Effects of Abuse and Neglect on Child Development (for Caregivers)

Time: 6 hours

Developmental Competencies

- **CCW204-01**: Knows how to advocate and obtain assessments, treatment, and services for children in care for health, mental health, developmental delays, and other issues.
- **CFAM231-01**: Knows how to recognize developmental delays in child development, including those resulting from poverty, trauma, neglect, maltreatment or genetic factors.
- **CFAM231-03**: Understands and recognizes effects of poverty, trauma, and maltreatment and to identify resultant developmental delays.
- **CFAM232-01**: Understands the need to identify and seek services, supports or training available to develop the skills needed to support and help to heal the emotional trauma of children in care.
- **CFAM233-01**: Understands the difference between healthy and unhealthy attachments in children.
- **CFAM234-04**: Knows how to implement and apply non-physical behavior management and discipline techniques: behavioral expectations appropriate for the age, capability, and cultural background of each child.
- **CFAM239-04**: Understands the possible effects of pre-natal exposure to drugs on a child’s development.
- **CFAM239-05**: Knows the signs and behaviors of a child who may have FASD; understands the need to utilize caregiving and behavior management strategies that are appropriate for children affected by fetal alcohol spectrum disorders.
- **CFAM239-15**: Understands the need to teach and mentor children and youth in age appropriate life skills.
- **CFAM331-01**: Able to apply knowledge, skills and advocacy to address childhood developmental concerns.
- **CFAM333-01**: Able to recognize the difference between healthy and unhealthy attachments in children.
- **CFAM333-03**: Able to use nurturing skills to stimulate early learning and development with children in care.
Talking About Competencies

This 6 hour in-service level training for Caregivers explores the principles of child development across the age ranges of birth to three years, three to five years, five to 11 years, and 11 to 18 years. In each age range, factors that affect development across physical, social, emotional, cognitive and reproductive domains, as well as the developmental effects of abuse and neglect on those domains are examined through group discussions, videos, worksheets, and case scenarios. Information is provided about services and resources to support caregiving families and children in the care.

Materials and Preparation

1. Show view projector/computer
2. Computer
3. Internet connection

Handouts

- Section 2 Job Aid – Developmental Milestones from Birth to Five Months
- Section 2 Worksheet – Birth to Three Years Old
- Section 3 Job Aid – Developmental Milestones from Three to Five Years: Preschool
- Section 3 Worksheet – Three to Five Years Old
- Section 3 – Case Scenario Kendra – Part 1
- Section 3 – Case Scenario Kendra – Part 2
- Section 3 – Case Scenario Kendra – An Expert’s Opinion
- Section 4 Job Aid – Developmental Milestones – Five to 11 Years: School Aged
- Section 4 Worksheet- Five to 11 Years
- Section 4 – Case Scenario Jenwei
- Section 4 – Case Scenario Jenwei – An Expert’s Opinion
- Section 5 Job Aid – Developmental Milestones from 11 to 17 Years: Adolescence
- Section 5 Worksheet – 11 to 17 Years
- Section 5 – Guttmacher Report – American Teens’ Sexual and Reproductive Health
- Section 5 – Case Scenario Malcolm
- Section 5 – Case Scenario Malcolm – An Expert’s Opinion

Resources & Videos

- Video: Diversity: Contrasting Perspectives (10 mins): https://vimeo.com/127276780
- Video: Change in the First Five Years (4 mins): https://vimeo.com/127276782
- Video: Understanding the Traumatized Child (9 mins): https://vimeo.com/127276783
### Session Flow

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<td><strong>Effects of Abuse and Neglect on Child Development</strong></td>
<td>In-Class</td>
<td>6 Hours</td>
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<tr>
<td>1</td>
<td><strong>Section 1: Foundational Concepts of Child Development</strong></td>
<td>Video, large group discussions</td>
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<td>2</td>
<td><strong>Section 2: From Birth to Three Years</strong></td>
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<td><strong>Section 3: From Three to Five Years</strong></td>
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<td><strong>Section 4: From Five to 11 Years</strong></td>
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<td>5</td>
<td><strong>Section 5: From 11 to 17 years</strong></td>
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### Classroom Training

**Slide 1**

(<1 min) Good Morning and welcome to today’s training from the Alliance for Child Welfare Excellence. Today we will be training “The Effects of Abuse and Neglect on Child Development (for Caregivers)”
(<1 min) The Alliance for Child Welfare Excellence is the State of Washington’s first statewide partnership aimed at improving the outcomes for children in the child welfare system. This partnership involves the Department of Social and Health Services (DSHS), the University of Washington, Eastern Washington University, the community group Partners for Our Children, and you!

Your feedback has helped shaped this training and we will continue to gather feedback at the end of today’s training.

(<2 mins) First, we want to acknowledge the work of child welfare professionals in our own state and across our country who helped shape and develop this training.

Thanks also to the following people for providing information, review, and expertise:

- Susan J. Astley, Ph.D., Professor of Epidemiology/Pediatrics
- Julie Gelo, BSHS/M, Executive Director NOFAS Washington, Family Advocate FASDPN UW
- Nelly Mbajah MSW, Project Manager Early Childhood Development, Washington State Children’s Administration
- Barb Putnam MSW, LICSW, Supervisor, Well Being and Adolescent Services, Washington State Children’s Administration

Slide 4

(<2 mins, this slide and next)

All trainings created by the Alliance are competency based, meaning, they are crafted from the learners perspective and emphasize information related to WHAT needs to be known and HOW specific tasks or activities are expected to be completed by our caregivers.

Please take a moment to look through today’s competencies on this slide and the next.

Slide 5

(Continued from previous slide)
Today’s training, Effects of Abuse and Neglect on Child Development is a daylong training and contains 5 sections. There will be an introductory section, and then 4 sections where you will learn about typical child development in different age ranges, as well as the effects of abuse and neglect on the development of children in that age range.

Most sections exploring development through an age range will also have several handouts:

- a **Job Aid** to provide you with a summary of typical and atypical development,
- as well as a **Worksheet** to help you process what you’re learning as you go through that section.

The 5 sections for today’s trainings are:

- Section 1: Foundational Concepts of Child Development
- Section 2: From Birth to Three Years
- Section 3: From Three to Five Years
- Section 4: From Five to 11 Years
- Section 5: From 11 to 17 Years

Let’s review a few housekeeping rules before we get started.
(<2 mins)
Before we dive into Section 1, let’s review a few Housekeeping items.

• Restrooms are located here and there. We will have breaks throughout today’s training, but you are welcome to stand up and move around, or go use the restrooms as needed.
• Please set your cell phones to vibrate. The information in today’s training may feel familiar at times and can be pretty technical at other times. We want to respect the learning environment for everyone in the room, so if you do have to take a call, please step out and do so.
  • UNLESS you have an old-school brick phone like this lady, feel free to whip that out at any time. All other cell phones, please set to vibrate or put away.
• Please only 1 person talking at a time
• Any other rules the room wants?
• If you are interested in other trainings for caregivers, or trainings related to Abuse and Neglect, Development, or any other topic, please check out our website at Alliance for child welfare dot org.
• Let’s get started!

Slide 8

(<1 min) Welcome to Section 1: Foundational Concepts of Child Development.

Slide 9
The first section of this training has four parts:
- Principles of Child Development
- Factors That Affect Development
- Developmental Domains
- Developmental Effects of Abuse and Neglect

In Section 1, Part 1, Principles of Child Development we will be covering generally agreed upon principles of child development. Many researchers and psychologists have tackled this subject. We will primarily be pulling information from major theories of child development from the work of Piaget, Erickson, and Kohlberg.

Although there are differing theories around human development, there are five generally agreed upon principles.
- Development is an ongoing process.
- Development is a dynamic process.
- Development is directional.
- Development may involve stages.
- Development is cumulative.

Slide 12

(5 mins) LARGE GROUP DISCUSSION or DISCUSS AMONG TABLES
Let’s take a moment and dig a little deeper about these 5 main principles of Child Development. See whether you can match each developmental principle with its description.
If Large Group – trainer read #1, and ask group which letter corresponds. Repeat through 2-5.
If completed at tables, give the tables 3 mins to complete, and then ask each table to report out on a specific answer.
ANSWERS:
1 – D
2 – A
3 – B
4 – E
5 – C

Slide 13
(<1 min) The major theories of child development center around the work of Piaget, Erickson, and Kohlberg. You are not expected to know these theories at great depth, but we will be pulling out main points from their work in our training today.

Slide 14

(<1 min) In part 2, we will be discussing Factors that Affect Development.

Slide 15

(<2 mins) There are two major categories of factors that contribute to development: Hereditary Factors and Environmental Factors.

Hereditary factors predictably influence development of all human beings, because all human beings have a common genetic structure. The development that results directly from the expression of our shared genetic potential occurs in predictable steps, regardless of environment or culture. Examples of this include early infant motor skills, such as grasping, sitting, crawling, standing and walking. These skills do not have to be taught to a baby; they are the result of our genetic make-up.
Environmental factors may have a positive or negative influence on development. By changing a harmful environment to a nurturing and supportive one, Workers and Caregivers can change a child’s developmental course.

**Slide 16**

![Cultural Differences in Child-Rearing](image)

(<2 mins) The child’s environment is influenced by the culture of the family. Culture is defined as: The total system of values, beliefs, attitudes, traditions, and standards of behavior or codes of conduct which regulate life within a particular group of people.

Research shows that development occurs in similar ways and in similar timeframes across cultures. However, expectations for child development and children’s behavior, as well as parenting patterns, vary among cultures.

A lack of understanding of the cultural context can lead to errors in assessing children and their parents. Workers should provide parenting advice that is consistent with the parents’ cultural practices.

**Slide 17**

![Diversity: Contrasting Perspectives](image)

(10 mins) VIDEO -> Diversity: Contrasting Perspectives [https://vimeo.com/127276780](https://vimeo.com/127276780)
Now let’s watch a 10 minute video, Diversity: Contrasting Perspectives
This video will explore development through different cultural lenses and styles.

Slide 18

(<10 mins) LARGE GROUP DISCUSSION
Allow the group to process the video. Some possible questions or discussion points are on screen.

• What surprised you?
• What do you agree with?
• What don’t you agree with?
• Consider, how does your family view Independence vs Interdependence
• Were you able to shift your views to understand the views of families who held differing beliefs?
  • “If early independence is a primary value then this child is being held back, but, what if it isn’t? Not all families in the United States hold independence as their highest value. In fact, some families believe that babies are born too independent. The goal in these families is to emphasize connections and downplay self-help skills. They feed their children, not only because it is neater, but because it is more important to accept help than to stand on one’s own two feet.”
Part 3: Developmental Domains
In this section we are going to review information about the different developmental domains for humans. There are differing opinions about which domains or how many domains there may be.

For our training today, we will consider four major domains, or areas, of development:
- Social
- Physical,
- Cognitive
- Emotional.

Development in any domain affects, and is affected by, development in all of the other domains.
(<5 mins) Let’s take a moment to review and think about this information. Please take a moment to read the 4 descriptions on the left as well as the 4 developmental domains on the right. I am going to ask you to see whether you can match each developmental domain with its description.

ASK THE GROUP -
1) Includes thinking, perception, and reasoning (D. COGNITIVE DOMAIN)
2) Includes the child’s interaction with others (A. SOCIAL DOMAIN)
3) Consists of the development of the body structure (B. PHYSICAL DOMAIN)
4) Includes the development of personal traits and characteristics (C. EMOTIONAL DOMAIN)

(< 1 min) In Part 4, we will discuss the Developmental Effects of Abuse and Neglect.
Maltreatment sometimes occurs because parents or Caregivers misinterpret the child’s behavior, or have expectations beyond what the child is developmentally capable of. Some maltreatment can be prevented with a basic understanding of child development and milestones.

Understanding typical development helps parents to have appropriate expectations and to use appropriate discipline strategies. Parents who are unaware of typical development may, for example,

- Use physical discipline with an infant who is unable to control or change his or her behavior
- Punish a 5-year-old for “lying” when the child is incapable of consistently separating fact from fantasy
- Become personally insulted and “ground” a teen who would rather spend time with friends than with family

Child maltreatment can result in developmental delays, developmental disabilities, social problems, emotional problems, and behavioral problems.
Workers and Caregivers should recognize early indicators of delays, disabilities, and problems, in order to begin developmental interventions and treatment as early as possible. We will take a greater look at these areas in this training and allow time to discuss resources as well.

**Slide 25**

<1 min> You have now completed the first section of this training and are ready to move on to Section 2 – From Birth to Three Years.

**Slide 26**

<3 mins>
HANDOUT – Section 2 Job Aid  
HANDOUT – Section 2 Worksheet
In this section, you’ll learn more about the development that occurs during the first 3 years of life. First, you’ll learn about typical development in each domain, and then you’ll learn how abuse and neglect impact development.

You will be using a Job Aid and a Worksheet throughout this section and for each section after this. Let’s go ahead and pull those out for Section 2, Birth to Three Years now.
The Job Aid provides you with a summary of typical and atypical development. The Worksheet has questions that will help you process what you’re learning as you go through this section.

**Slide 27**

![Section 2: Main Menu](image)

(<1 min) This section of this training has five parts:
- Typical Physical Development
- Typical Social and Emotional Development
- Typical Cognitive Development
- Developmental Effects of Abuse and Neglect
- Services and Resources

**Slide 28**

![Developmental Tasks](image)

(<3 mins) The task of the toddler is to seek autonomy. **Autonomy** means wanting to do things for oneself, and it is reflected in many of the toddler’s behaviors, from screaming “NO” to insisting on “Me do it”!
If allowed, a toddler will try to dress, wash, and feed himself.
If secure, the toddler will trot off... out the door and down the street, confidently striking out.
Can anyone think of any other ways toddlers seek independence?
- Playing
- Brush teeth
- Put on shoes
- Open cabinets, drawers

**Slide 29**

(<1 min) Let’s get into Part 1 where we will discuss Typical Physical Development.

**Slide 30**

(<1 min) During the first several weeks of life, newborns go through remarkable changes.
- Their eyes become more focused.
- Their movements, which at first appear rough and random, become more refined and coordinated.
- They begin to raise their head and shoulders off of the floor.
- They may begin to smile and imitate or mimic the facial expressions of others.
(<2 mins) Because infants have limited physical control and coordination during the first year of life, it is critical that they have a safe sleep environment that removes the threats of suffocation, asphyxia, and entrapment.

A safe sleep environment includes a firm sleeping surface, free of any blankets, pillows, toys or other soft objects.
There should be nothing but the baby in the bed.
If you are interested in more information about Safe Sleep, check out the Alliance training, *Infant Safety and Care*

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(<3 mins) During the first several months, babies continue to gain control of their bodies:
- They begin to use their arms and shoulders to support their upper body.
- They reach for objects, improving their fine motor control and eye-hand coordination.
- They amuse themselves by playing with their feet, or exploring other parts of their own bodies.
• Infants explore all parts of their bodies -- including their genitals, during diaper changes or in the bath. Some infants will rub themselves, or rock on their stomachs for the pleasurable sensation.

**Slide 33**

(<2 mins) Between 6 and 12 months, babies continue to grow even stronger and they gain more control over their bodies:
• They become well-balanced and stable while sitting.
• They learn to crawl or scoot from one place to another.
• They begin to stand alone, and may begin to walk.

