Chapter 1
Common Early Childhood Behavior Problems

Abstract Challenging behavior in young children is common. It can be difficult for parents or early childhood professionals to know what behaviors fall within the typical range of behavior. This chapter outlines the prevalence of common behavioral concerns among young children (sleep problems, feeding issues, colic/excessive crying, toileting issues, fears/worries/anxiety, sexual behaviors, aggression, and social skills) and outlines guidelines for how to address these concerns. Strategies to ensure cultural competence in working with a diverse range of families are also outlined.

Keywords Behavior problems • Behavior disorder • Sleep problems • Sleep disorders • Sleep hygiene • Feeding problems • Colic • Toilet training • Anxiety • Fear • Worries • Sexual behaviors • Sexual behavior problems • Aggression • Parent–child interaction • Social skills • Autism spectrum disorders • Attention-deficit/hyperactivity disorder • Cultural competence

Behavior problems in young children are common (Williams, Klinepeber, & Palmes, 2004). Healthy toddlers are extremely active, restless, and impulsive, not because they have a disorder, but because they need to move about and experience to learn. Furthermore, each child comes with his or her own temperament, making for huge variations of personalities, even within families. Providing parents with basic parenting guidelines can help most families successfully navigate through the early childhood years. These strategies, such as developing and maintaining consistent routines, removing dangerous temptations, praising desired behavior, and redirecting problem behavior, are beneficial to all children.

Even so, approximately 20 % of US children have a diagnosable behavioral health disorder, and less than 20 % of those in need will receive help (Society for Research in Children's Development, 2009; U.S. Public Health Service, 2001). Upon entering kindergarten, problem behaviors, especially aggression and

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hyperactivity, place children at risk not only for poor academic outcomes but also for social-emotional and behavioral problems in school which may persist throughout adulthood (Coie & Dodge, 1998; Dishion, French, & Patterson, 1995; Tremblay, 2000). Thus, it becomes important to differentiate between behaviors that are normal and will possibly be outgrown and those needing more individualized attention.

It can be difficult to separate typical behaviors of early childhood from those that would be considered problematic. For example, problems such as sleep difficulties or short attention spans may be typical with young children, but those issues become more problematic as children get older. Research suggests that rather than just considering the behavior by itself, one might want to observe for patterns of behavior (Mathiesen & Sanson, 2000). For example, early onset behavior problems such as aggression and noncompliance are more likely to be indicative of later problems if they are exhibited across settings, including home and daycare, rather than in just one setting (Miller, Koplewicz, & Klein, 1997).

The next sections provide information on a number of common behavioral concerns in early childhood, including sleep problems, feeding issues, colic/excessive crying, toileting issues, fears/worries/anxiety, sexual behaviors, aggression, and social skills. These challenging behaviors were selected for discussion because (1) they are frequent concerns for young children and their families (prevalence rates for most is at least 20 %), (2) they are issues presented frequently in our clinical practice, and (3) these difficulties have been described by other authors as prevalent concerns in young children (e.g., Young, Davis, Schoen, & Parker, 1998). This overview is intended to help early childhood professionals know what behaviors can be expected during the typical course of development, and to be able to distinguish behaviors which may be indicative of more serious and chronic problems in need of more intensive intervention. Information about these common concerns as well as guidelines to promote healthy development are presented.

Sleep Problems

Prevalence

Sleep problems are one of the most commonly reported difficulties in young children, and may be associated with a variety of conditions and medical problems. Sleep is important for renewing mental and physical health, while sleep disorders can lead to reduced health and in some cases may be life threatening (Luginbuehl, Bradley-Klug, Ferron, Anderson, & Benbadis, 2008). Research suggests that between 20 and 25 % of children and adolescents may have a sleep disorder (Mindell, Owens, & Carskadon, 1999), yet few are screened and treated (Luginbuehl et al., 2008). Children with developmental disabilities, asthma, and other medical conditions are at increased risk for sleep problems (Armstrong, Kohler, & Lilly, 2009; Buckhalt, Wolfson, & El-Sheikh, 2007). A number of factors have been

Table 1.1 National Sleep Foundation Guidelines for hours of sleep needed

Age	Hours of sleep
Infants (3–11 months)	9–12 h during the night +
	30 min to 2-h naps, 1–4 times a day
Toddlers (1–3 years)	12–14 h
Preschool (3–5 years)	11–13 h
School-aged children (5–12 years)	10–11 h (children typically do not nap after 5 years)

associated with disturbed sleep in young children, including maternal depression, being introduced to solid foods prior to 4 months of age, attending childcare outside of the home, and watching TV/videos (Nevarez, Rifas-Shiman, Kleinman, Gillman, & Taveras, 2010).

The most common sleep problems in young children are difficulty falling asleep, waking up during the night, or a combination of both (Lyons-Ruth, Zeanah, & Benoit, 2003). In addition, toddlers and preschool children may have difficulty with nightmares, night terrors, sleepwalking, and sleep talking (Armstrong, Kohler, & Lilly, 2009).

