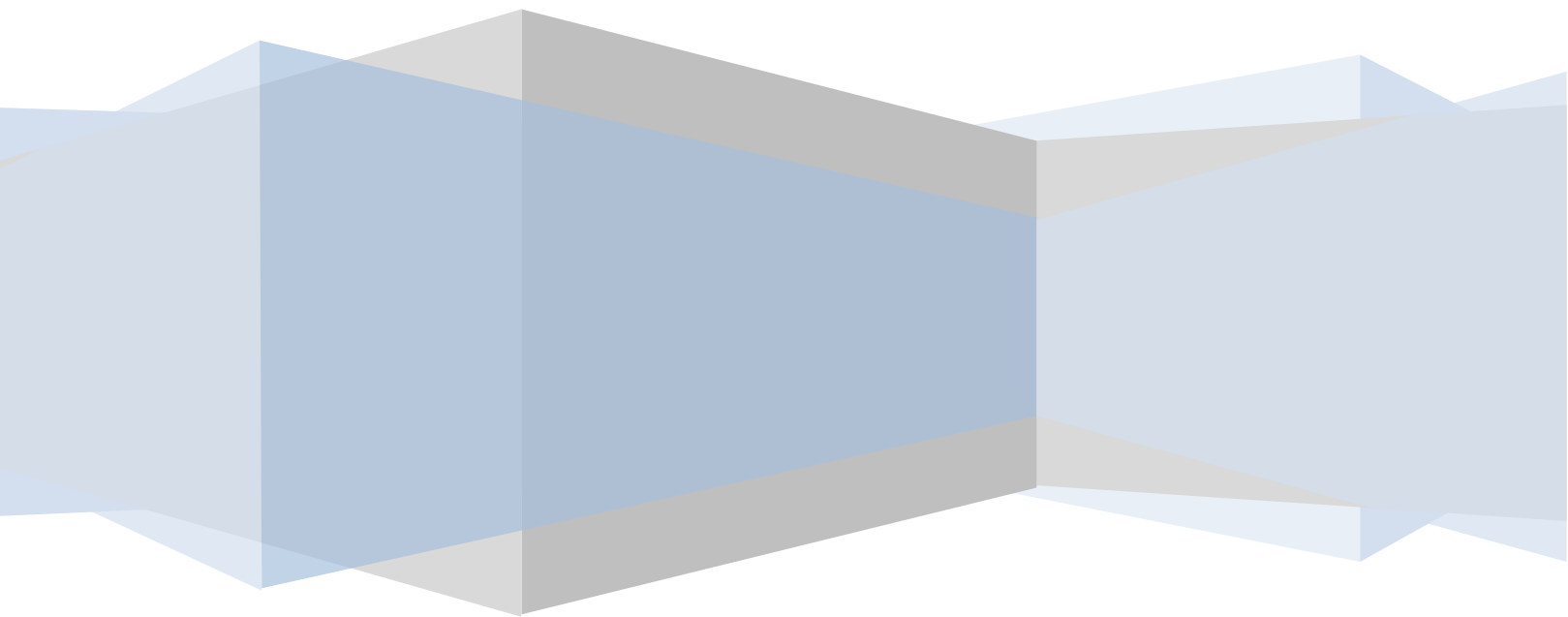




VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

CWS 1021W: Effects of Abuse and Neglect on Child and Adolescent Development

**GoToWebinar
Handouts Day 2**



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ADOLESCENT DEVELOPMENT

PHYSICAL DOMAIN

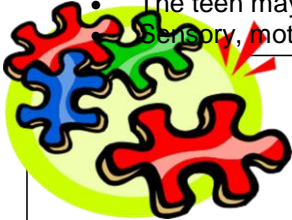


Normal

- Teens must become accustomed to rapid changes in their bodies
- Hormonal changes promote the rapid physical growth of bones, muscles, and body tissues
- Weight and height increase in short growth spurts causing teens to feel clumsy and awkward until they relearn coordination
- The changing voice is unpredictable and the teen may sound like a stranger to him/herself
- Menstruation can be traumatic for girls who have not been educated about normal development, and especially for girls who have been sexually abused
- Erections become frequent and spontaneous, which can cause great embarrassment; ejaculation begins
- Secondary sex characteristics emerge including growth in the sexual organs, facial and pubic hair

Abnormal

- The onset of puberty may be affected by malnutrition and other consequences of serious or chronic neglect
- The teen may be sickly or experience chronic illness
- Sensory, motor, and perceptual-motor skills may be delayed and coordination may be poor



Normal

- Early in adolescence, precursors to formal operational thinking appear including a limited ability to think hypothetically, the ability to calculate consequences of thoughts and actions, and the ability to take on multiple perspectives; later formal operational thinking becomes well-developed
- Adolescents develop the ability to think about thought itself; they are preoccupied both with thinking about themselves and thinking about what they think about
- Insight develops fully and perspective taking assumes its most advanced form. Teens are able to understand and consider the views of other people and systems of thought

Abnormal

- The teen may not develop formal operational thinking or may demonstrate deficiencies in logical and hypothetical thinking or problem-solving
- Thinking processes may appear to be typical of younger children
- May be unable to understand others' perspectives or motives
- Insight may be lacking
- May appear academically delayed and exhibit poor school performance

COGNITIVE DOMAIN

Adapted from: Rycus, J.S., & Hughes, R.C. (1999). *The effects of abuse and neglect on child development (Core 103)*. Columbus, Ohio: Child Welfare League of America and Institute for Human Services. [Course curriculum.]

EMOTIONAL DOMAIN



Normal

- The teen is truly at the mercy of his or her emotions
- Most teens exhibit anxiety about their physical appearance and are likely to be self-conscious about changes. Minor physical features assume enormous significance and considerable emotional energy is spent scrutinizing oneself; Adults tend to forget how important perceived flaws are at that age!
- Teens frequently worry about being “normal”
- A gap exists between teens’ physical and emotional development; the greater the discrepancy, the more conflict that results
- Exaggerated mood swings and emotional volatility are the norm

Abnormal

- Maltreated teens may display a variety of emotional and behavioral problems
- May lack internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent, volatile mood swings
- May appear to have little empathy for others
- Problems with formulation of self-identity and poor self-image
- May appear directionless, expressing no hopes for the future

SOCIAL DOMAIN



Normal

- Social relationships center on the peer group; teens may alter behavior, compromise values or beliefs, or reject longtime friends to gain acceptance into the group that affords the most social status
- Adolescents become interested in sexual relationships, but most young adolescents are not sexually active
- Early expressions of sexuality are largely experimental
- The first step in developing an independent “self” is distancing from one’s family

Abnormal

- The maltreated teen may have difficulty maintaining relationships with peers
- May withdraw from social interactions, display a generalized dependency on peers, adopt group norms or behaviors in order to gain acceptance, or demonstrate ambivalence about relationships
- May avoid or mistrust adults
- Maltreated teens, particularly those who have been sexually abused, may have considerable difficulty in sexual relationships due to intense guilt, poor body image, shame, lack of self-esteem, and lack of trust
- Limited concern for others may be displayed
- The teen may not attempt to conform to socially acceptable norms and may be involved in criminal behavior
- Maltreated teens often have difficulty conforming to social rules and roles



MORAL DOMAIN

Normal

- Significant changes in moral thought are brought about by advancements in abstract thinking, perspective taking, and insight
- Adolescents are typically able to understand that moral principles have social utility and that rules exist for the betterment of society and benefit its members

Abnormal

- Moral development may appear lacking

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ADOLESCENT ASSESSMENT EXERCISE

Scenario:

Four teenagers were recently arrested for speeding 90 miles per hour down the highway after midnight. All of the juveniles had been drinking and several joints were found in the car. After their arrest, they were placed in juvenile detention, pending a social worker making other plans for their placement and service needs.

The teens' names are Francie, Lee, J.J., and Leslie. The trainer will assign one teen to your group.

Your group represents a child welfare team in a DSS setting. You have been assigned to **assess** the teenager assigned to you.

Instructions:

1. Assign one person in your group to present a brief description of your teenager to the large group, and one person to present your group's assessment of the teen's development.
2. Read the pages in this handout relating to the teen assigned to your group.
3. As a small group, take about ten minutes to discuss the scenario and assess the teen. Be sure your reporters are prepared to share your findings with the large group.
 - ◆ Use the **assessment sheet** at the end of the handout to guide your discussion.
 - ◆ Think about the central developmental issues and developmental norms that we have discussed as you become familiar with the teens' stories.
4. Refer to **Handout F-1: Adolescent Development** as needed.

Adapted from: Rycus, J.S., & Hughes, R.C. (1999). *The effects of abuse and neglect on child development (Core 103)*. Columbus, Ohio: Child Welfare League of America and Institute for Human Services. [Course curriculum.]

FRANCIE

My name is Francie. I'm sixteen. I live with my mother. I have one sister who's ten and the other is twelve. They get on my nerves. We live in a little house. People where I live don't have much money. We're on welfare ... I hate where we live. My stupid social worker would say I've been "neglected." I don't know—maybe. I ain't got nothin'—that's for sure.

Since I was born, I've been here and there—with Mom, with my grandparents... crappy foster homes. When I was five, Mom up and ran off to California with some guy she met in a bar. She didn't come back until I was six. I can't remember who I stayed with then ... that's weird, why can't I remember?

Don't know who my dad is—never seen him. Never seen my sisters' dads either. My dad may not be around, but my mother's boyfriends have been. Most of them beat her. Sometimes they beat me, too.

My mom just got back together with her boyfriend. When I was ten he used to touch me. I told my Mom. She broke up with him, but I'm really mad because I can't believe she would let him come back. I think she's tired of turning tricks or something and he has money. I wonder if he'll come after me or my sisters now?

Nobody likes me. My mom's against me. My social worker's against me. My teachers are too. They're all dumb. Everybody's tryin' to boss me around and make me do stuff they want. People around me act so stupid. They make no sense—like they just do stuff for no reason! And they try to blame ME for stuff that happens at home and school. It's always, "Francie, your behavior—blah, blah, blah." It's really their fault! It's always someone else's fault. I don't do anything!

The way I see it, there should only be one way: my way. If people just leave me alone and let me do what I want, the way I want, I'm great—I feel great. If things don't go my way, then I get really, really mad. I get mad a lot actually. Lots of stuff stresses me out—like people telling me what to do at school or home.

(CONTINUED)

FRANCIE (CONT.)

When I get stressed or don't understand stuff, I get mad and I fight. My social worker says I have tantrums because I'm "impulsive," whatever that means. If I want something, I take it—or else, I ain't gonna get it.

I don't get "deep" with people. People are sort of here for a little while and gone. I don't understand other people. Other people don't seem to feel the same way about stuff that I do. I guess people who are nice are my friends. People who don't do what I want are mean, and I drop them quick. I have a couple "best friends," though. This girl Tiffany, I met her three days ago and she's like my best friend ever now! And there's this girl at the shelter I met this morning. We're like best friends now, too.

I can't figure out what people want from me. I can't figure out what the "rules" are that adults keep griping about—"You have to follow the rules!" What rules? I'm not following anybody else's dumb rules. Why should I? Sometimes, I just don't "get" what people are saying. I have to guess what people mean a lot. But if you say, like, "Pick up your clothes and put them in the basket," then I get that. I can do that.

My dumb social worker asked me what I want for my future. What a stupid question! I want stuff now and I want people to do stuff for me now! I just want someone to take care of me until I turn eighteen—like, just give me a place to stay and some cool clothes and food and then leave me alone. When I turn eighteen, everything is gonna be so cool and great! I'll be on my own then. I'll be able to take care of myself and no one can ever tell me what to do again. That will be so great! I can't wait to turn eighteen.

