: 13-15

Training Activity:

■ **Step #1.** Display slide 13 and ask the class for 2-3 quick examples of how (a) heredity and (b) environment play a role in child development. Then continue with the lecture/discussion below.

■ **Step #2.** Discuss the influence of genes on development. Note that in the 1950s and 1960s, it was believed that babies were born as “blank slates” and that the environment was the major force contributing to healthy or unhealthy development.

One infamous research project even posited that mothers’ behaviors caused schizophrenia to develop in their children, a line of thinking that has since been discredited. By 2004, through discoveries made possible by the Human Genome Project¹, scientists were able to identify genes associated with schizophrenia and bipolar disorder.



- “In the past decade, the Human Genome Project has made extraordinary strides in the understanding of fundamental human genetics. The complete human genetic sequence has been determined, and the chromosomal location of almost all human genes identified...” (Kelsoe, 2004).
- Of relevance to child welfare practice, studies are now being conducted on the genetic basis of resilience, isolating genes that may explain why some people rebound more easily than others after experiencing traumatic stressors (*New York Times Magazine*, 2006).

Use this opportunity to stress that due to the rapid pace of scientific advancement in areas that relate to child development, on both the genetic and environmental front,

¹ “A genome is the complete set of genetic material and information in an organism. Genomics has been variously defined as the study of the structure and function of whole genomes...” (Kelsoe, 2004)

it is important as child welfare professionals to keep abreast of current research and its implications for best practice.

■ **Step #3.** Refer briefly to the *Trainee Content: Nature and Nurture* to mention the following manifestations of genetic inheritance, and display the corresponding PowerPoint slide (14).

- Maturation
- Physical Development
- Social and Emotional Development

Segue to the influences of environment.

■ **Step #4.** Discuss the influence of environment on development. Genetic inheritance plays a much larger role than previously thought in child development, but environmental factors also remain highly significant. From the perspective of child welfare social workers, a key environmental influence on child development is the parental interaction with the child. How a parent nurtures a child and whether or not a child is subjected to abuse or neglect have a profound influence on the well-being and development of that child particularly in the early years, even to the point of promoting or inhibiting development.

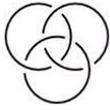
■ **Step #5.** Refer to the *Trainee Content: Nature and Nurture* and corresponding PowerPoint slide (15) to note the many types of environments that shape development:

- Prenatal
- Physical
- Social/cultural
- Learning
- Emotional

The following general examples of prenatal and physical environmental concerns can be mentioned:

- Pregnant women are warned against exposing the fetus to the extremely hot temperatures of a hot tub during the first 37 days of pregnancy, lest the fetal spinal cord not develop properly.
- Obstetricians have also cautioned against pregnant women eating seafood with mercury levels that could adversely affect the fetus.
- Public health warnings are routinely issued to keep vulnerable children inside when air quality is unhealthy.

Ask trainees to provide additional examples of environmental concerns from the other types of environments (social/cultural, learning, emotional).



Emphasize that child welfare workers also need to be aware of the effect of the larger social environment on children's well-being such as:

Familial factors

- educational attainment of the parents
- medical and mental health status of family members

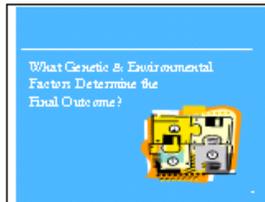
Community factors

- conditions related to poverty and underfunded schools
- rates of incarceration, crime, and prevalence of drugs in the neighborhood
- the presence of poor air quality, and toxic materials, such as lead, asbestos, pesticides, and mercury in the living environment
- differences between child's neighborhood or family culture and the larger mainstream culture

Transition to the next topic, brain development: the playground for the interaction of nature and nurture.

End of Activity

PowerPoint Slide, Activity 4B: Slide 13-15



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ACTIVITY: Brain Development

Activity Time: 30 min

Materials:

- Trainee Content: *Principles of Neurodevelopment* (page 27 of Trainee's Guide)
- Trainee Content: *The Architecture and Functions of the Brain* (page 29 of Trainee's Guide)
- PowerPoint Slides: 16-20

Training Activity:

- **Step #1.** Establish the context for this topic using the following points (slide 16):
 - The most complex of all the organs in the human body is the human brain (Perry, 2002).
 - The mature brain has 100 billion neurons connected by trillions of synapses, the product of billions upon billions of complex chemical transactions in the process of neurodevelopment (Perry, 2002).
 - The brain's prime mandate is survival of the species. Consequently, the brain has crucial neural systems dedicated to:
 1. the stress response and responding to threats—from internal and external sources;
 2. the process of mate selection and reproduction; and
 3. protecting and nurturing dependents, primarily the young (Perry, 2002).
 - The creation of social relationships has been our primary survival strategy and the key to our success on the planet. That is why powerful and complex neural systems are dedicated to social affiliation and communication (Perry, 2002).
- **Step #2.** Provide the following information to further explain the influence of environment on brain development during the critical early childhood years (slide 17):



- When babies are born they have 100 million neurons (Shonkoff & Phillips, 2000, in Virginia Child Protection Newsletter, 2006).
- Brain development before age one is more rapid and extensive than previously realized (Carnegie Foundation). Neurons are influenced by the environment; they are modified by experience. Refer to the noticeable growth of synapses between age 1 and age 6 on the slide (17).
- Brain development is much more vulnerable to environmental influence than was ever suspected (Carnegie Foundation). The environment that the developing brain is exposed to will affect the development and function of the neural circuitry that is responsible for many cognitive and behavioral

- functions. These functions include memory, learning, emotional regulation, and planning responses (Virginia Child Protection Newsletter, 2006).
- The influence of early environment on the brain is long lasting (Carnegie Foundation). The time in life when the brain is most sensitive to experience—and therefore most easy to influence in positive and negative ways is in infancy and childhood. It is during these times in life when social, emotional, cognitive and physical experiences will shape neural systems in ways that influence functioning for a lifetime. This is a time of great opportunity—and great vulnerability—for expressing the genetic potential in a child (Perry, 2002).
 - Development is use-dependent. Particularly in infancy, healthy development requires repeated exposure to positive experiences that stimulate the brain.

■ **Step #3.** Refer to slide 17 to illustrate the “use it or lose it” process.

Note that many cell connections are not formed at birth, but proliferate after birth to their highest density at 6 years of age. Nerve cells constantly interact with the environment. If they are used, they remain. If not, they are “pruned” or cut back and the connection is lost.

Ask trainees why this information matters to practice. Elicit the point that it underscores the importance for early and intensive intervention.

■ **Step #4.** Refer trainees to the four principles of neurodevelopment in the *Trainee Content: Principles of Neurodevelopment* and slide 18 “Principles of Brain Development.” Review the principles of neurodevelopment:

- Neurodevelopment proceeds from genetic and environmental influences.
- Neurodevelopment is sequential.
- Neurodevelopment is activity-dependent.
- Neurodevelopment involves windows of opportunity and windows of vulnerability.

■ **Step #5.** Discuss how the brain works by providing a basic understanding of brain structure and how the various structures operate. Show slide 19 “Brain Functions” and note the three basic brain functions that correlate with the three main brain structures.

The brain is responsible for:

- Regulation and control of body functions via the brain stem, the most primitive part of our brain.
- Reception and interpretation of sensory data via the limbic system, cortex, and neocortex.
- Conscious thought, memory, and emotions via the cortex and neocortex.

■ **Step #6.** Refer trainees to the Trainee Content: The Architecture and Functions of the Brain for additional details about the brain anatomy. Identify the structures listed below and discuss them in conjunction with the impact of trauma on brain development (slide 20).

Brain Stem

The brain stem is subject to damage from shaken baby syndrome, resulting in death if the damage is severe enough.

Reticular Formation

The reticular formation, responsible for arousal and basic attention, contains fibers that run throughout the brain stem. This area may have implications for involvement in attention deficit disorder. Even subtle damage to this area may result in attention problems. Problems with basic attention will then result in learning and memory difficulties.

Cerebral Cortex

This is where planning, reasoning and cognition take place. It houses the capacity for symbolic language and conscious awareness (Stien & Kendall, 2004).

Limbic System

The amygdala and hippocampus in the limbic system provide a primitive memory system which gives us conditioned learning and allows us to learn by association. They permit us to link sensations—whether pleasurable or painful—to context (Stien & Kendall, 2004). For this reason, this system plays a central role in memories of maltreatment.

■ **Step #7.** Tie the above information together by exploring how all the structures in the brain interact and how that interaction shapes brain development.

When the brain receives stimuli from experience with the environment, the brainstem sends signals conveying physiological information from the body to various areas of the limbic system where they are processed and integrated. These areas then feed emotional and somatic input to the cerebral cortex, which also processes information from sensory, conceptual, and linguistic centers (Siegel, 1999, in Applegate & Shapiro, 2005).

While processing information from the environment, the brain is simultaneously being shaped by that information. Processed input “used” by the brain creates or strengthens synaptic interconnections, according to the “use it or lose it” principle. *“Experience can shape not only what information enters the mind, but the way in which the mind develops the ability to process that information”* (Siegel, 1999, in Applegate & Shapiro, 2005 [italics in original]).

Ask trainees what implications this information has for parenting practices in light of the child-rearing environments of many children in the child welfare system. Ask trainees to consider how they would convey this information to parents and other caregivers. Be sure to include:

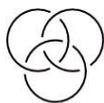
- the “use it or lose it” principle regarding the development of synaptic interconnections could be conveyed in terms of providing experiences such as speaking to infants and providing visual stimulation to infants to help them build brain power
- the idea that rapid brain development during infancy provides great opportunity and vulnerability to lay the foundation for future brain development could be conveyed in terms of protecting the infant from stressful stimuli such as domestic violence, neglect and abuse so that brain development can occur in a calm atmosphere without distractions of stress from the limbic system

■ **Step #8.** Note the following about brain structures and functions:

- Although the neocortex made intellectual achievement possible, it did not render the limbic system and brain stem obsolete. These lower regions of the brain continue to have a profound impact on our functioning, because the brain’s central pursuit is survival. The urges and emotions generated in the limbic system are relayed through nerve pathways to the cortex where they can be consciously registered. Then, the cortex must figure out what to do to satisfy these urges (Stien & Kendall, 2004). This has implications for working with maltreated children, who may experience maltreatment as life-threatening at the level of the limbic system. This experience may overpower and diminish their cortical functioning

■ **Step #9.** Conclude this topic with the following points:

- The human brain continues to grow through all of life’s stages; however, the early years are a critical period of rapid brain growth with ramifications throughout the lifetime. Adolescence is another critical period for brain development and this will be covered during the section on adolescent development.
- The child welfare worker can assist families by making timely referrals and educating parents about the basic principles of neurodevelopment.
- Social workers can assist parents to actively promote their babies’ well-being by explaining how and why their babies’ brains should be stimulated to promote optimal brain development.
- Emphasize that it is important that health professionals identify any deficits and provide treatment as early as possible.



■ **Step #10.** Note that we have established a framework for our look at child development:

- The brain develops within the constraints of its genetic potential.
- The environment can either stimulate brain development to reach the brain's maximum capacity or hinder brain development by inhibiting growth.

Transition to the next topic by inviting participants to move on to the third party in this transaction: culture. We will consider the role of culture and how culture guides infant and child development through its effect on the child's environment (and brain).

End of Activity

PowerPoint Slide, Activity 4C: Slides 16-20

The Brain

- Most complex organ in the human body
- 100 billion neurons
- Filled w/ synapses
- First matured structurally
- Creation of neural connections is the primary developmental activity

Synaptic Density*

- Born with 100 trillion synapses
- Brain develops more rapidly and extensively during the first year than previously thought
- Synaptic pruning: refinement of experience
- Synaptic Pruning: "Use it or lose it"



Principles of Brain Development

- Genes provide the initial developmental blueprint of growth
- Structure develops in a sequential order
- Healthy growth needs specific hormonal support of activity
- Trauma can disrupt or slow | periods of childhood disrupt the brain

Brain Functions

- Brain: (left) regulation & control of body
- (right) motor, control & reception & interpretation of sensory data
- Cerebellum: coordination, thought, memory, & attention



Brain Function and Trauma

- Brain Stem
- Reticular Formation
- Cerebral Cortex
- Limbic System



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ACTIVITY: The Role of Culture

Activity Time: 20 min

Materials:

- Trainee Content: *The Role of Culture in Development* (page 35 of Trainee's Guide)
- DVD: *Childhood: Louder Than Words* (approximately 8 minutes)
- PowerPoint Slides: 21-22

Pre-training Preparation:

Instructions for Cueing the DVD:

Play the DVD, *Childhood: Louder Than Words*. There are no title menus or chapters on the DVD. Fast forward 24:50 into the DVD (about a third of the way through the video) and play for approximately 7 minutes (until 32:10). Start playback just after the research experiment in which a mobile string is tied to a baby's foot. Stop at the end of the culture section, just before the introduction of the Russian father and his newborn son.

Training Activity:

■ **Step #1.** Display slide 21 and transition to the role of culture, another powerful force that shapes a child's development. Use the following points to set the context for the dynamics of culture:



- Culture shapes children by influencing brain development "... to the extent that culture modifies caregiving, (e.g. mothering) and the coregulation of caregiver and infant behavior, then to that extent does culture affect the developing brain" (Tronick, 2007). For example, there are cultural variations in the amount of touching between caregiver and infant. This affects brain development in that growth hormone production varies based on caregiver touch (Tronick, 2007).
- Culture helps to define those features of the child's behavior and communication that require attention and response and then culture also defines that response.
- Culture and child development have a reciprocal relationship, mutually influencing each other around issues of values, aspirations, expectations, and practices.

■ **Step #2.** Refer to the *Trainee Content: The Role of Culture in Development* and emphasize coverage of the following points that relate to practice applications:



- Definition of culture (system of shared values, beliefs, attitudes, traditions, and standards of behavior)

- Why understanding the influence of culture is essential for child welfare practice
- How to talk to caregivers to learn more about their cultures
- How cultural considerations affect child welfare assessments and interventions

Ask participants how beliefs and practices related to individualism and interdependence might vary across cultures. European and European-American societies tend to value individualism, while Asian, African, and Latin American societies tend to favor interdependence (Shonkoff & Phillips, 2000). Elicit that these values will influence the socialization of children along a continuum anchored by each of these concepts. Ask participants how these concepts might manifest in child development (e.g., sleeping patterns, interaction with child).

■ **Step #3.** Display slide 22 and show the video clip from *Childhood: Louder than Words*. Use the discussion examples below to process the video by asking the trainees how culture affects child development.

1. As shown in the video, children may walk later depending on cultural practices. Tell trainees that American babies walk earlier now than they did in the past. Ask trainees if they know why.

The answer is that American families do not use play pens as frequently as they did in the 1950s and 1960s, so babies now have the motor skills and motivation to walk earlier.

2. Another example is that infants in our country now lift their heads later. Ask the group why they think this is.

The answer is that parents are now advised to put infants to sleep on their backs due to concerns about SIDS; hence the infants don't experience the same motivation to lift their heads.

3. Ask the group for other examples of cultural differences in parenting. When and how parents toilet train, wean, or take away the bottle are good examples. It is also helpful to talk about how quickly some parenting norms can change. For example, whether to breast feed, for how long, and where have changed in the last several years. Another shift has occurred regarding the choice as to whether to put one's baby to bed alone or keep the baby in the parents' bed.
4. Stress that cultural values change through time.

■ **Step #4.** Conduct a brief discussion on distinguishing cultural variations from child maltreatment. Cover the information below.



Child welfare workers need to be able to distinguish parenting practices that are merely different from those of the dominant culture versus those that constitute a threat to child safety.



It is important to understand the family's cultural norms for parenting in order to assess for maltreatment and to determine what, if any, interventions are needed.

Facilitate a discussion of cultural norms, including practices that might at first glance seem to be maltreatment, but are not. (Coining tends to be one that trainees mention frequently.) Ask the group, *“Are there things that we do to our children that other cultures might think are strange? What about braces?”*



Stress that when trainees do an assessment of safety, risk, and protective capacity, they need to keep culture in mind and not make assumptions or conclusions before conducting a thorough assessment.

Explore with trainees examples of cultural practices that can be harmful. As a child protection worker, one has to draw the line at concerns for safety. One might say to the parent, *“I want to express my respect for our differences in culture and I hope to learn more about your culture, but I have to intervene if I assess a danger to your child and your actions in this situation are considered unacceptably dangerous.”*



With some cultural norms, like bruising from coining, practices may be acceptable according to the standards of the child welfare system. In some cultures, parents will touch their baby's penis in affection and are proud to show their infant's penis to family members as a way of expressing joy in having a son. In other cultures, this might be seen as an example of inappropriate parenting. Nonetheless, some cultural practices such as female circumcision are unacceptable to the child welfare system.

■ **Step #5.** Note to trainees that the foundational piece of the training is now complete and the group will move forward after lunch to address development during infancy. The content related to infant development will refer back to brain development as infants experience phenomenal brain growth.

End of Activity

PowerPoint Slide, Activity 4D: Slides 21-22



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Day 1, SEGMENT 5

Age Range 0-2 Infants and Toddlers

Total Segment Time: 155 min

TRAINING ACTIVITY 5A

ACTIVITY: Normal Development Age Range 0-2

Activity Time: 15 min

Materials:

- Trainee Content: *Newborns: The APGAR Test* (page 39 of Trainee’s Guide)
- Trainee Content: *The Normal SPECS of Development for Infants & Toddlers* (page 41 of Trainee’s Guide)
- Supplemental Handout: *The SPECS of Normal Development*
- Supplemental Handout: *Milestones* (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC—see Materials Checklist)
- PowerPoint Slides: 23-26

Training Activity:

■ **Step #1.** Display slides 23 and 24. Review the normal SPECS for each age range 0–2. Refer trainees to the *Milestones* booklet, particularly in the context of developmental concerns. Also encourage the trainees to use the booklet as a handy reference. The CDC information cards about developmental milestones can be distributed now for use in this segment.

■ **Step #2.** Introduce the first section on the developmental domain of infants and toddlers, normal development. Note that trainee content *The Normal SPECS of Child & Youth Development: Infants & Toddlers* divides the first year of life into 4 phases: infancy overview; birth up to 3 months; from 3 to 6 months; 7 months to 1 year. Briefly review the information below.

Newborns

The APGAR test in the *Trainee Content* is briefly covered here as a baseline for indicators of the baby’s overall condition at birth. It is likely that once trainees are

assigned cases, they will read about children’s APGARs in medical reports in the case files.

Infants (birth to 1 year)

Stress the following learning points when reviewing the infant SPECS:

- Focus on the concept, “*They are what they are given.*” Infancy is a time of rapid development that sets the foundation for later growth.
- Stress brain development, bonding and attachment. These are the key subjects for infant development.
- Note that physical development begins with involuntary reflexes and progresses to more controlled movements. This is the beginning of gross, and later, fine, motor development. Most children will begin to walk by the age of 1 year.
- As social workers in child welfare, trainees also need to understand *object permanence* and *stranger anxiety*. Use the examples in the *Trainee Content* or personal stories that illustrate these concepts. Explain simple ways to test for these phenomena (e.g., placing a child’s favorite toy under a towel and then revealing it; noticing that a child is shy toward a social worker upon their first meeting). Ask trainees to consider that culture may intersect with stranger anxiety and object permanence.
- Note the relationship between a baby’s temperament and the responses of its parents. A baby with a difficult, slow-to-warm, or mixed temperament may be more likely to elicit negative parenting responses. The study cited in the *Trainee Content* has practical application for child welfare workers assisting parents who have children with such temperaments.
- The sexuality domain can be challenging for some trainees to address. Refer to the sexual development in the *Trainee Content* for this segment, noting the infant’s self exploration includes exploration of the genitalia which can be pleasurable for the child.

■ **Step #3.** Display PowerPoint slides 25 and 26 and stress the following learning points when reviewing the toddler SPECS:

- Parenting toddlers is hard work. They are constantly exploring the world around them and do not like anyone to limit this exploration. Toddlers react to stress in their environment and may be most stubborn at times when parents most need them to be cooperative.



- Note that toilet training can be a particularly challenging phase of development. Child welfare workers need to know that toilet training can be a factor in physical abuse. Issues such as when children should be trained, how they are trained, and the pressure to train, are culturally driven and can provoke anxiety in parents. Note that there are often cultural variations in toilet training.

- For toddlers, imitation is the primary means of play and learning. Toddlers begin to learn first from their parents, and later expand their learning arena to include their peers. Play with their peers takes the form of parallel play, where toddlers play side by side, but do not yet interact with each other.
- On a cognitive level, toddlers are developing symbolic thought which sets the foundation for the development of receptive and expressive language.
- Lack of knowledge about child development can lead to parenting challenges and even child maltreatment. This can be especially true for the toddler years. Parents can misinterpret behaviors related to autonomy as being purposely bad. When the toddler tries to separate from his or her caregivers and see how s/he can influence the world, parents may construe this as misbehavior. Understanding that such exploration is part of healthy development can help parents survive toddlers who insist on having their own way.
- Toddlers are very social creatures. It is important for child welfare workers to know that apathy in children under age 5 may signify an underlying problem. If toddlers are not curious about their environments and the people around them, consider seeking further developmental evaluation through a public health nurse, pediatrician or Regional Center. Note that we will discuss Regional Centers in more detail on Day 2.

Stress that when child welfare social workers see development that they think is atypical, they must consider all the influences on a child’s behavior, including cultural differences, possible developmental problems, or the effects of abuse and neglect.

Transition to the next section on the discussion of brain development in infants and toddlers.

End of Activity

PowerPoint Slide, Activity 5A: Slides 23-26



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ACTIVITY: Brain Development Age Range 0-2

Activity Time: 20 min

Materials:

- PowerPoint Slides 27-29

Training Activity:

■ **Step #1.** Discuss key aspects of brain development for infants and toddlers. Start with a discussion on the critical windows for infants and toddlers. Show the corresponding PowerPoint slide (27).

As you provide information about each critical window, ask trainees how they could convey this information to parents and caregivers and what they could advise parents and caregivers to do to help the child develop.

