How to Use This Chart

Overview: This developmental milestones chart is designed specifically for Children Services staff. It includes normal expectations of developmental milestones for children birth through adolescence, and information about the possible effects of maltreatment.

How To Use: Caseworkers and other CPS professionals will find many ways to use this chart. Below are some suggestions:

- Review the chart prior to scheduled interactions with children to prompt your recall of common milestones and to help you identify potential developmental delays or concerns.
- Copy the chart that corresponds to the age of the child you will be seeing, and use it to assess the child’s achievement of milestones and apparent delays. Circle apparent delays, or developmental areas needing further assessment.
Infants and Toddlers

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn: rough, random, uncoordinated, reflexive movement</td>
<td>Sensori-motor: physically explores environment to learn about it; repeats movements to master them, which also stimulates brain cell development</td>
<td>Attachment: baby settles when parent comforts; toddler seeks comfort from parent, safe-base exploration</td>
</tr>
<tr>
<td>3 mo: head at 90 degree angle, uses arms to prop; visually track through midline</td>
<td>4-5 mo: coos, curious and interested in environment</td>
<td>5 mo: responsive to social stimuli; facial expressions of emotion</td>
</tr>
<tr>
<td>5 mo: purposeful grasp; roll over; head lag disappears; reaches for objects; transfer objects from hand to hand; plays with feet; exercises body by stretching, moving; touch genitals, rock on stomach for pleasure</td>
<td>6 mo: babbles and imitates sounds</td>
<td>9 mo: socially interactive; plays games (i.e., patty-cake) with caretakers</td>
</tr>
<tr>
<td>7 mo: sits in “tripod”; push head and torso up off the floor; support weight on legs; “raking” with hands</td>
<td>9 mo: discriminates between parents and others; trial and error problem solving</td>
<td>11 mo: stranger anxiety; separation anxiety; solitary play</td>
</tr>
<tr>
<td>9 mo: gets to and from sitting; crawls, pulls to standing; stooping and recovering; finger-thumb opposition; eye-hand coordination, but no hand preference</td>
<td>12 mo: beginning of symbolic thinking; points to pictures in books in response to verbal cue; object permanence; some may use single words; receptive language more advanced than expressive language</td>
<td>2 yr: imitation, parallel and symbolic, play</td>
</tr>
<tr>
<td>12 mo: walking</td>
<td>15 mo: learns through imitating complex behaviors; knows objects are used for specific purposes</td>
<td></td>
</tr>
<tr>
<td>15 mo: more complex motor skills</td>
<td>2 yrs: 2 word phrases; uses more complex toys and understands sequence of putting toys, puzzles together</td>
<td></td>
</tr>
<tr>
<td>2 yrs: learns to climb up stairs first, then down</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Possible effects of maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-1 yr: learns fundamental trust in self, caretakers, environment</td>
<td>Chronic malnutrition: growth retardation, brain damage, possibly mental retardation</td>
</tr>
<tr>
<td>1-3 yr: mastery of body and rudimentary mastery of environment (can get other’s to take care of him)</td>
<td>Head injury and shaking: skull fracture, mental retardation, cerebral palsy, paralysis, coma, death, blindness, deafness</td>
</tr>
<tr>
<td>12-18 mo: “terrible twos” may begin; willful, stubborn, tantrums</td>
<td>Internal organ injuries</td>
</tr>
<tr>
<td>18-36 mo: feel pride when they are “good” and embarrassment when they are “bad”</td>
<td>Chronic illness from medical neglect</td>
</tr>
<tr>
<td>18-36 mo: Can recognize distress in others – beginning of empathy</td>
<td>Delays in gross and fine motor skills, poor muscle tone</td>
</tr>
<tr>
<td>18-36 mo: are emotionally attached to toys or objects for security</td>
<td>Language and speech delays; may not use language to communicate</td>
</tr>
<tr>
<td></td>
<td>Insecure or disorganized attachment: overly clingy, lack of discrimination of significant people, can’t use parent as source of comfort</td>
</tr>
<tr>
<td></td>
<td>Passive, withdrawn, apathetic, unresponsive to others</td>
</tr>
<tr>
<td></td>
<td>“Frozen watchfulness”, fearful, anxious, depressed</td>
</tr>
<tr>
<td></td>
<td>Feel they are “bad”</td>
</tr>
<tr>
<td></td>
<td>Immature play – cannot be involved in reciprocal, interactive play</td>
</tr>
<tr>
<td>Physical</td>
<td>Cognitive</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Physically active</td>
<td>Ego-centric, illogical, magical thinking</td>
</tr>
<tr>
<td>Rule of Three: 3 yrs, 3 ft, 33 lbs.</td>
<td>Explosion of vocabulary; learning syntax, grammar; understood by 75% of people by age 3</td>
</tr>
<tr>
<td>Weight gain: 4-5 lbs per year</td>
<td>Poor understanding of time, value, sequence of events</td>
</tr>
<tr>
<td>Growth: 3-4 inches per year</td>
<td>Vivid imaginations; some difficulty separating fantasy from reality</td>
</tr>
<tr>
<td>Physically active, can’t sit still for long</td>
<td>Accurate memory, but more suggestible than older children</td>
</tr>
<tr>
<td>Clumsy throwing balls</td>
<td>Primitive drawing, can’t represent themselves in drawing till age 4</td>
</tr>
<tr>
<td>Refines complex skills: hopping, jumping, climbing, running, ride “big wheels” and tricycles</td>
<td>Don’t realize others have different perspective</td>
</tr>
<tr>
<td>Improving fine motor skills and eye-hand coordination: cut with scissors, draw shapes</td>
<td>Leave out important facts</td>
</tr>
<tr>
<td>3–3 ½ yr: most toilet trained</td>
<td>May misinterpret visual cues of emotions</td>
</tr>
<tr>
<td></td>
<td>Receptive language better than expressive till age 4</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preschool**

**Physical**
- Physically active
- Rule of Three: 3 yrs, 3 ft, 33 lbs.
- Weight gain: 4-5 lbs per year
- Growth: 3-4 inches per year
- Physically active, can’t sit still for long
- Clumsy throwing balls
- Refines complex skills: hopping, jumping, climbing, running, ride “big wheels” and tricycles
- Improving fine motor skills and eye-hand coordination: cut with scissors, draw shapes
- 3–3 ½ yr: most toilet trained

**Cognitive**
- Ego-centric, illogical, magical thinking
- Explosion of vocabulary; learning syntax, grammar; understood by 75% of people by age 3
- Poor understanding of time, value, sequence of events
- Vivid imaginations; some difficulty separating fantasy from reality
- Accurate memory, but more suggestible than older children
- Primitive drawing, can’t represent themselves in drawing till age 4
- Don’t realize others have different perspective
- Leave out important facts
- May misinterpret visual cues of emotions
- Receptive language better than expressive till age 4

**Social**
- Play:
  - Cooperative, imaginative, may involve fantasy and imaginary friends, takes turns in games
  - Develops gross and fine motor skills; social skills; experiment with social roles; reduces fears
- Wants to please adults
- Development of conscience: incorporates parental prohibitions; feels guilty when disobedient; simplistic idea of “good and bad” behavior
- Curious about his and other’s bodies, may masturbate
- No sense of privacy
- Primitive, stereotypic understanding of gender roles

**Emotional**
- Psycho-social task is identity formation
- Young adolescents (12-14): self-conscious about physical appearance and early or late development; body image rarely objective, negatively affected by physical and sexual abuse; emotionally labile; may over-react to parental questions or criticisms; engage in activities for intense emotional experience; risky behavior; may engage in activities for intense emotional experience; risky behavior; may engage in activities for intense emotional experience; risky behavior
- Middle adolescents (15-17): examination of others’ values, beliefs; forms identity by organizing perceptions of ones attitudes, behaviors, values into coherent “whole”; identity includes positive self image comprised of cognitive and affective components
- Additional struggles with identity formation include minority or bi-racial status, being an adopted child, gay/lesbian identity

**Possible effects of maltreatment**
- All of the problems listed in school age section
- Identity confusion: inability to trust in self to be a healthy adult; expect to fail; may appear immobilized and without direction
- Poor self esteem: pervasive feelings of guilt, self-criticism, overly rigid expectations for self, inadequacy
- May overcompensate for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self
- May engage in self-defeating, testing, and aggressive, antisocial, or impulsive behavior; may withdraw
- Lack capacity to manage intense emotions; may be excessively labile, with frequent and violent mood swings
- May be unable to form or maintain satisfactory relationships with peers
- Emotional disturbances: depression, anxiety, post traumatic stress disorder, attachment problems, conduct disorders
<table>
<thead>
<tr>
<th>Physical</th>
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<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growth spurt: &lt;br&gt;Girls: 11-14 yrs &lt;br&gt;Boys: 13-17 yrs</td>
<td>Formal operations; precursors in early adolescence, more developed in middle and late adolescence, as follows:</td>
<td>Young (12 – 14): psychologically distance self from parents; identify with peer group; social status largely related to group membership; social acceptance depends on conformity to observable traits or roles; need to be independent from all adults; ambivalent about sexual relationships, sexual behavior is exploratory</td>
</tr>
<tr>
<td>Puberty: &lt;br&gt;Girls: 11-14 yrs &lt;br&gt;Boys: 12-15 yrs</td>
<td>Think hypothetically; calculate consequences of thoughts and actions without experiencing them; consider a number of possibilities and plan behavior accordingly</td>
<td>Middle (15 – 17): friendships based on loyalty, understanding, trust; self-revelation is first step towards intimacy; conscious choices about adults to trust; respect honesty &amp; straightforwardness from adults; may become sexually active</td>
</tr>
<tr>
<td>Youth acclimate to changes in body</td>
<td>Think logically; identify and reject hypotheses or possible outcomes based on logic</td>
<td>Understands concepts of right and wrong</td>
</tr>
<tr>
<td></td>
<td>Think hypothetically, abstractly, logically</td>
<td>Self-esteem reflects opinions of significant others</td>
</tr>
<tr>
<td></td>
<td>Think about thought; leads to introspection and self-analysis</td>
<td>Curious</td>
</tr>
<tr>
<td></td>
<td>Insight, perspective taking; understand and consider others’ perspectives, and perspectives of social systems</td>
<td>Self-directed in many activities</td>
</tr>
<tr>
<td></td>
<td>Systematic problem solving; can attack a problem, consider multiple solutions, plan a course of action</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive development is uneven, and impacted by emotionality</td>
<td></td>
</tr>
</tbody>
</table>

### Emotional Possible effects of maltreatment

- Self-esteem based on what others tell him or her: Poor muscle tone, motor coordination
- Increasing ability to control emotions; less emotional outbursts: Poor pronunciation, incomplete sentences
- Increased frustration tolerance: Cognitive delays; inability to concentrate
- Better delay gratification: Cannot play cooperatively; lack curiosity, absent imaginative and fantasy play
- Rudimentary sense of self: Social immaturity; unable to share or negotiate with peers; overly bossy, aggressive, competitive
- Insight, perspective taking: Attachment problems; overly clingy, superficial attachments, show little distress or over-react when separated from caregiver
- Systematic problem solving: Underweight from malnourishment; small stature
- Cognitive development is uneven, and impacted by emotionality: Excessively fearful, anxious, night terrors
- Self-esteem reflects opinions of significant others: Reminders of traumatic experience may trigger severe anxiety, aggression, preoccupation
- Curious: Lack impulse control, little ability to delay gratification
- Self-directed in many activities: Exaggerated response (tantrums, aggression) to even mild stressors
- Physical injuries; sickly, untreated illnesses
- Eneuresis, enopresis, self stimulating behavior – rocking, head-banging
## School Aged

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slow, steady growth: 3-4 inches per year</td>
<td>Use language as a communication tool</td>
<td>Friendships are situation specific</td>
</tr>
<tr>
<td>Use physical activities to develop gross and fine motor skills</td>
<td>Perspective taking: 5-8 yr: can recognize others’ perspectives, can’t assume the role of the other</td>
<td>Understands concepts of right and wrong</td>
</tr>
<tr>
<td>Motor &amp; perceptual motor skills better integrated</td>
<td>8-10 yr: recognize difference between behavior and intent: age 10-11 yr: can accurately recognize and consider others’ viewpoints</td>
<td>Rules relied upon to guide behavior and play, and provide child with structure and security</td>
</tr>
<tr>
<td>10-12 yr: puberty begins for some children</td>
<td>Concrete operations: Accurate perception of events; rational, logical thought; concrete thinking; reflect upon self and attributes; understands concepts of space, time, dimension</td>
<td>5-6 yr: believe rules can be changed</td>
</tr>
<tr>
<td></td>
<td>Can remember events from months, or years earlier</td>
<td>7-8 yrs: strict adherence to rules</td>
</tr>
<tr>
<td></td>
<td>More effective coping skills</td>
<td>9-10 yrs: rules can be negotiated</td>
</tr>
<tr>
<td></td>
<td>Understands how his behavior affects others</td>
<td>Begin understanding social roles; regards them as inflexible; can adapt behavior to fit different situations; practices social roles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Takes on more responsibilities at home</td>
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<tr>
<td></td>
<td></td>
<td>Less fantasy play, more team sports, board games</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Morality: avoid punishment; self interested exchanges</td>
</tr>
</tbody>
</table>

## Emotional

| Self esteem based on ability to perform and produce |
| Alternative strategies for dealing with frustration and expressing emotions |
| Sensitive to other’s opinions about themselves |
| 6-9 yr: have questions about pregnancy, intercourse, sexual swearing, look for nude pictures in books, magazines |
| 10-12 yr: games with peeing, sexual activity (e.g., strip poker, truth/dare, boy-girl relationships, flirting, some kissing, stroking/rubbing, re-enacting intercourse with clothes on) |

## Possible effects of maltreatment

| Poor social/academic adjustment in school: preoccupied, easily frustrated, emotional outbursts, difficulty concentrating, can be overly reliant on teachers; academic challenges are threatening, cause anxiety |
| Little impulse control, immediate gratification, inadequate coping skills, anxiety, easily frustrated, may feel out of control |
| Extremes of emotions, emotional numbing; older children may “self-medicate” to avoid negative emotions |
| Act out frustration, anger, anxiety with hitting, fighting, lying, stealing, breaking objects, verbal outbursts, swearing |
| Extreme reaction to perceived danger (i.e., “fight, flight, freeze” response) |
| May be mistrustful of adults, or overly solicitous, manipulative |
| May speak in unrealistically glowing terms about his parents |
| Difficulties in peer relationships; feel inadequate around peers; over-controlling |
| Unable to initiate, participate in, or complete activities, give up quickly |
| Attachment problems: may not be able to trust, tests commitment of foster and adoptive parent with negative behaviors |
| Role reversal to please parents, and take care of parent and younger siblings |
| Emotional disturbances: depression, anxiety, post traumatic stress disorder, attachment problems, conduct disorders |
WELCOME !!

