UCDAVIS EXTENSION
CENTER FOR HUMAN SERVICES
Northern California Training Academy

Core 2.0: Child and Youth Development

Workbook Materials

Content Page

Child and Youth Development (v1.2, 2012)

COMPETENCIES and LEARNING OBJECTIVES

RELEVANT CHILD WELFARE OUTCOMES

Permanency 1

Children have permanency and stability in their living situations without increasing reentry to foster care

Permanency 2

The continuity of family relationships and connections is preserved for children

Well-being 1

Families have enhanced capacity to provide for their children's needs

Well-being 2

Children receive services appropriate to their educational needs

Well-being 3

Children receive services adequate to their physical, emotional, and mental health needs.

CORE COMPETENCIES

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

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

LEARNING OBJECTIVES

Knowledge:

K1. The trainee will be able to explain and give examples of the processes and milestones of normal development of infants, toddlers, pre-schoolers, school-age children, adolescents, and emerging adults across the physical, cognitive, social, emotional, and sexual domains.

K2. The trainee will be able to provide examples of how cultural variations, such as parenting practices, can influence the manifestation and timing of developmental skills and stages.

K3. The trainee will be able to explain how parent-child interactions affect early brain development, and provide examples of parenting behaviors that stimulate optimal brain development.

K4. The trainee will be able to provide examples of how parent-child interactions affect the development of attachment and bonding.

K5. The trainee will be able to explain how physical and emotional trauma and neglect affect brain function and development.

K6. The trainee will be able to recognize the necessity of mental health collaboration when cognitive and behavioral symptoms of mental health needs are recognized in children, adolescents, and emerging adults and be able to articulate when a mental health referral is necessary.

K7. The trainee will be able to recognize possible adverse consequences of in utero drug and alcohol abuse on infant and child development, including fetal alcohol syndrome, mental retardation and developmental delays and identify appropriate interventions including early referral and collaboration with mental health providers.

K8. The trainee will be able to identify symptoms associated with failure to thrive and be able to articulate when a medical assessment is useful or necessary.

K9. The trainee will be able to recognize the principal characteristics of Attention Deficit Hyperactivity Disorder and the basic concepts underlying current methods of assessment and treatment including early referral and collaboration with mental health providers.

K10. The trainee will be able to identify the social, communication, and behavioral indicators associated with autism and other pervasive developmental disorders and explain why early intervention ~~is~~ and collaboration with service providers are important.

Skills:

S1. Given a case example, the trainee will be able to distinguish between normal and delayed developmental milestones and identify steps to take for collaborative early intervention.

S2. Given a case example, the trainee will be able to articulate, in terms a parent can understand, strength-based parenting strategies for children at different stages of development.

S3. Given a case example, the trainee will be able to analyze symptoms and possible causes of developmental delays and disorders and recommend appropriate referrals and interventions.

Values:

V1. The trainee will value an understanding of how poverty, lack of education, community distress and environmental stressors can impair a parent's ability to provide for a child's developmental needs.

V2. The trainee will value utilizing a strength-based perspective with families/caregivers when gathering information and assessing the child's developmental history.

V3. The trainee will value and respect cultural variations in child-rearing practices and beliefs when working with families from diverse ethnic, racial, and socio-economic backgrounds.

V4. The trainee will value keeping abreast of emerging research evidence regarding attachment, child development, and disorders of childhood, and applying current knowledge to child welfare practice.

V5. The trainee will value helping parents meet the challenges of providing nurturance and collaborative mental health and medical intervention to a child with a developmental delay, medical challenge, and/or mental or emotional concern.

V6. The trainee will value collaboration with mental health providers for early and appropriate interventions to assist children with disorders, delays and other challenges associated with prenatal exposure to alcohol and drugs, or resulting from other causes.

RELATED TITLE IV-E MSW CURRICULUM COMPETENCIES

CF 4.d. Demonstrate ability to understand and communicate the effects of individual variation in the human developmental process and its importance to the shaping of life experiences within diverse groups.

CF 5.a. Demonstrate, through assessment, intervention and evaluation practices, a working understanding of the role and function of historical, social, political, and economic factors as the underlying causes and mechanisms of oppression and discrimination.

CF 6.b. Demonstrate knowledge of how to consult and utilize research evidence to inform ongoing practice and policy at all levels.

CF 7.a. Demonstrate beginning ability to apply conceptual behavioral frameworks to social environments involved in assessment, intervention and evaluation.

CA 7.1. Integrate knowledge and theory of human behavior and the social environment from diverse perspectives to conduct reliable and valid assessments, comprehensive service plans, effective interventions, and meaningful evaluations in child welfare.

CP 7.1. In evaluation of child welfare practice (engagement, assessment, planning, intervention, and evaluation), demonstrate the ability knowledgably to apply information about human behavior and the social environment from diverse perspectives.

CF 7.b. Demonstrate beginning ability to gather and interpret behavioral knowledge in perceiving person and environment.

The Normal SPECS of Child Development

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

Social Domain

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

Physical Domain

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

1. Motor activity depends upon muscle strength and coordination. **Gross motor** includes activities such as standing, sitting, walking, and running, and involves the large muscles of the body. **Fine motor** activities include things such as speech, vision*****, and the use of hands and fingers, which involve the smaller muscles in of the body. Both large and small muscle activities are controlled and coordinated by the central nervous system.

2. Sensory development includes the development of vision*****, hearing, taste, touch, and smell, and the coordination and integration of perceptual input from these systems by the central nervous system.

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

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

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

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

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

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

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

Rasa (Case Scenario)

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

Rasa's Story

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

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

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

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

Discussion Questions

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

Jazmine (Case Scenario)

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

Jazmine's Story

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

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

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

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

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

Discussion Questions

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

Case Application Activity: Tammy

Tammy
Tammy is 4 years old and of appropriate weight and height for her age. She is Caucasian and currently lives in a foster home. Tammy has been in child protective custody for one month, since she was found wandering on a busy street by herself. Tammy was removed from her birth mother, Sue and her adoptive mother Jeannie (Sue's partner). After Tammy was found alone on the street, Sue admitted to using drugs and often sleeping until 11 or 12, leaving Tammy to get herself up in the morning when Jeannie is not home. Jeannie's job requires frequent travel and Jeannie notes that Sue has been the primary caregiver. Jeannie states that she was aware that Sue was drinking a lot, but she was not aware of the full extent of the problem. The team explored options with Jeannie including Jeannie taking a leave of absence to stay home with Tammy. Jeannie does not feel able to make that change. Jeannie noted she has a substance abuse history as well and is not clean and sober herself.

