NCC Pediatrics Continuity Clinic Curriculum: **Behavior I**

Overall Goal:

The Good, The Bad, & The Ugly: To identify key behavior issues in infant, toddlers, and children and understand their management.

Overall Outline:

Behavior I:	***Behavior II:***
Temperament	Infant Colic
Discipline	Toilet Training
Problem Behaviors Potluck	Childhood Habits Potluck

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Pre-Meeting Preparation:

- Temperament (Ch 77 from Developmental & Behavioral Pediatrics*)
- Behavioral Management (Ch 13 from Developmental & Behavioral Pediatrics*)
  - *N.B.: Please refer to AAP Policy Statement for "official" stance on spanking.*
- "1, 2, 3 Magic" Parent Newsletter *(with links)*
- **Select a "problem behavior" from your own clinical experience OR from this parent-education list.** Present the problem behavior and your recommendations for management to the group.

* S. Parker, B. Zuckerman and M. Augustyn (Eds.), Developmental and Behavioral Pediatrics; A Handbook for Primary Care, 2nd edition, 2005; Philadelphia: Lippincott Williams & Wilkins.

Conference Agenda:

- Complete Behavior I Quiz & Case Studies
- **Problem Behaviors Potluck:** *Each resident* should present. Please skip Case 3 and move to the "Potluck" if your group is running behind.

Post-Conference: *Board Review Q&A*

Extra Credit:

- "Practicing Safety": Temperament Overview & Tip Sheet *(parent guide)*
- HealthyChildren.org—Communication & Discipline links *(parent guide)*
- **AAP Policy Statement on Discipline** *(1998)—includes EBM on spanking,* and **Policy Summary**
- The art and science of disciplining children *(scientific review)*
- **Physical Punishment & Mental Disorders**: Results from a . . . US Sample *(Peds, 2012)*
- **Socioeconomic Gaps in Parents' Discipline Strategies From 1988 to 2011** *(Peds, Dec2016)*

77 Temperamentally Difficult Children

Stanley Turecki

I. **Description of the problem.** A "difficult child" is a normal young child whose innate temperament makes them hard to raise. Inherent in this definition is a view of normality that is broad: children are different and do not have to be average in order to be normal. For a child to be considered temperamentally difficult, a basic criterion has to be met: the child's constitutionally determined personality traits—their very nature—must cause significant problems in child rearing.

A. Epidemiology.

- About 15% of young children are temperamentally difficult according to this definition.
- Difficult children are not all alike. Some are impulsive, distractible, and highly active; others are shy and clingy. Some throw loud tantrums; others whine and complain. Some can hit, kick, or even bite; others are verbally defiant. Some are unpredictable in their eating or sleeping habits; others are sensitive to noise, textures, or tastes. Most difficult children have trouble dealing with transition and change, and almost all are strong-willed and extremely stubborn.
- Highly active, impulsive, difficult children are more likely to be boys. All other temperamentally difficult traits are as likely to be seen in girls as in boys.
- There is no correlation with birth order, intelligence, or socioeconomic status.

B. Etiology.

- Temperament refers to dimensions of personality that are largely constitutional in origin. Genetic factors definitely contribute. Pregnancy and delivery complications may be somewhat more common in the histories of difficult children. Some of these children are allergic, with a propensity to develop ear infections. Uneven language and learning skills development are not uncommon. Many difficult children are intelligent but socially immature. All of these factors suggest a biologic basis for a difficult temperament.

C. The concept of temperament. Temperament is the *how* of behavior, rather than the *why* (motivation) or the *what* (ability). For example, three equally motivated and able children may approach a homework assignment quite differently, depending on their behavioral style. One will begin on time and work steadily to completion, the second will delay and procrastinate but then work very persistently, and the third will jump in immediately and quickly lose patience. Inherent in the temperamental perspective is a broad view of normality and a bias towards seeing atypical behavior as different rather than abnormal.

Temperament may also be defined as the behavioral expression, evident early in life, of those dimensions of personality that are constitutional in origin. Family, twin and adoption studies point to a 50% multigenetic heritability. The stability of temperament is detectable at 18 months, substantial at 3 years and most evident in middle childhood. As development proceeds, temperamental qualities are neither rigidly fixed nor completely malleable—like cartilage rather than bone or muscle. A range exists for each category. Table 77-1 lists the categories of temperament.

1. **The child and the environment: A transactional model.** The concept of a difficult temperament should always be combined with that of ***goodness of fit***—the match or compatibility between a child and their environment. Behavior that presents a problem to one family may be readily accepted by another. For example, a child's idiosyncratic and strongly held tastes in clothing and food would only trouble a fashion- and nutrition-conscious parent. The context of the behavior is always important. A highly active boy who has some problems with self-control and concentration, if placed in a class of (25 children (of whom another 5 are "challenging") with one somewhat inexperienced teacher, would undoubtedly meet all the criteria for attention deficit hyperactivity disorder (ADHD). However, if the following year he is in

Table 77-1 Categories of temperament

Trait	Description	Easy	Difficult
Activity level	General statement about level of motor activity; actual amount of physical motion during play, eating, sleep etc.	Low to moderate	Very active, restless, fidgity; always into things; makes you tired; "ran before they walked"; easily overstimulated; gets wild or "revved up"; impulsive, loses control, can be aggressive, hates to be confined
Self control	Ability to delay action or demands	Good, patient	Poor, impulsive
Concentration	Ability to maintain focus in the face of distractions	Good, stays with task	Poor, distractible, has trouble concentrating and paying attention especially if not really interested; doesn't listen, tunes you out; daydreams, forgets instructions
Intensity	Energy level of responses; how forcefully or loudly reactions are expressed, whether positive or negative	Low, mild, low-keyed	High, loud, forceful whether miserable, angry or happy
Regularity	Predictability of physical functions such as appetite, sleep-wake cycle, and elimination	Regular, predictable	Irregular, erratic, can't tell when they'll be hungry or tired; has conflicts over meals and bedtime; wakes up at night; moods are changeable; has good or bad days for no obvious reason
Persistence	Single-mindedness, "stick-to-it-iveness"; may be positive (focused when involved) or negative (stubborn and doesn't give up	Low, easily diverted	High, stubborn, won't give up, goes on and on nagging, whining or negotiating if wants something; gets "locked in"; has long tantrums
Sensory threshold	Sensitivity to physical stimuli—sound, light, smell, taste, touch, pain, temperature	High, unbothered	Low, physically sensitive, "sensitive"—physically not emotionally; highly aware of color, light, appearance, texture, sound, smell, taste or temperature; "creative" but with strong and unusual preferences that can be embarrassing; clothes have to feel and look right; picky eater; refuses to dress warmly when weather is cold
Initial response	Characteristic initial reaction to new persons or new situations	Approach, goes forward	Withdrawal, holds back, doesn't like new situations; may tantrum if forced to go forward
Adaptability	Tolerance of change; ease with which gets used to new or altered situations	Good, flexible	Poor, rigid, has trouble with change of activity or routine; inflexible, very particular, notices minor changes; can want the same food or clothes over and over
Predominant mood	General quality of mood; basic disposition	Positive, cheerful	Negative, serious or cranky; doesn't show pleasure openly; not a "sunny" disposition

a class of 15 children with a high ratio of girls to boys and the teacher has an assistant, the child would still be a handful but a clinical diagnosis of disorder would be inappropriate.

