COURT IMPROVEMENT PROGRAM TRAINING

Child Development

A Multi-disciplinary Curriculum for Improvement of the Child Welfare System

Colorado Supreme Court
Court Improvement Program
A Multidisciplinary Approach to Improving Systems to Benefit Families and Children

Child Development:

A Multi-Disciplinary Curriculum for Improvement of the Child Welfare System

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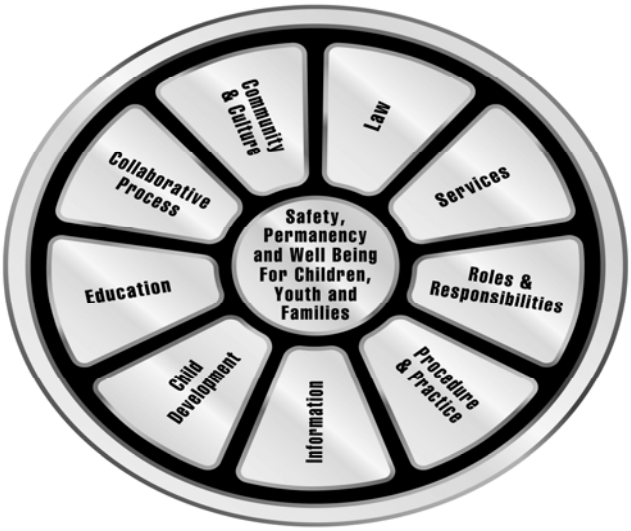

Colorado Court Improvement Program Training Wheel Curricula

It is not surprising that the diverse culture of the child welfare system creates knowledge and experience gaps for child welfare participants and practitioners alike, which leads to the question, "How can individuals who are involved in the child welfare system know about that system as a whole as well as the roles of others involved in it? "

The Colorado Court Improvement Program (CIP) is in the process of designing training to answer this very question. The Training Wheel Curricula is made up of nine separate modules, each representing a discipline or service area associated with the Child Welfare process. The purpose of each module is to assist multi-disciplinary Best Practice Court Teams in building a foundation of core knowledge within each discipline or service area. While each discipline or service area may have a required professional knowledge and skill base that exceeds core knowledge, it is core knowledge in all areas that creates an understanding of the child welfare process as a whole.

The *Child Development* curriculum was authored by Diane Baird of The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect.

For questions about the *Child Development* curriculum or about other Training Wheel curriculum, please contact Kay Yorty, Training Coordinator for the Colorado Court Improvement Program at margaret.yorty@judicial.state.co.us.

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CHILD DEVELOPMENT

TIME: 6.5 hours of training content

PURPOSE: To provide stakeholders in the child welfare system with sufficient understanding of human developmental stages to make decisions that promote lifelong healthy development for children and youth involved in the child welfare system.

COMPETENCIES: Those involved with the child welfare system should have an understanding of the following issues regarding child development:

- Developmental stages of children
- Parental bonds
- Impact of substance abuse on children and families
- Impact of domestic violence on children and families
- Impact of neglect on children and families
- Impact of physical and sexual abuse on children and families
- Educational needs and problems

LEARNING OBJECTIVES:

- Participants will demonstrate a basic understanding of the stages of early human development.
- Participants will be able to recognize and identify signs of developmental damage that have occurred in children, youth, and parents due to child abuse and neglect.
- Participants will understand how the behavior of children, youth and adults may be symptomatic of underlying traumatic events that have caused developmental issues.
- Participants will be able to identify and recognize developmental strengths of children, youth, and families in the child welfare system.
- Participants will be empowered to articulate their concerns as needed to fulfill their responsibilities in promoting the safety, permanency, and well-being of children within their roles.

MATERIALS: Flip chart, markers
DVD player and monitor(s)
Video Produced by the Kempe Center
Screen for the PowerPoint projection

EXPECTATIONS OF TRAINERS:

The lead trainer should be a person familiar with the child welfare system, the principles of child development including infant mental health, and the clinical consequences and treatment of maltreatment at all stages of the child's development. Trainers should be skilled at involving the group in discussion and should be knowledgeable of community resources and needs.

CHILD DEVELOPMENT PREPARATION

FACILITY: A large conference room or public meeting area such as in a library, church, or government building will be a suitable setting. A classroom or modified classroom setup with tables allows participants to comfortably take notes. The room should be large enough to divide participants into groups of 6-8 people for breakout activities. A screen will be needed for the PowerPoint presentation, and a DVD player and monitor will be necessary for video presentations. Usually one television sized monitor per 15 or 20 people is desirable unless the videos can be projected onto a larger screen.

RECRUITMENT: A diverse group of stakeholders will enrich the success of this training and promote multi-disciplinary thinking. A good cross-section of stakeholders would include representatives from various groups, such as child welfare and child placement personnel, CASA's, Guardians ad Litem, foster parents, attorneys, public health workers. mental health workers and therapists, substance abuse providers, domestic violence program staff, judicial officers, law enforcement, educators, tribal leaders, etc.

The lead trainer should ensure that registration forms include email addresses for all participants. Prior to the training, the leader should divide the group into multidisciplinary subgroups for breakout sessions. The leader should encourage the participants to continue to maintain contact in order to address community needs identified in small group sessions.

ADVANCED READING: Instructor must ensure that the Hypothetical Case Scenario is emailed in advance. The leader and participants should be familiar with the Hypothetical Case Scenario of Marianne and her children.

WELCOME AND INTRODUCTIONS
Time: 15 minutes
Description of Activity:

Welcome participants and thank them for being here.

Introduce yourself and provide a brief biographical summary of your experience with the child welfare system. Then give participants an overview of the training content. Refer participants to the agenda in their training materials, Handout 1.

Have participants briefly introduce themselves to those sitting at their table, including their role and what they hope to gain from today's training. If participants are unable to sit in small groups at tables, then have participants choose 4-5 people to introduce themselves. Encourage participation, questions, discussion throughout the day's presentation. Have participants wear nametags or use name cards where they are seated.

Take care of housekeeping information: restrooms, parking, CLEs, and other details.

Introduce the plan for the day, which is to review basic developmental stages of childhood and age associated competencies and vulnerabilities and to examine the effects of maltreatment at each developmental stage.

Briefly discuss the community's interest in healthy child development. Explain that Erik Erikson identified developmental or ego tasks for each stage of development, which must be resolved as the individual progresses through the life cycle, developing an "ego" (or sense of autonomy and self-efficacy) strong enough to function independently and pro-socially in a complex social environment. This process explains why communities have a collective interest in how children are raised. Professionals who are entrusted with caring and decision-making for the community's maltreated children must have an understanding of the impact of abuse and neglect on the developing mind and body. Our interventions must always serve healthy developmental outcomes, which are results that ultimately benefit the community when "at risk" children are able to develop into productive citizens.

Explain that the training will look at child development from birth to adolescence along these developmental dimensions: physical, cognitive, emotional, social, and behavioral. It will also examine the effects of maltreatment on the developing child.

The following corresponds with the PowerPoint presentation slides set forth in Faculty Resource 1.

💻 Slide 1: Child Development A Multi-Disciplinary Curriculum

💻 Slide 2: Colorado Court Improvement Program Training Wheel Curricula

💻 Slide 3: A Special Thanks To:

- Children and Their Families for participating in our Videos
- Mark Groth, University of Colorado, for Technical Wizardry and Support
- Kempe Center, Past and Present

Explain that all videos are confidential, so if participants think they recognize individuals in videos, please do not say so. All video material was obtained with informed consent and clients specifically authorized their use for training professionals. Most videos are over 10 years old to further protect confidentiality of families.

THE ROLE OF PARENTS AND ATTACHMENT

Time: 90 minutes

Description of Activity:

Explain that the role of parenting in child development is as follows: Humans are completely dependent upon their parents/caregivers in the first few years of life, during which their developing world view is organized and shaped by the quality of the care they receive.

💻 Slide 4: New science important for the majority of children in foster care.

- Over 70% of children in foster care in the United States are infants and toddlers
- 90% of post natal brain development occurs before the second birthday
- Infants and toddlers are extraordinarily vulnerable to developmental insult.
- Infants and toddlers do not "forget and recover"--they adapt their relationships and behaviors to maladaptive caregivers.

Instruct participants that this morning will begin by examining the effect of the care giving environment on young developing minds.

💻 Slide 5: "Even Low Risk Parents Have High Risk Days" (Richard Krugman, MD).

