Module 3: Child Development
Module 3: Child Development

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Time: 6 hours

Module Purpose: In this module, participants will learn about child maturation; the child’s developmental stages; the child’s need for protection, nurturing and well-being.

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Agenda:

Unit 3.1: How Children Develop (6 hours, 30 minutes)
Unit 3.2: Protection, Nurturing and Well-Being (4 hours)

Review the agenda with the participants.

Materials:
- Trainer’s Guide (TG)
- Participant’s Guide (PG) (participants should bring their own)
- PowerPoint slide deck
• Flip chart paper
• Highlighters/Markers (at least three per participant)
• Videos:
  o Still Face (YouTube) - 49

Activities:

**Unit 3.1:** 0-36 months - 38
**Unit 3.1:** 3-6 Year Olds – 46
**Unit 3.1:** 6-11 Year Olds – 52
**Unit 3.1:** 13-18 Year Olds – 57
Unit 3.1: How Children Develop

Display Slide 3.1.1

Time: x hours, x minutes

Unit Overview: The purpose of this unit is to provide participants with a strong understanding of the stages of child development and to provide participants with the ability to evaluate children based on the developmental stages. It also introduces the child functioning domain, how to assess a child’s functioning, and how to write adequate content about a child’s functioning.

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Learning Objectives:

1. Define the term ‘child,’ and explain the child’s role in the family.
2. Explain the maturation process of the child from cognitive, emotional, psychological and behavioral points of view.
3. Explain each stage of child development from social, cognitive, emotional, psychological, behavioral and academic perspectives.
4. Analyze child development stages.
Trainer Notes: Participants may have varying degrees of exposure to child development and developmental stages. They may also have children in any one of the developmental stages that may or may not be exhibiting the milestones you present. Be sure to address this in the beginning of class.

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We are going to start this module with a discussion on how children develop.

One of the more challenging concepts to grasp in child welfare practice is an understanding of how child development relates to abuse and neglect. This is often because our experiences, knowledge and perspectives are diverse and/or limited. We tend to infuse our beliefs, without the science to back it up.

Let’s start with talking about your comfort level in working with different age groups. In your small groups, I would like you to discuss your personal, educational and professional experiences with each of the age groups listed on the slide. I would also like you to talk about your comfort level with the varied age groups. You can think about comfort level as a 1-to-3 scale with 1 being ‘not comfortable at all,’ 2 being ‘somewhat comfortable’ and 3 being ‘very comfortable.’

Make sure that one person has made a tally of the comfort level of each member of the group and is ready to report out their findings to all participants.

Use small table groups or randomly assign participants to small groups. Allow no more than 10 minutes for this preliminary discussion. This exercise may
Now that you have exchanged information, please have one person from your table share your results with all participants. Please present the experience level of everyone at your table, and present the age groups that you were collectively ‘very comfortable’ with and ‘not comfortable at all’ with.

Allow for an exchange of information. Record on an easel pad the age groups where there is a low comfort level. This will assist you with knowing the age group(s) that you will need to spend more time on.

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How would you define “child”?

Allow for responses and point out the differences.

We use the term ‘child’ a lot in child welfare. It is important that we understand that the term has a legal definition as well as a cultural definition.

The legal definition is clear, but the cultural definition is far less clear. As a result, this lack of clarity can sometimes impact our perspective on how parents interact with their children and roles they (the children) assume as they develop into adulthood.

First, let’s talk about the legal definition of ‘child.’
Who can read for us the definition of child that is presented in Chapter 39 of the Florida Statues? (subsection 39.01(12), F.S.)

Allow for a response. Be sure that someone uses the following definition and, if it is not presented, state the following:

Chapter 39, F.S., uses the term ‘child’ and ‘youth’ interchangeably and defines a child as “any unmarried person under the age of 18 years who has not been emancipated by order of the court.”

The legal definition of ‘child’ is very clear. It is the definition you as child welfare professionals will utilize in practice.

What is important to remember is that a child’s chronological age is sometimes not congruent with a child’s developmental age. For example, a 10-year-old child with a very low IQ may be functioning only on a developmental level of a 4-year-old. As you will learn later, a child who has been abused or neglected can be one chronological age, but because of the abuse and neglect could developmentally be far younger.

How might this example impact how you view the ‘child’ in your practice as a child welfare professional?

It is also important to recognize that the concept of ‘child’ changes over a lifespan, as the child grows and develops to embrace new roles within the family structure.

The legal definition remains the same for every child, but the developmental and functioning expectations are individualized.

What factors may influence child development other than chronological age?

List the responses on an easel pad or post notes on the wall.
Who in the group would like to share factors from their own experience that affected their development either positively or negatively?

If you are comfortable with starting the conversation with your own examples, do so now. Allow ample time for participants to share, as a segue into the importance of family culture and roles impacting development.

You can use prompts such as military families, affluent families, families living in poverty, female-headed households, single-parent-headed households, African-American families, Asian-American families, etc. to elicit responses.

As you can see there are multiple variables that can impact development. Each child’s family dynamics contribute to how the child develops and the current child functioning.

To understand the child separate from the maltreatment, it is essential to understand who the child is in the context of these general milestones in concert with who the child is in relation to his or her role in the family; the impact of the child’s parenting and discipline; and the effect of how the adults and family function as a whole. All of these factors contribute to the child’s overall functioning.

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Let’s watch a brief video about the “science” of child development, what has been learned about how children develop and the lifelong impacts of child development. See PG: 4 for a brief on this topic.
The science of early brain development can inform investments in early childhood. These basic concepts, established over decades of neuroscience and behavioral research, help illustrate why child development—particularly from birth to five years—is a foundation for a prosperous and sustainable society.

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

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

**POLICY IMPLICATIONS**

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

Take a few minutes at your table to come up with some reasons for why you need to know about development.

*Allow ample time for discussion but do not collect responses. This is the foundation for the next slide’s discussion.*

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

**Why Should Child Welfare Professionals Know About Child Development?**

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

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**Trainer Notes:** Florida Center for Prevention and Early Intervention Policy

[http://cpeip.fsu.edu](http://cpeip.fsu.edu)
When we are talking about the maturation process, we are really talking about ‘normal development.’ It is important to understand that ‘normal’ means that timeframes and skills are what is ‘typical’ or ‘average’ for a specific age or age range.

For example, we would say that children learn to walk unassisted on average between the ages of 11-14 months. Does this mean some ‘normal’ children walk earlier than 11 months and after 14 months? Of course!

Remember that the term ‘normal’ or ‘typical’ has boundaries. If a child is reaching the upper boundary of that range or exceeds it, then it is imperative to ask, “Why?”

Consider an 18-month-old who is not walking. There could be a medical reason why he or she is not walking, or it could be an abuse or neglect issue, or some other reason. It is up to us to know what the ‘norm’ is so that we can make educated or informed decisions on the safety and well-being of that child.

It is also important to remember that development is sequential. Babies don’t talk before they babble; young children don’t run before they walk. Children typically have to master each skill before they move on to the next one.

It is important for you to know that ‘normal’ child development is based on the relationships that children have with those in their family system. Children are social creatures and do not develop in
It is the quality of relationships, including nurturing, protecting and remaining attached, that determines a child’s developmental trajectory. We typically think about developmental relationships as being with parents/caregivers, but this changes as we grow into childhood and adolescence. The span of the relationships a child has widens exponentially, and will include siblings, relatives, peers, and community members.

The child’s development is uniquely dependent on the relationship he or she has with his or her environment. For example, an infant who has been ‘environmentally deprived’ – experiencing little sensory interaction – will not meet developmental milestones unless there are other protective factors in place to overcome negative environmental influences.

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Community resources that are available in many Florida communities for parents are Head Start (including Early Head Start), Healthy Families Florida and quality child care. Some programs specifically focus on families who meet certain income criteria.

Your role as a child welfare professional includes knowing who your local providers are, sharing the information with families who might benefit and helping families consider why these services might be helpful to their family.
Head Start and Early Head Start programs support the mental, social, and emotional development of children from birth to age 5. In addition to education services for children, programs provide children and their families with health, nutrition, social, and other services.

Healthy Families Florida is an evidence-based, home-visiting program for expectant parents and parents of newborns experiencing stressful life situations. Early Steps provides screening and evaluation of children suspected of having developmental delays, and interventions if a delay is diagnosed.

High-quality child care may be a necessity or a choice for children who would benefit from more early stimulation and pre-school curricula. Florida’s Office of Early Learning is a resource you want to be familiar with in order to help your families identify local community choices.

We will talk more about the impact of parent/caregiver relationships on the child in the next unit and future modules in this training.

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Before we talk about the child’s developmental stages after birth, we must take an important, though brief, look at the child’s prenatal development – the child’s development before birth. If we want to understand the ‘child,’ we have to understand the relationship between prenatal development and post-birth development.
What factors do you think can impact prenatal development?

Respond appropriately, using the information in the trainer note below.