Critical Windows

Vision (Critical Window—Birth to 6 months)

At birth, the brain is not yet completely wired for sight. Therefore, visual stimuli during the first 6 months facilitate the permanent neural connections (synapses) that form during this time.

- *How can this be conveyed to caregivers:* Explain that what the baby sees between birth and 6 months will impact how he or she sees for the rest of his life, influencing the ability to distinguish details and the ability to quickly scan and understand visual information.
- *What parents/caregivers can do to help:* Guide the developing connections in the brain by holding the infant so s/he can look around. Provide infants the opportunity to use their eyes; give them something interesting to look at when they are in the crib or on the floor.

Vocabulary/Speech (Critical Window—Birth to 3 years)

An adult’s vocabulary is largely determined by the speech that is heard within the first three years of life. The brain pays attention to sounds, not the words, and builds the neural connections that allow us to retrieve the sounds as our vocabulary grows. If hearing is disrupted during the first 2 years by something like chronic ear infections, speech will not develop normally. Note: children who live in bilingual homes may

develop speech later than children in monolingual homes, but this does not indicate a speech problem.

- *How can this be conveyed to caregivers:* Explain exposing the baby to words and ways of using words, including tone of voice, teaches the baby to talk and affects speech throughout the rest of the child's life.
- *What a parent/caregiver can do to help:* Speak to the child in full sentences; talk and read to the child often. Explain to the child what is happening, like washing clothes or making dinner. Talk with the child about what is being seen while driving or walking down the street. General conversation in a calm tone of voice is important even though the child can't yet respond.

Emotional Development (Critical Window—Birth to 18 months)

Although numerous studies link emotional disorders to genetics, a child's environment also plays a role in how personality traits develop. A nurturing environment can strengthen emotional stability. Repeated exposure to stress can create pathways that trigger fear, hyperactivity, and anxiety.

- *How can this be conveyed to caregivers:* Explain that a stressful environment with a lot of noise or physical discomfort causes the baby's brain to focus on survival rather than on developing in other ways.
- *What a parent/caregiver can do to help:*
 - Respond quickly and warmly.
 - Pick up the baby when s/he cries.
 - Avoid responding with frustration and hostility.
 - Use the same caregiver as much as possible.

■ **Step #2.** Discuss the effects of maltreatment (neglect) on infant brain development. As covered earlier, the brain develops through use. It follows that the environment plays a key role.



The process of brain development, particularly in the early years, is constantly modified by environmental influences (Glaser, 2000). Limited environmental stimulation due to neglect and chronic stress due to maltreatment adversely affect brain development, which may ultimately hinder the physical, cognitive, language, and psychosocial development of children.

Display PowerPoint slide 28.

Remind the trainees of the previous content about synaptic density. During the first 2 years of life there is a genetically determined overproduction of axons and dendrites and synapses in different regions of the brain. Synaptic connections allow brain signals to flow to appropriate areas. Not all synaptic connections survive. During this period, the determination of which synaptic connections will persist is

regulated by the environment and dependent on the environmental information received by the brain.

Neglect and the limited environmental stimulation that is often associated with neglect may lead to the elimination of certain synaptic connections and the failure to develop other connections which, in turn, may result in permanent deficits in cognitive abilities (Glaser, 2000).



Acute stress: When children respond to stressful events, they experience a physiological coping response that involves the sympathetic nervous, neurotransmitter, and immune systems. The reactions and operations of these systems can alter the development of multiple neurotransmitter systems and promote structural and functional alterations in brain regions (Kaufman & Charney, 2001).

A child who encounters one or more episodes of child maltreatment will experience these psychological responses that over time will have a negative effect on brain development.

These stressful events can be related to neglect:

- Physical discomfort from being left cold, wet, or hungry
- Emotional discomfort from interacting with an adult with a flat affect

Stressful events can also be related to other forms of maltreatment:

- Living in a stressful environment as in homes with domestic violence
- Physical pains from injury (Cummings et al., 1991)

Note that caregivers can ameliorate this stress by protecting infants from abuse and neglect, providing a consistent routine, and responding quickly to an infant who is in physical or emotional discomfort.

■ **Step #3.** Display PowerPoint slide 29 to illustrate the difference in brain development between a child at three years of age who was severely maltreated, and a child who was not. Obviously, the effects of maltreatment would have begun in infancy and toddlerhood. Note that there will be further discussion of this concept in the segment on the effects of maltreatment.

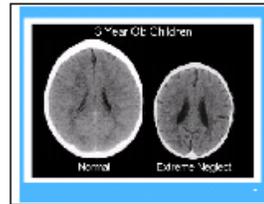
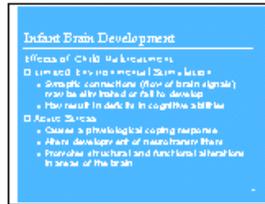
Conclude the discussion on brain development with the following:

Understanding brain development informs our understanding of the effects of child maltreatment on aspects of child development. This discussion has provided a biological context for understanding the effects of child maltreatment on the developing brain.

Transition to the next domain for the age range: attachment. Note the importance of attachment in brain development and the key role child welfare workers can play in protecting an infant's ability to attach.

End of Activity

PowerPoint Slide, Activity 5B: Slides 27-29



Materials:

- Trainee Content: *The Concept of Attachment* (page 59 of Trainee’s Guide)
- Trainee Content: *Rasa (Case Scenario)* (page 65 of Trainee’s Guide)
- DVD: *The First Years Last Forever* (15-minute opening segment)
- Flip chart
- Markers
- PowerPoint Slides: 30-39

Pre-training Preparation:

Instructions for Cueing the DVD

Show the first half of *The First Years Last Forever* (about 15 minutes). Start at the introduction and stop the video at “Health and Nutrition.”

Training Activity:

■ Step #1. Discuss the importance of attachment.

- According to Erikson, the development of autonomy is the next task of psychosocial development after the establishment of basic trust in infancy. The *Trainee Content* provides a detailed list that characterizes behavior of the securely attached and insecurely attached child. As noted in this listing, the status of a child’s attachment, whether secure or insecure, has direct implications for his/her development of autonomy.
- Ask trainees to consider all of the information about attachment in this segment as it applies to their work, and specifically through the lens of children entering foster care during this stage of development.

■ **Step #2.** Display slide 30 and tell trainees that the video is directed to parents to assist them with caring for their newborns, but that the value of the information for their work with infants will quickly become apparent. Emphasize that they can use the concepts presented in the video as a basis for talking with caregivers about successful parenting techniques. The 15-minute video clip covers the following topics:

- Brief introduction to brain development of newborns and infants
- Introduction to attachment and its relationship to brain development
- Discussion of attachment as it relates to communication and the acquisition of language

Show the video.

■ **Step #3.** Discuss the video with the class. Ask trainees to consider the following questions:

- What did they notice about brain development in the first years?
- Discuss the dance of reciprocal connectedness and attunement between caregiver and baby. How does this allow the infant to know that his/her environment is safe, enabling higher levels of the brain to develop?
- Discuss how the video shows that parents who fall in love with their babies have children that fall in love with them.
- What can they teach parents in child welfare based on this video?

■ **Step #4.** Review the following additional learning points and display the corresponding PowerPoint slide (31):

The Importance of Rhythm, Repetition, and Consistency

These elements assist with the fundamental organization of the brain that serves as the foundation for current and later learning. Examples include singing and talking to baby, and providing consistent parenting behaviors.

Reciprocal Communication with Baby

The DVD shows how the baby's behavior serves as a means of communication. When parents understand this, they can have more empathy for their child. Instead of becoming aggravated, for example, they can understand that their child is trying to communicate with them. This allows the parent to become more engaged with his/her child and to meet the child's needs more effectively.

Enjoyment of Parenting

Many of the families served by the child welfare system experience daily challenges to basic survival. These challenges may pose obstacles to having the awareness, time or energy to fall in love with their child. We can help parents learn to enjoy their child and have fun, while employing nurturing parenting methods. Parents who enjoy their children are much less inclined to harm them.

■ **Step #5.** Draw from the *Trainee Content: The Concept of Attachment* to explain the main learning points below. Display PowerPoint slide 32.

Attachment refers to the social and emotional relationships children develop with the significant people in their lives. An infant's first attachment is usually to its mother. In some circumstances, someone other than the infant's mother can become the primary attachment figure. This may be a father, grandparent, or an unrelated adult. Attunement is the act or "dance" of creating attachment through a series of actions and responses between the infant and the attachment figure.

■ **Step #6.** Display the corresponding PowerPoint slide (33) and use the following points to emphasize why attachment is important:

- Attachment:
 1. Promotes the development of trust and a positive world view
 2. Promotes the development of self-esteem
 3. Reduces anxiety and promotes a sense of security
 4. Serves as a foundation for other forms of learning through social interactions, and serves as the basis for forming intimate relationships later in life
 5. Promotes self-reliance

- Social and linguistic interactions between infants and their caregivers foster the development of language and nonverbal communication

■ **Step #7.** Review the following stages of attachment formation from the *Trainee Content* and display the corresponding PowerPoint slide (34).

Pre-attachment (birth to 3 months)

- Infant orients towards the sound of the caregiver's voice; s/he tracks visually.
- Infant smiles reflexively.

Recognition/discrimination (3 to 8 months)

- Infant differentiates between primary caregiver and others.
- Infant's smiles are based on recognition.

Active attachment (8 to 36 months)

- Stranger reaction emerges.
- Infant shows clear preference for the primary caregiver.
- Child demonstrates behavior that is intermittently dependent and then independent

■ **Step #8.** As each stage of attachment is introduced, ask trainees to list things they could do to influence attachment during that stage.

List the responses on flip chart paper.

Add the following responses if trainees do not include them:

Birth to 3 months

- Encourage caregiver to play face making games with baby.
- Play audio tape of mother and father talking to baby.
- Give baby items that smell like mother.

3 to 8 months

- Encourage visiting parent to maintain a routine structure for each visit – song, then a game of peek-a-boo, then story, etc.
- Develop special routines for beginning or ending the visit.
- Hold the baby while talking to him or her in a soft voice, smiling, making eye contact and responding to the nonverbal cues of the baby.

8 to 36 months

- Teach parents about stranger anxiety as a normal part of development, and give them specific feedback if they are overwhelming the child.
- Work with parents to be attuned to child’s personality and activity level, and plan activities to suit child’s needs.
- Develop and follow a separation routine.

■ **Step #9.** Discuss some of the key factors associated with attachment. Display the corresponding PowerPoint slide (35).

Claiming and Disclaiming

Briefly explain the concept of claiming using the subsection for this topic in the *Trainee Content* and ask trainees for one or two implications for practice regarding working with parents who have children with a physical difference.

Attunement

Refer back to the concept of attunement as discussed in the video – the reciprocal communication between infant and caregiver.

Physical Contact

Emphasize physical contact as very important in establishing attachment.

Disruptions in Attachment

Direct trainees’ attention to the table in the trainee content indicating the stages in the cycle of disrupted attachment.

■ **Step #10.** Discuss attachment disruption. Note that although minor disruptions in the child-caregiver relationship are usually harmless and unavoidable, major separations from the caregiver and loss of the caregiver can disrupt the child’s attachment in very destructive ways. A distinct, three-stage cycle (noted in PowerPoint slide 36 “Responses to Disruptions in Attachment”) can be seen in the child’s response to disruptions in attachment. This cycle can be useful for understanding the responses of children to their removals and resulting placements out-of-home.

Attachment problems in children are often the result of mistimed, abnormal, or absent caregiving interactions and may represent a special case of neglect. More

than 85% of children removed from their parents for abuse or neglect have disturbed attachment capacity (Perry, 2002).

■ **Step #11.** Conduct a small group activity to apply the concepts of attachment. Ask trainees to read the subheading in *Trainee Content: The Concept of Attachment*, “Disruptions in Attachment” and the short scenario *Trainee Content: Rasa (Case Scenario)*, and answer discussion questions in their table groups. Process the answers in the larger group.

Display PowerPoint slide 37 which contains the following discussion questions:

- What do you think is happening between Azar and Rasa?
- What do you think needs to happen between Azar and Rasa?
- How would you talk with Azar to help her with parenting?
- How can you address the role of culture in your interactions with Azar & Rasa?

Allow about 5 minutes for small group discussion. Ask trainees to summarize their discussions with the larger group. Look for the following responses:

- Azar’s flat affect may be related to guilt or shame. She may be scared to interact with the baby because she feels she is being judged and she is afraid of doing something wrong. She may not know how to take care of a baby.
- Talk to Azar about child rearing practices specific to her family and her culture.
- Explore the feelings Azar has about the abuse she experienced and how that is affecting her parenting.
- Azar may need specific directions in terms of how best to interact with the baby to forge an attachment. They need more frequent contact.
- Explain the concept of reciprocal connectedness and the baby’s need repetition and consistency. Talk to Azar about developing a visit routine including how to increase the frequency of visitation and how to structure each visit to encourage attachment.

As you summarize the feedback from the group, begin framing the concept of the child’s first relationship with the primary caregiver as a template shaping later emotional connections.

■ **Step #12.** Display PowerPoint slide 38 and delve further into the concept of templates.

According to Schore (1997b, p. 30 [italics in original] in Applegate & Shapiro, 2005), the child’s first relationship with the primary caregiver “acts as a template for the imprinting of circuits in the child’s emotion-processing right brain, thereby permanently shaping the individual’s adaptive or maladaptive capacities to enter into all later emotional relationships.”

Dr. Bruce Perry also uses the “template” concept to corroborate this observation:



As we study the nature of early, emotional connections, we are finding out how important they can be for the future development of the child. Indeed, many researchers and clinicians feel that the maternal–child attachment provides the working “template” for all subsequent relationships that the child will develop. A solid and healthy attachment with a primary caregiver appears to be associated with a high probability of healthy relationships with others. Poor attachment with the mother or primary caregiver appears to be associated with a host of emotional and behavioral problems later in life.” (B. Perry)

Schore also notes:

“Secure attachment & adequate nurturing... builds neural connections... Abuse & neglect induce chaotic biochemical changes...”
(Schore, 2001 cited in Stien & Kendall, 2004, in the Virginia Child Protection Newsletter, 2006)

Dr. Perry adds:



“Experiences in childhood act as the primary architects of the brain's capabilities throughout the rest of life. If these organizing childhood experiences are consistent, nurturing, structured and enriched, the child develops the ability to be flexible, responsible and a sensitive contributor to society as an adult. However, if childhood experiences are neglectful, chaotic, even violent and abusive, the child could become aggressive, remorseless, and intellectually impoverished” (B. Perry).

■ **Step #13.** Show slide 39 and ask the trainees to discuss how being a “foster kid,” a “group home kid,” and changing caregivers or schools reinforce children’s negative templates, often shaping children’s interactions with the world by causing them to be apprehensive and feel undervalued.

Ask the group what they and the child welfare system can do to change these templates. Allow a few minutes to process their ideas.

Use the concept of attachment disruptions to segue into the next section on grief, loss, and separation for the age group, 0–2.

End of Activity

PowerPoint Slide, Activity 5C: Slides 30-39

Video Clip

-The First Year: Last Frames-



the degree of attachment

Video Concept Review

- **Physiology, Neurobiology, & Coherence**
 - Attach as regulator
 - Neuroendocrine and life history
- **Attachment (Coherence) & Goals**
 - Goals as motivation for the
 - Goals need to align as time unfolds
- **Exploring Attachment**
 - Family, relationships, attachment

Infant Emix Development

Attachment & Attachment:

- **Attachment** refers to the social and emotional relationships children develop with the significant people in their lives.
- **Attachment** is being a source of, and response to, another person.

“But it’s the love, the care, the tenderness, that, like the music of a string quartet, demands to be heard” (Bowlby)

Infant Emix Development

Attachment: Play & Role

- **Developmental:**
 - Birth to 36 months
 - 36 months to 6 years
 - 6 years to 12 years
- **Attachment:**
 - 0-36 months
 - 36 months to 6 years
 - 6 years to 12 years

Stages of Attachment Formation

- **Birth to 3 months**
 - Pre-attachment
- **3-6 months**
 - Insecure attachment
- **6-12 months**
 - Attachment formation
- **12 months and beyond**
 - Attachment



Key Factors for Attachment

- Clinging
- Attunement
- Physical Contact

Responses to Disruptions in Attachment

- **Protest**
- **Despair**
- **Detachment**

Application to Practice

- **Read the case scenario “Be gentle” with your table group.**
- **Discuss the following questions:**
 - What is happening between Shreya & Devvika?
 - What needs to happen between Shreya & Devvika?
 - How would you help Shreya with her parenting?

Infant Emix Development

Attachment: Form & Function

- **Form:**
 - Attachment is a relationship
 - Attachment is a process
 - Attachment is a state
- **Function:**
 - Attachment is a goal
 - Attachment is a strategy
 - Attachment is a resource

Implications for Practice

- **How do we, as educators and clinicians, respond to the negative developmental implications of attachment disruption and how do we help?**



HOW DO OUR KIDS GET LEFT BEHIND?

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ACTIVITY: Grief and Loss Age Range 0-2

Activity Time: 20 min

Materials:

- Trainee Content: *Grief, Loss & Separation in Infancy and Toddlerhood* (page 67 of *Trainee's Guide*)
- Flip chart
- Markers
- PowerPoint Slide: 40

Trainer's Tip:

The intent of this topic is to parallel the overwhelming loss of a parent due to death, prolonged illness, or divorce with the profound loss that children experience when they are separated from their parents or caregivers due to out-of-home placement.

Additionally, the material covered here is intended to serve as a foundation for a more comprehensive presentation in the *Placement and Permanency* core curriculum, in which grief and loss are related specifically to the circumstances of out-of-home placement, by ages and stages.

Training Activity:

■ **Step #1.** Display slide 40 and introduce the concept of grief and loss by drawing a comparison between the emotional impact of loss through out-of-home placement and loss by other means. Ask trainees the following discussion questions:

- What relationship do they see between disrupted attachment and grief and loss in young children?
- How does a child's age or stage affect how s/he processes grief and loss?

■ **Step #2.** Discuss how grief and loss are presented and experienced in infancy. Include the indicators and characteristics of infant grief and loss listed below.

Grief and Loss in Infancy

- Infants do not recognize death, but feelings of loss and separation are part of developing an awareness of death.
- Children who have been separated from their primary caregiver (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.

■ **Step #3.** Conduct a brief partner exercise. Ask trainees to review the Normal SPECS for this age range. With their partner they should discuss how separation and the corresponding grief and loss impact children in this age range. They should then discuss how they as child welfare workers can reduce the harm of grief and loss for children age 0-2. Allow a few minutes for this discussion.

■ **Step #4.** Process the activity. Ask trainees for their responses and generate discussion. During the large group discussion, generate the following information (suggested actions social workers can take are italicized below):

- Infants' cognitive/language limitations greatly increase their experience of stress. Without a well-developed cognitive perception of an event, any change is threatening. Infants will be extremely distressed simply by changes in the environment and the absence of familiar caretakers. ***The use of relative caregivers, shared family care, or having an offending parent leave the home so that child is not displaced can reduce this stress.***
- Infants have few internal coping skills. Adults must "cope" for them by removing stressors from their lives and meeting all of their needs. When deprived of adults whom they have learned to trust and depend upon, infants are more vulnerable to the effects of internal and external stresses. ***To counteract this vulnerability, the social worker can educate the substitute caregiver about the need to provide immediate relief to infants' experiences of internal and external stress.***
- An infant experiences the absence of caretakers as immediate, total, and complete. Infants do not generally turn to others for help and support in the absence of their primary caretaker. An infant who has lost his or her primary caretaker often cannot be comforted by others. ***The social worker can gather specific information from the child's primary caregiver about the routines and soothing techniques, so the substitute caregiver can follow a similar protocol.***
- If separation occurs in the first year, it can interfere with the development of trust. ***The social worker can educate the parents and foster parents about this***

damage to the child's ability to trust, so that special attention can be paid to always following through on promises and consequences.

- The infant's distress will be less if the new environment can be made very consistent with his/her old one, and if the primary caregiver can visit regularly, preferably daily, and provide direct care to the child. **The social worker can encourage a positive relationship between the parent and foster parent to facilitate frequent and meaningful visitation.**

Transition to a discussion on the effects of maltreatment and the red flags of development during the infant/toddler years.

End of Activity

PowerPoint Slide, Activity 5D: Slide 40



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ACTIVITY: Effects of Maltreatment Age Range 0-2

Activity Time: 25 min

Materials:

- Trainee Content: *Failure to Thrive* (page 69 of Trainee's Guide)
- Trainee Content: *Risk Factors for Infants and Toddlers* (page 71 of Trainee's Guide)
- Trainee Content: *The Effects of Abuse and Neglect on Infants and Toddlers* (page 73 of Trainee's Guide)
- DVD: *Understanding Traumatized Children: The Core Concepts: Series 1, Part 4, How Poverty of Experience Disrupts Development*, Segment titled Self-Esteem, Dr. Bruce Perry [3 ½ minutes]
- Flip chart
- Markers
- PowerPoint Slides: 41-44

Pre-training Preparation:

Instructions for Cueing the DVD

Play section four, "Neglect: How Poverty of Experience Disrupts Development." Fast forward past the section with Art Linkletter, and continue past: Socio-cultural Neglect, Types of Neglect, Trauma & Neglect, and Impulsivity. Play the section titled, "Self-Esteem." Note that the clip is mislabeled and does not include a discussion of self-esteem.

Training Activity:

■ **Step #1.** Display slide 41 and introduce the video by explaining that this video clip dramatically illustrates the effects of severe neglect on the developing brain.

■ **Step #2.** Discuss the video and make the following points. Display the corresponding PowerPoint slides (42-43). The neurobiological definition of neglect is *not getting the necessary stimulation at the right time*. It is the absence of critical organizing experiences at key times during development and is highly age-dependent according to the period at which the experience is absent.

According to Rycus & Hughes (1998), the following are key concepts for the effects of child maltreatment on child development during this stage:

- The *specific* dysfunction resulting from maltreatment will depend upon:
 1. the **timing** of the insult (e.g., was the insult *in utero* during the development of the brainstem, or at age 2 during the active development of the cortex?)

