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| **COMPETENCIES** |
| **100-1** The worker knows how to use the state’s legal definitions of physical abuse, sexual abuse, neglect, dependency/neglect, dependency and endangerment to determine the validity of child maltreatment reports.  **100-2** The worker understands the Family Service Worker’s role in the court systems and how to use the court systems to protect children including:   * How to gather pertinent evidence and write effective affidavits and court reports * How to prepare for court * How to present effective testimony   **101-1** The worker knows the values of family centered child welfare practice and understands that effective family-centered services can strengthen families, promote positive change and help prevent removal of children from their homes. Family-centered child welfare values include:   * Safe and stable families * Permanence for children * Preservation of parents’ and children’s rights and dignity * Client self-determination * Reasonable efforts * Respect for individual and cultural differences * Awareness of how one’s own values and culture can impact the delivery of child welfare services.   **101-2** The worker understands the dual roles of the Family Service Worker to protect children from maltreatment and to empower families by providing services designed to strengthen and support families.  **101-3** The worker understands the dual roles of the family service worker to protect children from maltreatment, empower families, and provide services that preserve safe and stable families.  **101-5** Using required agency protocols, the worker can determine when reports of maltreatment are true, when they are unsubstantiated and can use the data gathered in assessments to plan and provide relevant protective and supportive services.  **101-6** The worker knows the broad range of responsibilities of the child welfare agency and the range of interventions to assure child safety from least intrusive to most intrusive, including providing supportive services, differential response, in-home services, arranging temporary out-of-home placements and reunification, placement with fit and willing relatives, and providing permanent homes for children who cannot return to their parents or caregivers.  **101-7** The worker knows the proper roles and responsibilities of other community agencies and child welfare service providers and knows how to collaborate with these agencies and providers to develop case plans and provide services that assure a safe and stable family environment for children.  **101-8** The worker can recognize indicators of mental health problems, substance abuse, and interpersonal violence and can assess the degree to which these problems are impacting child safety and family stability.  **102-1** The worker understands knows the importance of effective assessment, case planning and concurrent planning and understands the factors that must be addressed in a thorough assessment including contributing factors to maltreatment, the functioning of the family as a unit, the cognitive, behavioral, social and emotional strengths and limitations of each family member, the formal and informal resources available to the family, and any other domains address by agency assessment tools and protocols.  **102-2** The worker knows strategies to engage family members in constructive and collaborative casework relationships that empower families; promote family participation in assessment and planning; overcome resistance; are culturally sensitive; and defuse anger, fear and hostility while appropriately using authority to assure the protection of children.  **102-3** The worker knows how to involve families in the development of appropriate, time limited case goals and objectives; knows how to prioritize family and child needs; knows how to formulate observable, behavioral measures of goals and objectives which address the highest priority needs; and knows how to identify the most appropriate services and activities to meet the case plan objectives  **102-4** The worker understands the factors that must be addressed in the family strengths and needs assessment, including the contributing factors to abuse or neglect, the functioning of the family as a unit, the cognitive, behavioral, social, and emotional strengths and limitations of each family member, and resources available to the family.  **102-6** The worker understands the dynamics of resistance and knows how casework methods can defuse family member’s hostility, fear, and anger.  **102-7** The worker knows how family-centered casework methods are used to promote safe and stable families and to promote permanency for children by involving parents and other family and/or community members in assessment and case planning; providing services to maintain children in their own home; assuring family members’ involvement with their children in placement; and providing the necessary services to achieve timely reunification or other permanency options.  **103-1** The worker has a thorough knowledge of the stages, processes and milestones of normal physical, cognitive, social, and emotional development of children from birth through adolescence.  **103-2** The worker knows the potential negative impacts of maltreatment and trauma on normal development and can identify indicators of developmental delay or problems related to trauma in children who have been abused or neglected.  **103-4** The worker is able to educate and advise families, caregivers, and foster parents about the effects of abuse and trauma on children and help them have reasonable expectations for abused, neglected and traumatized children.  **104-1** The worker understands the process and dynamics of normal, reciprocal attachments.  **104-2** The worker understands the potentially traumatic outcomes of separation and placement for children and families - including psychological crises, serious disruption of family relationships and attachment, and disturbances in the child’s development – and can weigh the risk to a child of remaining with his/her family against the trauma of separation when deciding whether to place a child out-of-home.  **104-3** The worker understands the serious negative effects on children in changing and inconsistent living arrangements, including many changes in out-of-home caregivers, and can recognize the physical, emotional, and behavioral indicators of placement-induced stress  **104-4** The worker understands the necessity of permanency planning and reasonable efforts to prevent removal, to prevent placement disruption and to achieve timely reunification or other permanency options.  **104-5** The worker can identify ways that agency foster care policies and practices can contribute to successful out-of-home placements, including properly structuring a placement to help prevent crisis and its consequences; involving agency team members, and designing placement activities, including pre-placement preparation and visits, that minimize stress and provide emotional support to the child and family.  **104-6** The worker understands the concept of "continuum of care" in determining the best placement for a child; knows strategies to identify, strengthen, and maintain the least restrictive, most homelike, culturally relevant placement to meet a child’s needs; and knows how to prepare kinship relatives, foster parents, and other caregivers to receive children in placement to reduce stress and facilitate adjustment.  **104-7** The worker knows the necessity of regular and frequent visits to maintain family members’ relationships with the child in out-of-home placement, and can use casework strategies that empower families to participate in planning and attending visits, assessing the child’s developmental, medical, social , and emotional needs and determining appropriate services.  **105-1** The worker understands the importance of CHRIS in the effective delivery of casework to the family and the management of the child welfare system.  **201-3** The worker understands the value of pre-service and ongoing in-service training for foster and adoptive families.  **201-4** The worker can assess the needs of children requiring foster or adoptive placement and can select the most appropriate, least restrictive, most homelike, culturally relevant placement setting to meet the child s developmental and treatment needs.  **201-8** The worker can prepare children for adoption, including use of life books, stories, play, and other methods to communicate with the child, to reduce placement-induced stress and to maintain identity and continuity for the child  **\*Division of Children and Family Services**  **FSW Competency List** |

**CHILD DEVELOPMENT AGENDA**

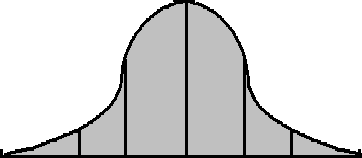
1. **Introduction to Development**
2. **Pre-Natal**
3. **Nutrition**
4. **Medical Care**
5. **Attachment Behaviors**
6. **Birth to Pre-School 0-5**
7. **Developmental Milestones**
8. **Attachment/Bonding Behaviors**
9. **Nutrition/Feeding Behaviors**
10. **Immunizations**
11. **School-Age Children 6-11**
12. **Developmental Milestones**
13. **Working with the Educational System**
14. **Adolescence 12-21**
15. **Developmental Milestones**
16. **Teen Brain Development**
17. **Warning Signs for At-Risk Behavior**
18. **Sexual Development**
19. **Homework Assignment**

**OBJECTIVES**

***At the completion of this training, the Program Assistant will:***

* Know developmental milestones and know what behaviors can be expected of children from birth through adolescence.
* Know how to observe children's physical, cognitive, social, and emotional development and recognize when development is delayed or follows abnormal patterns.
* Understand the importance of attachment in the developmental process.
* Know ways to promote healthy interaction between parents and children in each stage of development.
* Understand issues related to the normal sexual development of children and adolescents.

**WHAT IS “NORMAL”?**



**Standard Deviations from Mean (z-scores)**

**+3**

**+2**

**+1**

**0**

**-1**

**-2**

**-3**

**14 MONTHS**

**10 MONTHS**

**12 MONTHS**

**Frequency**

**BEHAVIORS THAT SHOW ATTACHMENT/BONDING TO GROWING FETUS:**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**WAYS I CAN PROMOTE BONDING/ATTACHMENTS:**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**NUTRITION DURING PREGNANCY**

***Please note: The following information is intended to assist Program Assistants in helping expectant mothers plan nutritious diets. It is not intended to replace regular pre-natal care visits with a health-care provider. A woman should always follow the nutritional plan and advice given to her by her doctor.***

There's no magic formula for a healthy pregnancy diet. In fact, during pregnancy the basic principles of healthy eating remain the same — get plenty of fruits, vegetables, whole grains, lean protein, and healthy fats. However, a few nutrients in a pregnancy diet deserve special attention. Here's what tops the list.

* **Folate and folic acid- Prevent birth defects**Good sources: Fortified cereals are great sources of folic acid. Leafy green vegetables, citrus fruits, dried beans and peas are good sources of naturally occurring folate.
* **Calcium- Strengthen bones**  
  Good sources: Dairy products are the best absorbed sources of calcium. Nondairy sources include broccoli and kale. Many fruit juices and breakfast cereals are fortified with calcium, too.
* **Vitamin D — Promote bone strength**  
  Good sources: Fatty fish, such as salmon, is a great source of vitamin D. Other options include fortified milk and orange juice.
* **Protein- Promote growth**  
  Good sources: Lean meat, poultry, fish, and eggs are great sources of protein. Other options include beans and peas, nuts, seeds, and soy products.
* **Iron- Prevent iron deficiency anemia**  
  Good sources: Lean red meat, poultry and fish are good sources of iron. Other options include iron-fortified breakfast cereals, beans, and vegetables.
* **Supplements- May be recommended by a health care provider**  
  If you're considering taking an herbal supplement during pregnancy, consult your health care provider first, as some herbal supplements might be harmful to your pregnancy.

This information was obtained from the Internet site:<https://www.mayoclinic.org/>

**PRENATAL CARE VISITS**

During pregnancy, regular checkups are very important. This consistent care can help keep the mother and her baby healthy, spot problems if they occur, and prevent problems during delivery. Typically, routine checkups occur:

* Once each month for weeks four through 28
* Twice a month for weeks 28 through 36
* Weekly for weeks 36 to birth

Women with high-risk pregnancies need to see their doctors more often.

On the first visit, the doctor will perform a full physical exam, take the mother’s blood for lab tests, and calculate her due date. The doctor might also do a breast exam, a pelvic exam to check the mother’s uterus (womb), and a cervical exam, including a Pap test. During this first visit, the doctor will ask the mother lots of questions about her lifestyle, relationships, and health habits. The mother needs to be honest with her doctor.

After the first visit, most prenatal visits will include:

* Checking mother’s blood pressure and weight
* Checking the baby's heart rate
* Measuring mother’s abdomen to check her baby's growth

Mother will have some routine tests throughout her pregnancy, such as tests to look for anemia, tests to measure risk of gestational diabetes, and tests to look for harmful infections.

It is encouraged that the mother becomes a partner with her doctor to manage her care. Keep all of her appointments — each one is important! It is important for mothers to ask questions and read to educate themselves about this exciting time.

*The above information was obtained from the Internet site:* [*https://www.womenshealth.gov/*](https://www.womenshealth.gov/)

**PRE-NATAL SCENARIOS**

**Read your assigned scenario and then answer the following questions:**

* What are the strengths of the family?
* What interventions can you make to help clients have healthier, more fulfilling pregnancies?
* Are there any cultural issues that need to be discussed?