**Trainer Notes:** Responses should fall into one of the three categories below. The three factors that can have significant impact on prenatal development are:

- **Genetics**
- **The effects of teratogens or substances such as prescription or illicit drugs or alcohol.** Teratogens include things like viruses, drugs, chemicals, stressors, smoking, and malnutrition that can impair prenatal development and lead to birth defects or even child death. (Teratogens are any agent or factor that causes malformation of an embryo.)
- **Environmental factors,** such as domestic violence, parent/caregiver mental illness, poverty and/or poor nutrition during pregnancy.

All three of these prenatal factors can impact the child’s development after he or she is born, and they can be contributing factors to developmental delays or issues in each of the developmental domains, and with attachment.

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

1. Smoking increases chances of SUID (Sudden Unexplained Infant Death) deaths.
2. Prenatal depression increases the risk for postpartum depression and child neglect.
3. Substance abuse increases risks for maltreatment.
4. Prenatal stress impacts a baby’s stress response system.

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

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

Effects of Depression on Capacity to Parent - Depressed parents are:

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

Stress Impacts Development In Utero:

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

Implications for Child Welfare Staff:

- The way women take care of themselves during pregnancy can/may provide insight into how they will care for their baby.
- Many of the choices in pregnancy have long-term consequences for the baby’s development and the risks for maltreatment.
- Encouraging healthy pregnancies can reduce potential for
later abuse and neglect.

- Child neglect should trigger questions about possible depression.
- Know the signs of depression because of a high correlation between depression and neglect. Depression in one parent should also trigger clinical attention to the other parent.
- Encourage the family to see their health care provider or mental health specialist for depression screening.
- Know about community resources and in-home treatment.

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About 70-80% of women have ‘baby blues’ after childbirth, beginning 2-3 days after birth and receding in a few hours or a week later without treatment. This is common and typical.

About 10% of women develop postpartum depression. The onset is most commonly 1-3 weeks after delivery and requires treatment, which could include medication and/or counseling. Research does not link postpartum depression to the mother’s age or number of children. Risk is very high to infants; however, the risk over time can be significantly diminished if the condition is identified and treated.

Newborns of depressed mothers are more irritable and hard to soothe, have more problems sleeping, and have higher levels of the stress hormone cortisol in their blood.

There are two particularly critical windows of brain development during a child’s maturation:
- The first window is between the ages of birth to three years.
- The second window is during the teen years.

The brain is the only organ in the human body that is not fully developed at birth. All other organs - the heart, the lungs, and the kidneys - are doing exactly what they will do when you become an adult.

Your brain, however, is only at 35% of its adult weight when you are born. Brain growth is dramatic by age 3 and it is highly dependent on environmental input.

There are literally billions of cells produced and hundreds of trillions of connections or synapses between these cells between the ages of birth and 3. These connections are made in large part by the sensory input that the parent/caregiver provides. That is the way they touch or nurture their child, the colorful, happy sights and sounds they are exposed to, as well as the pleasing smells and tastes.

*Display Slide 3.1.11 & 3.1.12 (PG 10)*

Neglect is the most common maltreatment among infants.

Early childhood holds the greatest opportunities for children, but also is the time when they are most vulnerable.
We are going to watch a brief video produced by the Harvard University Center on the Developing Child, which presents the impact of neglect on child development. See PG: 11-12 for a two-page brief on this video.
Thriving communities depend on the successful development of the people who live in them, and building the foundations of successful development in childhood requires responsive relationships and supportive environments.

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

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

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

### Science Helps to Differentiate Four Types of Unresponsive Care

<table>
<thead>
<tr>
<th>OCCASIONAL INATTENTION</th>
<th>CHRONIC UNDER-STIMULATION</th>
<th>SEVERE NEGLECT IN A FAMILY CONTEXT</th>
<th>SEVERE NEGLECT IN AN INSTITUTIONAL SETTING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Features</td>
<td>Ongoing, diminished level of child-focused responsiveness and developmental enrichment</td>
<td>Significant, ongoing absence of serve and return interaction, often associated with failure to provide for basic needs</td>
<td>&quot;Warehouse-like&quot; conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive</td>
</tr>
<tr>
<td>Effects</td>
<td>Can be growth-promoting under caring conditions</td>
<td>Often leads to developmental delays and may be caused by a variety of factors</td>
<td>Wide range of adverse impacts, from significant developmental impairments to immediate threat to health or survival</td>
</tr>
<tr>
<td>No intervention needed</td>
<td>Interventions that address the needs of caregivers combined with access to high-quality early care and education for children can be effective</td>
<td>Intervention to assure caregiver responsiveness and address the developmental needs of the child required as soon as possible</td>
<td>Intervention and removal to a stable, caring, and socially responsive environment required as soon as possible</td>
</tr>
</tbody>
</table>
With more than a half million documented cases in the U.S. in 2010 alone, neglect accounts for 78% of all child maltreatment cases nationwide, far more than physical abuse (17%), sexual abuse (9%), and psychological abuse (6%) combined. Despite these compelling findings, child neglect receives far less public attention than other physical abuse or sexual exploitation and a lower proportion of mental health services.

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

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

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

IMPLICATIONS FOR POLICY AND PROGRAMS:

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

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

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

The authors gratefully acknowledge the contributions of the National Governors Association Center for Best Practices and the National Conference of State Legislatures.

Center on the Developing Child
HARVARD UNIVERSITY
www.developingchild.harvard.edu

**Also in this series:**
- INBRIEF: The Science of Early Childhood Development
- INBRIEF: Early Childhood Program Effectiveness
- INBRIEF: Preparing for Lifelong Health
- INBRIEF: Executive Function: Essential Skills for Life and Learning
- INBRIEF: Early Childhood Mental Health
Now that you have learned about the interaction between parents and children referred to as “serve and return,” how will that impact your observations of parents and infants or young children? What will you be looking for?

Endorse and elicit (make certain that all 3 points are made):

- The parent’s attentiveness to child—eye contact
- Whether the child is looking to the parent for a response
- Assessing a young child requires observation of child and parent

Significant brain development occurs at two distinct critical periods in the growth of a child into an adult. However, each child development stage is important. In this module, we will methodically walk through each critical development stage from ages 0-18.

First, we will learn more about the developmental stages that occur in a child between the ages of birth to 3. We do this because this is the most critical time period for all growth and development, not just brain development.

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Within each one of the developmental stages, there are four distinct domains:

- Physical
- Cognitive
- Social
- Emotional.
The rate and progress of a child’s development must be evaluated individually for each developmental domain.

When we talk about ‘normal’ for a child, normal describes what is typical for the majority of children in that age group.

Remember that each one of these four domains is interrelated with the other three. We will look at them individually in our discussions now, but it is important to keep in mind that the four developmental domains together, collectively, make up the child. In your work, you should not evaluate one child development domain without evaluating the others.

First, let’s talk about Physical Development.

This refers to the child’s physiological or actual body growth. Physiological, or physical, development includes such things as the child’s height, weight, body hair, breasts, hips, etc. and development of their body structure, which includes muscles, bones, and organ systems.

The development of coordination, strength and muscle tone progresses from head to toe and from the center of the body to hands and feet. Babies learn to roll over, sit, crawl, cruise and finally to walk. Motor skills lead to mobility and the independence needed to explore their world.

Motor delays may include difficulties in crawling, walking or using fine motor skills, such as holding a pencil. Some motor delays may be the result of neglect, being left in cribs for extended periods without stimulation or adjustments or a lack of experience with parenting. Motor delays may indicate a parent’s or child’s fear of exploration with attempts to stay close by for safety. Motor delays may manifest as a child continuing to crawl even though there is no medical or other indication that the child does not have the
ability to walk. This “skill regression” is a key indicator of possible trauma.

Physical abuse may result in motor delays (broken arms, legs, etc.).

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In the early years of the child’s physical development, it is important that you know growth is rapid, but it can also be deceiving. For example, right after birth, newborns will lose 5-10% of their birth weight. Then, around 2 weeks-old, a child experiences rapid physical growth. Between 4-6 months of age, the baby actually doubles its birth weight.

However, between the ages of 1 and 3, a toddler will only gain around 5 pounds and then 5 pounds each year until the age of five.

Growth and development occur at a rapid rate during the first three years of life.
- Development is dependent upon the child’s physical health.
- Physical development is also benefits from adequate stimulation and opportunity for physical activity.
- Good physical, nutritional, auditory, visual and dental health are fundamental necessities for child wellness.

**Other than weight gain, what will you be looking for as signs of good physical health and development?**

**Endorse and elicit:**
- Child can do activities typical for his/her age (crawling, walking, climbing)
- Child gets regular health check-ups and immunizations
- Child with special medical needs gets the care needed

**Why do you think most child welfare professionals are most comfortable with evaluating a child in this domain and addressing physiological concerns?**

*Correct answer should include ‘we can see it, measure it’, etc.*

Of all of the domains, the physiological aspect of child development is the easiest to assess because we can see it and measure it, and it is easy to describe or report. It is easy to say: “...the child appeared to be of appropriate weight and height for his age of 36 months and was observed to be climbing, jumping and running in an age-appropriate manner.”

