
CHAPTER 5:
HEALTHY, THRIVING CHILDREN

Key Benchmarks in this Chapter:

Prenatal care

Immunizations

Child maltreatment

Child care

Ready for school at age 5

Key Chapter Topics:

Characteristics of Thriving Children

Early and Comprehensive Prenatal Care

Elements of care

Risks and barriers to care

Healthy Growth and Development

Income and insurance

Health conditions and service needs

Healthy environments

Early intervention

Nurturing, Responsive Care

Characteristics of nurturing care

Family effectiveness as first teachers

Family literacy activities

Approaches to support nurturing care

Parenting across cultures

(over)

Safe and Supportive Environments

Child safety

Healthy, Thriving Children

Television viewing
Developmentally appropriate learning environments
Quality childcare and preschool experience

Social Competence and Positive Peer Relationships
Social competence and prosocial behavior
Conflict resolution, problem-solving, and self-control
Peer relationships and friendships
Environments and social skills

CHAPTER 5:

HEALTHY, THRIVING CHILDREN

Children deserve to grow up in caring, supportive environments where they are encouraged to become the best that they can be. Families, schools, and communities share a responsibility for healthy, thriving children. Schools can offer supportive learning environments, access to positive peer and adult relationships, and connections to the community. Communities can provide access to health care, family support services and constructive opportunities for enriching children's lives. But families provide the most essential ingredient of all – loving and caring support that lays the foundation for healthy, thriving children.

Characteristics of thriving children. Six interrelated functional areas define the markers for children's developmental progress. These areas include children's physical well-being and motor development, social-emotional development, approaches to learning, language and literacy skills, and cognition. Within these functional areas, healthy, thriving children show age-appropriate behavior and development. Children with disabilities or developmental delays are healthy and thriving when they are growing and developing in accordance with *their* capacities.

- *Thriving children show physical well-being and age appropriate motor development. They are well-rested, fed, properly immunized and healthy. They are developing physical skills and abilities.*
- *Thriving children possess social competencies that allow them to make friends and get along, balancing their needs with those of others in group activities. They deal with frustration and anger without hurting others. They find pleasure in engaging others and develop close friendships with other children.*
- *Thriving children have a sense of confidence and personal well-being. They are usually in a good mood, enthusiastic, and interested in lots of different things. They show empathy for others. They have the capacity to modulate and control their own actions in age-appropriate ways, with a sense of inner control.*

- *Thriving children possess the important qualities of curiosity, creativity, motivation, and persistence that enable children from all cultures to maximize their learning. They have the will and capacity to set a goal and work at it. They have confidence that they will succeed and that adults will be helpful.*
- *Thriving children use age-appropriate language skills --- both in oral and written language --- to communicate effectively with others and express their thoughts, feelings, and experiences. They enjoy exchanging ideas, feelings, and concepts with others, including adults.*
- *Thriving children understand basic information, including patterns and relationships, causes and effects, and can solve problems in everyday life (National Educational Goals Panel, 1992; Zero to Three, 1992).*

Foundations for thriving children. The developmental foundations for healthy, thriving children are established in early childhood. Increasing levels of poverty, inadequate health care, and *poor quality* child care have created a “quiet crisis” among children younger than three (Carnegie Task Force on Meeting the Needs of Young Children, 1994).

One in four children, aged three and under, live in

Children flourish when they have adequate nutrition, health care and opportunities to learn and succeed. Too many children live in poverty. While the U.S. is the richest nation in the world, approximately one in four of its youngest children, aged three and under, live in families whose annual income is less than \$15,000 (CDF, 1996). Poverty can hurt children in a variety of ways. Poor nutrition, living in deteriorating and dangerous neighborhoods, housing problems and homelessness, parental stress --- all contribute to increase the vulnerability of poor children.

Too few children experience supportive, caring relationships that will nurture emerging competencies and provide a sound foundation for growing up into healthy, caring and responsible adults. Resilient children who have succeeded despite adverse conditions typically have a strong, long-term relationship with competent, caring adults. These relationships begin within the family and, as the child’s world expands, include peers and other adults such as teachers or neighbors (Werner, 1995).

The National Education Goals seek to insure that, by the year 2000, “all children in America will start school ready to learn.” In associated objectives, the legislation calls for:

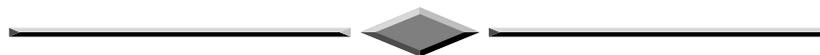
- assistance to every parent to be their children’s first teacher;
- assurance that all children receive adequate nutrition and comprehensive health care, beginning with prenatal systems;
- access for all children to high-quality preschool programs.

The National Education Goals have been framed with the awareness that “a large number of the very young do not enjoy a childhood most adults would call desirable. . . nor do they experience the type of parental support that enriches childhood” (National Education Goals Panel, 1992, p. 18).

Research showing the importance of supportive family relationships is reviewed in a previous chapter (Chapter 3). In this chapter, we focus on five key areas necessary for healthy, thriving children:

- Early and Comprehensive Prenatal Care
- Healthy Growth and Development
- Nurturing Responsive Care
- Safe and Supportive Environments
- Social Competence and Positive Peer Relationships

***Families,
schools, and
communities
share the
responsibility
for healthy
thriving
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**Early and Comprehensive Prenatal Care:
Measurable Interim Outcomes**

Availability of comprehensive quality prenatal services.	Parental knowledge of perinatal health risks.
Accessibility of comprehensive quality prenatal services.	Preventive care for newborn infants.
Improved health for expectant mothers.	Avoidance of tobacco, alcohol, or non-prescription drugs during pregnancy.
Normal birth weight.	
Full term delivery.	

Research Linkages

The risk to children’s health and development begins before birth. Nationally, there has been a 6% increase in the proportion of low birth weight babies between 1985 and 1993 (Annie E. Casey Foundation, 1996). The U.S. has a higher rate of low-weight births than 16 other nations. Birth weights of less than 2,500 grams (about 5.5 pounds) and pre-term delivery are associated with increased infant mortality. Even when infants survive, significant long-term health and developmental problems often limit children’s opportunities to lead full and productive lives (Shiono & Behrman, 1995).

Comprehensive early prenatal care includes medical, educational, social, and nutritional services.

Elements of Prenatal Care

Early prenatal care begins in the first trimester of life. Comprehensive prenatal care includes medical, educational, social and nutritional services and is associated with better developmental outcomes for infants and more positive outcomes for families. Benefits of early, comprehensive prenatal care include:

- better outcomes for infants and increased numbers of newborns receiving needed preventive care;
- decreased parental behaviors harmful to the developing infant, including smoking and alcohol use;
- prevention of maternal deaths; and

- increased parental knowledge of pregnancy, labor and delivery, and newborn care (Shiono & Behrman, 1995).

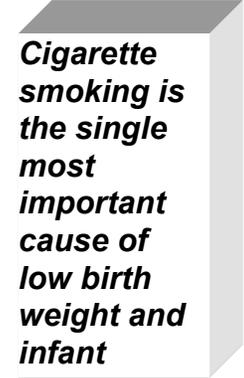
The content of prenatal care varies widely. At a minimum, quality prenatal care should include early and continuing risk assessment, linkage to needed social services, health education and promotion, and medical or psychosocial interventions and follow-up when appropriate.

While the specific content and timing of prenatal services varies depending on the risk status of the pregnant woman and her fetus, timing should be flexible with *more* visits occurring early in pregnancy. Integrating various aspects of care into each visit can minimize the number of necessary visits and the resulting inconvenience to parents (Rosen, Merkatz, & Hill, 1991).

Cigarette smoking. The most successful way to decrease the rate of low birth weight and pre-term births is to decrease cigarette smoking during pregnancy. Cigarette smoking is the single most important known cause of low birth weight and infant mortality, causing almost 20% of all low weight births. Clinical trials of smoking cessation interventions have reported significant effects in increasing birth weights (Alexander & Korenbrot, 1995).

Studies of the cost effectiveness of smoking cessation interventions in pregnancy show that relatively small investments can easily be recovered by reductions in the medical costs of caring for low birth weight babies and in the subsequent chronic care needs of both mother and child. Including smoking cessation programs in health insurance coverage can provide the economic means to pay for these important prevention activities (Marks, Koplan, Hogue, & Dalmat, 1990).

Nutrition services. Prenatal nutrition education and services assure that mothers understand normal weight gain, receive essential calories and nutrients, and, whenever possible prepare for breast-feeding. Among low income women, prenatal participation in WIC (Women, Infants, and Children Supplement Program) is associated with increases in breast-feeding and decreases in low birth weight, premature births, and inadequate prenatal care. Research indicates that WIC participation of at least 7 months is needed before improvements in birth weights are measured (Stockbauer, 1987). Thus early prenatal services are critical.



Cigarette smoking is the single most important cause of low birth weight and infant

71% of low income women reported problems accessing prenatal care.

Barriers to prenatal care. Most women believe that prenatal care is very important and should begin in the first trimester. But a variety of psychosocial, systemic, and attitudinal barriers reduce women's access to effective prenatal care.