1. Jill is a 28-year-old African American. She is five months pregnant with her third child. DCFS has an open Protective Services case on the family, due to physical abuse of the two older children: Mark (age 5) and Lindsey (age 2). The children were whipped with a belt by their mother. The children had new and old injuries at the time of the assessment. Jill is married to William, but he is often absent from the home with his job as a truck driver. Jill states she did not want or plan this pregnancy and that she and her husband “don’t need any more kids”. They have not picked out any possible names for the baby and haven’t begun to make any space for the baby in their three-bedroom home. Jill’s only close friends are Marsha and Kate (both 28) who live in the neighborhood. Neither of the women have children.
2. Debbie is a 15-year-old white female. She is the oldest child in a home with an open Protective Services case. Debbie recently told her mother that she had missed three periods and thinks she’s pregnant. Debbie’s mother is a substance abuser, who regularly left Debbie with her two younger sisters at home alone for weeks at a time. Debbie stated that she wanted to get pregnant and that she loves her boyfriend very much. She wants to quit school and get married. You have never met her boyfriend; Tim. Debbie has no maternity clothes and doesn’t know how she will afford to buy items for the baby. Her mother is very angry with Debbie and called her a “slut” when Debbie told her she was pregnant. Debbie loves “junk food” and smokes a pack of cigarettes each day.
3. Carmen is a 21-year-old Latina female. She believes she is about seven months pregnant, but she has had no pre-natal care. She and her husband, Carlos, have another child who is 2 years old. This child is currently in DCFS out-of-home care because of severe physical abuse by Carlos. The family speaks very little English and although Carmen has expressed an interest in learning, but her husband does not want her to attend classes. Since the older child was placed in out-of-home care one year ago, several other family members have moved to this country and are living with Carmen and Carlos. Carmen’s mother and sister are among the family members who have moved in with the couple.

A child development stage report

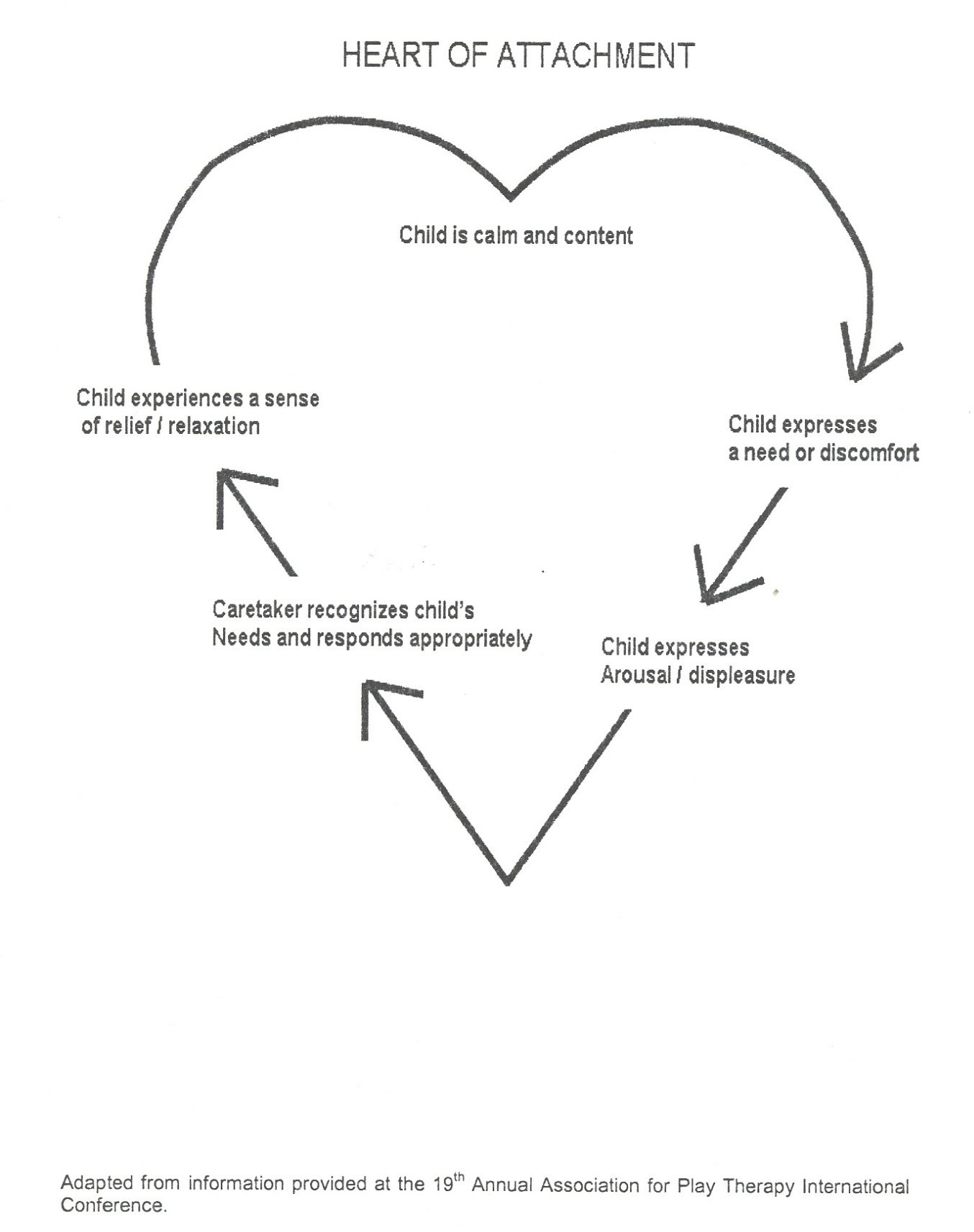
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**CHILDHOOD IMMUNIZATIONS**

**At what age does a child need their immunizations?**

* Immunizations are given on a schedule that usually begins with birth.
* Shots are also needed at **one, two, four, and six months** and **between 6 and 18 months** of age.
* More shots are needed between the ages of 18 months to 18 years (refer to handout for specific schedule).
* Most vaccines come in a series of shots that are given over time. The child must have *all* doses in the series to be immunized.
* It is *important* to closely follow the *doctor’s* instructions about when to bring the child in for more shots, as each child’s immunization schedule may differ slightly.

**What if children don’t get all their shots when they are supposed to, or have fallen behind schedule?**

* They can still be fully immunized. It’s never too late!
* If the child has some immunizations, the ones given will count. They will not have to “start over.”
* If the child has had no immunizations since birth, contact a doctor or health department clinic. They will tell you when to bring the child for an appointment.

**What are some of the side effects of immunizations?**

* Usually, they are mild effects like a sore arm or a slight fever.
* Some vaccinations also cause “fussiness” or a swelling of the shot area.
* A doctor or nurse will discuss the possible side effects before giving the shots.
* It is important to remember that children are in more danger from diseases than from the shots.

**Immunization exemptions:**

* If a parent chooses not to vaccinate their child(ren), an exemption for philosophical/religious/medical reason(s) will need to be on file with the family’s PCP or on file with the child’s school.
* If a child with a vaccination exemption on file comes into custody, the department cannot make the choice to vaccinate the child.

**POTTY-TRAINING**

**DO:**

**Watch for signals** from children that they are ready to be potty-trained, such as:

1. Using the family’s words for a bowel movement or urination – “pee,” “poop,” etc.
2. Showing a preference for clean diapers, bringing a clean diaper to the parent, or asking to be changed.
3. Showing signs that they know they need to go, such as squatting or holding their privates.
4. Indicating they have at least some ability to hold it for a short period of time, possibly by going off by themselves for privacy when using their diaper, or by staying dry during naps.

* **Buy a potty chair** after the child has started to show the above-mentioned signs. The child should feel this is his or her own special chair and should be allowed to customize it with stickers, designs, or their name.
* **Dress the child in easily managed clothes,** such as shorts or underpants with elastic waistbands. This will enable them to pull down their own clothing when ready to use the potty.
* **Have children sit on the potty chair** whenever they start to give signals they might need to go, such as pacing, holding their privates, or passing gas. Fifteen or twenty minutes after meals is another good time to have the children sit on the chair. Have them sit with their pants down and encourage them to try to go. If they can’t/won’t, have them sit there for a short time and engage them in a fun activity, such as reading a book.
* **Limit each session on the chair to five minutes,** even if the child is enjoying just sitting there. Give them lots of praise, even if they don’t use the potty every time they sit there.
* **Give them lots of praise** if they are able to use the potty. Make a big production out of emptying the chair into the toilet and if they wish, let the child flush.
* **Let them start wearing training pants** once they can express when they need to go, on a regular basis. Make use of diapers only for sleeping time.
* **Parents should still supervise** the wiping and hand-washing processes to ensure proper hygiene.
* **If they have an accident, change them right away.** Tell them they are doing very well and will get better with practice.Use mild, matter-of-fact statements if you can tell that the child knew they needed to go and didn’t tell. An example would be, “Big boys and girls don’t mess in their pants. You need to tell Mommy and Daddy when you need to go”.
* **Use mild, matter-of-fact statements** if you can tell that the child knew they needed to go and didn’t tell. An example would be, “Big boys and girls don’t mess in their pants. You need to tell Mommy and Daddy when you need to go”.
* **Keep plenty of extra clothes available**, especially at the beginning of the training process.
* **Remember, kids are different.** Girls may be trained faster than boys, because boys must learn when to stand up and when to sit down. Potty-training is no indicator of a child’s intelligence or a parent’s parenting skills.
* **Consult with your family doctor** if you are having an unusually hard time getting your child trained, especially if the child is over three years of age. A medical condition could be causing the problem.
* **Relax and be patient.** Potty-training is not usually one of parenthood’s many joys, but you’ll get through it!

**DON’T:**

* **Try to train too early.** To be potty-trained, children must have developed enough muscle control to be able to hold their urine or bowel movements until they can reach the bathroom. This control comes with age. In most cases, when a child seems to be trained very early, it is the parent(s) that is trained. They just manage to get the child to the potty regularly enough that there are no accidents.
* **Listen to tales of other people’s “super children.”** The age at which children are potty- trained depends on the particular child. Some kids begin the process between 15 to 18 months of age, when they become aware of the discomfort of soiled diapers and express the need to be changed. Others are ready at about two years, some not until two-and-a-half. By age three, nearly all children should be able to control their bowels and bladder during the day.
* **Punish or humiliate the child** when they use the bathroom in their pants. Accidents will continue to happen occasionally, even after the child seems to be trained. Children tend to get involved and excited about activities and will not pay attention to their need to go to the bathroom until it is too late. Harsh scolding or physical punishment will only engage the child in a power struggle and can lead to problems such as chronic severe constipation.