Guidelines

According to the National Sleep Foundation (http://www.sleepfoundation.org/), by 6 months of age, infants can learn to sleep for at least 9 h per night, and by 9 months 70–80 % of infants are able to sleep through the night. Table 1.1 outlines the National Sleep Foundation Guidelines for the amount of sleep needed by children, and may be used to help parents begin to pinpoint sleep problems and take steps to improve sleep.

To address difficulty falling asleep, the first step is to alter the child's sleep habits, often referred to as sleep hygiene. Sleep hygiene includes strategies which can be used to solve sleep problems and begins with the establishment of a regular nighttime routine. Difficulty falling asleep can be a pattern of behavior which develops because the child has connected the action of falling to sleep with something else, generally related to the parent, such as rocking, being held, nursed, or some sort of motion, and cannot fall asleep by him or herself. To correct this sleep problem, parents have to reteach the child to fall asleep with a new set of associations, such as a blanket or stuffed animal. The process involves developing a relaxing bedtime routine, followed by gradual separation from the child beginning with 2 min intervals, and brief comforting to let child know he or she is safe. Parents will find this intervention difficult to follow because their child will protest, and will need encouragement to stay the course. Most children will learn to sleep on their own within 5 days of consistent teaching (Ferber, 2009).

Even when caregivers are attempting to set healthy routines, limit setting problems around bedtime generally begin around age 2, when toddlers are naturally testing limits, and resolve when parents develop consistent bedtime routines and remain firm in their expectations. Bedtime routines that help children sleep well include wind down activities such as a warm bath; avoidance of television or other media before bed; keeping bedrooms cool, dark, and distraction-free; and building in time for some personal interaction at bedtime, like reading books or saying prayers. Parents should also avoid giving their child food or drinks containing caffeine, or over-the-counter cough medications that contain stimulants.

To address the issue of young children staying asleep during the night, an initial consideration is nighttime feedings. Nighttime feeding problems are addressed by gradually reducing the habit of providing the child with food at night. By 6 months of age, a baby should be able to sleep through the night without feeding or feeling hungry (National Sleep Foundation, 2010). Nursing babies can wait to be fed in increasingly longer intervals, until nighttime feedings are eliminated. Bottle-fed babies are offered one ounce less at each feeding and at less frequent intervals during the night, until the problem is resolved. A protein snack shortly before bed for older children can help ease hunger until morning.

Feeding Issues

Prevalence

Feeding problems are very common, with estimates of prevalence as high as 35 % in young children (Jenkins, Bax, & Hart, 1980). Feeding issues become evident at different stages of infancy and early childhood, with the prevalence of feeding problems increasing with age. Four percent of children at 18 months experience significant feeding problems, while at 30 months this number rises to 8 % (Mathiesen & Sanson, 2000). When moderate feeding problems are considered, 47 % of children at age 18 months are considered by parents to have a problem, while at 30 months, 62 % were considered to have moderate feeding problems (Mathiesen & Sanson, 2000).

On the extreme side of pediatric feeding issues is failure to thrive. Failure to thrive is diagnosed in children whose weight falls below the fifth percentile for age on growth charts (Lyons-Ruth et al., 2003). One to five percent of all pediatric hospital admissions are due to failure to thrive (American Psychiatric Association [*DSM-IV-TR*], 2000), providing evidence of how severe feeding problems can become in young children.

Although there is not clear consensus in the literature, it is believed the feeding problems in young children can result from organic and nonorganic causes. For example, physical difficulty with the feeding process can be one organic reason that children have difficulty getting adequate nutrients through their food. Chronic

medical issues such as reflux can make eating very painful and set up an aversion to feedings. Alternatively, some nonorganic feeding problems develop and are maintained by problematic parent–child relationships, expectations, and lack of mealtime routines. For example, children may refuse healthy foods during dinner because they have learned that they will be allowed to have preferred snacks later.

Guidelines

Most professional guidelines, including those from the American Academy of Pediatrics (AAP) and the World Health Organization (WHO), recommend breast milk or formula as the main food for children until 6 months of age. The AAP recommends that solid foods be introduced no sooner than between 4 and 6 months of age. The WHO has reported that the introduction of complementary feeding (or transitioning from breastfeeding or formula to other foods) can be a “vulnerable” time period for young children. The WHO guidelines suggest that complementary feeding should begin around 6 months. They also recommend that the nutritional value of the complementary foods be high and free of possible toxins.

Parents are often concerned with how much food their child should eat, especially once they start to introduce foods that are not premeasured in jars. The United States Department of Agriculture (USDA) recommends the following calorie guidelines for young children each day:

- Around 520–570 calories for children 0–6 months
- Around 676–743 calories for children ages 7–12 months
- Around 992–1,046 calories for children ages 1–2 years
- Around 1,642–1,743 calories for children ages 3–8 years

Beginning at age 2, calories should be obtained from six servings from the Grain food group, three from the Vegetable food group, two from the Fruit group, two from the Milk group, and two from the Meat and Beans Group.

In addition to the guidelines for how much to eat, the AAP also offers tips for dealing with feeding and eating issues:

- Don’t threaten, punish, or force-feed your child.
- Provide structure at mealtime with regard to the timing and seating requirements for mealtime. In other words, have mealtimes on a regular schedule and require your child to sit at the table to minimize other distractions.
- Prepare several healthy foods you would be ok with your child eating and allow them to choose which foods they want to eat.
- Limit the length of time for meals.
- Avoid making special meals for children who are picky. Instead, include one preferred item in the meal and encourage the child to try other foods.
- Food refusal should not be rewarded by offering snacks or preferred foods.