Poverty is strongly and consistently associated with inadequate prenatal care. Approximately 71% of low income women report problems accessing prenatal care. Those who receive the least care cite finances as the most important reason for not getting care sooner and more often (Alexander and Korenbrot, 1995; Sanderson, Placek, and Keppel, 1991).

Psychosocial factors may also create barriers to accessing available services. Common reasons for *not* accessing prenatal care include:

- having small children at home;
- not having a medical assistance card;
- sadness or ambivalence about the pregnancy;
- fear of detection of drug use or other unhealthy lifestyle;
- lack of support and encouragement from family and friends; and
- lack of knowledge about the community.

Overcoming these barriers requires early risk assessment and increased responsiveness to *individual* reasons for not accessing early prenatal care. Needed support services include child care, transportation, counseling, confidentiality, assurance, and other support (Chomitz, Cheung, & Lieberman, 1995).

The *delivery methods* for prenatal care can also reduce access and utilization of prenatal services. Common barriers to accessing prenatal services include:

- language incompatibility or poor communication between health care providers and pregnant women;
- negative attitudes of health care providers;
- inconvenient locations or times;
- inadequate health care facilities, personnel, resources, or time;

and

- inadequate coverage and financing of prenatal care.

Proven strategies to surmount these barriers include providing prenatal care in well-known, well-advertised settings that are comfortable to consumers, such as school-based clinics for teens and neighborhood clinics for ethnic minorities. Services should be offered at hours designed to accommodate working and adolescent mothers and offer child care as needed (York & Munro, 1993).

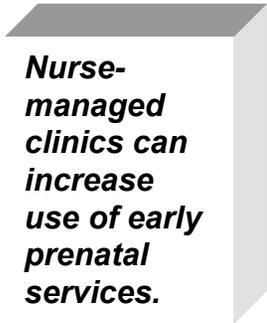


Prenatal care is cost-effective.

Costs and providers. Prenatal care is cost-effective. Initial cost outlays for new services may be quickly recovered by even the most conservative estimate of a cost savings of \$1.49 for each extra \$1 spent on prenatal care (Rosenbaum, 1992).

However, current levels of available prenatal care are limited by lack of family practitioners and obstetricians willing or able to provide prenatal care, especially in medically under-served areas. This shortage could be partially alleviated by increased utilization of certified nurse midwives and nurse practitioners. Subsidies may also be offered to providers who are willing to care for clients regardless of ability to pay or who are willing to relocate to under-served areas (Avery & DelGiudice, 1993, Schramm, 1992).

Comparisons of prenatal care provided by physicians and certified nurse midwives demonstrate *no difference* in quality of care, and suggest some financial and psychosocial advantages of midwifery care. Successful nurse-managed prenatal clinics demonstrate decreased incidence of low birth weight infants, pregnancy-induced hypertension, and emergency room visits, as well as increased use of first trimester prenatal services (Capan, Beard, & Masburn, 1993; Heins, Webster, McCarthy, & Efird, 1990; Wilson, 1989).



Nurse-managed clinics can increase use of early prenatal services.

Philosophies of prenatal care differ by profession, with nurse midwives scheduling significantly longer prenatal visits and doing more education than physicians. Seeing a midwife may appeal to the population of women for whom psychosocial and delivery barriers decrease care utilization (Yankou, Petersen, & Oakley, 1993).

**Healthy Growth and Development:
Measurable Interim Outcomes**

Good health.	Adequate physical activity.
Regular health and dental care.	Healthful environments.
Immunizations.	Early and periodic screening for normal growth and development.
Breast-feeding.	Early intervention services as needed.
Adequate nutrition.	
Parental and child nutrition knowledge and practices.	

Research Linkages

Good health is essential to children’s development. The foundations for good health are built in the first three years of life. This is a time when children are *most* vulnerable to disease, injury, and nutritional deficits that can have life-long effects on their physical and psychological health. It is also an optimal time for identifying developmental health problems.

Early and periodic screening for developmental delays and physical and mental conditions is important if the best possible outcomes for children are to be achieved (DeWoody, 1994). Good health has long term consequences for children, including improved school achievement, since healthy children are able to actively engage in the learning process.

Income and Health

Most children in the U.S. experience good health, but rates are lower for poor children and those with minority status. Families with annual incomes under \$10,000 report a substantially smaller percentage of children with excellent health than families with incomes of \$35,000 or more. Among children under 5, 71% of black children are reported to be in good or excellent health, compared to 82% of white children. Similar differences exist for other minority children and are related to limited family income and insurance coverage (U.S. Health and Human Services, 1996).

The foundations for good health are built in the first three years of

Although every child needs health care, nationally a growing number of children and families lack even the most basic health insurance coverage. The percentage of children covered by health insurance through a family member's job fell from 64% in 1987 to 57% in 1993. This decline results from fewer families being able to afford coverage for dependents and fewer employers offering or subsidizing dependent health insurance. Nationwide, about 13% of children have health insurance coverage (USDHHS, 1996).

Health care insurance poses a particular challenge for the working poor who can neither afford service nor access Medicaid managed care plans. A substantial minority of young children in poor families have undiagnosed treatable conditions that are not discovered until they enroll in school (Children's Defense Fund, 1995; Zill, Collins, West, & Hausken, 1995). Although the Oregon Health Plan has made Oregon a national leader in the health care coverage of low-income children, continued attention to economic access to care is essential to reach all lower income families and children. In Oregon, 8 % of children lack such coverage statewide; in eastern Oregon, the rate is 17% (Oregon Progress Board, 1997).

8% of Oregon's children lack health insurance.

Children's Health Conditions and Service Needs

Although most children are healthy except for normal childhood illnesses, some face serious, chronic, and even life-threatening conditions. A major health impairment represents a developmental and behavioral challenge. Children's illness is associated with a wide variety of physical symptoms and/or psychosocial stresses, including parental overprotection and poor peer relationships (Shonkoff, 1994). Regular, effective health screening and care can dramatically improve the outcomes of potentially devastating chronic or life-threatening conditions (USDHHS, 1996).

Preventive care is as important for children's health as is treatment for chronic or acute illness. Children who receive ongoing preventive care have been found to have fewer health problems. They also have annual health care costs for these children are about 10% lower than for children who do not receive such care (Rosenbaum, 1992).

Children who receive ongoing preventive care have fewer health problems.

Respiratory conditions. Respiratory conditions are the most prevalent type of chronic health problems experienced by children. Rates of chronic bronchitis, chronic sinusitis, and asthma have increased substantially between 1982 and 1993. Young children are vulnerable to respiratory infections but fewer suffer long term effects *if* they are well-nourished and receive preventive care.

Regular dental care starting at an early age is essential to insure good

Infants and toddlers are the most susceptible age groups since they have had little prior exposure to most infectious pathogens. The higher incidence of colds and respiratory diseases can cause recurrent ear infections and hearing loss in some children. Children with persistent health problems are more likely to miss school and require regular medical assistance and follow-up. Chronic problems also present difficulties for parents who may experience emotional distress, miss days from work, and incur additional medical expenses (U.S. Health and Human Services, 1996).

Oral health. Oral health problems are among the most common, yet preventable, health problems of childhood. Approximately 25% of children account for 60% of the incidence of decayed, filled, and missing teeth.

When minority children live in poverty, they are likely to have dental disease and to experience few opportunities for treatment. Oral health problems tend to be cumulative with adolescents experiencing the greatest risk of oral disease. Regular dental care starting at an early age is essential to insure good health (Rosenbaum, 1992).

Immunizations. Timely administration of immunizations is a critical component of good health care. Over 80% of all routine childhood vaccinations should be administered within the first 2 years of life. Although between 97% and 98% of children receive their complete series of immunizations before or shortly after starting school, rates of complete immunization of preschool children are considerably lower.

- Preschool children are most vulnerable to the communicable childhood diseases than can be prevented by vaccinations.
- Impoverished children are least likely to be fully immunized. In 1993, approximately 59% of preschool children living in poverty received a complete vaccination series with four doses of DPT in comparison to 71% of children living above the poverty level (U.S. Health and Human Services, 1996).
- Requiring parents to make appointments reduces rates of immunizations (Orenstein, Atkinson, Mason, & Bernier, 1990).

Immunizations beginning in the first months of life can eliminate death and disabilities that result from preventable childhood diseases such as measles, mumps, and polio. It is estimated that every dollar spent to immunize a child can save between \$11 and \$14 in related health costs by reducing childhood illness and death (Rosenbaum, 1992).

Adequate nutrition. A healthy diet during childhood is essential to promote normal health, growth, and development. Breast-feeding is the healthiest

Every dollar spent to immunize a child can save between \$11 and \$14 in related health costs by reducing illness.

start for most babies. Breast-feeding can help insure that infants receive necessary nutrients and antibodies that offer early protection. However, although many mothers begin breast-feeding following delivery, almost one-third do not continue breast-feeding at home. Active support is often needed to initiate breast-feeding and resolve difficulties that may arise with breast-feeding. Once established, breast-feeding is typically more convenient and less costly than bottle feeding. Furthermore, breast-feeding assures close physical contact between mother and baby.