**Slide 34**

(<2 mins) Between 1 and 2 years, fine motor skills, including finger-thumb opposition, become more refined and coordinated.
Babies of this age can routinely finger-feed themselves, and can drink from a cup.
Babies have learned to walk, and may develop more complex motor skills, such as pushing or pulling a toy, throwing a ball, and climbing.
(<1 min) Between 2 and 3 years, babies continue to refine their large motor skills. They learn to walk up stairs using alternating steps, and to jump and land on both feet.

Fine motor skills are also improving, and the child can now turn pages in a book, as well as make scribbles and strokes using pencils and crayons.

Slide 36

(<3 mins) By age three, most children are toilet-trained and able to meet most of their own toileting needs.

Toilet training is one of the most difficult parenting tasks during toddlerhood. Toileting accidents and other problems in toilet training are a common precipitant in the abuse of toddlers.

Toilet-training problems may occur for several reasons:
• The Caregiver begins toilet training before the child is ready and the child, therefore, cannot comply.
• The Caregiver may misinterpret the child's lack of bladder or bowel control as deliberate defiance.
Toilet training may become a battle for control between the parent and the child. If delayed until the child demonstrates readiness to be trained, the toilet-training process will be shorter and less of a struggle for the parent.

Very few children are ready to begin before the age of two. Most children are ready to begin by age 2 1/2.

Slide 37

Part II
Typical Social/Emotional Development

(<1 min) Now that we looked at typical physical development, let’s take a look at typical social/emotional development.

Slide 38

Infant Attachment
Attachment develops over time.
It is:
• Reciprocal
• Strengthened by both the Caretaker’s behaviors and the infant’s positive response
• Visible

(<1 min) The cornerstone of all Social and Emotional Development is the development of attachment. Attachment develops over time, and is reciprocal. Both the Caretaker’s behaviors, and the infant’s positive response to the parent’s behaviors, create and strengthen the attachment between Caretaker and child.
Attachment between a Caretaker and baby is visible in the way the Caretaker holds, cuddles, and responds to the baby's needs.

**Slide 39**

<1 min) Attachment has three components:
- An enduring emotional relationship with a specific person,
- A sense of security, comfort, and pleasure provided by the presence of that person, and
- Intense distress evoked at the loss or threat of loss of that person.

Attachment responses are instinctive between most parents and their infants. However, some parents who never developed strong attachments as infants may have difficulty attaching to their own child.

**Slide 40**

<7 mins) Attachment in infancy is critical to many parts of the baby’s development.
- For starters, **sense of trust.** The infant develops a fundamental sense of trust when provided with security and safety. This has a profound effect on the child’s ability to form and maintain healthy interpersonal relationships throughout life.
- **Language.** Social interaction between infants and Caretakers stimulates communication.
• **Emotional control.** When parents soothe, comfort, and calm their babies, they are helping the child learn to modulate his or her emotions, and control impulses.

• **Social skills.** Social and playful interactions with others promote skills like sharing, cooperation, negotiation, and recognition of emotions.

• **Self-esteem.** Healthy attachment helps develop a healthy self-esteem. When a baby cries and his needs are met, the infant develops a fundamental sense of being loved and valued, as well as a sense of powerfulness – “when I need you, I can make you come to me”.

• **Security.** Proximity to Caretakers reduces stress, and affords a sense of security.

• **Self-reliance and Autonomy.** The secure emotional base derived from healthy attachment promotes exploration, experimentation, and the development of self-confidence and self-reliance.

• **Cognitive skills.** Play, interaction, and appropriate stimulation promote early cognitive development.

Slide 41

(4 mins) One can gain a general sense of the attachment between a child and Caregiver by observing the following:

**CAREGIVER**

• Does the Caregiver accurately recognize the child’s cues of distress and need, and quickly intervene to provide comfort and remove the stress?

• Does the Caregiver provide the child with stimulation and initiate playful social interaction?

• Does the Caregiver provide the child with contact comfort and closeness?

• Does the Caregiver generally enjoy the child’s company?

**CHILD**

• Does the child seek proximity to the Caregiver, and approach the Caregiver for reassurance when distressed, or in need of comfort or reassurance?

• Does the child obtain comfort or reassurance from the Caregiver when needed, and then return to play?

• Does the child generally enjoy the Caregiver’s company?
Healthy attachments lead to healthy development. During the first year, typically-developing babies are very responsive to social stimulation. When something interesting happens, they respond with vigorous physical activity, direct eye contact, big smiles, and loud vocalizations.

As they grow older, their sociability becomes directed toward people to whom they are attached. This may result in separation anxiety when the Caregiver leaves the room, and stranger anxiety when someone else enters the room. These are both a sign of healthy attachment.

Cultural variables may affect children's responses to separation and strangers. A child who is rarely left in the care of others may show greater anxiety with strangers, and may be greatly distressed when separated from the Caregiver.

However, a child who has multiple Caregivers and is often with large groups of people may show little or no distress when separated from the primary Caregiver or when in the presence of strangers.
In 1 to 2 year olds, social development continues to build upon close and affectionate relationships:

- They play simple games, such as Patty Cake, Peek-a-boo, and High Five; and
- They begin to imitate tasks they see performed by those around them.

Between age 2 and 3, the toddler’s play patterns begin to change. Younger children usually engage in “parallel play”, meaning they watch each other play, or play side-by-side with the same toys, but they don't play cooperatively. That transition happens around age 3, where we begin to see interactive play.

Changes in Emotional Development also occur between 2 and 3:

- Children begin to feel pleasure when praised for doing something well, and begin to feel shame when they do not please primary Caregivers.
- Children can recognize distress in others, which is the beginning of empathy.
- However, children are still emotionally impulsive and have not developed internal controls.
• They generally want their own way and respond to frustration with aggression, such as hitting, biting, and temper tantrums.

Cultural factors can affect the way in which the child expresses frustration and aggression. Aggression may be valued as being "tough" and "standing up for yourself", or it may be viewed as a negative attribute that should be suppressed in the interests of cooperation and group cohesion. Therefore, different amounts of aggression may be evident, depending upon the cultural perspectives.

Slide 46

(<1 min) In Part 3, we will discuss Typical Cognitive Development

Slide 47

(<4 mins) Now, let’s watch a video by the Alberta Family Wellness Initiative called “How Brains are Built.”
This short video will help explain brain development, as well as how stress and toxic stress can impact a child’s brain development.
https://vimeo.com/127276781
The brain grows at a very rapid pace while still in the womb. However, the time of fastest growth occurs just after birth, when the brain produces neurons, as well as connections between neurons, in order to lay the foundation for later learning.

The quantity and quality of these neural connectors are the foundation of the brain’s potential to develop intellectual abilities.

Cognitive development is noticeable in very young babies. At just a few weeks old, they can track an object in view as it moves from the periphery of their visual field to the "midline". The midline is an imaginary line that transects the center of the body from head to toe. At this age, babies can track to the midline, but they do not track through the midline to the other side of their visual field.

By about 5 months old, babies have left behind the early grasping reflex of closing their hands around objects and replaced it with purposeful grasping.
Infants in this age range also begin to anticipate events, and may become visibly excited when they see a favorite object or person.

Slide 50

(<1 min) In this age range, a baby shows early problem-solving skills, such as tucking their bottle under their arm so that they can use both hands to pick up a second item, demonstrating an ability to manipulate the environment to solve problems. The baby's activities are purposeful and show a beginning understanding of how to sequence activities to reach the desired end.

In this same age range, babies are attracted to shapes, colors, and textures. Babies this age also repeat the same activity many times in succession. They appear to get pleasure from repetition and mastery. We begin to see the development of attention span.

Slide 51

(<1 min) 1- to 2-year-olds begin to understand and process symbolic thought and language.

- They learn through imitating behaviors, and they can repeat actions with variations.
- They know objects are used for specific purposes.
- They can typically use at least 6 words and speak in 2-3 word sentences.
- They can point to body parts on themselves or a doll.
Children who are 2 to 3 years old can name familiar objects, and understand sequences in putting toys and puzzles together.

Toddlers are working to perfect language skills; they are communicating with others, and are beginning to talk in sentences. They have learned the concepts of "in," "out," "under," and "over".

They are very curious.

In Part IV, we will discuss the Developmental Effects of Abuse and Neglect on Child Development.
HANDOUT – Section 2 Worksheet – Birth to Three Years Old

Let’s take a moment and look at the worksheet for Section 2. Please take a few moments to think about and answer Questions 1 through 3 on your Worksheet. Later on, you’ll have a chance to discuss and revise your answers as necessary with your table.

There are several characteristics that make maltreatment of infants and toddlers more likely.

First off, **infants are demanding**; they require constant attention. Caregivers of newborns experience frequent sleep interruptions, causing them to be chronically tired. This is inherently stressful to even the most competent Caregiver.

**Infants cry and scream**, and this can be extremely distressing to a Caregiver, particularly if the Caregiver is unable to quiet the infant. Infants can have a period of increased crying, peaking somewhere between 2 weeks and 2-4 months and decreasing in the months that follow. This is called the Period of Purple Crying, and it can be very frustrating to Caregivers. It is critical that they receive education on this period of increased crying, as it is part of normal child development. Education typically includes how to soothe the child, how to deal effectively with frustration, and how to avoid shaking the baby. There is also a separate online course that covers additional information on the “Period of PURPLE Crying”.

**Newborns are not very social for the first three or four months.** They demand a lot and give little back. Caregivers should not expect expressions of gratitude or recognition from the infant.

**Caregivers may have difficulty attending to infants who are premature or have medical issues** requiring hospitalization. Sickly or premature infants inherently require more care than...
healthy infants. Additionally, some infants and toddlers can have more challenging temperaments than others, and may be more frustrating to care for. On the other hand, some Caregivers may not provide enough stimulation for babies who are placid, compliant, and easily entertained, since they don’t demand much attention.

Slide 55

(<5 mins) The Caregivers’ perception of the child, and the quality of the caregiving experience also contribute to the likelihood of maltreatment of toddlers:

- Some Caregivers perceive a developmental disability to be a punishment, curse, or terribly unfair burden on the family.
- Caregivers who abuse their children may misinterpret children’s natural curiosity, persistence, high activity, or stubbornness as bad, evil, or irritating.
- Some Caregivers interpret a child’s distress, misbehavior, or developmental or emotional problems as indicators of bad caregiving. This can lead to anxiety and low self-esteem for the Caregiver, as well as lack of appropriate discipline. (Hughes, 2006).
- Some Caregivers are able to care for “easy” children, but not for more difficult children, or can more easily care for certain ages, but not others. Caseworkers should assess the degree to which the Caregiver can adjust his or her caregiving strategies to the particular child.
- The toddler is developing autonomy. Struggles for power and control may develop. Oppositional behaviors can try the patience of even the most knowledgeable and understanding Caregiver.
- As previously discussed, toilet training can be one of the most stressful developmental tasks for both children and Caregivers. Some Caregivers over-discipline their children for mistakes in toilet training. A common injury occurs when Caregivers place their children in scalding water, as a punishment for toileting accident.

Ask the group – Can you think of any other characteristics of toddlers that may make it more likely for maltreatment to occur? What have you seen in your experience?
Infants and toddlers are more susceptible to serious outcomes from maltreatment. Here’s why:

- They cannot protect themselves. They can't run, scream, or go for help. They are dependent and vulnerable, and will die if they are not properly cared for.
- They are often socially isolated, since they are not yet in school.
- Very rapid brain and body growth during the first two years makes infants extremely susceptible to the effects of malnutrition. Developmental delays and growth deficiencies can result.
- Their soft skulls and unprotected bodies are very susceptible to injury.
  - Head injuries easily lead to severe brain damage, and the soft bones of the skull are more likely to fracture from a blow.
  - Muscles are not developed adequately to protect the trunk and abdomen, and blows to this part of the body will cause serious internal injuries.

Next, we are going to watch a 20 minute video from Programs for Parents, called, “A World of Hope”. This video is specifically for caregivers and is about exploring milestones, observations, and how you can make a world of a difference in a struggling child’s life.
- Skills and Milestones to look for
- Identifying children who need extra help
- How to get help for those kids in need

https://vimeo.com/127276404

Slide 58

(3 min)

Use HANDOUT – Section 2 Worksheet.

A child who has suffered from abuse or neglect, will likely be affected in many domains of their development. For example, the infant or toddler may:
- Be physically small or lacking in motor skills,
- Have no interest in other people and a general lack of curiosity,
- Have difficulty regulating their behavior and emotions, and
- Be delayed in speech.

Let’s take 2 minutes to return to your Worksheet and revise your responses to Questions 1 through 3 as necessary.

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(1 min) Complex trauma refers to the pervasive effects of chronic child abuse in young children.
The common characteristics of children suffering from complex trauma include:

- Attachment issues,
- Difficulty regulating emotions,
- Hyper-alertness to perceived danger in the environment, and
- “Flight”, "fight" or "freeze" responses to perceived danger.

This kind of trauma can have long-term negative consequences on the child’s functioning.

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![Fahlberg's Arousal/Relaxation Cycle](image)

(3 mins) Secure attachment is critical to healthy development and recovery from the trauma caused by child maltreatment. Appropriate treatment for attachment issues consists of teaching Caregivers to “attune” to their infant and helping them develop nurturing, supportive, and empathic relationships with their infant. One way to help Caregivers is by teaching them about **Fahlberg’s Arousal/Relaxation Cycle**.

Attachment issues are often related to the breakdown of this cycle. The **cycle is based on our understanding that trust, security, and attachment are built when a consistent, adult Caregiver repeatedly meets a child’s needs**. For example, a child becomes hungry and cries, reflecting a state of tension and arousal. The Caregiver responds by meeting the infant’s needs, feeding and comforting the infant. This comfort relieves tension and promotes contentment. The Caregiver feels good in that he has provided empathic care for the child. This cycle is repeated multiple times each day in a healthy Caregiver-child relationship.

**While there may be cultural differences in caregiving practices, the result is the same: the child’s needs are met, and attachment is strengthened.** However, some children, such as severely abused children, do not outwardly communicate distress, and Caregivers must learn to read subtle cues.
(<1 min) When deliberately working to develop or improve attachments, **Caregivers should not wait for the child to “take the first step”**. A lack of trust, and an ambivalence about attachments, may make this impossible for many children. Caregivers must be encouraged to regularly approach the child in a non-threatening, gentle manner to initiate social interactions, and they must be prepared to continue to engage the child in interaction without expecting the child to reciprocate.

(<1 min) Another way to encourage attachment is through **“claiming” behaviors**. “Claiming” activities **communicate acceptance and integration of the child into family life**. Examples of claiming behaviors might be: introducing the child to others as a member of the family; including references to the child in family histories; giving the child a special role or responsibility in family traditions; and including the child in important family events.
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(<1 min) For some attachment issues, mental health therapy may be necessary. It may consist of short-term, specific counseling – with Caregivers and the child – to provide stability in the relationship. It may also include increasing the positive quality of the Caregiver-child relationship. This approach focuses on teaching positive caregiving skills, rather than on the child’s pathology.

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(<1 min) Prior to birth, an infant’s development may be impacted by the prenatal environment. This includes the presence of substances that can enhance or impede the developmental process in utero. For example, a pregnant woman’s nutritious diet and vitamins, or conversely, her use of alcohol or drugs, or living under extreme stress. At birth, an infant’s development has already been affected – either positively or negatively – by prenatal environmental factors.
One of the greatest traumas that can happen to a child prenatally is exposure to alcohol. Alcohol destroys and damages cells in the central nervous system and brain of the fetus. Widespread destruction of brain cells in early fetal development causes malformations in the developing brain structures, which produces atypical brain function throughout life.