Tammy has been doing well since she has been in foster care. She goes to preschool in the mornings, three days a week. The foster mother, Mary, tells you that Tammy loves to play with the family dog and can dress herself now with minimal help, something that she could not do when she arrived.

At school, Tammy struggles with expressing herself. Her feelings are easily hurt by the other children. The teacher says that more than any other child in the class Tammy will find an isolated corner and stay there introspectively playing by herself. She is not easily comforted by the teacher and does not show a preference for one teacher over another, like most of the other children. She can follow simple two-step directions and likes books with colorful pictures. On the playground, Tammy likes to climb the stairs to the slide and to go down. She is learning to ride a tricycle and can now pedal by herself. She was not potty trained when she moved to the foster home but now she is and rarely has an accident. This is a source of pride for Tammy. She is curious about her body and understands now about where potty comes out and can recognizes the sensations associated with simple body functioning. When the foster mother comes to pick her up from her school, Tammy does not run to her and sometimes does not even seem to recognize her. The transition from school to home is often emotional with Tammy refusing to talk or react to the foster mother for a couple of hours afterwards.

Tammy has been referred for developmental assessment and therapeutic play. The process for beginning this assessment and treatment has been underway for about three weeks and as the social worker you are building Tammy's treatment team.

Sue has started drug treatment and has been doing well. Jeannie has participated in outpatient treatment. Both Jeannie and Sue have begun learning new ways of interacting with Tammy and learning about child development. They are eager to see Tammy and try out their new parenting skills. As the social worker, you attend the next supervised visit. When you arrive you notice Tammy and Mary sitting, reading a book. Tammy is smiling and appears relaxed. Sue and Jeannie arrive and you go with them and Tammy into the play room for the visit.

Tammy immediately becomes quiet, goes to the far end of the room, and sits down facing away from Sue and Jeannie. Tammy begins sucking her thumb and holding a book very tightly. Sue asks how Tammy is doing. Tammy just looks at her, vacantly. Sue looks hurt, gets angry, and tells Tammy that she is not her friend. Sue goes and sits on the opposite side of the room and begins to play with a puzzle refusing to look at Tammy or at you. Jeannie looks to you to take action and does not make any effort to engage Tammy.

1. Assess Tammy across the SPECS of normal development.
2. How does Tammy's behavior reflect developmental delays or unresolved developmental issues?
3. If Tammy's issues are not attended to what will be her SPECS as a school-age child? What about an adolescent?
4. How might this behavior, if untreated affect her school life and school progress?
5. How does the mother's behavior suggest developmental issues?
6. What, if any are the cultural issues in this case?
7. What would you say to Sue and Jeannie to help them with Tammy during this visit?

Case Application Activity: Marcus

Marcus

You are the social worker for Marcus. Marcus is 11 years old and of normal height and weight for his age range. He is Latino and lives with his maternal grandparents, who also care for his older brother and younger sister. Marcus has another brother who has a different father and the brother lives with that paternal grandmother. Marcus' mother, Carmen is in prison on drug related charges. She is serving a three-year sentence; however, for the past six years Carmen has been incarcerated for most of the time. When Carmen is released she quickly gets strung out on drugs and then gets picked up again. Marcus tells you that this is the only reason that she is still alive. Marcus and his siblings lived with their mother for the first two years of their life and then for short periods when she was not incarcerated. During that early period the case file suggests that Carmen led a transient lifestyle with many people coming in and out of the home and her focus was on obtaining drugs and partying. Marcus' father, Miguel was incarcerated during Marcus' early years. When he was released from prison 2 years ago Miguel tried to re-establish contact with Marcus, but Marcus' maternal grandparents were very opposed to any contact and Miguel became discouraged. Miguel has recently resumed efforts to build a relationship with Marcus, but the situation is challenging because the grandparents do not trust Miguel and have not allowed him to be in touch with Marcus.

Marcus talks lovingly about his mother and of wanting to take care of her when she comes out of jail. His grandparents regularly tell him that his mother needs to clean up, grow up, and come take care of her children as they are getting old and will not be around for very much longer. They are angry and heartbroken about their daughter.

Marcus' grandparents own a modest home in a part of the community that used to be well respected. As the community has moved on to attract affluent people from surrounding cities this part of town is no longer looked upon with as much respect as it once was. Marcus' grandparents are proud people who believe that they should be able to take care of their own and to keep their own business private. It is very difficult for them to have child protective services in their life and they wonder what they did to Carmen to make her lead this lifestyle. They do not believe in allowing outside people into their family to help them and resist any type of therapy for the children or themselves. When the Department insists, they reluctantly take the children to their appointments, but it has been difficult to engage them with a therapeutic team for Marcus. Their life has not turned out as they had imagined and

they cycle from lovingly talking about taking care of the children to being resentful that they are forced to care for them.

Marcus is a handsome boy with a quick wit and a quick smile. He is mischievous and loves to go get lunch with you whenever you pick him up. Marcus is in special education and has a therapist, psychiatrist and behavior specialist on his treatment team. Marcus' grandparent's have been asked to meet with the behavior specialist in their home weekly, but they have not been keeping these meetings.

Marcus has a teacher's aide that follows Marcus wherever he goes at school. Marcus is embarrassed by this. You notice that when you visit him at school that the other children look at him and look away. He does not seem to have many friends, but really wants them, and the opinions of the other children seem extremely important to him. Marcus directs a lot of anger at his shadow. Marcus can sit with you and read a book and work on his homework if you sit quietly next to him. He will not sit for very long and do his work on his own. Marcus does not do extracurricular activities, like sports, etc.… He was sent home last week for getting into a fight during a basketball game with the other children because someone went over the line with his feet and the point was still good. The other children told him that there had been agreement before they started that it was allowed to go over the line but Marcus apparently did not understand that. He was suspended from play with the other children for a week.