2. Difficult children are, above all, **hard to understand**. Their behavior confuses and upsets the most experienced parent or teacher. The tried-and-true methods of child rearing simply do not work, so that effective discipline is replaced by inconsistency, power struggles, excessive punishment, or overindulgence. Parents will say that "nothing works" or that the child controls the family. A vicious cycle develops wherein the child's trying behavior and the erratic overreactions of the parent augment each other.

   The primary caregiver of such a difficult child (usually the mother) may also be bewildered, overinvolved, and exhausted. She may feel guilty, inadequate, and victimized. Often such children are somewhat easier with their fathers, who may become increasingly critical of the mothers. Marital strain is common. A fragile but potentially viable marriage may be ruptured by the stress of a difficult child. In addition, individual vulnerabilities of adult personality may be accentuated, resulting in parental syndromes of anxiety, depression, or substance abuse. The siblings are often expected to behave in an excessively adult manner and their needs can be neglected as the household increasingly revolves around the difficult child. The child is also affected by the vicious cycle. Behavior problems are accentuated and secondary manifestations, such as fears and feelings of being "bad" are quite often evident.

II. **Making the diagnosis.** A pathology-oriented model is limiting and often counterproductive. There is no "difficult child syndrome," just as there is not a definitive "test for ADHD." Much more valid in dealing with problem behaviors in young children is a **model that focuses on individual differences and goodness of fit**. The aim is to describe the child's behavior, temperamental profile, and strengths, as well as areas of vulnerability.

   A. **History.** Questioning the parent about the manifestations of a child's difficult temperament and its impact on the family is the key to identification. The clinician should inquire about the parents' approach to discipline, the child's school functioning, and the presence of secondary manifestations, such as fearfulness, nightmares, excessive anger, and emotional oversensitivity. Impaired self-image is seen in poorly managed difficult children.

   B. **Temperamental questionnaire.** These may be used as part of well-child examinations or to determine areas of difficulty with a view to temperament based parent guidance. Research-based questionnaires tend to be lengthy with 75–100 parent responses. It is often acceptable for a busy primary care provider to devise their own brief questionnaire, provided it is used as an aid in conjunction with other information and not as a "diagnostic instrument."

   C. **Behavioral observations.** Some problem behaviors are readily apparent in the office visit: impulsivity, hyperactivity, disruptiveness, clinging and withdrawal, tantrums, aggressiveness, or undue sensitivity to pain. However, a child may be stubborn, irregular, negative and cranky, intense, sensitive to light and taste, or poorly adaptable. When a parent reports such "nonvisible" difficult behavior that is not apparent during the office visit, the clinician should not assume that the parent is inventing or causing the problem.

   D. **Differential diagnosis.** A difficult temperament is evident from an early age and is relatively stable and consistent over time. A child, 3 years or older, whose behavior has become difficult may be going through a developmental stage or reacting to stress. An example is a youngster who begins to misbehave after parents separate. When does the clinical picture go beyond a very difficult temperament and become indicative of a psychiatric disorder? The distinction is not only problematic but it is actually often irrelevant to treatment decisions. A "brain disorder", such as ADHD, is essentially a behavioral syndrome based on descriptive criteria subject to some extent observer bias. There is no "test' for ADHD. While it is now generally accepted that ADHD is neurobiologically based, the same can be said for temperament. Adopting a continuum based, rather than a categorical approach to diagnosis allows a clinician much greater flexibility.

III. **Management: The role of the pediatric clinician—helping the child and family.** The difficult child's adjustment can be greatly enhanced by the ongoing involvement of the primary care clinician. The central therapeutic goals are to improve the compatibility between a child and the significant persons in their life, relieve the child's suffering and improve adaptation.

   A. **General issues.**

1. **Erroneous perceptions can be corrected.** The parents of very difficult children invariably feel victimized and often assume that the child's behavior is intentional. Parents need to understand that their children are not enemies who are "out to get them." Seeing the problem behavior as temperamentally determined rather than willful disobedience allows the parent to deal with it far more neutrally. Many parents are confused and made anxious by pressures to have their child "diagnosed" and placed on medication.
2. **The caregivers need support and understanding**, especially when the child's behavior is very difficult at home but unremarkable at school or in the clinician's office.
3. **Practical advice can be offered** on issues such as school selection and communication with teachers. The parents may need guidance on how to share responsibility more evenly, how to deal with other family members, and how to respond to the often plentiful advice offered from several quarters that tends to make parents (particularly single parents) feel defensive and inadequate.

   B. **Principles of adult authority.** The fundamental goal for the parents of a difficult child is to replace the power struggles, frustration, and wear-and-tear of an ineffective disciplinary system with an educated, rational, kind, accepting, yet firm attitude of adult authority. Inevitably, habitual patterns of negative interaction have developed. It is the parents' job to initiate the necessary changes to improve the fit between their child-rearing style and expectations and their child's temperament. In order to begin the process, a key shift in attitude is needed. It should be clear to everyone that the parents are in charge. Certainly the child's opinion should be solicited when appropriate, but the ultimate decision lies with the parents. The model is that of the excellent supervisor at work: approachable, supportive, clear in expectations, and very much in charge. Key ingredients of this model are:

1. **Strategic planning and planned discussions.** The automatic, often excessively punitive, reactions to the child's behavior must be replaced with a system that emphasizes structure and predictability. Decisions about rules, new procedures or routines, and consequences should be made privately by the adults and then presented to the child. Such a planned discussion always takes place away from the heat of the moment. The child is calmly, clearly, and deliberately told what will be expected from now on. Both parents, if possible, should be present at such a meeting. The attitude is kind but serious. The parents should be concise and avoid moralizing, lest they lose the child's attention. The child should be viewed to some extent as a junior collaborator in the planning to improve the family atmosphere and input elicited. At the end of a planned discussion, the child needs to repeat the key points to make sure they understood them and is then encouraged to "do your best." Asking a young child, at a calm time, to try hard to meet a specific and reasonable expectation is a very powerful statement. Generally planned discussions can be used with children as young as age 3 years.
2. **Active acceptance.** The parent makes the deliberate choice, based on understanding their child and the child's temperament, to accept the youngster for the person they truly are, vulnerabilities as well as strengths. The practical consequence of this conscious decision is that parental expectations become more consistent with the genuine capacities of the child.
3. **Rational punishment.** Going hand in hand with planned discussions is the clear, firm enforcement of consequences for unacceptable behaviors that are within the child's control and important enough to warrant taking a stand. In a typical vicious cycle, a mother may find herself punishing and saying "no" repeatedly, but no parent can possibly be effective in such circumstances. Most difficult children need less punishment, rather than more, and this can be achieved through consistency, structure, and routines in everyday life.