Colic/Excessive Crying

Prevalence

Colic and excessive crying are common problems in very young children (from birth to about 6 months old). Colic is often defined by "Wessel's Rule of Threes" which describes colic as:

- Crying for at least 3 h a day
- For at least 3 days in any 1 week
- For at least 3 weeks

This group of symptoms becomes colic when they occur in an otherwise healthy infant and when no cause for the child's discomfort can be identified (Lucassen et al., 1998). Studies of the prevalence of colic have generated estimates as high as 40 % of young children, but most estimates indicate that between 14 and 19 % of families seek assistance from a physician (Lucassen et al., 2001). The prevalence of colic decreases with age, as one study found that up to 29 % of infants between 1 and 3 months had colic, but once a child is between 4 and 6 months old, the prevalence drops to 7–11 % (St. James-Roberts & Halil, 1991). The cause of colic is often unknown and may include painful intestinal contractions, lactose intolerance, food allergies, gas, or have no physical cause at all. In addition, a parent may perceive normal amounts of crying as being in excess (Lucassen et al., 1998).

Guidelines

There are few effective interventions for colic, and most cases resolve without intervention by 6 months of age. However, several reviews have examined the effectiveness of common interventions used to (1) lessen a child's crying and/or (2) lessen parent anxiety over the child's crying (Joanna Briggs Institute, 2004; Lucassen et al., 1998, 2001). Interventions for colic are often divided into three categories: (1) pharmaceutical interventions, or giving medicine to the infant; (2) dietary interventions, or altering the diet of the child or breast-feeding mother to reduce the existence of certain allergens, and (3) behavioral interventions, or the changing of parent behavior in reaction to the infant's crying (Joanna Briggs Institute, 2004). The Joanna Briggs Institute has evaluated interventions falling under all three of these categories to determine if they could be categorized as being possibly useful, having no effect, or having possibly harmful effects (Joanna Briggs Institute, 2004). "Possibly Useful" interventions have been found to be at least moderately effective across several studies. "No Effect" refers to interventions where either no effect was found or the evidence is very mixed. Finally, the "Possibly Harmful" interventions have evidence of harmful effects or potential harmful effects, as well as limited support for their effectiveness in lessening crying.

According to the Joanna Briggs Institute (2004), there are no pharmaceutical interventions that are potentially useful. In contrast, some medications (Simethicone) have been shown to have no effect, while others may actually be harmful (Anticholinergic drugs, Methylscopolamine). With regard to dietary interventions, several have been shown to be possibly useful (low allergen diet for breast-feeding mother, low allergen formula milk, soy substitute formula milk, and sucrose solution for short term of relief); several other interventions have been shown to have no effect (elimination of cow's milk from breast-feeding mother's diet, lactase supplement/low lactose milk, fiber-enriched formula). Behavioral interventions that have been shown to be possibly useful are reduced stimulation and improved parental responsiveness, while increased carrying, car ride simulators, and focused parent counseling have been shown to have no effect. Early childhood professionals should recommend that families consult with their pediatrician first to address colic; however, knowledge of effective and potentially ineffective or even harmful interventions can help early childhood professionals be prepared to work with families of children with colic.

Colic/Excessive Crying Vignette

Annie has been listening to her 6-week-old daughter Leah cry for over 2 hours. Annie feels upset and frustrated because she has changed Leah's diaper, made sure she did not have gas, and tried to feed her. Realizing her nerves are shot and she needs a break, Annie lays Leah down in her crib, turns on her video baby monitor (with the sound off), and closes the door to Leah's room. Annie decides to take a few minutes for herself and walks outside and sits on her patio drinking hot tea. After 15–20 minutes, Annie is feeling better and returns inside to check on Leah. Although Leah is still crying, Annie reminds herself that this is just a phase that many children go through and it will hopefully be decreasing over the next few weeks.

In addition to these suggestions, another resource is the program *The Period of Purple Crying* (http://www.purplecrying.info/). The website and program was created by the National Center on Shaken Baby Syndrome (NCSBS) and has suggestions for parents to help them cope with the stress of having a child who has colic. The website suggests that colic is typical, although the intensity may vary for each infant, and provides strategies parents can use to both meet their baby's needs and reduce their own stress. The program recommends that after checking to make sure that the baby's needs are met (fed, burped, clean diaper, etc.) and the baby is still crying caregivers should trade off care. If only one caregiver is available, after making sure the baby's needs are met, the caregiver should lay the child down in his or her crib (on his or her back) and take a 15 minutes break to calm himself or herself down. After caregivers are feeling calmer, they can return to their normal caregiving activities. This recommendation comes as a way to prevent Shaken Baby Syndrome, where parents resort to shaking their infant out of frustration over his or her crying.