LEE

Hey, I'm Lee. I'm sixteen. I come from a big family. There were six kids—I have three brothers and two sisters. When I was born, my dad was really old—he was fifty—and my mom was twenty-two. My parents, me and my brothers and sisters, my grandma, an old aunt, and a cousin, we all lived on a farm. So I know a lot about animals and growing stuff. We had enough money to get by okay, but not much else. We ate okay, though—my mom's a good cook. My dad's dead now—two years ago his drinking killed him finally. I wasn't surprised. Every night he'd drink until he passed out somewhere—in the living room, in bed, in the yard. At least when he was passed out he wasn't yelling. He liked to yell about how useless and stupid we all are. He was really loud and mean, but he never hit anybody. Being hit might have hurt less. We had to move to the city after my dad died. My mom couldn't manage the farm. My older brother and sister had to find their own places to stay. I don't know where they are. My mom and the rest moved into one of those ... what's it called? ... public assistance apartments in the city. I don't like it. I miss the farm.

This is a lot of talking for me. I don't talk much. My mom says I'm quiet. I'm not "slow" though. I have a brother who's slow. I can do math and tell you what causes things to happen. I can figure things out on my own.

I get along with people, too. My mom says I don't know how to stand up to "peer pressure." She says I go along too easy and let people lead me wrong. I just like to be part of the group. My friends are really smart and really fun—they watch out for me. I almost never mind doing what they want to do. Sometimes, I get a little nervous that we'll get in trouble. But getting in trouble is better than them telling me to get lost.

I guess I don't feel so good about myself a lot of times. I don't feel as smart as my friends. It's easier if I just let other people around me—other kids, the adults, whoever—do the thinking and tell me what to do. People like me better that way. Tom likes me better that way. Tom is my friend. He's thirty, but he's really cool.

(CONTINUED)

LEE (CONT.)

He has his own car and his own apartment—and cable TV. I like being with him. I know my mom gets mad when I don't come home, but Tom likes for me to stay there and I don't want him to tell me not to come back. I don't know why she doesn't like Tom. He just wants to be my friend. He says he's glad I feel safe at his place. He says he had a hard time growing up too. I know what people are like by the way they act. My mom's nice because she doesn't hit and cooks real good. My dad was a drunk who worked the farm. Me, I'm friendly. I'm a good friend.

I know a lot of important stuff, too. I know right from wrong. I know it's wrong to skip school. It's good to go to church. I can get a better job if I do better in school. It's wrong to hurt other people. It's important to be nice to people. I know all that stuff, but still, when I get an idea in my head or someone wants to do something, all the other stuff I know just sort of disappears. What does my mom call me? Oh, yeah, "impulsive." I know I shouldn't have been drinking and riding in that car, but when we started, I thought it would be fun and all those other kids were going. I'm not really sure the other kids wanted me there. They weren't exactly what you'd call "nice" to me—they just sort of let me go. And they even tried to say the beer and weed belonged to me. That wasn't very nice. I guess they weren't such great friends. I don't know if I'll hang out with them anymore or not.

J.J.

I'm J.J. Man, I don't know why I'm in trouble. I didn't do nothing, man. I was just hitching a ride to go find my crew. I didn't even know those losers. I'd just seen them around school. I wasn't drinking or nothing—honest. I shouldn't be here. You gotta explain to them that this ain't right. It's an injustice!

Let me tell you a little about J.J., man. I'm sixteen and I got it all worked out. Everything's fine. I was living with my crazy old grandma—she is SO wrong! She's sixty-five and like completely senile or something. You'd know if you met her—she's crazy, man. I haven't been there for a couple of weeks. I moved in with her when I was four. Well, I guess the social worker moved me there. They took me away from my mom. My mom was beating me all the time. It wasn't cool, man. She'd beat me with cords and books and stuff. My grandma did treat me better than that. Okay, she tried, but, man, she's old now and she don't know nothing and she don't do nothing. She just sits around frettin' about her diabetes and heart. It's always, "J.J. What am I gonna do if I have a heart attack and you're not here to call 911?" I'm like, "You gonna die, Grandma. What you think?" I ain't hanging around there to dial her phone—she needs to get one of those Life Alert things and punch her own button.

For a while my aunt was living there. She's been coming and going for years—in and out of places living with boyfriends. When she ain't got a boyfriend she comes home so grandma can pay her bills. And when she's there I'm her boyfriend. We was ... close when she was home. I started being her boyfriend I guess when I was about seven. She taught me stuff ... you know, how to do it. She's the only adult I like. I don't trust adults and I do everything I can to avoid them.

The only people I want to be around are the guys in my crew. I joined this gang when I was twelve and I've hung out with them ever since. They help me. Adults never helped me do squat. But I do everything with my crew. We dress alike—see, we all wear these same jeans, black t-shirt, and red sweatshirt. Our hair even looks the same.

(CONTINUED)

J.J. (CONT.)

I feel totally safe when I'm with them—nothing can hurt us when we're together. We tough and everybody knows it. Everybody's scared of us. I don't feel comfortable when I'm not with them. We all got different personalities: James is smart and calls the shots. Tony is quiet. RayRay is funny. Man, that player cracks us up! We all hate school. Why should I sit around trying to listen to dumb stuff I don't understand that don't relate to real life at all? And lots of big words—like my stupid social worker's always usin'—"adjudicated" and "compliance"—what a load of crap! Man, he's worthless! We all hate home. Yeah, we do some drugs, but we're not like addicts.

Our crew's got rules we have to follow that make sense. Like you don't do another guy in the gang wrong. There's a way you handle things with other gangs. You're loyal. You do the right thing. You know how to treat each other. It's all these other people that are livin' crazy. Like adults, like my grandmother. They got no rules as far as I can understand them. They're just like—out there or something. Trying to deal with people outside the crew gets me nothin' but trouble. But I don't owe nobody outside my crew nothing and I ain't got to do anything for anybody outside my crew. They do for me. I do for them. Man, I owe those guys my life.

LESLIE

My name is Leslie. I just got into trouble for drinking and having marijuana in a car. That was really sort of stupid, wasn't it? But, you know, free beer! I like drinking. Drinking helps me not think about home.

I'm sixteen now. I was living with my mom, two younger brothers, and stepfather, Jerry, until a few weeks ago. I had a pretty good childhood, I guess. I did well in school, had a lot of friends, and my parents had good jobs so we had a nice house and I had lots of toys and books. My dad worked in a factory and my mom is a secretary. My parents were great then. When I was fourteen, my dad got sick—a coronary condition—and he died six months after he found out about it. My grandmother came to live with us and my mom was able to hold everything together—but it was still a rough time. A year later my mom met Jerry.

I hate Jerry. He moved in and she married him about six months after that. Jerry was okay at first, but he started acting weird and wouldn't leave me alone. I didn't know what to do ... my mom loved him. I couldn't believe what he was doing. I asked a friend's mother if I could stay with them. When she asked me why, I confided that Jerry had felt me up, and had started coming into my room at night after everybody was in bed so he could put his hands all over me. I should never have told. She called my mother. My mother went ballistic and told me I could never see my friend again. She told me I was a liar and she would "put me away" if I kept saying stuff like that about Jerry, because he was a "good man" who "loved us" and would provide for us. She grounded me for a month.

After that, I just started running away, skipping school, and quit doing my homework. All I could think about was what Jerry was doing and how my mom protected him. He was wrong! He shouldn't have been messing with me! I told him to stop one time and he just laughed at me and said he'd do what he wanted, when he wanted, and I'd better just get used to it.

I don't understand what my mom sees in him. She used to be great, but I guess something happened to her when my dad died.

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LESLIE (CONT.)

I miss my friends from school, but now I'm hanging out with a different group of friends. These friends are older and more mature. They can get me stuff to drink. I tried drugs with them, but I really didn't like them. The drugs scare me. I know that drinking too much is wrong, but it helps me feel better for a little while. When I'm wasted I don't have to think about Jerry or worry about what's going to happen. I'm not going back home where Jerry can get me again. I've been staying with a friend's sister. She's 18 and has an apartment over a store. I've been sleeping on her floor. She says I can stay as long as I want, but I've got to start paying rent.

I wish things were different. I miss my old life. I'm sorry that I've embarrassed my mother by getting arrested. I don't want to see her. She's going to yell at me. Worst of all ... she's never forgiven me.

ADOLESCENT ASSESSMENT WORKSHEET

CORE ISSUES	
<i>Identity</i>	
<i>Dependence/ Independence</i>	
<i>Sexuality</i>	
<i>Self-Esteem</i>	
DEVELOPMENT ACROSS DOMAINS	
<i>Cognitive</i>	
<i>Emotional</i>	
<i>Moral</i>	
<i>Physical</i>	
<i>Social</i>	

(continued)

ADOLESCENT ASSESSMENT WORKSHEET (CONT.)

RELATED DIMENSIONS	
<i>School Performance</i>	
<i>Relationships and Attachments</i>	
<i>Perspective-Taking</i>	
<i>Insight/Judgment</i>	
<i>Empathy</i>	
<i>Behavior</i>	

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DEVELOPMENTAL DISABILITIES AND SPECIAL CONDITIONS

<u>Cerebral Palsy</u>	<u>Autism Spectrum Disorder (ASD)</u>
<ul style="list-style-type: none"> Cerebral palsy includes disorders of movement and posture that occur due to damage or abnormality of the immature brain (generally prior to age 16) This disorder occurs in approximately 2 out of every 1000 births Three types of cerebral palsy include: Pyramidal or spastic: abrupt breakdown of muscle tone affecting either the legs, the arms, or both; may only affect one side of the body; seizures and visual or auditory impairments are often associated Extrapyramidal: problems controlling movement and maintaining posture due to involuntary movements of extremities; muscle tone may be rigid or floppy; facial muscles are often involved causing problems with feeding and speech; walking and sitting are difficult; problems with tongue and vocal cord movement may make communication difficult Mixed-type: elements of both previous types are involved, generally along with extensive brain damage and other developmental disabilities Causes generally include labor and delivery complications, chromosomal abnormalities, exposure to radiation, exposure to harmful drugs during the first trimester, lead poisoning, meningitis, and head trauma Infants with cerebral palsy may sleep excessively, be irritable, have poor reflexes like the suck reflex, have a weak cry, maintain an unusual resting position (arched or floppy), not be alert Intellectual development may appear normal in the first year but not motor development <p>Other disabilities are commonly seen in children with cerebral palsy including intellectual disabilities in 60%, visual problems (40%), hearing and language problems (20%), seizure disorders (30%), and emotional and behavioral disorders, particularly in adolescents</p>	<ul style="list-style-type: none"> ASD is a developmental disability that can cause significant social, behavioral, and communication challenges. (ASD encompasses conditions that used to be diagnosed separately including autistic disorder, pervasive developmental disorder, and Asperger syndrome.) Disorder occurs in 1 in 68 children in U.S. About half of the identified children have average or above average intellectual ability Boys are about 4.5 times more likely to be identified with ASD than girls Doctors consider a child's development and behavior to make a diagnosis of ASD. Most children with ASD are diagnosed after age 4, but ASD can be diagnosed as early as age 2. This is noteworthy because early intervention can provide better outcomes. Signs/symptoms (which typically last throughout a person's life) include: repeating certain behaviors; ; echoing words/phrases; resisting change in daily activities; avoiding eye contact; having trouble understanding other people's feelings or talking about their own feelings; showing interest in people but not knowing how to talk, play, or relate to them; having trouble expressing their needs using typical words or motions; preferring not to be held or cuddled; reacting unusually to how things smell, taste, look, feel, or sound; not playing "pretend games; losing skills they once had (e.g. vocabulary) There is currently no cure but early intervention can improve a child's development. Risk factors include: genetic or chromosomal conditions (such as Down syndrome, fragile X syndrome or tuberous sclerosis); sibling with ASD; certain prescription drugs taken during pregnancy; children born to older parents. Critical period for developing ASD occurs before, during, and immediately after birth.