   The important first step for parents is to recognize and address major unacceptable behaviors and ignore the myriad minor irritations that take place every day with a very difficult child. Whenever possible punishment should contain a natural consequence. For example, a child who continues to act too roughly with the family pet should be prohibited contact for a day— rather than being given a time-out. Ideally, a punishment should be administered briefly and without anger. Its main objective is to show the child that the parents are serious about stopping the behavior. Simplicity and predictability are important; a variety of punishments are unnecessary. With a younger child, parents can show seriousness by facial expression, direct action and tone of voice.

   C. **Management strategies.** Management, as distinct from punishment, is used when the adult decides that the misbehavior is temperamentally based; the child, in effect, "can't

help it." The parent's attitude, while still firm, is much more sympathetic and kind. The basic message is "I understand what's happening. I know you can't really control yourself, and I am going to help you with this." Sometimes behavior falls into a gray area, where it is not clear whether it is deliberate. In such instances, it is best for the parent to make the emotionally generous decision and help rather than punish the child.

Management suggestions designed to promote the child's success can be geared to particular temperamental characteristics. Strategies should be explained to the youngster during a planned discussion.

1. **The impulsive child.** A child who is easily excited can lose control in an overly stimulating environment and misbehave or become aggressive. The most common mistake parents and teachers make is to wait for the youngster to strike out and then lecture or punish, instead of intervening early.

   If the child is easily excited, it is important to recognize the signs of escalation—for example, moving more rapidly, talking in a louder voice, or laughing excessively. The adult should try to step in before the child gets out of hand. This technique is called **early intervention.** Some youngsters can be distracted. Others need a **time-out** (not as punishment, but as a cool-down period away from the action). A parent can say, "You're getting too excited. Let's do something quiet until you calm down."
2. **The highly active child.** High-energy children can become restless when they are confined to the dinner table or a classroom seat. They may begin to fidget or have difficulty paying attention. This behavior can be managed once the adults in charge **recognize the signs.** A restless youngster can be permitted to leave the dinner table and walk around between courses; a sympathetic teacher could ask the child to run an errand. Building vigorous physical activity into their daily routine is also helpful.
3. **The irregular child.** Most people fall easily into a regular rhythm of sleeping and eating, but some are naturally irregular. Battles can result when parents insist that a child who is not hungry must eat or that a youngster who is not tired must sleep. One strategy is to **differentiate between bedtime and sleep time, mealtime and eating time**. It is reasonable to require a child to be in bed by a certain hour or to join parents and siblings at dinner. However, parents should not force a youngster to sleep when he is not tired, or to eat when he is not hungry. To avoid overburdening the family chef, a child with an irregular appetite can be taught to fix simple snacks, such as fruit, cold cereal, or yogurt.
4. **The poorly focused child.** Some children are easily distracted by their environment or even by their own thoughts. As a result, they appear to not "listen" or, if they miss instructions, to be willfully disobedient. Parents and teachers can manage the problem by **making eye contact** in a friendly way before giving such a child directions. Instructions should be kept brief and simple. Set up, with the child, a system of reminders. Begin to teach organizational skills early.
5. **The child who resists change.** Some youngsters have difficulty with transitions. A poorly adaptable or shy child may be distressed by anything new. Other children focus so intently that they are locked into one activity and refuse to move to another. When they are asked to shift gears, they may cling, have a tantrum, or otherwise react negatively. If the issue is poor adaptability, parents can help by **preparing the child for change.** Even a simple warning, such as, "Finish playing with your trains, because we have to go shopping in 10 minutes," can be effective.
6. **The shy child.** Shy children require time and sympathetic understanding. A parent might say, "I know it's hard for you to get accustomed to new things, so I won't leave until you're used to being here." At the same time encourage a time-limited trial of an activity the youngster has previously shown he enjoys.
7. **The stubborn child.** Persistent, stubborn children can be extremely frustrating for parents and teachers. With these children, adults can take a stand early and terminate the confrontation. This technique is called **bringing it to an end.** A parent should not try to reason with a stubborn expert negotiator. Instead, the discussion should be ended. However, it is common for parents of a stubborn child to engage in a constant battle of wills and say "no" all the time. They should be encouraged to say "yes" more often, especially when the issue at hand is not really important.
8. **The finicky child.** Certain children are particular because they have heightened sensitivity to touch, taste, smell, sound, temperature, and colors (not necessarily all of these). Parents may get into arguments because a youngster insists on wearing the same comfortable green corduroy pants day after day or refuses to eat the inexpensive brand of frozen pizza that the rest of the family enjoys. Parents should be advised to **respect a child's preferences** when possible and to seek compromises that avoid unnecessary power struggles.
9. **The cranky child.** Parents can be distressed and angered by a child who is generally negative, somber, or pessimistic. Treats that would delight most children scarcely rate a smile from this youngster. The harder the parent tries (and fails) to make the child happy, the greater the tension becomes. A suggestion for parents is to **accept the child's nature** and not to expect a level of enthusiasm that they cannot give. The parent should not feel guilty; the child's negative mood is not the parent's fault.

D. **The use of medication.** If one aims for the relief of suffering rather than the cure of illness, target symptoms can be greatly reduced by the judicious and often temporary use of psychotropic medications. According to this view, the use of a stimulant would be completely appropriate for the balance of the school year in the child described earlier who was in an unfortunate but unavoidable classroom situation. A referral to the parent's provider may be appropriate for the parent who is tense and caught up in the "vicious cycle."