Module VII

Child Development:
Implications for Family-Centered
Child Protective Services

What’s In It For Me?

Discuss and be ready to report out:

- Why is it important for you to know about child development and the effects of abuse and neglect on development?
- Record on Flip Chart:
  3 – 5 learning needs for your group

Principles of Development

- Ongoing process
- Dynamic
- Interactive
- Directional
- Cumulative
- Stages
- Environment
- Heredity
Influence of Heredity

- Maturation: predictable patterns regardless of environment or culture
- Child practices the skill, but emergence is not dependent on environment

Influence of Environment

- Prenatal
- Physical
- Social/cultural “shapes” expression of traits, abilities
- Learning environment: need stimulation
- Emotional environment: need secure, calm

What is “Normal”?

The Normal Distribution Curve

- Standard Deviation Below the Mean
- Standard Deviation Above the Mean
Developmental Domains

Physical:
- Body structure
- Sensory development
- Motor development

Developmental Domains

Cognitive
- Thinking
- Perception
- Memory
- Reasoning
- Problem solving
- Language
- Executive function

Developmental Domains

Social:
- Interactions with others
- Involvement in social groups
- Development of relationships
- Social roles
- Adopt group values, values
- Sexual development
- Moral development
- Assuming a productive role
Developmental Domains

- Emotional:
  - Personal traits
  - Identity
  - Self esteem
  - Mood, affect

Remember: Development is interactive

Stages of Cognitive Development

- Sensorimotor (Infancy)
- Pre-Operational (Toddler/Early Childhood)
- Concrete Operational (Elementary/Early Adolescence)
- Formal Operational (Adolescence/Adulthood)

ATTACHMENT

- A special emotional connection that infants develop with their caregivers during the first year of life

Attachment: 3 Components

- Enduring relationship with specific person
- Presence of person provides security, comfort
- Intense distress with loss or threat of loss of that person
**ATTACHMENT IS CRITICAL TO DEVELOPMENT**

- Trust
- Language
- Emotion
- Social
- Self esteem
- Security
- Autonomy
- Cognitive

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**Assessing Attachment**

- Parent recognizes signs of distress and intervene?
- Parent stimulates child and initiates playful interaction?
- Parent provides comfort and closeness?

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**Assessing Attachment**

- Child seeks proximity to parent?
- Child approaches parent for reassurance, comfort, protection?
- Child directly communicates needs?
- Child obtains comfort, then returns to play?
- Child and parent enjoy each other’s company?
Brain Development
- Explosive development pre-birth and first year of life
- Neurons increase and connect (through dendrites) with other parts of brain
- Quality and quantity of neural connections critical to brain development
- Experience stimulates some brain development

Small Group Discussion
- Why are infants and toddlers at higher risk of abuse and neglect?
- Why are they more likely than older children to suffer severe and serious consequences?
- List potential effects of abuse and neglect on physical, cognitive, social, and emotional development. Differentiate type of maltreatment.

Images from Bruce Perry, M.D., Ph.D. Baylor College of Medicine
Parental Perception of Child

- Meaning attributed to a developmental disability
- Misinterpret normal behavior as bad, irritating, etc.
- Mistakenly look to child for approval
- Ability to adapt parenting to specific child

Insecure Attachment

Caused by:
- Traumatic separations
- Abuse and neglect

Majority of maltreated children have insecure attachment

Attachment Problems

Insecure Attachment
Parent is unresponsive, rejecting, lacks warmth, avoids physical contact, is unpredictable, provides inconsistent care

Disorganized Attachment
Parent is frightening to child
Complex Trauma

Chronic maltreatment by parents or caregivers that begin early in childhood:

Outcomes: Pervasive developmental outcomes across several domains (Cook, 2003)

Treatment for Maltreated Infants

- Medical and health care
- Early Infant Stimulation Programs
- Substitute care, if necessary
- Treatment for Attachment Problems

Fahlberg’s Arousal/Relaxation Cycle

Building Attachment

Child and Parent Relax – Mutual Satisfaction

Child’s Need Felt

Child Expresses Need

Need Satisfied by Empathetic Care – Social Interaction
**Treatment for Attachment Problems**

- Arousal - relaxation cycle
- Positive interaction:
- Claiming behaviors (often used by adoptive parents)
- Mental health therapy

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**Faces in Fetal Alcohol Syndrome**

Slide courtesy of Research Society on Alcoholism, Alcohol and Alcohol Actions Lecture Series

http://rsoa.org/lectures/about.html

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**FASD: Facial Features**
Growing up with FAS

Brain damage resulting from prenatal alcohol

Fetal Alcohol Spectrum Disorders

- Pre and post natal growth deficiency
- Average IQ - 63
- Irritability in infancy, inattention, hyperactivity, mood disorders in childhood
- Mild to moderate microcephaly
- Dysfunction in fine motor control
- Difficulties with executive functioning
Risk Factors

- Dose of alcohol
- Pattern of exposure - binge vs chronic
- Developmental timing of exposure
- Genetic variation
- Maternal characteristics
- Synergistic reactions with other drugs
- Interaction with nutritional variables

FASD Interventions

- Pre-natal counseling
- Assessment
- Infant Stimulation
- Teach parent
- Special school interventions and accommodations
- Counseling and education for parent

Failure to Thrive: Causes

- Organic disease

- Non-organic
  - Unintentional
  - Child Neglect
**Cerebral Palsy**

- Motor control center of brain affected
- Damage to brain before, during, after birth (including abuse)
**Cerebral Palsy**

- **Spastic**: stiff, tense, weak muscles
- **Athetoid**: slow, writing, involuntary movement, weak muscles
- **Ataxic**: motor incoordination, poor balance and depth perception

**Preschool Social Development**

- Interactive play
- Functions of play
- Play as a casework strategy

**Preschool Emotional Development**

- Development of initiative
- Development of self-control
- Development of conscience
- Self esteem dependent on other’s reactions
Preschool Cognitive Development

- Egocentric thought
- Illogical thinking
- Vivid imaginations and magical thinking
- Immature sense of time
- Role of cognition in effects of maltreatment

Memory and Suggestibility

- Better at cued recall than free recall
- Can provide accurate info from memory
- Can’t recall single episode from series of experiences (neither can adults)
- Moresuggestible than older children

Preschooler Language Development

- Pre-operations
- Duos
- Vocabulary expands
- Non-stop talk
- Asking questions
- Promoting language development
- Culture and language
Preschoolers Physical Development

- Rule of “3s”
- Cultural influences
- Busy, active

Preschoolers’ Sexual Development

- Varying levels and frequency of sexual behavior
- Stereotypic understanding of gender roles
- Haven’t learned rules of privacy
- Understand “where babies come”
- Touch own and other’s genitals
- May masturbate

Assessing Sexual Behavior

Normal sexual play is:
- Mutual
- Between peers
- Voluntary
- Spontaneous
- Playful affect
- Easily re-directed
- Masturbation, or touching does not persist beyond pain
ASSESSING SEXUAL BEHAVIOR

Concerning sexual behavior:
- Interferes with other activities
- Involves coercion
- Causes emotional distress
- Is compulsive or anxious
- Persists beyond pain

Challenging Aspects of Preschool Development

- Normal challenges
- Special Problems

Parent’s misperceptions and unrealistic expectations may increase frustration

Working with Preschool Children

- Review your pre-training handout
- Compare your responses to what you have learned about preschool children
- Make any necessary changes based on what you’ve learned
- Be ready to discuss
Cheryl Part I

Read Cheryl Part I
Discuss and be ready to report on:
- What would you ask Ms. Robinson about Cheryl’s development?
- How and what would you observe in Cheryl to assess her development?
- Where else would you gather additional information about Cheryl’s development?

Cheryl Part II

Read Cheryl Part II
Discuss and be ready to report:
- Your initial assessment of Cheryl’s physical, social, emotional, and cognitive development
- How her development was affected by abuse and neglect
- Services you would put in place for Cheryl
  Use Therapeutic Interventions for Preschool Children as a resource.
- How you would help Cheryl and her aunt attach
  Use Promoting Attachment as a resource.

Treatment Goals

For children traumatized by maltreatment:
- Ensure a secure, safe, environment
- Secure attachment
- Learn to appropriately express and regulate emotions
- Develop appropriate social skills
- Understand his/her maltreatment
- Develop effective problem-solving skills

from National Traumatic Stress Network (Cook, 2003)
Emotional disturbances

Emotional disturbances associated with maltreatment in preschoolers:
- Reactive Attachment Disorder
- Anxiety Disorders
- Post Traumatic Stress Disorder

School Aged

School Aged Physical Development
- Slow and steady growth
- Activities promote gross and fine motor skills
- Perceptual-motor well integrated
- Development of motor skills influenced by culture
**School Aged Cognitive Development**

- Language
- Emergence of perspective taking
- Concrete operations
- Development of better coping skills

**School Aged Social Development**

- Social world is larger
- Meaningful and mutual friendships
- Rules guide behavior
- Rigid social role expectations
- Sexual development

**Inappropriate expectations for responsibilities at home**

- Responsibilities beyond child’s maturity or ability
- Responsibilities that compromise child’s development
- Dangerous tasks
- Punishing child for events out of his control
- Expecting child to meet adult needs for love, sex
School Aged Emotional Development

- Erickson: Industry vs Inferiority
- Sensitive of other’s opinions of him/her
- Better self-control and frustration tolerance

Outcomes of Maltreatment

- On school performance
- On child’s behavior and development
- On emotional well-being
- On relationships with parents and other adults
- On relationships with peers
- On ability to be self-directed and competent

Emotional Disturbances

Emotional Disturbances Associated with Maltreatment:

- Affective Disorders
- Conduct Disorders
Remembering Your Adolescence

- What five words would describe you as an adolescent?
- What cultural, environmental, family factors influenced you during adolescence?

Adolescent Physical Development

- Growth spurt: girls age 11 – 14  
  boys age 13 – 17
- Puberty:  
  girls 11 – 14  
  boys 12 - 15
- Early vs late puberty  
- Self conscious
- Self image affected by emotional factors

Adolescent Cognitive Development

- Brain growth spurt
- Formal operations:  
  Hypothetical thought  
  Logical thought  
  Think about thought  
  Insight and perspective taking  
  Systematic problem solving
Social Development: Young Adolescents

- Psychologically distance from parent
- Strong identification with peers
- Social status = group membership
- Conform to group traits or roles
- Ambivalent about sexual relationships

Middle Adolescent Social Development

- 1:1 friendships
- Self – revelation
- Expect loyalty, confidence, trust
- Conscious choices of adults
- Respect honesty and straightforwardness

Adolescent Sexual Development

- Cultural expectations regarding sexuality
- Early sexual behavior largely exploratory
- Sexual abuse negatively affects sexual development
Moral Development

- Punishment/Obedience (preschoolers)
- Self Interested Exchanges (school aged)
- Conventional Morality (teens)
  - Golden Rule; law and order

Emotional Development

- Identity
- Independence
- Cultural variations in:
  - When to leave home
  - Role of parent
  - Home vs. outside responsibilities

Adolescent Emotional Development

- Impetus: separate from parents
- Blatant rejection of parents’ standards
- Rely on peer group for support
**Young Adolescent’s Emotional Development**
- Emotionally labile
- Want intense emotional experiences
- Preoccupied with “faults”

**Middle Adolescent’s Emotional Development**
- Perspective taking → examine other’s values
- Awareness of inconsistencies in values is threatening
- Formulation of personal identity
- Self esteem: cognitive and affective

**Specific Identity Issues**
- Identity Confusion
- Sexual Identity
- Cultural/Ethnic/Racial Identity
- Identity Issues for Adopted Children
Working with Adolescents

Review your pre-training worksheet on adolescents
Make changes or additions to your responses on the work sheet, if needed
Be ready to discuss

Degree of Effect of Child Abuse and Neglect on Child

- Age of onset of maltreatment
- Frequency of maltreatment
- Severity of maltreatment
- Nature of relationship with perpetrator
- Constitutional factors of child
- Family Context
- Developmental importance

Adolescent Exercise

Read the case examples
Answer these questions for each teen:
- What is the teen’s development level in all domains?
- What are his/her strengths?
- What are your concerns for this youth?
- What would your service plan include?
Thanks to all
Good luck in Module VIII!

Remember to take "Milestones of Child Development" chart to Module VIII
Handout List for Module 7

1. Mod VII PowerPoint
2. Agenda and Objectives
3. LMS Competencies
4. Promoting Attachment
5. Fetal Alcohol Spectrum Disorder
6. Prenatal Exposure to Drugs
7. Failure to Thrive
8. Special Care for Severely Abused Infants
9. Cerebral Palsy
10. Structured Note Taking - Preschool
11. Cheryl Part I
12. Cheryl Part II
13. Therapeutic Interventions for Preschoolers
14. The Effects of Abuse and Neglect on Preschool Children
15. Reactive Attachment Disorder
16. Anxiety Disorder
17. Post Traumatic Stress Disorder
18. Depression
19. Conduct Disorder
20. Laurie
21. Teen Sexuality
22. Francie
23. Terry
24. Kathy
25. Lee
Caseworker Core Module VII: Child Development: Implications for Family-Centered Child Protective Services

Agenda and Objectives

Section I   Introductions

Objectives:

• Trainees introduce themselves to each other and the trainer.