This information was obtained from the Internet sites:

“Flush with SUCCESS” by Glenn P. Matney, M.D. “Helping Your Child To Arrive At Successful Potty Training.” [http://victorvalley.cgipro.com/health&law/hlaw-feb/matney.htm](http://victorvalley.cgipro.com/health%26law/hlaw-feb/matney.htm)

“Learning to Love the Potty” by Dr. Paula Prezioso. “New Standard: 8/28/96.” [http://www.s-t.com:80/daily/08-96/08-28-96/c08lil16.htm](http://www.s-t.com/daily/08-96/08-28-96/c08lil16.htm)

**HUMAN DEVELOPMENT QUESTIONS**

1. Where does a preschooler’s self-esteem come from?
2. What can be done for this age group to enhance their self-esteem?
3. Why are secure attachments so important for preschool children?
4. What are three (3) things parents can do to reduce sibling rivalry?

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**WARNING SIGNS –**

**When an adolescent might be in trouble:**

1. Frequent breaking of family rules (ex: curfew – hours late, not just 5 minutes, or never coming home).
2. Violent threats or aggression toward siblings or parents.
3. Increased isolation.
4. Suicidal thoughts.
5. Changes in sleeping patterns.
6. Significant eating behavior changes.
7. Drugs.
8. Disinterest in appearance.
9. Depression followed by hyperactivity.
10. Grades drop from A to F.
11. Problems with all authority.
12. Cutting classes.
13. Loss of friend

**“NORMAL” OR “AT RISK”?????**

**Read these scenarios and then answer the following questions about each one:**

* Is this teenager “at risk” or displaying “normal” adolescent behavior?
* Is it harder to decide on some scenarios than on others? Why?
* Could some scenarios be either “dangerous” or “at risk” depending on information that is missing? What is the information you need?
* What interventions would you recommend for these adolescents, even if behavior seems “normal?”
* How does the race/ethnicity of the adolescents influence your decision?

1. Mary is a 13-year-old African American female in the eighth grade. During elementary school, Mary got good grades and scored highly on aptitude tests. Her parents describe her as having been an “easy child.” In the last year, Mary has begun to look more physically mature and her relationship with her parents has become strained. She wants to wear makeup and date boys, but her parents are opposed to these behaviors at her age. Recently, Mary’s mother was called to the school when Mary was caught “skipping” class and she was wearing makeup. She has also been caught trying to sneak out of the house on several evenings. Mary’s grades have fallen to average, and her parents complain that all she wants to do after school is talk on the phone.
2. Jennifer is a 14-year-old white female in the ninth grade. During elementary school, Jennifer got good grades and scored highly on aptitude tests. Her parents describe her as having been an “easy child.” In the last year, Jennifer has begun to look more physically mature and her relationship with her parents has become strained. Jennifer has begun to wear very short skirts and low-cut tops. One of Jennifer’s teachers has told her parents she is concerned because Jennifer often leaves school at the end of the day with several boys who are Juniors and Seniors. Jennifer’s grades have dropped and she has none of the same friends she had throughout elementary school. Last week, she was caught shoplifting from a local store.
3. Jerome is a 16-year-old white male. His parents report that he has always been “quiet and shy,” but has done well in school. Jerome has only two close friends, other boys of the same age he has known for some time. They spend a lot of their time playing games on Jerome’s computer and on his gaming system. Jerome always wears black, baggy clothes, and has dyed his hair platinum blonde. He has also pierced his nose and eyebrow. Jerome’s mother said she is afraid of the music he and his friends listen to because she cannot understand the words.
4. Juan is a 16-year-old male of Latino descent. His family moved to this country two years ago. Juan is very bright, and he has quickly learned to speak English fluently. He also has become very interested in sports and is currently on the school’s football team. Juan has told you that he is in love with his girlfriend, Carrie, and that they have started having sex. He reports they do not use any form of birth control because that “would ruin it.” Juan expresses that he wants to go into the Army after high school so that he can then go to college.
5. Maria is a 15-year-old Latina female. Her parents are very upset because she recently told them she no longer accepted Catholicism. They report that she has become “wild” and argumentative in the last year, and that she constantly fusses with her younger sister. They do not approve of her boyfriend, a 17-year-old Caucasian male, with whom she spends most of her spare time. Maria’s mother is also very angry because she found a pack of cigarettes and a condom in Maria’s purse.
6. Donald is a 13-year-old African American male. His mother reports that he is rarely at home and is usually down the street, “hanging out” in a house with several older boys. While she was in his room recently, putting away laundry, she found a handgun and two “joints” of marijuana. One of Donald’s close friends was killed in a drive-by shooting several months ago. Since then, he has become increasingly distant from his mother and siblings. He was recently suspended from school for threatening another student.

**SEXUAL DEVELOPMENT TEST**

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| 1. Children do not exhibit sexual play or sexual behavior until they have been sexually abused or inappropriately stimulated. | T | F |
| 1. Parents should be concerned if baby boys have erections while they are nursing. | T | F |
| 1. Infants (boys and girls) touch their genitals as soon as they develop the necessary motor coordination, but these touches are less likely to occur than the infant touching any other body part. | T | F |
| 1. Even though six and seven-year-olds have a strong sense of modesty, the natural curiosity of childhood is likely to emerge in games that permit sexual exploration. | T | F |
| 1. School-age girls (six – 12) don’t usually masturbate, although school-age boys do. | T | F |
| 1. The adolescent growth spurt is an old wives’ tale that has no validation through research. | T | F |
| 1. Adolescents should not fantasize when masturbating because fantasy at this age is a sign of deviant sexual development. | T | F |
| 1. Children or adolescents who engage in same-sex play or exploration usually grow up to be gay, so such behavior should be punished when discovered. | T | F |
|  |  |  |

1. What are some of the reasons parents are uncomfortable with the sexual interest or sexual behavior of their children?
2. What is the earliest age that males have erections?
3. At what age do children establish a sense of being a girl or a boy?
4. Which is not true of four-year-olds?
   1. They are interested in how babies are made.
   2. They may believe that mommy has a patch of dirt inside her body if they have been told that babies are made “when daddy plants the seed in mommy.”
   3. They do not play sex games unless they have been abused.
   4. They are fascinated with bathroom functions and like to try out “dirty” words.
5. Name two criteria for deciding when sexual contact between siblings is abusive.
6. List three physical indicators of puberty.

1.

2.

3.

1. A teenager on your caseload tells you he is gay. What should you do?
2. A 14-year-old female child in out-of-home care on your caseload tells you she’s sexually active. What should you do? Does your answer change if the 14-year-old is a male?

**TWELVE CASE SITUATIONS FOR PRACTICING CHILD DEVELOPMENTAL ASSESSMENT**

Read each case carefully. What age range (e.g., 3-to-6 months) would you estimate the child in each story to be? Answers these questions based on the earliest possible age at which the child could be expected to demonstrate the behavior described. You will have to use the developmental milestone chart in the Supplemental Resources section of your Participant Manual.

1. **John:**

John walked easily down the front steps, one foot to a step, picked up a ball, and threw it overhand. He told me he was Dwight Gooden, the baseball hero. I asked him if he wanted to put his coat on and he said, “No, but it’s in the car.”

1. **Jennifer:**

Jennifer was sitting up in her playpen, banging a “tick-tock” clock with a string of “pop- beads,” happily singing “da-da-da-da.”

1. **Roz:**

I wanted to talk quietly with Roz, but she kept jumping up and down on the steps and wouldn’t stop talking. She named her nose, ears, eyes, cheeks, and chin for me. She was also quite proud of being able to wash her hands by herself.

1. **Children:**

A friend of the mother said the mother enjoyed children who had minds of their own. She said the kids always let their parents know when they disagree. She pointed out that both children could be very competitive, but well organized while playing.

1. **Linda:**

Mrs. Lee was upset about her daughter, Linda. She no longer felt that she knew her little girl. Linda began to express her desire for independence more often. Her arguments about going places were reasonable and expressive, and this frustrated Mrs. Lee a great deal.

1. **Anna:**

Anna walked up to me, and said, “Hi!”. I sat down and she scribbled with crayons on a piece of paper. She then got her bottle out of her crib, smiled mischievously, and put the nipple in her mouth. Later, she was drinking from a cup, and using a spoon. However, she still used her fingers a lot to eat her macaroni.

1. **Grade-Schoolers:**

A teacher said she enjoyed her class because they had better impulse control, more pride and self-confidence. They were less dependent on “mother” than children in the lower grades.

1. **Tom:**

I was in the park with Tom on a picnic. He’d just finished eating some potato salad (which he fed himself with a spoon) when he suddenly ran down the path. He was about one block away before I could catch up with him. When I called for him to stop, he said “No!” and kept running.

1. **Henry:**

The grandmother said that at playtime, Henry liked to cut up colored paper, or ride his trike up and down the sidewalk. When I saw Henry, he asked me if I wanted to play under the table with him.

1. **Juan:**

While lying on his back in his crib, Juan vigorously sucked on his pacifier. When the pacifier fell out of his mouth, Juan began to cry and whimper when it wasn’t put back in position. With his hands clenched into fists, he stared up at the ceiling.

1. **Lucy:**

Lucy was lying there playing with her feet. She even managed to grab one foot and put it into her mouth. It looked like she enjoyed chewing on her toes. Then she crawled over to the television set and pulled herself up to a standing position by holding onto the knobs and dials on the set. When her mother said “No,” Lucy frowned and sat down on the floor.

1. **Louella:**

Louella looked up from printing her name and told me she liked to do the dusting and put dirty dishes in the sink sometimes to “help Mommy.” She then counted four plates to put on the table, pretending she was “the mother.”

Source: University of Florida, *Child Abuse and Neglect*, Book I

**PHYSICAL ABUSE, NEGLECT, EMOTIONAL ABUSE, AND SEXUAL ABUSE AGENDA**

* 1. **Introduction**

1. **Icebreaker**
2. **Scope of the Problem**
3. **Reporting Child Maltreatment**
   1. **Physical Abuse**
4. **Physical and Behavioral Indicators**
5. **Slide Presentation**
   1. **Neglect**
6. **Physical and Behavioral Indicators**
7. **Neglect vs. Poverty-Vignette Exercise**
   1. **Emotional Maltreatment**
8. **Physical and Behavioral Indicators**
   1. **Sexual Abuse**
9. **Physical and Behavioral Indicators**
10. **Stages of Sexual Abuse**
11. **Sexual Abuse Exams**
12. **Working with the Non-Offending Parent and Child Victim**
    1. **Conclusion**

**OBJECTIVES:**

***At the completion of this training, the Program Assistant will:***

* Review definitions of maltreatment in the Child Maltreatment Act.
* Understand the role and obligations of the mandated reporter.
* Be able to identify physical, emotional, and behavioral indicators of abuse, and neglect, in child victims and their families.
* Recognize the factors for assessing the level of risk for a child that’s been maltreated.
* Be able to distinguish between poverty and neglect.
* Know how one’s own culture affects behavior and values; and know how cultural/ethnic differences may affect the delivery of child welfare service

**IDENTIFYING, REPORTING, AND RESPONDING TO CHILD MALTREATMENT**

**Scope of the Problem:**

**The Child Maltreatment Report 2022 was** prepared by the Children’s Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services. According to this report.

