California Social Work Education Center

C A L S W E C

INTERPROFESSIONAL COLLABORATION

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CalSWEC PREFACE

The California Social Work Education Center (CalSWEC) is the nation’s largest state coalition of social work educators and practitioners. It is a consortium of the state’s 19 accredited schools of social work, the 58 county departments of social services and mental health, the California Department of Social Services, and the California Chapter of the National Association of Social Workers.

The primary purpose of CalSWEC is an educational one. Our central task is to provide specialized education and training for social workers who practice in the field of public child welfare. Our stated mission, in part, is “to facilitate the integration of education and practice.” But this is not our ultimate goal. Our ultimate goal is to improve the lives of children and families who are the users and the purpose of the child welfare system. By educating others and ourselves, we intend a positive result for children: safety, a permanent home, and the opportunity to fulfill their developmental promise.

To achieve this challenging goal, the education and practice-related activities of CalSWEC are varied: recruitment of a diverse group of social workers, defining a continuum of education and training, engaging in research and evaluation of best practices, advocating for responsive social policy, and exploring other avenues to accomplish the CalSWEC mission. Education is a process, and necessarily an ongoing one involving interaction with a changing world. One who hopes to practice successfully in any field does not become “educated” and then cease to observe and learn.

To foster continuing learning and evidence-based practice within the child welfare field, CalSWEC funds a series of curriculum sections that employ varied
research methods to advance the knowledge of best practices in child welfare. These sections, on varied child welfare topics, are intended to enhance curriculum for Title IV-E graduate social work education programs and for continuing education of child welfare agency staff. To increase distribution and learning throughout the state, and worldwide, curriculum sections are made available online through the CalSWEC Child Welfare Resource Library (www.csulb.edu/projects/ccwrl).

The section that follows has been commissioned with your learning in mind. We at CalSWEC hope it serves you well.
EDITOR’S PREFACE

The California graduate schools of social work have been educating public child welfare workers using the Competency Based Child Welfare Curriculum since 1992. The curriculum was modified in January 1996 based on input from all constituent members of CalSWEC, including deans and directors of social work programs, directors of county welfare agencies, professional organizations such as NASW, field liaisons, classroom faculty, student graduates, and community members throughout the state. Our coalition now includes 12 graduate schools of social work and plans are underway for the graduate curriculum to articulate with the statewide training academy inservice curriculum for child welfare workers.

The competency-based approach is designed to encourage schools to infuse public child welfare practice content into already existing resources, to develop new courses addressing a specialization in public child welfare, and to create guidelines for consistency in field placements in public child welfare. It is intended to allow for maximum decision making opportunities on the part of the schools while still paying attention to the provision of a consistent experience for the preservice student of child welfare.

This curriculum module, Interprofessional Collaboration, is the result of a curriculum development opportunity that the Curriculum Committee of the CalSWEC Board offered to social work faculty in California. A request for proposals was published in Fall 1996, which was based on what our stakeholders (child welfare and mental health practitioners, colleagues from the legal profession, faculty, graduates, students,

and administrators) had identified as gaps in the preparation of social workers for public child welfare service.

This product is meant to teach social workers to convey their knowledge of human development to other professionals who work with them in the field of child welfare. As such, it begins with three modules about the principles of interprofessional collaboration, team building, and communication styles. Two modules follow about working with families in interprofessional teams, addressing the interdisciplinary problems with which families and children have to cope (e.g., mental health, health, and environmental) using an integrated services method. It leads to the understanding of the whole child and family ecological approach to child welfare and utilizing the social worker's knowledge of human development.

This curriculum module can be used in several different ways. The Curriculum Committee intended it for social work students in the classroom as well as for workers in the agency. Furthermore, this curriculum product can be easily applied to an interdisciplinary training or classroom situation with social workers from different agencies and with other professionals:

- As curriculum materials which could stand on their own for use in individual classes within courses or training.

- To encourage the development of courses, which cross-cut the traditional social work education categories (methods, human development, policy, research, and field) with public child welfare practice.

- As discussion tools/exercises, which can be used in already existing courses needing interprofessional collaboration examples.
We encourage the reader to use this material freely. We only ask that you cite us when you do.

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October 1997
INTRODUCTION

The following five curriculum modules were developed to promote interagency and collaborative practice for interprofessional teams working with children and families. It is hoped that the modules will be used for the purpose of training social work professionals and others working in the area of child welfare.

The modules were developed as an extension of the principal authors' collaborative work in conjunction with the Interprofessional Training Project at California State University, Fresno. This joint effort between the School of Education and Human Development and the School of Health and Human Services has been ongoing for approximately 3 years. Six curriculum modules were produced by the collaborative team on that project, but the content in these modules is not duplicative. Some basic universal themes of interdisciplinary collaboration cut across many published works in the field, and the authors have blended these with specific Title IV-E competencies to produce this publication.

Suggested uses of the curriculum modules include university courses in social work, inservice training for child welfare professionals, and cross-training workshops for multiple helping professions. Where possible, it is best to conduct interprofessional training and education with a cross-section of disciplines actively engaged in work with families. The modules draw from current theory and research and provide opportunities for students to discuss case studies, engage in role plays and activities, and demonstrate critical thought.
Module I addresses interdisciplinary collaboration, principles of interagency practice, and how to work effectively with other professionals in various settings. Module II discusses team building and potential barriers to collaboration in the context of effective client outcomes. Module III examines the important skills of conflict resolution, negotiation, and effective communication. Module IV includes information on child development, parenting, family assessment, risk and resiliency research, and the use of interdisciplinary teams. Examination of the effects of poverty, racism, and cultural influences is also included. Module V defines and explains the whole child perspective. Family and community contexts are examined as well as risk and protective factors. The impact of academic problems, physical disabilities, and health and emotional issues are also explicated.

Other resources for those interested in interdisciplinary collaboration include an Internet Listserv available from Fordham University (clinton@mary.fordham.edu), as well as the references listed at the end of the curriculum. We hope that these modules may stimulate interest in this exciting movement.

The authors would like to acknowledge the support of our Dean, Dr. Benjamin Cuellar, the encouragement of the Associate Dean of the School of Education and Human Development, Dr. Berta Gonzalez, and the team members of the Interprofessional Training Project at CSUF.
MODULE I

INTERPROFESSIONAL COLLABORATION
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INTERPROFESSIONAL COLLABORATION

INTRODUCTION

This introductory module sets the context for the following four modules. Clarity regarding the unique characteristics and value assumptions regarding interprofessional collaboration are essential in knowing what interprofessional collaboration represents. Because interprofessional collaboration is often misunderstood as only a method of working together, such as in coordination or cooperation, it is particularly important that its distinctive features be comprehended in theory and in practice.

The interprofessional collaboration approach to provision of services to children and families emphasizes shared team accountability, mutuality and respect among team members, participation by all individuals and agencies who are relevant to a child's difficulties (including parents), and integrated service delivery. A distinguishing characteristic, based on the inclusiveness of the collaborative ethic and the vital role of the parents on the team, is the view that successful collaboration will ultimately augment community development.

Ecosystemic concepts that provide a framework for interprofessional practice methods are reviewed. Central in this conceptual formulation are the perspectives that a child's behavior needs to be understood in relation to others around him or her, rather than viewing the child in isolation. Individual behavior is understood in light of all relevant factors (i.e., biopsychosocial, physical, and social environmental) and in terms of clusters of individuals (family functioning, teacher/student, student/peers, etc.). It is

essential to understand the systems (family, school, health, peer, etc.) that a child is a part of in order to understand the child's experience. Equally important is the strength-based perspective of the interconnectedness and adaptiveness of children and families to their environment. An emphasis on exploration of all possible factors that may play a role in understanding a child or family's difficulties involves attending to diversity issues. These factors include ethnicity, gender, socioeconomic class, disability, and other determinants that may contribute to low social power in the lives of the child and his or her family.

Although there are several programs offering coursework and certification in interprofessional collaboration nationally and at other California universities in particular (e.g., Fullerton, Long Beach, Monterey Bay, Sacramento, and San Francisco), we do not have information regarding the similarity of this module to curricula at these other universities.

The CalSWEC competencies addressed in this module are derived from the Workplace Management and Child Welfare Management Sections. These include:

5.3 Student is able to identify organizational strengths and weaknesses in the organization in which he or she works.

5.4 Student works through formal and informal channels to enhance organizational effectiveness.

6.5 Student understands how the manager facilitates effective teamwork by staff.

It is intended that this module will supplement social work theory of practice curriculum regarding multidimensional assessment and intervention to include the social work role and purpose on human services teams. Greater clarity about the unique
contribution of interprofessional collaboration emphasizes intervention skills with different size systems (individual, family, organization, and community), and contains content that is directly relevant to policy formation. While this module is developed for students across disciplines, it is expected that this content will build on and sharpen social work students' knowledge about case management concepts and skills. Regarding field work, this module is most directly relevant to students in school-based or related human services. References provided in this module and the other four modules identify resources regarding research, concepts, and examples of interprofessional models.

To date, this module has not been piloted by the authors. While each of the five modules can be presented in different combinations, it is suggested that presentations of Modules II through V, always include core concepts from Module I, because of the structure and framework that is provided here. As mentioned earlier, this module is the most applicable to the practice and policy sequences, and in some instances, to field instruction.

**GOALS**

Students will understand the purpose and unique characteristics of interprofessional collaboration. They will learn how collaboration is distinct from other forms of interprofessional team work and about examples of successful models. Through introduction to content and experiential activities, students will learn about the perspectives that they bring to interprofessional collaboration and key concepts that will guide their practice.

OBJECTIVES

At the completion of this module, the student will be able to:

1. Be knowledgeable about the unique characteristics of collaboration as distinct from other forms of team practices such as cooperation, coordination, and linkage interventions as found in case management.

2. Be knowledgeable about successful models of interprofessional collaboration.

3. Be knowledgeable about ecological theory and systems theory and their application to interprofessional practice.

4. Be familiar with the knowledge base, values, and skills that underlie effective interprofessional practice.

5. Be knowledgeable about the principles that guide competent interagency team work, including awareness about possible pitfalls.

6. Be knowledgeable about team dynamics that support successful team functioning or undermine achievement of team goals.

7. Be aware of legal/ethical considerations relating to interprofessional practice, and particularly as these concerns relate to practice with diverse populations.

DEFINITIONS AND MODELS OF INTERPROFESSIONAL COLLABORATION
(Allender et al., 1997)

Definition of Collaborative Work (Overhead 1)

- Coordination: Directed by a team leader, this approach is characterized by sharing mutual goals and pooling of resources.

- Cooperation: The team maintains individual agency identity, power, authority, and independence. Activities include resource sharing. Decision making is characterized by negotiation between agencies.

- Collaboration: Joint team effort is a well-defined, mutually beneficial working relationship, showing mutual respect, commitment to common goals, and shared accountability governance.
Examples of Collaborative Training Models and Programs (Overhead 2)

- Five Models (Hooper-Briar & Lawson, 1994)
  - Home and neighborhood based: This approach operates from a neighborhood facility (e.g., home, storefront, urban project).
  - Community-based: These services operate from local facilities (e.g. Child Protective Services Agency, clinic, mental health/public health multi-service center, shopping mall, library).
  - School-linked: Although services are not housed at a school site, a particular school-based population is defined as the population being served.
  - School-based: Services are located at the school site.
  - Saturation-oriented: This represents a combination of the above.

- Successful models at the University of Utah (Winitzky, Sheridan, Crow, Welch, & Kennedy, 1995)
  - Collaborative educational problem solving and conflict management course
    - A graduate course was developed and co-taught by faculty from Educational Administration, Educational Psychology, Educational Studies, and Special Education.
    - An ecological theoretical framework was used as an orientation to define the various professional roles and their purpose. Client problems were defined in relation to contextual variables, such as family-school interactions, family difficulties (low income, overburdened with problems). Ecological theory proposes that all organisms are in dynamic interaction and therefore interconnected. The emphasis on the active participation and adaptiveness of individuals with their environments is the basis of a transactional view of behavior. "Goodness of fit" is examined in the person's environment interaction (individual needs vs. environmental resources) in order to assess problem areas. Rather than view behavior from a deficit and potentially victim-blaming perspective, ecological theory defines client problems as "problems in living" (Germain, 1978).
    - Objectives included:
      - Learning the collaborative model of educational problem solving and decision making.
- Understanding the roles and functions of educational personnel within a school system.
- Recognizing the methods of identifying resources, pooling expertise, and sharing responsibilities.
- Applying collaborative decision-making strategies to case studies.

- Conflict management addressed learning about their personal style in interpersonal communication and conflict management, and effective ways of dealing with differences on the team.

- Students engaged in creating a video of interprofessional interaction on a team for purposes of analyzing interaction.

  - Interprofessional roles can be assigned to role-play the first meeting of a team at school site (i.e., nurse, teacher, social workers, psychologist, principal, parent), identify the presenting problem (specific behavioral terms), and the purpose of the meeting. Be explicit about what you want the students to focus on as an outcome (e.g., building rapport, clarifying the presenting problem, delegating tasks, team assuming mutual responsibility).

- Faculty may want to experiment with:
  - A role-play with the parent present and one with the parent not present.
  - Examples of strained vs. flowing discussion.

- Students engage in structured problem-solving activities that facilitate skill building of competencies.

  - Site-based Transdisciplinary Educational Partnerships Project (STEPships Project): School of Education, a federally funded project.

    - The three objectives include to:
      - Instill a collaborative ethic in preservice education for teachers.
      - Enhance collaborative skills.
      - Provide knowledge base and skills to understand the process of change in the contexts of site-based school reform and restructuring of service delivery.

- Planning included project directors meeting with school administrators to identify preservice training needs.

~ Education faculty involved the public schools in the creation of Professional Development Schools.

~ Preservice teachers worked on-site with teachers on interprofessional teams for two semesters identifying specific areas of need (i.e., special population) and utilized problem-solving methods in dealing with children's issues. The first semester involves applying ecological theory to problem solving on a special issue (i.e., risk factor) and the second semester involves implementing the intervention plan.

~ Inquiry activities are grounded in three activities (p. 113-114): Individuals and the team pose specific questions about serving students at risk and those with special needs.

- **Reflection**: The team focuses on the needs of at-risk students and the resources (e.g., within and outside of the school) that can be utilized to augment the experiences of students and teachers. The process involves dialogue in the classroom and journaling.

- **Outcomes**: Quantitative and qualitative outcomes are measured at the student, teacher, and school levels.

### Utah Network Project: Schools of Education and Social Work joined an elementary school, school district, and community organization to develop, implement, and evaluate new approaches to collaboration in the education of social workers and educators.

~ The project focused on teaching school social workers and educators how to work effectively together at a school site.

~ The primary activity was the involvement of institutional and community participants in the classroom and practicum curriculum development.

~ Activities are focused on the special population, for example, learning needs of at-risk children.

~ The program is implemented in increments:

- **1st year**: Activities include creating working relationships among participants, developing a collaborative at the school site, recruiting university students for internships, educating school staff on a collaborative model of problem solving, and organizing the project’s governance structure.

- **2nd/3rd years**: Activities involve implementation of the community-based problem-solving model and integration of education and social work university students.
- Practice-focused models of interprofessional collaboration. Although many of the following models were developed in California, these models are now implemented nationally.

  ~ Child Sexual Abuse Treatment Program (CSATP) and Henry Giarretto Model

  - Developed in Santa Clara, CA, this model has an interprofessional approach to assessment and treatment of sexual abuse (i.e., social work, probation, juvenile justice, school personnel, mental health, public health, etc.).

  - Training emphasizes collaborative efforts needed between the professional, the child, and the family.

  ~ Child Death Review Teams (Michael Durfee, Los Angeles, CA).

  - A human services team holds monthly meetings that are a forum for the review of non-accidental and suspicious children's deaths identified by the Coroner's office.

  - The focus of the discussion is a retrospective discussion of the role various human services roles played in the life and the death of the child.

  - All relevant agencies and individuals are present at discussions.

  ~ Suspected Child Abuse and Neglect (SCAN) teams.

  - Monthly interprofessional team meetings are held and comprised of human services professionals (i.e., child welfare services, mental health, public health, teachers, juvenile justice, and other service representatives).

  - The meetings are a forum, where "high risk" cases are identified by professionals for case review.
ACTIVITY 1-1

The purpose of the activity is to have students examine their value assumptions about teams, how they work, and what they see as their role on a team. First, ask them to draw a picture (instructions below), and then ask them, one at a time, to explain their drawing to the class. Remind students that they don’t have to be a good artist! The purpose is to get at their impressions and to share those with one another. The activity is estimated to take approximately 30-40 minutes. Faculty have the option of listing feedback on a board and working with the feedback.

Instructions:

1. Please get a sheet of paper and draw an image of what you imagine to be the purpose of an interprofessional collaboration team and your role in achieving that purpose. You may draw symbols, representational figures (people), or anything that you please. Remind students that the quality of the drawing is not important. The purpose of the activity is for them to express their impressions of these two concerns.

2. Ask the students, one at a time, to share their image and to present their thinking about their perception about the purpose of the team and their role on the team. (You may want to create two columns, purpose and role, on the board and list student comments under each.)

3. When everyone has shared, ask if students have responses to one another or if there is anything that anyone would like to observe or ask.

4. Summarize the central themes that students identified.
   a. Emphasize similarities: Identify dynamics and perceptions that students shared.
   b. Make observations about differences: Point out the diverse perceptions that individuals bring to teams that can influence their interactions with others.

Modified from “institution in the mind” activity, (Grubb Institute, London, England).
Interprofessional Collaboration: Knowledge, Values and Skills (Overhead 3)

Effective practice on an interprofessional team should be based on the following:

- Knowledge
  - Team members have familiarity regarding diverse professional terminology that can interface with direct and open communication.
  - Each team member identifies and defines their profession's and/or personal perspective on commonly used terms.
  - Ecological Systems Theory (Compton & Galaway, 1994): This perspective interprets individual behavior in a context of the person-environment interrelatedness and from transactions between person and environment. That is, all possible factors are considered in assessing and understanding behavior. Factors are considered on three levels: micro (individual, psychological), mezzo (family, social support), and macro (physical and social environment). Focus is shifted from a cause and effect (i.e., linear) view of behavior, to one that views the person and situation as an interrelated whole. For example, in understanding a child's acting out in the classroom, all possible factors that may include family functioning, family stressors, child's health, and family-school interaction are explored.
  - Team members have familiarity with systems concepts. These include:
    ~ Boundaries: A boundary is a "closed circle around selected variables, where there is less interchange of energy or communication across the circle than there is within the circle." Systems can be open or closed and are relatively open (p. 121).
    ~ Feedback and purposive systems: Systems are characterized by goal-directed feedback loops. Feedback refers to "a communications network [that] produces action in response to an input of information and includes results of its own action in the new information by which it modifies its subsequent behavior (Deutsch, 1968, p. 390 as cited in Compton & Galaway, 1994).
    ~ Equifinality: The achievement of identical outcomes from different initial conditions.
    ~ Multifinality: Similar conditions may lead to dissimilar end states.
    ~ Change and stability: "Systems are both goal directed and require a degree of order and stability. There is support for the view that once a pattern of interaction is established (homeostasis), that it cannot be changed by the system alone" (pp. 123-124).
• Values reflected in team practice include:
  ▪ Openness, risk-taking, flexibility, and good communication. The capacity to give and take feedback is essential. This involves effort that is directed at creating mutually developed goals and processing differences in perspectives.
  ▪ The ecological systemic perspective views behavior from a person-environment interactional perspective. All possible factors that may have a part in creating "problems in living" for the child and family are explored.
  ▪ Mutuality: This approach focuses on the development of partnerships and joining together for goal achievement. Team members understand the significant role of shared accountability.

• Skills
  ▪ Ability to facilitate effective team functioning and team accountability is negotiated. The team participates in:
    ~ Problem formulation.
    ~ Intervention planning and implementation.
    ~ Follow-up.
    ~ Evaluation of process—Use of qualitative and quantitative measures for evaluation of change.
  ▪ Managing differences through conflict resolution:
    ~ The team learns to manage conflict directly and constructively. This involves validation of each individual's concerns and examination of possible gains for all involved.
    ~ The team engages in negotiation strategies (Covey, 1989).
      - The team engages in "mutually" beneficial and mutually satisfying "solutions."
      - This perspective assumes that there are sufficient resources for everyone and that one entity's success is not achieved at the "expense or exclusion of the success of others."
      - There is appreciation for the interdependency of the involved parties.
      - There is openness by the conflicting parties to consider a new third option that is different from those options already proposed. This option is most applicable in the beginning of a working relationship.
- Essential ingredients for effective negotiation include character, working relationships based on open communication, trust, and support (e.g., direct communication, giving and taking feedback).

- Communication skills: Learning to give and take feedback, give direct communication, and practice active listening.

- Keeping focused on outcomes: A clear focus on shared accountability and goals facilitates the team keeping perspective on role and purpose.

- Examining how various professions frame problems (e.g., code of ethics).
  - The team shares the various professional perspectives on the helping process/roles.
  - The team minimizes the use of jargon by making efforts to use descriptive language.

- Dealing with differences in personal styles: Team members need to be cognizant of their own communication style, its possible effects on interaction with others, and the effects of other individuals' communication styles on them.

- Process skills in interprofessional collaboration are based on:
  - Recognition and awareness of the multi-professional identities and perspectives on the team.
  - Team members having the skill and ability to engage differences between professionals by focusing on interaction in negotiating differences of opinion.

- Case Management: Case management is a client-focused intervention that promotes coordination of human services, opportunities, or benefits, and leads to boundary spanning that links clients to agencies and organizations (Rubin, 1987). The purpose is to achieve continuity of care (Johnson & Rubin, 1983) and ensure that persons receive appropriate services in a timely fashion (Moxley, 1989; Raiff & Shore, 1993, p. 4). Case management focuses on identifying and meeting a broad range of client needs and to the changing nature of those needs” (Moxley, p. 12).

  - Basic concepts include (Moxley, 1989, p. 12):
    - Client-level services: The practitioner works on behalf of a specific person or group of persons.
    - Coordination of services: The practitioner mobilizes human
service providers in formulating focused service goals for the client. Agreement is secured across agencies regarding the client's care.

- Integration: The case manager strives to create a direction of services that reflect a distinct plan for services.
- Continuity of care: A comprehensive plan of care that meets the client's needs over time is developed. Case management functions include:
  - Identifying common goals.
  - Involving parents; by joining with the family rather than "doing" for the client.
  - Interagency support is explored in relation to task achievement.
  - Team appreciates and utilizes community resources.
  - The team utilizes an Ecological/Systemic approach to assessing problem child "behavior" (i.e., micro, mezzo and macro level factors).

PRINCIPLES OF INTERAGENCY PRACTICE

The Team Value on Self-Reflection is a basis of the team’s professional growth and development. Such an attitude is open to change and appreciation of diversity.

- Team effectiveness needs to be founded on recognition of each of the participating agencies and their organizational administrative procedures and protocols.
- Interprofessional collaboration is transformative in that it leads to change in the way that "business as usual" is conducted. Greater attention is given to understanding the uniqueness of problem situations and the special needs of children and families who are confronting difficulties.
- Cross-cultural competency is institutionally valued (Cross, Bazron, Dennis & Isaacs, 1989). Cross cultural competency is the ability to practice effectively with clients of diverse backgrounds. It is more than awareness, it represents an ability to apply cross-cultural concepts in practice.
  - Cross-cultural competency involves awareness of one's own cultural limitations and openness to cultural difference. It is a client-oriented learning style (i.e., ethnographic orientation), and a willingness to learn about and utilize diverse cultural resources (Green, 1982, pp. 54-56).
Cultural competence includes a knowledge, skill, and value base. This perspective includes motivation to learn about other cultures’ specific practices and worldviews, a capacity to effectively assess a client in the context of cultural factors, appreciation for difference, and an ability to distinguish the heterogeneity within a specific culture (Manoleas, 1994).

Organizational Life as Culture (Overhead 4): Organizational values are important to recognize in order to achieve team goals.

- Awareness of organizational values assists in understanding professional experiences.
  - Awareness of organizational culture directs us to examine the values, norms, and practices that are encouraged and those that are not. For example, how is difference dealt with?
  - A healthy organization is clear about boundaries regarding responsibilities. Direct and open communication is encouraged.
- Identifying resources for change is useful in force field analysis (Brager & Holloway, 1978). It can be utilized to identify factors that have a role in supporting or blocking change. For example, it is useful to examine organizational policy and practices as well as organizational roles.
  - Identify persons and roles that act as barriers toward change and determine strategies for dealing with these.
  - Identify persons and roles that act as resources for change.
- Formal vs. informal systems
  - Knowledge regarding working with formal organizational systems.
  - Utilization of informal networking can be used for building support and as a base for interprofessional collaboration.
  - Work with informal power structure to enhance team effectiveness.
- Feedback processes and change:
  - Team members need to explore value assumptions regarding how feedback is used.
  - Exploration of team differences encourages appreciation of diversity and flexibility in working with feedback from all team members.
- Perspective on behavioral change: It is essential for students to examine the value assumptions that they hold regarding how people change and what is
needed to initiate change in the lives of their clients. Their value assumptions have implications for what information they seek and how they view their role and purpose.

- Deficit ("fixing" clients) vs. strength perspective (Saleeby, 1997). The deficit model views clients from a psychopathology perspective and emphasizes a worker-dominated intervention rather than a mutual perspective on practice intervention. The strength perspective encourages workers to seek information on and reinforce the adaptive coping client behaviors.

- Value assumption regarding how change occurs. A view by the practitioner of individual character as determined in infancy and childhood orients the practitioner in a very different way from a perspective that views the individual as changing with experience over the lifespan.

**Interagency Appreciation of Interprofessional Mission, Philosophy, and Goals**

- It is essential that involved agencies have clarity regarding the interprofessional team's evolving purpose.

- Team members have a responsibility to maintain open communication between their staff from their own agency and the other team members' organizations. It is important to keep their staff apprised of the activities and purpose of the team.

**Failure of Existing Services** are often associated with the following (Hooper-Briar & Lawson, 1994):

- Services are crisis oriented.

- There is a fragmented and decontextualized view of the client problem.

- Poor communication exists between agencies.

- Services are too specialized.

- There is a lack of outreach services.

- There is a lack of diversity delivery system services.

**Bridging Strategies: Promoting Service Delivery Across Agencies**

- Integrated services can be developed that interweave service delivery to children and families.
• Negotiate differences among team members’ perspectives regarding what is "helpful" to the client.

• Acknowledge and work with agency/organizational mandates.

**WORKING WITH OTHER PROFESSIONALS AND PARENTS TOWARD IMPROVED OUTCOMES FOR CLIENTS:** Children (motivation to learn and grow) and families (healthy functioning, flexible boundaries, protection, and socialization of children).

*Facilitation of Team/Group Process* and achievement of outcomes requires appreciation of unique worldview and values of all team members (professionals and parents).

*Teams Can Benefit by Structuring Time (Overhead 5)* to discuss each member’s point of view:

• Values: The team should set aside time to discuss their perspectives on the following issues:
  - Perceptions and beliefs regarding how clients change.
  - The role of the helping professional.
  - The nature of the working relationship (i.e., what responsibilities does the family take? Professional?)
  - The importance of engaging the family in mutually determining service outcomes.
  - Assessment and intervention implications of abuse (emotional, physical, and sexual) and neglect.
  - Involuntary clients: How to engage with them.

• Formulation of problems needs to include:
  - An assessment focus that assesses all possible factors that may have a role in creating the presenting problem.
  - The use of ecological systemic concepts in the formulation of problem and intervention planning (e.g. psychological, behavioral, developmental, educational, medical, and family factors).

• Team role expectations and stressors that the team may experience.
  - Team members need to develop awareness regarding other members' roles and purposes and each discipline's unique dynamics related to:
    ~ Unique stressors that arise in each profession.
Knowledge regarding professional qualities that are valued in each profession.

Team discussion of members’ unique backgrounds should include:

- The variety of professional requirements and criteria for educational degrees and licensing makes it useful for the team to be aware of the unique professional requirements of its members.

- Contributions of parent and community liaisons: Non-professional members need to feel equally visible and integrated into the team functioning. The team may want to acknowledge the civic and community contributions and/or other activities of parent team members.

- Client/agency/professional responsibilities: The team needs to examine separate and shared responsibilities, as well as clarity regarding expectations of team members.

Legal/Ethical Issues (Overhead 6): The diverse legal and ethical constraints and responsibilities held by team members need to be examined. (Refer to California Welfare and Institutions Code, Section 827 and Section 10850 regarding exchange of information on child welfare cases).

- Confidentiality: Explore the responsibilities of professionals to different (possible conflicting) laws regarding client confidentiality. The participation of parents on the team raises special concerns regarding exercising confidentiality and respectfulness toward the participating parents’ concerns as well as issues raised about other families.

- Client records: Team needs to address questions regarding ownership of team records – Who does the recording? What information is collected? How is the information gathered and by whom? Who "owns" the records? How will information be shared and confidentiality maintained?

- Informed consent forms should include:
  - Client(s) names, signature, date, and date of expiration.
  - Type of information to be gathered and produced.
  - Reasons for request for services.
  - Information regarding who has access to records and for what purpose.
  - What copies can be made by whom.

• Mandated reporting responsibilities: It is essential to be cognizant of current and impending mandated reporting laws as they relate to each of the team members.
  ▪ Team discussion may focus on the professional responsibilities and the implications for the team.
  ▪ Team explores possible effects of mandated reporting and the implications for "working through" with families the mandated reporting event.

