

# Challenging Behavior

by Holly M. Bishop and Douglas S. Baird

It seems as if everyone in early childhood education is talking about children with *challenging* or *difficult* behaviors. The widely-publicized study of preschool expulsions by Walter Gilliam at the Yale Child Study Center, documenting the high rate of three- and four-year-old children expelled from various categories of preschool settings because of disruptive or aggressive behaviors, brought a lot of these concerns and issues to a head. What

can we do to help children and their families, and the teachers and providers who care for them, before children's behavior escalates so far that staff gives up on teaching and supporting them?

One of the findings of the Gilliam study was that programs with access to some kind of mental health consultation have lower rates of expulsions. At Associated Early Care and Education we have been providing mental health and social service support to our child care and early education programs for over 20 years, and we do not expel children from our programs.

Associated provides programming from birth to school in centers and family child care homes for a multi-lingual, multiracial, and multicultural population of families who are eligible for publicly supported early education and care. About one in ten of the children in our programs have active cases with Massachusetts' protective services agency. Many of these families struggle for stability in their work and family lives. Typically, these are children likely to present a high incidence of behavioral issues.

We have an approach to working with children and their families that is deeply rooted in inclusion — identifying successful strategies, child by child, with their family, directed to success. Our experience teaches us that the solutions for children whose behavior is out of control are neither simple nor singular. The problems need to be addressed on at least three levels: the individual child, the classroom or family child care environment, and the family. In the absence of intervention on any (and all) of these three levels, the solution is unlikely to be found.

Community stressors — poverty, homelessness, violence, pervasive substance abuse, lack of community support or connections with social and faith institutions — surely add to toxic environments for young children. It is also true that children with behavioral difficulties are not all from communities with limited resources. There is a growing incidence of asocial, disconnected, aggressive, and sometimes explosive children from apparently successful families living in well-founded communities. Advocacy and systemic intervention aimed at improving community conditions, while crucial, is beyond the scope of this paper.

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## From the child's point of view

In order to understand better the meaning of challenging behavior, sometimes it is helpful to try to *feel inside of*, or empathize with, a child's experience. What does it feel like to be out of control of one's feelings, at any age? What is the internal experience that usually accompanies aggression or disruptive, defiant behavior? Do we think this child is enjoying himself? Of course, these behaviors are signals that something is not right in the child's experience. The child is communicating the pain and distress of this *not-rightness* to the adults around him, in the way that children under six mostly do communicate about important emotional issues, i.e., through behavior. So the first level of intervention is to see how much information about the problem can be gathered from observing and interacting with the child himself; watching and recording the concerning behaviors very closely; trying to identify common precursors and/or results of the behaviors; forming ideas or hypotheses about what is going on for this particular child. At this stage it is important to rule out any medical condition or physical problem that may be causing the behavior, such as poor hearing or undiagnosed pain from some hidden condition like dental decay.

When our mental health staff is asked to help out with a child who is exhibiting these kinds of behaviors, the first thing we do is go into the classroom or provider home and observe the child and her interactions with others. Through observation and through teacher or provider report, we identify what kinds of circumstances seem to precede or trigger the child's *meltdowns*, aggression, or out-of-control behavior. We also note what generally happens as a result of the behavior, i.e., what kind of attention results? We talk with the teaching team or provider about how they see the child and what strategies they have already tried to improve things.

## From the teacher's point of view

Sometimes this observation and conversation give rise to immediate suggestions for how the adults in the situation could engage differently with the child or provide structural support in the classroom to lessen the behavior at issue. We try to help the teacher/provider understand what the child's experience might be, what he might be feeling, to frame the behavior as something other than *bad behavior*, or *acting out*, or a power struggle between the child and the adult. We suggest things like working to increase the child's sense of safety in the setting, or ways to help the child feel more valued or respected, as well as ways to alter routines in order to avoid the observed triggers and/or secondary gains the child may be obtaining from the behavior. We urge the teachers to write down every incident that happens, so we have objective information to draw conclusions from and to share with the family.

Sometimes by the time a consultation happens, the teacher or home provider and the child have already built up an unconstructive recurrent repertoire of mutually unsatisfying interactions, which polarizes the situation and makes both members feel frustrated and hopeless about the situation. The child's communication in this dialog is usually behavioral — the solutions must also be behavioral. Providing the adult teacher with that behavioral repertoire is the essence of effective intervention, since it is, if done well, prevention.