Ask the group for comments about this statement and discuss parenting complexities. Is it also true that even high risk parents have low risk days as well?

Then discuss the following questions and statements on the next two slides with the large group. The overall discussion of this section should last approximately 10 minutes.

Remind participants that many parents may have feelings of rage triggered by their children.

💻 Slide 6: Occasionally some of us may have overreacted or treated our own child too harshly. Is this abuse? Are we abusive parents?

Ask participants to reflect on and discuss this question. What feelings come into play for us when we reflect on our behavior? Empathy, remorse, protectiveness, or more rage? How important is repair and correction in healthy parent-child relationships? What do we do when we have treated our child unfairly? What makes a parent high risk?

Explain that patterns exist within relationships, and within maltreating relationships. For example, a parent may have inappropriate developmental expectations of the child; the child may represent a negative figure in the parent's own history; domestic violence may be

present in the care giving environment; the parent may have excessive needs for power and control; or parents may be reenacting their own histories of childhood maltreatment, etc.

Explain that maltreatment is a symptom of a larger disturbance within the parent-child relationship that must be addressed in treatment. More often than not, maltreating parents are burdened with unresolved childhood trauma or neglect themselves and have disturbances in mood regulation and impulse control.

💻 Slide 7: Diminished empathy and exaggerated developmental expectations, high stress, mood disorders, problems with impulse control, and poor coping abilities on the part of the parent may result in abuse or neglect to the child.

The incident of abuse or neglect that brings a family to the attention of Child Protection is usually just the tip of the iceberg. It is a symptom of a relationship that has been disturbed for some time, maybe since the child's birth. The myth of the one-time incident is just that, a myth. Parent-child relationships develop over time with repeated themes and interactive patterns.

Explain how meeting the child's dependency needs leads to exploration and increasing autonomy through childhood. Development can be thought of as movement from external to internal regulation, beginning with caregivers who must do for the infant what the infant cannot do for him/herself.

Child development is fundamentally SOCIAL.

💻 Slide 8: Infancy: The Role of Dependence in Human Development

- 90% of post natal brain development occurs between birth and the second birthday.

💻 Slide 9: The Risk of Death is Greatest During Infancy

- Over 75% of child abuse fatalities occur in children 0-3 years old.

Discuss with the group how early experience shapes brain development beginning with baby/caregiver dialogue. How might this dialogue prevent or allow abuse? For example, a toddler's efforts at differentiation from the caregiver begin with "No." If the parent perceives this as rejection, he or she might react "in kind." A better reaction would be to recognize that the toddler's word is a possible sign of healthy development and respond accordingly.

💻 Slide 10: "There is no baby without a mother." – D.W. Winnicott

Explain this statement by Winnicott: This statement means that the baby cannot exist without a mother or a caregiver to protect, meet needs, and provide human interaction.

Attachment in the human infant is biologically obligatory. The newborn brain is neurologically designed for interaction with a caregiver to meet all needs- physical, social, and emotional. The baby must adapt to whatever caregiver is there. The caregiver brings a history that will affect the development of relationship with the baby.

💻 Slide 11: Historical figures in the study of child development

- Renee Spitz
- Anna Freud
- John Bowlby
- Mary Ainsworth

In World War II, Rene Spitz was a physician attending babies being cared for in hospital after being orphaned by the war. Although the infants' physical needs were met and they were kept in a safe environment, many died in despair because they had no one who "belonged" to them, and they belonged to no one. At the same time, Anna Freud was involved in relocation efforts to move children out of London and into the countryside during the bombings in London. Anna Freud explained the emotional and behavioral effects of separation, grief, and loss in children who were separated from their parents.

John Bowlby, eventually known as the "father" of attachment theory, examined the psychological effects of children experiencing separation and loss. He had noted the effects of disrupted attachment in his work with maltreated boys placed in a juvenile facility. Bowlby theorized that attachment was an evolutionary adaptation in which the physical closeness of a child to its mother increased the likelihood of survival. Proximity to the parent also ensured that the child would learn other skills including feeding, social interaction, and learning about the environment.

Mary Ainsworth, Bowlby's colleague, designed an attachment assessment tool which still has clinical validity, and has triggered ongoing study of individual differences in attachment quality which are related to the kinds of experiences the baby has with its caregiver(s). Ainsworth's "strange situation" study was originally conducted with one year olds and their mothers. The dyad was introduced to a strange situation, which was a room where they had not been before. Rooms were comfortably furnished and included a few toys. The mother and baby were taken to the room and encouraged to settle in for a bit. The mother sat on the couch and the baby's exploratory efforts were observed and documented, as well as the parent-child dialogue. The mother was asked to leave the room for a couple of minutes and the baby's reaction to the separation was documented. When the mother returned, reunion

behaviors were observed and documented, and whether and how the baby resumed exploration was also noted. The separation sequence was repeated after a time with researchers gathering the same information.

The "Strange Situation" paradigm led to Ainsworth's identification of 3 attachment styles: secure, anxious / ambivalent, and avoidant. Mary Main, Carol George, Judith Solomon, Patricia Critttendon, and other clinical researchers who had studied with or been influenced by Bowlby and Ainsworth, began to study children who were considered "unclassifiable." In other words, their behavior during the strange situation demonstrated an inability to derive comfort from or approach the caregiver with any strategy for getting needs met. These children were ultimately classified as "disorganized."

Refer participants to <u>Handout 2</u>: Attachment Categorization, which summarizes attachment classification and outcomes of healthy attachment.

💻 Slide 12: Attachment Categorization

- Anxious Avoidant (A pattern)
- Secure (B pattern)
- Anxious Resistant (C pattern)
- Disorganized (D pattern)

Discuss each style of attachment, the kinds of experiences/ caregiver interactions in first year which lead to development of secure, anxious/ambivalent, avoidant, and disorganized attachment categorization, and how children will look as they get older.

<u>Anxious Avoidant Attachment:</u>

- *Mother or caregiver is emotionally unavailable, dislikes dependency, promotes premature independence, may meet caregiving needs of infant with resentment or hostility.*
- *Baby seeks little physical contact by end of first year.*
- *Baby is randomly angry with mother or caregiver.*
- *Baby is unresponsive when held, but upset when put down.*
- *Toddler does not seek mother when distressed, and does not signal need for comfort.*
- *Preschoolers tend to be angry, aggressive, and defiant.*
- *Preschoolers may stay close to teacher, and may elicit angry or controlling feelings.*
- *School aged children lack enthusiasm and warmth and are likely to avoid physical closeness.*
- *Many children present with a neutral, flat, or "distant" affect.*
- *Throughout childhood these children are often isolated or disliked.*
- *Adolescents may be inclined toward jealousy or anger.*
- *Withdrawal becomes a coping style.*

- *Adult style of attachment termed "dismissive;" dismissing importance of love, intimacy, and relationship or emotions and feelings, self and others.*
- *Minimal self-reflection and shallow.*
- *May idealize parents without actual memories.*

Secure Attachment:

- *Mother or caregiver is warm, sensitive, attuned.*
- *Infant develops confidence in caregiver to meet needs and to protect.*
- *Preschooler easily makes friends, is flexible, and resilient under stress.*
- *During the school age, parents are warm and enthusiastic; child is open and engages in meaningful dialogue/communication.*
- *Middle childhood includes close friendships.*
- *Secure adults have a balanced view of their parents and their own history.*

Anxious/resistant Attachment:

- *Mother or caregiver is unpredictable and chaotic.*
- *Mother or caregiver may be attentive but out of sync with baby's needs.*
- *Infant is never really satisfied and does not develop confidence in caregiver. Infant may give confusing cues.*
- *Infant cries a lot, is clingy and demanding.*
- *Baby/toddler is angry or upset by minor separations or transitions.*
- *Toddler is limited in exploration and chronically anxious.*
- *Toddler is difficult to soothe after separation, angry, and seeking comfort simultaneously.*
- *Preschoolers are often overly dependent on teachers.*
- *Preschoolers are fretful, easily overwhelmed, and immature.*
- *Young children are easily victimized by bullies.*
- *School age children mix intimacy seeking with hostility.*
- *May be ingratiating or over concerned about mother or caregiver.*
- *Middle childhood friendships are difficult and conflictual*
- *Adult attachment style is "preoccupied;" embroiled with anger and hurt with own parents.*
- *Unable to see own responsibility in life/relationships.*
- *All ages experience fears of abandonment.*

Disorganized Attachment:

- *Infant/baby/toddler has no clear strategy for engaging caregiver or getting needs met.*
- *Regards caregiver/attachment figure as frightening; impossible paradox for a wholly dependent human.*

- *Approach to caregiver is confused, avoidant, resistant. Some children become physically dysregulated, falling or stumbling; others may appear frightened or become dissociative.*
- *Children are observed to be hostile and abusive to parents.*
- *This attachment style is common in families with violence and substance abuse problems.*
- *If untreated, disorganized attachment leads to psychopathology, early onset, long term dysfunction.*

Be sensitive to audience reactions. This sometimes causes people to examine their own parenting and become self-critical or worried. Remind them where we began- even low risk parents have high risk days, etc.