Section II   Applying Principles of Development to Child Welfare

Objectives:

• Trainees will identify their training needs for the workshop

• Trainees will know the concepts and principles of normal child development.

• Trainees will understand why a thorough knowledge of child development is essential for effective child welfare practice.

  A. WIIFM and Importance of Learning about Child Development and the Effects of Abuse and Neglect on Development
  B. Underlying Principles Regarding Development

Section III   Development of Infants and Toddlers

Objectives:

• Trainees will know the processes and milestones of normal development of infants and toddlers.

• Trainees will understand the potential negative outcomes of abuse and neglect on the physical, cognitive, social, and emotional development of infants and toddlers.

• Trainees will know why infants and toddlers are at particularly high risk of abuse and neglect.
Trainees will learn case planning and treatment options for children who are developmentally delayed.

Trainees will understand common special development problems, and appropriate case plan and treatment strategies.

A. Normal Development of Infants and Toddlers
B. The Effects of Abuse and Neglect on Infants and Toddlers
C. Treatment for Abused and Neglected Infants
D. Recognizing Developmental Delays in Infants and Toddlers
E. Special Developmental Problems of Infants

Section IV  Development of Preschool Children

Objectives:

Trainees will know the processes and milestones of the normal development of children between the ages of 3 and 5.

Trainees will understand the potential effects of abuse and neglect on the physical, cognitive, social, and emotional development of preschool children.

Trainees will know strategies for providing services that promote the healthy development of abused and neglected preschoolers.

A. Normal Development of Preschool Children
B. Aspects of Preschool Development That May Challenge Parents
C. Developmental Aspects of Working with Preschool-Aged Children
D. The Effects of Abuse and Neglect on Preschool Children

Section V –Development of School-Age Children

Objectives:

Trainees will know the processes and milestones of the normal development of children between the ages of 6 and 12.
• Trainees will understand the potential negative outcomes of abuse and neglect on the physical, cognitive, social, and emotional development of school-age children.

• Trainees will know strategies for providing services that promote healthy development of school-age children.
  
  A. Normal Development of School-Age Children  
  B. The Effects of Abuse and Neglect on School-Age Children  
  C. Emotional Disturbances Associated with Maltreatment  
  D. Developing a Service Plan for a School-Aged Child

Section VI – Development of Adolescents

Objectives:

• Trainees will know the processes and milestones of normal development of children ages 12 to 18.

• Trainees will understand the potential negative outcomes of abuse and neglect on the physical, cognitive, social, and emotional development of adolescents.

• Trainees will know how to conduct an assessment of youth who display behavior problems as a result of maltreatment.

• Trainees will know strategies for providing services in adolescents that promote healthy development and to treat developmental problems.
  
  A. The Nature of Adolescence: A Developmental Transition  
  B. Normal Adolescent Development  
  C. Challenging Aspects of Parenting Adolescents  
  D. Working with Adolescents  
  E. Application Exercise: Differential Assessment of Adolescents

Section VII – Evaluation, Post Training Assignment, Close
CHILD DEVELOPMENT: IMPLICATIONS FOR FAMILY-CENTERED CHILD PROTECTIVE SERVICES

Competencies

Skill Set #1: Ability to identify indicators of age-appropriate development in all domains for children of varying ages

1. Aware of the caseworker’s role as an advocate to promote healthy development of all children served by the agency

2. Knows combined effects of heredity (genetics and maturation) and environment on children’s development

3. Knows essential prerequisites for healthy child development in all domains

4. Knows how “normal” development is determined and assessed

5. Knows the difference between chronological age and developmental age

6. Knows characteristics of the primary developmental domains (physical, social, emotional, cognitive) and their sub-domains

7. Knows stages, processes and milestones of normal development of infants (age birth - 1 year) in all domains

8. Knows stages, processes and milestones of normal development of toddlers (age 1-3 years) in all domains

9. Knows stages, processes and milestones of normal development of preschool children (age 3-5 years) in all domains

10. Knows stages, processes and milestones of normal development of school-age children (age 5-11 years) in all domains

11. Knows stages, processes and milestones of normal development of preadolescent children (age 11-13) in all domains

12. Knows stages, processes and milestones of normal development of adolescents (age 13-18) in all domains
13. Understands how development can be influenced by culture, and how a misinterpretation of cultural factors may confound a developmental assessment.

14. Understands how development in each developmental domain impacts development in the others.

15. Knows how to observe children's behavior and gather information about children's developmental level from family members and other sources.

16. Can determine a child's approximate developmental age in each domain.

Skill Set #2: Ability to recognize indicators of developmental delays, disabilities, illness and other conditions that impact children's development.

1. Aware of the profound negative impact of child maltreatment on children's health and development.

2. Aware of the worker's responsibility to screen children for untreated illnesses, developmental delays and disabilities, and to arrange for appropriate remedial services.

3. Knows potential negative effects of physical abuse, neglect, sexual abuse and separation trauma on the formation and maintenance of attachment in young children.

4. Knows potential negative effects of physical abuse, neglect and sexual abuse on the development of children aged birth through adolescence.

5. Knows indicators and early warning signs of developmental delays or abnormal development.

6. Knows indicators and early warning signs of behavioral and developmental conditions commonly seen in children who have been maltreated.
7. Understands how children’s behavior problems may be symptoms of underlying developmental delays or emotional disturbance, and how they may also become contributing factors to abuse or neglect

8. Knows how to observe children’s behavior and ask relevant questions to identify early indicators of developmental delay or disability

9. Can assess children’s behavior and development and identify inconsistencies between chronological and developmental age

10. Can recognize primary indicators of common developmental conditions and disabilities associated with child maltreatment

11. Can use assessment data to identify and prioritize children’s developmental or treatment needs, and write case plan objectives that address these needs

Skill Set #3: Ability to help families access appropriate community resources to address children’s developmental needs

1. Aware of worker’s role as case manager to help families access needed services to promote children’s healthy development

2. Knows the range and types of services needed by children with developmental delays, disabilities and behavior disorders, and their families, to enable families to support their children’s development

3. Knows agencies, providers, and funding options in the child’s home community to provide special services for children with delays or disabilities

6. Can design and implement a comprehensive case plan that addresses children’s developmental and special needs

Skill Set #4: Ability to help parents/caregivers identify parenting strategies that meet their children’s developmental needs

1. Knows age-appropriate expectations for children’s behavior at different stages of development
2. Understands how age-appropriate children's behaviors can be experienced as stressful or misinterpreted by parents

3. Understands how stresses of parenting children with developmental or behavioral problems can contribute to maltreatment

4. Understands how parenting strategies that involve power and coercion can contribute to maltreatment and to developmental, behavioral, and emotional problems in children

5. Understands how inconsistent parenting interventions and failure to establish and enforce structure can support and sustain children's behavior problems

6. Understands the importance of helping parents correct unrealistic expectations for their children's behavior and development to prevent maltreatment

7. Understands the value of parent education, support groups, mentors, buddy systems, and respite services to help decrease stress experienced by parents or caregivers of children with developmental or behavior problems

**Skill Set #5: Ability to promote and sustain healthy attachments between children and their families or caregivers**

1. Knows the parenting practices that support the development of positive secure attachments in children

2. Knows the parenting practices that contribute to insecure or maladaptive attachment in children

3. Knows the behavioral and emotional indicators of maladaptive attachment in both children and adults

5. Understands the potential lifelong consequences of chronic insecure or maladaptive attachment on children's development and mental health
6. Understands how child maltreatment at different ages and developmental stages can negatively impact attachment

7. Knows how to recognize indicators of insecure attachments between children and their parents or caregivers

9. Can observe the behavior of children and caregivers to determine the strength and type of attachment in the family

10. Can identify parenting behaviors in a family that promote or interfere with the development and maintenance of positive attachment

11. Can accurately identify children with very disturbed or severely maladaptive attachment who need psychological treatment

12. Can identify community resources to refer children and families for comprehensive developmental assessment and treatment to strengthen attachment
Attachment: Helping Parents Encourage the Development of Attachment
Parenting Strategies that Build and Strengthen Attachment
adapted from Dr. Vera Fahlberg

The Arousal-Relaxation Cycle

The Arousal-relaxation Cycle is based on our understanding that trust, security and attachment are strengthened when a consistent adult caregiver repeatedly meets a child’s needs. For example, a child becomes hungry and cries, reflecting a state of tension and arousal. The caregiver responds by meeting the infant’s needs, feeding and comforting the infant. The child receives comfort, which relieves tension and promotes contentment. The parent feels secure, and happy that he/she has provided empathic care for the child. The good feelings are mutually reinforcing and reciprocal. This cycle is a healthy parent/child relationship and is repeated multiple times each day.

The adoptive parent’s job, guided by the worker, is to learn to identify the needs of their new youngster and to meet those needs in a consistent, nurturing response. The challenge for new parents of maltreated children is that these children may express their emotional needs with problematic behavior. Parents must recognize that these tantrums, nightmares, oppositional behaviors, refusal to do what is asked, feigning illness, and other outwardly negative behaviors are often expressions of anger, fear, sadness and loneliness. They must learn ways to meet the child’s emotional needs, while still being able to control their negative and harmful behaviors.

In addition to these behaviors, severely neglected or abused youth may have attachment problems, and may be aloof, or appear not to care about or for the adoptive parent. This can be very disturbing to adoptive parents. We will discuss how to address attachment problems later.

Positive Interaction Cycle

While the arousal-relaxation cycle is dependent on the child’s expression of need, in the Positive-Interaction cycle, parent initiates affirming emotional and social exchanges with the child. The cycle begins when the parent engages the child in a positive interaction. The child enjoys the interaction and reacts in an affirming manner. Both the child and parents feel a sense of self worth and are motivated to continue to interact. This type of interaction greatly augments the attachment process.

Many adoptive parents believe wrongly that the child should “take the first step” in forming attachments with them. For adopted children, the lack of trust and their ambivalence about
new attachments may make this impossible. Adoptive parents must be encouraged to regularly approach the child in a non-threatening, gentle manner to initiate social interactions. Parents must be prepared to continue to engage the child in a meaningful and pleasurable interaction without expecting the child to reciprocate in kind.

**Claiming Behaviors**

A third means Fahlberg recommends to promote attachment is “claiming.” Claiming is the process of assimilating the child into the family and helping the child feel part of the family. Claiming behaviors also promote the development of entitlement by the parents - the firm belief that they have a right to parent the child as their own. These activities are symbolic in that they communicate acceptance, and integration of the child into family life.

Examples of claiming behaviors are as follow. These activities are symbolic in that they communicate to the child and the world at large that the child is a member of the family.

- Having the family picture taken which includes the child and send that picture to family members that child regularly visits.
- Adding the child’s name to the mailbox; allowing the child to sign greeting cards;
- Sending out announcements to family and friends when the child joins the family;
- Including the child’s lifebook with other family albums
- Teaching the child old family traditions, incorporate traditions the child remembers from his earlier life into adoptive family traditions, involve the child in developing new family traditions.
- Planting a tree or flower bulbs in the yard, with the child, to celebrate the adoption and symbolize the “planting” of the child in a permanent family. Enlist the child to tend the new plants as they put down roots and flourish
- Having the child help plan future vacations, activities, holidays, etc. to communicate to the child that s/he is a permanent part of the family’s future.
SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS

Fetal Alcohol Spectrum Disorder

Sokol et al (2003) (page 4) state that prenatal alcohol “exposure has been implicated as the most common cause of mental retardation and the leading preventable cause of birth defects in the United States, accounting for significant educational and public health expenditures.”

Alcohol destroys and damages cells in the central nervous system. Widespread destruction of brain cells in early fetal development causes malformations in the developing brain structures. This, of course, can produce abnormalities in brain function.

Some physicians and researchers are now using the term Fetal Alcohol Spectrum Disorder to indicate the continuum of effects, from severe to mild. The most severe end of the spectrum is often called Fetal Alcohol Syndrome. It refers to a combination of symptoms that are associated with prenatal exposure to large amounts of alcohol. Fetal Alcohol Effect is a milder form, and refers to children who have some of the following outcomes. Since there are no physical features, these children often are not recognized as having FAE.

Outcomes of FASD

- Pre- and post-natal growth deficiency (failure to grow)
- An average IQ of 63, which falls within the mild range of mental retardation
- Irritability in infancy
- Inattention, distractibility, hyperactivity, mood disorders in childhood (Sokol, et. all, 2003)
- Decreased reaction time in infancy and preschool children
- Mild to moderate degrees of microcephaly. (Microcephaly is small head circumference. It is usually associated with varying degrees of mental retardation and abnormal brain development.)
- Dysfunction in fine motor control, such as weak grasp, poor eye-hand coordination, and tremulousness
• Specific facial features, including thin upper lip, epicanthal folds, low nasal bridge, minor ear abnormalities, flat midface. These features often become less obvious during adolescence.

• Difficulties with executive functioning: problem solving, higher level thinking, self-monitoring, regulation of emotion, motivation, judgement, planning, working memory, time perception. These behaviors are often misinterpreted as willful, deliberate, or “bad behavior”. This is unfortunate, because children with these problems may not be accurately diagnosed, and may not receive developmental services.

• The degree and type of damage done to the developing fetus depends upon several factors including which developmental processes were occurring when the alcohol was ingested, how much was ingested, and whether the drinking was chronic or binge drinking. Research has shown that even low levels of alcohol consumption and infrequent binges can damage the developing fetus. Research has not identified a safe limit for drinking during pregnancy. “The only prudent conclusion is that alcohol can affect the developing brain even a low exposure levels. Abstinence during pregnancy is the only way to avoid such effects”. Goodlett and West, 1992, p 64-65, found in Streissguth, page 61)

**Recommended interventions**

• Prevention, including counseling to pregnant women regarding the risks to their offspring, and referral to medical services and Alcohol programs.

