ZERO TO THREE®

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Supporting Children With Emotional and Behavioral Challenges

THIS ISSUE AND WHY IT MATTERS

The most frequently searched terms on the ZERO TO THREE Web site are about challenging behaviors, such as biting, separation anxiety, and discipline. Similarly, the last issue of *Zero to Three* (January 2009) to focus on children's challenging behaviors was one of our most popular. Parents and professionals are clearly eager both for information and resources to help with both the everyday challenges of caring for infants and toddlers and to know how to identify when a problem is more serious.

Challenging behavior is an interesting concept because it means different things to different people and under different circumstances. Most often, caregivers are concerned about aggression, noncompliance, and temper tantrums. Issues around daily living, such as sleep, eating, and toileting, are also the focus of much time, energy, and worry during the early years. The role of temperament, both that of the child and the caregiver, has a huge impact on the relationship and how the adult perceives a child's behavior. The complex nature of early development and social interaction guarantees that there will never be a "one size fits all" solution to the issues that perplex and worry parents and other caregivers. Thus, a more useful approach, as the articles in this issue provide, is to build adults' skills to:

- Become better observers of the nuances surrounding problem behavior;
- Understand child development;
- Communicate effectively about the problems;
- Individualize their response;
- Improve staff competence in working with parents and children; and
- Increase resilience in children and families.

The contributors to this issue of *Zero to Three* describe a range of services and supports to address challenging behavior and support early social and emotional competence: A model of early childhood mental health consultation to reduce the rate of preschool expulsion; how child care professionals and parents can have useful conversations around sensitive behavioral issues; an approach to coaching early educators to prevent and manage challenging behavior in the classroom; a parent–infant play group to build parenting skills; the treatment of common sleep issues; and a program of support to strengthen military families when a parent returns from deployment. Also included is an additional feature article, both in English and in Spanish, about the Abriendo Puertas/Opening Doors program that seeks to improve the school readiness outcomes of Latino children by strengthening the leadership and advocacy skills of parents.

Many of the issues that challenge parents and other caregivers—helping a baby learn to sleep through the night, dealing with a picky eater, and setting limits on children's behavior—are discussed in ZERO TO THREE's new podcast series, ***Little Kids, Big Questions***, hosted by Ann Pleshette Murphy, a past contributor to ABC's *Good Morning America* Parenting Segment and vice president of the ZERO TO THREE Board of Directors. Made possible with generous support from Metlife Foundation and available on our Web site at www.zerottothree.org/parentingpodcasts, the series of 12 podcasts with leading experts translates the research of early childhood development into useful information for parents and other caregivers. Let us know what you think of the podcasts by completing the online survey, or leave a note on our Facebook page at www.facebook.com/zerotothreejournal.

Stefanie Powers, Editor
spowers@zerotothree.org

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Sally Provence, Editor 1980 –1985
Jeree Pawl, Editor 1985–1992
Emily Fenichel, Editor 1992–2006

Editor
Stefanie Powers

Director of Production
Jennifer Moon Li

Design Consultant
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Challenging Behavior and Expulsion From Child Care

The Role of Mental Health Consultation

DEBORAH F. PERRY
COURTNEY HOLLAND
Georgetown University

NIKKI DARLING-KURIA
CKD Communications, LLC
Martinsburg, West Virginia

SARAH NADIV
University of Maryland

Abstract

Preschool children are being expelled from child care programs at an astonishing rate, often because of challenging behaviors such as aggression, tantrums, and noncompliance. Teachers say they need more training in how to manage these behaviors in child care settings. Early childhood mental health consultation (ECMHC) has been shown to build provider's capacity to better cope with challenging behavior. This article describes the lessons learned from interviews about 20 children receiving ECMHC who nonetheless exited their child care settings because of behavioral concerns. The authors outline the common characteristics of children at risk for expulsion, as well as the common characteristics of programs that may exacerbate challenging behaviors. A discussion of how ECMHC can help reduce the risk for expulsion is included along with a detailed list of specific strategies consultants recommended for use with teachers.

There is strong evidence that social and emotional skills are as critical to school adjustment as are competencies in language and academic readiness skills. When kindergarten teachers report that children are not entering school ready to learn, they are most often referring to deficits in social and emotional skills. Left untreated, early behavioral problems can develop into more serious mental health conditions that can effect learning and achievement (Joseph & Strain, 2003; Raver & Knitzer, 2002; Wentzel & Asher, 1995). In fact, roughly half of all children with problem behaviors in kindergarten are placed in special education by the 4th grade. Research has shown that social and behavioral competence in young children more accurately predict their academic performance in 1st grade than do their cognitive skills and family backgrounds (Fox & Smith, 2007).

The prevalence rates for young children with challenging behavior ranges from 10% to 30% (Fox & Smith 2007). Campbell (1995) estimated that approximately 10–15% of all typically developing preschool children have chronic mild to moderate levels of behavior problems. Emotional and behavioral problems of children are typically divided into two general categories: externalizing and internalizing problems. Externalizing problems involve aggressive, defiant, and noncompliant behaviors. The most common externalizing emotional and behavioral problems are attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder. Internalizing problems include withdrawal, depression, and anxiety. The most common internalizing problems are separation anxiety disorder, generalized anxiety disorder, and depressive disorders. In addition, very young children commonly exhibit problems that do not fall within either of these general diagnostic categories, for example, sleeping problems, eating problems, and toilet-training–related problems. Many of these are best diagnosed using the *Diagnostic Classification 0–3R* (ZERO TO THREE, 2005). The most common specific challenging behaviors in children less than 5 years old are aggression, noncompliance, defiance, tantrums, and destruction of property (Strain & Timm, 2001).

When challenging behaviors in young children are not addressed early, emotional and behavior problems in preschool and kindergarten children are often stable over time. Young children with challenging behavior are more likely to experience early and persistent peer rejection, frequent

punitive contacts with teachers, unpleasant family interaction patterns, and school failure. In addition, more than 65% of students identified with emotional and behavioral disorders drop out of school, leading to poor job outcomes, limited income, and a pattern of failure that persists into adulthood (Fox & Smith 2007).

Challenging Behaviors and Child Care

Many of the problem behaviors mentioned in the previous section are first manifest in child care settings. As children spend longer hours in care, stress in families mounts, and that stress contributes to the increasing numbers of children exhibiting problematic behavior. This in turn leads to a growing number of child care providers struggling to address the mental and behavioral health needs of young children. Assistance with children's challenging behaviors is the greatest need identified by preschool administrators and educators (Busecmi, Bennett, Thomas, & DeLuca, 1996; Yoshikawa & Zigler, 2000), who often have had little training in behavior management or ways to promote social and emotional competence (Scott & Nelson, 1999). Teachers, administrators, and family members identify this lack of knowledge and skill as the greatest challenge to effective practice (Fox & Smith, 2007). Preschool administrators and educators, who often have had minimal training in behavior management or ways to promote social and emotional competence (Scott & Nelson, 1999), report that those are the top areas in which they need training (Busecmi et al., 1996; Yoshikawa & Zigler, 2000). Eighty percent of teachers report that problem behavior negatively affects their job satisfaction, and directors report that teachers are not effective in implementing prevention or promotion practices (Fox & Smith, 207).

Expulsion from child care is the most extreme outcome of early care and education providers' inability to cope with challenging behaviors. According to a landmark national study (Gilliam, 2005), the rate of expulsions from state funded pre-kindergarten programs was roughly 3 times the rate of expulsions from K–12 programs. Although rates of expulsion vary widely among the 40 states funding pre-kindergarten, state expulsion rates for pre-kindergarteners exceed those in K–12 classes in all but 3 states (Gilliam, 2005). The pre-kindergarten expulsion rate was 6.7 per 1,000 pre-kindergarteners enrolled. Four-year-olds were expelled at a rate about 50% greater than 3-year-olds were. Boys were expelled at a rate more than 4.5 times that of girls. African-Americans attending state-funded pre-kindergarten were about twice as likely to be expelled as Latino and Caucasian children, and more than 5 times as likely to be expelled as Asian-American children.

Early childhood mental health consultation (ECMHC) is a model for building providers' skills and reducing problematic behavior in young children in child care that has shown promising results. ECMHC aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to 6 years old and their families. It involves a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with expertise in infant and early childhood development (Cohen & Kaufmann, 2000; Donohue, Falk, & Provet, 2000; Johnston & Brinamen, 2006).

ECMHC provides an opportunity for early care and education (ECE) providers to receive one-on-one coaching and mentoring that can target the child, the family, or both or can focus on an entire program or classroom. In the former, referred to as child- and family-focused consultation, the consultant works with the provider and a child or family to address the specific behaviors of concern in an individual child or family. In contrast, program-focused consultation is intended to improve the overall quality of the classroom environment and provide strategies to build staff capacity to address problematic behaviors or programmatic problems that may be affecting one or more of the children, families, or staff.

There is a growing body of evidence that ECMHC is an effective strategy in reducing the impact of social–emotional and behavioral challenges on young children in child care and their caregivers. Gilliam (2005) reported that pre-kindergarten programs that had on-site mental health consultants had lower rates of expulsion than those without access to this service. In addition, two systematic reviews of more than 30 evaluations of ECMHC conducted across the country showed evidence that these programs can lead to reduced expulsions and improvements in children's behavior and teacher attitudes and behaviors (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010).

Understanding the Role of Mental Health Consultation Through a Study of Expulsions

As part of an evaluation of Maryland's statewide ECMHC project, we studied the cases of 20 children who left child care programs because of challenging behavior. For each case, we interviewed the consultant who was working with the child. We also invited the child care program directors, the child's care providers, and the child's parents to participate in an interview. These interviews were arranged whenever a consultant found out that a child she was working with was going to be expelled from a child care center. Sometimes parents decided to remove their child from child care before the child was formally asked to leave, and we interviewed consultants, directors, teachers, and parents in those cases as well. There was a different interview script for each type of respondent—consultant, director, teacher, and parent. The questions were open-ended in order to allow each interviewee to direct the conversation as much as possible. In total, we conducted 35 interviews: 20 with consultants, 7 with child care program directors, 5 with teachers, and 2 with parents. Most of the children were White, 3- or 4-year-old boys. Only two of the children were girls.

Photo: Kiwi Street Studios

Young children with challenging behavior are more likely to experience early and persistent peer rejection.

Our research team recorded, transcribed, and analyzed the interviews using qualitative data analysis software. We routinely returned to the transcripts to gather more information and make sure any conclusions we drew or themes we found accurately represented the interviewees' descriptions of their experiences. These interviews yielded a rich array of stories that informed our understanding of the factors that led to expulsions and the role mental health consultation can play in facilitating smooth transitions for children with challenging behaviors. We present a vignette to illustrate the range of children's experiences with mental health consultation that we studied.

Photo: Kiwi Street Studios

Program-focused consultation is intended to improve the overall quality of the classroom environment.

Ben's story

Three-year-old Ben started attending Little Stars Child Care after the child care center he previously attended closed in the middle of the year. Ava, an early childhood mental health consultant, had been working with Ben at that center for 5 months. He had been diagnosed with ADHD and sensory processing disorder and had an individualized education plan. Ava was teaching Ben and his providers strategies to reduce Ben's challenging behavior and increase his ability to participate in classroom activities. Ava continued working with Ben at Little Stars, starting on his very first day in the program.

At first, things seemed to go well. Ben's teachers were aware of his diagnoses and knew that he was receiving occupational therapy. They expected that it might take Ben a little extra time to adjust to his new environment, and Ava came to Little Stars once a week for 3 hours at a time to help him. Because Ben was at a new child care center, Ava had developed a new action plan and reviewed it with the director at Little Stars, Ben's teacher, and Ben's parents. After a few weeks, though, Ben's teacher and the director at Little Stars became concerned about Ben's behavior.

Ben had a difficult time engaging in classroom activities and interacting with other children. Because he was underregistering sensory information, he did not realize when he was hurting other children, sometimes squeezing them too tightly when he wanted to give a hug or knocking them over when he ran in to a play area. He struggled to pay attention, follow directions, and sit still to complete worksheets or participate in circle time. He was frustrated by his difficulty expressing himself and participating in the classroom, and that frustration caused aggressive behavior. He sometimes bit and kicked when he was angry and seemed impossible to calm down.

The amount of noise and activity at Little Stars created additional challenges for Ben. There were 8 children in his classroom, but there were no walls between classrooms, and there were 10 children in the classroom right next to his. Each afternoon, the teachers in each classroom switched rooms and taught the other class. His teachers knew that his behavior was a result of ADHD and sensory processing disorder, and they tried to do everything they could to help Ben, but it was difficult to give him the constant attention that he needed.

Ava continued to help Ben through his day, coaching him and trying to prevent his frustrations from escalating into tantrums that disrupted the whole class. She suggested a variety of tools that might help Ben focus, including a weighted lap pad, a wiggle cushion, and stress balls to hold during structured sitting time. Ava modeled ways to teach Ben appropriate language and use positive reinforcement, and she made a storybook about Ben, the things that made him angry, and what he could do to calm himself down.

Ben's parents communicated regularly with the providers at Little Stars and with Ava. They explained that, because Ben was their only child, they were not sure how concerned they should be about his behavior because they had nothing to compare it with. They followed all of Ava's recommendations, used the same positive reinforcement strategies at home that Ben's teachers were using at school, and bought the lap pad and wiggle cushion that Ava suggested.

But Ben continued to struggle at Little Stars. He learned to calm himself down more effectively, but despite everyone's best efforts, Ben's behavior did not improve and continued to interrupt the class. He jumped on his wiggle cushion and threw his lap pad across the room. Parents of other children became aware that Ben was causing chaos in the classroom, and other children were starting to imitate Ben's negative behavior.

A week later, the director told Ben's parents that the program at Little Stars could not meet Ben's needs. Though she had hoped Ben would be able to stay at Little Stars, after spending 6 months working with him, Ava agreed that Little Stars was not the best place for Ben. She felt that Ben would be more likely to succeed with more individual attention in an environment with fewer distractions.

Fortunately, Ben's parents were able to enroll him in a children's institute in Maryland a few days later. The children's institute is a therapeutic child care center with large classrooms, 3 or 4 children in each class, special education teachers, and a full-time social worker on staff. Ben's parents had been surprised and upset when Ben was asked to leave Little Stars, but after a few weeks at the children's institute, they felt differently.

Ben's mother said:

You know, I wasn't happy about it then, but now I think everything happened for a reason... he's gotten used to it now. He knows exactly where to go to his classroom, and a couple times he wanted to stay; they were doing something he wanted to do, and he seems happier there.

Ben's parents asked Ava to continue seeing Ben at his new school, but Ben was doing well. Five weeks after Ben started his new program, Ava had not received any requests to work with Ben at the children's institute.

Ava's work helped his child care providers and parents realize that Ben needed something that Little Stars—even with special accommodations—could not provide. Ava helped the providers at Little Stars work hard to meet Ben's needs, and she facilitated open communication between the providers and Ben's parents. When his behavior did not improve, knowing that Ben had a team working together to help him made it easier for everyone to accept that Ben might be happier at another program. The director at Little Stars wished that Ben could have stayed in the program but felt like Ava had steered all of Ben's caregivers towards the right decision for Ben. She stated:

She [the consultant] was definitely a great resource for us because we felt we could go to her with any questions. She would try to come up with answers; she brought lots of things here that we could utilize. You know, she definitely was a good thing for us and for Ben because basically that's what her role is, to make sure a child has every avenue to succeed. So she certainly did her part.

Photo: Stephen Bobb

Defiant behavior often requires a lot of teacher attention and interrupts the rest of the class.

Lessons Learned From the Children Who Exited Preschool Programs

Ben's story illustrates many of the common themes that we identified as we analyzed the 20 stories of children who exited their programs because of challenging behaviors. Our team was able to identify some common characteristics of the children who exited as well as common experiences they had in child care. Our results have implications for policy and practice as communities integrate mental health consultation into their ECE systems.

Characteristics of Children at Risk for Expulsion

The reasons that young children are expelled from child care programs are complicated and diverse. It is impossible to identify one primary factor that causes an expulsion, but we were able to identify characteristics and situational factors that are often present when children are at risk of being asked to leave child care programs. These children often exhibit problem behaviors, have mental or developmental health needs or challenges, have complicated family situations that affect the child's ability to succeed in the child care program, or have a combination of these factors.

The consultants, directors, teachers, and parents we interviewed described several different kinds of behaviors that caused problems in the classroom, such as aggression, hyperactivity, lack of social skills, and defiance. Violent or aggressive behavior, such as biting or throwing chairs, is particularly concerning because it poses serious safety issues, both for other children and for child care program staff. Defiant behavior often requires a lot of teacher attention and interrupts the rest of the class. And defiant behavior can become a safety issue. For example, several children tended to run out of the classroom or building when they did not want to do what was asked. Staff worried about leaving the other children alone in the classroom to chase a running child, but they were particularly concerned that the child might run into the street. Children's problem behaviors often led to other parents pressuring the child care director to expel the child or risk other parents withdrawing their children.

Like Ben, many children exhibited concerning behavior as a result of developmental or mental health issues. Some children had specific diagnoses or were already receiving health or mental health services, including physical therapy, anger management counseling, occupational therapy, and behavioral therapy. Occasionally, interviewees identified internalizing behaviors that concerned them, such as withdrawal from classroom activities. But more often, children's emotions, like frustration or anger, would be expressed through externalizing behavior that was inappropriate for the classroom. And many of these children lacked the social skills required to participate successfully in normal classroom activities. Unfortunately, however, knowing the cause of a child's concerning behavior does not necessarily lead to the child's improvement. As long as the behavior persists, it causes problems in the classroom. And when other children begin imitating negative behavior, classroom management becomes even more difficult.

We also learned that many of the children at risk for expulsion experienced a variety of challenging family situations. Children's schedules were often inconsistent, with several different caregivers picking up, dropping off, and spending time with the child on a complex or irregular schedule. Consultants, directors, and teachers often commented that parents were inconsistently involved in their child's care, or that parents did not seem to have developed effective behavior management strategies. Communication with parents was often infrequent or inconsistent. Some of these children recently experienced significant changes, such as divorce or the death of a grandparent.

Characteristics of Programs Where Children Had Difficult Times

The ECE programs that children exited from had some common characteristics. One major theme that emerged from the interviews illustrated specific characteristics that programs shared in cases where children were having the most difficult times. The most commonly referred to characteristic was that the physical environment of the program was too open, unclearly defined, or lacked structure. In addition, there were often larger child–caregiver ratios in these open, undefined spaces that consultants sometimes referred to as "chaotic."

One child care program had to be relocated to a temporary building because of remodeling. The new building had no walls to separate classrooms and the noise traveled throughout the space, which created sensory issues for some children who had trouble concentrating on their own learning. This configuration led to frequent distractions, wandering among centers, and inappropriate use of materials, which is likely to have increased the teacher's stress as she struggled to contain and direct the children in a chaotic environment.

Some centers lacked structure. Teachers did not establish or follow routines, or the routines were so restricting they would not allow for "teachable" moments to emerge.

In addition to the environment, teacher stress could be factored into a chaotic setting. One consultant remarked,

When a teacher is in a classroom with 9 other children, and [the child under discussion] making 10, unfortunately it would escalate before she could even probably address it or probably know what was going on, because you know you are constantly being pulled in a thousand different directions, you know?

Other programs were over structured. For example, one program planned the children's schedule down to the minute. In one classroom, children were required to rotate centers every 7 minutes. In another classroom, the teacher would end an activity without a transition or warning if it appeared that the children would be late for their next scheduled activity.

Finally, in many of these cases, consultants expressed concern that in some programs teachers were unwilling to implement the plans the consultants had developed for various reasons. They frequently heard that the things they suggested had been unsuccessful in the past, that the children would not respond to new materials or classroom changes, and, the teachers were reluctant to try these strategies at all. Another common concern raised by the teachers was that they were unable to dedicate so much one-on-one time to an individual child.

How ECMHC Helps Reduce the Risk for Expulsion

ECMHC seeks to improve children's social–emotional well-being through changes made in the early childhood environment (e.g., routines, changes to the classroom layout), and through the acquisition of new skills by the ECE teachers. Mental health consultants build the capacity of ECE professionals to improve behavior management and enhance social skills in the children in their programs. These approaches may target an individual child who is presenting with a specific problem behavior or may build skills in the entire group of children in the classroom. At times, mental health consultants may provide some direct services (e.g., observing individual children, conducting screenings, or modeling effective practices), but these activities are implemented with the goal of building the skills of the early childhood professional (Brennan et al., 2008). Another focus of ECMHC is to promote positive adult-to-adult interactions, especially communication among members of the teaching team and between teachers and parents and teachers and administrators.

The primary instrument of intervention in ECMHC is capacity building; that is, assisting staff and caregivers to acquire knowledge, attitudes, and behaviors that will help them to support the social and emotional health of young children. The consultant works with and through staff and caregivers, building their capacity to problem solve and change practices that will help them change their behaviors to be more effective in their role in working with young children, including those with diagnosed developmental or mental health disorders. With new perspectives, skills, and strategies, caregivers can promote early childhood social–emotional functioning and address and solve current problems as well as future concerns that might arise (Cohen & Kaufmann, 2000).

ECMHC influences young children's social skills and problem behaviors primarily through its effects on the teachers' knowledge, attitudes, and behaviors as well as through changes in the classroom climate; for child-specific consultation, a parallel process occurs with the consultant and the family members' knowledge, attitudes, and behaviors. These effects are mediated through the quality of the relationship

Photo: Kiwi Street Studios

Early childhood mental health consultation can lead to reduced expulsions and improvements in children's behavior.

Learn More

Book:

Collaborative Intervention in Early Childhood: Consulting With Parents and Teachers of 3- to 7-Year-Olds
D. Hirschland (2008)
New York: Oxford University Press

Reports/Written Resources:

What Works? A Study of Effective Early Childhood Mental Health Consultation Programs
F. Duran, K. S. Hepburn, M. Irvine, R. Kaufmann, B. J. Anthony, N. Horen, & D. F. Perry (2009)
Washington DC: Georgetown University, Center for Child and Human Development. Available at http://gucchd.georgetown.edu/78358.html

Early Childhood Mental Health Consultation: An Evaluation Tool Kit
K. S. Hepburn, R. K. Kaufmann, D. F. Perry, M. D. Allen, E. M. Brennan, & B. L. Green (2007)
Washington, DC: Georgetown University, Technical Assistance Center for Children's Mental Health; Johns Hopkins University, Women's and Children's Health Policy Center; and Portland State University, Research and Training Center on Family Support and Children's Mental Health. Available at http://gucchd.georgetown.edu/products/ECMHCToolkit.pdf

Web Sites:

The Center for Early Childhood Mental Health Consultation
www.ecmhc.org

Center for Social Emotional Foundations for Early Learning
http://csefel.vanderbilt.edu/

Technical Assistance Center for Social Emotional Interventions
www.challengingbehavior.org/

Georgetown University Center for Child And Human Development
http://gucchd.georgetown.edu/67637.html

ZERO TO THREE
www.zerotothree.org/

between the mental health consultant and the ECE provider and family members. When a skilled consultant provides advice that is well-received by the consultee, behavior change is more likely to occur, leading to: reduced stress, a more positive affective climate, increased reflective practice, and an increase in the adoption of evidence-based practices likely to reduce problem behaviors and increase children's social skills. In those cases where the consultant is working in-depth with the young child's family, there may be indirect effects of consultation through improvements of teacher–parent communication and increased consistency in the implementation of behavior strategies in home and school-settings. We also believe that effects of consultation are moderated by the attitudes and behaviors of the ECE administrators. When there is significant buy-in and follow-through from the director, changes in teacher and classroom effects will be more positive and sustained. Finally, there may also be some direct effects of the activities of the mental health consultant on children's problem behavior.

Table 1 identifies specific examples of strategies that ECMHC used when working with children at risk for expulsion. These strategies are routinely used by mental health consultants to reduce challenging behavior and increase social–emotional skills. Variations of the strategies can be applied to both the program and child-specific cases.

Practice and Policy Implications

The stories of the 20 children in Maryland who exited their program because of behavioral problems point to several areas where practice and policy could be improved. A large percentage of these children had significant (diagnosed) mental health or developmental disabilities. Community child care providers did not have the skills, training, or resources to successfully maintain these children in their ECE programs. Like Ben, some of these children needed to be in a more therapeutic program in order to have their needs met. Mental health consultants can often serve as a bridge to other systems and services, such as early intervention or preschool special education. They can also help families realize that their child's needs are not being met in their current program and help navigate them to a more appropriate placement.

