Module 3: Child Development

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Unit 3.1: How Children Develop

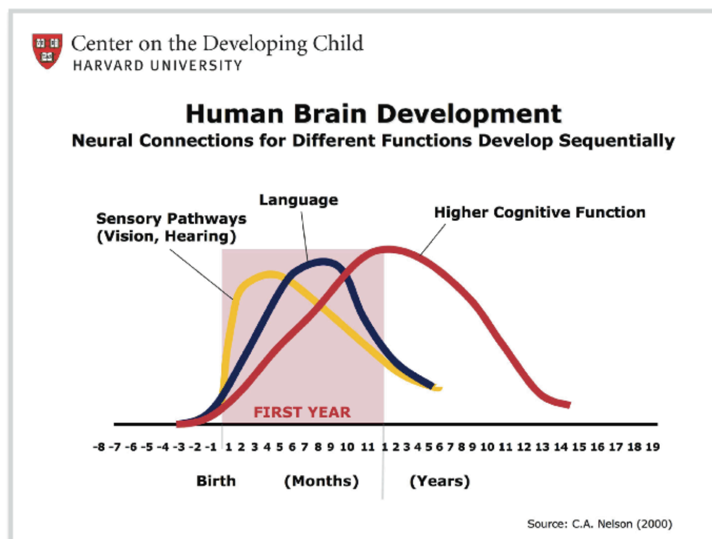
What is a Child?

- The legal definition of the term child: Chapter 39, Florida Statutes:
  - "any unmarried person under the age of 18 years who has not been emancipated by order of the court"
  - The terms child and youth are interchangeable.
- A child's chronological age sometimes is not congruent with a child's developmental age.
- The concept of 'child' changes over a lifespan, as we assume new roles within the family structure.
- The legal definition remains the same for every child, but the developmental and functioning expectations are individualized.
- A child's chronological age is sometimes not congruent with a child's developmental age. For example, a 10 year old child with a very low IQ may be functioning only on a developmental level of a four year old.
  - A child who has been abused or neglected can be one chronological age, but because of the abuse and neglect could developmentally be far younger.

A series of brief summaries of the scientific presentations at the National Symposium on Early Childhood Science and Policy.

The science of early brain development can inform investments in early childhood. These basic concepts, established over decades of neuroscience and behavioral research, help illustrate why child development—particularly from birth to five years—is a foundation for a prosperous and sustainable society.

1 Brains are built over time, from the bottom up. The basic architecture of the brain is constructed through an ongoing process that begins before birth and continues into adulthood. Early experiences affect the quality of that architecture by establishing either a sturdy or a fragile foundation for all of the learning, health and behavior that follow. In the first few years of life, 700 new neural connections are formed every second. After this period of rapid proliferation, connections are reduced through a process called pruning, so that brain circuits become more efficient. Sensory pathways like those for basic vision and hearing are the first to develop, followed by early language skills and higher cognitive functions. Connections proliferate and prune in a prescribed order, with later, more complex brain circuits built upon earlier, simpler circuits.



In the proliferation and pruning process, simpler neural connections form first, followed by more complex circuits. The timing is genetic, but early experiences determine whether the circuits are strong or weak.

2 The interactive influences of genes and experience shape the developing brain. Scientists now know a major ingredient in this developmental process is the "serve and return" relationship between children and their parents and other caregiv-

POLICY IMPLICATIONS

- The basic principles of neuroscience indicate that early preventive intervention will be more efficient and produce more favorable outcomes than remediation later in life.
- A balanced approach to emotional, social, cognitive, and language development will best prepare all children for success in school and later in the workplace and community.
- Supportive relationships and positive learning experiences begin at home but can also be provided through a range of services with proven effectiveness factors. Babies' brains require stable, caring, interactive relationships with adults — any way or any place they can be provided will benefit healthy brain development.
- Science clearly demonstrates that, in situations where toxic stress is likely, intervening as early as possible is critical to achieving the best outcomes. For children experiencing toxic stress, specialized early interventions are needed to target the cause of the stress and protect the child from its consequences.

Why Should Child Welfare Professionals Know About Child Development

This information comes from the Florida State University Center for Prevention and Early Intervention Policy.

1. To understand why young children are the most vulnerable to maltreatment
2. To assess child functioning, including the impact of maltreatment
3. To identify problems early and make appropriate referrals
4. To dispel myths about young children
5. To do no further harm
6. To help make better-informed decisions.

The Maturation Process

- Maturation process = typical development
- Definition of typical: “timeframes and skills are what is ‘typical’, or ‘the average’ for a specific age or age range”
- Normal or typical has boundaries, and if a child is reaching the upper boundary of that range or exceeds it, then it is imperative to ask “why?”
  - Example: If an 18-month-old is not walking, there could be a medical reason why they are not walking or it could be an abuse or neglect issue or both.
- We must know what the ‘norm’ is so that we can make educated or informed decisions on the safety and well-being of that child.
- Development is sequential. Developmental skills are like building blocks.
- ‘Typical’ development is based on the relationships that children have with those in their family system. It is the quality of relationships that determine their developmental trajectory.
- We typically think about developmental relationships as being with parents/caregivers but this changes as we grow into childhood and adolescence. The span of the relationships a child has expands exponentially, and will include siblings, relatives, peers, and community members.
- The child’s development is uniquely dependent on the relationship he or she has with his or her environment.
  - For example, an infant who has been ‘environmentally deprived’ – where they have experienced little sensory interaction –will not meet developmental milestones unless there are other protective factors in place to overcome negative environmental influences.
- Two critical windows of development:
  - Between the ages of birth to three

    - The teen years
    - These two critical periods ***are uniquely tied to brain development and the relationship that the child has with their environment***.
- The brain is **the only organ** that is not fully developed at birth. It is only at 25% of its adult weight when you are born.
- **Brain growth is dramatic by age three and highly dependent on environmental input.**
- Review of the video: ***10 Things Every Child Needs***

Encourage Family Use of Community Resources

- Community resources that that are available in many Florida communities for parents who meet income criteria are:
    - Head Start, including Early Head Start
        - Support the mental, social, and emotional development of children from birth to 5.
        - Also provide children and their families with health, nutrition, social and other services
    - Healthy Families Florida
        - An evidence-based home visiting program for expectant parents and parents of newborns experiencing stressful life situations.
        - Early Steps provides screening and evaluation of children suspected of having developmental delays, and interventions if a delay is diagnosed.
    - Quality child care
        - A choice for children who would benefit from more early stimulation and pre-school curricula.
        - Early Learning is a resource to help your families identify local community choices.

Prenatal Development

There are three factors that can have significant factors on prenatal development. They are:

- **Genetics**
- **The effects of teratogens or substances such as drugs or alcohol.** Teratogens include things like viruses, drugs, chemicals, stressors, and malnutrition that can impair prenatal development and lead to birth defects or even child death.
- **Environmental factors**, such as domestic violence, parent/caregiver mental illness, poverty and/or poor nutrition, and having a teenage mother.

Certain prenatal experiences predispose children for later challenges/issues, including abuse and neglect:

1. Smoking increases chances of SIDS deaths.
2. Prenatal depression increases the risk for postpartum depression and child neglect.
3. Substance abuse increases risks for maltreatment.
4. Prenatal stress impacts a baby's stress response system.

Effects of Maternal Depression on Baby - Newborns of depressed mothers are more irritable and hard to soothe, have more problems sleeping, and have higher levels of the stress hormone cortisol in their blood. Maternal depression and anxiety during pregnancy is associated with higher rates of impulsivity, hyperactivity, and emotional and behavioral problems.