• Professional codes of ethics: The team can identify common themes across professions by:
  ▪ Reviewing any differences among professional codes of ethics.
  ▪ Identifying value assumptions that organize the diverse codes of ethics.

• Working toward a collaborative ethic:
  ▪ Each member builds on their own (professional) ethics toward the development of a team ethic.
  ▪ A common mission statement and/or goal statement should be developed and regularly re-examined by the team.

ACTIVITY 1-2

In the class meeting prior to the activity, ask students to write a summary of their own professional code of ethics. Tell the class there will be an activity on ethics and to bring their own code of ethics. Place each student in small groups of similar profession (if possible).

1. Ask the students to discuss the following in the small group.
   a. Ask students to identify core concepts, practices, and themes identified in their professional code of ethics.
   b. Ask students to discuss two or three key values that they view as relevant to interprofessional collaboration (e.g., they may end up talking about what attracted them to their profession).

2. Report out small group activity to larger class and then list key feedback on the board. Organize feedback into significant themes.

3. Follow up by asking students to come together in small groups to look for similar themes and develop a team philosophy/ethic.
VIGNETTE 1: LAURA (Handout 1)

Instructions: Ask the class to break into small groups of 3-4 and review the “Laura” case study. Once they have completed reading the vignette as a group, respond to the following questions and apply them to the vignette. Ask each group to select a representative who will report back to the class. This activity can also be used as a written assignment and discussed in small groups in class.
MODULE II

TEAM BUILDING
MODULE II
TEAM BUILDING

INTRODUCTION

This module is intended to introduce the dynamics that interprofessional team members will encounter in the process of team development and interaction. An understanding of group process and how it applies to interprofessional teamwork is essential for team members to have appreciation for the evolutionary nature of team development and efforts that enhance team effectiveness. Teamwork skills need to be grounded in awareness of knowledge and values that deal with issues associated with teamwork, such as managing diverse team member perspectives arising from agency mandates, professional terminology and values, and personal beliefs and values.

Effective teamwork is characterized by open communication and an ability to collaboratively formulate and implement integrated services for children and families. The establishment of a successfully working team makes possible the creative and interweaving of services that are needed for integrated service delivery. For example, home visits, which are an effective way of engaging with families creating trust and conducting assessment, can function as an integrated service intervention. Team members can collaborate on achieving multiple team (i.e., agency) goals through one team member's contact in home visits.

It is essential that team members recognize possible dynamics and interactions that can undermine the maintenance of the team. These factors include conflicts or lack of support between members and their organizations, exclusiveness of team subgroups,
and difficulty in managing conflict or change. The module content reviews these concerns and includes activities with which to engage the class in learning concepts and applying them to practice.

The Interprofessional Training Project (Allender et. al., 1997) team development module provided some key concepts for creating this competency-based module. Information is not available regarding how other universities with interprofessional curriculum have developed and integrated the content developed here into their programs.

The Child Welfare Competencies that are integrated in this module were derived from the Social Work Skills and Methods, Workplace Management, and Child Welfare Management Sections. These are:

3.5 Student understands the importance of home visiting and other out-of-office visiting to child welfare services.
3.8 Student identifies crises and conducts crisis counseling activities.
3.13 Student implements problem-solving strategies and empowers family members by teaching these new strategies.
3.16 Student understands theory of group process and can develop, lead, and evaluate support groups, treatment groups, and/or educational groups.
5.3 Student is able to identify organizational strengths and weaknesses in the organization in which he or she works.
5.4 Student works through formal and informal channels to enhance organizational effectiveness.
6.5 Student understands how the manager facilitates effective teamwork by staff.

This module is best suited for courses that have integrated content on working with organizations. In social work programs, this content may reside in the Human Behavior and Social Environment or Policy sequences. Also, practice sequence content
that addresses home visits, problem solving methodology, and crisis work can utilize this content in relation to implementing those methods in the context of team interventions. This module supplements field instruction activities that occur in staff team settings.

This module also supplements social work content on the role and purpose of the social worker in relation to other human services professionals and families. This content assists the practitioner in engaging with other human service providers, professionals, and parents in achieving mutually determined goals for children and families.

To date, this module has not been test piloted. Presentation of this module is recommended with Module I, which introduces the basic concepts of interprofessional collaboration. It also complements Module III, which addresses communication skills and conflict resolution.

**GOALS**

Students will gain familiarity with the unique team dynamics that lead to interprofessional collaboration in team settings. They will gain knowledge regarding key values in team building, communication processes, and skills that are essential for the maintenance of team effectiveness. Students will learn about team activities that are needed in working with families, as well as obstacles that can undermine such activities.
OBJECTIVES

After completing this module the student will be able to:

1. Identify the principles of interprofessional team building.
2. Describe the knowledge base and values of team building and team facilitation.
3. Name the basic skills needed for effective participation on an interprofessional team.
4. Describe team-building tasks and processes.
5. Demonstrate an ability to engage with and involve parents in interprofessional team activities.

PRINCIPLES OF INTERPROFESSIONAL TEAM BUILDING (Overhead 7)

Components: Effective team building involves the following factors

- Communication
  - Team members must have a willingness and ability to give and take feedback.
  - Members’ ability to self-reflect provides a basis for dialogue.
  - Flexibility in ability to initiate new directions through articulation of ideas, and capacity to engage in ideas proposed by other team members promotes open communication.

- Shared accountability and negotiating team roles include:
  - Team agreement on shared responsibility for intervention planning, implementation, and outcomes need to be established early.
  - Clarification and agreement on integrated service delivery outcome.
    - The team needs to commit to the development of clarity regarding an integrated service delivery model.
    - Team practices should reflect appreciation for and utilization of integrated service model.
Knowledge and Values of Team Building

- Team clarity regarding intervention plan and valued client system outcome is based on:
  - Application of ecological and systems theory in:
    - Problem-solving method of data gathering.
    - Assessment of the full range of problem factors affecting child and family.
  - Intervention means "to enter into an ongoing system" (Argyris, 1970, p. 15).
  - Appreciation for multilevel interventions (e.g., child behavior, family functioning, agency, and organizational factors) is based on understanding of systems concepts.

<table>
<thead>
<tr>
<th>ACTIVITY 2-1</th>
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<tr>
<td>STAND UP</td>
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<td>(De Rosa, 1992)</td>
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The purpose of this activity is to recognize and appreciate differences in experiences. Each individual has unique multiple experiences that affect self-perception and social identity. It is important not to "just tolerate;" but also a need to appreciate uniqueness in context of individual’s history, experiences, and meaning of experiences (Phinney, 1996). (The following will need to be modified according to your unique population.)

1. How many people were born in central valley? Fresno? Visalia?
2. How many were born in the USA?
3. How many people’s parents were born in another country?
5. How many people speak a language other than English? Speak three languages? More? Which ones?

Summary—point out that this was a brief exercise whose purpose was to explore differences in the group. There may be times that what you might expect of someone’s identity may be stereotypical. This reminds us that it is important to be curious and be open to exploring.

This activity can be followed by a discussion on professional differences on teams that result in diverse points of view. Discussion can focus on identifying skills professionals may need in order to work with these differences.
• Core values guiding team facilitation (Schwarz, 1994, p. 9):
  ▪ The team actively seeks valid information:
    ~ All valid information is shared.
    ~ The team continually seeks new information and appreciates ongoing assessment.
  ▪ Free and informed choice involves:
    ~ Members not feeling coerced or manipulated.
    ~ Members feeling that they base their choices on valid information (i.e., informed decision making).
  ▪ Commitment to the choice made by the team must be based on:
    ~ Members feeling responsible for team decisions.
    ~ Members finding the choices made by the team satisfying.

• Willingness for the risk-taking that is needed for open team communication is based on:
  ▪ Mutual respect between all members.
  ▪ Awareness that feedback will be direct when a team member takes the risk to express a controversial point or give critical feedback to another member, he/she needs to feel that the feedback to him or her will be straightforward when team members respond to him or her.
  ▪ The belief that differences are respected and that there is a team willingness to process differences.

• Possible problem areas and pitfalls include:
  ▪ Role ambiguity: There may be a lack of clarity regarding responsibilities.
  ▪ Role conflict: Overlapping of responsibilities or contradictions in team member’s outcome goals for child and family can result in disparate goals.
  ▪ Uneven distribution of responsibility on the team can lead to frustration and anger.

• Familiarity with evolutionary process of team building is essential.
  ▪ A process orientation toward team functioning focuses on the team’s affective interaction.
  ▪ Awareness of various team needs related to stage of development promotes open communication.

Skills

- Active listening (Brammer, 1985, p. 62) skills are characterized by:
  - A response to the total message (i.e., verbal and non-verbal).
  - The team member demonstrates cross-cultural competency.

- Team members recognize and can engage in metacommunication (Bateson, 1972, 1980).
  - Metacommunication is the "subject of the discourse is the relationship between the speakers" (1972, p. 178).
  - "Metacommunication refers to discussion that defines context or makes context intelligible" (1980, p. 129).

- Qualities of effective communication (Covey, 1989) are characterized by:
  - "Humility and reverence to recognize own perceptual limitations and [to] appreciation for the rich resources available through interaction with…other[s]" (p. 277).
  - "A willingness to understand the other and communicate that through one's conduct" (p. 238).

- Critical thinking (Brookfield, 1987, pp. 7-9) is an essential skill that facilitates:
  - The capacity to identify and challenge assumptions in one’s own and others’ thinking.
  - Challenging the importance of context: Team members are aware that practices, structures, and actions are never context free.
  - Imagining and exploring alternatives.
  - Engaging in reflective skepticism.

- Group members have the flexibility to attend to process and outcome tasks (e.g., gatekeeping, clarifying, and a willingness to take a risk by sharing a provocative and novel idea).
ACTIVITY 2-2
ON DEALING WITH OPPRESSION AND DIFFERENCE
(Melendez, 1994)

This exercise directs students to look for differences and similarities between people by first appreciating one’s own uniqueness and experience of that uniqueness and by being aware that all individuals have felt marginalized at some point about some issue.

Remind the students that everyone has experienced oppression in some way, such as in situations where individuals have to deal with negotiation and adaptation. These dynamics affect our practice and professional role in that the low social power associated with feeling oppressed puts an individual in a position of having to confront their feelings about that (those) experience and his or her feelings about others based on that experience.

Explain that this is an exercise in perspective taking. It is not about blame or responsibility taking, nor is it about choice. It will assist students in understanding the distinction between ascription and achievement.

Remind the class that this exercise will focus on psychological and social dynamics that have a role in supporting or undermining team building and maintenance. This exercise addresses beliefs and feelings that may get triggered in work with other professionals as well as work with children and families.

Instructions:

1. We will do the exercise first. During the exercise, people do not have to say anything. You will be asked to position according to your response to a question. Once you are in a position you are to look across at each other. While you are standing in the position, reflect on the implications of occupying that position.

2. When we have gone through the exercise we will take a break.

3. After the break, we come back to debrief and discuss the process. We will emphasize the concepts and values that emerge. We will discuss how this may affect your practice. We will also think about how this self-awareness can be reflected in your work.

Ask the class the following questions and follow with the reflections identified below.

Ask the class to stand up and point out that with each statement you will ask them to choose one of two corners of the room to go to.

A. “Do you identify as a person of color?” (All who say yes, go to the right; all others go to the left. Face each other. “All you have to do is listen.”)
This was originally a nation of color. Color has always had a charge in the U.S.

The experience of Native Americans has been genocide. The example of enforced acculturation – The Carlise School. The goal was to make the Indian into a White man. Currently, there are efforts to use reservations to store radioactive material or to take over lands that have been discovered to be mineral rich.

African Americans endured the importation of a whole group of people. It is important to see the connection between colonialism and capitalism. Despite their coerced migration, they have also been systematically excluded from mainstream American life.

- The U.S. Constitution declared a slave three-fifths of a person. The Worchester (Massachusetts) Studies show that African American men are more often diagnosed with severe mental illness. In medical science, the Tuskegee Syphilis study stands out as an unethical investigation in the name of science (i.e., control groups with no treatment in order to observe the progression of the disease and regular spinal taps as part of the treatment). Although organizations publicized the experiment in order to stop it, it didn’t received support until the ‘90s (Jones, 1993).
- Overrepresentation in agencies of social control: criminal justice and child welfare.
- Perception: African American males and the myth of violence.
- African American males constitute “25% of males involved in the criminal justice system.”
- There is differential sentencing in the justice system of African American males.
- There is greater alcohol and drug use and abuse.

Asians: Historic laws restricted entry thus creating gender disparity.

- Misappropriation of land and housing in camps during WWII (and not Germans).
- The myth of the model minority.
- Fear and competition – wish to limit entry to higher education.

Latinos: English only laws.

- Growing anti-immigrant sentiment.
• The myth that non-documentated aliens/workers only come to take from the U.S. economy.

• Colonialization of two groups:
  ▪ Mexican land appropriated by U.S. in 19th century; Mexican American labor force utilized as a surplus labor pool.
  ▪ Puerto Rican territorial status endowed population with citizenship status; U.S. presence remains today.

If you know anything about these historical, social, and political dynamics then you are familiar with oppression: Racism represents institutionalized race privilege.

B. IF NEITHER OF YOUR PARENTS WENT TO COLLEGE – go to the right side of the room. Consider the following facts:

• If your parents did not go to college, you have less than 7% of becoming a college professor.

• Parallels and intersections: Who bears the weight of integration? The White working class.

• Lost opportunity and access.

• The need to work longer hours, more difficult work that feels more like a job than a career and for less money.

• Status, power, and respect. How do you get it? Who gets it and who doesn’t?

• Issue of transracial adoptions: Oftentimes the family needs to be middle class in order to adopt.

• The underclass: Who is in it? How do individuals and families get caught in it? How do you get out?

• Whose values count?

• Education: Do children really get an equal education or does it depend on the community location?

If you know anything about this, then you know something about oppression called “Classism”: Middle- and upper-class privilege dominates the poor working underclass.

C. IF YOU WERE RAISED BY A SINGLE FEMALE PARENT OR ARE CURRENTLY A SINGLE FEMALE PARENT – go to my right. Consider the following:
Think of an overburdened woman who is the sole support of her children.

Are the attitudes regarding her “singlehood” immorality or co-dependency?

Women generate $.59 to every $1.00 of male income.

Human services staff is 655 women where their pay is not comparable to male salaries.

In social work, 80% of the labor force is female. Consider positions of authority.

Who is in administration? Devaluing of the profession is also due to providing services generally to poor women (i.e., through association).

Issues in mental health: Some diagnoses are found more often with women (e.g., Hysteria, Borderline Personality Disorder). Why?

The rise of domestic violence and rape.

If you know anything about this, then you know something about oppression called “Sexism”: Gender privilege of males results in domination, devaluation, marginalization, and invisibility of women.

D. IF YOU HAVE EVER CARED ABOUT SOMEONE WHO IS GAY, LESBIAN, OR BISEXUAL – step to my right.

(You may also ask the class to self-identify as gay/lesbian/bisexual.)

Recently in a survey of social work schools, 5% indicated that they would not admit someone who identifies as gay, lesbian, or bisexual. Some schools of social work are asking for CSWE exemption status from teaching mandated diversity content on sexual orientation.

Attitudes toward this group include: “Bad” (malicious), “mad” (mentally disordered), and “sad” (depressed). The presumption in most developmental theory is that sexual orientation outcome is either heterosexual or it is deviance. Traditionally, homosexuality was seen as paranoid schizophrenia and as a cause of alcoholism.

Reparative psychotherapy is often used, particularly the use of aversion techniques and lobotomy.

Politically, many problems remain:

- Political figures will refer to gay women as “those damn lesbians.”
There are legal acts of disenfranchisement in the way laws are written.

The stereotype exists that gay individuals are child molesters despite the research that 95% of molesters are heterosexual.

• “Fag” bashing results in loss of life, job, home, and children.

If you know anything about this, then you know something about the oppression called “Heterosexism”: Heterosexual gender privilege defines what is valued in terms of sexual activity.

Other exercises focus on: Anti-semitism, Adultism, Ableism, and Ageism.

TEAM BUILDING PROCESS AND TASKS

Assessing the Context of Team Building and identifying barriers and resources

• Adequate organizational supports have to be in place in order for the team to function at its best. In order to accomplish this, team members need to address:
  ▪ Each team member has sufficient release time to work with the team.
  ▪ Resources available through each organization/agency can be identified.
  ▪ The team can identify limitations presented by various organizations/agencies.
  ▪ Team effort can be directed at securing organizational/agency support from its respective team member to speak on its behalf.

• Liberty is obtained to make decisions on behalf of representative agencies (Allender et. al. 1997).

• Support is developed for creative team proposals and exploration of effective integrated service delivery methods.

Team Building Processes (Overhead 8)

• Stages of team development (Syer & Connolly, 1996). It is useful for team members to be aware of the stages of development that a team progresses through. Such knowledge facilitates insight into team processes and encourages greater flexibility in dealing with team dynamics.
  ▪ Team members are aware of their own perspective, of each other's perspectives, and of differences. Differences are appreciated. This perspective encourages members to look at professional values and
ethics in an inclusive way rather than from an either/or, good/bad perspective.

- Validation of professional values and ethics means that the team makes the time, when relevant, to learn about members' professional mandates.

- Acknowledgment of personal style includes the flexibility by the team for different methods of communicating that can emanate from personality, culture, or situational determinants.

- Achieving team outcome is promised on members contributing their unique perspectives and thus, their differences. A successful team is characterized by each member feeling that their contribution is valued.

- **Contact and communication with each other include:**
  - Practicing active listening.
  - Attending to each member's contribution with full awareness.
  - "Awareness of boundaries between members. Boundaries define, limit, and allow us to be in touch with what is not us" (Harman, 1982; in Syer & Connolly, 1996, p. 92).
  - Five personal behaviors that can interfere with contact between members:
    - **Projection:** Overreacting to a quality in another. The person is unaware that one has the quality in oneself.
    - **Introjection:** There is a lack of discrimination and unequivocal acceptance of information.
    - **Retroflection:** Doing to self what one would like to do to others, or doing for oneself what one would like others to do for us.
    - **Confluence:** There is a strong reluctance or inability to withdraw from interaction.
    - **Deflection:** There is an avoidance of contact by not showing interest or interrupting another.

- **Growth of respect, trust, and team spirit involves:**
  - Knowing one's own patterns of behavior and patterns of others and appreciating differences. It is not solely built on communication and contact.
  - The team reaches new levels of humor, directness, brainstorming, and creative conflict.
There are examples of productive teams where members may not like each other, but not where there is lack of trust and respect. Respect must be built on contact/awareness and knowing one another.

Factors that work against development of team cohesion in large groups (Slater, 1958, in Steiner, 1972, p. 86) include:

- Lack of coordination (i.e., direction).
- Insufficient opportunity to express one’s own point of view.
- Poor time management.
- Lack of meaningful outcomes.

Creating and Maintaining Support With On-Site School Staff involves (Allender et al., 1997):

- Outreach to school staff regarding role of team and parameters of tasks and responsibilities. This involves familiarizing teachers with the role and purpose of the team as a whole and of the individual team members as a resource to the school and families.
- Communication with school staff regarding referral making, teacher participation on the team, and teacher consultation on student concerns.

Creating and Maintaining Support With Parents and Community:

- Outreach to parents is viewed as an ongoing process that involves the following perspectives and practices based on ecological and systems theory:
  - Home visits are valued by the team as an integrated service delivery intervention (i.e., one contact by a team member can address several team members agency goals and/or purposes).
  - Home visits are utilized for the following goals:
    - Engage with and build trust with families.
    - Conduct time assessments for team review and formulation of services.
    - Assess for crisis situations that might affect child’s functioning in school.
- The parent is viewed and valued as an equal team member.
- Parent community activities that promote development of resources for children and their families are supported.

- The team supports and utilizes problem-solving methods in data gathering and interventions.

| ACTIVITY 2-3
| VALUE FOCUS
| (Adapted from Simon, Howe, & Kirschenbaum, 1978) |

This activity is designed to help students to be open to, accept, and understand others' values even though they may not agree with different points of view.

Procedures:

Ask students to complete the following sentences:

1. I feel best when I am in a task group of people that…

2. I feel worst when I am in a task group of people that…

After each has completed their sentences, ask the students to get into groups of three. Each student is to have 5 minutes to talk about his or her responses, with the full attention of others. The group's interaction is governed by the following rules:

a. **The rule of focusing**: Each member is to have full attention for 5 minutes. Do not let the focus shift until the 5 minutes are up or the person asks to stop. Maintain eye contact with the person at a comfortable level. Questions may be asked of the person as long as the focus does not shift to another member.

b. **The rule of acceptance**: Be warm, supportive, and accepting of the focus person. Expressions of acceptance (nods, smiles) when sincere are helpful. If you disagree, do not express it yet. There will be time later to do so.

c. **The rule of drawing out**: Attempt to understand the person’s position, feelings, and beliefs. Ask questions that will help to clarify the reasons for the focus person’s feelings.

You may want to ask the students to rate themselves regarding how well they were able to follow the three rules.

After rating themselves and how well they listened, students can react to each other's position.
BARRIERS TO TEAM BUILDING AND MAINTENANCE

Organizational Factors that can create barriers to team functioning include:

- A lack of agency/organizational validation and support for the team member's participation on the team.
- Ambiguity of the agency definition of the practitioner role and purpose.
- A lack of team self-evaluation. Absence of a plan for the evaluation of team functioning can effect agency support. It is essential for agencies to have some feedback on the effectiveness of team efforts (i.e., for the group to jointly reflect on how it is functioning).

Team Dynamics that can undermine teamwork include:

- A "sticking together of professionals when conflict emerges between professionals" (Grant, 1995).
- Team members have difficulty in managing change.
- The team experiences a lack of openness to diverse views and has difficulty taking risks needed to implement new ideas.
- An ability to evaluate outcome and make needed adjustments.
- Difficulty in resolving team conflict.

VIGNETTE 2: ALICIA (Handout 2)

Instructions: Ask the class to break into small groups of 3-4 and review the vignette on Alicia. Once they have completed reading the vignette as a group, ask them to respond to the following questions and apply them to the vignette. Ask each group to select a representative who will report back to the class. This activity can also be used as a written assignment and discussed later in small groups in class.
EFFECTIVE TEAMS (Syer & Connolly, 1996)

Characteristics of Effective Teams:

- The development of a team identity and an ability by the team to self-regulate, self-govern, and self-direct.

- Through the development of a capacity to balance negative feedback and improve effectiveness through reinforcing positive feedback, the team gains confidence in its ability to direct itself.

- Effective teams are able to engage in discussion on various aspects of the team dynamics. Some of the concerns that are particularly important to focus on are:
  - Observations about the team interaction. For example, it is helpful to occasionally check during decision-making processes to assure that all members participated. Also, the team may want to set aside time to review patterns of interaction and members’ estimations of team functioning.
  - The team may develop skills at applying their knowledge of group dynamics (e.g., stage of development, effects of changing composition, etc.) to their experience and discussing this when needed.
  - The team has the ability to monitor its process in a way that if there is a loss of focus on goals or team process is not supported, the team will discuss these issues.

- Team members feel satisfaction in their work as a result of achieving their potential (pp. 149).

Processes and Skills that facilitate effective team functioning

- Teamwork is based on the capacity and ability to engage in brainstorming and problem-solving activities as individuals and as a team. The team seeks relevant information and has permeable boundaries. There is openness to new feedback and particularly, critical feedback. The team is motivated to initiate getting feedback from relevant others (e.g., families, teachers, involved agencies and organizations) and act on significant information.

- Team members appreciate and utilize the significance of working through the formal relationships and in developing informal ties. This perspective applies to the team and to representatives of agencies and organizations.

- Team members have competencies in technological resources support such as, statistical software, word processing, e-mail/internet, and utilization of databases.
• Team members have the ability to manage change and can initiate and work with new ideas.

• There is appreciation of and an ability to work with diverse communication styles.

• The team achieves agreement regarding shared goals.

**Significant Team Outcomes that are essential for team's functioning**

• The team needs to see that the team productivity has visibility that promotes team cohesion.

• Outreach to relevant agency staff, community groups, etc. (e.g., open forum meetings Allender et al., 1997) promotes a sense of efficiency.
MODULE III

COMMUNICATION SKILLS AND CONFLICT RESOLUTION, MANAGING DIFFERENCE, AND NEGOTIATING RESPONSIBILITIES
MODULE III
COMMUNICATION SKILLS AND CONFLICT RESOLUTION,
MANAGING DIFFERENCE, AND NEGOTIATING RESPONSIBILITIES

INTRODUCTION

Teamwork concepts are useful for interprofessional human service providers to have a context for understanding and working with larger systems and group processes that evolve on teams. It is also essential for interprofessional team members to value and be knowledgeable about the interpersonal communication skills that sustain effective teams. The reciprocity of "giving and taking" feedback must be grounded in an individual willingness to self-reflect, evaluate consequences of one's own interactions with others, and initiate change in how one communicates.

This module provides content on basic process skills that are the foundation for meaningful dialogue. Characteristics associated with awareness about one's own communication style are reviewed. Because conflict between individuals or in teams is most often avoided, this module will address dealing with conflict. Individuals most often want to avoid the discomfort that arises with conflict or may fear that they do not have the skills to address the conflict. Concepts are provided that explore sources of conflict (e.g., the change process), conflict resolution, and positive and negative types of communication.

Some themes in this module overlap with themes in the Interprofessional Training Project (Allender et al., 1997); however, the development of the context is organized in relation to the CalSWEC competencies. Information is not available

regarding the overlap that this module may have with curriculum development at other schools.

The Child Welfare Competencies that are integrated in this module were derived from the Social Work Skills and Methods, Workplace Management, and Child Welfare Management Sections. These are:

3.7 Student assesses family dynamics, including interactions and relationships, roles, power, communication patterns, dysfunctional behaviors, and other family process issues.

3.16 Student understands theory of group process and can develop, lead, and evaluate support groups, treatment groups, and/or educational groups.

3.17 Student can teach appropriate parenting strategies including behavior management and setting realistic expectations.

5.3 Student is able to identify organizational strengths and weaknesses in the organization in which he or she works.

5.4 Student works through formal and informal channels to enhance organizational effectiveness.

6.5 Student understands how the manager facilitates effective teamwork by staff.

This content can be utilized in the Practice and Human Behavior and Social Environment Sequences. The communication emphasis lends itself to theory of practice presentations, and the team emphasis applies to curricula on organizational culture as found in the Human Behavior and Social Environment sequence. This module should be presented with Module I, which provides the conceptual framework of interprofessional collaboration. It can also be supplemented with Module II, which deals with more specifics on the dynamics that teams encounter.
GOALS

Students will become knowledgeable about communication concepts and process skills that are essential for the effective functioning on an interprofessional collaboration team. Students will understand the significance of self-reflection as the basis of competent communication. Students will become familiarized with the types of communication that facilitate the team change process, managing conflict resolution, and relevant outcomes for the team.

OBJECTIVES

After completing this module the student will be able to:

1. Define basic process skills in the provision of human services in the context of an interprofessional collaboration team.

2. Identify the significant role of self-awareness as the basis of effective communication.

3. Discuss dynamics associated with the change process that can thwart effective management of change in team functioning.

4. Apply conflict resolution concepts to situations in the practice setting.

5. Evaluate whether communication patterns facilitate positive outcomes or not.

RELATIONAL PROCESS SKILLS (Overhead 9) (Martin, 1989; Rogers, 1961; Traux & Carkhuff, 1967).

Basic Process Skills: For meaningful dialogue to occur, participants need to be grounded in an appreciation of the uniqueness of others and a willingness to work at achieving clear communication.

- Empathy:
  - The development of an ability to accurately perceive another's feelings.
  - The ability to communicate that understanding to another in a way that is attuned to the other's experience at that moment. In other words, it isn't enough to "tune into someone's feelings," empathy also involves the ability to convey that awareness to another person.
- Genuineness/Authenticity involves:
  - Sharing and being open about oneself in a spontaneous way.
  - Conveying congruency between one's own feelings and verbal expressions.
  - Demonstrating non-defensiveness. The ability to convey that one does not have to justify their point-of-view can be particularly difficult in the midst of conflict or "heated" discussion. In such situations, team members' capacity to communicate their position in an assertive (descriptive) and not aggressive manner (violating rights of others) is essential.
  - Team members' ability to self-disclose and share relevant feelings and perceptions with other team members facilitates the quality of dialogue needed to discuss sensitive issues and models, and encourages others to do the same. This skill is particularly important for team members to share personal perspectives that are pertinent to team functioning, interaction, and goal achievement.

- Warmth/Respect involves:
  - Team members are able to convey attentiveness in a relaxed manner to others.
  - Inflection of the team member’s voice communicates interest in another's experience.
  - Responsiveness to others is based on an appreciation of others' uniqueness and holding their dignity in esteem.

- Concreteness is characterized by:
  - Communication on the team focuses on specific domains and areas of mutual concern.
  - Team members engage in direct and explicit discussion of relevant issues. Such communication is based on commitment to open communication and a willingness to take risks.

- Confrontation involves:
  - Team members are able to identify contradictions and are given attention in team discussions.
  - The team shares exploration and probing into sensitive issues for the purpose of clarification and gaining information.
**Active Listening** is characterized by:

- Team members are able to listen for content and feelings when others are speaking.

- The team members demonstrate awareness of one's own responses and ability to self-reflect. This is conveyed, in part, by the team member disclosing observations of their interaction and experience on the team.

**Engaging in Clarification:**

- Team members are able to take responsibility for not feeling clear about someone else's communication and give that feedback in team meetings.