• Developmental assessment of children thought to have been exposed prenatally to alcohol to identify growth retardation and delay, and to diagnose fetal alcohol syndrome.

• Referral of affected children to infant stimulation and early intervention programs.

• Training the parent or caregiver to plan and implement activities that will address developmental delays and promote healthy development of their children.

• Advocating for special school, social, and work accommodations throughout the child’s life so that he/she can function to his/her full potential, and to prevent “secondary conditions” such as depression and anxiety.

• Counseling and education for parents about meeting the child’s developmental needs and promoting optimal development and adjustment.
SPECIAL DEVELOPMENTAL PROBLEMS OF INFANTS AND TODDLERS

Prenatal Exposure to Drugs

The effects of drug exposure upon children during pregnancy are not completely understood. What was once believed to be a consistent syndrome of symptoms known as crack/cocaine exposure to infants and children is now not believed to be totally attributable to crack/cocaine exposure during pregnancy. While research indicates that children who are exposed to other stressors in utero often suffer a variety of developmental difficulties, the specific effects of various illegal or street drugs are not completely known.

A number of factors known to affect the fetus during pregnancy probably combine to place the newborn child at risk for a variety of developmental problems. These factors include cigarettes, marijuana, cocaine, poor prenatal care and parenting practices, poverty and low socioeconomic status including low education level and associated social risks, and the risks associated with drug-seeking behavior.

**Infants**

Infants who have been drug exposed during pregnancy may be very irritable and difficult to soothe. These children are often labeled “disorganized” or lacking the ability to self-regulate their emotional states. At birth and shortly thereafter these children are often identified as stiff and irritable by caretakers. These patterns are usually short-lived and seldom continue beyond infancy.

Drug-exposed infants have a tendency to be smaller at birth in weight and length. They typically catch up to non-exposed children with proper care and nutrition.

Other symptoms in newborns include gaze aversion; a frowning or furrowed brow that gives the infant a worried look, motor agitation, hiccups, spitting up and crying.

Caretakers should receive education and instruction in strategies to soothe newborns and learn to reduce their stress. Examples of soothing strategies include providing firm touch, swaddling the infant with arms close to his/her body, using a pacifier, and vertical rocking. It is often helpful to reduce the amount of stimulation in the newborn’s environment. Finally, it is critical for parents and caretakers to learn to
“read” the infant’s cues, and adjust their interactions with the baby so as not to overwhelm or irritate the baby.

**Toddlers and preschool children**

Children exposed to drugs in utero are more likely to experience delays in development for a number of reasons. While the precise origin of the delays is not known, it is important that children with developmental delays receive appropriate services. Early intervention services that stimulate cognitive, motor, language, and social development are effective for children with delays caused by drug-exposure.

Drug exposed children may exhibit any number of symptoms. Common problems include behavioral symptoms such as low tolerance for frustration, distractibility, and impulsive behavior. Language delays are frequently found in children with impoverished home environments. These problems may appear as articulation problems or as delays in verbal expression.

**Treatment**

Caretakers of children who are drug exposed should be aware of indicators of developmental delays and should seek medical, developmental or psychological assessments for children who exhibit difficulty.

Early intervention services that stimulate cognitive, motor, language and social development are effective for children with delays caused by drug-exposure. These services are available through "Help Me Grow" programs.
SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS

*Failure to Thrive*

**Definition**

The term "failure to thrive" (FTT) has been used to describe a wide variety of conditions in which infants fail to achieve age-appropriate weight and height levels. Block, et al (2005) state that “inadequate nutrition and disturbed social interactions contribute to poor weight gain, delayed development, and abnormal behavior. The syndrome develops in a significant number of children as a consequence of child neglect”

The one characteristic common to these children is nutritional deficiency. This can be caused by a number of problems, and is often caused by a combination of the following factors:

- **Unintentional:** Breast-feeding problems, errors in formula preparation, poor diet selection, improper feeding technique
- **Organic diseases:** Including but not limited to cystic fibrosis, cerebral palsy, HIV infection or AIDS, inborn errors of metabolism, celiac disease, renal disease, lead poisoning, major cardiac disease
- **Child neglect:** Treatment approaches must include both medical and environmental management, regardless of the cause of the problem. (Block, 2005)

FTT from neglect often causes attachment problems. FTT is often not merely a feeding problem; it often indicates serious problems in the attachment, especially disorganized attachment, between the baby and primary caretaker. (Carlson, 2003) However, not every child with FTT has an attachment problem.

**Physical characteristics of children with FTT associated with neglect**

- Most appear emaciated, pale, and weak; and have little subcutaneous fat and decreased muscle mass.

- The infants are often below their birth weight, indicating weight loss; or their weight is well below the normal range.

- Most are listless, apathetic, motionless, and at times irritable.
Some infants are unresponsive or resist to social involvement. Others become distressed when approached. Many show a preference for inanimate objects.

Infants may sleep for longer periods of time than is appropriate for age.

Infants may display immature posturing; that is, postures more appropriate for newborn or very young infants, including lying with hands held near or behind the head, legs flexed in a "frog" position or thumbs closed inside fists.

Some children display self-stimulatory rocking, head-banging, or rumination (vomiting and swallowing).

Developmental assessment will likely reveal primary delays in gross motor and social domains.

**Common characteristics of parents of malnourished children are as follows:**

Research has repeatedly described mothers of underfed children as depressed, socially isolated, withdrawn, and anxious.

Many parents have histories of abuse and neglect, including an absence of attachment, in their own early childhoods.

Parents often fail to interact warmly and in a nurturing manner with their infants.

Many parents are "overwhelmed" by chronic stress, which can be exacerbated by the demands of caring for an infant.

Parents often show little ability to empathize with their infants; they often misread or ignore their infant's cues. Their behavior meets their own needs rather than their infants'.

The parent may create an unpleasant or painful feeding situation for the infant; as a result, the child may not cooperate or may reject food. The parent might be impatient, might force-feed the child, or might remove food abruptly. When the child resists or fails to eat, the parent may assume the child is not hungry and discontinues the feeding.
• Some parents, while expressing sincere concern about their children’s conditions, appear not to know how to interact meaningfully with their infants. There is typically little interpersonal activity between the parent and the infant. Some parents play with their infants in a competitive manner rather than as a nurturing adult.

**Specific problems related to feeding might include:**

• The parent may not realize the child is failing to grow, nor recognize the lack of weight gain and emaciation.

• The parent may notice the child’s feeding problems but think they are the result of vomiting, diarrhea, or other physical illness, rather than problems in the feeding situation itself. The parent may believe the child is being adequately fed.

• The parent may not be able to accurately report feeding times, schedules, or the quantity of formula the infant has taken. The parent may not be assuring adequate caloric intake.

• The parent may allow long periods of time to elapse between feedings because "the baby doesn't appear to be hungry." Apathy and listlessness that result from low caloric intake are mistaken for the absence of hunger.

• Breast-fed infants can be undernourished if the mother does not produce adequate milk or does not know how to nurse her infant. Breast-fed infants over the age of 5 months may not be able to get adequate nutrition from breast milk alone.

**Recommended treatment for malnourished infants and their families**

• A thorough medical assessment must be conducted to determine the etiology of the failure to thrive.

• The American Academy of Pediatrics (Block, 2003) states that in severe cases, where the child’s weight is less than 70% of expected weight-for-length, urgent intervention is needed. Immediate hospitalization or placement in foster care may be necessary. A treatment that provides caloric intake far in excess of that needed for
maintenance under normal conditions is effective. This typically leads to rapid weight gain, called "catch-up growth," in children who are undernourished from underfeeding. Some infants achieve age-appropriate weight within a couple of weeks.

- Rapid catch-up growth during hospitalization is diagnostically significant for this syndrome, particularly when the child is fed in the hospital with the same formula used at home.

- Intense feeding problems appear to resolve some secondary physical conditions affecting the infant, as well as apathy and depression.

- A team approach to treating FTT is needed. The team includes child welfare caseworker, physician, nurse, and often includes a dietician.

- Parents should be directly involved in all aspects of the treatment program. Supportive counseling and education by a caring, nurturing professional can help parents feel less guilty, anxious, and depressed. It can teach and reinforce proper feeding methods and improve parent-child interactions. This treatment program should begin in the hospital. *If the parents are not treated, the child can be expected to quickly regress when returned to the home.* In severe cases, the infant can die.
SPECIAL DEVELOPMENTAL PROBLEMS
OF INFANTS AND TODDLERS

Special Care for Severely Abused Infants

Infants who have been abused severely, and at an early age, demonstrate predictable developmental patterns and delays, as follows:

- They are withdrawn, apathetic, and look weak and sick.
- They allow manipulation of their bodies with no protest.
- They do not enjoy being touched or held, and do not positively respond to affectionate handling.
- They exhibit generalized passive compliance.
- They appear to enjoy nothing. They do not laugh or smile; they show no interest in objects or people. They do not take pleasure in feeding, bathing, play, or other normal activities.
- They do not risk contact with people. They appear to feel best when they are left alone.
- Their movements are slow and cautious; they display limited mobility. They may stay in one place for long periods of time.
- They do not often cry. They may occasionally whimper or wail.
- They do not cling to parents or other adults in threatening situations.

Treatment Interventions

Specialized treatment methods are necessary if we are to help this child. Simply eliminating the abuse is not enough. Parents and foster caregivers must be trained to nurture this child in a predictable, measured fashion. "Too much too soon" can overwhelm the child and have the effect of further closing him off. As a result, treatment may take months.

- Move SLOWLY! Take care to approach the child slowly at all times, and do not institute too many changes at once.

- Create a calm, comfortable environment. The environment should not, however, be sterile and devoid of stimulation. Stimulation must be given in measured doses. A foster home with five noisy and active children may not be the best environment for this infant.

- Read the child's cues to determine his or her needs. When the child withdraws from an approach, back off, and approach again more slowly or tentatively. The child needs to become acclimated. There is a fine line between providing nurturance and overwhelming the child.
• Choose times in which to interact with the infant, and keep these times short at first.

• Talk to the child using a soft, affectionate tone of voice. QUIET and COMFORTING is the rule.

• Introduce pleasure into care giving. Any interaction with the child, including feeding, bathing, and changing clothes, should be performed gently, allowing the infant to experience normal infant pleasures. Adequate time should be taken; these activities should not be rushed.

• Do not discipline the child harshly. If the child approaches a dangerous situation, she should be gently redirected or removed.

• The parent or caregiver must allow latitude in permitting the child to behave in ways that are developmentally more appropriate for a young infant. For example, messing with food, spitting, splashing in the bath, and otherwise "making a mess" are preferable to withdrawal and immobility. After several months, set gentle limits.

• Do not force physical affection. Begin with gentle touching, patting, and stroking. When holding the child, hold lightly. Cuddling is fine when the child appears to respond positively by conforming to the adult's body, or "settling in." Follow the child's cues about physical affection.

• After a period of time the child may exhibit such behaviors as thumb sucking, clinging, other dependent behaviors, frequent crying, stranger anxiety, separation anxiety, and other signs of social need. These must be viewed as PROGRESS rather than as problem behaviors.
Cerebral palsy is a developmental disability. According to the National Institute of Neurological Disorders and Stroke (NINDS), “cerebral palsy is an umbrella-like term used to describe a group of chronic disorders that appear in the first few years of life and generally do not worsen over time. The disorders are caused by faulty development of or damage to motor areas in the brain that disrupts the brain’s ability to control movement and posture”. (NINDS web page 9-22-06)

There are multiple possible causes of cerebral palsy, including prenatal and postnatal abuse and neglect. Most often, cerebral palsy is present at birth, and is thought to be the result of some prenatal insult from illness, injury, or presence of toxic substances. Mothers who have no prenatal care, or who abuse alcohol or drugs, increase the risk of cerebral palsy in their infants.

Child welfare workers must be skilled at recognizing the early warning signs of cerebral palsy in populations of abused and neglected infants and children. This can ensure optimum early intervention.

Early symptoms of cerebral palsy are variable. In milder cases, problems may not be apparent until the child reaches school age. Generally, the more severe the condition, the earlier it can be detected.

There are many different conditions that fall within the broad term "cerebral palsy," and there are considerable differences in descriptive terminology in the literature. The types of cerebral palsy can, however, be broadly divided into three major categories.

- **Spastic** cerebral palsy is characterized by stiff, chronically tensed muscles combined with muscle weakness.

- **Athetoid** cerebral palsy is characterized by slow, writhing, involuntary and uncontrolled muscle movements, with muscle weakness.

- **Ataxic** cerebral palsy is characterized by motor incoordination and difficulty with balance and depth perception.

Many persons with cerebral palsy have mixed types. 90% of cerebral palsy is either spastic, athetoid, or a combination of both.
Abnormal Muscle Tone

Infants may exhibit either hypotonia, a significant lack of muscle tone characterized by loose, floppy muscles; or, hypertonia, an excessive degree of muscle tone characterized by tightness, stiffness, and constricted movement. Typical signs of hypertonia related to spastic cerebral palsy might include:

- Keeping one or both hands fisted, or keeping the thumb clenched inside the fist, if the child is over 4-5 months.
- Tightness of the hips, making it difficult to separate the infant's legs to diaper him;
- Keeping the legs in an extended position, or crossing the legs or ankles; kicking the legs in unison, bringing the knees together up to the chest, rather than the more normal alternating leg, bicycle style kicking.
- Evidence of lack of vision, inability to focus or to track moving objects.
- Tongue thrust, moving tongue in and out of the mouth, excessive drooling.

Typical signs of hypotonia or lack of muscle tone may include an inability to maintain head control, and a generalized "floppiness" that will contribute to delayed motor development.

Abnormal Patterns or Delayed Motor Development

Delayed motor development may exhibit itself in numerous ways.