**Why would it be more challenging to assess a child’s development from an intellectual standpoint?**

*Correct answers should include that it is more difficult to identify and connect behavior to cognitive or intellectual development.*

*Display Slide 3.1.16 (PG: 14)*

**Cognitive Development** refers to the development of the child’s thinking, judgment and perception.

This includes what a child knows, understands and remembers. Most importantly, cognitive or intellectual development is the domain that deals with the way a child processes information, solves problems, and thinks abstractly.
Young children are like scientists testing and discovering ways to figure things out and problem-solve. They explore, touch, mouth, grasp or gaze at anything interesting. As memory expands, they can search for hidden objects or remember people who are not present.

Young children understand more words than they are able to say. This is obvious when a baby turns his/her head toward a parent’s voice or when an older baby babbles back-and-forth with a parent. These early conversations are an important part of how children learn language. Singing, talking and reading expose children to rich vocabularies and words for later expression.

Abuse and neglect impair the prefrontal cortex, the part of the brain that controls executive functioning, which includes the ability to focus, plan, organize, remember details, manage time and attention, initiate and complete complex tasks, and persevere through challenges. As a result, children in stressful environments find it harder to concentrate, sit still, follow directions, or rebound from disappointment. Often, these manifestations of trauma are misinterpreted as “bad behavior” or medicated as Attention Deficit Hyperactivity Disorder (ADHD). Fortunately, executive functioning skills can be learned.

Cognitive delays are all too common in maltreated children, not because they are born less smart, but because of exposure to toxic stress and trauma. As you heard in the video, stress impacts the brain’s “executive functioning” and many abilities critical for academic success. Maltreated children commonly experience language delays because maltreating parents may spend less time talking with their children. Children may not talk as a response to trauma or violence. Behavior problems are common in children who lack communication skills and are frustrated when needs are not met.

The way in which developmental skills are acquired are referred to
as “approaches to learning” and include eagerness & curiosity, persistence and grit, creativity and problem-solving.

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**Social & Emotional Development**

Although the social and emotional domains are often presented as separate domains, they actually go hand-in-hand and we will discuss them as one domain. The social-emotional domains are the domains that encompass interactions with family members and peers.

Although they are often overlooked, the social-emotional domains are by far one of the most telling and developmentally influential domains in child welfare.

Trust and emotional security provide the basis for all relationships. Trust is developed as babies’ needs are met. When children feel emotionally secure, they are eager to explore their world and establish relationships and attachments.

Infants and toddlers depend on adults to help them regulate emotions:

- provide comfort to help alleviate negative emotions and reinforce positive ones;
- change the environment to provide a change of pace when needed;
- help the child label and validate their feelings, for instance, “I know that you are scared; it’s OK to be scared and I am right here for you;” and
• model coping during emotional experiences.

What would you want to learn about a child to assess the child’s social and emotional development?

Endorse and elicit:
• Relationships with parents, siblings
• Interactions with other adults, children
• How does the child get along with children at child care, school?
• For older children, do they have friends?
• Does child seem happy, moody, sad (temperament)?
• How parent manages child temperament (is it perceived as a problem)?

The earliest social task is attachment, which will be discussed in detail later in this module. Attachment is the ability to form relationships that are positive and developmentally appropriate. It is through relationships that we develop personality traits, self-esteem and a sense of well-being. Well-being is dependent on social-emotional stability and competence.

Display Slide 3.1.18

Next, we are going to look at normal developmental milestones for ages birth to 3. Please turn to PG: 16-24, Child Development Stages Matrix so that we can look at the domains together.

In addition to developing attachment, during the period of birth to 18 months, the child learns to either trust that his parent/caregiver will love and nurture him, or the child will learn to mistrust
parent/caregiver. Children develop mistrust if they do not receive the love and nurturing they need. It is during this 18-month period that children are totally dependent on their caregiver.

Between 18 months and 3 years of age, the child who has learned to trust his/her parents will exhibit self-assurance and feel proud of his or her accomplishments, whereas the child who did not have a loving and nurturing beginning may exhibit fear and doubt, and a lack of healthy ability for self-control and exploration of the world.
## Child Development Stages Matrix

### Infants and Toddlers

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

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Core Child Welfare Pre-Service Curriculum | Module 3-TG
<table>
<thead>
<tr>
<th></th>
<th>Physical</th>
<th>Socio-Emotional</th>
<th>Cognitive</th>
<th>Indicators of Developmental Concern</th>
<th>Positive Parenting Characteristics</th>
</tr>
</thead>
</table>
| **12-18 months** | Walls alone                                  | Extends attachment for primary caregivers to the world; seems in love with the world and wants to explore everything | Begins to show intentional behavior, initiates actions (drops, throws, shakes, bangs) | • Doesn’t respond to name  
• Unable to finger feed  
• Not gaining weight  
• Flat affect (no smiling)  
• Not interested in play such as peek-a-boo  
• Not taking steps  
• Cannot hold spoon  
• Doesn’t look at pictures in book | Encourages exploration  
• Applauds child’s efforts  
• Interprets new unfamiliar situations  
• Talks to child in simple clear language about things going on in the environment |
|                | Manipulates small objects with improved coordination | Recognizes image of self in mirrors  
• Solitary or parallel play  
• Fears heights, separation, strangers and surprises |                                |                                                 |                                               |
|                | Drinks from a cup with a lid and uses a spoon |                                |                                |                                                 |                                               |
|                | Builds tower of 2 blocks                      |                                |                                |                                                 |                                               |
|                | Removes hat, socks, and shoes                |                                |                                |                                                 |                                               |
| **18-24 months** | Runs and walks up steps                      | Likes to hard things to others as play  
• May have temper tantrums  
• Shows affection to familiar people  
• Plays simple pretend, such as feeding a doll  
• Explores alone but with caregiver close by | Begins to make two-word combinations that mean something  
• Imitates words readily and understands a lot more that he or she can say  
• Shows memory improvements, understand cause and effect; experiments to see what will happen  
• Begins to sort shapes and colors | • Cannot walk  
• Does not speak at least 5 words  
• Does not imitate actions or words  
• Cannot push a wheeled toy  
• Does not follow simple instructions  
• Doesn’t notice or mind when a caregiver leaves or returns | Provides opportunities to choose  
• Sets appropriate limits  
• Assists child in coping with range of emotions  
• Support new friendships and experiences  
• Responds to wanted behaviors more than disciplining unwanted behaviors |
|                | Can help get undressed                        |                                |                                |                                                 |                                               |
|                | Drinks from a cup                            |                                |                                |                                                 |                                               |
|                | Eats with a spoon                            |                                |                                |                                                 |                                               |
|                | Scribbles spontaneously                      |                                |                                |                                                 |                                               |
|                | Loves to practice new skills                |                                |                                |                                                 |                                               |
|                | Makes tower of 4 blocks                     |                                |                                |                                                 |                                               |
### Pre-School

