



**CHARTING THE COURSE TOWARDS
PERMANENCY
FOR CHILDREN IN PENNSYLVANIA:
A Knowledge and Skills-Based Curriculum**

**MODULE NINE (9)
CHILD DEVELOPMENT**

A Training Outline

**Developed by:
The Pennsylvania Child Welfare
Training Program**

**University of Pittsburgh,
School of Social Work
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Module 9: Child Development

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Module 9: Child Development

Agenda for One-Day Workshop on Module 9: Child Development

Estimated Time	Content	Page
50 minutes	Section I: Introduction	3
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Module 9: Child Development

Section I: Introduction

Estimated Length of Time:

50 minutes

Learning Objectives:

Participants will be able to:

- ✓ Recognize the competencies and learning objectives for Module 5.
- ✓ Identify level of knowledge concerning child development

Methods of Presentation:

Lecture, Large Group Activity, Individual Activity

Materials Needed:

- ✓ Name Tents
- ✓ Colored Markers
- ✓ Overhead projector and screen
- ✓ **Handout #1 (Learning Objectives and Competencies)**
- ✓ **Handout #2 (Agenda)**
- ✓ **Handout #3 (The Learning Grid)**
- ✓ **Overhead #1 (Learning Objectives)**
- ✓ **Overhead #2 (Agenda)**

Outline of Presentation:

- Prepare the training room
- Welcome trainees to Charting the Course for Children in Pennsylvania
- Introduce himself/herself to the group
- Facilitate trainee introductions
- Review the learning objectives for the session using **Overhead #1 (Learning Objectives)** and **Handout #1 (Learning Objectives and Competencies)**

Section I: Introduction

Trainer Note: Prepare a poster for the wall entitled WIIFM (What's In It For Me)?

Trainer Note: Prepare the training room in advance by placing name tents, markers, and handout packets at each table. As participants arrive, greet each one.

Transfer of Learning Note: As trainees enter the room, ask them if they completed their assigned pre-work. Trainees should have:

- 1) Observed a child under the age of five and note if the child appears to have any developmental delays. If so, what did you see, hear, or observe that lead you to that conclusion? If not, what did you see, hear or observe that lead you to conclude that the child was developmentally on target for their age?
- 2) Asked a colleague what programs/resources are available to conduct child developmental evaluations.

Tell them they will be referred to their TOL activities during the training. If they do not have their pre-work, trainer should discuss the importance of preparing for training and make recommendations. (Such as how the trainee can remember to complete their pre-work for the next section.)

Step 1: (5 minutes)

Lecture:

Trainer Note: If you are working with a cohort this may be a very brief reminder.

The trainer starts the training session by covering the following points:

1. Welcome participants to the training.
2. Introduce the trainer
3. Complete name tent
4. Remind participants of the classroom cultural including:
 - Be on time -15 minute rule
 - Training Schedule – 9:00 to 4:00 with Breaks
 - Document your presence -sign-in sheet
 - Provide Constructive and Motivational Feedback
 - Respect
 - Risk taking
 - Practice makes permanent
 - Focus on Learning - No cell phones, put pagers on vibrate, & only contact office for emergencies

Step 2: (5 minutes)
Individual Activity

This step is eliminated, if the training is for a cohort group. These participants will complete their name tents upon arrival. If this training session is not part of a cohort group guide participants through the completion of their name tents.

The trainer instructs participants to write the county in which they work in the top right corner of the nameplate. The trainer instructs participants to write their position in the agency in the top left corner.

The trainer asks participants to write the amount of time they have been in their position in the bottom left corner. The trainer asks participants to write the amount of experience they have in child welfare in the bottom right corner.

When the name and four corners are complete, the trainer asks participants to stand their name tent in front of them.

The trainer asks participants to share introductory information from their name plates with the others seated at their table.

Trainer should ask participants to think of one thing that they want to learn about child development. Participants should write this thought on the WIIFM poster. At the end of the training, review the WIIFM poster and make sure that all of the concerns and questions have been addressed.

Step 3: (5 minutes)
Lecture

The trainer refers participants to their workshop packets and reviews the competencies, objectives, and agenda for the workshop. **Handout # 1 (Learning Objectives and Competencies)** and **Overhead #1 (Learning Objectives)**. The trainer describes how the learning objectives will be accomplished by reviewing the **Handout #2 (Agenda)** and **Overhead #2 (Agenda)**.

Inform participants that it is critical for Child Welfare Professionals to understand the domains and milestones of “normal” child and adolescent development and how to utilize this knowledge in child welfare practice. During intake and investigation of the allegations of child abuse and neglect, the application of this theoretical framework is critical for identifying visible and not so noticeable damaging effects on the child’s development. Any evidence of developmental delays should provide the basis for recommendations for expert evaluations. The trainer will address how to evaluate ASFA-specific health and mental health well-being outcomes with the use of child and adolescent development milestone indicators. The trainer will also emphasize the importance of a safe family environment that supports and promotes a child’s well-being.

Step 4: (5 Minutes)
Large Group Activity

Refer participants to **Handout #3 (The Learning Grid)**.

Trainer Note: This activity provides a “visual” of the group’s current level of knowledge. It will help assess what the participants already know about the effects of abuse and neglect on child development. The trainer must use the information to adapt training content. Repeat this activity at the close of the training so the group and you can see the shift in learning. This activity will assist participants in identifying the learning they experienced during training. When completing the grid tell them to tune in to self and consider how confident they feel with their current level of knowledge and skills.

Trainer Note: Making **Handout #3 (The Learning Grid)** into a wall poster and having participants put their name on a post it note and placing it by the appropriate statement will provide a visual of the group’s current knowledge of child development.

Trainer reads the seven statements on **Handout #3 (The Learning Grid)** to participants. After reading the statements, participants are directed to mark their handout with what they believe to be their current level of knowledge. The participants should start at the bottom of the grid and work up. Their highest level of knowledge is where they stop as they travel up the grid.

After the participants have marked their perceived current level of child development knowledge, the trainer should explain that this exercise helps the trainer to gauge the overall level of knowledge in the room. Trainer should also encourage the participants by telling them that by the end of the training day, their knowledge will be increased. Trainer should go around the room and identify participants who marked either #7, #6, #5, or #4. Trainer must be sure that each table has at least (1) participant who marked their knowledge at one of these levels.

Transfer of Learning Note: Remind participants that their pre work for Module 9 was to observe a child under the age of five and note if the child appears to have any developmental delays. Ask participants: If so, what did you see, hear, or observe that lead you to that conclusion? If not, what did you see, hear or observe that lead you to conclude that the child was developmentally on target for their age?

Step 5: (30 minutes)
Video

Trainer Note: Start the video at the beginning and stop it after approximately 24 minutes when the screen displays the segment on “Child Care”.

Explain to participants that the video they are about to see, *I Am Your Child: The First Years Last Forever*, is an introductory video that teaches the vital importance of the relationship between caregiver and child in the critical first years of life. It includes information on bonding and attachment, communication, health and nutrition, discipline, self-esteem, and self-awareness. The video will set up the participants for the rest of the day's content on child development.

Module 9: Child Development

Section II: Applying Principles of Development to Child Welfare Services

Estimated Length of Time:

2 hours, 30 minutes

Learning Objectives:

Participants will be able to:

- ✓ Recognize why knowledge and understanding of the principles and milestones of child development are essential for effective Child Welfare practice.

Methods of Presentation:

Lecture, Small Group Activity, Individual Activity, Large Group Discussions

Materials Needed:

- ✓ Blank Flip Chart Paper (individual pieces)
- ✓ Blank Flip Chart
- ✓ Colored Markers
- ✓ Masking Tape
- ✓ Overhead projector and screen
- ✓ **Child & Adolescent Development Resource Book**
- ✓ **Handout #4 (Developmental Milestone Areas of Growth: Ages 0-24 months)**
- ✓ **Handout #5 (Developmental Milestone Areas of Growth: Ages 2-5 years)**
- ✓ **Handout #6 (Developmental Milestone Areas of Growth: Ages 6-11 years)**
- ✓ **Handout #7 (Developmental Milestone Areas of Growth: Ages 11-14 years)**
- ✓ **Handout #8 (Developmental Milestone Areas of Growth: Ages 15-18 years)**
- ✓ **Overhead #3 (Questions for Individual Group Discussion)**
- ✓ **Overhead #4 (Definition of Development)**
- ✓ **Overhead #5 (The Influence of Environment on Development)**
- ✓ **Overhead #6 (Developmental Domains)**

Outline of Presentation:

- Review effects of child maltreatment on child development
- Review the Child and Adolescent Resource Book
- Review principles of child development
- Review nature vs. nurture factors
- Review “normal” vs. “abnormal” child development
- Review developmental domains

Section II: Applying Principles of Development to Child Welfare Services

Step 1: (20 minutes) Small Group Activity

The trainer begins the discussion on child development by having the participants count off 1-2-3-4, and dividing into four small groups. After moving to their assigned table, each group should appoint a recorder and a presenter. If the group cannot agree, the trainer suggests that the presenter be: (1) the participant whose next birthday is closest to today or (2) the participant whose last birthday is closest to today.

Give the groups 15 minutes to complete their part of the exercise. Give each group a sheet of flip chart paper to record their answers to the questions listed on **Overhead #3 (Questions for Individual Group Discussion)**. The recorder must write the question at the top of their piece of flip chart paper.