2. the **nature** of the insult (e.g., is there a lack of sensory stimulation from neglect or an abnormal persisting activation of the stress response from trauma?)
 3. the **pattern** of the insult (i.e., is this a discreet single event, a chronic experience with a chaotic pattern, or an episodic event with a regular pattern?)
- The earlier and more pervasive the neglect is, the more devastating the developmental problems for the child.

Although neglect has been understudied, largely because it is difficult to “see” (Perry, 2002), dramatic, real-life historical examples exist of the consequences of early and severe neglect.

The trainer can use any or all of the following examples of consequences of neglect:

- Records of feral child Kaspar Hauser (circa 1833), who was raised in a dungeon, attest to his primitive, delayed emotional, cognitive, and behavioral functioning. Upon autopsy, his brain was found to have cortical atrophy (Heidenreich, 1834 in Perry, 2002).
- Rene Spitz’ landmark study of institutionalized infants found that infants who weren’t touched had a mortality rate of nearly 30%.
- Spitz also found that children raised in foster homes with more attentive and nurturant caregiving had improved physical, emotional, and cognitive outcomes than children raised in orphanages.
- In a study comparing a group of infants raised in an orphanage with minimal care with another group of infants raised by a woman who was serving a prison sentence, only 2 of the 26 orphanage children could walk, and only a few could talk. Of the other group, nearly all the children had reached these milestones (Spitz, 1945 and 1946 in Perry, 2002 and Stien & Kendall, 2004).
- More recently, a study of children in a Lebanese orphanage conducted by Dennis (1973, in Perry, 2002) demonstrated that the older a child was at the time of adoption (an indicator of longer time spent in the neglectful environment), the more pervasive and resistant to recovery were their deficits. By adolescence, children adopted at age 6 had a mean IQ of about 50; children adopted between ages 2 and 6 had IQs of about 80, and children adopted prior to age 2 had a mean IQ of 100.



- In a recent study by the Child Trauma Academy, of 200 children under the age of 6 removed from parental care following abuse and neglect, significant developmental delays were demonstrated in more than 85% of the children. The severity of the delays was determined to have increased with age, suggesting that the longer the child was in the adverse environment, the more enduring and pervasive the deficits. (Perry, 2002)

■ **Step #3.** Briefly discuss non-organic failure-to-thrive, a severe consequence of neglect. Refer to the *Trainee Content* and PowerPoint slide 44 to discuss the definition, causes, signs, and symptoms of Non-Organic Failure to Thrive (NOFTT). Note that a physician’s assessment is necessary for diagnosis and that there are also children for whom failure to thrive is not related to maltreatment. Stress that



treatment planning is complex, requiring a multidisciplinary team that includes the child welfare worker. Also note that NOFTT affects brain growth, eating, and social and emotional development.

Ask trainees if they have ever seen a baby that suffered from failure to thrive. What did s/he look like? Ask if there could be other reasons why a child might look like they have failure to thrive, but do not (e.g., they may just be small or have another medical problem). Advise trainees that it is important not to automatically judge or blame parents, particularly since a medical diagnosis is necessary. If the child is diagnosed with NOFTT, the parents will need to play a crucial role in carrying out the treatment plan for their child.

Advise trainees that there are other developmental delays in all domains of the SPECS and in every age group that, due to time limitations, this class is unable to cover. Encourage them to use the *Trainee Content* as a reference when needed.

■ **Step #4.** Engage in a large group discussion about the fact that infants and toddlers are at higher risk for abuse and neglect.

Ask: “Why are infants and toddlers at particularly high risk of abuse?” Refer to *Trainee Content: Risk Factors for Infants and Toddlers* and subheading “Factors that Make Infants and Toddlers at High Risk of Abuse.”

Ask: “Why are infants and toddlers more likely than older children to suffer severe and permanent injuries from abuse or neglect?” Refer to subheading “Factors that Make Infants and Toddlers Vulnerable to Injury.”

■ **Step #5.** Discuss the effects of abuse and neglect on infants and toddlers by developmental domain. Using a chart pad and markers, list the domains along the left hand side of the page (S. P. E. C. S.), and then add the trainee’s responses. Refer to the *Trainee Content: Effects of Abuse and Neglect in Infants and Toddlers*.

Encourage the following responses:

S: lack of response to stimulation, passivity

P: physical abuse can cause significant injury at this age resulting in disability and death while a neglected infant may be small in size and have poor muscle tone

E: fearful, anxious, withdrawn, hypervigilant

C: language and speech delay, lack of initiative to interact with the environment to solve problems

S: Sexualized play, inappropriate sexual knowledge

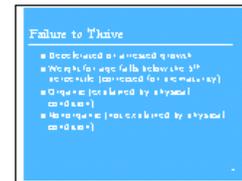
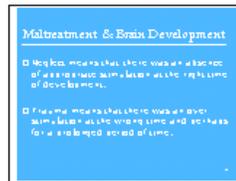
Since the most critical psychosocial developmental task is attachment, it is important to spend time reviewing and discussing the impact of maltreatment on attachment and other social relationships for very young children.

Review and expand on the handout with the trainees as you discuss the impact of abuse and neglect on each developmental domain.

Encourage discussion by asking trainees to describe what they have seen in children with whom they work.

End of Activity

PowerPoint Slide, Activity 5E: Slides 41-44



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ACTIVITY: Effects of Maternal Substance Abuse

Activity Time: 20 min

Materials:

- Trainee Content: *The Impact of Parental Substance Abuse on Children* (page 77 of Trainee's Guide)
- DVD: *The Listening Heart* [8 minutes]
- PowerPoint slide: 45

Pre-training Preparation:

Instructions for Cueing the DVD

Show two segments from *The Listening Heart*. Play Chapter 1, "The Introduction" (2:33), and Chapter 4, "Brittany" (5:30).

Training Activity:

■ **Step #1.** Display slide 45 and introduce the video. Tell participants that while it's important to read and discuss effects of fetal alcohol syndrome, there's nothing so powerful as actually seeing it. Show the first chapter of the DVD, which introduces Fetal Alcohol Syndrome. Then show Chapter 4 which discusses Brittany. Note that while Brittany is school age in the video, intervention for her FAS started at 6 months of age.

Ask participants if they ever had children on their caseloads who matched these descriptions.

Briefly discuss some of the implications for caseworkers (e.g., working closely with foster parents or providing supportive services).

■ **Step #2.** Refer to the *Trainee Content: The Impact of Parental Substance Abuse on Children*. Note that this handout include specific information about Fetal Alcohol Syndrome that can be used later as a reference but there is not sufficient time to fully review it in class.

Be sure to say that alcohol is leading cause of *developmental disability* in the United States.

■ **Step #3.** Refer to *The Impact of Parental Substance Abuse on Children* in the trainee content.

Briefly tell participants:

In addition to the direct harm resulting from drug exposure while in utero, infants and children can suffer further abuse and neglect due to continuing parental substance abuse. The basic needs of children, including nutrition, supervision, and nurturing, often go unmet due to parental substance abuse, resulting in neglect. 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 place children at risk for abuse and neglect.

The *Trainee Content* covers the following drugs:

- Alcohol
- Cigarettes
- Cocaine & crack cocaine
- Amphetamine & other stimulants
- Heroin & other opiates
- Oxycontin
- PCP & angel dust
- Marijuana

Some detailed information is provided in the *Trainee Content* about the effects of opiates, cocaine and marijuana on the fetus and the neonate. This is followed by a table that indicates, for each of the categories bulleted above, (1) the effects on the mother, (2) the effects on the baby, and (3) the effects on children. Draw trainees' attention to this information but do not review it. Tell participants they can use this later as a reference.

The *Trainee Content* also features strategies for early intervention for infants, toddlers, and preschoolers. These strategies have direct practice applications. Emphasize the importance of early intervention by medical practitioners, service providers, and caregivers.

Transition to the next section, a discussion of red flags and implications for practice.

End of Activity

PowerPoint Slide, Activity 5F: *Slide 45*

Video Clip

The Listening Heart



How to help
your child
develop a
listening heart

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ACTIVITY: Red Flags and Implications for Practice Age Range 0-2

Activity Time: 20 min

Materials:

- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- PowerPoint Slide: 46

Training Activity:

■ **Step #1.** Display slide 46 and refer trainees to pages 3, 6, 9, and 12 of the “Milestones” Supplemental Handout to briefly review signs of possible developmental delays at the end of ages 3-4 months, 7 months, 1 year, and 2 years, respectively. Explain that these are the “red flags” they should be watching for when interacting with children. The red flags may be the effects of maltreatment or some other indication that further developmental assessment is warranted.

■ **Step #2.** Note that although we will discuss developmental disability in greater detail tomorrow (*Trainee Content Developmental Delays and Disorders of Childhood*), there are two specific developmental disabilities that are diagnosed most commonly in infancy. Child welfare social workers can expect to encounter children with these disabilities in the course of their work.

Early intervention and treatment can improve outcomes for children with these diagnoses. Families sometimes need support and assistance to advocate for services for their special needs infant, especially if the family is also experiencing challenges in other areas.

Down Syndrome

Down Syndrome is the most common cause of intellectual delay. As a result of chromosomal malformation, people with Down Syndrome have physical and mental symptoms including mild to moderate intellectual delay, stereotypical facial features and other physical differences (National Institute of Child Health and Human Development).

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).

Ask trainees why infants with developmental disabilities are at increased risk for abuse and neglect (Prevent Child Abuse America).

■ **Step #3.** Ask trainees to spend a few minutes discussing at their tables what they would do if they saw some of these red flags with families. Responses may range from trying to talk to caregivers about their concerns to making arrangements for a full-blown developmental assessment. The discussion should focus on what workers should do next. Allow just a few minutes for discussion and bring the group back together and ask for their thoughts.

■ **Step #4.** Provide a broad framework for intervention at this age range.



Intervention can include referral to a Regional Center for assessment or giving a caregiver tips on attachment and various strategies in between. Ask trainees for examples of how they would engage families to accept interventions given the issues of denial that may emerge.

Wrap up the discussion on the age range of 0–2. Transition to the end-of-the-day activities.

End of Activity

PowerPoint Slide, Activity 5G: Slide 46



Day 1, SEGMENT 6

Summary of Day 1/Preparation for Day 2

Total Segment Time: 10 min

TRAINING ACTIVITY 6A

ACTIVITY: Transfer of Learning Points

Activity Time: 10 min

Materials:

- Flip chart papers posted on wall with the heading “Most Useful for My Practice”
- Markers
- PowerPoint Slide: 47

Training Activity:

■ **Step #1.** Ask trainees to write on the posted flip chart paper a concept, word or phrase that reflects a learning point they plan to incorporate in their work. Then ask for a few volunteers to report out. Engage in a large group discussion about key points from the day.

■ **Step #2.** Re-cap the agenda topics covered today and provide a preview of the topics to be covered in Day 2.

End of Activity

PowerPoint Slide, Activity 6A: Slide 47



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DAY 2, SEGMENT 7

Welcome and Review of Day 1

Total Segment Time: 15 min

TRAINING ACTIVITY 7A

ACTIVITY: What Do You Remember?

Activity Time: 15 min

Materials:

- Large light bulbs, cut out of yellow construction paper, which are large enough to write on with a marker.
- Blue masking tape
- Prizes for the winning table
- Flip chart
- Markers
- PowerPoint Slides: 48-49

Pre-training Preparation:

- Put three “light bulbs” on each table prior to the class starting.
- Place three pieces of tape on the side of each table for use with the light bulbs.
- Put different colored markers on each table.

Training Activity:

■ **Step #1.** Display slide 48 and welcome everyone back for Day 2.

■ **Step #2.** Display slide 49 and explain that the following activity is designed to review important learning points from Day 1, based on what trainees remember.

Explain that one of the most remarkable things about the brain is its capacity to hold memories. Our memories allow us to build on existing information and to navigate and understand our world in ever more sophisticated ways. *“What we want to do first today is work with our amazing memory system... and, there could be prizes involved!”*

Ask trainees to select a person at their tables who writes fast to record their group’s responses on a flip chart. Assign each table with one of the dimensions of the foundations of development: normal development, brain development, heredity & environment, and the role of culture on implications for practice. Ask them to write

their foundation topic on the top of their flip chart sheet. Explain that this is a *timed* activity in which they should discuss, think about, and write down everything that their group remembers from yesterday about their assigned topic. Encourage trainees to use their books and any other materials that would help them. Then, look at your watch and say, “Go!”

Let the group do this exercise for about 7 to 8 minutes until you hear the conversation start to die down. Meanwhile, walk around the tables and listen to what trainees are saying. Encourage them with active listening responses, by saying, for example, “Oh, yes that was really interesting,” and “You mean _____,” etc.

End their table discussions. Ask each group to count how many ideas, concepts, and learning points they have on their flip chart. Tell them that honesty counts in this activity. Then ask for a show of hands as to how many groups have more than 8 items on their list. How about more than 12? More than 18? More than 22...? Keep going until there is only one group with their hands up. (If it is very close, you may want to have two tables win.) Applaud the winning table(s), and give them their prizes.

Next, ask the groups to look at their lists and pick the top three items that they feel are most important and that they want their colleagues to remember about yesterday’s training. Ask them to write those items on the light bulbs, one idea per light bulb.

One at a time, ask each group to have someone post their ideas on the wall while briefly telling the group why their ideas are important. The trainer should support the most important ideas from the day before and shape any of the ideas that are not fully realized. Refer back to the learning goals posted on chart paper at the beginning of the previous day and note which goals are met and which will be covered in Day 2.

Some key concepts to include are:

Normal Development:

- Normal development is on an ongoing, dynamic process.
- Normal development refers to a statistical range.
- Development must be evaluated individually for each domain.

Environment & Heredity:

- Environmental stressors can impair a parent’s ability to provide for a child’s developmental needs.
- Genetics plays a much larger role than previously thought in determining developmental potential.
- Genetics and environment are interdependent.

Brain Development:

- Parent-child interactions affect brain development.
- The brain develops in a use-dependent way.
- The early years are a critical period of rapid brain development.

The Role of Culture:



- Cultural variations can influence development.
- Child welfare workers must differentiate between cultural differences and safety concerns.
- Culture determines our expectations for children and their development.

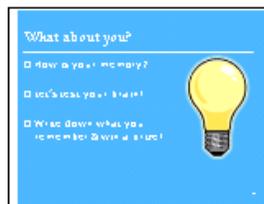
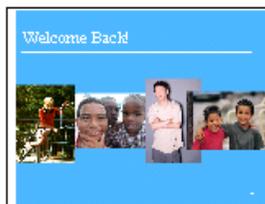
Implications for Practice:

- Social workers can help identify developmental problems and provide referrals for assessment and intervention.
- Social workers should keep up with current research on child development.
- Social workers may need to work through issues of denial with parents in order to help parents see developmental problems in their children.

After each group has posted their ideas, the instructor can briefly review them again as a way to review yesterday's material.

End of Activity

PowerPoint Slide, Activity 7A: Slides 48-49



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DAY 2, SEGMENT 8

Age Range 3-5 Preschoolers

Total Segment Time: 60 min

TRAINING ACTIVITY 8A

ACTIVITY: Normal Development Age Range 3-5

Activity Time: 10 min

Materials:

- *Trainee Content: The Normal SPECS of Development for Preschoolers* (page 89 of *Trainee's Guide*)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Supplemental Handout: CDC information card, "It's time to change how we view a child's growth" (available free from CDC—see Materials Checklist)
- PowerPoint Slides: 50-51

Training Activity:

■ **Step #1.** Display slide 50 and refer trainees to *Trainee Content: The Normal SPECS of Development for Preschool*. Refer trainees to the Milestones booklet, particularly in the context of developmental concerns. Also, encourage them to use the booklet as a handy reference in the field. The CDC information cards about developmental milestones can also be used for this segment.

■ **Step #2.** Display PowerPoint slide 51 as you review the preschool SPECS, stressing the following learning points:

- *Social*—Preschool-age children are learning social roles and rules, and engaging in interactive play. They are expanding their relationships with adults outside the family. As they progress through this period, play becomes less focused on toys and more focused on structured peer interaction involving playing highly defined roles and directing each other. At the end of this stage, children are working together toward a common goal. By age 5, children show preference for specific friends.
- *Physical*—Their brain growth slows as their brain reaches 4/5ths of its adult size. They are refining their gross and fine motor skills, as they considerably

- expand their repertoire of physical abilities. Their physical appearance begins to change noticeably as they look less like a toddler and more like child. They have good control over their muscles, engaging in gross motor tasks such as running, jumping, and standing on one foot. They can feed themselves and control fine motor movements well enough to write letters and color. By age 5, children should be fully potty-trained during waking hours.
- *Emotional*—Preschool children are developing initiative, self-control, self-esteem, and moral conscience. They have a sense of themselves as separate from others. They can also evaluate themselves in terms of good and bad and feel proud of good behavior and ashamed of bad behavior. Their self-assessment is driven by others’ reactions. Praise and encouragement for initiative and efforts to try things independently are key during this stage to build self-esteem.
 - *Cognitive—Language development*: At this age, children are rapidly increasing their vocabularies and mastering language, but their language skills can be deceptive. For example, preschoolers don’t always understand the words they use, especially those words related to time, size, distance, and relationship (Walker, 1999). Furthermore, because they try very hard to follow social roles for interaction, they are likely to answer questions even if they do not know the answer and often answer yes as a default (Walker, 1999). The motto for understanding preschoolers is: “*They only know what they know, and they don’t know what they don’t know.*”
 - *Cognitive—Magical thinking and egocentricity*: Preschool children see the world through their own experience and assume that others see the world in the same manner. Their egocentricity as well as their magical thinking gives them a unique worldview. To further illustrate this point, the trainer can add a humorous anecdote about preschool cognition, if one is known. Caution trainees that parents who do not understand magical thinking and egocentricity may interpret some of their young child’s behavior and speech as necessitating a harsh disciplinary response, resulting in child abuse.
 - *Sexuality*—(Keep in mind that a few trainees may be uncomfortable talking about the sexuality of preschoolers.) Preschoolers can display sexual and sensual behaviors. Masturbating and being curious about other people’s bodies is a normal aspect of preschool experience. It is not unusual for a preschooler to reach up and touch a woman’s breast. Preschoolers are just curious about what it feels like. Since they don’t mind people touching them, they do not have the awareness that an adult might be uncomfortable. It is important for social workers to understand that these types of issues are often practical concerns for parents. Since cultural values may shape sexual expression, social workers need to consider cultural norms when assessing a

family's response to preschool sexual behavior. It is useful to provide some examples of this.

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. Less frequent behaviors are the more intrusive behaviors involving direct sexual contact, oral/genital contact, or masturbation with objects. Children with the less frequently reported, more intrusive behaviors would benefit from further assessment.

■ **Step #3.** Review the developmental concerns for this age range in the Milestones booklet – Developmental concerns by the end of the 4 years. Note that children of this age will have more interaction with the social worker during home visits, so it may be easier for the social worker to identify concerns. Also note that parents may mistakenly identify developmental concerns as behavioral problems in children this age. The social worker may be able to offer a developmental perspective on a problem behavior.

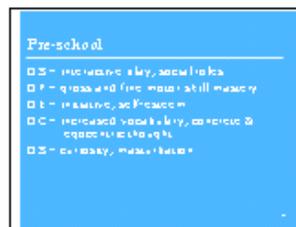
■ **Step #4.** Discuss the role of culture in child development at this age. Ask trainees to identify ways in which culture could affect development. Some key examples include:

- Cultural variations in the expectations of autonomy and independence for preschoolers may affect the child's ability to feed and dress him or herself.
- Cultural expectations of gender roles may lead boys to excel in gross motor tasks while girls excel in fine motor tasks during this stage.

Transition to the next topic: attachment. Mention that the preschool child with typical development is a child who has experienced positive attachment during infancy and toddlerhood.

End of Activity

PowerPoint Slide, Activity 8A: Slides 50-51



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ACTIVITY: Attachment Age Range 3-5

Activity Time: 15 min

Materials:

- Trainee Content: *Jazmine (Case Scenario)* (page 101 of Trainee's Guide)
- PowerPoint Slides: 52-54

Training Activity:

■ **Step #1.** Review the definition of attachment. Attachment is the reciprocal social and emotional relationship between a child and a significant caregiver. Review the key points of attachment for preschoolers and display the corresponding PowerPoint slide (52). Cover the following information:

Partnership (36+ months)

- Attachment solidifies.
- Child shows increased ability to communicate needs verbally.
- Child negotiates differences.

■ **Step #2.** Display PowerPoint slide 53 and discuss the developmental effects of insecure or interrupted attachment.

- Repeated separations interfere with the development of healthy attachments and a child's ability and willingness to enter into intimate relationships in the future.
- Children who have attachment problems may suffer significant developmental effects such as:
 - Low self-esteem
 - A general distrust of others
 - Mood disorders, including depression and anxiety
 - Delayed social skills
 - Generalized cognitive delays
 - Language delays

■ **Step #3.** Discuss identifying and working with attachment issues.

- Child welfare caseworkers can identify children with behaviors that indicate attachment issues and can help children and their families learn how to develop and maintain healthy attachments. Parents who have abused or neglected their children may have maladaptive attachment in their own histories. Many parents and children can be helped to strengthen the capacity to attach.

- While it is not our intent to train to diagnose attachment disorders, you can observe and document behaviors that indicate attachment issues and that will be useful to the professional who would make such a diagnosis.
- Social workers will facilitate early referral to mental health partners for assessment and intervention of children exhibiting signs of attachment problems.



- Social workers will also facilitate a team approach for development plans for helping children with attachment issues.

■ **Step #4.** Ask participants about cultural variations and attachment issues.



Generate examples such as some cultures may have multiple caregivers so children form multiple attachments; also variations in expressions of attachment may vary by culture.

Conduct a small group activity to apply the concept of helping a parent build attachment with preschoolers. Ask trainees to read the short scenario, *Trainee Content: Case Scenario: Jazmine*, and answer the discussion questions in their table groups. Process the answers in the larger group.

Display PowerPoint slide 54, which contains the following discussion 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 kind of suggestions would you make to Marisol to help her engage with Jazmine?

