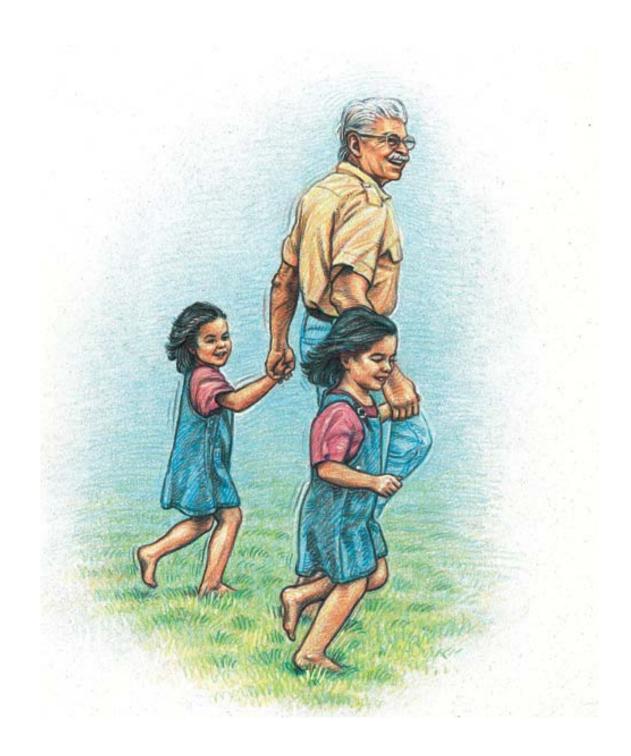# EARLY CHILDHOOD

Introduction

During early childhood, ages 1–4, children make enormous gains in the development of their concepts of self and the ways they interact with family and friends. For the 1-year-old, mobility is a goal to be mastered. By age 4, mobility has become the means for exploration and increasing independence. The 1-year-old imitates sounds and gestures; the 4-year-old has mastered most of the complex rules of spoken language and can communicate thoughts and ideas. The 1-year-old learns from what he can see, hear, feel, and manipulate physically; the 4-year-old integrates the use of mental symbols and the development of fantasy. The 1-year-old is on the threshold of developing a sense of self, separate from his parents and other caregivers; the 4-year-old begins to pursue relationships outside the family as an individual in his own right (Green and Palfrey, 2000).

Parents continue to be the major influences and facilitators of healthy development during early childhood. Parents seek ways to help their children develop regular sleep and eating patterns, toilet independently, and begin to master their emotions both to help them cope effectively with frustration and to prepare them for the demands of school. More subtle is the development of self-esteem through positive and accepting experiences. Self-esteem and feeling valued, loved, and accepted are critical to the child's future academic success, behavior, and happiness. Socialization, which occurs first with family members and later with friends, requires a growing set of interactive skills.

As a result of wide variations in development during these years, many parents have questions about their child's development and, near the end of this period, about their child's readiness for school.

The primary care health professional can build on the relationship developed with the family in the child's first year to promote healthy development, be sensitive to ways in which the child and the family may be having difficulty, and guide the family in alternative approaches if necessary.

SELF

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to self in early childhood:

What are Rosa's sleep habits?

What are her eating habits?

What kinds of physical activities does she like?

How is her toilet training progressing?

Do you feel pressure to toilet train her?

How do you deal with tantrums?

What are some new things that Charles is doing?

How do you deal with his greater independence?

What do you do when he has ideas that are different from yours?

How do you set limits for him?

Which of his behaviors concern you?

How would you describe Charles's personality these days?

SELF: SELF-CONTROL

Children develop self-control during early childhood through mastering basic functions such as sleeping, eating, and toileting as well as learning to cope with issues such as separation and fear. Parents can assist in this process by allowing as much independence as the child can handle at any given moment within a structure of healthy and safe alternatives. Too much autonomy may not satisfy the child's need for support; too little can restrict development or produce parent-child conflict. Children with particular vulnerabilities may need more support to feel capable. Optimal development requires progressive expectations and experiences that help children learn to tolerate frustration, delay gratification, and maintain emotional control when upset.

Adjusting for Temperament

A child gains self-control more easily when parents understand and respect the child's temperament. (See also Self: Temperament, p. 18, in the Infancy chapter.)

Tips

■ Ask parents to describe their child's typical behavior on a good day and a bad day.

■ Discuss parents' expectations and parenting styles to determine how these fit with their child's temperament.

■ If differences in parents' expectations and parenting styles and their child's temperament appear to be causing misunderstandings, consider administering a temperament questionnaire such

as the Behavioral Style Questionnaire (McDevitt and Carey, 1978), and discuss the results objectively with parents.

■ Encourage parents to adjust their pace to their child's pace to allow the child greater autonomy and to avoid frustration and unnecessary battles. For example, parents could find time to take an active child to the playground, provide a sensitive child with quiet time after child care, allow an insistent child to choose which clothes to wear, or provide structure and limit options for a child who has difficulty making decisions.

Resources for Families

Carey WB, Jablow MM. 1997. *Understanding Your Child's Temperament.* New York, NY: Macmillan.

Elkind D. 1998. *The Hurried Child: Growing Up Too Fast Too Soon* (rev. ed.). Reading, MA: Perseus Books.

Green C. 1985. *Toddler Taming: A Survival Guide for Parents* (1st American ed.). New York, NY: Fawcett Columbine.

Fostering Healthy Sleep Patterns

To enable children to develop sleep patterns that allow them to get enough rest, parents need to establish appropriate bedtime routines and set limits. Inadequate sleep predisposes children to behavior problems.

Tips

■ Encourage parents to establish routines for bedtime that include putting their child to bed at a consistent time, spending time with the child,

engaging in soothing activities such as cuddling and reading bedtime stories, and ensuring that the child does not spend a prolonged period of time in bed awake. Consistency of approach can help reduce tension at bedtime.

■ Support the use of transitional objects (i.e., comfort objects such as blankets and stuffed toys) at bedtime, and explain that self-soothing behaviors such as rocking and thumbsucking can help the child fall asleep.

■ Ask parents about sleeping arrangements. Usually it is desirable for the child to fall asleep on his own after the bedtime routine, although for some families and cultures, "family bed" or co-sleeping is the norm. In these cases, counsel parents on safety issues related to co-sleeping. Discuss the physical circumstances in which the child and parents co-sleep, and identify hazards, including loose bedding, overlying, the risk of falls, parental smoking in bed, and spaces where a child might become entrapped and suffocate (young children should never sleep in a water bed). Explain that parental alcohol or drug use increases the risk of harm to the child while co-sleeping. Evaluate families that practice co-sleeping to be sure that the practice is not being used for anyone's sexual gratification and that it is not resorted to because of the parents' inability to control the child's bedtime behavior.

■ To help parents deal with their child's bedtime fears, see Tool for Families: Fears in Early Childhood, *Mental Health Tool Kit,* p. 78.

Area of Concern: Bedtime Struggles

When a child refuses to go to or stay in bed, consider the following:

- The child may not be tired because of irregular schedules, such as going to bed at inconsistent times, napping in the afternoon, or sleeping late in the morning. Keeping a sleep diary can help parents determine the reason for and solve their child's sleep problem. (See Tool for Families: Sleep Diary, *Mental Health Tool Kit,* p. 80.)

- Parents may believe that their child needs more sleep than is necessary.

- The child may need more adult assistance in going to bed.

- Consistent behavioral limits are not being maintained during the day. (See Tool for Families: Principles of Limit Setting, *Mental Health Tool Kit,* p. 81. See bridge topic: Oppositional and Aggressive Behaviors, p. 291.)

- Fears may be causing the child to resist going to bed. (See Tool for Families: Fears in Early Childhood, *Mental Health Tool Kit,* p. 78.)

- Parents may be having trouble separating from their child at bedtime, which could be creating a sleep problem. This is most common if the parent-child relationship involves a lot of struggles, if parents feel guilty because of the limited time they spend with their child, or if parents are experiencing depression or marital conflict. Parents may need to become aware of how they are signaling their own ambivalence. They may need to spend special time with the child daily and to set appropriate limits. Referral to a mental health professional may also be needed. (See Tool for Families: Guidelines for Special Time, *Mental Health Tool Kit,* p. 82.)

Eating Independently

Children in early childhood need healthy meals and snacks at scheduled times throughout the day (Story et al., 2000).

Tips

- Reassure parents that their child's diet will likely be nutritionally balanced over a period of weeks if she is offered a variety of healthy foods and sweets are limited, even if her diet is not balanced at each meal, or even each day. Also reassure parents that their child will probably consume enough calories during a 48-hour period even if her caloric intake varies among meals.

- Encourage parents to have their child sit at the table during meals for at least 10 minutes and to allow the child to feed herself and eat what she wants. Reassure parents that picky eating is the norm in early childhood, and encourage them to offer a variety of healthy foods but not to force their child to eat foods she does not want. Encourage parents to involve the child in food selection and preparation, to respect her food preferences by always serving at least one food she likes, and to provide small servings to minimize eating struggles.

- Encourage parents to eat with their child. Some families, because of busy adult schedules and children's tendency to eat only familiar foods, feed children separately from adults. Explain to parents that they can help their child establish healthy eating behaviors by eating with her. The child may want to try food on the parents' plates, thereby increasing her exposure to new foods.