Adapted from: Filip, J., McDaniel, N., & Schene, P. (Eds). (1996). *Helping in child protective services: A competency-based casework handbook*. Englewood, CO: American Humane Association. & www.cdc.gov

<u>Intellectual Disability</u>	<u>Severe Visual Impairment/Legal Blindness</u>
<ul style="list-style-type: none"> • Intellectual disabilities occur before age 18 and result in significant limitations in intellectual functioning (more than two standard deviations below the norm; IQ of 70 or below) and adaptive behavior. • Attainment of developmental stages progresses slowly and may require prolonged dependence on caregivers. • Impairment of general mental abilities impact adaptive functioning in three domains. These domains determine how well and individual copes with everyday tasks: • Conceptual domain- includes skills in language, reading, writing, math, reasoning, knowledge, and memory • Social domain- refers to empathy, social judgment, interpersonal communication skills, the ability to make and retain friendships, and similar capacities. • Practical domain-centers on self-management in areas such as personal care, job responsibilities, money management, recreation, and organizing school and work tasks. • DSM-5 emphasizes the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone. • Supports include the resources and individual strategies necessary to promote the development, education, interests and well-being of a person. 	<ul style="list-style-type: none"> • Defined as having visual acuity in both eyes of less than 20/200. • May be isolated impairment or associated with another condition. • Blindness affects 4 in 1000 children, with 46% being born blind and 38% losing sight prior to age one. • 50% can read enlarged type, 25% have some visual perception, 25% are totally blind • Most often caused by viral infections and/or eye malformation, then causes including trauma, tumors, and prematurity • Infants with visual impairments display abnormal random, jerky eye movements; neither focus on nor follow objects; do not blink or cry in response to sudden or threatening movements; have pupils that do not constrict when light is shown upon them • Most blind children have delayed gross motor skills due to poor muscle tone; most blind children do not crawl and do not sit up until after the eighth month and do not walk until two to two and one-half years • Speech and language is often delayed but normally will improve by the time the child starts school • In children with normal intelligence, bizarre behaviors may be demonstrated (head banging, eye-gouging, rocking) but will generally disappear by age four. If deafness or intellectual disability is also present, the behaviors are likely to persist. • Generally the blind child can develop positively and be a functioning adult. • Caregivers need to be encouraged not to become discouraged by slow development, provide extra stimulation through the other senses, describe in detail, touch a lot; avoid being overly protective

<u>Hearing Impairment</u>	<u>Language Delays or Disorders</u>
<ul style="list-style-type: none"> • Hearing loss may be due to damage to the external or middle ear and/or the cochlea and/or the auditory nerve • Range of severity: <ul style="list-style-type: none"> • Mild hearing impairment: speech and conversational skills are normal; difficulty hearing distant sounds • Moderate hearing loss: articulation is affected; significantly limited ability to hear conversation • Severe hearing loss: unable to participate in spoken conversation absent hearing aid • Profound hearing loss: may be able to hear very loud sounds but unable to engage in communication; likely to be unable to speak or articulate normally • Hearing loss may occur in just one, or both, ears; less than 20% of hearing losses occur in just one ear • Hearing loss may be caused by middle ear infections or other infections, cleft palate, Down's Syndrome, genetic or chromosomal abnormalities, noise pollution, or trauma • Hearing loss occurs to approximately 1% of all children • The long-term results are determined by severity of the hearing loss and the presence of other disabilities: • Some children will grow up and function successfully, employing verbal communication • Others will never develop oral communication unless the hearing loss occurred after they learn to speak • Deaf children may excel in math and science but generally do poorly in reading, even when their intelligence is above normal • Early intervention involving all family members in learning appropriate "total communication" skills is considered essential for the child's optimal development 	<ul style="list-style-type: none"> • The child's speech, verbal expression, and/or understanding of language is significantly less developed than other abilities given normal developmental assumptions • Language delays are generally associated with broad cognitive delays such as intellectual disability. • Language delays are often seen in children who have been maltreated • Speech disorders (stuttering, articulation difficulties, voice defects) affect less than 5% of children • Besides maltreatment, causes include prematurity, labor and delivery complications, infections, recurring ear infections, and genetic or chromosomal disorders • Language problems may be isolated conditions or may be accompanied by cerebral palsy, intellectual disability, or brain injury • Severe difficulties are generally noticeable early in life; mild deficits may not be recognized until the child is in school • Early intervention is considered imperative as children who cannot communicate experience significant frustration

<p style="text-align: center;"><u>Learning Disability</u></p> <ul style="list-style-type: none"> • A broadly defined condition wherein children with normal or high intellect demonstrate low achievement in one or more academic subjects; poor functioning is clearly not the result of emotional disturbance, physical disability, health problem, or an inadequate educational environment. • Perceptual, memory, attention, neurological processing, or language impairments may be present. • 10-15% of school-age children have a learning disability. • Low self-esteem, anxiety, depression, and behavior problems are frequently associated with learning disabilities. • The impact of a learning disability can be lessened by teaching the child special skills, but learning disabilities cannot be cured. • Medications can be useful for children whose learning disabilities are associated with Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder. 	<p style="text-align: center;"><u>Attention Deficit Disorder</u> <u>Attention Deficit Hyperactivity Disorder</u></p> <ul style="list-style-type: none"> • These disorders are thought to be caused by genetic neurochemical abnormalities. • Affected children experience difficulty paying attention and are easily distracted. They may also be restless, hyperactive, have very poor impulse control, and be aggressive and easily angered. Many respond poorly to traditional behavioral techniques. • These disorders affect 10% of school-age children. • Girls are more likely to experience ADD while boys are more likely to experience ADHD. • Hyperactivity may decrease as the child ages, but the attention deficits remain and are likely to affect adult educational and vocational performance. • Other conditions, such as severe anxiety, may mimic ADD symptoms and a thorough evaluation should be completed before “diagnosing” a child as ADD. • While some children with ADD/ADHD may also experience learning disabilities, they should not be confused. • ADD can be managed through environmental and/or pharmacological intervention. • Low-stimulus environments that are highly structured are considered crucial, as are predictable routines. Clear directions and immediate rewards/consequences are often effective management techniques. • Stimulants such as Ritalin have a paradoxical effect and suppress hyperactivity symptoms. Medications to treat ADD/ADHD should only be prescribed by an experienced child psychiatrist after completing a thorough examination. Evaluation and drug treatment by a general practitioner or family doctor should be discouraged since they are not trained sufficiently to correctly diagnose and treat these disorders.
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Resources:

CDC <http://www.cdc.gov>

ARC <http://www.thearc.org/what-we-do/resources/fact-sheets>

National Council on Disability-Parents with Disabilities
<http://www.ncd.gov/publications/2012/Sep272012/>

Revised August 2016

DEVELOPMENTAL CONCERNS FOR SUBSTANCE EXPOSED CHILDREN

INFANCY

Unpredictable sleeping patterns

- ◆ Most infants develop predictable 6-7 hour nighttime sleeping patterns by 4 to 6 months of age.
- ◆ Some infants who have been prenatally exposed to drugs or alcohol continue to demonstrate sleeping patterns more typical of a newborn throughout the first year.
- ◆ Erratic sleeping schedules, coupled with their increased irritability, can be exhausting for even the most experienced caregiver.

Feeding difficulties

- ◆ By the time they are 2 weeks old, most infants have established a somewhat regular pattern of feeding and are able to suck effectively enough to have regained their birth weight.
- ◆ Infants prenatally exposed to drugs or alcohol may have a variety of feeding difficulties.
- ◆ Feeding problems include prolonged feeding time due to uncoordinated and ineffective sucking movements or lethargy, infant distractibility during feeding, frequent spitting up of formula, and increased need to suck (hyperphagia).

Excerpted from: Kropenske, V., Howard, J., Breitenbach, C., Dembo, R., Edelstein, S.B., McTaggart, K., Moore, A., Sorensen, M.B., Weisz, V. (1994). *Protecting children in substance-abusing families*. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

- ◆ Suggestions:
 - Swaddle and hold the baby during feeding.
 - Frequently burp infants who spit up a lot (some babies need to be burped after each ounce).
 - Feed irritable infants in a quiet place away from other children and distractions.
 - Encourage sleepy babies to feed by using techniques to keep the baby awake such as massaging the back or rubbing the soles of the feet while talking softly.
 - For a baby who has an intense need to suck even after the infant's stomach is full, the parent can offer a pacifier to avoid overfeeding.

Irritability

- ◆ Some infants tend to be easygoing and are readily soothed when fussy, but others tend to be more irritable and are harder to calm.
- ◆ Infants who have been prenatally exposed to drugs and alcohol can be easily overstimulated and, once aroused, have great difficulty calming themselves.
- ◆ Suggestions:
 - Swaddle the baby, with hands exposed.
 - Walk and hold the baby close to the body, using a front carrier (the combination of swaddling, body contact, and gentle motion puts many fussy babies to sleep).
 - Bathe the baby in warm water, followed by a gentle massage.
 - Place the infant face down on the parent's/caregiver's abdomen and gently massage his/her back.
 - Offer a pacifier.

- Speak softly.
- Gently rock the baby in a windup cradle or swing, ensuring that his/her head is well supported.
- Play soft music in a quiet room, and avoid bright lights, jostling, and loud noises.
- Support the baby's bottom with one hand and his/her head with other hand, hold the baby away from the parent's/caregiver's body in an upright position, and rock the baby gently in an up and down motion.

Atypical Social Interactions

- ◆ Infants who have been prenatally exposed to drugs and/or alcohol may have a number of atypical social responses, including indirect gaze or gaze aversion.
- ◆ Suggestions:
 - Encourage caregivers not to personalize the infants' lack of interactive behaviors.
 - Encourage consistency of parents/caregivers to support the children's early attachment needs.

Delayed language development

- ◆ Language development during early infancy involves cooing, smiling, chuckling, squealing, and crying.
- ◆ Infants who have had prenatal exposure to drugs and alcohol may demonstrate fewer vocalizations and less babbling.

- ◆ Suggestions:
 - Talk with the infant during bathing, feeding, and changing times.
 - Respond to the infant's attempts to vocalize, reinforcing responses with eye contact and animated facial expressions.

TODDLERHOOD

Atypical Social Interactions

- ◆ Healthy toddlers consider themselves the center of the universe.
- ◆ A child who develops a secure attachment relationship with the primary caregiver, is likely to form strong relationships with others throughout life.
- ◆ Prenatally-exposed toddlers frequently lacked consistent care that encouraged the development of trust.
- ◆ Suggestions:
 - Provide consistent and nurturing care giving, responding quickly to the child's needs.
 - Enroll the toddler in an early intervention program that can provide daily substitute nurturing and consistency when the parents/caregivers are not readily available.

Minimal play strategies

- ◆ Play is central to the young child's early cognitive development, but prenatally-exposed children often demonstrate limited interest in play or lack play experience.
- ◆ Suggestion:
 - Model play with toys using words and body language so that the child can imitate and, eventually, generalize this behavior.

PRESCHOOL YEARS

- ◆ Many substance-exposed children demonstrate increased activity levels, short attention spans, impulsivity, mood swings, and problems with moving from one activity to another.
- ◆ Some continue to demonstrate difficulties in auditory and visual processing.
- ◆ Suggestions:
 - Limit the number of toys and activities available at a given time when working with an easily overstimulated child.
 - Use verbal cues and physical contact to direct or redirect the child's activity and model behavior that emphasizes taking turns.
 - Maintain regular play, rest, and feeding routines so that children can predict what behavior is anticipated at a given time.
 - Praise children when they manage transitions successfully.
 - To reduce inappropriate behavior, plan physically active play as well as play or activities (like books or videos) that will stimulate emotional expression in a healthy manner.

SCHOOL AND TEENAGE YEARS

- ◆ The influence of prenatal substance exposure on development may need to be assessed formally as the child transitions from preschool to elementary school and high school.
- ◆ Treatment teams can develop intervention plans to help the child or adolescent overcome identified problems in development and behavior.

◆ **Suggestions:**

- Advocate for needed specialized educational services within the school system, tutoring for academic underachievement, and assessment and intervention for psychological and behavior problems.
- Encourage a stable relationship with an adult role model through participation in programs such as Big Brothers or Big Sisters.
- Refer parents to support groups that provide education and guidance for dealing with difficult childhood and adolescent behaviors.