Group #1: List reasons how knowledge and understanding of the principles of child development could improve child welfare practice.

Group #2: What are some of the effects of maltreatment on child development?

Group #3: Identify and list types of developmental information Child Welfare Professionals must know to be most effective in their jobs.

Group #4: What should a Child Welfare Professional do if they believe they have encountered a developmental problem with a child?

At the end of the time allotted, have each group post their completed flip chart papers on the wall. Starting with group #1, have each group scribe present their work and tell why their answers are important to a Child Welfare Professional.

The trainer must support (and elaborate, if necessary) every answer while being certain that the content is covered fully. Trainer must make the following points after each group has completed their presentation:

Group #1: List reasons how knowledge and understanding of the principles of child development could improve child welfare practice.

1. To be able to educate and counsel parents/foster parents regarding proper child care practices and discipline strategies.
 - The age and developmental maturity of the child will determine the proper behavior management or discipline strategies for that child. Examples of behavior management strategies that are not age-appropriate are:

- a. The use of "reasoning" with a one-year old, who can understand neither complex language nor logic.
- b. The use of physical discipline with an infant. Infants lack the cognitive ability to put the discipline in context.
- c. The excessive use of force with a two-year old child, who is developing autonomous behavior. Misunderstanding the child's autonomous behavior can result in overreaction by the parent and subsequent conflict to retain control.

Note: Abusive and neglectful parents often use discipline strategies that are not appropriate for their children's level of development. Many abusive parents have unreasonable expectations for their children's behavior. A lack of understanding of normal development expectations contributes to the parent's misinterpretation of the child's actions.

2. The Child Welfare Professional should be able to identify the nature of the child's developmental problems, should refer the child for further assessment and diagnosis, and should include developmental and remedial services in the family service plan.
3. Accurate knowledge of a child's cognitive and emotional capabilities can help Child Welfare Professionals understand the child's experience of separation and placement. The Child Welfare Professional can plan and implement placement activities that minimize the child's stress, and help the child cope with the placement experience. This can help prevent an emotionally disabling crisis and permanent negative consequences to the child.
4. Communication skills of a child are tied to developmental stages and can have a major effect on how casework activities, like interviewing, are carried out.
5. Developmental delays could be indicators of child abuse and/or neglect.

Group #2: What are the effects of maltreatment on child development?

1. There is a high correlation between abuse or neglect and developmental disabilities. Child Welfare Professionals should recognize the early warning signs of the primary developmental disabilities, including mental retardation, spina bifida, and cerebral palsy. A knowledgeable Child Welfare Professional can recognize when children on their caseloads exhibit early warning signs of serious developmental problems.
2. Children with serious development problems or disabilities are at increased risk of maltreatment. By recognizing such delays and disabilities, Child Welfare Professionals can often provide supportive and

counseling services to parents and thereby help to prevent maltreatment.

3. Children who have been abused or neglected are often delayed in their development or may show abnormal patterns of development. Early recognition and the proper intervention by the Child Welfare Professional can greatly minimize the negative effects of maltreatment on the child's development.
4. Although there are multiple ways in which maltreatment may be linked to brain development, two ways maltreatment is thought to affect brain development involve the environmental stimulation (or lack of it) received by the child and the amount of chronic stress the child might experience as a result of maltreatment.

Group #3: Identify and list types of developmental information Child Welfare Professionals must know to be most effective in their jobs?

The Child Welfare Professional should have essential knowledge and skill related to development, including:

- Knowledge of the stages and processes of normal development in all domains for children ages birth through adolescence.
- Ability to observe and assess a child's development in the primary developmental domains.
- Knowledge of the early warning signs of developmental delay or disability.
- Knowledge of appropriate resources for developmental assessment and for remedial services, and how to properly access these resources.
- Knowledge of developmental services that are available through community resources, and ways to routinely incorporate development services into case plans.
- Knowledge of proper parenting and discipline strategies for children at different stages of development.
- Ability to counsel and educate parents regarding normal developmental expectations for their children in language the parents are able to understand.

Group #4: What should a Child Welfare Professional do if they notice what they believe to be a developmental disability with a child?

1. Child Welfare Professionals should be able to identify early warning signs of developmental disability and begin early intervention services.

- Early intervention services provided by the Child Welfare Professional can often enhance the positive outcomes of a developmental disability on a child's development.
2. Child welfare professionals should be able to assist parents and foster caregivers to access services and activities to meet children's special needs and to enhance development.
- Child welfare professionals should help caregivers to identify and access social, recreational, psychological, and educational services and resources that can promote the child's healthy development and help overcome developmental delays. These activities might include:
 - a. Health and medical services to address physical problems resulting from abuse or neglect.
 - b. Special school programs to address intellectual delays.
 - c. Recreation programs to teach social skills and interpersonal relationships.
 - d. Physical education activities to develop coordination and fine motor skills.
 - e. Participation in activities that are structured to help a child develop positive self-esteem.
 - f. Speech therapy, Infant Stimulation, psychological counseling, Play Therapy, and other types of treatment for developmental and emotional delays.

At the end of this exercise, the trainer must ask participants if they have any questions about the Child Welfare Professional's need to have knowledge and understanding of the principles of child development.

Step 2: (5 minutes)

Lecture, large group discussion

Trainer Note: It is imperative that the trainer become very familiar with the **Child and Adolescent Development Resource Book** before facilitating this section.

Distribute the **Child and Adolescent Development Resource Book**. Explain to participants that the rest of the day will be spent examining specific age group development, detailing what Child Welfare Professionals can do to help families recognize delayed development, and establishing where to go for additional evaluation

and treatment.

The Pennsylvania Child Welfare Training Program developed the **Child and Adolescent Development Resource Book** to help Child Welfare Professionals assess children's physical and emotional developmental concerns. This reference book contains information on principles of child and adolescent development and discusses major human development theories. Additionally, the book provides general guidelines on what to expect of children and adolescents at different ages and stages of development, as well as "red flags" for developmental concerns. This knowledge will enhance the Child Welfare Professional's ability to assess a child's developmental concerns and help the family gain access to appropriate interventions.

Remind participants of the opening activity where they identified their knowledge and skill in child development. Remind them that the Child Development Book is a tool everyone can use to support their existing knowledge and skill base.

Step 3: (25 minutes)

Lecture

Go through the book and highlight a few sections so that the participants can see the length and breadth of information covered in the book.

Instruct participants to turn to page 6 of the **Child and Adolescent Development Resource Book**. This section, Special Topics in Development, includes an overview of development in several areas that have lifelong implications for a child's functioning. The first area discussed is attachment.

Attachment refers to the close emotional bond children normally form with those who care for them early on—a mother and/or father, and/or other caregivers. This happens through regular, positive contact and interaction between the infant and the caregiver(s) or other familiar figures, as when the adult feeds, comforts, plays with, and talks with the infant and the infant responds. In this way, ideally, the infant learns that he/she can communicate a need to the caregiver (e.g., by crying) and get a response that meets the need.

You can see attachment forming in the way a baby responds to the figure to whom he or she is becoming attached; for instance, the baby touches the parent's face.

Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978,) describes four patterns of attachment that may develop based on early interactions between child and caregiver. These are:

- *Secure attachment* – Infants separate readily from their caregivers when caregivers leave, but then happily greet them when they return. Infants use their caregivers as a secure base, leaving them to explore, but then returning to them for occasional reassurance.

- *Avoidant attachment* – Infants rarely cry when their caregivers leave, and avoid them upon their return. They do not reach for their caregivers in time of need.
- *Ambivalent or resistant attachment* – Infants become anxious even before their caregivers leave, but then show ambivalence toward them when they return (seeking them out and then resisting contact with them.) These infants do little exploring and are hard to comfort.
- *Disorganized-disoriented attachment* – Perhaps the least secure attachment. Infants show inconsistent, contradictory behavior. They greet their caregivers, but then turn away or approach them without looking at them. They seem confused and afraid.

The child who is *securely attached* generally prefers the parent to a stranger and is comfortable leaving the parent to explore farther afield, but will then return to the parent. Children who are not so securely attached may not appear to prefer the parent, or may indiscriminately seek attention and affection.

Attachment is important because it is the first kind of relational experience the baby has and thus becomes the foundation for other relational experiences in life.

Securely attached infants are more likely to become securely attached children. These children are more likely to show:

- Self-esteem;
- Independence and willingness to explore on their own;
- Social and academic competence;
- Trust in people;
- Willingness to ask for help when they need it; and
- Success in their relationships with peers and significant adults.

Though early secure attachment is believed by many to be crucial to ongoing normal development in later stages, consistency of attachment is also important. Trust can be lost if attachment is not maintained. Attachments may also become more secure if parents or other caregivers are able to improve their parenting and show more positive emotion in their interactions with their children.

It is also important to recognize that, in some cultures, children have more caregivers, or are parented more by siblings or grandparents, for example, than by parents. These children may form more attachments or may form primary attachments, not to parents, but to other people. When multiple attachments are a cultural and social norm, you would expect to see children easily moving between adult caregivers.

Ask participants to name some situations where a child may fail to become attached to a caregiver or where the child was attached to a caregiver and the attachment was disrupted. Record the participant's responses on a flip chart:

- Death of a caregiver
- Abandonment of a child by his/her caretaker

- Caretaker does not meet the basic needs of an infant: food, nurturing
- Without proper preparation, a child is removed from caretaker and placed in out of home placement
- Child is removed from caretaker and placed in out of home placement and the caretaker does not visit or keep contact with the child on a regular basis.