- Recommend that parents avoid expressing intense emotions at mealtime, insisting on certain foods or amounts, or preparing separate meals in response to complaints.

- Parents may be more concerned about their child's eating if they are worried about the child's health, are being pressured by relatives, or have a personal history of eating disorders or obesity. Ask parents, "Are you concerned about your child's eating? Who else is concerned about his eating?" Monitor the child's growth and physical health and provide feedback to parents.

- Encourage parents to provide their child with opportunities to eat with other people (especially peers) who eat a variety of healthy foods and to try visually different and unusual foods.

Resources for Families

Lansky V. 1994. *Feed Me! I'm Yours.* Deephaven, MN: Meadowbrook Press.

Satter E. 1991. *Child of Mine: Feeding with Love and Good Sense.* Palo Alto, CA: Bull Publishing.

Area of Concern: Difficult Behavior at Mealtime

If a child demonstrates difficult behavior at mealtime, ask about parental expectations regarding behavior and eating, what else is going on during mealtimes (e.g., whether the television is on, whether children are included in conversations), and general behavioral problems. A child who displays difficult behavior can be removed for the remainder of the meal but should be offered healthy foods a half hour to an hour later.

Area of Concern: Gorging, Begging for Food, Refusing Food

Gorging, begging for food, and refusing food can be signs of underlying family conflict or other psychosocial, developmental, or neurological problems. After evaluating the child for possible medical causes, assess for family difficulties and consider referral to a mental health professional.

Toilet Learning

Learning to use the toilet is a milestone in independence that affects the relationship between parent and child. Because parents are often intensely invested in the results, toilet learning can become a locus of child-parent power struggles and conflict.

Tips

- Help parents recognize signs of toilet-learning readiness (e.g., signaling before voiding, remaining dry for long periods).

- Encourage parents to

  - Wait for signs of readiness before starting training.

  - Deal with accidents with acceptance.

  - Avoid starting training during periods of major change or high stress, such as after the birth of a sibling, during a change in child care arrangements, or when the family is in the process of moving.

  - Provide a potty chair, or place a stool in front of the toilet so that the child's feet are touching the floor, not hanging.

Resources for Families

Frankel A. 1980. *Once Upon a Potty.* Hauppauge, NY: Barron's Educational Series.

It's Potty Time. 1991. Produced by Learning Through Entertainment. 25 min. Videocassette. Phone: (800) 23-POTTY (237-6889).

Learning Through Entertainment. 1996. *It's Potty Time.* Dallas, TX: Learning Through Entertainment.

Rogers F. 1997. *Going to the Potty.* New York, NY: Putnam & Grosset Group.

Area of Concern: Resisting Toilet Learning

Simple techniques can encourage most children $2\frac{1}{2}$ years of age and older who are resisting toilet learning. Pressure can be removed by returning the child to diapers and offering "big kid" underwear as an incentive. Disposable pull-up training pants can delay toilet learning.

Independent toileting symbolizes growing up and some loss of intimate caregiving. Acknowledging this and helping the parent and child create alternative intimate moments such as "cuddle time" can further toilet learning progress.

Assess for the possibility of physical or sexual abuse in cases of extreme fears or significant delays or regression associated with toilet learning. (See bridge topic: Child Maltreatment, p. 213.)

Resource for Families

Viorst J. 1996. *Necessary Losses: The Loves, Illusions, Dependencies and Impossible Expectations That All of Us Have to Give Up in Order to Grow.* New York, NY: Ballantine Books.

Area of Concern: Toileting Fears

Toileting fears, such as fears of falling into the toilet or losing genitalia, are common in early childhood. These fears can result in withholding or toilet refusal. Suggest use of a potty chair or toilet insert or allowing children to sit backward on the toilet for security. Tell children that their genitalia are "theirs forever." Suggest exploration of the toilet and its pipes to desensitize children to their fears. Assess for the possibility of physical or sexual abuse in cases of extreme fears or significant delays or regression associated with toilet learning. (See bridge topic: Child Maltreatment, p. 213.)

Area of Concern: Stool Refusal

In cases of stool refusal, help ensure that children produce one or two soft, nonpainful stools per day by recommending a high-fiber diet and sufficient fluids and, if necessary, regularly giving the child mineral oil, laxatives, or fiber supplements before stool has a chance to build up. Address parental control issues and the child's fears while allowing the child to use a diaper. In persistent cases (i.e., those lasting more than 6 months), consider other interventions, including referral to a mental health professional or developmental-behavioral pediatrician. (See Tool for Families: Principles of Limit Setting, *Mental Health Tool Kit,* p. 81.)

Assess for the possibility of physical or sexual abuse in cases of extreme fears or significant delays or regression associated with toilet learning. (See bridge topic: Child Maltreatment, p. 213.)

Encouraging Self-Care

Acquiring self-care skills is a major area of mastery that symbolizes children's growing independence and self-control.

Tips

- Advise parents to develop routines, such as for brushing teeth and washing hands, when their child is young, to reduce resistance and facilitate learning. Encourage parents to make routines fun.

- Encourage parents to use self-care as an opportunity for their child to make choices and to act independently (e.g., choosing clothing, washing herself). Children need extra time and opportunities to learn from their mistakes during self-care. Encourage parents to praise their child for taking even small steps toward self-care.

- Anticipate regression in self-care at times of stress or transition, and encourage the family to accept this and to assist the child rather than criticize her.

- If the child has fine motor delays or sensory deficits, suggest accommodations, such as loose-fitting clothing, angled spoons, and other adaptive equipment, so that she can maximally care for herself. Occupational therapists can suggest specific equipment and teach the child to use it.

- Consider the possibility that temper tantrums during self-care could indicate that the child feels too much pressure or restriction or that she may have a weakness in motor skills that needs to be evaluated.

Area of Concern: Parents Who Limit Independence in Self-Care

Parents who are having trouble allowing their child to mature may be underestimating the child's abilities. Parenting groups or classes, play groups that parents attend, and other opportunities to talk with parents of children of similar age can help parents develop realistic goals. Discuss the risk of oppositional behavior resulting from parental interference in self-care.

Resources for Health Professionals

Sattler JM. 2001. *Assessment of Children: Cognitive Applications* (4th ed.). San Diego, CA: J. M. Sattler.

Sparrow SS, Balla DA, Cicchetti DV. 1984. *Vineland Adaptive Behavior Scales (VABS).* Circle Pines, MN: American Guidance Service.

Managing Emotions

One of the most difficult tasks of self-control is managing intense negative emotions.

Tips

■ Advise parents to help their child with experiences such as taking turns, sharing parents' time, sharing possessions, and learning to communicate their needs. The ability to delay gratification develops slowly. Parents may help their child cope by talking her through her feelings, providing distractions, or holding her. Parents can gradually increase waiting times and praise self-control. These techniques are especially important for children with a low tolerance for frustration as a result of temperament. (See Tool for Families: Charting Positive Behavior, *Mental Health Tool Kit,* p. 83.)

■ Reassure parents that tantrums are common at this age, often reflecting the tension between emerging self-control and parental expectations.

■ Ask about the rules parents have for their child and which ones cause the most tension. Setting limits is important, but limits should be appropriate for the child's age and level of development.

Resource for Families

Lieberman AF. 1993. *The Emotional Life of a Toddler.* New York, NY: Free Press.

Area of Concern: Excessive Temper Tantrums

Excessive temper tantrums may reflect problems with social, self-care, or verbal skills. Disruptions in sleeping, eating, and caregiving routines can intensify tantrums. Ask parents how they respond when their child is distressed. Overly sympathetic responses may reinforce the child's disruptive behavior. Parents can provide support without giving in to unacceptable demands by standing by or holding the child without speaking.

Development of a Moral Sense During Early Childhood

Moral development provides a framework of principled behavior for relating to others. Children learn the do's of relating to others by observing and experiencing caring interactions. They learn the don'ts of relating to others by being told what is appropriate behavior, by observing and receiving feedback on inappropriate behavior, and by feeling bad for hurting others. Children process the interactions and rules they experience progressively in the context of their cognitive maturity and integrate more sophisticated understandings of moral concepts (e.g., fairness, justice, equality, rights). Childen typically master rules by testing them and experiencing guilt for breaking them, feeling pride and receiving praise for following them, and developing an understanding of the moral concepts that justify the rules that govern behavior.

Tips

- Encourage parents to praise their child for following rules and caring for others. Encourage them to provide opportunities that foster development of moral responsibility, kindness, and helpfulness (e.g., feeding pets, assisting with meals, helping care for younger siblings or siblings with disabilities).

- Encourage parents to elicit empathy by explaining the other person's point of view in terms their child can understand or, if the child is old enough (i.e., around age 4), by asking the child to role-play to see another's point of view.

- Reassure parents that their child's defiance and apparent pleasure in breaking rules are part of the developmental process (i.e., the child is fulfilling a need for power or autonomy), but that explanation of rules and consequences for breaking them are still needed. Suggest that parents use small, immediate consequences that relate to the problem behavior and explain why it is important to follow a particular rule to increase the child's internalization of rules.

- Monitor for shaming or humiliation of the child or labeling the child as a liar, thief, or sneak for normal rule-testing behavior. Encourage parents to explain rules calmly and to establish reasonable consequences for breaking them.

