
Social and Emotional Development of Children



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California Childcare Health Program
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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To describe the social and emotional development of young children.

To identify why young children behave in different ways.

To describe the impact children with challenging behaviors have on early care and education (ECE) programs, staff and families.

To describe three ways a Child Care Health Advocate (CCHA) can assist ECE programs with meeting the needs of children with behavioral health problems.

To identify resources available to assist and support ECE providers and families.

RATIONALE

An important role of the CCHA is to help ECE providers and families work together to support children's social and emotional development, and to provide resources and referrals for families who need them. ECE providers spend a great deal of time and energy managing children's behavior. Many children in ECE programs show difficult or hard-to-manage behaviors. To be able to work well with all children and their families, CCHAs need to understand children's social and emotional development and to understand why children behave the way they do. In this module, the terms *difficult*, *challenging* and *hard-to-manage* all mean the same thing when they are used to describe behavior.

WHAT A CCHA NEEDS TO KNOW

To encourage healthy social and emotional development, ECE providers must be familiar with the various stages of development for young children, as well as understand that each child develops at his or her own pace. The process and timing of development is not the same for every child.

The first 5 years of life are a critical time in the development of young children. Children's early social and emotional development depends on a variety of factors, including genes and biology (e.g., physical health, mental health and brain development) and environmental and social issues (e.g., family/community, parenting and child care). These factors can have a positive or negative influence on children's development. Some children may have difficult behaviors that make it harder to adjust to an ECE program (Haring, Barratt & Hawking, 2002). Research shows that brain development during the first 5 years of life creates learning patterns that can last a lifetime. ECE programs which create trusting, safe and developmentally appropriate environments can help children learn to adjust to changes in their lives, get along well with others and be healthy. A socially and emotionally healthy child will be ready to start school and thus, fully participate in learning experiences and form good relationships with caregivers and peers (Peth-Pierce, 2000).

The following issues, either within the child or within the environment, influence young children's social and emotional development in the first 5 years of life:

- overall physical health of the child
- child's temperament (style of behavior the child is born with)
- family stress and resources available to provide support and how this is handled
- community stress and resources
- child's experience in ECE programs, including child-ECE provider relationships, group size, training for ECE providers, expectations of ECE providers and consistency in caregiving
- goodness of fit between the child and the parent (Does the child meet the parents' expectations? Do their temperaments match?)

- child abuse
- exposure to violence in the home or the community
- parent-child relationship
- parents' ability to cope with demands of parenting
- parents' self-esteem
- capacity to protect the child from overstimulation
- social supports

THE ROLE OF THE CCHA

Because CCHAs are often in the ECE program everyday, they can observe children playing with different people and at various times across a period of several weeks. Their role includes working closely with the ECE staff to identify children whose behavior or health are of concern or raise questions. The CCHA can talk about possible causes of troubling behavior, talk to the program director and Child Care Health Consultant (CCHC), and participate in developing good intervention strategies and action plans that focus on improving the social and emotional development of young children in ECE programs and that focus on addressing the behavior. CCHAs should also make sure staff and parents talk to one another regularly about any conflicts or problems, and support follow-up activities as necessary. The CCHA can serve as the key contact at the ECE program.

Understanding Behavior

Just as physical development occurs in "ages and stages," so too does social and emotional growth and development. Being familiar with the appropriate ages and stages of social and emotional development is important to be able to accurately understand children's behavior. There are many factors which affect a child's behavior that the CCHA should know about.

Behavior is the main way children let adults know what their needs are. Young children who cannot yet speak often communicate by using body language and emotional expressions, such as crying, cooing or smiling. Children from birth to 5 years of age have a limited ability to understand and to express themselves clearly using words. However, their general behavior, and ability to play well with other children and with adults can tell us a great deal. Good, objective obser-

vation skills are the key to identifying what children need. Even infants show signs as to their needs; ECE providers need time to assess and interpret these signs. According to Poulsen (1996), some of the ways children tell us they are stressed and overwhelmed is when they show these behaviors on a regular basis:

- Are overactive.
- Have difficulty focusing on or completing a task.
- Become easily frustrated.
- Have difficulty making decisions.
- Have difficulty following directions.
- Solve problems by hitting, biting, grabbing or pushing.
- Have tantrums.
- Cling to adults.
- Avoid new tasks.
- Do not play with other children.
- Cry frequently and cannot be soothed easily.
- Do not eat.

ECE providers spend a fair amount of time teaching and modeling good behaviors and managing inappropriate behaviors of children in ECE programs. Positive behaviors are encouraged while negative behaviors are not rewarded or given undue attention.

Understanding the specific reasons behind a child's behavior is important. The Program for Infant-Toddler Caregivers (PITC) defines five possible causes for behavior in young children (Johnston & Thomas, n.d.). See Table 1 for more information.

Young children are still learning how to be social and how to control their behaviors. Sometimes it is hard to tell whether a certain behavior is typical for a certain age or whether it is part of a larger problem. Of course, extreme behavior that consistently happens in more than one setting and with different ECE providers is of particular concern. Children who disrupt the routines of the ECE program cause a great deal of stress for ECE providers. Learning the possible cause of the behavior may help ECE providers work with the child to improve his or her behavior.

To figure out possible causes for a child's behavior, first come up with a *hypothesis*—a potential reason for *why* the behavior is occurring. Second, try to under-

stand the *function* of the behavior (*what* is the purpose it serves for the child). Use the following three questions to begin the process of understanding challenging behavior:

1. Why is this happening? (What is the child getting from this behavior?)
2. How do you know that is the reason?
3. What should be done?

For a child with challenging behavior it is important for ECE providers and parents to work together and talk openly. ECE providers need to tell parents what is going on in the ECE program. And parents need to tell ECE providers what is going on at home. See Table 1 for more information.

The best way to learn about a child's behavior is to observe and collect information that can describe the characteristics of the behavior in a variety of settings and situations. See *Handout: Behavioral Data Collection Sheet* for more information. Be objective and take at least 15 to 20 separate observations in different settings over 2 to 5 days. Be sure to include both past and current information collected from the parents. Gather all of the information until a clear pattern develops and you know whether your original hypothesis for *why* you think the behavior is happening is right or wrong.

A log documenting positive and negative behavior combined with the parent's information can offer a useful way for parents and ECE providers to share information with one another and with other professionals. Collecting all this information allows you to better see the relationship between the child's environments and the challenging behavior, and to see whether there have been changes in the child's behavior. With these observations, the ECE provider can develop an intervention plan tailored to meeting the child's needs. If the ECE provider has made a large effort and things still are not better, look at different ways to observe the child's behavior or seek more help (Kaiser & Rasminsky, 1999).

**TABLE 1: TOWARD A BETTER UNDERSTANDING OF CHILDREN’S BEHAVIOR:
POSSIBLE CAUSES OF BEHAVIOR PROBLEMS AND ACTIONS**

First Possible Cause: Developmental Stage		
Why is this happening?	What are the clues?	What actions should ECE providers take?
<p>The behavior is a usual part of development and is due to the child’s developmental stage.</p> <p>The child is learning a new developmental skill and is practicing</p>	<ul style="list-style-type: none"> • I have seen other children at the same developmental stage behave this way. • I have read about it in child development books. 	<p>Relax. All children behave this way. The behavior will change with development. Find ways to make it safe for the child to practice the skill, which sends a message to the child: “I know it is important.”</p> <p>Channel: Allow the behavior in certain situations and at certain times (as long as no harm is being done to others or to the child).</p> <p>Stop: Stop the behavior when it is disruptive or dangerous.</p>

Second Possible Cause: Individual Differences		
Why is this happening?	What are the clues?	What actions should ECE providers take?
<p>Temperament accounts for differences in behavior.</p> <p>All children experience the world differently based in part on their temperament.</p> <p>Not all children of a certain age act in exactly the same ways.</p>	<ul style="list-style-type: none"> • Not due solely to developmental stage. • I have information about the child’s temperament by observing the child in the ECE setting, and by talking to the child’s parents about the child’s behavior at home. • I have read about research on temperament. 	<p>Observe. Observe and identify each child’s unique style.</p> <p>Adapt. Adapt your expectations and interactions with this child based on temperamental characteristics.</p> <p>Give choices. When possible, offer options that allow for and appreciate children’s unique expressions and responses to the world.</p> <p>Communicate. Ask parents for possible explanations and solutions.</p>

(Adapted from *Understanding Your Child* by John Hymes)

Third Possible Cause: The Environment		
Why is this happening?	What are the clues?	What actions should ECE providers take?
<p>The behavior is due to the environment or to conflict between different environments the child spends time in.</p> <p>Environments might include the following:</p> <ul style="list-style-type: none"> • ECE program • home setting • family routines • family lifestyle • cultural context 	<ul style="list-style-type: none"> • Behavior is not due to developmental stage or to individual differences. • In the ECE program, several children behave in similar ways. • There are different expectations of the child in the home and ECE settings. • The child is responding to changes in the home environment and showing a sudden change in behavior at home. 	<p>Change. If the child is responding to something specific in the ECE setting, change the environment to help the child feel in control.</p> <p>Adapt. Adapt your expectations to reduce conflict.</p> <p>Communicate. Ask parents about the characteristics of the other environments the child spends time in. Ask parents for possible explanations and solutions.</p>

Fourth Possible Cause: The Child Does Not Know but Is Ready to Learn		
Why is this happening?	What are the clues?	What actions should ECE providers take?
<p>The child does not know something but is ready to learn.</p> <p>It may take time for a child to understand and to master new social rules.</p>	<ul style="list-style-type: none"> • Behavior is not due to development, individual differences or the environment. • The child is in a new or unfamiliar situation. • The child is facing a new task or problem. 	<p>Teach. Teach a new skill, rule or expectation, and explain it repeatedly. Give reasons for the new rule.</p> <p>Encourage. Give encouragement for small successes.</p> <p>Help. Offer help and be patient with failures.</p>

Fifth Possible Cause: Unmet Emotional Need		
Why is this happening?	What are the clues?	What actions should ECE providers take?
<p>The child may have missed out on some part of development that was emotionally important.</p> <p>The child may be searching for new ways to meet this need.</p>	<ul style="list-style-type: none"> • The behavior is developmentally inappropriate (child is not acting his age). • The behavior is consistent across time and place. • The behavior has a driven quality as if the child has to do it. • The usual ways of handling and helping most children with this behavior do not seem to be helping. 	<p>Respond. Respond to the child's needs actively with actions and support.</p> <p>Be firm. Meet the child's needs with quiet firmness and patience.</p> <p>Control. Remember that the child cannot stop or control the behavior.</p> <p>Seek help. Get more support for yourself, the child and the family.</p>

What Is Temperament?