Each year in the United States, an estimated 40,000 babies are born with Fetal Alcohol Spectrum Disorders, or FASD, making these disorders the leading preventable cause of intellectual disabilities. Fetal Alcohol Spectrum Disorders (FASD) is the umbrella term used to describe the range of effects that can occur in individuals whose mothers drank alcohol during pregnancy.

These effects may include physical, mental, behavioral, and/or learning disabilities, with possible lifelong implications such as:

- Pre- and/or post-natal growth deficiency;
- Irritability in infancy;
- Dysfunction in fine motor control, such as weak grasp, poor eye-hand coordination, and tremulousness;
- Decreased reaction time in infancy and preschool children;
- Inattention, distractibility, hyperactivity, and mood disorders in childhood; and
- Difficulties with: problem-solving, self-monitoring, regulation of emotion, motivation, judgment, planning, memory, and time perception.

Prenatal alcohol exposure has its greatest impact on complex brain functions. Because of this, children exposed to and damaged by prenatal alcohol exposure do deceptively well in their preschool years. The full impact of their alcohol exposure may not be evident until their adolescent years. Early diagnosis and intervention helps reduce this impact later in childhood.
(<1 min) Fetal Alcohol Syndrome, a subset of FASD, includes minor facial anomalies, as well as some of the characteristics previously discussed.

The three diagnostic facial features of Fetal Alcohol Syndrome include:
1) Short palpebral fissure lengths – that is, the length of the eye slits;
2) A smooth philtrum - the vertical groove between the nose and upper lip; and
3) A thin upper lip.

(<1 min) Because of the complexity and array of outcomes observed in individuals with prenatal alcohol exposure, an FASD diagnostic evaluation should be conducted by an interdisciplinary team, using rigorous, evidence-based FASD diagnostic guidelines. An interdisciplinary FASD diagnostic team typically includes a medical doctor, a psychologist, a speech language pathologist, an occupational therapist, a Social Worker, and a family advocate. In WA State, FASD diagnostic evaluations can be obtained from the Fetal Alcohol Syndrome Diagnostic & Prevention Network. http://depts.washington.edu/fasdpn/htmls/appointments.htm
The Diagnostic Team will suggest specific developmental interventions to be included in case planning and caregiving.

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(<1 min) The effects of drug exposure on children during pregnancy are not completely understood and the specific effects of various illegal or street drugs are not completely known.

However, it is known that cigarettes, poor prenatal care, poor nutrition, and the risks associated with drug-seeking behavior – such as prostitution and other illegal behaviors – can combine to affect the fetus during pregnancy and place the newborn child at risk for a variety of developmental problems.

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(<5 mins total) Infants who have been drug-exposed during pregnancy may be very irritable and difficult to soothe. These behaviors are usually short-lived and seldom continue beyond infancy.

Drug-exposed infants have a tendency to be smaller at birth, both in weight and length, but they typically catch up to non-exposed children with proper care and nutrition.
Other symptoms in newborns include gaze aversion, a frowning or furrowed brow that gives the infant a worried look, motor agitation, hiccups, spitting up, and crying.

Caretakers should receive education and instruction in strategies to soothe newborns and reduce their stress. It is critical for Caretakers to learn to "read" the infant’s cues, and adjust their interactions with the baby so as not to overwhelm or irritate the infant.

DISCUSSION (3 mins) – Now I know we have a lot of caregivers in the room and some of you may have taken placement and/or provided care for drug-exposed children. Does anyone want to share their experiences? And if you had training or support, can you describe that too?

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(<3 mins) Drug-exposed children may exhibit any number of symptoms. Common problems include behavioral symptoms such as low tolerance for frustration, distractibility, and impulsive behavior. Language delays are frequently found in children with impoverished home environments. These problems may appear as articulation problems or as delays in verbal expression.

Early intervention services that stimulate cognitive, motor, language, and social development are effective for children with delays caused by drug-exposure.

HANDOUT - Take 2 minutes to return to your Section 2 Worksheet and answer Question 4.
(<2 mins) The term "failure to thrive" (FTT) has been used to describe a wide variety of conditions in which infants fail to achieve age-appropriate weight and height levels. These babies may also exhibit delayed development, and atypical behavior.

The one characteristic common to Failure to Thrive children is nutritional deficiency. This is often caused by a combination of the following factors:

- Organic diseases, including but not limited to: cystic fibrosis, cerebral palsy, HIV infection or AIDS, inborn errors of metabolism, celiac disease, renal disease, lead poisoning, and major cardiac disease;
- Unintentional issues, such as breast-feeding problems, errors in formula preparation, poor diet selection, and improper feeding technique; and finally,
- Child neglect: FTT from neglect is often not merely a feeding problem; it often indicates serious problems in the attachment between the baby and primary Caregiver.

Treatment approaches should include both medical and environmental management, regardless of the cause of the problem.

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(<2 mins)

- Most Failure-to-Thrive infants appear emaciated, pale, and weak; and have little subcutaneous fat, and decreased muscle mass.
- The infants are often below their birth weight, indicating weight loss; or their weight is well below the typical range.
- Most are listless, apathetic, motionless, and at times irritable.
- Some infants are unresponsive or resistant to social involvement. Others become distressed when approached. Many show a preference for inanimate objects.
- Infants may sleep for longer periods of time than is appropriate for their age.
- Infants may display immature posturing; such as lying with hands held near or behind the head, legs flexed in a "frog" position or thumbs closed inside fists.
- Some children display self-stimulatory rocking, head-banging, or rumination (vomiting and swallowing).

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A thorough medical assessment should be conducted to determine the reason for the failure to thrive. In severe cases, urgent intervention is needed; immediate hospitalization or placement in Foster Care may be necessary.

A treatment that provides high caloric intake is effective. This typically leads to rapid weight gain in children who are undernourished from underfeeding. Some infants achieve age-appropriate weight within a couple of weeks.

A team approach to treating FTT is needed. The team includes a Child Welfare Worker, a physician, a nurse, and often a dietician.

As safety permits, Caregivers should be directly involved in all aspects of the treatment program. Supportive counseling and education by a caring, nurturing professional can help Caregivers feel less guilty, anxious, and depressed. It can teach and reinforce proper feeding methods and improve Caregiver-child interactions. This treatment program should begin in the hospital, because if the Caregivers are not treated, the child can be expected to quickly regress when returned to the home. In severe cases, the infant can die.
Infants who have been abused severely, and at an early age, demonstrate predictable developmental patterns and delays, as follows:

- They may be withdrawn, apathetic, and look weak and sick.
- They may allow manipulation of their bodies with no protest.
- They may not enjoy being touched or held, and may not positively respond to affectionate handling.
- They may exhibit passive compliance.
- They may appear to enjoy nothing. They may not laugh or smile, and they may not take pleasure in feeding, bathing, play, or other typical activities.
- They may appear to feel best when they are left alone.
- Their movements may be slow and cautious, and they may display limited mobility.
- They may stay in one place for long periods of time.
- They may not cry very often. They may occasionally whimper or wail.
- They may not cling to Caregivers or other adults in threatening situations.
Severe abuse, such as shaking babies, or blows to the head, may lead to Cerebral Palsy. Cerebral Palsy describes a group of chronic disorders that appear in the first few years of life and generally do not worsen over time. The disorders are caused by faulty development of, or damage to, certain areas of the brain, and they disrupt the brain’s ability to control movement and posture.

Cerebral palsy can be present at birth, and is thought to be the result of prenatal illness, injury, or exposure to toxic substances. Mothers who have no prenatal care, or who abuse alcohol or drugs during pregnancy, increase the risk of cerebral palsy in their infants.

Specialized treatment methods are necessary for babies who have been severely abused. Simply eliminating the abuse is not enough. Caregivers should be trained to nurture the child in a predictable, measured fashion. "Too much too soon" can overwhelm the child and have the effect of further closing him or her off.

Caregivers should be encouraged to:

• Move slowly. Take care to approach the child slowly at all times, and do not institute too many changes at once. There is a fine line between providing nurturance and overwhelming the child.
• Create a calm, comfortable environment.
• Read the child's cues to determine his or her needs.
In Part 5, we will review the services and resources available to support you and children placed in your care.

The Child Health and Education Tracking (CHET) Program is for children who are in out-of-home care for 30 or more days. CHET can provide valuable information on the strengths and needs of young children. When a concern about an infant’s or toddler’s development is identified during the screening process, the CHET Worker will make a referral to an early intervention program within two working days. In addition, the CHET Worker will make a referral for services to the Foster Care Public Health Nurse (FCPHN) for all children identified with complex health needs.
(<5 mins total) The 2003 amendment to the Child Abuse and Prevention Treatment Act (CAPTA) requires that all children who have been involved in a substantiated case of child abuse or neglect be referred to an early intervention program.

In some cultures, it is customary to seek assistance from within the cultural group, or within the neighborhood, and people may be reluctant to go outside the group or neighborhood for help. Workers will need to help these families find resources within their group or neighborhood, or help them adjust to seeking help from outsiders. For example, Workers could ask respected members of the cultural group to help the family accept help from outsiders.

HANDOUT - Take 3 minutes to return to your Section 2 Worksheet and answer Question 5.

(10 mins total) Additionally, there are many Infant and Early Childhood Programs available. Check with your local resources about what services and programs are available in your area. Here are the most common resources:
• **Early Head Start (EHS)** is a comprehensive preschool program serving children birth to two and a half and their families, and pregnant women. EHS includes: early childhood education; Caregiver-child attachment support; nutrition services; health screenings and follow-up; family support; and family involvement and leadership opportunities.

• **Head Start** is a federal center-based early childhood program that promotes school readiness for children ages birth to 5. All children placed in out-of-home care are automatically eligible for Head Start. Head Start programs provide comprehensive bilingual and culturally-sensitive services to enrolled children and their families, including health and nutrition counseling, and parenting education.

• **Early Childhood Education and Assistance Preschool (ECEAP, pronounced "E-Cap")** is a program similar to Head Start, but funded by Washington State.

**DISCUSSION (5 mins)** – Let’s check in with the caregivers in the room. Has anyone accessed these programs or other programs for Infancy and Early Childhood?

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(<1 min) You have now completed the second section of this training and are ready to move on to Section 3 – From Three to Five Years.

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(<1 min) In Section 3, we will be reviewing child development and the effects of CA/N on kids aged 3 to 5 years old. We will be using several handouts in this section.

To start with, please refer to your HANDOUTS - Section 3 Worksheet, and Section 3 Job Aid.

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Section 3: Three to Five Years
Main Menu
Introduction
Part I  Typical Physical Development
Part II  Typical Social Development
Part III  Typical Emotional Development
Part IV  Typical Cognitive Development
Part V  Typical Sexual Development
Part VI  Developmental Effects of Abuse and Neglect
Part VII  Case Scenario: Kendra
Part VIII  Services and Resources

(<1 min) This section of this training has eight parts:
- Typical Physical Development
- Typical Social Development
- Typical Emotional Development
- Typical Cognitive Development
- Typical Sexual Development
- Developmental Effects of Abuse and Neglect
- Case Scenario: Kendra
- Services and Resources

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Developmental Tasks
To learn to understand, and attempt to master, the world around them.

Physical
- * Constantly on the move

Social
- * Expanding their ability to play and interact

Emotional
- * Courageous, industrious, and just beginning to feel guilt and shame

Cognitive
- * Asking a multitude of questions: “Why?”
(<1 min) The task of the preschooler is to learn to understand, and attempt to master, the world around them. This is seen in all domains of their development:

- They are constantly on the move
- They are expanding their ability to play and interact with others
- They are courageous, industrious, and just beginning to feel guilt and shame, and
- They ask a multitude of questions, whose answers are then followed by the ultimate question: “Why?”

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(<1 min) In Part 1, we will look at Typical Physical Development for this age.

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(<1 min) This is a very busy and active time in a child’s life. They cannot sit still for long periods of time, and they experience weight and height gains that are fairly constant. An easy way to remember the average height and weight for a three-year-old child is to think of "threes": 3 years, 3 feet tall, 33 pounds.
The preschool child loses the swayed back and protruding abdomen that are typical of the toddler. Also, the rate of the brain growth for a 3- to 5-year-old slows considerably. By early preschool, the brain will have already reached approximately 4/5 of adult size.

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<1 min> The 3- to 4-year-old can balance on one foot for a few seconds, and can jump over obstacles. They can pedal and steer a tricycle. They can run, and can stop, start and turn. They can use playground slides unassisted. They can kick and throw a ball. They are usually toilet-trained.

The 4- to 5-year-old year old can hop on one foot for several hops, and has improved finger dexterity that allows for the comfortable use of pencils and crayons.

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<1 min> Motor abilities may differ between boys and girls, and this may be due to cultural expectations. In cultures that reinforce "rough and tumble" play for boys, boys will typically develop large muscle strength and gross motor coordination; whereas, the quieter more "refined" play often encouraged in girls, such as use of toys, crayons, and dolls, will generally promote the development of fine motor coordination.
(<1 min) Let’s look at typical Social Development.

(<2 min) Children enter the preschool period with limited play skills. Toddlers typically engage in parallel play, which is actually solitary play in the presence of other children.

Between the ages of 3 and 5, the development of language enhances play skills. Increasingly complex social interactions develop in stages throughout the preschool period.

For three-year-olds, toys are the focus of most play. The preschool child must learn basic social rules, such as sharing and taking turns, before they will be able to play cooperatively with other children. Three-year-olds are usually unable to share.

Between ages of four and five, children form friendships with other children and will ask to play with certain friends. Play is more cooperative and each child may play a specific role in imaginative play. Joint involvement toward a common goal is more frequent.
(<1 min) Culture and society influence how and what children play. Although preschoolers’ play typically reflects cultural and social norms, their cognitive ability precludes them from understanding the complexities and subtle nuances of various social roles. Therefore, their play reflects a simplistic, stereotyped understanding of social roles. This is especially true for gender roles.

(<1 min) Play helps the preschool child with the following:
- The development of language skills;
- Practice of basic social skills, such as sharing, taking turns, cooperating, and controlling one's own impulses;
- Development of both gross and fine motor skills; and
- Experimentation with social roles.
The preschool years are a time of active discovery. A healthy child is exuberant, self-directed, and a "self-starter." He delights in orchestrating activities and being in charge. He takes pleasure in "attack and conquest," and experiments with new roles and skills.

The healthy development of trust and autonomy during the infant and toddler stages contributes greatly to the preschool child's ability to be self-starting and self-directing.

Let’s take a look at Typical Emotional Development
Preschoolers often recognize visual emotional cues (mad, happy, sad), and can label them properly.

- Preschool children are better able to control their own emotions and behavior than they were as toddlers.
- Their improved cognitive ability helps them think about problems and solutions. Crying and temper tantrums decrease during the preschool years as children develop better self-control and the ability to use language to express themselves.
- Preschool children are also better able to delay gratification. "You can have a cookie after dinner" may not lead to a tantrum in the same way it did in earlier development. Studies indicate that the child's previous experience affects his or her ability to delay gratification; in other words, predictability and consistency in the child's environment make him or her better able to delay gratification.

During the preschool period, the development of conscience appears. By age 5, most children understand the meaning of right and wrong, have internalized their parents' prohibitions, and feel guilty when they have done something wrong.
Children who grow up in chaotic environments where the rules continually change or where no rules exist often show signs of anxiety and emotional distress. Clear and consistent rules provide children with a dependable structure and a sense of security.