Many teachers continue to struggle with implementing evidence-based behavior management strategies, such as those contained with the Teaching Pyramid promoted by the Center for Social Emotional Foundations for Early Learning (Fox, Dunlap, Hemmetter, Joseph, & Strain, 2003). In Maryland, all of the mental health consultants were trained in the Teaching Pyramid model, and some served as coaches in ECE programs who had also been trained in the model. But many more community child care programs have not been trained in this approach, and continued training, with ongoing coaching, is needed to help ECE teachers and directors implement these practices with fidelity. Mental health consultants can serve as an important support to ECE programs that are incorporating elements of positive behavioral supports into their classrooms, both as a coach and working with a Teaching Pyramid coach in sites that are fortunate to have those resources (Perry & Kaufmann, 2009).

Finally, to be effective, mental health consultants need to engage the families of young children with challenging behaviors in a partnership with the ECE programs. In too many of the cases that we studied, the relationships between the family and the ECE programs were neither well-developed nor collaborative. Families often felt surprised by the news that their child was being asked to leave the ECE program. And this was the result of poor communication between the teachers, directors, and parents. Unfortunately, in many of these cases the mental health consultant was called in too late—the ECE staff and directors had already decided that this child needed to leave their program, and there was not enough time to mend the relationships between the ECE program and the family. Child care programs that are working with a mental health consultant on an ongoing basis are in a better position to build those collaborative relationships with families—going beyond simply securing permission to do child-specific work. In these cases, directors and teachers are able to build partnerships with parents to meet the needs of young children with challenging behavior, with support from the mental health consultant.

Table 1. Specific Examples of Strategies Used by Mental Health Consultants Working With Children at Risk for Expulsion

Programmatic Strategies	Child-Specific Strategies
Arrange the room to make a larger number of interactive centers available. By adding more small-group activities children have more opportunities at the same time instead of waiting for the teacher to interact one-on-one. Not every activity can be teacher-directed, and children need to learn to work together.	Apply different sensory techniques such as allowing a child to play with play dough if he was having trouble keeping his hands to himself. Or to strengthen his writing skills, encourage him to write in sand or salt with his finger. Other ideas include using a weighted lap pad, stress balls, or small hand-held objects known as "fidgets" to hold during circle time or a giving him a wiggle cushion to sit on.
Add pro-social materials, such as board books titles *Hands Are Not for Hitting* and *Feet Are Not for Kicking*, and engage the children in group conversations about keeping their hands to themselves.	Provide a nap bag of activities so that if a child has trouble sleeping he has some specialized activities to occupy his time. A visual timer is also useful so that the child can see when his time on the nap mat is going to be over.
Even when walls or other boundaries are not available, masking tape or painter's tape can be used to create visual boundaries on the floor or other surfaces. If there isn't a large area for gross motor activities, in one taped-off section, directive signs could indicate "Do 5 jumping jacks here!" to allow children to actively move in safe ways using minimal space.	During transition times it's important to give children a heads-up that a change is coming. A 5-minute warning and then a 1-minute warning are good opportunities to help children prepare themselves for a change. Depending on the transition, jobs can help the children move the group along. Assign line leaders, room checkers, and door holders. This builds responsibility and gives them ownership over their own contribution.
Often teachers find themselves saying "No" a lot to the children. But this can create some confusion about just what it is they are supposed to be doing. So instead of saying "Don't run inside," try saying "Please use your walking feet indoors."	When a child bites another child, support the child who was hurt and encourage the one who bit to soothe the injured child by holding an ice pack on the wound. Spend some time with the one who bit reading *Teeth Are Not for Biting* and engage that child in activities that involve more oral muscles such as eating crunchy foods (e.g., pretzels, apples, or carrots), drinking applesauce through a straw, and blowing bubbles.
When sharing a concern with a child, sandwich it with a positive, then the negative, followed up by another positive. This reassures the child that she is not "bad" but that the behavior may need to change in order to make the situation better.	When helping children build strong social–emotional skills, use feathers to show the difference between gentle and rough touch, and show cards with children expressing different emotions to help him with empathy building.

Deborah Perry, *PhD, is an associate professor at the Georgetown University Center for Child and Human Development. She currently serves as the project director for a Head Start funded center for early childhood mental health consultation. This center translates research on effective mental health practices to practical products that can be used by Early Head Start and Head Start programs across the country. Dr. Perry's research and evaluation focuses on designing and testing preventive interventions for young children and their caregivers; perinatal depression prevention is one of her areas of expertise . She has led efforts to evaluate early childhood mental health consultation models in Maryland and the District of Columbia. She has authored numerous peer-reviewed articles and translational publications, and she conducts trainings and lectures on a wide variety of maternal and child health and early child development topics. Dr. Perry has a doctorate in maternal and child health from Johns Hopkins and a master's degree in psychology.*

Courtney Holland *has been a research assistant at the Georgetown University Center for Child and Human Development since graduating from Georgetown with a BA in psychology in 2008. Her work has focused on evaluations of expanded school mental health programs, early childhood mental health consultation, family involvement in children's mental health services, and peer-to-peer support for families of children with special needs. Courtney also spent 3 months teaching preschool in Karanga, Tanzania. She is a candidate for a masters degree in Organizational Leadership at Gonzaga University and expects to graduate in December 2011.*

Nikki Darling-Kuria, *MA, founded CKD Communications, LLC, in to provide expert consultation in early care and education, specializing in family child care. Nikki has served as a family child care provider for 16 years and has been nationally accredited twice by the National Association for Family Child Care. Nikki served as a partner with the University of the Maryland and Georgetown University to evaluate Early Childhood Mental Health Consultation. Her first book,* Brain-Based Early Learning Activities: Connecting Theory and Practice, *was published by Redleaf Press in 2010. She holds a master's degree in human development from Pacific Oaks College.*

Sarah Nadiv *is a data analyst at the University of Maryland, School of Medicine. She is also works at the University of Maryland's Center for Infant Studies as a clinician and a Head Start Mental Health Consultant. Sarah started in Head Start in 2004 as a family service coordinator. She then obtained her degree in counseling psychology from Towson University and became a licensed graduate practicing counselor in Maryland. In addition, she has spent the past 3 years researching early childhood mental health consultation and manages the Maryland's Early Childhood Mental Health Steering Committee. She is also an active member of Maryland's Social Emotional Foundations for Early Learning (SEFEL) Leadership Committee and will be heading SEFEL data collection for Maryland.*

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Communicating About Challenging Behavior

Helpful Conversations Between Caregivers and Parents

AMY HUNTER
ZERO TO THREE,
Washington, DC

LINDA BROYLES
Southeast Kansas Community Action Program,
Girard, Kansas

Rhonda[1], a caregiver at my son Wes's child care program, held and squeezed Wes tightly as she said to me (Amy Hunter), "He's my baby." I could tell from the look on her face and the way she was holding him that Rhonda really loved my son. I wondered if she felt that way about all the toddlers in the class or if she had a special relationship with Wes. One day Rhonda shared with me that Wes was quite verbal for his age and that he really knew the routine of the day. She explained how after lunch he toddled right over to the cots. As I listened to Rhonda sharing her observations I was so proud of my son. As I thought about Rhonda spending time noticing Wes's development and behavior, I felt comforted about the quality of care he was receiving.

A few days later, when I picked Wes up, Rhonda shared that he had bitten a classmate. I was horrified. I didn't know what to say. I wondered what she expected me to say. Wes was only 15 months old. I hoped she didn't want me to scold him or reprimand him so many hours after the incident. In his mind the bite that occurred hours earlier would likely have been long forgotten. I wasn't sure what the center policy was on biting. Thoughts began racing through my mind, "Who did he bite? Why did he bite someone? What was happening when he bit? How big of a deal was this for Rhonda? How hurt was the other child? Does this change Rhonda's view of my son or of me? Does she think I'm a bad parent?"

As I tried to think of the best way to respond, Rhonda gently said, "It's normal. Children this age bite. We just needed to let you know. We comforted the other child and told Wes 'no biting.' I wouldn't worry about it" she said. Her words relieved me.

However, in the coming days, during our regular end of the day talks when I picked Wes up, Rhonda shared more and more incidents of biting. Rhonda gently asked me if Wes ever bit at home. She asked if there had been any changes at home that he might be upset about or bothered by. I said that at home he had not bitten anyone; however, sometimes on the playground he did hit other children. I told her I couldn't think of any changes going on. She assured me sometimes children act differently at home than they do in a group setting. Despite Rhonda's sensitive demeanor, I couldn't help but feel that somehow Wes's biting was my fault.

Rhonda stated that she was trying to observe him carefully. She noticed that before Wes bit, the other child had reached across his body. Rhonda wondered if Wes was possibly trying to protect his space. Perhaps he felt the other child had crowded him or intruded on his space and he didn't know how to tell the other child to stop. I again was comforted by the fact that she was trying to observe and understand what Wes might be communicating through his biting. She seemed to be trying to pay extra attention

Abstract

The normal developmental challenges experienced during early childhood as well as more significant emotional and behavioral problems require that parents and caregivers communicate effectively. The manner in which parents and caregivers communicate with each other about children's behavior can have a significant and lasting impact on children, families, and those in the caregiving setting. In this article, the authors describe concrete strategies for effective communication that support the children's development, the parent–child relationship, and the partnership between caregivers and families.

[1] Names have been changed for confidentiality.

to observe what was happening before, during, and after the biting incident. Rhonda continued to emphasize that she wanted to understand why he might be biting. To try to prevent the situations in which he might be more likely to bite, Rhonda was going to increase her observation and try to intervene when she noticed other children in his space.

In our conversation, Rhonda asked me if I had any additional ideas that might be helpful. She asked what I did at home to guide his behavior. I had used books in the past to talk to Wes about hitting. I brought a children's book, *Teeth Are Not for Biting* by Elizabeth Verdick, for Rhonda to borrow. Over the next few days, Rhonda shared with me that she had used the book to talk with Wes about what teeth were for. She described how they read the board book many times and looked at teeth in the mirror. Rhonda talked to Wes about how teeth were for biting and chewing food. As they talked about chewing food she gave him some apple slices just like in the book. Throughout the coming days when Wes bit, in addition to saying, "no biting" the teachers offered him an apple. The other caregivers also tried to help Wes to say "no," "stop," or "mine" if other children appeared to be in his space. After a while the biting subsided as Wes appeared to develop additional, more appropriate, ways to communicate his needs.

Reflecting on Conversations About Challenging Behavior

I never talked to Rhonda about her thoughts and feelings during the biting phase. However, over the years, I've thought a great deal about my conversations with Rhonda. I've appreciated how she approached the situation. I've often wondered what it was like for Rhonda and other caregivers to have conversations with parents about a child's challenging behavior.

Clearly, not all parent–caregiver conversations are as insightful as the one I was fortunate enough to have encountered with Rhonda. Parents and caregivers often have strong feelings associated with a child's behavior. Even when discussions about behavior are effective, they can be stressful. Talking about challenging behavior can evoke feelings, in both parents and caregivers, such as guilt, worry, embarrassment, anxiety, frustration, confusion, or anger. In the absence of thoughtful planning, parents and teachers can walk away from a conversation about a child's behavior feeling blamed or judged. A parent might think, "If you were a better teacher my child wouldn't act this way." A caregiver might believe, "If you were a better parent your child would not exhibit these behaviors." Both parents and caregivers may feel that the child's behavior is their fault even if the other person neither believes nor implies this opinion.

Photo: Kiwi Street Studios

Regular and frequent communication with parents offers an opportunity to build a meaningful relationship.

Conversely, effective conversations about challenging behavior can help parents and caregivers feel validated, understood, respected, trusted, supported, and relieved, and they can lead to positive solutions. The context in which the conversation takes place, the relationship between the caregiver and parent, the words that are used, the tone of voice and the body language of both parent and caregiver, and the approach to the challenging behavior all impact how the caregiver and parent may feel when talking about challenging behavior.

Why Communicate About Challenging Behavior?

When parents and caregivers communicate about children's behavior, children benefit from a stronger partnership between families and caregivers and ultimately receive a higher quality of care. Parents and caregivers can pool their knowledge of the child to develop a greater understanding of the child's behavior across different settings and contexts. Parents know their child best. Caregivers—and other professionals who work with children—see a child through a lens of norms. In other words, whether it is through formal screening or daily observations, caregivers evaluate a child's behavior in the context of what is typical for children of similar age and development. By working together, parents and caregivers can develop the most comprehensive understanding of the behavior and the most effective approach to preventing and responding to the behavior. Together, parents and caregivers can explore child guidance techniques, cultural views of a child's behavior, and various strategies for preventing the behavior, teaching new skills and ultimately working to prevent adverse impacts on the child's later development.

Behaviors such as inconsolable crying, hitting, temper tantrums, high activity levels, destructiveness, refusal to participate in routines or activities, eating and sleeping problems, or any combination of these are challenging to both caregivers and families. These types of behaviors are quite common and are often part of the normal developmental process. However, when these behaviors persist over time and become increasingly frequent and intense they can interfere with the child's relationships and development and cause significant distress. (Holtz, Carrasco, Mattek, & Fox. 2009). Thus, whether a child's behavior is within the typical range or rises to the level of interfering with his relationships or development, a conversation between caregiver and parents is critical.

Research has indicated behavior problems in very young children are related to a variety of negative consequences, including having an adverse impact on relationships with parents and caregivers; the child's development of social skills (Mendez, Fantuzzo,& Cicchetti, 2002), language development (Kaiser, Hancock, Cai, Foster, & Hester, 2000), and future academic achievement (Neilsen & McEvoy, 2004). Significant behavior problems in very young children may also result in expulsion from day care settings (Roberts,

Photo: Kiwi Street Studios

The routine of drop-off and pick-up in center-based care can be hectic and harried.

Mazzucchelli, Taylor, & Reid., 2003). In fact, Gilliam (2005) reported that the prekindergarten expulsion rate is 3.2 times the rate for K–12 students. Research has not established the impact of expulsion on preschoolers but studies on older children consistently demonstrate the outcomes of expulsions and suspensions lead to further expulsions and suspensions and higher rates of school drop out. (Balfanz, Spiridakis, Curran Neild, & Legters, 2003; Tobin & Sugai, 1999).

Adult responses to challenging behavior can make a significant difference in child outcomes. Success in reducing challenging behavior is more likely when parents and caregivers work together to consistently implement appropriate responses to behavior both in the home and in the center. How parents and caregivers talk about a child's behavior with each other can determine whether they are able to develop and implement successful interventions and can help to prevent or minimize the risk of further problems in the future.

Elements of Effective Conversations

What if the kinds of conversations we have are *the kinds of relationships we have?—Harlene Anderson, Family Therapist, Galveston Family Institute* (quoted in Decter, 2009)

In the years since the incident with Wes, Linda Broyles, director of Southeast Kansas Community Action Program Early Head Start/Head Start, and I have had the opportunity to hear from many caregivers, home visitors, and parents about the experience of talking about a child's challenging behavior. A number of themes have emerged from these conversations that can facilitate effective parent–caregiver communication about challenging behavior. The themes and processes identified below reflect significant training and experience staff members have had using the approaches outlined in the materials of the Center for Social Emotional Foundations for Early Learning.

Develop a Trusting Relationship

Exchanging information that may potentially be difficult to say or to hear can be much easier in the context of a trusting relationship in which each party believes the other has the other's best interest in mind. When parents and caregivers trust each other, a conversation about a child's challenging behavior has more likelihood of leading to successful intervention and increased hope for change.

How does this trust develop? In every conversation we've had with caregivers they stated that from their first encounter with a family they are working hard to develop a positive relationship with the family. One home visitor said that when she has her first interview with the family she begins to try to build a rapport with them. She described how she explains very specifically what her role is and what the family can expect from the program. By explaining the structure of the home visits and what the expectations are within the home visiting program, the families know what to expect. Knowing what to expect helps families feel a sense of security and trust.

One parent noted that he developed trust with his child's teacher because she was always straightforward with him. The parent said that his child's teacher was one of the few people in his life that he felt was truly honest with him. This parent also explained that his trust grew as he spent time in his child's classroom and observed how well his child's teacher knew his child. By frequently observing his child's teacher, he came to understand that the teacher truly had his child's best interest in mind. Through their trusting relationship this teacher and parent were able to address issues that arose and openly share observations and ideas that ultimately lead to a more consistent set of expectations for the child.

Demonstrate Respect and Be Open to Other Perspectives

One home visitor said that she strives to ensure that each family feels respected. She explained that if careful attention is not paid to respecting families during home visits, parents may easily feel judged or "like their personal life is being invaded." Teachers and home visitors have said that while they are confident in their own observations and knowledge of child behavior, they are also very open to the perspectives of parents and other caregivers. As caregivers described the details of their conversations with parents, in almost every instance the caregiver started the conversation by asking the parent, "Have you ever seen your child hit, bite, or cry for long periods [naming the specific behavior of concern]?"

Caregivers express that they are genuinely curious about what the child's behavior is like in the presence of the parent, and they are very open to the strong possibility that the behavior the child exhibits in front of the caregiver may not be the same behavior that occurs typically in the home in the presence of the family. Inviting the parent to describe how they see the child's behavior respects the unique characteristics of the different nature of the relationships and settings where the child spends time. Asking parents if they have noticed a child's behavior demonstrates the importance of the parents' observation and perspective about their child's behavior. Using inquiry and inviting the parents' perspective demonstrates the beliefs that parents are the expert on their child's behavior and that their input, reflections, and observations are essential to identifying the meaning of the behavior.

Prioritize the Caregiver–Family Relationship From Day One

Conversations about a child's challenging behavior are critical; however, a conversation about a child's behavior in the absence of a focus on the caregiver–family relationship may be detrimental. One experienced home visitor noted that even though she had a concern about a child's behavior from the first day she met the child she waited until the fifth or sixth home visit with the family to ask the parent about the child's behavior. By this time the caregiver believed she had developed a strong relationship with the family and the child so that the family might be more receptive to a conversation about their child's behavior.

In many instances caregivers have said that, despite believing they had a strong relationship with a family, a conversation about challenging behavior could still lead to parents feeling blamed, defensive, or guilty, causing a disruption in the relationship. Time and attention are then needed to repair the relationship and re-establish trust. Prioritizing the relationship with the parents and allowing conversations about the child's challenging behavior to remain only one of the many topics of conversation (i.e., not the central or sole topic of conversation) or even

to remain on hold for a short period of time may help build trust so conversations about a child's behavior may be more effective.

Focus on the Behavior and Specifics About the Behavior

Experienced caregivers relayed the message over and over that the behavior is the concern, not the child. Conversations are most often successful when caregivers and parents use specific terms to describe the behavior. For example, instead of saying the Jonah is "a wild child who is out of control" a caregiver may describe that most mornings after the parent leaves Jonah cries and screams for approximately an hour. During that hour he often hits the caregivers or other children and sometimes he throws toys. By describing the specific behavior both the parent and caregiver can have the same understanding of what the behavior looks like and how often it occurs. Attempting to understand the behavior and identify the patterns of the behavior (when it occurs; with whom it occurs; and what happens before, during, and after the behavior) provides clues to the function of the behavior. Tracking how often and when the behavior occurs is the only way to know if the behavior is improving, staying the same, or increasing in frequency. Focusing on what the behavior is and developing a hypothesis about why the behavior is occurring leads to specific strategies parents and caregivers can use to help the child change her behavior. Adopting and expressing a philosophy of "the child is not 'bad' she is just exhibiting some challenging behavior" increases the likelihood of positive and productive conversations about a child's behavior leading ultimately to better developmental outcomes.

Use Reflection

Understanding a child's behavior and developing strategies to adjust relationships or teach a young child new skills, or both, require reflection. When caregivers and parents step back and together speculate about what the behavior is trying to communicate, they are more likely to find successful responses and interventions. Perhaps when a child bites he is trying to say, "Hey, I want that toy and I don't yet know how to ask." Or maybe a toddler's crying is trying to communicate that he is tired and needs an earlier nap.

In addition to reflecting on the meaning of the behavior, parents and caregivers can explore together what in the environment might be contributing to the child's behavior. For example, they may review the classroom routine and determine a child's behaviors seem most challenging at transition time. The child may not understand the routine or the behavior expectations in the classroom. Upon reflection, a caregiver may decide to offer a child additional prompts about what comes next (e.g., "We will have clean up time after play time" or extra warnings about the end of play time "Five more minutes...3 more minutes...1 more minute...clean- up."). Similarly, a parent and home visitor may consider whether the home environment could be set up to encourage positive behavior instead of negative behavior. For example, a parent may decide to make changes to the environment such as moving fragile items that the toddler shouldn't touch to higher shelves to remove the temptation for the child to explore them with her hands and mouth.

Reflection can also be used to talk about the conversation itself. For example, a caregiver may ask a parent, "How is it is for us to have this conversation?" Allowing caregivers and parents to speak about the experience of talking about a child's behavior brings honesty and authenticity to the conversation. Any hesitancy, frustration, or worry can be put on the table to be addressed rather than remaining under the surface to cause resistance, withdrawing, and potential blaming.

Communicate Regularly

Trust is built over time. Regular and frequent communication with parents offers an opportunity to build a meaningful relationship. Regular or daily communication with a family sets the expectation that parents and caregivers will work as a team. Daily discussions may focus on the child's day, night, behavior (both positive and challenging), sleeping and eating patterns, and overall development, always keeping the health and well-being of the child as the focal point. Regular and frequent communication allows parents and caregivers to get to know each other beyond simply talking about the child. As the relationship develops a parent may be more likely to share additional information about factors that may be having an impact on the child's behavior including transitions or changes at home. Frequent communication can facilitate conversations about family events such as a grandparent visiting, a family vacation, or the planning of a big birthday celebration. Even positive events such as these can contribute to a child's temporary behavior change.

The routine of drop-off and pick-up in center-based care can be hectic and harried. Often children express strong emotions during these transition times, however, caregivers who describe having positive relationships with families explain that they find ways to build in even a few minutes of uninterrupted time with the parent to check in and talk about the evening's or day's events. Some parents prefer written communication such as using a daily notebook to share observations of the child's behavior. Other parents and caregivers have found that regularly scheduled phone calls are most effective. Regardless of the mode of communication, regular and frequent communication should emphasize the child's successes as well as areas to improve.

PHOTO: ANDREA BOOHER

Every child exhibits both positive behavior and behavior that is sometimes challenging.

Focus on the Positive

Every child exhibits both positive behavior and behavior that is sometimes challenging. From the very beginning of a family's relationship with a caregiver, the family and caregiver can work together to identify the child's areas of strength and areas to improve. When caregivers talk about these areas with families in the very beginning of their relationship, they begin that relationship on the same page and set the expectation for similar future conversations. For parents, hearing observations of the child's positive behavior make hearing concerns about challenging behavior a little easier. One caregiver described that as she speaks with parents she frequently makes *positive deposits* (e.g., descriptions of the child's positive behavior and what the child does well) so that when she needs to *make a withdrawal* (share a concern regarding challenging behavior that may trigger a parent's feelings of guilt, worry, or embarrassment), there is still a great deal of positive feeling left.

When parents notice that a caregiver observes all aspects of a child's behavior and does not exclusively focus on the challenging

behavior, they are likely to feel more open to discussing the areas of concern. Focusing on a child's positive behavior may help direct strategies for responding to and addressing the behavior. For example, Robert often cried for long periods of time when his mother brought him to the center. Robert really enjoyed playing with trucks. When he played with trucks and cars he was focused, played well next to other children, smiled frequently, and appeared calm. He even demonstrated a strong ability to share and trade the cars and trucks. On the basis of this observation, after Robert and his mother engage in a daily good-bye ritual the teacher may try to engage Robert in his favorite game of trucks. The teacher can also use the trucks to play out the theme of leaving and returning.

Listen

When a child exhibits extremely challenging behavior there is often a strong desire or sense of urgency to change the behavior. However, in the rush to talk about the behavior, caregivers sometimes forget to take the time to truly listen to the family. It is important to share behavior concerns clearly and in a straightforward manner, however, listening can help caregivers better understand the family's perspective and, ultimately, the child's behavior. By listening caregivers can respond to the specific concerns of a parent. Caregivers and parents alike respond to conversations more positively when they feel heard. Specific skills such as providing one's full attention, refraining from interrupting, keeping one's mind focused on what the parent is saying, staying with the topic rather than continuing to try to bring it back to one's own agenda, and maintaining eye contact all help to demonstrate that one is truly listening. Listening in this way acknowledges the parent's perspective and demonstrates respect for them.