<table>
<thead>
<tr>
<th>Physical</th>
<th>Socio-Emotional</th>
<th>Cognitive</th>
<th>Indicators of Developmental Concern</th>
<th>Positive Parenting Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Has developed sufficient muscle control for toilet training</td>
<td>✓ Has great difficulty sharing</td>
<td>✓ Is capable of thinking before acting</td>
<td>• Cannot run, jump, or hop</td>
<td>✓ Provides opportunities for child to make choices</td>
</tr>
<tr>
<td>✓ Is highly mobile—skills are refined</td>
<td>✓ Has strong urges and desires, but is developing ability to exert self-control</td>
<td>✓ Explores language ability—it becomes very verbal</td>
<td>• Cannot feed self with spoon</td>
<td>✓ Encourages independence and provides guidance with self-care (dressing, hand washing, etc.)</td>
</tr>
<tr>
<td>✓ Uses spoon to feed self</td>
<td>✓ Wants to please parents but sometimes has difficulty containing impulses</td>
<td>✓ Enjoys talking to self and others</td>
<td>• Does not speak in simple sentences that use normal word order</td>
<td>✓ Sings, plays, and dances with child</td>
</tr>
<tr>
<td>✓ Throws and kicks a ball</td>
<td>✓ Displays affection—especially for caregiver</td>
<td>✓ Loves to pretend and to imitate people around him or her</td>
<td>• Does not enjoy make-believe games</td>
<td>✓ Counts objects and identifies colors with child</td>
</tr>
<tr>
<td>✓ Disassembles simple objects and puts them back together</td>
<td>✓ Initiates own play activity and occupies self</td>
<td>✓ Enjoys creative activities—i.e., block play, art</td>
<td>• Does not spontaneously show affection for familiar playmates</td>
<td>✓ Encourages creativity</td>
</tr>
<tr>
<td>✓ Has refined eye-hand coordination—can do simple puzzles, string beads, stack blocks</td>
<td>✓ Is able to communicate and converse</td>
<td>✓ Thinks through and solves problems in head before acting (has moved beyond action-bound stage)</td>
<td>• Does not express a wide range of emotions</td>
<td></td>
</tr>
<tr>
<td>✓ Begins to show interest in peers</td>
<td></td>
<td></td>
<td>• Does not separate easily from primary caregiver</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Does not object to major changes in routine</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>Socio-Emotional</td>
<td>Cognitive</td>
<td>Indicators of Developmental Concern</td>
<td>Positive Parenting Characteristics</td>
</tr>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>✓ Continues to run, jump, throw, and catch with better coordination</td>
<td>✓ Emotional self-regulation improves</td>
<td>✓ Asks “why” questions — believes there is a reason for everything and he or she wants to know it</td>
<td>• Falls down a lot or has trouble with stairs</td>
<td>✓ Provides a sense of security by maintaining household routines and schedules</td>
</tr>
<tr>
<td>✓ Walks up and down stairs, one foot on each step</td>
<td>✓ Understands taking turns and sharing</td>
<td>✓ Engages actively in symbolic play — has strong fantasy life, loves to imitate and role-play</td>
<td>• Drools or has very unclear speech</td>
<td>✓ Supports child’s need for gradual transitioning</td>
</tr>
<tr>
<td>✓ Rides tricycle</td>
<td>✓ Self-conscious emotions become more common</td>
<td>✓ Speech can be understood by others</td>
<td>• Can’t work simple toys (such as peg boards, simple puzzles, turning handle)</td>
<td>✓ Provides warning of changes so child has time to shift gears: “We’re leaving in 10 minutes”</td>
</tr>
<tr>
<td>✓ Uses scissors</td>
<td>✓ Forms first friendships</td>
<td>✓ Should be able to say about 500 to 900 words</td>
<td>• Doesn’t make eye contact</td>
<td>✓ Points out colors and numbers in the course of everyday conversation</td>
</tr>
<tr>
<td>✓ Can button and lace</td>
<td>✓ Shows concerns for a crying friend</td>
<td>✓ Understands some number concepts</td>
<td>• Doesn’t play pretend or make-believe</td>
<td>✓ Encourages independent activity to build self-reliance.</td>
</tr>
<tr>
<td>✓ Eats and dresses by self with supervision</td>
<td>✓ May get upset with major changes in routine</td>
<td>✓ Converses and reasons is interested in letters</td>
<td>• Doesn’t want to play with other children or with toys</td>
<td>✓ Provides lots of sensory experiences for learning and developing coordination — sand, mud, finger paints, puzzles</td>
</tr>
<tr>
<td>✓ Uses toilet or potty chair; bladder and bowel control are usually established</td>
<td>✓ Scribbles in a more controlled way — is able to draw circles, recognizable objects</td>
<td>✓ Scribbles in a more controlled way — is able to draw circles, recognizable objects</td>
<td>• Lashes out without any self-control when angry or upset</td>
<td>✓ Reads and sings and talks to build vocabulary</td>
</tr>
<tr>
<td>Stage</td>
<td>Physical</td>
<td>Socio-Emotional</td>
<td>Cognitive</td>
<td>Indicators of Developmental Concern</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3-6 years</td>
<td>Has refined muscle development and is better coordinated, so that he or she can learn new skills</td>
<td>Plays cooperatively with peers</td>
<td>Is developing longer attention span</td>
<td>Poor muscle tone, motor coordination</td>
</tr>
<tr>
<td></td>
<td>Has improved finger dexterity — ties shoes; draws more complex picture; writes name</td>
<td>Enhanced capacity to share and take turns</td>
<td>Understands cause and effect relationships</td>
<td>Poor pronunciation, incomplete sentences</td>
</tr>
<tr>
<td></td>
<td>Climbs, hops, skips, and likes to do stunts.</td>
<td>Recognizes ethnic and sexual identification</td>
<td>Engages in more dramatic play and is closer to reality, pays attention to details</td>
<td>Cognitive delays, inability to concentrate</td>
</tr>
<tr>
<td></td>
<td>Gross motor skills increase in speed and endurance</td>
<td>Displays independence</td>
<td>Is developing increasingly more complex and versatile language skills</td>
<td>Cannot play cooperatively; lack curiosity, absent imaginative play</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Protects self and stands up for rights</td>
<td>Expresses ideas, asks questions, engages in discussions</td>
<td>Social immaturity: unable to share or negotiate with peers; overly bossy, aggressive, competitive</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identifies with parents and likes to imitate them</td>
<td>Speaks clearly</td>
<td>Attachment problems: overly clingy, superficial attachments, show little distress or over-react when separated from caregiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Often has “best friends”</td>
<td>Is able to draw representative pictures</td>
<td>Excessively fearful, anxious, night terrors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Likes to show adults what he or she can do</td>
<td>Knows and can name members of family and friends</td>
<td>Lack impulse control, little ability to delay gratification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continually forming new images of self-based on how others view him or her</td>
<td>Increased understanding of time</td>
<td>Exaggerated response (tantrums, aggression) to even mild stressors</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Enuresis, enoprosis, self-stimulating behavior—rocking, head-banging</td>
</tr>
<tr>
<td>6-9 Year</td>
<td>Physical</td>
<td>Socio-Emotional</td>
<td>Cognitive</td>
<td>Indicators of Developmental Concern</td>
</tr>
<tr>
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</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Thought becomes more logical, helping the child categorize objects and ideas</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Can focus on more than one characteristic of concrete objects</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Attention becomes more selective and adaptable</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Can use rehearsal and organization as memory strategies</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Emotional intelligence is developing; self-awareness and understanding of own feelings; empathy for the feelings of others; regulation of emotion; delaying gratification</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Vocabulary increases rapidly</td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Makes the transition from “learning to read” to “reading to learn”</td>
</tr>
<tr>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>Carries on long conversations</td>
</tr>
</tbody>
</table>

**Physical Developmental Concerns**:
- Gradual replacement of primary teeth by permanent teeth throughout middle childhood
- Fine motor skills: writing becomes smaller and more legible; drawings become more organized and detailed and start to include some depth
- Gross motor skills: can dress and undress alone; Organized games with rough-and-tumble play become more common

**Socio-Emotional Developmental Concerns**:
- May have a special friend
- Likes action on television
- Enjoys books and stories
- May argue with other children but shows cooperation in play with a particular friend
- Self-concept includes identifying own personality traits and comparing self with others
- Becomes more responsible and independent
- Still obeys adults to avoid trouble
- Can adapt ideas about fairness to fit varied situations

**Cognitive Developmental Concerns**:
- May focus on more than one characteristic of concrete objects
- Attention becomes more selective and adaptable
- Can use rehearsal and organization as memory strategies
- Emotional intelligence is developing; self-awareness and understanding of own feelings; empathy for the feelings of others; regulation of emotion; delaying gratification
- Vocabulary increases rapidly
- Makes the transition from “learning to read” to “reading to learn”
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>9-11 years</td>
<td></td>
<td></td>
<td></td>
<td>6-11 years, continued</td>
<td></td>
</tr>
<tr>
<td>Girls’ adolescent growth spur</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Gross motor skills are better coordinated (running, jumping, throwing and catching, kicking, batting, and dribbling)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reaction time improves, which contributes to motor skill development</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Fine motor skills improve; depth cues evident in drawings through diagonal placement, overlapping objects, and converging lines</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Self-esteem rises</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Distinguishes between effort and luck as causes of successes and failures; can become critical of others quickly</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Has adaptive set of strategies for regulating emotion</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Peer groups emerge</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Friendships are based on the pleasure of sharing through activities or time spent together</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Sibling rivalry tends to increase</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Planning improves</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Can apply several memory strategies at once</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Long-term knowledge base grows in size and organization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Improves in cognitive self-regulation (monitoring and directing progress toward a goal)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Grasps double meanings of words as reflected in comprehension of metaphors and humor</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Improved understanding of complex grammatical constructions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Conversational strategies become more refined</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Helps child develop own sense of right and wrong. Talks with child about risky things, peer pressure, etc.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Encourages child to respect other people</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Spends quality time listening to child and talking about accomplishments and possible challenges</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Talks with child about normal physical and emotional changes of puberty</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>✓ Is affectionate and honest with child.</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>11-15 Years</td>
<td>Period of rapid skeletal and sexual maturation</td>
<td>Preoccupation with body image</td>
<td>Acne may appear</td>
<td>Boys ahead of girls in endurance and muscular strength</td>
<td>Rapid growth may mean large appetite but less energy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Wants unreasonable independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dramatizes and exaggerates own fears, worries, and tears</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Resists any show of affection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Often moody; anger is common; resents being told what to do; rebels at routines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intense interest in teams and organized, competitive games; considers membership in clubs important; has whole gaggle of friends</td>
</tr>
<tr>
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<td>Girls show more interest in opposite sex than boys do</td>
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<td>Recognizes that differences exist between and within groups</td>
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<td></td>
<td>May experience prejudice, discrimination, or bias due to ethnicity or poverty</td>
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<td>Girls show more interest in opposite sex than boys do</td>
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<tr>
<td>15-21 Years</td>
<td>Physical</td>
<td>Socio-Emotional</td>
<td>Cognitive</td>
<td>Indicators of Developmental Concerns</td>
<td>Positive Parenting Characteristics</td>
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<tr>
<td>✓ Preoccupation with body image (continues through adolescence)</td>
<td>✓ Relationships with parents range from friendly to hostile</td>
<td>✓ May lack information or self-assurance about personal skills and abilities</td>
<td>✓ Physically immature, small, not showing signs of puberty or secondary sex characteristics</td>
<td>Recognizes and compliments physical maturity</td>
<td></td>
</tr>
<tr>
<td>✓ Late maturing girls (by 10th grade) are more satisfied with their body image than early maturing girls</td>
<td>✓ Usually has many friends and few confidants</td>
<td>✓ Continuing formal operational thought with abstract, idealistic, logical, hypotheticalex-</td>
<td>unable to form or maintain satisfactory relationships with peers</td>
<td>Provides accurate information on consequences of sexual activity</td>
<td></td>
</tr>
<tr>
<td>✓ Completed physical maturation</td>
<td>✓ Worries about failure</td>
<td>deductive reasoning</td>
<td>Can’t put him/herself in place of another; doesn’t consider how behavior affects others</td>
<td>Thinks not to cry, but is available to talk and listen</td>
<td></td>
</tr>
<tr>
<td>✓ Physical features are shaped and defined</td>
<td>✓ May appear moody, angry, lonely, impulsive, self-centered, confused, and stubborn</td>
<td>✓ Has conflicting feelings about dependence and independence</td>
<td>Poor self-esteem / guilt</td>
<td>Maintains positive relationship by being respectful and friendly</td>
<td></td>
</tr>
<tr>
<td>✓ Probability of acting on sexual desires increases</td>
<td>✓ Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds</td>
<td>✓ Girls may form identity and prepare for adulthood through establishing relationships and emotional bonds</td>
<td>Overcompensates for negative self-esteem by being narcissistic, unrealistically self-complimentary; grandiose expectations for self</td>
<td>Accepts feelings; doesn’t overreact and avoids disapproval</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Interest in forming romantic relationships as part of separation task; implies separation from family</td>
<td>✓ May be judgmental of adults or peers if they do not do what is “fair”</td>
<td>Engages in self-defeating testing and aggressive, antisocial, or impulsive behavior</td>
<td>Recognizes and accepts current level of interest in opposite sex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Cultural differences may cause conflict</td>
<td>✓ Seriously concerned about the future</td>
<td>Lacks capacity to manage intense emotions; moods change frequently and inconsistently</td>
<td>Encourages experiences with a variety of people (e.g., older, younger, different cultures)</td>
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</tbody>
</table>