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*Cultural Considerations*

Some children are allowed more freedom in activity and exploration.

(<1 min) Cultures differ considerably in what is considered appropriate and inappropriate for preschool children. We must be careful not to assume that children who are allowed more freedom in activity and exploration are "out-of-control" or "wild" without first understanding the cultural context of the child's behavior.

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*Fantasy Characters & Scenarios*

Fantasy helps children:
- Discharge tension and anxiety
- Cope with stress
- Reduce fears

(<1 min) The child’s emotional development will also be seen in play. The preschool child will create fantasy characters and scenarios, including imaginary friends. Well-developed language allows him or her to talk to, and about, these friends. These play fantasies may help the child do the following:
- Discharge tension and anxiety.
- Cope with stress. (Through play children can rehearse and try out various coping strategies to help them deal with difficult situations.)
• Reduce fears. (The "imaginary companions" of many children are wild animals who are made to be docile, cooperative, friendly, and totally under the child's control.)

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(<2 mins) By age 3 the child has a rudimentary sense of "self" and may begin to evaluate their own behavior as "good" or "bad." They feel pride when they are "good" and guilt or shame when they are "bad".

Preschool children's self-esteem is largely dependent upon other people's reactions to them. If people respond with praise and support, children are likely to feel positive about themselves.

Conversely, if a child’s behavior results in criticism or punishment, the child is likely to believe they are a bad child and may experience guilt and shame. Low self-esteem and lack of confidence can result, with the child being less likely to initiate and engage in new activities. This can interfere with development in all other domains.

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(<1 min) Now let’s take a look at Typical Cognitive Development.
The cognition of preschool children has certain very discernible characteristics. When considered together, these can help us to understand the "world view" of the preschool child. The first of these factors is egocentric thinking.

The preschooler’s universe is confined – with themselves, their family, and their homes at the center. They view the world only from this perspective, and they do not realize that other people might have different perspectives. They view everything through their own eyes, and believe that their experiences are universal – so much so that preschoolers leave out important and obvious facts when they describe an event, because they assume that everyone already knows the details.

Preschoolers cannot always differentiate between fact and fantasy. In describing an experience, a child of this age will often embellish it to the point of fantasy. Preschoolers have vivid imaginations and magical or superstitious thinking. This may make their memory and recall both suspect and suggestible.
Many preschool children are actually capable of providing accurate information from memory; they are deficient in free recall, but are better at cued recall. In other words, they can recall a memory in response to a stimulus, such as a question, person, smell, or sound that triggers the recollection.

It’s also important to note that preschoolers may have problems recalling a single episode among a series of similar episodes; it is difficult for them to recall the details of one specific event if that event has been repeated many times (such as sexual abuse).

Preschool children are also more susceptible than older children to repeating erroneous “memories” that have been suggested to them. Their desire to please adults likely complicates this process.

Preschoolers do not have a well-developed understanding of time, particularly of long time periods. They may understand "today," but yesterday and tomorrow are harder, and "next week" is incomprehensible. Preschoolers also have a hard time with chronology; they confuse first, middle, and last, and cannot order events in time.
Preschoolers have limited understanding of cause and effect. Many preschool children placed into Care believe that their behavior caused them to be placed in Foster Care.

Note that preschoolers cannot think abstractly, nor understand concepts that they cannot see, hear, feel, or manipulate. For example, they often cannot tell time, and most do not understand value of money. While preschool children's reasoning may be faulty by adult standards, their conclusions make perfect sense to them, and they will stubbornly cling to them when presented with more complicated explanations.

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(<3 mins) A preschooler develops their language into full sentences by adding "linking words" – including prepositions, conjunctions, objects, and other components – and their grammar improves.

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

Regardless, most preschool children talk nonstop. It is common for them to talk to themselves, and they often talk just to talk.

They also enjoy using language to communicate with others. They are intrusive and will try to involve themselves in other peoples' conversations. Preschoolers are adept at asking questions, particularly "why?“, but they are not always interested in the answer; they may enjoy interjecting the "why" just to keep the conversation going.
The nature of language, the specific meanings of words, and rules for when and how people talk with one another, are culturally determined; but the fact that language ability develops is universal.

When a child's language development is assessed, the assessment should be made within the child's cultural context. It is important not to confuse language delays or speech deficits with differences in language or speech.

Words may have different connotations within certain cultures or subcultures, and the rules of grammar and syntax may not be the same as in standard English. For example, if a Worker can’t understand a four-year-old’s language, the Worker should determine whether family members are able to fully understand the child's language. It could be that the child’s communication skills are appropriate within his or her cultural context. If they are not understood by family members, then the child may have speech and language delays.

In assessing a child’s language development, it’s also important to note that some cultures discourage children from approaching adults to begin conversations. These children are taught to remain silent in the presence of adults. The child may need to be observed in situations in which talking is encouraged, such as when playing with other children, to determine the child's language ability.
(<1 min) To successfully engage a preschool child, try the following suggestions:
- Use concrete language. For example, ask, “What did you do when you came home from preschool,” rather than, "How was your day?“
- Check frequently for comprehension; don’t assume the child understands you.
- Check frequently that you understand the child; don’t assume you understand him/her.
- Do not ask questions regarding time of day; instead, ask questions that tie events to the child’s daily routine, like before or after preschool.

(<1 min) Now let’s explore Typical Sexual Development.
(<3 mins) Preschool children are beginning to notice differences between female and male bodies, and are interested in these differences.

Younger preschoolers may not have learned the rules of privacy yet. They are usually not self-conscious about their bodies, so they will often toilet, bathe, and dress with open doors, and in front of others. Many children also masturbate during this age, and have not yet learned that this should be done in private.

Older preschoolers begin to understand “where babies come from”. With concrete explanations, they can understand pregnancy, birth and nursing. However, they usually are not aware of intercourse, nor ask questions about it, unless they have been exposed to sexually explicit materials or behavior, or have heard about intercourse from an older child.

It is not unusual for boys and girls to look at and touch their own and each other’s genital areas.

(<2 mins) Children are human beings, and human beings are sexual beings – so even very young children may display sexual behaviors. The most common sexual behaviors in preschool
children include self-stimulation, exhibitionism, and behaviors related to their immature sense of boundaries.

When assessing sexual behavior, determine whether the behavior meets these characteristics of typical sexual play:

- It is mutual and voluntary, between children of similar age, size, and developmental status;
- It has a playful, light-hearted affect.
- It is easily redirected to other activities.
- It does not persist until it is painful or uncomfortable for the child.

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(<1 min) The following behaviors may indicate that the child is developing atypically.

- The child engages in sexual behavior to the exclusion of other developmentally appropriate activities, such as playing, being with friends, etc.
- The child coerces, intimidates, or forces other children to engage in sexual behavior, or the child hurts another child through sexual activity.
- The child, or their playmate, experiences emotional distress as a result of the sexual behavior.
- The child does not stop the sexual behavior, despite consistent and clear requests to stop.
(<1 min) Let’s take a look at some of the Developmental Effects of Abuse and Neglect

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(10 mins total)
(5 mins) VIDEO “Change the First Five Years and You Change Everything” https://vimeo.com/127276782
(<5 mins) HANDOUT – Section 3 Worksheet, questions 1-2
Now we are going to watch a 5 minute video, “Change the First Five Years and You Change Everything”.

Once the video is over, please refer to your HANDOUT – Section 3 Worksheet, specifically questions 1-2.

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(<1 min) Abuse and neglect may impact a child’s development across several domains.

Physically, abused and neglected preschool children may be small in stature, and show evidence of delayed physical growth.
They may be sickly and susceptible to frequent illness, particularly upper respiratory illnesses, like colds and flu, and digestive upsets.

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

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(<1 min) When under stress, our bodies secrete “stress hormones” that prepare us to fight, flee, or freeze in response to danger or threat of danger. When children are under chronic stress, such as abuse or neglect, they may become “stuck” in this stress response, resulting in hyper-arousal or hyper-sensitivity to perceived dangers or threats. This has significant social implications for children: If a traumatized preschooler frequently assumes that other children intend to harm him or her, it can be difficult for that child to form friendships and play with other children.

In addition, the child may demonstrate social immaturity in peer relationships: They may be unable to enter into reciprocal play relationships; be unable to take turns, share, or negotiate with peers; or be overly aggressive, bossy, controlling, and competitive with peers.
(<1 min) A maltreated preschooler may appear emotionally detached, isolated, and withdrawn, from both adults and peers. The child may have indiscriminate, superficial, or clingy attachments.

In addition, the child may show signs of more serious issues, including anxiety, depression, post-traumatic stress, and reactive attachment disorder.

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(5 mins) LARGE GROUP ACTIVITY
Now let’s do a short quiz-activity to assess your basic understanding of Anxiety, Depression, Post-Traumatic Stress Disorder and Reactive Attachment Disorder.
On your own, read the symptoms on the left and try and match them to the “Issues” on the right. Take 3 mins, and then we will report out as a large group.
Answers are:
1 – D
2- A
3- B
4- C

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The effects of abuse and neglect on cognitive development may be seen in the following areas:
- Speech may be absent, delayed, or hard to understand.
- The child may have an unusually short attention span.
- The child may have less flexibility and creativity in problem-solving.
- The child may show a combination of faulty reasoning, and inaccurate or distorted perceptions.

Abused preschool children almost universally believe that the abuse was "punishment" because they did something wrong. It is also typical for young children in Foster Care to believe they were "sent away" because they were bad. It makes no logical sense to them that they should have to leave home because someone else, such as their parents, did something wrong.

**Here's an example:** Josiah was placed in a Foster Home at age 5 and a half. His step-father was a violent and dangerous man who once threw a cat through a plate glass window in a fit of temper. He and his wife had a violent argument during which the police were called, and Josiah was removed to ensure his safety. At the time of the argument, Josiah had been in the kitchen pouring a glass of milk, and he spilled it. Six months after his placement, he solemnly assured the Social Worker that he was bad, and that he had to live in a Foster Home because he spilled his milk all over the kitchen. When the Worker told him he was placed in Foster Care so his daddy wouldn't hurt him, he indicated that his daddy only hurt his mommy, not him, so that couldn't be the reason.

**ASK THE GROUP - Does anyone an example of distorted perception from a child placed in their care? If so, what did it look like? How did you know something was off or distorted?**

Slide 119

(<1 min) Now, let’s take a look at a Case Scenario involved a child named Kendra. For this section, you will use several handouts:
- Handout – Section 3 – Case Scenario Kendra – Part 1
- Handout – Section 3 – Case Scenario Kendra – Part 2
- Handout – Section 3 – Case Scenario Kendra – An Expert’s Opinion
Meet 5-year-old Kendra. She and her nine-year-old sister were referred to CPS for neglect when neighbors found her trying to cross the street, unsupervised, at 10:00 PM on a Saturday evening.

The summary of her case contains information from the CPS Worker who removed Kendra and placed her with her maternal aunt. This information is included in HANDOUT – Section 3 – Case Scenario Kendra – Part 1.

Imagine that your supervisor has assigned you this case and has asked you to gather as much developmental information about Kendra as possible.

Take a few minutes and describe your process and your approach by answering Questions 3 through 5 on your Section 3 Worksheet.
We are going to use two handouts here.
HANDOUT – Section 3 Worksheet
HANDOUT – Section 3 – Case Scenario Kendra – Part 2
You have completed your first health and safety visit to Ms. Roberson’s home. Take a minute to read about the visit on HANDOUT – Section 3 – Case Scenario Kendra – Part 2 and then answer Questions 6 through 9 on your HANDOUT Section 3 Worksheet.

(15 mins) Two Handouts for this slide.
HANDOUT – Section 3 Worksheet
HANDOUT – Section 3 – Case Scenario Kendra – An Expert’s Opinion
Now compare your responses to those of an expert and then discuss what you notice among your tables.

LARGE GROUP DISCUSSION
If your answers differ, why do you think they differ? If your understanding has changed or improved as a result of comparing your answers to the ones provided, add notes to your answers about how they are similar or different, and explain what you learned or where you still need to learn more.

Slide 123
(<1 min) Let’s take a quick moment to review services and resources specifically aimed at supporting preschool families.

**Slide 124**

![Services and Resources](image)

(1 min) Occupational Therapy, Physical Therapy, and Speech and Language Therapy may be helpful for preschool children with developmental needs.

Additional programs and services for preschool children and families may be available in your area, including psychological and psychiatric assessments, parent skills training, and mental health resources.

**Slide 125**

![Section 3: Complete](image)

(<1 min) You have now completed the third section of this training and are ready to move on to Section 4 – From Five to 11 Years.
In Section 4, we will discuss typical development and the effects of CA/N on development of children between 5 and 11 years old.

As you noticed, we will explore this age range in eight parts:
- Typical Physical Development
- Typical Social Development
- Typical Emotional Development
- Typical Cognitive Development
- Typical Sexual Development
- Developmental Effects of Abuse and Neglect
- Case Scenario: Jenwei (pronounced JEN-WAY)
- Services and Resources
The task of the child aged 5 to 11 revolves around the need to be industrious and competent. This is seen in the child’s willingness to begin and end projects – often with peers – and the child’s sense of inferiority or failure when a job is not completed to the child’s exacting standards.

First let’s take a look at Typical Physical Development.
Physical growth between the ages of 5 and 11 is slow and steady.

School-age children are active, energetic, and in perpetual motion. They may rarely stand still, and they don’t often walk when they can run, jump, tumble, skip, hop, or climb instead. They direct their physical activity into both formal and informal games and sports.

Fine motor skills are refined and practiced through painting and drawing, crafts, using tools, building models, playing musical instruments, and other projects that require the use of the hands. Cultural factors may influence the development of motor skills. Cultures that value physical strength and skill tend to reinforce activities that involve gross motor abilities.

Can anyone provide more examples of activities or groups a child can join that encourage development of physical skills?

- Girl Scouts
- Boy Scouts
- Sports teams
- Music classes, etc.

Part II
Typical Social Development
(<1 min) Now let’s look at the Social Development of children 5-11 years old.

Slide 132

Typical Social Development

- The child develops meaningful and mutual friendships.
- The child may have a "best friend", usually of the same sex.
- Friendships develop based on common interests or proximity.
- Because many friendships are situation-specific, they may also be transitory.

(<1 min) Specific characteristics of school-age social development include the following:
- The child develops meaningful and mutual friendships.
- The child may have a "best friend", usually of the same sex.
- Friendships develop based on common interests or proximity.
- Because many friendships are situation-specific, they may also be transitory.

Slide 133

Social Rules

- Ages 5-6: Rules can be changed to suit one's needs.
- Ages 7-8: Rules are perceived as fixed and unchangeable.
- Ages 9-10: Rules are a useful means of regulating activities, but may be flexible.

(<3 mins) The child's understanding and use of rules in social settings becomes more sophisticated as the child gets older. For example:
- Children aged 5 or 6 believe rules can be changed to suit one's needs, and they will alter the rules of a game at whim to get what they want. This is a holdover from the egocentric thinking of toddlerhood, in which the self is at the center of the world.
- By age 7 or 8, the child is very conscious about obeying the rules. Rules are perceived as fixed and unchangeable. This leads to strict interpretations of what is right and wrong. Issues of fairness are prevalent, and children this age become angry and complain bitterly if someone has broken a rule or is not treating them fairly.
• By age 9 or 10, children begin to view rules as a useful means of regulating their activities, but they understand that rules may be flexible and negotiated. For example, if everyone in the group agrees that the rules of a game should be changed, so be it.