Marcus' grandmother says that he leaves the home each afternoon when he gets home from school and roams the neighborhood getting into trouble. When you have suggested that Marcus get involved in an after school activity the grandparents looked alarmed and overwhelmed. The grandmother says that he just needs the good love of his family and he will be all right. Marcus will not actively engage on his own with other children when they are playing a game. Marcus does not seem confident in his skills.

At grandmother's house, if you speak to the grandmother without him being the focus of attention, he will act out by knocking something off of the coffee table or irritating the other children. If the conversation is about Marcus, he will get very red in the face, scream a profanity, and storm out of the house. At your last visit, the grandmother said that she was fearful that Marcus was a "pervert" as he talks about his "dick" and girls all of the time and she caught him masturbating in his bedroom the other morning.

Your office is very close to the school and on most days for the past two weeks you have been called to the school to come pick up Marcus in the middle of the day as the office tells you that he has had a blow-out. When you get to his classroom Marcus is usually sitting in a chair with his arms crossed, his face flushed, looking down at the floor with an angry stare. When you ask what happened the teacher tells you that

she asked Marcus to go get his homework out of his backpack in the coat room and Marcus jumped up and looked confused. She insisted that he go get it and he jumped on the table and started kicking books off of it with his feet. The shadow had to step in.

The teacher says that the ADHD medication that Marcus is on is not working and that he needs to be seen by the psychiatrist again to increase his medication. Marcus says that he does not like the medication. It does not help him and it makes his mouth dry.

1. Assess Marcus across the SPECS of normal development.
2. How does Marcus' behavior reflect developmental delays or unresolved developmental issues?
3. What developmental age is Marcus in the different areas?
4. Why do you think so?
5. What are the cultural issues in this case?
6. Does the system contribute to the developmental issues at all? If so how?
7. What would you say to Marcus' grandparents in order to help them understand and parent Marcus?
8. What could you do to facilitate more interaction between Marcus and his father?
9. What could you do to better engage Marcus' grandparents in the team working to help Marcus with his behavior?

Erik (Case Scenario)

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

Erik's Story

You are the social worker for Erik, a 9-year-old Caucasian boy. He entered foster care 8 months ago due to physical abuse and neglect. Erik's mother hit Erik with a piece of a broken bookcase because he would not listen to her. Erik suffered a deep laceration to his face and his parents did not provide medical treatment for the injury. Their home was in significant disarray and did not have running water at the time Erik was removed. Erik is living with his maternal grandmother. His parents visit sporadically, dropping in at the grandmother's home to play with Erik, but not providing any parenting. His parents have acknowledged a history of substance abuse and domestic violence.

Erik is behaviorally challenging to his grandmother. He has been diagnosed with ADHD and takes medication every day. He has moments of close attachment to his grandmother and the two share a loving relationship, but he is defiant of her efforts to ensure he completes homework or chores. Erik is on track in his motor development and speech. He has cognitive, social and emotional delays. He has been held back at school and is repeating the third grade. He has difficulty forming friendships and has been in two physical altercations at school.

You arrive at the school at 10:30 am for a face to face contact visit with Erik. He is called out of class and brought to the office to meet with you. There is no meeting space available, so you are left to meet with Erik in the teacher break room. Erik immediately finds a stapler and begins pushing staples into the bulletin board. After repeated requests from you and several minutes of chasing him around, he finally gives you the stapler, but he then picks up your keys and will not return them.

Discussion Questions

- What can you do engage Erik during this meeting?
- What could you do differently to plan the next meeting?
- What could you do during the next meeting to make it easier to interact with Erik?

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Child Developmental Milestones

Normal physical development: Approximately birth to 3 months

Birth to 3 months: Gains about 1 oz. per day after initial weight loss in first week

Birth
- ✓ Reflexes (e.g., sucking, grasping, hands fisted, random movement, etc.)
- ✓ Vision at 8-12 inches and can lift head

1 month
- ✓ Can lift head to 45-degree angle
- ✓ Vocalizes and gurgles

2 months
- ✓ Alert to people

3 months
- ✓ Chuckles
- ✓ Smiles
- ✓ Whines and vocalizes
- ✓ Rolls over

1

Activities that promote healthy growth: Approximately birth to 3 months

- ✓ Offer me a finger to hold. Listen to me and learn my responses. Smile and touch me when you talk to me. Tell me I am wonderful.
- ✓ Help me to develop trust. Gently hold me while talking in sweet encouraging tones. Call me by name and make eye contact.
- ✓ Pick me up when I cry and reassure me. Don't leave me alone crying and give me the impression that no one cares for me.
- ✓ Learn how to soothe me and meet my needs before I cry.
- ✓ Gently rub my back, sing to me, play music for me or bounce me gently to music. I am sensitive to sound so keep music low.
- ✓ Hold me securely in new places and protect me.
- ✓ Keep me clean, well fed and clothed appropriately for the temperature.
- ✓ Give me colorful toys that make interesting sounds.
- ✓ Sucking calms me so let me suck my fingers or a pacifier. Be gentle and don't interrupt my sucking by pulling or jiggling something I'm sucking on.