Be Persistent

Following the old adage "if at first you don't succeed, try try again," many caregivers identified the need to be persistent when talking about challenging behaviors. One teacher stated that when she initially approached a parent about her child's challenging behavior the parent expressed frustration and anger toward the teacher. The parent countered that she felt the teacher had something against her and her daughter. This teacher realized she needed to spend more time building a trusting relationship with this parent. She then made a point of communicating with the parent on a daily basis. Each day she shared some specific and positive aspects of the child's behavior and casually yet less frequently she explained the strategies they were using in the classroom to address the challenging behavior. Eventually the parent came to trust that her daughter's teacher truly cared for her daughter. Now, 2 years after this child was in the Early Head Start program, the parent calls the teacher once a month to check in and share how things are going. The persistence of this caregiver certainly paid off in developing a meaningful and supportive relationship.

Be Confident

Parents are their child's first teacher and know their child best, however, caregivers and home visitors specialize in child development and have seen many children and families over time. Caregivers consistently stated that conversations with parents seem to be most successful when they are able to balance a desire to understand the unique insights and perspectives of the family with a confidence in their own knowledge of child development. One caregiver said that before each conversation with a parent she reviews the observations of the child's behavior, reflects on where the child is developmentally, and thinks about developmental milestones. One teacher noted that sharing her objective observations (i.e., sharing simply the actions the child performed rather than an interpretation of the child's behavior) helps her to feel confident in sharing what occurred without imposing judgment.

Photo: ©iStockphoto.com/Javier Sanchez Mingorance

Parents are their child's first teacher and know their child best.

Learn More

The Center on the Social Emotional Foundations for Early Learning
http://csefel.vanderbilt.edu/
The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) is focused on promoting the social emotional development and school readiness of young children from birth to 5 years old. CSEFEL is a national resource center funded by the Office of Head Start and Child Care Bureau for disseminating research and evidence-based practices to early childhood programs across the country.

The Technical Assistance Center on Social Emotional Intervention for Young Children
www.tacsei.org
The Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI) takes the research that shows which practices improve the social–emotional outcomes for young children with, or at risk for, delays or disabilities and creates free products and resources to help decision-makers, caregivers, and service providers apply these best practices in the work they do every day. Most of these free products are available on the TACSEI Web site for immediate view, download, and use.

Early Head Start National Resource Center
www.ehsnrc.org
The Early Head Start National Resource Center (EHS NRC) serves the Early Head Start community by creating new resources and sharing information related to the unique needs of infants, toddlers, and expectant families and EHS and Migrant and Seasonal Head Start Programs. The EHS NRC disseminates timely information through face-to-face meetings, the Early Childhood Learning and Knowledge Center, and state-of-the-art distance learning experiences.

Together, parents and caregivers can reflect on the meaning of the behavior to try to understand its purpose and come up with the most appropriate strategies to prevent and respond to it.

Many caregivers said that having a few suggestions of potential strategies helped families begin to feel hopeful that their child would be able to learn new skills and improve the behavior. In fact, in response to a caregiver's reassurance and confidence that a child's behavior would improve, one parent expressed significant relief saying, "Wow, you mean my child doesn't have to act this way? Things can get better? I just thought this is how he was."

Conclusion

The evidence is clear that the first 5 years of a child's life have great impact on her later development. Behavior problems ranging from eating and sleeping difficulties to hitting, biting, and defiance in the early years of life are common, yet can pose significant challenges to parents and caregivers. Although these behaviors often resolve themselves on their own, the consequences of leaving them unaddressed can be dire.

Conversely, the benefits of caregivers and parents working together to discuss a child's behavior (whether it is typical or extreme) are great. When parents and caregivers develop a trusting relationship with each other, the caregiver's capacity to influence the child's growth and development expands. When concerns about behavior are openly shared and discussed, the caregiver effectively supports the child and also supports the parent–child relationship. Positively discussing challenges can help parents and caregivers increase their own feelings of competence. The way caregivers and parents approach these conversations can make a difference in a child's developmental trajectory.

Amy Hunter, *MSW, LICSW, is a program manager at ZERO TO THREE, in Washington, DC. In her capacity at ZERO TO THEE, Amy works with the Early Head Start National Resource Center and the Center on the Social Emotional Foundations for Early Learning project. Prior to coming to ZERO TO THREE 4 years ago, Amy served for 2 years as a National Head Start Fellow at the Office of Head Start. Amy provides training and technical assistance throughout the country in the area of early childhood mental health.*

Linda Broyles *is the deputy director of the Southeast Kansas Community Action Program (SEK-CAP). She is also responsible for overseeing the Early Childhood Services Department which includes child care and Head Start services for 900 children from birth to 5 years old. Linda began her journey in the field of early childhood as a licensed child care provider in her home. She became a Head Start parent in 1979 when her youngest child entered the program. Since that time she has worked within the same program in a variety of positions, including a classroom teacher, a site manager, a home visitor, parent involvement specialist, and transition specialist.*

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Coaching Early Educators to Implement Effective Practices

Using the Pyramid Model to Promote Social–Emotional Development

LISE FOX
University of South Florida

MARY LOUISE HEMMETER
Vanderbilt University

The Pyramid Model provides a conceptual framework for organizing practices needed to promote young children's social–emotional development, prevent the development of challenging behavior, and deliver individualized interventions to children with persistent behavioral concerns (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003; Hemmeter, Ostrosky & Fox, 2006; Hunter & Hemmeter, 2009). The model organizes evidence-based practices within four levels:Nurturing and Responsive Relationships; High-Quality Supportive Environments; Targeted Social Emotional Supports; and Intensive Individualized Interventions (see Figure 1). At the base of the Pyramid, "Effective Workforce" refers to the supports, training, and infrastructure needed to ensure that practitioners can implement the Pyramid Model practices with fidelity.

Coaching Early Educators to Implement Effective Practices

Over the last 10 years, national efforts to assist programs and practitioners in the implementation of the Pyramid Model have been guided by two federally funded projects: the Center for the Social and Emotional Foundations for Early Learning (CSEFEL), funded by the Office of Head Start and the Office of Child Care, and the Technical Assistance Center on Social Emotional Intervention for Young Children, funded by the Office of Special Education Programs. The Pyramid Model framework has been implemented within group care settings for infants, toddlers, and preschool age children and early intervention home visiting programs. In each of these applications, the levels of the framework are described similarly although the practices within the levels are unique to the developmental ages of children who are included in the program and the nature of services (i.e., home visiting versus group care) provided by practitioners.

The Pyramid Model provides guidance about the research-based caregiving practices for promoting young children's social–emotional competence and intervening with challenging behavior. Practices are presented for each level of the model beginning with the foundation of Establishing Nurturing and Responsive Relationships with the child and developing trusting and supportive relationships with families. The second level of the Pyramid Model, High-Quality Supportive Environments, refers to the importance of providing a classroom environment that is safe, developmentally stimulating, responsive to children's individual needs, and predictable and that provides developmentally appropriate opportunities for play and social interaction. In addition, practitioners are encouraged to support families in their efforts to develop home environments and routines that promote social–emotional competence. At the Targeted Social Emotional Supports level of the Pyramid Model, practitioners are guided to think about how to support the social–emotional needs of children including guiding children in their interactions with peers, supporting children to learn how to resolve peer conflicts, promoting social and play skills, helping children

Abstract

The Pyramid Model is a conceptual framework for organizing practices for promoting young children's social–emotional development and preventing and addressing challenging behavior. In this article, the authors describe a coaching approach that is focused on supporting early educators' implementation of the Pyramid Model. The authors provide a description of the Pyramid model, an overview of the coaching process, and vignettes illustrating the coaching process in action.

identify and understand emotion labels and the emotions of others, and supporting families as they promote their children's social development. The final level of the Pyramid Model, Individualized Intensive Interventions, provides guidance on a team-based process for understanding young children's persistent behavior challenges and developing individualized interventions that can be implemented by all care providers including the family.

In the following vignette, we describe a teacher who attends training on the Pyramid Model and is excited about implementing the practices in her toddler classroom. This vignette will be used through this article to describe the Pyramid Model and how to support early educators in implementing the model.

Carola was excited to attend a Pyramid Model workshop with her co-teachers. Her child care program had decided to train all their teachers in the implementation of the model. She was eager for ideas that she could use within her toddler classroom. Carola was the lead teacher of a classroom for 10 children who were 18 to 24 months old. When she moved from a preschool classroom to become the teacher of the toddlers, she thought that teaching a smaller group of children was going to be easier than her former classroom of 18 children. She was surprised by how challenging it has been. In her classroom, she had two children who were biting others and another one who really seemed to have the case of the "terrible 2s" with extreme tantrums multiple times a day. She collaborated closely with her two assistant teachers to make sure they were all working together and on the same page about how to address children's social and behavioral needs. Carola was particularly interested in learning more about the Pyramid Model because she thought it would provide information on how she could help children learn social skills and how she could address challenging behavior. She felt that her teaching team needed all the ideas they could get about those topics.

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Coaching begins by establishing a relationship between the coach and coachee.

Figure 1. The Pyramid Model

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Beyond the Workshop: Classroom Coaching

A COMMON MECHANISM in the ongoing professional development of early educators is the provision of a training workshop on a topic related to classroom practices (Sexton et al., 1996; Snyder et al., in press). In general, the goal of a workshop is to provide practitioners with the knowledge and inspiration needed to return to the classroom and implement practices learned within the workshop in a manner that leads to outcomes for children. Research on professional development efforts has indicated that it is most effective when change in teaching practice is an explicit focus of the training (National Research Council, 2001; U.S. Department of Education, 2010). The research also suggests the need for follow-up support in the classroom to help teachers implement new practices (Joyce & Showers, 2002). There is evidence that changes in teacher practices occur optimally when training is followed up with on-site coaching to support implementation of the targeted practices (Sheridan, Edwards, Marvin, & Knoche, 2009; Snyder & Wolfe, 2008).

In this article, we describe the use of a practice-driven coaching model to support early educators in their implementation of the Pyramid Model practices. The content

Photo: Kiwi Street Studios

Observation helps the coach understand the dynamics of the classroom, the children, and the strengths of the teaching team.

and process of this model are illustrated by Carola's experiences in receiving training and working with a classroom coach as she began the implementation of the Pyramid Model within her toddler classroom.

The Pyramid Model workshop was 2 days long and full of helpful ideas and ways to think about the design of the infant–toddler classroom, how to build relationships with children and families, and guidance on how to promote the social-emotional development of very young children. Carola and her team enjoyed the workshop activities and opportunities to role play and practice the content they were learning. During the workshop, Carola and her colleagues were given multiple opportunities to reflect on the Pyramid Model practices and how they might implement the practices in their classroom. At the end of each day, her team had an opportunity to discuss what was presented and identify ideas for implementation within their classroom. Luckily, the training was only the first step toward Carola's implementation of the Pyramid Model. The program was providing her and her classroom team with a coach who would be working with them to guide their implementation efforts.

As illustrated by Carola's experience, the first step in a professional development effort aimed at changing teacher practice is to expose teachers to the knowledge or skills that are the goals for implementation. In the Pyramid Model, an *Inventory of Practices for Promoting Infant and Toddlers' Social Emotional Competence* (Allard, Hunter, & Simmons, 2011) is used to illustrate practices related to each level of the Pyramid Model, identify ongoing professional development needs, and develop action plans for implementation. These practices serve as a foundation for the training workshops so that early educators are knowledgeable about the practices, understand why selected practices are important to children's social–emotional competence, and can explore how the practices might be implemented within their setting.

The *Inventory of Practices* (Allard et al., 2011) can be presented within a training context as a reflection and action planning tool. It helps reflect on their strengths in implementing practices linked to promoting children's social–emotional competence and identify areas to improve. The use of the *Inventory* within a training setting makes explicit the goals for implementation and the intended outcomes of the professional development experience. The *Inventory* also provides a transitional tool that bridges information learned in the training workshop to actions for classroom implementation. Early Educators can leave the workshop with goals (i.e., practices) identified for implementation.

Carola left the Pyramid Model workshop excited…but also a little overwhelmed. There was so much that her team wanted to implement. In their review of the Inventory, *they were pleased to see that so much of what they were already implementing was recognized as effective practice. They also were able to see some areas for improvement. Although they felt they had good relationships with the children's families, their classroom environment did not have spaces for family members to be comfortable in the classroom and did not have resources available to help families learn about ways to support their child's social–emotional development and prevent challenging behavior. They had strong relationships with children, and the environment they offered for children's play and exploration was well-designed and engaging; however they felt they could be better at guiding children in their understanding of the schedule, routines, and the expectations within routines. They were very intrigued by the use of visuals and photographs to support toddlers' understanding of routines and expectations. Carola and her assistant teachers were most excited about the new information they received on how to begin to teach social–emotional skills to toddlers (e.g., problem solving, empathy, social interactions, identifying emotions, understanding others' emotions). Finally, Carola and her team noted that they really did not have a plan for how to team with other pro fessionals and the family when children had persistent behavior challenges. They would try various techniques to resolve children's challenging behavior in the moment, but most often the strategies did not work. They didn't have a systematic plan, and they weren't sure how to involve families in the design of those interventions.*

Practice-Driven Coaching and the Pyramid Model

Coaching involves creating a supportive context for the coach and coachee to work together to examine and reflect on current practices and identify new skills or strategies for implementation. Coaching helps the practitioner achieve the confidence and competence to be reflective, identify actions for implementation, engage in self-correction, and use new skills and strategies. Practice-driven coaching refers to providing coaching or mentoring to a practitioner that is explicitly linked to identified practices with the goal of helping the practitioner become more proficient with implementing the practices with fidelity (Snyder, Fox, & Hemmeter, 2011). Practice-driven coaching requires that a practitioner be supported by a coach or mentor who is knowledgeable about the desired practices or intervention and that there is a fidelity tool or checklist that helps identify what practices are currently being implemented and what practices might become the focus of coaching.

Coaching begins by establishing a relationship between the coach and coachee. Many coaches find that it is helpful to have a conversation about the goals of coaching and the goals of the practitioner who will be coached. It is best, although not always possible, for the coach to serve primarily as

a support to the teacher and not also serve in roles as a program administrator who has supervisory or performance evaluation authority over the coachee. Often, the coach and coachee complete an agreement that defines the coaching relationship and what each person can expect within the process.

We recommend the use of a coaching cycle that includes the following steps: gathering information and assessing implementation; action planning and goal setting; observation; and debriefing and providing feedback (Fox, Hemmeter, Snyder, Binder, & Clarke, 2011). These steps are not linear, rather they represent a cycle. For example, action planning and goal setting is an ongoing process. Once an action plan is developed, it guides the other steps of the process. However, when an action plan goal is met, the action plan is revised and new goals for implementation are identified. Information from ongoing observations and debriefing meetings is used to measure progress toward action planning goals and to determine when new goals are needed.

Gathering Information

The coaching process begins with gathering data on the practitioner's current implementation of Pyramid Model practices. Information is gathered through at least two sources: observations and discussions with the coachee. Observations of the classroom include the use of a formal tool such as *The Pyramid Infant Toddler Observation System* (Hemmeter, Carta, Hunter, Strain, & Baggett, 2010) or a checklist of practices such as the CSEFEL Inventory of Practices for *Promoting Infant and Toddlers' Social Emotional Competence* (Allard et al., 2011). The observation helps the coach understand the dynamics of the classroom, the children, and the strengths of the teaching team. Further, it will help the coach identify potential implementation goals related to specific Pyramid Model practices. Coachees can be guided to self-assess their practice using the same checklist.

In addition to the observations, the coach encourages the coachee to reflect on the Pyramid Model practices and the training that has been received, and to create an initial list for action planning goals. The coach provides the coachee with the *Inventory of Practices* (Allard et al., 2011) on which the coachee can reflect and identify areas where support for implementation is needed. This is often done initially during the training workshops as was described above.

Denise, the curriculum specialist with the program, was Carola's assigned coach. They had met during the training workshops and established a time when Denise could observe the classroom and meet with the classroom team. In a meeting following this brief observation of the classroom and children, Denise complimented the teaching team on how well they worked together, their responsiveness to children's needs, and their carefully arranged and inviting classroom environment. She told the classroom team about herself and her experiences and asked them about themselves. Denise explained what would happen in the coaching visits and the goal of the coaching process. She was careful to point out that she would be providing support to them in the implementation of the Pyramid Model, but was not evaluating them and would not be talking with their supervisors about what she observed. Further, she explained to them that this was a collaborative process to which she brought knowledge about the Pyramid Model and they brought knowledge about the children and their classroom. She asked the team to share what they had identified as goals for implementation during the workshops. Carola took out the planning worksheet on which they had identified some initial goals during the workshop. It was quite a long list! Denise suggested that they begin by identifying two or three initial goals for the first action plan and over time they could add goals related to their other concerns. She advised the team to think some more about what might be the first priorities for them and suggested that she return the next week and conduct a long observation in the classroom so that she could really get to know the strengths of the teaching team and help them identify their first action planning goals.

Action Planning and Goal Setting

After gathering information, the coach then meets with the early educator and together they select two or three goals for an initial action plan. Often, practitioners want to put many goals on an action plan. The coach guides the early educator to select just a few so that the early educator can narrow her focus to a manageable set of new practices. Once the goals are selected, the coach and coachee develop an action plan that outlines which steps are needed, who is responsible for making materials that are needed, when the coachee will start working on the practice, and how they will know when the goal has been accomplished (See sample action plans in Tables 1 and 2). The benefits of using an action plan include: providing a focus for observations, targeting skills the early educator identifies as important, breaking a complex model into concrete steps for the early educator to use, and ensuring that the coach and coachee have a common set

Table 1. Action Plan for Carola

Goal	Action Steps	Materials or Resources Needed	Timeline	How will I know when I've been successful?	Date Step Completed
Help children learn the routines of the classroom.	1. Post a photograph schedule of the daily activities 2. Teach classroom staff how to use visual schedule 3. Show the children pictures on the schedule prior to any change in activity 4. Post visuals of routines and activities (e.g., hand-washing, stop sign). 5. Use visual schedule and other visuals when redirecting	• Make a visual schedule (Denise will take photographs at next observation)	Post in 2 weeks	Children look at pictures and transition to next activity	
		• Make visuals for routines including hand-washing, brushing teeth, and stop sign for door	Post in 2 weeks	Children look at picture or visual and follow step or information	

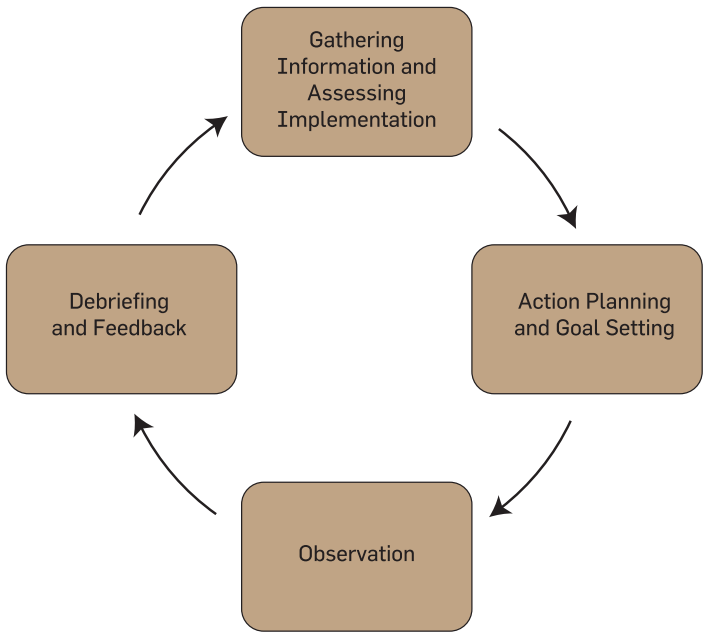
Table 2. Action Plan for Helping Children Understand Emotions

Goal	Action Steps	Materials or Resources Needed	Timeline	How will I know when I've been successful?	Date Step Completed
Teach children how to identify and understand emotions.	1. Post photographs of children with different emotion faces around classroom. 2. Label children's emotions using a variety of emotion words throughout the day. 3. Make "Our Feelings" book with pictures of children from the classroom for children to take home. Include CSEFEL parent handout. 4. Identify toddler books on emotions to share during story time and when children initiate. Select 4 to 6 books.	• Pictures of children (Denise will take at next observation, Carola will ask parent volunteer to look through parent magazines)	Post in 2 weeks	Children express interest in photographs and adults label or describe emotions	
		• Post list of emotion words around room to remind adults of what they might use (near changing table, at cubbies, at book area)	Posted in 1 week	Adults frequently discuss emotions during routine interactions	
		• Feeling book (Denise will make extra printout and bring)	Completed in 3 weeks	Feeling book is going home with children. Caregivers report that children appear to enjoy sharing book at home.	
		• Print out class list and post near door to track whose turn it is to take book home			
		• Get book list from CSEFEL Web site (www.vanderbilt.edu/csefel)	Books selected in 1 week	Children are interested in book and imitate emotion expression	

of goals. Once the action plan is developed, coaching occurs in a cycle following the steps listed below (see Figure 1 Coaching Cycle).

The following week, Denise returned to the classroom and conducted a 2-hour observation. She used the The Pyramid Infant Toddler Observation System *(Hemmeter et al., 2010) to guide her observation. This tool helped her note the practices that were areas of strengths and identify practices to target. She noted that the toddlers in the classroom often seemed confused about what was expected within a routine. This was often when challenging behavior would occur. Denise felt that if the classroom staff helped the children learn the expectations of the routine, the children could be more independent and problem behavior would be reduced. When she met with the team, they expressed that they were really excited about teaching children social skills and wanted to focus on that as a priority action planning goal. With Denise's guidance, the team decided to initially focus on two action plan goals: one for teaching children about emotions and one focused on using photographs to teach children classroom routines and expectations. Denise and Carola completed a written action plan for the steps needed to achieve those goals. For each of the steps, a specific timeline for implementation was identified. In Tables 1 and 2, the initial action plans for Carola's classroom are displayed. Before leaving, Denise and Carola discussed what would happen in the next coaching visit and confirmed the day and time.*

Figure 1. Coaching Cycle



Observation

A coaching session always begins with an observation. During the observation, the coach may do a variety of things including (a) observe and collect data or take notes to inform coaching, (b) demonstrate and model new strategies, (c) help with the classroom while the early educator tries new strategies, (d) videotape the activities, and (e) make suggestions to the early educator as she tries out new strategies. What the coach does during the observation is determined jointly by the coach and coachee during their meetings. Some coachees might want the coach to provide her with suggestions in the context of a busy classroom while others will prefer

that the coach wait until the debriefing meeting to provide suggestions. Some coachees might like to have the coach demonstrate the strategies live while others may prefer that they role-play or watch videos of others using the strategies. When the coach observes and for how long will depend on what strategies or practices the coachee is targeting. For example, if the coachee's action plan goal is focusing on transitions, the coach will observe during multiple transitions during the day. If the coachee is working on guiding children through daily routines such as snack, the coach will observe during those routines.