- Team members are able to give feedback in a way that it can be heard by others without making them feel defensive.

- Team members are open to feedback about their communications with others and are willing to work with the feedback.

**Initiative Taking** in introducing new ideas, information, and suggestions involves:

- Team members’ willingness to take risks by stating their opinions, sharing impressions, and proposing new ideas.

- Taking initiative needs to be grounded by the team members trusting and knowing that any differences others have with him or her will be communicated to them directly.

**Metacommunication** is essential for team functioning because it focuses on assumptions that underlie team members’ perceptions and behaviors. Team members’ engagement in metacommunication is characterized by:

- The team is able to engage in mutual reflection of its observations and impressions regarding its functioning and decision-making process.

- The team is able to explore dynamics and underlying assumptions in their communications with one another and organizations.

- The team is able to apply summarization techniques to their dialogue. For example, at the end of meetings, the team may want to set aside time to review what they accomplished, where they are now, and if there is clarity regarding the next step.
SELF-AWARENESS ABOUT ONE'S OWN COMMUNICATION STYLE (Overhead 10)

Cross-cultural competency begins with having clarity about one's own social identity, cultural identification, and family history.

**Being mindful about our own responses in interactions with others includes:**

- Individuals have awareness about the consequences of their own behavior on others. Professionals need to be cognizant of and concerned with the consequences of one's own behavior because although one may have intentions of positive outcomes, it is difficult to predict how others will respond. Others' perceptions of our interaction need to be reviewed when needed.

- Team members need to have some awareness regarding how they have internalized societal projections about low social power groups (i.e., based on gender, ethnicity, sexual orientation, physical ability, etc.) and how their biases affect their interactions. Societal projection (Pinderhughes, 1989), like transference on an individual level, can be directed at other team members as well as children and families receiving services. It is helpful to point out that everyone, regardless of ethnicity or socioeconomic class, has been affected by societal stereotype.

**Team members develop capacity for reflecting on their communication style and communication style of those who are different.**

- Team members will demonstrate an appreciation for culture-based differences in communication styles (e.g., direct eye contact, rapid speech, quick response, etc.). This suggests that members are aware of how culture influences communication and do not view those unique qualities as indicators of a deficit.

- Team members will appreciate the significance of non-verbal behavior (Sue & Sue, 1990).
  - Nonverbal behavior is culture bound. We develop ways of communicating nonverbally based on our own culture (e.g., ethnicity, socioeconomic class). This socialization can affect an individual's comfort level with other's communication styles. Practitioners need to be curious about understanding how nonverbal behavior (e.g., direct eye contact) is viewed in other cultures.
  - Team members are aware that it is impossible to make universal interpretations of communication. We need to notice, be curious, and take responsibility for learning about other cultures and inquire when appropriate.
Team Members Manage Their Own Intense Affect as they feel emotionally uncomfortable with others whose behavior, practices, or values may be different from their own.

- Team members will respect diverse emotional expression without judging negatively.

- Dealing with our own emotional response involves the risk of disclosing one’s feelings, managing them, and dealing with feedback from others.

Team Members Are Aware of how life experiences have influenced what they notice in themselves and in others.

- Knowledge regarding the impact of negative societal ethnic stereotypes on self and others gives a context for evaluating consequences of the team members’ behavior.

- The team members’ awareness of the implications of social identity involves acknowledging and "working through" the internalization of negative stereotypes.

THE CHANGE PROCESS (Overhead 11)

Teams will find that members have diverse feelings about change and different perspectives regarding how change occurs. It is useful for the team to discuss their personal and professional beliefs about how individuals and larger systems change.

Types of Change

- First order change involves responding to and working with feedback from others. In this situation, individuals become aware of change that they value and make efforts toward that valued outcome (e.g., becoming more assertive).

- Second order involves individuals evaluating their beliefs and values in a way that results in a reorganization of their beliefs (i.e., worldview). The basis for self-evaluation is changed.

Exploring Beliefs and Feelings About the Change Process

- Oftentimes individuals find themselves clinging to the past because it is more familiar and thus more comfortable. Marris (1974) calls this the "conservative impulse."
• Change can create discomfort due to the ambiguity and lack of structure often found in the change process.

**Examining Beliefs About the Role of Practitioners in the Change Process.**

• Team members need to acknowledge and manage feelings regarding their desire to see situations "fixed" quickly.

• The team needs to acknowledge that the role the professional takes in the change process is viewed in different ways within various disciplines (e.g., directive, mutuality, educational focus, process orientation, etc.).

**CONFLICT RESOLUTION:**

Conflict can have positive or negative consequences depending on how it is perceived and managed.

**Definition**

• Conflict can arise from power differences, personality differences, or from clashing values or beliefs (Kirst-Ashman & Hull, 1993).

• Conflict can evolve within different size systems such as personal, interpersonal, and collective. On a team, each level is essential to deal with, otherwise all levels of systems can be affected.

• A four-step problem-solving method consists of (Friesen, 1987):
  ▪ Recognizing conflict: It may be between individuals or between groups and may not be overt.
  ▪ Assessing conflict: Open discussion with involved parties is essential for the purpose of identifying the nature of the conflict.
  ▪ Choose a strategy and intervene: If a conflict is on an individual level, differences can be resolved primarily through bargaining or negotiating. If conflict is related to agency organization, the solution must be structural. This is labor intensive work and involves engaging all relevant individuals.
  ▪ Win-Lose and Win-Win situations: A team can avoid becoming involved in a conflict by not allowing a win-lose situation to develop (e.g., becoming too narrow in viewing problems and its possible solutions). In win-win situations, each side feels their perspective was validated and goes away with something from the encounter.
Patterns of Communication in teams can either enhance or interfere with team process (Allender et al., 1997).

- Constructive communication is characterized by:
  - Aiming at promoting clear and open communication.
  - Developing meaning-focused discussion and checking to see that diverse perspectives are shared.
  - If messages are not clear, time is taken to clarify these.

- Destructive communication is characterized by:
  - There is an orientation toward negating or devaluing individuals, options, or perspectives. This represents either/or thinking. The team sees individuals or alternatives as all good or all bad.
  - There is a power orientation on the team where the goal is to win at any cost.
  - Individuals have an inability or unwillingness to self-reflect or reflect on assumptions underlying their communication pattern. This functions to obstruct dialogue and models to others what is acceptable on the team.

- Collaborative communication is characterized by:
  - Mutuality which is inclusive and engages all relevant parties.
  - Positive regard toward all participants.
  - Individuals have an ability to recognize and act on conflict that involves risk-taking and substantive communication.
  - Communication is process- and outcome-oriented. How the goal is achieved and the goal itself are both valued.
  - There is accountability that involves taking shared responsibility.
  - Team members share appreciation for difference.

Application of Conflict Resolution to Practice With Families.

- Knowledge about identifying and managing conflict on teams can be applied to interventions with families.

- Home visits can be used to assess family communication patterns. Formulation of intervention planning can include working with families to utilize more effective communication in managing conflict.
PROMOTING WIN-WIN RELATIONSHIPS ON THE TEAM AND BETWEEN THE TEAM AND AGENCIES

Organizational Validation of Team Efforts: It is essential that the team and organizations perceive a benefit from the team efforts.

- Communication between the team and agency is essential.
- Agencies need to perceive an investment in positive outcomes.

Availability of Basic Resources includes:

- Having sufficient support staff.
- Having space for meetings.
- The team has familiarity with community resources.

Appreciation for Historical Context of Current Work includes:

- Historical perspective on building connections with the various agencies and services (e.g., schools, health/social/mental health services).
- Ongoing development of network resources for team efforts.

Development and Resolution of varying team members’ perceptions of their individual role and purpose. A team attitude of a willingness to engage in resolving differences is essential.

Team Openness to Activities that facilitate the team resolving differences (e.g., experiential activities).

- The team needs to be alert to committees in dealing with team conflict.
- The team may need to explore resources, such as consultation by an outside source for conflicts that are not managed effectively.
MODULE IV

WORKING WITH CHILDREN AND FAMILIES

Cherie Rector, PhD, RN-C
GOALS
For students to have a greater understanding of child development, parenting styles, family systems, as well as environmental factors that affect the outcomes for children and their families. A further goal is for students to discover the value of interdisciplinary teamwork and "joining with families" to design effective interventions and strategies.

OBJECTIVES
At the end of this module, the student will be able to:

1. Identify developmental tasks of childhood and adolescence in relation to role-taking and psychosocial development.
2. Differentiate between successful and unsuccessful resolutions of Erikson's life stage crises.
3. List parenting styles or characteristics and the attendant child's responses described in current research.
4. Note cultural variations in parenting style found in current research.
5. Explain the critical areas which should be included in assessment of family systems.
6. Discuss risk and resiliency research in relation to environmental, family, and within-child factors.
7. Describe effective uses of interprofessional teams working with children and families.

CHILD DEVELOPMENTAL TASKS AND NEEDS
A critical period of human development occurs between infancy and late adolescence. During that period of time, physical, cognitive, social, emotional, and behavioral development occur at a very rapid pace. It is important for those of us who
work with children and their families to possess a good understanding of the average or “normal” developmental trajectories, as well as individual differences and environmental effects that constitute the process of development for all human beings (Willis, Holden, & Rosenberg, 1992).

**Developmental Tasks of Childhood and Adolescence**

- Each stage, from infancy to childhood and on through adolescence, is comprised of certain developmental milestones and tasks to be mastered.
  - Physical development can be measured by growth charts (e.g., height and weight graph or body mass index) or by developmental inventories (e.g., Brigance, Denver II).
  - Cognitive development can be measured by various intelligence tests (e.g., WISC-Wechsler Intelligence Scale for Children) or can be explained by cognitive theories (e.g., Piaget).
  - Social, emotional, and behavioral development can also be quantified (e.g., Vineland Adaptive Behavior Scales, Behavior Rating Profile), or theories of social development can be employed to help us determine a child’s level of development in these areas (e.g., Selman’s Stage Theory of Social Cognition).

- It is important for child welfare workers, and other professionals working with children, to have an adequate understanding of normal development as developmental concerns have been associated with child abuse.
  - Parents’ unrealistic expectations regarding child development and behavior have been associated with increased instances of child abuse (Azar, Robinson, Hekimian, & Twentyman, 1984).
  - Children with developmental delays are also at greater risk of abuse by their families (Sullivan, 1991; U.S. Department of Health & Human Services, 1995).

- The goal of successful development during childhood and adolescence is to become a “normal” adult. Atkinson, Atkinson, Smith, & Bern (1990) characterize this person as having: self-awareness, a sense of self-worth, realistic perceptions, voluntary control of their own behaviors, a feeling of acceptance by others, the ability to have affectionate or loving relationships, and productivity.
Developmental Needs of Children and Adolescents have been enumerated by Michelle Karns in her book, DOisms: Ten Prosocial Principles that Ensure Caring Connections with Kids (1995), which encompasses values and assumptions regarding children and their parents or caregivers.

- Five basic assumptions apply to children and adolescents (Overhead 12):
  - They need adults who don't blame or shame them.
  - Their behavior is motivated by a perceived benefit to themselves.
  - They all have a basic need to feel competent (which is the basis for self-esteem).
  - They need values, guidance, and an internal dialogue which supports prosocial behavior (e.g., self-talk leading to self-discipline).
  - They all need a chance to play, to laugh, to have friendships, as well as physical challenges.

- Five basic beliefs about parents and those working with children and adolescents include:
  - We must establish positive and nurturing relationships with them.
  - We must determine why a child is choosing to act out in a certain manner and to discover their reality.
  - We must support competence by modeling cooperation and providing them with experiences to build their self-esteem by developing competency.
  - We must provide a positive social orientation (with respect, safety, and hope), so that they can internalize, value, and accept societal rules.
  - We must work toward a quality relationship with them through the use of spontaneous play, humor, and a positive attitude.

Developmental Perceptions, Coping, and Responses to Stress

- Each individual has a unique personality and style of coping.
  - Personality is the sum of an individual's emotional, behavioral, mental, temperamental, and character patterns (Papalia & Olds, 1992).
  - Individual's responses to stress and patterns of coping are based partly on their personality and partly on their individual environment (e.g., person-environment interaction).
- Adults have a larger repertoire of coping styles than children, due to their wider experiences and social roles.

- Adolescent coping styles have been tested using the A-COPE (Adolescent-Coping Orientation for Problem Experiences), which includes subscales for Ventilating Feelings, Seeking Diversions, Developing Self-Reliance and Optimism, Developing Social Support, Solving Family Problems, Avoiding Problems, Seeking Spiritual Support, Investing in Close Friends, Seeking Professional Support, Engaging in Demanding Activity, Being Humorous, and Relaxing (McCubbin, Thompson, & McCubbin, 1996).

- Families also utilize coping styles to handle problems or stressors. Examples of some of the external coping patterns exhibited by families include involvement with church or religious resources, extended family, friends and neighbors, and the use of community resources (McCubbin, Thompson, & McCubbin, 1996).

- Perceptions of stressful events, coping styles, and responses to stress differ over time and situation.
  - Infants and toddlers may cry and become fussy when physically tired or frustrated.
  - Childhood fears and worries may center around the loss of a parent through death or divorce, embarrassing events such as wetting their pants in public, being held back a grade in school; or being sent to the principal (Yamamoto, Soliman, Parsons, & Davies, 1987).
    ~ School-age children may "act-out" their emotional problems by fighting, lying, stealing, destroying property, and other rule-breaking behaviors.
    ~ Stomachaches, headaches, and other physical symptoms of distress may be a sign of emotional problems in children who are more prone to anxiety disorders.
    ~ Tiredness, inability to concentrate, or problems with sleeping and eating can be signs of depressive symptoms. Ryan et al. (1992) found that prepubertal children had more somatic complaints, psychomotor agitation, and depressed appearance than adolescents. Children tend to have an inclination toward action rather than introspection and self-evaluation, which is evident more in late adolescence and adult years.
  - During adolescence, stress has been characterized as being at "a lifetime peak", and studies reviewed by Joy Dryfoos suggest that adolescents have "high rates of stress and depression, overexposure to violence, [and] excessively high rates of risk-taking behavior" (1990, p. 22).
~ Dryfoos also suggests that a greater likelihood to substance abuse exists when adolescents are in stressful situations.

~ Stressors for adolescents, especially in relation to substance abuse, include susceptibility to peer influence, hassles with parents characterized by lack of parental support or caring, and school problems that can lead to poor achievement or truancy.

- Situational stress and/or chronic stress
  - Leonard Pearlin (1993, p. 314) posits that the "confluence of life events, chronic strains, and self-concept" are the sources of major stress in human beings.
  - Rather than separate, discrete sources of stress, Pearlin feels that stress research should focus on the processes leading to the experience of stress.

**Developmental Theories/Models**

Worldviews influence the organization of theories and the selection of constructs included in various models of human development. Some theorists view the world through behaviorist/mechanistic lenses (e.g., there is “something” that needs “fixing,” like a cog in a machine, and believe that by simply locating the offending part and “fixing” it, we can help the child and her family overcome the perceived problem or “deficit”). Others use a more humanistic perspective (e.g., Maslow's Hierarchy of Needs, which views the most basic survival needs as predicatory to other needs). Some theories and models that can help us better understand development during childhood and adolescence include:

- Selman's Stage Theory of Social Cognition or Role-Taking *(Overhead 13, Handout 3)*

Selman's (1973) theory addresses how to acquire knowledge about the social world and how to reason about social matters, based on the ability to take another's role or viewpoint. This role-taking perspective is critical to being able to put oneself in another's position and then to imagine how the other person thinks.
and feels. Asking a child why they did what they did helps to determine what level or stage of social cognition they have achieved. This theory is important when working with children and adolescents in the juvenile justice system, as research has shown that training in moral reasoning can lead to improved outcomes for adolescents (Dryfoos, 1990). The stages of Selman’s theory include:

- **Ego-Centric, Undifferentiated Stage: 3-6 years**
  - Kids can’t make clear distinctions between their own interpretation and another person’s point-of-view.
  - There is also no consideration of another person’s feelings or motivation.

- **Differentiated & Subjective Perspective-Taking Stage: 5-9 years**
  - Children begin to realize that others can have different viewpoints (that not everyone sees things as they do). They are better able to understand intentions for actions.
  - Trust in friendship is based egotistically. You get them to do what you want, and if they do, then they are a “friend.”

- **Self-Reflective Thinking or Reciprocal Perspective-Taking Stage: 7-12 years**
  - Child can now move beyond understanding that others have different perspectives or points-of-view and realize that others are also aware of his or her thoughts and feelings as well.
  - Friendship is based more on reciprocity, but self-interest still dominates.

- **Third-Person or Mutual-Perspective-Taking Stage: 10-15 years**
  - At this stage, the child moves beyond taking another’s perceptive, and is able to see all parties from a third person perspective. They are more objective and can step outside a relationship to see it from a third point of view (like a judge).
  - Friendships develop more deeply over time.

- **In-depth Societal Perspective-Taking Stage: 12 years-adult**
  - Moves to higher and more abstract level of perspective-taking. Sees all possible interactions including morality and general rules of society. Realizes that different values and views cannot always be overcome by “talking out the problem.”
  - With friends, there is a struggle for balance in trust and respect.
**Erikson's Theory of Psychosocial Development** *(Overhead 14, Handout 4)*

Erik Erickson (1968) was a Freudian psychoanalyst who became interested in the role of identity as a common theme of personality development. The basic premise is that, at each stage, there is a pivotal crisis or conflict that must be resolved (based on level of maturation). If successful resolution of the crisis does not occur, it will continue to be revisited at later stages in life, and healthy ego development is affected. Each possible positive outcome is balanced by a negative one. Erikson's theory has been critiqued as being gender biased toward males, comprised of constructs which are difficult to objectively assess, and weak in substantiating research showing that the stages occur in the exact sequence or time frame that he proposed (Chiriboga, 1989). This theory is thought to be more relevant for white, middle-class populations than multiethnic or diverse groups. Erikson's theory also assumes that the major responsibility for the way the child turns out is with the mother. There is no real acknowledgment of the child's contribution or the impact of other people or life circumstances (Erikson's 8 Stages of Life, adapted from Papalia & Olds, 1992):

- **Crisis 1: Basic Trust vs. Mistrust (Birth to 12-18 months)**
  
  Infant senses if world is a place where people and things can be relied upon. There should be a balance of trust, leading to the development of the virtue of hope (e.g., the belief that their needs will be met). This is generally established in feeding situations, where the mother plays a principal role (e.g., by responding quickly and sensitively). Trust allows the infant to let their mother out of their sight. This lays the groundwork for a sense of self in the child. *New Research:* Healthy development, including cognitive development, is the result of sensitive, responsive, and overall parenting (not just that shown by mothers in a feeding situation).

- **Crisis 2: Autonomy vs. Shame and Doubt (12-18 months - 3 years)**
  
  Autonomy is related to maturation of the toddler (vs. the infant). They try to expand their boundaries of the world, using locomotion, etc. Virtue of will emerges as they learn to make their own decisions and as they exercise self-restraint. They begin to trust their own judgment and substitute it for their mother's. This may appear to be negativism. The key issue is self-regulation and self-control vs. external regulation and control. A certain amount of self-doubt is necessary for safety's sake. Shame at this stage helps them learn to live by reasonable rules. *New Research:* Self-regulation and self-control have been studied. By the age of 18-24 months, children can think and remember well enough to connect what they do with what they have been told to do. By 2 years old, they know rules about what to eat, how to dress, etc. By 3 years old, they have greater flexibility, conscious thought, and willingness to wait so that they...
can have greater self-control. Language increases their sense of power and independence.

- Crisis 3: Initiative vs. Guilt (3 - 6 years)

This stage involves conflict between the child's urge to form and carry out goals and their moral judgments about what they want to do. If they don't succeed in meeting their goals, they feel guilty. Resolution of this crisis involves the virtue of purpose, the courage to pursue valued goals uninhibited by defeat, guilt, or punishment. Positive resolution of this stage leads to adults who have spontaneous enjoyment of life and a sense of responsibility. Those who do not resolve this stage may become adults who inhibit their impulses, are self-righteously intolerant of others, or suffer from psychosomatic illness. If initiative is over-emphasized they may feel that they must constantly achieve.

Other important concepts at this stage that are not in Erikson's theory include: Gender Identity: develops about age two. Gender Constancy: (your gender will not change) develops by age four to five. Gender Schema Theory: Children learn what is “appropriate” for girls and boys from a cultural perspective (gender roles). If the child's behavior matches the stereotypical roles, then their self-esteem rises. New Research: Aggression should begin to decline as language increases. If aggressive tendencies continue, then further problems may develop later. Parental discipline can play a role—reasoning with children tends to decrease their aggression, while spanking and threats tend to increase it.

- Crisis 4: Industry vs. Inferiority (6 years - puberty)

Efforts at mastery help a child to develop a positive self-concept. The virtue that develops is competence. If they feel inadequate, they may regress to an earlier level and lack the sense of initiative to pursue a goal. If too industrious, however, they may become “workaholics” and neglect relationships. Other concepts and theories to consider at this stage include:

Coopersmith's Theory of Self-Esteem (Four Main Concepts):

- Significance: to feel loved and important
- Competence: in performing tasks, etc.
- Virtue: to have moral standards
- Power: to influence their own lives and the lives of others. As the sense of self grows, they develop:
  - Self-awareness: separate from others (infant)
  - Self-recognition: recognize self in mirror (18 months)
- Self-definition: identify inner and outer characteristics of self concept (real self and ideal self)
- New Research: authoritative parenting is related to high self-esteem (However, most research has been done with White, middle-class populations.)

**Crisis 5: Identity vs. Identity Confusion (puberty - young adult)**

The individual must define their own sense of self. The virtue is Fidelity. The task is to form their own identity and become unique adults with an important role and they need to decide on a career. Role confusion occurs when too long a time is taken in choosing a career path. There is a search for commitment, which includes sustained loyalty, faith, and a sense of belonging to friends or loved ones, or an ethnic group, etc. (e.g., self-identification).

Criticisms/Comments: There is no allowance for cultural and gender differences in identity formation. Women have been shown to develop identity and a sense of self differently than men. Carol Gilligan (1982) criticizes Erikson's theory in relation to identity development. In her research, she found that female "identity is defined in a context of relationship and judged by a standard of responsibility and care" (p. 160). Male identity, Gilligan states, is developed through "individual achievement and great ideas or distinctive activity through work" (p. 163), much as Erickson has delineated.

Substages: In adolescence, Crisis 5 (Identity vs. Identity Confusion) has further substages. The central theme of this stage is knowing "who you are" and "trying out" various adult roles. When this stage is not negotiated well, individuals may not be sure who they are, and this affects who they eventually become and who they want to be with.

~ The seven Sub-Crises for Crisis 5 form a Horizontal Axis with the Eight Stages of Life. They include:

- **Temporal Perspective vs. Time Confusion**
  This includes the ability to think about the past and the future. Also included is the ability to ponder what to become. This compares with the infant's highs and lows, and rest and activity cycles.

- **Self Certainty vs. Self Consciousness**
  The person feels that they have a reasonable chance to accomplish their plans, and a belief that "if I do this, I can succeed." This substage recalls previous feelings of Shame and Doubt. If there was a problem with those feelings, it is revisited.

- **Role Experimentation vs. Role Fixation**
  They may be bewildered by all of the possibilities (both positive and negative). They need to “try out” roles.

- **Apprenticeship vs. Work Paralysis**
  They test out abilities. This relates to Industry vs. Inferiority in Crisis 4.

- **Sexual Polarization vs. Bisexual Confusion**
  There is an attempt to define male and female roles. Erikson states that lesbian and gay influences may cloud this.

- **Leader/Followership vs. Authority Confusion**
  This subcrisis involves determining how to work with others and be in charge of others. They learn to use different roles and behaviors around different people.

- **Ideological Commitment vs. Confusion of Values**
  This includes the search for Fidelity. They need to develop a belief that no matter how bad things are, they can salvage their own sense of identity and uniqueness. They must feel that what they do matters, makes sense, and has value. There is a need to know their purpose in life.

  The last three substages influence the next main stage. The first three substages are influenced by the previous stages. Erikson notes that a person doesn't “find” their identity; they “develop” it over time.

- **Crisis 6: Intimacy vs. Isolation (young adult)**
  This stage is dependent upon the successful achievement of identity in the prior stage. Individuals are able to fuse their identity with another's. There are conflicting demands of intimacy, competitiveness, and distance. They develop an ethical sense. The virtue that develops in this stage is love or mutuality of devotion. Erikson states that healthy development occurs through loving, heterosexual relationships that produce children. (This appears to exclude celibate, single, homosexual, and childless lifestyles.)

  Criticisms/Comments: This theory is dependent on male development and has a narrow focus. There is no consideration given for alternatives to Erickson's norm (e.g., divorced individuals, single-parents, or remarried couples).

- **Crisis 7: Generativity vs. Stagnation (middle age)**
  At this stage, the individual works to foster the development of the next generation by becoming a mentor. Some stagnation provides a respite...
that can lead to greater future creativity. Too much stagnation leads to physical or psychological invalidism—inactivity or lifelessness. Creativity or productivity furthers the development of personal identity. The virtue of this stage is care—to take care of persons, ideas, or products one has learned to care for. Erikson states that childless people have problems with this stage (a criticism, as noted above).

- **Crisis 8: Integrity vs. Despair (old age)**
  At this stage, individuals achieve a sense of acceptance of their own life allowing the acceptance of death or else they may fall into despair. The virtue gained is wisdom.

**ACTIVITY 4-1**

Break students into small groups (5-9), and ask them to discuss the pros and cons of Selman’s and Erikson’s theories. Give them copies of Handouts 3 and 4 for both theories.

- You may want to ask them to think of examples in their internship caseloads that depict the stages as described by Erikson and Selman. Can they pick out instances of successful and unsuccessful resolution of these life stage crises?

- What parental behaviors would they want to promote in order for parents to assist infants, children, and adolescents to reach their specific task at each stage of Erikson’s theory?

- After 20-25 minutes, ask members of each group to share their overall impressions about the efficacy of these theories for their clients. What criticisms do they offer? What inconsistencies have they found? What alternative stages or tasks have they identified (if any)?

**Developmental Milestones and Behavioral Assessment**

- Infant and toddler development can be assessed through various measures and behavioral observations. Following are the broad developmental milestones and their approximate ages (adapted from Committee on Psychosocial Aspects of Child and Family Health, 1988; Green, 1994):

<p>| 2 months | Grasps a rattle that is placed in their hand, demonstrates some head and neck control (may still be wobbly), responds to adults’ voices and smiles (coos and smiles), responds to sounds and sights (especially their primary caregiver). |</p>
<table>
<thead>
<tr>
<th>4 months</th>
<th>Smiles, laughs and squeals in response to family members, has good head control when held upright, plays with hands and holds rattle, rolls over from stomach to back, holds head up high and can raise body on their hands when lying on their stomach, shows a range of affect (sadness, pleasure, anger).</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>Rolls over, may sit with some support, can stand and bear weight when placed in this position, can transfer objects from one hand to the other, starts to feed self, imitates razzing noises, may show first tooth erupting, plays with feet, turns toward sounds that come from outside their immediate area, reaches for/grasps objects.</td>
</tr>
<tr>
<td>9 months</td>
<td>Responds to their name (also some simple phrases—“no-no”), may crawl or creep, pulls to a standing position (some may begin to walk), begins to vocalize first words (babbling), pokes food and toys with index finger, plays games like “peek-a-boo,” may react to strangers with fear or anxiety, throws/bangs/drops objects, feeds self with fingers.</td>
</tr>
<tr>
<td>1 year</td>
<td>Usually can walk with some support (or alone), puts one object inside another (blocks in a bottle), has precise grasp (thumb and index finger), may use a cup, may speak (a few words) and gesture (point, shake head), imitates play and actions of others, can bang two blocks together, looks for dropped/hidden objects.</td>
</tr>
<tr>
<td>18 months</td>
<td>Can walk fast (and may run very stiffly), walks up stairs with adult support, climbs into a chair, can stack three to four blocks (put rings on a cone and dump them over to start again), uses two-word phrases, plays with pull toys, uses cup and spoon, shows affection by kissing, has a vocabulary of 4 – 10 words, can follow some simple directions, may point to some body parts when asked (nose, eyes, ears), scribbles and imitates a crayon stroke, may dump an object from a bottle without prior demonstration.</td>
</tr>
<tr>
<td>2 years</td>
<td>Can go up and down stairs alone by taking one step at a time, kicks a ball, stacks five to six blocks, uses two-word phrases and has a vocabulary of 20 words, refers to himself by his name, may make circular and horizontal strokes with a crayon, can follow two-step commands or directions, imitates adults, may show an interest in bowel/bladder control, may open doors and throw overhand.</td>
</tr>
</tbody>
</table>

- There are longer intervals between child developmental milestones, especially when compared to the rapid pace of infant development. By middle childhood, approximate ages and their corresponding milestones include (adapted from Rector, C., & Garcia, B. (with Foster, D.). (1997). Interprofessional collaboration. Berkeley: University of California at Berkeley, California Social Work Education Center.)
Committee on Psychosocial Aspects of Child and Family Health, 1988; Green, 1994):

<table>
<thead>
<tr>
<th>Age</th>
<th>Developmental Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years</td>
<td>Can jump in place, kick a ball, balance on one foot, ride a tricycle, copy a circle and a cross, shows self-care skills (feeds self, can help with dressing), can climb stairs by alternating feet, builds a tower of nine cubes, knows own name/age/sex, and plays imaginatively with toys (fantasy play with dolls), uses three- to four- word sentences and speech is clear enough to be understood the majority of the time (by strangers or nonfamily acquaintances), has control of bowel/bladder, listens to stories, and demonstrates manual dexterity.</td>
</tr>
<tr>
<td>4 years</td>
<td>Can sing a simple song, knows first and last name, can draw a person (three parts), may hop or jump forward and stand on one foot for three to five seconds, knows own (and others’) gender, likes to talk about daily activities, may ride bicycle with training wheels, can cut and paste, holds/uses a pencil, begins to ask questions (why, when, how), can name three to four colors, counts from one to five, can wash hands and brush teeth, dress/undress with supervision, enjoys playing with other children (cooperative play), understands the difference between “fantasy” and “real”, can use utensils and describe how their favorite toy is used.</td>
</tr>
<tr>
<td>5 years</td>
<td>Knows address and phone number, dresses self unassisted, can count on fingers, copies a triangle and square, draws a person (six parts – head, body, arms, and legs), recognizes most of the letters of the alphabet and prints some letters, may skip and walk on tiptoes, can identify coins and name four to five colors, can tell simple stories and repeat nursery rhymes or poems, plays dress up (make believe games, domestic role-playing), speaks clearly to strangers, plays games with peers and can follow rules.</td>
</tr>
<tr>
<td>6 years</td>
<td>Ties shoelaces and knows right from left, can usually skate and ride a bicycle, can play in groups and identifies with peers, has one or more close friendships, knows the difference between right and wrong, can throw and catch a ball (bounces it four to six times), enjoys school (ask them what they are best at, what they like to do at school and after school, if they ever get into trouble at school).</td>
</tr>
<tr>
<td>8 years</td>
<td>Can read books for fun and uses library if assisted, can do chores responsibly (keep room tidy, feed animals), can tell time (by eight or nine), can use reading, writing, and thinking skills more creatively, can begin to be responsible for doing homework, can begin to appropriately express feelings (ask them what they are proud of, what they do for fun, if they have been pressured to do things they didn't want to do, if they feel safe, what they would change about their school, their home, their friends).</td>
</tr>
</tbody>
</table>
10 years

Should have pride in school and other activities, shows self-confidence, demonstrates awareness of safety rules and comply with most home and school rules (ask them how their grades are, if they have a best friend, how they get along with their parents and siblings, what they like about themselves, what they like about school, what things they worry about, what things make them happy, what makes them sad or angry and how they deal with those emotions).