2

Developmental Concerns: By the end of 3-4 months

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Does not seem to respond to loud noises
- ✓ Does not notice hands by 2 months
- ✓ Does not follow moving objects with eyes by 2 to 3 months
- ✓ Does not grasp and hold objects by 3 months
- ✓ Does not smile at people by 3 months
- ✓ Cannot support head well by 3 months
- ✓ Does not reach for and grasp toys by 3 to 4 months
- ✓ Does not babble by 3 to 4 months
- ✓ Does not bring objects to mouth by 4 months
- ✓ Begins babbling, but does not try to imitate any of your sounds by 4 months
- ✓ Does not push down with legs when feet are placed on a firm surface by 4 months
- ✓ Has trouble moving one or both eyes in all directions
- ✓ Crosses eyes most of the time (occasional crossing of the eyes is normal in these first months)
- ✓ Does not pay attention to new faces or seems very frightened by new faces or surroundings
- ✓ Experiences a dramatic loss of skills he or she once had

3

Normal physical development: Approximately 4-6 months

4-6 months: Gains 5-6 oz. per week

4 months
- ✓ Grasps rattle
- ✓ Pulls to sit up
- ✓ Can bear some weight on legs
- ✓ Laughs and smiles

5 months
- ✓ Birth weight doubles
- ✓ Sits without support
- ✓ Feeds self cracker
- ✓ Turns toward voice

6 months
- ✓ Adds 2-3 inches to height
- ✓ Sits up
- ✓ Holds 2 cubes and works to reach for desired toy
- ✓ Imitates speech sounds

4

Activities that promote healthy growth: Approximately 4-6 months

- ✓ During bath time, try washing me in a sitting position. I may also want to sit up and play. Help me sit up for 5-10 minutes and help me keep my back straight.
- ✓ Give me safe healthy finger foods at 5-6 months. (e.g., crackers)
- ✓ Lay me on a blanket on the floor and let me roll and reach.
- ✓ Spend time with me - play, smile, nod, talk and laugh with me. Give me toys or attention when I need a distraction.
- ✓ Respond to my fears and cries by holding, talking to and reassuring me. Talk to me about what I'm feeling and tell me that it's OK.
- ✓ Talk to me, sing to me or give me my favorite toy at diaper changing time. Don't scold, make loud noises or frowning faces.
- ✓ Keep me in my car seat even if I complain. Distract me with songs or toys and reassure me. Put my seat where I can see outside.
- ✓ Avoid separating me from you for days. I need consistent, reliable relationships so if you leave me for long periods expect me to be more clingy for awhile and need more reassurance.

5

Developmental Concerns: By the end of 7 months

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Seems very stiff, with tight muscles
- ✓ Seems very floppy, like a rag doll
- ✓ Head still flops back when body is pulled to a sitting position
- ✓ Reaches with one hand only
- ✓ Refuses to cuddle
- ✓ Shows no affection for the person who cares for him or her
- ✓ Doesn't seem to enjoy being around people
- ✓ One or both eyes consistently turn in or out
- ✓ Persistent tearing, eye drainage, or sensitivity to light
- ✓ Does not respond to sounds around him or her
- ✓ Has difficulty getting objects to mouth
- ✓ Does not turn head to locate sounds by 4 months
- ✓ Does not roll over in either direction (front to back or back to front) by 5 months
- ✓ Seems impossible to comfort at night after 5 months
- ✓ Does not smile on his or her own by 5 months
- ✓ Cannot sit with help by 6 months
- ✓ Does not laugh or make squealing sounds by 6 months
- ✓ Does not actively reach for objects by 6 to 7 months
- ✓ Does not follow objects with both eyes at near (1 foot) and far (6 feet) ranges by 7 months
- ✓ Does not bear weight on legs by 7 months
- ✓ Does not try to attract attention through actions by 7 months
- ✓ Does not babble by 8 months
- ✓ Shows no interest in games of peek-a-boo by 8 months
- ✓ Experiences a dramatic loss of skills he or she once had.

6

Normal physical development: Approximately 7-11 months

7-11 months: Gains 2-3 oz. per week

7 months
- ✓ Plays peek-a-boo, pulls to stand, gets to sitting position
- ✓ Nonspecific "dada" or "mama"

8 months
- ✓ Thumb-finger grasp is weak
- ✓ Shakes head "no" and shouts for attention

9 months
- ✓ Walks holding onto furniture and plays pat-a-cake
- ✓ Shy with strangers

10 months
- ✓ Stands momentarily
- ✓ Specific "dada" or "mama" and can put 2 words together

11 months
- ✓ Stands alone well
- ✓ Plays ball with strangers
- ✓ May recognize words as symbols

7

Activities that promote healthy growth: Approximately 7-11 months

- ✓ Play peek-a-boo, puppets, wave bye-bye, and teach me words and colors even if I can't repeat the words right now.
- ✓ Have a regular bedtime routine. Slow my activity an hour before bedtime, rock me, pat my back and bring my favorite blanket. Once dry, fed and well prepared for bed, leave me with a kiss. Ignore my cries for a few minutes until I am asleep.
- ✓ Encourage physical exploration within your eyesight. Keep dangerous objects away from me and baby-proof my environment. Be there to comfort me when I get hurt.
- ✓ Help me stand by holding my hands. Make sure my heels are flat.
- ✓ I may purposefully drop and throw things as an experiment. Give me safe things to drop and throw.
- ✓ Open a cupboard in the kitchen kept safe for my exploration. Keep only non-breakable objects that are baby-friendly.
- ✓ Give me something interesting on my tray to explore at mealtime. (e.g., cooked spaghetti, spoons)
- ✓ Do not force me to eat and understand that I am learning and will be messy with my food.

8

Development Concerns: By the end of one year

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range.

- ✓ Does not crawl
- ✓ Drags on side of body while crawling (for over one month)
- ✓ Cannot stand when supported
- ✓ Does not search for objects that are hidden while he or she watches
- ✓ Says no single words ("mama" or "dada")
- ✓ Does not learn to use gestures, such as waving or shaking head
- ✓ Does not point to objects or pictures
- ✓ Experiences a dramatic loss of skills he or she once had

9

Normal physical development: Approximately 12-23 months

1 year
- ✓ Birth weight triples
- ✓ Stoops and recovers, learning to drink from cup, pulls up to a standing position, walks holding on to furniture
- ✓ Knows 3 words other than "mama" or "dada"

13–14 months
- ✓ Scribbles, 6+ word vocabulary, tries to sing, points
- ✓ Walks backwards. Better cup control, spilling less
- ✓ Towers 2 cubes and begins using a spoon

15–16 months
- ✓ Begins using double syllable words and asks "What's that?" Learns names of body parts, objects, colors
- ✓ Removes clothes, pulls adult hand to show something

17-19 months
- ✓ Walks up steps, towers 4 cubes, asks for "more," 20 word vocabulary, hands toy to adult if unable to operate
- ✓ Throws ball, follows directions, helps in simple tasks