E. **Criteria for referral.** The decision to refer to a mental health professional is often determined by the primary care clinician's interest in behavioral issues, expertise in parent guidance, and time availability. Assuming the presence of all these, a referral would still be needed in the case of an extremely difficult child, when the vicious cycle of ineffective discipline is longstanding, or when a clinical syndrome is suspected or can be identified in the child or other family members.

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13 Behavioral Management: Theory and Practice

Edward R. Christophersen

Traditional behavioral management techniques can be very useful to the primary care clinician. This chapter describes the concepts and techniques that parents can routinely use in interacting with their children.

I. Techniques to teach or improve behaviors.

A. Time-In and verbal praise.

1. *Time-In* refers to the way parents interact with their children when they do not necessarily deserve praise but when their behavior is acceptable. Parents should be encouraged and educated to provide their children with frequent, brief, nonverbal, physical contact whenever their child is not engaging in a behavior the parents consider unacceptable or offensive. They do not have to wait for "good behavior."
2. *Verbal praise* is used only when a child has done something "good." The best time to use verbal praise is during natural breaks in an activity. For example, when a child is coloring, the parent should provide lots of brief; nonverbal, physical contact (time-in); simple physical contact, without any praise, is much less likely to distract a child. When the child has finished coloring or stops coloring to show it to a parent, verbal praise is appropriate.

   Advantages. Time-in and verbal praise encourage children to continue to engage in acceptable behaviors. These techniques take no additional parent time and do not distract children.

B. Incidental learning.

Children learn behaviors by being around individuals who engage in those behaviors naturally. This is called *incidental learning.* For example, if both parents smoke cigarettes, their child is significantly more likely to become a smoker than if neither parent smokes. A surprising number and variety of children's behaviors appear to have been learned incidentally, including language, gestures, and anger management strategies.

Advantages and disadvantages. Incidental learning can be achieved without any additional effort on the part of the parents. They need only be aware that such learning occurs naturally and be cognizant of incidental learning during the time they spend with their children. The negative side is that children also learn behaviors the parents never intended for them to learn (e.g., swearing).

C. Modeling.

1. Two basic modeling techniques exist: live and videotape. Most modeling procedures work best if the model is approximately the same age as the target child. For example, a 6-year-old boy who has previously had his teeth cleaned by a dentist and who behaved appropriately during the procedure could be observed live or on videotape while being examined. A second child who observes the dental procedures being performed on this model can learn both what to expect of dental procedures and how to react to those procedures.

   Advantages and disadvantages. Children are more likely to believe what they see a peer doing than what their parents *tell* them, particularly if the two messages are contradictory (e.g., one a verbal message that the child should relax, and the other the anxiety that a child feels in the dental chair). However, modeling can teach maladaptive behaviors as well as adaptive behaviors. For example, if a child is observing a peer model in the dentist's office and the peer model becomes very upset, the target child will probably have a more difficult time when it is his turn for the procedure.

D. Reinforcement.

No other topic in the behavioral literature has been more misunderstood than reinforcement. An item or activity can be said to have reinforcing properties for an individual child if and only if that child has previously worked in order to obtain access to that item or activity.

1. *Choosing rewards.* Under the right circumstances, reinforcement, by definition, will work with virtually any age group and with many different behaviors. However, no item or activity can be accurately described as a reinforcer unless and until it has

produced a change in behavior. For example, although candy is reinforcing for the vast majority of children, it cannot be referred to as a reinforcer until it has been demonstrated that the child will either work to obtain the candy or stop a behavior that prevents him from receiving it.

Principles of reinforcement, or the manner in which the reinforcer is made accessible to a child, are extremely important:

a. **Small rewards offered frequently are better than large rewards offered infrequently.** A physical hug offered several times during a household chore will usually be more effective than a big reward at the end of the chore. Small rewards during the chore and a reward at the end will also work nicely.
b. **Repetition, with feedback, enhances a child's learning.** A child will learn more from performing the same task repeatedly, with help from his parent, than from performing it once. While parents will often expect their child to perform a task correctly the first time, the child will actually learn the task better if he has many opportunities to practice. For example, a child who helps one of his parents do the laundry several times each week for two years will probably be able to do the laundry for the rest of his life.
c. Children learn more quickly and retain the learning better if they are **relaxed while they are learning.** While children can be very frustrating, the parent who becomes angry or impatient only exacerbates the situation. Similarly, an upset child does not learn as rapidly or as permanently as a calm child.
d. **Warnings only make children worse.** While parents have a natural tendency to warn their children, it is far more effective to discipline the child for not performing the task and then give the child another opportunity to do it, rather than frequent warnings that the tasks must be done.
e. **A behavior must already be learned before it can be reinforced.** If the child doesn't know how to perform the expected behavior, offering a reward, in lieu of teaching the child how to perform the behavior, is ineffective.

Advantages and disadvantages. Reinforcing items and activities frequently can become part of normal, everyday life without substantial planning on the parents' part. Reinforcing items and activities may sometimes be inadvertent. For example, when a parent picks up a child who has been crying in bed after bedtime, the parent may be reinforcing that child for crying.

Additionally, the child's behavior may return to its prereinforcement level as soon as the reinforcers are no longer available. For example, in research on the use of reinforcers for automobile seatbelt use, many children stopped wearing their seatbelts as soon as the reinforcers were no longer available. Procedures that have been shown to be successful in maintaining desired behaviors after reinforcement ceases include gradually making the reinforcer available less often (e.g., on the average, every second behavior is reinforced, then every third behavior, then every fourth behavior). Once a behavior becomes habitual, the individual will engage in it whether it is reinforced or not.

E. Conditioned reinforcers. Many items and activities that have no intrinsic reinforcing properties can take on reinforcing properties. Money, for example, is not usually a reinforcer to a small child. When the child learns what he can purchase with money, it begins to take on reinforcing properties. As another example, to a distressed child in the middle of the night, even the sound of the bedroom door opening can take on reinforcing properties, as the child associates the sound of the door opening with receiving attention from a caregiver.

Advantages. Conditioned reinforcers are usually more readily available than the actual reinforcer, and most children work just as hard for a conditioned reinforcer as they will for the actual one. Conditioned reinforcers, such as money, also have the advantage that they can be traded for a wide variety of items or activities as the child's tastes and preferences change.

F. The token economy. Conditioned reinforcers work best if there is a consistent method of exchange. In the case of money, the exchange system is already in place, and the money becomes a "token" of what can be purchased. Entire "token economies" have been devised as treatment programs for children from age 4 years to adulthood. The term token economy refers to the organized manner in which tokens are gained and lost, as well as what can be purchased with them. The success or failure of a token economy depends almost entirely on how it is implemented and on how many reinforcing activities are realistically available to the individual who must earn, lose, and spend tokens. The mere use of tokens does not make a token economy.