Slide 134

(<2 mins) The school-aged child is beginning to understand social "roles", including gender roles. The expectation that males and females are different in significant ways is fairly universal, but cultural expectations and family values typically determine how they are different, and what behaviors are acceptable for boys and girls. Children will emulate the qualities that their culture values for their gender.

As children mature, their role within the family may change as they are expected to take on household chores. Cultures and families vary considerably in the degree to which school-aged children take on family responsibilities.

Slide 135

(<1 min) Part 3 – Let’s examine Typical Emotional Development
Throughout the school years, children become increasingly decisive, responsible, dependable, productive, and goal-oriented with respect to making plans and following through with them. The child's self-esteem is largely dependent upon their ability to perform and produce. The child who fails at being productive is likely to experience feelings of inferiority. Children this age are particularly sensitive to criticism; it is important to be liked, to do well, and to be viewed positively by others.

However, some cultures discourage recognition or commendation in public or in front of a third party, because this elevates that person above others in the group and disrupts group harmony. We must be careful to abide by these cultural codes of conduct, and should be careful not to assume that a parent is not supportive if they refrain from praising their children in front of us.

A child’s self-concept is also affected by societal forces such as racism, sexism, and other forms of prejudice, as well as family dynamics.

Throughout the early school years, children develop better self-control and frustration tolerance, and are less likely to respond to frustration with emotional outbursts.
There are cultural variations in how much emotional expression is permitted, and in which settings. For example, children whose families and cultures encourage free expression of emotion may be louder and more boisterous than children who are encouraged to be generally reserved.

Slide 138

(<1 min) In Part 4 we will explore Typical Cognitive Development.

Slide 139

(<1 min) There are distinct differences between the cognitive abilities of preschool and school-age children, possibly because significant changes in the organization of the child's brain permit the appearance of these new abilities.

Research has demonstrated that these changes occur in cultures that are markedly different from each other in values, norms, and educational practices.
(<1 min) School-age children have an excellent use of language.  
- They actively listen and consider what others say.  
- They ask questions, and continue asking questions until they are satisfied with the answer.  
- They request instructions or directions.  
- They describe events logically and sequentially.  
- They can discriminate between relevant and irrelevant information in a conversation.

(<2 mins) By age 8 to 10, children can recognize the difference between behavior and intent. For example, if a father accidentally steps on a 3-year-old’s hand, the child will likely be angry at the father for hurting them. If the child is 8 or 9, they’ll understand that the father didn't mean to hurt them, and they won't be angry.

Throughout the school-age years, children become increasingly aware of, and able to consider, the needs and feelings of others. By the age of 10 or 11, children have the ability to listen to each other's points of view and discuss them. When their views are in conflict, they can identify solutions that consider what both children want.
School-age children no longer interweave fantasy and reality in their conversations or play. Their imaginary friends typically disappear.

School-age children typically perceive and describe themselves and the world in concrete terms. For example, a child is more likely to say, “I'm a girl, I have brown eyes, and I play the piano.” than to consider abstract qualities, such as, "I'm friendly," or, "I'm artistic."

The school-age child can remember events that happened weeks, months, or even years earlier. Children also have increasingly good short-term memories, which allow them to better follow instructions.

Children can now think about past actions or events and remember their consequences. They better understand how their activities and behaviors affect other people and events, and can use this information to plan strategies to avoid or solve problems.

However, problem-solving strategies are closely linked to the family’s and culture’s expectations. For example, some cultures encourage children to rely on their own problem-solving and critical-
thinking skills from an early age, while in other cultures, children are expected to defer to their elders for help in resolving problems.

Slide 144

(<1 min) In Part 5 we will explore Typical Sexual Development in 5-11 year olds.

Slide 145

(<1 min) Although there are differences among individual children, the following are common and expected behaviors related to sexual development for 6- to 9-year-olds:

- They are interested in, and have questions about, pregnancy and intercourse.
- They experiment with sexual swearing.
- They adhere to social divisions between boys and girls.
- They look for nude pictures in books, magazines, and catalogues.
- They masturbate in private.
For children ages 9 to 11, the following are common and expected behaviors related to sexual development:

- Children often experience the onset of puberty, including menstruation and wet dreams.
- They may initiate games involving sexuality, such as strip poker, truth or dare, or spin the bottle.
- They often feel awkward about physical changes in their bodies, worry that they are developing too slowly or too rapidly, and are concerned and embarrassed about physical changes.
- They may read information about sex with avid interest.
- They show intense interest in viewing others’ bodies.
- They practice discreet masturbation.
- They may begin sexual or romantic fantasies.
- They begin boy-girl social relationships, including flirting, hand holding, and spending time together.

In Part 6 we will discuss the Developmental Effects of Abuse and Neglect on 5-11 year olds.
(15 mins) Let’s watch a 10 minute video, “Understanding the Traumatized Child”. [https://vimeo.com/127276783](https://vimeo.com/127276783)

After the movie is over, we will take **5 minutes to use HANDOUT Section 4 Worksheet to answer Question 1 and discuss as a group.**

**9 mins - VIDEO** – the video is about 9 minutes long.
**2 mins** - After the video ends, direct the group to **Section 4 Worksheet, Question 1** and let them spend about 2 mins answering.

**4 mins – Large group discussion:**
- What did you come up with for the worksheet question?
- What was new or surprised you about the movie?

(<1 min) School age children who are abused or neglected may:
- Have delays in physical growth,
- Have poor coordination or delays in motor-skill development,
• Be chronically ill,
• Be absent from school a lot, or
• Have wetting and soiling problems, even during the waking hours.

Slide 150

(<1 min) The school-aged child who has been abused or neglected often feels inferior and incapable. The child often withdraws from social contact because their lack of appropriate social skills makes them feel embarrassed and ashamed.

The child may act out feelings of helplessness by attempting to control, exploit or coerce others. The child may be bossy, a bully, or domineering with other children. In addition, he or she may blame others when things go wrong.

Slide 151

(<1 min)

• Maltreatment of the school-aged child may severely damage the child’s self-esteem.
• The child is often chronically anxious or depressed, and is unable to trust others.
• Impulse control is hampered, as is the ability to regulate emotions.
• The child may show extreme responses to minor stressors. Maltreated children may act out anxiety, anger, and frustration in antisocial ways, including hitting, fighting, destroying property, swearing, and lying.
• The child may also behave impulsively or begin to steal, in order to be rewarded immediately. Coming from an unpredictable environment, where rewards are inconsistently given or absent, children often lack the ability to delay gratification.

Slide 152

Cognitive Effects
- Small vocabulary
- Thinking like a younger child
- Inability to concentrate
- Lack of problem-solving skills
- Speech and language delays

(<1 min) School-aged children who are abused or neglected may be affected in their cognitive development in the following ways:
• They may have a small vocabulary,
• Think like a younger child,
• Be unable to concentrate on school work,
• Be lacking problem-solving skills, and
• Have speech and language delays.

Slide 153

Effects in School
- Frequent emotional outbursts
- Inability to sit still
- Inability to concentrate; expending their energy trying to maintain self-control and worrying
- High rate of grade retention
- Social effects

(<2 mins) For children of abuse and neglect, the highly-structured and demanding school setting can be very threatening. Frequent emotional outbursts and an inability to sit still are typical.
A child of abuse or neglect may be anxious and unable to concentrate on schoolwork, as they may be expending their energy trying to maintain self-control, and worrying about what may happen when they go home. Because of this, there are higher rates of grade retention and dropping out among maltreated children.

If lacking social skills, the maltreated child is likely to be bullied or ignored by other school children.

**Slide 154**

(10 mins) For this activity we will be using several worksheets.  
**WORKSHEET - Section 4: From Five to 11 Years**  
**WORKSHEET – Section 4 – Case Scenario Jenwei**

Jenwei is nine years old and in her third Foster Home after having disrupted from an adoption placement. Her case was recently transferred to you.
Using HANDOUT – Section 4 – Case Scenario Jenwei, take a minute to read about Jenwei’s case. Once you are done, use HANDOUT – Section 4 Worksheet to answer Questions 2 through 5.

Slide 156

(10 mins) GROUP ACTIVITY
Now, at your tables, let’s use HANDOUT – Section 4 – Case Scenario Jenwei – An Expert’s Opinion to compare your responses to those of an expert.

Take a few minutes to review the handout. Then discuss at your table.
If your answers differ, why do you think they differ?
If your understanding has changed or improved as a result of comparing your answers to the ones provided, add notes to your answers about how they are similar or different, and explain what you learned or where you still need to learn more.

Slide 157

(<1 min) Let’s discuss some Services and Resources for this age group.
(<1 min) Occupational Therapy, Physical Therapy, and Speech and Language Therapy may be helpful for school-aged children with developmental needs. They may also benefit from services from the DSHS Developmental Disabilities Administration.

You can also ask the child’s assigned Social Service Specialist for additional programs and services for school-aged children and families in your area, and ask them to consult their regional contracts directory, which often includes psychological and psychiatric assessments, parent skills training, and mental health resources.

(<1 min) You have now completed the fourth section of this training and are ready to move on to Section 5 – From 11 to 17 Years.
Our last section for today’s training covers the Effects of Abuse and Neglect on Child Development during the ages of 11 to 17 years.

You will be using a Job Aid and a Worksheet in this section. There will be additional scenario based handouts used as well.

**Handout – Section 5 Job Aid – Developmental Milestones**
**Handout – Section 5 Worksheet – 11 to 17 years**

We will approach this age group as we have done before; This section of this training has eight parts:

- Typical Physical Development
- Typical Social Development
- Typical Emotional Development
- Typical Cognitive Development
- Typical Sexual Development
- Developmental Effects of Abuse and Neglect
- Case Scenario: Malcolm
- Services and Resources
 Adolescence is a challenging time for both teens and their Caregivers, in part because of the tasks to be accomplished during this time.

Identity: Teens are defining themselves, their values, and their beliefs - separate from anyone else's expectations.

Independence/Dependence: Adolescents often strongly state a desire for independence, but actually display an ambivalence between wanting to be independent, and also enjoying the benefits of dependence. They will tell you that they can take care of themselves and make their own decisions, but then they’ll ask you what you are making them for dinner.

Issues of sexuality: Adolescents often experience embarrassment about their own bodies and physical changes, a need for acceptance by opposite-sex peers, awkwardness in sexual relationships, and moral conflicts.
(<1 min) Cultures vary considerably in expectations for the development of identity, independence versus interdependence, and issues of sexuality.

Some cultures expect that adolescents will rely on and follow parental advice for all important aspects of their lives; other cultures expect adolescents to make many decisions on their own and to consult with parents only when necessary.

Immigrant and refugee families may have difficulty with their children seeking the identity and perceived independence and freedom of American teens, while the adults cling to traditional cultural norms.

Slide 164

(1 min) Adolescence is usually sub-divided into three stages:
- Early adolescence is ages 11 – 13 (usually middle school),
- Middle adolescence is ages 14 – 17 (usually high school), and
- Late adolescence is ages 18 – 21 (usually post-high-school)
Because most adolescents served by child welfare agencies are under the age of 18, this training will focus on early and middle adolescence.

Slide 165
(<1 min) We will begin by exploring Typical Physical Development for ages 11-17.

**Slide 166**

![Physical Development in Girls](image)

(<1 min) Early adolescence, with the onset of puberty, brings about the biggest changes in a child's body since the first 3 years of life.

Girls generally begin puberty earlier than boys, with the emergence of breast development, pubic hair, and menstruation. The average age range for the onset of menstruation is 11 to 14, but may be younger in children who have been sexually abused.

**Slide 167**

![Physical Development in Boys](image)

(<1 min) Most boys have a physical growth spurt between the ages of 13 and 17.

In boys, changes during puberty include the enlargement of the penis and scrotum; the production of semen; the development of pubic, body, and facial hair; and changes in the tone and quality of the voice.

Erections become more frequent, and ejaculations are now possible.
Most teens exhibit anxiety and self-consciousness about their physical appearance.

- Generally, youth are most self-conscious about their bodies during early adolescence.
- Girls often perceive themselves as fat and unattractive, even when they are very normal in build. Eating disorders in adolescents, such as anorexia and bulimia, indicate serious concerns.
- By middle to late adolescence, physical development has usually stabilized and youth have become more comfortable with their physical self.

Next, let’s review Typical Social Development for ages 11-17.
The first step in the development of independence is to distance oneself from one's parents. This happens concurrently with the establishment of a strong peer group. The peer group provides teens with clear standards regarding dress, language, and behavior. Teens may greatly alter their behavior, compromise their beliefs, and even reject childhood friends to gain acceptance into a group.

The teen’s family and culture will have guidelines about peer interactions during adolescence. For example, some cultures may limit peer interactions to structured events, while others may permit the youth to engage in friendships freely.

Early attempts at forming an identity involve rejection of parental values, and generally occur in areas such as hair style and manner of dress.

Youth consider themselves independent because they are behaving differently from their family. However, their conformity to peer standards simply reflects dependence on a different group of people to provide self-definition.
The peer group encourages youth to try out different ideas and behaviors. Joining a peer group is the first step towards developing meaningful social relationships outside the family, which are necessary for adult functioning.

**Slide 172**

![One-on-One Friendships](image)

(*1 min*) During the high school years, one-on-one friendships with peers of both sexes become increasingly important. Middle adolescents commonly talk to each other with great intensity and conviction about very personal feelings and issues. They expect loyalty, confidence, and trust from friends. Good friends are expected not to disclose personal information to others and to remain loyal and understanding, regardless of the information shared.

**Slide 173**

![Part III: Typical Emotional Development](image)

(*1 min*) Next, let’s review Typical Emotional Development for ages 11-17.
Adolescence is emotionally chaotic and the young teen is often at the mercy of his or her emotions.

Emotional development focuses on forming and defining one’s personal identity. This includes exploring the significance of race, ethnicity, and culture, and how these apply to the individual. The child’s experience with prejudice and racism has a dramatic effect on how she feels about her ethnic, cultural, or racial identity.

In addition to normal identity struggles, adolescents who are multi-cultural may have to deal with issues related to group identification.

ASK THE GROUP – Because this last idea, fostering children of other cultures or children who are multi-cultural as they form their self identity and emotional identity, is such a big idea, I wanted to ask the group:

- Has anyone had any experiences with this?
- How have engaged with or supported a child in your care experiencing this?
- Does anyone feel comfortable sharing any successes or mistakes they made along the way?
Adolescence can be a particularly difficult time for adopted youth. The circumstances of the adoption, and the emotional struggles common to adopted children “add another layer of adjustment to two tumultuous tasks: identity formation and separation from family”. (Ginther and Severs, 2004)

Slide 176

(<1 min) Next, let’s review Typical Cognitive Development for ages 11-17.

Slide 177

(<1 min) New cognitive abilities develop gradually over the teen years, and teens often use these new skills inconsistently.

These cognitive abilities include the following:

- The ability to think hypothetically: This allows the youth to consider a large number of possibilities and plan one's behavior accordingly.
- The ability to think logically: This allows the youth to identify and reject possible outcomes on the basis of their logic.
- The development of insight: This allows the youth to consider how his or her behaviors affect other people, and how other people's behaviors affect him or her.
The emergence of systematic problem-solving: This skill is based on the ability to hypothesize possible outcomes and to understand logical relationships.