Resources:

ARC: <http://www.thearc.org/what-we-do/resources/fact-sheets/fetal-alcohol-spectrum-disorder>

National Center on Substance Abuse and Child Welfare:

<https://www.ncsacw.samhsa.gov/resources/substance-exposed-infants.aspx>

Resources updated August 2016

SEXUAL DEVELOPMENT AND SEXUAL ABUSE TEST

Based on your knowledge of children's sexual development and sexual abuse, determine whether you believe each of the following statements is TRUE or FALSE.

1. (True or False) Children who have been sexually abused sometimes experience significant long-term aftereffects.
2. (True or False) Children's sexual behaviors indicate sexual abuse and/or the desire to abuse other children.
3. (True or False) Sexual abuse is the most damaging form of abuse that a child can experience.
4. (True or False) Children with sexual behavior problems have been sexually abused.
5. (True or False) Children who have been sexually abused never experience sexual pleasure during their own sexual abuse.
6. (True or False) Children who have been sexually abused become sexualized and constantly seek arousal.
7. (True or False) All adult and adolescent sexual offenders were sexually abused as children.
8. (True or False) Child sexual abuse victims become adult sexual offenders.
9. (True or False) Sex offenders never stop being sex offenders.
10. (True or False) Sexually abused children molest other children.

Adapted from: Cavanagh Johnson, T. (1999). *Understanding your child's sexual behaviors*. Oakland, CA: New Harbinger Publications, Inc. [no longer in print, but can be found in many libraries]

Resource:

National Center for Victims of Crime

<http://www.victimsofcrime.org/media/reporting-on-child-sexual-abuse/effects-of-csa-on-the-victim>

Resource updated August 2016

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COMMON MISCONCEPTIONS REGARDING CHILD SEXUAL DEVELOPMENT AND SEXUAL ABUSE

1. *MYTH: Children who have been sexually abused are certain to experience significant long-term aftereffects.*

REALITY: Children who are sexually abused will respond in different ways. A small percentage will suffer practically no effect at all and a greater percentage will be affected throughout their lives. Research findings in the area of outcome effects of sexual abuse vary, but there is no clear indication that ***all*** children who experience sexual abuse will suffer long-term consequences. Some factors have been identified that appear to influence the degree to which sexual maltreatment leads to lasting harm for children:

- ◆ A closely related perpetrator being involved
- ◆ Multiple sexual contacts over a long period of time
- ◆ Use of physical, verbal, or emotional force
- ◆ Oral, anal, or vaginal penetration being involved
- ◆ The child's life being stressful prior to (or concurrently with) the abuse
- ◆ The child experiencing psychiatric or developmental problems prior to the maltreatment
- ◆ The child having a poor relationship with the caregivers prior to the abuse
- ◆ The child having poor problem-solving skills
- ◆ The child and family being isolated and not having an adequate support system prior to or after the abuse
- ◆ The family experiencing great levels of conflict and stress
- ◆ The family lacking cohesion
- ◆ Caregivers having poorly developed problem-solving skills
- ◆ Caregivers not supporting the child after disclosure of the maltreatment

Adapted from: Cavanagh Johnson, T. (1999). *Understanding your child's sexual behaviors*. Oakland, CA: New Harbinger Publications, Inc. [no longer in print, but can be found in many libraries]

Another important factor is the nature of the sexual act itself. Different sexual acts are not equally traumatizing (and there is even greater difference in consequences as the context in which the act occurs changes). Also, a single event or very short-term series of events is rarely as traumatic as a long series of sexual contacts. For example, although both are unacceptable activities, being forced to participate in pornographic videos as a middle-schooler is likely to have a much different effect on the child than being fondled through clothing once as a preschooler. Each child's circumstances must be assessed **individually** to determine how the maltreatment has affected him or her—universal consequences are a myth.

2. MYTH: Children's sexual behaviors indicate sexual abuse and/or the desire to abuse other children.

REALITY: Sexual behavior is often the same for children who have been sexually maltreated and those who have not been. Adults are likely to jump to conclusions about **motivation** for sexual behavior once they become aware that a child has been abused. For example, it is as normal for a preschooler who has not been abused to want to touch another preschooler's penis, as it is for a preschooler who has been abused, but an assumption may be made that the child intended to molest another child. Sexual abuse will actually retard some children's normal sexual curiosity and exploratory behaviors.

3. MYTH: Sexual abuse is the most damaging form of abuse that a child can experience.

REALITY: Certainly, sexual abuse is very serious and its negative effects cannot be minimized, but neither can they be over-generalized. For some children, it will be the worst thing they will ever experience; for other children, that will not be the case.

Remember, the child's reaction will be based on a particular constellation of risk and resiliency factors. Research suggests that sexual abuse most frequently occurs in homes where there are other forms of maltreatment. Substance abuse and domestic violence are most commonly found in the same homes. Pervasive emotional and/or physical neglect/abuse may lead to more dire consequences for children. However, the presence of other forms of maltreatment clearly amplifies the negative effects of sexual maltreatment.

4. MYTH: Children with sexual behavior problems have been sexually abused.

REALITY: Not all children who display adult-type sexual behaviors have been sexually abused. Certainly in some situations, this will be the case. However, it is important to remember that children try to make sense of the world and information that is presented to them in ways that are not logical to adults. Acting-out behaviors is one such way. A child who is acting out may be repeating something he or she has been intentionally or accidentally exposed to (for example, finding a teenage brother's hidden stash of pornographic magazines; watching the "soaps" or R-rated movies; or, even, spying on the prostituting mother's encounters with customers). It is important to remember not to make an assumption that a child has experienced an incident of sexual abuse when sexual behaviors are demonstrated. A "hands-on" experience is not the only kind of experience that can lead to sexual behaviors.

5. MYTH: Children who have been sexually abused never experience sexual pleasure during their own sexual abuse.

REALITY: Children experience a range of physical sensations during sexual abuse encounters. Some describe their genital sensations as "unpleasant" but others did find them pleasant.

Many have described strong physiological sensations such as tension and anxiety. Children who felt positive sensations may feel very guilty, not understanding that their bodies are biologically programmed to respond to certain physical stimuli after different developmental changes occur. Consider the young male who may be very confused or feel guilty that he developed an erection in response to the perpetrator's touch. Again, **physical response does not have the same meaning as an adult's concept of sexual pleasure.** However, perpetrators may use that idea to make children feel responsible and to shift blame for the activities.

6. MYTH: Most children who have been sexually abused become sexualized and constantly seek arousal.

REALITY: It is a mistake to believe that all children who have been sexually abused will seek sexual stimulation frequently, or at all. Very few pre-pubertal children experience mature sexual feelings prior to puberty. Children who are engaged in normal sexual contact with other children generally are “exploring” and are not trying to achieve sexual satisfaction. Even for children who have been abused, problematic sexual contact may be less a means of achieving sexual stimulation as **replicating or processing their own experience or trying to establish a sense of control**, but in a way that is not logical or appropriate. Children can be helped to reduce their problematic sexual behaviors and can learn what appropriate limits are for their natural, appropriate sexual behaviors. “All behaviors have limits. Sexual behaviors are no different...All children can be helped to decrease problematic sexual behaviors. How well and how quickly they succeed in modifying problematic sexual behaviors will depend as much or more on the adults who help them as on them” (Cavanagh Johnson, 1999, p. 67).

7. MYTH: Almost all adult and adolescent sexual offenders were sexually abused as children.

REALITY: Research now suggests that only a percentage of offenders were sexually abused themselves as children: adult perpetrators (20-30%) and adolescent perpetrators (17-47%).

8. MYTH: Child sexual abuse victims become adult sexual offenders.

REALITY: Delinquency and adult criminal activity have been found to be more likely for child sexual abuse victims, but contrary to popular belief, adult perpetration has not. Adult sexual offenders generally share a history of extensive maltreatment and/or abuse in many forms as well as a pervasive sense of insecurity. There is some evidence to consider that the lack of a secure attachment as a child may influence later adult offending behavior.

9. MYTH: Sex offenders never stop being sex offenders.

REALITY: Counter to the prevailing idea “once a sex offender, always one,” research involving thousands of sex offenders and child molesters indicates that treatment can be effective. Recidivism rates are believed to range between 11% and 14%. Many sex offenders do stop perpetrating once they are treated.

10. MYTH: Sexually abused children molest other children.

REALITY: Current findings suggest that, despite the prevailing stereotype of the sexually abused child, less than ½ of 1 percent of children who have been sexually abused will molest other children.

See also:

Alexander, M. (1999). Sexual offender treatment efficacy. *Sexual Abuse: A Journal of Research and Treatment*, 11(2), 101-116.

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Haugaard, J.J., & Tilly, C. (1988). Characteristics predicting children's responses to sexual encounters with other children. *Child Abuse and Neglect*, 13, 209-218.

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Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry*, 57(2), 186-192.

Kendall-Tackett, K.A., & Williams, L. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, 113(1), 164-180.

Rind, B., & Tromovich, P. (1988). A meta-analytic examination of assumed properties of child sexual abuse. *Psychological Bulletin*, 124(1), 22-53.

Sirles, E., Smith, J., & Kusama, H. (1989). Psychiatric status of intrafamilial child sexual abuse victims. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28, 225-229.

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CHILDREN'S NORMAL AND PROBLEMATIC SEXUAL BEHAVIORS

The charts on the following pages identify common sexual behaviors of children of normal intelligence and developmental ability at different ages, during different developmental stages. The behaviors are considered normal and healthy in one context, yet inappropriate in another. The circumstances under which the behavior is discovered (where the behavior occurs, who it involves, how long it has been happening, the degree to which any force or coercion was involved) must be considered carefully before deciding whether behavior is abnormal. Remember, these charts should not be used for assessing child sexual maltreatment. "Children engaged in any behavior in any column may or may not have been sexually abused. There are many influences on children's lives that alter their behavior. Not all of them stem from sexual abuse" (Cavanagh Johnson, 1999, p. 51).

Sexual Behaviors of Preschool Children

HEALTHY, NATURAL	BE CONCERNED	SEEK CLINICAL ASSESSMENT
Touches/rubs own genitals when diapers are being changed, when going to sleep, when tense or excited or afraid	Continues to touch/rub genitals in public after being told repeatedly to stop	Touches/rubs self to the exclusion of normal childhood activities; hurts own genitals by touching/rubbing
Explores differences between males and females	Continual questions about genital differences after all questions have been answered fully by an adult	Plays male or female roles in an angry, sad, or aggressive manner; seems to hate own/other gender
Touches the private parts of familiar adults and children	Touches the private parts of an unknown adult, a vaguely known adult, or an unknown child; touches familiar people's genitals after being told "no." Asks any of these people to touch his or her private parts.	Sneakily touches adults. Makes others allow his/her touching; demands that others touch him/her

Adapted from: Cavanagh Johnson, T. (1999). *Understanding your child's sexual behaviors*. Oakland, CA: New Harbinger Publications, Inc. [no longer in print, but can be found in many libraries]

HEALTHY, NATURAL	BE CONCERNED	SEEK CLINICAL ASSESSMENT
Takes advantage of chances to look at nude adults and children	Stares at nude adults and children even after having seen several nude people	Asks people to remove their clothing or tries forcibly to undress others
Asks about genitals, breasts, intercourse, where babies come from	Keeps asking even after an adult has provided age-appropriate answers	Asks unfamiliar people after an adult has answered questions; sexual knowledge appears too adult for age
Boy has erections	Boy has continuous erections	Boy has painful erections
Likes to be nude; shows others his/her genitals	Wants to be nude in public after adults have said "no"	Refuses to put on clothes; secretly flashes privates in public
Interested in other people's bathroom behaviors	Interest in bathroom activities does not wane after a few days	Refuses to leave people alone in the bathroom; forces way into bathroom
Interested in having/birthing a baby (either gender)	Boy's interest does not wane after several days	Displays fear or anger about babies, birthing, or intercourse
Uses "dirty" words for bathroom functions or sexual behaviors	Continues to use such words after being told not to	Uses such words in public and/or at home after repeated scoldings or consequences
Interested in own feces	Smears feces on walls, floors, or self more than one time	Repeatedly plays or smears feces after scolding
Plays "doctor" and inspects other's bodies	Frequently plays doctor after being told not to	Forces another child to take off clothes in order to play
Puts an object into own genitals or rectum once for curiosity and exploration	Puts an object into these areas of self or others after being told not to	Using any coercion, force, or threat to put something into the genitals or rectum of self or another child
Plays house, acts out roles of mommy and daddy	Humps other children with their clothes on	Oral sex; simulates or initiates actual intercourse without clothes