**Nationally:**

* Nationally during FFY 2022, 3,096,101 children received either an investigation response or alternative response at a rate of 42.4 children per 1,000 in the population.
* For FFY 2022, 52 states reported 558,899 victims of child abuse and neglect. This is a national rate of 7.7 victims per 1,000 children in the population.
* Among these 3,096,101 chldren:
  + 74.3 percent of victims experience neglect
  + 17.0 percent are physically abused
  + 10.6 percent are sexually abused
  + 6.8 percent are psychologically maltreated.
* The majority (76.0%) of perpetrators are a parent of their victim.
* For FFY 2022, a national estimate of 1,990 children died from abuse and neglect at a rate of 2.73 per 100,000 children in the population.

**Who are the child victims:**

* Children younger than 1 year old have the highest rate of victimization at 22.2 per 1,000 children of the same age in the national population.
* The victimization rate for girls is 8.2 per 1,000 girls in the population, which is higher than boys at 7.1 per 1,000 boys in the population.
* American Indian or Alaska Native children have the highest rate of victimization at 14.3 per 1,000 children in the population of the same race or ethnicity; and Black or African-American children have the second highest rate at 12.1 per 1,000 children of the same race or ethnicity.

**Arkansas:**

Arkansas statistics tend to conform closely to the national statistics in terms of types of reports made and found to be true.

A screenshot of a website

Description automatically generated

* For FFY 2022 a total of 57,339 reports were received for children
* This is a rate of 82.3 potential victims per 1,000 children in the population
* Of these, 55.7 percent received an investigation or alternative response in the state of Arkansas.
* Of these, there were 9,363 substantiated investigations and 6,873 alternative responses.

Data retrieved in part from: U.S. Department of Heath and Human Services, Administration for Children and Families – the Children’s Bureau

<https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf>

*Kids—you just can’t beat them! ~Source Unknown*

**MANDATED REPORTERS OF SUSPECTED MALTREATMENT**

**Child Maltreatment Defined – See Handout 1, Week 2, Day 5**

**Reporting Suspected Maltreatment:**

Key concept: *Reasonable Cause to Suspect*

**Arkansas Child Abuse Hotline**: **1-844-728-3224 (844 SAVE A CHILD)**

**Child Abuse Hotline**: **1-800-482-5964**

(Reports may also be made directly to DCFS county offices.)

Information required for a report:

* A circumstance that, if true, would meet the legal definition of maltreatment.
* Identifying information on the victim/family – enough to locate the alleged victim.
* As much detail as the reporter knows about the alleged maltreatment and the circumstances surrounding it

.

**SHOULD IT BE REPORTED?**

1. A 13-year-old child comes to you with 13 belt marks spread over his lower back, buttocks, and upper thighs. He says the punishment was administered by his father because he (the boy) had lied about doing his homework.
2. Your neighbor is a single mother of three children ages nine years, seven years, and six months. She leaves the children alone from 5:30 p.m. to 9:30 p.m., while she attends night classes at college. The children have strict instructions not to let anyone in the house and the oldest child knows how to dial 911.
3. You witness your neighbor lose her temper with her five-month-old daughter. She shakes the child violently and slams her down into the crib because the child will not stop crying.
4. A toddler is notorious for biting. His teacher at daycare bites him back to punish the biting behavior. The next day, the child has two visible bruises on his arm in the shape of teeth marks.
5. A single father has four children ranging in age from 12 to six. The 12-year-old daughter has many childcare responsibilities after school. All the children wear old, ill-fitting clothes. The clothes are clean but are not always appropriate for the weather.
6. A 22-month-old has two cigarette burns. One is on the back of the hand, and one is on the right cheek. The caregiver tells you that the child accidentally ran into a lit cigarette while toddling around the house.
7. You notice four small circular bruises on the arm of a one-month-old infant. When questioned, the mother says she has no idea how the child got them.

**A MEASURE OF HOW FAMILIES ARE DOING**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SAFE | SHELTER | NUTRITION | HEALTH CARE | ALCOHOL/ DRUG USE | EMPLOY- MENT | INCOME/ BUDGET | ADULT EDUCATION | CHILDREN’S EDUCATION | PARENTING | FAMILY RELATIONS |
| This family is secure and has the potential to move forward | Lives in affordable housing  Spends less than 1/3 of income for shelter  Able to secure home, feels safe in neighborhood | Has enough food to satisfy hunger  Has appliances and utensils needed to prepare food  Understands basic nutrition  Eats three meals a day | Can get medical care when needed  Insurance covers partial cost of care, can make arrangements to pay balance  Sound, basic health, hygiene practices; seeks timely treatment | No drug or alcohol abuse in immediate family  Abusers have sought treatment  Parents discuss use of drugs/alcohol with children and model appropriate behavior | Has attained marketable skills  Employed by secure company offering some benefits  Long-term employment | Sufficient to meet basic family needs  Plans and sticks to monthly budgets, saves when possible  Able to obtain secured debt; Pays bills on time, delays purchase to handle debt load | Have high school diploma (GED)  Ambivalent attitude toward learning  Sets and pursues short- term career and personal goals | Absenteeism is not high enough to be a concern  Passing marks in all subjects  Few discipline problems  Children get along with other students | Children live with parents and are physically, emotionally safe  Realistic rules, manageable conflict  Children usually happy, outgoing; little violence or aggression  Able to relate to parents | Positive extended family support  Feel a part of the community  Sense of family unit  Members physically safe, emotionally secure; seek to change negative habits |
| AT RISK  This family cannot meet its needs; growth potential of its members is minimal | Lives in temporary or shared housing  Spends over 1/3 of income for shelter  Deterioration of housing conditions; feels afraid in home neighborhood | Not enough food, family members are hungry  Unable to prepare food  Little or no nutritional knowledge  Eats when food is available | Can’t always get medical care  Not covered by insurance, inadequate income  Doesn’t care for self, ignores health problems | Use of illegal drugs/abuse of alcohol or prescription drugs  Abuser denies problem, refuses to seek treatment  No discussion of drugs/alcohol usage in home, parents exhibit  abusive behavior | Minimum/ entry-level job skills  Short-term temporary or no employment; no benefits, no growth opportunities  Lacks job- seeking skills | Unable to meet its basic needs  Spontaneous, inappropriate spending; no savings  Unable to obtain credit  Unpaid bills; High debt load | School dropout, history of academic failure  Does not consider learning important  Does not set nor pursue systematic career and personal goals | High absenteeism  Failing one or more subjects  Continual discipline problem  Children in conflict with other students | Outside placement; threatened children have run away from home unrealistic or non-existing rules; constant conflict  Children unhappy, withdrawn, violently aggressive  Fearful of parent(s) | Members do not relate to one another  Isolated from others  No family identity; family make-up changes frequently  Nurturing with- held, members are subjected to physical violence |

From: Making a Difference: Moving to Outcome-Based Accountability for Comprehensive Service Reforms

The 10 categories listed across the top of this chart are elements of family life that can be measured to determine if and where a family is at risk. The descriptors are not meant to offer a total picture of families functioning at each stratum of well-being, but instead, are intended to provide general characteristics of families who fall in the two strata

**PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT**

|  |  |  |
| --- | --- | --- |
| **Type of Child Abuse/Neglect** | **Physical Indicators** | **Behavioral Indicators** |
| Physical Abuse | Unexplained bruises and welts   * (on face, lips, mouth) * torso, back, buttocks, thighs * in various stages of healing * clustered, forming regular patterns * reflecting shape of article used to inflict (electric cord, belt buckle) * on several different surface areas * regularly appear after absence, weekend or vacation * human bite marks * bald spots   Unexplained burns:   * cigar, cigarette burns, especially on soles, palms, back or buttocks * immersion burns (sock-like, glove-like, doughnut-shaped on buttock or genitalia) * patterned like electric burner, iron, etc. * rope burns on arms, legs, neck or torso   Unexplained fractures:   * to skull, nose, facial structure * in various stages of healing * multiple or spiral fractures   Unexplained lacerations or abrasions:   * to mouth, lips, gums, eyes * to external genitalia | * Wary of adult contacts * Overly compliant - low profile * Apprehensive when other children cry   Behavioral extremes:   * aggressiveness, or * withdrawal * overly compliant * lags in development * afraid to go home   Report injury by parents or caregivers  Exhibits anxiety about normal activities, e.g., napping  Complains of soreness and moves awkwardly  Destructive to self and others  Early to school or stays late as if afraid to go home  Accident prone  Wears clothing that covers body when not appropriate  Chronic runaway (especially adolescents)  Cannot tolerate physical contact or touch |

**\*From Cynthia Crosson Tower, *Child Abuse and Neglect: A Teacher’s Handbook for Detection, Reporting, and Classroom Management,* pp. 82-83. Copyright 1984 by the National Education Association of the United States. Reproduced with permission.**

**PHYSICAL AND BEHAVIORAL INDICATORS OF NEGLECT**

**Neglect involves inattention to the basic needs of a child. While physical abuse tends to be episodic, neglect tends to be chronic. Neglect is more difficult to separate from cultural issues. It is useful to assess whether most of the children in each community display these indicators, or only a few.**

|  |  |
| --- | --- |
| **Physical Indicators** | **Behavioral Indicators** |
| Constant hunger  Poor hygiene  Clothing inappropriate for the weather  Consistent lack of supervision  Constant fatigue  Unattended physical or medical problems  Lice (untreated)  Failure-to-Thrive (non-organic) | Begging or stealing food  Constantly falling asleep in class  Poor school attendance  Coming to school early/staying late  Addiction to alcohol/drugs  Delinquent acts  Stating there is no one to look after him/her  Destructive  School dropout (adolescents)  Self-harm |

**Characteristics of Neglectful Parents**

|  |
| --- |
| Neglectful parents may: |
| * Have a chaotic home life * Live in unsafe conditions * Abuse alcohol/drugs * Have intellectual limitations * Have psychiatric conditions * Be impulsive; lack ability to delay gratification * Be unable to afford child care * Be emotionally needy * Have low self-esteem * Be passive * Need help developing skills to make changes |

**POVERTY vs. NEGLECT**

**Vignettes**

1. The house consists of two rooms with a front and back porch. The porches and many of the open windows are covered with torn screens. Flies are abundant inside of the house and on the porch, as the cool morning breeze blows. The three children, ages 1, 3, and 4 are asleep on the two old sofas in the larger room and are covered with flies as well. There is a pallet in the middle of the floor. In addition to the sofas, there is an old end table with a lamp. The mother is in the second room slaughtering a hog on the only table present. This second room appears to be a kitchen, of sorts, with a few free-standing cabinets, two mismatched chairs, a pump, and a wood stove. Bare plank boarding covers the floor of the house, and the bathroom facilities consist of an old outhouse adjacent to the house. The house has no electricity, but there are two oil lamps in the kitchen area and one lamp has no oil.
2. A family of five; mom, dad, and three kids, have traveled from the state of Washington to Arkansas in a car. They left Washington because they were looking for employment. The trip took over a month, as they had been sleeping in the car at roadside parks along the way. The family arrived in Arkansas one week ago and has been sleeping in the car, under a bridge in downtown Little Rock. The parents attempted to enroll the children in school so that they could eat at least two meals per day. The children are dirty, have a strong body odor, and all have head lice. The family has informed the school officials that they have applied to stay at the Salvation Army.
3. Mom, 23-years-old, and Dad, 24-years-old, live with their five children in an old, abandoned trailer. There are utilities, but these are frequently cut off due to non- payment. When the water is cut off, the family uses the outdoors as their restroom. The yard and trailer have a strong odor. Both are swarming with flies and roaches. Neither Mom nor Dad graduated from high school. Mom has never been employed, and Dad has worked for a wrecker company and as a truck driver. Dad is currently unemployed. The children are regularly sent to school but are just as often sent back home due to head lice and poor hygiene. The two-bedroom trailer has been home to this family for two years. There is no air conditioning and no heat. The windows are uncovered in the summertime and covered with cardboard in the winter.