💻 Slide 13: Video and Discussion: Two Mother-Infant Dyads (10 Minutes)

First, explain how to observe. In other words, it is important to suspend judgment, and watch for patterns of interaction. Also instruct the participants to watch the babies' responses not just the mothers' behavior.

The first dyad in the video is a healthy mother infant pair. Instruct participants to focus on the feeding: the mother is calm, facilitating, and responsive. In play vignette, timing is everything. Draw attention to maternal attunement, reciprocity, mutual interest, and pleasure. The mother elicits the baby's capacities and encourages development.

Engage the participants with respect to the second example, a depressed, disengaged mother and baby breastfeeding. Dysregulated and empty interaction characterizes this relationship in which the baby has failed to thrive. Non-organic failure to thrive often involves a baby who is "not heard" by the mother and, thus, does not develop ability to clearly communicate needs because baby has no confidence that his/her needs will be met on demand. In effect he/she "loses" his/her voice in the child-caregiver dialogue. After play sequence discuss the effect to the baby of repeated similar interactions in daily life with mother (baby's voice is extinguished and baby becomes less confident/competent around getting needs met).

Emphasize the importance of patterns within observation of interactions.

Note that certain contexts are particularly useful for observation: reunions, feeding, play, structured tasks, e.g. parent teaches child, parent/child/family build or draw something together, etc. (useful for foster care visit observers).

Briefly explain importance of understanding a child's early attachment experiences when planning intervention in maltreatment cases: rehabilitation of the parent-child relationship

is essential to successful reunification. For example, a goal for an avoidant attachment style would be for the child to be able to consistently ask the parent for comfort when needed; a goal for an insecure attachment style could include the parent's encouragement and support of age-appropriate exploration, and so on.

15 MINUTE NETWORKING BREAK

EXAMINING COMMUNITY SUPPORT FOR INFANTS, YOUNG CHILDREN, AND THEIR FAMILIES- BREAKOUT GROUPS

Time: 45 minutes

Description of Activity:

Explain that the next 45 minutes will be spent looking at model programs to support early childhood development and prevent abuse and neglect. Spend 10 minutes reviewing the PowerPoint presentation. For the remaining 35 minutes, participants will then break into small groups for stakeholders to discuss what resources are available or needed in their own community and to report their findings back to the large group.

💻 Slide 14: Promoting Maternal and Child Health and Preventing Child Maltreatment:

- David Olds, PhD, Professor of Pediatrics, Psychiatry, Nursing, and Public Health, University of Colorado Health Sciences Center

Dr. Olds' research has involved three clinical trials in Rochester, New York, Memphis, Tennessee, and most recently in Denver. His work is longitudinal;, data is still coming in from all three sites. David's work ingeniously integrates an economic aspect. He has demonstrated that by the time the babies are 4 years old, the intervention has paid for itself, with a dividend. Clients are more likely to delay onset of second pregnancies, more likely to seek well child care than rely on emergency room visits, less likely to need public assistance or protective services, and most enter the workforce and pay taxes!

💻 Slide 15: Nurse Family Partnership

- Prenatal and infancy home visiting
- Activates parents' instinct to protect
    - Makes sense to parents
    - Nurses bring caring, competence, & respect
    - Program model focuses on critical influences on early development
- Rigorously tested

This program targets high risk first time mothers (smokers, teen mothers, others) who are enrolled in the program during the second trimester of pregnancy. Home visits occur on a weekly basis and information about health, child development, and parenting is provided via a structured visit by visit protocol. Families are followed until the child's second birthday.

💻 Slide 16: Families Served

- Low income pregnant women
  - Usually teens
  - Usually unmarried
- First-time parents

💻 Slide 17: Nurse Family Partnerships: Three Goals

- Improve pregnancy outcomes
- Improve child health and development
- Improve parents' economic self-sufficiency

Nurse Family Partnership has been so successful, and the research so solid, that it has been replicated across the United States.

💻 Slide 18: Consistent Results Across Trials

- Improvements in women's prenatal health
- Reductions in children's injuries
- Fewer subsequent pregnancies
- Greater intervals between births
- Increases in fathers' involvement
- Increases in employment
- Reductions in welfare and food stamps
- Improvements in school readiness (low resource mothers)
- Effects greatest for most susceptible

Nurse-Family Partnership strengthens families. It's interesting that when women take charge of their reproductive systems via planned pregnancies and birth control, they also take charge of other aspects of their lives as well.

💻 Slide 19: Elmira Sustainable Results: Benefits to Children

- Abuse and neglect (Down 48%)
- Arrests (Down 59%)
- Adjudications as PINS (Person in Need of Supervision) for Incorrigible Behavior (Down 90%)

The Elmira trials were conducted over 20 years ago. Clearly these results are sustainable. Memphis and Denver are yielding similar results.

💻 Slide 20: National Replication

- Now operating in over 370 counties in 28 states, serving over 17,000 families per day.

💻 Slide 21: Other Programs that Support Healthy Development of Young Children and Families:

- Public health: WIC, community health, family planning
- Head Start, early Head Start
- Community sponsored day care
- Parenting classes
- Others? What's in your community?

💻 Slide 22: Exercise: Breakout Groups

- Examining Community Support for Infants, Young Children, and their families

Participants should be divided into multidisciplinary groups as prearranged by trainer. Discuss availability of these and similar programs in breakout groups. Have the groups analyze efforts at prevention and early childhood support within own communities.

Allow groups approximately 15 minutes to identify both available resources and needs within their community as it pertains to the area assigned to the group for discussion.

Each group should designate a spokesperson to report findings to the larger group following small group discussions. Allow each group 5 minutes to report their findings to the larger group.

Note: This section should be further developed by leaders at the local level to include handouts for community resources, or perhaps to identify working groups for resource development in the future.

NEUROSCIENCE AND DEVELOPMENT
Time: 30 minutes
Description of Activity:

Refer the group to Handout 3: Quote from The Developing Mind. Explain this session of the training is a brief review of brain development. This is a new and rapidly growing field of knowledge. It supports what we know about attachment and child development via neuroscientific study.

Handout Quote: Daniel Siegel, MD, in The Developing Mind, page 21:

> *"…in this book I am proposing that the mind develops at the interface of neurophysiological processes and interpersonal relationships. Relationship experiences have a dominant influence on the brain because the circuits responsible for social perception are the same as or tightly linked to those that integrate the important functions controlling the creation of meaning:*
>
> *the regulation of body states,*
> *the modulation of emotion,*
> *the organization of memory,*
> *and the capacity for interpersonal communication.*
>
> *Interpersonal experience thus plays a special organizing role in determining the development of brain structure early in life and the ongoing emergence of brain function throughout the lifespan…"*

Secure, healthy attachment requires that the caregiver have the capacity to perceive and respond to the child's mental state.

> *"…Recent findings from neuroscience help us understand how these early reciprocal communication experiences are remembered and how they allow a child's brain to develop a balanced capacity to regulate emotions, feel connected to other people, to establish an autobiographical story, and to move out into the world with a sense of vitality. The capacity to reflect on mental states, both of the self and others, emerges from attachment relationships which foster such processes. These patterns of communication literally shape the structure of the child's developing brain."*

💻 Slide 23: Video with Dr. Jerry Yager (22 minutes)

> *Show the entire video which will explain how the brain develops sequentially, how states become traits, and effects of trauma on the brain, which are explained in detail in the video. The video is intended to be complete and self-explanatory.*

1 HOUR NETWORKING LUNCH

THE TASKS OF CHILD DEVELOPMENT: TOWARD PROSOCIAL DEVELOPMENT

Time: 90 Minutes

Description of Activity:

Introduce Erik Erikson's schema of developmental tasks. Erikson's book Childhood and Society, first published in the 1950's and later revised, identified developmental tasks to be resolved at each stage of childhood as the child matures toward responsible participation in society. The community's interest in child development is embedded in its need to produce capable and productive citizens.