- Adolescent developmental milestones center around the physical changes of puberty, and its attendant social and emotional changes surrounding the transition from childhood to adulthood (Feldman & Elliott, 1990).
  - Adolescence is divided into three stages: Early Adolescence (10-14), Middle Adolescence (15-17), and Late Adolescence (18-24). Typical developmental tasks at each stage include (Felice, 1992):

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Adolescence</td>
<td>This stage is usually characterized by rapid physical growth (girls start puberty about 2 years before boys), increased anxiety in response to numerous changes (body, peers, school), separation from parents and family with a preference for peers (beginning with same-sex friends), testing boundaries and value system of parents, concrete thinking, unrealistic or vague career goals, and sexual curiosity (may begin to masturbate).</td>
</tr>
<tr>
<td>Middle Adolescence</td>
<td>During this period of &quot;trying on different images to find (the) real self&quot; (Felice, 1992, p. 69), teens may have mixed feelings about independence from parents, demonstrate self-centeredness especially in relation to values, display concrete thinking with some fascination regarding abstract thought, and move toward sexual experimentation (begin to view the opposite sex as a sex object).</td>
</tr>
<tr>
<td>Late Adolescence</td>
<td>This stage marks the beginning of the integration of body image and personality, and as well as issues related to independence, sexual intimacy and caring begin to develop, individual relationships become more important than peer group, begin to develop specific plans for career (with incremental steps to implement the plan), abstract thought is possible, values develop around idealism (with rigid thoughts about right and wrong).</td>
</tr>
</tbody>
</table>

- Some achievement goals at this stage include beginning to develop social and conflict resolution skills and a personal value system, development of a capacity for intimacy, good coping skills and psychosocial strategies,
and demonstration of competence in academic areas as well as the world of work (Green, 1994).

**PARENTING STYLES AND RESPONSIBILITIES**

Children learn specific behaviors from their parents and other adults at the same time that they acquire values and internal controls that aid them in regulating the new behaviors required by new and more complex situations. Initially, young children comply with parental demands, and later, they identify with their parents' attributes and behaviors. Later, they internalize their values, and these internal controls operate to guide them when their parents are no longer easily available to them. What fosters that self-control, or lack of it, is the approach taken by parents in interacting with their children. While the exertion of power can afford immediate control (e.g., in preventing a toddler from grabbing a boiling pot from the stove), it is the least effective method of promoting internalized values and controls. Responsiveness to a child's need for independence, along with a more warm and accepting (or democratic) style of interaction, generally fosters a more enduring form of self-control (Rutter & Rutter, 1993).

*Research on Parenting Styles (Overhead 15)*

Baumrind (1989) began studying parenting styles in the late 1950s, based on the observed differences in child outcomes related to parent behaviors (e.g., demandingness and responsiveness). The majority of this research focused on White, middle-class samples, and no measurement of the child's temperament or behavior was attempted. Consequently, the interaction between parenting style and different child behaviors was not examined. The following three categories emerged from her studies:
• Authoritative: These parents use rational, issue-oriented means to direct their children's activities. They encourage open two-way communication between themselves and the child. They explained the reasoning behind their decisions, while firmly and consistently guiding actions. They are affectionate and responsive, and there is a sense of respect for both their own and their child’s rights.

• Authoritarian: This style of parenting is characterized by control. These parents have a need to shape, control, and evaluate their child's behavior according to an absolute standard. They highly value obedience and respect for authority, traditional values, and order. These parents have the final word and were the ultimate authority. There is little two-way communication observed.

• Permissive: These parents are less controlling than the other two categories. They are warm and accepting, making very few demands. They encourage their child to regulate their own activities and avoid the use of overt power. They do not insist that externally defined standards be obeyed.

  ▪ The permissive category has been further refined and broken down to include indulgent and neglectful styles. (Dornbusch et al., 1985; Steinberg, Mounts, Lamborn, & Dornbusch, 1991).

    ~ Neglectful families do not demonstrate high levels of acceptance or involvement and exhibit low levels of supervision and/or strictness.

    ~ Indulgent families are involved with their child but are not strict.

  ▪ Inconsistent parenting style has also been described; however, stability of the parenting style has not been established.

    ~ The parenting style may adapt to meet the needs of children's differing temperaments and personalities.

    ~ Developmental changes in the child may alter the parenting style, for example, as the child's safety needs change from infancy through adolescence.

    ~ Parents may exhibit markedly different styles of parenting (e.g., one Indulgent and the other Authoritarian).

  Authoritarian and Neglectful Parenting Styles have been associated with child maltreatment; however, there is no consistent, clear picture borne out by research. 

• Rickel & Becker-Laussen (1995) have proposed a theoretical model of child outcomes based on child, parental, and environmental factors.

  ▪ Nurturant or restrictive parenting practices are two key concepts of this model.
• Parental history (or how the parent was reared), Socioeconomic Status (SES), and parental temperament all act to moderate parenting practices (nurturant or restrictive), which interact with the child’s temperament, ultimately moderating child development.

• Stressors such as marital dissatisfaction, unemployment or financial problems, substance abuse, and family violence can impact parenting and the parent-child relationship (Rickel & Becker-Lausen, 1995).
  ▪ Alcohol abuse has been correlated with Restrictive Parenting practices (Rickel & Becker-Lausen, 1995).
  ▪ In about half the instances of domestic violence against women, the same man is also physically abusing the children (Browne, 1987).

**Reported Cultural Variations in Parenting Style**

• Asian, Black, and Hispanic families were more often identified as “authoritarian” than White families in a study which employed questionnaires completed by over 7,800 high school students in San Francisco (Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987).

• In another study, Whites were found to be predominantly “authoritative” in their parenting style, when compared to Hispanic, African American, and Asian-American parents in a large-scale study covering two states with over 15,000 high school students (Steinberg, Dornbusch, & Brown, 1992).

• It is difficult to get a true picture of cultural variations in parenting style because the types of instruments used to measure this construct generally separate subjects into three or four discrete groups based upon their comparison with the other subjects in a sample.
  ▪ For example, compared to all Whites in a sample, Hispanics may be more likely to be grouped in the “authoritarian” category due to their (comparatively) more traditional cultural values that may be perceived as stricter or more controlling.
  ▪ However, within the Hispanic subgroup, there may be wide variations in parenting style, just as there are for Whites.
    ~ In a largely Hispanic study (over 67% of the total sample) of adolescents and their parents, no statistical differences were noted between White, Mexican-American, and Filipino parents in their parenting style (Rector, 1994).
    ~ Also, “authoritarian” parenting has been shown to have different child outcomes across cultural groups (e.g., Authoritarian parenting
was shown to have positive outcomes for Asian-American adolescents and more negative outcomes for White students in a study of academic achievement by Steinberg et al., 1992).

- Feldman & Elliott (1990) contend that “authoritarian” parenting style identified by many large-scale studies is actually more a function of these families living in poverty than of true racial or cultural differences.

**Research on Child Responses to Parenting Styles**

- A permissive style of one parent, along with an over-involved style of the other, combined with inconsistent discipline and lack of involvement in a child's activities, predicted initiation of drug use in a study by Hawkins, Catalano, and Miller (1992).
  - Lack of parental support has been identified by Dryfoos (1990) as an antecedent of high-risk behaviors in adolescents (e.g., substance use, truancy and school failure, early sexual activity).
  - Both “authoritarian” and “permissive” parenting styles have been negatively associated with adolescents’ grades (Dornbusch et al., 1987).

- In a longitudinal study of 58 children and their mothers, Kochanska (1991, p. 1389) found that parental discipline which de-emphasizes the use of power capitalizing on a child's internal responses to wrongdoing, generally results in a "more internalized conscience and more intense feelings of discomfort."
  - Observational measures of parental discipline and child anxiety, as well as compliance to maternal demands, were gathered when the children were toddlers and again 5 – 6 years later.
  - This study supported the concept of self-regulation that develops with the use of an “authoritative” parenting style.

- “Authoritarian” parenting has been associated with adolescent development of a coercive interpersonal style (Simons, Whitbeck, Conger, & Conger, 1991).
  - Coercive interpersonal style was related to problems at school with peers and authority figures and involvement with a deviant peer group.
  - Coercive interpersonal style included behaviors such as use of alcohol, destruction of property, and use and sales of drugs.
Effective Parenting Strategies

- Behavior Management
  - Effective uses of punishment include timing (as close to the misbehavior as possible), explanation (brief reason for punishment), consistency, and a positive relationship with the parent (Papalia & Olds, 1992).
    - Inconsistent and hostile punishment can lead to negative outcomes (e.g., avoidance of parent, encouragement of aggressive behavior, and passivity).
    - Physical punishment is not considered to be beneficial in most instances.
  - Proactive management of behavior is best. This requires a good grounding in normal child development, along with the parent being “in tune” to their child (knowing their temperament and personality), and being able to prevent problems before they can occur (e.g., deflecting the attention of a toddler away from a safety hazard or using child safety measures to prevent exposure to hazards).
  - Dreikurs (1964) suggests that allowing the child to experience natural and logical consequences to their behaviors is more effective than the use of punishment and reward.
    - This should be within reason and occur at times when children are less likely to suffer serious and permanent consequences.
    - Firmness, respect for the child, avoidance of criticism, listening, and consistency are important for effective parenting.
    - Family councils are suggested as a means to deal with problems in a democratic manner.
  - Bodenhamer (1983) expresses the need for parents to exercise parental authority, and feels that this is especially important during the critical years of early adolescence. Some basic premises of his "Back in Control" program are:
    - Rules are categorized as mandatory (children must obey these), optional (parents want these obeyed, but children look for methods to evade them), or discretionary (parents have given children permission to set these for themselves).
    - Children are motivated to do things in their own way and time, and if rules are unclear, they will choose to avoid them.
    - Parents must follow through and enforce rules—inconsistency is the most common problem.
• Realistic Expectations
  ▪ Developmentally appropriate expectations for children are important, as are social and cultural norms which promote the child's self-esteem and self-confidence.
  ▪ Positive expectations are also important—expecting a child to do good, to succeed, and to handle disappointment set the stage for them to more consistently live up to these expectations.

• Parental Standards of Care in a Developmental Perspective
  ▪ Parents of infants must provide nourishment and protection from harm as well as nurturing (e.g., holding, smiling, talking). They must be accepting and sensitive of their moods, consistent in their responsiveness and behavior, and emotionally available in order for adequate growth and development to occur (Halpern, 1990).
  ▪ Toddlers and young children need cognitive stimulation—parents who can elaborate on play activities, and exercise firm, flexible, and consistent control without excess restrictiveness (Halpern, 1990).

ACTIVITY 4-2

Divide the students into small groups (3-5) and ask them to read “Case Study: The Garrola Family” (Handout 5) Have them answer the following questions. Bring the class back together and ask someone from each group to discuss their responses to the questions.

- Give the classic four-category system of classification of parenting style, decide what group the Garrolas would most likely fall into? Why?
- Given the current research findings on parenting style (not considering cultural factors), what behaviors might be expected of Pedro, the 12-year-old son (e.g., on academic achievement, school behavior, peers, and risk-taking)?
- What information could you share with the Garrolas that may help them through this transitional period?

FAMILY SYSTEMS MODELS/ASSESSMENTS (Overhead 16)
(Wright & Leahey, 1994).

Families are important contexts in which to consider child development. Families, as a system, have unique developmental, structural, and functional characteristics.
While there are some commonalities noted among families, as with any other construct, wide variations from the “norm” can be found.

**Developmental Assessment** *(Families may experience developmental crises as they move from one stage to another. Note that the stage is generally determined by the age of the eldest child.)*

- Mainstream Families (There are different stages for single-parent, divorced/remarried, adoptive, low income, and other types of families. See Carter & McGoldrick, 1988 for additional information).
  - **Stage One:** Launching of Single Young Adult
    - Tasks: At this stage, it is essential to differentiate the self in relation to the family of origin. Developing intimate peer relationships is also critical. There is a need to establish the self in relation to work and financial independence.
    - Key Process: Acceptance of emotional and financial responsibility for oneself.
  - **Stage Two:** Marriage and Joining of Families
    - Tasks: The main task is to establish Couple Identity (e.g., negotiate issues, rules, and traditions). It is necessary to realign relationships with extended families to include the new spouse. Decisions about parenthood occur at this stage.
    - Key Process: Commitment to the new system.
  - **Stage Three:** Families With Young Children
    - Tasks: Adjusting the marital system to make room for a child (or children). It is best to join together in child-rearing, financial, and household tasks. Realignment of relationship with extended families occurs to include parenting and grandparenting roles.
    - Key Process: Acceptance of new members into the family system.
  - **Stage Four:** Families With Adolescents
    - Tasks: Essential to shift parent-child relationships to permit adolescents to move in/out of system (not too rigid or too loose). There is also a refocus on midlife/career issues for parents and a shift toward joint caring for elders.
    - Key Process: Increased flexibility of boundaries to include children's independence and grandparents’ frailties.
- **Stage Five: Launching Children and Moving On**
  - **Tasks:** There is a renegotiation of the marital system as dyad, with a need to develop adult-to-adult relationships between grown children and parents. There is further realignment of relationships to include in-laws and grown children. The couple must deal with disabilities and death of elders.
  - **Key Process:** Acceptance of many entries and exits from the family system.

- **Stage Six: Families in Later Life**
  - **Tasks:** Maintenance of individual and/or couple functioning and interest in the face of physiological decline (exploring new family and social role options). Making room for the wisdom and experience of seniors, and dealing with the loss of a spouse, siblings, and peers (preparing for death) is another critical feature of this stage.
  - **Key Process:** Acceptance of the shifting of generational roles.

- Developmental stage is determined by the addition and subtraction of family members (birth, leaving home, and death).
  - Even though there will be cultural variations, the life cycle of a family usually moves through a fairly predictable sequence of stages or transitions.
  - Family therapists (e.g., Minuchin, Carter, and McGoldrick) believe that stressors surrounding family developmental transitions lead to family disruption and warrant family counseling.

**Structural Assessment** has three components—internal, external, and context. This part of family systems assessment discovers who the family is and how they fit in the larger context.

- **Internal structural assessment** asks the question: Who is the family?
  - Family composition can be determined by asking the members to "map out" their members by use of a genogram (Wright & Leahey, 1994, p. 50).
  - Gender (numbers of males and females) and rank order (birth order of children) are two other categories of structural assessment that can be visually represented by the use of the genogram (see Handout 6 for instructions on constructing a genogram).
    - Family composition has implications for child development. A single female child raised by two female parents may be expected to have
different social and gender role expectations than a fifth son of a male/female dyad.

~ Changes in family composition can affect family systems (e.g., recent death of an infant can lead to marital problems, older sibling’s fears and insecurities).

- Subsystems form in families and mark their level of differentiation. Subsystems can be determined by asking family members if there are different subgroups in their families and what effects they may have.
  - These subsystems can form around dyads (e.g., husband-wife, mother-daughter), or may be delineated by gender, generation, interest, or function.
  - For example, the oldest girl in a traditional family of five girls and two boys may be a member of the sibling subsystem, the female subsystem, the mother-daughter subsystem (they share an interest in sewing), and the father-daughter subsystem (they do the grocery shopping together each week).
  - Subsystems afford family members an opportunity to use different skills and levels of power in different situations.

- Boundaries define the limits of the family system, or who participates and who does not, as well as how that participation is determined.
  - Boundaries are generally described as adequately permeable, too rigid, or too diffuse.
  - *Enmeshment* is a term used to describe diffuse boundaries in families where members are tightly enmeshed with one another and cannot separate as discrete individuals. Members lack autonomy and are over involved (Minuchin, 1974).
  - *Disengagement* is at the other extreme, where boundaries are rigid and communication is inhibited. Family members are not part of a cohesive unit, but individual members who limit contact and support (Minuchin, 1974).

- External structural assessment consists of determining how the family fits in the larger context (e.g., within their own extended family and the larger social system).
  - Extended family can be depicted by adding it to the genogram (e.g., both mother's and father's families of origin and their grandparents can be added to delineate a three generation “snapshot”).
Extended families are important despite their physical presence or lack of it, because of their emotional impact on family members (e.g., a mother may be unable to emotionally separate from her family of origin, which can have repercussions for her relationship with her spouse and her children).

Asking family members about extended family members with whom they have close (or strained) relationships can give clues to support, which may be available in times of need or to real or potential stressors.

- Larger systems can include social agencies and personnel with whom the family has contact, friends, work systems, public welfare systems, religious groups, and other helpers.

- Questions to elicit information about the larger system can include: Who gives you support and interaction outside your immediate and extended family? What agencies and professionals do you work with most often?

- It is important to discover the most meaningful system of helpers.

- The ecomap is a visual method of determining social support for families (see Handout 7 a description of how to construct an ecomap for a family).

- Contextual structural assessment examines the family in the context of the broader system within which it functions.

  - Ethnicity is determined by the commonality of processes or activities which are passed down from generation to generation and may be reinforced by the surrounding community (e.g., ethnic beliefs surrounding childrearing practices, how to be a “good” parent).

  - Racial factors can also influence families through discrimination and stereotyping, and may lead some helping professionals to initially regard all families from a particular racial group as “the same,” when in fact there is a wide variation within each group.

  - Social class distinction encompasses income, occupation, and educational attainment, and is a powerful influence on family values and belief systems (Wright & Leahey, 1994).

  - Religion can affect a family’s composition, size, values, and socialization practices. It is important to note if spiritual beliefs are a resource for families.

  - Environment can include the immediate home and the larger neighborhood or community. It is important to note if there are adequate
social services available for families (e.g., jobs, recreation, public transportation, schools, safety personnel, day care), and if the home is safe and appropriate for the size of the family.

**Functional Assessment** involves determining daily routine activities and functioning of the family, including how they relate to one another.

- **Instrumental Functional Assessment**
  - Activities of daily living include who is responsible for preparing meals, the routines involved in eating, sleeping, taking care of children and sick family members, and so forth.
  - Families may be very good at these everyday routines and still have problems due to poor expressive functioning.

- **Expressive Functional Assessment**
  - Emotional, verbal, and nonverbal communication include the range of emotions expressed by families and the usual patterns of expression (e.g., adults can show anger, children are not allowed this expression of emotion), as well as the clearness and correctness of communication within the family.
  - Circular communication "refers to the reciprocal communication between persons," or the patterns of communication which have developed over time, especially between dyads (Wright & Leahey, 1994, p. 83).
    ~ An example might involve a father criticizing an eldest son for "not helping around the house enough," which leads the son to feel rejected and withdraw even further from family/household interactions. The more the son avoids engaging in family chores or activities, the more the father criticizes.
    ~ Each person is actively influencing the behavior of the other and the circular pattern continues.
    ~ It is important to note maladaptive patterns and assist families with breaking the cycle.
    ~ Circular communication can also be adaptive and helpful, as with positive reinforcement.
  - Problem-solving ability of the family.
    ~ It is important to determine if the family can effectively solve its own problems.
    ~ What solution patterns has the family developed? Who usually identifies problems (someone within or outside the family)?
• Roles refer to consistent patterns of behavior in specific circumstances and are influenced by others' norms and sanctions.
  ~ How comfortable are the parents with their respective formal roles?
  ~ What informal roles are present (e.g., scapegoat, good son, the heavy)?

• Influence encompasses the methods used to change or affect another's behavior.
  ~ This can be done through reward (money, attention), communication (praise, criticism), or control (spanking, hugging).
  ~ Both positive and negative methods of influence should be determined and evaluated for appropriateness (this could be an early indicator of maltreatment of children or spouse).

• Beliefs are associated with behaviors. Beliefs about problems or situations influence a family's actions or steps toward solution.
  ~ Asking about the family's belief regarding the degree of control over a situation or problem is important.
  ~ Also, it is good to note what beliefs the family hold that may have helped them deal successfully with situations in the past.

• Alliances/coalitions exist in families and triangles are not uncommon.
  ~ With triangles, usually two parties align and a third member is alienated or opposed.
  ~ To discover common triangles in families, practitioners can ask who is most likely to get in the middle of a fight between two members, or who would most likely try to stop an argument.

**Family Factors That May Contribute to Abuse/Neglect (Overhead 17) are multifactorial and may be best identified by an interdisciplinary team (Rosenberg & Sonkin, 1992).**

• Parental functioning can be influenced by each person's personality or psychological health, as well as the quality of the marital relationship.
  ▪ Substance abuse and marital violence are also risk factors for child maltreatment.
  ▪ Stress reduction activities, developing social support systems and coping skills, self-esteem building activities, and counseling are helpful in dealing with these parental risk factors.
• Child factors can include temperament and other characteristics (e.g., physical features or stature, health or disability, planned vs. unplanned birth). [see Module V for temperament research.]

• Contextual sources of support or stressors (e.g., extended family support systems, informal support systems, poverty) are also important risk factors for maltreatment of children.
  
  ✷ Low socioeconomic level has been identified as one major stressor associated with family violence (Kaufman, Johnson, Cohn, & McCleery, 1992).
  
  ✷ Poverty status also places children at risk for school failure, increased health problems, and death (Palfrey, 1995).
  
  ✷ Early childhood education programs and parent support services have shown to be effective support systems for families living in poverty (Rosenberg & Sonkin, 1992; Palfrey, 1995).

**Family Factors That May Be Helpful (Overhead 18) in decreasing the likelihood of child maltreatment include** (Rosenberg & Sonkin, 1992):

• Unified couple parenting (husband and wife are united and act as a single entity when setting limits and dealing with children).

• Authoritative parenting style which promotes their authority as parents, but includes flexibility to allow for a child’s needs for independence and autonomy.

• Positive modeling of communication and negotiation skills.

• Permeable family boundaries which allow participation in school and community activities.

• Parenting education programs can help all parents learn to better manage their children’s behavior and feel more self-confident about their parenting skills. The support offered from other parents, skill rehearsal opportunities, and role playing work to bolster parents’ abilities to deal with difficult transitions and situations (Seppa, 1997a).

**Single-Parent Families**

• Because single parents must be both mother and father, children from these homes have been found to exhibit less gender stereotyping than those from two-parent homes (Papalia & Olds, 1992).
• Single parents must deal with the stresses and strains of parenting and making a living without a spouse, which may lead to maltreatment of children.
  ▪ Culbertson & Schellenbach (1992) report on studies with adolescent single mothers who demonstrated more positive parenting skills, and increased affection and responsiveness to their infants when grandmothers and fathers of the children provided child care.
  ▪ Divorced parents need to be able to accept that their marriage has ended and examine their own part in that loss, as well as deal appropriately with the realignment of relationships with the ex-spouse, the extended family, and custody, visitation, and financial issues (Wright & Leahey, 1994).

Assessing Potential Effects of Racism and Poverty may help practitioners better understand a family’s motivations or actions.

• Determining the differences that a family may see between themselves and their relatives (from the same background) on parenting or child discipline issues may help to determine potential effects (Wright & Leahey, 1994).

• Knowledge of how a family's financial situation has affected their access to health care, their housing (number of moves, adequacy of the home, numbers of schools attended by children), the number of hours per week worked, and the meaning they ascribe to these things (e.g., we can't afford to take the kids to the dentist, we don't belong in this neighborhood) is another method of determining potential effects.

• The pervasive and chronic nature of poverty affects parenting in many subtle ways (Halpern, 1990).
  ▪ Low-income women are more likely to have low birth weight babies, and babies born under these circumstances present additional stressors for their caregivers.
  ▪ Low-income women are more likely to have marital problems and their extended families are generally also struggling financially, further weakening their social support network.
  ▪ Low-income women frequently start childbearing in adolescence, and they have the highest rates of depression, which impacts their ability to nurture and respond appropriately to their infants (Halpern, 1990).

• Cultural values and beliefs impact on parenting behaviors and certain behaviors may be perceived by the larger culture as inappropriate.
  ▪ Halpern (1990) reported on a research study of recent Haitian immigrants who held beliefs that a good child is quiet, obedient, and undemanding.
They further thought that infants were incapable of cognition. Because of this, they did not provide adequate stimulation and enriched environments common to most American children, and their children were then poorly prepared for American schooling. This behavior was considered incompetent even though it had been the norm in their country.

- Many beliefs and values stem from environmental and historical survival techniques. Halpern (1990) also cites the behavior of inner-city mothers who discourage curiosity in their children, while demanding unquestioning obedience. Because they live in very dangerous circumstances, their children may not survive without adhering to these adaptive patterns of behavior.

**Cultural Values and Beliefs** are not only present in children and families, but also in members of interdisciplinary teams.

- Each person brings their own personal, cultural, and professional viewpoints, values, beliefs, and communication styles to team interactions.

  - We are the sum of our experiences, and our own professional and personal paradigms may not permit us to recognize alternative realities.

  - Diversity is a vital strength of interdisciplinary teams; however, sensitivity to the similarities and differences expressed in teams is essential for effective functioning.

- It is important to be cognizant of families' unspoken, or hidden, cultural influences and beliefs, just as it is important for each team member to be aware of their own unique biases and viewpoints (Kreps & Kunimoto, 1994).

  - Professionals must try to understand the meaning of families' behaviors in the context of their cultural and environmental circumstances and historical relationships with professionals (Cross et al., 1989).

  - Professionals must examine their own attitudes and stereotypes related to different cultural groups as well as other disciplines and professionals on the team. Attitudes about power and control, as well as one's expectations for clients and of other professionals must be scrutinized.

  - Self-awareness and self-examination are vital to achieving cultural competence (Cross, Bazron, Dennis & Isaacs, 1989).

- Flexibility in thinking and perception of behaviors, along with respect and appreciation for another culture's values, beliefs, and practices are important to achieving cultural competence (Pinderhughes, 1995).
Assessing Family Strengths can be accomplished by comparing the strengths noted in the three main areas (structural, developmental, and functional) with the following (adapted from Wright & Leahey, 1994):

- Does this family communicate feelings and thoughts effectively and demonstrate sensitivity to the needs of its members?
- Can the family provide adequately for the physical, social, emotional, and spiritual needs of its members, as well as support, encouragement, and security?
- Is the family flexible in the performance of its roles, and can the family grow with and through the children?
- Does the family have the ability to maintain growth-producing relationships both inside and outside the family, and can the family develop and maintain responsible and constructive community relationships?
- Can the family accept help appropriately and demonstrate self-help skills as well as use repeated crises as a means of growth?
- Is there mutual respect for each family member's individuality, yet a demonstration of family loyalty, unity, and inter-family cooperation?

Assessing Family Problems involves examining biopsychosocial issues arising from the three levels (structural, developmental, and functional) and determining at which level these may be occurring (Wright & Leahey, 1994).

- Problems may arise at the Individual Systems Level (within one member of the family), at the Sibling Subsystem Level (between two or more siblings), at the Parent-Child Subsystem Level (between parent and child/children), at the Marital-Parental Subsystem Level (between spouses), or at the Community-Family System Level (between extended family system and the family system, between the school system and the family system) or may cross over several systems.
- Prioritizing the family's concerns and working with the family's presenting issue (or most pressing concern) is considered to be the most appropriate course (Wright & Leahey, 1994).
- Examination of the strengths in relation to the problems can help the interdisciplinary team begin to examine the strengths that can be used in developing interventions to resolve the problems. [See Strength-Based Perspective in Module I.]
The problem is the solution (Hooper-Briar & Lawson, 1994). Somewhere inside the problem is the basis for its solution.