Answer the questions below:

1. Is this situation neglect or poverty? Why?
2. What actions should be taken? What resources are needed to make the situation better?

**CHECKLIST FOR MAKING OBSERVATIONS IN THE HOME FOR REPORTS OF NEGLECT\***

The following conditions are present, and parents exhibit no concern or interest in remedying the situation.

* Bare electrical wire, frayed cords, overloaded sockets or open sockets
* Exposed heating elements or fan blades
* Gas leaks
* No railings on stairs
* Broken, jagged, or sharp objects
* Unprotected windows, e.g., upper story windows which are uncovered yet accessible to a small child
* Medicines, cleaning compounds, and hot liquids within child’s reach
* Loose boards, holes in walls

**Sanitation**

* Overrun with vermin Urine-soaked mattresses
* Eating utensils obviously reused over and over again, without washing Human or animal feces on floors and walls
* Encrusted or multi-layered dirt throughout Toilets being used, but not in working order
* Garbage left to rot inside house

**Furnishings**

* Inadequate number of beds for number of persons residing in the home
* Stove not working
* Refrigerator not working
* Cupboards barren of food

**Utilities**

* Heating inoperable
* Electricity inoperable
* No water

**Space**

* Inadequate space and privacy relative to the number, and ages, of residents of the home

**Structure**

* Repairs needed to make the home habitable

**REFER TO CURRENT PUB-357 TO COMPARE CRITERIA FOR A REPORT**

\*Adapted from “Child Neglect Severity Scale,” developed by Aileeen Edington and Marilyn Hall, Dallas Children and Youth Project, Southwestern Medical School, University of Texas, Health Science Center, June 1980.

**EMOTIONAL MALTREATMENT (MENTAL INJURY)**

**EMOTIONAL MALTREATMENT** is injury to a juvenile’s intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the juvenile’s ability to function within the juvenile’s normal range of performance and behavior.

**INDICATORS:**

 Common, everyday occurrence

 A systematic belittling of character

 Consistent indifference to the needs for attention, praise, or affection

 A consistent attack on the fulfillment of needs

**PHYSICAL AND BEHAVIORAL INDICATORS OF EMOTIONAL MALTREATMENT**

|  |  |  |
| --- | --- | --- |
| **Type of Child Abuse/Neglect** | **Physical Indicators** | **Behavioral Indicators** |
| Emotional Maltreatment | Speech disorder  Lags in physical development  Failure to thrive (especially in infants) Asthma, severe allergies, or ulcers Substance abuse | Habit disorders (sucking, biting, rocking, etc.)  Conduct disorders (anti-social, destructive, etc.)  Neurotic traits (sleep disorders, inhibition of play)  Behavioral extremes:   * compliant, passive * aggressive, demanding   Overly adaptive behavior:   * inappropriately adult * inappropriately infantile   Developmental lags (mental, emotional)  Delinquent behavior (especially adolescents)  Self-mutilation |

\*From Cynthia Crosson Tower, *Child Abuse and Neglect: A Teacher’s Handbook for Detection, Reporting, and Classroom Management,* pp. 82-83. Copyright 1984 by the National Education Association of the United States. Reproduced with permission.

**IDENTIFYING EMOTIONAL MALTREATMENT**

|  |  |
| --- | --- |
| **PARENT** | **CHILD** |
| Does the parent: | Is the child: |
| * Describe the child as “bad” or “different” * Continually berate / belittle the child in the presence of the child or others * Humiliate the child publicly * Seem unable to accept the child as he / she is – limitations and potential * Demand excessive academic, athletic, or social performance * Withhold physical and verbal contact * Blame the child for the family’s problems * Use the child as a vehicle for marital fighting * Use gestures, tone of voice, or statements to intimidate * Destroy child’s possessions * Force the child to watch violence * Place the child in chaotic circumstances | * Disruptive, hyper-aggressive, or overly demanding * Timid, withdrawn, overly compliant * Exhibiting unaccountable learning difficulties * Manipulative * Exhibiting a sudden behavior change * Fearful of caregiver * Depressed / suicidal * Failure-to-thrive * Indifferent to caregiver * Experiencing eating disorders, sleep disorders * Experiencing intrusive memories, hyper-arousal, general inability to focus * Willfully injuring animals * Fire setting |

**PHYSICAL AND BEHAVIORAL INDICATORS OF SEXUAL ABUSE**

|  |  |  |
| --- | --- | --- |
| **Type of Child Abuse/**  **Neglect** | **Physical Indicators** | **Behavioral Indicators** |
| Sexual Abuse | Difficulty in walking or sitting  Torn, stained or bloody underclothing Pain or itching in genital area  Bruises or bleeding in external genitalia, vaginal or anal areas  Sexually transmitted disease  Frequent urinary or yeast infections Frequent unexplained sore throats Pregnancy | Unwilling to participate in certain physical activities  Sudden drop in school performance  Withdrawal, fantasy, or unusually infantile behavior  Crying with no provocation  Bizarre, sophisticated, or unusual sexual behavior or knowledge  Anorexia (especially adolescents) Sexually provocative  Poor peer relationship  Reports sexual assault by caretaker  Fear of or seductiveness toward males  Suicide attempts (especially adolescents)  Chronic runaway |

**\*From Cynthia Crosson Tower, *Child Abuse and Neglect: A Teacher’s Handbook for Detection, Reporting, and Classroom Management,* pp. 82-83. Copyright 1984 by the National Education Association of the United States. Reproduced with permission.**

**BEHAVIORAL INDICATORS**

Read the following scenarios. Evaluate the situations and determine if there are any behavioral indicators of sexual abuse.

1. You have been contacted by a worker at Kiddie Kat Day Care who works in the three-year-old room. She is concerned about possible sexual abuse of J, a three-year-old in her class. J’s mother has recently remarried, and J’s stepfather has been picking her up from the daycare. The teacher knows that there are approximately two hours between the time J is picked up and the time her mother gets home. J is somewhat reluctant to go with her stepfather at times, although lately she has been acting happy to see him when he gets there. The teacher has noticed that J frequently masturbates at naptime by rubbing against a soft toy. When questioned, J says she touches herself “because it feels good.” J recently told her teacher that “Daddies and boys have wienies.”
2. You have been contacted by a school counselor about eight-year-old K. The counselor is concerned about possible sexual abuse of K. K seems very quiet and reserved. This behavior is different from last year when K was seen as outgoing and sociable. K has been noticed hanging around the playground after school is out, but she always leaves if someone asks what she is doing. K is performing poorly in class, after having been an “A” student. She frequently seems sleepy or preoccupied. The counselor has talked to K. K was fearful, and anxious, but finally told the counselor she didn’t like “him touching me like that. It’s a dirty touch.” The counselor called the Hotline at that point.

**TABLE 1**

**Behaviors Related to Sex and Sexuality in Preschool Children**

|  |  |  |
| --- | --- | --- |
| ***NATURAL AND EXPECTED*** | ***OF CONCERN*** | ***SEEK PROFESSIONAL HELP*** |
| Touches/rubs own genitals when diapers are being changed; when going to sleep; when tense,  excited, or afraid. | Continues to touch/rub genitals in public after being told many times not to do this. | Touches/rubs self in public, or in private, to the exclusion of normal childhood activities. |
| Explores differences between males and females, boys and  girls. | Continues questions about genital differences after all  questions have been answered. | Plays male or female roles in an angry, sad, or aggressive  manner. Hates own/other sex. |
| Touches the genitals or breasts of familiar adults and children. | Touches the genitals or breasts of adults not in the family. Asks  to be touched himself/herself. | Sneakily touches adults. Makes others allow touching, demands  touching of self. |
| Takes advantage of opportunity to look at nude persons. | Stares at nude persons, even after having seen many persons  nude. | Asks people to take off their clothes. Tries forcibly to undress  people. |
| Asks about the genitals, breasts, intercourse, and babies. | Keeps asking people even after  parent has answered questions at age-appropriate level. | Asks strangers after parent has  answered. Sexual knowledge too great for age. |
| Erections | Continuous erections | Painful erections |
| Likes to be nude. May show others his/her genitals. | Wants to be nude in public after the parents say “No.” | Refuses to put on clothes. Secretly shows self in public,  after many scoldings. |
| Interested in watching people doing bathroom functions. | Interest in watching bathroom functions does not wane in  days/weeks. | Refuses to leave people alone in bathroom, forces way into  bathroom. |
| Interested in having/birthing a baby. | Boy’s interest does not wane after several days/weeks of play  about babies. | Displays fear or anger about babies, birthing, or intercourse. |
| Uses “dirty” words for bathroom and sexual functions. | Continues to use “dirty” words at home after parent says “No.” | Uses “dirty” words in public, and at home, after many scoldings. |
| Interested in own feces. | Smears feces on walls or floor more than one time. | Repeatedly plays or smears feces after scolding. |
| Plays doctor, inspecting others’ bodies. | Frequently plays doctor after being told “No.” | Forces child to play doctor, to take off clothes. |
| Puts something in the genitals or rectum of self or other *due to curiosity or exploration.* | Puts something in genitals or rectum of self or other child after being told “No.” | Uses coercion or force in putting something in genitals or rectum of other child. |
| Plays house, acts out roles of Mommy and Daddy. | Humps other children, with clothes on. | Simulated or real intercourse without clothes, oral sex. |