During the next classroom observation, Denise was pleased to see that Carola and her team had a photograph schedule of the classroom activities. The schedule was posted using Velcro and Denise noted that the adults in the classroom frequently removed the photographs and brought them to a child to prompt a transition or provide a redirection. The toddlers seemed to really notice the photographs and gain meaning from their presentation. She also saw that the team had posted photographs that depicted the hand washing sequence near the sink and the steps for brushing teeth. There was also a stop sign on the door that led to the outside patio. As a child moved to the door and pushed on it, the teacher assistant gently cued the child by pointing to the stop sign and saying "We are playing inside now, outside will be after snack. The stop sign means time to stay inside." She observed a very brief group time where Carola read Baby Faces, *a chunky board book of photographs of baby facial expressions to children who chose to come to group. The children seemed intrigued by the photographs and some patted the photographs of children in the book. Denise noted that during play time with push toys, a child seemed frustrated and began whining. Carola moved right to her and assisted her in pushing the toy while saying "Hush, hush Krystal... you can do it." After indoor play, the children went outside. Sammy, one of the older toddlers, had a huge meltdown when a peer picked up a toy that he wanted to play with. When the adult responded by stating "You are frustrated. Emily is playing with the truck now. I know you want the truck. You will have a turn after Emily," Sammy bit and hit the adult.*

Debriefing and Providing Feedback

Following observations, the coach and coachee meet to discuss progress toward action plan goals. The purpose of these meetings is to reflect on and provide feedback about the early educator's implementation of the jointly identified action plan goals. During this meeting, the coach begins by providing the early educator an opportunity to reflect on how things are going. The coach can ask questions like "How do you feel the transitions went today", "Tell me what happened when you tried using the visual schedule", and "How did the children respond when you read them the book about emotions?" In addition, the coach can provide feedback to the early educator. Feedback should include comments about things that are going well (e.g., "When you showed Emory the photo of the sink, she went right over and started washing her hands. The visuals really seem to be helping the children understand the routines."). Feedback may also include some constructive suggestions such as "I noticed that after children went to the potty, they sometimes started playing with toys before washing their hands. I know that was a really busy time, let's think about some ways that you can remind or prompt them to wash her hands when you are also attending to other children." During the debriefing meetings, the coach will also ask the early educator if she needs specific suggestions for addressing the individual needs of a child. We sometimes call this *targeted support*. It is important to be thinking about how to apply the strategies to all children in the classroom and how to address the needs of individual children. Finally, the coach and the early educator discuss next steps in terms of what the early educator is going to work on and what the coach is going to do during the next observation. They also discuss any additional resources or supports the early educator needs (e.g., a visual for a special activity that is coming up) to implement the action planning goals. Finally, in addition to talking about the action plan and the specific practices, these meetings should be used to talk about the coaching process. The coach provides the early educator with the opportunity to reflect on the coaching and to discuss how it is going and how the coach can be most helpful.

Following the fifth coaching observation, Denise met with Carola to debrief. She started the session by commenting on posted visuals. She asked Carola for her reflections on the use of visuals by saying "I see the team using the visual schedule, how it that working for the children?" Carola noted that schedule has become a useful tool for the team and that children seem to understand what is next when they see the picture. She said it has been particularly valuable when a child "needs an extra prompt or redirection." Denise shared her observation of the teaching assistant noting the stop sign and redirecting a child at the door. Carola was pleased to hear that Denise had seen that and commented on how everyone on her team was excited about "the power of the visuals in helping children understand." Denise commented on the emotion book that was shared at story time and complimented Carola on her skills at engaging children during the reading. After discussing more of the achievements that Denise had noticed, Denise said "I noticed that Krystal became frustrated with the push toys. You were right there to guide her. Those situations are great opportunities to label emotions. So, you might say 'Krystal, I know you are frustrated. You can do it. Give it a push.' When you label emotions in context, children gain a lot about the meaning." Carola nodded her head and stated that this was something that the team knew they needed to remember to do. Denise then asked about Sammy. Carola shared that Sammy had been having long episodes of meltdowns "that seem more intense than what typically might happened" and that over the last 2 weeks the frequency of his meltdowns with aggressive behavior has increased. Denise asked Carola what she thought her next step should be to support Sammy. Carola expressed that "We really don't know what to do. I asked his mother if something different was going on at home and she seemed upset by the question." Denise helped Carola plan what to say to Sammy's mother and promised to email a handout on how to initiate conversations with families about challenging behavior after the meeting. She also assisted Carola with thinking through some additional action steps for supporting Sammy that included asking the mental health consultant to conduct an observation and beginning to collect simple information on behavior incidents by noting when and where they occur, the triggers, what Sammy does and how long it lasts, and how adults or peers respond to the behavior incident. In the last 15 minutes of the debriefing meeting, Denise and Carola reviewed the action plan related to posted visuals (Table 1) and determined that the goal had been met. They agreed that there was still a little work left on the action plan related to emotion expression. Carola added an action step for meeting with her team each day to reflect on how they did in their use of emotion labeling to see if they could increase these opportunities to use emotion words with children. They also began developing a new action plan related to supporting Sammy and the use of a systematic process for addressing the support needs of children with persistent challenging behavior.

Coaching Outcomes

A PRACTICE-DRIVEN COACHING approach provides early educators with the knowledge and support to implement evidence-based practices. Coachees who participate in this approach have stated that they experience the process as beneficial and supportive. For example, a coachee shared that "It was wonderful to have somebody right there with you, showing you along the way, rather than going to the training

and 'Here are your materials and I will see you in a couple of weeks or a couple of months.' " The process creates a comfortable context for encouraging the early educator and supporting the early educator in the implementation of new practices and strategies. A coachee who participated in this process reflected on her relationship with the coach by stating that "She gave me encouragement to be consistent and keep going. Even when I was like 'Okay this will not work' and she said, 'Let's stick with it.' And it all worked out!"

The Pyramid Model involves a complex array of practices that are related to meeting the social–emotional development and intervention needs of all children in the classroom. To implement this framework of practices, early educators need both knowledge of the practices and support for implementation. Because the model is complex, it is critical that early educators are supported as they grow in their implementation fidelity over time. A practice-driven coaching process provides both the clarity for practitioners about what to implement and the support to become more fluent in their implementation fidelity.

Lise Fox, *PhD, is a professor in the Department of Child and Family Studies of the College of Behavioral and Community Sciences and the co-director of the University Center for Excellence in Developmental Disabilities (Florida Center for Inclusive Communities) at the University of South Florida. She is also the director of the Technical Assistance Center on Social Emotional Intervention for Young Children and a faculty member with the Center on the Social Emotional Foundations for Early Learning.*

Mary Louise Hemmeter, *PhD, is an associate professor in the Department of Special Education at Peabody College of Vanderbilt University. She is the director of the Center on the Social and Emotional Foundations for Early Learning and a faculty member on the Technical Assistance Center on Social Emotional Intervention for Young Children.*

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Parents Interacting With Infants

Strengthening Parent–Child Relationships to Support Social and Emotional Development

TWEETY YATES
University of Illinois at Urbana-Champaign

Jared (15 months old) attends a Parents Interacting With Infants (PIWI) group with his mother, Jana. During a recent conversation, Jana told the PIWI facilitators that Jared doesn't play with anything or anyone for very long. She has a hard time keeping up with him as he moves from toy to toy! She is very worried that Jared won't do well in school once he is old enough to go.

Similar concerns were expressed by several of the parents in this parent–child group. But, the PIWI facilitators know that children of this age are explorers. They recognized that much of the behavior the parents were describing and concerned about was appropriate for the age of the children. The facilitators decided that the first step in addressing the parents' concerns would be to give them an opportunity to learn more about their children as explorers.

The facilitators planned a PIWI group focused on the topic "How I Explore My Environment." They set up the environment with a variety of familiar, age-appropriate objects including a jack-in-the box, hand puppets, and shape sorters. They also included unfamiliar objects like a big cardboard box with doors and windows cut out and streamers hanging from the ceiling to the floor. Prior to the parent–child play/observation time, they asked the parents to think about what their children might do in this environment. Will they dive right in and begin exploring, or sit back and observe and then explore? Will they explore the familiar objects first or the unfamiliar objects? Parents had fun making predictions ("guesses") about what they thought their children might do. The facilitators then transitioned to the play/observation time by saying, "Let's go play and find out what they do!"

Supporting Parents as Observers and Supporters of Their Child's Development

The ZERO TO THREE *Parenting Infants and Toddlers Today* parent survey (Hart Research Associates, 2009) found that while the majority of parents understood ways of promoting their child's development, their understanding of the milestones related to social and emotional development was less consistent. In general, parents seemed to underestimate the emotional and psychological abilities of infants and overestimate the self-regulatory abilities of toddlers (Newton & Thompson, 2010). This is an important finding in light of the fact that researchers now know that young children who are socially and emotionally healthy have a much greater chance of achieving success in school and in life. In fact, research has shown that children who have healthy social and emotional skills tend to learn better, are more likely to stay in school, and will be better able to make and keep lifelong friends. Social and emotional development has even been referred to as the "secret ingredient" for not only being ready for school, but for succeeding once there (Parlakian, 2003, p. 2).

The social and emotional development of infants and toddlers refers to the developing capacity to form close and secure relationships; to experience, regulate, and express emotions in socially and culturally appropriate ways; and to explore the environment and learn—all in the context

Abstract

One of the findings from the ZERO TO THREE *Parenting Infants and Toddlers Today* parent survey (Hart Research Associates, 2010) was that while the majority of parents understood ways of promoting their child's development, their understanding of the milestones related to social and emotional development was less consistent. This is an important finding in light of research showing that young children who are socially and emotionally healthy have a much greater chance of achieving success in school and life. This article describes a model used for parent–child groups and home visits for helping parents become better observers and supporters of their child's social and emotional development.

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In general, parents seemed to underestimate the emotional and psychological abilities of infants.

of family, community, and culture (ZERO TO THREE Infant Mental Health Task Force, 2001). Families play a vital role in promoting their child's social and emotional development. Family members are the ones who interact the most with their child and create opportunities and safe environments for exploring and learning (Keilty, 2010). When parents understand the impact they have on development and how playing with their child can support that development, they are more likely to engage in activities that enhance their child's development and growth (Kaiser & Hancock, 2003). The findings from the ZERO TO THREE *Parenting Infants and Toddlers Today* (Hart Research Associates, 2010) survey revealed that professionals need to do a better job of helping parents understand how their young children's social and emotional development unfolds and what they can do to support this critical area of development (Lerner & Ciervo, 2010). This article describes a model that can be used for parent–child groups and home visits for helping parents feel confident and competent as observers and supporters of their child's social and emotional development.

PIWI

The broad purpose of the PIWI Model (McCollum, Gooler, Appl & Yates, 2001, McCollum & Yates, 1994) is to enhance social and emotional development opportunities for the child by expanding on and strengthening the parent–child relationship. These goals are accomplished by providing parents with information and support for being sensitive and responsive to their children's characteristics and development. The best interactions happen when parents have knowledge of their child's development, understand their own roles in their child's development, and feel confident and competent in these roles. Hence, PIWI aims to enhance parents' ability to:

- Observe and interpret their child's social and emotional competence;
- Expand their understanding of factors that influence what their children do, feel, and learn;
- Feel confident in their own role in supporting their child's development and learning; and
- Feel comfortable and competent in expanding their own knowledge and skills with respect to their child.

PIWI parent–child groups and home visits always occur with the parent and child together, and with the parent as the primary interactor with their child. The role of the PIWI facilitator is to promote parent–child interaction by commenting, interpreting, collaborating, listening, and enjoying with the goal of supporting competence, confidence, and mutual enjoyment within the dyad. As one parent explained, "They [the PIWI facilitators] provided a lot of activities and toys, but they didn't come in and take over the children. So you interacted with your own child. It was very easy to be involved with your child."

The parents' ability to see through the eyes of their child, and alter their own interactive behavior to better match and support their child, are important keys to parenting competence as well as to parents' sense of well-being as parents. Parents' understanding of their own child's development, rather than just general developmental knowledge, is regarded as pivotal to parent sensitivity and responsiveness. Because this is assumed to be dependent on the parents' ability to observe and interpret their child's perspective, PIWI sessions are organized around developmental observation topics (DOTs) that support parents as observers and interpreters of social and emotional development within the context of ongoing play and caregiving activities. Focused observations highlight the child's competence and the influence of environmental factors, such as activities and materials, on behavior. In PIWI, DOTs are the primary means of assisting parents to become better observers and supporters of their child's development and learning style.

What Is a DOT?

DOTs provide a framework that programs can use during parent–child groups, socializations, and home visiting for giving parents information about their children's social and emotional development. In PIWI, using DOTs allows us an opportunity to expand on general developmental information and help parents learn what that developmental information means in relation to their particular child. DOTs help parents learn what their child is like (e.g., how their child communicates, explores, interacts) and how they can best support their child's development. When parents observe their children's interactions, they gain greater understanding of their child's development. Through focused observations, parents also gain a greater appreciation of their own role in supporting their child's development. Interactions are enhanced when parents are tuned into their child's development. This is important because the ability to observe and interpret behavior from the perspective of one's child is basic to sensitivity and responsiveness that underlies developmentally supportive parent–child interactions (Dunst & Trivette, 2009; Lohaus, Keller, Ball, Elben, & Voelker, 2001).

Being a good observer brings child development to the forefront of parents' awareness by encouraging them to experience the environment from their child's perspective, reinforcing what they already know about their child's characteristics and behaviors. DOTs help parents observe what their children can do, how they do things, and why they do things. They also provide a purpose for parents' own actions as they interact with their child. Individual differences not developmental status are the focus, making the activities interesting and useful to all parents irrespective of their child's age or abilities. DOTs are developed from the

child's perspective and reflect what children are working on developmentally, what they are interested in, and any concerns and interests that parents have about their children. For example, a parent might be concerned because her child doesn't like to play with anyone but her (Mom). The PIWI facilitators plan the DOT "How I Interact With Others When You Are Close By" in response to the parent's concern. During the parent–child observation/play time, the facilitator tries playing with the child while Mom stands close by and supports her child. It made Mom feel really good to see her child happily playing with another adult. She learned that if she stays close by, her daughter felt safer and was more willing to play with adults and children. Additional sample DOTs can be found in Table 1.

As mentioned earlier, there are many benefits to focusing parents' observations of their child's social and emotional development. When the parents focus their attention on a specific topic, it is easier for them to observe their child and learn new things about how to support their development. As one parent reported

You set goals for what you would be looking for throughout the evening. It was more, "Let's see how they do things," rather than strictly just come here and play. I had an idea of what I was supposed to do with him from the discussion beforehand and the wrap-up after.

Table 1. Sample Developmental Observation Topics (DOTs)

Helping adults understand…	
What I	Do Feel Know
How I	Explore my environment Communicate my wants and needs Express my independence Use an adult to help me explore and learn Interact with others Show my interests in objects Use an adult to help me feel safe and secure Respond to others' emotions Use my senses to learn
Why I	Try to "do things myself" Test limits on my behavior
How adults	Support and expand my confidence Support and expand my competence Help me feel safe and secure

Photo: Kiwi Street Studios

Research shows that children who have healthy social and emotional skills tend to learn better and are more likely to stay in school.

For PIWI, the goals of using DOTS for infants and toddlers are: to provide opportunities to practice and demonstrate what they can do; to expand on what they already do, know, and feel; to gain confidence in their ability to influence their environment; to feel good about themselves; and, most important, to have fun with their parents. For parents, the goals are: to better understand what their child is like; to experience pride in what their child can do; to better understand their role in supporting their child's social and emotional development; to gain confidence in observing and supporting their child's development and learning; and to have fun with their child. To demonstrate how DOTs fit within the PIWI schedule, let's look at a parent–child group example.

PIWI Play Groups in Action

A PIWI group is about to begin! The two PIWI facilitators, Lori and Juan, have carefully arranged the room for the arrival of the infants, toddlers, and their parents. Objects and materials to be used in later activities are out of sight: turned to the wall, covered up, or in tubs in the closet. All that is out are a few small, quiet objects—just enough for each child—matched to the children's ability levels so that their parents can support them, but also be free to talk.

Parents and their young children begin entering the room and putting on their name tags, which are in a basket near the door. This is the third session of a 12-week group so everyone is becoming more familiar with the routines of the group. As they enter, some children go directly to the central rug where the toys are; others cling to their parents, watching but still a little hesitant to go to the rug. As parents and children gather on the rug the parents engage in informal conversation with the facilitators and other parents. The facilitators also use this time for brief follow-ups with parents. For example, Lori checks with a father about their move to a new apartment that occurred since the last session. The group then begins by singing the "hello song" which welcomes each child and parent by name. The children listen attentively and even the youngest seem to recognize their own names, smiling or looking up at their parent when it is their turn.

The opening discussion begins with sharing about the previous week's DOT ("How I Explore My Environment") and the suggestions for "things to try at home" that they'd been given. Did anyone try the activities? What happened? How did the children explore? Juan then reminds the parents of the different ways their children explored at the last session. The infants touched, banged, and mouthed toys while some of the older children picked the toys up, manipulated them, and imitated others as they explored. He then shares that today's DOT builds on the one from last week, "What You [parents] Can Do and Say to Help Me Explore and Learn." He reminds the parents that they had expressed concern about the fact that their children did not explore any of the materials for very long, but quickly went from one toy to the next. Today's DOT is focused on what parents can do and say to help their child develop motivation and skills for exploring and learning. He

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Families play a vital role in promoting their child's social and emotional development.

begins by talking about how, at every age, children notice and are interested in their environment. Some objects just seem to entice children to try them out. Of these items, some can be explored by the child alone, for example when an infant is watching the play of light in the window or a toddler is pouring water from a container during bath or water play. Many times, however, adult support can help children explore at a deeper level, learn new ways of using the materials, persist in accomplishing a goal, and attach new vocabulary words to objects and actions. Juan then talks about some things that parents can try with their children such as modeling what to do with the materials, noticing and commenting on what children are interested in, or providing words to describe what children are seeing and doing. He also reminds parents why opportunities for exploring are so important to children's social and emotional development. As he is talking, he points out what the children are doing that is related to the DOT, "Look at Katie, she is trying to figure out how the jack-in-the-box works. She is banging on the top and turning it upside down to try to figure it out. Mom showed her how to turn the knob and now she is making it work! She needed her mom to show her how to make it work so she would stay and explore the toy. That is a great example of our topic for today!"

Juan and Lori have carefully planned the environment so parents can observe (wait and watch) what their children are interested in and then join in and support their children's exploration of the materials. Juan explains how the environment will be set up today and talks about some of the materials and toys. He explains that some of the materials are the same ones that were used last week, but they have added some new items. For example, the large cardboard box now has streamers taped inside and a bucket of puppets and cars that parents can use to extend their child's play and exploration in the box. There will be a variety of materials and activities because children explore and learn about different things in different ways. With familiar objects and activities, parents can help their child go beyond what he or she can already do, using the materials in new ways. With new objects and activities, parents can help by modeling possibilities for playing and exploring. Juan then asks the parents to predict how they think their child will respond as they try out some of the strategies that they have talked about (remembering that their role is to help their child explore and learn). As they talk, Lori writes parents' predictions on a large piece of chart paper, which she tapes on the wall. As the discussion ends Juan says, "Let's go play and try some of the strategies and see what they do!"

During the parent–child play/observation time parents and children move about as they wish, while the facilitators move among them and join each parent–child dyad. The facilitators will notice, comment, and enjoy the child with the parent—supporting the competence and confidence of both parents and child. They may point out the child's abilities, comment on what happens when parents try one of the strategies, or interact briefly with the child in order to highlight exploration abilities. They will also watch carefully to see that all parents and children are engaged and quickly bring out new objects to extend play or to reengage if needed. Toward the end of the parent–child play/observation time, Lori quietly moves over to prepare the snack area. As children notice what is happening, they begin to move in that direction with their parents joining them.

As snack time progresses, a lively discussion develops about bedtime problems and routines, as parents share their ideas with one another. The facilitators ask parents if a handout about bedtime routines would be helpful and volunteer to bring one to the next session. As some children begin to finish their snack, Juan moves away from the table to the central rug area. He begins to blow bubbles to entice children to transition from the snack area. The facilitators have planned a variety of familiar interactive songs and games, as well as new ones that parents want to share. As they play, parents show or help children with the motions. One song in which children sit facing their parents holding hands is a particular favorite, and it is sung multiple times before moving on to the next. When the interest of the children begins to wane, new toys are placed around the rug area, signaling the end of parent–child songs and games and the beginning of the closing discussion.

As in the opening discussion, during the closing discussion parents are seated comfortably on the rug as their children play in the center of the circle or nearby. Juan asks the parents to share their observations and compare these to their predictions that Lori wrote on the chart paper earlier. As the parents share, the facilitators also add their own observations. What strategies did you try? What happened? How did your child respond? Did your child stay and explore for longer periods of time? Did your child explore differently with different kinds of objects? Was this different from how they explored last week? The parents and facilitators have fun talking about their predictions and if they "nailed it" or if their child did something completely different from what they thought they would. Juan then asks parents to think about some times or routines during the coming week where they might be able to use some of the strategies from today's group. A handout is also given to the parents with a list of the strategies. Juan and Lori then summarize the parents' observations by sharing that young children are very interested in exploring and learning, and that parents have very important roles in supporting their children. Parents can make sure children have plenty of opportunities to explore and can engage in the activities and experiences at their own level of understanding; and they can be available to support, join, and extend children's exploration and play. The facilitators tell the parents that they were thinking that the DOT for next week might be "How I Interact With Others When You Are Close by to Help Me" because they had expressed concerns and interests in this topic. The parents are excited and comment that they will watch to see how their child interacts with others before for the next group.

The session ends with the "good-bye song." Again, each child and parent are recognized by name. As the song ends, everyone claps and gets ready to leave. Once the parents and their children have gone, the facilitators review the

Learn More

Center on Social and Emotional Foundations for Early Learning (CSEFEL)
www.vanderbilt.edu/csefel
Look under Training Modules/Infant–Toddler Parent Module to find PIWI training resources and Developmental Observation Topic (DOT) plans for parent–child groups/socializations

session, discussing each segment of the schedule and each dyad individually. Were they all engaged? Did the DOT and activities support parent observations as well as competence and confidence? Did the parents learn new things about their child? Did any of the parents mention interests or concerns that could become new developmental observation topics?

Conclusions

The PIWI play group model is one example of how to help parents understand how their young children's social and emotional development unfolds and what they can do to support this critical area of development. Jared and Jana, like other parent–child dyads in their group, have much to gain from a well-planned, supportive environment that builds on their interactions with one another as a foundation for Jared's social and emotional development. For Jared, the use of DOTs can result in opportunities to practice and demonstrate his competence, and expand beyond what he already does, knows, and feels. PIWI provides a setting in which he can gain confidence in his own abilities and in himself as a learner. For Jana, the DOT sets a context in which she can experience pride in Jared's competence, understand individual characteristics and environmental factors that influence what Jared does, and develop ideas for what she can do to expand on Jared's experiences. It is also a safe and supportive environment in which she can gain confidence and competence in her own role as a parent and in supporting Jared's social and emotional development and learning. DOTs offer a carefully planned, focused, and fun way to achieve these important outcomes for infants, toddlers, and their families and is best illustrated in the words of parents who have participated in the PIWI groups:

"I love having a focus at every play group. I feel like I'm learning so much more about my child and we are both having so much fun! He loves to go!"

"I found myself watching for things that she would do at home related to what we were looking for in the play group. I showed my husband, watch what happens!"

"I wish we had done the groups like this when my older son came. I would have learned so much more about him."

"The structure of the group helped me to know what my role is in the group. I know what I am supposed to do and I am learning so much about my son!"

"I liked the discussions because comments that I made were acknowledged, even though the things my kid was doing were different from what someone else's kid was doing. When the facilitators would say, 'How did your child communicate?' I could express ways that Katie was communicating that might be completely different than theirs, but my answers were still acknowledged."

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With familiar objects and activities, parents can help their child go beyond what he or she can already do, using the materials in new ways.

Tweety Yates, *PhD, is a research assistant professor at the University of Illinois at Urbana-Champaign. She was co-project coordinator of the Center on the Social and Emotional Foundations for Early Learning and currently works on the National Center on Quality Teaching and Learning. Her work has primarily focused on the development of materials around parent–child interaction, social and emotional development of young children, and early literacy.*

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Sleep and Sleep Problems

From Birth to 3

COURTNEY DU MOND
Upstate Golisano Children's Hospital

JODI A. MINDELL
Saint Joseph's University
Children's Hospital of Philadelphia

Rebecca and John were thrilled when they found out that they were pregnant with their first child. During the first 2 weeks after their daughter, Zoe, was born, John was able to stay home from work and then Rebecca's mother came to stay for the next 2 weeks. By that time, Rebecca figured she wouldn't need any additional help. But Zoe is now 9 months old and, unfortunately, Rebecca is having a difficult time coping. Zoe continues to wake up at least twice each night, and Rebecca is finding it hard to function during the day. She reports, "I feel like a failure and a bad parent because I can't do it all." In contrast, Sarah and Steve, who now have a 19-month-old toddler, made some changes in his bedtime routine when he was 4 months old that made a significant difference in his sleep habits. Looking back, Sarah states "He has slept through the night almost every night for about 15 months. There were a few bumps in the road, but he quickly was back to sleeping. He is happy. We are happy. Life is good."

