Let's Talk-Managing Difficult Behaviors in Young Children – Handout*

Presenters at September 12, 2002 Audio-Conference

- ***Child Care Overview***: Marlene Weinstein, MA, Director of Child Care Matters, United Way of Southeastern PA
- ***Common Difficult Preschool Behaviors***: Barbara J. Howard, MD, FAAP, The Johns Hopkins University School Medicine
- ***Tricks of the Trade in Collaborating with Child Care Providers***: Stephen J. Bagnato, Ed.D., NCSP, UCLID Center, University of Pittsburgh

***This handout was adapted from original slide set found in larger print at www.paaap.org Archives**

PA Pathways – CBK

- K7C1 "Identify ways to support the emotional growth and health of children and their families."
- K7C2 "Prepare and encourage families to utilize community health resources when needed."
- K7C3 "Evaluate the current practices for effectiveness and conformity with national health and safety standards for child care and institute corrective actions where needed, including determining the need for outside expertise."

(Begin 1st Speaker: Child Care Overview – Ms. Weinstein)

Child Care Centers

A classroom in a Pennsylvania child care center

- 10-12 toddlers; 16-20 preschoolers
- Two adults, but given two shifts and breaks, likely there are more over the day
- Teachers typically have limited background in child development and group care; highly trained and experienced teachers are not the norm

Centers

- Regulations require 40 square feet of space per child (measured wall-to-wall).
  - A room for toddlers is about 500 square feet and for preschoolers 800 square feet; often bathrooms are not in the room
- Children spend 9-12 hours each day in child care
- Routines include 2-3 meals (either provided by the program or brought from home by each child), diapering or toileting, tooth brushing, napping, clean-up
- Activities are designed for small and large group, indoor and out, fine and gross motor

Teachers and Environment Support Positive Behavior

- Room arrangement includes interest areas which are designed to give kids lots of independence and success
- Communication with parents is daily and lots of opportunities for parents to partner with the caregivers to assure continuity between home and center
- Teachers role is to interact with individuals and small groups as other children 'buzz' with activity around her; teachers observe and bring insights about each child's individual development to each interaction

Teaching

- Even while doing task a teacher is both preparing for the next activity and tuned into all the activity in the room.
- Although plans are made for the group, a good program will accommodate individual needs for food and rest.

Challenging Behaviors

- Examples: biting and other physically aggressive behavior; tantrums; toileting issues; sexually explicit behavior; perseveration; very short attention; hyperactivity; apathy; eating stuff that's not food
- Impact on the room and on other children

Challenging Behaviors & Parents

- The effect on parents
  - often embarrassed or perplexed or angered by their own child's behavior; angry and scared if their child is the victim of another child's aggression; or emotional about a situation they know about in the room. This compounds the management challenge.
- Often, difficult behaviors lead to complaints to the director by other parents

Problem Solving

- Teacher/program approaches:
  - observation and analysis of the problem
  - environmental changes
  - specific consequences/rewards
  - anticipation and prevention
  - schedule adjustments
- Engaging parents
- Managing other parents
- Engaging the pediatrician is often an option considered, but with care. Too often the problem is dismissed, or 'solved' with unrealistic recommendations.

(Begin 2nd Speaker: Common Difficult Preschool Behaviors – Dr. Howard)

Pediatrician's Role in Child Care Behavior Problems

- Assessing health aspects/causes for problem
- Integrating understanding of developmental level, temperament, family, environment
- Providing objective position re: child care
- Doing so with confidential relationship
- Providing behavioral counseling
- Facilitating any needed referrals

The Most Common Behavior Problems in Child Care

- Aggression
- Oppositionality
- Tantrums
- Sexual behaviors

Behavior as Common Concern

- 90% of mothers of 2, 3 and 4 year olds have "some" concern
- 20% of mothers of 4 year olds have "significant" concern

Factors Contributing to Behavior Problems

- Medical problems
- Inherent child factors e.g. temperament
- Family management/stresses
- Unmet needs of child
- Child care environment

“Medical” Problems

- Sleep deprivation debt-decreases self control
- Hunger-irritability
- Lead Poisoning- attention and activity problems
- Pain e.g. otitis, injuries-irritable
- Other chronic conditions/illnesses e.g. celiac
- Developmental delays especially language-frustration/aggression
- Mental health problems e.g. ADHD, PDD

Inherent Child Factors and Behavior Problems

More problems with:

- Difficult temperament
- Developmental disabilities
- Mental health problems

Fewer problems with:

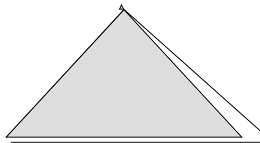
- Higher IQ
- Better language skills

Family Factors & Discipline Problems

- Lack of social support
- Marital discord
- Caregiver discord
- Multiple life stressors especially poverty
- Low educational level or low IQ
- Mental health problems especially
  - depression
  - substance abuse
- Teenage parenting status if isolated
- Family history of teen parent, abuse, antisocial
- Own history of poor discipline

Interdependent Components of Effective Discipline

reinforce (+) behavior / consequences (-)behavior



positive parent-child relationship

Disorders of Parenting

- Under regulated
- Over regulated
- Irregular regulation
- Chaotic
- Disorders of affective exchange

Prevalence of Aggressive Behavior in Young Children

- 15-30% of preschoolers have significant behavior problems, usually incl. aggression
- 25-40% boys 2-5 yrs mod to high aggression
- 10-28% girls 2-5 yrs mod to high aggression
- Peak of aggression before age 3 years
- 40% of severe aggression began < 8 yrs
- Early aggression correlates 0.68 with later behavior disorders especially conduct disorder

From thwarting of developmental needs

Needs of Young Children

- Need for state regulation
- Need for mastery
- Need for positive emotional tone
- Need for assistance regulating negative affect
- Need to learn pro-social behavior & empathy

The Need for State Regulation

- Routines of eating, sleep
- Consistent responsiveness
- These stabilize mood, reduce resistance
- Avoid over stimulation- noise, awake time, sex
- Especially important for temperamentally irregular, unadaptable children
- Especially vulnerable- CNS damaged, lead poisoned, prenatal substance exposed
- Likely missing in social chaos, overextended
- Rx- routines, responsivity

The Need for Mastery

- Experiences of mastery respect need for autonomy but avoid overwhelm
- Over protectiveness or over strictness both problems
- Inconsistency evokes aggression
- Rx-
  - counseling on discipline
  - instruction in smaller consequences
  - treatment of gaps in skills e.g. fine motor, expressive language
  - appropriate child care
  - placement with younger children

Need For Positive Emotional Tone

- Positive tone & stable attachment avoid suspiciousness & enhance resilience under stress which otherwise evokes aggression
- Hostility in the family:
  - raises tension
  - models aggression
  - includes pain which evokes aggression
- Rx:
  - Teach nonphysical discipline
  - Elicit parental history of being disciplined
  - Family therapy
  - Substance abuse treatment as needed
  - Removal of the child as needed

Need For Assistance Regulating Negative Affect

- Regulation occurs through: jollying, distracting, modeling, acknowledging, verbalizing, compromising
- Excessive negative affect is encouraged by: covert encouragement e.g. projection, passive avoidance, punishment. These are likely when parents can't tolerate negative feelings.
- Child depression can be source of aggression
- Rx-
  - echoing, anger exercises
  - alternative outlets e.g. teething ring
  - referral if in "coercive cycle" where child aggression results in parent backing off

The Need to Be Taught Pro-social Behavior and Empathy

- Skills include: trading, taking turns, waiting, asking for things, thanking, taking other's point of view, seeing effects of own actions, recognizing feelings of others
- Excess stress associated with aggression include:
  - large family size
  - low income
  - single parenthood
- Rx = Not just consequence for aggressor:
  - More individual attention e.g. special time
  - Selective attention & labels for pro-social behaviors e.g. marks
  - Positive role models
  - Sympathy to victim rather than to perpetrator

Biting

- Very primitive. Evokes strong emotions
- Peaks at 6 mo with teeth, 9-12 with affection,
- 15-18 with aggression, 2 1/2 yr if aggression not well handled
- Persists in: reinforced, physical punishment, blind, language delayed, poor VPM skills (Visual-perceptual-motor i.e. fine motor skills)
- 1/2 of children in day care are bitten, average 3x/yr
- Worst when stressed, learning to cope

Biting Management

- Calm down caregivers
- Assess skills, coping, environmental stresses
- Prevent if possible: activities, small groups, alert caregivers, big toys
- Offer teething ring to bite
- Teach negotiating skills
- If attacks->shout, Time Out, comfort victim
- If persists-> further evaluation, change care

Consequences for Undesirable Behaviors

- Ignoring (with explanation)
- Verbal disapproval (with consequences)
- Nonverbal disapproval e.g. glaring
- Time out
- Marks, tokens
- “Use the least that works”

Natural Consequences

- Occur naturally
- Caregivers need to protect from
  - damage
  - social disgrace
  - child’s impulses

Logical Consequences

Should be:

- Meaningfully related
- Dosed appropriately-shorter is better
- Calm delivery
- Prompt- can ponder major
- Private, respectful
- Expecting recovery
- Decided along with older children

Setting Limits

- Makes children feel secure, protected, noticed
- Adults may not limit because:
  - they feel it is a hardship on their special child
  - they are reacting to limits put on them
  - they are reacting to other parent's limits
  - setting limits elicits anger they can't tolerate
- Limit setting also needs to be: reasonable, flexible (especially proactively), done with a sense of humor!