- Failure to achieve head control, or to lift head and chest from a prone position when the child is on his stomach, in a child older than 5 months.
- Failure to reach for objects or to transfer objects from one hand to the other, in a child older than 7 months.
- Collapsing forward when placed in a sitting position, or rounded back when seated, in a child older than 8 months.
- Inability to roll from back to front, in a child older than 6 months.
- Inability to stand, in a child older than 10 months.
Abnormal patterns of motor development refer to developmental milestones that are only partially completed, or to differences in the infant's skill in mastering motor tasks using various parts of the body. For example:

- Persistent use of only one hand when playing with a toy, including reaching across the body to retrieve an object, rather than reaching with the arm that is on the same side of midline as the object. Infants typically use both hands equally for the first 15 months of life.

- Good use of hands and arms, but drags legs. While many infants go through a stage of "G.I. Joe" crawling on their stomachs, failure to progress to more advanced use of the legs might be indicative of cerebral palsy.

- Trembling or inaccurate aim when reaching for an object may indicate athetoid cerebral palsy.

- Walking on tiptoes. Young infants typically stand on their toes when held in a standing position in an adult's lap. By the time the child learns to walk, heels should be flat on the floor. A persistent toe-walking reflex may indicate cerebral palsy.

**Treatment Recommendations**

Early intervention can increase range of mobility and prevent unnecessary deterioration of motor abilities.

Early intervention can help children learn and grow in spite of their physical problems. (More than 50% of children with cerebral palsy have intellectual potential within the normal range.)

Ongoing physical therapy and proper medical management are necessary.

Developmental assessments should be performed to help determine treatment needs in all developmental areas.

Special infant stimulation programs can greatly improve motor development as well as cognitive and social development.

Vision and hearing should be routinely screened and monitored as the child develops. Cerebral palsy can affect both.

Speech therapy should be provided for children whose motor ability to
speak is involved. For severely involved persons, alternate communication systems (symbolic communication systems, "voice boxes," use of pictures) can increase language development even though speech is absent.

Parents will need considerable support and education. Caring for a child with cerebral palsy can be stressful and difficult. Special services and support for the parent can help them manage.
Please note important insights from the video:

TAKE 1: Social and Emotional Development

TAKE 2: Cognitive and Language Development

TAKE 3: Physical Development
Cheryl – Part I

Cheryl is five years old. She and her-nine-year old sister were referred to the public children services agency for neglect when neighbors found her trying to cross the street, unsupervised at 10:00 PM on a Saturday evening. The subsequent investigation found that she had been severely, chronically abused, and occasionally neglected. Her mother was addicted to heroin, and used other drugs and alcohol as well. Her mother often locked Cheryl up in the closet for punishment, beat her, and left her alone with her 9-year-old sister when she went out partying. She has no visible means of support. Neighbors think she prostitutes herself to earn drug and rent money.

Cheryl and her sister were immediately placed in her aunt’s (Ms. Robertson) care. At the shelter-care hearing, mother arrived high, and the agency was granted temporary custody of both girls, and maintained them at Ms. Robertson’s home.

Ms. Robertson was not surprised that the agency became involved. She stated that she had been worried about the girls for some time, and that she had kept them overnight on several occasions, when the older sister would call her for help. Ms. Robertson had not reported the situation to children services, hoping to avoid outside intervention.

Ms. Robertson is a single mother, with five children. She scrapes by on her salary as a nurse’s aide and child support she receives from her ex-husband. She stated that she loves both girls immensely, and is prepared to care for them for “as long as it takes”.


FINAL – July 2008
Discussion questions for Cheryl Part I:

For the purpose of this exercise, you will discuss only Cheryl, not her sister.

You are an ongoing family services worker. This case was transferred to you today. The investigation occurred three weeks ago, and Cheryl and her sister have been in the aunt’s home since that time.

Your supervisor asked you to assess Cheryl’s developmental needs, in preparation for developing the case plan.

Please discuss, and be ready to report out on the following questions:

1. **What would you ask Ms. Robertson about Cheryl’s Development?**

2. **How would you make your own observations about Cheryl’s development?**

3. **Where else would you gather additional information about Cheryl’s development?**
Cheryl – Part II

You have completed your first home visit to Ms Roberson’s home. You spoke with Ms. Robertson, and engaged Cheryl in some activities such as looking at books, and coloring in a coloring book. You have gathered the following information:

- Cheryl stays close to her aunt as much as possible, and follows her around the house.
- Cheryl uses immature language, using only simple, short sentences. Her pronunciation is difficult for you to understand. The aunt can seldom understand her, although she stated that she is starting to catch on to Cheryl’s speech patterns.
- Cheryl is physically awkward. She walks pigeon-toed, with a halting gait. Her hand-eye coordination is poor, and she’s “always bumping into things”.
- Cheryl has night terrors, with screaming and crying, though it seems that she never fully wakes up from these dreams. It is very difficult to calm Cheryl during these episodes. Ms. Robertson holds her, and rocks her until she settles down.
- Cheryl had difficulty staying on task when you and she colored in the coloring book. She was easily distracted, and you noticed that her coloring marks were haphazard, jagged lines, and that very little of her coloring was within the lines.
- Ms. Robertson explains that Cheryl tries to play with children her own age, but doesn’t know how to play cooperatively, and doesn’t indulge in any “pretend play” like other children her age. Most of the children in the neighborhood avoid her.
- Cheryl has severe temper tantrums about 5 – 10 times a day. These tantrums include hitting, screaming, biting and throwing toys against the walls. Ms Robertson states, “its good she’s such a little thing, I can hold her still, if need be.”
- These tantrums occur when Cheryl is frustrated, or when she cannot get her own way. She experiences frustration continually: other children and most adults cannot understand her most of the time and she is often snubbed by neighbor children who think she is “a baby”. Furthermore, she becomes angry when other children expect her to share her toys and take turns in games.
- Ms Robertson states that when checking on the children before she goes to bed at night, she often finds Cheryl in her sister’s bed. She doesn’t separate them, figuring that Cheryl needs her sister for security.
Discussion Questions for Cheryl Part II

What is your initial assessment of Cheryl’s physical, social, emotional, cognitive development?

How do you think abuse and neglect affected her development?

One the basis of your assessment, what kinds of services would you put in place for Cheryl? Use the “Therapeutic Interventions for Preschool Children” as a resource for this discussion.

How would you help Cheryl and her aunt develop a positive attachment relationship? Use the handout, “Promoting Attachment” as a resource for this discussion.

Therapeutic Interventions for Pre-School Children

Head Start

Description: Head Start is a federally funded program to help disadvantaged children develop cognitive and social skills. Although the program is not intended specifically for children with developmental delays, teachers are trained to identify delays and to help children from deprived environments attain developmentally appropriate cognitive and social skills. Children are taught in small groups, in classroom settings. Head Start programs are located in neighborhood settings.

Eligibility requirement: 165% Percent of poverty level; parents must be working.

Location: Often in low-income neighborhoods, churches, or community centers.

Occupational Therapy, Physical Therapy, Speech and Language Therapy

Occupational Therapy provides services that help children who have impairments in fine motor movements.

Physical Therapy provides services that help children who have impairments in large motor movements.

Occupational and physical therapists are state licensed and provide individual services to help children improve their fine and large motor control and movement respectively. Therapists use a variety of exercises, treatment, and games. Often the treatment is extended at home with exercises. Therapists often use their treatments to help patients re-gain use of their muscles when recovering from an injury, surgery or stroke. In children these delays are often caused by a neurological condition such as cerebral palsy, however, in many young children the origins of the motor delays are often unknown.

Eligibility: Children who exhibit significant impairment in fine or gross motor control. Must be referred by a physician.
Location: Children’s hospitals, early childhood intervention services, and private practices.

Speech and Language Therapy. Speech therapy is for children who have problems with the production of words, such as mispronunciation and stuttering. Language therapy is for children who have difficulty understanding or processing what is said to them (i.e.: receptive language disorders); or have difficulty putting words together, limited vocabulary, or using language in a socially appropriate way (i.e.: expressive language disorder).

Speech and language therapists are state licensed and certified through the American Speech and Hearing Association. They conduct speech and language assessments and develop and implement specific treatment strategies for each child. Speech therapy may be conducted one-to-one, in a small group, or in the child’s classroom.

Location: Speech therapy is available in facilities for children who have mental retardation or developmental disabilities, Head Start, Help Me Grow, schools, and through private providers.

Mental Health Services

Description: Counseling with children and adolescents is quite different from counseling adults. Children and adolescents have different developmental needs and abilities than adults. A child’s ability to verbalize his psychological pain or concerns is not fully developed. Adolescents often do not have the psychological benefit of perspective and experience to help with decision-making regarding activities with long-term implications such as alcohol, education, and sex. Children and adolescents seldom have the authority or ability to fully implement therapy recommendations after solutions are identified. Case workers will need to understand that linking a child to even the most accomplished therapist is only a beginning in helping restore a child’s emotional well-being. Mental health strategies devised in psychotherapy need to be implemented collaboratively in the child’s home and school environment.

Day Treatment or Partial Hospitalization: In more serious cases the typical outpatient counseling process is not adequate to meet a child or adolescent’s needs. Options such as day-treatment programs may be available. This allows a child to receive mental health interventions and medication monitoring without requiring that he or she be hospitalized or placed in a residential program. Day treatment or partial hospitalization programs typically involve the child attending mental health programming several hours per day and returning to their homes.
for the remainder of the day. Programs often have an academic component so that the child can continue attending school while in treatment.

*Psychological Assessment* determines levels of skills and abilities and develops profiles of characteristics for various psychological functions. A psychological assessment often includes intelligence levels, intellectual achievement levels, behavioral tendencies, diagnostic and personality characteristics, and levels of symptomology. Psychological tests are selected and administered on the basis the objectives of the referral source and the problem being addressed.

*Psychiatric Evaluations* are conducted by psychiatrists and determine the psychiatric status of the client. A psychiatrist seeks to identify a physical or medical condition causing psychiatric symptoms. He or she will conduct a psychiatric history and gather data about behavior and physical and emotional functioning in order to diagnose a mental disorder. Psychiatrists may prescribe medications to treat mental disorders. Mental health emergencies requiring hospitalizations are usually managed by psychiatrists. Some mental disorders of childhood are best managed by medication.

*Play Therapy* – is a method of psychological counseling that uses play activities and materials to allow a young child to communicate important psychological information through activities that make it more comfortable for the child to communicate the events or concerns in his or her life. During play, a trained therapist can both learn about a child’s emotional life and can introduce therapeutic thoughts and behaviors to assist the child.

*Parent Oriented Therapies* – Most emotional problems young children experience require the parent to be involved in order to be more effective. This is especially true in the younger child. The changes made by the people who have the most control of the child’s environment have the best chance of being effective. Counseling with parents about the nature of the mental disorder and the steps that parents can take to prevent potential problems is usually a critical component of therapy for young children. Families function better when parents have an understanding of their child’s particular condition. Parents’ confidence increases when they develop strategies for managing difficult situations with their children.

*Eligibility:* There are no eligibility requirements.

*Payment:* Medicaid covers mental health treatment, and some private insurance companies cover a portion of payment. Many mental health centers use a “sliding fee scale” for people who do not have insurance coverage.
Location: Mental health services are located in each county. Smaller counties often combine with one or more counties to provide mental health services.

Early Childhood Intervention Programs

Help Me Grow Program: Birth to Three

Children ages 0 through 2 years who exhibit signs of developmental delay or at risk of developmental delay are eligible for assessment, and where appropriate, intervention and referral services through the Help Me Grow program. Help Me Grow is a collaborative initiative of the Ohio Department of Mental Retardation, the Ohio Department of Developmental Disabilities, and the Ohio Department of Job and Family Services. It is administered by the Ohio Department of Health. Help Me Grow is directed in county by the Family and Children Council. Each county has a Help Me Grow contact office that can receive referrals to the program.

• A Service Coordinator is assigned to each family to assist them throughout assessment and intervention.

• An Individualized Family Service Plan is developed for each eligible family. This plan details the services the child and family will be engaged in. Families are essential components of planning in this program.

• Developmental evaluations for children include assessment of Cognitive Development; Communication Development; Social and Emotional development; Adaptive Development and Physical Development including vision, hearing and nutrition screening. The adaptive behavior and social/emotional screening attempt to identify early signs of behavioral and social disturbances and the early prevention activities to foster mental health that can be implemented. This may include consultation with families in the home or developing more specialized services or program.

• Services provided: to children with developmental delays and disabilities, or who are at-risk of delay, and their families. The focus of services is to support child development and provide support to families. Services include prenatal and newborn home visits; health screenings; speech, physical, and occupational therapy; and early intervention services including home visits or developmental services provided by the Early Childhood Center and by County Boards of MRDD; and specialized services.
Developmental Services through Department of Education: Older than 3 years

Beginning at age 3 years, developmental services are administered by the Department of Education. Each county has a contact office or agency who can take referrals for early intervention services.

- **Assessment:** Children with suspected delays in development are eligible for assessment services. If eligible delays are discovered, early intervention services are available under Department of Education guidelines.

- **Individualized Educational Plans (IEP)** are developed for children with qualifying conditions. This plan delineates the services that will be provided. Schools often provide special-needs preschool programs with classrooms designed to assist children who exhibit delayed development.

- **Special Education Services:** Children with delays across certain developmental domains are eligible for special education services. Cognitive development, communication development, motor development, social behavior, and medical conditions are among the developmental domains that the Department of Education targets for intervention.

- **Specialized preschool programs:** Children with emotional and behavior problems, whose symptoms meet eligibility criteria for specialized education services can benefit from specialized preschool services programming. These include symptoms of common mental health disorders such as anxiety and depression, and behavioral impairments which can significantly impair learning.

Specialized preschool programs are classrooms with a smaller teacher/child ratio. They provide specialized services according to the IEP. A child with a mental disorder would not necessarily be in a class with children with similar problems. He or she would receive services within the classroom setting such as behavior assessment, development of a behavior plan, environmental adaptations, and teaching of prosocial behaviors and skills.