As can be seen in the above examples, not only is sleep a critical aspect of a child's early development but it is also essential to family well-being. During their first 3 years, infants and toddlers spend more than 50% of their lives sleeping (Iglowstein, Jenni, Molinari, & Largo, 2003). However, things do not always go smoothly when it comes to sleep. Concerns about sleep and sleep problems are among the most common issues brought to the attention of pediatricians (Lozoff, Wolf, & Davis, 1985). Although sleep is one of the most natural things a baby can do, it presents enormous challenges for many families, with studies finding that a large number of young children (from 20% to more than 50%) have a sleep problem (Armstrong, Quinn, & Dadds, 1994; Burnham, Goodlin-Jones, Gaylor, & Anders, 2002; Mindell, Meltzer, Carskadon, & Chervin, 2009).

Sleep Across Development

Sleep changes distinctly across development, with transitions in sleep architecture, sleep consolidation, and sleep regulation.

Newborn Sleep

In the earliest months after birth (birth to 2 months), newborns spend the majority of their time sleeping, anywhere from 10 to 18 hours a day (Iglowstein et al., 2003). Sleep is a time of incredible brain activity. In fact, a newborn's brain is more active during some stages of sleep than it is during wakefulness (Mindell & Owens, 2009). Sleep in this early period is essential for important aspects of brain development, including the development of neurosensory systems (e.g., visual, auditory, touch, olfactory, limbic system, hippocampal system). Most of this activity occurs during active sleep, which is similar to rapid eye movement (REM) sleep. Newborns spend a larger proportion (50%) of their sleep time in REM than at any other

Abstract

Sleep is an important aspect of a child's early development and is essential to family well-being. During their first 3 years, infants and toddlers spend more than 50% of their lives sleeping. However, concerns about sleep and sleep problems are among the most common issues brought to the attention of pediatricians. Although sleep is one of the most natural things a baby can do, it presents enormous challenges for many families, with studies finding that a large number of young children (20% to more than 50%) have a sleep problem. In this article, the authors review the prevalence and treatment of common sleep issues.

time in their life (Mindell & Owens, 2009). At this age, sleep periods are separated by 1 to 2 hours of wakefulness. Nocturnal and diurnal patterns have yet to be established, with sleep occurring equally during the day and night.

Sleep disorders are remarkably rare at this age, however, many parents worry about their newborn's sleep. In general, simple reassurance is all that is needed. For example, there is incredible variability in the amount of sleep a newborn needs, which can lead to uncertainty and concern for parents. Other concerns stem from the lack of a nocturnal and diurnal pattern. Day–night reversal is common and totally normal in the first few weeks. Increasing the newborn's exposure to natural light during the day, especially in the morning, will help to improve nighttime sleep. Finally, new parents sometimes misinterpret body movements, twitches, and sudden jerks in sleep (including smiling, sucking, and grimacing) as signs of restless or disrupted sleep. In fact, these movements are typical of active sleep and are not indicative that a child is not getting restful sleep.

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Sleep is a critical aspect of a child's early development and is also essential to family well-being.

Infant Sleep

As circadian rhythms begin to develop between 2 and 3 months old, sleep gradually consolidates, occurring for longer continuous periods of time with a preference for sleep during the night (Mindell & Owens, 2009). During infancy, babies sleep on average 9 to 10 hours at night and 3 to 4 hours during the day (Iglowstein et al., 2003). Much like the newborn period, there is significant variability in appropriate sleep times. The proportion of sleep time in active/REM sleep begins to decline as infants develop additional stages of non-REM sleep. They now cycle through the various stages of sleep approximately every 50 minutes. Sleep consolidation, or the infant's ability to sleep through the night, begins to develop between 4 weeks and 3 months. Approximately 50% of infants sleep through the night (8 hours between 10:00 p.m. and 6:00 a.m.) by 5 months old (Henderson, France, Owens, & Blampied, 2010).

During infancy, sleep and development are highly intertwined. Self-soothing skills begin to develop during the first 12 weeks of life, reflecting neurodevelopmental maturation and learning (Mindell & Owens, 2009). These skills play an important role in the infant's ability to negotiate the sleep-wake transition at bedtime and during normal arousals throughout the night. Typically, parents are more concerned about their baby's inability to self-soothe during night wakings than at bedtime. Note that arousals during the night are normal, with infants averaging brief arousals 2 to 6 times at night. Parental concerns about night wakings typically arise from the infant's need for parental intervention to return to sleep (see behavioral insomnia of childhood—sleep-onset association type in the Night Wakings and Bedtime Problems section). Common sleep disturbances occurring during infancy include frequent night wakings and bedtime problems, as well as benign sleep-related rhythmic movements (e.g., head banging, body rocking).

Toddler Sleep

As infants develop into toddlers, their sleep continues to mature with REM sleep continuing to decrease (Mindell & Owens, 2009). Toddlers sleep on average 9.5 to 10.5 hours per night and 2 to 3 hours during the day (Iglowstein et al., 2003). Over time, toddlers' naps decrease from two per day to one (most make this shift by the time they are 18 months old) or even none by the time they are 3 years old. At 1 year, nearly 100% of toddlers nap, but only 81% of 2-year-olds nap (Iglowstein et al., 2003). By 4 years, rates of napping decrease to just over 50%.

Sleep issues are quite common in toddlers. Bedtime problems, such as bedtime stalling and bedtime resistance, are problematic for 25% to 30% of toddlers, and night wakings occur in up to 50% of toddlers (Armstrong et al., 1994; Burnham et al., 2002; Goodlin-Jones, Burnham, Gaylor, & Anders, 2001; Mindell, Meltzer, et al., 2009). Developmental factors play a leading role sleep problems for toddlers (see Developmental and Medical Issues That Impact Sleep).

The most common sleep issues in this age group continue to include bedtime problems and night wakings, as well as sleep-related rhythmic movements. Parasomnias, including confusional arousals and sleep terrors, are also quite prevalent.

Common Behaviorally Based Sleep Problems

The most common behaviorally based sleep problems experienced by young children include night wakings, bedtime problems, sleep-related rhythmic movements, nighttime fears, and parasomnias.

Night Wakings and Bedtime Problems

Night wakings and bedtime problems are the most common sleep issues experienced by young children (Mindell, Kuhn, Lewin, Meltzer, & Sadeh, 2006). Overall, pediatric insomnias occur when there is "repeated difficulty with sleep initiation, duration, consolidation, or quality that occurs despite age-appropriate time and opportunity for sleep and results in daytime functional impairment for the child and/or family" (Mindell, Emslie, et al., 2006, p. 1224). According to the *International Classification of Sleep Disorders , Second Edition* (American Academy of Sleep, 2005), these sleep problems are classified as behavioral insomnia of childhood and include three subtypes: (a) sleep-onset association type, (b) limit-setting type, and (c) combined type.

Sleep-onset association type occurs when the conditions habitually present at bedtime (sleep-onset associations) are not immediately available to the child during normal nighttime arousals, resulting in problematic and often prolonged night wakings. Common examples include

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Newborns spend the majority of their time sleeping.

pacifiers, bottles, parental presence (e.g., rocking, feeding, or simply being in the room), or a favorite stuffed animal or blanket. As children learn to fall asleep, they do so in the presence of these conditions (e.g., nursing, thumbsucking) and ultimately come to require them to fall asleep and return to sleep in the middle of the night. In other words, the same conditions that are necessary for the child to fall asleep at bedtime are again necessary for the child to fall back to sleep after normal nighttime arousals. For example, an infant who is nursed to sleep each night will likely require breastfeeding in the middle of the night when she rouses normally between sleep cycles. Sleep associations can be helpful (positive sleep association) or problematic (negative sleep association) for sleep primarily depending on whether or not they involve the presence of a parent and if the child can easily access them herself. Pacifiers, blankets, and other transitional objects are positive ways for a child to self-soothe to sleep, but feeding and rocking are generally problematic as they involve the presence of a parent. The sleep-onset association type of sleep problem is highly prevalent, occurring in approximately 25% to 50% of infants (Mindell, Kuhn, et al., 2006).

The limit-setting type of sleep problems typically presents with parental complaints about a long, drawn out bedtime battle. Children with limit-setting type resist, stall, or refuse to go to bed, ultimately resulting in a prolonged sleep onset latency, a late bedtime, and, ultimately, insufficient total sleep time. Examples of bedtime resistance behaviors include refusing to stay in bed, stalling (e.g., frequent "curtain calls" to use the bathroom, get a drink), or temper tantrums. In simple terms, the child will do whatever he has learned will elicit a response from parent(s) to ultimately delay bedtime or the bedtime routine. These problems are often the result of inadequate enforcement of limits and behavior management. Approximately 10% to 30% of toddlers and preschoolers have bedtime resistance (Mindell, Kuhn, et al., 2006).

A combined-type sleep problem occurs when the bedtime struggles characteristic of limit-setting type ultimately result in a problematic sleep association. For example, Henry, a 3-year-old boy, resists going to bed by continually coming out of his room with various requests. Henry's parents respond to his requests for one more hug, a drink of water, and a trip to the bathroom, but become increasingly frustrated with his endless requests. After more than an hour of back and forth, Henry finally says that he is scared and his mother agrees to lay down with him until he falls asleep. In the middle of the night, he wakes up and is unable to self-soothe back to sleep. Henry cries for his mother who comes and lays down with him again until he falls back to sleep.

Sleep-Related Rhythmic Movements

Head banging, body rocking, and body rolling are all examples of sleep-related rhythmic movements. Although often distressing to caregivers, sleep-related movements are usually benign and serve as a self-soothing behavior for the child. They can occur at sleep onset, during normal nighttime arousals, and even during sleep. Rhythmic behaviors occur in almost two thirds of infants, decreasing to one third by 18-months, and only 5% by 5 years (American Academy of Sleep, 2005). The duration of rhythmic movements can last from minutes to hours, but does not typically interfere with sleep or cause injury to the child. In rare instances, often involving children with neurological or psychiatric disorders, rhythmic behaviors can be more severe, persisting into the day and resulting in injury to the child. Simple reassurance and safety guidance (e.g., ensure crib bolts are regularly checked as rhythmic movements may result in loosening over time, install guardrails on beds) is all that is needed for most typically developing children, however, a referral is warranted if the behaviors significantly disrupt sleep or result in physical injury. Increasing total sleep time and decreasing attention and other reinforcement for the behavior may decrease rhythmic behaviors especially during night wakings.

Nighttime Fears

Nighttime fears are common and generally not concerning. These fears develop in concert with a child's cognitive skills. With an emerging imagination, toddlers often develop fears of monsters or other imaginary creatures. Although typically benign, nighttime fears can persist and become problematic, resulting in a refusal to go to bed or to be left alone. In addition to basic reassurance, the most effective strategies for improving nighttime fears recognize and capitalize on the imaginary basis of the fear. If the imagination created it, the imagination can get rid of it. Simple, creative strategies such as monster spray (e.g., water bottle decorated as monster spray) are incredibly effective in eliminating nighttime fears. Other strategies include having a pet (even a goldfish will do it) "protect" the child during the night and having a child create a drawing of her fears that is then crumpled up and thrown away, thus vanquishing the fear.

Parasomnias

Parasomnias such as sleepwalking, sleep terrors, and confusional arousals are episodic behaviors that occur primarily during non-REM sleep. These behaviors are also generally benign but are often distressing to parents and result in potential safety concerns. Children often have the appearance of being awake during parasomnic episodes, but have amnesia for the event. Most parasomnias occur within the first few hours of sleep when slow wave sleep predominates (Mason & Pack, 2007).

Sleepwalking is a common childhood parasomnia in which children appear awake (eyes open), but confused or dazed. They may mumble or talk nonsensically and, in rare instances, they may appear agitated. A sleepwalking child is often easily guided back to bed. The most important consideration in

cases of sleepwalking is safety. Although rare, a sleepwalking child may leave the house, exit a window, or engage in other dangerous behavior. Parents should ensure that windows and doors are locked and that they are alerted when their child is sleepwalking (a bell on the door is often helpful).

Confusional arousals are an aptly named parasomnia, sometimes referred to as "sleep drunkenness." During a confusional arousal, children appear confused, disoriented, or both. They can be quite difficult to rouse and will occasionally become agitated if they are forced awake. These episodes are less dramatic than sleep terrors and typically respond well to simple monitoring and increased total sleep time.

Sleep terrors are characterized by a sudden arousal from sleep, accompanied by behavioral manifestations of intense fear. These episodes are often dramatic, resulting in significant distress for the caregivers. While very disturbing for caregivers, children are completely unaware of their behavior. The best course of action during a sleep terror episode is to simply monitor the child for safety. Attempting to rouse or comfort the child typically results in escalation and increased duration. With this monitoring-only approach, episodes typically resolve on their own within a few minutes. If sleep terrors (or other parasomnias) occur nightly or on a regular basis, increasing the child's total sleep time may result in a significant reduction or complete resolution of episodes. Professional consultation should be sought if parasomnias do not respond to sleep extension, to rule out seizures and other potential causes.

Behavioral Interventions to Improve Sleep

Research has clearly documented the efficacy of behavioral interventions for early sleep problems. Recent reviews have shown that 94% of behavioral interventions are efficacious, with 80% of treated children demonstrating clinically significant improvement maintained for 3 to 6 months (Mindell, Kuhn, et al., 2006; Morgenthaler et al., 2006). In fact, the American Academy of Sleep Medicine recently released practice parameters for behavioral treatment of bedtime problems and night wakings (Morgenthaler et al., 2006). Below is a brief review of some of the most effective behavioral interventions.

Age-Appropriate Bedtime

Setting an age-appropriate bedtime is very important. Research has clearly shown that bedtimes that occur later than 9:00 in children up to 10 years of age result in prolonged sleep latency, increased night wakings, and ultimately less total sleep time (Mindell, Meltzer, et al., 2009). Children with limit-setting or combined type often present with a shifted sleep onset that occurs later than desired because of stalling at bedtime. For these children it is often helpful to institute bedtime fading. Bedtime fading occurs when a temporary bedtime is set at the child's present sleep onset time (e.g., 10:00 p.m.) and is gradually advanced to the desired bedtime (e.g., 8:00 p.m.). This strategy allows the child's circadian rhythm to slowly adjust to the earlier bedtime and helps avoid unnecessary bedtime struggles.

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Transitional objects such as stuffed animal can be very helpful in fostering a child's independent sleeptimes.

Bedtime Routine

One of the simplest and most effective interventions to improve sleep is a bedtime routine. Research has shown that the institution of a consistent bedtime routine results in significant improvements in child sleep, including a shortened sleep onset latency, decreased night wakings, and greater total sleep time (Mindell, Telofski, Wiegand, & Kurtz, 2009). In order to be most effective, bedtime routines should occur 20 minutes (without a bath) to 45 minutes (with a bath) before the child's bedtime and should happen in the same temporal sequence every night. A bedtime routine might include a bath, pajamas, and reading two stories. As discussed above, children form associations with things that happen before they fall asleep. These can be problematic such as the sleep associations involving a caregiver or helpful, such as a bedtime routine that facilitates "winding down" and signals the child that it is almost time to go to sleep. Families of older toddlers and preschoolers may want to create a picture chart that shows the steps of the bedtime routine. Parents can use these charts to help set limits. For example, a frequent bedtime stalling technique is asking for "Please, one more book Daddy!" Instead of engaging in an argument or giving in to the child's request, the parent can refer back to the chart and simply say "Look, the picture only shows two books, I guess we'll have to save the next book for tomorrow night." Bedtime routines should also be "sweet," meaning that they include activities that the child enjoys and finds relaxing. It is important to avoid additional conflict around bedtime. Parents and children are tired and therefore behavior problems are more likely to occur at this time. For example, if a child does not like to take a bath, move the bath to the morning or earlier in the day. Finally, bedtime routines should head in the same direction. This refers to many families' habit of moving all over the house before bedtime. For example, Stephen first takes a bath and puts on his pajamas in his room. Then he goes downstairs to watch TV, followed by a quick snack in the kitchen before being sent to bed. This bedtime routine involves too many transitions and does not send a clear message that it is time to go to sleep. It also sends the message that when a child goes into his room at night it does not mean he has to stay there. Bedtime routines work best when they head in one direction and end in the child's bedroom.

Transitional Objects

Transitional objects such as a blanket, stuffed animal, or even a thumb or pacifier can be very helpful in fostering a child's independent sleeptimes. If a child does not already have a transitional object, parents can facilitate one by first pairing it with times of cuddling and feeding.

Behavioral Strategies

For sleep-onset association and combined types of sleep problems, in addition to establishing a good bedtime routine and sleep schedule, parents should be advised on how to phase themselves out of bedtime. Children with negative sleep-onset associations

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Across the first years of life, the acquisition of gross motor and cognitive milestones may result in sleep disruptions.

have not learned to self-soothe to sleep and require a caregivers' presence to fall asleep and return to sleep. The most common approach involves having the parents put the child to sleep when she is drowsy but awake and waiting progressively longer periods before checking on the child. The waiting time should be set by the parent and can be anywhere from 3-20 minutes, depending on the parent's tolerance and the child's temperament. When parents do check on their child, contact should be minimal, such as a simple statement (e.g., "Goodnight, it's time for sleep."). Checking intervals can be extended, although this is not necessary, until the child ultimately falls asleep between checks, thereby learning to self-soothe. Other more gradual approaches can also be used, such as progressively moving the parent out of the room. For example, if Sarah usually falls asleep while nursing and being rocked, the first step would be to move the nursing to the beginning of the bedtime routine when Sarah is most awake. Once this step has been accomplished and Sarah falls asleep easily without nursing, her mother can stop rocking and simply hold her to sleep. Next, she can place Sarah in the crib and sit next to her. Finally, the chair is gradually moved out of the room. In this scenario, Sarah is slowly learning to self-soothe to sleep while being gradually weaned of her mother's presence. Parents should be offered both methods and allowed to choose the one they feel will work best for their family.

For all behavioral treatment strategies, it is important to warn families of the *extinction burst*. An extinction burst is a temporary increase in intensity and duration of the undesired behavior (usually crying or temper tantrums) when behavioral treatments are first instituted. Usually families can expect to see improvements within 3 to 7 days, with consistency and perseverance being of utmost importance. It is often helpful to follow-up with families in the first few days of a behavioral plan to offer reassurance and problem solve for any complications they may have encountered.

Learn More

National Sleep Foundation
www.sleepfoundation.org

Customized Sleep Profile
www.johnsonsbaby.com/sleep

Developmental and Medical Issues That Impact Sleep

There are multiple issues that can impact sleep in a young child that should be considered, including both developmental and medical issues.

Developmental Issues

Sleep and development are highly intertwined throughout life, but perhaps never more so than in the earliest years of life. Developmental issues such as attachment, gross motor development, and cognitive development can influence a child's sleep patterns. Research has shown that infants who are insecurely attached to their caregivers are more likely to have sleep problems; however, sleep problems at this age do not necessarily imply poor attachment (Beijers, Jansen, Riksen-Walraven, & de Weerth, 2011). In fact, other studies have shown the more socially engaged infants are with their caregivers, the more reluctant they are to separate at bedtime leading to early sleep problems (Schwichtenberg & Goodlin-Jones, 2010).

Across the first years of life, the acquisition of gross motor and cognitive milestones may result in sleep disruptions. For example, as babies achieve various gross motor milestones such as rolling over, pulling to standing, crawling, and ultimately walking, temporary disruptions may be seen in their sleep patterns. The sleep disruptions may even occur in the weeks prior to the developmental milestone. Similar, but perhaps more pervasive, disruptions can be seen with cognitive milestones. As children develop object permanence late in their first year, separation anxiety may result in bedtime resistance and problematic night wakings. In the toddler and preschool years, rapid cognitive development may lead to difficulty settling at bedtime, and development of imagination and fantasy may lead to increased nighttime fears. Finally, as children gain further independence both motorically (e.g., increased locomotion and freedom resulting from transition from crib to bed) and cognitively (e.g., increasing communication and understanding of cause and effect) limit-setting problems at bedtime may increase. Fortunately, these cognitive developments also include a basic understanding of cause and effect, which allows the child to respond to simple behavioral interventions (see Behavioral Strategies above) to improve his sleep.

Medical Issues

Although most sleep problems in the early years of life are behaviorally based, some problems result from medical issues. In infancy, uncontrolled gastroespophageal reflux can result in difficulty settling to sleep and frequent arousals from sleep (Ghaem et al., 1998). These infants typically sleep for short periods of time before waking because of physical discomfort. Infants with behaviorally based sleep problems are easily comforted by their parent's presence, but infants with reflux are usually not sufficiently comforted by caregiver presence to return to sleep. Similarly, other early childhood illnesses, such as ear infections, teething, and colds, commonly result in temporary disruptions in a child's sleep. Generally, sleep patterns return to normal following resolution of physical discomfort.

Obstructive sleep apnea (OSA), a common medically based sleep issue, can also be experienced by young children, which is often contrary to popular belief that it is only an adult disorder (Katz, Marcus, Sheldon, Ferber, & Kryger, 2005). OSA is characterized by repeated episodes of prolonged upper airway obstruction, with common symptoms including loud snoring, pauses in breathing, labored breathing, heavy sweating, and mouth breathing. Children with OSA may also be sleepy during the day because of disrupted sleep during the night. In young children, sleepiness can often present as irritability or even overactivity. Prevalence rates for OSA peak in children between the ages of 2 and 8 years because of increasing tonsil and adenoid size. Left untreated, OSA is associated with significant medical (e.g., increased blood pressure, insulin resistance), neurocognitive, and

neuro-behavioral (e.g., deficits in attention and executive functioning) consequences (Katz et al., 2005). Therefore, children exhibiting any symptoms (especially snoring, labored breathing, apneas, or a combination of these) should be referred for further evaluation. Treatment for OSA in young children typically involves removal of the tonsils and adenoids.

Effects on the Family

As outlined above, sleep issues are highly common during the early years. However, as depicted by the parents in the opening paragraph, it is important to note that the effects of a child's sleep patterns are felt throughout the family. Poor infant and early childhood sleep results not only in insufficient sleep for the child but also results in decreased parental sleep and mood, as well as increased family tension (Mindell et al., 2011; Mindell, Kuhn, et al., 2006). Fortunately, research has shown that when a child's sleep improves, family functioning improves. These findings further highlight the need for prevention and early intervention for early childhood sleep problems, not only for the child's sake but also for the well-being of the entire family.

Courtney Du Mond, *PhD, is a clinical associate professor of pediatrics and co-director of the Sleep Center at Upstate Golisano Children's Hospital. Dr. Du Mond specializes in pediatric sleep medicine, primarily early childhood sleep disorders.*

Jodi A. Mindell, *PhD, is a professor of psychology at Saint Joseph's University and the associate director of the Sleep Center at The Children's Hospital of Philadelphia. She is the author of* Sleeping Through the Night: How Infants, Toddlers, and Their Parents Can Get a Good Night's Sleep (*HarperCollins*) *and* A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems (*Lippincott Williams & Wilkins*). *Dr. Mindell has been on the Board of Directors of the National Sleep Foundation and the Sleep Research Society. She is on the editorial boards of the journals* Sleep *and* Behavioral Sleep Medicine.

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When Military Parents Come Home

Building "Strong Families Strong Forces," a Home-Based Intervention for Military Families With Very Young Children

RUTH PARIS
MICHELLE L. ACKER
ABIGAIL M. ROSS
ELLEN R. DEVOE
Boston University

U.S. military families serving since September 11, 2001, have endured lengthy and sometimes frequent deployments to Afghanistan or Iraq or both in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Also particular to these wars has been the heavy reliance on the National Guard and Reserve (NG/R) members who live in thousands of communities around the country, in addition to active-duty service members living on or near military installations. Managing separations when a service member parent is being placed in harm's way puts these families under extreme stress (Barker & Berry, 2009; U.S. Department of Defense, 2010). Although all branches of the military have increasingly offered support to families with children during OEF/OIF, with weekend programs for couples, clubs for school-aged children, and camps for preteens and teens, to name a few examples, babies, toddlers, and preschoolers are typically forgotten (Robichaux & McCarroll, 2011).

Military Families With Young Children

More than 2 million American men and women have been deployed to Iraq and Afghanistan since 2001; of those service members, more than 40% are parents of approximately 2 million children (Office of the Deputy Under Secretary of Defense, 2010). Forty-one percent of children who have experienced at least one parental deployment are from birth to 5 years old (Office of the Deputy Under Secretary of Defense, 2010). Military families with young children are a diverse group. They include those with single parents, two parents, and caregiving grandparents; are from varied racial, ethnic, and religious groups; and originate from every part of the United States (U.S. Department of Defense, 2010). All families face similar challenges of raising young children, with the primary tasks of offering supportive, safe, and loving environments within which to nurture their children's optimal growth and development.