Activity: 0-36 Months Old

Display Slide 3.1.19

Purpose:
Given scenarios, assess the child’s developmental stage in each of the three domains:

- Physical
- Cognitive
- Social-Emotional

Materials:
- Child Development Stages Matrix – PG 16-17
- Child Development Stages Worksheet – PG 25-27

Trainer Instructions:
Provide case scenarios of a child and family. Participants should read the scenarios and assess each child’s development along each developmental domain. Participants should write out their assessment.

Trainer Notes:
Allow sufficient time, depending on how many scenarios are provided, for the participants to process the information and apply analysis using the Child Development Stages handout as a reference. Be available and walk around helping participants think through the activity. This activity can include one to several (or all) examples, depending on the trainer’s assessment of the class’ understanding and learning.

Scenario 1
You conduct an initial home visit where you observe a 3-month-old female resting in her car seat in the closet in her bedroom. The mother reported that when the child cries, she places her daughter in her car seat and straps her in and places her in the dark closet because her daughter likes it in there and she
sleeps better in a dark room. When you ask the mother to change the child’s diaper, you observe no rashes or obvious bruising. The back of her head is somewhat flat, but the mother reported that her head was that way when she was born. The mother described that she breastfeeds the child but was unable to provide how often or the average number of diapers she uses daily. The child’s birth weight was 7.5 lbs. and the mother reported that her daughter’s current weight is 15 lbs. The mother stated that the child doesn’t cry. You observe the child moving her arms and legs. When the child did cry, she was placed in a swing and calmed quickly.

Answer:

Physical: Weight is within typical limits. The back of her head is flattened, perhaps from extended periods of lying on her back which raises concerns for isolation and lack of stimulation. Is placed in a closet at rest times, which should be explored and is concerning.

Cognitive: Did not vocalize sounds or smile during visit; did not demonstrate tracking. Need more information to determine

Social-emotional: Appeared to be within typical limits; calmed when fed and soothed in swing; responded to caretaker ministrations.

Scenario 2

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

Answers:

Physical: Delayed but may be due to physical disability; concern re: parents’ lack of knowledge, lack of physical/occupational therapy or physical stimulation; need additional information

Cognitive: Delayed but may be due to cognitive disability; concerns with under-stimulation; need additional information

Social-emotional: Delayed but may be due to cerebral palsy; need additional information. Does show recognition of her caregivers and attempts to engage
them by kicking her legs and waving her arms.

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

Answer:
**Physical:** Not within typical limits. Concerning. Child is only 5 lbs. over his birth weight at 6 months old; he is not sitting up on his own, is not seen grasping items using both hands, appears to be dehydrated as there are no visible tears and his skin is non-responsive; parents are watering down formula but this appears to be an education issue vs. neglect issue.
**Cognitive:** Within typical limits as the child was seen smiling responsively, socializing with his caregivers, recognizing his caregivers
**Social-emotional:** Within typical limits as the child seemed to show a broad emotional range and stronger preference for familiar people

Scenario 4
After visiting her 7-year-old sister at school, you conduct a home visit and observe a 3-year-old with two black eyes, head lice, and in filthy clothing. She appeared to be within normal limits for weight and height, although on the lighter side of the scale. The child is reported to be potty-trained, however she was in urine-and feces-saturated diaper. When talking with her, she was able to tell you her name, the name of her sibling, and her age. She did not know any letters of the alphabet, any of the eight standard colors or any basic shapes. Her mother is a stay-at-home parent. There were a number of curdled bottles of milk in the kitchen, and the home was in complete disarray except for the mother’s room, which was set up as a gaming room where the mother acknowledged she spent the majority of her day. She informed you that she gets frustrated when she is in the middle of a game and she has to stop to feed or change her daughter, saying “but I do it.” The mother said that when she is gaming, her 3-year-old daughter usually just watches television or stays in her room.

Answer:
**Physical:** Need more information regarding daily activities and overall assessment of physical abilities and development. Appeared to be within
typical limits for weight and height given age.

**Cognitive:** Concerning and does not appear to be within normal limits.

**Social-emotional:** Concerning and does not appear to be within normal limits.

**Scenario 5**

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

**Answer:**

**Physical:** within normal limits

**Cognitive:** within normal limits

**Social-emotional:** within normal limits

**Trainer Note: Answers**

In the following table, find information related to each scenario’s child development stages as indicated in the narratives. For each portion of the narrative on the left, the related developmental stage indicator is on the right.
<table>
<thead>
<tr>
<th>Narrative Information</th>
<th>Stage</th>
<th>Assessment</th>
<th>Stage</th>
</tr>
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</table>
| Scenario 1            |       | □ Within typical limits  
|                       |       | □ Not within typical limits – parents managing  
|                       |       | □ Not within typical limits – parents not managing; needs attention  |
| Scenario 2            |       | □ Within typical limits  
|                       |       | □ Not within typical limits – parents managing  
|                       |       | □ Not within typical limits – parents not managing; needs attention  |
| Scenario 3            |       | □ Within typical limits  
|                       |       | □ Not within typical limits – parents managing  
|                       |       | □ Not within typical limits – parents not managing; needs attention  |
| Scenario 4            |       | □ Within typical limits  
|                       |       | □ Not within typical limits – parents managing  
|                       |       | □ Not within typical limits – parents not managing; needs attention  |
| Scenario 5            |       | □ Within typical limits  
|                       |       | □ Not within typical limits – parents managing  
|                       |       | □ Not within typical limits – parents not managing; needs attention  |

Activity STOP
Now let’s turn our attention to the next stage of child development, which is the Preschool Period.

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

Please turn again to **PG: 18-20, Child Development Stages Matrix**, and let’s review the information in the table related to the Preschool Period.

*Walk through the table of children during the Preschool Period and point out the various indicators of ‘normal’ child development.*

*Ask participants if there are any questions so far about child development, and respond appropriately.*

We have just looked at all of the developmental milestones by domain for ages birth to 3.

I want to spend a couple of minutes talking about social-emotional development in the early years, keeping in mind that children are at most risk for maltreatment during this period.

**PG: 33**
How do we develop socially and emotionally?

**Trainer Notes:** There should be an understanding by now that social-emotional development is dependent on relationships and healthy, stimulating environments.

Emphasize that, during the first five years, we become socially-emotionally competent if we are parented in a loving and consistent manner. Social-emotional competence means that even as young children we can manage our interactions with our parents/caregivers, siblings and friends, and we can regulate our emotions in a developmentally appropriate manner.

What is important to remember is that social-emotional competence or incompetence is ingrained and habituated. In other words, it is firmly established, even at an early age, and is difficult to change.
Can someone tell me the relevance social-emotional development between ages birth to five has on the later periods?

Endorse:
- It sets the foundation for all future relationships, including school-based relationships and functioning.
- It is directly tied to brain development, physical development and cognitive development.

What relevance does this have on child welfare practice?