Programs for children with emotional impairments are available, in some form, in every county. However, the specific services and whether they are administered through the local Department of Mental Retardation and Developmental Disability or the local school system, varies from county to county.
THE EFFECTS OF ABUSE AND NEGLECT ON PRESCHOOL DEVELOPMENT

Physical

1. Abused and neglected preschool children may be small in stature, and show evidence of delayed physical growth.

2. They may be sickly and susceptible to frequent illness; particularly upper respiratory illness (colds, flu) and digestive upset.

3. They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, awkward gait, or lack of muscle strength.

4. Gross motor play skills may be delayed or absent.

Cognitive

1. Speech may be absent, delayed, or hard to understand. The preschooler whose receptive language far exceeds expressive language may have speech delays. Some children do not talk, even though they are able to.

2. The child may not use language to solve problems (Cook, et al 2003).

3. The child may articulate and pronounce poorly, form sentences incompletely, and use words incorrectly.

4. Cognitive skills may be at the level of a younger child.

5. The child may have an unusually short attention span, a lack of interest in objects, and an inability to concentrate.

6. The child may have less flexibility and creativity in problem solving tasks (Cook, et al 2003)

7. Children who have experienced trauma may have conditioned fear responses when something in their environment (a sight, sound, and smell) is associated with a sight, sound, smell made during a violent incident. These may be subtle associations made by the child whose memory is attuned to the presence of potential danger. This is common in children who have experienced complex trauma.
Social

1. When under stress, our bodies secrete "stress hormones" that prepare us to fight, flee, or freeze in response to danger or threat of danger. When children are under chronic stress, such as abuse or neglect, their bodies become unable to regulate this stress reaction resulting in hyper-arousal or hyper-sensitivity to perceived danger or threat in their environment. This has significant social and interpersonal implications for children. For example, if a traumatized preschooler frequently assumes that other children intend to harm him, it is difficult for that child to form friendships and play with other children. Children who are continually poised to fight, or flee will have difficulty functioning in preschool. This is associated with complex stress.

2. The child may demonstrate insecure or disorganized attachment; attachments may be indiscriminate, superficial, or clingy. The child may show little distress, or may overreact, when separated from caregivers. The child’s reaction to parent may be completely disorganized, or the child may fear an abusive or terrorizing parent. This is also common in children who have experienced complex trauma.

3. The child may appear emotionally detached, isolated, and withdrawn from both adults and peers.

4. Alternately, the child may be more dependent on others for support. (Cook, et al 2003)

5. The child may demonstrate social immaturity in peer relationships; may be unable to enter into reciprocal play relationships; may be unable to take turns, share, or negotiate with peers; or may be overly aggressive, bossy, controlling, and competitive with peers.

6. The child may prefer solitary or parallel play, or may lack age appropriate play skills with objects and materials. Imaginative and fantasy play may be absent. The child may demonstrate an absence of normal interest and curiosity, and may not actively explore and experiment.

7. The child may have lower frustration tolerance, show more anger, and be non-compliant.

8. Children may engage in specific, odd behaviors that represent their attempts to cope in their abusive or neglectful environment. Examples
include food hoarding, wearing several layers of clothing to bed (to avoid sexual abuse), or manipulativeness.

**Emotional**

1. The child may be excessively fearful, may have night terrors, and may seem to expect danger.

2. The child may show signs of poor self esteem and a lack of confidence.

3. The child may lack impulse control and have little ability to delay gratification. The child may react to frustration with tantrums and aggression.

4. The child may have impairments in affect regulation, stress management, empathy, and pro-social concern for others. (Egeland et al, 1983 and Vonra et al, 1990, from NCTSN paper).

5. The child may have a bland, flat affect and be emotionally passive and detached.

6. The child may show an absence of healthy initiative, and often must be drawn into activities. He may emotionally withdraw and avoid activities.

7. The child may show signs of emotional disturbance including anxiety, post-traumatic stress disorder, depression, attachment problems, emotional volatility, self-stimulating behaviors such as rocking, or head banging, enuresis or encopresis, or thumb sucking, or Reactive Attachment disorder.
Reactive Attachment Disorder Of Infancy or Early Childhood

Description

Reactive Attachment Disorder (RAD) is a diagnostic label described in the DSM-IV and refers to a disorder usually first diagnosed in infancy or early childhood. As such, this disorder has specific diagnostic criteria. The disorder does not cover many of the behavioral concerns that may be observed when the attachment process is disrupted by separations, illnesses and disability on the part of the caretaker, or even by disturbed parenting practices. While these environmental conditions are often precursors to Reactive Attachment Disorder, the diagnosis of Reactive Attachment Disorder identifies criteria for both the behavioral characteristics and problematic environmental precursors necessary for making the diagnosis this diagnosis.

The DSM-IV recognizes two general types of behavioral manifestations of Reactive Attachment Disorder. The Inhibited Type is characterized by a child who exhibits a "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hyper vigilant, or highly ambivalent and contradictory responses (e.g., the child may respond to caregivers with a mixture of approach, avoidance, and resistance to comforting, or may exhibit frozen watchfulness)." Diagnostic criteria for the Disinhibited Type describe a child with "diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (e.g., excessive familiarity with relative strangers or lack of selectivity and choice of attachment figures)." (DSM IV)

In either type, there must be evidence of "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years," (DSM IV) It is important to note that the criteria for disturbed attachment includes the following:

- That the developmentally-inappropriate social relatedness is evident in most contexts;
- That the child exhibits the disturbances across settings and among different caretakers in most instances;
- That the disturbances in social relatedness are presumably the result of parenting or caregiver practices, or disturbances and disruptions in the living environment;
• That the developmental disturbances in social relatedness are not caused by developmental delays related to Mental Retardation or a Pervasive Developmental Disorder.

The DSM-IV states, "by definition, the condition is associated with grossly pathological care that may take the form of persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection; persistent disregard of the child's basic physical needs; or repeated changes of primary caregivers that prevent formation of stable attachments”.

As children mature into adolescence Reactive Attachment Disorder can have many expressions. With the Disinhibited Type the hallmark criteria include diffuse, indiscriminate sociability and difficulty making appropriate selective attachments. Interference with intimate social functioning is at the core of this disorder. Disturbances of conduct, oppositional behavior, and diffuse manifestation of disinhibition or impulsive behaviors are not core symptoms according to the DSM-IV.

**Treatment**

Attachment therapy is any therapy that attempts to repair damaged attachment as the result of trauma. It addresses relationship issues between the child and his parents.

In the past, attachment therapy included a variety of coercive methods to force the child to submit to the will of the parents, such as forcibly holding the child for long periods of time, and enforcing eye contact. These methods have since been discredited by several professional organizations (American Psychiatric Association, American Academy of Child And Adolescent Psychiatry, American Professional Society on the Abuse of Children).

The field of attachment therapy has moved away from these techniques, and now promotes the use of a variety of techniques to help parents become attuned to their children; and to help children learn to regulate their emotions and behavior, and come to terms with trauma that may have occurred in their past. Appropriate treatment emphasizes short term, specific counseling to provide stability and improve the quality of the parent-child relationship. The focus is on providing a stable environment for the child, and taking calm, sensitive, non-intrusive, non-threatening, patient, predictable, and nurturing approach to parenting. This approach emphasizes teaching positive parenting skills, rather than the child’s pathology. (Chaffin, 2006)
When referring children therapy for attachment problems, workers should clarify which strategies will be used. Furthermore, caseworkers should seek guidance from their supervisors if the therapist suggests using any coercive strategies.
**Description**

Anxiety disorders refer to a cluster of disorders whose primary features include excessive fearfulness and stress response. In general, the term anxiety disorder describes an excessively fearful or stressful response to a perceived threat in the present environment or to anticipate future threat. Anxiety Disorders are relatively common among the mental disorders.

Anxiety disorders usually include strong somatic symptoms, such as stomach aches, headaches, nervousness and problems with sleeping and eating that can be quite uncomfortable for the child.

The DSM-IV indicates that children can be diagnosed with the following anxiety disorders:

- panic disorder with agoraphobia,
- panic disorder without agoraphobia,
- acute stress disorder,
- generalized anxiety disorder,
- post-traumatic stress disorder,
- adjustment disorder with anxiety,
- social phobia,
- specific phobia, and
- obsessive-compulsive disorder.

Additionally, all forms of anxiety disorders involve the loss of functioning in important domains of life, such as school, social functioning and peer relationships.

As you can see by the number of DSM-IV diagnoses, anxiety can have many presentations. Human adaptive responses to severe stress vary widely and, as in all mental disorders, the outcome depends upon the nature and severity of the environmental stressors and the heritable characteristics of the person experiencing them. However, child abuse and neglect increase children’s vulnerability to anxiety disorders. Likewise, children who are exposed to domestic violence may be more likely to develop an anxiety disorder.
In cases of extreme abuse and neglect children are believed to experience a chronic stress response that includes anxiety. This results in withdrawal isolation, lethargy, and unresponsiveness to the environment. It is believed to be connected to neurological changes in brain chemistry and even structural changes in the brain. This can happen to very young children and often has deleterious effects to the attachment process and on social functioning.

**Physiology of stress reactions: flight, flight, freeze**

Under conditions of stress or threat, (which research has concluded include severe neglect and abuse), the hippocampus chemically signals the pituitary to release neurotransmitters which in turn signal the adrenal cortex to release stress hormones (such as cortisol and adrenaline) into the bloodstream. These chemicals prepare the body to respond to threat. They cause many changes in the body including increased alertness, heightened startle response, increased heart rate, and other changes that increase the availability of oxygen to muscles and certain organs. These responses prepare the individual to *flee* (run away from danger), *fight* (for survival), or *freeze* (refrain from reacting in order to fully perceive the threat) in response to the perceived threat. This is very adaptive, because it ensures survival. In normal circumstances the brain stops the release of stress hormones when the threat is no longer present, and the person’s functioning returns to normal. However, there are two ways in which this response can be compromised:

1. **Chronic stress:** Problems can occur when the child experiences chronic states of anxiety and perceived threat such as chronic abuse or neglect. In this situation, the body maintains its response to stress by continuing to release cortisol into the bloodstream. It is believed this prolonged exposure to cortisol interferes with the brain’s ability to stop the release of cortisol when the threat or danger is removed. Therefore, children experience prolonged stress reactions, such as heightened awareness of danger, over-reaction to even mildly threatening situations, and slow ability to calm down, or withdrawn behavior. In other words, the child is in a persistent state of “flight – flight – freeze”

2. Additionally, problems can occur when a “trigger” event activates the fight – flight – freeze response. One of the body’s adaptive responses to trauma (including severe abuse and neglect) is the capacity to generalize from circumstances of threat to other situations that are similar to the original threat. This response pattern can be maladaptive when the emotional and physiological response generalizes to non-threatening situations of daily life and interferes with normal functioning, as in Post Traumatic Stress Disorder (PTSD). For example, the smell of the cologne that a sexual abuse perpetrator wore can evoke, or trigger fear and
anxiety when the child encounters that smell later, whether or not the perpetrator is present.

**Long-term effects**

People who have a history of severe stress as children remain vulnerable into adulthood, even when they recover to normal functioning. If they are subject to another trauma or experience a severe loss they remain more likely to have a catastrophic response (major depression, traumatic stress response) to the later event.

**Treatment for Anxiety**

Cognitive Behavioral Therapy has been shown help reduce anxiety symptoms. Treatment may involve exposing the child to anxiety producing events in a safe and supportive environment and teach him to relax instead of responding with anxiety. It can also involve self-talk to help the child correctly interpret the non-threatening environment, interrupt and stop the escalation of his or her physiological reaction, and think more accurately about the anxiety-producing situation. For example: a child who responds with anxiety whenever she smells the cologne worn by the sex-abuse perpetrator may be taught to remind herself that lots of men wear that cologne, and the perpetrator is not present.

Some treatment protocols include a therapy component for parents as well.

Pharmacological therapies can by very beneficial as an adjunct to psychotherapy, but are not recommended as the sole form of treatment for trauma related disorders.
POST-TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) is a psychological disturbance resulting from a person’s exposure to a traumatic event, such as inter-personal violence, a natural disaster, a plane wreck, etc. in which the person experienced overwhelming fear and anxiety about his safety. PTSD can also result from child abuse.

This condition is diagnosed when the following symptoms have been present for longer than one month:

- Re-experiencing the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma.
- Routine avoidance of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future).
- Increased sleep disturbances, irritability, poor concentration, startle reaction, and regressive behavior.

Rates of PTSD identified in child and adult survivors of violence and disasters vary widely. For example, estimates range from 2 percent after a natural disaster (tornado), to 28 percent after an episode of terrorism (mass shooting), and 29 percent after a plane crash.\(^{13}\)

The disorder may arise weeks or months after the traumatic event. PTSD may resolve itself without treatment, but some form of therapy by a mental health professional is often required in order for healing to occur. Fortunately, it is more common for traumatized individuals to have some of the symptoms of PTSD than to develop the full-blown disorder.\(^{14}\)

As noted above, people differ in their vulnerability to PTSD, and the source of this difference is not known in its entirety. Researchers have identified factors that interact to influence vulnerability to developing PTSD. These factors include:

- Characteristics of the trauma exposure itself (e.g., proximity to trauma, severity, and duration),
- Characteristics of the individual (e.g., prior trauma exposures, family history/prior psychiatric illness, gender; women are at greatest risk for many of the most common assault traumas), and
• Post-trauma factors (e.g., availability of social support, emergence of avoidance/numbing, hyper-arousal and re-experiencing symptoms).

Research has shown that PTSD clearly alters a number of fundamental brain mechanisms. Abnormal levels of brain chemicals that affect coping behavior, learning, and memory have been detected among people with the disorder. In addition, recent imaging studies have discovered altered metabolism and blood flow in the brain as well as structural brain changes in people with PTSD.  