Toileting Issues

Prevalence

Toilet training is a major milestone achieved by young children and anticipated by parents. Since the 1950s, the age at which children are expected to be potty trained has increased from 2 to 3 years old (Schum et al., 2002). Based on a survey of the parents of approximately 300 children, Schum and colleagues suggest that most children are ready to be potty trained between 22 and 30 months, and most children are able to stay dry during the day just before their third birthday (Schum et al., 2002). Research has suggested that children who start potty training earlier will be potty trained earlier than their peers; however, the process takes longer to complete when started with younger children versus older children (Blum, Taubman, & Nemeth, 2003).

The age at which children are potty trained can vary across genders. Schum et al. (2002) examined the average age that boys and girls are able to engage in different types of toileting behavior ranging from "staying BM-free at night" to "wipes poop effectively by oneself." The study looked at a series of 26 skills and found that girls on average mastered 25 out of 26 toileting skills before boys. The order in which children learned the skills was very similar across genders. Girls were dry during the day by 32 months, while boys met these criteria at 35 months. The lowest level skill in the study ("staying BM-free during the night") occurred on average for girls at 22.1 months and at 24.7 months for boys. The most complex skill of "wiping poop effectively by themselves" occurred at 48.5 months for girls and at 45.1 for boys.

Guidelines

Toilet training will be more successful if parents wait until their child shows global readiness skills, which include both developmental and physical readiness for being trained. The first signs are developmental readiness, such as the child being able to sit on the toilet, understand words for potty functions, and wanting to be independent (Schum et al., 2002). Physical readiness for toilet training includes bladder control and expressed discomfort with soiled diapers (Schum et al., 2002). Even when a child presents these global readiness skills, there may be times when parents might want to postpone toilet training, for example, during major life transitions, such as the birth of a sibling or a move, or during developmental phases when the child is most resistant.

There are a variety of strategies that can be used to promote successful toilet training, which are recommended by the AAP (1999) and Azrin and Foxx's (1974) *Toilet Training in Less Than One Day*. Some parents may prefer the more casual approach recommended by the AAP, during which parents gradually introduce the potty and allow the child to set his or her own schedule. Praise and positive attention make going to the toilet fun; however, one should expect occasional accidents. For

others, the Azrin and Fox method is favored, and this involves establishing a regular schedule of sitting on the potty (generally at hourly intervals and after high probability times, such as meals), along with providing positive attention and specific praise. To prepare children to accomplish this major milestone, parents should eliminate diapers and switch to training pants, take their child into the bathroom with them so the child can see what to do, practice with a doll or older sibling, and read books about toileting. Most experts recommend that boys start by sitting on the toilet, and once they understand the concept of using the toilet and have greater physical coordination, they can practice standing. An incentive which works for many boys is to drop Cheerios or bits of toilet paper into the toilet and encourage them to aim.

Fears, Worries, and Anxiety

Prevalence

Fears are common in young children, although variability may occur in terms of how many fears or how intense the reactions to those fears may be. Needleman (2004) reports that, in a survey of parents with preschool age children, over 80 % indicated that their child had at least one fear, while almost 50 % of parents reported that their child had seven or more fears (Needleman, 2004).

Some of the irrational fears that commonly develop in young children (ages 2–6) are thought to increase as a child develops more of an imagination and then gradually decrease as a child becomes more confident and develops cognitive skills to differentiate reality and fantasy (Spencer, 2000). As children grow and develop, they also become more aware of what may go wrong and then worry about such things. The following fears in Table 1.2 are relatively common in young children (Spencer, 2000).

If a child has a fear that is not included in this list, it may also be normal. Sometimes the cause of a fear may be obvious (i.e., the first time at a day care), but it may also be unclear how the fear developed. With the development of fears, parents should be mindful of stressful events such as a move or being left with a new caregiver, which may intensify an existing fear or establish new fears. If a fear seems to be extremely challenging or enduring, the early childhood professional may want to encourage parents to approach their pediatrician or arrange for other

Table 1.2 Common fears in young children

Fear of being left behind/separation anxiety	Fear of loud noises
Fear of dogs or other large animals	Fear of bath time or parts of it
Fear of monsters/witches/clowns/etc.	Fear of flushing toilets
Fear of the dark	Fear of doctors

outside help (Spencer, 2000). At school entry, approximately one in ten children meet the diagnostic criteria for an internalizing disorder (e.g., anxiety and depression; Carter et al., 2010).

Guidelines

Children will outgrow most fears. However, while the child is expressing the fear, it is important to refrain from discounting or invalidating it. General guidelines for addressing fears include gradual exposure to feared event along with support from a nurturing adult, preparing children in advance for stressful situations, teaching them how to relax, and maintaining routines as much as possible. The eventual goal is to increase the child's confidence and coping skills (Spencer, 2000). For example, rather than counteracting a child's fear with reason, parents can join their child and redirect their child's fear in a playful manner (Needleman, 2004). Monsters in the closet can be warded off by spraying "Monster Spray" (a spray bottle of water) toward the closet. These approaches work because most children believe that their parents can protect them and will take care of them.

For fears of separation from the caregiver, it can be helpful to ease children into these transitions so that their anxiety and tension is reduced (Spencer, 2000). This can be accomplished through practicing short separations (i.e., leaving the child with a family member for a few minutes) and having the new caregiver spend time with the child with the primary caregiver present.