Neglectful or abusive relationships interfere with social and emotional development. First relationships set the foundation for future relationships. Failure to meet basic needs lead to mistrust and an inability to form close and secure social relationships. Lack of emotional security makes children fearful to explore their world.

Abusive or non-responsive relationships impair the child’s ability to experience, regulate and express emotions. Children learn by imitation-smiling back to happy parents, or learning a flat dull affect if parents are non-responsive or depressed, or learning to avoid angry interactions. These stressful interactions become toxic without the buffering of responsive, caring adults. Excessive cortisol disrupts developing brain circuits, making it hard to calm down and apply other skills in self-regulation.

Correct response should include the necessity to assess and evaluate a child’s functioning, as well as the child’s caregivers’ capacity to protect the child.
Activity: 3-6 Year Olds

Display Slide 3.1.21

Purpose:
Given scenarios, assess the child’s developmental stage in each of the three domains:

- Physical
- Cognitive
- Social-Emotional

Materials:
- Child Development Stages Matrix – PG: 18-20
- Child Development Stages Worksheet – PG: 30-32

Trainer Instructions:
Provide case scenarios of a child and family. Participants should read the scenarios and assess each child’s development along each developmental domain. Participants should write out their assessment.

Trainer Notes: Allow sufficient time, depending on how many scenarios are provided, for the participants to process the information and apply analysis using the Child Development Stages handout as a reference. Be available and walk around helping participants think through the activity. This activity can include one to several or all examples depending on the trainer’s assessment of the class’ understanding and learning.

Scenario 1
James is a 4 year old who does not attend formal Pre-K education program. He has a 6 year old sibling and a 2 year old sibling. James’ favorite things to do are color. While you were visiting, he engaged you in trying to sit with him on the floor and to play the “hopping” game and red light/green light. You both took turns being the traffic light and he brought you to his room to see his
toys. When his mother asked him to grab a diaper and wipes for his sister, he cooperated and retrieved the requested items. His verbal skills were excellent and shared several stories about his siblings and a recent holiday trip.

**Scenario 2**
Josh is a 5 year child who was interviewed and observed at home. He has an older sibling in the 6th grade. His mother was reported to be depressed and not managing her self-care or personal hygiene. Upon arriving, the child welfare professional attempted to engage Josh in rapport building but he appeared not to hear. Josh was distant and disengaged and sat on the floor the whole visit putting his toy cars in a straight line, readjusting them and reorganizing them by color. His mother reported that he does not like to be disturbed so leaves him to play on his own. She reported he does not have peer aged interaction except with his sibling and even then it is distant since Josh prefers solitude. Josh’s mother believes Josh is just a quiet child. She is looking forward to his starting kindergarten next year so he can have more social interaction. Josh is verbal, though not by direct observation. The mother denied any diagnosis for herself or Josh.

**Answer:**
**Physical:** Within typical limits – by organizing and reorganizing his toys, he was seen to have refined muscle development. His height and weight appeared to be within the normal range for his age.

**Cognitive:** Concerns, but need additional information. Unable to determine cooperative play or assess his cognitive capacity; however he did organize his toy cars by color. Disengaged, flat affect. He did not communicate orally during the visit. Consider autism or Asperger’s.

**Social-emotional:** Concerns, but need additional information. Has developed a longer attention span within normal child development milestones; did not express ideas, ask questions or engage in discussions.

**Scenario 3**
Sam is a 4 year old child who was diagnosed as a drug-exposed infant to methamphetamine and crack at birth. He is an active child and goes from one activity to another quickly. He climbed on furniture and ran up and down the
stairs during the home visit. When Sam’s mother would correct his behavior by yelling or talking to him, Sam would immediately mimic his mother and repeat back to her what she said in the manner in which she said it. At random times during the interview, Sam would throw items across the room for attention. At one point during the interview, Sam went into the kitchen and spilled a whole box of cereal on the table and floor, then began running through it and throwing it up like confetti. Sam is potty-trained, and his mother stated that he does not enjoy reading. She said he will sit for a few minutes and color, but he prefers to watch television or play video games.

**Answer:**

**Physical:** Within normal limits — Sam demonstrated gross and refined muscle development; coordinated, able to climb, hop, run and do stunts

**Cognitive:** Concerns related to attention span and attention to detail; able to express ideas, ask questions and engage in discussion for brief periods of time.

**Social-emotional:** Concerns related to his ability to play cooperatively, share or take turns given his poor attention span; displays independence and likes to show adults what he can do

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**Scenario 4**

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

**Answer:**

**Physical:** Within normal limits, considering his demonstrated ability to manipulate fine muscles to connect puzzle pieces; he was ambulatory

**Cognitive:** Need additional information regarding his ability to play cooperatively and to understand his capacity to share and take turns. He seemed to display some independence. He was able to name standard colors and shapes, verbalize and recognize letters of the alphabet and names of all family members.

**Social-emotional:** Need additional information but concerns associated with flat affect and head-banging or other self-harm behaviors. Although the mother was able to calm him, his explosive frustration and associated
negative behaviors will be a continued concern when he begins school.

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

<table>
<thead>
<tr>
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**Activity STOP**
We just finished going through the developmental milestones for birth to five.

Does anyone have any questions?

Display Slide 3.1.22 (PG: 36)

Now, we are going to turn our attention to latency age.

When we use the term ‘latency age,’ we are talking about the ages between 6 and 11 years old. It is during this time that school becomes a very important aspect of the child’s life. Children are exposed to new demands socially as well as academically. From a social-emotional standpoint, children who are successful in school feel competent, and those who experience failure feel inferior.

From ages 6-8, school gives children more contact with the larger world, so they begin to develop:

- Independence from family
- Unique personalities
- Important friendships
- Confidence in schoolwork and sports.

Children ages 9-11 experience:

- Growing independence
- Peer pressure
- Physical changes of puberty, especially for girls
Concerns for a child in this age range would include:

- Excessive concerns about competition
- Extreme rebellion
- Teasing, whining
- Extreme procrastination
- Overdependence on caregivers for tasks, e.g., combing hair, going to the store, tying shoes, finding a restroom
- Social isolation; lack of friend or involvements
- Inappropriate relationships with “older” people.

**How might school performance impact relationships (parent/caregiver and peer)?**

**Trainer Notes:** Try to elicit behaviors that could be observed.

Please turn again to the **Child Developmental Stages Matrix** located in the Participant Guide. You will notice that as we move forward in the developmental stages, we begin to master the previous physical milestones, and thought process becomes more refined.

**What has been your personal experience with children who are school-age?**

*As responses are offered, help participants put their response into one of the developmental domain categories. Also, be sure to ask about the environmental influences that impacted any of the domains (positively or negatively), and associate it back to infancy and early childhood.*

In general, for most children, this period will be a pretty calm and enjoyable period if the appropriate foundation was set in infancy and early childhood.

*Ask if there are any questions about what they have learned so far regarding the various indicators of behavioral, cognitive and social/emotional child development.*

*Respond appropriately, to the extent necessary, using the Child Development Stages Matrix as the focus.*
**Activity: 6-12 Year Olds**

*Display Slide 3.1.23 (PG)*

**Purpose:**
Given scenarios, assess the child’s developmental stage in each of the three domains:
- Physical
- Cognitive
- Social-Emotional.

**Materials:**
- Child Development Stages Matrix – *PG: 21-22*
- Child Development Stages Worksheet – *PG: 34-36*

**Trainer Instructions:**
Provide case scenarios of a child and family. Participants should read the scenarios and assess each child’s development along each developmental domain. Participants should write out their assessment.

**Trainer Notes:** Allow sufficient time, depending on how many scenarios are provided, for the participants to process the information and apply analysis using the Child Development Stages handout as a reference. Be available and walk around helping participants think through the activity. This activity can include one to several (or all) examples, depending on the trainer’s assessment of the class’ understanding and learning.

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

Answer:

**Physical:** Within typical limits – There are no obvious concerns with Sadie’s physical development by report and observation.

**Cognitive:** Within typical limits – Sadie is emerging as a unique individual and personality, and can be very independent at times. She has some degree of success in school and enjoys reading. She has learned verbal basic structure and uses language creatively.

**Social-emotional:** Sadie is strongly influenced by her peer group, and her boyfriend and her group identity is important to her; she is judging herself by how her boyfriend and peers view her. She is conflicted between her parent’s values and those of her peers. While many of these points are within typical limits for child development, the concern is associated with Sadie’s volatility, provocative behaviors with her mother, sexual activity at an early age, decision-making related to her boyfriend, her self-esteem and her mother’s ability to manage Sadie’s increasing defiance.