Temperament is the natural, inherited style of behavior of each person. It is a combination of inborn traits and personal experience that shapes how we see and respond to the world around us. It is the “how” of behavior, not the “why.” It is important to understand how children’s temperament influences their behavior (see *Handout: Temperament and Behavior*). For example, some children are always hungry at the same time of day and like to eat the same thing everyday. Other children are hungry at different times of the day and like to change what they eat. The following are nine types of temperamental characteristics that can be challenging for ECE providers and families (Rothbart, Derryberry & Hershey, 2000):

High Activity. Very active, always into things. Makes you tired. “Ran before he walked,” gets wild or “revved up,” loses control easily. Hates to be restricted or confined (does not like car seats, strollers, high chairs).

High Distractibility. Has difficulty concentrating and paying attention, especially if not really interested; seems not to be listening.

High Intensity. A loud child whether miserable, angry or happy. Highs are higher and lows are lower; considered very dramatic.

Irregular. Unpredictable. Cannot tell when he or she will be hungry or tired, constant conflict over meals and bedtime, moods change suddenly, wakes often at night. See *Handout: Health and Safety Notes: Temperament and Regularity* for more information.

Negative Persistence. Stubborn, goes on and on nagging or whining if wants something, will not give up. Seems to get “locked in” to a behavior; tantrums can be long and hard to stop.

Very Sensitive. Sensitive to sounds, lights, colors, textures, temperature, pain, tastes or smells. Clothes have to “feel right,” making dressing a problem. Does not like the way many foods taste. Overreacts to minor injuries. Easily overstimulated.

Initial Withdrawal. Does not like new situations: new people, places, food or clothes. Often hesitates, and protests by excessive crying or clinging. Needs time to “warm up.”

Slow Adaptability. Has a hard time with changes and going from one activity to another; even after initial response, takes a long time to adapt to anything unfamiliar. Gets used to things or routines and refuses to give them up. Strong preferences for certain foods or clothes.

Negative Mood. Frequently serious or cranky. Whines or complains a lot. Not a “happy child.”

It is key to note that behaviors that may be difficult or challenging for one ECE provider may be easy for another, as individual expectations and interactions vary. This highlights the importance of a “goodness of fit” in the child-ECE provider relationship (see *Handout: Temperament and Goodness of Fit*). ECE providers should identify the child’s temperament and their own (see *Handout: Temperament Assessment Scale for Children* and *Handout: Temperament Assessment Scale for Caregivers*). ECE providers should respect uniqueness and adapt without comparing, labeling or trying to change the child (this is sometimes called positive reframing). In the end, it is necessary to recognize individual differences when matching an ECE provider with an individual child.

What Is Challenging Behavior?

There is an endless list of challenging (or hard-to-manage) behaviors, which may include, but are not limited to, hitting, shoving, yelling, having tantrums, not sharing, throwing and breaking toys, grabbing, biting, spitting and kicking. And at one time or another, every ECE program has dealt with a child with such behaviors (see *Handout: Health and Safety Notes: Caring for the Spirited Child*). Challenging behavior is any disruptive or destructive behavior that does the following:

- Gets in the way of the child’s learning, development and success at play.
- Is harmful to the child, other children or adults, or causes damage to the environment.
- Socially isolates the child because other children do not want to play with him or her.
- Puts the child at high risk for later social problems or problems in school.

In some ECE programs, as many as 4 out of 10 preschoolers have one or more problem behaviors, such

as aggression, according to teacher reports (Kupersmidt, Bryant & Willoughby, 2000). The focus of much of challenging behavior is on aggressive behavior, though children who have shy behavior are often considered equally challenging. But because aggressive behavior is so determined and outward focused, it is very important to support these children to make sure that they continue any improvements they have made (Kaiser & Rasminsky, 1999).

What Is Aggressive Behavior?

Aggressive behavior is any behavior that results in physical or mental injury to any person or animal, or in the damage to or destruction of property. Aggressive behavior in young children can be accidental or unintentional, which is a common and natural form of behavior for infants and toddlers, as these behaviors get the response desired (e.g., if a child wants a toy, he or she grabs it from another child). Aggressive behavior can also be deliberate or on purpose in pursuit of a goal, in which the child means to cause harm (Jewett, 1992). Aggression is a problem in ECE programs because the ECE providers' goal is to provide a safe place for children to play and grow. In ECE programs, children cannot be allowed to hurt other children. Certainly, no child can be permitted to hurt other children repeatedly.

Strategies to Help Deal with Aggressive Behavior

(Greenstein, 1998)

- Young children often behave aggressively because they feel left out or because they do not know acceptable ways to enter play. ECE providers can help children to learn necessary play and social skills. Offer positive and pleasant feedback when children show good behavior.
- The child needing more attention should never be given it at the moment he or she is hurting another child. At another time, when a positive opportunity occurs for a quiet conversation, the child can be encouraged to talk about and even rehearse what he or she might do next time.
- If a child hurts another child, turn your full attention to the child who has been hurt. It does not help to tell the aggressor how much it hurts the other child to be hit or pushed down. The

aggressor knows from previous episodes and from the other child's behavior.

- If the child is frequently and severely aggressive, the child may need to be removed from the group each time he or she acts out. Time-out is a nonaggressive way to help the child learn that he or she absolutely may not attack other children.
- Time-out must be agreed upon by parents and ECE providers. Time-outs should be brief; sometimes referred to as 1 minute per age. The child should be told, "I cannot let you hurt other children," but no other attention should be paid to him or her at that time. When returning the child to the group, do not lecture the child, but help the child get started in a new activity and offer positive, frequent comments if he or she plays well.

If children's challenging behavior is allowed to continue, they tend to have poor self-esteem as they grow older and remain at a greater risk for a number of problems. This is especially true for children with aggressive behavior, where their behavior leads them to be rejected by peers and ECE providers, hurts their friendships and reduces their opportunities to learn positive social skills. Young children with troublesome aggressive behaviors need help and support to learn to manage and express their emotions. If acted upon early, we can help children feel better about themselves and teach them ways to get along with others.

Examples of Behavioral Challenges in ECE Programs

Children may behave in difficult or challenging ways for a variety of reasons. Here are several examples to highlight the process for evaluating, addressing and coping with children's behavior.

Situation One: A 2-year-old bites a younger child who is receiving attention from an ECE provider.

For this situation, the ECE provider and CCHA should first recognize that a toddler who bites occasionally may be showing developmentally typical behavior. If the biting occurs frequently and is more severe or is directed at specific children, then there is a need to involve the family and develop a plan to address the child's behavior. This might involve staying close to the biter to protect other children and stepping in to

stop the biting before it occurs. Both the ECE provider and CCHA should support families by talking about how common this behavior is in early childhood. Tell the families that you are taking steps to stop it. The CCHA should also provide resources to support both the ECE program and the family, such as an article or pamphlet on “biting behavior” that describes what a child might be trying to say through the behavior and how to help the child (see *Handout: Health and Safety Notes: Biting in the Child Care Setting*).

Situation Two: A 4-year-old shows constant, widespread aggression towards adults and children in the ECE program as well as when at home with his siblings and parents. The 4-year-old is aggressive with everyone around him. His behavior is not age-appropriate and he is not able to control it.

For this situation, the ECE provider and CCHA are not sure exactly why this is happening. There is a feeling that the child has an unmet emotional need, especially since his mother has told us that he has seen domestic violence in the past. Both the ECE provider and CCHA are concerned that someone will be seriously hurt. The child’s family may benefit greatly from outside professional help. It is important to have a meeting with the family so that everyone can share their concerns and work together to provide resources to help the child and his family (for a list of resources, see the *Resources* section of this module). The CCHA can take the lead and get more information about the situation and encourage open communication that will allow the ECE provider and family to work together as a team to assist the child with his aggressive behavior. Ultimately, the aim is to look beyond behaviors and learn to address the child’s needs.

Situation Three: A 3-year-old has daily, all-out, head-banging tantrums, which occur just before her mother picks her up in the afternoon. This alarms the staff, as well as the mother, who says it never happens at home and she does not know what to do.

The ECE provider and CCHA agree that a 3-year-old with intense tantrums everyday is common, especially at a time of day when she can be expected to be a bit tired and have trouble handling her frustration. They also agree that special planning to help the child handle her frustration and intensity throughout the day might help. However, the ECE provider and

CCHA recognize that the child’s tantrums are more intense than usually seen at this age and they think she might be more easily frustrated than most children. The ECE provider should meet with the parents to share the concerns and suggest ways to allow for the child’s intensity and frustration while beginning to help her understand her own temperament and personal resources. For example, the CCHA could provide support for the family by referring them to a Web site (<http://www.preventiveoz.org>) where they can get information and complete a questionnaire on their child’s temperament. Also, seeking an on-site observation and assessment by a CCHC or other trained professional followed by advice on changes in routine and environment might help this child cope more easily.

The bottom line is that when ECE providers and CCHAs work with a child over a period of time, they can help him or her to develop the skills necessary to get along well with others. What ECE providers and CCHAs teach and model stays with children and helps to support them in a variety of settings over time. If children do not respond to this extra support, and the behaviors do not change, CCHAs may refer the family to a health care professional for a more complete look at the child’s development and behavior.

How to Identify When Children Have Behavior Problems

It is appropriate to seek help from health care professionals if a child’s behavior is causing long-drawn-out suffering for the child, parents or ECE provider. Behavior problems that continue over a period of time and in different contexts (i.e., at home and in the ECE program), often despite negative outcomes (such as time-outs), sometimes require involvement from mental health professionals. Catching problems early and trying to help is best. It is important not to let problems simmer and then create a crisis situation. Asking for help is not a sign of weakness. The CCHA should arrange a planning meeting and involve the family early on if a child’s behavior is problematic or puzzling. The CCHA should also establish a system for evaluation and referral (Young, Downs & Krans, 1993).

A child who displays a troubling behavior only once or twice, such as a 4-year-old who punches a class-

mate in the absence of other risk factors or “red flags” (warning signs), is probably not a concern. If the child punches classmates frequently despite assistance with using words to express his or her feelings or time-outs for unacceptable behavior, the ECE provider should take action. Mental health consultation or intervention offers support not only with severe mental health problems (e.g., post-traumatic stress disorder, depression, severe emotional disturbance), but also with common developmental experiences that can be stressful for children, parents and ECE providers (e.g., infants not sleeping through the night, toddlers having difficulties with toilet learning and preschoolers being very active).