Ask participants to turn to page 8 of the Child and Adolescent Development Resource Book: Special Topics in Development. Briefly review the following information about language development.

Language development is crucial to the development of higher-level thinking, reasoning, and memory processes. Language gives us a way to experience and manipulate our world through symbols. For example, language gives children a way to express emotions without physically acting them out, and a way to relate to and learn from others' thoughts and feelings.

Children learn language in the social context—by hearing others use words and word combinations and connecting these with things, happenings, and other kinds of meaning. Words are symbols.

Attentive parents or other caregivers help babies learn to talk in several ways: by talking with them, especially slowly and distinctly, and as if they could understand whatever is being said; by talking about what children are looking at or doing; and by playing games with them that involve words and taking turns, as in conversation (for example, pat-a-cake.)

Exposure to speech helps children learn to speak. More specifically, ways to help children learn to speak are *labeling* (identifying the names of objects,) *echoing* (repeating what the child says,) and *expanding* or *recasting* (restating what the child has said, but in a more sophisticated form.)

Culture plays a big part in how children learn languages. For example, in a large, extended family that interacts regularly, a child is likely to be exposed to more talk and may learn more words faster than a child who interacts with only one parent. Also, when the language spoken at home is different from the language of the culture in which a family lives, children in the family may have a harder time learning the culture's language.

Ask participants to name some impediments to children learning language:

- Social isolation: no one talks to them, the child has very little contact with the world outside of their home
- Lack of response to attempts to speak: the child is ignored or admonished when he/she talks or attempts to talk
- Disabilities: hearing impaired, orthodontic problem, pervasive developmental disability (PDD)
- Multiple languages spoken in the home

Pages 10 and 11 explain brain development and emotional intelligence. Participants should be encouraged to review these sections at a later time.

The next section (pages 12-18) explains the foundations of child development and theories by various theorists. Participants may have studied these theories in college and can review them on their own.

The next section (pages 20-21) explains fetal development and (pages 23-31) explains how to use growth charts. Participants should be encouraged to review these sections on their own as the material is important but time constraints prevent the group from reviewing them in class.

Skipping to page 80, the trainer must review the effects of maltreatment on development. Trainer refers the participants to the chart on page 80 (developmental problems observed in maltreated children.) From each of the categories select a few factors to discuss: behavioral, social-emotional, and cognitive.

Pages 81-82 discuss the effects of maltreatment on attachment. This section is particularly important for Child Welfare Professionals to know and reference when helping children in out-of-home placement, whether the child is in a kinship, foster, or adoptive placement.

- Many abused and neglect children experience some degree of insecure attachment.
- Older children who have an unsteady or compromised foundation often start life as infants who were never securely attached to a parent or parent figure.
- Children with attachment difficulties are more likely to show:
 1. Delays in any of the developmental domains
 2. Unusual fears for their age in leaving the parent—they are less likely to have developed an age-appropriate sense of autonomy
 3. Unusual ease in appearing to attach to another adult, with no signs of missing the parent
 4. Aggression, withdrawal, or anxiety-based hyperactive behaviors
 5. Conflictual or superficial relationships with peers
 6. Impaired “social cognition” or awareness of oneself in relation to others and awareness of the feelings of others, results in a lack of empathy
- Separation from a parent, especially under stressful circumstances or for prolonged periods of time, negatively affects most children. Children who are not securely attached to their caregivers are particularly vulnerable to separation difficulties.

How the Child Welfare Professional can help:

1. Remember that the birth parents, as well as the child, grieve

- when their child enters care
2. As much as possible, involve parents in all aspects of the planning and placement process
 3. Encourage parents to help explain the reasons for the placement to the child, and give the child a positive parting message
 4. Ask parents to provide in-depth information about the child
 5. Whenever possible, schedule pre-placement visits to the placement
 6. Arrange for as much family contact as possible and appropriate
 7. Ensure that the child and parents have family pictures
 8. Place children with their kin whenever possible
 9. Encourage substitute caregivers to talk daily with the child about the absent caregivers
 10. Do not criticize parents

Explain that while we have highlighted some of the sequence of developmental stages and milestones for various age groups, it is critical to keep this book on hand as a reference tool when evaluating a child in the field.

Step 4: (15 minutes)

Lecture

Trainees who have studied child development may feel they have adequate knowledge of child developmental principles. While the presentation may be familiar to some trainees, the trainer should advise that a thorough understanding of these concepts is essential for assessing what is "normal" and therefore, what might be considered "delayed" or "abnormal" development. The trainer must reassure the group that this information will be directly applied to casework practice throughout the remainder of the workshop.

Explain that there are as many child and adolescent development perspectives as theorists. Different disciplines have approached this subject matter from different theoretical orientations and empirical evidence. Psychology, psychiatry, social psychology, sociology, and cultural anthropology emphasize different domains of human development and experiences that shape human personality from childhood to adulthood. The current view of "normal" development suggests progressive achievement of physical, mental, and emotional development milestones at given timeframes. Despite differing developmental theories, there are several principles on which theorists agree.

The first issue to be addressed is, "What is development?"

Display **Overhead #4 (Definition of Development)** and lecture as follows:

- Development is an Ongoing Process

Development begins with conception and does not end until death. A broader view of development is that it begins before conception, since the genetic basis for any individual's development is present in the reproductive cells of that individual's parents. This view of development is called phylogenetic, and it represents the continuous development of life across generations.

The development of any one individual is referred to as ontogenetic development. Ontogenetic development begins with the formation and fertilization of the reproductive cells which begin the new life.

Early child development theory suggested that development beyond childhood was limited. We now have ample evidence to indicate that this is not the case. Development is an ongoing process and occurs throughout the life span.

- Development is a Dynamic Process

Development involves continuous growth. Growth indicates progressive movement toward development into the next step. Without growth, we do not have development.

- Development is Directional

Most developmental processes evolve in predictable, defined directions.

Development typically proceeds from simple to complex. This is repeated in all developmental domains. Biologically, an individual begins as a single cell and develops into a complex organism with many millions of cells that are highly differentiated by both structure and function. These cells are organized into more and more complex, interacting structures as development proceeds.

We see the same basic pattern repeated, for example, in motor development. The rudimentary and uncoordinated motor movements of a newborn infant become increasingly complicated and efficient as the child grows. Complicated patterns of gross motor, fine motor, and eye-hand coordination and skills are precursors to such simple actions as maneuvering through space without injury, as well as to more complex activities such as playing basketball.

- Development May Involve Stages

At certain predictable times in the development process, particular tasks or activities emerge. These developmental points or plateaus are often referred to as "stages." Stages may represent a qualitative change in development. This can result in the emergence of a new or different ability or trait that has no obvious precursors from earlier developmental periods. An example is the emergence of stranger anxiety in an infant who previously was happy being held by anyone.

After the emergence of a new skill or behavior, there is usually a period of "leveling off," when the new skills or abilities are practiced, mastered, and integrated into the child's behavior. For example, after an infant has learned to walk, he may spend several months perfecting balance, coordination, and stability.

Stages represent the emergence of more complex behavior patterns. These behaviors may replace earlier, less effective ones. A four-year old with well-developed language and good social skills is less likely to respond to frustration by having a tantrum. The new skills are more effective in removing the source of frustration and negotiating a solution.

Stages may build upon each other. Early tasks and abilities may form the foundation for later development. For example, the ability to engage in reciprocal interpersonal relationships is based on trust, a developmental milestone of the first year of life. Stage development is an essential concept for many theories of child development, including those of Jean Piaget, Erik Erikson, Lawrence Kohlberg, and Sigmund Freud.

- Development is Cumulative

Early developmental tasks form the foundation for the development of later, more complicated tasks. This is a critical concept in understanding the importance of early recognition and intervention when children are developmentally delayed.

A child who fails to master early tasks will have more difficulty mastering the demands of later stages, and without remedial intervention, the child's development becomes more delayed, and shows increasingly abnormal patterns, over time. The effects of early development deficits increase as the child grows, and as demands become more complex. A circumscribed deficit such as the inability to recognize letters of the alphabet does not critically affect the life of a 6-year-old.

However, an adult who can not read faces serious difficulties in social and economic functioning.

Step 5 (10 minutes)

Large Group Discussion

Explain that there are many variables that determine the final outcomes of development. The factors that affect development are generally divided into two major categories: heredity, or genetic predisposition, and environment. While there has historically been considerable debate regarding the relative importance of these two factors, most child development theorist agree that development is shaped by the extremely complex interaction of the individual's genetic predisposition with the environment in which the individual lives and grows.