To continue healthy development, children of all ages need adequate, nutritious food. Tragically, however, there has been a resurgence of hunger for America's children. In 1995, approximately 13.6 million children younger than 12 went hungry during some part of the month. These children regularly miss meals, live in households that run out of food at or near the end of the month, or exhibit other warning signs of hunger. Children who are hungry are more likely to be sick than their more advantaged peers. Nutrition-related disorders such as iron deficiency anemia are greater among poor children than among the general population (Parker, 1989).

During childhood, poor or inadequate nutrition has serious detrimental effects on children's health.

- Consequences are especially severe prenatally and during infancy when adequate nutrition and sufficient caloric intake are necessary for brain growth. Malnutrition has been associated with decreased numbers of brain cells, chemical changes in the brain, and faulty transmission of neural impulses resulting from disrupted myelination (Berndt, 1992).
- Among children who are not adequately nourished, common childhood illnesses such as measles, chicken pox, or even pneumonia are more likely to permanently depress the growth.
- Nutritional deficiencies can also affect attention and motivational processes important for school success. Iron deficiency is one of the most prevalent nutritional problems for children in the U.S. and is associated with anemia, shortened attention span, irritability, fatigue, difficulty with concentration, and increased absorption of lead which threatens children's brain development.

Nutritional deficiencies affect attention and motivational processes important for school success.

Parent attitudes and behaviors play a major role in childhood obesity.

Participation in food stamp and other food provision programs, coupled with nutrition education for families, substantially improves the dietary health of low-income children (Children's Defense Fund, 1996).

Poor eating habits, including overeating and skipping meals, lead to poor health and are common among children of all income levels. Obesity has increased over the last several decades with current estimates suggesting that 25% of children are overweight (Dietz, 1991).

Obese youngsters often are among the least popular students in grade-school classrooms (Sigelman, Miller, & Whitworth, 1986). Overweight children are less able to regulate their food intake than children whose weight is within a normal range. While biological characteristics account for some of the individual differences among children, parental attitudes, and behaviors related to food and eating play a major role.

- When parents make access to highly desirable foods contingent on the consumption of less desirable ones, or use foods as bribes or rewards, children are less likely to self-regulate their food intake (Birch, Johnson, & Fisher, 1995).
- Families who avoid high-calorie snack food such as chips, candy, and non-diet soda, use fruit as a regular snack food to replace most baked goods and ice cream, and who keep to scheduled meals and snacks are more likely to have healthy, well-nourished children (Edelstein, 1995).
- Because weight-loss programs for children can have harmful consequences, diets must be carefully monitored so that children receive all the necessary essential nutrients. Increasing activity is an essential part of weight control as is family support and education.

Children eat healthy foods when good food choices are consistently available.

Overall, the best strategy is not to treat obesity and other nutritional problems after they arise but to prevent them (Berndt, 1992). Selecting healthy foods is a learned behavior. When good food choices are a consistent part of family life, children are more likely to select foods that provide adequate vitamins, minerals, and other nutrients, such as calcium and zinc, that are essential for healthy growth and immune functioning (Edelstein, 1995).

Meeting nutritional needs of young children can be difficult due to:

- children’s finicky behaviors about food, and
- a lack of nutrition knowledge among caregivers for the provision of nutritious meals and snacks.

The amount children eat may be affected by their growth rates, parental eating habits, and the availability of different kinds of foods. Caregivers and parents who threaten children due to finicky behavior or over-eating only antagonize the situation (Birch et al., 1995).

Physical activities. Children benefit from daily opportunities for *active* play, either outside or in a large covered space, such as a gymnasium. The most important active play experiences in early childhood involve interactions with a loving parent or other caregiver, siblings, and peers. Engaging in active, physical play helps children learn to control and coordinate body movement and develop competencies.

Children benefit from daily opportunities for active, physical play.

Children need daily routines that include safe exploration and unstructured large-motor play. Children cannot be expected to participate in physical activity unless adults plan opportunities into the everyday schedule. When young children have these experiences, a majority will have mastered the skills of throwing, kicking, running, jumping, catching, striking, hopping, and skipping before they reach grade school (Edelstein, 1995).

Physical skills (or the lack of them) significantly influence a child’s self-concept and peer relations. However, children gain physical skills at varying rates, depending in part on their individual biological blueprint for growth and maturation. Children who are taught that physical competence is an incremental process and that effort is related to success are most likely to experience positive outcomes (Curry & Johnson, 1990).

Healthy environments. Environmental factors that adversely affect children’s health and safety include exposure to secondary smoke and air pollutants, pesticides and chemical residues, and lead poisoning. Environmental health hazards affect children differently than they affect adults. Vulnerability is closely related to developmental stage with the youngest children being the most vulnerable (Bearer, 1995).

When parents smoke, children have more respiratory illnesses.

- Children's breathing zones are closer to the floor than breathing zones for adults. Heavier chemicals such as mercury, radon, and large breathable particles from tobacco smoke tend to accumulate in these lower areas.
- Children consume more oxygen relative to their size than adults, resulting in a higher exposure rate to these air pollutants (Leaderer, 1990).
- Children whose parents smoke have more respiratory conditions, including asthma, sick in bed days, and hospitalizations (Klerman, 1993).
- Children consume more calories per body weight than adults do. If food or water contains a contaminant, children will receive more of it relative to their size than an adult will.
- Infants who are fed formula that has been reconstituted with tap water containing lead show high blood levels of lead, even though the concentration may be too low to affect adults (Shannon & Graef, 1992).

Children who live in substandard housing are at risk of environmental contaminants.

Children who are inadequately nourished and who live in substandard housing are particularly at risk of environmental contaminants, including lead poisoning. For these children, routine and periodic testing to detect exposure is essential since lead poisoning comes from the cumulative effects of long-term, low-level exposure (DeWoody, 1994). Programs involving lead screening and treatment of children are effective ways of insuring good health (Klerman, 1991).

Early Intervention

Developmental disabilities and delays can result from literally hundreds of differing biological and environmental conditions. Screening for health or developmental problems can identify children who are likely to be at risk. Early detection of special needs leads to timely and effective interventions and the achievement of the most positive outcomes.

- For example, at least 70% of preschool children with identified disabilities have speech, language, and communication impairments (Wetherby & Prizant, 1996).

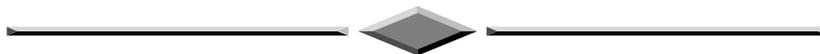
- Infants and toddlers with communication delays are at high risk for the development of emotional and behavioral disorders and academic problems (Baker & Cantwell, 1987).
- Prompt intervention in communication delays can have a positive impact on many domains of development since language plays a significant role in children's development.

Developmental screenings and assessments for communication and other delays should be done on a regular basis in the early years. Approximately 30% of infants in high-risk populations may need some type of intervention service before school (Squires, Potter, & Bricker, 1995).

Parental screening and monitoring of children's development is an effective and reliable way to identify these children. One effective resource for developmental screening is the Ages and Stages Questionnaire which uses parent knowledge of their own children's behaviors and development to accurately identify those who need further assessment (Squires, Potter, & Bricker, 1995).



**Early
direction of
special needs
leads to
timely and
effective**



**Nurturing, Responsive Care:
Measurable Interim Outcomes**

Nurturing care	Family literacy activities
Family effectiveness as child's first teacher	

Research Linkages

Nurturing Care

The power of nurturing adults to insure positive outcomes for children cannot be underestimated. Parental nurturance is one of the *best* indicators of successful growth and development in children. Nurturing means providing love, support, acceptance, affection and warmth. Parents who are nurturing are:

- deeply committed to the child's welfare;
- responsive to the child's needs;
- willing to spend regular, reasonable time in joint enterprises, often of the *child's* choosing;
- ready to show enthusiasm over the child's accomplishments and acts of altruism; and
- sensitive to the child's emotional states (Maccoby, 1980).

Nurturing care fosters intellectual development, self-reliance, and social competence.

Children whose parents are warm and nurturing tend to have positive social relations, and to be happier, more self-reliant, and higher in academic achievement. Parent support and encouragement fosters the development of a mastery orientation where children believe they can succeed and get pleasure from their accomplishments. During the grade school years, these children are more likely to be competent students who make steady academic progress and score average or above on IQ tests (Estrada, Arsenio, Hess, & Holloway, 1987).

At all ages, attentive, warm care acts as a protective mechanism against risks associated with peer rejection and anti-social behavior among school-age children (Patterson, et al., 1989). Parents who develop and maintain close, warm relationships with their teens experience greater success in inhibiting drug involvement and other problems (Coombs &

Landsverk, 1988; Search Institute, 1996).