Behavioral Warning Signs

ECE providers should be able to identify behaviors which are “red flags” or warning signs that suggest social and emotional difficulties outside the normal or expected range. Experienced caregivers report that they have a sixth sense for identifying children with behavior problems because these children stimulate uncomfortable feelings in others. Their behavior is often characterized as follows:

- emotionally extreme (extreme anger or sadness)
- not age-appropriate
- hurtful to themselves or others
- difficult in that others have trouble forming positive relationships with them
- driven, excessive, persistent or out-of-control

The following behaviors suggest that an infant or toddler’s social and emotional development may be at risk:

- Shows very little emotion.
- Does not show interest in sights, sounds or touch.
- Rejects or avoids being touched or held.
- Unusually difficult to soothe.
- Unable to comfort or calm self.
- Extremely fearful.
- Shows sudden behavior changes.

The following behaviors suggest that the preschool age child’s social and emotional development may be at risk:

- unable to play with others or objects
- absence of language or communication
- frequent fights with others
- very sad
- extreme mood swings
- unusually fearful
- loss of earlier skills (e.g., toileting, language, motor)
- sudden behavior changes
- destructive to self and others

Based largely on the ECE provider’s observations of the quality of the behaviors, the ECE provider must determine whether a child’s behavior is part of normal development or a warning sign for social and emotional difficulties. To assess quality of behavior, the ECE provider must observe the child closely and decide the following:

- Whether the behavior appears casual and pleasurable for the child or whether the behavior is driven, excessive, out-of-control or has an unpleasant quality to it.
- Whether the child is otherwise healthy and well-adjusted, or has other behaviors that raise concern.

Assessing Children’s Behavior and Development

Meeting the needs of children with social and emotional problems can be difficult. It is important for ECE providers to know when and how to seek additional information and help from the family, colleagues, supervisors and mental health specialists.

To confirm concerns about children with social and emotional difficulties, the ECE provider should do the following:

- Observe and record the child’s behavior over time and in a range of different relationships, environments and activities over the course of several days (identify how often the behavior occurs; when, where and with whom the behavior occurs; and what happens as a result of the behavior).
- Get information from the family about the child’s prebirth and birth history, medical conditions, development, temperament, likes and dislikes,

family relationships, previous child care experiences and behavior at home.

- Have a coworker or supervisor observe the child to get a different point of view.
- Calmly, objectively and briefly summarize concerns about the child's behavior when meeting with the parents, and then work together with them to understand the behavior and develop strategies to better meet the child's needs.
- Ask that a mental health consultant or behavioral specialist observe and assess the child and provide consultation on strategies for intervention, with the parents' consent.

The use of screening tools that monitor development is an important part of understanding children with social and emotional problems (Zeanah, Stafford, Nagle & Rice, 2005). See Table 2 for a list of standardized screening tools which can be helpful in monitoring development or identifying problems. Developmental screening tools are meant to identify whether or not there is a significant problem needing further diagnostic testing. Developmental screening tools do not give a child a diagnosis. Instead, they inform parents and ECE providers about whether a problem exists, and whether to seek additional information and support. *The Compendium of Screening Tools for Early Childhood Social-Emotional Development* was published by the California Institute of Mental Health and is available online at <http://www.cimh.org/publications/child.cfm>.

Quality ECE Programs as Protective Factors

ECE programs can serve as very important community support systems to families of young children. Quality ECE programs can help protect children at risk by providing responsive care, secure attachment to a primary caregiver and safe, predictable routines. Additionally, quality ECE programs offer parent support and education services that may strengthen families and connections to the community. To protect and support children, ECE providers should make sure that the following is true:

- Each child has a caring relationship with at least one adult.
- Each child participates in the group and feels included.

- The ECE provider has high expectations for each child and believes that each child can make a contribution.
- The ECE provider recognizes each child's abilities and is hopeful for each child's future.

Parents as Partners

Parents are partners in any ECE program and the more closely you work with them, the better. It is important to encourage and keep up strong relationships with parents and families, as it not only helps if there is a concern about a child, but also promotes good communication between parents and ECE providers on an ongoing basis. Providing the best possible care for children is easiest when parents and ECE providers work in partnership with each other.

Establishing a partnership with parents begins as soon as they enter the ECE program. Here are some ways to encourage lasting partnerships with families:

- Greet sensitively, with a smile and welcoming words.
- Make time to have informal, friendly conversations often.
- Ask them about their goals and expectations for their child.
- Respect their culture and language. Ask about their routines and customs, and adapt caregiving as much as possible.
- Check in daily about the child's previous night and any other issues that may affect the child's day.
- Give them information about their child's development whenever you can.
- Give them feedback everyday about their child's day, not just when things go wrong.
- Use notebooks or daily notes to send home information in writing about the child's day.
- Make time for occasional longer talks on a regular basis with parents, including parent-teacher meetings and special parent nights.
- Advertise and encourage an "open-door" policy for parents and families.
- Make a special effort to spend more time with parents whose values are different than yours.
- Offer coffee and tea or fresh fruit on a regular basis to encourage families to "hang out" a bit at the program.

TABLE 2: DEVELOPMENTAL SCREENING INSTRUMENTS FOR CHILDREN LESS THAN 6 YEARS OF AGE

Screening Tool	Ages	Completed by Whom?	# Items/ Format	What Does It Tell Us?	Languages Available?	Reference and/or Web Site
The Ages and Stages Questionnaire: Social-Emotional (ASQ-SE)	6-60 months	Parent or teacher	30	<ul style="list-style-type: none"> Recognizes young children at risk for social or emotional difficulties. Identifies behaviors of concern to caregivers. Identifies need for further assessment. 	English and Spanish	Squires, Bricker & Twombly (2002) http://www.pbrookes.com/store/books/squires-asqse/index.htm
The Child Behavior Checklist, Early Childhood Inventory	1½-5 years	Parent or teacher (Caregiver-Teacher Report Form [C-TRF])	99	<ul style="list-style-type: none"> Assesses externalizing and internalizing behaviors. Gives clinical cutoff scores. 	English and Spanish	Achenbach & Rescorla (2000) http://www.aseba.org/products/cbc11-5.html
Devereux Early Childhood Assessment Program (DECA)	2-5 years	Parent or teacher	Frequency of 27 positive behaviors; 10-item Behavioral Concerns Scale	Identifies children who may be experiencing emotional or behavioral problems.	English	LeBuffe & Naglieri (1999) Kaplan Press
Parents' Evaluation of Developmental Status (PEDS)	Birth to 8 years	Parent	10 items	Determines when to refer, provide a second screen, provide patient education or monitor	English, Spanish and Vietnamese	Glascoc (1997) http://www.pedstest.com/index.html

TABLE 2: DEVELOPMENTAL SCREENING INSTRUMENTS FOR CHILDREN LESS THAN 6 YEARS OF AGE -

Screening Tool	Ages	Completed by Whom?	# Items/ Format	What Does It Tell Us?	Languages Available?	Reference and/or Web Site
Brief Infant/Toddler Social Emotional Assessment (BITSEA)	12-36 months	Parent or caregiver	42 items	Identifies social, emotional and behavioral problems, and delays in social competence.	English	Briggs-Gowan, Carter, Irwin, Wachtel & Cicchetti (2004)
Vineland Social-Emotional Early Childhood (SEEC) Scales	Birth to 5 years, 11 months	Parent or caregiver	Interview takes 15-20 minutes	Identifies strengths and weaknesses in specific areas of social and emotional behavior, including interpersonal relationships, play and leisure time, and coping skills.	English	Sparrow, Balla & Cicchetti (1998) Published by American Guidance Service http://www.agsnet.com
Brigance Infant and Toddler Screen (BITS)	Birth to 2 years	Parent	Interview takes 10-15 minutes	Identifies infants and toddlers in need of further diagnostic testing or special services.	English and Spanish	Curriculum Associates http://www.curriculumassociates.com
Eyberg Child Behavior Inventory (ECBI)	2-16 years	Parent or caregiver	36 items	A cutoff score is given suggesting the presence of disruptive behavior problems.	English	Eyberg & Pincus (1999) Psychological Assessment Resources http://www.parinc.com
Temperament and Atypical Behavior Scale Screener (TABS)	11-71 months	Parent or caregiver	15 items	Identifies behavioral indicators of developmental delay, based on temperament and self-regulation problems.	English	Bagnato, Neisworth, Salvia & Hunt (1999) Brookes Publishing http://www.pbrookes.com

- Establish a “parent corner” or bulletin board sharing information and local resources for families.
- Use the primary ECE provider model (having each child assigned to a specific teacher as the main person in charge of care), promote consistency in caregiving and keep the group sizes small.
- Give parents a list of ways to participate in their child’s care, such as the following:
 - Bring a healthy snack to share.
 - Help with planting a garden.
 - Volunteer to read at circle time or sing a favorite song.
 - Write articles for the newsletter.
 - Fix broken toys.
 - Do laundry, or other cleaning or maintenance work as needed.
 - Serve on a parent advisory committee or the board of directors.
 - Help with a staff appreciation day.
 - Help with fundraising.
 - Go along on field trips and community outings.

Tips for Relationship-Building and Communication Success with Families

When ECE providers and CCHAs talk with parents, it is important to be truly sensitive and use good people skills. Be sure to have discussions in quiet, private places and set aside sufficient time. Be calm and state the issue simply, specifically and objectively in a non-judgmental manner. Share what you *see* rather than what you *think*. Do not impose your values, and be sure to *separate the child from the behavior*. Rather than saying, “Sam is an aggressive child,” it is better to say, “Sam’s behavior has been more aggressive than it used to be.” Describe the skills being worked on, the group expectations, plus the methods you use to guide and encourage the children. Let parents know where their child is succeeding and where the child is having difficulty. It is important to talk to parents as soon as you can before behaviors cause bigger problems.

Remember that no matter how you tell parents about their child’s behavioral issues, they may hear: “There is

something wrong with my child, and therefore with me (as a parent).” Any remarks that sound like criticism of their child may affect them deeply. Most parents feel that they are doing their best for their child, and hearing that their child has challenging behaviors may make them feel sad, upset, depressed, defensive or angry. Recognize that this is the way the parents are trying to accept their child, give them opportunities to talk about their feelings and allow them time to come to terms with what you are sharing. Do not demand answers or a response; instead, be patient and listen carefully and respectfully. The goal is to work together to find solutions that satisfy everyone.