**1993 Toni Cavanagh Johnson, Ph.D**

**.**

**TABLE 2**

|  |  |  |
| --- | --- | --- |
| ***NATURAL AND EXPECTED*** | ***OF CONCERN*** | ***SEEK PROFESSIONAL HELP*** |
| Asks about the genitals, breasts, intercourse, and babies. | Shows fear or anxiety about sexual topics. | Endless questions about sex.  Sexual knowledge too great for age. |
| Interested in watching/peeking at people doing bathroom functions. | Keeps getting caught watching/peeking at others doing bathroom functions. | Refuses to leave people alone in the bathroom. |
| Uses “dirty” words for bathroom functions, genitals, and sex. | Continues to use “dirty” words with adults after parent says  “No” and punishes him/her. | Continues use of “dirty” words, even after exclusion from school  and activities. |
| Plays doctor, inspecting other’s bodies. | Frequently plays doctor, and gets caught, after being told  “No.” | Forces child to play doctor, to take off clothes. |
| Boys and girls show interest in having/birthing a baby. | Boy keeps making believe he is having a baby after months. | Displays fear or anger about babies or intercourse. |
| Shows others his/her genitals. | Wants to be nude in public, after the parent says “No” and  punishes child. | Refuses to put on clothes. Exposes self in public after many  scoldings. |
| Interested in urination and defecation. | Plays with feces. Purposefully urinates outside of toilet bowl. | Repeatedly plays with, or smears, feces. Purposefully  urinates on furniture. |
| Touches/rubs own genitals when going to sleep; when tense, excited, or afraid. | Continues to touch/rub genitals in public after being told “No.”  Masturbates on furniture, or with objects. | Touches/rubs self in public, or in private, to the exclusion of normal childhood activities.  Masturbates on people. |
| Plays house, may simulate all roles of Mommy and Daddy. | Humps other children, with clothes on. Imitates sexual behavior with dolls/stuffed toys. | Humps naked. Intercourse with another child. Forcing sex on other child. |
| Thinks other-sex children are “gross” or have “cooties.”  Chases them. | Uses “dirty” language when other children *really* complain. | Uses bad language about other child’s family. Hurts other-sex  children. |
| Talks about sex with friends. Talks about having a  girl/boyfriend. | Sex talk gets child in trouble. Romanticizes all relationships. | Talks about sex and sexual acts a lot. Repeatedly in trouble, with  regard to sexual behavior. |
| Wants privacy when in bathroom, or changing clothes. | Becomes very upset when observed changing clothes. | Aggressive or tearful in demand for privacy. |
| Likes to hear, and tell, “dirty” jokes. | Keeps getting caught telling “dirty” jokes. Makes sexual  sounds, e.g., moans. | Still tells “dirty” jokes, even after exclusion from school and  activities. |
| Looks at nude pictures. | Continuous fascination with  nude pictures. | Wants to masturbate to nude  pictures, or display them. |

**Behaviors Related to Sex and Sexuality in Kindergarten Through Fourth-Grade Children**

**TABLE 2** *Continued*

|  |  |  |
| --- | --- | --- |
| ***NATURAL AND EXPECTED*** | ***OF CONCERN*** | ***SEEK PROFESSIONAL HELP*** |
| Plays games related to sex and sexuality with same-aged  children. | Wants to play games related to sex and sexuality with much  younger/older children. | Forces others to play sexual games. A group of children  forces child(ren) to play. |
| Draws genitals on human figures. | Draws genitals on one figure and not another. Genitals’ size  disproportionate to body. | Genitals stand out as most prominent features. Drawings of  intercourse, group sex. |
| Explores differences between males and females, boys and  girls. | Confused about male/female differences after all questions  have been answered. | Play male or female roles in a sad, angry, or aggressive  manner. Hates own/other sex. |
| Takes advantage of opportunity to look at nude child or adult. | Stares/sneaks to stare at nude  persons, even after having seen many persons nude. | Asks people to take off their  clothes. Tries forcibly to undress people. |
| Pretends to be the opposite sex. | Wants to be the opposite sex. | Hates being own sex. Hates own genitals. |
| Wants to compare genitals with those of peer-aged friends. | Wants to compare genitals with those of much older, or much  younger, children or adults. | Demands to see the genitals, breasts, or buttocks of children  or adults. |
| Interested in touching genitals, breasts, or buttocks of other same-age children, or have child  touch his/hers. | Continuously wants to touch genitals, breasts, or buttocks of other child(ren). Tries to engage  in oral, anal, or vaginal sex. | Manipulates or forces other child to allow touching of genitals, breasts, or buttocks. Forced or  mutual oral, anal, or vaginal sex. |
| Kisses familiar adults and children. Allows kisses by familiar adults and children. | French kisses. Talks in sexualized manner with others. Fearful of hugs and kisses by adults. Gets upset with public displays of  affection. | Overly familiar with strangers. Talks/acts in a sexualized manner with unknown adults. Physical contact with adult  causes extreme agitation. |
| Looks at the genitals, buttocks, or breasts of adults. | Touches/stares at the genitals, breasts, or buttocks of adults.  Asks adult to touch him/her on genitals. | Sneakily or forcibly touches genitals, breasts, or buttocks of  adults. Tries to manipulate adult into touching him/her. |
| Erections. | Continuous Erections. | Painful Erections. |
| Puts something in own genitals/rectum *out of curiosity and exploration.* | Puts something in own genitals/rectum when it feels uncomfortable. Puts something in the genitals/rectum of other  child. | Uses coercion or force in putting something in genitals/rectum of other child. Anal, vaginal intercourse. Causing harm to  own/others’ genitals/rectum. |
| Interest in breeding behavior of animals. | Touching genitals of animals. | Sexual behaviors with animals. |

**1993 Toni Cavanagh Johnson, Ph.D.**

**INCEST STAGES**

**Intra-familial sexual abuse frequently passes through the following stages:**

* + Engagement
  + Sexual Interaction
  + Disclosure
  + Recanting/Suppression

**Some professionals list secrecy as an incest stage. However, for purposes of our discussion secrecy is assumed to be a dynamic that permeates all stages.**

|  |  |
| --- | --- |
| **Engaging- Key Issues**   * Building Trust * Favoritism * Alienation * Boundary Violations   **Sexual Interaction**   * Progression * Place * Time * Bribes, threats, punishment, guilt – to maintain the secret | **Disclosure**   * Accidental vs. Purposeful * Crisis   **Recanting/Suppression**   * System mobilizes to maintain status-quo * Overt/covert pressure * Victimizes by “helping” systems |

**PROGRESSION OF SEXUAL ACTS**

*Nudity*

***LEAST INTRUSIVE***

*Disrobing*

*Genital Exposure*

*Kissing – Lingering, Intimate Fondling*

*Masturbation*

*Fellatio*

*Cunnilingus*

*Digital Penetration of Anus or Vagina*

*Dry Intercourse*

***MOST INTRUSIVE***

*Vaginal and/or Anal Intercourse*

**SEXUAL ABUSE EXAMINATIONS**

**WHAT IS THE PURPOSE OF A MEDICAL EXAM?**

* The physician can detect, diagnose, and treat any physical injuries.
* The physician can diagnose, and treat, any sexually transmitted diseases.
* The physician can arrange for any needed follow-up treatment.
* The physician can collect medical/legal evidence.
* The physician or treatment team can meet the immediate psychosocial needs of the family, and offer crisis intervention services.
* The physician or treatment team can assure the child that his or her body is all right, or if the child has been injured, that he/she will heal.

**WHAT IS MEDICAL EVIDENCE?**

**WHAT ARE SIGNIFICANT FINDINGS?**

* Scars, lacerations, notches
* Thickening or wearing away of the hymen
* Lax anal tone
* Hemorrhoids, fissures, anal dilatation

**WHAT FINDINGS ARE MOST SIGNIFICANT?**

* Sexually transmitted diseases, specifically syphilis, gonorrhea, and chlamydia
* Sperm
* Pregnant

**WORKING WITH NON-OFFENDING PARENTS**

Involving parents in treatment is crucial for overcoming the damage of sexual abuse, and for stopping the cycle of abuse. Parents can be a tremendous support to their children. Even parents who were aware of abuse can make changes, and rebuild a positive relationship with the victim, one built on trust and commitment. Parents play a crucial role in children’s lives, and also play a critical role in recovering from sexual abuse. It will be in the best interest of the child for workers and therapists to help parents become more aware, concerned, and protective of their child.

1. **CRISIS INTERVENTION**
   * Deal with the parent’s personal needs so they may focus on the child and his/her needs.
   * Meet the parent’s basic survival needs first.
   * Praise parents for what they have done right.
   * Empower parents by giving them specific tasks, e.g., talking with the child, following through with legal authorities, therapists, etc.
   * Confront denial and recants directly.

**Crisis Intervention Goals**

1. Gain an intellectual understanding of sexual abuse.
2. Get feelings out, and gain mastery over them.
3. Explore past and present coping mechanisms.
4. Find, and use, situational supports.
5. Work on a plan to reduce the trauma and protect the child.
6. Learn typical reactions and signs of stress in children (parents need to see the abuse from the child’s perspective).
7. **DISCUSSING SEXUAL ABUSE WITH THE VICTIM**

* Encourage parent to allow the child to talk about the abuse (parents should not pressure child to go over specifics of assault).
* Focus on the child’s feelings with reflective messages, e.g., “I’m sorry you got hurt,” “It was not your fault,” “I believe you.”
* Discuss “safe people” for a child to talk to about the abuse.

1. **SUPPORT GROUPS FOR MOTHERS**

* Two types: short-term, crisis intervention, and long-term support and skill building experiences.
* Help the mother decide whom to believe (child or partner?).
* Give information about sexual abuse (dynamics, law/protocol).
* Help mothers negotiate the system of support services.
* Discuss sexual abuse prevention.
* Put strategies in place to deal with mother’s denial.

1. **TREATMENT ISSUE FOR MOTHERS**

* Dealing with guilt for not knowing about, or stopping, the abuse
* Feeling pressure to keep families together and to solve all their problems
* Dealing with real or imagined fear
* Working on trust issues
* Dealing with a history of failure and low self-esteem
* Treating acute or chronic depression
* Learning to constructively deal with anger
* Dealing with abusive relationships
* Overcoming the “victim” lifestyle
* Recognizing power/responsibility issues
* Developing a sense of healthy sexuality
* Rebuilding the mother-daughter bond

**POEM WRITTEN BY A TWELVE-YEAR-OLD GIRL, WHO IS AN INCEST SURVIVOR**

Do you know what it’s like when your sisters hate you?

-and your brother calls you a liar?

Do you know what it’s like to be the one everyone blames for the trouble…?

When all you wanted was some help?

I asked you for help, and you told me you would,

If I told you the things my Dad did to me.

I asked you for privacy and you told me to trust you,

Then you made me tell my story to fourteen strangers.

And you sent two policemen to my school, who said in front of everyone,

“Let’s go downtown for a talk,”

Like I was the one being busted.

I asked you to believe me, and you said that you would…

Then you connected me to a lie detector test,

Like you really didn’t.

I asked you for help and you gave me a doctor

Who spread my legs and stared

Just like my Father…

Who said it wouldn’t hurt – just like my Father…

Who said, “Relax – it will be over soon” –

Just like my Father.

I asked you for protection, and you gave me a social worker

that grinned and called me Honey…

Then you sent me to live with strangers in another place,

With another school –

While he went home on bail.

Do you know what it’s like to live where there’s a lock on the refrigerator?

-Where you have to ask permission to use the shampoo,

And where you’re not allowed to call your friends.

I asked you to put an end to the abuse; You’re putting an end to my whole family.

So, it’s my word against his now;

I’m twelve years old-

And he’s the manager of a bank.

You say you believe me – Who cares?

If nobody else does.

Your questions got me confused;

My confusion got you suspicious.