As Charles Smith (1994, p.36) and his colleagues note, “*nurturance has so consistently been found to be important in the raising of children that it has sometimes been called the super-variable in parenting.*”

Resilience. Children can benefit from nurturance by nonparental adults as well. Despite adverse conditions such as family discord, chronic poverty, or parent psychopathology, children who have had an opportunity to establish a close bond with at least one competent and emotionally stable adult are more likely to be resilient and experience positive outcomes.

Nurturing frequently comes from the extended family including grandparents or older siblings, but favorite teachers can also provide nurturance and support. Resilient youth tend to rely on peers and elders in the community as sources of emotional support, counsel and comfort in times of crisis. The alternate caregivers serve as role models, showing that difficulties can be overcome by individual effort and the support of family and friends (Egeland, Jacobvitz, & Sroufe, 1988; Luther & Zigler, 1991; Werner, 1993).

Increasing nurturance. Nurturing children is challenging for many families today, due to work commitments and other stresses that can drain emotional resources. Parent education programs and parent support groups can increase family nurturance by helping parents to focus on specific, positive behaviors and nurturing practices, including the ability to:

- express affection and compassion;
- foster children’s self-respect and hope;
- listen and attend to children’s feelings and ideas;
- teach and model kindness;
- provide for the nutrition, shelter, clothing, health, and safety needs of children;
- celebrate life and have fun with one’s children; and
- help children feel connected to their family history and cultural heritage (Smith et al., 1994).

Children who establish a close bond with at least one caring adult tend to be resilient in the face of adversity.

Family Effectiveness as the Child’s First Teacher.

The early years are a time when parents are most receptive to information and support.

Families play a primary role in laying foundations for healthy development and school achievement (Kellaghan, Sloane, Alvarez, & Bloom, 1993). Child development researchers agree that the first four years of a child's life are critical. The early years are also a time when parents are most receptive to information and support.

Children benefit when parents understand their needs, are sensitive to their activity and play interests, while at the same time, encouraging developmental advances. Parents who are effective teachers:

- are sensitive to children's needs and interests and let children explore and learn;
- demonstrate what is acceptable through their own behavior;
- enjoy interacting with children and are both responsive and stimulating;
- provide variety without chaos;
- maintain an emotional climate that does not overwhelm the child;
- provide toys and objects that function as tools of learning; and
- encourage mastery and a sense of competence (Bradley & Caldwell, 1987).

Sensitive parenting promotes emotional security, behavioral independence, and social competence. Parents who are overly restrictive undermine initiative and cognitive development by limiting exploration (Sternberg & Williams, 1995).

Adults facilitate children's play through modeling and encouraging developmental advances.

Cognitive and emotional development are enhanced when parents interact and play with children. Adults give meaning to children's actions by labeling and describing. Adults also facilitate children's play through modeling and encouraging developmental advances. Children also need ample opportunities to explore and learn on their own while being monitored appropriately (Uzgiris & Raeff, 1995).

Children benefit when families adapt home environments for safe, unstructured play and exploration, and provide a variety of simple play materials.

- Organization of the physical environment of young children, beginning in the first year of life, is associated with children's future cognitive development (Caldwell & Bradley, 1994).
- Toys and materials that can be used in a variety of increasingly complex ways have lasting play value and provide a sound foundation for development (Bronson, 1995).
- Daily experiences with music, art, and drama are not only pleasurable for young children, but are also associated with school achievement in 4th and 5th grades (Bradley, Caldwell, & Rock 1988).

When parents expect children to show relatively mature behavior for their age and encourage developmental advances, children develop a sense of competence that carries over into school settings (Pettit, Dodge, & Brown, 1988; Werner & Smith, 1982).

Constructive ways that adults encourage developmental advances include:

- verbal and non-verbal encouragement of attempts and successes;
- following the child's lead and elaborating on what the child is doing; and
- offering toys, play materials or learning opportunities without unnecessary restrictions on their use (Smith et al., 1994).

Family Literacy Activities

Emergent literacy refers to the development of literacy-related skills prior to the beginning of formal instruction (Whitmore & Goodman, 1995).

Emergent literacy skills include:

- oral language such as the ability to talk, to offer explanations or descriptions, or describe a fantasy world outside of a physical context;
- awareness of the sounds that make up words (phonemic awareness);
- print knowledge including experience with print, development of print skills, and awareness of the alphabet; and
- familiarity with writing instruments and letter forms.

Children's development can be encouraged through supportive interactions and high but age-appropriate expectations.

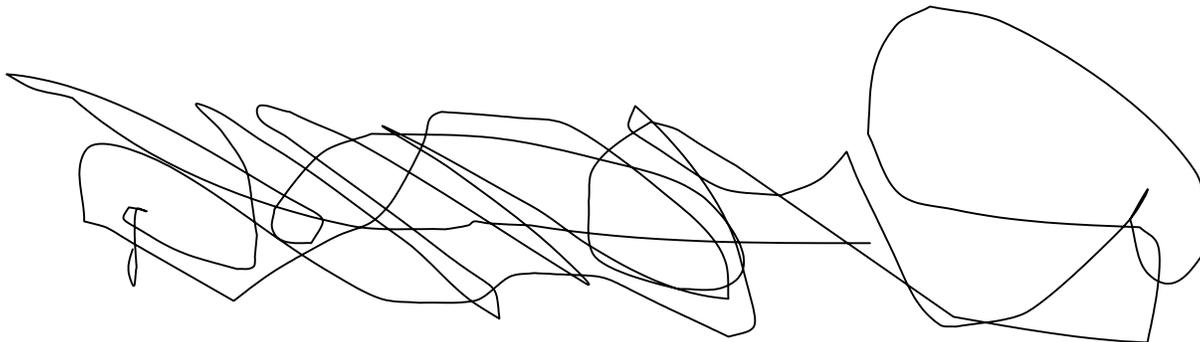
Print knowledge, phonemic awareness, and oral language facility are associated with early reading achievement and reading comprehension skills (Snow, 1991).

Talking and reading with children. Adults who talk and listen interactively with children help develop emergent literacy skills (Bornstein, 1985; Stevens, Hough, & Nurss, 1993). Emergent literacy skills are enhanced by family activities including:

- frequent and reciprocal adult-child communication;
- exposure to a variety of stories, letters, and words;
- interactions around reading and storytelling; and
- adult modeling of literacy behaviors (Dyson & Genishi, 1993; Morisset, 1993; Strickland & Taylor, 1989).

Parents support literacy by encouraging children to write and draw.

Emergent literacy skills also develop as children write and draw shapes. Parents who are sympathetic to a child's developing interests may even allow drawing on important papers:



(Amei Pratt, age 19 months, 4/22/97.)

Because of the rapidity of brain development in the first few years of life, stimulating activities such as reading, singing, and affectionate interactions are critical. Yet only 39% of parents with children 3 years or younger read or look at a picture book with their child at least once a day. Sixteen percent of parents do not read to their children at all. Reading patterns were the same for both working and nonworking parents (Young, Davis, & Schoen, 1996).

Reading to children, even infants, has a number of positive effects on development and later outcomes.

- Infants benefit from hearing sounds, rhythms, and intonations. Adults may read part of the newspaper aloud, or signs in the grocery store, or sing. Nursery rhymes, finger games, cloth and board books are ideal for babies.
- Toddlers enjoy naming books, animal books and stories with large, realistic pictures.
- Preschoolers thrive on picture books that are informative or have simple stories, told with humor (Dyson & Genshi, 1993).

Dramatic improvements in children's reading skills and attitudes toward reading have resulted from interventions that encourage parents to read to their children more often, to listen to their children read (or pretend to read), and to help their children with the mechanics of reading (Kellaghan et al., 1993).

Interactive reading is important. Thinking and language skills are enhanced when adults and children interact while looking at or reading picture books. From the adult point of view, interacting includes:

- asking open-ended questions that require children to think;
- labeling objects in illustrations;
- helping children understand sound concepts; and
- providing informative feedback to children (Morisset, 1993).

Reading interactively with young children has benefits for later school success. When adults ask questions and encourage self-expression, children learn how to respond appropriately. Children with these experiences "fit" more readily into the school environment where similar processes are common (Mason & Sinha, 1993).

Basic literacy skills are also enhanced when young children are exposed to, and participate in story-telling and dictation, dramatic play, acting out stories, singing, fingerplays, and music, rhymes and poems, manipulatives and puzzles, and exploration with art materials (Dyson & Genishi, 1993).

Reading is most effective when adults interact with children.

Children gain school-related skills when adults ask questions and encourage responses.

Scaffolding helps children step up to the next developmental level.

Scaffolding. Children’s cognitive and literacy development are enhanced by a number of techniques categorized as “scaffolding” or “building up” children’s learning. In scaffolding, adults provide children the support needed to accomplish what would normally be beyond a child’s ability. Adults serve as active participants in learning, and experiment along with the children in order to guide children to discover what adults already know. Components of scaffolding include:

- developing a shared view and engaging in joint problem solving;
- expressing warmth, responsiveness, approval and encouragement;
- providing challenges matched to children’s developmental progress and ideas for activities when appropriate;
- encouraging children to think about the activity by asking them questions, from simple to more complex; and
- promoting self-regulation by allowing children to make decisions and guide activities (Berk & Winsler, 1995).