Examples of Communicating with Parents

Story 1

ECE Provider: “Mrs. Jacobs, I know that you are working hard at work and school. I admire your determination. I think that Tommy is doing very well overall and is really improving in his attention and patience during circle time. However, Tommy hit other boys two times today and had to go into time-out to calm down. I have noticed that he does not speak very clearly, and it is hard to understand him sometimes. It might be helpful to take him to his pediatrician and check his hearing and speech. He may be frustrated at not being understood and may be using other ways to express his feelings. Please let me know what happens.”

The ECE provider should check back with Tommy’s mother in 2 to 3 days and encourage her to call for an appointment if she has not yet done so. Parents may be exhausted, frustrated and depressed if they have a child with ongoing behavioral issues. Be gentle, be supportive and be on their side. If a specific plan is made about how to handle the behaviors, a form may be filled out to document the plan. See *Handout: Special Care Plan for Children with Behavior Problems*.

Story 2

ECE Provider: “You seem tired. Janet was having a hard time again today—she was very clingy and slept longer than usual. She was not her usual boisterous self! She does not seem ill. Is she getting enough sleep at night? Are you?”

Do not assume parents are concerned about the same things that you are. It is normal for parents to experience denial and grief before accepting that they have a child who shows challenging behavior. Have educational materials about social and emotional development available so that you can give them to all parents. Arrange for speakers to come and talk to parents as a group about how to identify behavior problems and how to find resources. Ask parents what support or help they would like. Emphasize prevention and proactive messages. Always remember confidentiality when discussing children and families. And never talk about parents disrespectfully with anyone.

WHAT A CCHA NEEDS TO DO

Model Positive Behavior

CCHAs should model good relations with all children and adults. CCHAs can show ECE providers and children how to help others and be cooperative.

Help Children Label Their Emotions

Support each child's struggle to resolve conflicts by helping children learn to label and talk about their feelings and those of others, developing simple ways to solve problems, getting help when in difficulty and noticing the effects of their aggressive actions.

Educate ECE Providers and Families about Positive Guidance

Model and support techniques for *positive guidance*, otherwise known as discipline. Offer consistent and encouraging direction to children. Help the child to understand the reasons for limits and to recognize the feelings of others (empathy). The ECE field has developed many resources related to positive guidance, which include focusing on positive behaviors and recognizing children's efforts. Using positive guidance as a discipline tool, children develop self-control through understanding rather than punishment (Kaiser & Rasminsky, 1999). The National Association for the Education of Young Children (NAEYC) has resources about these techniques on their Web site (<http://www.naeyc.org>).

Educate ECE Providers and Families about Temperament

CCHAs can talk to ECE providers informally about what temperament is and why it is important to understand. CCHAs can teach a workshop on temperament for ECE providers or for families. Help ECE providers to identify and support each child's unique style. Provide information on temperament and behaviors of young children and methods for stepping in before behaviors get out of hand. See *Handout: Health and Safety Notes: Understanding and Caring for the Child with AD/HD*.

Observe and Document Children's Behavior

Help ECE providers learn how to observe children's behaviors and how to write their observations down, or complete standardized forms. Objectively observe children's behavior and their interactions with various peers and adults and develop a log documenting behaviors and play. Review with parents the details of behaviors and develop individualized plans based on children's specific needs. Make sure ECE providers and parents agree on how to act.

Provide Resources

Put posters in easy-to-see locations that demonstrate the range of growth and development across all areas for young children. Create a library with information about the social and emotional developmental process of young children. Have books for adults and children available. List Web sites that might be of interest to families and ECE providers (see *Resources* section at the end of this module).

Build Relationships with ECE Providers and Families

The CCHA's ability to build a trusting relationship with ECE providers and families is important. When the relationships are strong, problems can be solved together more easily. Promote and develop respectful and positive relationships with the families in your program. Continue honest and open communication with the ECE staff and families.

Link with Health Professionals in the Community

To promote positive social and emotional development in all children, ECE providers should link with local mental health professionals in the community (Collins, Mascia, Kendall, Golden, Shock & Parlakian, 2003). The CCHA should be familiar with the services and resources available to families with concerns. The CCHA can be in touch with community groups (e.g., child advocacy groups, church groups, civic groups) to reinforce a positive attitude towards child emotional and social health needs and resources. The CCHA can establish a relationship with the county Children's Mental or Behavioral Health Department and the Child Abuse Prevention Council to demonstrate the need for prevention services for children in ECE programs.

Cultural Implications

Culture can be broadly defined as the knowledge about customs, values, language, behaviors, traditions, belief systems, world views, food, dress and musical tastes shared by members of a group. It is important to remember that differences in cultural backgrounds, values and learning styles can affect a person's concept of acceptable and unacceptable behavior in children. Respect children and their families by responding in culturally sensitive ways. Remember that children are raised in a variety of home situations and are influenced by diverse cultural backgrounds. It is important to consider the cultural framework of the child when observing and addressing children's behavior. Ask families how they see the child's behavior, and why they think the child behaves in the way he or she does.

Implications for Children and Families

If ECE providers and CCHAs work closely and sensitively with families, there will be many possible benefits including the following:

- Children will have their needs met in a better way.
- Families will work better in partnership with ECE providers in guiding their children's behaviors.

- Families will feel more a part of the ECE program and will understand issues facing ECE providers with all the children in their care.
- Families will find it easier to build partnerships with the ECE provider.

Implications for ECE Providers

ECE providers benefit greatly from having the support of the CCHA. Some of the ways the ECE provider may benefit include the following:

- ECE providers will understand that encouraging positive social and emotional development in young children will help children be ready to learn in school.
- ECE providers will be able to anticipate the needs of children early to prevent acting-out behavior.
- ECE providers will better understand the needs of young children and how to best respond to those needs.
- ECE providers will know when to ask for outside help for children with behavior problems, and where to go for help.
- ECE providers will find it easier to build partnerships with parents and have better communication skills to deal with sensitive issues.

ACTIVITY 1: GOALS AT AGE THREE OR FOUR

Fill in the blanks in the *Handout: Goals for the Emotionally Healthy Child at Age Three or Four*. Talk about what an emotionally healthy child acts like and why. Talk about how being emotionally healthy may help a child get ready for school.

ACTIVITY 2: TEMPERAMENT TREASURE HUNT



Fill in the blanks in the *Temperament Treasure Hunt* by walking around the room and talking to one person at a time. See if you can find someone who fits each of the descriptions. Each name can only be used once. Talk about what you learned.

Can you find someone who:

- Their foot is always wiggling. _____
- Never asks a stranger for directions. _____
- Goes to bed at the same time every night. _____
- Can sit and read for hours at one time. _____
- Takes her shoes off whenever she can. _____
- Gets frustrated really easily. _____
- Does not enjoy meeting new people at a party. _____
- Cannot stand tight or clingy clothes. _____
- Can always find a problem with a situation. _____
- Enjoys plenty of alone time. _____
- Prefers to watch awhile before joining an activity. _____
- Loves a difficult and complex puzzle. _____
- Goes to bed at a different time every night. _____
- Is on the go all day long. _____
- Is constantly starting something new. _____
- Is always in a good mood. _____
- Loves hot weather. _____

Developed by Alice Nakabata for The Program for Infant/Toddler Caregivers (PITC). Modified by Mardi Lucich, MA 2/03 for the California Childcare Health Program <http://www.ucsfchildcarehealth.org>.

ACTIVITY 3: UNDERSTANDING A CHILD'S BEHAVIOR

Identify a child you have cared for and describe the child's challenging behavior on the grid in the *Handout: Understanding a Child's Behavior*. Talk about possible causes of the behaviors described using the information from Table 1: Toward a Better Understanding of Children's Behavior: Possible Causes of Behavior Problems and Actions.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

1.041, 2.054, 2.056, 2.067, 8.015, 8.075, 9.033, 9.041.

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

101218.1, 101223, 101226.3.

RESOURCES

Organizations and Resources

Organization and Contact Information	Description of Resources
<p>American Academy of Pediatrics (AAP) National Headquarters: 141 Northwest Point Boulevard Elk Grove Village, IL 60007-1098 (847) 434-4000 phone (847) 434-8000 fax www.aap.org</p>	<p>Professional association of pediatricians dedicates its efforts and resources to attain optimal physical, mental and social health and well being for all infants, children, adolescents and young adults.</p> <p>The Behavioral and Mental Health Web pages address child and family emotional well-being and coping. Look here for information on raising emotionally healthy children and coping with common behavioral and mental health conditions and stressful life situations. www.aap.org/healthtopics/behavemthlth.cfm</p> <p>Since December 1989, the Pennsylvania (PA) Chapter of the American Academy of Pediatrics (PA AAP) has operated the Early Childhood Education Linkage System (ECELS). Now operating Healthy Child Care Pennsylvania, ECELS provides health professional consultation, training, and technical assistance to improve early childhood education programs in the Commonwealth. www.ecels-healthychildcarepa.org.</p> <p>Bright Futures http://brightfutures.aap.org/web/familiesandcommunitiestoolsandresources.asp</p>
<p>Center on Infant Mental Health and Development University of Washington Center on Human Development and Disability Box 357920 Seattle, WA 98195-7920 (206) 543-9200 http://depts.washington.edu/chdd/ucedd/ucedd_infantmentalhealth.html</p>	<p>The Center on Infant Mental Health and Development is one of eight major programs of the University of Washington Center for Excellence in Developmental Disabilities. Its mission is to promote interdisciplinary research and training related to the social and emotional aspects of development for young children during their formative years.</p>
<p>American Orthopsychiatric Association Dept of Psychology, Box 871104 Arizona State University Tempe, AZ 85287-1104 (480) 727-7518 AmericanOrtho@asu.edu www.amerortho.org</p>	<p>The American Orthopsychiatric Association (“Ortho”) is an 80-year old membership association of mental health professionals concerned with clinical issues and issues of social justice. Ortho provides a common ground for collaborative study, research, and knowledge exchange among individuals from a variety of disciplines engaged in preventive, treatment, and advocacy approaches to mental health.</p>