Go around the room and ask each table to contribute a variable that might determine

the final outcome of a child's development. Provide an example to begin the process:

- A. Individual differences (biological/genetic and learned behavior) in thinking, feeling and reacting to the world.
- B. Cultural influences
 1. Culture is taught and it is learned; it arises from the way that groups of people live together; and it serves to promote the safety, security, and stability of groups.
 2. A developmental way of thinking about Culture: a system of beliefs, attitudes, and norms of social interactions.
 3. Culture influences our:
 - Expression of thoughts, emotions, behavior, etc.
 1. When is it OK to interrupt?
 2. How to express anger?
 3. How to express love?
 - Responding to injury or threat, getting help, and meeting needs
 1. Boys don't cry
 2. Don't call strangers-family will handle injury
 - Eating, sleeping, and hygiene patterns
 1. Eat as a family
 2. Go to bed early-rise at dawn
 3. Bathe weekly
 - Play patterns, and peer relationships
 1. Must share toys
 2. Cannot date until a certain age
 - Display of intimacy, affection, gender identity, and sexual behavior
 1. Hugging, kissing, sex before marriage
 2. Roles of men and woman
 - Self esteem and self concept
the needs of the individual is overshadowed by the needs of the group
 - Values, beliefs, and attitudes
vary widely among all cultural groups
- C. Economic influences
 1. Poverty does not prevent children from developing normally, but it does limit the resources that families have available to ensure healthy development.
 2. Nutrition; medical/dental care; environmental teratogens/hazards; early detection and prevention.

D. Effects of trauma on development

1. Trauma can significantly interfere, or even stop, the natural progress of developmental growth.
2. Types of trauma include (refer to pages 80-83 in *Resource Book*):
 - A. Neglect
 - B. Physical abuse/domestic violence
 - C. Life threatening situations or near death experiences
 - D. Sexual abuse
 - E. Separation and loss
 - F. Prenatal conditions: D&A abuse, mental health problems, lack of pre-natal care,

Step 6: (10 minutes)

Large Group Discussion

Ask each participant to write down (3) physical traits that they inherited. The traits should be generic such as eye color: not specific such as blue eyes, green eyes, etc.

Record the answers on a flip chart. After the list is complete, present the following lecture on inherited factors that influence development.

- The Influence of Heredity on Development

When we think of heredity, we usually consider the physical expression of our genetic inheritance, such as eye and hair color, body type, height, and skin color, etc. All humans have a common core of genes that accounts for the basic similarities in the structure and functions of our bodies, and that accounts for differences between humans and other species. Heredity exerts a strong and persistent influence on our development and determines our biological readiness to accomplish developmental tasks at any age.

The genetic influence of heredity is a primary reason that development is an ongoing, dynamic and directional process that involves stages. Its impact may most clearly be seen during the first year of life when the pattern of physical development is largely genetically determined. Early infant motor milestones, such as grasping, sitting, crawling, standing, and walking, generally occur in predictable patterns regardless of environment or culture.

Example: A child will not be able to walk until her physical structure, bones, muscles, and sense of balance have developed sufficiently to support upright body posture and to coordinate upright movement. Infants across cultures are biologically ready to walk somewhere between age 9-15 months. Environmental influences can override when a

child actually begins to walk; a child who is carried on his mother's back for the first three years of life will likely not walk at one year. However, were that child to be allowed to roam freely on the ground, he would begin walking around the age of one year.

Sensory abilities that directly arise from our genetic hardwiring (e.g., vision, hearing, vocalization, ambulation, abstract reasoning, visual-spatial recognition, memory) do not have to be taught. These abilities may be refined and nurtured over time to become well-honed skills, but the emergence of these abilities is first and foremost genetically determined.

Although physical maturation is the easiest type of development to casually observe, heredity also operates across all of the domains of child development. Ask participants to consider a developmental domain that is commonly thought to be primarily influenced by social/environmental factors, such as sexual behavior. Ask them to suggest how genetic heredity influences this area.

Possible answers include:

- Onset of secondary sexual characteristics is genetically determined.
- Levels of testosterone and estrogen have been shown to greatly influence sexual desire.
- Clinical research has indicated a link between brain chemistry and gender orientation.

Summarize by pointing out that no matter how strong the genetic influence, there is always some degree of environmental influence interacting with our development, and that we will consider that influence next.

Step 7: (10 minutes)

Lecture

Ask each participant to write down (3) environmental factors that influenced their development and record the answers on a flip chart. After the list is complete, using **Overhead #5 (The Influence of Environment on Development)**, present the following information on environmental factors that influence child development.

Environment can be defined as the total complex of external (non-genetic) influences that affect the survival and development of the child. In reality, there are multiple environments that influence the course of development.

- The prenatal environment includes the chemical balance of the mother's body and the presence of conditions or potentially toxic substances that can alter the development processes. Examples are the mother's use of drugs or alcohol, viral or bacterial diseases, pre-natal care, nutrition, mental health conditions, and the direct traumatic injury to the fetus.
- The physical environment in which the child grows includes the air the child breathes, the nutritional value of food the child eats, and exposure to conditions

that can lead to disease, accident, or injury. Other examples are safety and sanitary conditions of the home and neighborhood, and access to health, education, and recreational services within the community.

- The social/cultural environment consists of the norms, values, belief systems, morals and, in general, standards of behavior that regulate life in the cultural group in which the child is raised.
- The learning environment consists of the degree and type of stimulation available in the child's immediate environment. There is considerable data to suggest that sensory input promotes and shapes cognitive development. Stimulation, in adequate quantity and intensity, promotes establishment of, and "shapes," neural pathways in the brain. Examples: talking/communicating with children, loving interactions with children, exposing a child to music, books, and recreational activities.
- The emotional environment includes the extent to which the child's relationships with his parents and siblings are nurturing and promote the child's development. The emotional environment shapes personality and affects the development of self-esteem, identity, trust, the ability to form and maintain intimate relationships, and resiliency. Examples: parents encourage the child to express her fears, concerns, and anxieties without judgment or negative reaction; reinforce asking for assistance when needed.

The continuous interactions of the child's genetic predispositions with the environment determine the rate of development and shape its final outcomes.

Step 8: (25 minutes)
Small Group Activity

Explain that we must know what constitutes "normal" development to establish an accurate baseline from which to evaluate and understand delayed or "abnormal" development.

Ask each table group to take 5-7 minutes to write a sentence that defines "Normal" and "Abnormal Development." After the time, have a representative of each table read their definitions.

After they present their sentences ask them what they think the impact is of telling a parent, their child may not be "Normal" and or that their child is "Abnormal." They will likely say that if you use the word abnormal to describe a child, the parent will become concerned, perhaps defensive.

Skills practice: Communicating information -How to tell a parent their child may have a developmental delay. Remind participants that they have practiced "Tuning in to Self" and "Tuning in to Others" several times before in previous modules.

- Ask each participant to first Tune in to Others (The worker's efforts to get in touch with actual and potential feelings/ concerns/beliefs/values that the client/family member brings to the helping encounter) and write down how a parent may feel about hearing their child may have a delay. Call on a couple of participants to read their answers. (To engage the entire class throughout the day pick participants to respond who have not already participated.)
- Then ask participants to Tune in to Self (The worker's efforts to get in touch with their actual and potential feelings/concerns/beliefs/values that he/she brings to the helping encounter) and write down how they feel about explaining to a parent their child has a problem. How might their feeling impact on what they are going to say to the parent? Call on a couple participants to read their answers.

Communicating Information: (imparting important information or clarifying issues about the casework process)

Lastly, tell participants now that they have Tuned in to Self and Others they are to write down the statement they would use to tell a parent that that their child may have a developmental delay.

Call on different participants to read their statements. After you have reviewed a few examples tell participants you are going to explain the term "Normal" Development. Explain that "Normal" is a statistical concept that represents what is typical for the majority of members of a group. Child development specialists draw on empirical research, using representative samples of different age groups of children, to determine the "normal" distribution curve of developmental tasks in various domains and stages of child development.

For example, based on empirical evidence, child development researchers record their observations of children from different age groups to identify the "normal" age range when children take first steps and start walking. Researchers randomly select samples of children that are representative of the same characteristics as the entire population of children. Any findings related to such samples of children are assumed most likely to be true for all children. Studies are usually replicated to confirm the findings of other child development research.

Therefore, the term "normal" most appropriately *refers to the trait, not the child*; and, the rate and progress of a child's development must be evaluated individually for each developmental domain.

Step 9: (10 minutes)

Lecture

Explain developmental dimensions while displaying **Overhead #6 (Developmental Domains)**.

To facilitate the study of development, developmental tasks are typically divided into four primary categories, referred to as “domains.” The four primary domains are physical, cognitive, social, and emotional.

- Physical development consists of the development of the body structure, including muscles, bones, and organ systems. Physical development usually describes the relationship between the person’s ability to perceive the environment, and to respond to those perceptions by interacting within the environment. Thus, physical development is generally comprised of *sensory* development, dealing with the organ systems underlying the senses and perception; *motor* development, dealing with the actions of the muscles; and the nervous system’s coordination of both perception and movement.

Motor activity depends upon muscle strength and coordination. Gross motor activities such as standing, sitting, walking, and running, involve the large muscles of the body. Fine motor activities including speech, vision, and the use of hands and fingers, involves the small muscles of the body. Both large and small muscle activities are controlled and coordinated by the central nervous system.

Sensory development includes the development of vision, hearing, taste, touch, and smell, and the coordination and integration of perceptual input from these systems by the central nervous system.

Note that vision has both motor and sensory components. Muscles regulate the physical structures of the eye to permit focusing; neurological pathways transmit visual input to the brain.

For the first year of life, children’s development is most pronounced in the sensory and motor domains. For this reason, Piaget has named this early stage of development “sensorimotor.”

- Cognitive development is sometimes referred to as “intellectual” or “mental” development. Cognitive is the proper term. Cognitive activities include thinking, perception, memory, reasoning, concept development, problem-solving ability, and abstract thinking. Language, with its requirements of symbolization and memory, is one of the most important and complicated cognitive activities.