<u>Depressed Dads:</u>

- 10.4% of men experience postpartum depression sometime between their partner's first trimester and baby's first birthday.
- Rates are highest 3-6 months after birth – as many as 25% of new dads were depressed.
- Depressed dads interact less with their babies, which leads to less bonding and attachment.

<u>Effects of Depression on Capacity to Parent - Depressed parents are:</u>

- Less likely to engage with their babies in positive interactions;
- Less likely to respond to their baby's cues, or to simply play and talk with their baby;
- Likely to either disengaged and withdrawn, or irritable and hostile, neither of which is conducive to healthy attachments.

Stress Impacts Development In Utero:

- Stress during pregnancy can elevate mom's cortisol level.
- Evidence shows that cortisol can cross the placenta to directly cause poor development in parts of the baby's brain.
- Cortisol is the body's stress hormone.
- Severe or chronic stress may constrict pregnant women's blood vessels, reducing the amount of oxygen and nutrients delivered to the fetus.

Implications for Child Welfare Staff:

- The way women take care of themselves during pregnancy can/may provide insight into how they will care for their baby.
- Many of the choices in pregnancy have long-term consequences for the baby's development and the risks for maltreatment.
- Encouraging healthy pregnancies can reduce potential for later abuse and neglect.
- Child neglect should trigger questions about possible depression.
- Know the signs of depression because of a high correlation between depression and neglect. Depression in one parent should also trigger clinical attention to the other parent.
- Encourage the family to see their health care provider or mental health specialist for depression screening.
- Know about community resources and in-home treatment.

Post-Partum Depression

- After childbirth, about 70-80% of women have 'baby blues' after childbirth: beginning 2-3 days after birth and then receding in a few hours or a week later without treatment. This is normal.
- About 10% of women develop postpartum depression. The onset is most commonly 1-3 weeks after delivery and does require treatment, which could include medication and/or counseling. It does not seem to relate to mother's age or number of children.
- Risk is very high to infants; however the risk over time can be significantly diminished if the condition is identified and treated.
- Newborns of depressed mothers are more irritable and hard to soothe, have more problems sleeping, and have higher levels of the stress hormone cortisol in their blood.

Brain Development

- Children have two critical periods of development
  - Between the ages of birth to three
  - The teen years
- The brain is the only organ in the human body that is not fully developed at birth. All other organs; the heart, the lungs, and the kidneys, are doing exactly what they will do when you become an adult.
- The brain, however, is only at 35% its adult weight when you are born.
- Brain growth is dramatic by age three and it is highly dependent on environmental input.

Neglect and Child Development

- Children ages birth to five are the most represented in the child welfare system.
- Children are most likely to experience abuse or neglect between the ages of birth and 18 months with the highest risk period in the first year of life.
- The early years represent the most opportunities in terms of growth and development; but they also represent the most risk to growth and development by maltreatment.

Impact of Neglect on Child Development

- Neglect is the most common maltreatment among infants.
- Early childhood holds the greatest opportunities for children, but also is the time when they are most vulnerable.

IN BRIEF | THE SCIENCE OF NEGLECT

A series of brief summaries of essential findings from recent scientific publications and presentations by the Center on the Developing Child at Harvard University.

Thriving communities depend on the successful development of the people who live in them, and building the foundations of successful development in childhood requires responsive relationships and supportive environments. Beginning shortly after birth, the typical "serve and return" interactions that occur between young children and the adults who care for them actually affect the formation of neural connections and the circuitry of the developing brain. Over the next few months, as babies reach out for greater engagement through cooing, crying, and facial expressions–and adults "return the serve" by responding with similar vocalizing and expressiveness–these reciprocal and dynamic exchanges literally shape the architecture of the developing brain. In contrast, if adult responses are unreliable, inappropriate, or simply absent, developing brain circuits can be disrupted, and subsequent learning, behavior, and health can be impaired.

1 Because responsive relationships are both expected and essential, their absence is a serious threat to a child's development and well-being. Sensing threat activates biological stress response systems, and excessive activation of those systems can have a toxic effect on developing brain circuitry. When the lack of responsiveness persists, the adverse effects of toxic stress can compound the lost opportunities for development associated with limited or ineffective interaction. This multifaceted impact of neglect on the developing brain underscores why it is so harmful in the earliest years of life and why effective early interventions are likely to pay significant dividends in better, long-term outcomes in educational achievement, lifelong health, and successful parenting of the next generation.

2 Chronic neglect is associated with a wider range of damage than active abuse, but it receives less attention in policy and practice. Science tells us that young children who experience significantly limited caregiver responsiveness may sustain a range of adverse physical and mental health consequences that actually produce more widespread developmental impairments than overt physical abuse. These can include cognitive delays, stunting of physical growth, impairments in executive function and self-regulation skills, and disruptions of the body's stress response.

Science Helps to Differentiate Four Types of Unresponsive Care

	OCCASIONAL INATTENTION	CHRONIC UNDER-STIMULATION	SEVERE NEGLECT IN A FAMILY CONTEXT	SEVERE NEGLECT IN AN INSTITUTIONAL SETTING
Features	Intermittent, diminished attention in an otherwise responsive environment	Ongoing, diminished level of child-focused responsiveness and developmental enrichment	Significant, ongoing absence of serve and return interaction, often associated with failure to provide for basic needs	"Warehouse-like" conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive
Effects	Can be growth-promoting under caring conditions	Often leads to developmental delays and may be caused by a variety of factors	Wide range of adverse impacts, from significant developmental impairments to immediate threat to health or survival	Basic survival needs may be met, but lack of individualized adult responsiveness can lead to severe impairments in cognitive, physical, and psychosocial development
Action	No intervention needed	Interventions that address the needs of caregivers combined with access to high-quality early care and education for children can be effective	Intervention to assure caregiver responsiveness and address the developmental needs of the child required as soon as possible	Intervention and removal to a stable, caring, and socially responsive environment required as soon as possible

With more than a half million documented cases in the U.S. in 2010 alone, neglect accounts for 78% of all child maltreatment cases nationwide, far more than physical abuse (17%), sexual abuse (9%), and psychological abuse (8%) *combined*. Despite these compelling findings, child neglect receives far less public attention than either physical abuse or sexual exploitation and a lower proportion of mental health services.

3 Studies on children in a variety of settings show conclusively that severe deprivation or neglect:

- **disrupts the ways in which children's brains develop and process information,** thereby increasing the risk for attentional, emotional, cognitive, and behavioral disorders.
- **alters the development of biological stress-response systems,** leading to greater risk for anxiety, depression, cardiovascular problems, and other chronic health impairments later in life.
- **is associated with significant risk for emotional and interpersonal difficulties,** including high levels of negativity, poor impulse control, and personality disorders, as well as low levels of enthusiasm, confidence, and assertiveness.
- **is associated with significant risk for learning difficulties and poor school achievement,** including deficits in executive function and attention regulation, low IQ scores, poor reading skills, and low rates of high school graduation.

4 The negative consequences of deprivation and neglect can be reversed or reduced through appropriate and timely interventions, but merely removing a young child from an insufficiently responsive environment does not guarantee positive outcomes. Children who experience severe deprivation typically need therapeutic intervention and highly supportive care to mitigate the adverse effects and facilitate recovery.

For more information, see "The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain" and the Working Paper series from the Center on the Developing Child at Harvard University. *www.developingchild.harvard.edu/resources/*

IMPLICATIONS FOR POLICY AND PROGRAMS

Science tells us that repeated and persistent periods of prolonged unresponsiveness from primary caregivers can produce toxic stress, which disrupts brain architecture and stress response systems that, in turn, can lead to long-term problems in learning, behavior, and both physical and mental health. These advances in science should inform a fundamental re-examination of our approaches to the identification, prevention, reduction, and mitigation of neglect and its consequences, particularly in the early years of life.