A problem can be reframed to change its meaning or conceptual nature, and presented to families in a different light.

The family has lived with the problem the longest, and should be considered “the expert” who must be consulted for possible solutions (Hooper-Briar & Lawson, 1994).

**ACTIVITY 4-3**

Form small groups (3-5), and using “Case Study: “The Garrola Family” (Handout 5), Genogram (Handout 6), and Ecomap (Handout 7), ask each group to discuss one of the following areas. After 15-20 minutes, ask the groups to discuss their responses.

- Based on CFAM, in what developmental stage is the Garrola family? What are the main tasks of this stage? What resources could you provide them to assist them with the key process of this stage?

- Based on CFAM and the information given in the case study, determine who is in the Garrola family by completing a genogram. How would you begin to complete a three generation genogram? What questions would you need to ask?

- What questions could you ask to determine how the family fits in the larger environmental context? How could you begin to construct an ecomap? What family members are most important to include in this discussion? What components in the larger community are important to discuss and why?

- According to CFAM, functional assessment can be made by determining instrumental and expressive functioning. What questions might you want to develop to elicit the appropriate information in these two areas? What potential triangles might be operating?

- Look for an example of circular communication in the Garrola family. Who is involved? What does it center around? Is it adaptive or maladaptive? [Note: circular communication “refers to the reciprocal communication between persons,” or the patterns of communication which have developed over time, especially between dyads (Wright & Leahey, 1994, p. 83)].

- What are some strengths and possible problems? What strengths might be used to determine possible interventions or solutions?
ENVIRONMENTAL FACTORS

Community-Related Factors can have an impact on children and families. Communities can promote healthy families or they can inhibit their development.

- Healthy communities (Spradley & Allender, 1996) have been defined as:
  - Places where members feel that they “are a community,” can both use and conserve natural resources, and openly recognize and welcome the participation of subgroups in community affairs.
  - Places that are prepared to meet crises, that use community problem solving, and open channels of communication (in all directions and to all subgroups).
  - Communities that use effective and legitimate methods of settling disputes and encourage maximum citizen participation in decisions.
  - Communities that work to make resources available to all community members and promote a high level of wellness for all citizens.
  - Community system protective factors are comprised of good informal social supports, ample culturally-competent health and social services, caring and supportive schools, and neighborhoods that demonstrate positive expectations and provide opportunities for ongoing participation.

USE OF INTERPROFESSIONAL TEAMS (Overhead 19)

Empowerment of Families occurs when they are invited to be members of interdisciplinary teams. When families are included and regarded as “experts,” they approach meetings with professionals on a more equal footing. In the more traditional top-down professional-client relationship, they may feel more anxious about revealing sensitive issues or problems to someone who has a position of power over them. This can lead to defensiveness, and ultimately, ineffective interventions (Hooper-Briar & Lawson, 1994; Gutierrez, GlenMaye, & DeLois, 1995; Pinderhughes, 1995).

- To more effectively empower families, teams must demonstrate respect for the family and deference for their strengths and problems.
  - Teams should listen carefully ("engaged listening") to the family and their beliefs about the problem as well as their past attempts to solve it, and must be certain that they have truly understood what has been said (Kreps & Kunimoto, 1994, p. 53).
  - Teams must act on what they have heard, work on the issues the family considers to be important, and act to remove barriers that may impede the family’s success.
• Research reveals that effective interventions with vulnerable children and families have included the development of "solid relationships" that demonstrate caring and concern and exemplify principles of empowerment as a key component (Schorr, 1989, p. 178).

  ▪ One program, conducted by the Yale University Child Study Center, provided medical, psychological, educational, and social services to young disadvantaged families. A key feature was to show parents that their opinions and concerns would be sought out and heard, and open communication between families and the participating pediatricians and social workers was promoted. A further goal was to build capacity in the parents to enable them to function more effectively on their own, thus leading to greater self-esteem. Evaluation of the project determined that the professionals respected, cared about, and empathized with those they served, thus providing more effective services. At five years’ post-intervention, participants had smaller families and were more frequently employed. Ten years following the end of the study, most of the intervention families were off welfare, had completed more education, and their children had fewer serious school problems than the control subjects (Schorr, 1989).

  ▪ The Prenatal/Early Infancy Project sent nurse visitors to pregnant women and new mothers. Nurses developed relationships with pregnant women by visiting them nine times during their pregnancies and continuing these visits after the birth of the baby. Mothers were encouraged to build support systems and link with community services, and information/education on infant development and parenting skills was tailored to the parents’ needs and requests. Nurses encouraged problem-solving skills, provided emotional support, and role modeled good communication skills.

    Evaluation of the program revealed fewer cases of child abuse in visited versus non-visited families, as well as fewer repeat pregnancies, quicker returns to schooling, greater employment, and fewer premature and low birth weight babies (Schorr, 1989).

  ▪ Palfrey (1995) cites the success of the Head Start Program and other family support projects. A critical philosophical basis for their success centers around the concept of the child's parents as the most important teachers and the outreach made to include the entire family in the intervention.
Applying Problem-Solving Methods with families is an important strategy to promote successful outcomes and opportunities for role modeling, further empowerment, and support.

- One successful strategy is The Problem Solving for Parents Curriculum of the Infant Health and Development Program at the University of South Carolina (Palfrey, 1995).
  - The components of this problem-solving curriculum include seven steps: problem identification, goal selection, determining alternative solutions, evaluation of possible solutions, decision making, performance, and evaluation of the outcome.
  - This approach can be applied to issues raised first by the family and then carried over to other areas (e.g., child rearing, healthcare access, unemployment, housing).

Facilitating Effective Teamwork is an ongoing process and should include feedback from the family as a member of the Interprofessional team.

- Effective team-building skills have been addressed in Module II and should be consistently practiced with the family as team partners.
  - Hooper-Briar & Lawson (1994, p. 28) alert interdisciplinary teams to the problems of "pre-existing blame syndromes and win-lose power dynamics" and the need for a "shared language and rules for communication" (no jargon and positively worded statements). With parents as team members, language and statements made at team meetings will undoubtedly be revised and censored. It will be readily apparent to families if interprofessional team members do not “practice what they preach.”
  - Other suggestions include involving clients in the process from the beginning, making services consumer-focused/guided, and building in feedback loops (evaluative data from consumers, outcomes) that can ensure "inflight adjustments" (Hooper-Briar & Lawson, p. 29).

- Development of common goals and a common ethic can begin with a discussion of shared commitments (e.g., success for every child). [See Module I for more on this.]
  - Families usually want the best for their children, and this can be addressed as a common goal of the team. This does not mean success for the team or acknowledgement of their expertise and accomplishments, but a mutually shared goal of finding positive solutions for children and their families.
Interdisciplinary team members need to reexamine their professional values and beliefs, determine the motivations for entering their profession (e.g., ultimate rewards gained from their work—money, power, altruism) and have a clear perspective of their own personal and professional goals.

**Interprofessional Teams Can Provide Vital Information** in the assessment of risk of abuse and neglect. Each professional, and the family, hold important pieces of knowledge (based upon their unique frames of reference and background) that must be put together to form the complete picture of the puzzle.

- Team approaches to child abuse assessment have been used successfully by both hospital-based teams (e.g., physicians, nurses, social workers, psychologists) and community-based interagency teams (e.g., law enforcement/social worker teams conducting joint child interviews) over the past 10 years (Kaufman et al., 1992).

- A successful secondary intervention for high-risk parents included the use of a specialized interdisciplinary abuse prevention team (Holden, Willis, & Corcoran, 1992).
  - Parents were followed through pregnancy and birth and given support, extra contact time during health care appointments, and team-designed psychosocial interventions.
  - Team members reported positive relationship development, and outcomes for high-risk parents included some mild reduction in prematurity rates and in the risk for subsequent child maltreatment. However, high-risk parents had much higher rates of emotional disturbance than the control group.

**Interprofessional Teams May Provide Consultation** to child welfare practitioners who can draw from their varied areas of expertise when needing to make determinations regarding children and families.

- Members of such teams could include physicians, nurses, nurse practitioners, psychologists, family counselors, speech therapists, physical therapists, education specialists, and other professionals as needed.
- Consultation can also include the addition of members to a small core team when particular circumstances warrant it (e.g., medical specialists in sexual abuse cases).
  - Advantages of consultative methods include lower costs, as specialists needed only in rare cases may be accessed only when needed and not carried on agency payrolls, and greater flexibility for teams.
The configuration of the original team can expand and contract, as the problems of particular clients change, or with different cases that require various team compositions.

- Team consultation methods can include written opinions and reports or less formal verbal consultations (Bope & Jost, 1994).

**Interprofessional Teams Must Plan for and Evaluate Service Provision.** This component should be in place before services begin.

- Collaborative methods of evaluation can incorporate both quantitative and qualitative methods. Both process and outcome data should be collected and evaluated.
  - Consumers should be asked about their level of participation and their viewpoint about the outcomes.
  - Interdisciplinary team members must be part of the evaluation process, giving input and utilizing the evaluation output to improve their practice skills.
  - Both *formative* (early feedback, internal assessment) and *summative* (final outcomes, external assessment) evaluation techniques should be planned for and utilized (Grant, 1995).
  - Outcomes must be defined and measured (e.g., what approaches are most successful, what aspects of a client/consumer's experience are attributable to a collaborative teamwork approach).

- Team process should be continually evaluated and could include such factors as analysis of team communication, analysis of team members' willingness and attitudes toward collaboration, and assessment of the effectiveness of team conflict resolution (Grant, 1995).
  - Administrative supports or organizational structures necessary for team effectiveness must also be assessed (structural variables).
  - Discovering the potential barriers to team effectiveness is essential for promotion of the most effective outcomes for children and families.
MODULE V

THE WHOLE CHILD PERSPECTIVE

Cherie Rector, PhD, RN-C
GOALS
For students to have a greater understanding of the “whole child,” and the various theories and models that describe or explain the normal development of children in the context of their families. A further goal is to examine ecological perspectives, childhood problems and issues, as well as interdisciplinary practice implications.

OBJECTIVES
At the end of this module, the student will be able to:
1. Describe the whole child perspective in relation to current theories, models, and frameworks.
2. Apply cognitive theories and other models to a family case example.
3. Discuss issues related to the whole child perspective in the context of family and community.
4. List common problems of childhood (e.g., chronic health conditions, school difficulties).
5. Denote effective uses of interdisciplinary teams in addressing common childhood issues and problems.
6. Explain the purposes and goals of interprofessional collaboration in the emerging service delivery systems.
7. Discuss legislative and policy issues that affect vulnerable children and families.

THE WHOLE CHILD PERSPECTIVE
The Whole Child Perspective Involves All Facets of a child's life.

- In education, the “whole child” approach involves viewing the child in a holistic manner which takes into account a child's cognitive, social, moral, creative, emotional, and physical development (Hendrick, 1986).
Cognitive Development is an important focus of teachers, and many of their approaches are grounded in the work of Jean Piaget.

- Piaget's (1963) Stages of Cognitive Development include (adapted from Papalia & Olds, 1992; Hendrick, 1986):
  - Sensorimotor Stage (0 - 2 yrs.)
    Infant/toddler comprehends the present and real and uses his or her own senses and motor abilities to understand the world. This stage includes six substages, which includes moving from basic reflexes of the neonate to the toddler's intentional, as well as cause and effect behaviors that are meant to test and explore their environment.
  - Preoperational Stage (2 - 7 yrs.)
    The toddler/child uses symbolic representation of the present and real. This stage is preparation for the next stage (concrete operations). In the preoperational stage, the child uses mental images and language as symbols to represent real things (people, events, places). At this stage, the child has an understanding of verbal communication.
    - The child sees things from their “own point-of-view” (not others' perspectives) and only “one way” at a time (called centering). For example, in a test of conservation, two glasses of water (A and B are the same size) are shown to a child, and the child is asked to pour glass A into a taller, thinner glass (C). Then the child is asked if B and C are equal, or if one has more water. The preoperational child will state that C has more water because "it's taller," despite the fact that they have been told and could see that B and C have equal amounts of water. The child is only focusing on one aspect, which is the height of the glass. Thinking is also irreversible—they don't understand that operations can "go both ways," back and forth. The child only sees that they go “one way” (from B to C).
    - The child learns through trial and error, not logic, and this cognitive ability continues through first grade (Vail, 1987).
  - Concrete Operational Stage (7 - 12 yrs.)
    Children at this stage can logically solve problems that are focused on the “present”—the here and now. They are better able to focus on all aspects of an operation (decentering), but they develop this ability to know that two equal quantities of water are equal (as in the example above) at varying ages (i.e., for substance: 6 - 7 yrs., for weight: 9 - 10 yrs., and for volume: 11 - 12 yrs.)
    - They can group items by more than one classification, can arrange items in an ordered manner (from small to large, etc.), and can
mentally make manipulations of real objects. They understand that most operations are reversible.

- At this stage, from second through sixth grade, children begin to develop logic (based on the manipulation of objects), and by third grade begin to use their reading, spelling, and math skills to gain new knowledge (Vail, 1987).

- Formal Operations (12 - adult)
  The adolescent/adult can think in an abstract way by pondering a variety of possibilities and manage hypothetical situations using theoretical problem-solving abilities. They can use more flexible and complex modes of thinking at this stage. This occurs with neurological development and is influenced by cultural and educational experiences.

  - If there has been insufficient exposure to opportunities for rational problem solving, formal operations may begin later or may never be achieved. Studies have shown that only one third to one half of American adults may reach the stage of formal operations (Kohlberg & Gilligan, 1971). Also, some adolescents are capable of systematic deductive thought, but like some adults, may not use it in every situation.

  - By seventh grade, integration of earlier skills is necessary for the increasingly more abstract levels of written and verbal expression expected of middle-school students (Vail, 1987).

- Cognitive development and personality development are influenced by environments and experiences.
  - Children who live in chaotic settings and do not receive appropriate stimulation and opportunities for development, frequently lag behind counterparts who come from stable and supportive environments (Palfrey, 1995; Schorr, 1989).
  - Early preschool experiences can facilitate cognitive and social development by providing enriching activities and experiences, as well as continuous developmental monitoring for early detection of possible delays (Palfrey, 1995).

- Not all experts agree with Piagetian theory. Newer research does not support all of Piaget's concepts, especially regarding infants (Azar, 1997a).
  - Newer theories envision infants and toddlers as "scientists" conducting "experiments" and learning from each new piece of information (Azar, 1997a; Lach, 1997).
Infant development has been shown to be further advanced than Piaget posited (Azar, 1997a; Lach, 1997).

**ACTIVITY 5-1**

Divide students into small groups (3-5 students), and have them read the case study, “The Garrola Family” (Handout 5). Ask them to discuss the following points:

- In what Piagetian Stage would Rosa most likely fall? Johnny? Annie? Pedro? Mr. and Mrs. Garrola?
- What are the major differences in cognitive processes at each stage of Piaget’s model? [e.g. using senses to explore and discover, using symbols—language—to represent reality, using present reality and concrete objects to organize thought, and complex abstract thought.]
- What environmental factors (family, school, community) are evident that might promote cognitive development for Rosa, Johnny, Annie, Pedro? What might potentially delay cognitive development?

**Social development and personality** are influenced in many ways. A baby's temperament and attachment to a primary caregiver form the basis for later socialization. Family systems and adult or sibling role modeling also influence the development of young children’s social skills and behaviors.

- **Temperament Theory** (Thomas & Chess, 1984) delineates three basic patterns of temperament:
  1. The Easy Child: generally happy, rhythmic, and accepting.
  2. The Difficult Child: irritable, irregular, and shows intense emotions.
  3. The Slow-to-Warm-Up Child: mild and slow to adapt to new circumstances.

(However, a good number of children do not fit perfectly into one of these categories.) Another characterization of these three patterns is: flexible, feisty, and fearful (California Department of Education, 1990).

- While temperament is largely genetically determined, outcomes relate to the “goodness of fit” of a child's basic temperament and the parents’ adaptation to the child. Unrealistic expectations by parents and demands that the child conform to the parents’ own styles and pace may lead to social adjustment problems for the child.
Nine components determine temperament:

1. Activity level: how much a person moves.
2. Rhythmicity/regularity: predictability of cycles (sleep).
4. Adaptability: how easily initial response is modified.
5. Threshold of responsiveness: how much stimulation is needed to evoke a response.
6. Intensity of reaction: how energetically a person responds.
7. Quality of mood: whether a person's behavior is generally pleasant, unhappy or unfriendly.
8. Distractability: how easily an irrelevant stimulus can alter or interfere with a person's behavior.
9. Attention span/persistence: how long a person pursues an activity, or continues in the face of obstacles.

Attachment Theory (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1951) examines the affectionate and reciprocal relationship between two people (mother and baby were initially studied, current research includes fathers and others). At its base, attachment theory examines the care-seeking behaviors of infants and the complementary care-giving behaviors of adults (West & Sheldon-Keller, 1994).

The three basic patterns of attachment are:

1. Securely Attached
2. Avoidant
3. Ambivalent-Resistant

Most infants and toddlers studied have been reported to be securely attached (around 66%), with lower percentages noted for avoidant (around 20%) and ambivalent-resistant (around 12%).

~ A fourth pattern of attachment, disorganized, has been described as a "mixture of both patterns of insecure attachment" (West & Sheldon-Keller, 1994, p. 44).

~ The Strange Situation Protocol (Ainsworth et al., 1978) has been used in research studies of infants to identify and classify attachment behaviors.
- While attachment is based upon the interaction between the infant and the caregiver (usually mother), babies can initiate certain patterns of behavior from their caregivers based upon their basic temperament or because of problems related to prematurity or illness. However, the caregiver's behavior has usually been deemed the most significant to the ultimate pattern of attachment (West & Sheldon-Keller, 1994).
  
  ~ Infants and children develop "internal working models" that direct future behaviors. These models are representations of past experiences which "contribute expectations and learned responses" to later relationships (West & Sheldon-Keller, 1994, p. 55).
  
  ~ These "working models" develop to constrain our relational choices or perceptions, thus setting up differential developmental pathways (e.g., we are used to interacting with attachment figures in particular ways and we continue to seek out those similar patterns in later relationships).
  
  ~ Caregivers also develop working models regarding their interactions with their babies (e.g., feeding is a chore), and these may be facilitative or maladaptive. Anticipatory guidance for new mothers that is directed at their internal working models may be more effective in promoting better caregiver-infant interactions (Pridham, 1993).

- The behavior of mothers (or primary caregivers) has been noted to be different for babies in the three categories (adapted from Papalia & Olds, 1992; West & Sheldon-Keller, 1994):
  
  ~ Mothers of securely attached babies were found to be sensitive to their babies and more responsive and attentive to their cues. They looked into their babies' faces and answered their babies' sounds more than the other mothers, and they had more body contact (e.g., used soft baby carriers or slings, holding their babies next to their bodies) rather than infant seats. Their babies were less anxious about their mothers' absences and seemed to fare better in their surroundings than the other two groups of anxiously attached infants.
  
  ~ Avoidant babies' mothers were angrier and had difficulty expressing their emotions. They also did not initiate much close body contact and lacked confidence. Their babies were also angrier and seemed to dislike being held.
  
  ~ Ambivalent-resistant babies' mothers were found to have lower IQ scores and seemed to be less capable, but well-meaning, in meeting the needs of their babies. These babies explored less and
were more difficult to comfort than the other babies (adapted from Papalia & Olds, 1992).

- The influence of attachment has been noted in studies with preschool and early school-age children.
  - Children who were securely attached as infants had greater levels of social competence, more friends, and were more likely to show empathetic responses than children who had been anxiously attached (Papalia & Olds, 1992).
  - New research on adopted children who had interrupted attachment (e.g., Romanian orphans, foster-care infants) found that even with the secure attachment behavior of caregivers, early trauma (e.g., 6-8 months, 12 months of age) can lead to child attachment disturbances (DeAngelis, 1997).

- Attachment characteristics in adults have been examined by researchers, and attachment theory has been extended beyond childhood (West & Sheldon-Keller, 1994).
  - Adult reciprocal attachment is considered a unique construct, separate from dependency, social support, or even romantic love.
  - It is thought to be an important factor in relationship problems due to the internal working models (or schemata) that were developed in childhood, which organize "memory, knowledge, experiences, and affects into a coherent whole that can direct and influence evaluations and actions" throughout life (West & Sheldon-Keller, 1994, p. 54).
  - Insecure attachment patterns in adults are categorized in three ways (West & Sheldon-Keller, 1994):
    - Compulsive self-sufficiency (in response to failure of caregivers to see and meet their needs, they deny any need for attachment to significant others and "do" for themselves).
    - Compulsive care-giving (in response to maternal depression or disability that necessitates child caregiving, they renounce their own need for care and become the caregiver in succeeding relationships).
    - Anxious attachment (in response to real or threatened interruptions of caregiving or a confusing and contradictory relationship, they become focused on the need for proximity to the caregiver and an accompanying fear of loss, rather than the security it is supposed to provide).
Role-modeling is another important factor in the development of children. Social Learning Theory (Bandura, 1977) posits that children learn social behavior by watching and imitating the behavior of adults and other children (role-modeling).

- The role-model is chosen by the child based on the amount of power they hold or how caring or nurturant they are.
- Modeling is thought to be an important basis for gender identification.
- Role modeling of nurturant caregivers, and other significant mentors, can provide children with appropriate exemplars for later behavior with their own children.

Prosocial Behavior (Kestenbaum, Farber, & Sroufe, 1989) encompasses altruistic behaviors, or actions emanating from concern about another person, with no expectation of reward.

- Families are important models for this type of behavior, and prosocial children generally exhibit advanced reasoning abilities, are able to see things from another person's perspective, and take their role in various situations.
- Families of prosocial children have been found to exhibit love and respect for their child, model empathetic behaviors, hold high expectations for their children (including doing chores and having responsibilities at home), and encourage their child to reflect on the implications of their actions.
- Child-rearing practices and an emphasis on ethical principles can have a powerful effect on children's social behavior and development.

Moral Development is another important aspect of child development (adapted from Dembo, 1991; Kohlberg, 1981; Papalia & Olds, 1992).

- Kohlberg (1981) studied the development of moral reasoning by doing longitudinal research on a group of 75 boys. He posed hypothetical scenarios, each having a moral dilemma centering around justice and asked the boys to solve the problems. He was most interested in the reasoning behind their answers. A classic example of a moral dilemma involved a man (Heinz), his wife (who was dying of cancer), and a druggist (who discovered a drug with the potential to save the wife). The druggist charged a large amount of money for the new drug, and Heinz was unable to borrow enough money to buy it. The druggist would not respond to his pleas to lower the price, so Heinz broke into the drug store and stole the drug. To elicit moral reasoning, the following types of questions are asked: Should he have done that? Why or why not?

- Kohlberg describes six stages of moral reasoning nested within three levels (adapted from Kohlberg, 1981; Papalia & Olds, 1992; Dembo, 1991):
- **Level 1: Preconventional Morality (4 - 10 years)**
  - **Stage 1: Orientation to Punishment and Obedience**
    The child thinks in terms of punishment or of the magnitude of an act (e.g., Heinz shouldn't steal because he'll get punished for stealing).
  - **Stage 2: Instrumental Purpose and Exchange**
    Abide by rules of self-interest and consider reciprocal advantage (scratch my back, I'll scratch yours). Their own needs are paramount. Beyond their own needs, children may feel obligated to help others who have helped them (e.g., Heinz should steal to help his wife because he'll feel bad if she doesn't get better).

- **Level 2: Conventional Morality (10 - 13 years)**
  - **Stage 3: Maintaining Mutual Relations/Approval**
    The child conforms to social conventions or is motivated by the status quo, and thinks in terms of “doing the right thing” or obeying laws. The child wants to be “good” in the eyes of revered authority figures and cooperates in terms of applying the golden rule (e.g., Heinz should steal because people would think he was bad if he let his wife die).
  - **Stage 4: Social System/Authority Maintaining**
    If an act is a violation of a rule, then it is considered wrong. The child generally follows the rules (e.g., Heinz shouldn't steal because it's against the law).

- **Level 3: Postconventional Morality (13 years & up)**
  At this stage, a person develops his or her own moral principles. They recognize that moral standards are relative, that society evolves its own definition of right and wrong, and that cultural values differ. (This usually happens in college after exposure to wider cultural experiences.) However, some people may never reach this level.
  - **Stage 5: Morality of Legalistic Contract**
    Societal laws should take precedence, but there may be consideration for individual needs and political methods of changing laws in response to societal needs (e.g., Heinz should steal because, in this case, the law against stealing shouldn't protect people who want to make big profits from another’s misfortune).
  - **Stage 6: Universal Ethical Morality**
    Decisions are based on chosen principles that go beyond laws (e.g., justice, human rights). Conscience directs actions; relationships should be based on trust and mutual respect (e.g.,

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Heinz should steal because a life is more important and has more inherent value than a law).

- Criticism of Kohlberg's theory: It has been considered elitist and gender biased in that it does not consider male/female differences or cultural variations. It may promote moral chaos by encouraging individuals to “do their own thing” and develop their own system of moral behavior, rather than conform to overall societal standards. Gilligan (1982) disagrees with Kohlberg's theory, and has developed levels of moral development for women which are based more on the concept of caring rather than justice and fairness.

### ACTIVITY 5-2

Have students pair up and ask them to discuss the following:

- How can social development be facilitated by parents?
- What information about temperament, attachment, role modeling, and prosocial development might be helpful to share with parents of young children?
- What information could they share with parents and families to support healthier attachments?
- Does the moral dilemma used by Kohlberg (Heinz) in his research reflect real life situations that children and adults face?
- Are social, moral, and cognitive development inter-related? If so, how?
- Is the “whole child” approach useful when examining problems or issues related to children? Why? Why not?

**Creativity Is Tied to Imagination.** Creativity in thinking has been defined as divergent thinking (finding unusual solutions to problems), as opposed to convergent thinking (noting the singular “right” answer—the traditional approach to problems). Creativity is defined by Greeno (1989, p. 140) as "flexibility of thinking and restructuring of understanding in innovative ways.” Support for creative thought and action fosters further creativity.

- Miller & Gerard (1979) found that parents of creative children were somewhat unconventional and enjoyed artistic or intellectual hobbies and pursuits or meaningful occupations. They gave their children responsibility and freedom, and had high expectations (while not being rigid, or over controlling).
Creativity is a component of giftedness, according to the Renzulli Model (1982), which describes a triad of factors (intelligence, motivation, and creativity) in the identification of gifted children. This model of assessing giftedness, rather than the use of intelligence (IQ) tests in isolation, also encourages the discovery of giftedness in diverse populations of children and not only students who demonstrate success in school.

- Children with intellectual abilities in the top 2 – 3% of the population (I.Q. of 130 or above) have historically been characterized as “gifted” (Webb, Meckstroth & Tolan, 1982).
- Gifted children may have different clusters of traits. Common characteristics of gifted children include, for example, the following (Vail, 1987; Webb et al., 1982):
  - Advanced abilities with language (larger-than-expected vocabularies, early reading, understanding subtleties and puns).
  - Advanced learning abilities (needs less time to master basic skills, uses divergent thinking, retains large amounts of information, shows intense levels of concentration, quickly grasps concepts and patterns).
  - Personal characteristics (sensitive and empathetic, very curious and asks many questions, likes to experiment and do things differently, may have unusual sense of humor, high energy levels).

**Emotional Development** – Some basic emotions are present at birth, and toddlers can exhibit a wide range of emotional expression, which forms the basis for adult emotions and personality.

- As children mature cognitively, they are better able to recognize adult emotional cues. Social referencing, or learning to understand other’s emotional and cognitive reactions by “reading” their facial expressions, is used by infants and toddlers in unfamiliar situations (Papalia & Olds, 1992). They watch first for their mothers’ reactions to a novel person or experience, and this influences their own reactions.

- Newborns can cry in response to pain, react with a Moro reflex when startled, show disgust in response to unpleasant smells or tastes, and can turn toward adults’ faces (and later smile) in response to interest shown toward them.
  - By two months of age, babies begin to “coo” when excited or in response to direct speaking (Lach, 1997).
  - As infants mature, they begin to laugh, kiss, hug, pat, show aggression (bite, hit, kick, shove), display negativity (“No!”), and cry or pout in response to scolding (Lach, 1997).
• Tantrums, a specialty of toddlers, may be a response to fatigue, frustration, or impulsivity. Fears (especially to animals, the dark, being left with sitters) begin to emerge close to two years of age (Lach, 1997) and continue through later childhood (e.g., fear of injury, fear of loss of a parent, fear of social embarrassment).

• Aggression can be exhibited by toddlers, and this behavior can extend into school-age years. This can be due to an inability to deal with frustration, parental or other role modeling of aggression, or (as some studies have indicated) excessive viewing of violent television programs (Eron, 1982; Zuckerman & Zuckerman, 1985).

• Emotional problems may become apparent during middle childhood (e.g., depression, anxiety disorders, school phobia, acting out behaviors) and adolescence (e.g., schizophrenia, conduct disorder).