When a service member parent is deployed, the entire family experiences the upheaval and strain of the separation. However, most military families with young children cope well and manage the challenges of deployment using a variety of strategies (MacDermid, Samper, Schwarz, Nishida, & Nyaronga, 2008; U.S. Department of Defense, 2010). Although each phase of the deployment cycle (see box Cycle of Deployment) is accompanied by unique challenges for all family members (Logan, 1987; Pincus, House, Christensen, & Adler, 2001), the 6 to 12 months after the service member parent returns home can be some of the toughest times. For NG/R families, factors such as isolation due to geographic dispersal and differential access to military-connected services may exacerbate the adjustment

Abstract

The long wars in Afghanistan and Iraq have presented unique challenges to military-connected families with very young children, yet few evidence-based services are available to support these families through deployment and reintegration. In this article, the authors describe the process of developing and testing a culturally responsive home-based reintegration program for service members, their partners, and their very young children. Composite case examples are presented to illustrate the major concerns of military families and to highlight program elements aimed at enhancing parental reflective functioning and strengthening parent–child relationships.

experience. At the critical juncture of reintegration, military families can potentially benefit from an intervention that focuses on communication, enhancing understanding, and providing education about the multiple and diverse perspectives of each member. Changes in parent–child and coparenting relationships can be acknowledged and remediated where necessary. Given the history of home-based approaches within the military (e.g., the New Parent Support Program), the specific needs of families with very young children postdeployment, and evidence in the literature documenting the success of home-visiting interventions for therapeutic and educational purposes (Gomby, Culross, & Behrman, 1999; Jones-Harden, 2010), our team at the Boston University School of Social Work was funded by the Department of Defense to develop and test a reintegration-focused family intervention. We collaborated with our Massachusetts and Rhode Island NG/R military partners to develop Strong Families Strong Forces (SFSF), a home-based program addressing the reintegration period.

Reintegration Realities

After a deployment separation, returning service members may experience a continuum of emotions with respect to parenting. Many will be simultaneously delighted and challenged by their young children's advanced developmental capacities, such as eating, talking, walking, and climbing on play structures. On the other hand, returning parents may experience sadness, grief, and guilt as they acknowledge that they missed a phase in their child's life that they will never get to experience and may compensate by spoiling their young child to make up for lost time. Others, especially new parents, may not be fully aware of the child's current developmental abilities and may have to play catch-up.

Service members who have experienced the strains of deployment and, possibly, the traumas of war are expected to quickly acclimate to family roles and return to work. Some service members find it difficult to re-engage in life at home and seem emotionally detached from the young child.

Cycle of Deployment

The cycle begins with notification of an upcoming deployment (predeployment), includes a significant separation due to the service member's departure overseas (deployment), and is typically completed with the postdeployment transition (reintegration; Pincus, Leiner, Black, & Singh, 2011).

Photo: Kiwi Street Studios

U.S. military families serving since September 11, 2001, have endured lengthy and sometimes frequent deployments.

A number of studies have linked combat-related injuries, such as posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), to increases in parenting stress, decreases in intimacy and perceived social support, problematic communication patterns between service members and their spouses or partners, and difficulty in parenting (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Renshaw, Rodrigues, & Jones, 2008; Roberts et al., 1982). Typical symptoms of posttraumatic stress include anger, irritability, outbursts, detachment, and anxiety, or a combination of these. Crying babies and rambunctious toddlers can often function as triggers for service members coping with the aforementioned symptoms and conditions.

In two-parent families, the at-home parent often has functioned as sole caregiver of the children for a substantial period of time and may experience a newfound sense of empowerment, autonomy, and independence that is prompted by handling the responsibilities acquired during deployment. These responsibilities are sometimes difficult to relinquish on the service member's return. As a result, at-home partners may find themselves irritated with their returned spouses but also feeling guilty. The parent who has been at home may be reticent to leave the young child with the service member because of his or her lack of familiarity with routines as well as the possibility of triggering PTSD or TBI symptoms, such as irritability, angry outbursts, or emotional numbing (Pincus, Leiner, Black, & Singh, 2011). These dynamics can cause significant hurt and disappointment for the returning parent and serve to keep him or her out of the parenting role.

Young children who have relied solely on the at-home parent may feel confused by the role of the service member parent they are getting to know again. Some may not recognize or may be fearful of the service member parent and, hence, be reluctant to engage with him or her immediately or, conversely, may not let the parent out of sight for fear of another separation. Babies born shortly before or during deployment who are toddlers at postdeployment must establish new relationships with this other, unfamiliar adult. Preschoolers may experience excitement and confusion at their parent's return. If the service member parent returns with physical or emotional injuries, the entire family will need to adjust and organize around the new requirements for the care of this parent, and young children are particularly vulnerable to the stressful circumstances engendered by PTSD and TBI (Cozza & Lieberman, 2007; Gorman, Fitzgerald, & Blow, 2010).

The following case example illustrates some typical issues faced by NG/R families with very young children postdeployment, such as isolation, difficulties reconnecting for the at-home parent and service member, and the inability of the toddler to remember her deployed father. In addition, the family lives far from a military installation or Veterans' Affairs (VA) hospital and is not connected to military family services.

Rick was excited and nervous to be home after 12 long months in Iraq. His daughter, Isabel, was born 3 months before his deployment, and he had little time to spend with her. Adela, his wife, was nervous about Rick's leaving, but she

Photo: Kiwi Street Studios

Most military families with young children cope well and manage the challenges of deployment.

was most worried about his time in Iraq. She knew about being separated from family, as she was originally from Argentina and had left her family years before. But now she was being left to care for a 3-month-old infant by herself, with no other family around, and her husband was going off to a war that she did not really understand.

The months passed by very slowly. Isabel was a sweet baby, but she would never sleep for more than 3 hours at a time. Rick had no idea how difficult it was to care for a baby alone as Adela only shared the good parts of life when they used a video chat to talk on the computer. If he called and Isabel was awake, she put the baby on her lap so he could see how much she had grown. They both thought that Isabel perked up when she heard Rick's voice. Adela and Isabel grew very close as they were almost never separated over the entire 12 months. Rick's mother occasionally offered to care for Isabel, but Adela was nervous about leaving her baby and felt that her mother-in-law was offering to babysit out of obligation to Rick. True, her in-laws invited them for all holidays that year and Christmas was pleasant, but Adela felt more comfortable on her own with the baby and the few close friends who lived nearby. She never went to meetings of the Family Readiness Group as she felt awkward with the other wives.

It was wonderful when Rick first returned from Iraq. He was excited to see Isabel and Adela and so happy to be home. Isabel was very shy with Rick and would cry when he tried to snuggle her. Although he was amazed that she was now running around their house, as she had been a newborn when he left, he also felt that "she didn't know I was her daddy," a thought that saddened him greatly. Rick found that the house was completely different. Toys were all over the space that previously was neat and organized. Whenever he walked around, he tripped over a ball or a toy. Isabel was not sleeping through the night and had been in the couple's bed for most of the deployment. Rick wanted his wife to get Isabel into her crib, but she would cry for long stretches if Adela wasn't sleeping right next to her in bed.

Reintegration for Rick, Adela, and Isabel became very challenging. Rick was still very happy to be home, but he craved quiet time with his wife. He had no idea how hard coming home would be. Adela was thrilled to have him back, but he was moody and very impatient with Isabel. She realized her husband had never spent time with a baby or toddler, and Isabel clung even more to her when Rick was around. Although Adela missed Rick when he was away, there was something easier about just having to care for Isabel and not having to deal with another adult who had needs and demands. As the months wore on, tension between Adela and Rick continued to build, Rick's moods seemed to get worse, and Isabel became even more fearful of her dad. Rick longed to be closer to his daughter but felt impatient and unsure of how to accomplish this.

As is evident in the case of Rick and his family, the reintegration period often includes a mix of responses, including intense relief at the safe return of the service member along with recognition of sometimes difficult dynamics related to re-establishing parenting, coparenting, and parent–child relationships. Although Rick and Adela were aware of the troubles they were having with reintegration, they had no idea of how or where to get help, as they lived far from any military base. Providers in the community offering services to military families with young children must be educated about the many complex challenges inherent in the reintegration transition; this is particularly true for service members who are getting to know their children and working to become integrated back into parenting and couple roles after a long absence.

Home-Based Approaches to Helping Military Families

Home-based interventions for military families merit consideration for several reasons. First, given that home visiting is a service strategy and not a specific intervention, many types of programs for families and children can be adapted for use in a family's home (Jacobs, Easterbrooks, Brady, & Mistry, 2005). Numerous psychosocial stressors have been targeted in home-based services, ranging from child maltreatment prevention to literacy (Jones-Harden, 2010). More specifically, there is growing evidence of the efficacy of interventions focusing on the parent–child relationship where parents work to increase their own awareness of their children's emotional needs as well as the connections between their parenting experiences, emotions, and behaviors (Lieberman, 2004; McDonough, 2004; Slade et al., 2005). Second, services in the home allow the intervener to observe the natural environment wherein difficulties occur. Third, a home-based service model has been highly successful within the military since 1984, when the Family Advocacy Program was instituted to prevent child maltreatment (Kaufman Kantor et al., 1999; Raiha & Soma, 1997). The New Parent Support Program, within the Family Advocacy Program, offers home visitation to families parenting infants and toddlers from birth to 3 years old who are in need of extra support. Finally, for military service members, stigma is often a barrier to seeking help from VA hospitals or community mental health clinics (Gould et al., 2010; Greene-Shortridge, Britt, & Castro, 2007; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). Given the more private nature of home-based services, this stigma may be minimized and more families may take advantage of such programs.

Developing SFSF

Funding to develop and test SFSF was obtained through the Department of Defense as part of the Congressionally Directed Medical Research Program. SFSF was conceived as a community-based participatory research endeavor from its inception (see box Community-Based

Participatory Research). Community-based participatory research assumes a collaborative relationship between all interested parties throughout the research and intervention development process (Viswanathan et al., 2004). As civilian researchers and clinicians, we realized that, for the development of an effective and viable program to address reintegration needs of military families with young children, full collaboration with and support from our local and regional military communities were imperative. In our context, we understand that NG/R service members, veterans, and their families are the experts on their own deployment experiences, military identity, family strengths, and needs. We assume a stance of cultural humility in which we are invested in a process of continuous learning about military values and practices from the beginning and throughout our three-phase process of research. (See box, Development of Strong Families Strong Forces [SFSF] Using Community-Based Participatory Research [CBPR].) Starting in Phase 1, we engaged in extensive exploration of the needs of military families with young children. Specifically, we conducted in-depth interviews with service members, spouses or partners, and key informants (e.g., civilian and military providers working with military families) to glean pertinent information and delved into available literature with the purpose of developing an effective and relevant intervention. Given that we knew of no other home-based interventions serving military families with young children specifically focused on reintegration, we looked to other types of military family programs and attachment-based interventions for young children and parents in the nonmilitary populations (Paris, DeVoe, Ross, & Acker, 2010) to inform the development of SFSF.

In Phase 2, we piloted SFSF with OEF/OIF families and solicited extensive feedback about the feasibility, usefulness, and process elements of the program from participant families. Along with observations from clinicians, these data were used to revise our intervention.

We are currently in Phase 3 and have been testing the intervention with a randomized clinical trial. Families are eligible to participate in the study if (a) they have a child from birth to 5 years old, (b) a service member parent has returned from Iraq or Afghanistan within the past year, and (c) the family home is within a 90-minute drive from our site.

The following case example illustrates the potentially far-reaching effect of deployment long after the service member's return home. In this family, the service member's ability to reconnect with his young child after deployment and to parent a newborn 2 years later is significantly complicated by his symptoms of combat stress.

Community-Based Participatory Research

Community-based participatory research

- Has the overarching goal of the application of new knowledge to intervention development with the goal of change;
- Is an approach or process by which research can be conducted that involves active engagement of community partners in all phases of the research process; and
- Is based on a set of core principles that include collaboration, empowerment, and building community capacity (Viswanathan et al., 2004).

Sam and Annie had been married for 14 months when Sam deployed to Afghanistan. Annie was 4 months pregnant with their first baby and was employed full time as an occupational therapist. Sam had joined the Army Reserves when he graduated from college so that he could pursue his engineering and technology interests. Sam was on the "bomb squad" during his tour and estimates that he diffused more than 400 improvised explosive devices or roadside bombs in his time there. When asked what this job was like for him, he laughs and says, "It was a little stressful!" but is very proud that his team

Photo: Kiwi Street Studios

In two-parent families, the at-home parent often has functioned as sole caregiver of the children for a substantial period of time.

"never lost anyone." He refers to "close calls" and notes that every one of his team members has hearing loss even though "we took all the precautions." Although Sam was not injured in any explosives-related incident, he did sustain

Figure 1. Development of Strong Families Strong Forces (SFSF) Using Community-Based Participatory Research (CBPR)

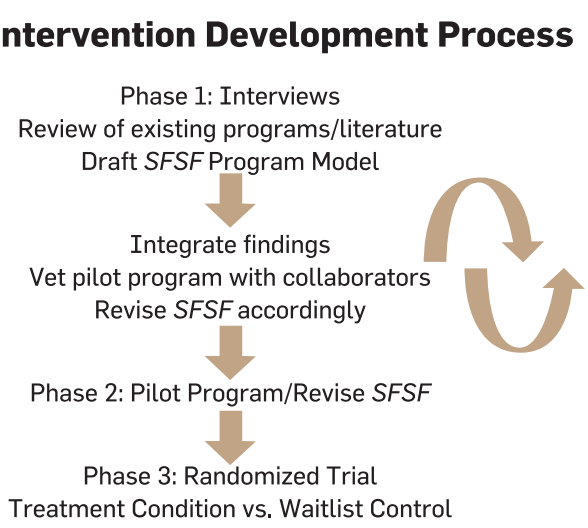

Photo: Kiwi Street Studios

Young children who have relied solely on the at-home parent may feel confused by the role of the service member parent they are getting to know again.

injuries to his lower back when his unit was caught in a firefight. He says, "I thought I was gone. I can't believe I'm on the bomb squad and I end up getting shot. Go figure!"

Annie kept herself very busy throughout her pregnancy and was able to work until the week before she gave birth. Annie and Sam had known each other since high school and were "very good friends" when they decided to marry. They were able to e-mail and use video chats, and Sam was very attentive and really "there for me" during the first couple of months postpartum. When Sarah was 3 months old, Annie returned to her job full time and enrolled Sarah in her agency's day care program. Annie was able to visit Sarah in the day care center several times a day, and Sarah thrived there. Annie was worried about Sam's injury, but he had been cleared to go back to work so she thought he must be OK. They continued to be in touch, but as Annie looks back now, she recalls Sam being "distant, a little spacey, and not quite there" when they had video chats. At the time, Annie was so busy with her job and taking care of Sarah, she couldn't be as focused on Sam.

When Sam arrived home, he was "not my Sam." Annie described him as "sort of a zombie," and he agreed. She had to teach him how to hold and talk to Sarah and then remind him to interact with her. Sam agreed to go to the local Vet Center for an intake and was diagnosed with severe PTSD. He was willing to go to treatment because he wanted to be a different father to Sarah and an actual husband to Annie.

When we met Sam and Annie 2 years later, Annie had recently given birth to their second child, Jon. Sam was interested in our home-based program because he found himself "obsessed" with taking care of the baby and hoped he could get "some parenting advice for newborns." Annie had also noticed that Sam was sometimes very irritable when the baby cried and was concerned that Sam's posttraumatic stress symptoms were being stirred up. Sam expressed flatly that he had "missed out on the whole thing with Sarah, even when I was physically here," but Annie described his outbursts of anger. Annie was also worried about how they would manage once she returned to her full-time work, when Jon was about 4 months old.

SFSF Intervention

Given the unique nature of war-related separation and the widely divergent tasks that the at-home parent, service member, and child have, each member of the family experiences the deployment cycle in a different way, and often there is very little mutual understanding of these diverse experiences among family members. Many service member parents and partners report that they do not talk to each other about their experiences during deployment, to protect the other. In addition, many military parents report that their babies and toddlers are "too young" to understand or remember the deployed parent's absence or that the children "didn't even notice they were gone." As a universal intervention, SFSF strives to help parents gain increased understanding and insight into their own, their partner's, and their child's experiences of the deployment separation and reintegration. The overarching goal of SFSF is to help military parents of very young children develop increased parental reflective function capacities; that is, to be able to reflect on and see their child's internal experiences—their wishes, fears, intentions, and emotions that drive their behavior (Slade et al., 2005)—and thus be more able to respond to their deployment-related distress, questions, and behavior in a more empathic and supportive manner.

SFSF is a short-term home-based program that recognizes the primacy of attachment relationships for very young children and places a strong emphasis on supporting the family relationships that promote and sustain the child's healthy development. Given that SFSF comprises full family sessions as well as separate parent and child activities, two family specialists conduct the home visit and use semistructured discussions and exercises, as well as play, to build on existing strengths within the parent–child, parenting, and couple relationships. Activities focus on facilitating dialogue between parents and developing deployment-related narratives with the family that highlight the emotional experiences of each member, particularly focusing on the perspective and needs of the very young child. In addition, SFSF creates and builds on opportunities for parent–child interactions that promote enjoyment, positivity, and a sense of competence. These are integrated throughout the intervention to remind or help establish how the service member parent and child, or the entire family, can play together and find pleasure in relationship. Psychoeducation about child development and parenting strategies in light of deployment-related experiences including combat stress and PTSD are provided on an as-needed basis.

SFSF comprises eight modules, each of which has a specific topic area. The program is designed to be flexible to meet the diverse needs of military families as they negotiate the tasks of reintegration. As such, although the order of the first four modules is set, the sequence and amount of time spent within the remaining modules can vary. The early modules address child and parenting domains, including the child's growth and development, deployment-related reactions, and adaptation, as well as parental beliefs and perceptions of the child, parenting history, and current parenting challenges. Next, topics include the service member and family's military identity, as well as the parents' and children's narratives of the deployment cycle experience. More specifically, this series of modules begins with a focus on the meaning of military service for the service member and within the couple's and family's history, how becoming a parent has influenced the experience of serving in

the military for both the at-home and service member parent, and their evolving cultural identity as a military family. Parents are also asked to reflect on their own experiences of the deployment cycle through the creation of individual maps or narratives and then to share these perspectives with one another. Parents repeat the exercise considering their child's experience of the deployment cycle. They are asked to "put themselves in their children's shoes" and to describe the deployment separation and reintegration from the child's perspective. Later modules address the effects that lengthy and war-related separation can have on the parent–child, parenting, and couple relationships and the need to catch up within these relationships and roles as a family. There is a focus on what is different now and on individual and relational strengths, losses, and challenges associated with the deployment experience. Catching up can include renegotiating parenting roles and routines, facilitating pleasurable play and interaction between the service member parent and child, promoting couple reconnection and intimacy, and encouraging parental reflection on the emotional and behavioral communications of the child. For families with older toddlers and preschoolers, reconnecting often includes telling the story of deployment using family storybooks, drawings, and play to help parents make meaning of the deployment separation experience for their young children.

The final case illustrates the process of SFSF with Samantha and Alyssa, a single mother and her young daughter. Unsure of her parenting abilities, Samantha is able to use the intervention to build greater reflective function capacities, thereby gaining more understanding of her daughter and developing enhanced parental self-esteem.

Samantha, 21, was deployed to Iraq for 12 months when her daughter, Alyssa, was almost 3 years of age. On her return, Samantha was exhibiting high levels of posttraumatic stress and depressive symptoms and had sought treatment at the local VA hospital. When she began SFSF, she said that her deployment had "changed everything" with her daughter and that she felt that she had lost her bond with her.

During a visit early in the program, Samantha was asked about Alyssa's specific reaction and adaptation on her [Samantha's] homecoming. Samantha responded that she felt completely rejected by her daughter and that this was the "most traumatic part" for her. She said that when she saw Alyssa for the first time, she had to ask for a hug and that Alyssa had avoided her. She said Alyssa cried for Nana (who had cared for her during the deployment) and wanted to go back to her house. Samantha said that, at some point, she lost touch and numbed herself to caring. After she spoke, she began to cry quietly. She said, "I feel so bad for her because she has me as a mother."

It was clear to the family specialists that Samantha had developed very powerful negative mental representations of herself as a mother and was also misperceiving her daughter's normative responses to her homecoming as a rejection. During the remaining modules, the family specialists used a combination of semistructured discussions/exercises and parent–child play to help Samantha see her daughter's experience of the separation and Alyssa's need for her mother. Through strengths-based reflections and developmental guidance, Samantha developed an alternate way to understand Alyssa's actions at reunion. The family specialists respectfully challenged Samantha's belief that she was not important to her daughter. They suggested that she and Alyssa had both changed over the course of the year-long separation and that they needed to get to know each other again.

As another strategy to strengthen the parent–child relationship, the family specialists integrated ongoing parent–child play into the visits. During a parent–child developmental activity, the family specialists noted that both Samantha and Alyssa began to giggle and smile when Alyssa had to hop and throw a ball. This was the first time during SFSF that Alyssa and Samantha had exhibited shared positive affect and pleasure with one another. At the next visit, the family specialists brought a ball and suggested that a game be incorporated into the visit. This parent–child pleasurable activity became ritualized throughout the remaining visits and gradually transformed into other games that were identified and led by Alyssa and, ultimately, by Samantha as well.

As the SFSF program moved into focusing on the deployment narratives, it became clear that Samantha was feeling uncertain about what she could contribute. Samantha found it difficult to talk about her own experiences in Iraq but was able to convey that being a mother complicated her ability to just "get her job done." She was unable to imagine what her daughter might have experienced while she was in Iraq. Adding more structure to the exercise, the family specialist used story stems to help elicit a reflective stance from Samantha and speak from her child's perspective. On the basis of these, the family specialist suggested that Samantha author a storybook for Alyssa to help her make meaning of her mother's deployment-related separation and return. Samantha was asked, "What do you want Alyssa to know about why you went away and what would be helpful for her to know?" Samantha was adamant that she had nothing she wanted to tell Alyssa and said, "I don't know what to say, but I'll try."

During the next visit, Samantha was still hesitant, but ultimately she was able to write pages filled with reassuring, clarifying, and loving messages. After it was finished, the family specialists read the book back to Samantha and celebrated her great accomplishment. Samantha had a huge smile on her face and quietly said, "I didn't know I had that in me." Samantha read the storybook to Alyssa at the next visit, and when she ended there was total silence for several seconds. Samantha anxiously said to Alyssa, "So, what do you think?" There was another pause, and then Alyssa looked right at her mother and said, "It's wonderful." Samantha and Alyssa made tremendous progress over the course of SFSF as Samantha gained confidence in herself as a mother again and found pleasure in relationship with her daughter. Ultimately, Samantha came to understand her daughter's experience during deployment, which allowed her to see her daughter as a little girl who greatly loved and needed her mommy.

Summary and Conclusion

What makes SFSF a beneficial program for military families with young children during the post-deployment period? As described earlier, the intervention was developed from the ground up, with collaboration from military families and service providers integrating the best practices from evidence-based models. Our home-based program focuses on the child and family, aligning with the adults' desire to be the best parents possible. We work to strengthen attachment relationships through the lens of reflective functioning, thus enabling parents to understand more about their children's emotions and behaviors as well as the mechanisms that drive their own parenting styles. Offering a service that is easily available and that focuses on building family strengths has garnered us participation from almost all military families that have been approached and are eligible for our randomized clinical trial. We believe that, given these parameters, the program would be easily transferable to other states, for NG/R families as well as military families in all branches that are installation based, as there are tremendous unmet needs during reintegration for parents and young children.

Ruth Paris, *PhD, LICSW, is an associate professor of clinical practice at Boston University School of Social Work where she directs the Family Therapy Certificate Program for advanced master's students. Her scholarship and teaching focus on family processes and interventions. Through a series of multiyear research projects, she has evaluated and developed family-based interventions serving high-risk populations such as immigrant/refugee mothers of young*

children, women with postpartum depression and their infants, military service members with children under 5 years old (SFSF), and parents in residential treatment for Substance Use Disorders and their children birth to 5 years old. Her clinical work has also focused extensively on families in a variety of settings including Massachusetts General Hospital, Kaiser Permanente, community mental health, and private practice.