- Encourage parents to talk with their child about their own moral decision-making processes in terms the child can understand.

- Support parents in modeling charitable behaviors (e.g., helping someone in need, donating to charity, doing chores for elderly or sick neighbors), and encourage them to involve their child as much as possible. Encourage families to participate in community activities, volunteer activities, and activities at places of worship to introduce their child to other people who share their values. This advice may be especially relevant if the parents' backgrounds differ from each other's.

Resource for Families

Damon W. 1988. *The Moral Child: Nurturing Children's Natural Moral Growth.* New York, NY: Free Press.

SELF: SELF-ESTEEM

Self-esteem is the sense of feeling valued, capable, and competent. Self-esteem develops as children experience the love and responsiveness of their parents. Self-esteem continues to develop as children at about age 3 begin to evaluate their accomplishments, such as making friends, developing self-care skills, learning, playing creatively, and mastering physical skills. As children in early childhood develop their sense of self, they test and evaluate it, becoming more confident about some aspects and less secure about others. The foundations of self-esteem are based on the development of a sense of self-efficacy, autonomy, moral competency, and self-control. Negative societal attitudes toward such attributes as race, culture, religion, gender, differing abilities, and physical appearance can diminish a child's self-esteem, more so if the child has less support from family or fewer self-perceived strengths. Positive self-esteem promotes mental health, academic achievement, responsible behavior, and resilience to stress. Poor self-esteem is associated with disruptive behavior, social withdrawal, and later mental health problems, poor academic achievement, and delinquency.

Encouraging a Positive Parent-Child Relationship

To foster children's self-esteem, parents need to provide them with a warm and nurturing environment as well as with opportunities that encourage a sense of individuality. Parents convey pleasure and acceptance of their children through praise, interactive play, and active listening.

Tips

- Explain to parents that some children need more companionship or more help with certain tasks (e.g., dressing, getting ready for bed) than other children the same age. Children should not be shamed for this.

- Discuss the importance of frequent expressions of nonverbal positive regard, such as smiles and hugs. As their child develops, help parents shift from mostly external praise to having the child recognize his own developing skills. Model this behavior by asking the child about his strengths and successes and how he views them (e.g., "I see you can button your shirt by yourself now. How does that make you feel?").

- Recommend that parents spend at least 5–15 minutes of uninterrupted, one-on-one special time with their child daily. (See Tool for Families: Guidelines for Special Time, *Mental Health Tool Kit,* p. 82.)

- Encourage flexible limit setting. Model giving "yes" as well as "no" answers to children during office visits. For example, you could say, "You may not use my ophthalmoscope because it might break, but you may try out my reflex hammer." Discuss this technique with parents who seem overly tense or critical when they correct their child. Consider that parents who appear overly critical or who devalue their child may be unconsciously repeating experiences they had as children or may be identifying their child with someone else (i.e., projecting).

  • Ask parents about expectations their own parents had for their behavior and how failure to meet expectations was dealt with. Ask parents

about what might have been helpful to them as children in order to help them identify alternative approaches to use with their child.

- Ask parents, "Whom does your child take after? In what ways? How does that affect your relationship with him?" Help parents separate their feelings about their child from their feelings about and past experiences with others who remind them of their child.

- Encourage parents to focus on the positive aspects of their child and not to expect perfection.

Resource for Families

Missildine WH. 1982. *Your Inner Child of the Past.* New York, NY: Pocket Books.

■ Advise parents to avoid shaming their child about body size, shape, or sexual behaviors. Young children practice self-stimulation through thumbsucking and genital play, with a peak at $2^1/2$ years. Counsel parents to ignore these behaviors or to redirect the child rather than shaming or punishing him. If there are concerns about sexual abuse, see bridge topic: Child Maltreatment, p. 213.

■ For children in child care or preschool, ask parents about the child care provider's or preschool's expectations for their child and how much time their child spends there. Inadequate opportunities for learning and play, inappropriate expectations, or excessive duration can result in a variety of problems, including children not feeling valued. Ask parents about how the child feels about child care or preschool. (See the following Tools for Families in the *Mental Health Tool Kit:* Stimulating Environments, p. 72; Safe, Quality Child Care, p. 74.)

Area of Concern: Critical or Detached Parents

Parents who have low involvement or negative interactions with their child may be exhausted or overly stressed, or may be repeating patterns from their own childhood. They may have a mental disorder such as depression or substance abuse. A comprehensive family health history questionnaire, such as the Pediatric Intake Form (Kemper and Kelleher, 1996), can elicit a history of such problems or risks. (See Tool for Health Professionals: Pediatric Intake Form, *Mental Health Tool Kit,* p. 4.) Referral to a mental health professional is indicated if family function is impaired. (See the following bridge topics: Parental Depression, p. 303; Child Maltreatment, p. 213.)

Helping Children Feel Competent

Experiences of personal success are a major contribution to children's self-esteem. Opportunities for success should be made available to children at whatever level they can achieve.

Tips

■ Help parents assess their child's skills and temperament. Help identify strengths on which to build. (See Tool for Health Professionals: What Can Your Child Do?, *Mental Health Tool Kit,* p. 30.)

■ Help parents differentiate between high expectations for their child and damaging pressure to succeed. Point out that their child's wish to please them may result in a sense of failure if expectations are not reasonable. This may lead to resistance, resentment, and damaged self-esteem. If parents appear to have unrealistic expectations,

a useful exercise is to help them devise at least one expectation appropriate for the child's developmental level. (See *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* [Green and Palfrey, 2000] for information on developmental milestones.)

■ Consider the possibility that a child's dawdling, acting out, or feeling bad about herself could be related to the child's being hurried. Some parents are so busy that their child's need for emotional support and/or her need for help with tasks go unrecognized, are not considered a priority, or result in the child being criticized. Advise busy parents to set aside more time for their child, especially during transitions, or to provide additional support for the child (e.g., a relative, friend, or familiar baby-sitter).

■ Discuss any delays in abilities revealed by developmental screening instruments. These delays may point to areas in which the child has not had the opportunity to develop. Encourage parents to support their child's development and build their child's self-esteem through appropriate challenges in the major developmental domains. For example, giving the child independence enhances social development; giving the child tasks requiring some effort to be mastered enhances motor and cognitive abilities; and talking and listening to the child enhance language skills and a sense of being valued. (See the following bridge topics: Learning Problems and Disorders, p. 251; Mental Retardation, p. 261; Pervasive Developmental Disorders, p. 317. See *Bright Futures Case Studies for Primary Care Clinicians:* Global Delay: Will David Catch Up? [Deutsch and Frazer, 2001] at http://www.pedicases.org.)

Helping Parents Accept Their Child's Personal Style

Self-esteem is enhanced when parents recognize and accept their child's temperament, emotions, and individual preferences and offer support, praise, guidance, and love. (See Self: Temperament, p. 18, in the Infancy chapter, for further discussion of temperament.)

Tips

■ Help parents accept their child's temperament, individual style, pace, strengths, and weaknesses. For example, ask parents what they are most proud of about their child and which things their child finds the most difficult to do. Ask them to describe their child's personality.

- Discuss temperament with parents. Encourage them to avoid shaming or criticizing their child for responses that result from her temperament, such as clinging or boisterousness.

- Encourage parents to demonstrate acceptance of their child's emotions by active listening, in which both behaviors and emotions are echoed without adding advice. For example, parents could say, "I hear you saying that your sister went into your room, took your coloring book, and marked it up, and you feel angry and disappointed." (See Tool for Families: Communicating with Children, *Mental Health Tool Kit,* p. 84.)

- Encourage parents to enhance their child's self-esteem by praising his efforts, communicating the idea that we learn from our mistakes, and praising him for accepting mistakes and failures gracefully and for continuing to try. Parents can model self-tolerance by accepting their own mistakes. (See Tool for Families: Charting Positive Behavior, *Mental Health Tool Kit,* p. 83.)

- Advise parents to avoid rescuing their children too quickly from difficult situations in order to help them build competence and self-efficacy. This is especially important for children with inhibited patterns of response (e.g., children who are shy, slow to warm up, or anxious in group situations).

Effects of Trauma on Self-Esteem and Development

Traumatic events, such as abuse, the death of a parent, or witnessing violence, can damage children's self-esteem and lead to the stalling of or regression in the acquisition of developmental skills.

Tips

- Monitor children for significant and/or traumatic life events regularly. Asking parents questions such as "Have there been any changes in your family since our last visit?" may help elicit information about significant events such as divorce, deaths, and moves.

- Discuss the importance of supporting children who have been traumatized. Advise parents to give these children accurate, developmentally appropriate information; to encourage them to express their feelings; and to allow them to regress temporarily. Monitor the child for signs of emotional distress (e.g., changes in activity level, irritability, changes in eating and sleep patterns), and refer the child to a mental health professional if signs of distress or diminished functioning appear. (See the following bridge topics: Anxiety Disorders, p. 191; Mood Disorders: Depressive and Bipolar Disorders, p. 271; Mood Disorders: Special Topic: Childhood Grief/Bereavement, p. 283; Child Maltreatment, p. 213.)

FAMILY

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to family in early childhood:

For All Parents

How are things going in your family?

What do you do for fun as a family?

How are you and your partner managing David's behavior?

What do you do when you disagree on discipline?

Do you talk with each other about your child-rearing ideas?