- **Address the distinctive needs of children who are experiencing significant neglect.** The immediate circumstances and long-term prospects of neglected children could be enhanced significantly by: (1) disseminating new scientific findings to child welfare professionals and focusing on the implications of this evidence for practice; (2) supporting collaboration between child development researchers and service providers to develop more effective prevention and intervention strategies; (3) coordinating across policy and service sectors to identify vulnerable children and families as early as possible; and (4) creating contexts for cooperation among policymakers, family court judges, and practitioners to improve access to non-stigmatizing, community-based services.

- **Invest in prevention programs that intervene as early as possible.** The earlier in life that neglected children receive appropriate intervention, the more likely they are to achieve long-term, positive outcomes and contribute productively to their communities. Key personnel in the primary health care, child welfare, mental health, and legal systems can work together to assure the earliest possible identification of families that require preventive assistance as well as children who need therapeutic intervention. Because child neglect often co-occurs with other family problems (particularly parental mental health disorders and addictions), specialized services that address a variety of medical, economic, and social needs in adults present important opportunities to identify and address neglectful circumstances for young children. Policies and programs that provide preventive interventions in high-risk situations before the onset of neglect present a particularly compelling goal.

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Center on the Developing Child
HARVARD UNIVERSITY
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ALSO IN THIS SERIES:
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Developmental Domains

- Within each one of the developmental stages there are four distinct domains:
    - Physical,
    - Cognitive,
    - Social and
    - Emotional
- A child's developmental rate and progress must be evaluated individually at each developmental domain.
- Normal for a child describes what is typical for the majority of children in that age group.
- The four domains are inter-related and must be evaluated collectively.

Physical Development

- Refers to the child's physiological or actual body growth. Such as height, weight, body hair, breasts, hips, etc. or development of the body structure, including muscles, bones, and organ systems.
- The development of coordination, strength & muscle tone progresses from head to toe and from the center of the body to hands and feet. Babies learn to roll over, sit, crawl, cruise and finally to walk. Motor skills lead to mobility and independence needed to explore their world.
- Motor delays may include difficulties in crawling, walking or fine motor skills like holding a pencil.
- Some motor delays may be the result of neglect or being left in cribs for extended periods without stimulation or adjustments or may result from just a lack of experience with parenting.
- Motor delays may indicate parent's or child's fear of exploration and staying close by for safety.
- Motor delays may manifest as a child continuing to crawl even though having no medical or other indication that the child does not have the ability to walk. This "skill regression" is a key indicator of possible trauma.
- In the early years of the child's physical development, growth is rapid, but it can also be deceiving.
    - Right after birth, a newborn will lose 5-10% of their birth weight birth.
    - Around two weeks old, a child experiences rapid physical growth.
    - Between 4-6 months of age, the baby actually doubles its birth weight.
    - Between the ages of 1 and 3, a toddler will only gain around 5 pounds and then 5 pounds each year until the age of five.
- Development is dependent upon the child's physical health.

- Physical development is also associated with adequate stimulation and opportunity for physical activity**.**
- Physical, nutritional, auditory, visual and dental health is basic for child wellness**.**

Cognitive Development

- Refers to the development of thought, judgment and perception which includes what a child knows, understands, and memory.
- This is the domain that deals with the way a child processes information, solves problems, and thinks abstractly; in other words the intellectual capacity to comprehend data often referred to as intelligence.
- Young children understand more words than they are able to say. Singing, talking and reading expose children to rich vocabularies and words for later expression.
- Cognitive delays are all too common in maltreated children, not because they are born less smart, but because of exposure to toxic stress and trauma.
- Stress impacts the brain's "executive functioning" and many abilities critical for academic success.
- Maltreated children commonly experience language delays because maltreating parents may spend less time talking with their children.
- Children may not talk as a response to trauma or violence.
- Behavior problems are common in children who lack of communication skills and are frustrated when needs are not met.
- The way in which developmental skills are acquired are referred to as "approaches to learning" and include eagerness & curiosity, persistence and grit, creativity and problem-solving.
- Abuse and neglect impair the prefrontal cortex, the part of the brain that controls executive functioning, which includes the ability to focus, plan, organize, to remember details, manage time & attention, to initiate and complete complex tasks, and to persevere through challenges.
- Children in stressful environments find it harder to concentrate, sit still, follow directions, or rebound from disappointment.
- Often these manifestations of trauma are often misinterpreted as "bad behavior" or medicated as Attention Deficit Hyperactivity Disorder (ADHD).

Social and Emotional Domains

- These are the domains that encompass interactions with other people and social groups. Although they are often overlooked, it is by far one of the most telling and developmentally influential domains in child welfare.
- The earliest social task is attachment. Attachment is the ability to form relationships that are positive and developmentally appropriate.
- It is through relationships that we develop personality traits, self-esteem and a sense of well-being. Well-being is dependent on social-emotional stability and competence.
- Trust and emotional security provide the basis for all relationships. Trust is developed as babies' needs are met. When children feel emotionally secure, they are eager to explore their world and establish relationships & attachments.
- Infants and toddlers depend on adults to help them regulate emotions:
    - provide comfort to help alleviate negative emotions and reinforce positive ones;
    - change the environment to provide a change of pace when needed;
    - help the child label and validate their feelings, for instances, "I know that you are scared, it's OK to be scared and I am right here for you;" and
    - model coping during emotional experiences.

Child Development Stages Matrix

Infants and Toddlers

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
0–3 months	✓ Rapid height & weight gain ✓ Reflexes: sucking, grasping ✓ Lifts head ✓ Responds to sounds by blinking, startling, crying ✓ Shows growing ability to follow objects and to focus	✓ Concerned with satisfaction of needs ✓ Smiles in response to caregiver's voice ✓ Prefers primary caregiver to stranger	✓ From birth, infant begins to "learn" with eyes, ears, hands, etc. ✓ Vocalizes sounds (coos) ✓ Smiles when faces evoke memories of pleasure	• Sucks poorly and feeds slowly • Doesn't follow objects with eyes • Doesn't respond to loud sounds • Doesn't grasp and hold objects • Doesn't smile at the sound of the primary caregiver's voice	✓ Makes eye contact with infant ✓ Interact with infant by talking, smiling, singing, etc. ✓ Gently rocks/bounces infant ✓ Picks infant up when distressed ✓ Allows for self-soothing (infant sucks fingers/pacifier, etc.)
3–6 months	✓ Rolls over ✓ Holds head up when held in sitting position ✓ Lifts knees, makes crawling motions ✓ Reaches for objects	✓ Smiles and laughs socially ✓ Responds to tickling ✓ Begins to distinguish own image in mirror from others' images	✓ Has recognition memory for people, places, and objects ✓ Uses both hands to grasp objects ✓ Exhibits visual interests ✓ Joins with caregiver in paying attention to labeling objects and events (4-6 months)	• Doesn't hold head up • Doesn't coo, make sounds, or smile • Doesn't respond to sounds or turn head to locate sounds • Doesn't roll over in either direction • Not gaining weight	✓ Helps infant "practice" sitting ✓ Encourages floor time on a blanket for rolling and reaching ✓ Responds to fears, cries by holding, talking, and reassuring ✓ Talks and plays with infant
6–12 months 6-12 months	✓ Sits alone ✓ Feeds self finger foods; holds own bottle (6-9 months) ✓ Crawls, pulls up, and walks with support (9-12 months) ✓ Baby teeth begin to emerge	✓ Indicates preference for primary caregivers ✓ May cry when strangers approach (stranger anxiety) ✓ Shows signs of separation anxiety ✓ Repeats performances for attention (9-12 months) ✓ Drops objects on purpose for others to pick up (10-12 months)	✓ Finds objects hidden repeatedly in one place, but not when moved ✓ Plays peek-a-boo ✓ Has recall memory for people, places, and objects (9-12 months) ✓ Imitates speech sounds ✓ Says da-da and ma-ma and knows who these people are (10-12 months) ✓ Uses preverbal gestures to communicate (by 12 months)	• Doesn't smile or demonstrate joy • Unable to sit without support • Does not follow objects with both eyes • Does not actively reach for objects • Doesn't look or react to familiar caregivers • Does not babble • Shows no interest in playing peek-a-boo (by 8 months)	✓ Discipline consists of redirecting to different activity. Sharp discipline, scolding, and verbal persuasion are not helpful ✓ Holds and cuddles baby ✓ Reads to baby ✓ Names objects when baby points to something ✓ Maintains consistent bed time routine of cuddling, rocking, and soothing