For fears of animals and other intimidating figures, early childhood professionals should never force the child to approach or touch the feared object. Instead, build the child's confidence in the situation by having a parent stay close or hold them when the feared object is near, encouraging any approaches (e.g., "Let's have Susie wave at the doggy" and "Look at the clown! He's juggling."). It can also be helpful to role-play how to interact with the feared object by using stuffed animals. If a child fears a cat, practice with a stuffed animal how the child could interact (e.g., "First, the kitty smells our hand. Then, we pet his back.").

Fears of the dark are best handled through a structured bedtime routine that is both relaxing and comforting. This provides a non-anxiety provoking transition into sleeping. If the routine is consistent and fears still are being expressed, early childhood professionals should recommend that parents offer to check on their child in 5–10 min after laying them down (and then follow-through!) or leave the door cracked open with a hall light on. It is not recommended that children be allowed to have the room light on. If a child needs to feel more in control or fears monsters in the dark, parents can give their child a flashlight which is guaranteed to "banish all monsters."

Fears of loud noises can be addressed by explaining the noise (i.e., where thunder comes from) and by remaining calm when the child is fearful so that he or she knows everything is fine. To allow the child more control over the situation, he or

she can be encouraged to cover his or her ears to lessen the noise. If a particular object causes the noise (vacuum, hair dryer, etc.), the child can be gradually exposed to the noise, or the use of that object while the child is in the room can be avoided.

Bath time can generate a number of fears such as being sucked down the drain or not feeling in control in a slippery tub. To ease the transition from bath chair to being in the tub, parents can bathe their child with a sponge next to the tub for a little while and then transition to the tub with an inch or two of water. Fears of the bath can also be lessened by encouraging play at bath time with toys or splashing or having parents bathe with their child.

Fears of flushing the toilet may be due to the noise or due to a fear of being sucked down the drain. Parents can choose to not flush the toilet while the child is in the bathroom or can explain that a person is too big to go down the hole at the bottom of the bowl. If this fear is interfering with toilet training, caregivers may opt to have the child use the toddler training toilet and flush the contents after the child has left the bathroom.

Finally, fears of the doctor often appear while a child is a toddler and can vary in intensity. Spencer (2000) offers several recommendations including: (1) have parents obtain and play with a child's pretend doctor's kit and role-play what happens at the doctor's office, (2) encourage parents to allow their child to sit on their lap while at the doctor's, (3) have parents reinforce that the doctor wants to keep the child healthy, (4) have parents tell their child honestly how certain procedures will feel (i.e., "The shot will feel like a pinch and then be all done."), and (5) follow the visit with an enjoyable activity.

Fears Vignette

Samantha is 2½ years old and is going on her first visit to Disney World. She loves all the characters on the Mickey Mouse Club, but her favorite is Goofy. Her parents, Ryan and Sarah, make sure that as soon as they get in the Magic Kingdom, they find out where Goofy will be so Samantha can go see him, get his autograph, and take a picture with him.

Later that day, Samantha and her parents wait 45 min in line for her to see Goofy. Once at the front of the line, Samantha stiffens and tries to get away from Goofy. She is clearly frightened by the six-foot-tall figure before her. Instead of forcing Samantha to stand next to Goofy, Ryan and Sarah take turns getting a picture with Goofy and encourage Samantha to join them. She is still scared and will not approach or look at Goofy. Then, Samantha is encouraged to wave at Goofy and watch as he signs her autograph book. Sarah and Ryan praise Samantha for being so brave and watching Goofy, making sure she feels positive about this interaction.

Sexual Behaviors

Prevalence

Some forms of sexual behavior in young children are common; before children are 13, more than half will have engaged in some type of sexual behavior (Kellogg, 2009). Early childhood professionals must have a clear understanding of what is normal sexual behavior versus what is considered abusive and problematic (National Center on Sexual Behavior of Youth [NCSBY], 2004).

By age 2, children are able to distinguish between boys and girls (Kellogg, 2009). They are naturally interested in body parts, so this is a good time to teach them the names for their genitals. Between the ages of 2 and 5, normal sexual behaviors include touching their genitals in public or private, masturbating, trying to look to see others nude, and showing their genitals to others (Kellogg, 2009). It is less common for children to try to stick their tongue in someone's mouth while kissing, attempt to touch other's genitals, and rub their body against someone else, as these behaviors occur in approximately 8 % of the population (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998). Sexual behaviors in young children tend to increase up through 5 years of age and then gradually decrease, as children become more concerned with privacy (Friedrich et al., 1998).

Some suggest that sexual behaviors are becoming more common in young children as a result of media exposure and cultural changes; however, it is not clear if this increase reflects a change in frequency of sexual behavior or if there is increased awareness of sexual behavior in young children. The NCSBY suggests that sexual behavior is problematic if it includes the following characteristics:

- If it occurs very frequently
- If it interferes with a child's development
- If it includes "coercion, intimidation, or force"
- If there is emotional distress
- If there are big differences in the developmental abilities between the children that are involved
- If after intervention, it occurs frequently in secrecy

Children who experience significant sexual behavior problems (SBPs) are defined as "children 12 years and under who demonstrate developmentally inappropriate or aggressive sexual behavior" (NCSBY, 2004).