Sexual Behaviors Of Kindergarten Age and Older Children

HEALTHY, NATURAL	BE CONCERNED	SEEK CLINICAL ASSESSMENT
Asks about genitals, breasts, intercourse, where babies come from	Shows fear or anxiety about sexual topics	Endless (or more and more mature) questions about sex; sexual knowledge appears too adult for age
Interested in watching/peeking at people doing bathroom functions	Keeps getting caught watching/peeking at others in the bathroom	Refuses to leave people alone in the bathroom
Uses “dirty” words for bathroom functions or sexual behaviors	Uses such words with adults after being punished; and after being taught correct language	Continues use of such words even after strong consequences have been applied
Plays “doctor” and inspects other’s bodies	Frequently plays doctor after being told not to	Forces another child to take off clothes in order to play
Interested in having/birthing a baby (either gender)	Boy’s interest does not wane after several days; recurrent theme in either gender’s play	Displays fear or anger about babies, birthing, or intercourse
Shows others his/her genitals	Continues to want to be nude in public after being scolded or punished	Refuses to put clothes on; exposes genitals in public despite scoldings
Interest in urination and defecation	Plays with feces; purposefully urinates outside of the toilet	Repeatedly plays with feces or urine; urinates or defecates on household objects or furniture
Touches/rubs own genitals when going to sleep, when tense or excited or afraid	Continues to touch/rub genitals in public after being told repeatedly to stop; rubs genitals on furniture or other objects	Touches/rubs self to the exclusion of normal childhood activities; hurts own genitals by touching/rubbing; rubs genitals against other people
Plays house; simulates many roles of mommy and daddy	Humps other children with clothes on; imitates sexual behavior with dolls or stuffed toys	Humping naked; voluntary or forced intercourse with another child
Thinks opposite gender is weird or “gross”; chases or teases children of opposite gender	Uses foul language to tease opposite gender children	Uses foul language to tease opposite gender children or to try to emotionally hurt children

HEALTHY, NATURAL	BE CONCERNED	SEEK CLINICAL ASSESSMENT
Talks about sex with friends; talks of having a girl/boyfriend	Child talks about sex to the point that it gets child in trouble at home or school; child has distorted perception of relationships as romantic when they are not	Chronically talks about sex and sexual activities; repeatedly in trouble because of sex talk
Wants privacy in bathroom or when changing clothes	Becomes very upset when observed	Aggressive, fearful, tearfully upset and demands privacy
Likes to hear and tell "dirty" jokes	Gets caught making dirty jokes, sexual sounds (moans, signs), or gestures	Shows no understanding of appropriate circumstances for telling jokes or mimicking sexual behavior
Looks at nude pictures	Continued fascination with nude pictures; secretly collects nude pictures, underwear ads, etc., particularly when child is prepubescent	Prepubescent child masturbates to nude pictures; older child displays inappropriate pictures; older child hordes nude or seminude pictures once caught; older child masturbates to unusual material (family photo, etc.)
Plays games with same-aged children related to sex and sexual behaviors	Wants to play sexual games with much younger or older children	Child or group of children force others to play sexual games
Draws genitals on human figures for artistic expression, realism, or because figure is being portrayed in the nude	Draws genitals on clothed figures; draws genitals on some nude figures but not others; genitals disproportionate to size of body	Draws unattached genitals; genitals stand out as prominent feature of a drawing; drawings of intercourse, group sex, bestiality, sadism, masochism, younger children
Explores differences between males and females	Confused about differences between males and females	Plays male or female roles in sad, angry, or aggressive manner; appears to hate own/other gender
Takes advantage of opportunities to look at nude adults or children	Stares at or tries to make opportunities to view nude people after having seen several	Asks people to remove clothing; tries to forcibly undress people

HEALTHY, NATURAL	BE CONCERNED	SEEK CLINICAL ASSESSMENT
Pretends to be opposite gender	Expresses desire to be opposite gender (not just curious about what it would be like)	Hates being own gender; hates own genitals
Wants to compare genitals with same-aged friends	Wants to compare genitals with much older or younger people	Demands to see others' genitals, breasts, buttocks
Interested in touching the genitals, breasts, buttocks of other same-aged children or having other children touch his/hers	Continuously wants to touch these areas of other children; tries to engage in oral, anal, or vaginal sex	Manipulates or forces other child to allow touching; forced or mutual oral, anal, or vaginal sex
Kisses familiar adults and children	French kissing; fearful of hugs and/or kisses from adults; kisses unfamiliar adults or children; greatly upset by public displays of affection	Overly familiar with strangers; talks in a sexualized manner to adults; physical contact causes agitation to the child or adult
Looks at the genitals, breasts, buttocks of others	Touches or stares at others' genitals, breasts, or buttocks; asks others to touch him/her on these parts	Sneakily or forcibly touches others' parts; attempts to manipulate others into this type of touching
Boy has erections	Boy has continuous erections (prior to puberty, when continuous erections become the norm)	Boy has painful erections
Puts an object into own genitals or rectum once for curiosity and exploration or for the physical sensation	Puts an object into these areas of self or others frequently, or although it will feel uncomfortable, or after being told not to	Using any coercion, force, or threat to put something into the genitals or rectum of another child; causes harm to own/others genitals or rectum
Interest in animals' breeding behavior	Touches genitals of animals	Sexual contact with animals

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POINTS TO CONSIDER REGARDING CHILDREN'S SEXUAL BEHAVIORS

- ◆ Children's sexual behaviors are generally normal and expectable.
- ◆ Sexual play between friends is not unusual. Sexual behavior between children who do not have an ongoing relationship is unusual.
- ◆ Not all acts of sexual contact between friends or between siblings should be considered "abuse"; however, the likelihood that one or both of the children will come to feel badly about the contact is greater when it occurs between siblings.
- ◆ In general, children choose to initiate sexual contact with other children who are approximately the same age (some professionals suggest the range is generally six months to a year while others suggest three years is the maximum difference in range) and who function at the same developmental level. There are exceptions:
 - When no other children in the age/developmental range are living in the same area (or have the same sitter, etc.).
 - When the initiating child is developmentally delayed, he or she may choose younger children who are closer in developmental characteristics.
 - When the initiating child has poorly developed social skills, a younger child may be engaged.
- ◆ Generally, the greater the span of time between the ages of the children, the more concerning the behavior should be to an adult.

Adapted from: Cavanagh Johnson, T. (1999). *Understanding your child's sexual behaviors*. Oakland, CA: New Harbinger Publications, Inc. [no longer in print, but can be found in many libraries]

- ◆ Children are most likely to characterize the sexual contact as negative if the age difference exceeds a year.
- ◆ A child's normal sexual curiosity should parallel his or her level of curiosity for many other topics. This interest usually fluctuates as new and different aspects of the environment become the objects of fascination. If the child appears preoccupied over a period of time (relative to the time he or she would remain fascinated with any other topic) then there may be cause for concern.
- ◆ Be concerned if a child prefers to masturbate instead of engaging in other activities or games.
- ◆ Be concerned if the child appears to have an **adult** understanding of sexual matters or exhibits an **adult** sexuality. Children pick up sexual content from many sources in their environments (television, radio, other children, internet, magazines, movies, etc.). Some parents choose to be very frank about sexuality and teach young children the proper names for genitalia. Be careful not to jump to conclusions without thoroughly examining the origins of the child's sexual understanding.
- ◆ Be concerned if the child's sexual behaviors are vastly different from those of the children with whom he or she interacts regularly (in the family, at school or daycare, in the neighborhood).
- ◆ Most children learn quickly that **openly** sexual behavior is prohibited. Sexual behavior that continues openly after repeated requests from an adult to stop should be considered suspect. The child in this case may be subconsciously signaling the adult that something has happened. It is normal for children who **have not been mistreated** to continue sexual behaviors in a clandestine fashion after being told to stop, just as it is not unusual for them to run in the house when caregivers are away although they are not supposed to do that. Children enjoy "getting away" with many behaviors that their caregivers do not find acceptable.

- ◆ Be concerned if the child who is demonstrating sexual behaviors appears “spaced out” during the behavior. If the child does not appear to know what he or she is doing, then the sexual behavior should be considered problematic.
- ◆ Be concerned if the child appears to be driven to engage in sexual behavior despite expecting consequences.
- ◆ Children with urinary tract infections or yeast infections may appear to be engaging in masturbatory behavior when they are simply responding to the itching or discomfort. Infections of this type are correlated with maltreatment, but, by themselves, are not grounds to conclude that maltreatment has occurred.
- ◆ If a child reports another child’s sexual behavior, then there is reason to be concerned. Generally children engage in sexual contact with a spoken or unspoken agreement not to tell. If a child is telling then it is likely that the other child was using threats or coercion, which is not normal behavior.
- ◆ Children are often spontaneously affectionate with adults but are usually sensitive to the adult’s reactions. Be concerned if a child touches an adult in a manner that appears inappropriate, continues to touch an adult after being asked not to, offers himself or herself for sexual engagement, or solicits sexual contact.
- ◆ Sex offenders scrutinize children’s behaviors and may target children who initiate inappropriate physical touch with adults.
- ◆ Be concerned if a child who is four years old or older does not understand other children’s rights to privacy and control of their bodies.

- ◆ Be concerned if an elementary school-aged child cannot contain sexual impulses. As children age, their sexual behaviors occur sporadically and, most often, occur in secret—in other words, sexual behavior and curiosity is contained. When an adult has “more than a sense” that a child is involved in sexual behavior because of frequency, intensity, or intrusiveness, then the child’s sexual behaviors are probably not contained and this should be considered problematic.
- ◆ Normal sexual contact between children leaves the children with positive feelings (amusement, silliness, sharing a fun secret). Being caught in sexual contact (and the situation being handled well by the adult) may leave children feeling embarrassed and guilty, but it does not cause the child to feel shame. Inappropriate sexual contact, conversely, may leave the child feeling deep shame, intense guilt, fear, and/or anxiety.
- ◆ Be concerned if a child’s sexual behavior is extensive and similar to **adults’** behaviors. Children’s normal sexual behaviors are generally spontaneous, sporadic, and clearly function to explore their curiosity not satisfy sexual urges.
- ◆ Be concerned if the child has sexual contact with animals, especially if the behavior is repetitive. Also be concerned if the child hurts animals in any way.
- ◆ Be concerned if the child perceives everyday objects or people as sexual objects, or ascribes sexual motives to other people’s behaviors.
- ◆ Be concerned if a child’s sexual behaviors cause emotional or physical pain or discomfort to the child or others.
- ◆ Be concerned if the child uses sexual behaviors such as gestures, language, or touches to express anger at another person directly or indirectly.