Organization and Contact Information	Description of Resources
<p>California Childcare Health Program 1333 Broadway, Suite 1010 Oakland, CA 94612-1926 (510) 839-1195 phone (800) 333-3212 Healthline www.ucsfchildcarehealth.org</p>	<p>CCHP is a community-based program of the University of California, San Francisco (UCSF) School of Nursing, Department of Family Health Care Nursing. The multidisciplinary team staffs a toll-free Child Care Healthline, trains professionals on health and safety issues related to ECE programs, and conducts research. CCHP produces a wealth of materials on health and safety in ECE settings for professionals and families. Publications on Web site include: Health and Safety Notes, Facts to Families about behavioral health issues. Most educational items are available in English and Spanish.</p>
<p>Center on the Social and Emotional Foundations for Early Learning University of Illinois at Urbana-Champaign Children's Research Center; 51 Gerty Drive; Champaign, IL 61820 (877) 275-3227 phone (217) 244-7732 fax http://csefel.uiuc.edu</p>	<p>The Center on the Social and Emotional Foundations for Early Learning is a national center focused on strengthening the capacity of Child Care and Head Start to improve the social and emotional outcomes of young children. The center will develop and disseminate evidence-based, user-friendly information to help early educators meet the needs of the growing number of children with challenging behaviors and mental health needs in Child Care and Head Start programs.</p>
<p>Centers for Disease Control and Prevention (800) 311-3435 www.cdc.gov</p>	<p>The Centers for Disease Control and Prevention (CDC) is recognized as the lead federal agency for protecting the health and safety of people in the United States.</p> <p>National Center for Chronic Disease Prevention and Health Promotion; Mental Health Work Group. Mental health organizations listed by state. www.cdc.gov/mentalhealth/state_orgs.htm</p> <p>CDC seeks to give people accurate and timely information about public health and the Autism Spectrum Disorders. www.cdc.gov/ncbddd/autism</p>
<p>Children and Adults with Attention Deficit/Hyperactivity Disorder 8181 Professional Place, Suite 150, Landover, MD 20785 www.chadd.org</p>	<p>Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) is a national nonprofit organization providing education, advocacy and support for individuals with AD/HD. In addition to our informative Web site, CHADD also publishes a variety of printed materials to keep members and professionals current on research advances, medications and treatments affecting individuals with AD/HD.</p>
<p>Civitas 1327 W. Washington Boulevard Suite 3D Chicago, IL 60607 (312) 226-6700 phone (312) 226-6733 fax www.civitas.org</p>	<p>Using the latest research in early childhood development, Civitas produces and distributes practical, easy-to-use tools that assist adults in making the best possible decisions on behalf of children.</p>

Organization and Contact Information	Description of Resources
<p>Council for Exceptional Children Division of Early Childhood 1110 North Glebe Road, Suite 300, Arlington, VA 22201 (703) 620-3660 phone (866) 915-5000 TTY (703) 264-9494 fax service@cec.sped.org www.cec.sped.org</p>	<p>The Council for Exceptional Children (CEC) is the largest international professional organization dedicated to improving educational outcomes for individuals with exceptionalities, students with disabilities, and/or the gifted.</p>
<p>Department of Mental Health Health and Welfare Agency 1600 Ninth Street, Room 151 Sacramento, CA 95814 (916) 654-3565 phone (916) 654-3198 fax (800) 896-4042 toll-free (800) 896-2512 TDD dmh@dmhhq.state.ca.us www.dmh.cahwnet.gov</p>	<p>The California Department of Mental Health, entrusted with leadership of the California mental health system, ensures through partnerships the availability and accessibility of effective, efficient, culturally competent services. This is accomplished by advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.</p>
<p>Early Childhood Research Institute CLAS University of Illinois at Urbana- Champaign 61 Children's Research Center 51 Gerty Drive Champaign, IL 61821 (217) 333-4123 phone (877) 275-3227 toll-free http://clas.uiuc.edu</p>	<p>The Early Childhood Research Institute on Culturally and Linguistically Appropriate Services (CLAS) identifies, evaluates, and promotes effective and appropriate early intervention practices and preschool practices that are sensitive and respectful to children and families from culturally and linguistically diverse backgrounds. The CLAS Web site presents a dynamic and evolving database of materials describing culturally and linguistically appropriate practices for early childhood/early intervention services. In this site, you will find descriptions of books, videotapes, articles, manuals, brochures and audiotapes. In addition, there are extensive web site links and information in a variety of languages. The CLAS Institute is funded by the Office of Special Education Programs of the U.S. Department of Education.</p>
<p>Federation of Families for Children's Mental Health 1101 King Street, Suite 420 Alexandria, Virginia 22314 (703) 684-7710 phone (703) 836-1040 fax www.ffcmh.org</p>	<p>The National family-run organization dedicated exclusively to helping children with mental health needs and their families achieve a better quality of life.</p>
<p>National Alliance for Autism Research National Office 99 Wall Street, Research Park Princeton, NJ 08540 (888) 777-NAAR phone (609) 430-9163 fax www.naar.org</p>	<p>The mission of the National Alliance for Autism Research is to fund, promote and accelerate biomedical research and science-based approaches that seek to determine the causes, prevention, effective treatments and, ultimately, a cure for autism spectrum disorders.</p>

Organization and Contact Information	Description of Resources
<p>National Alliance for the Mentally Ill Colonial Place Three 2107 Wilson Blvd., Suite 300 Arlington, VA 22201-3042 (703) 524-7600 phone (800) 950-NAMI (6264) Helpline (703) 524-9094 fax www.nami.org</p>	<p>NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, and other severe and persistent mental illnesses that affect the brain.</p>
<p>National Association for the Education of Young Children 1509 16th St. N.W. Washington DC 20036 (202) 232-8777 phone (800) 424-2460 toll-free www.naeyc.org</p>	<p>NAEYC Love and Learn, Positive Guidance for Young Children www.journal.naeyc.org/btj/200307/love-learn.asp</p> <p>NAEYC Brochures for Families www.naeyc.org/families/brochures.asp</p> <p>NAEYC Resources for Teachers, Strengthening Families Resource Guide www.naeyc.org/ece/supporting/resources.asp</p>
<p>National Clearinghouse on Family Support and Children's Mental Health Portland State University P.O. Box 751 Portland, OR 97207-0751 (800)628-1696 or (503)725-4040 www.rtc.pdx.edu</p>	<p>The Center is dedicated to promoting effective community-based, culturally competent, family-centered services for families and their children who are, or may be affected by mental, emotional or behavioral disorders.</p>
<p>National Institute of Mental Health (NIMH) Office of Communications 6001 Executive Boulevard, Room 8184, MSC 9663 Bethesda, MD 20892-9663 (866) 615-6464 nimhinfo@nih.gov www.nimh.nih.gov</p>	<p>NIMH is the lead Federal agency for research on mental and behavioral disorders. Their Web site describes many of the mental disorders affecting children and adolescents include the following:</p> <ul style="list-style-type: none"> Attention Deficit Hyperactivity Disorder (ADHD, ADD) Autism Spectrum Disorders (Pervasive Developmental Disorders) Bipolar Disorder Borderline Personality Disorder Depression Eating Disorders Childhood-Onset Schizophrenia
<p>National Mental Health Association 2001 N. Beauregard Street, 12th Floor Alexandria, VA 22311 (703) 684-7722 phone (703) 684-5968 fax www.nmha.org</p>	<p>The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.</p>
<p>Parents Helping Parents - San Francisco, Inc. 4752 Mission Street, Ste. 100 San Francisco, CA 94112 (415) 841-8820 phone (415) 841-8824 fax sfphp@earthlink.net www.sfphp.com</p>	<p>Parents Helping Parents - SF (PHP), is a nonprofit organization based in San Francisco, California formed by concerned parents working in cooperation with other nonprofit agencies and various federal, state and local agencies committed to alleviating some of the problems, hardships and concerns of families with children that have special needs.</p>

Organization and Contact Information	Description of Resources
<p>The Preventive Ounce www.preventiveoz.org</p>	<p>This interactive Web site lets you see more clearly your child's temperament, find parenting tactics that work for your child.</p>
<p>Program for Infant Toddler Caregivers 180 Harbor Drive, Suite 112 Sausalito, CA 94965-1410 (415) 289.2300 phone (415) 289.2301 fax www.pitc.org</p>	<p>The Program for Infant Toddler Caregivers seeks to ensure that America's infants get a safe, healthy, emotionally secure and intellectually rich start in life. Its three pronged mission is to</p> <ol style="list-style-type: none"> 1) increase the availability and quality of child care for all children under age three; 2) disseminate information that increases the practice of responsive, respectful and relationship based infant toddler care; and 3) influence national, regional and local policies and practices so that the needs and interests of individual infants, toddlers, and their families are the foundation for all curriculum development and program activity.
<p>U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration(SAMHSA) National Mental Health Information Center The Center for Mental Health Services. Child, Adolescent, and Family Branch P.O. Box 42557 Washington DC 20015 (800) 789-2647 (866) 889-2647 TDD (301) 984-8796 fax</p>	<p>Child, adolescent and family (2003). www.mentalhealth.org/cmhs/ChildrensCampaign.</p> <p>Leading the nation's mental health system into the 21st century (2002). www.mentalhealth.org/publications/allpubs/SMA02-3623/default.asp.</p> <p>www.mentalhealth.samhsa.gov/topics/explore/children</p> <p>Mental health facilities locator advanced search www.mentalhealth.org/databases/kensearch.asp</p> <p>State/territory resources www.mentalhealth.org/publications/Publications_browse.asp? ID=185&Topic=State%2FTerritory+Resources</p>
<p>ZERO TO THREE: National Center for Infants, Toddlers and Families 2000 M Street, NW, Suite 200 Washington, DC 20036 (202) 638-1144 www.zerotothree.org</p>	<p>ZERO TO THREE's mission is to promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf. We are dedicated to advancing current knowledge; promoting beneficial policies and practices; communicating research and best practices to a wide variety of audiences; and providing training, technical assistance and leadership development.</p>

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HANDOUTS FOR THE SOCIAL AND EMOTIONAL DEVELOPMENT OF CHILDREN MODULE

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Biting in the Child Care Setting

Biting causes more upset feelings than any other behavior in child care programs. Because it seems so primitive, we tend to react differently to biting than we do to hitting, grabbing or other aggressive acts. Because it is upsetting and potentially dangerous, it is important for caregivers and parents to address this behavior when it occurs. Though it is normal for infants and toddlers to mouth people and toys, and for many two-year-olds to try biting, most do not continue after the age of three.

Why do children bite and what can we do?