20-23 months
- ✓ Kicks ball forward, jumps in place, puts on clothes
- ✓ Plays with 2 toys, pedals tricycle, towers 8 cubes, washes and dries hands

10

Activities that promote healthy growth: Approximately 12-23 months

- ✓ Learning to walk takes time. Hold my hand and encourage me to take steps when **I'm** ready, don't rush me.
- ✓ If I grab, hit or bite when I'm mad, don't scold me or hit me. Teach me words to use instead of hurting others.
- ✓ It will take time before I'm able to do many things. Set limits, but I will break rules many times before I learn. "No!" is not enough, please explain why. (e.g., "The stove is too HOT!" Move me and show me a safe place to play.)
- ✓ Give me choices whenever possible. Don't say "no" too often and distract me if I am refusing something. Reward me for good behavior. Ignore my "no" if I do not get a choice.
- ✓ Let me scribble with thick washable crayons or felt markers, tape a paper to the table so it doesn't slip.
- ✓ Compare colors and sizes with me (big spoon, red balloon).
- ✓ Tell me about the story, let me pat the pages and make noises, help me learn to turn pages by half lifting one.
- ✓ Building blocks, sandboxes, ride and pull toys, jack-in-the-box, music toys and balls are very important learning tools.
- ✓ Understand that me and mine are important before I can learn about you and yours. Set up a box that is mine.
- ✓ Teach me about not hurting others and sharing, but don't shame me. Be patient and encourage my empathy for others.

11

Developmental Concerns: By the end of 2 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Cannot walk by 18 months
- ✓ Fails to develop a mature heel-toe walking pattern after several months of walking, or walks only on his toes
- ✓ Does not speak at least 15 words
- ✓ Does not use two-word sentences by age 2
- ✓ By 15 months, does not seem to know the function of common household objects (brush, telephone, bell, fork, spoon)
- ✓ Does not imitate actions or words by the end of this period
- ✓ Does not follow simple instructions by age 2
- ✓ Cannot push a wheeled toy by age 2
- ✓ Experiences a dramatic loss of skills he or she once had

12

Normal physical development: Approximately 2-4 years

2 years
- ✓ Average height: 32-36", weight: 22-31 lbs
- ✓ Uses short sentences and adds "ing" and plurals

2 ½ years
- ✓ Average height: 33-38", weight: 24-34 lbs
- ✓ Gains muscle control for toilet training
- ✓ Asks "what, where, who" questions
- ✓ Shows interest in peers, has difficulty sharing
- ✓ Displays some self-control

3 years
- ✓ Average height: 33-42", weight: 24-42 lbs
- ✓ Buttons clothes, walks downstairs and uses the toilet
- ✓ Increased vocabulary and uses past tense, asks "why"
- ✓ Has difficulty sharing and develops a basic sense of time
- ✓ Identifies preferences and increased sense of self
- ✓ Loses swayed back and large abdomen of the toddler at 3 ½ years old
- ✓ Can balance on one foot briefly and walks heel to toe

4 years
- ✓ Catches a ball 2 out of 3 times and cuts with scissors
- ✓ Talks to self and can share better

13

Activities that promote healthy growth: Approximately 2-4 years

- ✓ Let me do it myself when possible. Let me feed myself even if I'm messy. Give me 2 choices when you can.
- ✓ Let me make choices about the food I eat and let me refuse food. Reduce in-between snacks so I will be hungry at mealtimes. Don't use food as a reward or punishment.
- ✓ Teach me about dangerous things (matches, knives, strangers, stray animals, cars, etc.). Significant consequences should be given for dangerous behavior after giving warnings.
- ✓ Naps are still important to reduce cranky and moody behavior.
- ✓ Give me a warning that it will soon be time to move along.
- ✓ Don't hurry me too much, I need patience and time to learn.
- ✓ Read to me, color with me, teach me games.
- ✓ If there is a new baby, remember I **will** be jealous. Assure me of your love, give me special time and let me help with the baby.
- ✓ Talk to me about what I'm feeling - comfort me and don't scold me.
- ✓ Offer a hand when I'm in a new situation as a substitute for picking me up. Don't insist I have to grow up.
- ✓ Blow bubbles for me. Teach me to catch and throw a ball.
- ✓ Respect my fears and do not force me into fearful situations. Comfort me and encourage me that there is nothing to fear.

14

Strategies for potty training and tantrums: Approximately 2-4 years

Potty training tips
- ✓ No age is exact for toilet training. Watch for me to grimace at dirty diapers, show you my wet pants and stay dry for up to 2 hours. I need to be verbal enough to understand toilet training.
- ✓ Change me as soon as possible, tell me it's nice to be clean
- ✓ Let me have a toy to keep me happy and busy on the potty-chair. Put me on the potty briefly at first (up to 5 minutes).
- ✓ Praise my efforts and encourage me to let you know when I need to go potty. Teach me the family words for toilet training.
- ✓ Dress me in easy to remove clothing, be patient, never scold me, visit the potty before going somewhere, help me wipe, teach me to wash my hands and show me how to flush.

Tantrums
- ✓ Make sure I get enough sleep, eat healthy and keep a regular routine. I need physical activity during the day. Teach me to ride a tricycle, encourage running, dancing and jumping.
- ✓ Learn warning signs and distract me. Don't expect too much.
- ✓ Since tantrums are a release of frustrated feelings and a way to get attention, ignore me if I'm in a safe place. Don't reward tantrums. Stay calm and leave me reassuring me you will be back when I'm quiet. When I stop, talk to me, tell me what I'm feeling. Help me express my frustration in words.