I can’t help it if I can’t remember dates,

Or explain why I couldn’t tell my Mom.

I asked you for help.

I asked you to believe me. I asked you for protection.

You told me to trust you.

**CHILD HEALTH ISSUES AGENDA**

1. **Failure to Thrive/SIDS**
2. **ADHD**
3. **Depression**
4. **Reactive Attachment Disorder**
5. **PACE Exam for Children in Out-Of-Home Care**

**OBJECTIVES:**

***At the completion of this training, the Program Assistant will:***

* Know signs of FTT and SIDS and some PA interventions for both.
* Be able to identify the difference between ADD and ADHD and symptoms of both.
* Be able to demonstrate a beginning skill level of ADD/ADHD by recognizing some behavioral indicators.
* Be able to recognize some of the symptoms and risk factors of depression.
* Review how to prepare for taking children in out-of-home care to PACE exams and be able to ask questions about child health issues from someone who works with the PACE Program

**FAILURE-TO-THRIVE**

Failure-to-Thrive is a term applied to children under three years of age that are not growing at the rate expected for their age and sex. Children whose weight persistently falls below the established growth curve or whose weight when plotted on the growth chart crosses two major percentile lines over time are considered Failure-to-Thrive. Many of these children have delayed developmental skills. If the weight is decreased enough there may also be abnormal head circumference and body length.

**Causes of Failure-To-Thrive**

**Organic:** These children have medical conditions that explain their failure to thrive. These may be problems with their gastrointestinal, neurological, respiratory-pulmonary, cardiovascular, or endocrine systems. Cases of Failure-to-Thrive with purely organic causes will not be on the DCFS case-load.

**Inorganic:** Failure-to-Thrive in these children cannot be explained by medical problems. Causal factors are environmental, instead of biological.

**Mixed Interaction:** These cases have a mixture of causal factors, including medical problems and environmental conditions.

Many theorists and clinicians are moving away from the organic/inorganic classification. In most cases, multiple features of the child, family, and the environment interact and result in failure-to-thrive.

**Factors in Inorganic FTT:**

* **Poverty** – unemployment; unstable housing; lapse in financial assistance, may “water down” formula to save money.
* **Family Conflict and/or Dysfunction** – marital problems; domestic violence; crisis- oriented; caring for several small children.
* **Isolation** – parental abuse or inconsistency; lack of support systems (formal or informal); lack of social relationships.
* **Maternal Characteristics** – childhood experience of loss, separation, abuse/neglect; absent, ill, or abusive maternal caregiver; absent father; depression; often perceive baby negatively (“greedy,” “bad,” “hyper”); low self-esteem; chronic anger; chronically ill or fatigued; anxious; feelings of inadequacy and being overwhelmed.
* **Substance Abuse by Caregiver** – keeps parents from responding to child’s needs; takes family’s money for food.
* **Poor Information** – Parents do not have adequate knowledge of child development and nutrition.
* **Child’s Characteristics** – difficult feeders, temperament, appearance, and personality.

**FAILURE-TO-THRIVE**

**WHAT TO WATCH FOR:**

**Maternal Characteristics**

* Depressed, apathetic
* States child as “bad,” “greedy,” “hyper”
* Views child who never cries or wants attention as a “good baby”
* Waters down formula
* Has inadequate or incorrect knowledge about child development or nutrition
* Has childhood history of loss, deprivation, abuse

**Child Characteristics**

* Undernourished appearance; seems small for age
* Apathy, irritability, and sadness
* Less responsive and vocal than other children of same age
* Gaze abnormalities – either stares or refuses to make eye contact
* Less smiling
* Decreased cuddliness – may appear “stiff”
* Decreased interest in toys
* Diarrhea or vomiting

**Behaviors Related to Eating**

* Caregiver doesn’t take cues from child; she decides when the child has “had enough”; may terminate meal arbitrarily
* Caregiver spends less time looking at infant while feeding; may prop the bottle up for the infant instead of holding child
* Caregiver has difficulty pacing the meal; may feed quickly to “get it over with”
* Caregiver allows child to “graze”; child does not sit at the table, but instead moves around the house, eating little bits of food throughout the day; child eats less regular, skimpier meals
* Child is less enthusiastic about eating; may resist eating
* Child allowed to eat “junk food” to the exclusion of other, more nutritious foods
* Infant started on cereal, solid foods too early; drinks juice, water, soda, instead of milk or formula

**PA INTERVENTIONS**

* Obtain copy of nutritional plan developed by child’s doctor from family’s FSW. Help family follow plan.
* Generally, the following tips are recommended (but, refer to child’s specific nutritional plan before encouraging):
* Decrease intake of liquids other than milk or formula
* Decrease/eliminate chips, candy, cookies, etc.
* Add butter to anything!! Increases fat and calorie content
* No naked bread or crackers! – add peanut butter or cheese
* Use high-calorie formula in cooking anything that calls for milk
* Make sure there is enough formula in the home. If an additive (such as Polycose) is to be used, is it in the home?
* Make sure formula is being mixed properly. Mix formula for caregiver and then watch them mix some.
* Is there a high chair in the home? “Sippee cups” or bottle? Are the bottles clean?
* Make sure food is available in the home for older children.
* Observe feedings. No propped bottles! Does toddler sit in high chair? Are there regular mealtimes? Are they loud, chaotic? Does caregiver sit and assist the child with meal? Assist caregiver in learning how to appropriately supervise mealtime.
* Role-model for caregivers how to hold and nurture children.

This information was compiled from materials from two trainings:

“Failure to Thrive and Intrauterine Drug Exposure – A Training for DCFS” by Malinda Webb, M.D., Donna Holmes, R.N., and Lynn Sims, LCSW. Growth and Development Clinic, Arkansas Children’s Hospital. January 11, 1996. “Failure-to-Thrive: A Community Care Perspective.” Pine Bluff, October 5, 1995

**SUDDEN INFANT DEATH SYNDROME (SIDS)**

* Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant between one week of age and 12 months of age and the cause of the death remains unexplained after the following occurs:
  + A thorough case investigation, including the performance of a complete autopsy;
  + Examination of the death scene; and
  + Review of the clinical history.
* Death occurs within seconds, usually during sleep. The child does not suffer.
  + SIDS is not caused by suffocation or aspiration.
  + SIDS is not caused by abuse or by immunizations.
  + SIDS is not contagious or hereditary.
* SIDS occurs in families at all social and economic levels.
* There is no way to determine which baby will die of SIDS. Presently there is no way anyone can prevent the death.
* Rebreathing theory – infants sleeping in the prone (stomach) position are rebreathing trapped air and unable to sense and respond to the excess of carbon dioxide, die suddenly. An infant’s chest is “floppier” than an older child’s because it has cartilage instead of bone, and so an infant’s diaphragm has to work harder to breathe than does the older child’s diaphragm. The infant’s diaphragm also gets tired more easily in a baby, and the trachea (windpipe) is softer and more likely to kink or collapse. The older child would be less likely to suffer respiratory obstruction and more likely to have muscles and skeletal support, thus decreasing the probability of SIDS in children over 12 months old.

**IDEAS ABOUT SIDS FOR PAs**

**You can reduce the risk of SIDS by:**

* Putting a healthy baby to sleep on their back.
* Making sure the child is sleeping on a firm mattress or other firm surface.
* Not using fluffy blankets or comforters under the baby.
* Not letting the baby sleep on a waterbed.
* Not letting the baby sleep on a sheep-skin, a pillow, or other soft materials.
* Creating a smoke-free zone around the baby. Infants exposed have more colds and other upper-respiratory-tract infections, increasing the risk of SIDS.
* Calling the doctor or health provider right away if the baby seems sick.
* Making sure the baby’s mother receives early and regular pre-natal care.
* Breast-feeding the baby. Breast milk contains antibodies and nutrients to keep the baby healthy.
* Not sharing sleep surfaces with the baby

**ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)**

* Symptoms of the condition known as ADHD are behaviors such as:

1. Impulsivity
2. A tendency to be distracted.
3. Hyperactive movement.

*(Note: These symptoms literally disrupt a child’s ability to concentrate.)*

* Children with ADHD have difficulty remaining still for even short periods of time.
* Children with ADHD are often:

1. Aggressive
2. Rejected by peers
3. Have lowered self-esteem

* The Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition DSM – V) contains very specific guidelines for determining ADHD. The behaviors must:

1. Appear early in life;
2. Appear before age twelve; and
3. Continue for at least six months.

* In children, they must be more frequent or severe than in others in the same age group.
* Above all, the behaviors must create a real handicap in at least two areas of a person’s life, such as school, home, work, or social setting.

**Symptoms of the condition of ADHD are characteristic behaviors consistently displayed over a period of time.**

There are three major behavioral categories:

1. Inattention – Child has a hard time keeping his/her mind on any one thing and may get bored with a task after only a few minutes. Child may give effortless, automatic attention to activities and things he/she enjoys, but focusing deliberate, conscious attention to organizing and completing a task or learning something new is difficult.

***Some signs of inattention according to the DSM-V are:***

* Often has difficulty sustaining attention in tasks or play activities;
* Often fails to pay attention to details and makes careless mistakes;
* Often does not seem to listen when spoken to directly;
* Often loses things necessary for tasks or activities (e.g. schoolwork, keys).

1. Hyperactivity – Child will always seem to be in motion. It is hard for the child to sit still and he/she may dash around or talk incessantly. Sitting through a lesson can be an impossible task.
2. Impulsivity – Child may seem unable to curb his/her immediate reactions or to think before he/she acts. It may be hard for impulsive children to wait for things they want or wait their turn in games. They may grab toys from other children or hit when they are upset.

**Some signs of Hyperactivity and Impulsivity are:**

* Feeling restless, often fidgeting with hands or feet, or squirming;
* Running, climbing, or leaving a seat in situations where sitting or quiet behavior is expected;
* Blurting out answers before hearing the whole question;
* Having difficulty waiting in line or for a turn

**There Is No Cure For Attention Deficit Hyperactivity Disorder.**

* Effects can be reduced through an approach that combines medicine, psychology, and education.
* Medicines produce a clear and immediate short-term effect in behaviors of children with ADHD. Medications used to treat ADHD are stimulant medicines such as:
* Ritalin
* Dexedrine
* Adderall
* These medicines allow the brain and nervous system to communicate with the rest of the body more effectively, which improves attention span, concentration, motor control, and on-task behavior, while reducing hyperactivity.

**Some side effects of using stimulant medicines are:**

1. Loss of weight
2. Loss of appetite
3. Problems falling asleep

* ADD children perform best when they have an organized structure with consistent rules so that they can clearly understand what they are doing and what they should do next.