💻 Slide 24: Erik Erickson: Childhood and Society, 1950, 1963

- Identified psychosocial tasks for each stage of human development
- Successful resolution leads to maturity, prosocial citizens
- Development progression is toward independence, responsibility, increased social involvement

💻 Slide 25: Erickson, First Year Task:

- Trust vs. Mistrust

Development in first year is inseparable from attachment relationship. It is important to determine what the baby's experiences have been like in first year.

💻 Slide 26: 4 Substages of Infancy (First Year)

- 0-3 months — Physiologic regulation
- 3-6 months — "Hatching," becoming aware of environment
- 6-9 months — Self/other awareness, discrimination of familiar faces, onset of Stranger Anxiety
- 9-12 months — Object constancy, mobility, self feeding

Discuss the effects of separation and loss at each stage in first year and the implications for visitation if the child is in foster care. For example, from 0-3 months, too much visitation may disrupt child's regulatory efforts. From 3-6 months, the baby is more interested in the surroundings, so beware of overstimulation, but take advantage of baby's wakeful, interactive time of day to schedule visitation for successful engagement with parents. From 6-9 months, consistency is important. Infants become increasingly sensitive to loss, changes in caregivers, and with the emergence of stranger anxiety transitions around visits should be carefully planned. From 9-12 months, explosions in development include mobility, self-

feeding, movement toward autonomy. The loss of the primary attachment figure carries enormous psychological risks that must be addressed by caregivers and involved professionals.

Visits between foster children and their biological parents should be designed sensitively to address individual child's needs and capacities. Visits should not be formulas, but should increase in frequency and duration as successful, as defined by improvement in the parent-child relationship. Visitation is best used to rehabilitate unhealthy parent-child relationships damaged by maltreatment. Visitation is part of treatment.

Slide 27: Erikson: Ages 1-3----The Toddler's Task:

- Autonomy vs. Shame and Doubt

Slide 28: The Toddler's Task Explained

- The meaning of Autonomy vs. Shame and Doubt
  - We hope to see a confident toddler at this stage.
- Regulation of eating, sleeping, elimination
- Dance with caregiver since birth
- Impulse control, affect regulation rooted in caregiving relationship
- Vulnerable to the effects of separation and loss

Explain that what we hope to see at this stage is a confident toddler who is able to explore the environment by relying on caregivers for support and safety, and who is beginning to differentiate self from the caregiver first by saying "no." In the parent-child interaction, the child moves away from the parent to explore but returns frequently for emotional "refueling."

Discuss differences in parental approaches to this stage. For example a toddler takes a tumble while playing outside. Parent #1 hovers, is alarmed when the child falls, rushes over, is agitated, grabs the child, examines the child, and cries, "oh honey are you alright?" in panicked tones so that unhurt child begins to cry and cling, reacting mostly to the upset parent.

Compare to Parent# 2 who maintains emotional equilibrium. She calls to child in concerned tone, and says, "Kaboom! That was a big fall! You ok?" She watches the child for indication of fear or hurt before physically intervening.

Now compare to Parent #3 who is annoyed. She says, "I told you, you are too little to do that! Now you got what you asked for!" The parent remains annoyed even if the child appears hurt or scared.

The need for discipline and behavioral management begins in earnest in the second year. Limit setting should by and large be concerned with issues of safety, both to persons and property. Behavioral expectations should be realistic, but we know that children are often punished for being children at this age. Many transitions in caregiving, such as progression from being fed to self feeding, require caregiver flexibility, patience, and tolerance for mess.

Toddlers are experimenting with power and control. Toilet-learning is one developmental milestone associated with completion of this stage and illustrates the increasing complexity of the child's world. Healthy development is moving toward regulation of elimination, intake, expression of affect and powerful emotions, and impulse control.

Children in this stage of development are particularly vulnerable to the effects of separation and loss. Placement moves should be carefully orchestrated to offer emotional support to the toddler who will invariably blame him/herself for the perceived rejection.

The child's efforts at individuation may be compromised, or the attachment system so wounded that future attachments lack depth or veracity. Lifelong struggles with mood disturbance and emotional regulation are high risks.

Briefly discuss why this age group is so often and so severely targeted for physical abuse.

💻 Slide 29: Video: Two toddlers, each at Play with his Parents (3 minutes)

Explain that the first video of a toddler in aggressive play reflects his experience. Then show both video clips of the toddlers in their entirety.

After both videos are shown, explain that the second child's history is that of a healing attachment experience. For the first 6 months of his life the baby was neglected and failing to thrive, expressionless, with little or no eye contact. The foster family put him in playpen in center of family activity so he could watch, and people paid attention to him whenever they passed him, however fleetingly, and encouraged him to respond. He was gradually and lovingly drawn into a healthy toddlerhood in which he is able to explore freely while engaging in a dialogue with each of his parents that reflects his experiences with them.

💻 Slide 30: Case Scenario Discussion: Brianna

This discussion should be done in the large group and should last up to 15 minutes. Ask participants to look at the case scenario from Handout 6. Based on what we now know

about the needs of very young children and the effects of their experiences on their development, let's take a look at the youngest child. Ask for an "assistant" from the group to list everything we know about Brianna on a flip chart. Start eliciting responses from the group about what her first year has been like:

- Sandra, age 6, comforts and feeds Brianna
- Brianna has been exposed to domestic violence
- Her environment is filthy and chaotic
- Her caregivers are at times affected by substance abuse
- Brianna does not crawl
- She rarely babbles
- Sam asserts that she is the light of his life

Lead participants into a discussion about the following: Brianna is now in foster care. How will we assess her needs and plan to optimize her development? How will we discern which of her delays may be related to poor parental care? For example, if she quickly picks up language and communicative skills in foster care, could she have been neglected? Why might Brianna not crawl? How does substance abuse by a parent affect a baby? What effect might the condition of the home have on Brianna?

What will we do for Brianna? Medical, dental (talk about dental caries, or "bottle mouth"), developmental evaluations (e.g. Child Find, information from WIC about growth, etc.). Foster care is part of treatment. How will this care giving environment provide a healing experience? How will Brianna's negotiation of her first year task of "trust vs. mistrust" be impacted? How might this impact her transition into the next stage of development? What kind of visits with Marianne and Sam will be appropriate?

The goal is to restore Brianna to a healthier developmental/ psychological trajectory by meeting both unmet needs in her past and her current needs. We want her to build trust in caregivers so that she begins to freely explore her environment and move toward the next developmental stage.

Slide 31: Erikson: Preschool, 3-6 Years:

- Purpose/Initiative vs. Guilt

Slide 32: The Preschooler's Task:

- Initiative vs. Guilt
- Big/little; good/bad; dependence/autonomy
- Threes and Fours mastering language, increasing self control
- Fives less frustrated, less aggressive

- Fears, especially of the dark, common; often underlie separation fears
- Truths and untruths

Explain how preschoolers are learning to accomplish tasks on their own, with a growing sense of purpose and planning. Mastery may include riding a trike or crossing the street, and protective limits may need to be set if risk-taking exceeds judgment.

Children are beginning to feel responsible for what they can do and beginning to feel guilt when their performance does not meet their own expectations.

Anger and frustration may lead to aggressive behaviors. Development of self regulation still requires support from caregivers and adults.

Children are learning to make things cooperatively and to combine forces with peers. Moral development now includes a powerful and emerging sense of right and wrong, thus guilt and shame are forces in this developmental dilemma. Children will develop guilt and shame about their plans and initiatives when adults are overly dismissive or overly inhibiting. Guilt is a confusing new emotion sometimes related to feeling ineffective or thwarted.

Children are learning the skills necessary for school readiness, e.g. to sit quietly and for several minutes, listen, play cooperatively, etc.

Discuss briefly with group how failure to resolve these early developmental tasks may lead to long term behavioral problems including impulsive and aggressive behaviors, mood instability, regulatory disturbance, interpersonal/relationship difficulties, school problems, and increased risk for substance abuse. Many children in foster care who are well into middle childhood and beyond still struggle with regulatory issues, which frequently persists into adulthood.