Token economies are most effective when they are used as motivational systems to encourage children to engage in socially appropriate behaviors. Three different types of token economies are widely used with common behavioral problems:

1. A **simple exchange system** provides a means of keeping track of the child's appropriate and inappropriate behaviors. A list of behaviors can be taped to the door of the refrigerator. As the child completes assigned or volunteered tasks or chores, he marks these on the "positive side" of the exchange chart. Similarly, as the child engages in inappropriate behaviors, he marks these on the "negative side." When the child wants a special privilege or activity, there must be more positive marks than negative marks to "afford" the special privilege. The simple exchange system is appropriate for children age 5–12 years.
2. Under **chip systems**, the child earns a token, such as a poker chip, for positive behaviors. Each time poker chips are earned, the parent acknowledges the child's appropriate behavior while offering chips. The child is then expected to take the chips from the parent's hand, look the parent in the eye, and say, "thank you." In this way, the child not only receives the tokens for the appropriate behavior but also practices appropriate social behaviors. Similarly, when the child engages in a behavior that loses chips, he is expected to hand the chips to the parent politely and may receive one chip back for "taking the fine so nicely." The chip system is useful for ages 3–7 years.
3. The **point system** is similar to the chip system but can be much more sophisticated. Points can be used to motivate children and teenagers to practice the behaviors they are lacking, such as taking feedback well and sharing their feelings appropriately. Each time they engage in these types of behaviors, they earn points that can be used to purchase items and activities they want. The point system is useful for children ages 6–16 years.

G. Fading. Fading refers to changing something gradually instead of abruptly changing it. For example:

- Instead of taking away a toddler's bottle, a cup can be available with milk in it while the bottle is gradually diluted from 100% milk to 90% milk:10% water, then 80% milk:20% water, and so on, until the toddler is drinking pure water from the bottle and pure milk from the cup.
- Raising training wheels on a bicycle 1/8 in. every 2 weeks until they are about 3 inches off the ground and no longer necessary.
- Changing a child's bedtime 15 minutes each night at daylight savings time instead of abruptly changing it the entire hour in one night.
- Teaching a child how to swallow pills by starting out with very small cake sprinkles to wash down with a favorite beverage, then moving to slightly larger pieces of candy. Typically using 6 to 8 steps (sizes) is very effective.

Advantages and disadvantages. Fading often helps to avoid confrontations with a child. It can be used to accomplish something without incident that otherwise may have been difficult to accomplish. The disadvantage of fading is that parents have to spend more time than they would if their child could abruptly make the desired changes.

II. Procedures to decrease or discourage behaviors.

A. Time-in and time-out. Probably the most often recommended disciplinary technique is time-out. As initially used, time-out was actually referred to as "time-out from positive reinforcement." Over the past two decades or so the term has been shortened to time-out, and, in doing so, the idea of removing a pleasant interaction has been ignored or forgotten. Time-in and time-out are effective from less than age 1 year to early adolescence. But, in absence of good "time-in," there really is no such thing as "time-out."

The following variables have the most impact on the effectiveness of time-out;

- It must be presented immediately after an inappropriate behavior.
- It must be presented every time the inappropriate behavior occurs.
- The time-out must remove or make unavailable an otherwise pleasant state of affairs (i.e., time-in).
- The time-out should not be considered "over" or "finished" until the child has quieted down.
- All warnings about using time-out should be carried out.
- The child should be completely ignored during the time-out, regardless of how outrageous the behavior might become. One study demonstrated that time-out becomes more effective when the time-in is "enriched" (more fun, more enjoyable) and becomes less effective when the time-in is "impoverished."

Advantages. Time-in and time-out provide parents with an effective alternative to nagging, yelling, or spanking. Their consistent use also encourages children to develop self-quieting skills (a child's ability to calm himself without the assistance of a parent). It

encourages these skills because the parents are modeling the ability to cope with an unpleasant situation and because the child is learning how to cope with feelings he experiences when they do not like something their parents have done.

B. Extinction. Extinction is defined as the withdrawal of all attention after a child engages in undesirable behaviors. The most common example of extinction is letting a child cry at bedtime instead of paying attention to the whining, fussing, or screaming. When used properly, extinction involves completely ignoring a child's behaviors and protests.

A major problem with using extinction is an initial sharp increase in the child's inappropriate behavior, called an *extinction burst*. For example, when a child is ignored during a temper tantrum or when whining at bedtime, these behaviors usually increase at first, perhaps discouraging the parents from continuing the extinction procedure. If the parents continue with the extinction procedure, however, the change in the child's behavior will usually be forthcoming.

Although extinction procedures are often successful, parents may not be able to tolerate the technique. Several modifications have been made to make extinction techniques more acceptable to parents. For example, the day correction of bedtime problems technique involves teaching the parents to use extinction for whining and fussing during the day. The parents then gain confidence in their ability to use it properly and the child learns that the parents will follow through with the use of extinction once they start it. Only after the parents and the child are familiar with the use of extinction during the day are the parents encouraged to use it at bedtime. The day correction technique is actually more effective than using extinction only at bedtime.

Advantages and disadvantages. Extinction procedures have been effective with many different childhood problems. The time necessary to educate parents on the use of these procedures is reasonable, given the constraints of primary care practices. The main disadvantage is the extinction burst and the parents' inability to tolerate their child's initial distress at being ignored.

C. Planned ignoring. The parents gradually ignore their child's behavior more and more (as opposed to introducing complete extinction abruptly). Planned ignoring may result in less of an extinction burst, but it takes longer to be effective.

D. Spanking. With spanking, caregivers can vent their own frustration at the same time they are discouraging a child from engaging in the behavior that resulted in the spanking. Additionally, spanking will often produce an immediate decrease in the child's behavior.

Advantages and disadvantages. Spanking can teach a child that hitting is acceptable. The child, after being spanked, is likely to avoid or try to escape from the caregiver who administered the spanking. Spanking can also result in other discipline methods losing their effectiveness. Thus, a child who is frequently spanked at home is less likely to be responsive to the use of extinction at daycare. Since time-in and time-out can produce virtually the same effects as spanking but without the side effects, spanking does not need to be the first alternative that professionals recommend for parents.