- ◆ Be concerned when sexual behavior is preceded by, follows, or accompanies angry verbal or physical expressions. Children who link negative emotions to sexual conduct have likely witnessed verbal or physical aggression in the context of a sexual relationship at some point. Relating sexual words and violent behavior should always cause concern.
- ◆ Be concerned if a child justifies sexual behavior through distorted logic. Children normally make excuses when they are caught behaving improperly. If, however, their excuses indicate distorted thinking around sexual issues (“All girls want it,” “All boys are into sex” “She shouldn’t have been wearing that short skirt if she didn’t want to...”), then there is a need to be concerned.
- ◆ Be concerned if the child relies on force, coercion, bribery, manipulations, or threats to engage a partner in sexual activity. Teasing and daring often precede normal, healthy, exploratory sexual behavior between children. Threats, coercion, and physical force do not. Children who rely on these methods will often target physically or emotionally vulnerable children or younger children.
- ◆ If a child’s behaviors are troublesome, have the child assessed by a competent clinician. Consider Cavanagh Johnson’s (1999) caution to appropriately label behavior, “Mislabeling a child as a child who molests when the problem is of a lesser degree can have significant reverberations. It may result in the child identifying himself or herself in this way and being put into ‘sex offender specific’ treatment where he or she may be ‘treated’ for sexual offending that did not occur. If the child enters the child protective services system and is placed in out-of-home care with this label, it may cause the child to be removed from home and be placed separately from his or her siblings, and it will be very difficult (if not impossible in many locales) for the child to cast off this label. Since some people believe that there’s no successful treatment for ‘sex offenders,’ it’s possible that the child will always be seen as a child (then adolescent, then adult) who molests regardless of years of no offending behavior (p. 100).”

- ◆ Children **can** overcome problematic sexual behavior with adults' help. Children who experience such problems need the assistance of compassionate caregivers, school staff, social workers, and therapists.
- ◆ The degree of difficulty involved in correcting a child's problematic sexual behavior ranges from simple to extremely difficult. Minor interventions will only be required in some instances, but in others a sustained, focused treatment regimen requiring a team approach, may be necessary. Several factors should be considered to influence the treatment approach and expectable outcomes:
 - The number of problematic sexual behaviors
 - How long they have been occurring
 - Causes that can be identified as precipitating the behaviors
 - The child's level of impulse control and frustration tolerance
 - Adults' previous reactions to the behaviors and appropriate or inappropriate interventions they have tried
 - Adults' consistency, commitment, and willingness to adhere to a plan
 - A supportive, positive, nurturing environment
- ◆ Do not allow a sexual behavior to be a child's defining quality. Problematic or not, a sexual behavior is only one of many positive or negative behaviors a child may produce. Be sensitive to not allowing the negative behavior, and adults' responses to it, to corrupt the child's self-esteem.
- ◆ Expect concurrent problems that will also require treatment, such as enuresis and/or encopresis, severe anxiety, oppositional and/or aggressive behaviors, eating disorders, school problems, anxiety or depression, poor peer relationships and impaired social skills, trust issues, poor judgment, limited impulse control.

- ◆ Avoid placing children with caregivers who cannot manage their reactions to such behaviors in ways to support the child instead of shunning him or her. Punitive and judgmental reactions will only make the problem worse.
- ◆ Problematic sexual behaviors may be the child's unconscious attempt to process through pervasive feelings of anxiety, fear, shame, guilt, anger, or tension.
- ◆ Even sexually-reactive children need appropriate physical contact. Children who have sexual problems should not be entirely denied physical contact. They should be taught what level of contact is appropriate to the circumstances. Adults interacting with these children must be clear in setting expectations and demonstrating what is appropriate. For example, some responses might include, "I don't feel comfortable with that hug. It's too tight. Let's try again" (p. 103). "I want to give you a hug but it seems you wrap yourself all around me. Let's try a hug where we use our arms and hug around our shoulders" (p. 103). "That kiss feels too much like a grown-up kiss. Let's kiss on the cheek, like this" (p. 103).

Resource:

National Child Traumatic Stress Network (2009) *Sexual Development and Behavior in Children*.
http://nctsn.org/nctsn_assets/pdfs/caring/sexualdevelopmentandbehavior.pdf

Resource updated July 2016

ATTACHMENT OUTCOMES

STRONG ATTACHMENT DEVELOPED	WEAK ATTACHMENT DEVELOPED
<ul style="list-style-type: none"> • Self-esteem is higher • Independence and autonomy • Resilience in the face of adversity • Ability to manage impulses and feelings • Long-term relationships • Relationships with caregivers • Respects authority • Prosocial coping skills • Trust, intimacy, affection • Positive belief system about self/society • Empathy, compassion, conscience develop • Positive behavioral performance • Academic success likely • Secure attachment to own children as parent 	<ul style="list-style-type: none"> • Self-esteem is lower • Neediness • Decompensation when faced with stress • Lack of self-control and emotional modulation • Instability in developing and maintaining meaningful ties • Generally alienated from caregivers • Oppositional towards authority • Antisocial behaviors often including aggression/violence • Incapable of genuine trust, intimacy, and affection • Negative, pessimistic, hopeless views of self/society • Lack empathy, compassion, and remorse • Problematic behavior common • Academic performance problems likely • Perpetuates cycle of poorly formed attachment in own children

Adapted from: Levy, T.M., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorders in children and families*. Washington, DC: Child Welfare League of America, Inc.

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CHARACTERISTICS ASSOCIATED WITH TYPES OF ATTACHMENT

SECURE ATTACHMENT	ANXIOUS-AVOIDANT INSECURE ATTACHMENT
<p style="text-align: center;">Children</p> <ul style="list-style-type: none"> • While caregiver is present, toddler actively explores surroundings; becomes distressed if caregiver leaves • Toddler appears calm and cooperative • On reunification, toddler is excited and welcomes caregiver • Child becomes anxious around strangers and turns to caregiver for security • Older children are able to express their feelings verbally • Older children are able to develop strategies for coping with stress • Older children's relationships with caregivers are typically relaxed, friendly, warm, and genuine • Older children will display greater social ability, resiliency, resourcefulness, empathy, and popularity among peers 	<p style="text-align: center;">Children</p> <ul style="list-style-type: none"> • Demonstrate little, if any, distress when caregiver leaves • May seek attention from caregiver then reject caregiver when attention is provided • Display indifference to both caregivers and strangers • On reunification, toddler ignores caregiver • Prefer to interact with toys or other stimuli than caregivers • When distressed, child remains distant from caregivers, rejecting them and avoiding intimacy and connection • Children may appear clingy, antisocial, aggressive or submissive • Older children often seek attachments with teachers and other adults but experience difficulty relating to them, resulting in further alienation • Interactions with peers are generally negative, reinforcing child's perception that he or she is not worthy of love
<p style="text-align: center;">Caregivers</p> <ul style="list-style-type: none"> • Feed infant on demand and respond quickly to baby's cries • Use discipline effectively and are sensitive to age-appropriate behaviors 	<p style="text-align: center;">Caregivers</p> <ul style="list-style-type: none"> • Generally present as cold, angry, rejecting, distant, lacking in emotional sensitivity or empathy • May demonstrate mental limitations or psychopathologies • Behavior may generally be described as neglectful

Adapted from: Ainsworth, M.D.S., Blehar, M., Walters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum.

ANXIOUS-AMBIVALENT INSECURE ATTACHMENT	DISORGANIZED-DISORIENTED INSECURE ATTACHMENT
<p style="text-align: center;">Children</p> <ul style="list-style-type: none"> • Limited exploration of surroundings because separation from caregiver causes such distress • Toddlers appear anxious prior to separation from caregiver, very upset during the separation, but ambivalent upon the caregiver's return • Toddlers cry more, display general distress, and negatively respond to physical contact • Children are preoccupied with the whereabouts of attachment figures, but when they are reunited become difficult to soothe and generally resist being comforted • Older children often mix contact-seeking and resistant behaviors such as hitting, kicking, squirming, prolonged crying and extreme passivity. • Older children appear dependent upon, but extremely angry with, their caregivers • Maintain a parent-child relationship characterized by both closeness and hostility • Older children manipulate caregivers to get what they want; often act out dramatically if they do not get what they want 	<p style="text-align: center;">Children</p> <ul style="list-style-type: none"> • Infants exhibit contradictory behavior patterns by gazing away while being held, avoiding or resisting interactions with caregiver, or displaying unusual expressions of negative emotions • After separations, infants and toddlers display no emotion or display both avoidant and ambivalent behavior • Some children may appear markedly distressed during separation and be practically inconsolable upon reunion • Child may appear obsessed with caregiver and vacillate between a desire for closeness and distancing due to anger • Children respond to caregiver's neglect, rejection, and hostility with similar behavior • Older children frequently appear frightened or aggressive • Older children may have poor to non-existent coping skills. • Children often display behaviors similar to attention deficit disorders or separation anxiety disorders • Children are easily frustrated and have low tolerance for delayed gratification • Older children generally experience academic difficulties • Older children typically behave towards their caregivers in ways that demonstrate a desire to control or dominate them
<p style="text-align: center;">Caregivers</p> <ul style="list-style-type: none"> • Generally appear inconsistent and unpredictable • Behavior may at times appear warm, but responses to child are often insensitive and inconsistent or inappropriate 	<p style="text-align: center;">Caregivers</p> <ul style="list-style-type: none"> • Often appear depressed or demonstrate other psychopathology • Display little interest in their children • Responses are inconsistent and frequently insensitive

REACTIVE ATTACHMENT DISORDER

The following are RED FLAGS suggesting a child may be at risk of developing REACTIVE ATTACHMENT DISORDER and should be assessed by a mental health professional:

- ◆ The child's social relatedness is clearly disturbed and developmentally inappropriate, but it cannot be explained by a delay such as intellectual disability.
- ◆ Problems in social interaction are seen before age 5.
- ◆ The child has one or more of the following behaviors:
 - Resists comforting
 - Displays hypervigilance
 - Displays "frozen watchfulness"
 - Indiscriminately attaches to others
- ◆ The behavior manifests AFTER the child has received poor treatment in one or more of the following ways:
 - Emotional needs have been neglected
 - Child was inconsistently comforted when distressed
 - Basic physical needs were left unmet
 - Primary caregivers repeatedly changed and/or were non-responsive to child's needs

Adapted from: Morrison, J. (1995). *DSM-IV made easy: The clinician's guide to diagnosis*. New York: The Guilford Press.

Resources:

Parenting Children and Teens with RAD <http://www.reactiveattachment-disorder.com/>

Child Development Institute <https://childdevelopmentinfo.com/child-psychology/reactive-attachment-disorder/>

Resources updated July 2016

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WAYS TO ENCOURAGE ATTACHMENT

- ◆ Be patient but persistent in forming emotional connections.
- ◆ Turn tantrums into "trust building moments"—after tantrums, children relax and the opportunity to build trust presents itself.
- ◆ Share your family histories/rituals and ask the child to share his or hers.
- ◆ Nurture the child who is physically ill.
- ◆ Always accompany the child to doctor and dentist appointments—and offer to stay with him or her to provide support.
- ◆ Help the child express and cope with feelings of anger and frustration.
- ◆ Share the child's excitement over achievements.
- ◆ Help the child cope with feelings about moving.
- ◆ Help the child cope with ambivalent feelings about caregivers.
- ◆ Educate the child about sexual issues.
- ◆ Make affectionate overtures—hugs, kisses, physical closeness.
- ◆ Read to the child.
- ◆ Play games
- ◆ Go shopping together and give the child choices.
- ◆ Go on special outings—and sometimes let the child choose where to go.
- ◆ Support the child's outside activities by providing transportation or becoming involved with the child.
- ◆ Help the child with homework.

Adapted from: Fahlberg, V.I. (1991). *A child's journey through placement*. Indianapolis, IN: Perspective Press.

- ◆ Teach the child skills that he or she may admire—cooking, building, etc.
- ◆ Say, "I love you."
- ◆ Talk to the child about his or her extended family—look at the child's pictures/lifebook together.
- ◆ Clue the child in to "family" jokes, jargon, and traditions.
- ◆ Involve the child in family activities.
- ◆ Make certain all caregivers share the same expectations for the child.
- ◆ Encourage the child to come up with special names for substitute caregivers—if not "mom" and "dad" then something the child feels comfortable calling foster parents that lessens formality.
- ◆ Hang pictures of the child and the child's artwork throughout the house.
- ◆ Involve the child in family reunions and get-togethers—but be sensitive of how the child might react (enjoys self, becomes overwhelmed, painfully misses own family). Be responsive to the child's reactions and feelings.
- ◆ Have the child help pick out new clothes, new bedding, artwork to decorate room.
- ◆ Be supportive in correcting behavior: "In our family, we do it this way."