💻 Slide 33: Case Scenario Discussion: Leon and Sandra

This discussion should be done in the large group and should last up to 15 minutes. As before, ask participants to look at the case scenario from <u>Handout 6</u>. Based on what we now know about the needs of children and the effects of their experiences on their development, let's take a look at Leon and Sandra's experiences of caregiving. How have their experiences supported or undermined their development? Ask for an "assistant" from the group to list everything we know about Leon and Sandra on a flip chart. Start eliciting responses from the group:

Sandra:

- Sandra is 6

- Goes to school tired, dirty, hungry
- Has violent outbursts at school
- Has witnessed domestic violence
- Has a caretaking role with her siblings
- Has been exposed to parental substance abuse
- Lost a parent (father) in early life
- Does well in school
- Has a conflictual relationship with Sam

Leon:

- Is frightened, dirty, and hungry
- Looks to his 6 year old sister for comfort and care
- Has been exposed to parental substance abuse
- Has witnessed domestic violence
- Seems to be developmentally on target
- Is not enrolled in school or preschool
- Calls Sam "daddy"

What will Sandra and Leon need from foster caregivers (structure, safety, predictability…etc)? What other services might be necessary (play therapy, developmental evaluation)? How should visits be structured? What are the risks to these children in the care of mother and Sam?

Slide 34: Erikson: Childhood, 7-12 Years: Competence

- Industry vs. Inferiority

Slide 35: School Age Task:

- Industry vs. Inferiority
- Big expectations of selves
- May have trouble admitting mistakes
- Preoccupied with "fairness"
- Emerging ability to interact/cooperate in groups
- More worries than fears

Explain how these years are characterized by significant cognitive development. Concepts of space, time, cause and effect, calendar, and time all allow a more complex view of the world. Moral values and reading and mathematical skills all reflect new levels of abstract thinking and reasoning. Children are developing their work ethic, and if encouraged and supported in their efforts, they begin to demonstrate industry, diligence, and an ability to put

work before pleasure. Self worth by doing, succeeding, and being recognized helps the child's developing sense of self and worth.

School is the child's culture, where he/she can experience both achievement and disappointment related to his/her own efforts. The complexity and variety of the child's culture may include ethnicity, disability, or other variables which affect the child's development within the context of his/her world.

During these years the child's learning and mastery of cultural norms and patterns of communication will pave the way for involvement in social groups throughout his/her lifespan.

The child's personality is organizing during this phase of development. Moral judgment, ideas about status and rank, and acceptance of social norms are emerging. Our culture expects children in these years to be calm, in control of their impulses, and ready to learn.

Slide 36: Erikson: Adolescence, 13-19 Years

- "Identity vs. Role Diffusion"

Slide 37: The Task of Adolescence

- Who am I, Where am I going?
- Identity vs. Role Confusion
- Physical Changes
- Peers
- Progression of Values Clarification
- 4 questions:
    - Who am I?
    - Where do I belong?
    - What can I do or be?
    - What do I believe in?

Explain that neuroscience has now documented that there is a second wave of proliferation and pruning in the brain, during adolescence, but unlike prenatal changes, it is not the number of nerve cells but the number of synapses, or connections, that changes. The last part of the brain to develop (remember Dr. Yager's talk) is the prefrontal cortex—where "executive function" resides, including planning, setting priorities, organizing thoughts, managing impulses, and contemplating consequences of one's actions.

"Scientists and the general public had attributed the bad decisions teens make to hormonal changes," says Elizabeth Sowell, UCLA neuroscientist. "But once we started mapping

where and when the brain changes were happening, we could say, aha, that part of the brain that makes teenagers more responsible has not finished maturing yet."

Hormones, however, are an important part of teenage development. As the ovaries and testes begin to pour estrogen and testosterone into the bloodstream, not only do reproductive systems begin to develop, but adrenal glands release sex hormones that are very active in the brain, exerting a direct influence on serotonin and other neurochemicals that regulate mood and excitability.

These chemicals are especially active in the brain's emotional center, the limbic system. Not only do feelings become sudden and intense, but adolescents are also looking for experiences to create intense feelings.

💻 Slide 38: Temple University psychologist Laurence Steinberg said, "so you've got this time gap between when things impel kids toward taking risks early in adolescence, and when things which allow people to think before they act come online. 'It's like turning on the engine of a car without a skilled driver at the wheel.'"

Studies by Mary Carskadon at Brown University have shown that it takes longer for melatonin levels to rise in teenagers than in younger kids or adults, "the brain's program for starting nighttime is later." In other words, there is a biological reason why many adolescents struggle to wake in the morning and fight going to bed at night.

There's a debate over how much conscious control kids have," says Dr. Jay Giedd, chief of brain imaging in the child psychiatry branch of the Institute of Mental Health. "You can tell them to shape up or ship out, but making mistakes is part of how the brain optimally grows."

Generally it seems more useful to help them make up for what they lack by providing structure, organizational help, and help with tough decisions.

Portions of the foregoing are thanks to Alice Park, TIME magazine, May 10, 2004. What Makes Teens Tick; A flood of hormones, sure, but also a host of structural changes in the brain. Can those explain the behaviors that make adolescence so exciting--and so exasperating?

💻 Slide 39: Video: Adolescent Girl's Doll Play: The Urgent Plight of Children at Risk (7 minutes)

This video takes about 7 minutes. Tell participants that the video shows a 13 year old playing with dolls and a doctor kit. She reflects her own experiences of early care giving

and shares her need for protection and care in urgent terms. It is a good transition to the next topic as this child comes from a sexually abusive family.

15 MINUTE NETWORKING BREAK

CHILDHOOD SEXUALITY
Time: 30 Minutes
Description of Activity:

Discuss how children of all ages are curious about their bodies and sexuality.

Consensual exploration, within limits, is normal, but what are the limits? This is a slippery slope—it can be very uncomfortable.

State that the following information is from Toni Cavanagh Johnson, PhD: "Behaviors Related to Sex and Sexuality in preschool through 4th grade children." Dr. Cavanagh Johnson's website is on the first slide if participants would like more information on this subject. Participants can also refer to Handout 4 and Handout 5 during this portion of the presentation.

💻 Slide 40: Toni Cavanagh Johnson: Sex Play is Within the Expected Range of Childhood Behavior

- Sex Play is within the expected range of childhood behavior.
- Should be in balance with curiosity and exploration of all other areas of a child's life.
- When there is secrecy, anger, tension, anxiety, fear, coercion, force, or compulsive interest/activity, professional advice should be sought.
- See Dr. Cavanagh Johnson's website: www.tcavjohn.com/products.php

💻 Slide 41: Behaviors Related to Sex and Sexuality in Preschool Children

- Natural and expected behaviors: Touches, rubs own genitals when diaper is changed, when going to sleep, when tense, excited or afraid.
- Of Concern: Continues to touch/rub genitals in public after being told many times not to do this.
- Seek professional help: Touches, rubs self in public or in private to the exclusion of normal childhood activities.

💻 Slide 42: Preschool Sexual Behavior Examples, continued

- Natural and expected: Plays house, acts out roles of mommy and daddy.
- Of Concern: Humping/simulated sex with other children with clothes on.
- Seek professional help: Simulated or real intercourse without clothes, oral sex.

Note to group that these two slides and the following six slides offer information as to normal and expected sexual behaviors, behaviors that would be of concern, and behaviors that indicate a need for professional guidance.

💻 Slide 43: Behaviors Related to Sex and Sexuality in Kindergarten through Fourth Grade

- Natural and Expected: Asks about genitals, breasts, intercourse, babies.
- Of Concern: Shows fear or anxiety about sexual topics.
- Seek Professional Help: Endless questions or discussion about sex. Sexual knowledge too great for age.

💻 Slide 44: K through 4th Grade Sexual Behaviors, continued

- Natural and Expected: Talks about sex with friends. Talks about having a girl/boy friend
- Of Concern: Sex talk gets child in trouble. Child romanticizes all relationships.
- Seek Professional Help: Talks a lot about sex and sexual acts. Repeatedly in trouble for sexualized behavior.

💻 Slide 45: K through 4th Grade Sexual Behaviors, continued

- Natural and Expected: Pretends to be opposite sex.
- Of Concern: Wants to be opposite sex.
- Seek Professional Help: Hates being own sex; hates own genitals.

💻 Slide 46: K through 4th Grade Sexual Behaviors, continued

- Natural and Expected: Wants to compare genitals with peer aged friends.
- Of Concern: Wants to compare genitals with much older or much younger children or adults.
- Seek Professional Help: Demands to see the genitals, breasts, buttocks of other children or adults.