Children bite for many different reasons, and careful observation will guide your appropriate and effective intervention. Taking the time to understand why a particular child bites is invaluable in changing the behavior while maintaining a positive caregiving relationship.

Watch to see when and where biting happens, who is involved, what the child experiences, and what happens before and after.

Ask yourself why the child bites others. Is there a pattern to the situations, places, times or other children when biting occurs? What individual or temperamental needs might influence the child's behavior? Have there been changes in the child's health, family or home situation which might affect his/her behavior?

Adapt your environment, schedule or guidance methods to teach gentle and positive ways to handle the child's feelings and needs.

When a child bites another child

Intervene immediately between the child who bit and the bitten child. Stay calm; don't overreact, yell or give a lengthy explanation.

Talk briefly to the child who bit. Use your tone of voice and facial expression to show that biting is not acceptable. Look into the child's eyes and speak calmly but firmly. Say, "I do not like it when you bite people." For a child with more limited language, just say "No biting people." You can point out how the biter's behavior affected the other child. "You hurt him and he's crying."

Help the child who was bitten. Comfort the child and apply first aid. If the skin is broken, wash the wound with warm water and soap. Apply an ice pack or cool cloth to help prevent swelling. Tell the parents what happened, and recommend that they have the child seen by a physician if the skin is broken or there are any signs of infection (redness or swelling). Encourage the child who was bitten to tell the biter "You hurt me."

Encourage the child who bit to help the other child by getting the ice pack, etc.

Observe universal precautions if there is bleeding.

Alert the staff to the incident.

Notify the parents of all children who were involved. Let them know what happened but do not name or label the child who bit. Reassure them by telling how you handled the incident, and involve the parents in planning how to prevent and handle future biting.

When biting continues after several weeks

Plan a more concentrated program of intervention.

Meet with the parents of the child who is biting to discuss possible reasons and plan together to change the biting behavior.

Assign a special person to stay with the child to carry out the plan determined by the parents and staff with the aim of teaching and giving positive attention for acceptable social behavior.

When the child bites, use the techniques listed above and remove the child from the area where the biting took place. Tell the child he or she cannot play in the area where the biting took place for a while. (This is redirection, not a "time-out.")

If the child continues biting or does not seem to care about the consequences, seek professional help and/or explore the possibility that the child needs an environment with fewer children and more one-on-one adult attention.

Older preschoolers who continue to bite should be referred for more assessment and help.

What can programs do to handle biting?

Develop a policy for guidance and discipline which includes biting. Clearly state how you will handle biting occurrences for both the child who was bitten and the child who bites.

Communicate your policy with parents and staff before biting occurs. Reassure parents that this behavior is not uncommon and that you plan to work with the child in developing positive social skills.

Prevent biting by being alert to potential problem situations.

- Evaluate your program for stressors such as changes in providers or children, crowded play areas or insufficient materials which make children wait for turns, schedules requiring children to make many transitions, tired children at the end of the day.
- When a child is starting in your program, ask the parents whether biting or other aggressive behavior has been an issue and how it has been handled in the past.
- Be alert for children who are likely to bite based on past history.
- Remember that biting tends to be more common during the late summer and early fall months (perhaps due to lighter clothing or changes in the grouping of children).

Reinforce desired behavior. Notice and acknowledge when you like what the child is doing. Provide positive guidance for showing empathy or social behavior, such as patting a crying child, offering to take turns with a toy or hugging gently.

Help the child make connections with others. Encourage special relationships with caregivers, talk about how others feel, express empathy for the feelings of other children.

Do not label, humiliate or isolate a child who bites another child.

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by Cheryl Oku, *Infant-Toddler Specialist (rev. 06/04)*

When a child	You can
Experiments by biting	<ul style="list-style-type: none"> • Immediately say "no" in a firm voice. • Give him a variety of toys and materials to touch, smell and taste and encourage sensory-motor exploration.
Has teething discomfort	<ul style="list-style-type: none"> • Provide cold teething toys or chewy foods.
Is becoming independent	<ul style="list-style-type: none"> • Provide opportunities to make age-appropriate choices and have some control (the pretzel or the cracker, the yellow or the blue ball). • Notice and give positive attention as new self-help skills and independence develop.
Is using muscles in new ways	<ul style="list-style-type: none"> • Provide a variety of play materials (hard/soft, rough/smooth, heavy/light). Plan for plenty of active play both indoors and outdoors.
Is learning to play with other children	<ul style="list-style-type: none"> • Try to guide behavior if it seems rough. (Take the child's hand and say, "Touch Jorge gently. He likes that.") • Prevent conflicts by offering more than one of any especially attractive toy and creating open play space. • Reinforce pro-social behavior (like taking turns with toys or patting a crying child).
Is frustrated in expressing his/her needs and wants	<ul style="list-style-type: none"> • "Read" the child and say what he is trying to communicate. ("You feel mad when Ari takes your truck." "You want me to pay attention to you.")
Is threatened by new or changing situations such as a mother returning to work, a new baby, or parents separating	<ul style="list-style-type: none"> • Provide some special nurturing and be as warm and reassuring as possible, adding some stability and continuity to the child's life. • Help the child talk about feelings even when he or she says thing like "I hate my new baby."

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Caring for the Spirited Child

Not all children are the same. Some are easygoing and others are more challenging because they are strong-willed, easily frustrated, very active, have very intense emotions, and/or have trouble with changes, transitions or situations that are new.

Learning about *temperament* can help you understand and work more effectively with children. Temperament is each person's natural inborn style of interaction that we use to influence and respond to the world around us.

Who is a spirited child?

All toddlers are busy, but the spirited child is much busier. If you care for a spirited child you will have more on your hands. While a high-energy child is typical, some are more intense, persistent and empathetic than other children.

How to identify a spirited child?

Likes to perform. She may be charming, and among her peers she may be recognized as a charismatic leader. She may seem always hungry for attention and loves being the center of attention. She may feed on external stimulation including needing feedback from others.

Insatiable. He often demands immediate responses from you, and sometimes whatever you do, it does not seem to satisfy him.

High energy level. She may be physically active, always exploring, and unable to slow herself down without help. She may be restless, fidgety, constantly on the move. She may have no sense of what is appropriate behavior and may not follow rules.

Has a hard time adapting. Fearful of new situations, he may cling to you. He may need extra time to make transitions to new routines or activities. He may be shy and reserved when meeting new people.

He may “lock in” to important ideas, and may love to debate.

Intelligent. She is often bright, even gifted. She is creative and frequently a keen observer.

Needs less sleep. He may wake up often at night and may not take a nap during the daytime. He may not keep to a regular schedule for sleeping.

Extra sensitive. If usually sensitive to sights, sounds, smells, tastes and skin sensations, she may be quickly and easily over-stimulated by what is going on around her. She may hate to be confined physically.

Demanding. He often needs your attention constantly. He usually has very strong preferences in most matters.

Emotionally intense. Everything is black or white, happy or sad—there is no middle ground in her choices, opinions or life in general. As an infant, she cried more than others. She is usually loud and forceful whether miserable, happy or angry.

Working with the spirited child

Provide quality time. Though the child may be gaining some independence, it is best to maintain a day-to-day special time with just him. Find a favorite song or book that both of you enjoy together daily. This establishes a trust that you will always be there, focusing on the development of a meaningful adult-child relationship.

Keep her informed. When you explain to a child what she should expect, it defuses anxiety about what is coming. For example, offer advanced notice when an activity is about to end. “When we finish reading this book, we’re going to wash our hands and get ready for lunch.” Prepare and support the child for major and minor changes in the daily routine. Allow

a little extra time for this child to move from one activity to another.

Be consistent. High-spirited children need rules and limits. Express expectations simply and directly. And once you set the rules, stick to them by creating a predictable plan for activities, mealtimes, naptimes, etc. and adhere to it as much as possible.

Anticipate. If a high-spirited child acts up in certain places or situations, make other arrangements or adjustments. Acknowledge his reality and show you understand by validating his feelings, which helps to protect his sense of autonomy. “I know it’s hard for you to be in crowded, noisy places. I know that it can be overwhelming.” Offer physical comfort when he is distressed. Try giving him a big hug or massaging his back.

Offer praise. Positive reinforcement offers encouragement and raises a child’s self-esteem. When she sits through and finishes her lunch without getting distracted, let her know that you are pleased with her progress. Be specific. Instead of saying “good girl,” share with her exactly what you are delighted about, such as “I like the way you were able to eat your lunch with your friends today.”

Let him help. When a child wants to start doing things for himself, let him. It may take a few extra minutes or become messy, but it will probably prevent tantrums and power struggles, and it will promote self-mastery. For example, let him put on his own shoes, or set the table for dinner.

Avoid labels. Be careful how you describe a child. Labels have a tendency to stick and affect a child’s self-esteem. Focus on the child’s positive attributes, her strengths and competencies, rather than her difficulties and weaknesses. Instead of saying, “Jaime is so stubborn and bad,” try “Jaime knows what she likes and is energetic.” *Respect her pace and style.*

Do not punish him for who he is. He is not *overreacting*...he just needs help to express his strong feelings in a more appropriate manner. Proactively teach and model acceptable expressions of anger, sadness, fear and frustration.

All behavior has meaning. Specific behaviors may mean different things to different people, but they

mean something. We must appreciate that a child’s behavior and style are a combination of many things: age, personality, temperament, cultural roots, family traditions and expectations, experience, etc. And we may not always get it right, but it is important to understand *your* perception of the child’s behavior and temperament. It is *not* about changing the child; rather you must seek ways to accommodate in order to meet the child’s individual needs.

Temperament describes how a child reacts, not why she reacts in a particular way. Remembering that temperamental styles are part of the child’s nature helps us to better understand the child’s experience. And that in turn helps us to respond constructively to the child’s strengths and needs.

Additional Resources

Spirited Kids Family Resource Center at www.network54.com/Realm/Spirited_Kids.

The Preventive Ounce at www.preventiveoz.org.

Civitas at www.civitas.org.

Raising Your Spirited Child: A Guide for Parents Whose Child Is More Intense, Sensitive, Perceptive, Persistent, and Energetic. Kurcinka, M.S. (1991). New York, NY: HarperCollins.

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By Mardi Lucich, MA (03/03)

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Temperament and Regularity

It can certainly be difficult to manage children with widely different temperaments. *Regularity* is one of the traits which define temperament. Children who are *regular* and predictable in their daily routines like to eat, sleep and have bowel movements (BMs) at about the same time almost every day. If children are extremely regular, then you can practically set your watch by when they do things every day.