Treatment

People with PTSD are treated with specialized forms of psychotherapy and sometimes with medications or a combination of the two. One of the forms of psychotherapy shown to be effective is Cognitive Behavioral Therapy (CBT). In CBT, the patient is taught methods of overcoming anxiety or depression and modifying undesirable behaviors such avoiding reminders of the traumatic event. The therapist helps the patient examine and re-evaluate beliefs that are interfering with healing, such as the belief that the traumatic event will happen again. Children who undergo CBT are taught to avoid "catastrophizing." For example, they are reassured that dark clouds do not necessarily mean another hurricane, that the fact that someone is angry doesn't necessarily mean that another shooting is imminent, etc. Play therapy and art therapy also can help younger children to remember the traumatic event safely and express their feelings about it. Other forms of psychotherapy that have helped persons with PTSD include group and exposure therapy. A reasonable period of time for treatment of PTSD is 6 to 12 weeks with occasional follow-up sessions, but treatment may be longer depending on a patient's particular circumstances. Research has shown that support from family and friends can be an important part of recovery.

There has been a good deal of research on the use of medications for adults with PTSD, including research on the formation of emotionally-charged memories and medications that may help block the development of symptoms. Medications appear to be useful in reducing overwhelming symptoms of arousal (such as sleep disturbances and an exaggerated startle reflex), intrusive thoughts, and avoidance; reducing accompanying conditions such as depression and panic; and improving impulse control and related behavioral problems. Research is just beginning on the use of medications to treat PTSD in children and adolescents.

There is accumulating empirical evidence that trauma or grief-focused psychotherapy and selected pharmacologic interventions can be effective in alleviating PTSD symptoms and in addressing co-occurring depression. However, more medication treatment research is needed.
A mental-health professional with special expertise in the area of child and adolescent trauma is the best person to help a youngster with PTSD. Organizations on the accompanying resource list may help you to find such a specialist in your geographical area.

**Recent Research**

The National Institute of Mental Health (NIMH), a part of the Federal Government’s National Institutes of Health, supports research on the brain and a wide range of mental disorders, including PTSD and related conditions. The Department of Veterans Affairs also conducts research in this area with adults and their family members.

Recent research findings include:

- Some studies show that counseling children very soon after a catastrophic event may reduce some of the symptoms of PTSD. A study of trauma/grief-focused psychotherapy among early adolescents exposed to an earthquake found that brief psychotherapy was effective in alleviating PTSD symptoms and preventing the worsening of co-occurring depression.\(^27\)

- Parents' responses to a violent event or disaster strongly influence their children's ability to recover. This is particularly true for mothers of young children. If the mother is depressed or highly anxious, she may need to get emotional support or counseling in order to be able to help her child.\(^28-30\)

- Either being exposed to violence within the home for an extended period of time or exposure to a one-time event like an attack by a dog can cause PTSD in a child.

- Community violence can have a profound effect on teachers as well as students. One study of Head Start teachers who lived through the 1992 Los Angeles riots showed that 7 percent had severe post-traumatic stress symptoms, and 29 percent had moderate symptoms. Children also were acutely affected by the violence and anxiety around them. They were more aggressive and noisy and less likely to be obedient or get along with each other.\(^31\)

- Research has demonstrated that PTSD after exposure to a variety of traumatic events (family violence, child abuse, disasters, and community violence) is often accompanied by depression.\(^3,32-35\) Depression must be treated along with PTSD, and early treatment is best.
• Inner-city children experience the greatest exposure to violence. A study of young adolescent boys from inner-city Chicago showed that 68 percent had seen someone beaten up and 22.5 percent had seen someone shot or killed. Youngsters who had been exposed to community violence were more likely to exhibit aggressive behavior or depression within the following year.\textsuperscript{36,37}

**PTSD in Children**

*For children 5 years of age and younger,* typical reactions can include a fear of being separated from the parent, crying, whimpering, screaming, immobility and/or aimless motion, trembling, frightened facial expressions and excessive clinging. Parents may also notice children returning to behaviors exhibited at earlier ages (these are called regressive behaviors), such as thumb-sucking, bedwetting, and fear of darkness. Children in this age bracket tend to be strongly affected by the parents' reactions to the traumatic event.

*Children 6 to 11 years old* may show extreme withdrawal, disruptive behavior, and/or inability to pay attention. Regressive behaviors, nightmares, sleep problems, irrational fears, irritability, refusal to attend school, outbursts of anger and fighting are also common in traumatized children of this age. Also the child may complain of stomachaches or other bodily symptoms that have no medical basis. Schoolwork often suffers. Depression, anxiety, feelings of guilt, and emotional numbing or "flatness" are often present as well.

*Adolescents 12 to 17 years old* may exhibit responses similar to those of adults, including flashbacks, nightmares, emotional numbing, avoidance of any reminders of the traumatic event, depression, substance abuse, problems with peers, and anti-social behavior. Also common are withdrawal and isolation, physical complaints, suicidal thoughts, school avoidance, academic decline, sleep disturbances, and confusion. The adolescent may feel extreme guilt over his or her failure to prevent injury or loss of life, and may harbor revenge fantasies that interfere with recovery from the trauma.

Some youngsters are more vulnerable to trauma than others, for reasons scientists don’t fully understand. It has been shown that the impact of a traumatic event is likely to be greatest in the child or adolescent who previously has been the victim of child abuse or some other form of trauma, or who already had a mental health problem.\textsuperscript{8-11} And the youngster who lacks family support is at greater risk of a poor recovery.\textsuperscript{12}

-- Adapted from the booklet, “Helping Children and Adolescents Cope with Violence and Disasters”, at www.nimh.nih.gov/pulicat/violence/cfm
DEPRESSION

Description

Affective disorders, or mood disorders, can appear in children and adolescents as well as adults. The Depressive disorders are one of the mood disorders and include Major Depression, Bipolar Disorder, and Dysthymic Disorder. Childhood depression can affect a child's cognitive functioning, emotional functioning, behavior and body functioning.

As with many disorders, there appear to be genetic links between generations that result in vulnerabilities for acquiring depressive disorders. Children of parents who have affective disorders are at increased risk for acquiring affective disorders themselves. Environmental factors including child abuse and serious neglect are correlated with children exhibiting depressive symptoms.

Symptoms

In childhood, symptoms of depression can appear somewhat different from symptoms in adults. Irritability is often more prominent in children as opposed to the noticeable sadness that may be present in adults. In adolescents a pervasive lethargy may signal depression more than in adults (but not always). Depressive symptoms in children and adolescents may include*:

- sadness that won't go away
- hopelessness, boredom
- unexplained irritability or crying
- loss of interest in usual activities
- changes in eating or sleeping habits
- alcohol or substance abuse
- missed school or poor school performance
- threats or attempts to run away from home
- outbursts of shouting, complaining
- reckless behavior
- aches and pains that don't get better with treatment
• thoughts about death or suicide
* from National Institute of Mental Health “Fact Sheet – Major Depression in Childhood and Adolescence”

**Child Maltreatment and Depression**

Being the victim of abuse and neglect, especially chronic abuse and neglect, is stressful. Research indicates that exposure to such conditions is associated with depression symptoms. Experiences of loss such as prolonged separation or permanent separation from family and home make a child vulnerable to depression. Workers involved with children undergoing such dramatic changes and losses must be aware of depression symptoms in order to identify and treat them as early as possible.

**Treatment for Depression**

Childhood depression is a serious condition. There is increased susceptibility to alcohol and substance abuse problems, suicide risk, and academic problems for young people with depression. Interventions are available to help depressed children and adolescents. All children with depression should be evaluated by a physician to determine the likely causes of the depressive symptoms. Usually a combination of medical and psychological interventions is recommended in cases of moderate to severe depression. The need for psychopharmacological interventions should be assessed by a medical doctor.

Research has indicated that cognitive-behavioral therapy can be an effective psychological treatment for persons with depression. Counselors trained in treating depression can help educate caretakers about symptoms and treatment strategies for helping the depressed child or adolescent.

**Bipolar disorder**

Bipolar disorder is a mood disorder that often presents some early symptoms in childhood and adolescence. Bipolar disorder is a serious disorder that can persist through adulthood. This disorder can include fluctuations in mood and energy levels and disturbances in thought patterns that impair functioning in family relationships, academics and peer relationships. Treatment of bipolar disorder is often different from treatment for other forms of depression. Early detection of bipolar disorder is important because of the differing treatments bipolar disorder requires. However, symptoms associated with early onset bipolar disorder can be difficult to differentiate from other childhood disorders. The National Institute for Mental Health recommends that:
“A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness.” (Child and Adolescent Bipolar Disorder: An update from the NIMH, 2000)
Conduct Disorder

Description

According to the DSM-IV, essential features of Conduct Disorder are "a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated." It is important to differentiate occasional emotional outbursts that may be reactions to specific events from Conduct Disorders. The differentiating factor is that a person with conduct disorder has a consistent, persistent pattern of these behaviors.

These behaviors fall into one of four general categories:
- Aggression to people and animals
- Destruction of property
- Deceitfulness or theft
- Serious violations of rules

According to the DSM-IV, Conduct Disorder is generally diagnosed as one of two types: the "Childhood Onset Type", and the "Adolescent Onset Type," depending on when the behaviors began to emerge.

Gender Differences

Prevalence rates for Conduct Disorder are higher for males than females.

The expression of Conduct Disorder behaviors is different between genders. Males tend to exhibit more physically aggressive behaviors such as physical fights, use of weapons to physically harm others and physical cruelty. Females with Conduct Disorder are more likely to exhibit aggression through social intimidation, social cruelty, running away, staying out overnight despite parental prohibitions, truancy, or other nonphysical behavioral expressions.

Causes

Research indicates that Conduct-Disorder related behaviors may be caused by either environmental conditions or genetic pre-disposition, or a combination of both.
• **Parental History**

Parents with a history of alcohol dependence, mood disorders, Schizophrenia, and biological parents with a history of Attention Deficit Hyperactivity Disorder or Conduct Disorder have an increased chance of having children with Conduct Disorder.

• **Environmental Influences**

Children who have been physically or sexually abused are more likely to exhibit aggressive, antisocial, or conduct-related behavior problems. Parents who use coercive means to manage children's behavior are more likely to have children who display externalizing behaviors (i.e.: aggression, acting out, disruptive behavior in school) and coercive behaviors.

Parental neglect is also a risk factor for the development of externalizing behaviors including conduct disorder symptoms.

**Associated Conditions**

There are several known associated correlates to the development of Conduct Disorder. Although they are distinct disorders, Oppositional Defiant Disorder is frequently a precursor to Conduct Disorder. Attention Deficit Hyperactivity Disorder is also frequently found in histories of adolescents with Conduct Disorder. Persons with Conduct Disorder have a higher than expected chance of having a co-existing learning disability.

**Treatment**

Early intervention is very important for parents of children with aggressive, destructive, and defiant behavior. Conduct problems often persist into adolescence and beyond, especially when serious symptoms appear in childhood.

Parent training specifically designed for defiant and coercive behavior problems can be an effective intervention. It is important that therapy strategies be adaptable to the child's natural environment. Therefore engaging parents and school staff in learning effective strategies for managing the child's behaviors is often critical to success. Strategies could include providing a stable environment with predictable consequences for behavior, and anger management.
Laurie

Laurie is nine. She is in her third foster home after having disrupted from an adoption. You are her caseworker. The case was recently transferred to you, and you have just met Laurie. You know her foster mother, Jean Wilson, however. When you called Jean to tell her you had been assigned to the case, she said "Boy, am I glad to hear from you! I don't know what to do with this kid." Jean also told you Laurie's teacher had called and was having difficulty with Laurie in school.

You have gathered the following information from the case record, previous foster families, Jean, and the teacher. It is your job to develop a case plan for Laurie and to help Jean and the teacher manage Laurie in a way that helps resolve her problem, preserves the placement, and promotes more healthy development.

Laurie was born to a 17-year old girl who abandoned her at a neighbor's when Laurie was one year old. At that time she was functioning at a six to eight month old developmental level. There was no evidence of abuse, but it appeared Laurie had been chronically and severely neglected. She was placed in a foster home.

During the following year in foster care, she developed well and eventually closed most of the gaps between her chronological age and her developmental age. She was placed for adoption at age two.

The adoption disrupted a year and a half ago because the adoptive parents felt they could "never really get close to Laurie." She has lived in three foster homes since that time. The first foster family requested that Laurie be removed after five months. Her second foster family moved out of state, but the placement was not going well and was expected to disrupt. Jean agreed to take Laurie to stabilize placement. Jean is a flexible, affectionate, and patient woman who has worked with difficult children in the past. However, "something about Laurie" confounds her.

Laurie exhibits the following behavior patterns.

- When she is first placed in a foster home, she is "superficially compliant." After several months the foster parents describe her as "sneaky."
• Jean found piles of deteriorating food hidden in Laurie's closet. She became angry because of the unsanitary condition and patiently explained this to Laurie. Two weeks later she again found rotting food, this time in the bureau drawers. She doesn't understand this, as Laurie can get anything she wants from the kitchen any time she wants.

• Laurie does not sleep well. She cries out in her sleep, and sleepwalks.

• Laurie is enuretic and wets the bed several times a week. She often "forgets" to change her bedding, and will pull the covers over the wet sheets.

• She loves to help Jean in the kitchen, but is not reliable about completing her routine chores. She wants to be involved in activities, but is easily discouraged and gives up when they don't go exactly right. She seems to lose interest in many activities quickly.

• Laurie is in constant conflict with her foster siblings. She tries to participate in games, but demands that she be the center of attention and cannot share or take turns. When the game does not go her way, she becomes totally disruptive.

• She has low frustration tolerance. When confronted by events that would be only mildly annoying to most 9-year olds, Laurie becomes totally enraged and throws screaming tantrums, slams doors, throws objects, and kicks furniture and people.

• Laurie takes other people's belongings and hides them, and then forcefully denies having taken them. Jean thinks Laurie may be taking change off her husband's dresser.

• Jean says Laurie completes her school papers, but they are often carelessly done, messy, and at times, unreadable. She is below grade level in most subjects, and doesn't like school. She does well in reading. The school psychologist says she has average intellectual potential, with a measured full-scale IQ of 102. He noted no learning disabilities or attention deficit disorder.