Allow about 5 minutes for the small group discussion. Ask trainees to summarize their discussions for the larger group. Encourage the following responses:

- Talk to the foster parent about the times of day Jazmine is most engaged and the interactive toys or books she prefers (favorite story books, a preferred type of building blocks). Plan to incorporate a selection of two or three preferred activities in the visit.
- Schedule the visit for the time of day Jazmine is usually most interactive. Arrange to have the visit in a setting that is appealing to Jazmine and that can be the consistent setting for future visits. Include two or three things in the environment that are items Jazmine enjoys.
- Suggest to Marisol that she use a calm interaction style with Jazmine and follow Jazmine's lead in selecting one of the interactive toys available. Ask Marisol to avoid skipping quickly from one activity to another and allow time for Marisol warm up to her and the activities. Assist Marisol to establish a routine for the visit that she will follow on subsequent visits.



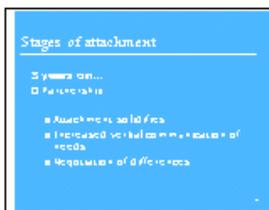
- Enlist a mental health provider to assess Jazmine and facilitate a team approach to the assessment and intervention process by supporting Marisol and the caregiver in the assessment and intervention.

■ **Step #5.** Ask participants for ways they can engage families around attachment issues related to preschool children, especially ways that are culturally meaningful (e.g., cooking, family traditions, reading books). Concepts from a psychodynamic approach are well-suited to supporting the development of healthy attachments. These include showing empathy by validating and mirroring the child's experiences and soothing the child when s/he is distressed.

Transition to the next segment, Grief and Loss Issues for Preschool Children.

End of Activity

PowerPoint Slide, Activity 8B: Slides 52-54



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ACTIVITY: Grief and Loss Age Range 3-5

Activity Time: 5 min

Materials:

- Trainee Content: *Grief and Loss in Preschoolers* (page 103 of Trainee's Guide)
- PowerPoint Slide: 55

Training Activity:

■ **Step #1.** Conduct a discussion on how grief and loss are presented and experienced in preschool-age children. Refer participants to the *Trainee Content: Grief and Loss in Preschool Children*. Whenever possible, ask questions to generate discussion.

Briefly mention the indicators and characteristics of grief and loss of preschool children listed below. Be sure to add the concept of culture to the discussion. Ask trainees to add examples of cultural differences. This topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.

- 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.
- 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 and may think 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.

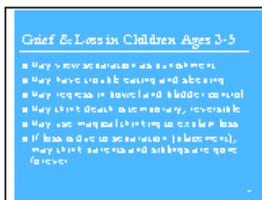
■ **Step #2.** Make the following learning points and display the corresponding PowerPoint slide (55):

- Preschool children need simple, brief explanations about loss. Focus on concrete examples the child will understand, e.g.: explaining that the person died because his or her body isn’t working anymore or that they aren’t living with their father right now because he has a grown-up problem that he is working on fixing. Give them an opportunity to ask questions. The child may need to hear the same explanation several times and may ask the same questions again and again.
- Preschool children have trouble putting their feelings into words and may need help identifying and expressing their feelings. Reassure the child that angry thoughts and feelings don’t cause death and nothing they did caused them to be in foster care. Provide a way for the child to express grief by working together on a drawing or a story that explains what happened.
- Preschoolers can associate a single outcome with the circumstances that lead to the death of a loved one. For example, they may need reassurance that sickness or hospitalization don’t always result in death.
- Use culturally relevant stories to provide information about death, grief and loss.
- Keep in mind that attitudes and behaviors associated with grief and loss are culturally driven, including expectations for how much information children will be given and whether or not they will attend funerals.

Transition to a discussion of Red Flags.

End of Activity

PowerPoint Slide, Activity 8C: Slide 55



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ACTIVITY: Red Flags Age Range 3-5

Activity Time: 10 min

Materials:

- Trainee Content: *Developmental Delays and Disorders of Childhood* (page 105 of Trainee's Guide)
- Trainee Content: *Regional Centers* (page 117 of Trainee's Guide)
- Flip chart
- Marker
- PowerPoint Slides: 56-57

Trainer Tip:

This segment focuses primarily on intellectual delay and autistic spectrum disorders. The trainer should allow discussion as s/he presents the information in this segment. Highlight the factors related to the potential for abuse, as children with intellectual delay or other developmental disorders can be highly vulnerable. Be sure to note that we're talking about these issues during the preschool stage but they can be diagnosed earlier than these years. Remind trainees of the previous discussion of Down Syndrome and Cerebral Palsy, commonly identified in infancy. The disorders discussed in this segment are usually identified after infancy. Note that we will discuss epilepsy in the section on school age children.

Training Activity:

- **Step #1.** Introduce the topic of developmental delays.

Display PowerPoint slide 56 and discuss the definition of developmental disability used in the State of California, which is consistent with the national definition as well. The key point is that the disorder must be diagnosed before age 18.

The term *developmental disability* refers to a severe and chronic disability that is attributable to a mental or physical impairment. In California, the disability must begin before the 18th birthday, be expected to continue indefinitely, and present a substantial impairment. Also, the disability must be due to one of the following conditions:

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

Explain that we are discussing this topic in the preschool-age range because developmental delays are most commonly observed and diagnosed during this time. Efforts are being made to diagnose and treat these issues much earlier. Emphasize that early intervention is important for improving outcomes and quality of life. A recent study found that 26% of children identified as developmentally delayed during preschool and provided with early intervention services no longer needed special education services by the time they reached third grade (Delgado, 2006).

■ **Step #2.** Provide the following brief definition of intellectual delay:

- is characterized by significantly sub-average general intellectual functioning (i.e., an IQ of approximately 70 or below)
- includes concurrent deficits or impairments in adaptive functioning.
- is the most common developmental disability
- is measured by testing

The areas affected by intellectual delay cut across a broad range of functioning. The assessment of intellectual delay in these areas should take cultural factors into account and be free from cultural bias.

■ **Step #3.** Display PowerPoint slide 57 and provide the following definition of autistic spectrum disorder (ASD):

- it is a spectrum disorder, affecting each individual with different severity and a different array of symptoms
- it involves differences in experiences and integrating sensory input
- it involves differences in processing and responding to information
- it may involve some of the following traits
 - insistence on sameness
 - difficulty expressing needs
 - tantrum-like behavior
 - repeated behaviors like spinning things or flapping hands
 - minimal responses to verbal cues
 - aggressive or self-injurious behavior
 - gross and/or fine motor delays

Use the following example to explain the concept of sensory integration:

Through our ability to integrate our senses, we make sense of our world. Sensory integration allows us to connect information we receive through our ears with information we receive through our eyes, thereby connecting the sound of rain and wind with the sight of trees blowing around and moisture

hitting us. Through sensory integration, we put all those pieces together, explain it to ourselves and move on to focus on other things.

Explain that autism is often diagnosed during the preschool years but an earlier diagnosis is considered more beneficial. Several specialists in the field of autistic spectrum disorders advocate that early intervention can make a significant difference in outcomes for ASD children, and innovative programs based on early intervention are currently being implemented to assist them and their parents. Note that symptoms of autism can be misinterpreted as ear infections in very young children.

Advise trainees that the prevalence of autism is increasing. In 2007, the CDC reported a prevalence rate of 1 in 150 children and 1 in 94 male children. They may see children on their caseloads with early signs of autism or other related disorders on the autistic spectrum. The trainer can also ask how many trainees know a child with autism. Chances are good that someone in the class knows a child with an autistic disorder, which makes the point about how prevalent it has become.

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.

It is important to point out that autistic children do show affection and have feelings of love. The myth that autistic children do not experience affection is harmful, and inhibits us from assisting them. Many people with autism like hugs and physical contact. Others may show affection in different ways. Emphasize that there is a great degree of variation in the severity and type of behaviors of children who have an autistic spectrum disorder.

■ **Step #4.** Refer to the *Trainee Content: Regional Centers* and discuss the Regional Center System in California as the primary provider of early intervention services for children 0-3. Note that persons between the ages of 3 and 22 receive services primarily through the school system but are also Regional Center clients. Ask the trainees about resources for families with developmental delays in their geographical areas. List these on flip chart paper and reinforce that it is helpful to find out about resources available in their areas.

Note to trainer: This is another opportunity to emphasize the need to stay current with new research and developments in the field.

■ **Step #5.** As a transition to the next section (a discussion of the effects of abuse and neglect on preschool children), ask the trainees how they would approach an interview with a child with autism or another developmental disability. Encourage



responses that involve building a team that includes parents, caregivers, and mental health and medical professionals and consulting with the team to identify the best setting and approach for the interview.

End of Activity

PowerPoint Slide, Activity 8D: Slides 56-57

Developmental Disability Definition

- Begins before 18 and continues indefinitely
- Includes autism and disability
- Major divisions:
 - Mental Retardation
 - Intellectual Disability
 - Physical
 - Autism
 - Other clinically related disabling conditions

Autism

- Prevalence with varying estimates
- Affects 1 in 130 children (1 in 94 males)
- Affects social interactions and communication
- Appears in the first 3 years
- Causes disability throughout life

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ACTIVITY: Effects of Maltreatment Age Range 3-5

Activity Time: 10 min

Materials:

- Trainee Content: *Effects of Abuse and Neglect on Preschool Children* (page 121 of Trainee's Guide)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Supplemental Handout: CDC information card, "It's time to change how we view a child's growth" (available free from CDC – see Materials Checklist)
- Flip chart
- Marker
- PowerPoint Slide: 58

Training Activity:

■ **Step #1.** Maltreatment can adversely affect a child's growth and development across the SPECS domains and into adulthood. Display slide 58 and refer participants to *Trainee Content: Effects of Abuse and Neglect on Preschool Children*. Ask trainees to describe the effects of abuse and neglect on preschool children. Encourage trainees to give examples from their practice.

List S.P.E.C.S. down the left hand side of a chart pad page and write trainee responses on the page.

Look for responses such as:

- S: attachment concerns as evidenced by the inability to engage in reciprocal play, take turns or share
- P: small stature, clumsiness, sickliness
- E: excessive fearfulness, flat affect, withdrawn behavior
- C: short attention span, lack of interest, delayed speech
- S: sexualized behaviors, excessive masturbation

Point out that the *key assessment skill* may be in determining how a child looks different, i.e., "What's wrong with this picture?" Knowing typical developmental milestones and behavior can provide a base or context from which to assess variations. Abuse and neglect in preschool children may result in myriad developmental impacts.

In addition to reviewing the *Trainee Content*, emphasize that the cognitive limitations of preschool children affect how they view their own maltreatment and placement out-of-home.

Explain:

- Children develop inaccurate and distorted perceptions due to attributing cause to events that happen concurrently, an inability to understand complex events, and faulty reasoning.
- Abused preschool children almost universally believe that the abuse was “punishment” because they did something wrong. This thought pattern may persist well into the early school years.
- It is also typical for young children in foster care to believe they were “sent away” because they were bad. It makes no logical sense to them that they should have to leave home because someone else (i.e., their parents) did something wrong. If necessary, the child will “invent” or fantasize reasons for their “punishment” to give a cognitive structure to their abuse.

Provide the following example:

- Lisa, age 6, had been placed in a foster home at age 5½. Her stepfather was a violent and dangerous man, who once threw a cat through a plate glass window in a fit of temper. He and his wife had a violent argument during which time the police were called, and Lisa was removed to ensure her safety. At the time of the argument, Lisa had been in the kitchen pouring a glass of milk, and she spilled it. Six months after her placement, she solemnly assured the caseworker that she was bad, and that she had to live in a foster home because she spilled her milk all over the kitchen. When the caseworker told her she was placed in foster care so her Daddy wouldn’t hurt her, she indicated her Daddy only hurt her Mommy, not her, and that couldn’t be the reason.

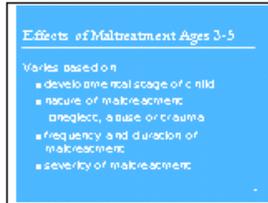
Note that the preschool child’s cognitive limitations, egocentric thinking, and concrete perceptions of “right” and “wrong” explain the common tendency for maltreated children to develop poor self-images and low self-esteem.

Point out that as children become older, it is more difficult to discern whether an atypical behavior is attributable to other causes. Other factors must be ruled out before identifying maltreatment as the probable cause.

Transition to the next section, a discussion of implications for practice with preschool age children.

End of Activity

PowerPoint Slide, Activity 8E: Slide 58



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ACTIVITY: Implications for Practice

Activity Time: 10 min

Materials:

- Trainee Content: *Ways to Help Maltreated Children* (page 125 of Trainee's Guide)
- Supplemental Handout: Behavioral Impact of Maltreatment: A Reference to Use with Parents and Caregivers
- PowerPoint Slides: 59-60

Training Activity:

■ **Step #1.** Note that a key intervention strategy is to educate families about parenting preschoolers. Ask trainees for specific examples of ineffective discipline strategies that they have encountered in their practice.

Identify specific strategies parents or caregivers could implement to address these behavioral issues.



Social workers can intervene and engage caregivers in strategizing ways to address these behavioral issues that are both more effective with children and not abusive. Some of these strategies include:

Positive Discipline (Nelson, 2007)

- Set natural and logical consequences
- Follow through (every time)
- Use time-out to teach coping skills
- Offer choices within limits (Do you want to clean up now or after nap?)
- Create games for unpopular tasks (beat the clock)



Display slide 59 and emphasize the importance of early development of a team approach to assist children with behavioral or mental health concerns. This includes early assessment and intervention and facilitation of team building with professional service providers, caregivers and parents.

■ **Step #2.** Cover the main points from the *Trainee Content: Ways to help maltreated Children* and conduct a discussion. Start with the premise that the severity of the developmental deficits are linked to the timing (age), nature (neglect, abuse, or other trauma), and pattern (single event or chronic) of the maltreatment (Rycus, 1998).

Refer trainees to the *Trainee Content: Ways to Help Maltreated Children*, and note that

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Age Range 6-12 School Age Children

Total Segment Time: 90 min

TRAINING ACTIVITY 9A

ACTIVITY: Normal Development Age Range 6-12

Activity Time: 15 min

Materials:

- Trainee Content: *The Normal SPECS of for School-Age Children* (page 129 of Trainee's Guide)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Supplemental Handout: CDC information card, "It's time to change how we view a child's growth" (available free from CDC—see Materials Checklist)
- DVD: *Childhood: Life Lessons* [8 minutes; demonstrates the "5-7 shift"]
- PowerPoint Slides: 61-63

Pre-training Preparation:

Instructions for Cueing the DVD

Play "Life's Lessons," Chapter 2, 5-7 shift. Stop after 8 minutes & 16 seconds, before the clip illustrating how Russian children begin their elementary school experience.

Training Activity:

■ **Step #1.** Display slide 62 and introduce the video clip: *Childhood: Life's Lessons* [8 minutes], which depicts the dramatic developmental changes known as the "5 to 7 shift" associated with school-age children. Introduce the concept of this "shift" before screening the video. Show the video.

■ **Step #2.** Conduct a brief discussion of the video clip after the screening.

■ **Step #3.** Display PowerPoint slide 63 and review the SPECS for school-age children. Stress the following learning points when reviewing the SPECS:

- *Social*—School-age children are increasing their social network beyond their families and developing meaningful and mutual friendships with peers.

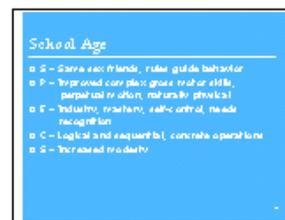
School-age children are better able to follow rules and they begin to understand the perspectives of others. Rules and roles are an important part of school-age social development. The trainer can relate the school-age child’s understanding of rules and roles to more general cognitive development at this stage. (Refer to the *Trainee Content: The Normal SPECS of Development for School Age Children*, subsection on the function of rules and roles.)

- *Physical*—School-age children master their gross and fine motor skills through engaging in sports, creative arts, music, and other similar activities.
- *Emotional*—School-age children achieve emotional satisfaction by mastering skills. Their self-esteem is based on their competence, and by 6 years of age, they know who is good at what in a classroom. Skill development is not only essential for this age, but developing a passion for a sport, art form, or field of study in childhood can enhance and ease the trials of adolescence. (Note that recent state legislation [A.B. 408] and WIC Section 362.05 uphold the need for children in foster care to have access to extracurricular activities equivalent to that of children who are not part of the child welfare system.)
- *Cognitive*: Memory, language use, and the development of rational and logical (concrete) thinking improve during the school-age phase. School-age children also develop the ability to understand other people’s perspectives.
- *Sexual*: School-age children typically engage in voluntary sexual play with other children of the same age. They have a clear understanding of gender and are refining their understanding of specific gender roles.

As a transition to the discussion on grief and loss issues for school-age children, note that children of this age have developed the cognitive and language skills to really talk about the grief and loss they feel.

End of Activity

PowerPoint Slide, Activity 9A: Slides 61-63



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ACTIVITY: Grief and Loss Age Range 6-12

Activity Time: 10 min

Materials:

- Trainee Content: *Grief and Loss in School Age Children* (page 139 of Trainee's Guide)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- PowerPoint Slide: 64

Training Activity:

■ **Step #1.** Discuss how grief and loss are presented and experienced in school-age children.

Display slide 64 and refer trainees to the *Trainee Content: Grief and Loss in School Age Children*. Note that children of this age need concrete information about how the change will affect their daily lives. They also need reassurance that they did not cause the loss and if the loss was related to death, that they are not going to die.

Note the following key grief and loss factors for this age group;

- The loss of the child's peer group adds to the trauma of placement.
- Children under age 9 need as much concrete information as possible to help with feelings of anxiety.
- Children under age 9 may show more expression of emotions other than sadness such as anger, fear, or a need for frequent affection.
- Children over age 9 are better able to understand the reasons for the separation and will blame themselves less.
- Children over age 9 express more worry about others in the family and need reassurances about their safety.

Make sure trainees know that this topic will be presented in greater detail in the core curriculum *Placement and Permanency*, particularly in relation to out-of-home placement.



Step #2. Ask participants for examples of ways to help school-age children through grief and loss issues.

Transition to a discussion on traumatic experiences and PTSD.

End of Activity

PowerPoint Slide, Activity 9B: Slide 64

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 - age 10-12
 - Have increased ability to understand reason for separation
 - May worry about parents more than about self

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ACTIVITY: Traumatic Experiences and PTSD

Activity Time: 20 min

Materials:

- Trainee Content: *Trauma and the Stress Response* (page 145 of Trainee’s Guide)
- Trainee Content: *Post-traumatic Stress Disorder* (page 149 of Trainee’s Guide)
- Trainee Content: *Children and Their Experience of Traumatic Events* (page 153 of Trainee’s Guide)
- Supplemental Handout: Milestones, provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- DVD: *Understanding Traumatized Children: The Core Concepts: The Fear Response: The Impact of Child Trauma* [10 minutes]
- PowerPoint Slides: 65-69

Pre-training Preparation:

Instructions for Cueing the DVD

Play disc 2, part five. Fast-forward 10:53 to the section labeled “The Arousal Continuum.” Play the DVD for 9 minutes & 36 seconds. Stop after the “Fear & Learning” section ends, before the section called “Oppositional Behavior.”

Training Activity:

■ **Step #1.** Review and highlight the main points indicated in the *Trainee Content: Trauma and the Stress Response*. Begin with the definition of trauma, and the examples of stressors. Explain that this information, while being presented in the school-age section, applies to all children.

Display slide 65 and provide a definition of trauma. Include the following key points:

- Trauma is a psychologically distressing event outside the range of usual human experience.
- Trauma revolves around intense fear.
- Trauma induces a prolonged stress response.

Distinguish trauma from neglect by recalling the definition of neglect given in the prior segment about the effects of maltreatment. Neglect is defined as not getting the necessary stimulation at the right time. It is dependent upon the age at which the experience is absent. Trauma, on the other hand, results from the over-activation of the stress network. It is physiologically different than neglect. Repeated activation of traumatic experiences makes the effects more severe and less amenable to treatment.

Tell trainees:

A child raised in an environment of persisting trauma (e.g., domestic violence, physical abuse, and/or community violence), will develop an excessively active and reactive stress-response system. Children who experience chronic trauma have behavioral impulsivity and cognitive distortions that result from activation of the lower regions of the brain.

■ **Step #2.** Display slide 66 and introduce the video clip. Play the DVD. After the DVD, continue the discussion and describe children’s immediate reactions to traumatic events, and then discuss the stress response.

■ **Step #3.** Display PowerPoint slide 67. Reinforce the total-body mobilization through physiological responses, and the adaptive responses of hyperarousal and dissociation.

Emphasize that individual adaptive responses will vary. Many factors appear to play a role in the individual response. Ask trainees for examples from their practice to further emphasize this content.

■ **Step #4.** Use the *Trainee Content: Posttraumatic Stress Disorder* and slide 68 to discuss the features and symptoms of PTSD. Refer trainees to the discussion in the trainee content of the neurobiology underlying PTSD and how PTSD can itself alter the brain’s structure and functioning.

Be sure to include the following key points:

- PTSD involves an extreme stressor event or repeated events with intense and overwhelming response (fear, helplessness, horror) followed by symptoms that continue including flashbacks, depression, and hypervigilance.
- Prolonged or overwhelming stress can impair the stress response structure in the brain, making it more reactive, even over-reactive.
- Trauma also affects brain chemistry through the abundance of the hormone cortisol which inhibits the brain’s ability to form memories.
- Treatment during the acute PTSD phase (1-3 months post traumatic event) can help reduce the risk of developing chronic PTSD. Note that this is a challenge for social workers providing services to traumatized children as there can be difficulties getting children started in therapy quickly.

■ **Step #4.** Note that children and adolescents with PTSD often present with other problems in addition to the PTSD. Those include ADHD, anxiety, phobias, panic, substance abuse, and increased likelihood of other health problems (PowerPoint slide 69).

Refer trainees to the Milestones booklet for a list of PTSD symptoms.

Transition to a discussion of red flags and tips for working with traumatized children.