Are your approaches similar and consistent?

What do you do when you become angry or frustrated with Cindy?

For Parents Expecting a New Child

Do you have other children? How are they getting along?

Have you talked to your children about your pregnancy?

Who will look after them while you are in the hospital?

FAMILY: COOPERATION

Learning to Cooperate

Children who feel loved and satisfied in their relationships are more willing to comply with rules and limits. During early childhood, children learn to balance their individual wants and growing independence with their relationships with parents and peers. Oppositionality or lack of cooperation can develop if children are not given enough autonomy, if their needs are not fulfilled, or if rules are inconsistently enforced.

Tips

■ Discuss ways to recognize and reinforce cooperation. (See Tool for Families: Charting Positive Behavior, *Mental Health Tool Kit,* p. 83.)

■ Help parents foster cooperation by encouraging them to develop routines and appropriate expectations for their child, and by building a nurturing relationship with him. (See Tool for Families: Guidelines for Special Time, *Mental Health Tool Kit,* p. 82.) Encourage parents to use approaches that encourage cooperation, such as making clear requests, praising the child for cooperating, and giving choices. Advise parents to avoid confrontations, shaming their child, or making requests that are inconsistent or confusing. (See Tool for Families: Communicating with Children, *Mental Health Tool Kit,* p. 84.)

■ Suggest that parents avoid directing their child to do something if they cannot follow through to ensure that the child completes the task. (See Tool for Families: Principles of Limit Setting, *Mental*

Health Tool Kit, p. 81.) To avoid reinforcing disobedient behavior, advise parents not to back down from directives to which the child refuses to respond. Suggest that parents reduce the number of requests, make sure requests are appropriate for the child's developmental level, and follow through on each one. Encourage parents to avoid nagging. Ask parents how the child's other caregivers gain the child's cooperation.

■ Monitor for excessive parental demands that do not respect the child's need for autonomy. Encourage parents to be selective in establishing rules. Determine expectations by asking parents, "What did your parents expect from you? What would happen if you didn't comply?" To begin a discussion of appropriate expectations, help parents recall the ages at which they were expected to do things.

■ Explore parents' feelings when their child reacts angrily to their directives. Parents who have difficulty tolerating their child's anger may have experienced overwhelming situations during their childhood, such as harsh discipline, abuse, or domestic discord. Help them differentiate between their current role and the past. Refer parents to a mental health professional for counseling as needed. (See the following bridge topics: Oppositional and Aggressive Behaviors, p. 291; Parental Depression, p. 303.)

■ If parents are inconsistent in following through on their directives, consider factors that may make them regard their child as special or vulnerable. Consider the child's history (e.g., history of a serious or recurrent illness, adoption history) as well as the parents' experiences with infertility,

miscarriage, or terminated pregnancies. (See Area of Concern: Vulnerable Child Syndrome, below.)

■ If children display excessive or consistent non-compliance, evaluate their hearing ability and level of development, especially in language skills, to determine whether they are able to respond to requests.

Area of Concern: Vulnerable Child Syndrome

Explore parents' feelings if they perceive their child as special or vulnerable, or if they have trouble tolerating their child's negative emotions. Ask parents, "How does your child's behavior make you feel? What does it make you worry about? What does your child's behavior remind you of in your past?" Taking a complete medical history is valuable because it may reveal infertility, fetal or newborn loss or other family losses, adoption history, or a history of serious illness, which may predispose parents to overprotect the child. A traumatic past may interfere with a parent's ability to allow the child to feel frustrated. To deal with such ghosts from the past, parents may need referral to a mental health professional for psychotherapy.

FAMILY: SIBLING RELATIONSHIPS

Siblings are a major influence on children's social development. Interactions with siblings provide extensive opportunities for conversing, fantasy play, sharing, negotiating, learning to manage aggression, and comparing gender roles and personal interests and skills. Sibling relationships, both supportive and antagonistic, can be the most lasting relationships in

a person's life. The primary care health professional can work with families to promote positive sibling relationships and address parental concerns.

Building Healthy Sibling Relationships

The relationships children have with their siblings are shaped by individual and family factors, including gender, temperament, and age of siblings; parental caregiving and discipline; and level of family stress.

Tips

■ Foster positive feelings for the newborn sibling or adopted sibling by encouraging parents to take sibling preparation classes. Encourage parents to

discuss with their other children what to expect when the newborn or adopted child comes home.

■ Advise parents not to force their other children to interact with a newborn.

■ Discuss ways parents can help their other children cope with the demands of a new sibling. (See Tool for Families: Helping Siblings Get Along, *Mental Health Tool Kit,* p. 86.)

■ Help parents recognize their feelings for each child to make them aware of how their feelings could affect sibling relationships. As you explore family dynamics, ask questions such as, "What are your children like?" "What unique characteristics do you notice in each of them?" "Who do you think each child takes after?" "How does each child fit your hopes or expectations?"

■ Encourage parents to respond to each child's unique needs while avoiding the perception by other siblings of preferential treatment.

Siblings and Socialization

By interacting with their siblings and observing how their parents respond to their siblings, children are provided with key opportunities to learn social skills such as empathy and the ability to negotiate and resolve conflicts. Children without siblings may need opportunities outside the family to gain these skills.

Tips

■ Help parents foster sibling cooperation by encouraging them to teach skills such as sharing, trading, and taking turns; providing chores and

games in which children work together; and encouraging noncompetitive activities. Encourage parents to positively reinforce successful interaction. (See Tool for Families: Charting Positive Behavior, *Mental Health Tool Kit,* p. 83.)

■ Encourage regular family meetings in which each family member can bring up concerns and conflicts in a supportive setting. (See Tool for Families: Family Meetings, *Mental Health Tool Kit,* p. 105.) Children as young as 3 years can participate in family meetings.

■ For children without siblings, discuss ways parents can provide opportunities to learn social skills (e.g., by arranging frequent play dates, spending time with extended family, becoming involved in community groups and activities).

Resources for Families

Aber LW. 1995. *101 Activities for Siblings Who Squabble: Projects and Games to Entertain and Keep the Peace.* New York, NY: St. Martin's Griffin.

Canter L, Canter M. 1993. *Surviving Sibling Rivalry: Helping Brothers and Sisters Get Along.* Santa Monica, CA: Canter and Associates. Phone: (800) 262-4347; Web site: http://www.canter.net/cn/books/parent/booklist.html.

Noble E, Sorger L. 1991. *Having Twins: A Parent's Guide to Pregnancy, Birth, and Early Childhood* (2nd ed.). Boston, MA: Houghton Mifflin.

Pickhardt CE. 1997. *Keys to Parenting the Only Child.* Hauppauge, NY: Barron's Educational Series.
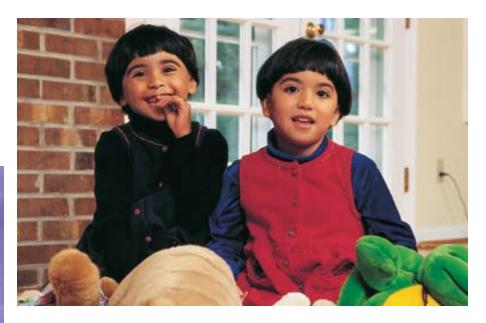
Sibling Rivalry

Rivalry among siblings is almost universal. Parents should differentiate between milder forms of conflict that siblings can resolve on their own and more damaging forms of conflicts, such as bullying and physical aggression, recognizing that parental intervention can sometimes escalate sibling disputes. (See Tool for Families: Helping Siblings Get Along, *Mental Health Tool Kit,* p. 86.)

Tips

■ Discuss ways of dealing with sibling squabbles and fighting. Encourage parents to set clear limits regarding physical and verbal aggression between siblings. (See Tool for Families: Helping Siblings Get Along, *Mental Health Tool Kit,* p. 86.)

■ Advise parents to allow children to solve problems with siblings on their own whenever possible. Parents can help children learn how to negotiate fairly. If parents must intervene, the situation can be reviewed later, encouraging children to generate constructive solutions and helping them reflect on the feelings of others.

■ Assess children who are frequently implicated as the source of sibling conflict for underlying difficulties such as unrealistic parental expectations for their behavior, or mental disorders such as attention deficit hyperactivity disorder or mood disorders. (See the following bridge topics: Attention Deficit Hyperactivity Disorder, p. 203; Mood Disorders: Depressive and Bipolar Disorders, p. 271.)

■ Assess families with high levels of sibling conflict for stress, especially marital conflict and differences over discipline strategies.

■ Ask parents about their relationships with their own siblings.

■ Ask children ages 3 and older about their relationships with their siblings, what their parents do when they fight with their siblings, and whether they think they are treated fairly.

■ Be alert for the need to protect vulnerable children.

FRIENDS

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to friendships in early childhood:

Does Tommy show an interest in other children?

Does he have playmates?

Does Yolanda have a will of her own?

How does she show that?

How is child care going?

FRIENDS: SOCIALIZATION

During early childhood, children learn to socialize and to follow social rules. The ability to manage strong feelings without losing control develops gradually. Regression can occur during stressful situations, such as when children are hungry, tired, or ill. Early childhood is a time when children gain the language skills they need to communicate verbally instead of through tantrums or aggression. Experience with siblings and peers teaches children to share, take turns, negotiate, wait patiently, understand others, deal with aggressive feelings in themselves and aggressive behavior in others, become assertive without causing harm, and develop friendships. After age 3, children have the capacity for communicating empathy, a critical skill for establishing and maintaining good interpersonal relationships throughout life.