E. Job grounding. A form of grounding whereby the child has control over how long the grounding is in effect. When a child has broken a major rule (e.g., gone to a shopping center by bike without telling parents), he is "grounded". The child loses all privileges (including television, telephone, having a friend over, playing with games, snacks and desserts) until he has completed one job properly. The jobs, which can each be written on a 3x5 card, should be agreed upon by both parent and child during a quiet, peaceful time. The child, upon being grounded, is asked to pick from a stack of cards that are held face down by the parent. Once the job is chosen, the child is restricted from most activities until the job is completed. The parents are instructed to refrain from nagging, prodding, and reminding. As soon as the child has completed the job (most jobs should take only 5–10 minutes to complete and be tasks that the child has done many times before), he is "off grounding." Job grounding differs from traditional time-based grounding in that the child determines how long the grounding lasts and, under most circumstances, the child has the option of getting the job done without missing valued social activities.

Advantages and disadvantages. Job grounding is usually effective, it lets the child practice a job that he probably did not want to do in the first place, and it gives him the opportunity to avoid losing a valued activity. The disadvantage is that if the child has no planned activities, he may stall on completing the job until some external motivation is present.

F. Habit reversal . Habit reversal procedures were developed for use with habit disorders. Habit-reversal training requires a level of cognition not reached before a mental age of about 4–5 years.

1. Components of habit reversal:
   - **Increase your child's awareness of the habit on a daily basis**
   - Keeping track of how often the habit occurs is the only way that you and your child can tell when progress is being made.
   - On a daily basis, have your child look in a mirror while performing the habit on purpose.
   - Help your child to become aware of how their body moves and what muscles are being used when they perform the habit.
   - Have your child identify each time they engage in the habit by either raising their hand when the habit occurs, or by stating, "that was one," when the habit occurs.
   - If you see the habit occur but your child does not appear to be aware that it occurred, use a prearranged gesture or expression to help make they aware.
   - Self-monitoring: Your child can record each occurrence of the habit on a 3x5 card.
   - **Competing response should be practiced daily**
   - Have your child practice their competing response in the mirror. This helps your child become comfortable with the response and assures them that the competing response is not noticeable socially. For example, a child who is pulling their hair can practice holding their thumbs on the waist of their pants or skirt.
   - Encourage your child to use the competing response when they feel the urge to engage in the habit or in situations where the child has a history of engaging in the habit.
   - Encourage your child to use the competing response for 1 minute following the occurrence of the habit.
   - **Stress anxiety reduction procedures** (all should be practiced daily)
   - Progressive muscle relaxation training
   - Visual imagery
   - Breathing exercises
2. Parent Involvement
   - **Feedback.** Work with your child to increase awareness of their habit by helping them identify the habit when it occurs.
   - **Support and Encouragement** Encourage your child to use their competing response and praise them when they do so. Praise any noted decrease in rates of their habits.
   - Remember, although many children and adolescents will notice a decrease in their habit within a couple of days, the greatest change from using these habit reversal procedures occurs during the second and third month. Don't quit practicing after only a couple of days or weeks.

   Advantages and disadvantages. Habit reversal training is effective and has no physical side effects. The overall reduction in habit disorders and tics is also far greater with this technique than with medication. The disadvantage is the time it takes to teach and monitor, as well as the time it takes to reduce the habit disorder (usually days).

G. Positive practice is the procedure of having a child practice an appropriate behavior after each inappropriate behavior. For example, when a previously toilet trained child wets his pants, he is required to practice "going to the bathroom" 10 times; five times from the place where the accident was discovered and five times from such alternative sites as the front yard, the back yard, the kitchen, and the bedroom. When used correctly, with no nagging or unpleasant behavior on the care givers part, positive practice can produce dramatic results.

Advantages and disadvantages. Positive practice gives a child a lot of opportunities to practice appropriate behaviors. This technique is typically effective quickly. The disadvantages include the length of time necessary to implement the practice, as well as the fact that the practice should be done immediately after the inappropriate behavior, which is not always convenient.

H. Practice, Praise, Point Out and Prompt. Several of these procedures can be combined into a very effective teaching tool. For example, when a child's interrupting is a problem, they can be taught an alternative to interrupting. Encourage the parent to practice having their child gently place their hand on the parent's forearm and the parent 'o immediately place their hand on the child's hand and ask them what they want. This should be practiced daily with a reward from practicing. The parent should "point out" to their child when they wait instead of interrupting, or when a character in a book is seen to be waiting. The parent can also "prompt" their child to place their hand, for example, on Daddy's arm when they want to get his attention. This strategy combines incidental learning, modeling, reinforcement, and praise.

III. **General remarks and conclusions.**

- Although the term "behavior management" frequently has been used to refer to coercive action taken in an effort to discourage a child from engaging in inappropriate behavior, many positive alternatives are available. Generally, the emphasis should be on teaching children appropriate behaviors, rather than concentrating on reducing inappropriate behaviors.
- The single most important consideration in implementing such behavior management strategies is taking a history that can help to identify precisely what strategy should be offered to the caregiver and how to offer that strategy. The primary care provider now has a variety of behavior management strategies available for dealing with situations encountered in the provision of care to normal children with minor behavior problems.
- As with many of the "medical interventions" offered to parents from the primary care provider, the use of written handouts summarizing the treatment recommendations can be very helpful to the parent who is trying to follow their providers recommendations.

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14 Transitions

W. Thomas Boyce

The primary care clinician is often the principal source of assistance for a family or a child during periods of stressful transitions. As such, he or she is especially well placed to offer advice, construct effective interventions, and provide encouragement and empathic care during critical moments in a family's life course. It is precisely during such moments that patients and families may find themselves unusually receptive to the words, reflections, and concerns of a caring professional. What may seem at first an insurmountable difficulty can become, under the guidance of the primary care provider, an occasion for growth and renewal. Stressful transitions may become turning points in a child's life and, through an alchemy of crisis, the pain of a seemingly catastrophic event can be memorably transformed into a moment at which life was indelibly changed for the better.

I. **Types of childhood transitions.** A childhood transition is a period of swift, challenging change that may alter a child's experiences of self, life circumstances, or future possibilities and expectations. Childhood is a period of rapid and dramatic developmental change and is filled with transitional events, ranging from the birth of a sibling or starting school to the death of a beloved grandparent or a parental divorce. Such transitions can be regarded as normative or nonnormative, biological or psychosocial, and "on-time or off-time" events.

   A. **Normative and nonnormative transitions.** Normative events (e.g., entering kindergarten) are those experienced by most children under ordinary conditions growing up in the Western world. Nonnormative transitions (e.g., the death of a parent) are those that represent unexpected deviations from the normal, anticipated sequence of life events. Events deemed as nonnormative within a given society may be regarded as normative in other social or cultural circumstances. Divorce, for example, has become so prevalent in North American society that it could arguably be viewed as a nearly normative stressor for many children. Normative transitional events may be planned, as in a family's move to a new home, or unplanned, as in the changes in a family's economic condition that typically follow the loss of a parent's job.