End of Activity

PowerPoint Slide, Activity 9C: Slides 65-69

Trauma

- The main results from the overwhelming of the brain circuitry
- Reduced activation of the amygdala circuitry increases the activity of the prefrontal cortex and makes them less amenable to treatment

Video Clip

Understanding Traumatized Children: The Core Concepts

The four concepts and the impact of child trauma



Brain Development

- The brain develops
- Survival strategies involve more primitive brain functions
- Primary adaptive responses in critical situations are:
 - Impersonal (fight or flight)
 - Descriptive (survival)
- Different people may have different responses to the same trauma

Posttraumatic Stress Disorder

- It is not a disease, it is a reaction to a traumatic event
- It is characterized by:
 - Intrusive thoughts of the traumatic event
 - Avoidance of reminders, feelings, thoughts
 - Persistent psychological hyperarousal
- It is a clinical condition
- The basis of treatment is restoring the stability of neural circuitry development

Co-Morbidity with PTSD

- It is common:
 - Major depression
 - Panic disorder
 - Anxiety disorders
 - ADD, ODD, Oppositional Defiant
- It is also common:
 - All of the above
 - All but panic disorder
- It is also known as:
 - All of the above
 - Increased likelihood of health problems

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ACTIVITY: Red Flags Age Range 6-12

Activity Time: 15 min

Materials:

- Trainee Content: ADHD (page 157 of Trainee's Guide)
- Trainee Content: Depression (page 165 of Trainee's Guide)
- Trainee Content: Other Mental Health Disorders of Children (page 169 of Trainee's Guide)
- PowerPoint Slides: 70-73

Training Activity:

■ **Step #1.** Explain to trainees that this segment will cover red flags for some of the mental health, health, and developmental concerns that typically emerge during the school years.

Display PowerPoint slide 70 and explain that a mental health disorder can appear at any time, but for our review of school age children, we will focus mainly on ADHD and depression which, like PTSD, may be first diagnosed during the school-age years.

Explain that this activity is merely an introduction to certain mental health issues in children. Advise trainees that they will have a core training on *Mental Health and Mental Disorders* and that there will be additional opportunities in their careers for other advanced trainings on mental health issues. Use the *Mental Health Concerns* slide (70) to segue to the subject of other mental health disorders in children that child welfare workers are likely to encounter. Explain that this is just a brief discussion to raise their awareness about these issues.

In addition to PTSD and the disorders of childhood covered in the previous segments, Attention Deficit Hyperactivity Disorder (ADHD) and depression are commonly diagnosed among children in the child welfare system. These disorders can be viewed in the context of child development, as their presence often influences the expression of several developmental domains.



Emphasize that social workers play a vital role in getting children the services they need through early referral and intervention. Note also that mental health intervention for children must involve a team as the child will need support and consistent care from school, service providers, parents and substitute caregivers. The social worker can facilitate this team by helping parents and caregivers come together and participate as team members.

■ **Step #2.** Display PowerPoint slide 71 and define ADHD by describing its principal characteristics:

- Inattention
- Hyperactivity
- Impulsivity

Note that all children have some level of inattention, hyperactivity, and impulsivity, but children with ADHD exhibit these characteristics to a much greater degree.

A diagnosis of ADHD is usually not made until the child enters school, because the diagnostic criteria require that the child exhibit the symptoms in at least two different settings for at least 6 months in duration.



Use the next slide (72) to emphasize the frequency of co-occurrence of ADHD with other psychiatric disorders. 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 have an anxiety disorder; and up to one-fifth have a mood disorder (ADHD Basics, 2008). Adolescents with untreated ADHD are at increased 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.

Ask trainees if they symptoms of ADHD sound similar to any other disorders. The expected response is that PTSD and ADHD have many features in common. Note that ADHD and PTSD can occur together, but PTSD can sometimes be misdiagnosed as ADHD. Social workers should seek additional assessment if a child who experienced trauma is not responding to ADHD treatment.

■ **Step #3.** Display PowerPoint slide 73, and discuss the causes and symptoms of depression, highlighting that abuse and neglect elevate the risk of depression.



Include the following 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. Get help immediately if the child talks about suicide or appears suicidal.

- Frequent sadness, tearfulness, crying, irritability, anger, agitation, or hostility
- Feelings of hopelessness, worthlessness, or excessive guilt
- Withdrawal from friends and activities
- Lack of enthusiasm or motivation
- Decreased energy level
- Major changes in eating or sleeping habits

- Frequent physical complaints such as headaches and stomachaches
- Indecision or inability to concentrate
- 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

Emphasize that recognizing the symptoms of depression in children can 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.

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).

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.

Briefly address bullying related to weight, gender identity, sexual identify formation or other issues that may begin to affect children in this age range. Note that social workers should assess for this possibility as children in foster care are especially vulnerable to bullying from peers. The California Department of Education provides resources related to bullying. Ask the trainees to flag the website in the trainee content (<http://www.cde.ca.gov/lr/ss/se/bullyres.asp>).

Point out that the *Trainee Content* contains additional information on other mental disorders listed below, but that these disorders will not be reviewed in this class. This is by no means an exhaustive list of mental disorders in children and youth, but may

represent some of the disorders that are more likely to be encountered in the course of their work.

- Anxiety Disorders
- Bipolar Disorder
- Schizophrenia
- Tourette Syndrome

Step #4. Discuss treatment.



Explain that comprehensive treatment must be team based and collaborative. It will likely involve multiple modes of treatment such as psychotherapy and, in some cases, medication. Ask participants how they could engage families in discussing treatment. Note that 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.

Step #5. Note that the school age period is typically a time of slow and steady growth and refinement of skills. By this age, any significant health or developmental problems have been identified. Note the following exceptions:

- Mild intellectual delay is usually not identified until a child enters school (Zeanah, 2005)
- Certain types of epilepsy have typical onset between ages 6 and 12 (Lahl, 2003). Epilepsy is a neurological disorder causing seizures. The seizures may be like short blackouts or may involve involuntary movements of the entire body and loss of consciousness.
- Juvenile diabetes usually appears after age 10 (Legault, 2008) and can be a significant child welfare concern as it requires close monitoring and supervision.

Transition to the next section, the effects of child maltreatment on school-age children.

End of Activity

PowerPoint Slide, Activity 9D: Slides 70-73

Mental Health Concerns

- In 1992, children and adolescents suffer their mental illness severe enough to cause a level of hospitalization.
- Fewer than 1 in 5 of these children actually needed treatment.
- Common disorders include anxiety disorders (OCD, PTSD), depression, bipolar disorder and conduct disorder.
- Social workers play a vital role in tracking children's needs with early assessment and intervention.

Attention Deficit/Hyperactivity Disorder

- The most common psychological disorder in children (12-17% of school age children).
- It is a chronic (long-term) condition.
- Symptoms include:
 - Inattention
 - Hyperactivity
 - Impulsiveness
 - Low tolerance for frustration

Co-Morbidity with ADHD

- Children with other psychological disorders:
- Depression 10% to 15%
- Conduct disorder 25-40%
- Mood disorders 10-20%
- Anxiety disorders 35%
- Learning disability 20-30%

Depression in Children

- May affect as high as 10% of children.
- Symptoms include:
 - School difficulties, refusal to attend
 - Withdrawal, isolation
 - Physical complaints
 - Negative attitude
 - Appropriate emotional behavior

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ACTIVITY: Effects of Maltreatment Age Range 6-12

Activity Time: 15 min

Materials:

- Trainee Content: *The Effects of Child Abuse and Neglect on School Age Children* (page 175 of Trainee's Guide)
- Trainee Content: *Sexual Behaviors that are Cause for Concern* (page 177 of Trainee's Guide)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Flip chart
- Marker
- PowerPoint Slide: 74

Training Activity:

■ **Step #1.** Display slide 74 and refer trainees to *Trainee Content: The Effects of Child Abuse and Neglect on School-Age Children*. Use the handout as a basis for a guided group discussion on the impact of abuse and neglect on school-age children. Stress the interrelatedness of the effects across the SPECS domains.

Ask trainees to describe how maltreatment affects the development of school age children. List S.P.E.C.S. down the left hand side of a flip chart page and document trainee's responses to the question.

Encourage trainees to give examples of behaviors and impacts on children from their own practice experience. Look for responses such as:

- S: excessive seeking of positive feedback or adult interaction, withdrawn behavior, taking on a parenting role
- P: generalized delays, sickliness
- E: withdrawn behavior, victimization by peers, excessive dependence on others and lack of initiative
- C: delays in speech and language, lack of problem solving ability
- S: developmentally inappropriate sexual play including sexual activity focused on adults

■ **Step #2.** Refer to the *Trainee Content: Sexual Behaviors that Are Cause for Concern*, which details problematic signs and symptoms related to the sexual development of school-age children.

■ **Step #3.** Ask trainees, “How might a chaotic, unpredictable, or explosive environment in an abusive family, or the absence of structure in a neglectful family affect the behavior and development of a school-age child? Make sure the following information is covered:

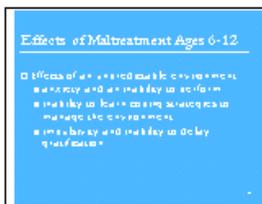
- When the environment is unpredictable, rules are rarely clear. The parent may impulsively change the rules, or may react differently to the child’s behavior or to a situation at different times. In a neglectful home, there may be no rules. The child is left without a clear structure to guide his activities, resulting in anxiety and an inability to perform.
- The absence of predictable outcomes interferes with the child’s ability to learn coping strategies to effectively manage and master his environment. The child may not learn that she has control to manage the environment.
- When rewards are inconsistently given or absent, the child may learn that the only way to assure having something is to take it when you can. The child learns to behave impulsively, and is rewarded immediately, which counteracts development of the ability to delay gratification.

Point out that as children become older, the effects of child maltreatment become less discernible from other factors that may be causing certain behaviors. Other causes should be ruled out before determining that a particular effect is the result of child maltreatment.

Transition to the next activity, a discussion of implications for practice with school age children.

End of Activity

PowerPoint Slide, Activity 9E: Slides 74



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ACTIVITY: Implications for Practice Age Range 6-12

Activity Time: 15 min

Materials:

- Trainee Content: Erik (Case Scenario) (page 179 of Trainee's Guide)
- PowerPoint Slides: 75-77

Training Activity:

■ **Step #1.** Display slide 75 and ask trainees to offer suggestions for how they might change the way they interact with traumatized children based on the information covered in this segment on school-age children.

Be sure the responses include ideas such as:

- Maintaining consistency in interaction, visiting regularly and establishing a routine
- Engaging children in a calm environment with few distractions
- Maintaining control of their own non-verbal cues during interaction
- Timing visits so they occur at low stress times of the day
- Letting the child lead the pace and content of the meeting – if he wants to play catch, play catch

Note that these strategies apply not just to school-age children, but all children.

■ **Step #2.** Discuss the differences in mental states related to anxiety and fear in children. Compare a low level of arousal with that of hypervigilance. The low level of arousal is optimal for learning, while hypervigilance requires constant checking of the environment to make sure that it is safe. When children are hypervigilant, they are not using or developing their rational brain (neocortex) due to preoccupations with ascertaining their level of safety.

■ **Step #3.** Discuss resiliency. Show the corresponding PowerPoint slide (76). Tell trainees that resiliency may be defined as the ability to adapt to and/or overcome adverse or traumatic experiences based on one's skills, attributes and access to outside resources (Alvord & Grados, 2005).

Though research is being conducted to determine the exact causes for resiliency, some studies have shown that there may be a neurobiological connection (Bazelon, 2006). Scientists have discovered the 5-HTT gene, which is found to play a role in the regulation of serotonin in the brain. This gene may



influence how some children cope and adapt to experiences of abuse and neglect, and seem to overcome extreme adverse circumstances (Bazelon, 2006).

Resiliency is associated with both individual and environmental factors (Brittain & Hunt, 2004):

Individual factors include good cognitive and social skills, a positive self-perception, and a willingness to seek out support.

Environmental factors include supportive family and friends, stability of the living environment, positive interactions with others, and a connection to the community.

- **Step #4.** Conduct a small group activity to apply the concept of designing face-to-face contact with children in a way that enhances their ability to participate in the meeting. Ask trainees to read the short scenario *Trainee Content: Erik (Case Scenario)* and answer discussion questions in their table groups. Process the answers in the larger group.



Display PowerPoint slide 77 which contains the following discussion 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 during the next meeting to make it easier to interact with Erik?

Look for the following responses:

- Ignore the behavior involving the keys and attempt to engage Erik in a task he will find rewarding, a task involving gross motor activity, or a task that is an area of skill for Erik.
- Plan the visit for a time and location that will give Erik an outlet for his energy and a chance to interact in a positive way. Talk to Erik's caregiver and teachers about scheduling the meeting for a time of day that is easier for Erik. Discuss the plan in advance with Erik so he knows what to expect.
- Plan a couple of activities that will be fun for Erik and allow him to choose. Build consistency and rewards into your interactions with Erik.

Transition to the next section, a discussion of normal development in adolescents.

End of Activity

PowerPoint Slide, Activity 9F: Slides 75-77

Implications for Practice

- What are we doing in schools that is not working for at-risk children?

How can we best intervene?



Resiliency

- Ability to overcome adversity
- Individual factors – cognitive and social skills, self-efficacy, hope, coping
- Environmental factors – adversity, stability, community resources
- Genetic factors – associated with the regulating serotonin levels

Application to Practice

- How do we measure “it’s not what you wish for”?
- Discuss the following scenarios
 - What are you doing to engage ELL during the meeting?
 - What are you doing differently to help the ELL meeting?
 - What are you doing differently during the ELL meeting to make a student involved with ELL?

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Adolescence and Emerging Adulthood

Total Segment Time: 60 min

TRAINING ACTIVITY 10A

ACTIVITY: Normal Development Age Range 12-21

Activity Time: 15 min

Materials:

- Trainee Content: *The Normal SPECS of Development for Adolescents* (page 181 of *Trainee's Guide*)
- Trainee Content: *The Normal SPECS of Development for Emerging Adults* (page 195 of *Trainee's Guide*)
- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC—see Materials Checklist)
- Flip chart
- Markers
- PowerPoint Slides: 78-80

Training Activity:

■ **Step #1.** Display slide 78 and introduce this section by asking for a one-word association with the words *adolescents* and *teenagers*. Write the words on a flip chart page. Trainees will typically voice a list of negative terms. This gives the trainer a chance to talk about our image of adolescents. Contrary to some expectations, recent studies show that parents have more positive than negative experiences with their adolescents. Studies also indicate that what teens most want today is not the latest gadget, but time with their parents. Adolescents need substantial adult attention to cope with the tremendous changes happening to them. They value time with adults to process what’s on their minds. Though they need to rebel to individuate and discover their self-identities, they also require strong support to help integrate what is happening in their bodies and minds. This is a time of both independence and dependence as adolescents seek their own identity yet cling to their families which may result in internal conflict for adolescents that then manifests in belligerence to adults or acting out behaviors.

■ **Step #2.** Provide the following introduction to adolescent development. Show the corresponding PowerPoint slide (79).

- *Defining Adolescence:* The exact definition of adolescence is difficult to pin down in a few words. Essentially it is marked by the onset of puberty (see below) and concludes when adult roles are assumed. In neuroscience, adolescence is considered to conclude when adult brain function is attained. This is generally thought to occur in the early 20s. However, as with most markers of brain development, there are individual differences.
- *Adolescence:* the interval between the onset of sexual maturation and the attainment of adulthood (Dahl, 2003)
- *Puberty:* the period of life when the reproductive glands begin to function (Webster’s Dictionary)
- What is clear is that adolescence is a time of transition, both in biology and in behavior. As the American Bar Association states, “Adolescence is a transitional period of life during which a child is becoming an adult. An adolescent is at the crossroads of change, where emotions, hormones, judgment, identity, and the physical body are so in flux that expert researchers, as well as parents, struggle to fully understand their impact.”
- *Specific concerns for adolescents in the child welfare system:* For youth in the child welfare system, adolescence can be an especially trying time. In addition to learning the skills they need for adulthood, adolescents in the child welfare system need to resolve what happened in childhood. If they have not gained trust as a baby, autonomy as a toddler, initiative in the preschool years and mastery in the school-age years, adolescence is especially challenging. Often caregivers of teens in the child welfare system observe that they move up and down the developmental ladder.
- *Overview of the significant changes of adolescence:* Most trainees have significant knowledge of the teenage years from their own life experiences in addition to their education and training. Emphasize that understanding adolescent development is the key to being successful in working with youth and for providing caregivers assistance with parenting.

■ **Step #3.** Revisit the one-word associations voiced earlier in order to stress the concepts of (1) identity formation, (2) changes in the brain, body, and emotions and (3) the development of conventional morality. Refer to the *Trainee Content* to highlight the most significant changes in these areas. Ask the class for some examples of these three concepts from their work with adolescents. Reflect with the

class on the passion of adolescents as well as their creativity and ability to master adult tasks.

Discuss:

- Other behaviors typical of adolescence that may present parenting challenges include:
 - ≡ Difficulty in remembering multiple tasks
 - ≡ Not doing things they find boring
 - ≡ A need for excitement (Since teens are likely to engage in risky activities, it behooves caregivers and social workers to help adolescents find exciting outlets that are safe.)

■ **Step #4.** Review the adolescent SPECS. Include the following information:

- *Social relationships:* Peer groups become a dominant source of social values and contact. Developing relationship skills and intimacy in the adolescent years is essential to having healthy relationships in adult life. Social workers need to help youth maintain their friendships so they can master the development of loyalty, confidence, and trust in relationships.



- *Physical:* A significant growth spurt supports the development of puberty. Brain development continues. Physiologically, research has indicated that teenagers need more sleep than adults, approximately 9 hours per night.
- *Emotional:* Adolescents often experience strong waves of rapidly changing emotions. They are more emotionally labile than at any other stage. They may seek out intense emotional experiences. According to Erikson, the adolescent's primary psychosocial task is to explore and establish his/her unique self-identity. One aspect of this is individuation from parents and other adult authority figures. Understanding one's culture of origin may become very important during this time.
- *Cognitive:* With the development of "formal operations" as described by Piaget, adolescents can begin to think hypothetically, refine their logical reasoning abilities, develop insight, and engage in systematic problem-solving.
- *Sexuality:* Sexual development is a significant part of adolescence and is heavily influenced by culture. While gender identity and sexual preference may be established before adolescence, youth engage in extensive exploration of these during adolescence. Explain that foster care providers are now required to adhere to legal guidelines regarding their responsiveness to the sexual orientation of their foster children (A.B. 458, the Foster Care Non-Discrimination Act).

■ **Step #5.** Display slide 80 and introduce the concept of emerging adulthood. Explain that because extended foster care now allows people ages 18-21 to remain in care as they transition to adulthood we must consider the developmental needs of this age group.

Explain that the brain continues to develop during this time and 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).

Further, 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).

Ask the group if they can think of any benefits for this brain process in emerging adulthood. Be sure to include in this discussion the role of healthy risk taking for young adults who are expected to take on new challenges by trying new things, new environments, and new roles (Dobbs, 2011).

Note that extended foster care can provide a valuable support network for young adults who are taking on new challenges and explain that this support may be especially important for youth who have experienced trauma. As we discussed earlier, trauma can impact brain development and young adults who have experienced trauma may have more difficulty with planning and organizing behavior and with inhibiting impulses (Aamodt & Wang, 2011).

Refer the trainees to the *Trainee Content: The Normal SPECS of Child & Youth Development: Emerging Adulthood* for more information about this stage of development.

Transition to a discussion of adolescent brain development.

End of Activity

PowerPoint Slide, Activity 10A: Slides 78-80

Adolescents

- I am what I identify



Adolescents

- S - Peer identity issues, social acceptance
- F - Growth, brain development, sexuality
- E - Individual identity, beliefs, increased cognitive, moral development
- C - Hormonal fluctuations
- S - Physical relationships, sexual identity, gender identity

Emerging Adults

- Ages 18-25
- Continued development of the prefrontal cortex
 - involving impulse control, planning, and goal setting
- Age of first dating
- Emerging adults may experience additional needs and requirements required as young adults

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ACTIVITY: Brain Development Age Range 12-21

Activity Time: 15 min

Materials:

- Trainee Content: *Adolescence and Brain Development* (page 199 of Trainee’s Guide)
- Trainee Content: *Sleepy Teens* (pages 201 of Trainee’s Guide)
- DVD: *Frontline: Inside the Teenage Brain*. [6 minutes]
- PowerPoint Slides: 81-87

Pre-training preparation:

Instructions for Cueing the DVD

The DVD does not have a title menu or chapters from the beginning. Fast-forward past the go-cart scene to the parking garage scene. Play the DVD for 6 ½ minutes. Stop at the party scene.

Training Activity:

■ **Step #1.** Display slide 81 and introduce the video *Inside the Teenage Brain*. Show the designated segment of the video. Have a short discussion on the changes to the teenage brain and expectations regarding teenage behavior.

■ **Step #2.** Discuss adolescence and brain development. Display slide 82 and refer participants to *Trainee Content: Adolescence: The Last “Best” Chance to Influence Brain Development*. Review the following:

Adolescence: The Last “Best” Chance

Adolescence has recently been identified as the last “critical window of opportunity” to influence brain development.

Display PowerPoint slide 83 as you begin the discussion of adolescent brain development.



During adolescence, the greatest changes in brain development occur in the parts of the brain that manage self-control, judgment, emotions, and organization. The frontal and parietal lobes are particularly involved.

However, portions of the limbic system also influence teen behaviors.

Interestingly, teens can influence the development of their own brains: “... unlike infants whose brain activity is completely determined by their parents and environment, the teens may actually be able to control how their own brains are wired... Kids who exercise their brains by learning to order their thoughts,

understand abstract concepts, and control their impulses are laying the neural foundations that will serve them for the rest of their lives. ‘You are hard-wiring your brain in adolescence. Do you want to hard-wire it for sports and playing music and doing mathematics – or for lying on the couch in front of the television?’” (Dr. Jay Giedd—NIMH) The latest information on brain research indicates that experience strongly informs brain architecture (Siegel, 2001, Siegel, 2007).