Learning Socialization Skills with Family

The first and perhaps most potent learning experiences about how people should treat one another come from observing and participating in interactions within the family.

Tips

■ Discuss with parents the importance of demonstrating self-control, verbalizing emotions, and using conflict resolution skills with their child. Although children can benefit from seeing their parents constructively negotiate disagreements, overt arguments between parents should be held out of earshot of their children.

■ Encourage parents to express affection, concern, and caring in front of their child. Also discuss with parents that being openly affectionate with each other will help their child learn that the characteristics of their parents' relationship are different from those in the parent-child relationship.

■ Encourage parents to listen actively to their child to help her verbalize emotions. (See Tool for Families: Communicating with Children, *Mental Health Tool Kit*, p. 84.)

■ Advise parents to allow children to solve problems with siblings and peers on their own whenever possible. Parents can help children learn how to negotiate fairly. If parents must intervene, the situation can be reviewed later, encouraging children to generate constructive
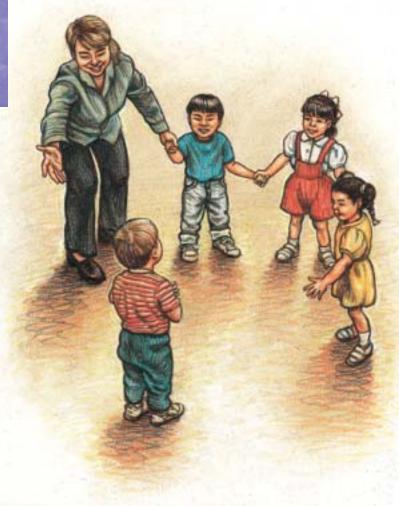
solutions and helping them reflect on the feelings of others.

Resources for Families

Coleman WL, Lindsay RL. 1998. Making friends: Helping children develop interpersonal skills. *Contemporary Pediatrics* 15(8):111–129.

Faber A, Mazlish E. 1999. *How to Talk So Kids Will Listen and Listen So Kids Will Talk* (20th anniversary ed., updated). New York, NY: Avon Books.

Fraiberg SH. 1959. *The Magic Years: Understanding and Handling the Problems of Early Childhood.* New York, NY: Scribner.

Learning Socialization Skills with Peers

Early childhood is a key time for children to gain social skills through peer interaction. Before age 3, children have limited ability to interact with other children, but they can still enjoy spending time with peers. After age 3, social experience with other children is important for the acquisition of social skills.

Tips

■ Encourage social learning through supervised experiences with other children (e.g., child care or preschool, organized play groups, activities at places of worship). Parents can begin by remaining with their child for 10 minutes and gradually separating for increasing lengths of time. Children can usually cope with groups with the same number of children as their age in years.

■ Explain that social experiences should ideally include children of both genders, with a variety of physical characteristics, and from a cross-section of racial, socioeconomic, and cultural backgrounds, because experiences in early childhood form the basis of the child's understanding of others.

Resources for Families

Berenstain S, Berenstain J. 1993. *The Berenstain Bears and the Wheelchair Commando.* New York, NY: Random House.

Cairo S, Cairo J, Cairo T. 1985. *Our Brother Has Down's Syndrome.* Toronto, Ontario, Canada: Annick Press.

Charles N. 1994. *What Am I?* New York, NY: The Blue Sky Press.

Lears L. 1998. *Ian's Walk: A Story About Autism.* Morton Grove, IL: Albert Whitman.

Medearis AS. 1991. *Dancing with the Indians.* New York, NY: Holiday House.

Starowitz AM. 1988. *The Day We Met Cindy.* Washington, DC: K. Green Publications.

■ Advise parents to supervise their child closely and to ensure that their child avoids frequent contact with playmates who are excessively aggressive.

Area of Concern: Difficulty Forming Friendships

For shy children or children who have difficulty making friends, suggest low-stress, structured play dates such as inviting a friend over to watch a movie, help make cookies, play with play dough, go to the zoo, or go duckpin bowling. Help parents reinforce appropriate social behaviors to help build children's social skills. (See Tool for Families: Charting Positive Behavior, *Mental Health Tool Kit,* p. 83.) A short, successful play date is better than one that lasts too long.

Resources for Families

Keats EJ. 1975. *Louie.* New York, NY: Greenwillow Books.

Mathers P. 1991. *Sophie and Lou.* New York, NY: Harper Collins.

McCully EA. 1991. *Speak Up, Blanche!* New York, NY: Harper Collins.

Udry JM. 1996. *What Mary Jo Shared.* Orlando, FL: Harcourt Brace.

Wells R. 1988. *Shy Charles.* New York, NY: Dial Books for Young Readers.

Zolotow C. 1988. *A Tiger Called Thomas* (2nd ed.). New York, NY: Lothrop, Lee & Shepard Books.

Learning Self-Control of Aggressive Feelings

Aggressive feelings and behaviors are a normal aspect of development in early childhood, with peaks at 18 months, $2^1/_2$ years, and 4 years. Assertiveness is an important skill that must be distinguished from aggression, which may hurt others. Parents need to provide feedback to children so that they can learn this distinction, but need to do so without shaming or punishing children, which can inhibit assertiveness. Children who are impulsive often have greater difficulty managing their aggressive feelings. (See bridge topic: Attention Deficit Hyperactivity Disorder, p. 203.) Witnessing or experiencing aggression in the home, school, or community or viewing it in the media can increase a child's aggression. Failure to meet the child's basic needs can also foster aggression.

Tips

■ Advise parents to support and provide outlets for their children's harmless aggressive energy, such as playing with modeling clay, throwing balls, crashing toy cars, wrestling, running, swimming, and jumping. These outlets are especially needed for

children who are very physical in their behavior. Some parents may need extra assistance in understanding aggression, especially if they have other children who exhibit little aggressive behavior. If children exhibit too much or too little aggressive energy, recommend that parents enroll them in a preschool karate class or other physical activity program. Such programs can help teach children self-control, help them understand appropriate use of aggression, and help them build self-esteem. Shy children may need smaller classes and teachers with a nurturing style.

■ Discuss that most children enjoy roughhousing with parents and siblings. Encourage parents to monitor roughhousing to ensure that no one gets hurt or feels threatened.

■ Advise parents to help children express their feelings and talk about negative emotions rather than act on them in a way that might harm others. Parents who feel that expressing strong emotions is unacceptable or disrespectful may need assistance in determining an acceptable outlet for their child. To help parents see the consequences of inhibiting the expression of strong emotions, ask, "How were strong emotions handled when you were a child?" "What did you do with your strong feelings?" "How did that make you feel?"

■ Recommend that parents respond to their child's excessive aggression promptly and calmly, showing their disapproval. Advise parents to remove any objects the child used aggressively, have the child take a time out, and make brief statements such as "No hitting. Hitting hurts people." These strategies should gradually reduce aggression, unless being aggressive is the child's main way of getting attention. (See Area of Concern: Chronically Aggressive Children, p. 73. See Tool for Families: Time Out, *Mental Health Tool Kit,* p. 88.)

■ Encourage parents to teach children negotiating strategies for getting what they want, including asking, trading, taking turns, and making a game out of a situation (e.g., flipping a coin to determine who gets to play with the toy, racing to the swing to determine who gets to use it first).

■ Discuss with parents ways to discipline their child without the use of corporal punishment so that they avoid fostering and modeling aggressive behavior. (See Tool for Health Professionals: How to Help Families Stop Spanking, *Mental Health Tool Kit,* p. 32.)

Resource for Health Professionals

Stein MT, Perrin EL. 1998. Guidance for effective discipline. *Pediatrics* 101(4 pt. 1):723–728.

Resources for Health Professionals and Families

Hyman IA. 1997. *The Case Against Spanking: How to Discipline Your Child Without Hitting.* San Francisco, CA: Jossey-Bass Publishers.

Straus MA, Donnelly DA. 2000. *Beating the Devil Out of Them: Corporal Punishment in American Families and Its Effects on Children* (2nd ed.). New Brunswick, NJ: Transaction Publishers.

- Ensure that parents are thoughtful about their child's exposure to media violence at home and at child care or preschool.

- If parents appear to have difficulty modulating their anger and therefore serving as positive role models for their child, assess the basis for the parents' anger. Ask parents to describe situations that make them angry, how often they get angry, and what they do when they are angry. Screening tools such as the Parent Stress Index (PSI) (Abidin, 1990) can be used to identify particular stressors. Consider referring parents who have difficulty modulating their anger to parent groups (e.g., Parents Anonymous, Children with Hyperactivity and Attention Deficit Disorder (CHADD), Alcoholics Anonymous, Al-Anon), social service agencies, or a mental health professional. (See bridge topic: Child Maltreatment, p. 213.)

Area of Concern: Chronically Aggressive Children

For chronically aggressive children who do not respond to the aforementioned strategies, assess and address potential contributing factors: life stresses; neglect or abuse at home or in child care or preschool; inadequate sleep; disruptions in routines; exposure to aggression, including domestic violence; skill deficits, especially in expressive language or fine motor areas; hearing loss; and signs of hyperactivity/impulsivity or depression. (See the following bridge topics: Oppositional and Aggressive Behaviors, p. 291; Child Maltreatment, p. 213.)