**Scenario 2**

Max is a 12-year-old, 7th-grader who excels in academics and sports. He is a well-rounded athlete playing baseball, soccer, and football. His mother died when he was 5-years-old. His father was a college athlete, and he expects Max to be the best. Max worries that he is never good enough at anything he does because, despite doing his best, his father is always correcting him. His dad will praise him publicly, but recently has started to yell or correct Max’s ‘mistakes’ during games. Max has several friends who come over to his house to play or hang out. When his friends are over, they usually go to his room to play video games and drink alcohol. Max had his first drink when he was 8-years-old and now has a drink before he goes to school and gets drunk at least once during the weekend. Max has started cutting himself on his legs. He said it is interesting to see the yellow fat, and he stops cutting when he sees it. He was observed with 9 straight lines of cuts on the inside of his calf.
**Answer:**  
**Physical:** Within typical limits as evidenced by his physical stature, his coordination and fine and gross motor skills to excel athletically.  
**Cognitive:** Within typical limits as evidenced by his academic performance, strong verbal communication skills and use of language; he is task-oriented; uses language creatively; feels that success depends on his ability to do well in school, to learn, and in sports.  
**Social-emotional:** Within typical limits in that he is emerging as a unique individual and personality; he can be independent and self-assured, but has some maladaptive behavior to coping (drinking, self-cutting). He enjoys working and playing with others and is beginning to feel conflicted between his parent’s values and those of his peers. Some of his malcontent stems from feelings of inadequacy and, although he drinks, he knows he is not supposed to so he is conflicted in his beliefs that rules are important and should be followed.

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

**Answer:**  
**Physical:** Delayed, not within typical limits  
**Cognitive:** Delayed, not within typical limits  
**Social-emotional:** Delayed, not within typical limits  
It seems obvious in this example that the child suffers from a physical and cognitive deficiency, but his needs appear to be met adequately. The purpose of our exercises is recognition and ability to connect to Developmental Services, if needed.

**Scenario 4**
Meg is an 8-year-old, 2nd-grader. She has significant absences from school and...
is often seen riding her bicycle in the neighborhood throughout the school day. When you meet Meg, she immediately hugs you, holds your hand while walking and wants to sit in your lap when you sit together to talk. DCF records indicate that Meg’s mother has a history of allegations of illicit drug use and there was one report alleging sexual abuse of Meg by the mother and her boyfriend. The report indicated that Meg’s mother was prostituting her daughter at a local daily motel for a six-pack of beer and that the mother’s boyfriend asked the mother if he could have sex with Meg for his birthday. It was unknown what the mother’s response was to her boyfriend related to his request. Meg is always dirty and appears unkempt and ‘on her own’ day and night.

**Answer:**

**Physical:** Within typical limits as evidenced by her ability to ride a bike, walk, run; she presents as meeting physical developmental milestones, is energetic and has increased coordination and strength.

**Cognitive:** Appears to be within typical limits in that she could converse, was inquisitive, had learned verbal structure and used language creatively. She is demonstrated to be truant from school due to parental failure to ensure she gets there and that this need is met. Education does not appear to be prioritized in this family, and there is concern for Meg’s continued growth in this area.

**Social-emotional:** Within typical limits in that Meg appears to have learned to be very independent and self-assured, and is at times childish and silly. She enjoys playing with others and alone. She likes school but said her mom doesn’t get up to bring her so she misses a lot of school. Meg seems to like affection from adults and seeks that attention in overt ways. It would be conceivable that she could be easily manipulated by adults and potentially exploited.

**Trainer Notes:** In the following table, find information related to each scenario’s child development stages as indicated in the narratives. For each portion of the narrative on the left, the related developmental stage indicator is on the right.
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**Activity STOP**

*Display Slide 3.1.24*
Now, we are going to move into adolescence and what occurs developmentally for children during adolescence.

What emotional or visceral responses do the words ‘adolescence’ or ‘teenager’ conjure up for you?

Depending on your age and life experience, the words ‘adolescence’ or ‘teenager’ usually evoke a response. This is because this is the second critical period of development. We are talking about the ages between 13-18 years old.

As we discussed earlier in this module, the second critical period for brain development is during the teen years.

Activity: 13-18 Year Olds

Display Slide 3.1.25

Purpose:
Given scenarios, assess the child’s developmental stage in each of the three domains:
- Physical
- Cognitive
- Social-Emotional.

Materials:
- Child Development Stages Worksheet – PG: 37-40
**Trainer Instructions:**
Provide case scenarios of a child and family. Participants should read the scenarios and assess each child’s development along each developmental domain. Participants should write out their assessment.

**Trainer Notes:** Allow sufficient time, depending on how many scenarios are provided, for the participants to process the information and apply analysis, using the Child Development Stages handout as a reference. Be available and walk around helping participants think through the activity. This activity can include one to several (or all) examples, depending on the trainer’s assessment of the class’ understanding and learning. It would be easy for participants to get sidetracked from what they are assessing given the information provided. Trainers should be cognizant to focus the attention to the development domain and reassure participants that assessing development and understanding the needs of a child given concerning behavior or presentation go hand in hand. The purpose of this assignment is that participants can recognize, using their tool, what is ‘within normal limits’ and what may not be and may need further evaluation or information.

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

**Answer:**
**Physical:** Within typical limits. There is nothing to indicate Eric is outside
typical limits for his physical development. He is of average height, weight and muscle mass given his age. He appears to have reached all sequential physical developmental milestones.

**Cognitive:** There is nothing to indicate that Eric has difficulty processing information, learning, and applying lessons learned. He is articulate and can use language creatively. His school performance was less than stellar but was within the average range for most of his educational training. He is not currently thinking about vocational choices and has not demonstrated or verbalized an interest in making money.

**Social-emotional:** Eric relies heavily on his parents, older siblings and his peers for entertainment. His mood is expressive and engaging. He may be letting behavior by peer groups influence his behavior. While his overall social-emotional development may not be outside the typical limits, there are signs and concerns that should be addressed in an effort to help Eric establish independence and individuality in a positive direction.

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

**Answer:**

**Physical:** Within typical limits. Martha’s physical structure is similar to an adult’s. She is beginning sexual maturity and experiences increased sexual drives.

**Cognitive:** Within typical limits. Martha is able to reason, problem-solve and think logically and abstractly. She uses language creatively, converses, and is average to above average in intelligence based on academic performance and observation. She shows an interest in doing well in school and sports, and was goal-and future-oriented. She was capable of introspection and perceiving differences between how things are and how they might be.
Social-emotional: Within typical limits; however, she needs help dealing with many changes taking place so she can retain a strong sense of identity and values, but this is conflicting with her parent’s values and she recognizes it. She is concerned with meaningful interpersonal relationships and developing a personal morality code.

Scenario 3
Aaron is a 16-year-old habitual runaway. Aaron has been in the child protection system since he was 4-years-old and in the foster care system since he was 11-years-old. He was sexually abused by his father and several of his father’s acquaintances for years. His mother abandoned him and his father when he was an infant. His father also frequently had women over and would pay them to have sex with Aaron starting at age 9. His father would watch these encounters, often masturbating while Aaron and the adult female would engage in sexual interactions, and he would correct Aaron’s ‘technique.’ Aaron’s father began masturbating Aaron and encouraging him to watch pornography so he could become a ‘real man.’ On several occasions, Aaron’s father would force Aaron to perform oral sex on him while they watched pornographic movies. Aaron was removed from his father’s care when his father was arrested for physically abusing Aaron. While in therapy, Aaron began disclosing the horrendous abuse he suffered. Aaron has difficulty forming relationships and had a number of failed placements given some challenging behaviors such as urinating in the refrigerator, masturbating in public areas of the home, uncleanness and general hygiene. Aaron built a website when he was 13 and started selling sex. Aaron has been prostituting himself and has been arrested several times and returned to his foster home. On average, Aaron has approximately 10 runaway episodes a month. Aaron denies depression, denies poor self-esteem and demonstrates that he thinks very highly of himself, of his intelligence and of his attractiveness. He said he sees no problem in what he is doing and says he is not hurting anyone.

Answer:
Physical: Within typical limits. No indications of any physical developmental anomalies.
Cognitive: Aaron lost interest in academic studies when his grades began to show poor performance. He is able to reason but does not engage in introspection. He sees things the way he must for his survival and will not entertain how things might be or the perils of his choices.
Social-emotional: Aaron was exposed to severe physical and sexual abuse as a child, and his sexual maturity and experiences were outside the typical age range for such exposure. He seeks attention from others in sexually inappropriate, provocative ways and receives validation by being sought after and paid for his sexual favors. Aaron does not have any close friendships or
emotional involvements, and is not concerned with meaningful interpersonal relationships. Aaron is engaging in high-risk behaviors that are a threat to him. He is within typical limits in that he is interested in making money, but the means to do so are not within appropriate limits and concerning.

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

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**Activity STOP**

**Does anyone have any remaining questions about the developmental stages of the child?**

*Respond to questions appropriately.*
Great work. We have practiced identifying, through narratives, the developmental stages of a resilient, protected child and a child who is not resilient due to his family circumstances and experience.

In this next unit, we will be taking a deeper dive into aspects of the child that are either influenced by, or influence, the child’s developmental stages.
Unit 3.2: Child Attachment, Permanency and Well-Being

Display Slide 3.2.1

Time: 4 hours

Unit Overview: This unit broadens the focus from the child’s developmental stages to look at the child’s needs within the family for safety, nurturing and attachment, and well-being, providing definitions and examples, as well as scenario or video practice to determine where these needs are and are not being addressed. In addition, participants learn about the importance of meeting the child’s needs from a well-being point of view.