If abuse of a child is suspected, early childhood professionals should follow their state law regarding reporting these incidents. In order to make a report it is highly recommended to have the following information on hand (Table 1.3).

Other helpful information includes directions to the victim's location and potential risks to the investigators who will visit the location.

In cases where an early childhood professional may not be sure whether to report or not, it is best to call the state abuse hotline and report the information. The operators receiving the call will assist in the final determination of whether further investigation is necessary.

Table 1.3 Important information to file an abuse report

• A description of the abuse incident, including who was involved, what occurred, when and where it occurred, why it happened, the extent of any injuries, and any other pertinent information
• Names of child and adults involved, along with gender and race/ethnicity information
• Birth date or approximate age of all persons involved
• Addresses for all persons, including current location
• Relationship of the alleged perpetrator to the victim

Guidelines

The NCSBY (2004) suggests that parents do not overreact to sexual behavior in their young children. The attention could inadvertently reinforce the sexual behaviors. The NCSBY also reports that sexual behavior is not a sign that a child has been sexually abused, and some degree of sexual behavior is normal. The NCSBY also suggests that children:

- Should be given the rules regarding sexual behavior (e.g., only masturbate in the privacy of their own room)
- Are taught that sexual behaviors are restricted in some settings
- Are closely supervised
- Are praised for appropriate behavior

Aggression

Prevalence

Aggression is a common problem in young children, and some degree of aggression is typical. Many parents and professionals who work with young children have witnessed aggressive behavior to obtain a desired item (usually a toy that is currently in the hands of a sibling) or to communicate their wants and needs (the sibling then letting the child know that they are not ready to give that particular toy up). Loeber and Stouthamer-Loeber (1998) define aggression as “those acts that inflict bodily or mental harm on others” (p. 242). They also differentiate aggression from violence in that aggressive behaviors do not cause serious harm. In general, aggressive behavior tends to be common in young children and decrease over time. By the time children enter elementary school, externalizing behavior problems, such as aggression, are observed in about 15 % of children (Carter et al., 2010).

The parent–child interaction is one factor that contributes to aggressive behavior in young children. According to Patterson, DeBaryshe, and Ramsey (1989), poor

parental discipline, including ignoring appropriate behaviors and allowing aggressive behaviors to escalate, sets the stage for the development of aggressive behaviors. Parental risk factors also contributing to aggressive child behavior include maternal depression, stressful life events, marital conflict, and exposure to violence (Webster-Stratton & Hammond, 1988).

Aggressive behavior is most detrimental to development when it is persistent and stable over time and when it occurs in multiple settings. Miller et al. (1997) report that young children who exhibit aggression at both home and school are more likely to have continued behavioral concerns down the road, compared to those children who are only aggressive at home. Boys are more likely to show aggression than girls. Girls appear to be better at self-regulating their emotions and verbally expressing their feelings. However, at later ages, girls may exhibit other forms of aggression such as shunning and gossiping (Weinberg & Tronick, 1997).

Guidelines

Strategies to decrease challenging behavior, including aggression, are discussed throughout this text. A common component of many parent training programs aimed at reducing aggressive behavior is to increase positive attention for desired behavior and redirect undesired behavior. The idea of "catching your child being good" helps to improve the parent–child relationship and reinforces pro-social behavior rather than aggression. Redirection of negative behaviors helps children learn what is acceptable and what is not, and avoids the negative reinforcement trap, whereby aversive behavior is mistakenly reinforced. Time out is a behavior strategy that when used properly will reduce aggressive behavior and will be discussed in Chap. 6 in more depth. In a nutshell, time out requires a brief removal from the activity in which the child has been aggressive. Time out works because attention is such a powerful motivator for most children. However, one must be mindful of the need to teach children what you want them to do, instead of just punishing them for problematic behaviors.

Numerous studies have shown that spanking has negligible influence on misbehavior. However, it is still used frequently with 26 % of American mothers reporting that they spank their children two or more times per month (Taylor, Manganello, Lee, & Rice, 2010). This is of concern given that spanking appears to increase aggression in children. A study published by Taylor et al. (2010) substantiated that children who were spanked twice or more per month at age 3 were significantly more aggressive by age 5. Spanking teaches a child that the bigger person can control the smaller person by force, and instills fear rather than helping them learn pro-social skills. The AAP does not recommend spanking in any circumstances.

Aggression Vignette

Two and a half-year-old Marcus is happily playing with a ball until he notices his younger brother, Patrick, playing with a toy truck. Quickly, Marcus turns to Patrick, draws back his hand, whacks him on the nose, and immediately grabs the truck. Marcus' display of aggression results in Patrick's wailing cries and Marcus receiving a scolding from his caregivers. This negative attention may inadvertently reinforce aggressive behavior, which may also be reinforced by Marcus obtaining the truck.

Rather than addressing the behavior by scolding, it is recommended that Marcus' caretakers take a different approach. To change his behavior, Marcus' caretakers need to work on "catching him being good" or providing Marcus with positive attention for desired behaviors, redirecting Marcus and providing him opportunities to engage in appropriate behavior, and modeling pro-social behavior, such as sharing and turn-taking.