Slide 178

A change in cognitive abilities generally leads to a change in moral development.

Prior to adolescence, moral development tends to be rules-driven and focused on “obey to avoid punishment”.

In adolescence, significant changes in moral thought are brought about by advancements in abstract thinking, perspective, and insight. Adolescents begin to understand that moral principles, such as the Golden Rule, have social utility; and that rules exist for the good of society and the benefit of its members.

These standards of morality become internalized during adolescence, meaning the youth no longer needs a strong external authority present to enforce the rules. Youth may experience shame, guilt, and other self-blame when they fail to live up to their own moral standards or the expectations of others.

Slide 179
<1 min) Next, let’s review Typical Sexual Development for ages 11-17.

Slide 180

Guttmacher Institute: Facts on American Teen Sexual and Reproductive Health

(<15 mins total)
  • (3 mins to read alone)
  • (<5 mins to discuss at tables)
  • (<5 mins to report out)
Take about 3 minutes to read the Guttmacher Institute Facts on American Teen Sexual and Reproductive Health report.

As you read the report, write down any new or surprising information on your Worksheet.

After a few mins, I will ask each table to discuss what you read and come up with 2 main points to report back to the group. We would like you to report out 2 things that were new, scary or maybe even doesn’t seem real.

Slide 181

Sexuality and Culture

Early expressions of sexuality are largely exploratory and experimental.

In some cultures, girls are expected to maintain their “purity”; while sexuality for boys is considered a rite of passage.

The birth of a baby outside of marriage may be considered shameful.
Early expressions of sexuality are largely exploratory and experimental, and are often based on biological and hormonal pressure, curiosity, a yearning for social acceptance, or an attempt to increase self-esteem.

Early expressions may also be subject to specific cultural expectations regarding sexuality for teens. In some cultures, for example, girls are expected to maintain their “purity”, while sexuality for boys is considered a rite of passage. The birth of a baby outside of marriage may be considered shameful and the girl may be sent away for the duration of the pregnancy; in other cultures, however, there may be more acceptance of the baby.

Due to such expectations, culture plays an important role in how teens approach sexuality.

LGBTQ adolescents and adults report feeling “different” from early childhood. As they develop cognitively, they come to understand their sexual orientation and society’s stigma towards it, and they are often without any social support.

LGBTQ youth who are members of ethnic minorities often have to manage more than one stigmatized identity. To further complicate things for these youth, some ethnic groups may interpret being lesbian, gay, bisexual, or transgender as a rejection of the ethnic group. Therefore, even less support may be available to LGBTQ adolescents in certain ethnic groups. (Ryan 2001)

We must be aware of the significant emotional and social struggles many LGBTQ youth may face, and help them find support. Many schools and communities have organizations to provide support for LGBTQ youth.
(<1 min) Next, let’s review the Developmental Effects of Abuse and Neglect for ages 11-17.

(<1 min) Due to their past maltreatment and trauma, many youth face the turbulence of adolescence without having completed previous developmental tasks. This may place them at high risk for a variety of dangers, such as:

- drug and alcohol abuse,
- violence in their relationships,
- sexual exploitation and human trafficking, and
- running away and life on the streets.
<1 min) Adolescents with a history of maltreatment may have a wide variety of physical delays.
  - They may suffer from stunted growth, chronic illnesses, and health conditions.
  - They may be malnourished and may have very unhealthy eating habits.
  - There may also be sleep disturbances.
  - Delays in the development of motor skills can result in poor coordination.
  - The beginning of puberty may be delayed from the impact of abuse and neglect, or may be accelerated in cases of sexual abuse.

(<1 min) Teens with a history of maltreatment may have significant difficulties relating to their peers and may not conform to social norms.
• They may not trust anyone, and may not have a sense of belonging to any group, either family or peer. They may struggle with *any* intimate relationship.
• They may appear as if they have little concern for others, and may become isolated and unreachable, avoiding any social interactions.
• Conversely, they may show a dependency, and clingingness toward peers, as well as a naïve acceptance of a peer group’s rules.
• Often, they gravitate toward much younger children.
(<1 min) The effects on the emotional development of a maltreated teen are often seen in their identity confusion and very poor self-image.

- They often don’t feel things in the same way as those on a normal developmental track, and they have difficulty expressing the emotions that are felt.
- They can appear very needy and clingy, and may be prone to anxiety or depression.
- Sometimes, they have grandiose beliefs about their capabilities and unrealistic expectations for themselves.
- It is not unusual to see a tendency toward anti-social beliefs and actions.

(<1 min) Cognitively, the maltreated teen may have the thinking processes of a much younger child.

- There are often delays in intellectual development and the development of memory.
- The inability to think logically or consider the consequences of actions can cause an inability to problem solve in productive ways.
- These teens often have very poor academic performance, and may meet the formal criteria of “developmentally delayed”.
The effects of sexual abuse can have a profound and universally negative impact on all domains of adolescent development.

- Sexually-abused youth tend to view themselves as "damaged goods": permanently damaged, both physically and socially, by their sexual experiences.
- Many children who have been sexually abused begin puberty at an earlier age than the typically developing child.
- In addition, intense guilt, shame, poor body image, lack of self-esteem, and lack of trust in sexual relationships are frequent developmental outcomes of sexual abuse.

Now let’s discuss a Case Scenario for Malcolm.
Malcolm is 16. He was arrested with a group of other kids at midnight, driving 80 MPH on the freeway. All the kids had been drinking, and several marijuana joints were found in the van. Malcolm had been a runaway, on and off, for several weeks. His mother didn't know where he was, but thought he had gone to visit a 20-year-old "friend," a man Malcolm had met a few weeks earlier in the next town.

Take a minute to read about Malcolm’s case, and then answer Questions 1 through 4 on your Worksheet.
Now compare your responses to those of an expert.

If your answers differ, why do you think they differ? If your understanding has changed or improved as a result of comparing your answers to the ones provided, add notes to your answers about how they are similar or different, and explain what you learned or where you still need to learn more.

**Slide 193**

(<1 min) Next, let’s review resources and services focused around children ages 11-17.

**Slide 194**

(<2 mins) While each youth’s strengths and needs are unique, all youth can benefit from a combination of natural supports, community resources, and professional treatments. These include the following:

- A trusting relationship with competent, caring adults;
- Pro-social community-based activities, which help youth to discover a sense of belonging and of social acceptance;
- Tutoring and other educational supports;
- Psychological and/or psychiatric evaluations and treatment;
• Family therapy, to assist the youth’s current Caregivers to better understand the youth’s strengths and needs;
• Chemical dependency evaluation and treatment;
• Occupational, physical, speech and language therapy; and
• Services from the DSHS Developmental Disabilities Administration.

Slide 195

(<1 min) You have now completed the fifth section of this training.

Slide 196

(<1 min) Congratulations! You have completed this training.

If you are a Caregiver, your trainer will let you know how to receive your Certificate of Completion.
Developmental Milestones Chart
From Birth to Five Months

Physical
- Can lift head up when lying on tummy
- Pushes down on legs when feet are on hard surface
- Holds a toy and shakes it
- Brings hands to mouth
- Begins to hold head steady
- Begins to push up to elbows when lying on tummy
- Swings at dangling toys
- Learns to roll from tummy to back

Social/Emotional
- Smiles
- Likes to play
- Copies facial expressions
- Cries in different ways for hunger, pain, tiredness
- Tries to calm self (hands to mouth)
- May cry when playing stops
- Copies some movements
- Likes to engage with people

Cognitive
- Pays attention to faces
- Follows objects with eyes
- Acts fussy when bored
- Responds to affection
- Turns head toward sounds
- Recognizes people at a distance
- Begins to babble and copy sounds
- Uses hands and eyes together
Developmental Milestones Chart
From Six to 12 Months

Physical
- Rolls over in both directions
- Likes to bounce on own legs
- Learns to get into sitting position
- Crawls or scoots
- Sits without support
- Stands, holding onto things
- Learns to pull to a standing position
- Passes things from one hand to other

Social/Emotional
- Knows familiar faces
- Loves to play
- Has favorite toys
- Reacts to strangers
- Likes to look at self in mirror
- May cling to familiar adults

Cognitive
- Responds to sounds by making sounds
- Responds to own name
- Understands “no”
- Uses finger to point
- Shows curiosity
- Looks for things that are hidden
- Likes to take turns “talking”
- Babbles and jabbers
- Copies sounds and gestures
- Looks around at things
- Tries to get things that are out of reach
- Plays peek-a-boo
Developmental Milestones Chart
From One to Three Years: Toddler

Physical
- Learns to walk
- Learns to walk up steps
- Drinks from a cup
- Stands on tiptoe
- Learns to run
- Can help with dressing
- Eats with a spoon
- Learns to kick a ball

Social/Emotional
- Shy/nervous with strangers
- Has favorite things and people
- Likes to give things to others as play
- Shows affection
- Copies affection
- Shows defiant behavior (does what he is told not to do)
- Cries when caregivers leave
- Loves interactive games
- May have temper tantrums
- Points to show interesting object
- Begins to show more independence
- Plays beside other children, but pays attention to them and notices them

Cognitive
- Explores things in different ways (shaking, banging, throwing)
- Follows simple directions
- Points to body parts
- Begins to make 2 – 4 word sentences
- Begins to sort shapes and colors
- May name items in a picture book
- Knows what ordinary things are for (telephone, hair brush)
- Says several words
- Knows names of familiar people
- Repeats words overheard
- Builds towers with blocks
- Finds hidden objects

Adapted from www.cdc.gov/actearly
The Effects of Abuse and Neglect on Child Development
Section 2: Birth to Three Years Old

Worksheet

1. Why are infants and toddlers at higher risk of abuse and neglect?

2. Why are infants and toddlers more likely than older children to suffer severe consequences from abuse or neglect?

3. List potential effects of abuse and neglect on physical, cognitive, social and emotional development.

4. As you review this information, please write down one or two of the most important things that you have learned about prenatal exposure to drugs.

5. As part of the case planning process, workers should ensure that infants receive the treatment they need to help resolve the effects of abuse and neglect. As you consider and learn about treatment for abused and neglected infants, please write down the primary resources you might seek.
The Effects of Abuse and Neglect on Child Development
Section 3: From Three to Five Years
Case Scenario: Kendra
An Expert’s Opinion

Physical Development

Her awkward gait and general lack of coordination are not normal for children of her age. It is unknown whether this indicates a developmental delay or some type of neurological problem, perhaps caused by prenatal exposure to drugs.

Social Development

Problems with social and emotional development can be considered along a continuum of mild to severe. Some problems result when children attempt to engage in age-appropriate activities when they haven't mastered the pre-requisite social skills. Other social or behavioral problems can be children's attempts to adapt to their abusive or neglectful environment; and some problems result from damage done to the child (i.e.: complex trauma). At the severe end of the continuum are emotional disturbances. Kendra has some severe problems which are common in children who have been traumatized by chronic abuse.

Kendra’s attachment with her aunt appears to be insecure. She follows her aunt constantly, and frequently seeks proximity and reassurance from her aunt.

Kendra is delayed socially. She engages in parallel play and does not engage in imaginative or cooperative play typical of preschoolers. She fights with peers whenever frustrated rather than trying to resolve disagreements verbally.

Emotional Development

Her frequent, violent temper tantrums and emotional outbursts are outside of normal behavior for preschool children. These are common outcome for children who have been traumatized by abuse. This may indicate emotional disturbance.

Night terrors may indicate anxiety or fear.

Cognitive Development

Kendra appears delayed in speech and language. Her aunt often cannot understand her. At this age; most children are understood by their caretakers. Also, her use of very simple sentences is more typical of 2- to 3-year-olds.
Her short attention span may be a reaction to the chronic stress of abuse. Children who are constantly alert to danger in the environment, or who are constantly poised for "flight or fight" are often unable to concentrate in school. Her short attention span could also indicate attention-deficit concerns.

**Case Planning & Interventions**

Case planning for Kendra should include the following interventions:

- Comprehensive developmental and psychological assessment of Kendra to determine the extent of her developmental delays and emotional disturbance.
- Evaluation by a physician for her awkward gait. The family doctor may refer her for a neurological evaluation.
- Kendra’s behavior may be too extreme for Head Start or other preschool programs. She may need a more intense program which has specialized staff prepared to help children with emotional and behavioral problems. If a specialized program is not available, then a Head Start program that has some capacity to manage Kendra’s behaviors could be considered.
- Speech Therapy would improve Kendra’s speech and language, which would likely decrease her frustration, and improve her peer interactions.
- Mental health therapy could help Kendra to do the following:
  - Learn to appropriately express and regulate her emotions;
  - Develop social skills appropriate to her age;
  - Understand that her past maltreatment is not her fault, and develop a more positive, adaptive view of herself in her present situation; and
  - Develop effective problem-solving skills.
Kendra is five years old. She and her nine-year-old sister were referred to CPS for neglect when neighbors found her trying to cross the street, unsupervised, at 10:00 PM on a Saturday evening. The subsequent investigation found that she had been severely, chronically abused, and occasionally neglected. Her mother was addicted to heroin, and used other drugs and alcohol as well. Her mother often locked Kendra up in the closet for punishment, beat her, and left her alone with her 9-year-old sister when she went out partying. Her mother has no visible means of support. Neighbors think she prostitutes herself to earn drug and rent money. Kendra and her sister were immediately placed in their aunt’s (Ms. Robertson) care. At the shelter-care hearing, mother arrived high, and the department was granted temporary custody of both girls, with continued placement at Ms. Robertson’s home.

Ms. Robertson was not surprised that CPS became involved. She stated that she had been worried about the girls for some time, and that she had kept them overnight on several occasions, when the older sister would call her for help. Ms. Robertson had not reported the situation to CPS, hoping to avoid outside intervention. Ms. Robertson is a single mother, with five children. She scrapes by on her salary as a nurse’s aide and child support she receives from her ex-husband. She stated that she loves both girls immensely, and is prepared to care for them for “as long as it takes”.

You are an ongoing CFWS caseworker. This case was transferred to you today. The investigation occurred two weeks ago, and Kendra and her sister have been in the aunt’s home since that time. Your supervisor asked you to assess Kendra’s developmental needs, in preparation for developing the case plan.
You have completed your first health and safety visit to Ms. Roberson’s home. You spoke with Ms. Robertson, and engaged Kendra in some activities such as looking at books, and coloring in a coloring book. You have gathered the following information:

- Kendra uses immature language, using only simple, short sentences. Her pronunciation is difficult for you to understand. The aunt can seldom understand her, although she stated that she is starting to catch on to Kendra’s speech patterns.

- Kendra is physically awkward. She walks pigeon-toed, with a halting gait. Her hand-eye coordination is poor, and she’s “always bumping into things.”

- Kendra has night terrors, with screaming and crying, though it seems that she never fully wakes up from these dreams. It is very difficult to calm Kendra during these episodes. Ms. Robertson holds her, and rocks her until she settles down.

- Kendra had difficulty staying on task when you and she colored in the coloring book. She was easily distracted, and you noticed that her coloring marks were haphazard, jagged lines, and that very little of her coloring was within the lines.

- Ms. Robertson explains that Kendra tries to play with children her own age, but doesn’t know how to play cooperatively, and doesn’t indulge in any “pretend play” like other children her age. Most of the children in the neighborhood avoid her.