Time Out

Definition: Time away from reinforcement and attention usually accompanied by disapproval, loss of freedom, and loss of interesting things to do.

Time Out-1

Principles for young children:

- Only for 2-3 behaviors at one time
- Only one warning, none for aggression
- Brief statement of offense
- Place in non-interesting place
- Brief, 1 min/year of age. Release after 15 sec quiet. Use timer
- If leaves: restrain, playpen, barrier,
- No discussion or lectures

Time Out-2

- Comment on first positive or neutral behavior after Time Out
- After understanding, restart timer if noisy, acts up, or leaves
- If calm, may discuss behavior, alternatives
- Practice before first use
- Effective from mental age 9 months - 12 yrs

Oppositionality

- Baseline compliance is 60%
- Noncompliance may signal lack of skills
- Noncompliance may be attention getting
- Noncompliance can be reinforced by inconsistency

"One request then move"

- Watch for a natural pause in child's activity
- Get attention
- Give instruction in short, simple language
- If no response in 10 seconds (grasp child while adult and/or child completes task)
- Praise any cooperation
- Alternatively - 1,2,3 Magic (goes to Time Out)
- If can't enforce - don't ask

Positive Reinforcement for Desired Behaviors

- Shapes approximations of desired behavior
- Nonverbal as well as verbal
- Tracking:
  - select desired behavior
  - count baseline rate
  - provide selective reinforcement
  - record changes in behavior
- Consistent usage, moderate strength, calm delivery
- Avoiding embedded criticism, attending to negative behavior

"Catch them being good"

Attention, praise, comments, touches, or rewards given selectively during desirable behavior increase its occurrence.

Marks

- Mark child's hand for appropriate behaviors (get parent's OK for type of marker)
- Use marks for brief period up to all day
- Aim for 6-10 marks per hour
- Reward for "bunch" of marks
- Give bonus numbers for outstanding behavior
- Phase out when behavior has improved and parent is practiced at other acknowledgement

Intervention in Peer Disputes

- Guess at or determine the meaning e.g. jealousy, hurt feelings, boredom, competition
- Verbalize the feeling first
- Ask what they could do differently
- Praise suggestions

Dealing with Competitiveness

- Remember- it's normal, All American
- Have them make suggestions for fairness
- E.g. taking turns by the calendar
- Consider putting disputed objects in time out

Temper Tantrums

- Start around 12 months
- Last to age 3
- Other peaks at 6 and early teens
- Emotions beyond their control
- Easily reinforced
- May be early sign of depression, ADHD

Management of Tantrums

- Assess management, developmental levels
- Explain- not just willful
- Reduce stresses, childproof
- Maximize choices
- Attend to cooperative behavior

During episodes:

- Safeguard
- Stand by silently, or hold
- Comfort, distract afterwards
- Discuss when calm

Normal Prepubertal Sexual Behaviors

- Erections start prenatally
- Boys more motoric by 13 months
- Can’t switch gender after 18 months
- Point to and compare body parts < 2
- Prefer to play with same sex peers by 2

Normal Prepubertal Sexual Behaviors

- State own gender by 3
- Aware of gender related toys by 3; prefer by 4
- Ask where babies come from at 5
- Courtship behaviors 3-6
- Play “doctor” 5-6 years
- Spontaneously modest around 6

Masturbation

- 6-8 mo boys, 8-11 mo girls masturbate
- peak 15-18 mos and 2 1/2 yrs
- 1/3 of girls persist, 1/3 indirect, 1/3 stop
- goal is to teach appropriate social context without shaming
- R/O neglect, lack of sensory input, ADHD
- R/O sexual misuse if stereotyped, substitutes for normal activity, frantic, other clues

Management of Sexual Issues

- Label body parts correctly
- Avoid shaming re genitals
- Answer questions matter of factly
- Discuss social aspects of discovered sex play without alarm
- Set limits on dirty jokes and personal questions
- Provide privacy. Keep kissing & hugging optional.