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
12–18 months	✓ Walks alone ✓ Manipulates small objects with improved coordination ✓ Drinks from a cup with a lid and uses a spoon ✓ Builds tower of 2 blocks ✓ Removes hat, socks, and shoes	✓ Extends attachment for primary caregivers to the world; seems in love with the world and wants to explore everything ✓ Recognizes image of self in mirrors ✓ Solitary or parallel play ✓ Fears heights, separation, strangers, and surprises	✓ Begins to show intentional behavior, initiates actions (drops, throws, shakes, bangs) ✓ Is curious about everything around him or her ✓ Sorts toys and other objects into groups ✓ Understands object permanence – realizes objects exist when out of sight & will look for them ✓ Says first words (mama, dada, doggie, bye-bye)	• Doesn't respond to name • Unable to finger feed • Not gaining weight • Flat affect (no smiling) • Not interested in play such as peek-a-boo • Not taking steps • Cannot hold spoon • Doesn't look at pictures in book	✓ Encourages exploration ✓ Applauds child's efforts ✓ Interprets new/unfamiliar situations ✓ Talks to child in simple clear language about things going on in the environment
18–24 months	✓ Runs and walks up steps ✓ Can help get undressed ✓ Drinks from a cup ✓ Eats with a spoon ✓ Scribbles spontaneously ✓ Loves to practice new skills ✓ Makes tower of 4 blocks	✓ Likes to hand things to others as play ✓ May have temper tantrums ✓ Shows affection to familiar people ✓ Plays simple pretend, such as feeding a doll ✓ Explores alone but with caregiver close by	✓ Begins to make two-word combinations that mean something ✓ Imitates words readily and understands a lot more that he or she can say ✓ Shows memory improvements, understand cause and effect; experiments to see what will happen ✓ Begins to sort shapes and colors	• Cannot walk • Does not speak at least 6 words • Does not imitate actions or words • Cannot push a wheeled toy • Does not follow simple instructions • Doesn't notice or mind when a caregiver leaves or returns	✓ Provides opportunities to choose ✓ Sets appropriate limits ✓ Assists child in coping with range of emotions ✓ Support new friendships and experiences ✓ Responds to wanted behaviors more than disciplining unwanted behaviors

Pre-School

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
2–3 years	✓ Has developed sufficient muscle control for toilet training ✓ Is highly mobile – skills are refined ✓ Uses spoon to feed self ✓ Throws and kicks a ball ✓ Disassembles simple objects and puts them back together ✓ Has refined eye-hand coordination-can do simple puzzles, string beads, stack blocks	✓ Has great difficulty sharing ✓ Has strong urges and desires, but is developing ability to exert self-control ✓ Wants to please parents but sometimes has difficulty containing impulses ✓ Displays affection – especially for caregiver ✓ Initiates own play activity and occupies self ✓ Is able to communicate and converse ✓ Begins to show interest In peers	✓ Is capable of thinking before acting ✓ Explores language ability – becomes very verbal ✓ Enjoys talking to self and others ✓ Loves to pretend and to imitate people around him or her ✓ Enjoys creative activities – i.e., block play, art ✓ Thinks through and solves problems in head before acting (has moved beyond action-bound stage)	• Cannot run, jump, or hop • Cannot feed self with spoon • Does not speak in simple sentences that use normal word order • Does not enjoy make-believe games • Does not spontaneously show affection for familiar playmates • Does not express a wide range of emotions • Does not separate easily from primary caregiver • Does not object to major changes in routine	✓ Provides opportunities for child to make choices ✓ Encourages independence and provides guidance with self-care (dressing, hand washing, etc.) ✓ Sings, plays, and dances with child ✓ Counts objects and identifies colors with child ✓ Encourages creativity

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
3–4 years	✓ Continues to run, jump, throw, and catch with better coordination ✓ Walks up and down stairs, one foot on each step ✓ Rides tricycle ✓ Uses scissors ✓ Can button and lace ✓ Eats and dresses by self with supervision ✓ Uses toilet or potty chair; bladder and bowel control are usually established	✓ Emotional self-regulation improves ✓ Understands taking turns and sharing ✓ Self-conscious emotions become more common ✓ Forms first friendships ✓ Shows concerns for a crying friend ✓ May get upset with major changes in routine	✓ Asks “why” questions – believes there is a reason for everything and he or she wants to know it ✓ Engages actively in symbolic play – has strong fantasy life, loves to imitate and role-play ✓ Speech can be understood by others ✓ Should be able to say about 500 to 900 words ✓ Understands some number concepts ✓ Converses and reasons ✓ Is interested in letters ✓ Scribbles in a more controlled way – is able to draw circles, recognizable objects	• Falls down a lot or has trouble with stairs • Drools or has very unclear speech • Doesn’t use sentences of more than three words • Can’t work simple toys (such as peg boards, simple puzzles, turning handle) • Doesn’t make eye contact • Doesn’t play pretend or make-believe • Doesn’t want to play with other children or with toys • Lashes out without any self-control when angry or upset	✓ Provides a sense of security by maintaining household routines and schedules ✓ Supports child’s need for gradual transitioning. *Example:* Provides warning of changes so child has time to shift gears: "We're leaving in 10 minutes” ✓ Points out colors and numbers in the course of everyday conversation ✓ Encourages independent activity to build self-reliance. ✓ Provides lots of sensory experiences for learning and developing coordination — sand, mud, finger paints, puzzles ✓ Reads and sings and talks to build vocabulary

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
4–6 years	✓ Has refined muscle development and is better coordinated, so that he or she can learn new skills ✓ Has improved finger dexterity – ties shoes; draws more complex picture; writes name ✓ Climbs, hops, skips, and likes to do stunts. Gross motor skills increase in speed and endurance	✓ Plays cooperatively with peers ✓ Enhanced capacity to share and take turns ✓ Recognizes ethnic and sexual identification ✓ Displays independence ✓ Protects self and stands up for rights ✓ Identifies with parents and likes to imitate them ✓ Often has “best friends” ✓ Likes to show adults what he or she can do ✓ Continually forming new images of self-based on how others view him or her	✓ Is developing longer attention span ✓ Understands cause and effect relationships ✓ Engages in more dramatic play and is closer to reality, pays attention to details ✓ Is developing increasingly more complex and versatile language skills ✓ Expresses ideas, asks questions, engages in discussions ✓ Speaks clearly ✓ Is able to draw representative pictures ✓ Knows and can name members of family and friends ✓ Increased understanding of time	• Poor muscle tone, motor coordination • Poor pronunciation, incomplete sentences • Cognitive delays; inability to concentrate • Cannot play cooperatively; lack curiosity, absent imaginative and fantasy play • Social immaturity: unable to share or negotiate with peers; overly bossy, aggressive, competitive • Attachment problems: overly clingy, superficial attachments, show little distress or over-react when separated from caregiver • Excessively fearful, anxious, night terrors • Lack impulse control, little ability to delay gratification • Exaggerated response (tantrums, aggression) to even mild stressors • Enuresis, encopresis, self-stimulating behavior – rocking, head-banging	✓ Encourages exploration ✓ Applauds child’s efforts ✓ Interprets new/unfamiliar situations ✓ Reinforces good behavior and achievements ✓ Encourages child to express feelings and emotions ✓ Encourages physical activity with supervision ✓ Gives child chances to make choices ✓ Uses time-out for behavior that is not acceptable