15

Development Concerns: By the end of 3 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Frequent falling and difficulty with stairs
- ✓ Persistent drooling or very unclear speech
- ✓ Cannot build a tower of more than four blocks
- ✓ Difficulty manipulating small objects
- ✓ Cannot copy a circle by age 3
- ✓ Cannot communicate in short phrases
- ✓ No involvement in "pretend" play
- ✓ Does not understand simple instructions
- ✓ Little interest in other children
- ✓ Extreme difficulty separating from mother or primary caregiver
- ✓ Poor eye contact
- ✓ Limited interest in toys
- ✓ Experiences a dramatic loss of skills he or she once had

16

Development Concerns: By the end of 4 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Cannot throw a ball overhand
- ✓ Cannot jump in place
- ✓ Cannot ride a tricycle
- ✓ Cannot grasp a crayon between thumb and fingers
- ✓ Has difficulty scribbling
- ✓ Cannot stack four blocks
- ✓ Still clings or cries whenever parents leave
- ✓ Shows no interest in interactive games
- ✓ Ignores other children
- ✓ Doesn't respond to people outside the family
- ✓ Doesn't engage in fantasy play
- ✓ Resists dressing, sleeping, using the toilet
- ✓ Lashes out without any self-control when angry or upset
- ✓ Cannot copy a circle
- ✓ Doesn't use sentences of more than three words
- ✓ Doesn't use "me" and "you" correctly
- ✓ Experiences a dramatic loss of skills he or she once had

17

Normal physical development: Approximately 5-7 years

Average height: 40-50", weight: 34-55 lbs.

4-5 years

- ✓ Paints and colors, draws figures in 6 parts, learning shapes and colors
- ✓ Climbs, runs, bike or trike riding
- ✓ Broad vocabulary, listens carefully, asks questions
- ✓ Learning letters, numbers and written name
- ✓ Recognizes differences and similarities
- ✓ Short and long term memory improves
- ✓ Develops friendships with peers, recognizes gender
- ✓ Believes rules can change to suit their own needs

6-7 years

- ✓ Body proportions are similar to that of an adult
- ✓ Imagination is an important part of development
- ✓ Enjoys achieving in sports, rides a bike without training wheels and learns to skate
- ✓ Can learn to swim, swing, climb on jungle gyms and other more complex physical tasks
- ✓ Learning to read and do simple math
- ✓ Understands concepts of first, next, last, large, larger, etc.
- ✓ Understands time concepts of yesterday, today, tomorrow
- ✓ Looks forward to holidays, birthdays and annual events

18

Activities that promote healthy growth: Approximately 5–7 years

- ✓ Discuss physical gender differences with me. Teach me the proper names for body parts without shame. If I am old enough to ask the question, I am old enough to understand the answer. Don't give me more information than I ask for.
- ✓ Create a home library with interesting books about heroines and heroes, fables and fun stories. Read to me every day and let me read a part of each book, discuss the ideas in the book.
- ✓ Remember rewards works better than punishment. Have a sticker chart, give balloons, pennies for the bank, etc.
- ✓ Play children's music, sing, clap and dance with me.
- ✓ Encourage physical involvement and imaginative expression. (e.g., "Itsy-Bitsy Spider" and "I'm a Little Teapot")
- ✓ Teach me to count, sing my ABC's and write my name with lots of patience. This will take time and repetition.
- ✓ I need a bike or trike, balls, clay and play space with toys.
- ✓ Plant a garden or a pot from seed. Help me water it and watch it grow. Pick flowers for my table and let me eat the vegetables.
- ✓ Follow a routine at bedtime. Show me the clock and tell me it's time for bed. Let me pick out my bath toys, choose my pajamas, read me a story, etc. Spend time with me. Sing me a song, rub my back. Kiss me, say goodnight, I love you.
- ✓ Give me permission to say no to adults that make me feel uncomfortable. Talk with me and get to know how I'm feeling.

19

Developmental Concerns: By the end of 5 years

Alert your child's doctor or nurse if your child displays any of the following signs of possible developmental delay for this age range:

- ✓ Acts extremely fearful or timid
- ✓ Acts extremely aggressively
- ✓ Is unable to separate from parents without major protest
- ✓ Is easily distracted and unable to concentrate on any single activity for more than five minutes
- ✓ Shows little interest in playing with other children
- ✓ Refuses to respond to people in general, or responds only superficially
- ✓ Rarely uses fantasy or imitation in play
- ✓ Seems unhappy or sad much of the time
- ✓ Doesn't engage in a variety of activities
- ✓ Avoids or seems aloof with other children and adults
- ✓ Doesn't express a wide range of emotions
- ✓ Has trouble eating, sleeping or using the toilet
- ✓ Can't tell the difference between fantasy and reality
- ✓ Seems unusually passive
- ✓ Cannot understand two-part commands using prepositions ("Put the doll on the bed, and get the ball under the couch.")
- ✓ Can't correctly give her first and last name
- ✓ Doesn't use plurals or past tense properly when speaking
- ✓ Doesn't talk about her daily activities and experiences
- ✓ Cannot build a tower of six to eight blocks
- ✓ Seems uncomfortable holding a crayon
- ✓ Has trouble taking off clothing
- ✓ Cannot brush her teeth efficiently
- ✓ Cannot wash and dry her hands
- ✓ Experiences a dramatic loss of skills he or she once had

20

Normal physical development: Approximately 8-12 years

Average height: 45-58", weight: 45-85 lbs.

8-9 years

- ✓ Play and imagination are still important developmental tools
- ✓ May enter puberty early
- ✓ Very verbal and asks factual questions, may request instruction
- ✓ Social roles are better understood
- ✓ School and neighborhood are important arenas for growth

10-11 years

- ✓ Girls may experience a growth spurt
- ✓ Tolerates frustration better, good with time concepts, can plan and understands cause and effect, more rational and logical
- ✓ Needs affection and affirmation from adults
- ✓ Concrete thinking with a strong sense of fairness
- ✓ Begin to see conflicts between peers and parent values

21

Activities that promote healthy growth: Approximately 8-12 years

- ✓ Turn off the TV and play a game with me or talk things over. Don't let me watch PG-13 or R-rated movies.
- ✓ Bake cookies with me. We can wear aprons and don't get too upset about how messy the kitchen becomes.
- ✓ Teach me cards and board games I can play with my friends.
- ✓ Encourage outside play. (e.g., jump rope, skates, balls, etc.) Draw a hopscotch grid on the sidewalk with chalk.
- ✓ Teach me about nurturing by giving me responsibility for a family pet. Understand I may forget and remind me.
- ✓ I need to know how to swim to stay safe in water.
- ✓ Teach me about nature through camping, hiking and going to the zoo.
- ✓ Let me organize a water fight with the hose and balloons.
- ✓ Establish family traditions. Remind me about what we did last year. Tell me why it is important.