Ask participants about how this information might influence their work with adolescents.

■ **Step #3.** Review, briefly, the progressive development of the brain and show slide (83), *Brain: Side View*. By adolescence, the three lower regions (brain stem, mid-brain, and limbic system) are essentially fully developed. Adolescence is a time of significant change in the cortical region, especially in the prefrontal cortex. The same principles that govern early development guide development during the adolescent years. The brain continues to develop in a “use-dependent” manner—that is, how the brain is used guides how the brain develops. The adolescent who has opportunities to practice decision-making activities in relatively safe environments is more likely to avoid the pitfalls of emotionally-driven behaviors and develop the skills associated with affect regulation.

Ask participants how they might use this information when working with adolescents (for example, encouraging opportunities for them to develop rational judgment).

■ **Step #4.** Discuss puberty and the brain, showing the corresponding slide (84) and a synopsis of the following material:

Behavioral Impact: Puberty

Brain changes during puberty include a combination of a highly active limbic system and an underdeveloped prefrontal cortex. This is a prescription for volatility, at least for some youth.

As stated by Ron Dahl, “... changes in adolescent brain development that are specific to puberty have their primary effects on motivation and emotion. These changes manifest as mood swings, increased conflict with parents, a greater tendency for risk-taking and rule-breaking, an increased draw toward novel experiences and strong sensations, alterations in sleep/arousal regulation, and an increased risk of emotional disorders (particularly depression in adolescent girls). Last, but certainly not least, are the alteration in romantic and sexual interest, which are also more closely linked to puberty than to age” (Dahl, 2003).

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 mothers 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).

■ **Step #5.** Display PowerPoint slide 85. Discuss affect regulation as a subset of processes involved in controlling feelings, particularly the strategic control of feelings to serve a goal or purpose. The strategic control of feelings involves determining whether a goal is actually attainable (cognitive) and, then, if it is worth pursuing – does it have sufficient value to justify pursuit (a more affective or emotional appraisal).

Explain that although an adolescent has more difficulty performing the higher-level activities mediated by the frontal cortex in the context of high-intensity social situations, he or she can, within the proper structure and with guidance, successfully navigate the challenges of adolescence.

■ **Step #6.** Provide an example of performance in situations of low intensity and high intensity, e.g., understanding the dangers of early sexual activity in a health class versus the back seat of a car!

■ **Step #7.** Continue the discussion. “Young teens, who characteristically perform poorly..., activated the amygdala, a brain center that mediates fear and other ‘gut’ reactions, more than the frontal lobe. As teens grow older, their brain activity... tends to shift to the frontal lobe, leading to more reasoned perceptions and improved performance” (Dahl, 2003).

Since the development of the prefrontal cortex is generally thought to continue at least into the early 20s, it follows that behaviors regulated by that section of the brain are likely to manifest late in adolescence. Hence, parents often report an evolution in behaviors as a son or daughter progresses through middle school to the late high school or college years.

Because their frontal lobes are still maturing, teens cannot react efficiently in situations of high emotional content. And, if they are thinking or doing other activities at the time an emergency arises, they may not respond appropriately. Driving down the highway talking on the cell phone, even when hands-free, the teen may not respond quickly enough when brake lights start appearing in front of them. The teen will take longer to appraise the situation and react appropriately.

Adolescence often presents life circumstances that overwhelm the capacity of the brain to make good decisions, quickly. Stress (cortisol) compounds the problem.

As the brain matures, the connections between the frontal cortex and the limbic region become more efficient (increased myelination), so the frontal cortex is more likely to inhibit the emotionally charged limbic response.

■ **Step #8.** Display PowerPoint slide 86. Discuss the issue of sleep and adolescence. Refer participants to the *Trainee Content: Sleepy Teens*. Discuss the findings about adolescents' increased need for sleep, consequences of sleep deficit, and the vicious cycle of sleep deprivation.

Include the following key points:

- The brain must have REM sleep in order to consolidate new information and effectively store it.
- During adolescence, sleep inducing hormones are released later in the day, leading teens to not get drowsy until later at night.
- Teens need at least 9 hours of sleep per night. Consequences of too little sleep include (PowerPoint slide 87):
 - decreased motivation
 - inability to concentrate
 - emotional lability
 - difficulty learning
 - impaired ability to process emotion and think at the same time
 - decreased reaction time



■ **Step #9.** Ask participants how they could use this information to engage youth and caregivers. For example, if sleep is so important, how could caregivers be engaged to make sure that teens have sufficient sleep?

Encourage responses such as:

- establishing school night curfew and weekend curfew
- limiting late night TV watching, texting, computer use
- encouraging teens to rest or nap when possible, but avoiding a pattern of “catch-up” sleep)
- avoiding emotional conflict at bed time

Transition to a discussion of grief and loss in adolescence.

End of Activity

PowerPoint Slide, Activity 10B: Slides 81-87

Video Clip
-Inside the Teenage Brain-



Brain development during adolescence

Adolescence

- The "Storm" of the "Storm and Drift"
- The "Storm" is puberty and behavior
- The "Drift" is withdrawal, resistance
- How and why some of them develop mental illness

Adolescent Brain Development



Behavioral Impact Puberty

- Highly sexual limbic system (emotions + decision making)
- Underdeveloped prefrontal cortex (Poor decision making + decision making)
- Risk taking, mood swings, irritability, etc.

Behavioral Impact Age-Related

- Adolescents need structure in their lives
- Structure helps to regulate the development of behavior
- How to regulate the effects of hormones
- How to help them cope with social anxiety in the face of being a "stranger" and/or conflicting feelings

Sleep and Adolescents

- Changes in circadian rhythm
- Increased need for sleep (8-10 hours)
- Difficulty falling asleep
- Teens who don't sleep don't have enough time for school



Consequences

- Decreased motivation
- Increased risk of substance use and other risky behaviors
- Difficulty learning
- Delayed recovery time

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ACTIVITY: Grief and Loss in Adolescence

Activity Time: 5 min

Materials:

- Trainee Content: *Grief and Loss in Adolescents* (page 203 of Trainee's Guide)
- PowerPoint Slides: 88-89

Training Activity:

■ **Step #1.** Display PowerPoint slide 88 and discuss how grief and loss are presented and experienced by adolescents. Review the indicators and characteristics of grief and loss in adolescents listed in the *Trainee Content: Grief and Loss in Adolescents*.

Include the following key points:

- Teens may feel guilt about the separation or loss.
- Teens may have difficulty accepting support and nurturance, but they need support and assistance in order to cope.
- Simultaneous feelings of love and anger may be difficult for the teen to manage.

■ **Step #2.** Display PowerPoint slide 89 and discuss how social workers can help teens process feelings of grief. Reinforce responses involving:

- Encouraging teens to express feelings
- Giving permission to feel or not feel
- Reaching out to shy teens
- Tolerating anger and hostility in the expression of guilt
- Recognizing gender differences in expression of guilt

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

Transition to a discussion of the effects of maltreatment.

End of Activity

PowerPoint Slide, Activity 10C: Slides 88-89

Grief & Loss in Adolescence

- ◻ **Losses & Challenges**
 - May feel guilty about the separation or loss
 - Loss may cause basic emotional fluctuations
 - Struggles/feelings may occur
 - May not always need for support and therefore not always necessary

Implications for Practice

- ◻ How can we help teens express feelings of grief?

How can we best intervene?



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ACTIVITY: Effects of Maltreatment Age Range 12-21

Activity Time: 10 min

Materials:

- Trainee Content: *The Effects of Abuse and Neglect on Adolescents* (page 205 of the Trainee's Guide)
- Flip chart
- Markers
- PowerPoint Slide: 90

Training Activity:

■ **Step #1.** Display slide 90 and refer trainees to *Trainee Content: The Effects of Abuse and Neglect on Adolescents*. Ask trainees how maltreatment affects adolescent development. List the S.P.E.C.S. domains down the left hand margin of a flip chart page. Ask trainees what consequences of abuse and neglect in adolescents they have seen. Note the responses in the correct domain.

Look for responses such as:

S: difficulty in peer relationships, antisocial behavior, running away

P: sickliness, clumsiness, delayed puberty

E: emotional lability, poor self-esteem, depression, anxiety, suicidal ideation

C: inability to think hypothetically, poor school performance, inability to take another's perspective

S: inability to form age appropriate relationships

Remind trainees of the effects of trauma on development for emerging adults. Young adults who have experienced trauma may have more difficulty with planning and organizing behavior and with inhibiting impulses (Aamodt & Wang, 2011).

■ **Step #2.** Generate discussion about the effects of abuse and neglect. Ensure that the following points are made:

- This is a challenging time for caregivers—and for adolescents whose primary task is to separate from those caregivers!
- Most adolescents who are served by child welfare agencies have a history of maltreatment and have been raised in dysfunctional families.

■ **Step #3.** Discuss the concept of differentiating developmental effects of maltreatment from other issues affecting adolescents. Include the following points:

- At times, one will encounter youth who have been maltreated for the first time during adolescence. The normal stresses of adolescence can create crisis situations for some families who were previously capable of more appropriate management.
 - *Youth who are maltreated for the first time during adolescence typically display very different development outcomes than do children who have been subjected to chronic maltreatment.*
 - They are often “healthier” and more amenable to short-term or crisis intervention counseling and services; however, their behavior may appear to be as dysfunctional as that of a chronically maltreated child.

- It is critical that the caseworker make a thorough and accurate assessment of the child’s developmental level and strengths before formulating a treatment plan.
 - *For some adolescents, the problematic or acting-out behaviors are an adaptive response designed to protect themselves from dysfunctional family situations.*

- The presence of sexual abuse should always be considered and carefully assessed. 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).
 - Truancy and acting-out behavior, combined with depression, are often responses to sexual abuse in the family.
 - 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).
 - Sexual development in adolescence for both boys and girls is almost universally *negatively affected by sexual abuse*. Porter, Blick, and Sgroi (1982) describe the tendency for sexually abused youth to view themselves as “damaged goods”—mysteriously altered and somehow permanently damaged physically and socially from their sexual experiences.
 - Intense guilt, shame, poor body image, lack of self-esteem, and lack of trust in sexual relationships are frequent developmental outcomes of sexual abuse. All of these factors can pose serious barriers to a youth’s ability to enter into mutually satisfying and intimate sexual relationships.

- Past maltreatment can affect how an adolescent negotiates the developmental task of identity formation. Failure to resolve earlier developmental tasks can contribute to identity confusion.

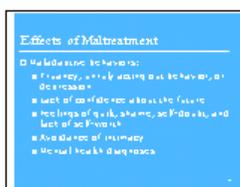
- Failure to achieve *basic* trust can have severe consequences on the development of identity, including failure to understand that changes in their lives are possible, inability to understand their own role in promoting changes, and inability to tolerate momentary delays in gratification.
- Failure to achieve *autonomy, initiative, and industry* during earlier developmental stages can affect the adolescent’s ability to develop a stable, positive identity. Youth 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.
- Youth may try to deal with these negative outcomes by over-compensating, including becoming narcissistic and unrealistically self-complimentary, or harboring grandiose ideas of their capability and having high expectations for their performance in the future. The youth can also “give in” and behave in self-defeating ways, or fail even to try to master the challenges of developing an independent self.
- To be comfortable in intimate relationships, one must have a well-developed and positive sense of self. The failure to achieve identity can interfere with development in the next of Erikson’s stages, the development of *mature intimacy*. The experience of emotional and sexual intimacy can be threatening to persons without a strong identity.

End this segment by calling attention to the importance of permanency in the lives of foster youth. Transition to a discussion on the implications of adolescent development issues on practice.

Transition to the next section, a discussion of implications for practice.

End of Activity

PowerPoint Slide, Activity 10D: Slide 90



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ACTIVITY: Implications for Practice Age Range 12-21

Activity Time: 10 min

Materials:

- Trainee Content: *Elements of Positive Youth Development* (page 207 of Trainee's Guide)
- PowerPoint Slides: 91-93

Training Activity:

■ **Step #1.** Discuss the Y.O.U.T.H. Training Project, a youth development program for current and former foster youth ages 16-24. The project prepares youth to develop and deliver training to child welfare professionals on how to better serve youth. Refer trainees to the *Trainee Content: Elements of Positive Youth Development*.

■ **Step #2.** Display PowerPoint slide 91. Youth success is predicated on youth having a sense of belonging, usefulness, power, and competence. When youth do not have permanency, they are that much more challenged to achieve success. Relate these priorities to the characteristics of adolescent development and needs.



■ **Step #3.** Engage participants in a discussion about how this developmental Information will change their work with adolescents. Given what we know about brain development, the SPECS milestones for adolescents, and the long-term effects of trauma, grief, and loss, how do we engage teens and their caregivers?



■ **Step #4.** Display PowerPoint slide 92. Adolescents who have successfully emerged from difficult personal circumstances, including institutionalization for uncontrolled behaviors have the following characteristics: (Hauser, Allen, & Golden, 2006)

- *Reflectiveness*: curiosity about one's thoughts, feelings, and motivations; willingness to try to make sense of them and handle them responsibly. Why do I behave this way and what can I do about it?
- *Agency*: conviction that what one does matters; one can accept responsibility for, and positively influence, one's own life. The individual no longer continually blames others for his/her situation.
- *Relatedness*: engaging and interacting with others; a willingness to accept and use supportive relationships.

Ask participants, “What does this mean? How do you activate reflectiveness? Agency? Relatedness?” Encourage responses related to talking to youth about their feelings and motivations, holding youth responsible for their actions and working with youth to find and maintain permanent connections.

■ **Step #5.** Refer to *Trainee Content: Positive Youth Development Elements*, and briefly review these elements written by youth as part of the Y.O.U.T.H. project. Tie these elements into the characteristics for success that we just discussed. Ask them which of these elements will lead to the characteristics of belonging, competence, power, and usefulness. Solicit responses such as self-determination will lead to a sense of competence and power.



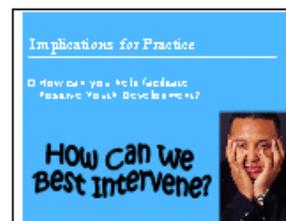
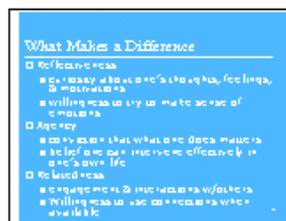
■ **Step #6.** Display slide 93 and refer trainees to the associated trainee content. Conduct an activity to stimulate thinking about how the trainees could help facilitate these elements in their work with youth. Ask them to discuss strategies to bring forth those elements in their table groups for about 5-7 minutes. Tell participants that at least one strategy should be completely out of the box. Ask them to consider how they might use this information to work with, and talk with, teens. Bring the group back together and ask participants for some of their best ideas as well as their “out-of-the box” suggestions.

Be sure to include youth ages 18-21 in the discussion. Stress the changing role of the social worker with young adults as they give more decision making power to the young adult but remain present as a support to the young adult.

Transition to the next segment, Case Application.

End of Activity

PowerPoint Slide, Activity 10E: Slides 91-93



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Case Application

Total Segment Time: 50 min

TRAINING ACTIVITY 11A

ACTIVITY: Tammy and Marcus

Activity Time: 25 min

Materials:

- Supplemental Materials: Tammy and Marcus scenarios. These are provided in the Trainer's Supplemental Materials.
- PowerPoint Slide: 94

Training Activity:

■ **Step #1.** Display slide 94 and distribute the Tammy and Marcus case vignettes. This is a table group exercise. Assign the Tammy case to half the tables and the Marcus case to the other half. Ask trainees to read their assigned vignette and answer the questions at the end. They can refer to the Supplemental Handout: "The SPECS of Normal Development" and *Trainee Content "Ways to Help Maltreated Children"* from the Trainee's Guide Day 2, (or any other *Trainee Content*) to assist them with making decisions.

■ **Step #2.** Ask each group to report out and process their responses, including how they would talk to the caregivers.

Points to bring out in the discussion include:

Tammy:

- Physical development: Tammy has appropriate height and weight.
- Neglect: Tammy may have experienced a deficit of experience in the first years of her life.
 - She could not dress herself and was not potty trained at age 4, not meeting commensurate physical and emotional development in this area.
- Social development problems: Tammy does not attach to caregivers and does not make transitions well.
- Regresses to an even earlier emotional level when she sees her mother.
 - The mother could also have emotional developmental deficits.

- Cognitive delay: She can only do 2-step directions.

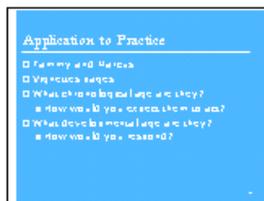
Marcus:

- Physical development: Marcus has appropriate height and weight.
- Neglect: Marcus may have experienced neglect in the first two years of life.
 - Has not dealt with abuse and neglect issues; grandparents do not want to address these issues, so they are prolonged.
- Social domain problems: Marcus does not have friends and other children do not engage with him.
- Cognitive: He does not understand rules, wants what he wants, has poor impulse control.
- Emotional: Marcus has tantrums like a 3-year-old; does not modulate his impulses.
 - Possible PTSD, diagnosed with ADHD, but he is able to sit and concentrate. Symptoms are more in line with PTSD and Marcus says that the ADHD medicine is not working.
 - Marcus freezes and escalates behavior when asked to do something that he does not immediately understand. This is consistent with children who have experienced trauma.
- Strengths:
 - Marcus is engaging
 - Has an extended family and involvement from his father may be very beneficial to him
 - Likes to eat
 - Likes to smile
 - Wants to engage with the children
 - Is embarrassed by his “shadow”
 - Knows that his medication is not right for him

Transition to the training activity “What would you do?”

End of Activity

PowerPoint Slide, Activity 11A: Slide 94



ACTIVITY: What Would You Do?

Activity Time: 25 min

Materials:

- Supplemental Materials: Case scenario cards. These are provided in the Trainer’s Supplemental Materials
- Flip chart
- Markers
- Prizes
- PowerPoint Slide: 95

Pre-training Preparation:

Reproduce the scenarios in the Trainer Supplemental Materials and place each scenario on a large index card. (Do not include the answers.) Make enough duplicate scenarios so that each table can have a copy of each of the scenarios.

Training Activity:

- **Step #1.** Display slide 95 and conduct an activity called “What would you do?”

Distribute one scenario at a time to each table, face down. Explain that starting with Scenario #1, for approximately 3 minutes, each table should discuss concerns and possible next steps to assist the “client” in each case scenario. Ask participants to decide if the scenario is 1) Typical, 2) Of concern, or 3) In need of referral (write these on the flip chart). Also, they should discuss the practice implications for each scenario. When a table group has an answer, they should raise their hands quickly.



Make it clear during this exercise that it is not the role of the child welfare worker to diagnose medical or mental health issues. However, they should be aware of signs and symptoms that require assessments by a medical and/or mental health professional, and make the appropriate referrals. Stress the importance of early assessment and intervention and the social worker’s role in identifying concerns, making referrals and establishing a team to provide services to the child and family.

Before starting the game, advise trainees that you will be the *Judge of Questions*, and players will have to accept your authority. (If there is an assistant in the room, then there can be a “panel of judges.”) Use the flip chart and markers to tally points.

Basis for points:

- 1 point for getting it first
- 1 point for getting the answers on the suggested answer sheet or for providing other reasonable answers. (If the first table has the right answer, proceed to the next question. If the first table has the wrong answer, then ask the next table.)
- Points for creativity
- Points for thoroughness
- Points for thoughtful assessments
- Points for whatever you want to give them

Each scenario is included below, along with possible discussion points in bold. These are only some of the possible correct answers that trainees may provide.

Case Scenario #1:

David is 8 years old. To date, he has no clearly identifiable learning disabilities. Although he has a lot of friends at school, he claims to dislike going to school and “thinks it’s boring”. Historically, his academic grades and report cards have indicated average performance. His teacher observes the following:

- Fidgets often with hands or feet; squirms while seated
- Often runs, climbs, and leaves his seat in situations where sitting or quiet behavior is expected
- Blurts out answers before hearing the whole question
- Has difficulty waiting in line and taking turns
- Interrupts others when they are speaking
- Often is easily distracted by irrelevant sights and sounds
- Often fails to pay attention to details and makes careless mistakes
- Rarely follows instructions carefully and completely
- Frequently loses or forgets things such as toys, pencils, books, and tools needed for a task
- Often skips from one uncompleted activity to another

Questions to ask the Group: What are your concerns? What would you do? What are the implications for your interactions with the child and family?

Possible Points Scenario 1:

- **Refer David for an assessment by a mental health professional for suspected ADHD.**
- **Work on increased body awareness and identify personal centering /calming techniques and behaviors.**
- **Discuss techniques and supports for setting David up for success in the classroom; i.e., an organizational checklist for materials; a daily review of a sequential outline of classroom rules and expectations; reward / incentive program for staying seated, completing tasks, taking turns, etc...**

Case Scenario #2:

Samir, age 6, was moved to a foster home after a drug raid on his home where his parents were found with a methamphetamine laboratory. The parents were arrested. You get a call from Samir's grandmother who is caring for him and she is very upset. She tells you that Samir started school today, but she was called to go meet with the teacher and principal. Samir is unable to comprehend the information that the teacher gives him and fights with other children on the playground. He cries when he is frustrated and when other children try to engage with him to do classroom work. He was fighting with the other children and ran around during the reading circle. He could not be redirected and refused to respond to the teacher. He would not play with the other children and wet his pants. He did not know his colors and threw a tantrum when the teacher tried to help him with them. Samir also did not know how to ride the tricycle.

Questions to ask the group: What are your concerns? What would you like more information about? What would be your next steps in working with this child? What resources might you want to engage?