• Protective factors for healthy emotional development and successful maturation into adulthood are found in resilience and hardiness research (Herrenkohl, Herrenkohl, & Egolf, 1994; Tartasky, 1993).
  - Rutter (1985) conducted research on resilient personality and described “invulnerable” children who overcame poverty, lack of parental support, and pervasive hopelessness in their communities. They succeeded because of access to a caring individual or mentor who assisted these vulnerable children, which is a consistent pattern found in numerous studies. [See Module IV for more on Resiliency, Vulnerability, and Protective Factors.]
  - Werner (1986) studied resilient children and their families on the island of Kauai, and found that these children exhibited more “hopefulness” rather than “learned helplessness.” They also were the products of smaller families where longer spacing between children was a key factor. The children had caregivers who were supportive. Even though they also came from the same poor communities as their high-risk counterparts, the resilient children had better social skills, verbal abilities, and school performance.
  - In a review of resiliency literature, Benard (1993) found three main themes: social competence (shows responsiveness and caring for others, has good communication skills and a sense of humor, conceptual and intellectual flexibility), problem solving skills (engages in abstract and reflective thought, can understand laws and rules as well as cause and effect, has critical reasoning skills and can develop alternative solutions when frustrated), sense of autonomy (has good self-esteem and self-efficacy; a positive sense
of independence; good impulse control, planning, and goal setting; believes in the future and feels that things will eventually work out; has an understanding of why things happen as they do; and has a sense that they can exert some control over their own lives)

- Protective factors ameliorate the risk factors and promote resiliency in vulnerable children. Families, schools, and communities that protect children against adverse conditions have been found to have three things in common:
  1. They are characterized by caring and support.
  2. They demonstrate positive expectations.
  3. They provide ongoing opportunities for participation.

  - Assisting vulnerable children to bond with families, schools, and communities promotes protective factors and decreases vulnerability (Schorr, 1989).
    ~ Consistent and caring individuals can make a real difference in the life of a child and his or her family.
    ~ Interventions can include provision of support and mentoring to a child, working with families to strengthen their capacity for providing a supportive environment for their child, or working with schools to develop support programs for vulnerable youth (e.g., after-school homework clubs, sports programs, music and art programs, Big Brother/Big Sister programs).

  - In a follow-up study of children from maltreating families, researchers found that resiliency was fluid over time, and a "function of the interaction between maturational, individual, and environmental influences" (Herrenkohl et al., 1994, p. 308).

- Parenting styles and practices, which are consistent and help children recognize their emotional reactions, have been found to help children learn to better regulate their emotions (Azar, 1997b).

  - Parents whose children were better emotional regulators had held and soothed their children when they were upset and used distracting techniques when they were toddlers. As they grew older, they challenged them to try new things and talked to them about use of coping strategies. These parents also talked about their own feelings and encouraged empathy (Azar, 1997b).

  - Children who have higher levels of self-regulation have been found to be more socially competent and have higher peer status (Azar, 1997b).
Physical Development progresses through stages. As infants grow and mature throughout childhood, and into adolescence and adulthood, it is apparent that the process of physical development occurs in an orderly and uniform manner. [See Module IV for ages/stages.]

- Any significant deviation from these normal patterns may be a cause for concern and should be evaluated by a healthcare practitioner or a developmental psychologist.
  - Growth deficiencies may be due to failure to thrive (FTT), a condition due to underlying medical conditions (e.g., congenital heart disease, chronic renal failure) or environmental deprivation (e.g., non-nurturing home, inadequate nourishment).
    - Failure to thrive can be determined by carefully measuring an infant's height and weight and plotting it on standardized growth curve charts. Infants and children whose height, weight, or weight for height fall below the 5th percentile are suspect. Also, if there is a decrease in the rate of growth (two major percentiles within 6 months), or delayed developmental milestones, it is important to investigate further for FTT (Berkowitz, 1996).
    - Babies with environmental FTT may not like to be held or cuddled, may avoid eye contact, and may exhibit muscle tenseness and avoidance to being held by arching their backs (Berkowitz, 1996).
  - Diagnosis and treatment of medical conditions and changes in environment and diet related to FTT should lead to dramatic improvements in weight gain and growth, as well as improved affective and cognitive functioning (Berkowitz, 1996).
    - Infants who have problems interacting with their mothers and do better with feedings by alternate caregivers generally improve in different environments (Berkowitz, 1996).
    - Children with severe kidney disease have been successfully given human growth hormone to help them increase their growth velocity (Salusky & Sanchez, 1996).
- When determining developmental age appropriateness, it is important to ask how the identified child's development compares to siblings' development at that stage or to same-age peers (e.g., are they similar or delayed, advanced).
ACTIVITY 5-3

Have the students divide into small groups (3-5), and discuss cases in their work experience or internships.

- What signs of resiliency, vulnerability (risk factors), and protective factors could be noted?
- What signs of creativity or giftedness were apparent?
- What cases of Failure to Thrive (FTT) have they observed? What were the possible causes and what interventions were successful?
- In what instances could an interdisciplinary team approach have been helpful? In what ways? Who should be part of the team? What expertise might be most helpful?

VIEWING THE CHILD WITHIN THE CONTEXT OF FAMILY AND COMMUNITY

The "whole child" approach also views the child within the context of their family system (a systems perspective) and the larger community while taking into account cultural and environmental influences.

Children Learn About Themselves and their world through experiences with their families and later their peers.

- Family Systems Theory (Wright & Leahey, 1994; See Module IV for Family Systems Assessment) can be useful when conceptualizing families as clients and examining the child's problem within the broader context of family.
  - The family is pictured as a mobile (the whole is in balance, steady, yet moving).
  - The family system is part of a larger suprasystem (e.g., community, extended family system) and is also composed of many subsystems (e.g., parental subsystem, sibling subsystem).

- Basic assumptions of family systems theory include:
  - The family as a whole is greater than the sum of its parts.
  - Individuals are best understood in their larger context (e.g., within their families and communities).
  - We can't truly understand the parts until we see and know how the whole works (e.g., parts can only be understood in relation to their whole).
- A change in one family member (e.g., a serious illness, substance abuse) affects all family members.
- Interventions can also affect the entire family (e.g., if one member changes, other family members then begin to behave or respond in different ways).
- Change and stability can coexist. Families are in a constant state of flux (e.g., when families are “stuck,” or having problems, it is generally because they are polarized in maintaining a rigid state of equilibrium, or may be experiencing too much change).
- Each person mutually contributes to adaptive as well as maladaptive interactions.
- Behaviors are best understood from a view of circular (not linear) causality. Therefore, it is best to look for patterns, recurring themes, and reciprocal relationships based on ascribed meaning.
  - Circularity is the development of a behavioral cycle.
  - Each individual’s behavior has an effect on and influences the other.
- Therefore, a child who is the “identified patient” should be assessed in the context of his or her family, due to the multiple interactions and transactions that occur within the family system.
  - Home visits provide assessment teams with valuable information about family interactions and the child's environment.
  - Behaviors that may be problematic at school may or may not be exhibited at home.
  - Changes in family environment and parenting style have been reported to dramatically change the IQ scores of children (Ceci, 1991).
  - The holistic approach to a child's identified problem "acknowledges that a problem child isn't solely responsible for the behaviors he or she is expressing" (Seppa, 1997a, p. 20).

**Community Characteristics** are also important and may have far-reaching implications for children. [See Module IV for more on community and environmental factors.]

- Public education is one of the few entitlements of our society; however, the quality of that education varies widely depending upon local and state standards and funding streams.
Increasingly, a growing number of "educationally disadvantaged" children are finding it difficult to succeed in school thus creating the "emergence of a large and permanent underclass" (Schorr, 1989, p. 221).

- Home environment was shown to have a strong effect in studies with diverse ethnic and economic groups. Children of higher income and higher educational level parents were noted to have higher IQ scores on follow up, largely due to richer environments (e.g., more language stimulation, more books, educational computer games, visits to museums) than those from lower economic and educational level parents (Murray, 1997).

- Time spent by parents talking and reading to their young children is thought to be one of the most important indicators of later educational success (Murray, 1997). This is more often possible in homes where there is parental free time, and where there are lower levels of stress and competition for caregivers' time (e.g., both parents, fewer children, fewer hours worked).

- Many signs of later school failure begin "as early as third grade" with poor achievement and reading levels, truancy, and inappropriate behavior noted in the early school years (Schorr, 1989, p. 221).

- Children who are behind in reading at the end of first grade can be helped by early intervention and tutoring. Without this, most of them will never catch up; however, federal special education laws do not promote early identification of reading disorders (Seppa, 1997).

- Phonetic approaches to reading instruction have been found to be effective in improving the reading speed of slow readers, and in assisting teachers in distinguishing children with true reading disorder from those who simply have less word training (Seppa, 1997b).

- "Urban schools heavily populated by students at risk are significantly different from “regular” schools’ negative environments, which consists of overcrowded, structured around teacher control, dominated by competitive rather than by cooperative academic tasks, and orchestrated by teachers who feel disempowered and removed from school policy" (Kagan, 1990, p. 114).

- Kagan also posits that teachers have differential expectations and educational standards for vulnerable students, and that they communicate these through verbal or nonverbal ways (e.g., by choice of tasks, use of ability grouping).

- In order to be effective, the “classroom culture” must be a nonthreatening environment where children feel free to problem
solve and relate new behavioral norms to the informal knowledge they bring from their individual homes and communities (Kagan, 1990).

- Moore (1992) identifies five standards for quality educational experiences for students. These include policies, practices, and resource allocations that:
  ~ enable/encourage attendance and eventual graduation
  ~ minimize sorting of students
  ~ promote humane school environments
  ~ create school environments that facilitate quality instruction
  ~ provide and promote high quality instruction

- Nationally, lack of access to adequate healthcare and the increasing numbers of uninsured children and families continue to have a great impact on the health of children. Currently, 1 in 7 children has no health insurance coverage, and the number is expected to grow by over 3 million in the next 5 years (Clay, 1997a). Other sources believe that over 20% of children have no health insurance, despite expansion of Medicaid coverage in some states (Moffitt & Slade, 1997).

  - Skyrocketing healthcare costs and phenomenal medical advances have led to drastic changes in the healthcare delivery system.
    ~ In order to reduce costs, managed care organizations have cut services and made access more difficult.
    ~ In capitated systems, the incentive to reduce services is even more pronounced.
    ~ It is even more important now for children to have access to a school nurse, public health nurse, or other healthcare advocate who can help them “work the system” to their best advantage.

  - In addition to these barriers to access, geographic (e.g., rural versus urban areas), and cultural (e.g., language, values) barriers can prevent adequate access to health care services (Bureau of Primary Health Care, 1996).
    ~ When clients feel unwelcome or misunderstood, they are also less likely to comply with medical regimens or suggested changes in health care behaviors (Kreps & Kunimoto, 1994).
    ~ Many rural areas are underserved with lower rates of physicians, dentists, and other healthcare providers per capita than more urban or suburban areas (Bureau of Primary Health Care, 1996).
• Fragmented services which are fueled by categorical funding sources (e.g., California Children's Services, Family Planning), as well as increasing specialization in health care (e.g., fewer primary care providers and more specialists), set up additional barriers to healthcare, especially for families with young children (Palfrey, 1995).

• Welfare reform and other legislation have led to marked changes in social services and even more overburdened professionals who work with vulnerable children and families.

  ▪ The effects of these changes may vary by community and state, as each state determines what is appropriate for their own population. However, a basic component of all welfare reform includes welfare-to-work requirements and recasts welfare into a more temporary form of support (Executive Summary, 1997).

    ~ A 5-year limit for welfare assistance is part of the new Temporary Assistance for Needy Families (TANF) plan that replaces the Aid to Families with Dependent Children (AFDC) system (Behrman, 1997).

    ~ Job programs and child care are part of the new welfare law, The Personal Responsibility and Work Opportunity Reconciliation Act. However, they may be inadequate to meet the needs of the diverse welfare population (Behrman, 1997).

  ▪ Changes in eligibility for assistance may increase the numbers of children who have inadequate access to health care, poor nutrition, inadequate housing, thus, leading to further stress for low-income families.

    ~ Close to half (44%) of the women with young children who began receiving welfare benefits in 1992 had not finished high school, making them less qualified for adequate employment (Behrman, 1997).

    ~ Even for those mothers who are able to find work, past studies have shown that between 50% to 66% of them lost their jobs within the first year after leaving welfare rolls, mostly due to employer layoffs and firings (Behrman, 1997).

    ~ With the new time-limited system, eligibility is not based solely on need, and more families may leave children unattended while working, spend less money on food or healthcare, or find themselves homeless (Behrman, 1997).

  ▪ Children of teen mothers, disabled and immigrant children, and children depending upon the income of relatives on the Supplemental Security Income (SSI) program will face loss of benefits (Clay, 1997c).
• Crime and violence in communities can also contribute to feelings of hopelessness and powerlessness in vulnerable children and their families.
  
  ▪ "Homicide is the leading cause of death among young black men" (Schorr, 1989, p. 5), demonstrating that the effects of crime and violence differ depending upon race and neighborhood.
  
  ▪ Younger populations are more often involved in crime, as perpetrators, not just as victims. "The peak age for arrests for property crimes is sixteen...for violent crime, eighteen" (Schorr, 1989, p. 5).
    ~ Most children who are "homicide victims are under age 4 or are adolescents" (Lewit & Baker, 1996, p. 150).
    ~ Rape, assault, and robbery victimization rates are "two to three times higher for 12- to 19-year-olds than for the adult population as a whole" (Lewit & Baker, 1996, p. 152).
  
  ▪ Wanton crime and violence are now more common, and the senseless drive-by shootings and murders that so many of our children witness only reinforce their sense of futility.
  
  ▪ In a 1994 survey, over 60% of large school districts reported using metal detectors or some other form of security to prevent gun carrying on school campuses (Lewit & Baker, 1996).

• Unemployment is another community factor that can further perpetuate vulnerability for children and their families.
  
  ▪ Lack of job availability, as well as the shift from lower-skilled jobs to higher-technology jobs, have made it difficult for many people to find work.
  
  ▪ Also, with corporate downsizing and the shift to a service-based economy, more companies are using part-time workers or temporary services to fill positions at a lower cost. (This also has implications for healthcare, as these temporary workers generally have no health insurance or other benefits such as sick leave.)
  
  ▪ Education and crime are related to unemployment levels, as high school dropouts are "twice as likely to be unemployed and...live in poverty" as those with a high school education (Schorr, 1989, p. 8). Furthermore, "dropouts are three and a half times as likely as high school graduates to be arrested" (p. 8).
ACTIVITY 5-4

Divide students into small groups (3-5) and ask them to discuss the following:

- Consider the Garrola family case study (Handout 5). Under the new welfare regulations, what services might be available to the family if Mr. Garrola was fired by his employer?

- What family systems changes might occur if Pedro were expelled from school for injuring another child in a fist fight? What community factors might impact Pedro and his family?

PROBLEMS IN CHILDHOOD THAT CAN BE ADDRESSED BY INTERDISCIPLINARY TEAMS

Academic Problems can greatly affect children's self-esteem because academic self-concept is an important component of global self-concept. Self-esteem and self-efficacy are closely related to learning motivation (Boekaerts, 1991).

- Learning disabilities may be found in 5-10% of school children; however, there has been an increased interest in early diagnosis of learning problems (Lyon, 1996; Palfrey, 1995, p. 102).
  - Approximately 20% of school children may have problems with age-appropriate academic performance (Boekaerts, 1991; Silver, 1989; Vail, 1987).
    - Some school problems may be caused by a mismatch between (a child's) learning style and the methods and materials used in the curriculum" (Vail, 1987, p. 8).
    - Some learning disabilities have a genetic cause and others are due to hostile social environments where learning is made more difficult (Vail, 1987).
  - "Students with specific learning disabilities now account for more than half of all disabled children served and more than 5% of all students ages 6 through 17 enrolled in school" (Lewit & Baker, 1996, p. 143).
    - Currently, it is estimated that 43% of all children are born with at least one learning or developmental barrier (U.S. Department of Education, 1993).
    - By school entry, more than one barrier may be present, especially as the additive effects of family and community factors are felt (Lawson & Briar-Lawson, 1997).
For the purpose of being identified as "learning disabled" in order to receive special education services, a child must demonstrate a discrepancy between academic achievement and ability in seven areas dealing with mathematics, language, and reading (Lyon, 1996; Rourke & Del Dotto, 1994).

- In order to be classified as having a specific learning disability, a child must be tested and found to have a discrepancy in one or more of these areas: listening, speaking, basic reading skills, reading comprehension, writing (expression), math reasoning, or math calculation (Lyon, 1996; Vail, 1987).

- Learning disabilities are frequently overlapping with problems in several areas of common finding. In addition, children may also have social or behavioral problems (e.g., attention deficit disorder).
  - General intellectual functioning is maintained (Lyon, 1996).
  - The child's learning difficulties can't be attributed to low intelligence, emotional problems, or environmental, economic, or cultural disadvantage (Lyon, 1996; Vail, 1987).
  - Social and behavioral problems have been identified as difficulties with following rules, poor impulse and anger control, and quarrelsomeness (Rourke & Del Dotto, 1994).

- The most common learning disabilities relate to reading problems (possibility up to 17%); however, about 6% of school children have difficulties with mathematics and between 8% and 15% may have disabilities in written expression (Lewit & Baker, 1996; Lyon, 1996).

- However, because there is no clear standard for diagnosis, children diagnosed by one school as "learning disabled" may not be eligible for special education services in another school who does not agree with the original results (Lyon, 1996).

- Use of the "discrepancy standard" in diagnosing learning disabilities invites a "wait-to-fail policy because a significant discrepancy between IQ and achievement generally cannot be detected until about age eight or nine" (Lyon, 1996, p. 59).

  - This delay in identification and intervention makes the task of "catching up" even more difficult for learning disabled children, as remediation is longer and generally less successful when it is not begun early.

  - Early diagnosis and treatment is the most successful model but is not possible when a child must wait-to-fail. This has
implications for the child’s motivation and self-concept, as well as missed critical periods of development (Lyon, 1996).

- **Cybernetics Model of Learning Disabilities** (Silver, 1989):
  
  ~ **Input Process:** Information goes from sense organs to the brain. Examples: (a) **Visual perceptual disabilities:** difficulty organizing shape or position of materials, or figure/ground problems, or difficulties with depth perception; (b) **Auditory perceptual disabilities:** difficulty distinguishing subtle differences in sounds/speech, or auditory figure/ground, or problems with auditory processing—auditory lag).
  
  ~ **Integration:** Information is recorded (processed and interpreted). Examples: (a) **Sequencing disabilities:** visual or auditory—may “see” center, not edges, or tell middle of story, then beginning and end; (b) **Abstraction disabilities:** ability to understand the correct general meaning from a specific word or symbol—this is basic to intelligence—child considered retarded if severe; (c) **Organization disabilities:** can’t relate to previous information, make a meaningful “whole out of parts,” problems with time organization, organization of notebooks/rooms, etc.)
  
  ~ **Memory Process:** Information is used or stored for later retrieval. Examples: (a) **Short-term memory:** retaining information briefly while concentrating or attending to information <visual/auditory>—phone numbers; (b) **Long-term memory:** storing information that has been repeated and can be retrieved by thinking about it.
  
  ~ **Output Process:** Information is sent out through motor/language activities. Examples: (a) **Language disability:** spontaneous, self-initiated, or demand language, response to questions, etc.; (b) **Motor disability:** gross motor, large muscle coordination, clumsy or fine motor, difficulty with handwriting; (c) **Visual motor disability:** visual perceptual problem, eye-hand coordination due to the brain’s incorrect processing of information, and sending the wrong message to the small muscles and hand)

- **Learning Disability Profile** (Silver, 1989): Each child has a unique profile of learning abilities and disabilities. Children with academic difficulties and behavior problems at school or home should be checked for learning disabilities.
  
  ~ We can find clues by asking the child specific questions about academic subjects, skills, or tasks.
Some examples of important information includes: A child with a reading disability might say that they “read the same line twice,” or that they “read but don’t understand” (comprehension is poor). A child with a math disability may say they “can’t remember the times tables” or they may confuse the lines or columns. A child with written language problems may say that their “hand gets tired from holding the pencil” or that their “hand doesn’t work as fast as my head is thinking.”

- Because learning disabilities are poorly defined and standards of assessment and intervention are not consistent, an interdisciplinary team approach is probably best so that the “whole child” is considered, not just one “specific part” (Lyon, 1996).

- Parents or teachers may be the first to notice problems in young children; however, an alert pediatrician or other healthcare worker may find delays on routine neurodevelopmental screening at even earlier ages (Blondis, Snow, & Accardo, 1990).

- Once a problem has been found, teams may divide assessment areas and work independently within their professional areas, or they may jointly conduct assessments related to learning disabilities.

- Dropout is a term used for students who fail to complete mandatory schooling. Dropping out of school is vividly described by one researcher as "disengagement from school" (Kagan, 1990, p. 106).

- Lyon (1996) reports that a large number (over 26% in one study) of learning disabled high school students dropped out before graduation, and researchers have also found links between dropout and early childbearing, substance use, and delinquency (Dryfoos, 1990).

- Common personal antecedents of dropping out include low grades and test scores, low expectations (no college plans), having been held back in earlier grades, disliking or feeling bored with school, truancy and suspension or expulsion, friends who have dropped out, attitudes of nonconformity and alienation, early “acting out,” and depression and stress (Dryfoos, 1990).

- Family factors that have been associated with risk of dropout include poverty, low parental education levels, being on welfare, frequent family moves, lack of parental support, an authoritarian or permissive parenting style, and speaking a language other than English in the home (Dryfoos, 1990).

- Research summarized by Kagan (1990) reveals that school environment can have a powerful influence on student retention rates.
- Students transferred from a school with a high dropout rate to a school with a lower rate of dropout led to improved student behaviors (e.g., conformity with the norms at the low dropout school).
- Labeling of at-risk students by school personnel and teachers can create a permanent caste system, or subculture, leading to dropout.
- Segregated schools and those that employ tracking or emphasize testing for placement have been associated with dropping out (Dryfoos, 1990).
  - Other school factors include large high schools with large classes (Dryfoos, 1990).
  - Dropping out is more common in public rather than parochial schools (Dryfoos, 1990).

- A dropout’s self-esteem has been found to rise after leaving school (Kagan, 1990).
- Students may drop out of school as a protective mechanism to preserve their self-esteem.
- Students at risk for dropping out tend to have friends with similar attitudes and behaviors, increasing their sense of alienation and “pulling them away” from school.

- Alternative schools are thought to be successful with at-risk students because of their more individualized learning environments, extended support services, smaller classes, supportive student culture, and committed teachers who work to “draw students in” (Raywid, 1984).

*Disabilities in Children* may be due to birth defects or traumas (e.g., Down Syndrome, Fetal Alcohol Syndrome), injuries (e.g., motor vehicle accidents), illness (e.g., hearing loss due to meningitis or chronic ear infections) or other causes (Kurtz, Dowrick, Levy, & Batshaw, 1996).

- The limitations resulting from these disabilities can have emotional, social, and developmental implications for children and their families.
  - Parents may overprotect children with disabilities by not encouraging their full development, or may have unreasonable expectations and think that they can accomplish any goal they set (Clay, 1997b).
  - Reasonable expectations and helping the child work through issues and “own” their disability are the best approaches parents can take (Clay, 1997b).
- Exposing the child to disabled peers and older role models can promote self-acceptance.

- Family support groups offer emotional support and information to parents.

• Mental retardation (developmental delays) is a generalized delay in cognitive, language, and social skills in children with an IQ below 70. The incidence for mental retardation is 2.5%, with genetic or family factors, metabolic disorders, or perinatal exposures to infection, toxins, or injury as possible causes. However, in some cases, the reason for delay may never be discovered (Kurtz et al., 1996).

  ▪ Cerebral palsy, feeding problems, seizure disorders, ADHD, and speech/language or other deficits may be associated with mental retardation.

  ▪ Children may be categorized as mildly retarded (or developmentally delayed) with an IQ range of 55-69, or severely retarded with an IQ below 55 (Kurtz et al., 1996).

  ▪ Mentally retarded (developmentally delayed) children may also have psychopathology (between 5 to 70%) such as aggression and self-inflicted injury. Dual diagnosis is more common with Down Syndrome, Fragile X Syndrome, Fetal Alcohol Syndrome, and Autistic disorders (Kurtz et al., 1996).

• Cerebral palsy (CP) occurs in less than 1% of children, as a result of central nervous system dysfunction or injury during the first three years of life (Kurtz et al., 1996).

  ▪ Babies born prematurely or exposed to environmental toxins, congenital infections, or high bilirubin levels after birth are more likely to develop cerebral palsy (Taft & Matthews, 1992).

  ▪ Infants with respiratory problems or seizures at birth and those with very low birth weights are more likely to develop CP (Taft & Matthews, 1992).

  ▪ In 25% of cases, no cause is found (Kurtz et al., 1996).

  ▪ Children with CP may also have cognitive impairments, swallowing problems, feeding problems (and growth problems), seizure disorders, and problems with vision and/or hearing and should be assessed by an interdisciplinary team to determine the best course of action.

  ▪ Early intervention programs that promote psychomotor development and the use of multiple professionals (e.g., speech therapists, nurses, physical therapists, occupational therapists, social workers, infant educators) can assist parents in working with their infants (Taft & Matthews, 1992).
• Profound hearing loss (deafness) may occur in 1% of children and is commonly due to genetic causes (e.g., chromosomal disorders). Hearing loss can also stem from infection (Kurtz et al, 1996).
  ▪ Genetic hearing loss may also be associated with visual problems, hyperactivity, and mental retardation.
  ▪ Language and speech dysfunction almost always are a result of severe/profound hearing loss (Kurtz et al, 1996).

• Visual impairment (blindness) occurs in less than 1% of children, and may be due to congenital glaucoma (corneal clouding), tumors, or traumatic injury (Kurtz et al., 1996).

• Orthopedic and neurological handicaps may be caused by birth defects (e.g., spina bifida) or trauma (e.g., paralysis).
  ▪ These types of disabilities may necessitate the use of a wheelchair, crutches, or other assistive devices.
  ▪ Accommodations in daily living activities and future plans for education or career may be necessary.

• Children exposed to substance abuse can exhibit varied effects of exposure depending upon the substance used and the timing of exposure (Bear, 1995).
  ▪ Maternal cocaine use has been associated with seizures, learning disabilities and language processing problems, attentional deficits and hyperactivity, and disorganized attachment behaviors in children. Mood disturbances and low frustration tolerance are also associated with cocaine exposure (Bear, 1995).
  ▪ Narcotics use during pregnancy can lead to neonatal abstinence syndrome (similar to adult “withdrawal”), apnea (stopping breathing), and sudden infant death syndrome (SIDS) in infants. Children born to narcotics-using mothers may have learning disabilities, attention deficits, and developmental delays, along with learning disabilities, hyperactivity, delayed speech, and impaired visual motor functioning (Bear, 1995).
  ▪ Tobacco exposure in utero can cause premature birth, intrauterine growth retardation, and tremulousness, along with other central nervous system abnormalities (Bear, 1995).
    ~ Passive, or secondhand, tobacco exposure in childhood is associated with more frequent upper respiratory infections, diminished lung function, chronic ear infections, asthma, and hyperactivity along with lower reading, math, and verbal skills (Bear, 1995).
~ Tobacco use in the mother can lead to many problems associated with pregnancy, beginning with conception (tobacco interferes with conception), and including inadequate weight gain during pregnancy, spontaneous abortion (i.e., miscarriage), and premature labor (Bear, 1995).

- Substance abuse by parents or other family members puts children at risk of abuse and neglect because of the attendant lifestyle associated with illicit drug use.

- Fetal alcohol syndrome is now considered the leading known cause of mental retardation in this country (Thomson & Lewis, 1995).

  - Fetal alcohol syndrome (FAS) and fetal death are the most critical complications of maternal alcohol consumption.
    - Common facial anomalies, growth deficiencies, and mild to moderate mental retardation are characteristics of FAS.
    - Behavior problems, such as attention deficits, poor judgment and concentration, impulsiveness, and social withdrawal are commonly noted in childhood and adolescence (Thomson & Lewis, 1995).

  - Some infants, however, may show little or no effect from maternal alcohol use. Fetal Alcohol Effects (FAE) is a milder form of alcohol-related defect with less debilitating mental, behavioral, and motor problems than FAS, and there are few or no facial anomalies noted in FAE children (Thomson & Lewis, 1995).
    - These children may have marginal mental retardation, poor motor skills, emotional instability, and hyperactivity.
    - FAE children may be difficult to discipline and have significant school problems.

**Health Concerns of Children** affect the entire family. Taylor and Aspinwall (1993, p. 515) state that children “do not develop chronic illnesses, families do.” Families may be overwhelmed with the constant care that is required, and the accumulated stressors may negatively impact family members (e.g., siblings may rebel in response to increased responsibilities, couples may have more marital dissatisfaction).

- Living with chronic health problems during childhood means facing the usual developmental transitions with an added burden, an oftentimes life-threatening illness. The normal adolescent period of independence and rebellion against adult values can have even more serious consequences if the adolescent has asthma or diabetes, for example, and refuses to comply with his or her regimen of medication and/or diet (Taylor & Aspinwall, 1993). Chronic health conditions...
Asthma affects between 5-10% of children with rates of asthma and asthma deaths increasing over the last ten years (Silkworth, 1993a).

- Asthma can be a life-threatening illness, but it can also generally be controlled with medication and self-care management (e.g., avoiding exposure to allergens, paying attention to “triggers” or early warning signs of problems).
- Children can be monitored at school and at home using peak flow meters as an early warning indicator (e.g., if child is out of his or her “safe” range, additional medication may be needed or further action taken).

Diabetes is a metabolic disorder caused by the lack of insulin leading to abnormal carbohydrate metabolism (Will, 1993).

- Diabetes may be Type I (insulin-dependent is most commonly found in children) or Type II (non-insulin-dependent is most commonly found in obese adults).