22

Strategies for child safety: Approximately 8-12 years

- ✓ Know where I am at all times. Teach me to check in and give me timelines. Provide clear instructions to me about what you believe is safe and supervise my activities.
- ✓ Make my house safe, friendly and child centered. Children can visit under your watchful eye.
- ✓ Get to know the parents in my neighborhood and my friend's parents. Teach me to keep away from places that are unsafe.
- ✓ Give me permission to say "my mom or dad wants me home" or "my mom won't let me" if they need to make an excuse to get out of an uncomfortable or pressure situation.
- ✓ Teach me about drugs, alcohol, smoking and teen pregnancy. Let me tell you how I feel about these things.
- ✓ Value me and teach me how to value and care for myself.
- ✓ Teach me to be cautious of overly friendly adults or strangers.
- ✓ Ask me how I'm feeling. Listen and keep communication open.
- ✓ Be reliable and predictable and create a safe place for me to put my trust. Forgive me when I fail and apologize when you have let me down. Teach me about respect by modeling it.
- ✓ Teach me about my bright future and celebrate each accomplishment along the way. Give me vision.

23

Normal physical development: Approximately 13-18 years

13-14 years
- ✓ Challenges limit setting and parent's judgment
- ✓ Wants to be with peers more often
- ✓ Puberty has begun or been achieved
- ✓ Awkwardness and self-doubt may occur with new growth

15-16 years
- ✓ Girls full stature is achieved, boys may continue some growth until age 18
- ✓ Skills are developed and refined
- ✓ Introspection and intense self-analysis
- ✓ Conflict between parents grows, will push you away as he or she attempts to take on more autonomy
- ✓ Peers values become more important
- ✓ Experimentation with social roles is expected
- ✓ Boys may experience a growth spurt.

17-18 years
- ✓ Hormonal and brain development continues
- ✓ Interest in school increases or decreases
- ✓ Youth relies more on peers for affection and approval
- ✓ Individual identity forms, seeks independence
- ✓ Parents and family are still important and necessary
- ✓ Vision for the future and belief in self is essential

24

Activities that promote healthy growth: Approximately 13-18 years

- ✓ Be clear about what you expect of me. Set curfews and know where I am at all times. Make sure I check in frequently.
- ✓ Start with small freedoms, assuring me that larger freedoms will be allowed once I've proven myself capable of the smaller ones.
- ✓ Allow me to have my own music in my room.
- ✓ Encourage me to express my feelings in writing and verbally. It's OK to be angry, not mean.
- ✓ When I speak, listen to the feeling underneath along with the words. Am I scared? Or hurting?
- ✓ Peers are very important for me. Allow me to talk on the phone and have friends over.
- ✓ As much as you can, let me wear what I like as part of self-expression.
- ✓ Encourage volunteer or paid work. Instill responsibility and polite public behaviors.
- ✓ Support and encourage me to gain a special talent early in my teen years (dance, music, drama, sports, art, etc.).

25

Strategies for dealing with conflict: Approximately 13-18 years

- ✓ Understand my need for developing a separate self and do not take my struggles to gain independence personally.
- ✓ Understand that I still need supervision, guidance and protection even if I push you away or am critical of you. Troubled children often report a parent doesn't "love them enough" to wonder where they are or what they do.
- ✓ Acknowledge my feelings and maintain consistent consequences for my disobedience of clear limits you set.
- ✓ Consequences should always be related to my disobedience. (e.g., If an hour late, set the next curfew time an hour earlier.)
- ✓ Don't give up - when I make mistakes, disobey or lose my temper when you set limits, know that this is normal. Reassure me that you still care and won't give up on me.
- ✓ Give me another chance. I want your love and approval and will keep trying. Reassure me that you are still proud of me.
- ✓ Give me a vision for who I can become. Give me a reason why I should make healthy positive choices.
- ✓ Maintain communication and physical affection.

26

At Risk Adolescents
- ✓ Typical adolescent behavior taken to the extreme -- more moody, more hostile.
- ✓ Defiance. Ignoring the rules. Violating curfew.
- ✓ Totally uncommunicative to you or teachers. Only talks to peers.
- ✓ Sense of complete aimlessness or alienation.
- ✓ Destructive eating habits. Eating disorders can be life-threatening.
- ✓ Missing money or greater expenditures.
- ✓ Greater secrecy.
- ✓ Drinking or other substance abuse

Factors that can increase risk
- ✓ Undiagnosed learning disability. This child is subject to constant personal frustration and criticism from others. Discouragement and disaffection soon follow. It's never too late for educational/psychological testing.
- ✓ Unhappy family life
- ✓ Family size
- ✓ Traumatic illness in the family
- ✓ Severe moodiness or depression
- ✓ Isolated family
- ✓ Friends that have destructive characters and behaviors

27

Symptoms of PTSD (Post Traumatic Stress Disorder)

Play

- ✓ Children begin to play out, draw, dramatize or tell their stories of trauma.
- ✓ Post-traumatic play is often grim, monotonous, and, at times, dangerous. Connection between the play and the trauma is usually not obvious.
- ✓ For this reason, it often goes unnoticed as a symptom by caretakers. The power to play is so strong that it impels the child to play.
- ✓ Even adolescents, well beyond the age-range of the usual "pretend" player, may play post-traumatically with art or music.
- ✓ For this reason, some "acting out" behavior in adolescents is actually post-traumatic play.

Symptoms in very young children

- ✓ Ego-centric
- ✓ Time Skew – Mis-sequencing trauma
- ✓ Omen Formation – should have seen it coming
- ✓ Bids for control

Symptoms in elementary school-aged children

- ✓ Generalized fear – stranger or separation anxiety, avoidance of situations or people associated with trauma
- ✓ Sleep disturbance
- ✓ Preoccupation with words
- ✓ Post-traumatic play
- ✓ Lost developmental skills

PTSD in Adolescents

- ✓ May begin to look like adults
- ✓ Traumatic reenactment

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Ways to Help Maltreated Children

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

Please note that social workers will assess behavioral indicators and will include mental health providers early as partners to ensure that children receive timely mental health assessment and intervention. The social worker, service provider, caregiver and parents will work as a team to identify the best interventions for the child. As part of this team, parents and caregivers make all the difference in the lives of maltreated children. This section suggests some different ways to help.