It is important to differentiate language and speech. Understanding the formulating language is a complex cognitive activity. Speaking, however, is a motor activity. Language and speech are controlled by different parts of the brain.

- Social development includes the child’s interactions with other people, and the child’s involvement in social groups. The earliest social task is attachment. The development of relationships with adults and peers, the assumption of social roles, the adoption of group values and norms, adoption of a moral system, and

eventually assuming a productive role in society are all social tasks.

- Emotional development includes the development of personal traits and characteristics, including a personal identity, self-esteem, the ability to enter into reciprocal emotional relationships, and mood and affect (feelings and emotions) that are appropriate for one's age and for the situation.

While each of these four developmental domains can be examined individually, it is misleading to suggest that development occurs separately in each of the four domains. Development in any domain affects, and is affected by, development in all of the other domains.

This can be illustrated by considering the effects of a developmental disability in one domain on development in other domains.

- How does a blind child learn the concepts of "near," "far," "round," and "hazy?" All these concepts (cognitive development) are normally learned through primarily visual (sensory) input. The absence of visual stimuli affects cognitive development.
- How will a child with a cognitive deficit, such as mental retardation, learn and understand the complicated social cues, rules, and roles that guide interpersonal relationships? The cognitive deficit can affect the person's acquisition of social skills.
- A child with emotional problems including low self-esteem and lack of confidence is likely to be fearful and anxious when confronted with difficult physical tasks, and he may avoid these activities. The child's physical coordination, mastery of his own body, and motor skills will be affected as a result.

Step 10: (20 minutes) **Small Group Activity**

- ✓ Inform participants they are now going to practice identifying childhood developmental milestones. While domains identify types of developmental tasks, milestones describe the timeframes for accomplishing different developmental tasks. Explain that in their small groups they will have a recorder and a presenter. Give each group a handout (**distribute Handouts #4-8 [Developmental Milestone Areas of Growth: Ages 0-24 months]; [Developmental Milestone Areas of Growth: Ages 2-5 years]; [Developmental Milestone Areas of Growth: Ages 6-11 years]; [Developmental Milestone Areas of Growth: Ages 11-14 years]; [Developmental Milestone Areas of Growth: Ages 15-18 years]**) with a different age group represented and a piece of flip chart paper.

Instruct participants to list (without using the Child and Adolescent Development

Resource Book) 3 of what they consider the most significant milestones for their age group in each of the areas of physical, cognitive, language, socioemotional, and moral development. Additionally, the group should list 3 milestones that if not achieved by the child would raise concern to a Child Welfare Professional. The milestones should not be generic: i.e., age 2, talks. They should be specific and say that the child will speak 2 word combinations.

When the groups are done have them hang their flip charts on the wall. Give the groups 15 minutes to complete this part of the exercise. The group presenters (from youngest to oldest age group) should stand and explain their chart.

The trainer must support (and elaborate if necessary) every answer, being sure that all of the content is covered fully. If not covered by the group, the trainer must direct participants to the appropriate section of the Child and Adolescent Development Resource Book and provide an overview of the following points; Note that time does not allow for discussing each milestone for each age group. The goal is to have participants gain a general knowledge and know that they can get additional information by using the Child Development Resource Book.

Advise participants to look at the Child and Adolescent Development Resource Book as a guide during the discussion (page 34-60). Point out that the book takes each age group and breaks them down into many more developmental milestones and indicators of concern than we will identify in the exercise.

Ages 0-24 months

Physical milestones:

1. Rapid height and weight gain
2. Walks alone (12-18 months)
3. Feeds oneself with fingers(6-12 months)
4. Can build towers with blocks (18-24 months)

Cognitive milestones:

1. Imitates adults (6-12 months)
2. Uses make believe (18-24 months)
3. Sorts objects (18-24 months)
4. Begins to sustain attention span (12-18 months)

Language milestones:

1. Coos and babbles (infants)
2. By 24 months, has 200-400 word
3. Can use simple sentences (18-24 months)

Socioemotional milestones:

1. Forms attachments (0-3 months)
2. Strange anxiety (6-12 months)
3. Claims "mine" (12-18 months)
4. Self control begins (18-24 months)

Moral milestones:

1. Egocentric (0-3 months)

2. Experience from reprimand signals misdeed (12-18 months)
3. Begins to distinguish intentional or deliberate behavior from accidental (18-24 months)

Indicators of concern:

1. Sucks poorly, doesn't focus or follow objects, doesn't respond to loud noises (0-3 months)
2. Does not crawl, says no single words, does not babble, cannot stand when supported (6-9 months)
3. Cannot walk, does not speak at least 15 words, does not imitate actions or words, does not follow simple instructions (12-24 months)

Ages 2-5

Physical milestones:

1. Slower weight and height gain (24-36 months)
2. Shows signs of coordination and aggression (24-36 months)
3. Begins to gallop/skip (ages 3-4)
4. Rides tricycle (ages 3-4)
5. Potty trained (ages 3-4)
6. Gross and fine motor skills increase in speed and endurance (age 5)
7. Dresses self, brushes teeth (age 5)

Cognitive milestones:

1. Uses make believe (24-36 months)
2. Understands colors/can recognize shapes and some alphabet letters, can count (age 3-4)
3. Simple addition and subtraction (age 5)
4. Begins sense of time (age 5)

Language milestones:

1. 3-4 word sentences (24-36 months)
2. Begins to use the word "I" (24-36 months)
3. Masters increasingly complex sentences (ages 3-4)
4. Vocabulary of 1,500 words/understands opposites (hot-cold) (ages 3-4)
5. Vocabulary reaches 10,000 words (age 5)
6. Uses questions to understand and conceptualize (age 5)

Socioemotional milestones:

1. Understands causes and consequences (ages 24-36 months)
2. Emotional self regulation improves (ages 3-4)
3. Understands sharing, interactive play (ages 3-4)
4. Grasps genital basis of sex difference (age 5)
5. Unreasonable fears, bossy/aggressive (age 5)

Moral milestones:

1. Has concept of right and wrong (ages 24-36 months)
2. Moral reasoning: avoid punishment and attain rewards (ages 3-4)
3. Has acquired many ideas and "rules" based culture (age 5)
4. Has sense of reciprocity

Indicators of concern:

1. Does not feed self with spoon, speak simple sentences, play make believe (age 24-36 months)

2. Cannot throw ball overhand, scribble, stack blocks, lashes out without self control when angry, doesn't use sentences of more than 3 words (ages 3-4)
3. Exhibits extremely aggressive behavior, unable to concentrate, sleeps and eats poorly, cannot build a tower of 6-8 blocks (age 5)

Ages 6-11

Physical milestones:

1. Gross motor skills increase: can play organized games (6-11)
2. Fine motor skills increase: writing becomes smaller, drawings more organized and detailed (6-11)
3. Girl's adolescent growth spurt begins (9-11)

Cognitive milestones:

1. Thoughts more organized
2. Attention span is adaptable and selective (6-11)
3. Can master more complicated math skills (6-11)
4. Long term knowledge base grows (9-11)
5. Emotional intelligence develops: self awareness, empathy, delaying gratification (9-11)

Language milestones:

1. Communicates clearly and in complete sentences (6-11)
2. Begins to read (6-11)
3. Grasps double meanings (9-11)

Socioemotional milestones:

1. May have special friend
2. Becomes responsible and independent (6-11)
3. Learns social problem solving (6-11)
4. Self-esteem rises (9-11)
5. Peer groups emerge (9-11)
6. Understands the linkage between moral rules and social convention (9-11)

Moral milestones:

1. Begins to understand rules and fair play (6-11)
2. Sees other's perspective (9-11)
3. Growing less "me" centered and more pro-social (9-11)

Indicators of concern:

1. Low self esteem, acts sad most of the time
2. Overly aggressive, poor self control, difficulty concentrating and sitting still
3. Does not respond to positive attention or praise
4. Cannot adapt behavior to social situations
5. No best friend
6. Cannot differentiate real from pretend

Ages 11-14

Physical milestones:

1. Rapid skeletal and sexual maturation
2. Wide variation in beginning and completion of puberty

Cognitive milestones:

1. Thinking is less concrete, more abstract, idealistic, logical, complex problem solving
2. Increased interest in social issues, ideas, values
3. Intense interest in music, hair, clothes
4. Ethnic minority youth learn how to negotiate 2 systems-their own and the dominant culture

Language milestones:

1. Questions authority, likes to argue

Socioemotional milestones:

1. Pressure to conform with peers
2. Mood swings common
3. Egocentric
many ethnic youths have multiple disadvantages: prejudices, discrimination, bias, effects of poverty, recognizes that differences exist between and within the group

Moral milestones:

1. Wants to be nice person and live up to others expectations
2. Continues to learn culture based moral values

Indicators of concern:

1. Physically immature
2. Lack of peer relationships
3. Does not consider consequences of actions
4. Poor school performance
5. Poor self esteem
6. Emotional and behavioral problems
7. Abuse drugs and alcohol
8. Changes eating and sleeping habits
9. Withdraws from friends

Ages 15-18

Physical:

1. Preoccupation with body image

Cognitive:

1. Formal operational thought with abstract, idealistic, logical, deductive reasoning. Complex problem solving and critical thinking
2. Think in black and white
3. Enjoy debating and arguing

Language:

1. May not communicate with adults
2. Question adult authority, enjoy talking with friends
3. Complain that others don't understand
4. Argue rather than discuss

Socioemotional:

1. Building self-identity, internal self, social self, self esteem
2. Interest in forming romantic attachments

3. Concerned about own thoughts, opinions, and ideas
4. Cultural differences may cause conflict: Latino and Asian dating standards may be more conservative than those of mainstream white and/or African American cultures.