Insulin-dependent diabetics must take insulin injections in order to keep their blood sugar levels within a normal range.

- High blood sugar levels cause nausea, vomiting, confusion, other symptoms, and can lead to coma and death (Will, 1993).
- Low blood sugar levels (or insulin reactions) can cause headaches, hunger, dizziness, blurred vision, irritability, confusion, drowsiness, nausea, and eventually coma and death (Will, 1993).

Non-insulin-dependent diabetics may take oral medication that allows their insulin to be used more effectively or stimulates insulin production.

- Diabetes in children and adolescents can lead to an emergency if there is too much insulin, which may lead to low levels of blood sugar.
  - This is usually due to too much insulin, lack of adequate calories consumed, or excessive exercise.
  - If they are conscious, immediately giving the child candy or fruit juice should bring their blood sugar level up.
- Emergencies can also occur when there is not enough insulin, which may lead to high levels of blood sugar (and diabetic coma).
- Usually, high blood sugar levels have been noted over a period of time, as most diabetics test their blood several times a day using a glucose monitor.

- This process is slower in onset than an insulin reaction, and can be reversed by injecting the appropriate amount of insulin.

~ It is important for families of diabetic children to work closely with the child's physician and the school nurse to assure that blood sugar levels are kept within prescribed limits.

- Cognitive abilities are hampered when blood sugar levels are very high or very low, thus impacting a child's academic functioning.

- Over time, consistently high blood sugar levels can lead to later complications such as blindness, kidney failure, and circulatory problems (Will, 1993).

- Other conditions (e.g., immunodeficiency diseases, seizure disorders, juvenile rheumatoid arthritis, sickle cell anemia, muscular dystrophy, congenital heart disease) require medication and treatment over long periods of time.

~ Chronic health conditions need careful healthcare monitoring by a primary care provider and other medical specialists, as well as case management at school, which is usually provided by a school nurse or social worker (Silkworth, 1993b).

~ School, home, and medical care should be coordinated with the child included as a member of the interdisciplinary team.

~ Team approaches offer support for families caring for children with chronic illnesses. Social workers, nurses, physicians, and other professionals may join together with families to form a network of support for medically-vulnerable children.

- Children with chronic illnesses may also benefit from peer support groups at school.

- Families may need to be referred to family support groups or linked to agencies or resources that can provide further information and support (e.g., American Diabetes Association).

- Medically fragile children are those who depend on "devices such as tracheostomies, oxygen, respirators, suctioning, gastric feeding, central venous lines, ostomies, (urinary) catheterization, and dialysis" (Palfrey, 1992, p. 784).
Due to better survival rates of premature babies, children with complex medical conditions, and children with human immunodeficiency virus (HIV), more children who depend on medical technology are of school age. These children are guaranteed the right to regular school attendance by federal laws (P.L. 94-142, P.L. 99-457) and Supreme Court decisions (Tatro vs. Irving Independent School District).

- Mainstreaming and full inclusion are terms used to signify placement of medically fragile or special education students in regular classrooms (rather than excluded from school or placed in special classrooms or schools, as had been the case in years past).

  ~ Legal issues related to medically-fragile children include interpretation of special education laws requiring school districts to provide “related services,” such as catheterization and suctioning, that "must be provided to remove the barrier to the child's education" (Palfrey, 1992, p. 784).

  ~ Schools have the responsibility to provide any necessary nursing service required by a child in special education (Martin, Martin, & Terman, 1996; Palfrey, 1992; Palfrey, 1995).

  ~ Children's and family's rights include parental input and due process, and should be strictly maintained by school districts (Martin et al., 1996).

- Specialized Physical Health Care Procedures (SPHCP) include gastrostomy tube feedings, clean intermittent catheterizations, tracheostomy care and suctioning, intervenous fluid administration, and other healthcare procedures that are generally performed by a licensed healthcare worker or a child's parent who has been trained by a licensed healthcare professional (Palfrey, 1992).

  ~ In schools, SPHCPs include those procedures that must be provided during school hours in order for students with medically-fragile conditions or disabilities to attend school (Silkworth, 1993b).

    - They may be done by teachers or aides, under the supervision of a trained and licensed healthcare worker (e.g., physician, school nurse, public health nurse).

    - Parents, school nurses, teachers, and other personnel should develop an Individualized Health Plan (IHP) tailored to the child’s specific health needs.

  ~ Complications with foster care related to SPHCP include inability of foster parents to provide a history of the child's illness or medical condition, the unfamiliarity of the foster parent with the particular
healthcare procedure or the child's physician, and the frequent moves associated with foster care (e.g., new schools, new personnel to be trained; Palfrey, 1995).

- Schools are now much more aware of the health problems of children because of laws related to special education, although not all schools are well equipped to handle all health conditions of children. Many children and families need professionals to advocate for them in order to ensure that they receive appropriate services.
  - Section 504 of the Rehabilitation Act provides that any "recipient of federal financial assistance must end discrimination in the offering of its services to persons with disabilities" and expanded the rights of the disabled in "employment, public accommodations, transportation, and telecommunications" through the Americans with Disabilities Act and the Individuals with Disabilities Education Act (Martin et al., 1996, p.29).
    - This section provides for coverage of children who did not meet other eligibility specifications for special education, but who have impairments that interfere with their schooling (e.g., ADHD, some learning disabilities).
    - Schools must now make accommodations for such children and have a plan, similar to the Individualized Education Plan (IEP) specified in P.L. 94-142 or the Individualized Family Service Plan (IFSP) outlined in P.L. 99-457, outlining specific classroom modifications to be made (Slenkovich, 1995).
  - Special education assessment teams must evaluate children in "all areas related to the suspected disability...and reevaluation is required at least every 3 years or when requested by a parent" (Martin et al., 1996, p. 31).
    - These teams may consist of a classroom teacher, a resource specialist teacher, a special education consultant, a school psychologist, a school administrator, a school nurse, a speech therapist, a physical therapist, or other professionals whose expertise is required for a specific assessment (Dowrick, 1996)
    - The interdisciplinary teams are required by law to work with families to identify problems, do appropriate assessments, clarify and identify goals and treatment plans, and achieve specific outcomes (Trachtenberg & Lewis, 1996).
      - The plan devised by teams should be culturally sensitive, family-centered, nonrestrictive, continuous, and effective (Trachtenberg & Lewis, 1996).
Case management should assure that children and families are linked to existing agencies and programs (Trachtenberg & Lewis, 1996).

**Social-Emotional Problems**

- Attention Deficit Hyperactivity Disorder (ADHD) occurs in about 3-10% of school-age children (Kurtz et al., 1996) and includes problems with attention, impulsivity, and motor activity (adapted from Guevremont, DuPaul, & Barkley, 1990):
  - ADHD children may display low tolerance of frustration, academic underachievement, learning disabilities, motor incoordination, enuresis, sleep problems, and increased physical illness (e.g., allergies, respiratory infections).
  - They have problems with social interactions and may be coercive, aggressive, and noncompliant.
    - Peer relationship problems and social rejection can be a result.
    - Poor self-esteem and mild forms of depression are also not uncommon.
  - There are variable effects with different situations.
    - They can demonstrate sustained attention with novelty, one-on-one attention, and a rich schedule of immediate and consistent feedback (e.g., videogames which are self-paced and have intrinsic interest).
    - They may show pronounced attention problems with repetitive tasks or tasks that have low intrinsic interest or rapid depletion of novelty. The majority of children continue to show problems with restlessness, inattention, and impulsivity into adolescence and adulthood.
  - Poor self-esteem, depression, alcoholism, and social/occupational difficulties continue (especially when added risk factors of lower intelligence, poverty, conduct problems, poor social relations, and untreated parental psychopathology are found).
  - There is no single etiology—familial-hereditary factors, pregnancy factors (e.g., alcohol, tobacco) and obstetrical complications (e.g., postmature) have been implicated. Elevated blood lead levels may lead to hyperactivity in some children.
  - There is no single diagnostic test (e.g., blood test, x-ray). Therefore, indirect measures must be used to determine diagnosis (Hinshaw, 1994).
The following are the most commonly used methods (adapted from Guervremont et al., 1990; Hinshaw):

~ Parent Interview

- **Referral Concerns:** Recent examples of behavior, age of onset, frequency, and pervasiveness of problem across situations, age/gender appropriateness of behaviors, parental expectations and tolerance, as well as knowledge of developmental norms.

- **Psychiatric/Mental/Developmental History:** This includes questions about anxiety, social skills, perceptual disturbances, developmental disorders, language and communication development, motor peculiarities, and intelligence to rule out other disorders (e.g., conduct problems, oppositional disorder).

- **Medical History:** Prenatal and perinatal conditions and/or complications, early milestones, chronic and acute medical conditions, physical disabilities. A history of Tourette's Syndrome.

- **School/Educational background:** Examination of conduct and achievement, age of onset of school problems, chronicity of problems, intelligence, academic deficits. Interprofessional evaluations to determine learning disabilities and other problems or concerns.

- **Family Hx/Psychosocial Functioning:** Prevalence of psychiatric, learning, behavioral, and developmental disorders in family members. Marital disharmony, maternal social isolation, parental depression, and alcohol abuse are not uncommon. Family functioning should be evaluated before any treatment is planned.

~ Teacher Interview

- **Child's Academic Status:** Evidence of any learning disability. Note particular subjects where child performs poorly on a consistent basis.

- **Specific Nature of Problem:** Onset, frequency, chronicity, eliciting events, situational fluctuations in performance. Other problems include anxiety and oppositional disorder. Other concerns include peer interactions and social problems. How do they compare with others in the class?
- **Previous Intervention Attempts**: What has been tried, why did it fail?

~ **Child Interview**

- Watch for basic language and social skills, motor, social thinking, or communication abilities which may be subtle problems.

- Ask child's perception of the problem (reason for referral), attitude toward family relations, and degree and quality of peer contact. (Accuracy may be somewhat suspect due to poor perceptual abilities—may say they have a lot of friends but when observed, it is apparent that they have serious social problems and few friends). For older children, ask about depression and their view of factors that contribute to the difficulties.

- Observe restlessness, inattention, impulsivity, and noncompliance with instructions. Children may behave well in novel and structured situations (especially one-on-one).

~ **Testing**

- **Child Behavior Ratings**: Use for variety of reasons—convenient sampling of wide array of behaviors, objectifying occurrence of behaviors across settings and informants, comparing scores with norms, repeated assessments can measure change over time (and with treatment).

- **Parent Rating Scales**: Child Behavior Checklist (113 items scale). Use Hyperactivity Factor only for ADHD. Social Competence Scale (20 items scale).

- Conners Parent Rating Scale-Revised: 48 items scale, yields five factors: conduct problems, learning problems, psychosomatic, impulsive-hyperactive, and anxiety. Has a separate Hyperactivity Scale for 3- to 5-year-olds. Used to discriminate ADHD from non-ADHD children, sensitivity to stimulant medication, and parental training interventions.

- **Home Situations Questionnaire**: Assesses situational variation in child's behavior, along with pervasiveness and severity of behavioral difficulties. Consists of 16 items about common situations arising at home and in public. There are two scores: number of problem situations and mean severity. Interventions can be planned from inspecting individual items. Used to discriminate ADHD from non-ADHD children,
sensitivity to stimulant medication, and parental training interventions.

- **Teacher Rating Scales:** Child behavior checklist/teacher report form—including many of the same items as the Parent Rating Scale. Adaptive Functioning Scale, Problem Behavior Scale (118 items).

Conners Teacher Rating Scale: A 39 item counterpart to the Parent Rating Scale. It consists of a 28-item revised scale, well-normed, but more sensitive to conduct problems.

School Situations Questionnaire: Evaluates types of situations in which problem behaviors occur in school. Twelve school-related situations. Problem and severity.

Attention Deficit Disorder Comprehensive: Teacher Rating Scale. Consists of four subscales (oppositional behavior, attention, hyperactivity, social problems). Is not well-normed.

**Self-Control Rating Scale:** Consists of 33 items regarding the ability to inhibit behavior, follow rules, and control impulsivity.

Edelbrock Child Attention/Activity Profile (CAP) assesses stimulant drug effects.

Children's Learning Profile (CLP) is a 14-item teacher rating scale being developed to assess teacher perceptions of children's academic behavior and learning over a 1-week period.

~ **Direct Observation**

- **Hyperactive Behavior Code:** Recording ADHD symptoms in classroom. Consists of six behavior codes (e.g., change of position, daydreaming) scored on interval scale.

- **Attention Span:** Continuous Performance Test (CPT) is widely used as a direct assessment of attention span or vigilance. The child observes a screen while stimuli (numbers, letters) are rapidly projected. The child responds by pressing a button when a certain stimulus appears. Test may last 9 - 15 minutes and requires continuous attention for maximum performance. The total correct responses including omissions and commissions are calculated. Total correct and omissions are thought to measure sustained attention.
- Commission score is thought to measure impulsivity and possibly sustained attention. The test makes use of computerized software programs, and interpretation of scores is limited due to absence of normed data.

- Gordon Diagnostic System (GDS) is a small, solid-state computerized device which has normative data. GDS has a test of impulsivity, called Delay Task, where a child must delay responding to earn points. Three measures are considered: the number of correct responses, the total number of responses, and the ratio of correct to total responses. New research has found that this is not a sensitive measure of medication effects or discrimination between ADHD/non-ADHD.

- **Impulsivity:** Matching Familiar Figures Test (MFFT): Child sees a sample picture and is told to select the same picture from an array of similar pictures. The amount of time taken to the first response and the number of errors before the correct picture is selected are recorded. There is normative data for 5- to 12-year olds.

- **Activity Level:** Actometer and pedometer can be attached to wrist or ankle to measure movement. No normative data available and it is difficult to use with children.

#### Intervention

- A multi-method approach is most successful.

- Parent support groups, behavior management program for parents with ADHD children (learn about ADHD and specialized discipline needed), a specialized classroom management program, home/school-based incentive system, and stimulant medication trial (controlled, double-blind placebo trial) are recognized components.

- Comprehensive psycho-educational testing should be done to rule out or specify learning disabilities.

- Social skills training programs to promote peer relations are another important intervention. Other programs can be included if needed (e.g., for bed wetting).

- Acting out and aggression may be responses to family, environmental, or individual stressors.
• Garbarino, Kolstelny, and Dubrow (1991) found that 25% of children in their study of inner-city families had witnessed a homicide.
  ~ These researchers further concluded that children living in these situations may develop hyperaggressive patterns of behavior as a defense mechanism.
  ~ While this behavior may serve as protection in their neighborhoods, it is often inappropriate for school settings, where they may be labeled as violent.

• Risk factors that have been found to predispose children to conduct disorder and problems with aggression include (Kazdin, 1995):
  ~ Child factors such as difficult temperament, neuropsychological problems (e.g., learning disabilities, ADHD, motor coordination deficits), early and frequent unmanageability or aggressiveness, and poor academic performance and IQ have been implicated.
  ~ Family factors can include genetic factors and family psychopathology (biological relatives or parents with conduct disorder or criminality), poor parent/child interaction (e.g., severe punishment, inadequate supervision and monitoring, lack of rules), parental divorce or discord, birth order/family size (more common in middle children, increased risk with larger families), and poverty.
  ~ Environmental factors such as perinatal complications (e.g., maternal drug use or infection), central nervous system injury, exposure to violence (e.g., neighborhoods, television, videogames), and schools or communities where aggression may be tacitly reinforced or rewarded (Kazdin, 1995; Pynoos, Sorenson, & Steinberg, 1993) also play a part.

• Acting out behaviors could be examined on a developmental trajectory (Kazdin, 1995).
  ~ For instance, problem behaviors may begin with temper tantrums or general stubbornness (oppositional symptoms) and progress to conduct disorders (e.g., lying, stealing, physical fighting) as children move from preschool to school age.
  ~ Behavioral problems can continue to a more severe level of conduct disorder with illegal activities such as carjacking and robbery.
  ~ Conduct disorder may be found in 2-15% of the population (Kurtz et al., 1996).

• Conduct disorder may continue into adulthood and have very serious consequences (Kazdin, 1995).
Adults who were identified as adolescents had higher rates of driving under the influence (DUI) and divorce, lower levels of education, greater psychological problems (e.g., antisocial personality disorder, alcohol and drug abuse), greater levels of criminal activity, were less likely to be employed, and more likely to be on welfare than subjects who were not identified as conduct disordered (Farrington, 1991).

Earlier onset and a larger variety and seriousness of episodes of conduct disorder in children, parental conduct disorder, and alcoholism and record of arrests have been identified as predictors of continued conduct disorder (Farrington, 1991; Kazdin, 1995).

Violent children can be characterized as having either reactive or proactive aggression (Dodge, 1991).

Reactively aggressive children may feel that everyone has hostile intentions against them. They can be easily provoked to anger and thus respond aggressively.

Proactively aggressive children use aggression to get what they want by means of coercion or domination, more so than as a reaction to others' perceived intentions.

Young children may have post-traumatic stress reactions to repeated victimization (e.g., sexual molestation) that include exaggerated acts of aggression, "atypical modulation of aggression," and chronic sleep disturbances (Pynoos et al., 1993, pp. 577).

Depression is found in children and adolescents and is characterized by sad mood; cognitive, motivational, and psychomotor disturbances; social impairment, and somatic symptoms (Cantwell, 1990).

Incidence varies from 3 - 34%, depending upon identification as depressive symptomatology or major depressive disorder (Rector, 1994).

Gender differences have been noted in rates of depressive symptomatology, with girls generally reporting higher levels of depression than boys, especially after puberty (Rector, 1994).

A "developmental trajectory of depressed mood has been found in adolescence, with increases noted between 13 to 15 years, and a peak around 17 to 18 years of age" (Rector, 1994, p. 82).

Younger children may show lower rates of depression than adolescents; however, those who begin having depressive symptoms in childhood are more likely to continue to have problems with depression throughout life (Cantwell, 1990).
Prepubertal children often have more somatic complaints and psychomotor agitation than adolescents (who generally express more hopelessness, have more weight loss or gain, and tend to sleep more) according to Ryan et al. (1992).

- Genetic factors, physiological and psychosocial stressors, as well as developmental factors may interact to predispose a child to depression (Cantwell, 1990).
- Severe physical and violent sexual abuse have been associated with adult depressive symptoms (Hall et al., 1993).
- Harsh, or perceived unfair, punishment was associated with adult major depression and alcohol dependence in a study of 200 adult subjects (Holmes & Robins, 1988).
- A family history of depression is a powerful predictor of childhood and adolescent depression (Cantwell, 1990).

- Suicidal ideation was found to be significantly higher in a group of adolescents with a depressive episode of 2 years or more (Ryan et al., 1992).
  - The study also found no differences in rates of suicide attempts or seriousness of suicidal intent for children and adolescents.
  - However, adolescents usually used more lethal methods than children (e.g., firearms).

- A team approach to identification and intervention of children with depression may help to promote early detection and treatment (Cantwell, 1990).

- Severely Emotionally Disturbed (SED) children comprise close to 1% of the school population (Palfrey, 1995).
- Children with severe emotional disturbances are usually segregated into special SED classes that too often focus on their behavioral problems and not their academic development (Palfrey, 1995).
  - This is commonly the case because regular education teachers "will not tolerate disruptive, aggressive, operational, defiant, or dangerous behaviors," which are commonly expressed by SED children (Hocutt, 1996, pp. 89).
  - Parental involvement, vocational education, and social integration in school activities such as sports were found to lead to better long-term outcomes (e.g., employment, residential independence) for SED students (Hocutt, 1996).
Diagnosis of SED usually includes unusual behaviors that continue over long periods of time and adversely affect the child's academic performance (Kern, Delaney, & Taylor, 1996).

- One or more of these characteristics are usually present: inability to have satisfactory peer relationships, inability to learn (not due to health, sensory, or intellectual factors), inappropriate types of behaviors or feelings (e.g., depression), or a tendency to develop physical symptoms or fears regarding school or personal problems (Kern et al., 1996).
- Less serious social problems are not considered serious emotional disturbances.

Mental health professionals, joining with school professionals (e.g., teachers, school psychologist, school nurses, administrators), health care providers, and families can plan more effective interventions for emotionally disturbed children and adolescents.

**Child Study Teams** at school sites and interdisciplinary teams in early childhood intervention programs (for 3-year-olds or younger) bring a variety of expertise to facilitate early intervention for various problems found during childhood (Lewis, 1995).

- As the problems become more complex, the team membership should become more extensive and varied.
- Child welfare issues such as poverty, child abuse and neglect, as well as public health issues, such as environmental hazards and communicable disease control, can be better addressed by the inclusion of child welfare workers from social services agencies and public health professionals from local health departments as members of school-based teams.
- Teams may choose to ask for consultation and collaboration from other professionals in specific cases that warrant additional input.
- Characteristics of successful collaborative teams in schools include (Dowrick, 1996):
  - Representation is comprehensive: all necessary professionals, family members, and community members are participating.
  - Representation is balanced and stable: team members are represented as needed, have long-term assignments to the team, are knowledgeable about the problems presented, and have the authority to make necessary commitments.
- Responsibility is shared: team members equally participate in decisions, in mutual goal setting, and in sharing accountability and rewards.

- Open communication and equal access: team members meet and communicate often, and information is available to all members equally (there are no informal subgroups or use of jargon to control or manipulate others).

- Attitudes and respect: team members should strive to be open, flexible, creative, and "appreciate and learn from other perspectives" (Dowrick, 1996, p. 194). Team members also need to keep their own boundaries and respect their own expertise. Acknowledgment should be given to the contributions of individual members, as well as the team as a whole.

- Effective collaborative team meetings can be facilitated by assuring that consideration is given to group process as well as group tasks. Paterna (1996) suggests that meetings begin by reviewing past task assignments and ongoing items, cover key successes and failures (as a process of learning), and conclude with summarization and setting the next meeting time, place, and date. Meetings should be characterized by consensus and discussion with open communication. Absent members should be debriefed by an assigned team member to promote continuity. Paterna also suggests that five key roles be chosen by team members at the beginning of each meeting:
  1. Facilitator: This should rotate among team members. The role is to set the agenda in consultation with team members and to keep the meeting on task and within the time limits set.
  2. Timekeeper: Role is to keep track of time spent on each agenda item and signal facilitator.
  3. Recorder: Role is to keep minutes and to outline specific tasks assigned and follow-up needed.
  4. Encourager: Role is to observe nonverbal cues and encourage participation of all members.
  5. Jargon Buster: Role is to restate information and minimize use of professional jargon.

ORGANIZATIONAL BARRIERS TO EFFECTIVE INTERDISCIPLINARY COLLABORATION

**Compartmentalized Agencies** dealing only with specific problems have not met the needs of vulnerable children and their families. Many children have multiple problems and are being served by multiple agencies, but not always effectively (Hooper-Briar & Lawson, 1994).
• Children have “fallen between the cracks” because of agency regulations that preclude services for problems other than those covered by specific funding streams or mandates.

• Families often feel confusion and frustration in dealing with multiple agencies and professionals.
  ▪ Appointments may be necessary at several different locations and times, and basic intake information must be given repeatedly.
  ▪ Differing professional points of view may cause families to abandon treatment efforts.

“We Don't Do Things Like That Around Here,” maintaining the status quo, has often been the rallying cry of agencies dealing with vulnerable children and families. In Moving from Principles to Practice: A Resource Guide, the Ad Hoc Working Group on Integrated Services (1996) cite the following barriers to agency collaboration:

• Early circling of the wagons: Defensiveness to integrating services may be due to lack of a common vision, taking on too much too soon, or leaving out key levels of authority in the early planning discussions.

• Excuses: Defensiveness may also stem from fear of the unknown, and perceived barriers (e.g., confidentiality) that have historically kept agencies at a distance.

• “But we don’t know how to play”: Because most agencies have been non-collaborative in the past, many professionals working there do not have the basic skills needed for integrated service delivery and need further training and skill development.

• “Not my money”: With shrinking program budgets, agencies may be turf oriented at first, wanting to protect their employees and budgets. Integrated services may be actually more costly at first, but should reap cost benefits in the long run.

• “Different strokes for different folks”: Agencies and professionals need to discover the reward systems under which they have operated (e.g., reducing caseloads, increasing caseloads, problem prevention, problem management), and move to a more outcomes-based system with common evaluations and data management.

• “We'll wait out this fad”: Continued leadership and skill development is needed, along with a clear vision and continuing involvement on all levels.
The Most Significant Barrier to Collaboration is the lack of leaders with true vision (Corrigan, 1996).

- In order for significant change to occur, leaders must be forward thinking and not view potential barriers as a rationale for doing nothing.
  - A true concern for children must be the motivating factor for visionary leaders.
  - Political strategies and policy development must be mastered by collaborative leaders in order to make effective changes.
- Contradictory agency policies and reward systems, turf battles, and elitist professional behaviors should be considered good motivators for systems change.
  - Move to outcomes-driven approaches to care must consider agency and professionally driven client barriers and work to remove them.
  - Unlike business, many helping professions do not rely on customer satisfaction as an evaluation method.
  - Joint client-professional problem solving methods and team approaches can go beyond these barriers.
- A "reluctance to get involved in controversy when community-based decision making and collaborative governance structures bump up against the vested interest of existing power structures" has characterized our leadership and created further barriers to collaborative systems of care (Corrigan, p. 119).
- Corrigan (1996) reminds universities that preservice interprofessional training and education is the key to a transformative move toward collaborative practice.
  - Professors and administrators must model (and value) collaborative behaviors in order for students to buy into this approach.
  - Research done by university faculty should focus on improving the lives of vulnerable children and families, rather than on "building professional careers" (Corrigan, p. 120).

CONTINUATION OF INTEGRATED SERVICES/COLLABORATIVE EFFORTS

State and Federal Initiatives have occurred simultaneously along with movement of professional groups and community organizations toward more collaborative systems of care.
• Schene (1996, p. 29) summarizes key points of consensus among the National Commission on Children, the National Governors’ Association, and other child and family advocacy groups noting that there is a need for a more comprehensive and realistic response to the problems of vulnerable children and families "moving away from categorical programs" to a "community system of care where professionals from schools, courts, mental health, law enforcement, social services, and substance abuse treatment work together."

• Over the last 20 years, the federal government has initiated funding to stimulate service integration pilot projects. Blended financing and block grants have further supported collaborative efforts, and federal standards requiring collaboration between agencies in order to get grant funding has been helpful. However, evaluations of quality and outcomes have not always coincided. Further, major financing and operational changes must be promoted in order to facilitate true lasting changes (Brandon, 1996).
  
  ▪ Schene (1996) notes that the federal government has moved to a stance of strengthening families, rather than rescuing them, by passing the 1993 Family Preservation and Family Support Act.
  
  ▪ The Office of Educational Research and Improvement in the U.S. Department of Education has organized an interagency steering committee on School-linked Comprehensive Services, in order to develop research and partnership opportunities for schools, state and local agencies, private foundations, and organizations (Karp, 1996).
  
  ▪ It is uncertain if the move to block grants will entirely wipe out the fragmentation and division that has characterized most state-level agencies and programs (Brandon, 1996).
  
  ▪ The federal government has given waivers from various categorical programs in order to enable states and local schools or other entities to attempt more integrated and collaborative approaches (e.g., Title I funds used in schools for broader purposes than the original intent).

• State efforts have promoted more seamless services and encouraged integrated service delivery as a means of trimming budgets. However, most collaborative efforts, at least in the beginning, are time consuming and more costly (Brandon, 1996; Hooper-Briar & Lawson, 1994).
  
  ▪ Georgia has initiated legislation to develop a preschool through college educational reform that brings together institutions of higher learning who prepare teachers and the preschools and elementary schools that hire them (Kettlewell, 1996).
  
  ▪ California developed Healthy Start grants to encourage community building and school-based or linked services for children and families.
• Other states, such as Arkansas, Kentucky, and West Virginia, have also initiated state-level grants for community capacity building and family-centered integrated services (Mutchler & Pollard, 1996).

**Policy Making and Legislative Change are necessary if collaborative efforts are to continue their forward momentum.**

- Our political system has not historically favored long-term commitments or solutions to difficult problems (Brandon, 1996).
  - Politicians, in order to be re-elected, often find an issue or cause to support and promote legislation specifically targeted to that issue.
  - Block grants have historically been susceptible to the budget ax because specific constituents and services are difficult to identify.

- Because of large federal bureaucracies that promote their own agendas, funding and projects generally reflect the bias of individual agencies (Tetelman, 1996).
  - Joint planning between federal agencies could help eliminate bias and promote collaboration.
  - This same process must occur at the state and community levels as well.

- It is vital for professionals working with vulnerable children and families to develop relationships with local, state, and congressional legislators.
  - In order to understand the local impact of their decisions and policies, legislators need continuing feedback from their constituents.
  - As advocates for our clients, we can promote policies and legislation that benefits all citizens, not just those who can afford lobbyists.
  - We can empower our clients by helping them tell their stories to policymakers and legislative aides.

**Grants and Funding for Collaborative Efforts may come from government or private foundations.**

- Block grants from the federal government to the states make it possible for more local initiatives geared toward community building and collaborative practice (Brandon & Meuter, 1995).
  - The Maternal Child Health Bureau of the U.S. Department of Health and Human Services has provided funding for interprofessional collaborative training projects at universities and development of family-centered service delivery models for professional education (Sia, 1996).
Other federal and state agencies (e.g., Centers for Disease Control and Prevention/Division of Adolescent and School Health, Bureau of Primary Health, Department of Health Services, Department of Education) have recently given grant monies to schools and other agencies to promote integrated services.

School-based and school-linked service models have received support from various public sources (as well as private foundations), and also may bill for services rendered (Lawson & Briar-Lawson, 1997).