Possible points Scenario 3:

- **Refer for assessment by both medical and mental health professionals.**
Concerns are:
 - **Samir may have been exposed to drugs by his parents.**
 - **Possible exposure to other trauma**
 - **Learning difficulties (can refer for an IEP; give extra points if trainees know how to do this). May need to have some academic assessment to ascertain school readiness.**
 - **Reaction to being taken away from his parents**
 - **Likely needs additional emotional support from grandmother, case worker and school personnel. Look into possible visitation with other family members and familiar community.**
 - **Neglect**
 - **Possible attachment problems**
- **Samir needs to be assessed for developmental issues that could include problems in the following domains:**
 - ⌘ **Social development (not being able to relate to the children or teacher)**
 - ⌘ **Physical/motor development (she would not sit still for circle time and could not ride the tricycle)**
 - ⌘ **Emotional development (tantrum; wetting his pants)**
 - ⌘ **Cognitive (he does not know his colors)**
- **It should also be considered that Samir is just having a hard time transitioning to the school setting.**
- **Grandmother could request that Samir be allowed to transition to the new setting more slowly (perhaps with grandmother present at first) to see if he**

settles down and is better able to tolerate and function in the new environment.

- **An individual meeting with Samir’s teacher and grandmother to discuss some ideas to help him be more successful in the classroom. Review classroom rules and expectations. Possibly create an incentive program like special outings or play dates for Samir as encouragement for good listening and cooperation.**
- **Look into a social skills play group to help Samir with his comfort and skill development in a larger group setting like school.**
- **An assessment would still be indicated.**
- **Provide grandmother ideas for interacting and bonding with Samir.**

Case Scenario #3:

Darius, age 18, has decided to stay in extended foster care as a non-minor dependent youth. When Darius was 10, he and his 3 siblings were placed in foster care because of his parents’ drug use. Darius was in the same foster home for many years, but when he turned 18 he left his long term placement and moved into a shared apartment nearby with two roommates. His plan was to attend community college to take classes toward an eventual degree in criminal justice.

You have just learned that Darius is no longer staying in his approved placement and has dropped out of school. He states he wants his case closed because he is tired of being in the system and feels like he can support himself with his job at a restaurant.

Questions to ask the Group: What are your concerns? What would you do? What questions would you ask Darius about his plans for the future?

Possible Points Scenario 3:

- **The trauma that Darius experienced in the past may be affecting his ability to plan for the future.**
- **Talk to Darius about depression and explore with him any feelings of depression that might contribute to his decision to drop out. Encourage Darius to participate in an evaluation if it is indicated.**
- **The transition to independent living may be overwhelming if Darius does not have the necessary independent living skills. Explore additional supports that could be made available to Darius.**
- **Darius may be overvaluing the immediate reward of income from his job and undervaluing the future benefits of staying in school. Help Darius consider his situation and whether or not his restaurant income will be enough to support him financially now and in the future.**
- **Honor Darius’ right to make independent decisions, but help him weigh the pros and cons of his decision.**

Case Scenario #4:

Timmy, age 6, is an extroverted little boy who has recently started exhibiting the following:

- Frequent nightmares
- Sophisticated sex play with other children
- Rage when asked to do a simple task by the foster mother
- Daydreaming in class

He has been in the same foster home for the last 3 years. It appears to be a stable environment and he has successfully bonded with the foster mother, his primary care provider.

Questions to ask the Group: What are your concerns? What would you do? What questions would you ask of Timmy's foster mother? What are the implications for your interactions with Timmy and his foster mom?

Possible Points Scenario 4:

- **Timmy may be a survivor of sexual abuse suffering from PTSD.**
- **Refer for assessment by a mental health professional.**

Case Scenario #5:

Theo, age 3, is quiet little boy who does not have a permanent placement. He has been in the foster care system since birth and has not had contact with his birth family. Theo is currently in a temporary placement with experienced foster parents who are trying to provide him with a preschool experience and regular contact with peers. Increasing behavioral concerns have been arising for Theo. He has displayed the following symptoms:

- Insistence on sameness, becoming upset when something is moved
- Difficulty in expressing needs; using gestures or pointing instead of words
- Echolalia (repeating words that are spoken to him)
- Aloof manner
- Difficulty in mixing with others
- Little or no eye contact
- Unresponsive to normal teaching methods
- Apparent over-sensitivity or under-sensitivity to pain
- No real fears of danger
- Uneven gross/fine motor skills, can manipulate small objects over and over, but will fall off of a curb
- Not responsive to verbal cues; acts as if deaf although hearing tests indicate a normal auditory range
- Loves numbers—can read numbers to 25
- Does not imitate others in his play

Questions to ask the group: What are your concerns? What would you do? How would you partner with Theo's primary care provider? What are the implications for your interactions with Theo and the foster family?

Possible Points Scenario 5:

- **Autistic Spectrum disorder.**
- **Refer for a developmental assessment. A developmental pediatrician will be able to assist in appropriate referrals.**
- **Explore resources for a developmental preschool setting, social skills play groups and other necessary services.**
- **Help the foster family work with Theo and develop stronger attachment.**

Case Scenario #6:

You are an emergency response social worker and have just received a referral that says that the home contains health hazards that are dangerous to 6-month-old baby boy Jerry. When you arrive, you are relieved to find the mother and Jerry at home, and the home appears clean and safe. However, you notice that baby Jerry is just lying on the floor, not making any sounds or gestures. When you go down to the floor to play with him, he does not focus on your face or the toy in your hand. He does not grasp the toy when you offer it to him. When you ask the mother about Jerry, she tells you that he is a good baby. He gives her "no trouble" and hardly ever cries. Jerry appears to be of a normal weight and height for his age.

Questions to ask the group: What are your concerns? What would you do? What next steps would you take in Jerry's case? What are the implications for your interactions with the family?

Possible Points Scenario 6:

- **Refer Jerry for a developmental assessment for possible developmental delays.**
- **Enlist the help of a Public Health nurse to do an initial assessment.**
- **Ask the mother when was the last time that Jerry was seen by a doctor, and what the doctor said.**
- **List any other appropriate assessment referrals.**
- **Assess the current level of developmentally appropriate play and stimulation techniques with the mother. Create a "plan" for tummy time, outside walks, reading, or playing music for Jerry for a designated period of time a number of days a week if needed.**
- **Assess for outside supports that may be called upon to help Jerry and family.**
- **Assess bonding and attachment.**

Case Scenario #7:

Eric is 15 years old. You get a phone call from a group home where Eric lives. Last night, he sneaked out of the house and was seen smoking and drinking alcohol with 4

or 5 boys at the local park. The police brought him home around 2 a.m. after finding him on the street, under the influence. Eric does not do well in school. This is most likely due to his poor attendance. When he is in school, he actually does quite well, unless there is a test. He gets very agitated when there is a test, and does not go to school that day. He responds to group home staff with an “I don’t care” attitude. He does not respond to reward or punishment. Eric has been in out-of-home care since age 4, and is in his 9th placement.

Questions to ask the group: What are your concerns? What would you do? How would you approach Eric and engage him? What are the implications for your interactions with Eric?

Possible points Scenario 7:

- **Refer Eric for a mental health assessment that may address the possible presence of one or more of the following:**
 - ⌘ **Learning disabilities**
 - ⌘ **PTSD**
 - ⌘ **Substance Abuse**
 - ⌘ **Rule out ADHD**
 - ⌘ **Rule out oppositional defiant disorder**
 - ⌘ **Rule out depression**
 - ⌘ **Attachment issues**
- **May be normal teen behavior: “I don’t care” attitude, smoking, drinking, and sneaking out of the house.**
- **Talk with the teachers and Eric about school. Try to learn from him why he does not want go to school, and how school could be made less anxiety provoking so that he might want to attend more. Find out what works for him at school and determine if he has interest in any extracurricular activities. Encourage his academic and other school-related abilities.**
- **May need an Individualized Educational Plan (IEP) or a formalized tutoring program for additional academic supports.**
- **Find a mentor for Eric that he can relate to who might have had similar problems in his teenage years.**
- **“Contract” with Eric an agreement regarding school attendance and performance resulting in some clearly identified incentive that he proposes.**

Case Scenario #8:

Petri is 18 months old. This is what you know about her:

- She has just learned to walk.
- She uses very few words.
- She does not understand somewhat simple statements made by adults.
- She has a wide forehead and wide-set eyes.
- She is the friendliest kid at social functions and interacts with all the adults.

Questions for the group: What are your initial concerns? What would you do? How would you talk to Petri’s caregiver? What are the implications for your interactions with Petri and her family?

Possible Points Scenario 8:

- **Refer Petri for an assessment by a medical professional for suspected Fetal Alcohol Syndrome.**
- **Additionally, may want to look into a referral to a Developmental Pediatrician.**
- **Assess for bonding and attachment problems.**

Case Scenario #9:

Adam is 14 years old and has recently been placed with a new foster family. You are Adam’s new social worker and are meeting him for the first time. He refuses to go to school and will not talk to his new foster family. Adam had been living with his biological maternal grandmother since he was 10 months old. His grandmother recently passed away and there were no other family members able to provide care for him. In the last two weeks, Adam has had to move, start a new school, say good-bye to his grandmother, and leave his neighborhood and friends.

Questions to ask the group: What are your concerns? What would you like more information about? What would be your next steps in working with Adam? What resources might you want to engage? What are the implications for your interactions with Adam and his foster family?

Possible Points Scenario 9:

- **Experiencing grief and loss surrounding his grandmother’s death. Consider possible referral for counseling or group therapy.**
- **Reacting to being taken away from his home.**
- **Likely needs additional emotional support from foster parents, case worker, and school personnel.**
- **Look into possible visitation with other family members and familiar community.**

Case Scenario #10:

Courtney is 3 years old. She was abandoned at birth and has been in the same foster home placement since that time. You have been assigned to Courtney’s case for the last two years. You feel that you have a good working relationship with the foster parents and Courtney is always happy to see you during your scheduled visits. Up to this point, she has seemed developmentally on track. Last month Courtney started attending preschool three days a week. Since that time she has begun regressing in her potty training activities, covering her ears during “circle time,” throwing toys, and displaying tantrum behaviors for no apparent reason.

Questions to ask the group: What are your concerns? What would you like more information about? What would be your next steps in working with Courtney? What resources might you want to engage? What are the implications for your interactions with Courtney and her foster family?

Possible Points Scenario 10:

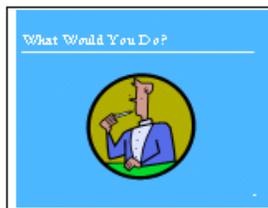
- Courtney is experiencing some stranger anxiety in her new school setting.
- She is unfamiliar with the new school schedule and facility, which has made using the bathroom regularly difficult for her.
- She has yet to feel safe in her new preschool environment and needs more time to adapt and acculturate.
- Being in a larger group setting of peers is overwhelming and she is having difficulty expressing her feelings and needs appropriately.
- A visit to her pediatrician might be in order to rule out an ear infection, water behind her ear drums, or other auditory concern.
- Consider establishing a school “buddy” to assist her to adjust to her new environment.

■ **Step #2.** Tally up the points. With ceremony, give a prize at the end to the team with the most points.

Transition to the last segment, a game reinforcing knowledge of child development milestones.

End of Activity

PowerPoint Slide, Activity 11B: Slide 95



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Child Development Review

Total Segment Time: 20 min

TRAINING ACTIVITY 12A

ACTIVITY: Child Development Game

Activity Time: 20 min

Materials:

- Supplemental Handout: SPECS of Normal Development (table)
- Supplemental Handout: Milestones booklet
- Supplemental Materials: Cards for the words and phrases to be distributed to table groups. These are provided in the Trainer’s Supplemental Materials in “cut-out” form
- Flip chart
- Markers
- Tape
- PowerPoint Slide: 96

Pre-training Preparation:

The words and phrases are located in the Trainer’s Supplemental Materials in “cut-out” form. The cards need to be created in advance by the trainer. For ease in scoring, allow for groups/teams to be able to identify their cards by making sets on different colors of card stock, by giving groups stickers to put on their cards, or by having groups label their cards with a team name.

Create a “developmental wall.” Hang large sheets of flip chart paper with the developmental stages (Birth to 6 months, Infants older than 6 months, Toddlers, Pre-schoolers, School age, Adolescents) written on the top on the wall for the SPECS cards to be attached.

Training Activity:

■ **Step #1.** Display slide 96 and introduce the game activity. Identify groups/teams. Divide the cards equally between the groups with each group receiving words/phrases from each category. Tell trainees they are going to play a game.

■ **Step #2.** Explain that the object of the game is to put the cards under the matching developmental stage (e.g., rolls over belongs under infants). Make sure to

tell trainees that they are not expected to get every card right and that mistakes are part of the game. Then tell the groups to decide where to place the cards and to attach them under the appropriate developmental stage listed on the wall or designated paper. Give participants 5 minutes to complete this step. Reconvene group after allocated game playing time.

■ **Step #3.** Once Step #2 is completed, using the list below as a guide, present each stage and review participants' corresponding placement of cards. Explain that as necessary, the instructor will move the cards to their correct developmental stages as each stage is presented.

Development Game Words and Phrases:

⚠ Indicates "red flag"

Birth to 6 Months

Alert to people

Rolls over

Pulls to sit up

⚠ *Does not show orientation towards sound of caretaker's voice*

Birth weight doubles

Grasps rattle

Rapid brain development

⚠ *Does not follow moving objects with eyes*

Trust (also in infants older than 6 months)

Smiles reflexively

⚠ *Does not reach for toys*

Infants Older than 6 Months

Trust (also in birth to 6 months)

Peek-a-boo

Stands alone

Shakes head "no"

Begins to show preferential responses

Crawling

⚠ *Not pulling self up*

⚠ *Exhibits no stranger reaction/anxiety*

Toddlers (1–3 years)

Symbolic thought

Can name body parts

Able to feed self

Reciprocal connectedness

Double syllable words

Follows 2-3 step directions
Developing sense of autonomy
Toilet training
⚠ No involvement in pretend play
⚠ Cannot copy a circle
Able to kick ball forward

Preschoolers (3–5 years)

Egocentric thought
Improved ability to share
Magical thinking
Learn letters & numbers
Memory (short & long term) improves
Initiative
Emergence of interactive & cooperative play
Ability to communicate needs verbally
Good control of bladder and bowel
1500-2000 words
⚠ Does not use plural or past tense
⚠ Shows little interest in playing with other children
Seeking to understand gender roles and identity

School-Age (6–12 years)

Concrete thinking
Rules & roles important
Able to take other's perspective
Understand cause & effect
Gender identity clear
Strength and coordination increase
Slow and steady physical growth
Sensitive to criticism
Early puberty
Social interactions & relationships outside of the family are increasingly important
⚠ Lacking curiosity about self in relation to the world/other people
Body proportions similar to adults

Adolescents (12–18 years)

Growth spurt
Strong identification with peer group
Brain development increases
Puberty
Identity formation
Introspection & self-analysis
⚠ Not beginning to demonstrate hypothetical & logical thinking

Need nine hours of sleep
Interest in sexual relationships increases

Emerging Adults

Brain development continues
Pubertal changes continue
Contractual democratic and individual rights explored
Self-analysis and problem solving increases
More focus on present than future
Focus on fairness
Begins considering vocational choices
Experimenting with social roles
Conflict between peers and parents regarding values
Depending less on family for affection and approval

End of Activity

PowerPoint Slide, Activity 12A: Slide 96



Evaluation

Total Segment Time: 30 min

TRAINING ACTIVITY 13A

ACTIVITY: Knowledge Post-test

Activity Time: 30 min

Materials:

- PowerPoint Slide: 97

Training Activity:

Note to Trainers: As new versions of curricula are edited and released, CalSWEC will remove the following evaluation-related documents from within the curriculum sections of a given Trainer's Guide with respect to knowledge tests and embedded evaluations (and from given Trainee's Guides for curricula with embedded evaluations):

- *Trainer Content/Tips:* remove instructions for facilitating the embedded evaluation process (both for the sample scenario and for the test scenarios) and instructions for facilitating the knowledge test process for applicable curricula and place such instructions solely in the Evaluation Protocols Tab (*and/or on the secure section of the CalSWEC website*).

The rationale for removing evaluation-related content from the respective sections of the Trainer's Guides is that when changes are made to the instructions for the evaluations, or to the sample/test answer sheets, we can avoid re-numbering the entire curriculum and just re-number the evaluation documents.

Please refer to the Evaluation Protocols Tab in your Trainer's Guide for a full copy of the instructions for facilitating the embedded evaluation test process.

End of Activity

PowerPoint Slide, Activity 13A: Slide 97



For security purposes, the pre-tests, post-tests, and answer sheets are not posted in the same area as the curriculum on the CalSWEC website.

Pre-tests, post-tests, and answer sheets can be found in the Evaluation Protocols Tab of the Trainer's Binder. If you don't have these documents in your binder, please contact:

1. California-based trainers: Please contact your RTA/IUC training evaluation personnel for copies of the scenarios and answer keys.

2. Outside of California: Please contact Leslie Zeitler lzeitler@berkeley.edu at CalSWEC for copies of the scenarios and answer keys.

Please do not allow trainees to leave the training room with any test materials.

Course Evaluation / Closure

Total Segment Time: 5 min

TRAINING ACTIVITY 14A

ACTIVITY: Closure

Activity Time: 5 min

Materials:

- Course evaluation forms
- PowerPoint Slide: 98

Training Activity:

- **Step #1.** Answer any remaining questions.
- **Step #2.** Ask trainees to complete the course evaluation.

End of Activity

PowerPoint Slide, Activity 14A: Slide 98





Child & Youth Development in a Child Welfare Context

Version 1.2, 2012



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

2

Agenda

- A Framework for Understanding Child Development
- Ages 0-2
- Ages 3-5
- Ages 6-12
- Adolescence
- Case Application
- Child Development Game

3

Age Range

- ❑ 0-2, Infancy/toddlerhood
- ❑ 3-5, Preschool
- ❑ 6-12, School Age
- ❑ 13+, Adolescence

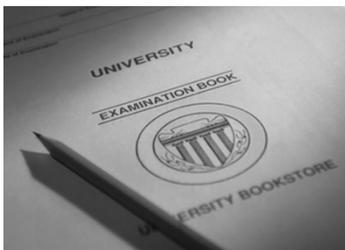
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Topics of Each Age Range

- ❑ Normal Development
- ❑ Brain Development
- ❑ Attachment
- ❑ Grief & Loss
- ❑ Red Flags
- ❑ Implications for Practice

5

Testing, testing...



6

What about you?



What small success have you had in your work recently that you are proud of?

Discuss in your groups.

7

What about you?



Core Competencies & Learning Objectives

- What will make this day worth your time?
- Any other areas you would like to discuss?

8

Understanding Development

- Dynamic and ongoing
- Directional
- May involve stages
- Cumulative
- Occurs across many domains

9

Developmental Domains: **SPECS**

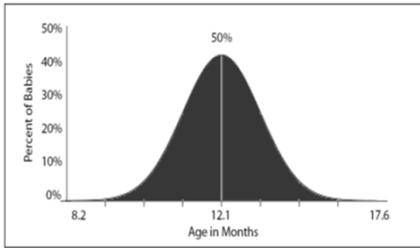
put on your glasses!

- Social**
- Physical**
- Emotional**
- Cognitive**
- Sexual**



10

Normal Distribution Curve



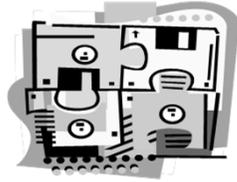
11

Theories

- Biological**
- Cognitive**
- Psychoanalytic**
- Family**
- Non-stage constructs**

12

What Genetic & Environmental
Factors Determine the
Final Outcome?



13

Heredity



Genetic potential
+ development
= maturation

14

Environment

- ▣ Prenatal
- ▣ Physical
- ▣ Social/Cultural
- ▣ Learning
- ▣ Emotional



15

The Brain

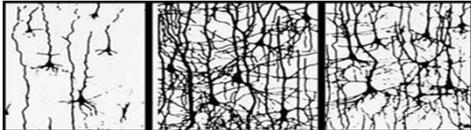
- ❑ Most complex organ in the human body
- ❑ 100 billion neurons
- ❑ Trillions of synapses
- ❑ Prime mandate is survival
- ❑ Creation of social relationships is the primary survival strategy

16

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

17

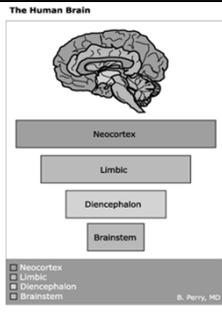
Principles of Brain Development

- ❑ 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

18

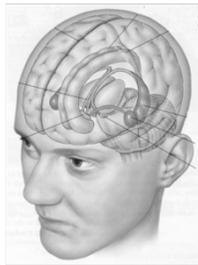
Brain Functions

- ❑ Brain Stem: regulation & control of body
- ❑ Limbic system, cortex & neocortex: reception & interpretation of sensory data
- ❑ Cortex & neocortex: conscious thought, memory, & emotions



Brain Function and Trauma

- ❑ Brain Stem
- ❑ Reticular Formation
- ❑ Cerebral Cortex
- ❑ Limbic System



What is normal within a cultural frame?



Video Clip

Childhood: Louder Than Words



The role of culture
in child
development

22

Infants

□ *I am what I am given*



23

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

24

Toddlers

- I am what I will



25

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

26

Infant Brain Development

Critical Windows of Opportunity:

Vision - Birth to 6 months

Speech - Birth to 3 years

Emotional Development - Birth to
18 months

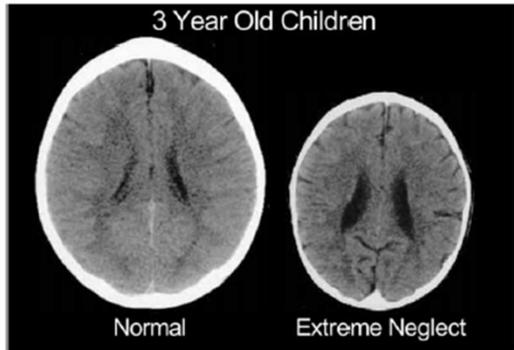
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Infant Brain Development

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

28



29

Video Clip

-The First Years Last Forever-



The dance of attunement

30

Video Concept Review

□ 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

31

Infant Brain Development

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

32

Infant Brain Development

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

33

Stages of Attachment Formation

- **Birth to 3 months**
 - Pre-attachment
- **3-8 months**
 - Recognition/discrimination
- **8-36 months**
 - Active attachment
- **3 years on...**
 - Partnership



34

Key Factors for Attachment

- Claiming
- Attunement
- Physical Contact

35

Responses to Disruptions in Attachment

- **Protest**
- **Despair**
- **Detachment**

36

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?