The most beneficial strategies stimulate children’s own thinking.

Supporting positive development. In sum, specific early activities can contribute to children’s early development and later school success. The most beneficial strategies stimulate children’s own thinking and encourage active, verbal involvement (Powell, 1989). Families enhance development by:

- creating a language-rich environment where adults converse with children and listen to them;
- introducing children to a variety of ideas, events, and experiences and exploring their meaning;
- setting limits and providing materials, but letting children improvise, explore, and solve problems;
- encouraging creative activities such as music, art and drama;
- providing ample opportunities for experiences and activities in the community; and
- communicating high but reasonable learning expectations and aspirations for children (Kaplan, 1992; Kellaghan et al., 1993; Smith et al., 1994).

High parental expectations for mature behaviors combined with strong emotional support for children are central characteristics of *authoritative parenting*, which is associated with children's overall positive development, cooperativeness, responsibility, independence, academic success, and positive peer relationships (Baumrind, 1989; Smith et al., 1994). (See Chapters 3 & 6 for further discussion of authoritative parenting.)

Proven Approaches

Hundreds of family support and parent education programs exist in the U.S. All seek to enhance parental abilities to nurture children.

The critical elements of family support and parent education are reviewed at the end of Chapter 3. Here we focus specifically upon programs to support families with young children.

Parenting across cultures. Parenting programs often make assumptions about what constitutes a “successful” child. While some outcomes, such as good health and normal development, are universally sought across cultures, other outcomes relating to children's behavior and socialization may vary. The key to supporting parent effectiveness as the child's first teacher among diverse families is to build on parents' own childrearing goals, rather than imposing a “mainstream” notion on them (Shartrand, 1996). As family educators have noted,

“The key to working with Hispanic families . . . is understanding the goals of childrearing. In this country, the goal of childrearing is to create independent children When you really look at our intrinsic cultural goals . . . that is not our goal. Our goal is creating interdependent children. Children who can be dependent, but who can also be caretakers You really need to look at what the cultural goals are for childrearing and for the family.”
(quoted in Shartrand, 1996, p. 19).



**Build on
parents'
own
childrearin
g goals.**

Avance Family Support and Education Program provides comprehensive, community-based family support and education programs for at-risk and Latino populations. The core service is the Parent-Child Education Program, teaching parents skills to enhance the development of their children and to provide an academically and emotionally secure environment in which to raise their children. All curriculum materials are available in both Spanish and English. Staff are bilingual and 75% of the staff are graduates of the program.

Evaluation results have shown significant increases in parent knowledge and skills, more positive attitudes toward childrearing, and greater ability to access social support resources in times of stress or crisis (Shartrand, 1996).

Contact:
Gloria G. Rodriguez
President and C.E.O.
301 South Frio, Suite 310
San Antonio, TX 78207
(210) 270-4630

The Brookline Early Education Project (BEEP) is a family support and parent education program based in public schools that provides an opportunity for continuity of experience and support from early childhood into the elementary grades. Based on findings from Burton White's Harvard Preschool Project, BEEP's major goal is to help parents become effective first teachers for their children from early infancy through their first 5 years.

BEEP provides parent and early childhood education, a network of family support services and regular home visitations.

Program evaluations indicated that, by second grade, children in the program were doing twice as well as comparison children in reading and mastery skills, and had fewer behavior problems. The effect was much greater for families with low educational levels than for families with higher educational levels. In addition, beneficial outcomes for children from less educated families were related to the extent to which families participated in the parent education program (Pierson, 1988; Tivnan, 1988).

Minnesota's Early Childhood Family Education (ECFE) programs are available to all families with children between the ages of birth and kindergarten enrollment. Parents and children participate together. Programs are conducted throughout the state in school buildings, shopping centers, apartment buildings, homeless shelters, churches, and other community sites. Typically, families participate two hours a week throughout the school year. Program components include:

- parent discussion groups;
- play and learning activities for children;
- parent-child activities and special events for the entire family;

- home visits;
- early screening for children's health and developmental problems; and
- libraries of books, toys, and other learning materials.

Evaluation shows that ECFE makes a positive difference in parents' approaches to parenting, parent-child relationships, and their child's behavior. Parents show improved awareness of their child and child development. Parents also report that children have increased independence, improved language and communication skills, improved relationships with other children, and more self-confidence (Mueller, 1996).

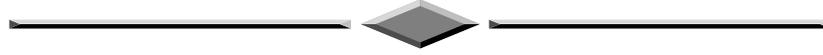
Parents as Teachers (PAT) provides three years of comprehensive parent education and support for parents of children from birth to four years. Taking a prevention perspective, specially certified parent educators make home visits to provide families with information and guidance to parents for enhancing their children's physical, intellectual, and social development. Educators follow a specific curriculum of developmental learning activities and discuss parenting issues, age-appropriate expectations and parenting practices.

Educators individualize their strategies according to family needs, and emphasize the importance of parents as the primary decision makers for their children and as their first teacher. Parents are also involved in group meetings to reduce stress, increase positive feelings about parenting, and increase knowledge of child development and parenting techniques. Children are periodically screened for hearing, vision, language and other developmental areas, and families are referred to other community services when appropriate.

Evaluation efforts with middle class families indicate that participation increases parents' provision of developmentally stimulating environments. The PAT model has been used successfully with teen parents, with culturally diverse populations, with low and middle income families, and in a variety of early childhood settings (Owen & Mulvihill, 1994).

Contact:

Parents as Teachers (PAT) National Center, Inc.
10176 Corporate Square Drive
St. Louis, Missouri 63132
(314) 432-4330



**Safe and Supportive Environments:
Measurable Interim Outcomes**

Safe environments	Developmentally appropriate learning environments.
Safety practices	Participation in quality child care and early childhood programs
Limited television viewing with interactive adults	

Research Linkages

Child Safety

Children deserve to be raised in safe environments that are free of danger, violence, disease, and stress. Yet too many children experience environments where they are exposed to a variety of hazards. Too many accidents occur that could have been prevented.

Childhood injuries resulting from unsafe situations are the leading cause of death among children aged one to fourteen (National Safety Council, 1991). Accidents vary in frequency by the age of the child.

- For older children, fatalities are most likely to result from motor vehicle accidents.
- For preschoolers, accidents in the home such as fires, falls, scalding, choking, poisoning and drowning are most likely to lead to fatal and disabling injuries.
- Over 90% of the injuries and more than one half of fatalities to children under 5 occur at home.
- Inadequate supervision and parental ignorance of safety procedures account for a majority of childhood accidents (Barone, Green, & Lutzker, 1986).
- The ready accessibility of guns in homes has increased the likelihood of both accidental shootings and suicides (Children’s Defense Fund, 1996). Fewer than half of the parents who own a gun keep it safely locked. Firearm violence has been increasing steadily among children. Homicide is the third leading cause of death among children aged 5 to 14 years.

Preventing accidents. Auto and home accidents are leading killers of

Childhood injuries are the leading cause of death under age 14.

children. Most of these accidents are preventable. Federal and state laws require children to wear seatbelts or be buckled into an appropriate car seat. Despite widespread media campaigns, many parents fail to use child restraints because they find them inconvenient, costly, or because children may resist them. Car seats are often in poor condition or not used properly. Parent education that focuses on proper usage and techniques to amuse young children in car seats can increase the likelihood that children will be adequately restrained in the event of an accident (Edelstein, 1995).

While parental monitoring of children's activities is important, passive accident prevention strategies that build protective changes into the environment are most effective for families with children (Bloom, 1996).

- Passive strategies that make hazards less available to children include using child-resistant closures for medicines and cupboards containing toxic substances, locking up firearms, and keeping dangerous items out of the reach of children.
- Families are most likely to “childproof” their homes when home visitors provide both education and feedback (Tertinger, Greene, & Lutzker 1984).

Resource for child safety. The [Guidebook for Communities for Child Safety](#) is a comprehensive resource to community planning to improve child safety. Developed by the National 4-H Council, this excellent guidebook outlines community collaborative actions to reduce accidents. The motto of this effort is “If it’s predictable, it’s preventable.” For further information, contact your local county Extension office or:

National 4-H Council
700 Connecticut Avenue
Chevy Chase, Maryland 20815-4999
(301) 961-2853

Violence

Children are more likely to observe or experience violence today than they were ten years ago. In a survey of school age children living on Chicago’s south side, 26% had seen a shooting and 30% had witnessed a stabbing (Bell & Jenkins, 1993). When children are witnesses, victims are likely to be family members or close acquaintances, heightening the emotional impact.

Parents often underestimate the amount of danger and violence that children are exposed to and also underestimate the emotional distress that violence causes their children (Martinez & Richters, 1993). Effects of exposure to violence include:

- increased aggressiveness or acting out behaviors;
- anxiety, fearfulness, and emotional distress;
- social isolation and depression (Slaby, Roedell, Arezzo, & Hendrix 1995).