Moral:

1. Wants to be a nice person and live up to the expectations of others
2. "Personal choice" seen as justification for opposition to parental and societal standard
3. Minority cultural perspectives may differ from those of the dominant culture-may be based more on familial and communal expectations: differences may cause moral dilemmas

Indicators of Concern:

1. Physical immature, not showing signs of puberty
2. Poor motor skills, coordination
3. Has not developed one-on-one friendships with same and opposite sex peers
4. Poor school performance: frequent absences
5. Moral behavior dependent on external authority to enforce
6. Not individualized: dependent on family
7. Poor self-esteem
8. Emotional and behavioral problems
9. Changes in eating and sleeping habits
10. Drug and alcohol abuse
11. Failure to plan for the future, sets very unrealistic or grandiose goals

At the conclusion of this exercise, advise participants to use this resource book when conducting investigations and creating service plans.

Module 9: Child Development

Section III: Using the Child and Adolescent Development Resource Book in Practice

Estimated Length of Time:

2 hours 10 minutes

Learning Objectives:

Participants will be able to:

- ✓ Use the Child and Adolescent Development Resource Book to:
 1. Identify the significant milestones of normal childhood and adolescent development;
 2. Identify potential developmental problems in need of further assessment;
 3. Describe healthy sexual development across developmental stages; and
 4. Identify the type and nature of impact that trauma can have on children's development identify the basic principles of child development
 5. Identify the negative effects of child abuse and neglect on child development

Methods of Presentation:

Lecture, Small Group Exercise. Large Group Discussions

Materials Needed:

- ✓ Blank Flip Chart Paper
- ✓ Colored Markers
- ✓ Overhead Projector and Screen
- ✓ **Child & Adolescent Development Resource Book**
- ✓ **Handout #9 (The Three Abbott Children)**
- ✓ **Handout #10 (Anthony's Story)**
- ✓ **Handout #11 (Observation Notes: Anthony at Age 3 months)**
- ✓ **Handout #12 (Observation Notes: Anthony at Age 1)**
- ✓ **Handout #13 (Observation Notes: Anthony at Age 4)**
- ✓ **Handout #14 (Observation Notes: Anthony at Age 13)**
- ✓ **Overhead #7 (Questions about Milo Abbott)**
- ✓ **Overhead #8 (Questions about Kira Abbott)**
- ✓ **Overhead #9 (Questions about Jack Abbott)**

Outline of Presentation:

- Use the Child and Adolescent Resource Book in Child Welfare practice

Section III: Using the Child and Adolescent Development Resource Book in Practice

Step 1: (25 minutes)

Large Group Discussion

Introduce the next activity by explaining that, now that we have become familiar with the **Child and Adolescent Development Resource Book**, it is time to apply that knowledge by using the book to look at two families who are receiving child welfare services.

Give participants **Handout #9 (The Three Abbott Children)**. Ask participants to read the introduction and Milo, 14, paying attention to any developmental milestones, concerns, or issues they see. (They will read about each of the other children after addressing the questions for Milo.) Explain that they will be asked to answer some questions about Milo's development in three specific domains—physical, cognitive/linguistic, and socio-emotional.

Display **Overhead #7 (Questions about Milo Abbott)**.

Lead a discussion on each question as to why participants chose the answers they did. For the questions asking if the child's development is on target, ask volunteers from those who answered "Yes" what indicators from the scenario led them to that conclusion. For those that answered "No," ask what indicators in the scenario led them to choose "No" as their answer. Similarly, for questions dealing with concerns, ask a sample of those who did and did not have concerns to volunteer what they based their answers on.

Content of discussion:

Is Milo's physical development on target for his age?

Yes

He is at about the 95th percentile for height and 80th percentile for weight. He is showing signs of puberty and is a good basketball player.

Do you have any immediate or long-term concerns related to Milo's physical development?

No

Is Milo's cognitive/linguistic development on target for his age?

Yes

He is an average student. He wants to do well in activities. His somewhat narrow understanding of other's views is normal at his age.

Do you have any immediate or long-term concerns related to Milo's cognitive/linguistic development?

No

Is Milo's socio-emotional development on target for his age?

Yes

Preoccupation with his appearance, thoughts about sex and reluctance to talk to his parents about his thoughts and feelings are typical of his age. Egocentric view of others' rights and social issues is also normal.

Do you have any immediate or long-term concerns related to Milo's socio-emotional development?

Yes

There may be a long-term concern regarding his tendency to keep his thoughts, questions, and fears to himself in view of his early history of being quiet and "parentified" during his sister's illness. It is developmentally normal for him not to confide in his parents; however, if he does not start to communicate more later in adolescence, there may be reason for concern.

What impact has the loss of Celine had on Milo?

Milo evidences signs of anger and resentment that his mother still talks about Celine and has a picture of her on the mantle.

What are the next steps that social service should consider when preparing a Family Service Plan?

The trainer must record the participants' responses on a flip chart. Some possible responses are:

- Encourage Mark and Joelle to get Milo into grief counseling
- Encourage Mark and Joelle to get into grief counseling for themselves
- Encourage Mark and Joelle to join a parenting group that specializes in parenting a teen

Transfer of Learning Note: Remind participants that they asked a colleague what programs/resources were available in their county that conducts child developmental evaluations. Ask a couple participants to share what resources are available in their county. Inform participants that in the next module they will learn about community service providers and skills to assist them with developing collaborative partnerships with service providers.

Activities for parents, for Milo:

- Encouraging self-expression—through a discussion with Dad while on the basketball court or through journaling or through talking with a teacher at school, etc.
- Participation in some other group/peer activities, like inter-mural basketball at the YMCA or at a church league, might provide other outlets for self-expression rather than keeping things bottled up.
- Talking with the parents about warning signs in changed behavior might also be useful.

Step 2: (25 minutes)
Large Group Discussion

Trainer Note: You may use one of two methods to complete steps 2 and 3.
1) You may do steps 2 and 3 as an individual exercise with large group discussion/large group; or
2) Assign tables groups to Kira and Jack (two tables may work on one child and alternate answering the questions). And have them work as table groups and then present the information to the large group.

Ask participants to read about Kira from **Handout #9 (The Three Abbott Children)**. After they have read the paragraphs, display **Overhead #8 (Questions about Kira Abbott)** and then discuss their answers as before.

1) Is Kira's physical development on target for her age?
Yes

She is on target, if not ahead of schedule, physically. She is a large child—around the 95th percentile in both height and weight. Some may think she is obese; however, it is normal for young children to be “square” (about the same percentile rank for height and weight.)

2) Do you have any immediate or long-term concerns related to Kira's physical development?
No

3) Is Kira's cognitive/linguistic development on target for her age?
No

Cognitively, she is not on target. By now she should get that letters and numbers are symbols for sounds and amounts, even if she can't associate letters with their sounds or count beyond a few numbers.

4) Do you have any immediate or long-term concerns related to Kira's cognitive/linguistic development?
Yes

This should be indicated as at least a long-term concern. If she has not begun to make these connections by the end of kindergarten, she will need further assessment.

5) Is Kira's socio-emotional development on target for her age?
No

She is also not on target in the socio-emotional domain. She should be more aware of other's emotional reactions and beginning to be able to play cooperative group games.

6) Do you have any immediate or long-term concerns related to Kira's socio-emotional development?
Yes

This area should be indicated as an immediate and long-term concern, especially since she is a large child and her boisterousness could be more problematic over time. She also wants to be part of the group. However, negative reactions to her overtures can have further negative effects on her socio-emotional development.

7) What impact has the loss of Celine had on Kira?

Kira was born shortly after the death of Celine. With the information given, no direct link from Celine's death to Kira's behavior can be made.

8) What are the next steps that social service should consider when preparing a Family Service Plan?

The trainer must record the participants' responses on a flip chart. Some possible responses are:

- Encourage Mark and Joelle to get into grief counseling for themselves.
- Refer Joelle to a child nutritionist to assist with planning healthy meals and snacks for Kira.
- Refer Kira for an evaluation for ADHD and/or a learning disability.

9) Activities for parents: for Kira

- Spending specific time in the cognitive areas of letters and numbers.
- Read to her.
- Teach her some simple words to spell to Jack as they play.
- Expose her to more social situations and help her handle peer relationships.
- Give her opportunities to play outside.

Step 3: (20 Minutes)

Large Group Discussion

Ask participants to read about Jack from **Handout #9 (The Three Abbott Children)**. After they have read the paragraph, display **Overhead #9 (Questions about Jack Abbott)**, and then discuss their answers as before.

1) Is Jack's physical development on target for his age?

Yes

Like Kira, he is approximately in the 95th percentile for height and weight. Participants may also be concerned that he is not walking. However, he is cruising and is still within the normal range.

2) Do you have any immediate or long-term concerns related to Jack's physical development?

No

3) Is Jack's cognitive/linguistic development on target for his age?

Yes

He babbles, communicates with gestures and facial expressions, tries to say Kira's name.