Social Skills

Prevalence

Social skills refer to the competencies that children need to develop in order to successfully navigate home, school, and community settings (Brown, Odom, & Conroy, 2001). Social skills include behaviors such as sharing, taking turns, using words to express feelings, greeting others, and participating in a group. The most important social skills for preschool age children to master before entering school are listening to others, following classroom rules, compliance with directions, asking for help, cooperating with other children, and controlling their temper (Elliott, Roach, & Beddow, 2008).

Social problems have been found in approximately 14–17 % of young children (Hair & Graziano, 2003; Konold & Pianta, 2005). Children with autism spectrum disorders (ASD) and attention-deficit/hyperactivity disorder (ADHD) are at higher risk for significant social difficulties as they get older. Social difficulties can involve both a lack of skills (e.g., not knowing how to initiate a conversation) and an unwillingness to use skills (e.g., issues related to compliance). As more social demands are placed on children, it is more likely that social difficulties will become more obvious.

Guidelines

The development of social skills in young children is influenced by a number of factors, most importantly, the opportunity to learn and practice social skills. There are

several curricula available to teach and reinforce social skills in young children (some evidence-based programs are discussed in Chap. 5). Most follow a similar sequence involving showing the child what to do, helping the child imitate the skills, and providing opportunities to practice in a variety of settings (Elliott et al., 2008). Increasing opportunities for the child to practice these skills during his or her typical daily activities leads to a more natural performance and ensures that the skills become a part of the child's repertoire. In addition, praising and reinforcing these skills when the child uses them will result in these behaviors occurring more frequently.

Social Skills Vignette

Four-year-old Donavan is happily swinging on the swing-set at the park until his caregiver stops pushing him and tells him that it is time to leave. Because Donavan wants to stay he begins to whine. When his caregiver insists that it is time to leave, Donavan's whines quickly turn into screaming and crying. When his caregiver takes his hand to guide him toward the car, he flails his arms around and then runs to the swing-set and wraps his arms and legs around the swing-set pole, continuing to scream and draw attention to himself and his caregiver. In an attempt to stop Donavan's inappropriate behavior, his caregiver lets him swing on the swings until he is ready to leave. Donovan's antisocial behavior may have been reinforced by allowing him to continue to play on the swings, and he may soon learn that by whining, crying, and using physical strength he will not have to comply with adult directives.

Rather than addressing the behavior by giving in to Donavan's demands, it is recommended that Donavan's caregiver take a different approach. Instead of telling him when it is time to leave, Donavan's caregivers should give him warnings when ending a preferred activity, explicitly show him what they want him to do when it is time to end the activity, provide specific positive feedback and praise for following directions, and increase Donavan's opportunities to practice appropriate behavior when transitioning and following directions in a variety of settings.

Cultural Competence

It is important for the early intervention professional to not only be aware of these general guidelines for development but also be prepared to apply these knowledge and skills to children and families from a wide variety of backgrounds and experiences. Recent data suggest that the United States is increasingly culturally and linguistically diverse. For example, 20 % of children in the United States are Latino, approximately 17 % of children in the United States live in poverty, and about 20 %

of school-age children speak a language other than English at home. Cultural competence can help early intervention professionals more effectively meet the needs of the children and families they work with and improve the quality of services and outcomes.

Culture has been defined as “An integrated pattern of human behavior that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting and roles, relationships and expected behaviors of a racial, ethnic, religious or social group; and the ability to transmit the above to succeeding generations” (National Center for Cultural Competence of Georgetown University, http://gucchd.georgetown.edu/nccc/). As this definition implies, culture is multidimensional and cultural competence requires a significant level of knowledge and understanding. The knowledge and skills to work effectively with children and families from all kinds of backgrounds is essential to being an effective early childhood professional.

The development of cultural competence is something that takes time, effort, and experience, and will be an ongoing process for the early intervention professional. A comprehensive discussion of this topic is beyond the scope of this text; however, we will present a model of cultural competence that involves awareness, reflection, and knowledge (National Association for the Education of Young Children [NAEYC], 1996; Wright Carroll, 2009). This model provides guidance in working effectively with culturally and linguistically diverse children and families.

Step 1: Awareness

Early intervention professionals must be aware of their own cultural perspectives and beliefs. Wright Carroll (2009) suggests that this step includes awareness of personal values and beliefs, awareness of other’s beliefs, awareness that individuals have multiple cultural identities, and awareness of systemic cultural issues such as privilege and exclusion. One of the keys to awareness is to consider the multiple identities that we have, as well as to recognize that other’s perspectives will be framed by a variety of cultural experiences.

Step 2: Reflection

As a second step, the professionals are encouraged to reflect upon how their own background and identity impact how they interact with young children and their families. Early intervention professionals should recognize when their knowledge and actions are not consistent with best practices or do not demonstrate cultural competency and take steps to increase their awareness and knowledge when this occurs.