💻 Slide 47: K through 4th Grade Sexual Behaviors, continued

- Natural and Expected: Kisses familiar adults and children. Allows kisses from familiar adults and children.
- Of Concern: French kissing. Talks in sexualized manner with others. Fearful of hugs and kisses from adults. Gets upset with public displays of affection.
- Seek Professional Help: Overly familiar with strangers. Talks/acts in a sexualized manner with unknown adults. Physical contact with adults causes extreme agitation.

💻 Slide 48: K through 4th Grade Sexual Behaviors, continued

- The foregoing examples were not a comprehensive list.
- For more information, see Dr. Cavanagh Johnson's website or publications.

Explain to participants that behaviors of concern and those that require professional intervention indicate that the child is preoccupied with sexual information and cannot be distracted or persuaded to give up those behaviors; this leads to further acting out as the child seeks to resolve the underlying issues that precipitate the sexualized behaviors.

Explain how the care giving environment must ensure sexual safety, especially if a child has a history of sexual abuse; for example, clearly outlined rules about privacy, sleeping arrangements, appropriate dress, touching, being alone with only one other person, physical play such as wrestling and tickling, and so on. Summarize effects of child sexual abuse via the following PowerPoint series:

Slide 49: Impact of Child Sexual Abuse

- Thanks to Terri James-Banks, LCSW

Slide 50: Statistics

- 60 million survivors of childhood sexual abuse in US.
- Approximately 31% of women in prison are victims of sex abuse.
- Children with disabilities are 5-10x more vulnerable to sexual abuse.
- 95% of teen prostitutes have been sexually abused.
- 67% of victims of sexual assault are juveniles.
- 34% of sexual assault victims are under 12 years old.
- 1 of 7 victims of sexual assault are under age 6.
- 40% of offenders who victimize children under 6 were juveniles.

Slide 51: Betrayal of Child's Trust

- In Caregiver—offending parent
- In sibling
- In Caregiver—non-offending parent
- In self, love, affection, relationships
- In self-efficacy
- DISRUPTION OF ATTACHMENT

As we have discussed, trust in caregivers is essential to healthy development. When the person entrusted with care of a child is the source of pain and fear for the child, the child is psychologically alone. Most experts believe that the loss of mother and her protection (sometimes she may not even believe the child) is the most damaging aspect of incest.

The child's inability to trust leads to behaviors which are often frustrating to caregivers and, if extreme, may lead to placement disruption.

Slide 51: Sex Offenders

- Typical child sex offender molests an average of 117 children, most of whom do not report the offense.
- 95% of victims know their perpetrators.
  The dramatic stories in the media, like Elizabeth Smart and others who were kidnapped by strangers is emphatically NOT the norm. Most perpetrators are people in caregiving roles of some kind.

Slide 52: Outcomes, Effects

- Sexuality becomes part of personal identity and self worth
- Correlation with revictimization
- Substance abuse
- Suicidality
- Depression
- PTSD
- Anxiety, fear
- Early pregnancy
- Health problems
- Sexual dysfunction
- Problems with eating and sleeping

Sexual abuse victims need appropriate treatment. The effects just listed are common, not rare. Untreated, sexual abuse victims are likely to be significantly affected in interpersonal and intimate relationships, including parenting. Many non-protective mothers of sexual abuse victims were themselves victimized. Nearly all sexual perpetrators were victimized as well.

Slide 54: Sexual Abuse May Alter the Brain

- Long term psychological disturbance
- Change in hippocampus: deals with short term memory and encoding, retrieval of long term memory.
- Dissociation and PTSD: allows victim to feel detached from the body or self as if what is happening is not happening at all.

- If repeatedly invoked in childhood, dissociation prevents memories from being integrated into consciousness and can lead to altered sense of self.

Communities are understandably concerned about the progression of victim to perpetrator.

Refer the group to Handout 5: Sexual Abuse in the Context of Whole Life Experience, from Gail Ryan, MA, Director, Kempe Perpetration Prevention Program: Sexual Abuse in the Context of Whole Life Experience.

Review matrix briefly with group to look at complexities of sexual abuse and its context in the life of an individual.

In that context share the following PowerPoint from Gail Ryan, founder of the National Adolescent Perpetrator Treatment Network.

Slide 55: Perpetration Prevention

- Reducing the Risk that Children Will Become Abusive
  - Thanks to Gail Ryan, MA
  - Director of Kempe Perpetration Prevention Project

Slide 56: Responding to the Sexual Behavior of Children

- Initial response from adults (universal goals)
  - Label behaviors with words (increase communication and learning)
  - Express emotion (foster empathy)
  - Attribute responsibility for behavior (accountability)
  - Define abusive or illegal behaviors
- Monitoring, Supervision, and Education
  - Laws, rules, risks, resources, and values
  - Prohibit abusive, exploitive, illegal behaviors
- Goals
  - Empathy (recognize signs of distress in others, respond by changing behaviors)
  - Accountability (personal responsibility for behavior)
  - Health (successful human interactions and relationships)

Appropriate sexual attitudes on the part of caregivers sets the stage for sexual development. It is normal for children to experiment with their sexuality but adults must redirect or otherwise address inappropriate behavior. This includes knowing legal implications as well as teaching values and appropriate behaviors. It is important for adults to be comfortable with their own sexuality and to be comfortable talking about sexuality with young people.

Slide 57: Defining Sexually Abusive Behavior

- Lack of consent
- Lack of equality
- Coercion
- Many juvenile offenses occur during puberty;
- Juveniles perpetrate at least one third of all child sexual abuse

The first three items on this slide are indicators of abuse, not normal sex play between curious children. "Juveniles" refers to children who may be under 10 as well as over 10. 10 years old is a significant age because in Colorado children can be arrested and prosecuted for criminal offenses.

💻 Slide 58: Defining CONSENT among Kids

- Similar knowledge:
  - Knowing what is being proposed, i.e. sexual behavior
  - Knowing the possible consequences, i.e. pain, punishment, stigma, risks
  - Knowing the standards in the community, i.e. what family and friends think about the behavior
- Free Choice
  - Without repercussion if refused

💻 Slide 59: Defining EQUALITY among Kids

- Size, age, intellect, strength
- Power, authority, popularity
- Relationship, roles

💻 Slide 60: Defining COERCION among Kids

- Pressure, trickery, bribery
- Threats of lost relationship, esteem, privilege
- Manipulation, force, violence, restraint

Understanding these three elements, consent, equality, and coercion, is essential for caregivers and important for planning appropriate treatment. When children are involved in sex play, these will help distinguish curiosity from pathology.

💻 Slide 61: Legal Sanctions

- In Colorado, children become legally culpable at age 10.
- They are experiencing punitive, intolerant consequences:
    - Arrest
    - Prosecution
    - Labeling
    - Stigma
    - Lifetime publicity…life altering consequences

It is possible in Colorado for someone who is 10 years old to be a registered sex offender for the rest of that person's life.

💻 Slide 62: Responsible Adults Must…

- Teach kids what laws and sanctions apply
- Be cautious in the records we create and the label we apply
- Advocate for juvenile justice and rehabilitation
- "Most juveniles who are adjudicated for sexual offenses are not continuing to commit sexual offenses as adults. Like most delinquent behavior, the misbehaviors of childhood should not determine a child's future."

Ryan, 2010

Adults are responsible to protect and guide children through their sexual development, and to recognize what is normal and what is worrisome or dangerous behavior. Overall, the treatment of victims is critical, and it may need to occur intermittently through the child's life at different developmental stages.

💻 Slide 63: That said…

- Evaluation and treatment is necessary to prevent further offenses
- What's available in your community?

Discuss the audience's reactions to children and adolescents who commit sexual offenses. Help participants examine the differences between "punishment" and treatment of young offenders. Providing appropriate treatment immediately and consistently helps assure that victims will not become perpetrators or repeated victims of abuse.

LASTING EFFECTS OF CHILD MALTREATMENT
Time: 30 minutes
Description of Activity:

Explain that in the aftermath of child abuse or neglect, children are changed. Dr. Bruce Perry's article, "Childhood Trauma: The Neurobiology of Adaptation," emphasizes the "use-dependent" aspects of brain development, stating that it is an ultimate irony that at a time when the human is most vulnerable to the effects of trauma, in early childhood, adults generally presume the most resilience. Frequent behavioral symptoms of trauma exhibited by young children and infants, include numbing, compliance, avoidance, and restricted affect. These symptoms indicate a primarily dissociative response pattern. The younger the child, the more likely he/she is to rely on dissociative adaptations over hyperarousal symptoms. The nature of the trauma seems to determine the pattern of adaptation – the more immobile, helpless, and powerless the individual feels, the more like they are to use dissociative responses.