- Kendra has severe temper tantrums about 5 – 10 times a day. These tantrums include hitting, screaming, biting and throwing toys against the walls. Ms. Robertson states, “It’s good she’s such a little thing, I can hold her still, if need be.” These tantrums occur when Kendra is frustrated, or when she cannot get her own way. She experiences frustration continually: other children and most adults cannot understand her most of the time and she is often snubbed by neighbor children who think she is “a baby”. Furthermore, she becomes angry when other children expect her to share her toys and take turns in games.

- Ms. Robertson states that when checking on the children before she goes to bed at night, she often finds Kendra in her sister’s bed. She doesn’t separate them, figuring that Kendra needs her sister for security.
Developmental Milestones Chart
From Three to Five Years: Preschool

Physical
- Physically active
- Rule of Three: 3 years, 3 feet, 33 lbs
- Weight gain of 4 – 5 pounds per year
- Grow 3 – 4 inches per year
- Cuts with scissors
- Toilet trained (usually by 3 ½)
- Can’t sit still for long
- Clumsy throwing balls
- Hopping, jumping, climbing, running
- Rides “big wheels” or tricycle
- Draws shapes

Social/Emotional
- Cooperative play
- Imaginative play
- Imaginary friends
- Reduced stranger anxiety
- Follows rules
- Simplistic idea of good and bad
- No sense of privacy
- Takes turns
- Experiments with social roles
- Wants to please adults
- Development of conscience
- Feels guilty when disobedient
- Curious about other’s bodies
- Stereotypic understanding of gender roles

Cognitive
- Ego-centric
- Illogical
- Magical thinking
- Poor understanding of time and value
- Don’t realize that others have different perspectives
- Accurate memory, but suggestible
- Primitive drawings
- May misinterpret visual cues of emotions
- Explosion of vocabulary
- Learning syntax and grammar
- Understood by most people
- Trouble sequencing events
- Difficulty separating fantasy from reality
- Vivid imagination
- Leave out important facts
- Receptive language better than expressive

Adapted from The Institute for Human Services for The Ohio Child Welfare Training Program
July 2008
1. Given what you know about child development in the first five years, did anything about the video surprise you?

2. Did you get any new insights on why caregivers and child welfare social workers need to understand child development?

3. What would you ask Ms. Robertson about Kendra’s development?

4. How would you approach Kendra to make your own observations? How would you engage her to assess her developmental strengths and needs?

5. Where else would you gather additional information about Kendra?

6. Please write down your initial assessment of Kendra’s physical, social, emotional and cognitive development.

7. How do you think abuse and neglect affected her development?

8. On the basis of your assessment, what kinds of services would you put in place for Kendra?

9. How would you help Kendra and her aunt develop a positive attachment?
The Effect of Abuse and Neglect on Child Development
Section 4: From Five to 11 Years
Case Scenario: Jenwei
An Expert’s Opinion

Assessment of Jenwei’s Development

**Physical development:** There is no information to suggest that Jenwei has significant physical delays. She appears to be developing normally.

**Social development:** Jenwei has few social skills. She is egocentric in her peer relationships and believes she should be at the center of games and activities. She cannot share or take turns. She gravitates to the youngest children on the playground. Her social skills are at a late-preschool developmental level.

**Emotional development:** Jenwei shows multiple signs of insecure and absent attachment. Jenwei also shows many signs of emotional concerns:

- Jenwei lacks trust: as evidenced in her clingy, demanding, attention-seeking behaviors, hoarding of food, and manipulativeness.
- Jenwei hoards food. This can be interpreted as an attempt to take control of her environment and to assure that her needs are met. Taking other people's belongings also suggests previous deprivation; there is no evidence that her behavior is intended to be malicious.
- Jenwei wets the bed and has night terrors. These are signs of generalized anxiety and emotional distress.
- She is easily frustrated and has poorly developed coping skills. She has not developed internalized controls to deal with frustration, and she reacts to stress at the developmental level of a 2- to 4-year-old child, with emotional overflow, physical outbursts, and tantrums.
- She has a short attention span. However, there is little if any evidence of attention-deficit disorder or hyperactivity. Her inability to sit still is more likely an emotional response to frustration or anxiety, or a pressing, chronic need to seek attention from other people.
- She displays autonomous behaviors; however, she is easily thwarted and reluctant to engage in activities in which she has little skill. She expresses a normal interest in being involved with other people and in trying new activities. However, feelings of inferiority and low self-esteem appear to interfere with her ability to stick to things when they are too challenging, or when she experiences even small failures.

**Cognitive development:** Jenwei is below grade level and is not doing well in school. Her IQ is in the normal range, and there is no evidence of an attention-deficit or learning disorder. She uses language appropriately. Her academic delays are probably related to emotional and environmental factors, including an inability to concentrate in school, and the disruption from changing schools each time she is moved. Her lack of learning does not appear to reflect an inability to learn.

Dealing with Hoarding food, Bed wetting, Stealing
Remember, you want to help Jenwei develop more normally and acquire age-appropriate skills at the same time you are managing her behavior. You also want to support Jean and her family and help to preserve the placement.

**Hoarding food**

Food hoarding often starts when the child fears that she will not have enough to eat. However, it often persists after the child has access to plenty of food. It becomes an emotional crutch for the child; and food becomes symbolic of love and nurture.

Jenwei should not be punished or criticized for hoarding food. She should be reassured that she can keep food that won’t spoil in her box, and should be assigned her a corner of the refrigerator where she can keep her perishables. When her food spoils, help her throw it out herself and replace it with something fresh. The other children should be helped to understand the reasons for Jenwei’s behavior and to be supportive and reassuring. The hoarding should diminish as she feels more secure.

**Bed Wetting**

There could be physical problems that result in bed wetting. Emotional problems, such as anxiety, can also cause it. A physical exam should be sought to rule out any physical problems, including bladder infections. (Bladder infections in young children may be symptomatic of sexual abuse.) The physician should be consulted regarding the benefits of medication.

Jean can restrict liquid intake before bed, and can wake Jenwei and take her to the bathroom before Jean goes to bed.

Jenwei should be responsible to notify Jean if the bed is wet, and Jean and Jenwei should change the linens. Jean should comment on Jenwei’s success when the bed is dry, but Jenwei should never be punished or chastised for wetting. Jenwei cannot control the wetting; therefore, making her responsible for a dry bed set up a performance test that Jenwei can’t live up to. Likewise, the family should not use a behavioral chart to track and reward “dry nights”. Since she likely has no control over her enuresis, such pressure to perform will likely increase Jenwei’s anxiety.

**Stealing**

The foster family should set clear rules that Jenwei not take other people's belongings without asking permission. Family members should be instructed to place important items out of reach to lessen the temptation.

When the family discovers that Jenwei has taken something, they should expect her to return the item. The family should negotiate a way for Jenwei to pay back the person from whom she
stole. This could be performing someone else’s chores or paying the other person an amount of money equal to what she took.

Jenwei should be taught to ask permission to borrow other family members’ possessions, and whenever possible, should be allowed to borrow or use the object. She should also be prompted to return things and rewarded for doing so. Jenwei could also perform small tasks for money, which can then be used to purchase things she wants. Her rewards should be immediate at first. She does not yet have the emotional ability to delay gratification.

Finally, the foster parent and caseworker should determine the purpose of Jenwei’s stealing, and adjust how they manage the problem accordingly. For example, the stealing may be an attempt to take control, to feel powerful, and at times, to get attention. The foster family should not reinforce these behaviors by becoming upset (which communicates that Jenwei does have power and control over them); or talking at length about why Jenwei took the item (this gives her considerable extra attention for stealing). Other acceptable means of getting and expressing power and control should be developed and reinforced. Conversely, if the purpose of the stealing is to deliberately hurt the foster parents, they would need help in strengthening the relationship between Jenwei and themselves. Stealing is often a complex problem which may require assistance from an experienced mental health practitioner or psychologist.

**Issues in School**

**Seeking Attention from the Teacher**

The teacher could use selective and differential reinforcement to promote desirable behaviors. The teacher should liberally reward Jenwei with attention for sitting in her seat, for doing her work, and for not bothering other children. At first, the teacher will need to reward Jenwei’s compliance every few minutes.

When Jenwei is disruptive, the teacher should return her to her seat with as little attention or interaction as possible. Jenwei will learn that the teacher’s praise and attention come from cooperative behavior. Longer periods of “good behavior” can be rewarded with the teacher’s undivided attention for a period of time.

Also, the teacher should help Jenwei to recognize when she becomes too physically affectionate with a person that she does not know well, and offer her more socially-appropriate ways to be friendly. Similar strategies should also be applied in the foster home.

For **performance below grade level, including messy, incomplete homework papers**, differential and selective reinforcement could again be the strategy. No attention should be given to messy papers. Jenwei should simply be instructed to re-do them neatly and completely, and should be amply (and tangibly) rewarded both for her attempts to do better, as well as for the finished product. Monetary reward or use of stars or stickers on her good papers by the teacher and the foster parents would be appropriate rewards.
Jenwei may be eligible for special educational planning, including the development of an Individualized Educational Plan (IEP). Teachers would be asked to evaluate her social and academic adjustment. She could be eligible for special services, such as tutoring, to help her “catch up” to her classmates.

**Lying to the Teacher**

Jean and the teacher should talk frequently, and if Jenwei is caught lying, it should be discussed with Jenwei matter-of-factly.

The teacher should be made aware of Jenwei’s attempts to manipulate and should be instructed how to avoid being manipulated. This includes checking Jenwei’s stories with Jean before reacting to them. For example, the teacher could have responded to the sweatshirt story with, “Sounds like you’d like to have a sweatshirt. Let’s tell Jean, and maybe she’ll help you get one.”

**Community Resources**

**Referral to a Children’s Mental Health center or Child Therapist**

Therapy or counseling, and possibly a play group, can help Jenwei deal with underlying emotional problems and issues of separation caused by the disrupted adoption and foster care placements.

**Special Recreational Opportunities**

Highly structured group activities designed to develop social skills, promote impulse control, and provide children with opportunities to succeed would be preferred, considering her levels of behavior.

**Stable Placement and Movement Towards Permanency**

All attempts should be made to provide Jenwei with a stable home and to support Jean and her family in their efforts to do so. As Jenwei’s needs are met, her behavior may stabilize and in turn, lead to options for permanency.

Jean and her family might benefit from respite and other supportive services. Jean should be encouraged to alert the worker when the stress of caring for Jenwei becomes excessive, or when she would like some time alone with her own children. Jenwei might be cared for by other foster families for a weekend, or an after-school or day-care program might be used as needed.

The foster parents should receive considerable support in managing Jenwei, and to help develop an attachment relationship with Jenwei. For instance, it may be necessary to arrange regular one-on-one time for Jenwei and Jean, in order to enhance the relationship.
If Jenwei is to receive mental health counseling, one of the foster parents should participate so that he or she can learn about how to support the therapeutic approach at home, and implement any appropriate behavior-management methods.
The Effect of Abuse and Neglect on Child Development
Section 4: From Five to 11 Years
Case Scenario: Jenwei

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

You have gathered the following information from the case file, previous foster families, Jean, and the teacher.

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

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

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

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

Jenwei does not sleep well. She cries out in her sleep, and sleepwalks. She wets the bed several times a week. She often "forgets" to change her bedding, and will pull the covers over the wet sheets.

Jenwei is energetic.

She loves to help Jean in the kitchen, but is not reliable about completing her routine chores. She wants to be involved in activities, but is easily discouraged and gives up when they don't go exactly right. She seems to lose interest in many activities quickly.
Jenwei is in constant conflict with her foster siblings. She tries to participate in games, but demands that she be the center of attention and cannot share or take turns. When the game does not go her way, she becomes quite disruptive.

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

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

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

She is disruptive in class. She is frequently out of her seat without permission, she persistently approaches the teacher for attention, she races to volunteer for any and all projects, and she bothers other children who are trying to work. She cannot attend to school work for more than a few minutes at a time.

At recess, Jenwei prefers to play with the first grade children. She can be bossy and argumentative with them. She does not get along with her classmates, who see her as a pest and "weird." She is chosen last by classmates to be on a team, and the children often complain to the teacher that "she'll just mess things up for us."

The teacher has told Jean that "Jenwei just seems to need more love." The teacher reports that Jenwei has told her many times how previous foster parents seemed to prefer their own children to her.

Once Jenwei complained that everyone in Jean’s family had been given new sweatshirts except her. The teacher responded by buying Jenwei a sweatshirt. Jean later told the teacher that none of the children had been bought sweatshirts, and that Jenwei was lying to her.

Jenwei is indiscriminately affectionate with adults. She wants to hug and kiss the teacher every day, she often clings to the teacher, and she becomes jealous and upset when the teacher shows attention to the other children.

When you met Jenwei for the first time, she said "I'm glad you're my new caseworker. I just love to get new caseworkers," and climbed onto your lap.
Developmental Milestones Chart
From Five to 11 Years: School-Aged

Physical
• Slow, steady growth
• Uses physical activities to develop gross and fine motor skills
• Puberty begins about 10 – 12 years
• Motor and perceptual skills better integrated

Social/Emotional
• More effective coping skills
• Understands how behavior affects others
• Relies on rules to guide behavior and play
• 7 – 8: Strict adherence to rules
• Sees social roles as inflexible
• Practices social roles
• Less fantasy play
• Tries to avoid punishment
• Self-esteem based on ability to perform and produce
• Rules provide structure and security
• 9 – 10: Rules can be negotiated
• Can adapt behavior to fit different situations
• Takes on more responsibility at home
• More team sports and board games
• Understands right and wrong

Cognitive
• Uses language well
• 5 – 8: Can recognize others’ perspective
• 10 -11: Can accurately recognize and consider others’ viewpoints
• Concrete thinking
• Reflects upon self and attributes
• Rational, logical thought
• 8 -10: Can recognize the difference between behavior and intent
• Understands concepts of space, time and dimension
• Accurate perception of events
• Can remember months and years past

Adapted from The Institute for Human Services for The Ohio Child Welfare Training Program
July 2008
The Effects of Abuse and Neglect on Child Development
Section 4: From Five to 11 Years

Worksheet

1. As you watched this video, what do you think are the most important points and insights? Please write down your ideas.

2. Assess Jenwei’s development in all 4 domains. Do her behaviors reflect developmental delays, and if so, which ones? Does she appear to have unresolved or poorly resolved developmental issues and if so, which areas concern you?

3. How would you suggest that Jean deal with the following problems: hoarding food; bedwetting; and stealing. How would you explain why Jenwei has these behavior problems?

4. How should the teacher deal with the issues of seeking attention from the teacher, performance below grade level, and lying to the teacher? Please write down your responses.

5. What additional community resource services would you include in your case plan for Jenwei? Identify possible resource agencies and the types of services you would recommend. What kind of support would you provide to the foster parents? Please write down your responses.
Assessment of Malcolm

Malcolm functions at a concrete operational level of cognitive development. He understands rules, but views them as manifestations of power and authority rather than as structures for justice and social guidance. He has limited perspective taking ability. He knows that people are different from him, but has no insight into other people’s feelings and behaviors. His moral development is at a pre-conventional level. He complies with rules without question if they are backed by authority.

He understands that there is a system to getting along in the world. However, he believes the answer is outside of himself. His success is determined by aligning with the “right people,” that is, adults or peers who have power, and therefore, have the key to success.

His lack of awareness of other people’s needs and feelings, and his low self-esteem, contribute to deficiencies in social skills. His peer relationships are poor. More socially-competent peers see him as inept and do not include him in their activities, except as a tag along. He is not given equal status.