4) Do you have any immediate or long-term concerns related to Jack's cognitive/linguistic development?

No

5) Is Jack's socio-emotional development on target for his age?

Yes

He plays with his sister, loves peek-a-boo and tickle threats.

6) Do you have any immediate or long-term concerns related to Jack's socio-emotional development?

No

7) What impact has the loss of Celine had on Jack?

Jack was born several years after Celine's death. With the information given, no direct link from Celine's death to Jack can be made.

8) What are the next steps that social service should consider when preparing a Family Service Plan?

The trainer must record the participants' responses on a flip chart. Some possible responses are:

- Encourage Mark and Joelle to get into grief counseling for themselves
- Refer Joelle to a child nutritionist to assist with planning healthy meals and snacks for Jack
- Jack's physical development should be monitored by his pediatrician and a referral made to Early Intervention Services should he begin to fall behind

9) Activities for parents: for Jack

- Spending time each day with helping him to practice walking while holding him by both arms or the torso.

Trainer Note: When there is agreement, it is not necessary to have in-depth discussions about all of the debriefing questions. However, be sure to discuss Milo's socio-emotional development, Kira's physical, cognitive/linguistic, and socio-emotional development, and Jack's physical development.

Close the activity by stating that if workers face a situation about which they are not sure they should get support from experienced Child Welfare Professionals or child development specialist.

Step 4 (30 minutes)

Lecture

Trainer should instruct participants to refer back to the Child and Adolescent Development Resource Book and then briefly cover pages 62-71 to explain some common Normal Developmental Challenges and Strategies. The trainer must go through the book ahead of time and highlight material that they feel is crucial for the participants to know (as time allows). This exercise will make the Child Welfare Professionals aware of some of the normal challenges parents face and give them some “tips” to share with the parents about how to deal with those challenges. Participants should be advised to read the entire text when time allows.

Pages 73-79 delineate some Challenges Beyond Normal Development. The trainer must pay special attention to:

1. Failure to Thrive (FTT) (pages 74-75): FTT is a nonspecific term applied to infants and young children who are failing to grow in a normal fashion.
 - Most often, FTT involves children under 3 years of age.
 - Based on a pattern or trend of growth that is consistently less than expected for a particular child.
 - Child’s weight and height falls below the 5th percentile.
 - Malnutrition, before and during the first few years of birth, has been linked to stunted brain growth and cognitive, social, and behavioral deficits.
 - Infants can be in significant, even life threatening, danger if their nutritional needs are not met.
 - FTT can be organic or nonorganic, i.e. the cause can be psychosocial (problems in the parent-child interaction or home environment) and not the result of an underlying medical condition.
 - Suspected FTT children should receive an immediate medical evaluation and a social assessment that evaluates the child factors, parent factors, family factors, and community and cultural factors.
2. Children with disabilities (pages 76-78): the Federal Government defines the term “child with a disability” as one “with mental retardation, hearing impairment (including deafness), speech or language impairment, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities” who need special education and related services.
 - Children with disabilities, particularly children with multiple disabilities, are at greater risk for child maltreatment than children without disabilities.
 - Parent and caregiver’s have psychological feelings and adjustments to having a child with a disability (grief over the loss of a “dream child”).
 - There are many challenges associated with providing care for a child with disabilities, i.e., stress associated with special diets, medical treatments, additional laundry, social restriction and isolation, financial pressures, anxiety about the future, and ongoing loss of sleep.
 - A CYS worker’s responsibility is to help the parents locate and use special

educational and therapeutic treatments for the child as recommended by medical, therapeutic, and educational specialists.

3. Alcohol and Drug Exposure (page 79): The most common trauma to a fetus that potentially leads to harmful long-term developmental problems is exposure to alcohol and illicit drugs. Some resulting conditions might include:

- May have major organ malformation, growth retardation, and facial and congenital anomalies (eyes droopy and far apart, thin upper lip, small heads, small body weight/size, failure to grow.

Child is at risk of abuse and neglect because the alcohol/drug involvement of the parents makes it difficult to care for the babies while under the influence.

Unlike a family with a disabled child, a Child Welfare Professional must seek medical and therapeutic treatment for the drug and alcohol dependent child AND the parent.

Trainer Note: Children with disabilities present the Child Welfare Professional with an opportunity to network with other social service systems in their counties to provide services for the child and his/her family. Participants should be advised that when working with children with disabilities, they must work closely with their county's Mental Health and Mental Retardation offices to be sure that the child is receiving all of the services that they may qualify for.

Ask participants if they are familiar with CASSP system and to explain it to the rest of the participants. If no one is familiar with CASSP, explain that CASSP an acronym for the Child and Adolescent Service System Program, and is a comprehensive mental health system of care for children and adolescents with serious emotional disturbance and their families. Each county has a CASSP coordinator whose job it is to see that children with serious emotional disturbances receive the services that they need. If a child is in need of mental health services or a modification of their services, the CASSP coordinator can call (or the Child Welfare Professional can request) a CASSP meeting. Participants at the meeting would be the child (if appropriate) and his/her caretakers, all known services providers for the child (including school personal), and anyone else who may have some input about the treatment needs of the child. This multi-disciplinary team will review with the child (if appropriate) and his/her caretaker what services are currently being provided and what services may need to be added or deleted. For more information on CASSP, refer participants to the CASSP website at <http://pacassp.psych.psu.edu>.

Another excellent resource for Child Welfare Professionals is the Early Intervention Program. The Department of Public Welfare (DPW), Office of Mental Retardation is responsible for the Commonwealth's Early Intervention Program for eligible infants and toddlers. The program is an entitlement program for qualified children and all services are free of charge. The County Mental Health/Mental Retardation Program administers the Early Intervention programs locally.

Early Intervention Services in Pennsylvania are services and supports designed to help families with children with developmental delays. Early Intervention builds upon the natural learning occurring in the child's first few years. In order to be eligible for Early Intervention Services, the infant or toddler must be birth to three years of age and have one of the following:

- A significant delay in one or more areas of development;
- A specialist's determination that there is a delay even though it doesn't show up on the assessments (called informed clinical opinion); and
- Known physical or mental conditions, which have a high probability for developmental delays.

For more information on Early Intervention Services, Child Welfare Professionals may visit their website at <http://www.dpw.state.pa.us/child/Earlyintervention>.

Trainer Note: Write the websites for CASSP and Early Intervention on a flip chart so that participants can copy them down for future use.

In a round robin fashion, ask participants to suggest how they, in cooperation with MH/MR services, might help to reduce the risk of children with disabilities being victims of maltreatment. Some possible answers may be:

- Allow the parent or caregiver an opportunities to talk openly with nonjudgmental peers and professionals;
- Assist parents with finding and enrolling in day programs or summer camps for children and youth with disabilities;
- Provide respite care as needed; and
- Assistance with financial demands associated with the disabilities.
- Assist parents with accessing services for their child through local their MH/MR offices.

Step 5: (30 minutes)
Small Group Activity

To develop their skills with the **Child and Adolescent Development Resource Book**, tell the group that they will continue practice with another family situation.

Divide the participants into small groups. Give each person **Handout #10 (Anthony's Story)**.

Trainer Note: If you have less than 4 table groups you can break the participants up into triads and pairs.

Assigned the participants in group 1 **Handout #11 (Observation Notes: Anthony at Age 3 Months)**.

Assigned the participants in group 2, **Handout #12 (Observation Notes: Anthony at age 1 year)**.

Assigned the participants in group 3, **Handout #13 (Observation Notes: Anthony at age 4)**.

Assigned the participants in group 4, **Handout #14 (Observation Notes: Anthony at age 13)**.

Give the groups 30 minutes to read and complete one observation form for their group using the **Child and Adolescent Development Resource Book** as a guide. In that this scenario has many “characters,” the trainer should suggest that the group list all the family members, their relationship to Anthony, and their ages. This will be helpful when examining the case.

Reconvene the group and ask each group to report on their observations. The trainer can refer to the completed observation forms and make sure that all essential factors are covered by the small-group presentations.

Completed Observation Notes: Anthony at Age 3 Months

Physical Development

Behavior or characteristics:

- Small but proportional for his age—
 - 5th percentile for height, weight, and head circumference; lifting his head, trying to roll over, reaches, and grasps.
- Normal Range? yes no
- Basis for conclusion:
 - Lifting his head (expected within 1-3 months) and trying to roll over (which he should be able to do by 4-6 months); reaches and grasps (expected within 1-3 months.)
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - His small size, coupled with his mother’s lack of prenatal care and proximity to drugs (although she denies using,) are concerns, but as yet he shows no delays.

Cognitive Development: (include notes about language development here)

Behavior or characteristics:

- Babbles and coos.
- Normal Range? yes no
- Basis for Conclusion:
 - Babbling and cooing (expected within 1-3 months.)
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:

- His small head circumference, his mother's lack of prenatal care and proximity to drugs (although she denies using,) put him at increased risk of learning disabilities; however, none are apparent.

Socio-emotional Development (include moral development here)

Behavior or characteristics:

- Startles to loud noises; doesn't seem to prefer mother.
- Normal Range? yes no
- Basis for Conclusion:
 - Startle is expected within 1-3 months; however, he should be showing preference for his mother.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Not enough known from scenario about possibility of neglect, but failure to prefer his mother is a red flag that attachment is not developing as expected. Mother doesn't know startle response is normal.