Resources:

Tips to Encourage Attachment in Adoption

<http://www.rainbowkids.com/adoption-stories/tips-to-encourage-attachment-in-adoption-1400>

Dr. Bruce Perry (n.d.) *Bonding and Attachment in Maltreated Children: How You Can Help*

http://teacher.scholastic.com/professional/bruceperry/bonding_help.htm

Parenting: Attachment, Bonding, and Reactive Attachment Disorder

http://www.healingresources.info/children_attachment.htm

Resources updated July 2016

MINIMIZING THE TRAUMA OF MOVES

Developmental Considerations

Infants

Emphasis on transferring attachment and caregiving routines during preplacement contacts. Maintain as many routines as possible in new setting. After move, provide consistency and **meet needs on demand**.

Toddlers

Preplacement preparation is crucial to reduce long-term anxiety and fear regarding separation, loss, and lack of safety with caregivers. Primary goal during moving process is to transfer attachment; best facilitated by cooperative contact between the caregivers the child is leaving and new caregivers. Provide support and understanding if regression occurs after move; undue pressure may have negative long-term effects. Note events surrounding the move on the child's permanent record, as this information may help caregivers and helping professionals understand the child's future actions and issues. Postplacement contacts with previous caregivers are important so that children understand the reasons for the moves as they grow older.

Preschool Years

Explaining in "child-friendly" language what is occurring and why reduces magical thinking and helps the child attain a sense of control over events. Preplacement services aid in transferring attachment to new caregivers and initiating the process of grieving. Identifying and modifying the child's negative perceptions (e.g., "It is my fault I lost my mom") prevents future emotional problems. As the child develops increased cognitive skills, around 8 or 9 years old, caregivers and/or helpers need to review the past, so that the child is not misinterpreting those events.

From: Levy, T.M., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorders in children and families*. Washington, DC: Child Welfare League of America, Inc.

Grade School Age

Despite increased cognitive and verbal skills, it remains necessary to identify and correct magical thinking and misperceptions. It is important to help the child understand what is happening, and to provide aid in identifying and constructively expressing emotions. Adults are responsible for decision making, but the child needs to be included as an active participant in the moving process. The child is encouraged to share feelings, worries, and desires regarding the transition. After the move, discussions about grief-related (or other) feelings helps the child free up energy for social, academic, and additional activities and accomplishments.

Adolescence

Moves during early adolescence (12 to 14) are more difficult than in later adolescence, because individuation is a major developmental task of this stage. It is difficult to encourage attachment to new caregivers when the child is in the process of emotionally separating from family. Caregivers need to be sensitive to these developmental issues: children do best with a clear and concrete commitment ("contract") to the new caregivers. Adolescents need to have input into decision making about their lives and future, consistent with their need to have increasing control over life events in general. They should be part of the process of deciding where to live, except in special situations (e.g., displaying poor judgment). Commitments and contracts are helpful in clarifying and attaining goals. Caregivers and helping professionals can assist the adolescent "come to terms" with prior losses and trauma, and encourage a healthy balance of dependence and independence.

RESILIENCY FACTORS

FOR THE INDIVIDUAL CHILD:

NEGATIVE	POSITIVE
<ul style="list-style-type: none"> • Genetic or congenital abnormalities • Serious medical disorders • Exposure to toxins • Developmental delays • Low birth weight • Premature birth • Gender • Age • Ethnicity • Physical characteristics not meeting the Caregiver's expectations • Temperament • Poor self esteem • Learning disabilities • Aggression • Noncompliant behavior • Emotional distance • Lack of affect • Irritates easily • Inconsistent sleep patterns • Limited self care skills • School problems • Poor peer relationships • Juvenile delinquency • Substance abuse • Emerging sexuality/sexual orientation issues • Colic or constant crying • Sexual behaviors (normal/abnormal) • Enuresis/encopresis • Toilet training • Suicidal or homicidal behavior • Limited ability to protect self of seek help • Afraid of caregiver or living situation • Friends caregiver dislikes • Behaviors learned from peers 	<ul style="list-style-type: none"> • Achievement of developmental milestones • Easy temperament • Outgoing, affectionate personality • Competent social functioning • High levels of self-esteem • Positive peer group • Age • Deep sense of belonging and security • Able to protect self or seek help • Not injured and harm is not imminent • Secure attachment to caregiver or adults • Appropriate behavior that meets family norms • If special needs are present, child is connected to appropriate remedial and support services
	<ul style="list-style-type: none"> • Attention Deficit Hyperactivity Disorder • Stress due to lack of resources or support • Demonstrates a belief system not congruent with caregiver's • Presence of physical symptoms of serious maltreatment • Acculturation difficulties, or conversely becomes overly acculturated • Predatory behaviors toward siblings, other children, or animals • Bizarre behaviors indicative of mental illness such as arson, feces smearing, hallucinations, or verbalizations

FOR THE INDIVIDUAL CAREGIVER:

NEGATIVE	POSITIVE
<ul style="list-style-type: none"> • Psychological distress or illness • Postpartum depression • Lack of impulse control • High levels of anxiety • Chronic and debilitating illness • Fatigue/interrupted sleep • Attachment disorder as a child • Poor problem solving skills • Lacks confidence as caregiver • Perpetrator or victim of violence • Thinks in all or nothing terms • Whereabouts are unknown • Expressed intent to harm child • Problems during labor and delivery • Substance use interferes with • Rigid and unrealistic parenting expectations • ability to provide minimal care • History of abusive/neglectful family of origin • Physical problems during pregnancy • Inconsistent or overly harsh discipline • Unresolved issues of trust, dependency, or autonomy • Bizarre behaviors associated with mental illness (see child entry) • Lacks understanding of the emotional complexity of the caregiver-child relationship • Will not engage in discussion or planning regarding treatment for self or child • Displays paranoia, is likely to flee, or refuses CPS access to child • Exhaustion/stress from demands of maintaining a family • Leaves child in care of a disinterested or incapable paramour or other unrelated adult • Provides inconsistent explanations for injuries or circumstances • Poor attachment because of early separation (ex. Complications at birth, imprisonment, extended absence due to military service or drug use) 	<ul style="list-style-type: none"> • Stable employment and economic security • Absence of negative peer group influences • Presence of strong social supports • Positive caregiver-child relationship • Effective parenting skills • Feelings of self-confidence and self-esteem • Intelligence (average or better cognitive skills) • Access to healthcare • Harmony between caregivers • Not abusing substances • Able to defer own needs • Facilitates CPS access to child • Remorseful if injuries caused to child • Desires avoiding further injury • Willing to intervene to protect child • Involvement/commitment to child's education and success in school • Leaves child with an attached, interested paramour or other adult • Able to identify actions that are required to prevent harm to child • Provides consistent, reasonable explanations for injuries and circumstances • Demonstrates capacity to learn from experiences and transfer learning across situations <ul style="list-style-type: none"> • Difficulties overcoming barriers resulting from lack of resources (lack of adequate housing and transportation, difficulty obtaining medicine for self/child, lack of adequate food/clothes, etc.) • Difficulty understanding the child's needs, perspectives, and developmental level • Poor or negligible outcomes from previous attempts to assist the caregiver or to provide therapeutic interventions

ENVIRONMENTAL FACTORS:

NEGATIVE	POSITIVE
<ul style="list-style-type: none"> • Limited opportunities for education • Limited opportunities for employment • Limited housing • Racial/ethnic/sexual discrimination • Social injustice • Poverty • Welfare stereotypes • Maladaptive or deviant social norms • Cultural prohibitions • Resources unavailable or restricted • Discord between caregivers • Lack of financial resources • Unemployment/underemployment • Lack of positive family/social support • Poor/dangerous living conditions • Single-parent family structure • Isolation, particularly in rural areas • Fragmented service delivery system • Conflict with systems such as the school • Inaccessible/unaffordable health care and child care • Lives in a socially impoverished, violent, crime-ridden neighborhood 	<ul style="list-style-type: none"> • Middle-class or above socioeconomic status • Access to health and needed resources • Consistent employment/opportunities • Adequate/safe housing • Good schools • Support systems available and used • Supportive adults to serve as role models and mentors for child

Adapted from:

Filip, J., McDaniel, N., & Schene, P. (Eds). (1996). *Helping in child protective services: A competency-based casework handbook*. Englewood, CO: American Humane Association.

Levy, T.M., & Orlans, M. (1998). *Attachment, trauma, and healing: Understanding and treating attachment disorders in children and families*. Washington, DC: Child Welfare League of America, Inc.

Virginia Department of Social Services. Safety Assessment Checklist [form]. *Child Protective Services Policy Manual*, Volume VII, Section III, Chapter A, Appendix B. Retrieved February, 2005, from <http://www.dss.state.va.us/family/cps/policy.html>

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RESILIENCY JENGA

- ◆ Your Jenga stack represents a child. In each round of play, your child will encounter an event that will impact resiliency.
- ◆ Your facilitator will read the event out loud and instruct the player either to REMOVE blocks from the middle of the stack and place them on the top of the stack, or to RESTORE blocks by taking them from the top of the stack and sliding them back into the middle.
- ◆ If your stack falls, discontinue play and watch the other groups. Note how resilient your child is compared to the other groups' children.

ROUNDS

A round lasts approximately 10 seconds. Players must quickly choose what block(s) they will move and proceed.

Facilitator, read each factor below out loud and instruct each player to remove or restore blocks as indicated. Be sure to take a turn yourself.

No prenatal care	REMOVE 2 blocks
Used cocaine during first 3 months of pregnancy	REMOVE 2 blocks
Premature birth	REMOVE 2 blocks
Low APGAR scores	REMOVE 1 block
Attachment evident between baby and mother	RESTORE 1 block
Grandmother moves in to provide support	RESTORE 1 block

Baby makes rapid gains in weight	RESTORE 1 block
Grandmother moves out after argument with mother	REMOVE 1 block
Mother allows baby's father to visit. He brings cocaine.	REMOVE 1 block
Mother uses cocaine and baby is present	REMOVE 3 blocks
Grandmother reports suspected drug use to CPS	RESTORE 1 block
Mother appears concerned about child's welfare	RESTORE 1 block
Mother's drug test is positive for cocaine	REMOVE 3 blocks
Mother willing to accept in-patient treatment in a facility where she and baby can remain together	RESTORE 1 block
Mother prematurely terminates treatment	REMOVE 2 blocks
Mother moves in with baby's father	REMOVE 1 block
Baby placed with grandmother	RESTORE 1 block
Mother and father separate because mother decides to return to treatment	RESTORE 1 block
Mother becomes employed full-time	RESTORE 1 block
Mother's drug tests remain clean for six months	RESTORE 1 block
Court review—custody returned to mother	RESTORE 2 blocks
Preschooler enrolled in Head Start program	RESTORE 2 blocks
Mother gets new boyfriend	RESTORE 1 block

Boyfriend loses job	REMOVE 1 block
Boyfriend starts drinking heavily	REMOVE 2 blocks
Mother now sole financial support for family	REMOVE 2 blocks
Boyfriend, intoxicated, beats mother and child is present	REMOVE 3 blocks
Mother calls police; boyfriend arrested	RESTORE 1 block
Grandmother reports incident to CPS	RESTORE 1 block
CPS accepts report	RESTORE 2 blocks
Mother agrees that boyfriend should not return to the home	RESTORE 1 block
Mother voluntarily agrees to drug test to prove still clean and passes	RESTORE 1 block
Preschooler demonstrates great separation anxiety at Head Start	REMOVE 1 block
Preschooler's behaviors at Head Start are problematic	REMOVE 1 block
Preschooler begins hitting other children and adults	REMOVE 2 blocks
Mother agrees to take child to play therapist	RESTORE 1 block
Preschooler responds to treatment and problematic behaviors decrease	RESTORE 2 blocks
CPS closes case	RESTORE 1 block

KAREN

Karen is enrolled in the second grade in a public school. She is struggling academically. The school has designated Karen as “learning disabled.” The teacher and Karen’s mother attend a meeting of professionals called together to develop an Individualized Education Plan. The teacher reports that Karen struggles in the classroom. She describes Karen as “quiet” and “withdrawn.” Karen, she claims, has the most difficulty with the academic work of any child in the class. Also, her English is so limited that she has difficulty communicating verbally. The teacher states that she is convinced that Karen has low self-esteem due to her poor performance.