   B. **Biological and psychosocial transitions.** Transitions in childhood can attend both biological and psychosocial changes. The onset of puberty is an example of a transition with biological origins, but it is also a transition with social and psychological consequences. The endocrine processes in early adolescence that set into motion a cascade of intricately interconnected changes ultimately transform the individual's reproductive capacity, self-identity, relationships with peers, and social role within the context of the family and community. On the other hand, religious rites of passage (such as a bar mitzvah or confirmation) are transitions that constitute points of psychosocial demarcation in the young person's emergence into the adult world.

   C. **On-time and off-time transitions.** On-time or off-time transitions depend on the timing of the event in relationship to personal and societal expectations. Pregnancy, for example, is a fundamentally different event in the life of a married 23-year-old woman than it is in the life of a 13-year-old. While the onset of puberty in a 14-year-old boy may be an occasion for celebration or relief, the same event may be bewildering and distressing to an 8-year-old boy. The meaning and adaptive significance of a transition depends in part on whether its timing conforms to cultural and biological norms regarding its location within life-course development.

II. **Factors defining stressful transitions.**

   A. **Manifestations of stress.** Not all transitions in childhood *are* stressful but many are accompanied by the behaviors and expressions of emotion that signal a child's efforts to overcome and adapt to stress. Transitions are capable of invoking a child's neuroendocrine stress response systems. Starting preschool or kindergarten, for example, has been shown to activate the hypothalamic-pituitary-adrenocortical axis, resulting in measurable elevations in the cortisol levels found in both blood and saliva and alterations in immune and cardiovascular function. Stressful transitions therefore appear capable

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What's Your Parenting Style?

Promoting the self-discipline and self-esteem of one's children often requires an emotional juggling act by parents. It is not easy to be firm and demanding one minute, then warm and affectionate the next. In addition, some adults naturally have personalities or temperaments that predispose them toward one parenting style or the other.

AUTHORITARIAN PARENTING

Parents who tend to *overemphasize* the discipline side of the equation are referred to as authoritarian. Authoritarian parents are demanding in the worst sense of the word. They are intimidators, requiring obedience and respect above all else. They become overly angry and forceful when they don't get that obedience and respect. Their love and acceptance appear totally conditional to the child. They do not listen to their kids or explain the reason for their expectations, which are frequently unrealistic. They often see their children's individuality and independence as irrelevant or threatening.

Research has shown that authoritarian parents tend to produce children who are more withdrawn, anxious, mistrustful and discontented. These children are often overlooked by their peers. Their self-esteem is often poor.

PERMISSIVE PARENTING

Parents who overemphasize the self-esteem side of the equation are referred to as permissive. They may be warm and supportive, but they are not good disciplinarians. They make only weak demands for good behavior and they tend to avoid or ignore obnoxious behavior. They seem to believe that children should grow up without any anger, tears or frustrations. They reinforce demanding and inconsiderate behavior from their children. Their love and acceptance are "unconditional" in the worst sense of the word, for they set few limits on what their children do. *Cont page 2*

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Research has shown that permissive parents tend to produce children who are more immature, demanding and dependent. These children are often rejected by their peers. Their self-esteem is often unrealistic and hard to interpret, for they often blame others for their misfortunes.

THE AUTHORITATIVE PARENTING MODEL

Parents who are able to provide for both the discipline and self-esteem needs of their youngsters are referred to as authoritative. They clearly communicate high—but not unrealistic—demands for their children's behavior. They expect good things from their kids and reinforce those things when they occur. When kids act up, on the other hand, authoritative parents respond with firm limits, but without fits of temper. They are warm, reasonable and sensitive to a child's needs. They are supportive of a child's individuality and encourage growing independence.

Authoritative parents tend to produce competent children. These kids are more self-reliant, self-controlled and happier. They are usually accepted and well-liked by their peers. Their self-esteem is good.

Logic and research, then, support the idea that children need both discipline and self-esteem to grow up psychologically healthy. Parenting expert Dr. Thomas W. Phelan deals with both sides of the equation in his best-selling book, 1-2-3 Magic: Effective Discipline for Children 2-12, and to a large extent, in its "sequel," Surviving Your Adolescents: How to Manage and Let Go of Your 13-18 Year Olds, which also recognizes the need to respect the growing independence of the adolescent.

TEMPER TANTRUMS

Temper tantrums are one of the *Six Kinds of Testing and Manipulation* tactics discussed in **1-2-3 Magic**. Displays of temper are obvious aggressive attacks. Younger children who aren't so adept with words yet, may throw themselves on the floor, bang their heads, holler at the top of their lungs and kick ferociously. Older kids, whose language skills are more developed, may come up with arguments that accuse you of being unjust, illogical or simply a bad parent.

Tantrums are often prolonged (1) if the child has an audience, (2) if the adults involved continue talking, arguing or pleading, (3) if the adults don't know what to do. As kids get older and more powerful, tantrums get more worrisome and just plain scarier. That's why we like to see them well controlled by the time a child is five or six.

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Behavior I Quiz:

1. The stability of temperament is first detectable at _____ and most evident in _____. Family, twin, and adoption studies point to a _____% heritability. About _____% of young children are temperamentally "difficult".

2. Please match the following ages with the *most effective* discipline techniques:

A. <6 mo: _____

B. 6mo – 18mo: _____

C. 18mo – 3 yrs: _____

D. 3yrs – 5 yrs: _____

E. > 5 yrs: _____

3. Please match the following 4 behavioral techniques, with the scenarios below: **modeling, reinforcement, token economy,** and **extinction.**

A. 2 year-old girl throws a temper tantrum, while shopping with her parents in Costco. Her father, embarrassed by the public outburst, pulls a Dora toy off the shelf and immediately gives it to her.

B. 4 year-old male receives stickers for each day of the week he completes three behaviors: putting dirty clothes in the hamper, sharing with his sister, and going to bed without fussing.

C. 12 year-old male frequently swears or makes crass sounds in public. His parents previously addressed this undesirable behavior with reprimands, but they have now begun ignoring him.

D. 6 year-old female refuses to clean up her toys and throws her clothes on the floor at the end of the day. Her parents admit that they have piles of undone laundry in their bedroom, and the floor of their home office is covered with piles of unfiled papers.

4. *Problem Behavior Potluck:* **Temper-tantrums** are most common between ages _____. They are often not manipulative or willful, but rather, due to _____. Tantrums that demand something should be _____.