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
6-9 Year	✓ Gradual replacement of primary teeth by permanent teeth throughout middle childhood ✓ Fine motor skills: writing becomes smaller and more legible; drawings become more organized and detailed and start to include some depth ✓ Gross motor skills: can dress and undress alone; Organized games with rough-and-tumble play become more common	✓ May have a special friend ✓ Likes action on television ✓ Enjoys books and stories ✓ May argue with other children but shows cooperation in play with a particular friend ✓ Self-concept includes identifying own personality traits and comparing self with others ✓ Becomes more responsible and independent ✓ Still obeys adults to avoid trouble ✓ Can adapt ideas about fairness to fit varied situations	✓ Thought becomes more logical, helping the child categorize objects and ideas ✓ Can focus on more than one characteristic of concrete objects ✓ Attention becomes more selective and adaptable ✓ Can use rehearsal and organization as memory strategies ✓ Emotional intelligence is developing: self-awareness and understanding of own feelings; empathy for the feelings of others; regulation of emotion; delaying gratification ✓ Vocabulary increases rapidly ✓ Makes the transition from "learning to read" to "reading to learn" ✓ Carries on long conversations	These indicators may be present for any child in the early adolescent range (6-11 years) • Low self-esteem • Acts sad much of the time • Acts nervous much of the time • Aggressive much of the time (hits, fights, curses, breaks or throws objects) • Exhibits poor control over impulses • Has difficulty concentrating or sitting still • Scapegoated or ignored by other children • Poor grades • Does not respond to positive attention and praise • Seeks adult approval and attention excessively • does not turn to adults for help or comfort	• Shows affection for child; recognizes accomplishments • Helps child develop a sense of responsibility – asks child to help with household tasks such as setting the table • Talks with child about school, friends, and things to look forward to in the future • Encourages child to think about consequences before acting • Makes clear rules and sticks to them • Engages in fun activities together • Praises child for good behavior • Supports child in takin on new challenges • Gets involved in child's school

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
9–11 Years	✓ Girls' adolescent growth spurt begins ✓ Gross motor skills are better coordinated (running, jumping, throwing and catching, kicking, batting, and dribbling) ✓ Reaction time improves, which contributes to motor skill development ✓ Fine motor skills improve; depth cues evident in drawings through diagonal placement, overlapping objects, and converging lines	✓ Self-esteem rises ✓ Distinguishes between effort and luck as causes of successes and failures; can become critical of others quickly ✓ Has adaptive set of strategies for regulating emotion ✓ Peer groups emerge ✓ Friendships are based on the pleasure of sharing through activities or time spent together ✓ Sibling rivalry tends to increase	✓ Planning improves ✓ Can apply several memory strategies at once ✓ Long-term knowledge base grows in size and organization ✓ Improves in cognitive self-regulation (monitoring and directing progress toward a goal) ✓ Grasps double meanings of words as reflected in comprehension of metaphors and humor ✓ Improved understanding of complex grammatical constructions ✓ Conversational strategies become more refined	**6–11 years, continued** • Suspicious and mistrustful of adults • Little frustration tolerance; difficult to engage and keep interested in goal directed activity • Cannot adapt behavior to different social settings • Does not understand that a person's identity remains the same regardless of outward changes (e.g., costume) • Cannot understand concepts of space, time, and dimension • Can't differentiate real from pretend • Can't understand the difference between behavior and intent (breaking a lamp is equally bad regardless of whether on purpose or an accident)	• Helps child develop own sense of right and wrong. Talks with child about risky things, peer pressure, etc. • Encourages child to respect other people • Spends quality time listening to child and talking about accomplishments and possible challenges • Talks with child about normal physical and emotional changes of puberty • Is affectionate and honest with child.

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
11–15 Years	✓ Period of rapid skeletal and sexual maturation ✓ Preoccupation with body image ✓ Acne may appear ✓ Boys ahead of girls in endurance and muscular strength ✓ Rapid growth may mean large appetite but less energy ✓ There is a wide variation in beginning and completion of puberty (body hair, increased perspiration and oil production in hair and skin. Girls: breast and hip development, onset of menstruation. Boys: growth in testicles and penis, wet dreams, deepening of voice) ✓ Increased possibility of acting on sexual desires	✓ Critical of adults; annoyed by younger siblings; obnoxious to live with ✓ Wants unreasonable independence ✓ Dramatizes and exaggerates own positions; has many fears, worries, and tears ✓ Resists any show of affection ✓ Often moody; anger is common; resents being told what to do; rebels at routines ✓ Intense interest in teams and organized, competitive games; considers membership in clubs important; has whole gang of friends ✓ Girls show more interest in opposite sex than boys do ✓ Recognizes that differences exist between and within groups ✓ May experience prejudice, discrimination, or bias due to ethnicity or poverty	✓ Thrives on arguments and discussions; challenges adults ✓ Increasingly able to memorize, think logically; engage in introspection ✓ Can plan realistically for the future; may have interest in earning money ✓ Is critical of own artistic products ✓ Interested in world and community; may read a great deal ✓ Needs to feel important and believe in something ✓ Social cognition: o Belief in an imaginary audience, that others are as preoccupied with one as oneself is (e.g., "everyone is looking at me") o Personal fable – belief in personal uniqueness (e.g., "no one understands me") and belief that self is invulnerable ("I won't get hurt") ✓ Able to understand other points of view, but tends to be egocentric	• By end of period, physically immature, small, not showing signs of puberty or secondary sex characteristics (wide range here; girls mature earlier) • Poor motor skills, coordination • Lack of peer group relationships and identification with peers • Can't think hypothetically; doesn't consider consequences of actions • Can't put him/herself in place of another; doesn't consider how behavior affects others • Difficulty problem solving; doesn't work through systematically and weigh solutions • Poor school performance • Doesn't reject or question parental standards and express self through clothes, hair, and other lifestyle choices • Poor self-esteem • Emotional and behavioral problems • (anxiety, depression, withdrawal, aggression, lack of impulse control, anti-social behavior) • Withdrawal from friends and from activities once enjoyed • Changes in eating and sleeping habits • Abuse of alcohol or drug	• Shows affection for child; recognizes accomplishments • Helps child develop a sense of responsibility – asks child to help with household tasks such as setting the table • Talks with child about school, friends, and things to look forward to in the future • Encourages child to think about consequences before acting • Makes clear rules and sticks to them • Engages in fun activities together • Praises child for good behavior • Supports child in takin on new challenges • Gets involved in child's school