Michelle Acker, *PsyD, is a clinical psychologist and the director of Training and Clinical Services for Strong Families Strong Forces at Boston University School of Social Work. Her clinical and research interests have focused on the impact of stress and trauma on young children and families and the evaluation of evidenced-based interventions. She also has a private practice in Newton, MA.*

Abigail Ross, *MSW, MPH, is the project director of the Strong Families Strong Forces program, a 4-year study funded by the Department of Defense to develop and test a home-based reintegration program for OEF/OIF veteran parents who have children less than 5 years old. Her research interests include anxiety and related disorders and development of family-based preventive interventions. Ms. Ross is currently a doctoral student in the Interdisciplinary Social Work and Sociology Program at Boston University.*

Ellen DeVoe, *PhD, LICSW, is an associate professor at the Boston University School of Social Work and founding director of BU's Trauma Certificate Program for graduate social work trainees. She teaches and conducts research concerned with the impact of trauma on young children, parent–child relationships, and parenting. Her funded scholarship has examined topics including child sexual abuse, the impact of domestic violence on preschoolers, and the effects of the September 11, 2001, attacks on New York City parents, parenting, and very young children (with Dr. Tovah Klein). Currently, she is principal investigator of the Strong Families Strong Forces project, funded by the Department of Defense, to develop and test a home-based reintegration program for military parents returning from Iraq and/or Afghanistan who have children birth to 5 years old.*

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When Is Challenging Behavior Due to an Impairment Improperly Managed?

RIZWAN SHAH
Blank Children's Hospital

Although there are many reasons for challenging behavior in young children, one reason is almost entirely overlooked: alcohol exposure in utero. These children are suffering from lifelong disabilities that result in their inability to regulate their behavior and emotions. In certain populations, disorders on the fetal alcohol spectrum are much more prevalent (National Organization on Fetal Alcohol Syndrome, 2006a, 2006b, 2006c). These populations include:

- Children (and parents) involved in the child welfare system,
- Youth in the juvenile justice system, and
- Children of women with substance abuse disorders.

In the United States, about 1% of all newborns are diagnosed with a birth defect or developmental disability related to prenatal alcohol exposure (Burd & Christensen, 2009; Sampson et al., 1997). Although 1% of infants born each year receive an alcohol exposure diagnosis, actual prenatal exposure to alcohol is estimated at 40% of all pregnancies, with nearly 400,000 pregnancies each year exposing the unborn infant to prolonged and high levels of alcohol (Burd, 2006; Centers for Disease Control and Prevention [CDC], 2004). It is impossible to specify the amount of alcohol that will cause damage to the developing fetus. The effect is dependent not only on the amount of alcohol the mother consumed during pregnancy but also on other factors, such as her nutritional status or other toxins she ingested or was exposed to in the environment. For this reason, there is no safe level of drinking during pregnancy. Alcohol passes easily through the placental barrier, circulating through the baby's body. Without a mature liver, the baby is unable to process the alcohol efficiently and so is bathed in it for far longer than the mother. The damage to the brain affects white matter more than gray matter. The white matter is the myelin sheath that wraps around the neurons and is responsible for effective functioning and communications between different areas of the brain. The size of the brain in the exposed infant may be smaller; more specifically, some areas of the brain are less developed than others, such as the frontal lobe, the parietal lobe, the occipital lobe, and the corpus callosum (Coles, 2011; Serendip, 2005).

Fetal alcohol spectrum disorder (FASD) includes a wide range of cognitive disabilities, including fetal alcohol syndrome (FAS), partial FAS, fetal alcohol effects, and alcohol-related neurodevelopmental disorder. Only 20–30% of alcohol-exposed people have FAS (Sampson et al., 1997). Early diagnosis is critical in developing appropriate management strategies. Establishing a working diagnosis of an FASD early can make a dramatic difference in how well the child's impairments are managed and, ultimately,

PHOTO: © ISTOCKPHOTO.COM/BART SADOWSKI

In the United States, about 1% of all newborns are diagnosed with a birth defect or developmental disability related to prenatal alcohol exposure.

the way in which that child's life will unfold. Although the manifestations of the child's brain damage will change over time, self-regulation, because of disorganized brain communication, is a lifelong problem for people affected by an FASD. For very young children, sleep problems are very common. Failure to achieve sleep regulation is a red flag for future problems in brain function. Whereas other children with behavioral problems may develop strategies to handle challenging situations, children affected by an FASD have difficulty with generalizing coping strategies to manage their behavior.

Undiagnosed FASD can lead from early behavior problems to a lifetime of bad decisions, social isolation, academic failure, juvenile delinquency, adult criminality, early unsuccessful parenting, and substance abuse (CDC, 2010). FASD-affected adults will require a lifetime of supervision and management (McGee & Riley, 2009), but they can become productive members of their community with consistent ongoing support that starts in the first years of life (CDC, 2011). A longitudinal study that followed children from birth into their 22nd year showed that the effects of FASD are persistent (Streissguth, 2007).

Diagnosis is challenging because individuals with an FASD may not exhibit physical features of classic FAS. Neurobehavioral malfunctions may be the only sign of an FASD. Although behavioral problems in children are multifactorial in nature, prenatal exposure to alcohol is an important and often overlooked cause of behavioral dysfunction in children. Because the approach to managing behavioral issues in a child affected by an FASD is different from the approach for a child without exposure, it is important for early childhood professionals to include the possibility of FASD when addressing difficult behaviors in children. Early diagnosis and proper interventions increase the chances for a successful outcome in an otherwise hopeless situation.

Rizwan Shah, *MD, is the medical director of the Child Abuse Program at Blank Children's Hospital in Des Moines, Iowa. In 1981, Dr. Shah was the first in the nation to recognize the link between parental crack cocaine abuse and abused children. She has taught widely on the linkage between child abuse and drug abuse. In 1999, she was one of a group of physicians to receive the Award of Merit from the Iowa Medical Society for helping to facilitate the establishment of children's health programs in Iowa. Dr. Shah teaches child abuse training programs both in Iowa and nationally, as well as clinical teaching in medical schools and hospitals.*

Photo: © iStockphoto.com/Rendery

It is impossible to specify the amount of alcohol that will cause damage to the developing fetus.

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Beyond a Haircut, Lunch Pail, and New Shoes

Opening Doors to School Readiness for Latino Children and Their Parents

MARGARET BRIDGES
University of California, Berkeley

SANDRA GUTIERREZ
Abriendo Puertas/Opening Doors
Los Angeles, California

Lupe, a Spanish-speaking mother of three, wanted to help her children succeed in school, but because she did not read or write in Spanish or in English, she did not think she had much to offer them. After all, she felt once her children reached school, the teachers would take over and do what was needed. As a stay-at-home mother, Lupe loved to prepare delicious meals for her family, as her mother and grandmother had done during her childhood. And her children were happy, well-fed, and well-loved. Recently, through a friend, Lupe learned about Abriendo Puertas/Opening Doors, a program developed by and for Latino parents of young children, and, while she was hesitant to participate, she went to listen to the first session. The class immediately made sense to Lupe, and she discovered a whole new way of thinking in which she had even more to offer her children than she had previously realized—and a lot to learn.

Lupe actively participated in all 10 sessions offered by the program, experiencing a range of topics addressing best practices in school readiness, goal setting, child development, family communication, language and literacy, healthy physical and social–emotional development, and education advocacy. Through Abriendo Puertas, Lupe learned that she could get her children ready for school by including them in daily activities, like preparing meals. At the market, Lupe began to talk to them about the color and size of the different fruits and vegetables she was buying, and they counted the pieces together as they put them in bags. The family's meals became healthier. And at home, while cooking, Lupe now talks with her children about the texture and source of the ingredients she uses, lets them help measure the ingredients, and has them share in the accomplishment of putting dinner on the table. With her youngest children, she has also started holding books and telling stories about the pictures as she turns the pages. The books have come from the neighborhood library, which Lupe had never entered before attending the program.

In an Abriendo Puertas class, Lupe stated,

I love this country and work hard so that my family can have opportunities and an education that I've never had. I enjoyed this program and met other women just like me—we all want the best for our kids. The experience

Abstract

Abriendo Puertas/Opening Doors is an evidence-based program developed by and for Latino parents of young children to address opportunity gaps related to young Latino children. The program gives parents the information they need to understand child development and to access needed supports and services that will allow their children to get the best possible start in school. The curriculum includes 10 interactive education sessions for parents that emphasize the importance of the parents' involvement in their children's education. Evaluation data reveals significant positive benefits from program participation.

helped me understand my role as a leader of my family. I've now set goals and made plans to reach them, step by step. For example, with reading—I don't want Miguelito to not read well. I learned that a lot of kids aren't reading at grade level and it makes it very hard for them to learn and do well in school. Miguelito is 3 years old. We have fun going to the library, reading books and telling stories. It's like they say in Abriendo Puertas—If you don't look forward, you stay behind. He will go the University one day.

The change brought about by Lupe's engagement in Abriendo Puertas has made her home a dynamic learning environment and Lupe a valuable teacher to her children. The program's evaluation (Bridges, Cohen, Fuller, & Velez, 2008) indicated that there was a significant increase in parents' reports of confidence after participating in the program.

Supporting School Readiness

Many low-income Latino parents thoughtfully get their children ready for kindergarten with a new haircut, a lunch pail, and a new pair of shoes—for them, this is the definition of school readiness. They often do not see their role as their children's first and most important teacher. And, as kindergarten becomes more academically demanding, their children often arrive at school unprepared for the real challenges that await them. Many Latino children start school academically behind their non-Latino peers, creating an achievement gap that continues throughout the school years. Latino children are at great risk for eventual school failure and dropout (Fuller et al., 2009; Reardon & Galindo, 2009).

Latino children are also likely to face other challenges. In 2009, the poverty rate for Latino children was already more than 33% (Nepomnyaschy, 2007). Compared to their non-Latino peers they also exhibit high rates of obesity, which is linked to more serious health problems like diabetes in adulthood or even earlier (Escarce, Morales, & Rumbaut, 2006).

Building on Family Strengths

School and health risks and poverty rates overshadow the many strengths of low-income Latino children. The majority of them have healthy birth outcomes, strong early social skills, nurturing and supportive families, and a rich cultural heritage, and these elements form a robust foundation for later success (Crosnoe, 2006; Fuller et al., 2009). Building on these strengths is increasingly important as Latino children are already one of the largest and fastest-growing segments of the U.S. population. Currently, Latinos make up more than 20% of American children. They are expected to represent nearly 33% by 2030 (Mather & Foxen, 2010; U. S. Census Bureau, 2004). The well-being of Latino children must become a national concern because their success or lack of success will play a large part in determining the nation's future and ability to compete in the future global market.

Photo: Courtesy Abriendo Puertas/Opening Doors

Abriendo Puertas/Opening Doors was developed to address opportunity gaps related to young Latino children.

Reducing Disparities and Increasing Opportunities

Many in the policy community note the health disparities between Latinos and their non-Latino counterparts, or the achievement gaps evident in school performance, but these gaps have to be addressed as opportunity gaps. Research has indicated that having an informed, attentive, and engaged parent is one of life's greatest advantages. Parents benefit from receiving information they can easily digest and put to use on a daily basis to support their children. Abriendo Puertas was developed to address those opportunity gaps related to young Latino children: the program gives parents the information needed to understand child development, access needed supports and services, and truly become their children's first and most important teacher and best advocate, and make their home their child's first school.

Curriculum Focus

Although it is also available in English, the Abriendo Puertas curriculum was developed in Spanish for and by Latino parents. It is a cost-effective, train-the-trainer program, which is easy to adopt and to adapt to make it relevant to the community in which it is being used. The 10 sessions are fun and grow from the culture of the families served. The Abriendo Puertas approach is multifaceted, covering child and family well-being, good health, social and emotional well-being, school readiness, the economic well-being of the family, and a parent's ability to advocate on behalf of children. The curriculum is based on evidence, both from child development research on how best to support child well-being and from an on-going evaluation of the most effective methods for working with participating parents. Program facilitators aim to demystify relevant research and provide the key information to parents so that they can discuss it and choose whether or not to incorporate it into their practices. Abriendo Puertas assumes that parents will do what is best for their children if they know more about their children's development and are presented with good options for action. The program uses social networks and relationships with the facilitator and among participants to deepen parents' understanding and new skills.

Specifically, Abriendo Puertas informs parents about local data on the health and education challenges their children face and offers important resources: most notably, the parents themselves. The program invites parents to consider the facts: (a) the time from birth until age 5—all before school even starts—is a vital time for children's learning;

Photo: Courtesy Abriendo Puertas/Opening Doors

Nurturing and supportive families and a rich cultural heritage form a robust foundation for later success.

(b) parents, even those without much formal education, are leaders of their family, and are their children's first, most important teachers; (c) there are resources available to support the development of their children; and (d) there are small things that parents can do every day in their homes to make a huge difference in their children's learning and in their lives.

Language Learning

Many participating parents are eager to learn how they can be effective teachers for their children, but are flummoxed by questions around language. For example, Maria wants her three children to have a lot of opportunity, which she knows will be helped by having them learn English. Because she is Spanish-speaking, she does not want them to be confused by learning two languages at once; she is just not sure what to do. Also, even though her parents never read to her, she has heard that parents should read to their children, but she isn't a very good reader—particularly in English.

Through Abriendo Puertas Maria learns that her children will have an easier time learning English if they have a good foundation in Spanish (Slavin & Cheung, 2005; Tabors & Snow, 2002). Abriendo Puertas encourages parents to support their children within their language, culture, and community, building on what is already in place to add to the children's—and family's—well-being. Evaluation results revealed that strengthening the connections parents felt to their social support networks and their communities, through involvement in the program, was significant (Bridges et al., 2008). Further, the program introduced Maria to her neighborhood elementary school's expectations for children entering school and encouraged her and others in the group to become active participants in their children's education—from cradle to college. Maria shared with other parents in the session:

I don't want my daughter to be one of the statistics we learned about. I'm glad I now understand what's happening in the schools, so many not graduating. I've made a commitment to be involved in her education and will talk to other parents about it, too. As parents, what we do is of great consequence—I won't forget that.

Health and Mental Health

In addition to focusing on academic preparedness, Abriendo Puertas supports children's broader well-being by addressing key health and mental health issues. Another participant, Gloria, has two boys and is proud of their being big and healthy, because she is keenly aware of times growing up when her parents had trouble putting food on the table regularly. Both of her siblings, who were small as children, now have health problems, including asthma and diabetes, so she makes sure her boys eat a lot to stay strong. They often get hungry when she is out with them, so she treats them to McDonald's, which is their favorite restaurant. And when they go to the market, the boys usually behave better if she buys them cookies or a soda.

Through Abriendo Puertas, Gloria learned that the average child eats 64 pounds of sugar in a year, and many are at risk for diabetes because they eat more fast food than fresh fruits and vegetables. She heard that almost 40% of Latino children from 2–19 years old are obese, which in reality is neither strong nor healthy (Mather & Foxen, 2010). Gloria learns that by feeding her children more of the wholesome food that her mother cooked for her as a child, her boys will actually be stronger and less likely to have health problems as they get older. And, in case she has questions or concerns about her boys' health, she finds out about health services in her community to get a second, professional opinion and deal with other health or mental health issues. Evaluation results of the program suggested that the health resources knowledge that participating parents gained was some of the most useful (Bridges et al., 2008).

Continuous Improvement

Abriendo Puertas aims to improve the outcomes of Latino children from within the community. The founders continue to receive input from parents about the subjects of utmost concern and feedback about the program's messages and delivery. The curriculum is based

Photo: Courtesy Abriendo Puertas/Opening Doors

There are small things that parents can do every day in their homes to make a huge difference in their children's learning and in their lives.

Learn More

Abriendo Puertas /Opening Doors
www.familiesinschools.org/abriendo-puertas-opening-doors/
The Web site for Abriendo Puertas provides information about training events, an overview of the curriculum in English and Spanish, and related resources.

on a popular education approach that conveys respect for participants' life experiences and includes them in both the teaching and the learning that take place. It also provides modeling for parental involvement in their children's schooling because research has indicated that parent engagement is linked to their children's academic performance (Rodriguez-Brown, 2010). From the opening session, which focuses on early brain development with an exercise that includes throwing colored yarn back and forth across the room to show neurons connecting, to the use of the *Loteria*[1] game to help emphasize some of the lessons presented, Abriendo Puertas engages parents in active and enjoyable learning. They become comfortable as they are guided by an enthusiastic, welcoming trainer who is armed with a comprehensive curriculum and community demographics and resource information.

This approach is borne out in the initial evaluation results. The evaluation tracked 109 parents over the course of their participation in Abriendo Puertas, using both quantitative and qualitative data collection and analyses. Participants reported significant increases (with effect sizes noted) in their:

- Confidence about parenting skills (*SD* = 0.48)
- Knowledge about and access to available health services (*SD* = 0.65)
- Social support and social connections in the community (*SD* = 0.27; *SD* = 0 .11)
- Community involvement (*SD* = 0.20)

[1] *Lotería* is a Mexican game of chance, similar to bingo, but using images on a deck of cards instead of numbers on ping-pong balls.

As shown in Figure 1, and illustrated in parents' stories, Abriendo Puertas made a difference—a big difference to many participants. These results and the associated feedback were used by the program developers to improve and refine the class.

The program's initial promising results and the clear relevance for the growing Latino community across the country have resulted in its adoption by many organizations around the country that provide services to low-income Latino parents of young children. It is now in 25 states and 76 cities and is training trainers and providing the curriculum to staff of the National Head Start Association and its members and to staff of the National Association of Child Care Resource and Referral Agencies and its members. Abriendo Puertas offers a 3-day training institute for professionals working with Latino families, teaching others how to facilitate the parenting program in their local communities. These efforts are strengthened by the program's ongoing commitment to improvement, conducting evaluations of both the train-the-trainer institutes and the parenting programs across the country with diverse Latino populations. Parents—as leaders of their family—are powerful agents of change. Abriendo Puertas is only the first step for Latino parents who are eager to learn more and build on the assets they have to improve the school and life success of their children. It does open the doors to opportunities.

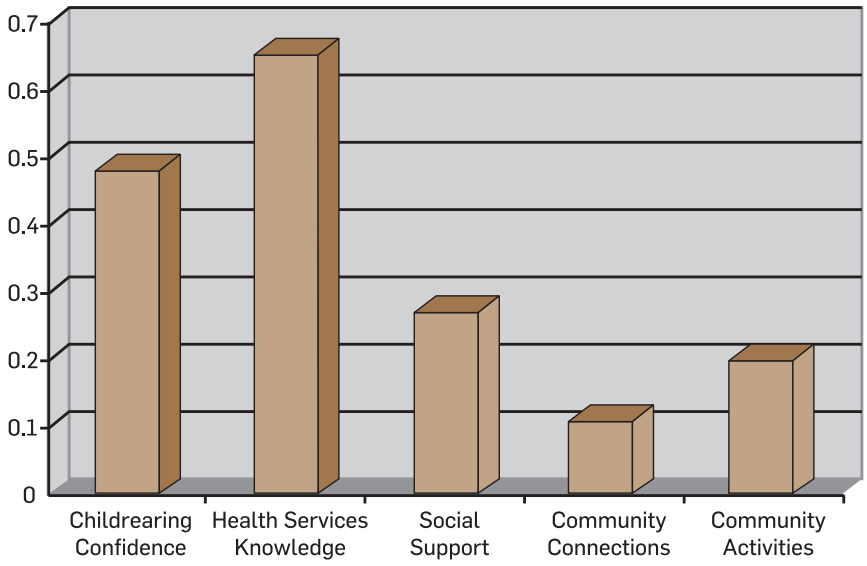
Margaret Bridges, *PhD, is a developmental psychologist and research scientist at the Institute of Human Development at University of California, Berkeley. Currently, she does research on the implications of expanding access to preschool—particularly how expansion would affect low-income and Latino preschool children. She also is conducting research on how Latino families experience preschool and how those preschool programs can best serve their children. Dr. Bridges completed her doctoral training at the University of Virginia and her postdoctoral training at University of California, San Francisco.*

Sandra Gutierrez *is the national project director of Abriendo Puertas/Opening Doors. Ms. Gutierrez led the development of Abriendo Puertas—the nation's first evidence-based, comprehensive training program for Latino parents with children birth 5 years old. Prior to her work with Abriendo Puertas, Ms. Gutierrez developed a series of training programs to support children and families involved in the child welfare system for Parents Action for Children. She brings more than 35 years of experience with legal, children's advocacy, and community service organizations. Her multifaceted career has included founding the first service organization to assist Central American refugees, developing health education programs for the United Farm Workers of America, and designing campaigns to promote the benefits of preschool to the Latino community. In addition, for 7 years, she served as a founding member and state commissioner for First 5 California.*

Photo: Courtesy Abriendo Puertas/Opening Doors

Many participating parents are eager to learn how they can be effective teachers for their children.

Figure 1. The Effect Sizes of Abriendo Puertas Indices



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Errata

Corrections to the January 2011 article "The Foster Care Baby Boom Revisited: What Do the Numbers Tell Us?" by Fred Wulczyn, Lijun Chen, Linda Collins, and Michelle Ernst, *Zero to Three, 31*(3), pp. 4–10, are listed here:

On page 5, errors in Table 2 are corrected here, in the shaded boxes at right.

On page 8, the third paragraph should read as follows (corrected text is underlined):

Infants are <u>more than</u> 4 times more likely than older children to enter foster care. The question of placement risk is addressed in Table 2, which displays entry rates per 1,000 children by age and race/ethnicity of the child. For example, between 2000 and 2008, the risk of placement for infants increased from <u>7.6 to 8.9</u> per 1,000 children. During that same period, the rate for all older children stayed at just under <u>2</u> per thousand (<u>1.8</u>/1000). This is consistent with the change in the proportion of all children admitted to foster care who are less than 1 year old.

On page 10, in the first column, the second bullet should read as follows (corrected text is underlined): The risk of placement for infants is more than <u>4</u> times greater than it is for most other children.

Table 2. Rate of Placement per 1,000 Children and Placement Disparity by Age and Age and Race/Ethnicity: 2000 and 2008

	Entry year	
Child characteristics	**2000**	**2008**
Entry age		
Infants	7.6	8.9
Older children	1.8	1.8
Age disparity	4.3	4.6
Age by Ethnicity		
Infants		
White (W)	4.5	5.9
Black (B)	21.1	17.5
Hispanic (H)	5.3	6.0
Disparity (B/W)	4.7	3.0
Disparity (H/W)	1.2	1.0
Older children		
White (W)	1.4	1.3
Black (B)	3.7	3.2
Hispanic (H)	1.4	1.5
Disparity (B/W)	2.6	2.5
Disparity (H/W)	1.0	1.2

Más Allá de un Nuevo Corte de Pelo, una Lonchera y Zapatos Nuevos

Abriendo Puertas a la Preparación Escolar para Niños Latinos y sus Padres

MARGARET BRIDGES
Universidad de California, Berkeley

SANDRA GUTIERREZ
Abriendo Puertas/Opening Doors
Los Angeles, California

Editor's Note: This is a Spanish version of the article appearing on pp. 46–50 of this issue.

Lupe, una madre que habla español, deseaba ayudar a sus 3 hijos a triunfar en la escuela, pero como no lee ni escribe en español e inglés, pensó que no tenía mucho que ofrecerles. Después de todo, ella creía que cuando sus hijos asistieran a la escuela, los maestros se encargarían y harían lo que fuese necesario. Como ama de casa, a Lupe le gustaba preparar comidas deliciosas para su familia, como su mamá y abuela lo habían hecho durante su niñez. Sus hijos estaban felices, bien alimentados y muy amados. Recientemente, a través de una amiga, Lupe se enteró sobre Abriendo Puertas/ Opening Doors, un programa desarrollado por y para padres latinos de niños pequeños, al principio se resistió en participar, pero fue a la primera sesión a escuchar. La sesión inmediatamente tuvo sentido para ella y descubrió una nueva manera de pensar e incluso descubrió que poseía más que ofrecerle a sus hijos de lo que ella creía tener y había mucho que aprender.