Management of Sexual Issues

- No evidence that discussion hastens sexual activity.
- “Driven quality” to sex behavior suggests abuse
- Consider sexual abuse when: new toileting concerns, sleep disruption, body complaints or fears in general.
- Beware of validity of sexual issues raised in discord/divorce context.

Qualities of Child Care Promoting Positive Behavior

- Safe and clean, no guns, no smoking
- Adequate caregiver:child ratios
- Continuity of caregivers
- Attention to positive behavior
- Anticipation of problems and redirection
- Adequately stimulating curriculum; but not overly academic
- Space and toys for small group play
- Nonphysical discipline

Communicating with Child Care Professionals about Child Behavior Problems

- First listen!
- Ask what they think, have tried
- Collaborate on plans with child care and parents
- Visit and observe if possible
- Try plans for 3 weeks then reassess

Behavioral Data Collection Sheet

http://www.paaap.org/pdf/ecels/behave.pdf

Special Care Plan for a Child with Behavior Problems

http://www.paaap.org/pdf/ecels/care.pdf

(Begin 3rd Speaker: Supporting Children with Challenging Behaviors in Early Childhood Settings – Dr. Bagnato)

Organization

- *Prevention*: Changes in the physical environment and classroom climate
- *Intervention:* Strategies for helping children and families directly; child vignettes re: at-risk status
- *Interdisciplinary Models and Supports:* Developing partnerships with others-Head Start, Early Intervention, psychologists
- *Professional Resources:* Books, articles, and intervention materials

Need and Philosophy for Behavioral Support in Early Childhood Settings

[Raver & Knitzer, 2002]

- Prevalence of early problem behaviors= 10%
- Prevalence of early problem behaviors for children in poverty and high-risk circumstances = 27%
- 4-6% of young children have serious emotional and behavior disorders at kindergarten entrance
- Foster social-emotional and self-regulatory behavioral competence for school readiness vs. psychopathological or deficit-based approach
- Emphasize evidence-based and "best practices" that are developmentally-appropriate (NAEYC; DEC)
- Advocate in classroom or "in-vivo" teacher-parent consultation and direct child support vs. pull-out services
- Conflicting education & healthcare regulations and philosophies; need for systems reform and integration of ECE, MH, HC

Assumptions of Effective Behavioral Support

- Challenging behaviors serve a function for the child—communicates needs.
- Challenging behaviors are context-related--social interactions with people and settings.
- Effective interventions result from a thorough understanding of the problem behavior and its contextual influences and function.
- Behavior support plans should be guided by a strong positive focus on strengths (skill-building) not deficits.

Prevention Strategies

[Strain & Hammeter, 2000]

1. Physical Environment

Reduce conflict opportunities via room center re-arrangements and traffic patterns

2. Activities and Materials

Ensure children are actively and appropriately engaged in activities with materials and people

3. Scheduling

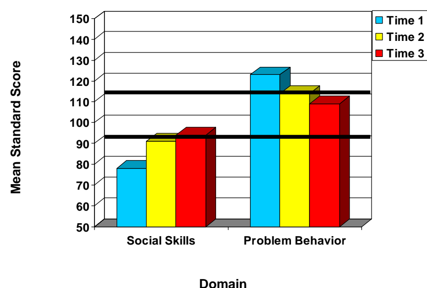
Implement a consistent schedule and predictable routines to reduce occasions for misbehavior

4. Promoting Appropriate Behaviors

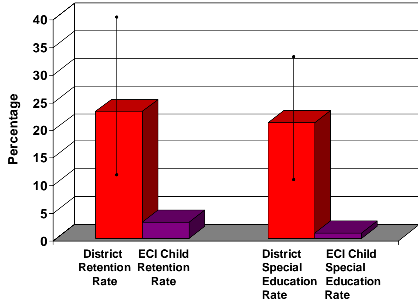
Teach social and self-control skills to prevent problem behaviors

What is the social behavioral progress and early school success of children with challenging behaviors who are supported in high-quality ECE settings? (Bagnato, 2002)

- Social Skill Delays
- Self-Control Behavior Problems
- Qualify for MH Diagnoses, but undiagnosed

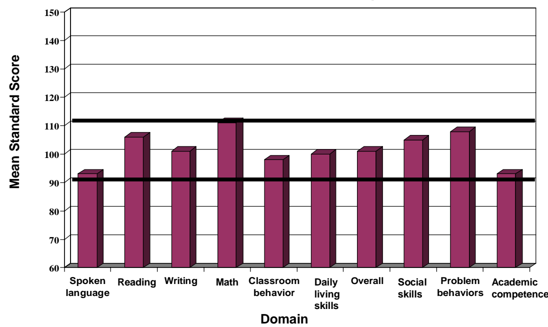


ECI vs. Typical School District Grade Retention and Special Education Rates



National Normative Comparisons for ECI Childrens' Early Learning Abilities: Second Semester Grades K-1