His emotional development has been thwarted, but not at the level of trust (he appears to be very trusting, and in fact, is open to letting others help him.) He lacks autonomy and exhibits little self-direction. His opinions and actions are determined by anyone in close proximity, whom he perceives as having power and authority. He has very low self-esteem. He lacks initiative and industry as well. He will, though, work hard to please others. His concept of himself is in very concrete terms. He has little insight into his feelings, nor can he describe what makes him different from other people. He would have considerable difficulty establishing a stable sense of identity.

He has potentially good relationship ability. He looks to others for help, and would not be difficult for him to engage in relationships. He would not participate as an equal member of a relationship, but would behave much as a younger child would with an esteemed adult.

Services for Malcolm and His Family

Malcolm’s friendship with 20-year-old Tom poses several dilemmas. Malcolm needs structure in his home environment and to stop leaving to go to stay with Tom, who the mother does not know. However, he has been leaving at will in the past, so getting Malcolm to comply with staying home will be a challenge. Family therapy could be helpful in strengthening his relationship with his mother and building a healthy structure he is willing to “buy into”. The caseworker and therapist could help the mother and Malcolm determine, what, if any relationship with Tom is appropriate.

He can benefit from both individual and family counseling. Cognitive Behavior Therapy should be a focus of individual treatment, in coordination with family therapy. An assessment for chemical dependency might be in order.
The mother needs support in her attempts to meet a variety of Malcolm’s needs for a healthy, structured home life. She can benefit from parent training and should be actively involved with both the family therapy and Malcolm’s individual therapist, as appropriate.

He should be encouraged and helped to connect with local pro-active social groups and activities. This provides opportunity to identify with accepting, competent peers.

Important goals for Malcolm are to develop Malcolm’s self-esteem and his awareness of himself as a capable, important individual. To do this, he will need to learn how his behavior affects others, learn to recognize his own feelings and what generates them, and begin to think about his likes, dislikes, and wants apart from others opinions.

Positive, consistent, and nurturing relationships with caring adults can be very effective strategies. This can include the social worker, mother, family, friends and the broader community.

Natural and logical consequences should be used within the home structure to reinforce the concept that his behavior affects what happens to him.
Malcolm is 16. He was arrested with a group of other kids at midnight, driving 80 MPH on the freeway. All the kids had been drinking, and several marijuana joints were found in the van. Malcolm had been a runaway, on and off, for several weeks. His mother didn't know where he was, but thought he had gone to visit a 20-year-old "friend," a man Malcolm had met a few weeks earlier in the next town.

After a brief time at juvenile detention, he was returned to the care of his mother. She contacted CA, requesting voluntary services.

History

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

Characteristics

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

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

His thinking ability is very concrete, and he views the world in simplistic, concrete terms. He has limited perspective-taking ability. He knows that people are different, but he evaluates them based upon observable behaviors, and he has no insight into other people's feelings. His mother is "nice, she cooks good meals." His father "was a drunk and worked a farm." good in school."

He knows his mother gets mad when he runs away from home, but he really likes to be with Tom, his 20-year-old friend. Tom is "cool - he has his own car and rents a neat apartment." He knows right from wrong; he knows it's wrong to skip school, and believes it's good to go to church and sit quietly. He knows he shouldn't fail in school, and he should get a good job when he grows up. He believes it is wrong to hurt other people and that it's important to be nice. He doesn't like "being in trouble" at all.
He understands his own feelings in concrete terms. He knows he gets mad; sometimes he's happy, sometimes he's sad. He doesn't think it bothers anyone when he gets mad. He is impulsive. He knows he shouldn't run away, and he should be in school. He should get better grades. But none of this changes his behavior. He was in the van with the other kids because "it seemed like it would be fun and all the others were going."

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

Malcolm is gifted at guitar, and plays a second-hand model that he bought at a thrift store. He does not talk about this with anyone else at school.
SEXUAL ACTIVITY

• Fewer than 2% of adolescents have had sex by the time they reach their 12th birthday. But adolescence is a time of rapid change. Only 16% of teens have had sex by age 15, compared with one-third of those aged 16, nearly half (48%) of those aged 17, 61% of 18-year-olds and 71% of 19-year-olds.[1] There is little difference by gender in the timing of first sex.

• On average, young people have sex for the first time at about age 17, [2] but they do not marry until their mid-20s.[3] This means that young adults may be at increased risk for unintended pregnancy and STIs for nearly a decade or longer.

• Teens are waiting longer to have sex than they did in the recent past. In 2006–2008, some 11% of never-married females aged 15–19 and 14% of never-married males in that age-group had had sex before age 15, compared with 19% and 21%, respectively, in 1995.[1]

• In 2006–2010, the most common reason that sexually inexperienced teens gave for not having had sex was that it was “against religion or morals” (38% among females and 31% among males). The second and third most common reasons for females were “don’t want to get pregnant” and “haven’t found the right person yet.”[4]

• Among sexually experienced teens, 70% of females and 56% of males report that their first sexual experience was with a steady partner, while 16% of females and 28% of males report first having sex with someone they had just met or who was just a friend.[4]

• Teen sex is increasingly likely to be described as voluntary. In 2006–2010, first sex was described as “unwanted” by 11% of young women aged 18–24 who had had sex before age 20, compared with 13% in 2002. For young men in the same age-group, the share reporting first sex as unwanted decreased from 10% to 5%.[4,5]
• Teens in the United States and Europe have similar levels of sexual activity. However, European teens are more likely than U.S. teens to use contraceptives generally and to use the most effective methods; they therefore have substantially lower pregnancy rates.[6]
• Three percent of males and 8% of females aged 18–19 in 2006–2008 reported their sexual orientation as homosexual or bisexual. During the same period, 12% of females aged 18–19 reported same-sex behaviors (any sexual experience, including oral sex), compared with 4% of males in the same age-group (includes any oral or anal sex).[7]

### Teen Sexual Activity

Adolescence is a time of rapid change.

% of adolescents who have had sex by each age

![Graph showing sexual activity by age and gender](www.guttmacher.org)

### CONTRACEPTIVE USE

• The majority of sexually experienced teens (78% of females and 85% of males) used contraceptives the first time they had sex.[4]
• The use of contraceptives during first sex by females aged 15–19 has increased, from 48% in 1982 to 78% in 2006–2010.[4]
• Adolescents who have sex at age 14 or younger are less likely than older teens to have used a method at first sex and take longer to begin using contraceptives.[1]
• The condom is the most common contraceptive method used at first intercourse; 68% of females and 80% of males use it the first time they have sex. [4]
• Contraceptive use at first sex has increased over time. Particularly large increases in condom use at first sex occurred partially in response to the AIDS epidemic. [4]
• In 2006–2010, some 96% of sexually experienced female teens had used a condom at least once, 57% had ever used withdrawal and 56% had used the pill. Smaller proportions had used other methods.[4]
• Dual method use offers protection against both pregnancy and STIs. In 2006–2010, one in five sexually active female teens (20%) and one-third of sexually active male teens (34%) reported having used both the condom and a hormonal method the last time they had sex.[4]
• In 2006–2010, 86% of female teens and 93% of male teens reported using contraceptives at last sex. These proportions represent a marked improvement since 1995, when only 71% of female teens and 82% of male teens had reported using a method at last sex. However, the proportions were generally unchanged between 2002 and 2006–2010.[4]
• In 2009, 4.5% of female teen contraceptive users relied on long-acting reversible contraceptives, including IUDs and implants. This is an increase from 1.5% in 2007 and just 0.3% in 2002. [8]
• In 2006–2008, eight percent of females aged 15–17 and 18% of females aged 18–24 had ever used emergency contraception. [9]
• Nearly one in four female teens at risk for unintended pregnancy (18%) were not using any contraceptive method at last intercourse.[10]
ACCESS TO AND USE OF CONTRACEPTIVE SERVICES

• No state explicitly requires parental consent or notification for contraceptive services. However, two states (Texas and Utah) require parental consent for contraceptive services paid for with state funds.[11]

• Twenty-one states and the District of Columbia explicitly allow minors to obtain contraceptive services without a parent’s involvement. Another 25 states have affirmed that right for certain classes of minors, while four states have no law. In the absence of a specific law, courts have determined that minors’ privacy rights include the right to obtain contraceptive services.[11]

• Among sexually active teen females, 66% received contraceptive services in the last year; about one-third received this care from publicly funded clinics, the rest from private health care providers.[12]

• Nearly two million women younger than 20 were served by publicly supported family planning centers in 2006; these teens represented one-quarter of the centers’ contraceptive clients.[13]

STIs

• Although 15–24-year-olds represent only one-quarter of the sexually active population, they account for nearly half (9.1 million) of the 18.9 million new cases of STIs each year.[14]

• Human papillomavirus (HPV) infections account for about half of STIs diagnosed among 15–24-year-olds each year. HPV is extremely common, often asymptomatic and generally harmless. However, certain types, if left undetected and untreated, can lead to cervical cancer.[14]

• Two HPV vaccines—Gardasil and Cervarix—are currently available, and both prevent the types of infections most likely to lead to cervical cancer. The Centers for Disease Control now recommends HPV vaccinations for both girls and boys, starting at age 11.[15]

• In 2011, 53% of females aged 13–17 had received one or more doses of the vaccine against HPV; 35% had completed the recommended three doses. Only 8% of boys had received one or more doses. [16]

• Trichomoniasis and chlamydia are the next most common STI diagnoses among 15–24-year-olds; combined, they account for slightly more than one-third of diagnoses each year. Genital herpes and gonorrhea together account for about 12% of diagnoses. HIV, syphilis and hepatitis B account for less than 1% of diagnoses.[14]

• Young people aged 13–24 accounted for about 21% of all new HIV diagnoses in the United States in 2011.[17]

• All 50 states and the District of Columbia explicitly allow minors to consent to STI services without parental involvement, although 11 states require that a minor be of a certain age (generally 12 or 14) to do so. Thirty-one states explicitly include HIV testing and treatment in the package of STI services to which minors may consent.[18]

• Forty-three percent of sexually active females aged 15–19 received counseling or testing for STIs or HIV in the last year.[12]
PREGNANCY

• Each year, almost 615,000 U.S. women aged 15–19 become pregnant. Two-thirds of all teen pregnancies occur among the oldest teens (18–19-year-olds).[19]

• Overall, 57 pregnancies occurred per 1,000 women aged 15–19 in 2010. In other words, nearly 6% of 15–19-year-olds become pregnant each year. The 2010 rate was a record low and represented a 51% decline from the peak rate of 117 per 1,000, which occurred in 1990.[19]

• Pregnancies are much less common among girls younger than 15. In 2010, 5.4 pregnancies occurred per 1,000 teens aged 14 or younger. In other words, fewer than 1% of teens younger than 15 become pregnant each year.[19]

• The decline in teen pregnancy rates in the United States is due primarily to teens’ improved contraceptive use.[20]

• Despite having declined, the U.S. teen pregnancy rate continues to be one of the highest in the developed world. It is more than twice as high as rates in Canada (28 per 1,000 women aged 15–19 in 2006) and Sweden (31 per 1,000).[21]

• In 2010, New Mexico had the highest teenage pregnancy rate (80 per 1,000); rates in Mississippi, Texas, Louisiana and Oklahoma followed. The lowest rates were in New Hampshire (28 per 1,000), followed by Vermont, Minnesota, Massachusetts and Maine.[19]

• Eighty-two percent of teen pregnancies are unplanned; teens account for about one-fifth of all unintended pregnancies annually.[22]

• Sixty percent of pregnancies among 15–19-year-olds in 2010 ended in birth, and 26% in abortion; the rest end in miscarriage.[19]
• Black and Hispanic women have the highest teen pregnancy rates (100 and 84 per 1,000 women aged 15–19, respectively); whites have the lowest rate (38% per 1,000).[19]

• The pregnancy rate among black teens decreased 56% between 1990 and 2010, more than the overall U.S. teen pregnancy rate declined during the same period (51%).[19]

• Most female teens report that they would be very upset (58%) or a little upset (29%) if they got pregnant, while the remaining 13% report that they would be a little or very pleased.[23]

**Teens Pregnancy Rates, in 2010**

The highest teen pregnancy rates are found in the South and Southwest

CHILDBEARING

• In 2011, there were 334,000 births among girls aged 19 or younger, representing 8% of all U.S. births.[24]

• Most births among teen mothers are first births. Eighteen percent are second or higher-order births.[24]

• Nearly all teen births are nonmarital—89% in 2011, up from 79% in 2000. Yet, over the last several decades, the share of all nonmarital births that are among teenagers has been declining, from 52% in 1975 to 18% in 2011.[24]

• In 2011, there were 31 births per 1,000 women aged 15–19; this rate marked a 50% decline from the peak rate of 62 reached in 1991.[24]

FATHERHOOD

• Most teen males report that they would be very upset (47%) or a little upset (34%) if they got someone pregnant, while the remaining 18% report that they would be pleased or a little pleased.[23]
• Teen fatherhood rates vary considerably by race. In 2010, the rate among black males aged 15–19 who became fathers (29 per 1,000) was more than twice that among whites (14 per 1,000).[25]

• The rate of teen fatherhood declined 36% between 1991 and 2010, from 25 to 16 per 1,000 males aged 15–19. This decline was far more substantial among blacks than among whites (50% vs. 26%) and about half of the rate among teen girls.[25]

ABORTION

• Women aged 15–19 had 157,450 abortions in 2010.[19] About 5% of all abortions are obtained by minors.[26]

• The reasons teens most frequently give for having an abortion are that they are concerned about how having a baby would change their lives, cannot afford a baby now, and do not feel mature enough to raise a child.[27]

• As of May 2014, laws in 38 states required that a minor seeking an abortion involve her parents in the decision.[28]

References


Figure 1: Sexual activity


Figure 2: Teen Contraceptive Use


Figure 3: Teen Pregnancy Outcomes


Figure 4: Teen Pregnancy Rates by State (map)

Developmental Milestones Chart
From 11 to 17 Years: Adolescence

Physical
- Girls: Growth spurt at 11 – 14 years
- Girls: Puberty at 11-14 years
- Acclimating to changes in body
- Boys: Growth spurt at 13 – 17 years
- Boys: Puberty at 12 – 15 years

Social/Emotional
- Psychologically distance self from parents
- Social status related to peer group
- Need to be independent from all adults
- Friendships based on loyalty and trust
- Personal morality
- Increasing ability to control emotions
- Curious
- May become sexually active
- Respect honesty and straightforwardness
- Social acceptance relies on conformity
- Exploratory sexual behavior
- Conscious choices about who to trust
- Self-esteem based on what others think
- Increased frustration tolerance
- May be self-directed
- Identify with peer group

Cognitive
- Able to think hypothetically
- Consider a number of possibilities and plan behavior accordingly
- Introspection and self-analysis
- Understand and consider others’ perspectives
- Systematic problem solving
- Think logically
- May calculate consequences of thoughts and actions without experiencing them
- Insight into others
- Cognitive development is uneven and impacted by emotions

Adapted from The Institute for Human Services for The Ohio Child Welfare Training Program
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The Effects of Abuse and Neglect on Child Development
Section 5: From 11 to 17 Years

Worksheet

1. What developmental level do you think Malcolm is at?

2. What are his strengths?

3. What are you concerned about for this youth?

4. How would you plan for services to meet his needs?