Effective strategies for dealing with real-life violence are important to use in violence-prone neighborhoods and communities, but are also relevant to all children growing up in America today. These strategies include:

- helping children to identify violence and its consequences;
- recognizing and talking with children about real-world violence;
- recognizing and responding to children's traumatic reactions to violence;
- training children in basic violence-related safety and self-protection;
- helping reduce "disciplinary" violence toward children; and
- supporting families as they help children cope with violence (Slaby et al., 1995, p. 8).

Television Viewing

The American Academy of Pediatrics (1990) recommends that children's television viewing be limited to between one and two hours *per day*. Despite this recommendation:

- In 1990 the average child of preschool age was watching television *more than 27 hours per week* (A. C. Nielsen Company, 1990).
- Prolonged television viewing is associated with less physical conditioning, and more physical aggression and academic problems for children (Centerwall, 1994).

Parents underestimate the emotional distress that violence causes their

Children's television viewing should be limited to between 1-2 hours per day.

- One in four American households have a television set in the child's bedroom (Centerwall, 1994), with the consequence of children spending many hours in uncontrolled viewing, often under isolated circumstances.

Negative academic effects of television viewing have been observed as early as first grade. According to a number of studies, the amount of time children spend viewing television *over* 10 hours per week is negatively related to their reading, writing, and math abilities, especially for more socially advantaged students and children with high IQ (Van Evra, 1990).

Modest viewing of 2-3 hours per day contributes somewhat to academic achievement for students *in highly disadvantaged homes* (Van Evra, 1990).

Young children are especially vulnerable to television

Because young children are unable to distinguish between program content and advertisements, they are especially vulnerable to the effects of television advertising. Young children are also unable to distinguish between reality and fiction, and may believe that what they see on the TV screen is actually happening. Indiscriminant viewing can result in more fearful children who think of the world as a more dangerous place than it actually is.

When children watch TV *with* adults who discuss the content of programming with them, they are more likely to be able to become resistant to the negative effects of television viewing. Parents who watch educational programs such as *Barney or Sesame Street* with their young children are better able to capitalize on the children's television viewing by weaving the content into the children's play and daily life. Some even refer to television characters to promote developmental advances such as remarking, "Barney will be so happy to know you're a big girl who uses the potty!"

Although several "critical viewing skills" programs have been developed, their long-term effectiveness is not clear (Van Evra, 1990). To insure the most positive outcomes:

- children should average no more than 2 hours of television a day;
- whenever possible, adults should watch TV together with children and discuss the content of programs; and
- adults should discuss television advertisements to help children develop critical viewing skills.

Developmentally Appropriate Learning Environments

A major determinant of the quality of early childhood learning environments, whether in the home or an early childhood program, is developmental appropriateness. The concept of developmental appropriateness has two dimensions:

- age appropriateness and
- individual appropriateness (Bredekamp, 1987).

When activities and interactions with children are developmentally appropriate and adjusted to fit individual temperaments, strengths and needs, children show better psychological and social adjustment (Berke & Winsler, 1995; Bredekamp & Rosegrant, 1992; Smith et al., 1994).

For children, especially young children, developmentally appropriate play and exploration are critical. Play has been called “*the primary vehicle for an indicator of children’s mental growth.*” (Bredekamp, 1987, p. 3). As children play, they explore the world around them, experimenting, inventing, learning how things work, finding rewarding and appropriate ways of interacting with others.

Learning activities and materials must be concrete, real, and relevant to the lives of the children. Child-initiated, child-directed, adult-supported play is an essential component of developmentally appropriate practice (Bredekamp, 1987).

Exploration and play results in children knowing their environment, mastering new skills, and combining information and knowledge in new ways. Children’s engagement in active exploration and play are associated with early writing, reading, and information gains (Pellegrini & Boyd, 1993).

Quality Childcare and Preschool Experiences

High quality early childhood environments and developmentally appropriate practices produce the best outcomes for children (Burts, Hart, Charleworth, & Kirk, 1990). Such environments can exist in childcare, preschool, and other settings. Positive early group experiences for young children occur in environments that stress child-initiated activities and encourage independence and cooperation (Schweinhart, Weikart, & Larner, 1986).

Play is “the primary vehicle for an indicator of children’s mental

High quality early childhood environments and developmentally appropriate practices produce the best outcomes for

Quality characteristics. Quality childcare and preschool programs can enhance the development of children from high risk populations and enrich the development of more advantaged children (Howes & Hamilton, 1993). Group settings offer more opportunities for education, interaction, and socialization (Howes & Hamilton, 1993; Vandell et al., 1988).

A key contributor to high quality childcare and preschool experiences is the adult providing care (Howes & Hamilton, 1993). Children develop more social and cognitive competence when the caregiving adult is able to effectively perform both a nurturing *and* a teaching role.

- Caregivers who have a formal education or specialized training, and who are paid well, tend to be more attentive and nurturing in their behavior toward children than those with less training.
- Children benefit from stable relationships with caring, sensitive teachers. Most studies find that children who attend higher quality child care centers score better on measures of social, language, and cognitive development than children in lower quality care (McCartney, 1984; Phillips, Scarr, & McCartney, 1987; Vandell et al., 1988).
- Programs that offer higher salaries, better benefits, and supportive management are more likely to have better qualified staff who remain longer in their jobs (Frede, 1995).

Children who attend higher quality child care centers score better on measures of social, language, and cognitive development.

Overall, effective, high quality programs are characterized by combinations of most of the following elements:

- small class sizes with low ratios of children to teachers;
- individualized support for learning and utilization of developmentally appropriate practices;
- teachers or care providers who receive training and support improve their teaching practices;
- on-going, child-focused communication between home and school; and
- use of some curriculum content and classroom processes similar to those in formal schooling (Frede, 1995; Howes & Hamilton, 1993).

Positive Peer Relationships and Social Competence:

Measurable Interim Outcomes

Positive social skills.	Age-appropriate self-control.
Low level of aggressive and disruptive behavior.	Peer acceptance and engagement.
Conflict resolution skills.	

Research Linkages

Children’s effectiveness in dealing with the social world emerges from their experiences in close relationships --- with families and other adults, with siblings, and with peers. As children grow and develop over time, they learn how to relate to others in mutually satisfying ways. They learn to share ideas and materials with one another. They find ways to negotiate and bargain effectively. Throughout childhood, children are gradually developing social competencies that will help them cope with the challenges, choices and opportunities in life.

Children’s effectiveness in dealing with the social world emerges from their experiences in close relationships.

Social Competence

Child development researchers have become increasingly interested in the connections between children’s thoughts and feelings (referred to as social cognition) and their behaviors with others. Skillful social interactions require more than limiting aggression and behaving in positive ways. Children also must pay attention to what others are saying and doing, and become skillful at blending their behavior with that of others.

Socially competent children tend to have the following characteristics:

- **Positive and agreeable behavioral style.** Socially skillful children are friendly, trusting, open, self-confident and show empathy to others. They act cooperatively, ask for and give help when needed, listen to others’ viewpoints, and effectively communicate their own.
- **Social knowledge.** Skilled children have larger repertoires of behavioral options and knowledge of the consequences of these options. They anticipate the responses of others to their own behaviors, and adjust their actions accordingly.
- **Ability to read social cues.** Skilled children attend to important interpersonal signals, interpret them accurately, and make constructive use of them. Children who are lacking in social

perception skills often overlook important cues and misconstrue the actions of others, often attributing antagonistic meanings to them.

- **Ability to engage in reciprocal exchanges.** Socially skillful children are able to sensitively and responsively “mesh” their behavior with others in synchronous exchanges. They are able to engage in imagination play with peers, make up and conform to agreed upon rules, and make friendships.
- **Expectations.** Competent children differ from less competent children in that they tend to view social relationships as rewarding and are confident in viewing themselves as capable of producing positive outcomes (Pettit & Harrist, 1993; Vanzetti & Duck, 1996).

Children expand their awareness and understanding of social relationships as they gain in experience and cognitive abilities. Children learn social competencies through experimentation and interactions with parents, caregivers, siblings, and peers throughout childhood. These interactions are affected by family characteristics, children’s temperaments, gender, physical characteristics, and their environmental and cultural milieu.

Prosocial behavior. Sharing, helping, and comforting others in distress are examples of prosocial behaviors that emerge in early childhood. By one year of age, infants show empathic distress when they see another person crying or in pain.

By 18 months, toddlers will pick up things from the floor, put away laundry, or try to set the table for a meal. As children gain more skill in interaction, more knowledge about the world, and more understanding of other people’s emotions, their prosocial behavior becomes more frequent and more effective (Berndt, 1992).

Empathy and other prosocial behaviors are related to positive emotional expression, effective conflict management, and better school performance. Children with positive social skills are more enthusiastic and teachable in simple tasks, exhibit fewer frustration-related behaviors, and are more sophisticated in negotiating coordinated problem solving (Hartup, 1989).