Dr. Perry also states that resilience is misunderstood. Children are not so much resilient as adaptive. Elements of their true emotional, behavioral, cognitive, and social potential are diminished; some capacity is lost; a piece of the child is lost forever.

The impact of trauma falls into four major categories and ranges on a continuum from mild to severe.

💻 Slide 64: Impact of Trauma

- 4 major categories:
    - Persistent fear state
    - Disorder of memory
    - Dysregulation of affect
    - Avoidance of intimacy

Persistent fear state: The experience of trauma for children is fear: a chronic state of anxiety, hyper-vigilance, fight-flight-freeze behavior, chaos, and unpredictability.

Disorder of memory: Poor attention, distorted reality, confusion, dissociation, somatic complaints.

Dysregulation of affect: Hyperactive, over-active or numb, anxiety, depression, impulsivity.

Avoidance of intimacy: Does not trust, seeks material gain rather than relationship, does not use adults for support, feels vulnerable, loss of control.

It is important to differentiate between abuse experiences that are truly traumatic events and those that are not. The effects may be quite different. Differentiating between traumatic and non-traumatic abuse involves determining whether the abuse involved the threat of death, injury or harm, and whether it provoked an overwhelming fear response and feelings of helplessness. The suddenness of the experience is also a factor.

💻 Slide 65: Traumagenic States

- Self blame
- Powerlessness
- Loss and betrayal
- Fragmentation of bodily experience
- Stigmatization
- Eroticization
- Destructiveness
- Dissociative disorder
- Attachment disorder

Beverly James, author of Treating Traumatized Children, identifies nine traumagenic states, or emotional conditions, originating from traumatic experiences.

Explain that "fear changes the way we think." In adults, fear changes the brain. In children, fear ORGANIZES the brain.

💻 Slide 66: Post Traumatic Stress Disorder

- Re-experiencing the trauma in flashbacks, play, nightmares, daydreams
- Avoidance of things that remind child of trauma
- Attempts to control trauma by re-living it in some way
- Numbing of general responsiveness, lethargy, flat emotions
- Hyper-arousal of nervous system: irritability, explosiveness, hyper-vigilance, exaggerated startle response, extreme despair or panic.

💻 Slide 67: Neglect

- The worst thing you can do for a neglected child is NOTHING

State that although neglect is by far the most pervasive form of maltreatment, with far reaching developmental, social, and emotional consequences for the child, the community's response to neglected children and their families often falls far short of what children need.

The following two slides contain information from Norman Polansky, who conducted extensive research on neglectful families in the 1970's and 1980's and identified outcomes for neglected children.

Slide 68: Neglected Children

- Generally have lower IQ scores than non-neglected children, probably due to lack of adequate cognitive stimulation.
- Often experience chronic depression and mood disturbance, impulsivity, and poor regulation.
- May turn to self-comforting rituals or retreat into fantasy to withdraw from their environment (impacting school performance, normal development, and pro-social behavior).

Slide 69: Neglected Children

- May become aggressive or delinquent because their capacities for empathy are diminished.
- May become indiscriminate in seeking attention, often leading to victimization or exploitation.
  – Polansky, Norman, et. al., Damaged Parents: An Anatomy of Child Neglect. Chicago: University of Chicago Press, 1981.

Reinforce that neglect cases tend to be long-term and difficult to treat. The current trend in child welfare to offer services for 1 to 2 years and close cases is a poor solution for these problems which tend to be multi-generational and chronic.

Outcomes for physical abuse and for emotional abuse also can have devastating effects to a child's development of a sense of self, self-efficacy and worth, and development of empathy.

Delinquency is a frequent outcome of pervasive neglect.

Ask for responses from the group regarding these questions: How does an incident driven protective services system manage neglect in their community? Are participants aware of the long term impacts of neglect?

In contrast, normal, healthy development is dependent on parental capacities for empathy.

Slide 70: The Healthy Child:

- Has many experiences of small amounts of frustration and pain.

- Learns how to cope with negative emotions and pain.
- Develops a strong sense of self as able to cope with the world.

💻 Slide 71: Characteristics of Maltreated Children: The Wounded Child

- May lack experiences of successfully coping with small amounts of frustration, anger, and pain.
- May have developed tension and reduction behaviors (anything that soothes or distracts) instead of coping skills due to ongoing or overwhelming pain.
- May over-depend on survival skills formed in desperation, and will refuse to give them up, even when there is ample evidence that they are now destructive.

Note that maltreated children present with symptoms including hyper-vigilance, mistrust, overcompliance, avoidance, precocious independence, impulsivity, and aggressive behavior. Some children may appear to be asymptomatic and may be internalizing their distress.

💻 Slide 72: Characteristics of Maltreated Children, continued

- May find it difficult or nearly impossible to trust someone or the world in general
- May have decreased self-awareness because of continual hyper-vigilance
- May seek out a "safe place" and avoid active exploration of the world at large

💻 Slide 73: Emotional Damage is the Primary Outcome of any Type of Child Maltreatment

- Insecure attachment, present and future
- Lack of academic and social competence
- Flattened affect
- Inconsistent cuing
- Low self-esteem
- Inability to function independently
- Depression and withdrawal
- Aggression
- External loss of control as the child's psychological life is directed from the outside rather than from internal resources
- Psychic energy is directed toward protection and survival rather than toward exploration, mastery, and joy.

ROLE OF DOMESTIC VIOLENCE AND SUBSTANCE ABUSE IN CHILD MALTREATMENT

Time: 45 minutes

Description of Activity:

Substance abuse is common in many families that come to the attention of child welfare services, and domestic violence is very frequently occurring in these families as well. These are intrafamilial dynamics that harm children, though many parents insist that the children are not aware of these activities.

💻 Slide 74: Domestic Violence is Harmful to Children

- The epidemic of domestic violence profoundly affects children:
  - Their caregivers' capacity to nurture and care for them is compromised
  - They are likely to become aggressive themselves
  - Outcomes are influenced by age, temperament, preexisting mental health problems, IQ, coping styles, and duration of the experience
  - Attachment to both parents is undermined

Remind participants about the morning discussion regarding children's responses to trauma, including exposure to violence. Also point out that parents are significantly less attentive and empathic when family violence is always a threat. This results in the formation of an insecure and/or disorganized attachment, with future psychological and relationship problems almost a certainty.

💻 Slide 75: Domestic Violence Statistics

- 50% of Domestic Violence cases involve a child less than 5 yrs. old in the household.
  - About half of these are also victims of child abuse or neglect.

Violence in intimate relationships teaches children that aggression and physical harm are included in "the language of love," and intergenerational transmission is nearly inevitable without recognition and treatment.

💻 Slide 76: The Role of Substance Abuse in Child Maltreatment

Refer to the case scenario and ask the group to reflect on the impact of both domestic violence and substance abuse on the family (both children and parents). Have participants make note of the following:

- *The children have been exposed to parental violence*
- *The apartment is filthy and in complete disarray*

- *The children are hungry and frightened, but this is NOT NEW to them*
- *Sandra has seen a meth pipe in the home*
- *The parents deny and minimize their substance abuse*

Ask the group to identify which substances they believe are most harmful or most commonly abused in maltreating families. As participants respond, list their answers on the flip chart and proceed to next slide.

💻 Slide 77: Alcohol Abuse Disorder

- Alcohol is associated with 100,000 deaths per year.
- Alcohol problems account for 15% of U.S. health care costs.
- Acute and chronic medical, behavioral and social problems result from alcohol abuse disorder.
- Annual economic cost of alcohol abuse= $100 billion.
  - O'Connor and Schottenfeld
    NEJM 1998; 338: 592-602

Alcohol is the most commonly abused drug in American society. Alcohol is associated with 100,000 deaths per year. Acute and chronic medical, behavioral, and social problems result from alcohol abuse, at an annual economic cost of $100 Billion- about 15% of health care costs!

Fetal Alcohol Syndrome is the most well-documented and researched outcome of substance abuse in pregnancy.