Basic School Skills Inventory-Revised



Individual Child Interventions: General Considerations

- Model strategies for teachers
- Partner with parents
- Develop a goal-plan collaboratively
- Build social and self-control behaviors that are prerequisites for Kindergarten Success
- Establish positive strategies together that work in real-life routines
- Put the plan in action, stick to it, stay positive, and monitor progress & revise
- Effective teaching = successful behavior management

Aggressive, Defiant Behaviors
[Darren, 4 year old in Head Start]

- Family: Single mother; 10 year old sister in Emotional Support classroom
- Behaviors: hitting, kicking, runs away, does not follow directions
- Strengths: behaves appropriately with one-one adult interaction; builds creative structures; enjoys books and quiet time with an adult
- Challenges: Entering play groups; attending during circle time; GM play outside; hitting to gain peer/adult attention, and to interact
- Support Plan Goal: Develop social skills/self-control behaviors; practice positive interactions with peers and teachers; adult guidance; make aggression incompatible with positive interactions and adult attention; praise; and adults model conflict management approach.

Aggressive, Defiant Behaviors

- *Strategies That Worked!*

1. Collaborate with parent, teacher, and SLP to model prosocial behaviors
2. Graduated modeling, prompts, praise, fading of teacher guidance to enter and play appropriately in small peer groups
3. Restructured outdoor gross motor play for all facilitated by adults to model cooperative game playing
4. Peer-pairing (Darren and 2 friends) with adult guidance to practice waiting, sharing, turn-taking; attention in a more conducive setting
5. Successful in Kindergarten and 1st grade

Biting
[Rachel, 3 year old in child care with Head Start support

- Family: Single mother working full-time and college too; in child care from 6:30 am to 9:30 pm 4 days/week
- Behaviors: screaming and biting peers or adults when play interrupted (doll taken from stroller) or when easily frustrated
- Strengths: enjoys childcare; attached to HS consultant;
- Challenges: 3 adults/21 children; poor classroom layout; materials and toys inaccessible; little structure; teachers constantly yelling and correcting rather than teaching prosocial behaviors
- Support Plan Goal: Eliminate biting by: partnering with mother on changing relationship with Rachel ; modifying classroom climate and routines; emphasize modeling and practicing prosocial behaviors; contingency between adult attention and non-biting appropriate behaviors

Aggressive, Defiant Behaviors

- *Strategies That Worked!*

1. Problem-solve with mother about changing schedule and attachment to Rachel
2. Modify classroom structure, materials/toy arrangements; and teacher relationships to children
3. Peer-pairing with adult guidance to practice prosocial behaviors and to properly gain adult attention and praise (DRO)
4. Rachel helps teacher with many classroom tasks: toy layout; cleanup; handout materials; leading group circle time; interrupt, limit, problem-solve; and redirection re: biting
5. Shorten class activities to fit frustration level of 3 year olds
6. Mother and aunt work in tandem with Rachel at home and in after-school care; aunt & mom take Rachel to special events
7. Rachel stopped biting and has matured in making friends and being comfortable with class routines; enjoys and thrives from greater time with mother.

Interdisciplinary Partnerships for Behavioral Health Support

INTERAGENCY RESOURCES:

- Head Start (Federal PS 1304.24)
- Early Intervention (IDEA, 1986; PA EI Entitlement Act, 1991); Intermediate Units, OMH lead agencies
- School Districts- Instructional Support (Grades K-3)
- Wrap-Around Behavioral Support-OMH

SYSTEMS REFORM EFFORTS:

- Pittsburgh-Children's Cabinet
- Infant Mental Health Initiatives
- School Readiness Efforts-Early Childhood Initiative
- School-Linked Healthcare Services (HealthyCHILD)

Healthy CHILD

Collaborative Health Interventions for Learners with Differences

- Regular, on-site, classroom-based consultation, mentoring, and intervention for teachers, parents, staff, and children
- Mobile developmental healthcare team: nurse, psychologist, pediatrician consultant, early childhood educator-generalist
- Individual *"Developmental Healthcare Plans"*
- Focus: medical needs; behavioral needs
- Primary care physician liaison and sign-off
- Collaborative parent-professional decision-making
- Community transagency linkages