Evaluate families for overt and covert encouragement of aggression. Elicit detailed examples of how parents respond to aggression to determine if they foster it by ignoring it, speak of it as a sign of strength, suggest using it as a problem-solving strategy, or argue openly about it.

Area of Concern: Chronic Biting

Most children do not bite people. Some 1- to 2-year-olds do bite, but by ages 3 to 4 biting is not a common behavior. Evaluate chronic biters for stressors such as multiple caregivers; hunger or fatigue; sources of pain such as teething, otitis, or headache; inadequate skills for their social group, especially expressive language ability; delays in the development of impulse control; and family stress or violence. For children ages 1 to 2, suggest a teething ring as an alternative for biting. For older children, counsel parents to firmly forbid biting (e.g., by saying, "Biting is not allowed. I don't want you to bite anyone ever. If you want something, ask for it. Ask someone to help you. Don't bite."). Advise parents to ask other caregivers to reinforce this message.

Emphasize that it is important to prevent biting, because once biting occurs, the reactions of others can reinforce the behavior. Work with parents to identify situations in which the child is most likely to bite, and assist parents in developing strategies to help the child avoid these situations. Other caregivers can help identify these situations as well and help the child avoid them. Ensure that the child is receiving praise and attention for acceptable behavior in all settings.

If the child does bite, advise parents to reinforce the message "It's not okay to bite. Ask when you want something." Recommend that parents or other caregivers remove the child promptly for a brief time out. Caregivers should pay immediate attention to the biting victim. If biting persists, a smaller child care setting may be helpful. Consider referral to a mental health professional for further evaluation as indicated.

COMMUNITY

Following are health supervision interview questions from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* relevant to community/school in early childhood:

How is Darryl doing in preschool?

What does his teacher say about him?

What is he especially good at?

Do you have any specific concerns about Nora's learning ability or behavior?

Is there anything you would like to discuss or have me examine before she goes to school?

COMMUNITY: SCHOOL READINESS

School readiness involves a variety of capacities, positive self-esteem, and motivation. The characteristics required for success may differ with the demands of particular school environments. Schools should be sensitive to the needs of children with varying abilities and individual styles. Some children may have academic needs, temperaments, or learning styles that are not attuned to the predominant mode of teaching in their school. Potential consequences of not being ready for school include emotional strain, difficulty in developing social relationships, and loss of motivation, as well as inappropriate labeling by adults, which can lead to decreased motivation and diminished expectations for performance.

Parents' Role in School Readiness

Parents can encourage their children to participate in activities that will help them enjoy learning and be ready to acquire academic skills. The earliest roots of readiness come from parents' responsiveness to their children, parents' encouragement of their children's curiosity and motivation, and children's exploration of imagination and problem solving through pretend play. In addition, parents can help their children get ready for school by reading to them in a warm, nurturing context. Children should be able to enjoy, at least for short periods of time, cooperative work and play with other children. Parents should take every opportunity to foster a positive attitude toward learning, particularly by sharing their own joy of learning. Children, especially those with learning problems, are better able to cope with

the inevitable frustrations of the classroom if they are experiencing success in one area of school or in a domain outside school. (See the following Tools for Families in the *Mental Health Tool Kit:* Parents' Checklist for School Entry and After, p. 89; Preparing Your Child for School, p. 90; Preparation for School Entry: Communication Skills, p. 91. See *Bright Futures Case Studies for Primary Care Clinicians:* School Readiness: Jesse and the School Quandary: Ready, Set, Go? [Albers and Knight, 2001] at http://www.pedicases.org.)
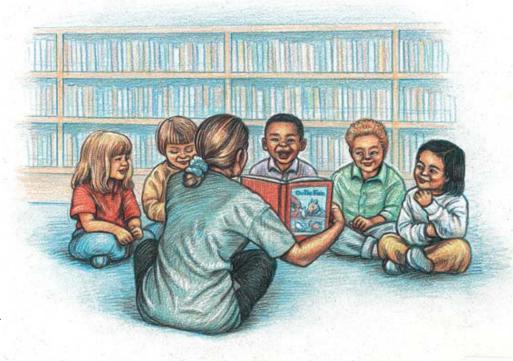
Tips

■ Advise parents to encourage pretend play at home and in their child's preschool or child care setting. Pretend play is a precursor to literacy as it progressively becomes less dependent on action and objects and more on ideas, imagination, and language, which are the foundation for storytelling, writing, and reading. Therefore, an emotionally supportive preschool or child care program that encourages pretend play helps foster school readiness. (See the following Tools for Families in the *Mental Health Tool Kit:* Stimulating Environments, p. 72; Safe, Quality Child Care, p. 74.)

■ Emphasize the importance of reading to children and discussing what they have been read. Consider establishing a practice-based reading program such as Reach Out and Read. (See Resource for Health Professionals, p. 76.) Recommend

books on relevant family issues or child difficulties (e.g., books about a new baby coming or a grandparent dying). Consider making such resources available in the office or providing access to a computer in the waiting room where parents can search for such resources.

■ Encourage parents to develop their child's prereading skills by showing the child that words are composed of component sounds that match up with letters. A number of computer programs for children include games aimed at heightening phonetic awareness (e.g., the Reader Rabbit series).

■ Encourage parents to make learning fun by focusing on areas that have already attracted their child's interest and attention (e.g., reading logos for fast food restaurants, counting the days until a birthday).

■ Encourage parents to visit preschools and child care centers before enrolling their child. Advise parents, particularly parents of shy children, to seek potential classmates for the child to play with before preschool or child care begins to improve their child's initial comfort and adaptation to the new setting.

■ Ask parents about their child's TV viewing habits and recommend clear boundaries on the amount and type of viewing. Encourage parents to watch and discuss some programs with their child.

■ Discuss the concept of "multiple intelligences" with parents (Gardner, 1993). Encourage the development of their child's potential talents (e.g., musical, athletic, creative, visual/spatial, interpersonal). Preschool-age children should be exposed to a variety of situations and opportunities for learning so that their talents become evident. Help parents make choices regarding how their time and finances should be spent toward the important goal of nurturing these talents.

Resource for Health Professionals

Reach Out and Read, 29 Mystic Avenue, Sommerville, MA 02145. Phone: (617) 629-8042; Web site: http://www.reachoutandread.org.

School Readiness: Identifying Children at Risk for Problems in Succeeding at School

Currently no measure exists that can identify all children who are at risk for problems at school entry. Screening tests can and should be used to identify children who may need further evaluation and special services because of disabilities such as mental retardation or speech and language disor-

ders. Given limitations in test sensitivity, multiple measures should be used to identify children who may qualify for special services. Early identification and intervention are important for children with emerging learning disabilities, such as dyslexia, as well as for children with emotional or attentional problems that may interfere with learning. (See *Bright Futures Case Studies for Primary Care Clinicians:* Global Delay: Will David Catch Up? [Deutsch and Frazer, 2001] at http://www.pedicases.org. See the following bridge topics: Attention Deficit Hyperactivity Disorder, p. 203; Learning Problems and Disorders, p. 251; Mental Retardation, p. 261; Pervasive Developmental Disorders, p. 317.)

Tips

■ Ask parents open-ended questions to uncover any areas of concern they may have about their child (e.g., "What specific concerns do you have about your child's learning ability or behavior?" "What do you think will be his biggest challenge in adjusting to kindergarten?") as well as specific questions about their child's skills (e.g., "Does your child know her ABCs and colors?"). (See Tool for Families: Learning Disabilities: Common Signs, *Mental Health Tool Kit,* p. 143.) Consider using a system of specific observations such as the Simultaneous Test for Acuity and Readiness Test (START) (Sturner et al., 1994).

■ Talk directly to the child to develop rapport and to observe the child's communication skills. It is useful to find a conversation piece that the child is interested in at the moment. A structured approach is to interview the child about a human figure drawing he creates in the office. (See Tool for Health Professionals: Suggested Child Interview Using a Human Figure Drawing As a Conversation Piece, *Mental Health Tool Kit,* p. 33.)

■ Consider using the Sentence Repetition Screening Test (Sturner et al., 1996) if concerns arise about the child's speech and language abilities. This test can assess articulation ability as well as language ability, because preschool-age children tend to omit grammatical forms they have not yet incorporated into their own "inner language processor" when repeating phrases or sentences. Refer children who do poorly on screening for further speech and language evaluation.

■ Watch for signs of potential reading disabilities, such as trouble with phoneme awareness (i.e., difficulty with tasks such as breaking words into sound segments or discrete phonemes). (See the following Tools in the *Mental Health Tool Kit:* Tool for Health Professionals: Risk Factors for Dyslexia, p. 34; Tool for Families: Learning Disabilities: Common Signs, p. 143. See bridge topic: Learning Problems and Disorders, p. 251.)

■ Identify children early who should be considered for further testing or follow-up. (See the following bridge topics: Attention Deficit Hyperactivity Disorder, p. 203; Learning Problems and Disorders, p. 251; Mental Retardation, p. 261; Pervasive Developmental Disorders, p. 317.) Refer for further educational assessment as indicated.