	Physical	Socio-Emotional	Cognitive	Indicators of Developmental Concern	Positive Parenting Characteristics
15-21 Years	✓ Preoccupation with body image (continues through adolescence) ✓ Late maturing girls (by 10th grade) are more satisfied with their body image than early maturing girls ✓ Completed physical maturation ✓ Physical features are shaped and defined ✓ Probability of acting on sexual desires increases	✓ Relationships with parents range from friendly to hostile ✓ Usually has many friends and few confidants ✓ Worries about failure ✓ May appear moody, angry, lonely, impulsive, self-centered, confused, and stubborn ✓ Has conflicting feelings about dependence and independence ✓ Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds ✓ Interest in forming romantic relationships part of separation task; implies separation from family ✓ Cultural differences may cause conflict	✓ May lack information or self-assurance about personal skills and abilities ✓ Continuing formal operational thought with abstract, idealistic, logical, hypothetical-deductive reasoning, complex problem solving, and critical thinking ✓ May enjoy debating and arguing ✓ Has a strong sense of awareness ✓ May be judgmental of adults or peers if they do not do what is "fair" ✓ Seriously concerned about the future ✓ Beginning to integrate knowledge leading to decisions about future	• Physically immature, small, not showing signs of puberty or secondary sex characteristics • Unable to form or maintain satisfactory relationships with peers • Can't put him/herself in place of another; doesn't consider how behavior affects others • Poor self-esteem / guilt • Overcompensates for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self • Engages in self-defeating, testing, and aggressive, antisocial, or impulsive behavior • Lacks capacity to manage intense emotions; moods change frequently and inconsistently • Has emotional disturbances: depression, anxiety, post-traumatic stress disorder, attachment problems, conduct disorders	• Recognizes and compliments physical maturity • Provides accurate information on consequences of sexual activity • Tries not to pry; but is available to talk and listen • Maintains positive relationship by being respectful and friendly • Accepts feelings; doesn't overreact and avoids disapproval • Recognizes and accepts current level of interest in opposite sex • Encourages experiences with a variety of people (e.g., older, younger, different cultures) o Encourages talking about and planning for future

Adapted from One or More of the Following Sources: Chadwick Trauma-Informed Systems Project. (2013). Guidelines for Applying a Trauma Lens to a Child Welfare Practice Model (1st ed.). San Diego, CA: Chadwick Center for Children and Families; Reducing the Trauma of Investigation, Removal and Initial Out-of-Home Placement Project. (2008-2009). Trauma Informed Practice Strategies for Caseworkers. Portland State University, Center for Improvement of Child and Family Services; Child Welfare Trauma Training Toolkit. (2013). The National Child Traumatic Stress Network; Child and Adolescent Development Resource Book. (2005). The Pennsylvania Child Welfare Training Program. University of Pittsburgh, School of Social Work: Florida State University, Center for Prevention and Early Intervention. www.cpeip.fsu.edu; John Hopkins University; http://www.hopkinsmedicine.org/healthlibrary/conditions/pediatrics/your_childs_growth_and_development_85,P01019/; Centers for Disease Control and Prevention. http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Activity: 0 – 36 Months Old

Directions: Read the scenarios and assess each child's development along each developmental domain (Physical, Cognitive and Social-Emotional). Write out your assessment under each scenario.

Scenario 1

You conduct an initial home visit where you observe a 3 month-old-female resting in her car seat in the closet in her bedroom. The mother reported that when the child cries, she places her daughter in her car seat and straps her in and places her in the dark closet because her daughter likes it in there and she sleeps better in a dark room. When you ask the mother to change the child's diaper, you observe no rashes or obvious bruising. The back of her head is somewhat flat, but the mother reported that her head was that way when she was born. The mother described that she breastfeeds the child but was unable to provide how often or the average number of diapers she uses daily. The child's birth weight was 7.5 lbs. and the mother reported that her daughter's current weight is 15 lbs. The mother stated that the child doesn't cry. You observe the child moving her arms and legs. When the child did cry, she was placed in a swing and calmed quickly.

Answer:

Scenario 2

Emma is a 3-year-old child with cerebral palsy who is found lying in a crib on every visit. You have conducted 5 home visits at various times of the day, scheduled and unannounced. The child always presents as clean and well-fed. She has supplies that are needed, which include a specialized wheelchair with straps to hold her body straight up, a stroller with straps, other accommodations to assist with her posture, but when asked, the parents do not demonstrate knowledge of how to use them, which leads you to believe the child is left in her crib for extended periods of time. They tell you that when they go anywhere, they just pick her up and carry her. When you enter the room, the child exhibits movements by kicking her legs and waving her arms; she turns her head to the person entering and vocalizes noises; she responds to her name and to simple interactions. The parents report that she is non-verbal, does not feed herself; she does not hold a cup or mimic simple actions.

Answers:

Scenario 3

Six-month-old who is 5 lbs. over his birth weight. During visit, child was crying but there were no visible tears. His skin was not responsive to pinch but the parents reported regular feeding and sleep schedule. They demonstrated bottle making and explained that because formula is so expensive, they make it last longer by adding more water and putting one less tablespoon in the bottle. They reported that they feed him 3 times a day. The child was not able to sit unaided and the parents reported he only just started to roll over. He appeared to know his mother and father and quieted when held. He used only one of his hands to grasp a toy when presented to him.

Answer:

Scenario 4

After visiting her 7-year-old sister at school, you conduct a home visit and observe a 3-year-old with two black eyes, head lice, and in filthy clothing. She appeared to be within normal limits for weight and height, although on the lighter side of the scale. The child is reported to be potty-trained, however she was in urine-and feces-saturated diaper. When talking with her, she was able to tell you her name, the name of her sibling, and her age. She did not know any letters of the alphabet, any of the eight standard colors or any basic shapes. Her mother is a stay-at-home parent. There were a number of curdled bottles of milk in the kitchen and the home was in complete disarray except for the mother's room, which was set up as a gaming room where the mother acknowledged she spent the majority of her day. She informed you that she gets frustrated when she is in the middle of a game and she has to stop to feed or change her daughter, saying "but I do it." The mother said that when she is gaming, her 3-year-old daughter usually just watches television or stays in her room.

Answer:

Scenario 5

James, a 2-year-old child, was observed to be within typical limits for height and weight given age. Upon entering the home, he was climbing the stairs. In the living room was a Duplo Lego set and several structures that the mother noted the child had just built. Several books lie strewn about the floor and when the child returned downstairs, he sat on the floor and, began to “read” one of the books. The mother reported that he is potty-training and only has accidents during the night. The child was observed spontaneously approaching and hugging his mother during the interview, and when he climbed on a chair to get something off of the table, the mother sternly got his attention and redirected him to his play area.

Answer:

In the table below, find information related to each scenario's child development stages as indicated in the narratives. For each portion of the narrative on the left, the related developmental stage indicator is on the right.

Narrative Information	Stage	Assessment	Stage
Scenario 1		☐Within typical limits ☐Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 2		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 3		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 4		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 5		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	

Preschool Period

- The preschool period is known as the 'play age.'
- This is when children who have had positive experiences in their lives will tend to step out and initiate activities.
- They will display great imaginations and start to play in a cooperative manner.
- They can easily transition from leader to follower.
- During this period, children develop a conscience.

Social-Emotional Development during the First Five Years

- During the first five years, we become socially-emotionally competent if we are parented in a loving and consistent manner.
- Social-emotional competence means that even as young children we can manage our interactions with our parents/caregivers, siblings and friends and we can regulate our emotions in a developmentally appropriate manner.
- Social-emotional competence or incompetence is ingrained and habituated. In other words, it is firmly established, even at an early age, and is difficult to change.
- It sets the foundation for all future relationships, including school-based relationships and functioning.
- It is directly tied to brain development, physical development and cognitive development.
- Neglectful or abusive relationships interfere with social and emotional development.
- First relationships set the foundation for future relationships.
- Failure to meet basic needs lead to mistrust and an inability to form close and secure social relationships.
- Lack of emotional security makes children fearful to explore their world.
- Abusive or non-responsive relationships impair the child's ability to experience, regulate and express emotions.
- Children learn by imitation - smiling back to happy parents, or learning a flat dull affect if parents are non-responsive or depressed, or learning to avoid angry interactions.
- These stressful interactions become toxic without the buffering of responsive, caring adults.
- Excessive cortisol disrupts developing brain circuits, making it hard to calm down and apply other skills in self-regulation.