## Engaging the family

In most cases a crucial step is immediate contact with the family. In the majority of situations with the most extreme kinds of difficult behaviors, such as daily or very frequent

episodes of aggression or inconsolable negative emotion, the family or home situation holds the most important key to helping the child.

Whenever possible we set up a meeting with the parents or primary caretakers, the child's teachers, the program director, and the clinical social worker or mental health consultant. In the meeting we try to arrive at a mutual description and understanding of the problem. Then we agree on a plan of action that may include coordinated responses to some of the child's behaviors both at home and at school, additional services we feel the child and family might benefit from, and a plan for ongoing communication between school and home. In some cases these additional services are provided on-site by the clinical team, including therapeutic play sessions with the child; in other cases we suggest referrals for evaluation for special needs services of various sorts. Early intervention services for children under age three are a critical component for some children.

In some situations where we know ahead of time that the family or parents may be particularly vulnerable or in frequent crisis, we may ask the parent or parents to meet initially with just the clinical social worker, who reassures the parent that the child care program does not see the child only as "a problem," and that we understand that the parent is trying to do the best she can for her child. (We believe that this assumption is an important part of a strengths-based approach to families in crisis: all parents, with very rare exceptions, want the best for their children and do what they can at any given time to care for them successfully, sometimes with limited internal or external resources and/or knowledge about parenting.) We try to get more information about the home situation, explore how the parent sees the child's functioning at the present time, see if the parent wants to

share anything that might be stressful for the child or family right now. We use all our clinical skills to communicate support rather than blame or confrontation to the parent, and begin to build a relationship that may be the basis down the road for assisting the parents to increase their capacity to support their child.

The family piece of this comprehensive plan is crucial for a variety of reasons. We are all familiar with the saying "Parents are children's first and most important teachers." This truth contains within it the key importance of a child's first attachments, his relationships with his earliest caregivers. The stability, consistency, warmth, and responsiveness of these early relationships will play a major role, along with the child's temperament and other factors, in the formation of the child's sense of self, his ability to feel safe and secure in the world, to learn new things, to trust new caretakers, to get along with others. Children, from almost the beginning of life, establish expectations about how the world will treat them, for better or for worse, and bring these expectations into our education and care settings. These underlying feelings and ideas about whether they are good or bad, whether adults are trustworthy or scary, whether their needs will get met or not, are expressed in children's behavior. Long before children can begin to use language to make their needs known, behavior is the language they speak and adult behavior the language they understand.

Many children we care for have not had an ideal start in the world, and may already be dealing with the effects of less-than-optimal early caretaking and other kinds of traumatic situations and events. Children have sometimes experienced difficult separations from their original caretakers, or they have

witnessed people they care for being hurt, have been hurt themselves, or live in families where there is constant stress and tension due to economic hardship, substance abuse, or mental illness.

Sometimes children are so confused by the intensity of their own feelings of loss, fear, or anger that these feelings erupt periodically in behavioral explosions. Very often they cannot handle normal levels of daily frustration or anxiety because the levels of these feelings and of chronic physiological tension created by stress are already so high.

The good news about these early learnings is that they are not cast in stone. The *hard wiring* taking place as a child emerges through the first few years can be repaired or *wired around*. New experiences of soothing and understanding, consistency, and stability can start to create new learnings, new expectations, and new neurophysiological paths. Teachers and therapists form significant remedial relationships with traumatized children, and these relationships can have important effects. When we can help parents and caretakers join in these efforts and learn new ways to help their child recover from early hardship, these effects are many times bigger and more lasting. In our early education and care programs, we need to intensify our efforts to reach, engage, and involve parents and families of all our children, but most especially the parents and families who are in the most crisis and whose children manifest the results of that crisis in their behavior.

### A multifocal comprehensive plan

In successful interventions, these ingredients and strategies come together. When teachers and

providers see the child and her behavior in a broader context and are able to make changes in classroom routines, structures or ways of relating to the child that will help her feel safer and more relaxed, de-escalation usually occurs. Formulating a mutually agreed on and continually reinforced action plan will help with the problem behaviors. When indicated, forming ongoing supportive therapeutic relationships with both parent and child will likely improve long-term functioning. We believe it is crucial to provide these supports, resources, and interventions for all children who need them. This kind of attention to behavioral and social-emotional issues in our early education and care programs will allow our work with vulnerable young children to fulfill its true promise of making a lasting, positive difference in the lives of children and families.

### References

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