■ Establish collaborative relationships with staff at community early intervention agencies and with school personnel, including special education staff, school psychologists, and school counselors.

■ Provide parents with information on early intervention services in the community and offer to participate in the child's Individualized Family Service Plan (IFSP) (ages 0–3) or Individualized Education Program (IEP) (ages 3 and up). (See Tool for Families: Individualized Education Program [IEP] Meeting Checklist, *Mental Health Tool Kit,* p. 120.) The IEP and IFSP are required under the Individuals with Disabilities Education Act (IDEA), Part B, Assistance for Education of All Children with Disabilities, and Part C, Infants and Toddlers with Disabilities, respectively. The IFSP and IEP document the child's (and family's, in the case of the IFSP) current level of functioning, establish goals, and delineate the services needed to meet those goals. Ensure that parents know that their child may also qualify for services under Section 504 of the Rehabilitation Act.

For further information about eligibility and services, families can consult the community's early intervention agency, the school's special education coordinator, the local school district, the state department of education's special education division, the U.S. Department of Education's Office of Special Education Programs (http://www.ed.gov/offices/OSERS/OSEP), the IDEA '97 Web site (http://www.ed.gov/offices/OSERS/IDEA), or the U.S. Justice Department's Civil Rights Division (http://www.usdoj.gov/crt/edo).

Resources for Families

Elovson AC. 1993. *The Kindergarten Survival Handbook: The Before School Checklist and a Guide for Parents.* Santa Monica, CA: Parent Education Resources.

Karnofsky F, Weiss T. 1993. *How to Prepare Your Child for Kindergarten.* Carthage, IL: Fearon Teacher Aids. Available from Frank Schaffer Publications, Catalog No. FE0932, 23740 Hawthorne Boulevard, Torrance, CA 90505-5927. Phone: (800) 421-5533; Web site: http://www.frankschaffer.com/catalog.html.

OFFICE PRACTICES TO PROMOTE
FAMILY PARTNERSHIP

Self-Control

❍ Set up the waiting room and exam rooms so that they are safe for children to explore and so that they take into consideration waiting behavior typical of young children (e.g., provide children with space to move around in and toys and books to play with; place dangerous objects out of reach).

❍ Train office staff to observe and note parents' discipline practices and to model for parents appropriate expectations for behavior in early childhood.

❍ Encourage office staff to verbally acknowledge and offer rewards (e.g., stickers) for any self-control children exhibit while undergoing medical procedures and in coping with the stress of the visit. Emphasize that shaming is never appropriate. Encourage staff to praise children for verbally expressing their pain or fear.

❍ Place toys and books in the waiting room and exam rooms to facilitate observation of interactions between the parents and the child, the child and siblings, and the child and other children. Comment on the interactions or play you see as a way of eliciting parent perceptions of the child (e.g., "I noticed that your child was playing with another child in the waiting room. How do you think he gets along with other children?").

Self-Esteem

❍ Ensure that your office restroom is set up to facilitate independent self-care, such as providing stools for the toilet and sink, easy-to-use faucet handles, accessible towels and soap, and child-friendly reminders to flush the toilet and wash hands.

❍ Be sensitive and responsive to regressions in behavior and to the difficulty in separating from parents, which many children exhibit under the stress of medical appointments. Techniques include approaching children slowly; greeting them and complimenting their clothes or possessions; suggesting that parents stay with, hold, and reassure frightened children; and conducting the exam slowly while describing each step and how it will feel.

❍ To help children who have trouble dealing with office visits, invite them back for social visits so that they can play in the waiting room and receive a sticker or treat. Providing toy doctor bags and doll "patients" to get "shots" can be helpful. If possible, stretch exams and needle sticks across visits. Do only what children can handle in a first visit. Affirm children's mastery of the experience, and schedule return visits as necessary.

❍ Ensure that office staff respect the cultural diversity of families. Show respect for cultural differences by asking about each family's background and approaches to childrearing and by incorporating their preferences into care plans.

❍ Incorporate cultural diversity in the artwork displayed in the office.

❍ Encourage families to get to know other families and children with similar cultural backgrounds, disabilities, or health conditions. Place a community bulletin board in the office, or offer the waiting room for group meetings. Keep a list of resources, such as parent support groups and organized play groups, on the bulletin board.

Siblings

❍ Treat siblings as individuals. Offer privacy for interviewing and examining each child even if the family came together.

❍ Provide resources regarding sibling relationships including catalogs of noncompetitive games, instructions for special time, and books about sibling relationships.

School Readiness

❍ Learn about the policies of local schools on screening, transition classes, retention, and acceleration.

❍ Set up a Reach Out and Read program in your office. Contact Reach Out and Read, 29 Mystic Avenue, Sommerville, MA 02145. Phone: (617) 629-8042; Web site: http://www.reachout andread.org.

❍ Set up a network (e.g., bulletin board, parent group) for exchange of information on local preschools and child care providers.

❍ Have access to the Web site of the local library to locate children's books and resources on specific topics for parents.

COMMUNITY PRACTICES TO PROMOTE MENTAL HEALTH IN EARLY CHILDHOOD

❍ Support quality services for children, including child care, Early Head Start, mental health services, Head Start, preschool, small kindergarten class sizes, after-school care, and other educational opportunities. Encourage parents to advocate for these services.

❍ Empower parents to advocate for their children's special needs. Recognize parents' efforts through newsletters, bulletin boards, ceremonies to honor them, and certificates.

❍ Encourage connections among parents whose children have similar needs through the Internet and the community (e.g., schools, community centers, faith-based organizations). Ask parents to share their resources with you so that you can pass these along to other families.

❍ Consider serving as a consultant or board member of agencies that serve children in early childhood and their families.

❍ Encourage local hospitals to establish prenatal sibling preparation classes.

❍ Report inefficiencies and inequities in mental health services to effect change (e.g., by contacting insurance administrators if needed mental health services are not covered).

❍ Support organizations that serve children (e.g., YMCA, YWCA, Early Head Start, faith-based organizations) by making referrals or contributing time, money, or expertise.

Selected Bibliography

Introduction

Green M, Palfrey JS, eds. 2000. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd ed.). Arlington, VA: National Center for Education in Maternal and Child Health.

Self

Adair RH, Bauchner H. 1993. Sleep problems in childhood. *Current Problems in Pediatrics* 23(4):147–470.

Brazelton TB. 1962. A child-oriented approach to toilet training. *Pediatrics* 29(1):121–128.

Carey WB, Jablow MM. 1997. *Understanding Your Child's Temperament.* New York, NY: Macmillan.

Carey WB, McDevitt SC. 1995. *Coping with Children's Temperament: A Guide for Professionals.* New York, NY: Basic Books.

Carnegie Task Force on Meeting the Needs of Young Children. 1994. *Starting Points: Meeting the Needs of Our Youngest Children.* New York, NY: Carnegie Corporation of New York.

Christophersen ER. 1991. Toileting problems in children. *Pediatric Annals* 20(5):240–244.

Damon W. 1988. *The Moral Child: Nurturing Children's Natural Moral Growth.* New York, NY: Free Press.

Deutsch A, Frazer C. 2001. Global delay: Will David catch up? In Knight JR, Frazer C, Emans SJ, eds., *Bright Futures Case Studies for Primary Care Clinicians: Child Development and Behavior.* Boston, MA: Bright Futures Center for Education in Child Growth and Development, Behavior, and Adolescent Health. Web site: http://www.pedicases.org.

Ferber R. 1985. *Solve Your Child's Sleep Problems.* New York, NY: Simon & Schuster.

Green M, Palfrey JS, eds. 2000. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd ed.). Arlington, VA: National Center for Education in Maternal and Child Health.

Kemper KJ, Kelleher KJ. 1996. Family psychosocial screening: Instruments and techniques. *Ambulatory Child Health* 1(4):325–339.

Lozoff B, Wolf AW, Davis NS. 1985. Sleep problems seen in pediatric practice. *Pediatrics* 75(3):477–483.

McDevitt SC, Carey WB. 1978. The measurement of temperament in 3- to 7-year-old children. *Journal of Child Psychology and Psychiatry and Allied Disciplines* 19(3):245–253. A series of five age-appropriate questionnaires further defining temperament, including the Behavioral Style Questionnaire for 3- to 7-year-olds, is available from Behavioral-Development Initiatives (Phone: [800] 405–2313; Web site: http://www.b-di.com) and TemperaMetrics (Phone: [800] 234-8303).

Needleman R, Howard B, Zuckerman B. 1989. Temper tantrums: When to worry. *Contemporary Pediatrics* 6(8):12–34.

Rappaport LA, Levine MD. 1986. The prevention of constipation and encopresis: A developmental model and approach. *Pediatric Clinics of North America* 33(4):859–869.

Sattler JM. 2001. *Assessment of Children: Cognitive Applications* (4th ed.). San Diego, CA: J. M. Sattler.

Schmitt BD. 1985. When baby just won't sleep. *Contemporary Pediatrics* 2(5):38–52.

Sparrow S, Balla DA, Cicchetti DV. 1984. *Vineland Adaptive Behavior Scales (VABS).* Circle Pines, MN: American Guidance Service.

Story M, Holt K, Sofka D, eds. 2000. *Bright Futures in Practice: Nutrition.* Arlington, VA: National Center for Education in Maternal and Child Health.