If a child is *irregular*, then it is hard to predict when he or she will want to eat, nap or have a BM. The child's biological schedule may be different every day. Maintaining a consistent routine between child care and home (even on the weekends) may help this child to regulate, but do not expect that the child will be as predictable as the more regular child.

Working with a particular child's temperament

Regular and irregular temperaments each bring their own challenges, especially if an irregular child is matched with a child care provider or parent who is regular, or vice versa. It can be frustrating for a regular child care provider or parent to try and predict the needs of an irregular child around such routines as mealtime, naps and elimination.

It's easy to plan outings, snack times and diapering needs for regular children because their habits are predictable. However, very regular children can be dramatically thrown off their schedules for a

short period of time by changes such as daylight savings time. They may feel a little disoriented, almost as if they have jet lag.

While irregular children are more difficult to predict, they are also less likely to be upset by changes in routine. Irregular children are more likely to adapt to variable routines without much of a problem. However, if a child is consistently refusing to eat at lunchtime, sleeps without a pattern of consistency, and has three BMs today and none tomorrow, this child may have a *very irregular* temperament. Ask the parent about the child's routines at home and if there are ways that consistency can be promoted in the child care setting. Parents may not be aware that their child's body can't be as routine-oriented as the other children, or even their own siblings, and they may see the irregularity of the child's response as deliberate or manipulative.

Working with parents

You may hear from parents whose children respond regularly at child care due to the consistency of the child care environment, but are irregular at home. This is a great opportunity to share your knowledge of temperament with them so that you can work together to meet this child's needs. Be sensitive when sharing information with parents who are frustrated by their child's irregularity, as it may seem to reflect on their parenting abilities.

by Susan Jensen, RN, MSN, PNP (rev. 03/03)



Understanding and Caring for the Child with AD/HD

What is AD/HD?

AD/HD is a condition that causes a person to be over-active and impulsive and/or have difficulty paying attention. These behaviors often appear in early childhood before age 7 but may also be detected when the child is older.

Diagnosis

AD/HD affects approximately 3 to 5 percent of all school-age children, possibly as many as 2 million children in the United States. AD/HD is three times more common in boys than girls and tends to run in families. Many children continue to have behaviors of AD/HD as adults. AD/HD affects all socioeconomic, cultural and racial backgrounds. More than 20 percent of children with AD/HD also have learning disabilities. However, having a diagnosis of either AD/HD or learning disability is not related to intelligence.

Diagnosis of AD/HD is made by a physician, psychiatrist, psychologist or licensed social worker, with close collaboration and input from the parents, teacher(s), and/or the child care provider(s). Children with AD/HD demonstrate behaviors that generally fall into three different categories: inattention, hyperactivity and impulsivity.

Examples of inattention (trouble paying attention) would include a child who:

- Makes careless mistakes
- Has difficulty paying attention in tasks or play activities
- Does not seem to listen to what is being said
- Does not follow through or finish activities or tasks
- Has difficulty organizing tasks and activities
- Avoids or strongly dislikes routine tasks or activities
- Is easily distracted and forgetful

Examples of hyperactivity (being very active) would include a child who:

- Fidgets with hands and feet, or squirms in seat
- Has difficulty playing quietly

- Is “on the go” or acts as if “driven by a motor”
- Talks excessively
- Has difficulty waiting in line or for a turn

Examples of impulsivity (acting before thinking) would include a child who:

- Blurts out answers to questions before they have been completed
- Has difficulty waiting in lines or waiting his turn
- Interrupts or intrudes on others

All of these behaviors are common for children at different ages and stages of development. For example, many 2-year-olds are “on the go” and seem to have short attention spans. For a child to be diagnosed with AD/HD, some of the behaviors listed above must have appeared before the child was 7 years of age, have lasted for at least six months, and should be happening frequently enough to cause concern both at home and at school or the child care setting.

Causes

Scientists have not been able to determine the exact cause of AD/HD, though the research suggests that it may be caused by a chemical imbalance or a lack of certain chemicals in the brain which are responsible for attention and activity. There is also evidence that if one or both parents have AD/HD, then their children are more likely to show symptoms as well. Exposure to toxins (including drugs and/or alcohol during pregnancy), brain injury and childhood illness may also contribute to the cause of AD/HD. AD/HD is not caused by too much television, poor parenting or poor schools.

Treatment

All interventions for children with AD/HD should help to build the child’s sense of self-esteem. A team approach using educational, psychological, behavioral and medical techniques is recommended and requires an effort by parents, teachers, child care and health care providers to find the right combination of responses.

Children with AD/HD are typically “hands-on” learners and often will respond to:

- Stimulating or novel activities
- Lower adult-child ratios
- Predictable environments
- Individualized programming
- Structure, routine and consistency
- Motivating and interesting curricula
- Shorter activity periods
- Use of positive reinforcers
- Supplementing verbal instruction with visual aids.

Medication has been used successfully for children with AD/HD as a *part* of the treatment plan—never alone. Stimulant medications have been found to improve symptoms such as attention span, impulse control and hyperactivity, with minimal side effects. Child care providers should work closely with families and health providers when a child is on medication and note any changes in behavior.

Counseling is also an important component of the treatment plan as it can help improve the child’s self-esteem, impulse control, and compliance with taking medications, as well as help address some of the behavioral issues. It may also be helpful to have the family involved in the counseling or support groups, as AD/HD affects the whole family, not just the diagnosed child.

Physical activities can help the child with AD/HD to improve coordination and self-esteem as well as provide appropriate outlets for extra energy.

Some parents may use special diets to eliminate foods that cause problems. Though there is no scientific evidence of specific foods or allergies causing AD/HD, many families believe that eliminating certain foods has improved the child’s behavior.

Tips for Child Care Providers

- Learn what you can about AD/HD.
- Ask the child’s parents for suggestions and tips that they have found useful at home.
- Try to be consistent with the ways the child’s parents guide and manage his or her behavior.
- Let the child take regular breaks and have access to a quiet place to regroup.
- Provide step-by-step instructions.
- Have clear rules and consistent schedules for the child.
- Don’t forget to look for and praise good behavior.

Is AD/HD covered under the IDEA or ADA?

Children diagnosed with AD/HD may be eligible for special education and related services under the Individuals with Disabilities Education Act (IDEA). Children who do not qualify for special education services, but still need environmental or other modifications to the program and/or environment, may be eligible under Section 504 of the Rehabilitation Act of the Americans with Disabilities Act (ADA). For more information, children should be referred to their local school district to see if they qualify for services.

References and Resources:

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National Institute of Mental Health. www.nimh.nih.gov.

By Pamm Shaw, MS, Disabilities Specialist with Lyn Dailey, PHN, and Vella Black-Roberts, MPH (November 1998).

Revised by C. Melissa Ryan, MSW (December 2001).

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Goals for
THE EMOTIONALLY HEALTHY CHILD AT AGE THREE OR FOUR

1. Has warm, _____, intimate relationships with other children and adults
2. Shows _____ self-esteem: feels good about what she or he does
3. Uses good control of impulses and _____: handles assertiveness, curiosity, and angry protest in ways that are in accord with:
 - a. society's _____
 - b. norms for _____ group
 - c. the _____ the child finds herself or himself in, such as preschool, church, playground
4. Separates _____ from reality and adjusts to the demands of reality
5. Exhibits a _____ imagination:
 - a. Incorporates and _____ feelings
 - b. Uses _____ to express needs, feelings, and ideas
6. Shows _____ and _____ for others; deals with _____ and the limitations of life
7. Concentrates, _____, and plans as a basis for learning in educational settings.

A VISION FOR SOCIAL AND EMOTIONAL DEVELOPMENT

1. **The Self:** The caregiver provides physical and emotional security for each child and helps each child to know, accept, and take pride in herself or himself and to develop a sense of independence.
2. **Social Skills:** The caregiver helps each child feel accepted in the group, assists children in learning to communicate and get along with others, and encourages feelings of empathy and mutual respect among children and adults.
3. **Guidance:** The caregiver provides a supportive environment in which children can begin to learn and practice appropriate and acceptable behaviors as individuals and as a group.

THE EMOTIONALLY HEALTHY CHILD AT AGE THREE OR FOUR

1. Has warm, trusting, intimate relationships with other children and adults
2. Shows positive self-esteem: feels good about what she or he does.
3. Uses good control of impulses and behavior: handles assertiveness, curiosity, and angry protest in ways that are in accord with:
 - a. society's goals (expectations)
 - b. norms for peer group
 - c. the settings the child finds herself or himself in, such as preschool, church, playground
4. Separates make-believe (fantasy) from reality and adjusts to the demands of reality.

5. Exhibits a rich imagination:
 - a. Incorporates and labels feelings
 - b. Uses words to express needs, feelings, and ideas

6. Shows empathy and compassion for others; deals with loss and the limitations of life.

7. Concentrates, focuses, and plans as a basis for learning in educational settings

UNDERSTANDING A CHILD'S BEHAVIOR

Child _____ /Age _____ Date _____

Behavior:

Cause (Describe indicators)	Strategies Tried	Additional ideas/strategies to teach/guide appropriate behavior
Developmental Stage		
Individual Differences		
The Environment		
Doesn't know-Ready to learn		
Unmet Need		

From PITC handout, *Toward a Better Understanding of Children's Behavior*
 Adapted by K. Johnston and L. Thompson from Janes Hymes' Understanding Your Child

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THINGS TO CONSIDER

WHAT IS YOUR IDEAL CHILD?

active	approaching	cautious	cooperative	dependable
honest	independent	industrious	loyal	obedient
persistent	quiet	predictable	playful	assertive
confident	curious	sensitive	sense of humor	spirited
		takes risks		

Janet Poole, Program for Infant/Toddler Caregivers, WestEd

What to Expect . . .*

Much of the behavior of young children that is annoying to adults is normal and is part of the child's learning process and growth. Adults can save themselves much worry and trouble if they know what to expect from children at different stages of development.

Of course, none of the 555 children in the study did any of these things all of the time. But all of the children did some of these things some of the time. Large percentages did some of them almost daily.