- Private foundations, such as the Ford Foundation, the W.K. Kellogg Foundation, the Stuart Foundation, the Robert Wood Johnson Foundation, the Danforth Foundation, and the Annie E. Casey Foundation have earmarked portions of their budgets to integrated service delivery or collaborative efforts (Alameda, 1996; Casto, 1994).
  - Grant funding is available for local initiatives that promote interagency collaboration.
  - Funding has also supported policy development on state and national levels.

**Evaluation Research** that can ultimately show real differences and effective outcomes will be the deciding factor.

- The School-Based Youth Services Program in New Jersey provides comprehensive services on or near elementary, middle, and high school campuses (Tetelman, 1996).
  - The program has 42 sites and has been operational for over 8 years, at a cost of over $7 million dollars per year.
  - The goals of the program are for students to graduate from high school with skills that can lead to employment or further education, and have healthy and drug-free lives.
  - For every $200 spent on a student for preventive and primary health care services, an estimated $20,000 to $65,000 is saved in mental health or criminal justice system services (Tetelman, 1996).

- Each year’s class of dropouts in this country costs over $240 billion in lost lifetime earnings and taxes (Dryfoos, 1990).
  - Early intervention, as discussed previously, can help prevent students from dropping out of school.
- Interdisciplinary teams and family-centered approaches have been shown to be effective in producing better outcomes for children and families (Hooper-Brier & Lawson, 1994).
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DEFINITION OF COLLABORATIVE WORK

(Allender et al., 1997)

1. **Coordination:** Directed by a team leader, characterized by sharing mutual goals and pooling of resources.

2. **Cooperation:** Maintenance of individual agency identity, power, authority, and independence. Includes resource sharing. Decision making characterized by negotiation between agencies.

3. **Collaboration:** Joint team effort is characterized by a well-defined, mutually beneficial working relationship, mutual respect, commitment to common goals, and shared accountability governance.

EXAMPLES OF COLLABORATIVE TRAINING MODELS AND PROGRAMS

1. Five Models (Hooper-Briar & Lawson, 1994)
   a. Home- and neighborhood-based
   b. Community-based
   c. School-linked
   d. School-based
   e. Saturation-oriented

2. Successful models at the University of Utah (Winitzky, Sheridan, Crow, Welch, & Kennedy, 1995)
   a. Collaborative Educational Problem Solving and Conflict Management course.
   b. Site-Based Transdisciplinary Educational Partnerships Project (STEPships Project): School of Education, a federally funded project.
   c. Utah Network Project: Schools of Education and Social Work joined an elementary school, school district, and community organization to develop, implement, and evaluate new approaches to collaboration in the education of social workers and educators.
   d. Practice-focused models of interprofessional collaboration. Although many of the following models were developed in California, these models are now implemented nationally.

INTERPROFESSIONAL COLLABORATION: KNOWLEDGE, VALUES, AND SKILLS

1. Knowledge
   a. Familiarity – diverse professional terminology
   b. Interprofessional Glossary
   c. Minimize use of jargon
   d. Ecological Systems Theory
   e. Systems Concepts
      i) Boundaries
      ii) Feedback and purposive systems
      iii) Equifinality
      iv) Multifinality
      v) Change and stability

2. Values
   a. Openness and risk-taking
   b. Ecological systemic perspective
   c. Mutuality

3. Skills
   a. Ability to facilitate effective team functioning
   b. Managing differences
      i) Conflict resolution
      ii) Negotiation strategies
      iii) Communication skills
      iv) Keeping focused on outcomes
      v) Examining how various professions frame problems
      vi) Dealing with differences in personal styles
   c. Process skills in interprofessional collaboration

d. Case management
   i) Basic concepts
   ii) Identifying common goals
   iii) Involving parents; joining with rather than doing for
   iv) Exploring interagency support in task achievement
   v) Awareness, appreciation, and utilization of community resources
   vi) Ecological/Systemic basis of assessing problem child “behavior”
ORGANIZATIONAL LIFE AS CULTURE

1. Organizational values

2. Identify resources for change

3. Formal vs. informal systems/networks

4. Feedback processes and change

5. Perspective on behavioral change
   a. Deficit-based view
   b. Value assumption regarding how change occurs

TEAMS CAN BENEFIT BY STRUCTURING TIME TO DISCUSS EACH MEMBER’S POINT OF VIEW

1. Professional and ethical values
2. Formulation of problems
3. Role expectations and stressors
4. Client/Agency/Professional responsibilities

LEGAL/ETHICAL ISSUES

Team members’ diverse legal and ethical constraints and responsibilities need to be examined

1. Confidentiality

2. Client records

3. Informed consent forms should include:
   a. Client(s) names, signature, date, date of expiration
   b. Type of information to be gathered and produced
   c. Reasons for request for service
   d. Information regarding who has access to records and for what purpose
   e. What copies can be made by whom

4. Mandated reporting responsibilities
   a. Team discusses professional responsibilities and the implications for the team.
   b. Team explores possible effects of mandated reporting and the implications for “working through” with families the mandated reporting event.

5. Professional Codes of Ethics
   a. Team will review differences between diverse professional codes of ethics.
   b. Team will identify values assumptions of the diverse codes of ethics.

6. Working towards a collaborative ethic
   a. Each team member builds on his or her own (professional) ethics as part of the development of a team collaborative ethic.
   b. A common mission and/or goal statement should be developed by the team and reviewed regularly.

PRINCIPLES OF INTERPROFESSIONAL TEAM BUILDING

1. Components: Effective team building involves the following factors:
   a. Communication
   b. Shared accountability and negotiating team roles

2. Knowledge and values of team building
   a. Team clarity regarding intervention plan and valued client system outcome is based on application of ecological and systems theory.
   b. Core values guiding team facilitation (Schwarz, 1994, p. 9).
   c. Willingness for the risk taking that is needed for open team communication.
   d. Possible problem areas and pitfalls include role ambiguity, role conflict, and uneven distribution of responsibility on the team can lead to frustration and anger.
   e. Familiarity with evolutionary process of building team building is essential.

3. Skills
   a. Active listening
   b. Team members recognize and can engage in metacommunication
   c. Qualities of effective communication
   d. Critical thinking is essential
   e. Group members have the flexibility to attend to process and outcome tasks

TEAM BUILDING PROCESSES
(Modified from Allender et al., 1997)

1. Stages of team development
   a. Develop self awareness, awareness of each other, and of differences.
      i) Validation of professional values and ethics.
      ii) Team acknowledgement of personal style.
      iii) Achieving team outcome is premised on members contributing their differences.
   b. Contact/communication with each other.
      i) Practice active listening.
      ii) Each member’s contributions are valued.
      iii) Team is aware and respectful of boundaries between members.
      iv) Five personal behaviors that can interfere with contact:
         ▪ Projection
         ▪ Introjection
         ▪ Retroflection
         ▪ Confluence
         ▪ Deflection
   c. Growth of respect, trust, and team spirit.
      i) These are not built exclusively on communication and contact.
      ii) Team reaches new levels of humor, directness, brainstorming, and creative conflict.
      iii) There are examples of productive teams where members may not like each other, but not where there is lack of trust and respect.

2. Factors that work against development of team cohesion in large groups:
   a. Lack of coordination (i.e., direction)
   b. Insufficient support and opportunity for team members to express their own point of view
   c. Poor time management
   d. Lack of meaningful outcomes
RELATIONAL PROCESS SKILLS

1. Basic process skills essential for engaging in meaningful dialogue
   a. Empathy
   b. Genuineness/Authenticity
   c. Warmth/Respect
   d. Concreteness
   e. Confrontation

2. Active listening

3. Engaging in clarification

4. Initiative taking in introducing new ideas, information, and suggestions

5. Team members value engaging in metacommunication

SELF AWARENESS ABOUT ONE’S OWN COMMUNICATION STYLE

1. Team members are mindful about their own responses in interactions with others.

2. Team members develop individual capacity for reflecting on their communication style.

3. Team members managing their own feelings when they feel emotionally uncomfortable with others whose behavior, practices, or values may be different from their own.

4. Being aware of how our life experiences influence what we notice in ourselves and in others; noticing what information we miss.

THE CHANGE PROCESS

1. Type of change
   a. First order change involves responding to and working with feedback from others.
   b. Second order involves individuals evaluating their beliefs and values in a way that results in a reorganization of their beliefs (i.e., worldview).

2. Exploring beliefs and feelings about the change process

3. Examining beliefs about the role of practitioners in the change process

FIVE BASIC ASSUMPTIONS ABOUT CHILDREN AND ADOLESCENTS
(Karns, 1995)

• They need adults who don’t blame or shame them.

• Behavior is motivated by a perceived benefit to themselves.

• They all have a basic need to feel competent.

• They need values, guidance, and an internal dialogue that supports prosocial behavior (e.g., self-talk leading to self-discipline).

• They all need a chance to play, to laugh, to have friendships as well as physical challenges.
SELMAN’S STAGE THEORY OF SOCIAL COGNITION OR ROLE-TAKING
(Selman, 1973)

- Ego-Centric, Undifferentiated Stage (3-6 years)

- Differentiated and Subjective Perspective-Taking Stage (5-9 years)

- Self-Reflective Thinking or Reciprocal Perspective-Taking Stage (7-12 years)

- Third Person or Mutual Perspective-Taking Stage (10-15 years)

- In-Depth Societal Perspective-Taking Stage (12 years-adult)
ERIKSON’S THEORY OF PSYCHOSOCIAL DEVELOPMENT
(Adapted from Papilia & Olds, 1992)

Crisis 1: Basic Trust vs. Mistrust *(birth – 12-18 months*)
Should be a balance of trust, leading to the development of the virtue of hope.

Crisis 2: Autonomy vs. Shame and Doubt *(12-18 months – 3 years*)
A virtue of will emerges as toddlers learn to make their own decisions.

Crisis 3: Initiative vs. Guilt *(3 – 6 years*)
A virtue of purpose is the courage to pursue valued goals uninhibited by defeat, guilt, or punishment.

Crisis 4: Industry vs. Inferiority *(6 years – puberty*)
Efforts at mastery help a child to develop a positive self concept. The virtue that develops is competence.

Crisis 5: Identity vs. Identity Confusion *(puberty – young adult*)
The individual must define their own sense of self. The virtue is fidelity. The task is to form their own identity and become unique adults with an important role.

Substages

- Temporal Perspective vs. Time Confusion
- Self Certainty vs. Self Consciousness
- Role Experimentation vs. Role Fixation
- Apprenticeship vs. Work Paralysis
- Sexual Polarization vs. Bisexual Confusion
- Leader/Followership vs. Authority Confusion
- Ideological Commitment vs. Confusion of Values

**Crisis 6: Intimacy vs. Isolation** *(young adult)*

The virtue that develops in this stage is love of mutuality of devotion.

**Crisis 7: Generativity vs. Stagnation** *(middle age)*

The virtue of this stage is care – to take care of persons, ideas, or products.

**Crisis 8: Integrity vs. Despair** *(old age)*

The virtue gained is wisdom.
PARENTING STYLES
(Baumrind, 1989)

Authoritative

- Used rational, issue-oriented means to direct child’s activities.
- Encourages open two-way communication.
- Explains the reasoning behind their decisions, while firmly and consistently guiding actions.
- Affectionate and responsive, shows sense of respect for own and child’s rights.

Authoritarian

- Characterized by control.
- Wants to shape, control, and evaluate their child’s behavior according to an absolute standard.
- Highly value obedience, respect for authority, traditional values, and order—they are the ultimate authority.
- Little two-way communication.
Permissive

- Less controlling than the other two categories.
- Warm and accepting, making very few demands.
- Encourage child to regulate their own activities—don’t insist on obedience to externally defined standards, and avoids use of overt power. Permissive category broken down to include (Dornbusch et al., 1985; Steinberg et al. 1991):

  1. Neglectful
     - Do not demonstrate high levels of acceptance or involvement, exhibits low levels of supervision and/or strictness.

  2. Indulgent
     - Involved with their child, but are not strict.
     - Inconsistent parenting style has also been described.
FAMILY SYSTEMS ASSESSMENT
(Wright & Leahey, 1994)

Developmental Assessment (Mainstream Families)

Stage One  Launching of Single Young Adult
Stage Two  Marriage and Joining of Families
Stage Three  Families with Young Children
Stage Four  Families with Adolescents
Stage Five  Launching Children and Moving On
Stage Six  Families in Later Life

Structural Assessment

Internal  Family Composition, Gender, Rank
Order, Subsystems, Boundaries
External  Extended Family, Larger Systems
Contextual  Ethnicity, Race, Social Class, Religion, Environment

Functional Assessment

Instrumental  Activities of Daily Living
Expressive  Communication, Problem-Solving,
Roles, Influence, Beliefs, Alliances/Coalitions

FAMILY FACTORS CONTRIBUTING TO ABUSE/NEGLECT
(Rosenberg & Sonkin, 1992)


2. Child factors – temperament and other characteristics (e.g., physical features or stature, health or disability, planned vs. unplanned birth).

3. Contextual stressors – poverty, lack of external support.

FAMILY FACTORS THAT DECREASE LIKELIHOOD OF CHILD MALTREATMENT

(Rosenberg & Sonkin, 1992)

1. **Unified couple parenting** – Act as a single entity when setting limits and dealing with children.

2. **Authoritative parenting style** – Promotes authority as parents, but includes flexibility to allow for child’s needs.

3. **Positive modeling** – Good communication and negotiation skills.

4. **Permeable family boundaries** – Allows participation in school and community activities.

EFFECTIVE INTERPROFESSIONAL TEAMS

- Empower families by inviting them to be team members from the beginning.
- Regard families as “experts.”
- Demonstrate respect for the family and their strengths and problems.
- Listen carefully to the family and develop common goals.
- Work first on the family’s issues and act on what has been discussed.
- Develop a “solid relationship” that demonstrates caring and concern.
- Apply problem solving methods with families.
- Facilitate effective teamwork (ongoing process).
- Use a shared language and rules for communication.

HANDOUTS

VIGNETTE 1
LAURA

Laura is a 5-year-old first generation Mexican only child. Her parents immigrated to the United States two years ago. Laura's father manages a grocery store and the mother is a factory worker. Both parents are Spanish dominant and although they don't speak English, they have some comprehension of the language. There is no extended family in the U.S.

Sexual abuse allegations were filed one year ago by a daycare center when a staff person discovered blood on Laura's underwear. Laura was removed from the home immediately and placed in foster care. When the investigation suggested that the father might be the perpetrator, the parents separated with the mother staying in the family home. The mother is very angry about Laura being removed from the home and is willing to do what is necessary for Laura to return home. After six months, Laura was returned to her home. During those six months, she had visitations with her mother, at her home, every Saturday. These visits eventually became overnight weekend visits. Supervised visits with the father were held at the social service agency. During the visits, Laura appeared remote and disengaged from her father. Laura was referred to psychotherapy by the child welfare worker due to withdrawn behavior, irritability, and frequent crying. The multiservice human service center where the child welfare worker had her office also housed the mental health unit that provided the psychotherapy services.

The initial meeting with a mental health worker revealed that in the last year, Laura has been in two foster homes. The first foster placement was terminated when it was discovered that the foster parent disciplined Laura by making her sit in a closet for an hour. Subsequently, when the mental health worker met with Laura for the first time, she discovered that Laura was frightened by being in the multiservice human services center because it was on the first visit with her child welfare worker that she was removed from her home and directly placed in the first foster care.
The mental health worker initiated a consultation with the child welfare worker regarding how to proceed with creating a safe environment for Laura to begin her treatment. At the child welfare worker’s suggestion, the welfare worker participated in the next meeting with Laura and her psychotherapist for the purpose of assuring Laura that there was no plan to remove her from her mother’s home again and that the worker’s goals were to strengthen the home situation. Before the welfare worker joined the meeting, the psychotherapist talked with Laura about her fears, assured her that there was no plan to remove her again, and asked if she would like to hear this from the welfare worker in a joint meeting between all of them.

Laura agreed and a meeting was held among the three. Once that issue was clarified, Laura appeared more at ease and more open to her psychotherapist.

Prompt questions for discussion:

1. What were some possible ways that the child welfare worker could have responded to or managed the problem identified by the psychotherapist?
2. What other information would be useful for the child welfare worker to gather? Why?
3. What other familial, community, or professional resources would be useful for the child welfare worker to access for this family?
4. What values were modeled by the child welfare worker and the psychotherapist that facilitated collaborative work between the two professionals?
5. What other intervention options should the child welfare worker offer?
You are a child welfare worker who will meet with other professionals who are providing services to the Gomez family. A team, consisting of a teacher, psychologist, child welfare social worker, and counselor have convened to coordinate goals for a family of three.

Ms. Gomez, age 37, is a single parent of two children, Alicia, age six, and Donaldo, age seven. Ms. Gomez has a 5th-grade education, receives AFCD and has not been employed in eight years. She has had a hearing impairment since the age of six, due to an infection that was not treated properly. Due to her hearing loss, she has some distortion in her speech. Ms. Gomez immigrated to the U.S. from Peru ten years ago and has one sister in this country. Ms. Gomez has been separated from the father of the two children for three years. During that time, there have been numerous threats made by the father to harm Ms. Gomez. Ms. Gomez recently ended a relationship in which she was not happy. Ms. Gomez does not have a history of substance abuse. Mental health psychotherapy services are provided to Alicia by a social worker through a community mental health clinic as a result of sexualized behavior on the school bus. A sexual abuse evaluation was inconclusive; however, it suggested that Alicia might have been sexually overstimulated as a result of witnessing her mother's sexual behavior. Ms. Gomez has resumed treatment with a counselor at another clinic due to stress in dealing with single-parent responsibilities. Recently, Donaldo was referred to treatment with a psychologist due to allegations by Alicia that he acts in a sexualized way toward her (e.g., going into the bathroom when she is there and attempting to fondle her).

A meeting was called for the service providers to discuss and coordinate the goals of interventions with the individual family members. (Ms. Gomez is not involved in the meeting.)

The kindergarten teacher is concerned that Alicia periodically withdraws from other students and becomes hyperactive in class. Alicia has a difficult time making friends in school; however, in the past year since treatment began, she has begun to socialize more and to adjust better to classroom activities.
The psychologist who treats Donaldo does not believe that Donaldo has acted sexually toward his sister and feels that Alicia is fabricating the story in order to get more attention from her mother.

The counselor who is treating the mother is concerned about the mother feeling overwhelmed by her isolation from her family, difficulties with her ex-husband, and need for more social support. Two years ago, the counselor's treatment focused extensively in providing Ms. Gomez with parenting skills.

The social worker is concerned about monitoring the situation closely. She is particularly concerned about assessing Alicia's at-risk status.

The team began to discuss the various perspectives of each professional in an effort to address and validate the perspective that each member brings to the discussion.

Questions to address in small groups:

1. If the team is effective, what would you expect to see regarding how the discussion evolves?

2. What kinds of pitfalls might the team fall into? What would be needed to get unstuck?

3. What are some outcomes that would indicate the team has been effective?

4. If you were in the role of Alicia's social worker, how would you feel about Donaldo's counselor's perspective? How would you work with her on the allegations regarding Donaldo's behavior with his sister?
SELMAN’S STAGE THEORY OF SOCIAL COGNITION OR ROLE-TAKING

(How to acquire knowledge about the social world and how to reason about social matters—based on the ability to take another’s role or viewpoint.)

The stages of Selman’s theory include:

Ego-Centric, Undifferent Stage 3-6 years

1. Kids can’t make clear distinctions between their own interpretation and another person’s point-of-view.
2. There is also no consideration of another person’s feelings or motivation.

Differentiated and Subjective Perspective-Taking Stage 5-9 years

1. Children begin to realize that others can have different viewpoints (that not everyone sees things as they do). They are better able to understand intentions for actions.
2. Trust in friendship is based egotistically – you get them to do what you want, and if they do, then they are a “friend.”

Self-Reflective Thinking or Reciprocal Perspective-Taking Stage 7-12 years

1. The child can now move beyond understanding that others have different perspectives or points of view to realizing that others are also aware of his or her thoughts and feelings as well.
2. Friendship is based more on reciprocity but self-interest still dominates.

Third-Person or Mutual-Perspective-Taking Stage 10-15 years

1. At this stage, the child moves beyond taking another’s perspective and is able to see all parties from a third person perspective. They are more objective and can step outside a relationship to see it from a third person point-of-view (like a judge).
2. Friendships develop more deeply over time.

In-depth Societal Perspective-Taking Stage 12 years - adult

1. Moves to higher and more abstract level of perspective-taking. Sees all possible interactions, including morality and general rules of society. Realizes that different values and views cannot always be overcome by “taking out the problem.”
2. With friends, there is a struggle for balance in trust and respect.
ERIKSON’S THEORY OF PSYCHOSOCIAL DEVELOPMENT

At each stage, there is a pivotal crisis or conflict that must be resolved (based on level of maturation). Each possible positive outcome is balanced by a negative one. Erickson's 8 Stages of Life (adapted from Papalia & Olds, 1992):

Crisis 1: Basic Trust vs. Mistrust (Birth – 12-18 months)
Infant senses if world is a place where people and things can be relied upon. There should be a balance of trust, leading to the development of the virtue of hope—( e.g., the belief that their needs will be met). This is generally established in feeding situations, where the mother plays a principal role (e.g., by responding quickly and sensitively). Trust allows the infant to let mother out of sight. This lays the groundwork for a sense of self in the child.

Crisis 2: Autonomy vs. Shame and Doubt (12-18 months – 3 years)
Autonomy is related to maturation of the toddler (vs. the infant). They try to expand their boundaries of the world, using locomotion, etc. Virtue of will emerges as they learn to make their own decisions and as they exercise self-restraint. They begin to trust their own judgment and substitute it for their mother's. This may appear to be negativism. The key issue is self-regulation and self-control vs. external regulation and control. A certain amount of self-doubt is necessary for safety's sake. Shame at this stage helps them learn to live by reasonable rules.

Crisis 3: Initiative vs. Guilt (3 – 6 years)
This stage involves conflict between the child's urge to form and carry out goals and their moral judgments about what they want to do. If they don't succeed in meeting their goals, they feel guilty. Resolution of this crisis involves the virtue of purpose—the courage to pursue valued goals uninhibited by defeat, guilt, or punishment. Positive resolution of this stage leads to adults who have spontaneous enjoyment of life and a sense of responsibility. Those who do not resolve this stage may become adults who inhibit their impulses, are self-righteously intolerant of others, or suffer from psychosomatic illness. If initiative is over-emphasized they may feel that they must constantly achieve.

Crisis 4: Industry vs. Inferiority (6 year – puberty)
Efforts at mastery help a child to develop a positive self-concept. The virtue that develops is competence. If they feel inadequate they may regress to an earlier level and lack the sense of initiative to pursue a goal. If too industrious, however, they may become "workaholics" and neglect relationships.

Crisis 5: Identity vs. Identity Confusion (puberty – young adult)

The individual must define their own sense of self. The virtue is Fidelity. The task is to form their own identity and become unique adults with an important role. They need to decide on a career. Role confusion occurs when too long a time is taken in choosing a career path. There is a search for commitment, which includes sustained loyalty, faith, and a sense of belonging to friends or loved ones, or an ethnic group, etc. (e.g., self-identification).

Substages: In adolescence, Crisis 5 has further substages. The seven subcrises for Crisis 5 form a horizontal axis with the Eight Stages of Life. They include:

- **Temporal Perspective vs. Time Confusion**
  This includes the ability to think about the past and the future. Also included is the ability to ponder what to become. This compares with the infant’s highs and lows, and rest and activity cycles.

- **Self Certainty vs. Self Consciousness**
  The person feels that they have: A reasonable chance to accomplish their plans and a belief that "if I do this, I can succeed." This substage recalls previous feelings of Shame and Doubt. If there was a problem with those feelings, it is revisited.

- **Role Experimentation vs. Role Fixation**
  They may be bewildered by all of the possibilities (both positive & negative). They need to “try out” roles.

- **Apprenticeship vs. Work Paralysis**
  They test out abilities. This relates to industry vs. inferiority.

- **Sexual Polarization vs. Bisexual Confusion**
  There is an attempt to define male and female roles. Erikson (1968) states that lesbian and gay influences may cloud this.

- **Leader/Followership vs. Authority Confusion**
  This subcrisis involves determining how to work with others, and be in charge of others. They learn to use different roles and behaviors around different people.

- **Ideological Commitment vs. Confusion of Values**
  This includes the search for Fidelity. They need to develop a belief that no matter how bad things are, they can salvage their own sense of identity and uniqueness. They must feel that what they do matters, makes sense, and has value. There is a need to know their purpose in life.
Crisis 6: Intimacy vs. Isolation (young adult)
This stage is dependent upon the successful achievement of identity in the prior stage. Individuals are able to fuse their identity with another’s. There are conflicting demands of intimacy, competitiveness, and distance. They develop an ethical sense. The virtue that develops in this stage is Love or Mutuality of Devotion. Erikson states that healthy development occurs through loving, heterosexual relationships that produce children.

Crisis 7: Generativity vs. Stagnation (middle age)
At this stage, the individual works to foster the development of the next generation by becoming a mentor. Some stagnation provides a respite that can lead to greater future creativity. Too much stagnation leads to physical or psychological invalidism—Inactivity or Lifelessness. Creativity or productivity further the development of personal identity. The virtue of this stage is Care—to take care of persons, ideas, or products one has learned to care for. Erikson states that childless people have problems with this stage (a criticism, as noted above).

Crisis 8: Integrity vs. Despair (old age)
At this stage, individuals achieve a sense of acceptance of their own life, allowing the acceptance of death or else they may fall into despair. The virtue gained is Wisdom.
CASE STUDY: The Garrola Family

The Garrola family lives in a small 50-year-old wooden frame house on a small dairy farm 7 miles outside of town. James, the father, works on the dairy as a feeder. Millie, the mother, cares for the children and cleans houses 3 days a week. The family receives some seasonal assistance (food stamps), and finds it difficult to live on their very low income. They have one car (sometimes in need of repair) and their extended family members live out of state. There is one other family that lives on the dairy, a young couple with a 2-year-old son. There are few children who live close by.

Pedro, age 12, is the oldest of four children. He rides the bus for a total of approximately 1½ hours each day to attend the 7th grade at the local middle school. Pedro struggles to do well in school. His report card shows that he is failing in the core subjects of English, Math, and History; however, he has passing grades in Art and Computers. He has also been sent home from school because of “disruptive behavior” in the cafeteria, and he persistently talks in class which results in his confinement to the office during several class periods a week. His father responds to Pedro's school difficulties with punishment (grounding him, sending him to his room after dinner, giving him extra chores, yelling at him, demeaning him for embarrassing the family, and occasionally swatting him on the backside). Pedro’s school problems have continued to worsen over the past year. He talks on the phone to school friends about how he can “get back at the teachers and his father.” His mother doesn't “know what to do with him,” but feels that Pedro must obey the rules and states that her husband “is the boss” and the children's disciplinarian. Occasionally, she will allow Pedro to miss school because “he feels so miserable there,” as long as his father “doesn't find out.”

Annie, age 9, is a quiet child who helps her mother with the two younger siblings. She does well in school, and her teacher has sent home notes commending her good manners and helpfulness in the classroom. Annie likes to quilt with her mother in the evenings after the two younger children go to bed. James goes to bed early because he gets up at 4:00 a.m. Millie appreciates Annie’s help with the children.

and around the house, so she rewards her with a later bedtime “so she can learn about sewing and quilting.” James calls Annie his “little peach,” but Annie and Pedro do not always get along. Millie tries to “keep the peace” when both Annie and Pedro are home together in the late afternoon and early evening.

Johnny, age 5, is in Kindergarten and likes to go to school with “the big kids.” He looks up to Pedro, but fears him because Pedro frequently hits or punches him when he thinks no one is looking. Johnny cries but doesn't usually complain to his mother or father about Pedro's behavior. James plays catch with Johnny when he is home in the early afternoon and Johnny returns from school. James returns to work before Pedro and Annie come home.

Rosa, the baby, is 3 and goes to a state preschool program on the days that Millie cleans houses. Rosa is an easygoing child who likes to play with Johnny and Annie. James takes her on walks to “see the cows” and likes to teach her new words. Pedro will occasionally pick Rosa up and put her on his shoulders, bouncing her there as he runs through the house. If he is present, James yells for Pedro to “stop” as he fears for Rosa’s safety. Millie encourages Pedro to play with the younger children, and hopes that he will “fit in” better with the family.

The family tries to eat dinner together and they usually watch television or videos in the evening. James and Millie met in high school, and married before his senior year. James completed high school, but Millie dropped out when she became pregnant (she is 2 years younger than James).
GENOGRAM: AN EXAMPLE  
Interprofessional Collaboration Training Project  
*California State University, Fresno*  
from: Sherman & Norman, (1986)

**HIS PARENTS**  
- Circle: Male 
- Square: Female 

**HER PARENTS**  
- Circle: Male 
- Square: Female 

**HUSBAND**  
- Circle: Male

**WIFE**  
- Square: Female

**CHILDREN**  
- Child: Female

**= a basic three-generational chart**

**= a triangle identifies a relationship in which a third person is brought into a dysfunctional relationship between a pair in order to reduce the anxiety or to stabilize that dyadic relationship**

**= a line around a combination of members points out that these members are in alliance or collusion**

**d. 1972 = died in 1972**

MODEL OF AN ECOMAP
Interprofessional Collaboration Training Project
California State University, Fresno

(Models borrowed from Wright and Leahey (1994)