**What *CAN* look like ADHD:**

* Underachievement at school due to a learning disability.
* Attention lapses caused by petit mal seizures.
* Middle ear infections that cause an intermittent hearing problem.
* Disruptive or unresponsive behavior due to anxiety or depression.
* PTSD Symptoms related to trauma

**What ADHD is *NOT* usually caused by:**

* Too much TV
* Food allergies
* Excess sugar
* Poor home life
* Poor Schools

**INFORMATION TO SHARE WITH PARENTS ABOUT ADHD**

1. Educate yourself about ADHD.
2. Work cooperatively with your child’s teachers, school administrators, special learning consultants, or school board when necessary.
3. Educate others and advocate for your child.
4. When first learning about ADHD, it can be helpful to talk with parents who have been rearing a child diagnosed with ADHD.
5. Get acquainted with other parents who have children with ADHD.
6. You may not be able to keep your anxieties from your child.
7. Allow yourself the time you need to grieve.
8. With information and support, most parents will move through the grief process to acceptance.
9. Get rest whenever possible.
10. Your child needs to have well-balanced parents.
11. If you are married, take the time to be alone with your spouse.
12. Believe in yourself as a good parent.
13. Inappropriate behavior is just that.
14. In raising children, there are no guarantees for success.
15. Be positive.
16. Being the sibling of a child with ADHD is also a challenging job.
17. Children with ADHD have difficult childhoods.
18. If you have a supportive religious community, consider yourself truly blessed.
19. Put things in perspective.

**DO YOU THINK YOU OR YOUR CHILD HAS ADHD?**

If most of the statements below apply to you or a loved one, you should have an evaluation and specific testing to determine this. There is treatment.

* Excessively fidgets or squirms. Likes to always be “on the go.”
* Has difficulty remaining seated in school or a meeting.
* Is easily distracted.
* Has difficulty awaiting turn in games or lines.
* Interrupts frequently.
* Has difficulty following instructions.
* Has difficulty sustaining attention.
* Shifts from one activity to another.
* Often talks excessively (even when trying not to).
* Often doesn’t listen to what is said.
* Often loses things.
* Often engages in dangerous activities.
* Often acts impulsively.
* Is often accused of overreacting or flying off the handle.
* Often feels that life is overly stressful.

There are many strategies and treatment options for dealing with ADHD. A good treatment plan includes counseling, education of parents and teachers, and sometimes includes medication.

All children need specific structure, discipline, and boundaries, but ADHD children are especially challenging because they do best with one-on-one and repeated instruction and a lot of structure.

**TEN STRATEGIES FOR KIDS WITH ADHD**

1. **Warning, warning!!**

Children with ADHD have a tough time moving from one task or activity to another. Try to give advanced warning about change (for example: “You need to be ready to go in ten minutes.”)

1. **Provide check points.**

For long-term projects or tasks, try breaking them into small attainable goals with transition aids. Rewards or someone acting as a coach helps the child move on to the next task.

1. **Clarify rules and consequences.**

Set clear, fair rules, and then be sure to enforce them. Help the child understand what the rewards are for good behavior and what the consequences are for bad behavior. Time-outs and removal of privileges are commonly-used consequences for inappropriate behaviors.

1. **Provide structure and consistency.**

Children with ADHD need to have a predictable environment.

1. **Work as a team with other adults.**

Teachers and parents can work together on specific goals reinforcing specific strategies.

1. **Create a positive environment.**

Create and maintain an environment that helps your child to succeed. Experiment to see what works. Sometimes a quiet place in a classroom or at home can help a child concentrate.

1. **Keep time.**

Using a timer can help keep a child on task by providing a reminder of what they are supposed to do. Sometimes just the ticking of the timer will work. It can also be used to help manage time so that specific tasks are accomplished within a certain time period. A watch with an alarm can be set to provide reminders to do certain tasks.

1. **Take time.**

Realize that your child might just need more time than other kids. Allow extra time for him/her to find and get on their shoes. Let your child live at his/her pace!

1. **Take time off.**

Allow for down time. Kids with ADHD need time to burn off steam. They need time to play, run, and laugh. Engaging in sports and physical activities can help children to harness their energies and learn to focus it when they need to.

1. **Don’t forget to laugh.**

Don’t forget to keep a sense of humor. Setting structure, rewards, and consequences is hard work so don’t forget to enjoy your child.

**DEPRESSION SYMPTOMS**

Not all people with depression will have all of these symptoms or have them to the same degree.

If a person has five or more of these symptoms nearly every day for two (2) weeks or more and nothing can make them go away, a doctor or psychiatrist should be consulted for an evaluation.

1. Persistent sad, irritable, or “empty” mood.
2. Feelings of hopelessness, pessimism.
3. Feelings of guilt, worthlessness, helplessness.
4. Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex.
5. Insomnia, early-morning awakening, or oversleeping.
6. Appetite and/or weight loss or overeating and weight gain.
7. Decreased energy, fatigue, tiredness.
8. Restlessness, irritability, or being “slowed down.”
9. Difficulty concentrating, remembering, making decisions.
10. Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain.
11. Thoughts of death or suicide; suicide attempts.

Note: “Most children suffering from depression don’t say that they are sad. They don’t even appear gloomy. Instead, they are often extremely irritable.”

Dr. Paramj and Kaur Joshi – Psychiatrists

**DEPRESSION RISK FACTORS**

**The diagnosis for depression in adults and children is not as clear-cut as it is for other illnesses. There is no test that can be given which will positively say that an individual has depression, much less pinpoint the cause(s). We do know that certain people have risk factors in their lives that could predispose them to depression or could “trigger” depression. These risk factors are listed below.**

* Heredity or family history;
* Chronic medical condition;
* Substance abuse;
* Reproductive issues;
* Personality styles;
* Domestic violence or sexual abuse;
* Marriage and children; and
* Poverty and minority status.

***Risk Factors for Children:***

* Repeated physical, emotional, or verbal abuse;
* Separation, divorce of parents or even close relatives;
* Loss of customary surroundings, family, or close friends;
* Move from one town, or even one neighborhood to another;
* Death of loved ones, friends, or even pets;
* Negative self and world views;
* Social skills deficits;
* Inability to problem solve; and
* Academic or athletic failures.

***NOTE:*****Depression can be wholly chemical, wholly due to psychological risk factors, or a combination of the two. More important than the cause, is identifying the illness and treating it as soon as possible.**

**DEPRESSION IN CHILDREN**

Signs of Depression in Children

Changes in behavior are one of the better ways to recognize depression in children. The following is a list of some behaviors which may indicate that a child is experiencing depression:

* Child may no longer play with their favorite or preferred toys
* Child may no longer engage in their favorite types of play or activities
* Child may no longer wish to engage in their routine day-to-day activities
* Child may have less energy or frequently report being tired
* Child may complain about physical symptoms such as head or stomach aches
* Child may experience significant changes in appetite or sleep patterns
* Child may not “act like” they are depressed or sad
* Child may be irritable
* Child may begin to engage in tantrum behavior(s)

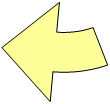
If any of these behaviors last for two weeks or longer, caregivers should consider the possibility that the child is suffering from depression.

**If you suspect a child under your care or supervision is suffering from depression:**

* Consult with the child’s pediatrician or other primary care provider (PCP) immediately. The child’s pediatrician or PCP may have contact information for area therapists who specialize in working with children.
* Stay involved and monitor child’s behavior.
* Spend time with the child. Engage the child in conversations and be sure to be attentive, understanding, and empathetic to the child’s perspective.
* If possible, maintain child’s regular routine including meals and sleep.
* Be proactive and create regular opportunities for the child to engage in physical activity. Even something as simple as “play dates” with friends and/or siblings are often therapeutic for a child experiencing symptoms of depression.

**Remember**

* The source of a child’s depression may not be easily recognizable. In regards to children, their first substantial experience with depression often begins with a significant stressor or life event (separation from family, parental divorce, death of a loved one, etc.).
* There are some types of depression that are considered to be a normal or expected phases of the human experience. Consult with a mental health professional who can identify whether or not the child’s depression would be best addressed with outside intervention



Baby protests, usually by crying

Mother does not respond to baby’s cry or else responds inconsistently

**REACTIVE ATTACHMENT DISORDER**

1. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
2. The child rarely or minimally seeks comfort when distressed.
3. The child rarely or minimally responds to comfort when distressed.
4. A persistent social and emotional disturbance characterized by at least two of the following:
5. Minimal social and emotional responsiveness to others.
6. Limited positive affect.
7. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
8. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
9. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
10. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in out-of-home care).
11. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
12. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).
13. The criteria are not met for autism spectrum disorder.
14. The disturbance is evident before age 5 years.
15. The child has a developmental age of at least 9 months.

Source: DSM V (Diagnostic & Statistical Manual of Mental Disorders)

**WHAT IS REACTIVE ATTACHMENT DISORDER?**

*The Diagnostic and Statistical Manual 5th Edition (DSM-5)* classifies reactive attachment disorder as a trauma- and stressor-related condition of early childhood caused by social neglect and maltreatment. Affected children have difficulty forming emotional attachments to others, show a decreased ability to experience positive emotion, cannot seek or accept physical or emotional closeness, and may react violently when held, cuddled, or comforted. Behaviorally, affected children are unpredictable, difficult to console, and difficult to discipline. Moods fluctuate erratically, and children may seem to live in a “flight, fight, or freeze” mode. Most have a strong desire to control their environment and make their own decisions. Changes in routine, attempts to control, or unsolicited invitations to comfort may elicit rage, violence, or self-injurious behavior. In the classroom, these challenges inhibit the acquisition of core academic skills and lead to rejection from teachers and peers alike. As they approach adolescence and adulthood, socially neglected children are more likely than their neuro-typical peers to engage in high-risk sexual behavior, substance abuse, have an involvement with the legal system, and experience incarceration.

**Cognition**

Abuse in childhood has been correlated with difficulties in working memory and executive functioning, while severe neglect is associated with underdevelopment of the left cerebral hemisphere and the hippocampus.

**Behavioral**

Social skills are below what would be expected of either their chronological age or developmental level. Children with RAD may respond to ordinary interactions with aggression, fear, defiance, or rage. Affected children are more likely to face rejection by adults and peers, develop a negative self-schema, and experience somatic symptoms of distress. Psychomotor restlessness is common, as is hyperactivity and stereotypic movements, such as hand flapping or rocking.

**Affective**

RAD increases the risk of anxiety, depression, hyperactivity, and reduces frustration tolerance. Ailing children are likely to be highly reactive, even in non-threatening situations.

*Information obtained from:* [*https://www.ncbi.nlm.nih.gov/*](https://www.ncbi.nlm.nih.gov/)

**TENETS OF THERAPLAY**

1. The primary motivating force in human behavior is a drive toward relatedness.
2. Individual personality development is interpersonal.
3. Early interaction between parent and child is the framework from which the self/personality develops.
4. Attachment results from playful, joyful, empathic, attuned responsiveness of caretakers and is essential to the development of a strong sense of self, feelings of self-worth and secure attachments.
5. Empathic responsiveness alone does not create attachment.
6. Also need energy, playfulness, joy
7. The capacity to soothe and nurture oneself in later life depends on early experiences of being soothed and nurtured.
8. Holding environment calm, nurturing, safe
9. Good enough mothering
10. Psychopathology results when early and ongoing experience leads to negative or inadequate sense of self. Without positive and responsive interactions, the child begins to:
11. View themselves as unlovable
12. View world as unsafe and full of threat