Most 2, 3 and 4 year olds:

- *Pay no attention to what they are asked to do*
- *Say "no;" refuse to do what is expected or asked*
- *Are poky, waste time eating, dressing, etc.*
- *Leave tasks undone, start but don't finish*
- *Wriggle; don't sit still*
- *Laugh, squeal, jump around*
- *Grab toys, shove, hit, attack others*
- *Refuse to share things with other children*
- *Ask "unnecessary" questions*
- *Cry, sulk easily*
- *Pick nose, play with fingers*
- *Stay close to adults*
- *Seek attention by showing off, look for praise*
- *Go to adults with criticism of others*
- *Boss others*
- *Stay awake at nap time; don't want to rest*
- *Refuse food*
- *Speak indistinctly*
- *Are hard to reason with*

Of course, none of the 555 children in the study did any of these things all of the time. But all of the children did some of these things some of the time. Large percentages did some of them almost daily.

**From "Including All of Us" Caring for Children with Special Needs in Early Childhood Settings: Module III Handout*

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TEMPERAMENT AND BEHAVIOR

Temperament is the **how** of behavior or behavioral style.

Ability is the **what** of behavior or content

Motivation is the **why** or reason behind the behavior.

from *The Emotional Life of the Toddler*, Alicia Lieberman

Temperament is thought to be a set of relatively stable tendencies to react in certain ways.

These tendencies can be **magnified**, downplayed, or **changed in quality** depending on the nature of one's encounters in the environment.



Supporting the Three Types of Temperaments

Temperament Type	Helpful Techniques	Things to Remember
Flexible: - Regular rhythms - Positive mood - Adaptability - Low intensity - Low sensitivity	+Check in regularly +Set aside special time	>Can be “invisible” >Can be taken advantage of
Fearful - Adapts slowly - Withdraws - Not highly active - Express emotions mildly	+Allow to observe from sidelines +Draw child in slowly +Allow independence to unfold.	Frequently: >Labeled insecure >Ridiculed for natural tendencies >Parents may feel social pressure
Feisty - Active/Tends to approach - Intense reactions - Distractible - Sensitive - Irregular rhythms - Moody - Often field independent	+Use redirection +Be flexible +Prepare the child for change +Make the most of quiet moments +Provide for vigorous play	>Problems eating, sleeping, etc. >Need secure base even more >Don't take behavior personally >Use sense of humor >Be available >Clear guidelines >Use support with, and time out from, child >Parents may feel criticized

From PITC Trainer's Manual Module I, *Resource Materials for Module I* (Temperaments Powerpoint handouts developed by Janet Poole), and *Fearful, Flexible, or Feisty* Video Magazine

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ATTITUDES AND ACTIONS

REFRAMING SOME COMMON ATTITUDES ABOUT DISCIPLINE

- | | | |
|--------------------------------|---|---|
| Get rid of conflict | ⇒ | Conflict is inevitable. Use it to teach. |
| Same problems over & over | ⇒ | What skills are missing? |
| Discipline interrupts teaching | ⇒ | Discipline/guidance is a key part of curriculum |

Adapted from: Reframing Discipline Unit 1, Educational Productions, 1-800-950-4949

TECHNIQUES OF DIRECT GUIDANCE*

PHYSICAL

1. Give help based on the individual child's need.
2. Demonstrate or model the desired behavior or skill.
3. Lead the child by the hand to give direction, reassurance, or assistance.
4. Restrain the child where necessary to protect him or others.
5. Remove the child from the scene to help him relax and regain composure.
6. Use no punishment that is meant to hurt or humiliate the child.
7. Get down to eye level and use meaningful gestures.
8. Use your body language to help the child feel good about himself and comfortable in school.
9. Use gentle touch (slight pressure) to help children refocus.

VERBAL

1. Speak to the child eyeball to eyeball.
2. Use short sentences.
3. Use positive directions, telling the child what to do instead of what not to do.
4. Place the action part of your direction at the beginning of your statement.
5. Give no more than two directions at a time, preferably only one.
6. Give the child directions when it is the time and place you want the behavior to occur.
7. Give only directions the child really needs.
8. Make it clear whether the child has a choice or not.
9. Give logical and accurate reasons for requests.
10. Keep competition to a minimum by motivating the child through helping him set new personal goals for achievement.
11. Praise the child for jobs well done.

AFFECTIVE

1. Give positive feedback for occasions other than when the child follows directions.
2. Give attention before the child demands it.
3. Reflect the feeling the child is expressing and give it a label.
4. Get to know the child better if you find yourself feeling negatively toward him.

*From "Including All of Us" Caring for Children with Special Needs in Early Childhood Settings: Module III Handout

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BEHAVIORAL DATA COLLECTION SHEET

This sheet is intended to be used by caregivers to document a child's behavior that is of concern to them. The behavior may warrant evaluation by a health care provider, discussion with parents, and/or consultation with other professionals.

Child's name: _____ Date: _____

1. Describe behavior observed: (See below for some descriptions.)

2. Behavior noted from: _____ to _____
(time) *(time)*
3. During that time, how often did the child engage in the behavior? (e.g. once, 2-5 times, 6-10 times, 11-25 times, >25 times, >100 times) _____
4. What activity(ies) was the child involved in when the behavior occurred? (e.g. was the child involved in a task? Was the child alone? Had the child been denied access to a special toy, food, or activity?) _____
5. Where did the behavior occur? _____
6. Who was around the child when the behavior began? List staff, children, parents, others.

7. Did the behavior seem to occur for no reason? Did it seem affected by changes in the environment?

8. Did the child sustain any self-injury? Describe. _____
9. Did the child cause property damage or injury to others? Describe. _____

10. How did caregiver respond to the child's behavior? If others were involved, how did they respond?

11. What did the child do after caregiver's response? _____
12. Have parents reported any unusual situation or experience the child had since attending child care?

Child Care Facility Name: _____

Name of Caregiver (completing this form): _____

Behaviors can include:

- *repetitive, self-stimulating acts*
- *self-injurious behavior (SIB) such as head banging, self-biting, eye-poking, pica (eating non-food items), pulling out own hair*
- *aggression / injury to others*
- *disruption such as throwing things, banging on walls, stripping*
- *agitation such as screaming, pacing, hyperventilating*
- *refusing to eat / speak; acting detached / withdrawn*
- *others*

Check a child's developmental stage before labeling a behavior a problem. For example, it is not unusual for a 12 month old to eat non-food items, nor is it unusual for an 18 month old to throw things. Also, note how regularly the child exhibits the behavior. An isolated behavior is usually not a problem.

S. Bradley, JD, RN,C - PA Chapter American Academy of Pediatrics
reviewed by J. Hampel, PhD and R. Zager, MD

SPECIAL CARE PLAN FOR A CHILD WITH BEHAVIOR PROBLEMS

This sheet is intended to be used by health care providers and other professionals to formulate a plan of care for children with severe behavior problems that parents and child care providers can agree upon and follow consistently.

Part A: To be completed by parent/custodian

Child's name: _____ Date of birth: _____
Parent name(s): _____
Parent emergency numbers: _____
Child care facility/school name: _____ Phone: _____
Health care provider's name: _____ Phone: _____
Other specialist's name/title: _____ Phone: _____

Part B: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist

1. Identify/describe behavior problem: _____

2. Possible causes/purposes for this type of behavior: (circle all that apply)

medical condition _____ (specify)	tension release
attention-getting mechanism	developmental disorder
gain access to restricted items/activities	neurochemical imbalance
escape performance of task	frustration
psychiatric disorder _____	poor self-regulation skills
	other: _____

(specify)

3. Accommodations needed by this child: _____

4. List any precipitating factors known to trigger behavior: _____

5. How should caregiver react when behavior begins? (circle all that apply)

ignore behavior	physical guidance (including hand-over-hand)
avoid eye contact/conversation	model behavior
request desired behavior	use diversion/distraction
use helmet*	use substitution
use pillow or other device to block self-injurious behavior (SIB)*	
other: _____	

*directions for use described by health professional in Part D.

6. List any special equipment this child needs: _____

7. List any medications this child receives:

Name of medication: _____

Name of medication: _____

Dose: _____

Dose: _____

When to use: _____

When to use: _____

Side effects: _____

Side effects: _____

Special instructions: _____

Special instructions: _____

8. Training staff need to care for this child: _____

9. List any other instructions for caregivers: _____

Part C: Signatures

Date to review/update this plan: _____

Health care provider's signature: _____ Date: _____

Other specialist's signature: _____ Date: _____

Parent signature(s): _____ Date: _____

_____ Date: _____

Child care/school director: _____ Date: _____

Primary caregiver signature: _____ Date: _____

Part D: To be completed by health care provider, pediatric psychiatrist, child psychologist, or other specialist

Directions for use of helmet, pillow, or other behavior protocol: _____

S. Bradley, JD, RN,C - PA Chapter American Academy of Pediatrics
reviewed by J. Hampel, PhD and R. Zager, MD

TEMPERAMENT AND GOODNESS OF FIT

Easy or flexible children are generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of their easy style, caregivers need to set aside special times to talk about the child's frustrations and hurts because he or she won't demand or ask for it. This intentional communication will be necessary to strengthen your relationship and find out what the child is thinking and feeling.

Slow to warm up or cautious children are relatively inactive and fussy, tend to withdraw or to react negatively to new situations, but their reactions gradually become more positive with continuous exposure. Sticking to a routine and your word, along with allowing ample time to establish relationships in new situations, are necessary to allow independence to unfold.

Difficult, active, or feisty children are often fussy, irregular in feeding and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in their reactions. Providing areas for vigorous play to work off stored up energy and frustrations with some freedom of choice allow these children to be successful. Preparing these children for activity changes and using redirection will help these children transition (move or change) from one place to another.

Here are principles to keep in mind as you strive try to achieve "goodness of fit":

- **Be aware of the child's temperament and respect his/her uniqueness without comparing him/her to others or trying to change the child's basic temperament.** Encourage him/her to accomplish tasks at his own pace. Praising him/her for his/her ideas and achievements, however small, will enhance self-image and make him/her feel capable of being independent.
- **Be aware of your own temperament & your own needs, including the ways in which your role as a caregiver is colored by your relationship with your own parents/caregivers.** And adjust your natural responses when they clash with a child's responses.
- **Communicate.** Take time to explain your decisions and motives. And listen to the child's points of view. Encourage teamwork on generating solutions to problems.
- **Make your expectations clear by setting limits to help the child develop self-control.** Respect opinions but remain firm on important limits and decisions.
- **Be a good role model because children learn by imitation and identification as well as discussion.** Children take their cues from the adults around them.

To be more inclusive of a wider range of temperaments and differences in cultural values...some questions for reflection:

1. What traits are highly valued by families in your program?
2. Is there a "fit" between those values and individual children?
3. Is there a "fit" between those values and that of the program and staff?