Activity: 3-6 Years Old

Directions: Read the scenarios and assess each child's development along each developmental domain (Physical, Cognitive and Social-Emotional). Write out your assessment under each scenario.

Scenario 1

James is a 4-year-old who does not attend a formal Pre-K education program. He has a 6-year-old sibling and a 2 year old sibling. James' favorite thing to do is color. While you were visiting, he engaged you in trying to sit with him on the floor and to play the "hopping" game and red light/green light. You both took turns being the traffic light, and he took you to his room to see his toys. When his mother asked him to grab a diaper and wipes for his sister, he cooperated and retrieved the requested items. His verbal skills were excellent and he shared several stories about his siblings and a recent holiday trip.

Answer:

Scenario 2

Josh is a 5-year-old child who was interviewed and observed at home. He has an older sibling in the 6th grade. His mother was reported to be depressed and not managing her self-care or personal hygiene. Upon arriving, the child welfare professional attempted to engage Josh in rapport-building, but he appeared not to hear. Josh was distant and disengaged and sat on the floor the whole visit, putting his toy cars in a straight line, readjusting them and reorganizing them by color. His mother reported that he does not like to be disturbed, so she leaves him to play on his own. She reported he does not have peer-aged interaction, except with his sibling and even then it is distant since Josh prefers solitude. Josh's mother believes Josh is just a quiet child. She is looking forward to his starting kindergarten next year so he can have more social interaction. Josh is verbal, though not by direct observation. The mother denied any diagnosis for herself or Josh.

Answer:

Scenario 3

Sam is a 4-year-old child who was diagnosed as a drug-exposed infant to methamphetamine and crack at birth. He is an active child and goes from one activity to another quickly. He climbed on furniture and ran up and down the stairs during the home visit. When Sam's mother would correct his behavior by yelling or talking to him, Sam would immediately mimic his mother and repeat back to her what she said in the manner in which she said it. At random times during the interview, Sam would throw items across the room for attention. At one point during the interview, Sam went into the kitchen and spilled a whole box of cereal on the table and floor, then began running through it and throwing it up like confetti. Sam is potty-trained, and his mother stated that he does not enjoy reading. She said he will sit for a few minutes and color, but he prefers to watch television or play video games.

Answer:

Scenario 4

Bobby is a 6-year-old emerging Kindergartener. While visiting the home, the child welfare professional noted that Bobby was easily frustrated and, when frustrated, he would engage in banging his head. He would either hit himself in the head with significant force or bang his head against the wall or table. When putting together a puzzle at the table, Bobby became frustrated, began yelling at the puzzle and started hitting himself in the face and about the head. He scattered the pieces off the table and began crying. His mother was able to help him calm down by talking calmly to him and holding his hands. Then together they cleaned up the strewn puzzle. Bobby was able to answer questions, but did not readily converse. He recognized letters of the alphabet, basic shapes and standard colors. He recited the names of his family members and pet dog, but his affect was flat.

Answer:

Narrative Information	Stage	Assessment	Stage
Scenario 1		☐Within typical limits ☐Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 2		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 3		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 4		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	

Developmental Stages – School Age

- School age = 6 to 12 years old, when school becomes a very important aspect of the child's life.
- Children are exposed to new demands socially as well as academically.
- From a social-emotional standpoint, children who are successful in school feel competent and those who experience failure feel inferior.
- As we move forward in the developmental stages, you will see that we begin to master the previous physical milestones.
- In addition, thought process becomes more refined.
- For most children, this period will be a pretty calm and enjoyable period, if the foundation was set in infancy and early childhood.
- From ages 6-8, school gives children more contact with the larger world, so they begin to develop:
    - Independence from family
    - Unique personalities
    - Important friendships
    - Confidence in schoolwork and sports.
- Children ages 9-11 experience:
    - Growing independence
    - Peer pressure
    - Physical changes of puberty, especially for girls.
- Concerns for a child in this age range would include:
    - Excessive concerns
    - about competition
    - Extreme rebellion
    - Teasing, whining
    - Extreme procrastination
    - Overdependence on caregivers for tasks, e.g., combing hair, going to the store, tying shoes, finding a restroom
    - Social isolation; lack of friend or involvements
    - Inappropriate relationships with "older" people.

Activity: 6-12 Years Old

Directions: Read the scenarios and assess each child's development along each developmental domain (Physical, Cognitive and Social-Emotional). Write out your assessment under each scenario.

Scenario 1
Sadie is a 12-year-old 6th grader. She was observed wearing all black and said she liked the gothic look because it showed what she feels inside. This is a relatively new 'look' for Sadie based on reports from school and her mother, and is believed to be tied to how her new boyfriend dresses and the peer group with whom they are interacting. Sadie indicated she had a new boyfriend who is 18-years-old and that she had been sexually active for several years. She met her boyfriend at the mall, and they spend hours texting when they are not together. Records indicated that Sadie was sexually abused by her mother's boyfriend from ages 4-11. The mother was protective, and Sadie was never removed from her mother's care. Sadie and her mother do not get along, and Sadie said that is because her mother tries to put too many rules and restrictions on Sadie and does not like Sadie's boyfriend. Sadie's grades were above average until about 5 months ago. Sadie denied drug use but her mother is concerned that Sadie and her boyfriend are smoking marijuana. When she brings it up with Sadie, Sadie becomes irate and starts hitting her mother and cursing at her.

Answer:

Scenario 2
Max is a 12-year-old 7th-grader who excels in academics and sports. He is a well-rounded athlete playing baseball, soccer and football. His mother died when he was 5-years-old. His father was a college athlete, and he expects Max to be the best. Max worries that he is never good enough at anything he does because, despite doing his best, his father is always correcting him. His dad will praise him publicly, but recently has started to yell or correct Max's 'mistakes' during games. Max has several friends who come over to his house to play or hang out. When his friends are over, they usually go to his room to play video games and drink alcohol. Max had his first drink when he was 8-years-old and now has a drink before he goes to school and gets drunk at least once during the weekend. Max has started cutting himself on his legs. He said it is interesting to see the yellow fat, and he stops cutting when he sees it. He was observed with 9 straight lines of cuts on the inside of his calf.

Answer:

Scenario 3

Jake is an 11-year-old, 3rd-grader in special education classes. He does not have a formal diagnosis, but his family describes that "he will never have a typical life, will never be able to live on his own or have a family of his own." He has demonstrated gross motor skills and can walk and run, but his run is slow, awkward and disjointed. He cannot easily throw a ball and does not engage well with others. He has some verbal skills but does not hold a conversation. If he is asked to do things, such as pick up his clothes or brush his teeth, he does not appear to know or understand what you are saying; he must be shown the activity and will imitate what he is shown. He enjoys watching preschool television shows and recognizes basic shapes and colors. His family and school have special accommodations in the home and classroom to meet the child's needs. The parents were involved in support groups but no longer attend. They are not interested in services and resent you being called to their home.

Answer:

Scenario 4

Meg is an 8-year-old, 2nd-grader. She has significant absences from school and is often seen riding her bicycle in the neighborhood throughout the school day. When you meet Meg, she immediately hugs you, holds your hand while walking and wants to sit in your lap when you sit together to talk. DCF records indicate that Meg's mother has a history of allegations of illicit drug use and there was one report alleging sexual abuse of Meg by the mother and her boyfriend. The report indicated that Meg's mother was prostituting her daughter at a local daily motel for a six-pack of beer and that the mother's boyfriend asked the mother if he could have sex with Meg for his birthday. It was unknown what the mother's response was to her boyfriend related to his request. Meg is always dirty and appears unkempt and 'on her own' day and night.