Children learn primary social skills and behaviors through the socialization process. Parent involvement, warmth, and moderate control are the primary factors related to children’s social competence.

- An impressive amount of research evidence shows that parents

Parent involvement, warmth, and moderate control are the primary factors related to children’s social

who use an *authoritative parenting style* -- characterized by a blending of firm and consistent control, affection, and respect -- are more likely to have socially competent children (Cohn, Patterson, & Christopoulos 1991).

- Parents who interact in a positive and agreeable manner with their children, and who are concerned with feelings tend to have socially skilled children.
- When parents are negative and controlling, or use harsh, punitive punishment, children are *less* likely to exhibit prosocial behaviors such as sharing, turn-taking, and cooperation (Putallaz & Heflin, 1990).

The most effective way to promote social competence is for parents to behave in prosocial ways and use positive social skills themselves, particularly in interactions with their children. Other parenting practices that are associated with socially competent children include:

- engaging in physical play that is accompanied by positive affect but does not go “over the top” to upset or hurt the child;
- being sensitive to children’s cues and engaging in smooth, synchronous and reciprocated exchanges;
- providing guidance and suggestions for constructive ways to interact with peers or siblings;
- assisting children to understand others’ frame of reference and to pay attention to their feelings;
- establishing firm expectations for socially appropriate behaviors; and
- managing children’s schedules to include ample opportunities to play with other children (Vanzetti & Duck, 1996).

Conflict resolution. Children learn conflict resolution skills from the way parents and other adults respond to the children’s early aggression and misbehavior. When adults are affectionate and use authoritative style of parenting, children learn peaceful ways to resolve conflicts. When adults rely on hostile interactions and use physical punishment, they provide children with a model of aggressive behavior.

Young children with high levels of aggression are typically growing up in

To promote children’s social competence parents must use positive social skills in interactions with their children.

When adults are affectionate and use authoritative style of parenting, children learn peaceful ways to resolve conflicts.

families who display little affection and are living under stressful conditions. Parents tend to ignore the good things that children are doing and instead, focus only on tactics such as hitting, yelling, and threatening to deal with misbehavior (Patterson, Dishion, & Chamberlain, 1993).

Aggression is a normal behavior as children begin to assert themselves.

Early anti-social or aggressive behavior is a strong predictor of later anti-social or aggressive behavior. Children who display high levels of impulsivity or aggression are at risk for poor school performance, juvenile crime, substance abuse, and other social and personal problems (Yoshikawa 1994).

Children often resort to aggressive actions because they lack the social skills to get what they want in more acceptable ways. Aggression is a normal behavior as children begin to assert themselves. A key to the development of conflict resolution skills is how adults respond to these early expressions of aggression:

“Withdrawing from a biting baby or redirecting the behavior of toddlers are good strategies to set the stage for conflict resolution skills” (Leffert et al., 1997, p. 76).

Researchers suggest successful conflict negotiation involves the ability of the child to:

- accurately identify and interpret social cues, including recognizing emotions and listening to and understanding others’ viewpoints;
- generate ideas for potential behavioral responses and choose an approach;
- think of ways to carry out these solutions; and
- evaluate others’ responses to the solutions.

Social problem-solving skills. Learning social problem-solving skills contributes to improved in peer relations and reduced internalizing and externalizing problem behaviors. For children from all socioeconomic levels, social problem-solving skills serve as a protective factor against later violence, substance abuse, and teen pregnancy (Shure, 1997).

Programs to teach social problem solving skills use sequential steps to teach the following techniques:

Social problem-solving skills serve as a protective factor against later violence, substance abuse, and teen

- maintain self-control and keep calm;
- listen carefully to what the other person is saying;
- gather information about the issue;
- objectively define the problem without a hostile bias;
- generate alternative solutions;
- choose the best solution;
- enact the chosen solution; and
- evaluate the response (Selman 1989; Shure, 1997),

Learning social problem-solving skills in the preschool years reduces the likelihood of behavior problems in elementary school (Shure, 1997). Children who lack these skills are at a disadvantage as they are likely to become socially disruptive when stressed, and typically fail to cope effectively with their own and other children's feelings and demands (Coie, Dodge, & Kuperschmidt 1990).

Self-control. To succeed in life, children must learn to control their impulses and regulate their behavior in accordance with the demands and values of families and society. Self-regulation gradually emerges through maturation and the socialization process. Self-control involves learning to:

- inhibit impulses;
- choose among alternatives;
- think ahead and weigh short-term gains against long-term losses;
- tolerate frustration; and
- channel emotions into constructive problem-solving (Maccoby, 1980).

Children learn to regulate their behaviors through experience and the reactions of those who care for them. New challenges to self-regulation emerge with each developmental stage and changing life events. Healthy children are continually making mistakes *and* learning from them.

With effective parental guidance, children can learn to assess social situations accurately and form internal standards of conduct. Parents teach

Healthy children are continually making mistakes and learning from them.

children how to behave socially, both by imposing limits on their behavior and by modeling socially appropriate ways of responding. With effective parental guidance, children are better at accepting the restrictions placed on them by parents and others. These children are more likely to be polite, to wait their turn, and to be patient when they want something.

Effective parents most often use clear rules, praise, and positive reinforcement to guide children's behavior.

Parents have many opportunities to model self-restraint and the benefits of making reflective choices. Effective parenting skills can encourage the development of a healthy level of self-control. These include:

- using praise and positive reinforcement to guide children's behavior;
- establishing clear and appropriate rules that children understand;
- being consistent in adhering to rules or routines previously established;
- following through on promises;
- respecting choices and decisions children have been allowed to make; and
- using reprimands and sanctions when the situation demands (Maccoby, 1980; Baumrind, 1996).

When parents fail to restrain or discipline children, opportunities for the children to learn self-control will

When parents fail to restrain or discipline children, opportunities for the children to learn self-control and appropriate ways of interacting with others will be lost. Instead, children may learn coercive techniques such as whining, crying, or throwing a tantrum to get what they want (Patterson et al., 1992). Alternatively, if parents exert *too much control*, children may exhibit excessive compliance and lack initiative and self-confidence, or fail to internalize appropriate standards of conduct and adopt a rebellious attitude toward parents or other authority figures.

Peer Relationships.

Peer relationships play a significant role in children's lives and development. Children learn different social skills from interacting with peers than they learn from adults. Close relationships fall into two general types, both important for healthy development:

- *Vertical relationships with parents and other adults*, who have *greater* social power and greater knowledge. Through these vertical relationships, children gradually learn to conform, to

regulate their behavior, control their impulses, and develop socially appropriate ways of interacting with others.

- *Horizontal relationships with peers and friends* who have similar social power and often, similar knowledge bases. These relationships are more balanced, and allow children to master the complexities of cooperation and competition. Through horizontal relationships, children gain an understanding of others' thoughts, emotions, and intentions (Hartup, 1989; Youniss, 1980).

Since young and middle years children tend to view adults as authority figures rather than as having individual personalities and preferences, their interactions and quality of play with adults is substantively different from interactions and play with peers.

When playing a game with parents, the child is expected to follow the rules the parent (or the rulebook) imposes. When playing a game with peers, children are more likely to collaborate, to make up and revise the rules as the game progresses. Both kinds of interactions are crucial to children's healthy development.

Peer interactions. Peer acceptance is associated with interpersonal sensitivity, rule-following, and academic success (Coie, Dodge, & Kupersmidt, 1990; Hartup, 1989; Kupersmidt, Coie, & Dodge, 1990). Children who are accepted by peers tend to be:

- physically attractive;
- outgoing, cooperative, and helpful;
- competent at negotiating social conflicts; and
- effective at finding positive ways to solve problems.

First interactions often strongly influence later acceptance or rejection by peers. Socially skilled children who can "fit in" and engage in conversation with a new group when they first meet are more likely to be accepted (Putallaz & Wasserman, 1990).

Friendships. Friendships involve more than routine peer interactions and represent "developmental advantages" for children. Children who form friendships do many things together and form emotional ties with one another. Through friendships with peers, toddlers and children learn to lead and to follow others, to collaborate on problem solving, and to cooperate in play (Howes, 1987). Friendships are linked to communication competence, ability to establish and maintain intimacy, and strategic

Through friendships with peers, toddlers and children learn to lead and to follow others.

Healthy, Thriving Children

conflict resolution skills across the life span (Hartup, 1989).

Children who have one or more close friends in their child care group display more socially skilled behaviors, and children who enter school with some of their peers from child care are more accepted by their classmates than children who enter school without familiar peers (Howes & Hamilton, 1993).

As children become older, they spend more and more time with close friends. By the age of 7, children begin to spend as much social time with friends and peers as with adults. Early friends are chosen on the basis of activities; later friends are chosen on the basis of “dispositional” or personal qualities. The more stable the friendships, the more complex and sophisticated are patterns of interactions.