Display Slide 3.2.2

Learning Objectives:
1. Explain the child’s need to be safe and feel safe.
2. Define and describe nurturing, attachment and permanency.
3. Explain why nurturing, attachment and permanency are so important to the child’s development.
4. Define and discuss the term ‘well-being’ as it relates to the child.
5. Given scenarios, assess the impact of a child’s life experience with his/her parent/caregiver, as well as with close but extended family, on
the child’s sense of feeling safe, and of his or her attachment, well-being and permanency.

**Trainer Notes:** It is essential that you make the connection to development throughout this unit.

*Display Slide 3.2.3 (PG: 41)*

In this unit, we are going to talk about the importance of nurturing and attachment and how it is related to child welfare practice, specifically permanency for the child.

The information in this unit is paramount to effective child welfare practice and ensuring that children are safe and that their well-being is attended to.

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

Remember the ‘still face’ experiment in the “Science of Neglect” video we watched. Infants have a fundamental need to interact with their caregiver. The quality and stability of these early relationships affects all aspects of child development.

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

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

_Display Slide 3.2.4 (PG: 41)_

“Although young children certainly can establish healthy relationships with more than one or two adults, prolonged separations from familiar caregivers and repeated ‘detaching’ and ‘re-attaching’ to people who matter are emotionally distressing and can lead to enduring problems.” (Young Children Develop in an Environment of Relationships, The National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University)

While removing a child may be essential in order to achieve immediate child safety, paying attention to who the child is emotionally attached to is imperative. Most children, despite the harm they have suffered, are attached to their parent/caregiver. Ongoing visitation, or family time, is imperative to the child’s well-being in a safe, sometimes supervised setting.

When children are removed from their parents and placed in care, it can also be further damaging to a child to be moved from one home to another.

Two of the most important performance measures associated with child well-being for the child welfare system are:

- Stability in out-of-home care, meaning no more than two moves
- Achievement of permanency within 12 months of removal (with exceptions possible when parents are making
Both videos that we watched discussed how social-emotional development is uniquely tied to the other domains.

As child welfare professionals, we want to create safe, caring and responsive homes that will support the development of socially and emotionally healthy children. We want positive environments for all children, to help them to become confident and independent adults.

Most importantly, as child welfare professionals we want children to be safe and feel safe.

Display Slide 3.2.5

At your table, take a few minutes to talk about what it means to ‘be safe’ and ‘feel safe.’

Have participants incorporate their own life experiences.

When did you feel safe or when did you feel not safe?

Walk around the room and listen to the discussions. Prompt participants to talk about emotional safety, as well as physical safety.

Debrief with all participants and have them discriminate between ‘being safe’ and ‘feeling safe.’ Make sure to provide them with corrective feedback to understand the difference.
‘Feeling safe’ has to do with being firmly attached to the parent/caregiver, having a sense of permanency, and being nurtured.

As we get further into Core, we will look at your response to a child who is unsafe and the sometimes unintended impact of the child welfare system on the child (traumatizing or retraumatizing the child in its efforts to keep the child safe). We will talk about psychological, or emotional, safety, and your role in making the child feel safe.

In this unit, we are focusing on the things that will make a child feel safe.

Display Slide 3.2.6 (PG: 42)

When we talk about child safety, there is a three-tiered hierarchy of safety, with physical safety being at the core of the hierarchy.

Physical safety means that a child is not at risk of injury or threats of injury.

The second level of the hierarchy is social safety, which refers to an interpersonal sense of the child being safe from verbal abuse, verbal threats or teasing.

The last level in the safety hierarchy is emotional safety, which means that you have an internal sense of being safe. Children must feel safe on all three levels, or development will be affected.
When you think about the developmental stages, starting with infancy, what are the places where you are most likely to see threats to safety?

Correct response should include the home, school and the community. Be sure that participants think about community activities, such as sports, churches, and ‘on the streets.’

When do you think the concept of ‘feeling safe’ begins for a child?

NOTE: As you discuss this and other aspects of the child feeling unsafe physically, socially and emotionally, make sure to bring up relevant things you talked about with participants at each of the developmental stages (Ages 0-3, 3-6, 6-11 and teen years).

Remember the “still face” experiment we watched in the second video. What did you see in the video in terms of ‘feeling safe?’

Guide participants in their thinking about physical, social and emotional safety as they discuss the video.

Whenever we talk about the three levels of safety, we have to talk about protective capacities. Protective capacities are the parent or caregivers’ personal characteristics that specifically and directly relate to the protection of one’s child.

We will learn much more about protective capacities in Module 8.

Display Slide 3.2.7 (PG: 42)
There are several factors that may impact a parent’s ability to be protective.

The following questions are being asked in order to help participants better understand the information being presented. Let participants share any stories they may have about their own experiences.

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

Remember, also, that no matter how functional or dysfunctional they are, most parents/caregivers love their children and believe they are good parents. When a child is removed from his home, he is being removed from the only family he’s known. That can be traumatic.

**How might the behavior of a child who has a developmental delay or a major medical need impact the parent’s ability to be protective?**

**How might a parent’s alcoholism or addiction impact that parent’s ability to be protective?**

**How might the health or cognitive capacity of a parent impact the parent’s ability to be protective?**

*Display Slide 3.2.8 (PG: 43)*

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**Core Child Welfare Pre-Service Curriculum | Module 3-TG**
As a child welfare professional, it is important to remember that our system, through its best of intentions to help a child, can inadvertently do harm.

So – the last factor that impacts child development is separation from the primary caregiver.

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

To help you understand, let’s put it in adult relationship terms.

I want everyone to close their eyes and think of the one person that you believe you have the best relationship with. It can be a romantic relationship, a family relationship or a peer relationship.

(Pause)

Now, I want you to visualize that someone comes in and removes you from the relationship, has you move in with people you do not know or barely know, and limits your interaction with that beloved person to just a few hours a week at most.

Allow a few minutes for participants to think about this scenario.

What feelings were you feeling? How do you think your relationship would fare after 1 month, 3 months, 4 months, 8 months or longer?

Allow for free discussion.

Now, consider that you are an infant...or a 3-year-old...or a 9-year-old...or a teenager?

Wouldn’t it be reasonable to believe that the relationship would
change, depending on the age of the child and the child’s ability to cognitively understand what is happening?

Back to our legal foundations, the concept of “least intrusive” in terms of child development means that if we can make a child safe in his own home while at the same time working with the parents to remediate the problem, that would be least intrusive and damaging from a child development perspective.

You will be learning how and when child removals are essential, and how to attend to a child’s important relationships with parents and others while in care.

*Display Slide 3.2.9 (PG 43)*

When we think about attachment, we also have to consider the multiple other significant relationships that a child may have. Considerations should be made beyond the parent or current caregiver.

Once again I want you to think about each one of your own relationships. What impact would it have on you if you were separated from not only your parents, but also the following: your siblings, your relatives such as your grandparents or your favorite aunt, your neighborhood and the park you loved to play in, and your school, sports team that you play on, or your church? Consider that you had to also leave behind your cat, or dog, that laid in the bed with you every night?
Does anyone want to share how this would make them feel?

We, as child welfare professionals, cannot discount any of these relationships. We have to be cognizant that when we remove a child from home, we are potentially breaking attachments in each one of these areas.

For right now, though, it is important that you recognize that breaking attachments will always be traumatic for the child.

The take-away here is that we should be working diligently to keep as many of these relationships intact when safe, because it can make a huge difference in stability for the child and reducing stress brought on by being involved in the child welfare system.

Display Slide 3.2.10 (PG: 43)

We all understand that a child’s safety is paramount in the child welfare system. We also must put a premium on child well-being and permanency.

By definition, child well-being refers to the overall health and welfare of a child. It refers to a “biopsychosocial” model in which the child’s medical needs, psychological needs, behavioral needs, and social-emotional needs are being met. Child well-being also means that the child is in a safe environment that meets the child’s developmental needs.

Permanency means that we work actively and diligently to find a
child a permanent home either through reunification, adoption or alternative placements. Other long-term planned permanency arrangements include: long-term foster care; independent living; physical custody to a relative on a permanent basis with or without legal guardianship; or physical custody to a foster parent or legal custodian on a permanent basis with or without legal guardianship.

Every child deserves a permanent home. Once a child is removed, there are legal milestones that must be met in order to ensure the best and most expedient opportunities for resolving the conditions in the child’s home that resulted in the child’s placement, and achieving permanency.

As a child welfare professional, you must rely on your own observations as well as the information you acquire from parents/caregivers, others who know the child and family, and from the child directly.

The practice you’ve gained from using the Child Development Stages tool is critical knowledge you will use as a child welfare professional. It will help you know what you need to learn about children and the protective capacities of their parents.

How you gather information to assess child development and child functioning by using your observation and engagement skills is what you will continue to learn in the communication labs. The child development stages will help to inform how you build rapport with children, assess their use and language, and use interviewing techniques that are appropriate for children.

In Module 4, we will learn about the lifelong impacts that trauma can have, whether experienced by a child or an adult. Many of the children and parents that you will be working with have experienced trauma. As a child welfare professional, you need to understand how important the treatment of the trauma is as well as your behavior as a professional in working with persons who have been trauma survivors.