Completed Observation Notes: Anthony at Age 1

Physical Development

Behavior or characteristics:

- Small but proportional for his age—
 - Around 5th percentile for height, weight, and head circumference; sits unsupported and holds bottle; stopped picking up food, pulling up, and reaching for things.
- Normal Range? yes no
- Basis for conclusion:
 - Sitting and holding bottle are expected by this age (6 months for sitting, 6-9 months for holding bottle.) Of more concern is that he should be pulling up and cruising, feeding himself finger foods, and reaching for toys and that he began, but has stopped doing these things.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
- His mother's drug use and lifestyle (many people in and out of the house,) and mother's neglect (dirty, runny nose, home alone.) Chronic neglect can lead to sensitized fear response patterns. Lack of stimulation can cause delays in development and affect development of neuronal pathways in the brain (previously developed pathways and capacities associated with them can be lost.)

Cognitive Development: (include notes about language development here)

Behavior or characteristics:

- Remembers grandmother; says “baa” for bottle and “Na” for Nonna; knows meaning of “no.”
- Normal Range? yes no
- Basis for conclusion:
 - Saying one or two words is expected around 12 months, as is recall memory for people, places, and objects. Understanding the word “no” typically appears from 12-15 months.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Early contact and stimulation from grandmother, cousin, and uncles.

Socio-emotional Development (include moral development here)

Behavior or characteristics:

- Recognizes and approaches grandmother; cried in response to Tom yelling “no”; stopped playing peek-a-boo; whimpered when Tom attempted to play with him.
- Normal Range? yes no
- Basis for conclusion:
 - Has signs of attachment to grandmother and responds to Tom’s reprimand, which is developmentally appropriate, but by 12 months should play games like peek-a-boo with familiar adults. It’s a concern that he once did that but has stopped.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development: Neglect by his mother.

Completed Observation Notes: Anthony at Age 4

Physical Development

Behavior or characteristics:

- Small for his age—
- Around 5th percentile for weight; height getting closer to average, but still only about 10th percentile. However, he is on his curve. Throws a ball over hand, runs, rides a tricycle.
- Normal Range? yes no
- Basis for conclusion:
 - Although he is small, he is still growing proportionately and is still “on his curve.” Large motor activities (riding trike, running, throwing) are within the normal range.

- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Early effects of lack of prenatal care still evident in small stature. Fine motor development being encouraged by activities with Nonna, drawing, playing with construction set, stacking blocks. Large motor growth stimulated by games (like catch) with Nero and opportunities to ride tricycle.

Cognitive Development (include notes about language development here)

Behavior or characteristics:

- Speaks in short grammatical sentences, scribbles, stacks four blocks, listens to stories and finds pictures; counts, but not accurately; talks to himself to guide himself through task; moves quickly from one activity to next.
- Normal Range? yes no
- Basis for conclusion:
 - By this point, Anthony should be able to count 4 objects accurately, and draw rather than scribble. His short attention span is a concern. By now he should listen to stories eagerly and for longer periods, and stack more than 4 blocks before knocking them down and moving on. Language seems more on target. Talking to himself through an activity is normal at this age, as are short grammatical sentences.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
- History of neglect—lack of stimulation with mother and possible drug use by mother may contribute to lag. More consistent care and attention from Nonna and other family members is a mitigating factor.

Socio-emotional Development (include moral development here)

Behavior or characteristics:

- Plays with his cousin and Nonna; frustrates easily and cries and hits when frustrated.
- Normal Range? yes no
- Basis for conclusion:
 - Interacts with family members; easy frustration and crying or hitting when frustrated are normal for this age.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Time spent with his grandmother, great grandmother, uncles, and cousin have helped Anthony with attachment and socialization.

Completed Observation Notes: Anthony at Age 13

Physical Development

Behavior or characteristics:

- Still small for his age—around 5th percentile for weight; height a little closer to average, but still only about 10th percentile. Beginning to get mustache.
- Normal Range? yes no
- Basis for conclusion:
 - Although he is small, he is still growing proportionately and is still “on his curve.” Start of mustache normal for age.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Early effects of lack of prenatal care still evident in small stature.

Cognitive Development

Behavior or characteristics:

- Diagnosed with ADHD and learning disabilities. Does not take prescribed Ritalin. Performs below potential at school. Feels school is “boring.”
- Normal Range? yes no
- Basis for conclusion:
 - Anthony’s school has indicated that he is not achieving as expected and that he is ADHD and has learning disabilities.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - History of neglect—lack of stimulation with mother and possible drug use by mother may contribute to lag. Lack of support for and assistance with schoolwork at home contributes to poor motivation and performance, as does failure to take his medication.

Socio-emotional Development (include moral development here)

Behavior or characteristics:

- Concerned with body image, peer acceptance, and establishing identity. Conflict with his mother, daydreaming, and desire to be independent. Does not talk readily to adults about his questions and concerns.
- Normal Range? yes no
- Basis for conclusion:
 - Behavior and concerns are normal in adolescents. Conflict with adults, daydreaming and failure to talk to and confide in adults is also typical.
- Describe the caregiver or environmental factors that contribute to this normal or below normal development:
 - Past neglect and poor relationship with his mother, physical abuse by his stepfather, and current ambivalence about fathers are concerns. Support from and attachment to his Nonna and other family members are still mitigating factors.

At the end of this exercise, the trainer should ask if there are questions about this exercise or the **Child and Adolescent Development Resource Book**. If not, the trainer should go to the closing activities.

Module 9: Child Development

Section IV: Self-Assessment and Transfer of Learning

Estimated Length of Time:

30 minutes

Learning Objectives:

Participants will be able to:

- ✓ Construct a plan for the successful transfer of their learning to the workplace.

Methods of Presentation:

Individual activity, Large Group Discussion

Materials Needed:

- ✓ Handout #3 (The Learning Grid) (revisited)
- ✓ Handout #15 (Self Assessment for Module 9)
- ✓ Handout #16 (Transfer of Learning Activities for Module 9)
- ✓ Trainer evaluation forms

Outline of Presentation:

- Presenter facilitates trainer self-assessments and transfer of learning plans

Section IV: Self-Assessment and Transfer of Learning

Trainer Note: This is a critical section and will need the entire 30 minutes assigned.

Trainer Note: Review the WIIFM poster and be sure that all of the questions and concerns have been addressed.

Step 1: (10 minutes)

Individual Activity

The trainer advises the group that they have reached the stage of the training that requires a transfer of learning plan to implement upon return to their agencies. The plan is their key to transferring what they learned to their work behavior.

As a transfer of learning exercise, the trainer must again read the seven statements on **Handout #3 (The Learning Grid)** to participants. After reading the statement, participants should be directed to mark on their **Handout #3 (The Learning Grid)** next to the statement which they feel represents their current level of knowledge. When all participants have done this, the trainer should ask how many participants stayed on the same level as they had at the beginning of the training. If there are any, the trainer must ask those participants to name something they learned that they thought would be useful to them when they return to their job. The trainer should then ask how many participants went to a higher level than they were at the beginning of the training. Trainer should ask those participants what was the most valuable thing they learned at today's training. The participant's answers should be commented on by the trainer.

Step 2: (5 minutes)

Lecture

Using **Handout #15 (Self-Assessment for Module 9)** the trainer reviews the objectives of the training day. Note these are the same as the self-assessment knowledge and skill categories.

Step 3: (10 minutes)

Individual Activity: Trainee Self-Assessment

The trainer refers participants again to **Handout #15 (Self-Assessment for Module 9)**, instructing participant to complete the Self Assessment. Inform the participants that it is important that they accurately assess their ability. It is not expected at this stage of training to have mastered all the areas of training. It is through their recognition of a need to continue to grow that they take the steps necessary to do so. For each item, participants list who will do what by when. Participants should not feel limited by the prescribed numbers and should list additional items if they choose.

The trainer then asks participants to (individually) complete their plans.

After they complete their forms ask each participant to share one piece of knowledge/skill they want to improve and the action they think will help them improve the identified knowledge/skill. Go around the room until each participant has participated.

Ask participants if they have shared their Self Assessments with their supervisors. Some may say “yes”, some may say “no”. For those who say “no” ask them what barriers they have faced regarding discussing their Self Assessments with their supervisors. Acknowledge that the barriers are real and will continue to exist.

Ask participants who said they have shared their Self Assessments how/when they have managed to do so. Ask them what they gain from these discussions. Hopefully the other participants will share some techniques that other participants can use. Also other participants will see the benefits from the information that the other participants are sharing.

Step 4 (5 minutes)

Next Steps – Preparing for Additional Training

If this is a cohort:

Use **Handout #16 (Transfer of Learning for Module 9)** to remind participants of their next day of training and their required post and pre-training responsibilities.

Tell participants that in Module 10, they will be presenting a case to a panel of social services experts from the fields of mental health, mental retardation, drug and alcohol, and domestic violence. In order to make the experience real for them, ask them to review their current cases and consider if one of those cases would be appropriate to present to the panel for input, help with case planning, help with accessing services, etc. The participants should be prepared to present their case to the panel.

If necessary, discuss with the participants the kinds of cases that might be appropriate to present to the panel.

Ask trainees to complete the Training Program evaluation, encouraging them to include written comments in addition to the feedback scores. Tell them that the comments are usually the most useful information for us in improving the curriculum and presentation.

Bibliography

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, N.J.: Erlbaum.

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