Positive and negative outcomes. Peer interactions and friendships help children learn important social skills such as perspective-taking, rule-making, creative problem-solving, and cooperation with others who have different interests. Interactions with peers help children develop their own sense of individuality and competence from the preschool years through adolescence (Youniss, 1980).

Older children and youth rely on peers and friends for advice and support as they spend more time in the extra-familial world. Teens rely on peers and friends for support during the developmental process of separation from emotional dependence on families and gradual assumption of adult roles and responsibilities (Steinberg, 1993).

Some friendships and other peer relationships can have *negative* impacts on children. Peers may influence children to reject prosocial values or academic aspirations and engage in antisocial behaviors. They may experience teasing, rejection, prejudice, or the betrayal of a close friend. Parents and caregivers who know their children’s friends are able to help their children understand and manage these important relationships.

Some children experience rejection by their peers over extended periods of time. Children who experience neglect or rejection from their peers are at risk for poor social and behavioral outcomes in later life. Poor peer relationships in childhood have been associated with a wide range of negative outcomes, from dropping out of school to criminal behavior to mental illness (Kupersmidt, Coie, & Dodge, 1990). Many of these children display hyperactivity and disruptiveness, aggression, and self-isolating behaviors. They also tend to experience more academic problems.

With increasing age, withdrawal becomes a correlate of peer rejection.

Peer interactions and friendships help children learn important social skills such as perspective-taking, rule-making, creative problem-solving, and cooperation.

Withdrawal and isolated activity may also be due to individual temperament or to hypersensitivity and a sense of social inadequacy. Consistent withdrawn behavior may lead to peer rejection (Dodge et al., 1990; Howes, 1989). Withdrawn children are at risk for such problems as depression and even suicide (Shure, 1997).

Supporting positive peer relationships. Sensitive, skilled parents, teachers, and other adults can facilitate children's formation of peer friendships and peer acceptance. Adults are most effective in promoting positive peer relationships when they:

- establish a warm, caring environment where *every* child is valued and treated kindly and respectfully;
- encourage children to use good social problem solving skills in everyday interactions;
- observe individual children's peer interactions and identify those who may need support or guidance in interactions; and
- use positive, affirming disciplinary practices when dealing with aggressive or disruptive behaviors.

In classroom or other group settings, teachers or supervising adults can further guide the development of positive peer relationships when they:

- facilitate the inclusion of withdrawn and peer rejected children into classroom games and activities, and display approval and acceptance for these individuals - "catch them being good;"
- provide withdrawn and rejected children with classroom responsibilities or leadership roles they can do well;
- engage parents' help in understanding possible reasons behind specific cases of negative peer interaction patterns;
- encourage their schools to develop a peer mediation program to facilitate positive peer interactions in the halls, on the playground, and other settings; and
- encourage schools to offer parent education programs so that parents may help their children learn social problem solving skills and develop positive peer friendships.

Finally, it is critical to remember that children's behavior patterns are strongly influenced by how they think. As early as the preschool years,

children can learn to recognize the distress of others. This in turn can influence their behaviors toward others (Hoffman, 1979; Shure, 1997).

Successful training of children in problem-solving skills is associated with improvements in peer relationships and reductions in both internalizing and externalizing problem behaviors, and serves as a protective factor across income levels and several ethnic groups against later violence, substance abuse, and teen pregnancy. Training of children without behavior problems in problem-solving skills in the preschool years also reduces the likelihood of later development of behavior problems in elementary school (Shure, 1997). (See end of section for resources.)

Child-interactive preschools and primary classrooms encourage prosocial behavior in early childhood and beyond.

Group Environments and Social Skills

Social skills increase as children play with mixed-age peers in quality group settings and learn negotiation strategies and cooperation. Early childhood classroom teaching styles have an important influence on children's development of social skills.

Preschool and primary classrooms that are strongly adult-directed are associated with fewer prosocial behaviors than those that emphasize more child-initiated learning and interactions. More participation in child-interactive preschool classrooms is associated with later increases in teenagers' social competency and decreases in juvenile delinquency (Honig & Wittmer, 1996).

Research-based strategies for teaching positive social skills in early childhood programs include:

- Design classrooms with adequate play spaces, activities, and resources to reduce negative interactions due to crowding, over stimulation, and lack of constructive involvement
- Create environments where children can help themselves and others with materials, freeing teachers for positive guidance roles.
- Provide extra guidance during unstructured times and when children are playing in activity areas where aggression is likely.
- Plan activities in which children can practice cooperating, sharing, and helping, including assigning classroom helper roles.
- Eliminate the frustration of abrupt transitions, excessive waiting, or sitting for long time periods.
- Practice good problem-solving skills in everyday classroom and

other interactions.

- Model cooperation by working cooperatively with the children (Slaby, Roedell, Arrezo, & Hendrix, 1995).

Resources

One effective model program is *I Can Problem Solve* (ICPS, Shure, 1997) training programs. ICPS teaches interpersonal problem solving in preschool, kindergarten, primary, and intermediate elementary grades. There is also a version for parents of 4 to 7-year-olds to use at home (Shure & Spivack, 1978; Shure, 1994, 1996a, 1996b, 1996c). Children as young as 2 and 3 can begin to learn some of the key skills involved in problem-solving, such as learning to identify how others are feeling.

The preschool curriculum uses games and dialoguing to teach a number of specific thinking skills:

- identifying another's feelings from visual and behavioral clues;
- predicting feelings that might follow specific experiences;
- understanding the effect of one's behavior on another (causality);
- judging concepts of fairness and turn-taking;
- thinking of alternative solutions to hypothetical and real problems;
- predicting possible consequences likely to follow specific actions; and
- pairing specific solutions with specific consequences.

Curriculum for kindergarten and primary grades includes the previous skills in more sophisticated forms and adds the concept of distinguishing between things that can, and cannot, be done at the same time. Curriculum for fourth to sixth grades adds means-ends thinking (what steps are involved in reaching a specific goal), and dynamic orientation (understanding the motives of others).

Program evaluations have indicated that one year of ICPS training in preschool or kindergarten resulted in significant behavioral improvements including decreased impulsivity, decreased inhibition, and increased cooperation, sharing, concern for others, positive peer relations, and academic performance (Shure, 1997).

Improvements in children's social behaviors are linked to children's ability to think of alternative solutions to

- Behavioral improvements were most closely linked to the skill in thinking of alternative solutions.
- Children whose parents learned and used ICPS problem-solving communication at home improved more in their behaviors than did other children.
- Children of various ethnic and economic backgrounds benefitted from ICPS training.
- Improvements were maintained through the second year following participation in the ICPS program.

Other resources for developing conflict resolution, anger management and other social skills are identified in Chapter 6 under Positive Peer Relationships.

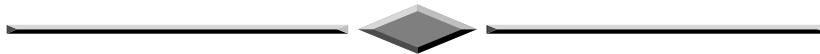


Table 5-1
Oregon's 1997 Benchmark Indicators^a Related to OCCF Wellness Goal: Healthy,
Thriving Children

	1990	1995/96	2000	2010
EDUCATION BENCHMARKS				
• Percentage of 8 th graders who achieve established skill levels (#23) ^b				
a. Reading	---	89%	92%	100%
b. Math	---	84%	89%	100%
• Percentage of 3 rd graders who achieve established skill levels (#24)				
a. Reading	---	93%	95%	100%
b. Math	---	86%	90%	100%
HEALTH BENCHMARKS				
• Percentage of babies whose mothers received early prenatal care (beginning in the first trimester) (#44)	75%	79%	90%	95%
• Infant mortality rate per 1,000 (#45)	8.3	6.2	6.0	5.6
• Percentage of two-year-olds who are adequately immunized (#46)	47%	---	90%	90%
• Percentage of families for whom child care is affordable (#51)	---	67%	70%	75%
• Number of child care slots available for every 100 children under age 13 (#52)	14	16/20	21	25
PROTECTION BENCHMARKS				
✓ • Number of children abused or neglected per 1,000 persons under 18 (#54)	11.2	9.9	8.8	6.5
• Percentage of infants whose mothers used: (#56)				
a. Alcohol during pregnancy (self-reported by mother)	5%	3%	2%	2%
b. Tobacco during pregnancy (self-reported by mother)	22%	18%	15%	12%
DEVELOPMENTAL BENCHMARKS (No baseline or targets are yet established)				
• Percentage of children entering school "ready-to-learn" (Developmental Benchmark #13)	---	---	---	---
• Percentage of school age children (preschool - 13) without tooth decay (Developmental Benchmark #24)	---	---	---	---
• Reported incidence of spousal abuse per 1,000 (Developmental Benchmark #25)	---	---	---	---
• Percentage of Oregonians with a lasting developmental, mental and/or physical disability who are living in the community with adequate supports (Developmental Benchmark #26)	---	---	---	---

^a Oregon Shines II: Updating Oregon's Strategic Plan, 1997; Oregon Progress Board.

^b Benchmark number in Oregon Shines II

✓ Key Benchmark to be tracked by Progress Board

Bold = Benchmark tracked by OCCF, 1995-97