Answer:

Narrative Information	Stage	Assessment	Stage
Scenario 1		☐Within typical limits ☐Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 2		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 3		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 4		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	

Activity: 13-18 Years Old

Directions: Read the scenarios and assess each child's development along each developmental domain (Physical, Cognitive and Social-Emotional). Write out your assessment under each scenario.

Scenario 1
Eric is a 15-year-old high school freshman. He has failed 6th grade, and 8th grade, and is at serious risk of being held back as a freshman due to excessive truancy and failure to meet minimum education standards in testing. Eric hates school and refuses to get up in the morning to go. His parents stated that they have tried to get him to go, pleading with him, turning on lights, buying alarm clocks and "doing everything we can to make him go but he won't." Both of Eric's parents are high school drop-outs and are receiving public financial and food program assistance. His parents are saying all of the right things about truancy, court compliance and efforts to support and assist their son. They blame the child for not waking and stated they feel helpless because they can't force him to go. The mother told you she has dis-enrolled Eric from school and has him enrolled in home-schooling. When asked to view the curriculum, she told you she could not locate it because the computer was down. Both parents had a long history with illicit drug use, but deny any current use. Eric spends most of his day sleeping, watching TV or playing video games with his 18-and 20- year old siblings. His 20-year-old brother was recently released from jail on charges of theft, and Eric was recently arrested for vandalizing a convenience store and stealing a car. Eric is charismatic and converses easily and readily with the child welfare professional. Eric admits to smoking marijuana and some methamphetamine occasionally but is adamant it does not influence his decisions or "make me do stupid stuff."

Answer:

Scenario 2
Martha is a 17-year-old high school junior who relocated from India several years ago. Her family is traditional in Indian culture and religious practices. She recently learned that she is pregnant. She has not disclosed that information to her parents but believes she is about 4 months along in her pregnancy. She has not received any prenatal care, has no experience with caring for younger siblings or children, and is planning to raise her child. Martha has always been a good student in school and had plans to go to college to become a nurse after high school. She is a high school soccer player, and her season just ended. Martha is not sure who the father of her baby is as she has had a number of sexual partners, none of whom she considers she is in a relationship with. Martha has several close, meaningful friends in whom she confides and seeks advice. Martha is afraid to tell her parents because she is certain they will disown her as she has embarrassed the family and soiled her purity by getting pregnant out of wedlock. Her parents have threatened to send her back to India to reside with extended family if she ever brings shame to them.

Answer:

Scenario 3
Aaron is a 16-year-old habitual runaway. Aaron has been in the child protection system since he was 4- years-old and in the foster care system since he was 11-years-old. He was sexually abused by his father and several of his father's acquaintances for years. His mother abandoned him and his father when he was an infant. His father also frequently had women over and would pay them to have sex with Aaron starting at age 9. His father would watch these encounters, often masturbating while Aaron and the adult female would engage in sexual interactions, and he would correct Aaron's 'technique.' Aaron's father began masturbating Aaron and encouraging him to watch pornography so he could become a 'real man.' On several occasions, Aaron's father would force Aaron to perform oral sex on him while they watched pornographic movies. Aaron was removed from his father's care when his father was arrested for physically abusing Aaron. While in therapy, Aaron began disclosing the horrendous abuse he suffered. Aaron has difficulty forming relationships and had a number of failed placements given some challenging behaviors such as urinating in

the refrigerator, masturbating in public areas of the home, uncleanliness and general hygiene. Aaron built a website when he was 13 and started selling sex. Aaron has been prostituting himself and has been arrested several times and returned to his foster home. On average, Aaron has approximately 10 runaway episodes a month. Aaron denies depression, denies poor self-esteem and demonstrates that he thinks very highly of himself, of his intelligence and of his attractiveness. He said he sees no problem in what he is doing and says he is not hurting anyone.

Answer:

Narrative Information	Stage	Assessment	Stage
Scenario 1		☐Within typical limits ☐Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 2		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	
Scenario 3		☐Within typical limits ☐ Not within typical limits – parents managing ☐ Not within typical limits – parents not managing; needs attention	

Unit 3.2: Child Attachment Permanency and Well-Being

Nurturing, Attachment and Permanency

- The importance of nurturing and attachment is paramount to effective child welfare practice and ensuring that children are safe and that their well-being is attended to.

- Young children experience the world as an "environment of relationships." Given their total dependency on others, they look to their caregivers to meet all of their basic care needs.

- Infants have a fundamental need to interact with their caregiver. The quality and stability of these early relationships affects all aspects of child development.

- Children who have healthy relationships with their primary caregivers are more likely to develop the ability to interact in appropriate and healthy ways with other adults and their peers.

- Relationships with peers and adults are important to school adjustment, and the ability to learn in school.

Stability and Permanency

- "Although young children certainly can establish healthy relationships with more than one or two adults, prolonged separations from familiar caregivers and repeated 'detaching' and 're-attaching' to people who matter are emotionally distressing and can lead to enduring problems." (*Young Children Develop in an Environment of Relationship*s, The National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University)
- While removing a child may be essential in order to achieve immediate child safety, paying attention to who the child is emotionally attached to is imperative.
- Most children, despite the harm they have suffered, are attached to their parent/caregiver. Ongoing visitation, or family time, is imperative to the child's well-being.
- When children are removed from their parents and placed in care, it can also be further damaging to a child to be moved from one home to another.
- Two of the most important performance measures associated with child well-being for the child welfare system are:

- Stability in out-of-home care, meaning no more than two moves
- Achievement of permanency within 12 months of removal (with exceptions possible when parents are making progress).

Three-Tiered Hierarchy of Safety

- **Core Level:**
  - **Physical safety:** a child is not at risk of injury or threats of injury.
- **Second level:**
  - **Social safety:** refers to an interpersonal sense of the child being safe from verbal abuse, verbal threats or teasing.
- **Last level:**
  - **Emotional safety:** you have an internal sense of being safe.

Children must feel safe on all three levels or development will be impacted.

Factors Impacting Protectiveness

- Protective capacities are the personal characteristics that specifically and directly relate to the protection of one's child. There are several factors that may impact a parent's ability to be protective.

- Parenting Model - every parent has an approach to parenting, or a parenting "model." For most people, they have learned to parent based on the way they were brought up. Much of it happens at an unconscious level when we become parents, although many people make conscious choices to do some things differently.

- No matter how functional or dysfunctional they are, most parents/caregivers love their children and believe they are good parents.

- When a child is removed from his home, he is being removed from the only family he's known. That can be traumatic.

Do No Further Harm

- The last factor that impacts child development is separation from the primary caregiver.

- While the system is well-meaning in that it is designed to keep children safe and focuses on child well-being, when children are removed from their homes for their own protection, the reality is that removals can and are detrimental to maintaining the relationship through which the child has experienced the world.

Important Child Relationships

- When we think about attachment, we also have to consider the multiple other significant relationships that a child may have. Considerations should be made beyond the parent or current caregiver.
  - Siblings
  - Relatives
  - Neighborhoods
  - Community
  - Pets
- Breaking attachments will always be traumatic for the child.

Child Well-Being and Permanency

- You must work diligently to keep as many of these relationships intact because it can make a huge difference in stability for the child and reducing stress brought on by being involved in the child welfare system.
- Child well-being refers to the overall health and welfare of a child. It refers to a "biopsychosocial" model in which the child's medical needs, psychological needs, behavioral needs, and social-emotional needs are being met.
- Child well-being also means that the child is in a safe environment that meets the child's developmental needs.
- Permanency means that we work actively and diligently to find a child a permanent home.
- As a child welfare professional, you must rely on your own observations as well as the information you acquire from parents/caregivers, others who know the child and family, and from the child directly.
- Understanding the child development stages will help you build rapport with children and interviewing techniques that are appropriate for children.