💻 Slide 78: National Trends

- 8.2 MILLION dependent on alcohol in U.S.
- 3.5 MILLION dependent on illegal drugs in U.S.
  - Source: http://www.drugabuse.gov/infofax/nationtrends.html

💻 Slide 79: How Does This Affect KIDS?

- Immediately
  - Family Life is unpredictable and chaotic
  - Children are confused and insecure
  - More at risk for Domestic Violence
  - Lack of desire to perform well in school
- Later On
  - Warped sense of "normal" when it comes to substance abuse
  - Children of alcoholics are 4 times more likely to become alcoholics themselves

Statistics about adult substance use are important, but the central concern here is how the adult substance use affects infants, children, and youth.

💻 Slide 80: Common Struggles of Kids

- Difficulty having fun
- Judging themselves mercilessly
- Difficulty with emotional relationships
- Feeling "different" from other people
- Tendency to be impulsive
- Desperately seeking approval and affirmation
- Suffering from chronic anxiety
- Lacking self discipline
- Fear and mistrust of authority figures

As in the previous slide, the concern is how adult use affects children, but this slide is also intended to get an empathetic reaction from the training participants. If you get reaction from the audience, pause to let them enhance the conversation.

💻 Slide 81: How Can We Help?

- HELP THE PARENTS: The best possible scenario is if the addict in the family receives treatment and overcomes the problem.

Remind the training participants that this is always "Plan A".

💻 Slide 82: How Can We Help the KIDS?

- Early Intervention:
    - Love and Encouragement From:
        - A Sober Parent
        - Another Relative
        - A Social Worker
        - A Guardian ad Litem
        - A CASA
- Counseling:
    - For the Family
    - For the Kids

This is not meant to be an exhaustive list. Stimulate conversation by giving participants time to suggest other solutions.

💻 Slide 83: Fetal Alcohol Syndrome

- How Does it Happen?
  - Alcohol in a pregnant woman's bloodstream circulates to the fetus by crossing the placenta.
  - There, the alcohol interferes with the ability of the fetus to receive sufficient oxygen and nourishment for normal cell development in the brain and other body organs.

💻 Slide 84: Fetal Alcohol Syndrome Effects

- Symptoms vary widely, but most often seen in 3 areas:
  - Growth deficiency
  - Pattern of facial malformation
  - Central nervous system abnormality: neurological, opthalmologic, hearing, processing problems (including poor understanding of consequences)

💻 Slide 85: Can We Help?

- Treatments and Drugs:
  - There's no cure or specific treatment for fetal alcohol syndrome.
  - The physical defects and mental deficiencies typically persist for a lifetime.
  - Heart abnormalities may require surgery.
  - Learning problems may be helped by special services in school.
  - Parents often benefit from counseling to help the family with a child's behavior problems.

Explain that while there is no cure, there are measures that can be taken to help prevent or ameliorate the symptoms.

💻 Slide 86: What Can Be Done?

- Stable, Nurturing Home:
  - Implement daily routines for the child
  - Create and enforce simple rules
  - Point out and use rewards
  - Teach daily living skills

- Problems later in life:
    - Stability can help protect FAS children from:
    - Drug Abuse
    - Dropping out of School

Emphasize the importance of stability, whether the home is with the biological family or with a placement family. The message to convey is that FAS is not hopeless.

💻 Slide 87: Methamphetamine Abuse

- Highly toxic
- Depletes dopamine levels and damages nerve terminals
- Neuro-cognitive deficits
- Functional and molecular changes in the brain
- Damage to organs, loss of body fat, muscle damage as a result of elevated body temperatures
- Dental decay
- Elevated blood pressure
- Skin lesions
- Decreased oxygenation to extremities
    - Thanks to Kathryn Wells, MD, Denver Health

Training participants will probably relate these symptoms to adult drug/alcohol users. Use it as an informational slide, but let participants comment if they volunteer.

💻 Slide 88: Methamphetamine Effects on Behavior

- Violent behavior
- Bizarre behavior
- Anxiety
- Heightened sexuality
- Confusion
- Insomnia
- Psychotic features:
    - Paranoia
    - Visual or auditory hallucinations
    - Mood disturbance
    - Delusions
    - Rages and /or homicidal thoughts
    - Can persist for years after use is discontinued

Briefly describe the effects that methamphetamine has on adult users. However, do not spend too much time on this, as the focus should be on the effects the caregiver use has on children.

Slide 89: Effects on Parents or Kids?

- BOTH

This slide is mean to have a least a little shock value. Encourage the training participants to share their own thoughts and to bring the focus back to the children who are affected by caregiver substance use.

Slide 90: Common Meth Effects on Kids?

- Tremors of arms and/or legs (shaking)
- Irritability/excessive crying
- Infant wanting to eat all the time or difficult to get infant to feed
- Poor self regulation of sleep/wake cycle
- Temper tantrums/aggressive behavior
- Various medical complications such as:
    - Stroke or seizure
    - Infectious diseases such as Hepatitis A, B, C, or HIV
    - Attention Deficit Hyperactivity Disorder

Describe the effects of both in utero and peri utero drug/alcohol exposure. Try and get the participants to "see" these effects.

Slide 91: How Can You Help?

- **Connecting** practitioners across disciplines to increase expertise and enhance their work with children and families.
    - Law Enforcement
    - Child Welfare Caseworker
    - Protective Custody Caregiver
    - Medical Providers
    - Who Else?
- What's Happening in Your Community?

Emphasize that the intervention approach needs to be multi-disciplinary. Explain that law enforcement is often the first to observe the phenomenon and law enforcement observations

are very important to the child welfare caseworker. In turn, the child welfare caseworker's assessment is essential to the caregiver and crucial to the child. For medical providers, mention that a complete physical is necessary both for treatment and prevention. Finally, ask the participants how the multi-disciplinary stakeholders work together in their community. Encourage conversation, but keep the responses short so that all participants will learn about possible best practices across the state.

💻 Slide 92: It's Only Marijuana

- Just because it is prescribed does not mean:
    - It is not being abused;
    - That parenting is not affected;
    - That treatment is not needed;
    - That comprehensive evaluation cannot be conducted;
    - That long term effects are not health or psychological risks

Remind participants that the legal, moral, and ethical controversy that surrounds medical marijuana is not the emphasis here. Rather, the focus is on the secondary effects that medical marijuana has on children. It does not matter to the secondhand user whether or not the drug is legal; the effect is the same.

💻 Slide 93: Educational Implications for Children of Addicted Parents

- Special Education Services because of:
    - Cognitive Damage
    - Developmental Delays
    - Physical Disabilities
- Truancy/Drop-Out because of:
    - Unstable Family Environment

Because foster youth have such a high drop-out rate, it is important to remind participants of two of the major effects that parental alcohol and drug use has on the education of children.

💻 Slide 94: What Can We Do To Improve Educational Outcomes?

- Early intervention helps because:
    - Can assist in PREVENTING secondary
    - Better Preparation for Learning
    - Decreased Special Education Placement

    - Increase Grade Level Progression
- Holistic approach helps because it considers the entire family unit's health:
    - Social
    - Emotional
    - Physical
    - Mental

This list is not meant to be exhaustive; rather, it is meant to emphasize two solutions that involve multi-disciplinary approaches to the problem.

Slide 95: Substance Abuse: Major Effects that Impact Parenting

- Substance abuse and addiction to any drug, legal or not, compromises parental awareness and availability.
- These effects are common to all substance abuse:
    - Interpersonal "disconnectedness"
    - Confusion
    - Impaired Judgment
    - Inability to complete tasks
    - Disorganization

Ask group for feedback about the effects of substance abuse on family functioning. There is little doubt that many in the group have seen the harmful dynamics of substance abuse within their own families, social circles, and communities.

What programs are available within the participants' communities? What have they known to be the components of effective treatment?

What should determine child protective services involvement in a family which has been identified to have issues with substance abuse?

CONCLUSION AND EVALUATION
Time: 15 minutes
Description of Activity:

End the day with feedback, final questions, etc.

Hand out evaluation forms (Handout 8) for participants to complete. Allow time to complete it, and encourage the participants to be specific as to what was useful and what was not helpful.

Remind designated group leaders to take information from breakout groups for future planning; allow time for scheduling a meeting. Refer participants to Handout 7: Resource Bibliography, if they want to locate additional materials and/or resources.

Thank participants for attending the training.

💻 Slide 96: It's the End of Our Day

💻 Slide 97: Thank You for Your Time and Your Commitment to Children