ZERO TO THREE: National Center for Infants, Toddlers, and Families. 1994. *Diagnostic Classification, 0–3: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.* Washington, DC: ZERO TO THREE: National Center for Infants, Toddlers, and Families.

Family

Barkley RA. 1997. *Defiant Children: A Clinician's Manual for Assessment and Parent Training* (2nd ed.). New York, NY: Guilford Press.

Boer F, Dunn J. 1992. *Children's Sibling Relationships: Developmental and Clinical Issues.* Hillsdale, NJ: L. Erlbaum Associates.

Dunn J. 1985. *Sisters and Brothers.* Cambridge, MA: Harvard University Press.

Dunn J. 1988. Sibling influences on childhood development. *Journal of Child Psychology and Psychiatry* 29(2):119–127.

Dunn J, Kendrick C. 1982. *Siblings: Love, Envy, and Understanding.* Cambridge, MA: Harvard University Press.

Faber A, Mazlish E. 1998. *Siblings Without Rivalry: How to Help Your Children Live Together So You Can Live Too* (10th ed.). New York, NY: Avon Books.

Faber A, Mazlish E. 1999. *How to Talk So Kids Will Listen and Listen So Kids Will Talk* (20th anniversary ed., updated). New York, NY: Avon Books.

Fortier JC, Carson VB, Will S, et al. 1991. Adjustment to a newborn. Sibling preparation makes a difference. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 20(1):73–79.

Lamb ME, Sutton-Smith B. 1982. *Sibling Relationships: Their Nature and Significance Across the Lifespan.* Hillsdale, NJ: L. Erlbaum Associates.

Patterson GR. 1976. *Living with Children: New Methods for Parents and Teachers* (rev. ed.). Champaign, IL: Research Press. Department 20W, P.O. Box 9177, Champaign, IL 61826. Phone: (800) 519-2707.

Schachter FF, Stone RK. 1987. *Practical Concerns About Siblings: Bridging the Research-Practice Gap.* New York, NY: Haworth Press.

Friends

Abidin RR. 1990. *Parenting Stress Index: Manual* (3rd ed.). Charlottesville, VA: Pediatric Psychology Press.

Canter L, Canter M. 1996. *Assertive Discipline for Parents* (rev. ed.). New York, NY: Perennial.

Christophersen ER. 1986. Anticipatory guidance on discipline. *Pediatric Clinics of North America* 33(4):789–798.

Coleman WL, Lindsay RL. 1992. Interpersonal disabilities: Social skill deficits in older children and adolescents. Their description, assessment, and management. *Pediatric Clinics of North America* 39(3):551–567.

Coleman WL, Lindsay RL. 1998. Making friends: Helping children develop interpersonal skills. *Contemporary Pediatrics* 15(8):111–129.

Dunn J. 1993. *Young Children's Close Relationships: Beyond Attachment.* Newbury Park, CA: Sage Publications.

Howard BJ. 1991. Discipline in early childhood. *Pediatric Clinics of North America* 38(6):1351–1369.

Howard BJ. 1996. Advising parents on discipline: What works. *Pediatrics* 98(4 pt. 2):809–815.

Howard BJ, Sturner RA. 1994. *Pediatric Behavioral Problems: AAFP Home Study Self-Assessment* (Monograph 186). Kansas City, MO: American Academy of Family Physicians.

Hyman IA. 1995. Corporal punishment, psychological maltreatment, violence, and punitiveness in America: Research, advocacy, and public policy. *Applied and Preventive Psychology* 4(2):113–130.

Lieberman AF. 1993. *The Emotional Life of a Toddler.* New York, NY: Free Press.

Spencer MB, Brookins GK, Allen WR. 1985. *Beginnings: The Social and Affective Development of Black Children.* Hillsdale, NJ: L. Erlbaum Associates.

Straus MA, Donnelly DA. 2000. *Beating the Devil Out of Them: Corporal Punishment in American Families and Its Effects on Children* (2nd ed.). New Brunswick, NJ: Transaction Publishers.

Webster-Stratton C, Hollinsworth T, Kolpacoff M. 1989. The long-term effectiveness and clinical significance of three cost-effective training programs for families with conduct problem children. *Journal of Consulting and Clinical Psychology* 57(4):550–553.

Community

Albers L, Knight JR. 2001. School readiness: Jesse and the school quandary: Ready, set, go? In Knight JR, Frazer C, Emans SJ, eds., *Bright Futures Case Studies for Primary Care Clinicians: Child Development and Behavior.* Boston, MA: Bright Futures Center for Education in Child Growth and Development, Behavior, and Adolescent Health. Web site: http://www.pedicases.org.

Carnegie Task Force on Meeting the Needs of Young Children. 1994. *Starting Points: Meeting the Needs of Our Youngest Children.* New York, NY: Carnegie Corporation of New York.

Cavanaugh DA, Lippitt J, Moyo O. 2000. Resource guide to selected federal policies affecting children's social and emotional development and their readiness for school. In *Off to a Good Start: Research on the Risk Factors for Early School Problems and Selected Federal Policies Affecting Children's Social and Emotional Development and Their Readiness for School.* Chapel Hill, NC: University of North Carolina, FPG Child Development Center. Available from the National Institute of Mental Health, Office of Communications and Public Liaison. Phone: (301) 443-4513; Web site: http://www.nimh.nih.gov/childhp.

Deutsch A, Frazer C. 2001. Global delay: Will David catch up? In Knight JR, Frazer C, Emans SJ, eds., *Bright Futures Case Studies for Primary Care Clinicians: Child Development and Behavior.* Boston, MA: Bright Futures Center for Education in Child Growth and Development, Behavior, and Adolescent Health. Web site: http://www.pedicases.org.

Farran DC, Shonkoff JP. 1994. Developmental disabilities and the concept of school readiness. *Early Education and Development* 5(2):141.

Gardner H. 1993. *Frames of Mind: The Theory of Multiple Intelligences* (10th anniversary ed.). New York, NY: Basic Books.

Huffman LC, Mehlinger SL, Kerivan AS. 2000. Risk factors for academic and behavioral problems at the beginning of school. In *Off to a Good Start: Research on the Risk Factors for Early School Problems and Selected Federal Policies Affecting Children's Social and Emotional Development and Their Readiness for School.* Chapel Hill, NC: University of North Carolina, FPG Child Development Center. Available from the National Institute of Mental Health, Office of Communications and Public Liaison. Phone: (301) 443-4513; Web site: http://www.nimh.nih.gov/childhp.

Jirgal D, Bouma K. 1989. A sensory integration observation guide for children from birth to 3 years of age. *Sensory Integration Special Interest Section Newsletter* 12(2).

Peth-Pierce R. 2000. *A Good Beginning: Sending America's Children to School with the Social and Emotional Competence They Need to Succeed.* Chapel Hill, NC: University of North Carolina, FPG Child Development Center. Available from the National Institute of Mental Health, Office of Communications and Public Liaison. Phone: (301) 443-4513; Web site: http://www.nimh.nih.gov/childhp.

Sturner RA, Howard BJ. 1997. Preschool development. Part I: Communicative and motor aspects. *Pediatrics in Review* 18(9):291–301.

Sturner RA, Howard BJ. 1997. Preschool development. Part II: Psychosocial/behavioral development. *Pediatrics in Review* 18(10):327–336.

Sturner RA, Funk SG, Green JA. 1994. Simultaneous Technique for Acuity and Readiness Testing (START): Further concurrent validation of an aid for developmental surveillance. *Pediatrics* 93(1):82–88. Available from START, Center for Promotion of Child Development Through Primary Care, 798 Cool Glade Court, Millersville, MD 21108.

Sturner RA, Funk SG, Green JA. 1996. Preschool speech and language screening: Further validation of the Sentence Repetition Screening Test. *Journal of Developmental and Behavioral Pediatrics* 17(6):405–413. Available from the Center for Promotion of Child Development Through Primary Care, 798 Cool Glade Court, Millersville, MD 21108.

EARLY CHILDHOOD CHECKLIST

The following list highlights key topics to consider in promoting mental health in early childhood. These topics may be discussed selectively during office visits, depending on the needs of the child and family.

Self

☐ Sleep patterns and bedtime routines

☐ Eating, including
- Healthy eating
- Self-feeding
- Picky eating
- Family meals

☐ Toilet learning, including
- Signs of readiness
- Parents' concerns
- Children's fears

☐ Self-care, including
- Encouragement of independence in feeding, dressing, and bathing

☐ Emotions, including
- Increasing self-control
- Tantrums
- Aggression
- Fears

Family

☐ Parent-child relationship, including
- Self-esteem
- "Goodness-of-fit" between parents' expectations and child's temperament
- Praise
- Limit setting
- Discipline

☐ Sibling relationships, including
- Preparation for new siblings
- Cooperation
- Conflict resolution

Friends

☐ Playmates (typically 3 years of age and older)

Community

☐ School readiness

☐ Child care

Bridges

☐ Opportunities for early identification and intervention, including
- Anxiety disorders
- Attention deficit hyperactivity disorder (ADHD)
- Child maltreatment
- Domestic violence
- Learning disorders
- Mental retardation
- Mood disorders (depression and bipolar disorder)
- Obesity
- Oppositional and aggressive behaviors
- Parental depression
- Pervasive developmental disorders