Nurturance

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

Understand behavior

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

Parent children based on emotional age

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

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

Be consistent, predictable, and repetitive

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

Model and teach appropriate social behaviors

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

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

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

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

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

Listen and play

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

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

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

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

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

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

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

Take care of yourself

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

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

The Effects of Abuse and Neglect on School Age Children[8]

Social

- The child may be suspicious and mistrustful of adults, or overly solicitous, agreeable, and manipulative, and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms about her family; may exhibit role reversal and assume a parenting role with the parent.
- The child may not respond to positive praise and attention, or may excessively seek adult approval and attention.

Physical

- The child may show generalized physical developmental delays.
- The child may lack the skills and coordination for activities that require perceptual motor coordination.
- The child may be sickly or chronically ill.

Emotional

- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by peer expectations for performance, and may withdraw from social contact; may be scapegoated by peers.
- The child may experience severe damage to self-esteem from the denigrating and punitive messages received from the abusive parent, or from the lack of positive attention in a neglectful environment.
- The child may behave impulsively, may have frequent emotional outbursts, and may not be able to delay gratification.
- The child may not develop coping strategies to manage stressful situations effectively and master the environment.
- The child may exhibit generalized anxiety, depression, and behavioral signs of emotional distress; may act out feelings of helplessness and lack of control by being bossy, aggressive, destructive, or by trying to control or manipulate other people.
- The child who is punished for autonomous behavior may learn that self-assertion is dangerous and may assume a more dependent posture. He may exhibit few opinions, show no strong likes or dislikes, may not be engaged into productive, goal-directed activity. The child may lack initiative, give up quickly, and withdraw from challenges.

[8] Rycus, J., and Hughes, R. (1998). *Field Guide to Child Welfare: Child Development and Child Welfare,* pp. 515-516, Arlington, VA: CWLA.

Cognitive

- The child may display thinking patterns that are typical of a younger child, including egocentric perspectives, lack of problem solving ability, and inability to organize and structure his thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on schoolwork, and may not be able to conform to the structure of the school setting. The child may not have developed basic problem solving or attack skills, and may have considerable difficulty in academics.

Sexual

- The child may engage in developmentally inappropriate sexual play with other children.

Behavioral Impact of Maltreatment: A Reference to Use with Caregivers and Parents[1]

The following material is adapted from the work of Bruce Perry, M.D. Social workers will find it useful to use as a reference to assist parents and caregivers to understand and nurture the children in their care, and to apply in their own interactions with children. This supplemental handout contains information relevant to all developmental levels.

What specific problems can I expect to see in maltreated children with attachment problems?

The specific problems that you may see will vary depending upon the nature, intensity, duration and timing of the neglect and/or abuse. They may also differ from child to child. Some children will have profound and obvious problems, while some will have very subtle problems that you may not realize are related to early life neglect. Sometimes, these children do not appear to have been affected by their experiences. However, it is important to remember the reason you are working with the children and that they have been exposed to terrible things. Below are some clues that experienced clinicians consider when working with these children:

Developmental delays: Children experiencing emotional neglect in early childhood often have developmental delay in other domains. The bond between the young child and caregivers provides the major vehicle for a child's development. It is in this primary context that children learn language, social behaviors, and a host of other key behaviors and skills required for healthy development. Lack of consistent and enriched experiences in early childhood can result in delays in motor, language, emotional, social, and cognitive development.

Eating: Atypical eating behaviors are common, especially in children with severe neglect and attachment problems. They will hoard food, hide food in their rooms, or eat as if there will be no more meals even if they have had years of consistent available foods. They may have failure to thrive, rumination (throwing up food), swallowing problems and, later in life, unusual eating behaviors that are often misdiagnosed as anorexia nervosa.

Soothing behavior: These children will use very primitive, immature and seemingly bizarre soothing behaviors. They may bite themselves, head bang, rock, chant,

[1] Adapted in part from: Perry, B. (2007). *Maltreated children: Experience, brain development and the next generation.* (New York: W.W. Norton & Company) and Bruce Perry, M.D. *Bonding and Attachment in Maltreated Children*, on-line curriculum.

scratch, or cut themselves. These symptoms will increase during times of distress or threat.

Emotional functioning: A range of emotional problems is common in maltreated children, including depressive and anxiety symptoms. One common behavior is "indiscriminant" attachment. All children seek safety. Keeping in mind that attachment is important for survival, children may seek attachments – any attachments – for their safety. Non-clinicians may notice abused and neglected children are "loving" and hug virtual strangers. Children do not develop a deep emotional bond with relatively unknown people; rather, these "affectionate" behaviors are actually safety-seeking behaviors. Clinicians are concerned because these behaviors contribute to the abused child's confusion about intimacy, and are not consistent with normal social interactions. Furthermore, although the child seeks safety, these inappropriately affectionate behaviors can, ironically, put the child in very dangerous situations.

Inappropriate modeling: Children model adult behavior – even if it is abusive. Maltreated children learn that abusive behavior is the "right" way to interact with others. As you can see, this can cause problems in their social interactions with adults and other children. Children that have been sexually abused may become more at-risk for future victimization. Boys that have been sexually abused may become sexual offenders.

Aggression: One of the major problems with neglected, poorly attached children is aggression and cruelty. This is related to two primary problems in neglected children: (1) lack of empathy and (2) poor impulse control. The ability to emotionally "understand" the impact of your behavior on others is impaired in these children. They do not understand or feel what it is like for others when they do or say something hurtful. Indeed, these children often feel compelled to lash out and hurt others. They will hurt those less powerful than they, such as animals, smaller children, peers and siblings. One of the most disturbing elements of this aggression is that it is often accompanied by a detached, cold lack of empathy. They may show regret (an intellectual response) but not remorse (an emotional response) when confronted about their aggressive or cruel behaviors.