Karen is from a First Nations tribe.

In your small groups, take five minutes to answer these questions:

1. Is Karen developing normally?

2. Should Karen’s caregivers be concerned about her development?

Adapted from: Trawick-Smith, J. (2000). *Early childhood development: A multicultural perspective* (2nd ed.). Upper Saddle River, NJ: Prentice-Hall.

STRATEGIES TO PROMOTE ETHNIC RESILIENCY

“If it is hard for a White teen to figure out who he is growing up...with his biological parents, how much harder is it for a biracial White/African-American girl who has lived in six different homes, with families of different ethnicities, in five different cities?” (Casey Family Programs, 2000, p. 7)

Children in foster care have even more difficulty developing a coherent identity, and particularly, a positive ethnic identity. The stress and lack of permanence make this process even more challenging as these children have been separated from their birth families, their links to their own, very personal cultures. Also, with each separation, security and stability is challenged and the child is faced with a new series of messages being conveyed by different caregivers, which may or may not support past messages or a positive ethnic self-identity.

Adults (caregivers and social workers alike) should:

- ◆ Affirm and validate children's racial/ethnic group membership.
- ◆ Provide frequent proactive and protective messages about race/ethnicity/culture during the childhood and school years to help children develop positive self-concepts.
- ◆ Be sensitive to the overt and covert messages that they send to children related to racial/ethnic/cultural values and stereotypes.
- ◆ Be willing to engage children in frank discussions related to race, ethnicity, and the climate of acceptance in their local and the larger communities. Respond to relevant events in the community and/or media with honest discussions and opportunities for children to express their beliefs and feelings.

Adapted from: Casey Family Programs. (2000). *A conceptual framework of identity formation in a society of multiple cultures: Applying theory to practice*. Seattle, WA: Author.

- ◆ Teach children about the traditions, beliefs, customs, and the sociopolitical histories of their individual cultures, as well as those of the caregiver if they differ.
- ◆ Prepare racial/ethnic minority children for the challenges they will encounter in the larger society (racism, discrimination) by providing strategies and affirmations that will counteract the negativity.
- ◆ Avoid messages that stereotype or encourage mistrust of other races/ethnicities (such as “Whites are not to be trusted”) because children are growing up in an increasingly multicultural society.
- ◆ Encourage multicultural competence, which research has found is connected to positive developmental outcomes, increased psychological resiliency, positive self-esteem, positive intergroup relations, motivation, and achievement.
- ◆ Help children develop a self-identity based on racial/ethnic group membership as well as ability to function in the larger dominant society, without promoting assimilation (the loss of individual pride and identity that comes from particular cultural membership).
- ◆ Expose children to positive racial or ethnic group images in literature, the arts, business, and popular media.
- ◆ Provide opportunities for children to play with similar children.
- ◆ Ask, when placing a child, “What will the shift in cultural context mean for the child?” (example, moving to a family with a different ethnic background, or being enrolled in a predominantly White school)
- ◆ Provide children with mentors, role models of the same race or ethnic group; arrange for participation in activities in community organizations that are relevant to children’s race or culture.
- ◆ Encourage cross-cultural contacts in many different contexts.
- ◆ Provide guidance and support.
- ◆ Steer children toward a positive, multicultural perspective.
- ◆ Validate the importance of the biological family.

- ◆ Obtain and provide birth family history that includes ethnic/cultural background.
- ◆ Help children develop accurate pictures of their absent birth family in order to stave off the development of either idealized versions of family members or versions based on negative stereotypes (i.e., a Latino boy believing his absent father was aggressive and violent, when he was actually quite gentle; an African-American girl believing her father is in jail for murder, when actually he is just living in another state).
- ◆ Encourage birth-family and permanency-family interaction throughout the child's placement. Substitute caregivers must be careful of the messages they explicitly and implicitly relay about birth family. Children are sensitive to the level of comfort/acceptance that caregivers show toward birth family. When there is a difference in race/ethnicity, it is even more important that substitute caregivers affirm birth family (or at least keep negative opinions private) because the child may interpret messages as expressions related to the value of the child's racial/ethnic group.
- ◆ Maintain birth family contact. Even when the child and substitute caregivers are of the same racial/ethnic group, there can be profound socioeconomic, religious, community, and cultural differences between the biological and substitute families.

Kinship Caregivers should:

- ◆ Provide role-modeling for dealing with difficult situations.
- ◆ Expose children to culturally relevant activities.
- ◆ Be positive role models.
- ◆ Have healthy self and ethnic identities.
- ◆ Have high expectations.
- ◆ Be willing to discuss race and their own biases.
- ◆ Defend children against discrimination.

Cross-Cultural Substitute Caregivers should:

- ◆ Be persistent in arranging birth family contacts.
- ◆ Expect wariness, initial discomfort, or alienation from the child.
- ◆ Express an interest in learning about the child's culture.
- ◆ Expose children to culturally relevant activities and positive images.
- ◆ Be aware of the importance of ethnic identity formation.

POINTS TO REMEMBER

- ◆ Development, which involves stages, is influenced by many factors and is directional, cumulative, ongoing, and dynamic.
- ◆ We have focused on six primary developmental domains—social, emotional, cognitive, physical, moral, and sexual. Our discussion has illustrated the ways in which development in these domains influences and is influenced by each other.
- ◆ Maltreatment may appear to impact a particular domain. However, in almost all cases, if one domain is affected, other domains will be affected as well. This is also true for developmental delay or disability.
- ◆ There is a strong link between poverty and child maltreatment. Access to quality services may moderate stressors associated with maltreatment.
- ◆ Knowledge of child development is critical to child welfare practice. As child welfare workers, we must know about developmental issues that increase risk of maltreatment and about the effects of maltreatment on development.
- ◆ Knowledge of child development enables us to educate caregivers about age-appropriate child care and discipline practices. It enables us to recognize the early warning signs of developmental disabilities. It helps us intervene with children and families in a manner that addresses developmental issues and focuses on helping children achieve their maximum potential.
- ◆ We need to recognize our own important role in the maltreated child's development. We can be a major source of support. The presence of one positive, supportive adult is a protective factor that promotes resilience

Adapted from: Rycus, J.S., & Hughes, R.C. (1999). *The effects of abuse and neglect on child development (Core 103)*. Columbus, Ohio: Child Welfare League of America and Institute for Human Services. [Course curriculum.]

- ◆ Knowledge of child development should enable us to facilitate placement into substitute care in a manner that is sensitive to the child's developmental level.
- ◆ We need to recognize our own important role in the maltreated child's development. We can be a major source of support. The presence of one positive, supportive adult is a protective factor that promotes resilience
- ◆ Knowledge of child development should enable us to facilitate placement into substitute care in a manner that is sensitive to the child's developmental level.
- ◆ In interviews, we must accept the child's rate of disclosure and capacity to process his or her experiences. We must remember that chronological age and developmental age are not synonymous. Children present very differently and require an approach consistent with individual needs and capacities
- ◆ Developmental level will affect the child's ability to respond to relationships and interventions
- ◆ We must always remember that most maltreated children have conflicted feelings regarding their caregivers, but still have an attachment to them. When discussing maltreatment, we must not transfer our own emotions towards the adults to the child.
- ◆ The meaning of abuse or neglect to a child will vary with the period or age stage in which maltreatment occurred. This is one reason that the consequences appear so varied.
- ◆ Because development is cumulative and continuous, the consequences of maltreatment will manifest in different ways over time. It is important to recognize that early experiences are likely to present challenges throughout life.
- ◆ We need to remind ourselves and others that children who have been maltreated need a great deal of nurturance, support, consistency and patience.

- ◆ There is no one best approach to working with maltreated children and their families. The range of recommended interventions and treatment reflects the diversity present among families. Causes, type of maltreatment, timing, and many other factors must be considered. A comprehensive, individualized assessment must guide intervention and service planning.
- ◆ Assessment and intervention should be sensitive to cultural, racial, and ethnic differences, as well as variety in family organization and structure. It is most important to be aware of one's cultural values and biases when assessing others' situations, behaviors, and development.
- ◆ In general, feeling loved and cared for is a major source of resilience for children. Attachment to a supportive adult can help a child recover from maltreatment. A secure and stable caregiver and feeling connected to a positive community both help children become more resilient.

SUGGESTED RESOURCES

Useful Websites

American Academy of Child and Adolescent Psychiatry
www.aacap.org/publications/factsfam/retarded.htm

Attachment
www.attachmentexperts.com
www.teachablemoments.com

Attention Deficit Disorder Association
www.add.org

Attention Deficit Hyperactivity Disorder
www.mentalhealth.com

Autism Speaks
www.autismspeaks.org

Brain Development
www.lili.org/marshall/yd_childdevelopment.html

Boston Child Health and Development Connection
www.bostonchildhealth.org

Casey Family Programs
www.casey.org

Cerebral Palsy: A Guide for Care
www.Gait.aidi.udel.edu/res695/homepage/pd_ortho/clinics/c_paly/cpweb.htm

Cerebral Palsy Network
www.geocities.com/Heartland/Plains/8950/

CHADD: Children and Adults with Attention Deficit Hyperactivity Disorder
www.chadd.org/

Child and Family Webguide: Parent Information on Child Development
www.cfw.tufts.edu/

Child Development
www.familyeducation.com/home/
www.questia.com
www.toddlersecrets.com

Child Development Institute
www.cdipage.com/

Child Development Resources
www.cdr.org/

Developmental Disabilities
www.state.sd.us/dhs/dd/division/devdis.htm
www.disabilityinfo.gov/Health/1110/

Down Syndrome
www.downsyndrome.com

Erickson Institute
www.erikson.edu

Fetal Alcohol Syndrome
www.specialchildren.about.com/cs/fasfae/index_2.htm

Foundation for Child Development
www.ffcd.org/

Frank Porter Graham Child Development Institute
www.fpg.unc.edu/

Hearing Loss
www.asha.org/hearing/disorders/effects.cfm

Infant and Child Development Journal
www.interscience.wiley.com/jpages/1522-7227/

Institute for Child Development (Focus: Autism)
www.lcd.binghamton.edu/

Learning Disabilities
www.nldontheweb.org/
www.nldline.colm/

Learning Disabilities Online: The ABCs of ADD/ADHD
www.ldonline.org/abcs-info/articles-info.html

MEDLINEplus: Child Development
www.nlm.nih.gov/medlineplus/childdevelopment.html

National Association for Child Development
www.nacd.org/

National Association for Down Syndrome
www.nads.org/

National Black Child Development Institute
www.nbcdi.org/

National Center for Birth Defects and Developmental Disabilities
www.cdc.gov/ncbddd/dd/ddmr.htm

National Child Traumatic Stress Network
www.nctsn.org

National Down Syndrome Society
www.ndss.org/

National Institute of Mental Health (Autism Spectrum)
<http://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd/index.shtml>

National Organization on Fetal Alcohol Syndrome
www.nofas.org/

The Child Development Web
www.childdevelopmentweb.com/

The Child Development Website
www.Childstudy.net/

The WWW ADD/ADHD FAQ Site
www3.sympatico.ca/frankk/

United Cerebral Palsy
www.ucpa.org/

Vision Loss
www.preventblindness.org/children/

Zero to Three (brain development and literacy)
www.zerotothree.org

Resources updated July 2016

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