• She is disruptive in class. She is frequently out of her seat without permission, she persistently approaches the teacher for attention, she races to volunteer for any and all projects, and she bothers other children who are trying to work. She cannot attend to school work for more than a few minutes at a time.
At recess, Laurie prefers to play with the first grade children. She can be bossy and argumentative with them. She does not get along with her classmates, who see her as a pest and "weird." She is always chosen last by classmates to be on a team, and the children often complain to the teacher that "she'll just mess things up for us."

The teacher has told Jean that "Laurie just seems to need more love." The teacher reports that Laurie has told her many times how the foster parents seem to prefer their own children to her. Once she complained that everyone in the family had been given new sweatshirts except her. The teacher responded by buying Laurie a sweatshirt. Jean later told the teacher that none of the children had been bought sweatshirts, and that Laurie was lying to her.

Laurie is indiscriminately affectionate with adults. She wants to hug and kiss the teacher every day, she often clings to the teacher, and she becomes jealous and upset when the teacher shows attention to the other children. When you met Laurie for the first time, she said "I'm glad you're my new caseworker. I just love to get new caseworkers," and climbed onto your lap.

Discussion Questions

1) Assess Laurie's development in all four domains. How do her behaviors reflect developmental delays and unresolved or poorly resolved developmental issues?

2) How would you suggest that Jean deal with the following problems? How would you explain why Laurie has these behavior problems? Remember, you want to help Laurie develop more normally and acquire age-appropriate skills at the same time you are managing her behavior. You also want to support Jean and her family and help to preserve the placement.

- Hoarding food
- Bed wetting
- Stealing, taking other family members' belongings

3) How should the teacher deal with the following problems?

- Seeking attention from the teacher
• Messy and incomplete homework papers, and performance below her grade level in academic subjects
• Lying to the teacher

4) What additional community resource services would you include in your case plan for Laurie? Identify possible resource agencies, and the types of services you would recommend. What kind of support would you provide to the foster parents?
Record ideas from your small group work here...
Francie

History

Francie was arrested with a group of other kids at midnight, driving 80 MPH on the freeway. All had been drinking, and several marijuana joints were found in the van. Prior to the situation in the van, Francie had been truant from home for several weeks, and her mother had no idea where she was. Francie was taken to the detention center after her arrest, and at the juvenile court hearing the next day, the children services agency was given protective supervision, and Francie returned to her mother’s home.

Francie has lived with her mother on and off since birth. She never knew her father. Her mother has lived on public assistance and minimum wage jobs since Francie's birth. She and her sisters, aged 12 and 10 all have different fathers. Francie's mother has lived with several men since her birth, some of whom beat her. She has never had a stable marital relationship. She has been arrested for prostitution.

Francie has been cared for on and off by neighbors, relatives, and licensed foster homes. Profound neglect, disorganization, and physical deprivation characterized her early years. It was suspected that her mother's current boyfriend sexually fondled her when she was 10, but there was never any proof and the mother broke up with the boyfriend. Her mother abandoned the children and moved to California with a man she met in a bar when Francie was 5, and returned when she was 6. Francie has been chronically truant from school.

Characteristics

Francie feels totally victimized by life's events. She feels she no control over her world or people in it. She does not understand how her behavior has any affect on other people, or on what happens to her. When bad things happen, it's the other person's fault. She is baffled when people try to assign blame to her. She also sees other people's actions as arbitrary. She has no awareness of rules or of a structure to the world.

She is very impulsive. She cannot tolerate frustration, and has no ability to delay gratification. She takes what she wants, fights when she's mad, runs away when she's afraid, and tantrums when cornered. She is easily frustrated by small stresses.
She is totally egocentric. There is only one perspective from which to assess any event: her own simplistic view. If things go her way, she feels good. If things don't go her way, she gets mad. The sum total of life revolves around how she feels, what she wants, her concerns and needs.

Francie displays a kind of "bottomless pit" dependency. She attempts to use all relationships for gratification of her immediate needs. She is transparently insincere, and makes clumsy, insincere efforts to flatter or please other people in order to get what she wants. She doesn't get emotionally involved with people beyond trying to meet her needs.

Her relationships with people are limited and very shallow, and without continuity. Her "best friend" could be someone she met 3 days (or 3 hours) earlier. As long as people are nice to her, they are "friends." If they withhold what she wants, they are "mean." It is entirely possible for Francie to like you one minute and hate you 30 seconds later, depending on whether you've been "nice" or "mean" to her. If you're "mean" enough she'll abandon you, until you're nice to her again. She has no ability to take other people's perspectives; she has no idea that other people have feelings, and doesn't understand what those feelings are. Therefore, she interprets other people's behavior in a very concrete and egocentric fashion.

Because she has no understanding of rules or the feelings of others, she doesn't understand what other people expect of her unless it is spelled out in crystal clear, concrete, behavioral terms. "Please be considerate" is meaningless to her. She does understand, "Pick up your clothes and put them in the basket".

She has no ability to think about or plan for the future. Her life exists in the present moment, and is dominated by getting her own immediate needs met. She feels other people should take care of her. In spite of feeling a victim, she has grandiose ideas about how wonderful things will be when she's 18 and "on her own." She has no conception of how this will happen, however.
Terry

Terry is 16. He was arrested with a group of other kids at midnight, driving 80 MPH on the freeway. All had been drinking, and several marijuana joints were found in the van. He lives in a run-down house with his stepfather and a mentally retarded uncle. Juvenile court ordered protective supervision of Terry a year ago when after he had broken into a neighbor’s garage. The agency has had a case open on him ever since. Terry had been truant from home for several weeks. His step-father didn't know where he was. Terry attends school sporadically. His stepfather works a job that often requires that he travel out of town. When he is gone, Terry does what he pleases. At the juvenile court hearing after his arrest, Terry was placed in the custody of children’s services.

History

Terry's mother was married twice. Her first husband was Terry's biological father. His stepfather and his mother were married when Terry was six, about a year after the divorce. Terry had been close to his father. After the divorce, his father remarried and left the state. At the time of the divorce, he promised that Terry could visit him any time he wanted. However, he has not communicated with Terry since. Terry's mother left his stepfather many times during their marriage to live with other men, always returning when things didn’t work out. She finally died of a drug overdose when he was 12.

Terry was a difficult child who wanted to have his own way. He and his stepfather have been in constant conflict since his mother's death. Terry thinks his stepfather is a "wimp" who lets people take advantage of him.

Characteristics

Terry likes himself. He sees himself as unique. He thinks that life is a game, and he feels great when he can beat it. Nobody in his family ever figured out how to "make it." He thinks he has, and claims it isn't hard. "Most people are pretty stupid," he says. "You can get what you want, if you're good enough." He sets up power struggles with adults in authority, and loves it when he wins. He says it gives him a real rush. He's in charge.

He was in the car with the other kids because "I figured since they had the joints, they could probably get some coke. I was about ready to score, too, when that damned police car pulled us over. We wouldn't have gotten caught if I'd been driving."
Terry is a manipulator. He approaches life by trying to figure out the rules of the game and then manipulates better than others. He figures you have to, or else others will "use you and take advantage of you. You have to be better than them." He's an expert at conning and conforming. He can be charming and cooperative, or can work a formula to get around you, depending on which strategy will best get him what he wants. He makes a good first impression, but people are quickly alienated when they realize his superficiality and lack of sincerity. He doesn't understand that conning and conforming are inappropriate and unproductive ways of relating to people.

Despite his ability to manipulate, he has a very circumscribed understanding of other people. Terry probably had the basic cognitive capabilities for insightful social interaction. However, he no longer has the capability or insight to recognize unselfish or cooperative motivation in others. He doesn't consider other people's feelings. He denies having any himself.

He has no close friends. He says he doesn't need them; he's perfectly capable of taking care of himself. He "doesn't have to depend on nobody!"

He claims he doesn't miss his mother. He says he was probably upset when she died, but got over it quickly. He doesn't remember much about his real Dad. He doesn't think he was sad for long after his Dad left. He doesn't remember, but "I was a pretty tough little kid. It probably didn't bother me." He creates an image of invulnerability and indifference.

He doesn't think being arrested was any big deal. He claims, "I'll be out of here soon, no big deal." He thinks it was pure bad luck they were arrested. He doesn't see himself as having any problems.
Kathy

Kathy is 16. She was arrested with a group of other kids at midnight in a van driving 80 MPH on the freeway. All the kids had been drinking, and several marijuana joints were found in the van. Kathy insisted she didn't know there were drugs in the van. She had been standing on the corner with some kids from school when "this kid came by in a car and asked if we wanted to go for a ride." Kathy said she hesitated, but went along because she didn't want her friends to think she was weird. Juvenile court gave the children services agency protective supervision of Kathy.

History

Kathy lives with her parents and two younger brothers and a younger sister. Her father is a minister, her mother a homemaker who is active in the church as the minister's wife.

Kathy's mother is a quiet, unassuming woman. She has devoted her life to serving others. She spends several evenings a week with church-related activities. Kathy's father cares for the children these evenings, unless he too has church related obligations. Kathy then has the responsibility of caring for the other children.

When Kathy was 12, her father began finding excuses to come into the bathroom when she was bathing and watch her out of the corner of his eye. Kathy would ask him to leave, but he repeatedly told her there was nothing wrong with his being there; after all, he was her father, and he'd seen her naked all her life. About six months later he began going into her bedroom at night. He began by fondling her, moved to finger penetration, and finally began intercourse when Kathy was 14. Her father told her that God thought the human body was beautiful, and that the relationship between parents and children was the most sacred of all human relationships. However, he said, other people who weren't as close to God wouldn't understand, and if she ever said anything to anyone about their "special relationship," he would be banned from the church, and they would lose their home and the family would break apart.

Kathy didn't disclose the abuse until she was placed in detention overnight, and disclosed to one of the staff members there. Kathy began to cry and told the worker how ashamed she was. Despite what her father had told her, she knew that what they had been doing was wrong. She had seen a TV program on incest, and realized what was happening. She had wanted to tell her mother, but her mother had also watched the TV program and blamed the child in the program indicating that the child was "a bad girl- she must have asked for
Kathy knew her mother would think her bad and blame her, and she was ashamed that maybe her mother was right. After all, she didn't fight her father. She said she was afraid her father would lose his job if she told anyone. She was sure nobody would forgive her, now that she really had told. She guessed it didn't matter because nobody would ever want to date her now anyway.

Kathy appeared to be anxious and very depressed. She claimed not to be a chronic user of drugs or alcohol. She said she did go out a lot with her friends to get away from her father. It made her Dad very angry, but she couldn't help it. She became "upset" when she stayed at home; her stomach ached, she had headaches, and sometimes she threw up. She felt better if she was out of the house "where there is some fresh air."

She told the worker she wished things could be different. She despaired of this being possible. A check of police records showed that Kathy had been arrested twice previously with groups of teens who were out late drinking, but charges were never filed against her. Teachers reported occasional angry outbursts at school between Kathy and other students, with Kathy apparently starting arguments over minor issues. Her teachers liked her but felt her to be withdrawn and pensive. A school counselor said Kathy would "wander in" to chat frequently, but seemed reluctant to talk about her private life. Kathy also seemed to work hard to prove that she was a good student, apologizing profusely when she didn't do well on school tests.
Lee is 16. He was arrested with a group of other kids at midnight, driving 80 MPH on the freeway. All had been drinking, and several marijuana joints were found in the van. Lee had been truant from home on and off for several weeks; his mother didn't know where he was, but thought he had perhaps gone to visit a 20-year old "friend," a man Lee had met a few weeks earlier in the next town. She was worried about Lee's whereabouts and called the police, who notified the children's service agency. At the juvenile court hearing after his arrest, the children services agency was given protective supervision of Lee.

History

Lee was the 4th of 6 children, born and raised on a farm. His family had enough money to get by, but they rarely had extra. Lee's father was an alcoholic and most nights would drink himself into a stupor. Occasionally he would be verbally abusive, but there is no evidence of physical abuse. Two years ago, Lee's father died of alcohol-related illness. Lee's mother couldn't manage the farm and moved with Lee and two younger siblings into the city. She survives on a minimum-wage job and food stamps.

Characteristics

Lee is a quiet, generally cooperative youth. He is easy to get along with, almost to the point of over-compliance and passivity. He readily agrees with others and conforms quickly to their demands, particularly when he views them to be in power. He typically over-estimates other people's power and sees himself as having almost none. He has very poor self-esteem and feels entirely inadequate in comparison to people around him. To adults, he appears helpless and in need of protection.

He is dependent on others to meet his needs. He craves social approval and acceptance. He yields quickly to peer group pressure when with peers, and to adult authority when he's with adults. He will comply with whoever is in control at the moment in order to be accepted and viewed in a positive light.

His thinking ability is very concrete, and he views the world in simplistic, concrete terms. He has limited perspective-taking ability. He knows that people are different, but he evaluates them based upon observable behaviors, and he has no insight into other people's feelings. His mother is "nice, she cooks good meals." His father "was a drunk and worked a farm." He is "friendly, not so good in school." He knows his mother gets mad when he runs away from home.
but he really likes to be with Tom, his 20-year old friend. Tom is "cool - he has his own car and rents a neat apartment."

He knows right from wrong; he knows it's wrong to skip school, and it's good to go to church and sit quietly. He shouldn't fail in school, and he should get a good job when he grows up. It's wrong to hurt other people. It's important to be nice. He doesn't like "being in trouble" at all.

He understands his own feelings in concrete terms. He knows he gets mad, sometimes he's happy, sometimes he's sad. He doesn't think it bothers anyone when he gets mad. He is impulsive. He knows he shouldn't run away, and he should be in school. He should get better grades. But none of this changes his behavior. He was in the van with the other kids because "it seemed like it would be fun and all the others were going."

He is viewed by peers as a "tag-along" and peers often use him. He will do whatever he's told, because he craves social acceptance. He is only marginally accepted, however, and at times is scapegoated.