37

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

38

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?



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

40

Video Clip

-Understanding Traumatized Children: The Core Concepts-



How poverty of experience disrupts development

41

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.

42

Dysfunction Resulting from Maltreatment

Depends on the insults:

-*Timing*

-*Nature*

-*Pattern*

43

Failure to Thrive

- Decelerated or arrested growth
- Weight for age falls below the 5th percentile (corrected for prematurity)
- Organic (explained by physical condition)
- Nonorganic (not explained by physical condition)

44

Video Clip

-The Listening Heart-



Fetal alcohol
syndrome
identification and
intervention

45

Implications for Practice

- What can we do to address red flags for delayed development in the children we serve?

How can we
Best Intervene?



Taking It Home

- What was the most important thing you learned today?



47

Welcome Back!



48

What about you?

- ❑ How is your memory?
- ❑ Let's test your brain!
- ❑ Write down what you remember & win a prize!



49

Pre-School

- ❑ I am what I can Imagine



50

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

51

Stages of attachment

3 years on...

- Partnership
 - Attachment solidifies
 - Increased verbal communication of needs
 - Negotiation of differences

52

Interrupted Attachment

Developmental Effects:

- Low self-esteem
- General distrust of others
- Mood disorders
- Inadequate social skills
- Generalized cognitive and language delays

53

Application to Practice

- 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?

54

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

55

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

58

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?**

60

School Age

□ I am what I learn



61

Video Clip

-Life's Lessons-

The 5-7 shift



62

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

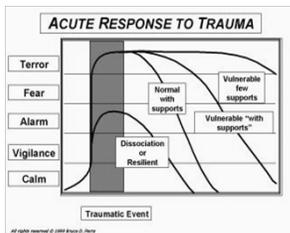
- Trauma results from the over-activation of the stress network
- Repeated activation of traumatic experiences increases the severity of traumatic effects and makes them less amenable to treatment

65

Video Clip

-Understanding Traumatized Children: The Core Concepts-

The fear response and the impact of child trauma



66

Brain Development

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

67

Posttraumatic Stress Disorder

- ❑ 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

68

Co-Morbidity with PTSD

- ❑ 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

69

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**

70

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%

72

Depression in Children

- 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

- 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

- What can we do to improve our interactions with traumatized children?

**How can we
Best Intervene?**



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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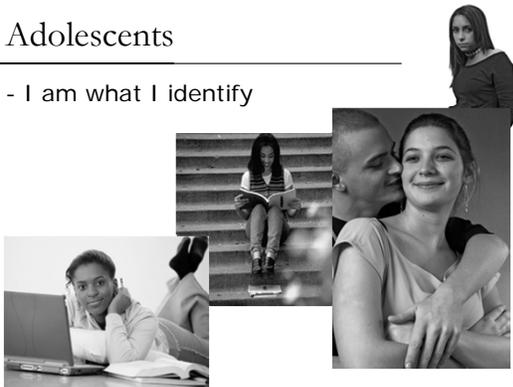
Application to Practice

- 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?

77

Adolescents

- I am what I identify



78

Adolescents

- ❑ 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

79

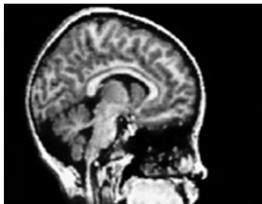
Emerging Adults

- ❑ 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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Video Clip

-Inside the Teenage Brain-



Brain development during adolescence

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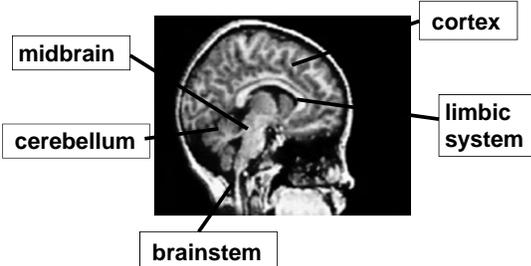
Adolescence

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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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



86

Consequences

- Decreased motivation
- Impaired ability to process emotion and think effectively at the same time
- Difficulty learning
- Delayed reaction time

87

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?

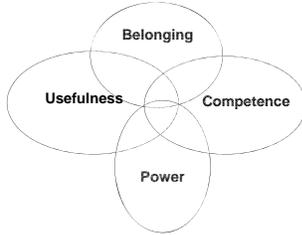


Effects of Maltreatment

- 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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Youth Development for Success



91

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?



Application to Practice

- 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?



95

Lets Play A Game



96

Testing, testing...



97

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>Fontanelles open</p> <p>Small for Gestational Age (SGA) if full-term weight is less than 5 lbs.</p> <p>Premature if less than 37 weeks, 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"> - can visually track objects past midline - can lift head to 90° <p>By three months:</p> <ul style="list-style-type: none"> - can visually track objects 180° - can put hands together - muscle control in upper body is good - can lift chest up with arm support - can be held in sitting position and hold head steady - beginning to develop hand-eye coordination - rolls over 	<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"> - happy - sad - angry - pain - fear - protest 	<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"> - may use 3 or more words other than mama and dada - object permanence beginning to develop - early problem solving skills arise - mastery of task is important - foundation for attention span laid - shakes head “no” 	<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"> - early imitation of parent/ caregiver behaviors - later, as child approaches 3 years of age, will begin to imitate other children <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"> - standing on one foot - running - jumping - climbing - more skillful use of one hand - balancing on toes <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"> - can draw specific shapes - controls movement of pencil or crayon <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"> - what - where - who <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"> - running - balancing on toes - jumping - catching and throwing <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"> - cutting with scissors - drawing - writing 	<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"> - school - clubs - activities <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"> - riding a bicycle - skating - swimming <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"> - active listening - asking questions 	<p>Sex play with other same age children may occur and can include:</p> <ul style="list-style-type: none"> - self-exploration - simulation - kissing - hugging - peeking - touching - exposure of genitals <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 & 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"> - Boys: 12-15 years of age - Girls: 11-14 years of age 	<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"> - Able to think hypothetically - Logical thinking - Ability to think about thought - Development of insight - Systematic problem solving 	<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>		<p>Peak of physical ability about age 25</p>	<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>	<p>In middle adulthood, generativity, or what one does to make things better for future generations is important.</p>	<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 out side 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>

Case Scenarios: What Would You Do?

Case Scenario #1:

David is 8 years old. To date, he has no clearly identifiable learning disabilities. Although he has a lot of friends at school, he claims to dislike going to school and “thinks it’s boring”. Historically, his academic grades and report cards have indicated average performance. His teacher observes the following:

- Fidgets often with hands or feet; squirms while seated
- Often runs, climbs, and leaves his seat in situations where sitting or quiet behavior is expected
- Blurts out answers before hearing the whole question
- Has difficulty waiting in line and taking turns
- Interrupts others when they are speaking
- Often is easily distracted by irrelevant sights and sounds
- Often fails to pay attention to details and makes careless mistakes
- Rarely follows instructions carefully and completely
- Frequently loses or forgets things such as toys, pencils, books, and tools needed for a task
- Often skips from one uncompleted activity to another

Case Scenario #2:

Samir, age 6, was moved to a foster home after a drug raid on his home where his parents were found with a methamphetamine laboratory. The parents were arrested. You get a call from Samir's grandmother who is caring for him and she is very upset. She tells you that Samir started school today, but she was called to go meet with the teacher and principal. Samir is unable to comprehend the information that the teacher gives him and fights with other children on the playground. He cries when he is frustrated and when other children try to engage with him to do classroom work. He was fighting with the other children and ran around during the reading circle. He could not be redirected and refused to respond to the teacher. He would not play with the other children and wet his pants. He did not know his colors and threw a tantrum when the teacher tried to help him with them. Samir also did not know how to ride the tricycle.

Case Scenario #3:

Darius, age 18, has decided to stay in extended foster care as a non-minor dependent youth. When Darius was 10, he and his 3 siblings were placed in foster care because of his parents' drug use. Darius was in the same foster home for many years, but when he turned 18 he left his long term placement and moved into a shared apartment nearby with two roommates. His plan was to attend community college to take classes toward an eventual degree in criminal justice.

You have just learned that Darius is no longer staying in his approved placement and has dropped out of school. He states he wants his case closed because he is tired of being in the system and feels like he can support himself with his job at a restaurant.

Case Scenario #4:

Timmy, age 6, is an extroverted little boy who has recently started exhibiting the following:

- Frequent nightmares
- Sophisticated sex play with other children
- Rage when asked to do a simple task by the foster mother
- Daydreaming in class

He has been in the same foster home for the last 3 years. It appears to be a stable environment and he has successfully bonded with the foster mother, his primary care provider.

Case Scenario #6:

You are an emergency response social worker and have just received a referral that says that the home contains health hazards that are dangerous to 6-month-old baby boy Jerry. When you arrive, you are relieved to find the mother and Jerry at home, and the home appears clean and safe. However, you notice that baby Jerry is just lying on the floor, not making any sounds or gestures. When you go down to the floor to play with him, he does not focus on your face or the toy in your hand. He does not grasp the toy when you offer it to him. When you ask the mother about Jerry, she tells you that he is a good baby. He gives her “no trouble” and hardly ever cries. Jerry appears to be of a normal weight and height for his age.

Case Scenario #7:

Eric is 15 years old. You get a phone call from a group home where Eric lives. Last night, he sneaked out of the house and was seen smoking and drinking alcohol with 4 or 5 boys at the local park. The police brought him home around 2 a.m. after finding him on the street, under the influence. Eric does not do well in school. This is most likely due to his poor attendance. When he *is* in school, he actually does quite well, unless there is a test. He gets very agitated when there is a test, and does not go to school that day. He responds to group home staff with an “*I don’t care*” attitude. He does not respond to reward or punishment. Eric has been in out-of-home care since age 4, and is in his 9th placement.

Case Scenario #8:

Petri is 18 months old. This is what you know about her:

- She has just learned to walk.
- She uses very few words.
- She does not understand somewhat simple statements made by adults.
- She has a wide forehead and wide-set eyes.
- She is the friendliest kid at social functions and interacts with all the adults.

Case Scenario #9:

Adam is 14 years old and has recently been placed with a new foster family. You are Adam's new social worker and are meeting him for the first time. He refuses to go to school and will not talk to his new foster family. Adam had been living with his biological maternal grandmother since he was 10 months old. His grandmother recently passed away and there were no other family members able to provide care for him. In the last two weeks, Adam has had to move, start a new school, say good-bye to his grandmother, and leave his neighborhood and friends.

Case Scenario #10:

Courtney is 3 years old. She was abandoned at birth and has been in the same foster home placement since that time. You have been assigned to Courtney's case for the last two years. You feel that you have a good working relationship with the foster parents and Courtney is always happy to see you during your scheduled visits. Up to this point, she has seemed developmentally on track. Last month Courtney started attending preschool three days a week. Since that time she has begun regressing in her potty training activities, covering her ears during "circle time," throwing toys, and displaying tantrum behaviors for no apparent reason.

Child Development Game Cards

**Birth to 6
months**

**Infants older than
6 months**

**Toddlers
(1–3 years)**

**Preschoolers
(3–5 years)**

**School-age
(6–12 years)**

**Adolescents
(12–21 years)**

Alert to people

 **Does not show
orientation
towards sound of
caretaker's voice**

Rolls over

**Birth weight
doubles**

Pulls to sit up

Grasps rattle

**Rapid brain
development**

Smiles reflexively



**Does not follow
moving objects
with eyes**

Trust

Trust



**Does not reach
for toys**

Crawling

**Begins to show
preferential
responses**

Peek-a-boo

Shakes head “no”

Stands alone

**Developing sense of
autonomy**

**Symbolic
thought**

Able to feed self

**Reciprocal
connectedness**

 **Not pulling
self up**

**Follow 2-3 step
directions**

 **Exhibits no
stranger
reaction/anxiety**

**Able to kick a
ball forward**

Toilet training

**Can name body
parts**

**Double syllable
words**

**Egocentric
thought**

 **No involvement
in pretend play**

**Improved ability
to share**

 **Cannot copy a
circle**

Memory (short & long term) improves

Learn letters & numbers

Magical thinking

Initiative

Emergence of interactive & cooperative play

1500-2000 words

**Ability to
communicate needs
verbally**

 **Doesn't use
plural or past tense**

**Good control of
bladder and bowel**

 **Shows little
interest in playing
with other children**

**Seeking to
understand gender
roles and identity**

**Gender identity
clear**

**Concrete
thinking**

**Understand cause
& effect**

**Rules & roles
important**

**Able to take
other's
perspective**

**Strength and
coordination
increase**

**Body
proportions
similar to adult**

**Slow and steady
physical growth**

**Social interactions &
relationships outside
of the family are
increasingly important**

**Sensitive to
criticism**

 **Lacking curiosity
about self in relation
to the world/other
people**

Early puberty

**Increased interest
in sexual
relationships**

Growth spurt

Puberty

**Strong
identification
with peer group**

**Identity
formation**

**Brain
development
increases**

**Introspection &
self-analysis**

 **Not beginning to
demonstrate
hypothetical & logical
thinking**

**Need nine hours
of sleep**

**Brain
development
continues**

**Pubertal changes
continue**

**Contractual democratic
and individual rights
explored**

**Self-analysis and
problem solving
increases**

**Begins considering
vocational choices**

**Experimenting
with social roles**

**Conflict between
peers and parents
regarding values**

**Depending less on
family for affection and
approval**

**More focus on
present than
future**

Focus on fairness

Behavioral Impact of Maltreatment: A Reference to Use with Caregivers and Parents¹

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,

¹ 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.



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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.

26

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

27

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

28

Northern California Training Academy
UC Davis Extension
University of California
1632 Da Vinci Court
Davis, CA 95616

Telephone (530) 757-8643

Fax (530) 752-6910

e-mail academy@unexmail.ucdavis.edu

Web site <http://www.humanservices.ucdavis.edu/academy/index.asp>

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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?

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?

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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San Francisco County
Behavioral Health

Jill Jacobs

Oakland, CA
Family Builders

Jody Marksamer

Los Angeles, CA
Former: National Center
for Lesbian Rights
Current: Child Welfare
Consultant

Joy Cronin

Fresno, CA
Fresno County
Department of Social
Services

Kathy Park

Madison, WI
National Council on
Crime and Delinquency

Lisa Parrish

Los Angeles, CA
LA Gay & Lesbian Center

Michael Ferrera

Los Angeles, CA
LA Gay & Lesbian Center

Rebecca Gudeman

Oakland, CA
National Center for Youth
Law

Rob Woronoff

Los Angeles, CA
Child Welfare Consultant

Shannan Wilber

San Francisco, CA
Former: Legal Services
for Children
Current: National Center
for Lesbian Rights

Sharon DeRego

Sacramento, CA
California Department of
Social Services

Hon. Shawna Schwarz

San Jose, CA
Santa Clara County
Superior Court

Zak Sinclair

San Francisco, CA
Facilitator, Sinclair
Consulting

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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



MASTER GLOSSARY

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/]

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 and Youth Development

MATERIALS CHECKLIST

ITEMS FOR THE TRAINER

- Trainer’s and Trainee’s Content, including Supplementary Materials for the Trainer and Trainees (Milestones booklets, SPECS, cards for games and cut-outs of scenarios)
- Pencils/Pens
- Masking tape

AUDIOVISUALS

- Flip chart paper
- Markers for flip chart
- PowerPoint presentation
- LCD projector and cables
- Laptop computer and cables (for PowerPoint presentation)
- DVD player (if needed in addition to laptop for the videos)
- Screen
- Television or monitor (if videotapes not connected through the LCD projector)
- Speakers (if needed for the videos)
- CDC information cards (free), “It’s time to change how we view a child’s growth”:
www.cdc.gov/actearly 1-800-CDC-INFO
- Videotapes/DVDs:
[For cost and ordering information, in this tab, see page: “Videos for Child & Youth Development: Ordering Information”]

Day 1, Segment 4D

Childhood: Louder Than Words

Day 1, Segment 5C

The First Years Last Forever

Day 1, Segment 5E:

Understanding Traumatized Children: The Core Concepts: Series 1, Part 4, How Poverty of Experience Disrupts Development

Day 1, Segment 5F:

The Listening Heart

Day 2, Segment 9A:

Childhood: Life Lessons

Day 2, Segment 9C:

Understanding Traumatized Children: The Core Concepts: Series 1, Part 5, The Fear Response: The Impact of Child Trauma

Day 2, Segment 10B:

Frontline: Inside the Teenage Brain

ADDITIONAL MATERIALS NEEDED (indicated by day & segment)

Day 1, Segment 2A:

- Pen/pencils for trainees to fill out test forms (*Please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. Please avoid the use of felt-tip pens for the answer sheets.*)
- Evaluation Packet #1: *Make sure there are enough copies for all trainees:*
 - ⌘ Letter to the participant explaining the evaluation
 - ⌘ Informed Consent Page
 - ⌘ ID Code Assignment instruction sheet
 - ⌘ Demographic Survey
 - ⌘ Knowledge Pre-Test (*specific to curriculum topic; obtain from RTA/IUC or county point person*)
 - ⌘ Answer Sheet for Knowledge Pre-Test (*Make sure the answer sheets are printed on*
 - ⌘ *WHITE PAPER ONLY; otherwise the scanner has difficulty capturing the test answers.*)
- Three 9x12 Envelopes:
 - ⌘ 1 for trainer to collect ALL pre-tests
 - ⌘ 1 for trainer to collect ALL post-tests
 - ⌘ 1 for trainer to collect ALL blank tests (pre and post)

Day 1, Segment 3A:

- Name tents
- Markers

Day 1, Segment 3B:

- Flip chart
- Markers

Day 1, Segment 4A:

- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension

Day 1, Segment 5A:

- ☑ Supplemental Handout: The SPECS of Normal Development
- ☑ Supplemental Handout: Milestones (use for the *developmental concerns*), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- ☑ Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC – see Materials Checklist)
- ☑ Supplemental Handout: Developmental Theories

Day 1, Segment 5C:

- ☑ Flip chart
- ☑ Markers

Day 1, Segment 5E:

- ☑ Flip chart
- ☑ Markers

Day 1, Segment 5G:

- ☑ Supplemental Handout: Milestones (use for the *developmental concerns*), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension

Day 1, Segment 6A:

- ☑ Flip chart papers posted on wall with heading, “Most Useful for My Practice”
- ☑ Markers

Day 2, Segment 7A:

- ☑ Large light bulbs, cut out of yellow construction paper, which are large enough to write on with a marker
- ☑ Markers
- ☑ Blue masking tape
- ☑ Flip chart
- ☑ Prizes for the winning table

Day 2, Segment 8A:

- ☑ Supplemental Handout: The SPECS of Normal Development
- ☑ Supplemental Handout: Milestones (use for the *developmental concerns*), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- ☑ Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC – see Materials Checklist)

Day 2, Segment 8D:

- ☑ Supplemental Handout: Services for Children with Developmental Delays in California: Regional Centers

Day 2, Segment 8E:

- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC – see Materials Checklist)
- Flip chart
- Markers

Day 2, Segment 8F:

- Supplemental Handout: Behavioral Impact of Maltreatment: A Reference to Use with Parents and Caretakers

Day 2, Segment 9A:

- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension
- Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC – see Materials Checklist)

Day 2, Segment 9B:

- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension

Day 2, Segment 9C:

- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension

Day 2, Segment 9E:

- Supplemental Handout: The SPECS of Normal Development
- Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension

Day 2, Segment 10A:

- Supplemental Handout: The SPECS of Normal Development

- ☑ Supplemental Handout: Milestones (use for the developmental concerns), provided courtesy of Northern California Children & Family Services Training Academy, UC Davis Extension.
- ☑ Supplemental Handout: CDC information card, “It’s time to change how we view a child’s growth” (available free from CDC – see Materials Checklist)
- ☑ Flip chart
- ☑ Markers

Day 2, Segment 10D:

- ☑ Flip chart
- ☑ Markers

Day 2, Segment 11A:

- ☑ Trainer Supplemental Materials: Tammy and Marcus Scenarios

Day 2, Segment 11B:

- ☑ Trainer Supplemental Materials: Case Scenario Cards
- ☑ Flip chart
- ☑ Markers
- ☑ Prizes

Day 2, Segment 12A:

- ☑ Supplemental Handout: SPECS of Normal Development (table)
- ☑ Supplemental Handout: Milestones booklet
- ☑ Trainer Supplemental Materials: Development Game Word and Phrase Cards (key words or phrases related to a developmental stage, based on the SPECS of Normal Development table or the Milestones booklet)
- ☑ Masking tape
- ☑ Markers
- ☑ Flip chart paper
- ☑ Prizes

Day 2, Segment 13:

- ☑ Pen/pencils for trainees to fill out test forms (*Please use ballpoint blue or black ink pens or other types of dark-ink pens that will not bleed through to the back of the answer sheet. Please avoid the use of felt-tip pens for the answer sheets.*)
- ☑ Evaluation Packet #2: Post-test and Answer Sheets only (*Trainer: Obtain from RTA/IUC or county point-person. Also, please make sure the answer sheets are printed on white paper only; otherwise the scanner has difficulty capturing the test answers.*)
- ☑ Three 9x12 Envelopes: (from pre-test instructions)
 - ≡ 1 for trainer to collect ALL pre-tests
 - ≡ 1 for trainer to collect ALL post-tests
 - ≡ 1 for trainer to collect ALL blank tests (pre and post)

Videos for Child and Youth Development Ordering Information

Title	Vendor	DVD	VHS
Childhood	http://www.ambrosevideo.com	\$149/set	\$149/set
The First Years Last Forever	http://www.parentsaction.org	\$25	Not available
Understanding Traumatized and Maltreated Children: The Core Concepts: Series One	http://www.childtrauma.org	\$549/set	Not available
The Listening Heart	http://www.ntiupstream.com	\$24.99	Not available
Frontline: Inside the Teenage Brain	http://www.pbs.org	\$29.98	\$29.98

* as of February 2009