Step 3: Knowledge

Another component of cultural competency is having an understanding of the cultural and linguistic backgrounds of those children and families that a professional works with. This knowledge can be helpful in how to approach children and families, as well as how to interpret other's actions. However, at this step it is also critical to not overgeneralize knowledge of group characteristics to individual children and families. Each child's and family's background will be the result of their unique experiences, just as an early childhood professional's cultural and linguistic identity is multidimensional.

This framework provides the early childhood professional with guidelines to follow when working with children and families. We have provided some additional resources below.

National Center for Cultural Competence
http://www11.georgetown.edu/research/gucchd/nccc/
This site has a lot of educational materials, as well as self assessments of cultural competence

U.S. Department of Health and Human Services
National Standards on Culturally and Linguistically Appropriate Services (CLAS)
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

American Academy of Pediatrics
Policy Statement: Ensuring Culturally Effective Pediatric Care—Implications for Education and Health
http://aappolicy.aappublications.org/cgi/content/full/pediatrics;114/6/1677

Conclusions

Challenging behavior is quite common in young children, especially emerging around the second year of life. Parents are often concerned about whether or not their child's behavior is normal, how to handle behavior problems, and where to seek help. In fact, one study found that 70 % of mothers were more worried about their parenting than about their own health (Hickson, Altemeler, & O'Connor, 1983). Furthermore, the availability of information and misinformation, via the internet and other media sources, can lead to further confusion at a time when parents need to decide upon a course of action. A well-informed early childhood professional can assist parents and other caregivers during this very crucial time, when toddlers are naturally testing the limits and forming their personalities, by providing guidance in positive methods that have a high likelihood of working, such as implementing consistent routines, providing specific praise and attention for desired behavior, preventing or redirecting problem behavior, and using time out infrequently and only when the child is able to understand. The relationship and

partnership established between the professional and the parent will provide the foundation to promote parenting skills that will strengthen the family and ultimately lead to optimal child outcomes.

Assess Your Knowledge

Use the questions below to assess your knowledge of the information presented in this chapter. Answers appear after the last question.

1. Why is it important to know if a child is experiencing sleep difficulties?
   a. Inadequate sleep has been linked to health and behavior problems, including academic, social, and emotional difficulties.
   b. Inadequate sleep is common in young children.
   c. Many children do not receive adequate treatment for their sleep problems.
   d. All of the above.
2. A parent of a 20-month-old girl tells you that they would like to potty train their daughter. Compared to the typical age that children are potty trained, you might tell them that:
   a. They should begin potty training their daughter immediately.
   b. They should consider whether their daughter has demonstrated global readiness skills.
   c. Children cannot be potty trained until 3 years of age.
   d. Children will tell you when they are ready to be potty trained.
3. How many hours of sleep are recommended for an 18-month-old child within a 24-hour period?
   a. 14–16 h
   b. 9–12 h
   c. 8–10 h
   d. 12–14 h
4. Giving in to an aggressive child's demands is likely to:
   a. Discourage the child from engaging in aggressive behavior in the future.
   b. Encourage the child to engage in aggressive behavior in the future.
   c. Not change the aggressive behavior.
   d. Make the child mad.
5. Which one of the following behaviors is a common sexual behavior in children ages 2–5?
   a. Masturbating
   b. French kissing
   c. Touching other's genitals
   d. Forcing another child to touch their genitals

6. Beginning at age 2, it is recommended by the USDA that children eat the following types of foods:

   a. Six servings of Grain food group, 3 from the Vegetable food group, 2 from the Fruit group, 2 from the Milk group, and 2 from the Meat and Beans Group.
   b. Six servings of Grain food group, 0 from the Vegetable food group, 1 from the Fruit group, 2 from the Milk group, and 2 from the Meat and Beans Group.
   c. Ten servings of Grain food group, 10 from the Vegetable food group, 10 from the Fruit group, 10 from the Milk group, and 10 from the Meat and Beans Group.
   d. Four servings of Grain food group, 3 from the Vegetable food group, 2 from the Fruit group, 3 from the Milk group, and 5 from the Meat and Beans Group.

7. Which of the following choices is NOT a recommendation for parents regarding how to deal with sexual behaviors in their young child?

   a. Children should be given the rules regarding sexual behavior (e.g., only masturbate in the privacy of their own room).
   b. Children should be taught that sexual behaviors is restricted in some settings.
   c. Parents should immediately draw attention to their children when they engage in sexual behavior.
   d. Children should be closely supervised.

8. Which of the following is NOT a guideline for dealing with eating issues in your child?

   a. Force-feed your child when they don't eat.
   b. Make mealtime structured with regard to the timing and seating requirements.
   c. Always serve milk with meals.
   d. Avoid making special meals for children who are picky.

9. Social skills are best taught to children

   a. In the therapist's office, where you have more control over the environment.
   b. When a child is in the middle of a tantrum.
   c. In everyday routines.
   d. Who know what to do, but choose not to do it.

10. Spanking as a disciplinary consequence is

    a. Very effective with young children in the long term.
    b. May temporarily stop the behavior.
    c. Useful to get a child's attention.
    d. Is the recommended consequence for aggressive behavior.

Assess Your Knowledge Answers

1) d 2) b 3) d 4) b 5) a 6) a 7) c 8) a 9) c 10) b