5. *Self-reflection Question:* Review Table 77-1 in the Temperament article. Categorize yourself, your significant other, your child, or even your pet as "easy" or "difficult". **For fun, take the "Goodness of Fit" online quiz and see how you and your "other" match up!**

Behavior I Cases:

Case 1: Discipline

You uncover during a routine 3-year old well child visit that "time out" has been ineffective for Joey. Whenever Joey disobeys his mother, he is immediately told to go to his room (without further explanation). In 5-10 minutes, his mother goes to his room and tells him that he is "released" from time out. Mom occasionally asks him after a time out why he was placed in time out, and he is generally unable to remember his violation. He often gets sent to time out for the same infraction - like hitting his twin brother, running around the house with an open glass of juice, or getting up from the table during mealtime – two or three times per day. Mom instituted this time-out system 6 months ago and would like your advice about why it's not "working".

What other questions would you ask?

The following information is obtained: time out is also failing with the twin brother. Both boys are (in Mom's words) "strong-willed, independent, and stubborn at times"; in fact, when he goes to his room for time-out, he will often throw a tantrum initially before settling down with his favorite toy cars. Sometimes the tantrum lasts "a long time" – and Mom usually goes into his room to comfort him before allowing time-out to end. Dad applies time out just as Mom does, although Mom is unsure if their day care provider does time-out or if another discipline method is used. There is no method by which either parent or child knows when time-out should end.

What are the problems with Mom's application of time-out?

What recommendations would you make?

Joey's mother thanks you for your advice. As you are concluding the appointment, however, dad comes in, having just received his weekly "high and tight" trim. The Master Sergeant tells you that your advice is too "New Age" for his taste, and he's thinking of using spanking: "like my dad did, and look how I turned out!" **What is your response?**

Case 2: Temperament

A young mother presents with her 2-month-old son Brian and 4-year-old son Christopher for well-child checks. As you walk into the clinic room, you note that Brian is crying loudly in his infant carrier, and Christopher is atop your exam table, pulling all of the otoscope specula off the wall and placing them on his fingers to make "MONSTER CLAWS!" Mother appears exhausted and reports that her husband left 1-month ago from R&R to complete his year-long deployment to Afghanistan. She adds that "things are spiraling out of control" with both boys.

Brian, she reports, is "very needy". He wants to be held all the time, and she is unable to "get anything done". Brian's crying is "making her miserable . . . and angry", and she confesses that she feels "like a bad Mommy". Her husband's parents, with whom she has moved in while her husband is deployed, criticize her for "spoiling" Brian. She too worries that if she picks Brian up too often, he will grow up to be too dependent on her.

Based on this information, how would you characterize Brian's temperament?

How would you counsel mother regarding Brian?

Mother seems reassured by your advice, and thankfully Brian has cried himself to sleep. Meanwhile, you notice that Christopher has crawled under your desk and is poised to pull the computer cords from the wall, as you are mid-AHLTA note. Mother apologetically scoops Christopher off the floor, and she explains that he "always like this . . . running around, out-of-control . . . misbehaving . . . never listens to me." She reports that he is generally very friendly and pleasant to others, but "when things don't go his way, he flips out". She admits that his behavior has gotten "much worse" since they moved in with her in-laws, who she also notes previously lived a very quiet and regimented life as dual-military retirees.

Based on this information, how would you characterize Christopher's temperament?

How would you counsel mother (and her in-laws) regarding Christopher?

Is ADHD a concern? If so, recalling what you discussed in Devo IV, how will you proceed?

Case 3: Problem Behavior Potluck:

You receive a phone call from a father of a 25 mo female named Susie. Susie's father is very concerned because the CDC on post has told him that they may not be able to take care of Susie too much longer if her behavior does not change. Susie is biting other children and hitting other children when they take her toy. He would like your advice.

What other information would help you give appropriate advice?

Susie's father reports that she is an only child. She is aggressive not only at daycare, but also at home. He is worried because if she is no longer able to attend daycare there will be no one able to care for her while he and Susie's mother are at work. **What is your advice?**

Behavior I Board Review:

1. The parents of a 2-year-old boy are concerned because they are having trouble managing his behavior. His language and social development are age-appropriate, but he frequently goes to his closet and throws his clothes on the floor. He also enjoys throwing food at the dinner table and would rather run around the dining room than sit and eat his food. His parents ask your advice on how best to manage his behavior.

Of the following, the MOST appropriate response is to
A. evaluate the child for attention-deficit/hyperactivity disorder and counsel the parents about the disorder
B. explain about setting limits and realistic behavioral expectations for toddlers
C. explain how to set up a behavior system using a token economy
D. reassure them that his behavior will improve with time and schedule a follow-up appointment in 6 mo.
E. refer the boy for behavioral therapy

2. The parents of 9-month-old twins ask you if they should be concerned about the vast behavioral differences between the children. They explain that the boy whimpers when he is hungry, but the girl has a vigorous scream. The boy plays quietly while his diaper is changed, but the girl is constantly moving. Finally, the girl tends to display her emotions with strong intensity, while the boy is more easygoing.

Of the following, your BEST response is that
A. the behaviors the infants display are typical of twins
B. the behaviors the twins display are due to their different temperaments
C. the girl's behavior is indicative of a developmental disorder that should be monitored closely
D. the parents need behavioral counseling to improve their parenting skills
E. the parents should respond to both infants similarly

3. One of your 2-year-old patients has prolonged crying and screaming episodes every time her parents deny her access to something she desires. The mother reports that the girl often throws herself on the floor, kicking and thrashing about for long periods of time. She asks you how she should handle her daughter's behavior.

Of the following, your BEST suggestion is that the parents should
A. consider giving in to the girl only when she is outside of the home to avoid a major tantrum
B. give the daughter 10 minutes of time-out for each temper tantrum
C. move the girl to a safe place if needed and ignore her when she has a tantrum
D. offer the child a treat if she calms down
E. physically restrain the child until the tantrum is over

4. A 3-year-old boy has a history of biting his parents' cheeks when he does not get his way, which they have always considered cute, calling it "love bites." His child care teacher has informed the parents that he is frequently biting other children. The boy's parents are concerned that he may be removed from his child care program and ask for your advice about how to stop this behavior.

Of the following, the BEST response is to
A. advise the parent to change child care centers
B. instruct the parents to set up a reward system for not biting
C. recommend treatment with a stimulant to help decrease the behavior quickly
D. explain to the child that his behavior is not acceptable and may cause him to be removed from care
E. tell the parents it is acceptable to gently bite the child or tap his backside to stop this behavior