Lupe participó activamente en las 10 sesiones ofrecidas por el programa, aprendiendo sobre una gran cantidad de temas: las mejores prácticas en la preparación escolar, establecimiento de metas, desarrollo infantil, comunicación familiar, lenguaje y alfabetización, sano desarrollo de salud física y socio emocional y conocimientos sobre abogacía. A través de Abriendo Puertas, Lupe aprendió que podía preparar a sus hijos para la escuela incluyéndolos en actividades diarias, como preparar comidas. En el mercado, Lupe empezó a hablarles sobre el color y tamaño de las frutas y verduras que compraba y las contaban cuando las metían en las bolsas. Las comidas familiares se hicieron más saludables. Ahora en la casa, Lupe habla con sus niños sobre la textura y el origen de los ingredientes que usa, miden esos ingredientes y comparten la labor de poner la cena en la mesa. También ha empezado a adquirir libros para sus hijos pequeños y a contarles cuentos sobre sus imágenes, conforme pasa las páginas. Los libros los adquiere de la biblioteca de la comunidad, a donde Lupe nunca había entrado antes del programa.

En una sesión de Abriendo Puertas, Lupe declaró,

Yo amo este país y trabajo duro para que mi familia tenga las oportunidades y la educación que yo nunca tuve. Disfruté el programa de Abriendo Puertas y me encontré con otras mujeres como yo, con las que compartimos el

Resumen

Abriendo Puertas/Opening Doors es un programa basado en evidencias desarrollado por y para padres latinos de niños pequeños para enfrentar las diferencias de oportunidades relacionadas con ellos. El programa ofrece a los padres la información que necesitan para entender el desarrollo infantil y tener acceso a recursos y servicios que permitirán a sus hijos tener el mejor inicio posible en la escuela. El currículo incluye 10 sesiones educativas e interactivas, que enfatizan la importancia del involucramiento de los padres en la educación de sus hijos. La evaluación del programa revela que los padres participantes adquieren importantes beneficios positivos.

Photo: Courtesy Abriendo Puertas/Opening Doors

Abriendo Puertas fue desarrollado para manejar esas brechas de oportunidades relacionadas con niños latinos de 0–5 años.

mismo deseo: todas queremos lo mejor para nuestros niños. Abriendo Puertas me ayudó a comprender mi rol de líder de mi familia. Ahora me he puesto metas y he hecho planes para alcanzarlas, paso a paso. Por ejemplo, con respecto a la lectura, yo no quiero que Miguelito no lea bien. Aprendí que muchos niños no están leyendo a su nivel de grado y esto les hace difícil aprender y realizar un buen trabajo en la escuela. Miguelito tiene tres años. Nosotros nos divertimos yendo a la biblioteca, leyendo libros y contando historias. Como nos dicen y aprendimos en Abriendo Puertas, el que adelante no mira, atrás se queda. Un día Miguel irá a la universidad.

Lupe ha tenido un cambio positivo por su participación en Abriendo Puertas, ha convertido su hogar en un ambiente dinámico de aprendizaje y es una maestra valiosa para sus hijos. La evaluación del programa (Bridges, Cohen, Fuller, & Velez, 2008) indicó que hubo un incremento significativo en la confianza que los padres adquieren como tales, después de participar en el programa.

Apoyando la Preparación Escolar

Muchos padres latinos de bajos ingresos preparan cuidadosamente a sus hijos para el kínder con un nuevo corte de pelo, una lonchera y un par de zapatos nuevos—para ellos, en esto consiste la preparación para la escuela. Muchas veces ellos no se ven a sí mismos como el primer y más importante maestro de sus hijos. Y como el kínder se vuelve académicamente más exigente, sus hijos llegan a la escuela sin preparación para los desafíos reales que les espera. Muchos niños latinos empiezan la escuela atrasados académicamente en comparación con sus compañeros no latinos, creando una brecha académica que continúa durante los siguientes años escolares. Los niños latinos tienen un riesgo muy alto de desertar y/o fracasar en la escuela. (Fuller et al., 2009; Reardon & Galindo, 2009).

Es probable que los niños latinos enfrenten otros retos. En el 2009, su índice de pobreza estaba arriba del 33% (Nepomnyaschy, 2007). Comparados con sus compañeros no latinos también muestran un alto nivel de obesidad, que está vinculado a serios problemas de salud como la diabetes en la edad adulta e incluso a temprana edad, (Escarce, Morales, & Rumbaut, 2006).

Construyendo sobre las Fortalezas de las Familias

Los riesgos escolares y de salud y los índices de pobreza opacan grandemente las fortalezas de muchos niños latinos de bajos ingresos. La mayoría de ellos tienen resultados saludables al nacer, fuertes y tempranas habilidades sociales, una familia solidaria que cría con amor y una rica herencia cultural. Estos elementos forman una fundación fuerte para el éxito posterior. (Crosnoe, 2006; Fuller et al., 2009). Por lo que es importante construir cada día sobre estas fortalezas, ya que los niños latinos constituyen uno de los segmentos más grandes y de rápido crecimiento de la población de los Estados Unidos. Actualmente los niños latinos representan más del 20% de los niños estadounidenses. Se espera que para el 2030 representen cerca del 33% (Mather & Foxen, 2010; U. S. Census Bureau, 2004). El bienestar de los niños latinos debe ser una preocupación nacional porque su éxito jugará un papel importante en determinar el futuro de la nación en su habilidad de competir en el futuro mercado global.

Reduciendo Desigualidades Incrementando Oportunidades

Muchos expertos advierten las disparidades de salud entre latinos y sus homólogos no latinos o la evidente brecha de su desempeño académico, pero estas brechas tienen que manejarse como brechas de oportunidades. Investigaciones indican que tener un padre informado, atento y comprometido es una de las ventajas más grandes de la vida. Los padres se benefician al recibir información que pueden entender con facilidad y usarla diariamente para apoyar a sus hijos. Abriendo Puertas fue desarrollado para manejar esas brechas de oportunidades relacionadas con niños latinos de 0-5 años: el programa da a los padres la información necesaria para entender el desarrollo infantil, tener acceso a recursos y servicios necesarios y realmente convertirse en su primer y más importante maestro y su mejor abogado, haciendo de su hogar su primera escuela.

Enfoque del Currículo

Aunque está disponible en inglés, el currículo de Abriendo Puertas fue desarrollado en español por y para padres latinos. Es un programa de bajo costo que capacita entrenadores que salen preparados para capacitar a otros facilitadores para implementar Abriendo Puertas en sus comunidades. Es un programa muy fácil de adoptar y adaptar para que sea relevante a la comunidad donde será implementado. Las 10 sesiones son divertidas y se originan desde la cultura de las familias servidas. El currículo de Abriendo Puertas es multifacético, cubre desde el bienestar del niño y la familia, buena salud, bienestar socio emocional, preparación escolar, el bienestar económico familiar, y hasta la habilidad de los padres para abogar por sus hijos. El currículo está basado en evidencias e incluye desde estudios recientes sobre el desarrollo infantil y la mejor manera de apoyar su bienestar, hasta una evaluación constante de los métodos más efectivos para trabajar con los padres. Los facilitadores del programa se aseguran de desmitificar y hacer accesibles las investigaciones relacionadas y proveen información clave para que los padres puedan analizarla y decidir si la incorporan o no en sus prácticas. Abriendo

Puertas cree que los padres harán lo mejor para sus hijos si conocen más sobre su desarrollo y se les dan buenas opciones para actuar. El programa utiliza redes sociales, las relaciones con los facilitadores y las relaciones entre los participantes para profundizar el conocimiento de los padres y adquirir nuevas habilidades y hábitos.

Específicamente, Abriendo Puertas informa a los padres con estadísticas locales sobre los retos en salud y educación que sus hijos pueden enfrentar y ofrece importantes recursos: siendo los mismos padres el recurso más notable. El programa invita a los padres a considerar los siguientes hechos: (a) el tiempo desde el nacimiento hasta los 5 años de edad—todo antes que empiecen la escuela—es un tiempo vital para el aprendizaje de los niños; (b) los padres, no importando su educación formal, son líderes de su familia y son los primeros y más importantes maestros, (c) hay recursos disponibles para apoyar el desarrollo de sus hijos, y (d) hay pequeñas cosas que los padres pueden hacer diariamente en sus hogares para hacer una enorme diferencia en el aprendizaje de sus hijos y en sus vidas.

Aprendizaje de Idiomas

Muchos padres están dispuestos a aprender cómo ser maestros eficaces para sus hijos, pero están desorientados, confusos y tienen dudas sobre el lenguaje. Por ejemplo, María desea que sus tres hijos tengan muchas oportunidades y ella sabe que será de mucha ayuda si aprenden inglés. Ella sólo habla español y teme que se confundan al aprender dos idiomas al mismo tiempo; ella no sabe qué hacer. Por otra parte, aún cuando sus padres nunca le leyeron, ella ha oído que los padres deben leerle a sus hijos y ella no es una buena lectora —especialmente en inglés.

A través de Abriendo Puertas, María aprende que sus hijos aprenderán inglés con facilidad si tienen una buena base en español. (Slavin & Cheung, 2005; Tabors & Snow, 2002). Abriendo Puertas anima a los padres a apoyar a sus hijos en su idioma, cultura y comunidad. Construyendo sobre lo que ya tienen, incrementa el bienestar de los niños y la familia. La evaluación reveló que a través de la participación de los padres en las sesiones, se fortalecen significativamente las relaciones entre los padres, sus redes de apoyo y sus comunidades. (Bridges et al., 2008). Además, el programa le mostró a María y a los otros padres, las expectativas que la escuela de su vecindad tiene para sus hijos y los animó a participar activamente en su educación — desde la cuna hasta la universidad. María compartió con otros padres en la sesión:

Yo no quiero que mi hija sea parte de las estadísticas que nos mostraron. Estoy contenta porque ahora sé lo que está pasando en las escuelas y por qué muchos estudiantes no se gradúan. Yo he hecho el compromiso de involucrarme en la educación de mi niña y también de hablar con otros padres sobre el tema. Lo que hacemos como padres tiene gran consecuencia—yo no lo olvidaré.

Salud Física y Salud Mental

Además de enfocarse en la preparación académica, Abriendo Puertas apoya ampliamente el bienestar de los niños abordando temas clave de salud física y mental. Otra participante, Gloria, tiene dos hijos y se enorgullece que sean grandes y saludables porque ella recuerda que cuando ella creció, sus padres regularmente tenían dificultades para poner comida en la mesa. Sus dos hermanos no fueron niños grandes y ahora tienen problemas de asma y diabetes, así que ella se asegura que sus hijos coman mucho para ser fuertes. Cuando salen y les da hambre les da el gusto de llevarlos a McDonald's, que es su restaurante favorito. Y cuando van al mercado, los niños se comportan mejor si ella les compra galletas o un refresco.

A través de Abriendo Puertas, Gloria aprendió que un niño promedio come 64 libras de azúcar al año y muchos están en riesgo de contraer diabetes porque comen más comida rápida en vez de frutas y vegetales. Ella se enteró que casi el 40% de los niños latinos de 2–19 años son obesos, y que eso no significa que sean ni fuertes ni saludables (Mather & Foxen, 2010). Gloria aprende a alimentar a sus hijos con alimentos más sanos de los que su madre cocinaba. Sus muchachos ahora en realidad serán

Photo: Courtesy Abriendo Puertas/Opening Doors

Una familia solidaria que cría con amor y una rica herencia cultural son elementos que forman una fundación fuerte para el éxito posterior.

Photo: Courtesy Abriendo Puertas/Opening Doors

Hay pequeñas cosas que los padres pueden hacer diariamente en sus hogares para hacer una enorme diferencia en el aprendizaje de sus hijos y en sus vidas.

Para más información

Abriendo Puertas /Opening Doors
www.familiesinschools.org/abriendo-puertas-opening-doors/
La página de internet de Abriendo Puertas ofrece información sobre calendarios de Institutos de capacitación, un resumen del currículo en inglés y español y recursos relevantes.

más fuertes y tendrán menos probabilidades de tener problemas de salud conforme vayan creciendo. Y si ella tiene preguntas o preocupaciones sobre la salud de sus niños, está informada sobre los servicios de salud en su comunidad, cómo obtener una segunda opinión profesional y cómo tratar con otros problemas de salud física y mental. La evaluación del programa indica que uno de los más útiles conocimientos que los padres participantes obtuvieron, fue sobre los recursos de salud. (Bridges et al., 2008).

Mejora Continua

Abriendo Puertas tiene como objetivo mejorar los resultados de los niños latinos de la comunidad. El programa continúa recibiendo aportes de los padres sobre temas de preocupación y retroalimentación sobre los mensajes del programa y su implementación. El currículo utiliza un método de educación popular que respeta las experiencias de vida de los participantes y las incluye en el desarrollo de las sesiones. También provee un modelo para la participación de los padres en la educación de sus hijos, porque las investigaciones indican que su involucramiento está vinculado con el éxito académico de sus hijos (Rodriguez-Brown, 2010). Abriendo Puertas envuelve a los padres en un aprendizaje activo y divertido. En la sesión que se enfoca en el desarrollo temprano del cerebro, se realiza un ejercicio utilizando una bola de estambre, se forma una red entre los participantes para demostrar las conexiones de las neuronas. En otra sesión se juega *Loteria*[1] para enfatizar algunos conceptos presentados. Los padres se sienten cómodos al ser guiados por un facilitador entusiasta y acogedor que está provisto con un currículo comprensivo, información demográfica de su comunidad e información sobre recursos.

Este enfoque se confirma con los resultados iniciales de la evaluación. La evaluación siguió la pista de 109 padres en el transcurso de su participación en Abriendo Puertas, usando datos cuantitativos y cualitativos y el análisis. Los participantes reportaron incremento significante (con índices de clasificación de efecto incluidos) en:

- Confianza en sus habilidades de ser padres (*SD* = 0.48)
- Conocimiento y acceso a servicios de salud disponibles (*SD* = 0.65)
- Apoyo social y conexiones sociales en la comunidad (*SD* = 0.27; *SD* = 0 .11)
- Participación en la comunidad (*SD* = 0.20)

Como se muestra en la Figura 1 y confirmado con los testimonios de los padres, Abriendo Puertas hizo una diferencia—una gran diferencia para muchos de los participantes. Estos resultados y las reacciones asociadas fueron usados por los creadores del programa para mejorar y refinar las sesiones.

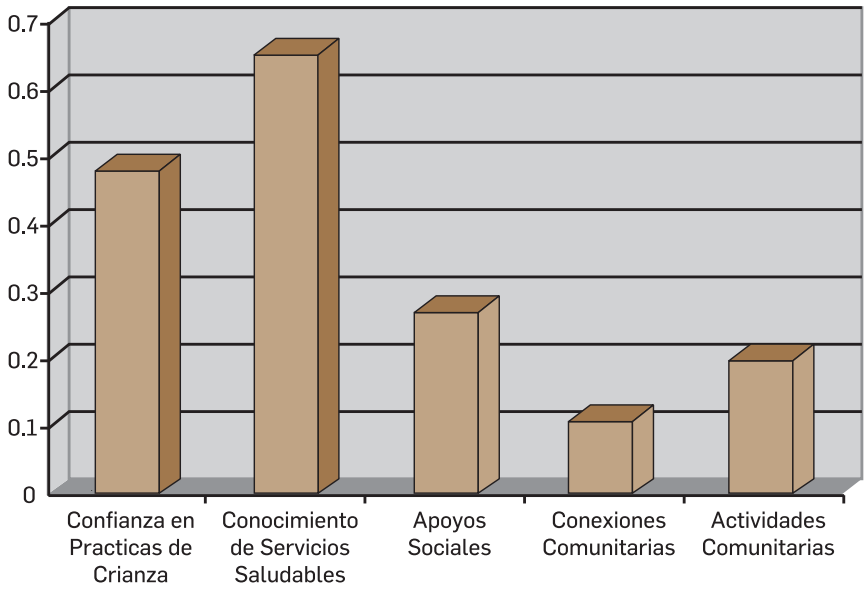
Los prometedores resultados iniciales y la clara relevancia del crecimiento de la comunidad latina en los Estados Unidos, han dado como resultado, la adopción de Abriendo Puertas por muchas organizaciones alrededor del país, que proveen servicios a padres latinos de niños pequeños de bajos ingresos. Ahora Abriendo Puertas está en 25 estados y 76 ciudades y está capacitando facilitadores y proveyendo el currículo al personal y miembros de la Asociación Nacional de Head Start, NHSA, y de la Asociación Nacional de Agencias de Cuidado de Niños y de Recursos y Referencias, NACCRRA. Abriendo Puertas ofrece un instituto de capacitación de 3 días para profesionales que trabajan con familias latinas, para que enseñen a otros a facilitar el programa en sus comunidades locales. Estos esfuerzos están fortalecidos por el compromiso de mejorar continuamente, conduciendo evaluaciones para el instituto de facilitadores y para los grupos de padres donde se implemente el programa. Los padres —como líderes de sus familias—son agentes poderosos de cambio. Abriendo Puertas es sólo el primer paso para los padres latinos que están ansiosos de aprender más y aprovechar los recursos para mejorar el éxito académico y la vida de sus hijos. Abriendo Puertas abre las puertas a las oportunidades.

[1] *Lotería* es un juego Mexicano de oportunidad, similar al bingo, pero usando imágenes con una baraja de tarjetas en vez de números con pelotas de ping pong..

Photo: Courtesy Abriendo Puertas/Opening Doors

Muchos padres están dispuestos a aprender cómo ser maestros eficaces para sus hijos.

Figure 1. Índices de las Clasificaciones de Efecto de Abriendo Puertas



Margaret Bridges, *Dra., es una psicóloga del desarrollo y una científica de investigación en el Institute of Human Development en la Universidad de California, Berkeley. Actualmente, está investigando las implicaciones de la ampliación al acceso a la preescuela—particularmente cómo esta ampliación afectará a los niños latinos de edad preescolar de bajos ingresos. Ella también está conduciendo una investigación sobre las experiencias de las familias latinas en programas preescolares y cómo esos programas pueden servir mejor a los niños. La Dra. Bridges completó su doctorado en la*

Universidad de Virginia y su post doctorado en la Universidad de California, San Francisco.

Sandra Gutierrez *es la directora nacional del proyecto Abriendo Puertas/Opening Doors. La Sra. Gutierrez dirigió el desarrollo de Abriendo Puertas—el primer programa comprensivo de la nación basado en evidencias para padres latinos con niños desde el nacimiento a los 5 años. Antes de su trabajo con Abriendo Puertas, la Sra. Gutierrez desarrolló una serie de programas de capacitación para apoyar a los niños y sus familias, envueltos en el sistema de asistencia de niños. Ella tiene más de 35 años de experiencia con organizaciones legales, de abogacía para niños y de servicios a la comunidad. Su carrera multifacética incluye la fundación de la primera organización para asistir a refugiados Centro Americanos, el desarrollo de programas educativos de salud para United Farm Workers of America y el diseño de campañas para promover los beneficios de la preescuela en las comunidades latinas. Además, por 7 años ha sirvió como fundadora y comisionada estatal para First 5 California.*

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Tuning in to Temperament

Frustration Tolerance

Every child is born with his own individual way of approaching the world—also known as *temperament*. Temperament shapes a child's behavior and development in significant ways, so understanding a child's temperament is very important for nurturing his healthy development. For example, if you know that a child has a difficult time with changes, you can anticipate and understand why drop-off time in the morning is so difficult for him. You might talk with his parent(s) about ways to make this morning ritual easier. For example, his mother might create a good-bye routine (like a special song and hug) that is especially comforting for her child.

Children Can Adapt

A child's behavior and temperament are shaped by her experiences, including her interactions with you. For example, children who are slow to warm up to new people and experiences can become more comfortable in these situations when their parents and caregivers slowly and sensitively help them adapt.

There Is no Right or Wrong, Better or Worse Temperament

Temperament is neither something a child chooses nor something that parents create in their child. It is very important for children to be accepted for who they are. It is true, though, that some temperaments are easier to handle than others. An intense, reactive child can be more difficult to soothe than a more laid-back child; a child who is very shy and slow to warm up may require more time and support to feel comfortable joining a group of children. Remember, the goal isn't to change the child, but to help him thrive by nurturing his strengths and providing support when needed. By watching and learning from each child, you can begin to help each adapt, learn, and feel more confident in the world.

Temperament Characteristics

There are five primary temperament characteristics, which are:

- Emotional intensity and reactivity
- Activity level
- Sociability
- Coping with change
- Frustration tolerance

Understanding Frustration Tolerance

Patience and persistence describe how a child copes with frustration and how likely she is to stick with a problem or challenge in order to find a solution.

Photo:© iStockphoto.com/Luis Alvarez

Every child is born with his own individual way of approaching the world.

Children who are easily frustrated tend to

- Get very upset the minute something doesn't go their way,
- Have a difficult time waiting for attention or help, and
- Give up quickly when faced with a challenge.

For the children in your care who have a low frustration tolerance, try the following strategies:

- **Help children learn to wait.** While they wait, talk to them about what you are doing. For example, you might say, "I'm heating up your bottle right now." Or, "I will help you in a minute. I will finish feeding Mikey and then help you with that toy."
- **Help children cope with frustration.** When they fall apart, let them know that you appreciate how difficult it can be: "Puzzles are hard! It makes you so mad when the bear won't fit in the space." Then become their coach—help them think through solutions without doing the work for them. Suggest or demonstrate strategies for solving whatever problem they are facing. One good idea is to break the challenge into manageable parts: "Why don't you put your thumb in the glove first? Then we will work together to get each of your other fingers in."
- **Use humor.** This can reduce tension. For example, you yell at the block that has fallen: "You silly block! You just won't stay on the tower! Well, we're not giving up!"

Children who are persistent usually

- Keep trying when faced with a challenge,
- Are slower to "lose it" when they don't get their way, and
- Can often tolerate waiting for their needs to be met.

For the children in your care who are persistent, try the following strategies:

- **Join in their play.** It's easy to let persistent children play alone for long periods because they are less demanding. But they still need and benefit from your time and attention.
- **As they grow, let the children know that everyone needs help sometimes and that you are available.** Sometimes, children get so much positive feedback for being independent that it's difficult for them to ask for help when they do need it.
- **Look for fun and challenging activities** that will help persistent children build and expand their skills. Because these children can tolerate frustration more easily, "stretching" activities that are difficult but achievable can be enriching and expand their learning. For example, give a toddler a collection of different-sized cardboard boxes and ask him to build the tallest tower he can.

Photo: © iStockphoto.com/Eduardo Jose Bernardino

Temperament is neither something a child chooses nor something that parents create in their child.

Be A Child's Champion

You can also help others see a child's behavior from a different perspective. For example, instead of being critical about a child's feisty nature, reframe your thinking: "Tess knows who she is and what she wants. She is loving and she is fierce. She puts her whole heart into everything."

Remember, the goal isn't to change a child's temperament, but to help him make the most of his unique temperament—both its strengths and the areas where he may need more support. By watching and learning from the child, you can begin to slowly and sensitively help him to adapt, to expand his world, and to feel more confident about his place in it.

For more information and resources about child development, visit the ZERO TO THREE Web site at www.zerotothree.org.

Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three,* we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	*What it means*
Circadian Rhythms	Circadian rhythms refer to the natural, biological pattern of sleeping and waking that begins to develop when a baby is between 2 and 3 months old. During this time, sleep gradually consolidates, occurring for longer continuous periods of time with a preference for sleep during the night. (Find it in Du Mond & Mindell, page 30)
Cycle of Deployment	The cycle of deployment refers to the phases of emotional and physical separation that begin with notification of an upcoming deployment (predeployment), include a significant separation because of the service member's departure overseas (deployment), and are typically completed with the postdeployment transition (reintegration). (Find it in Paris, Acker, Ross, & DeVoe, page 36)
Early Childhood Mental Health Consultation (ECMHC)	ECMHC is a model for building providers' skills and reducing problematic behavior in young children in child care. ECMHC aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to 6 years old and their families. It involves a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with expertise in infant and early childhood development. (Find it in Perry, Holland, Darling-Kuria, & Nadiv, page 4)
Obstructive Sleep Apnea (OSA)	OSA is characterized by repeated episodes of prolonged upper airway obstruction, with common symptoms including loud snoring, pauses in breathing, labored breathing, heavy sweating, and mouth breathing. (Find it in Du Mond & Mindell, page 30)
Parasomnia	Parasomnia is a type of sleep disorder that includes behavior such as sleepwalking, sleep terrors, and confusional arousals. (Find it in Du Mond & Mindell, page 30)
The Pyramid Model	The Pyramid Model provides a conceptual framework for organizing practices needed to promote young children's social–emotional development, prevent the development of challenging behavior, and deliver individualized interventions to children with persistent behavioral concerns. (Find it in Fox & Hemmeter, page 18)

UPCOMING ISSUES

January: Conversations With the Experts
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To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

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