Child Behavior

Spanking

When I discuss spanking{ XE "spanking" }, I am not referring to punishment. One or two light slaps on the "bottom," pinches or squeezes, serves the purpose of getting your child's attention. It is not for punishment. Instead try "time outs{ XE "time outs" }," withdrawal of favors or avoidance. If there are tantrums{ XE "tantrums" }, and your child could get hurt or hurt others, pick your child up and put him or her in a "time out" spot or place where he or she can't get hurt. Spanking an adolescent can be counterproductive. Withdrawal of privileges works most of the time and bargaining can produce good end results.

Never use belts, sticks or other hard items which could injure your child.

In todays environment parents sometimes are reluctant to control their children for fear of abuse charges, but firm measures are sometimes needed to distract your child and get them on-track to appropriate behavior outside the home.

Last reviewed January 9, 2006

Spoiled child

Spoiled children{ XE "spoiled children" } are inconsiderate of others, demand to have their own way, find it difficult to delay gratification, and are prone to temper outbursts. They are difficult to satisfy and do not remain satisfied long. They are unpleasant to be around, even for those who love them. One often gets the impression spoiled children do not enjoy being with themselves.

A common misconception is children are spoiled by overindulgence. Indulging children is one of the joys of being a parent or grandparent. Instead, spoiling results when you give material things, accept behavior without critical review or fail to provide essential guidelines for acceptable behavior.

Some parents believe it is abnormal for infants to cry except when they are hungry or need changing. Most young infants cry two hours or more a day, perhaps to relieve normal daily tension. Parents worry that holding their fussy baby will *spoil* or make the baby excessively demanding in the future. Research indicates colicky babies benefit from increased holding and interaction. However, after three to four months of age, infants may use crying in a manipulative way.

Many parents are unprepared for their child's intense curiosity and urge to explore the environment. Parents find themselves following children around, cleaning up messes and snatching them away from danger. Every comment seems to be "no!" Parents begin to believe the worst — their child is spoiled. They attempt to regain control by increasing the severity and frequency of punishment. The child is then repeatedly frustrated by normal impulses which create a state of continuing conflict. Parents should be forewarned of this developmental stage and not aggravate the situation by overreacting. A toddler's curiosity is normal and not a behavior problem.

Parents should child-proof their homes. With most of valuables and fragile items put away, you can give your child the freedom to learn without worrying that your child will hurt himself or herself or other household items.

Young infants have difficulty distinguishing between themselves and the people around them. At two years, infants start to develop more autonomy and an awareness of his ability to make decisions and influence events around them. This period is often described as the "terrible twos{ XE "terrible twos" }," and applies from 18 months until three years. During this stage, children resist efforts to control activity. Parents may think this resistance to their authority is an indication their child is becoming spoiled. In fact, negative two-year-olds really are showing they have minds of their own. The parent should try to avoid conflict and confrontation. Don't offer a choice of actions when there is no choice. Don't ask the child to say how he or she feels when in the end it will make no difference. Let your child know about what action is expected firmly and calmly. When appropriate, let your child make a choice

when either choice is acceptable. This allows your child to feel some degree of control without your giving up any authority.

Hyperactive children

A hyperactive child{ XE "hyperactive child" } worries parents, gives teachers a headache, and is a common concern parents ask about during office visits

A diagnosis often attached to a true hyperactive child is Attention Deficit Hyperactivity Disorder{ XE "attention deficit disorder" }. Many different behaviors are included in this disorder. It may be caused by a problem with the development of the central nervous system (brain). There may have been a chemical and structural imbalance in the brain that has been exacerbated by the child's environment. No chemical tests exist to determine the extent of problems in the brain. Psychological testing is sometimes used to determine if this disorder is present.

Hyperactive children are excessively impulsive{ XE "impulsive" }. These children have negative attitudes, great emotional up-and-down mood swings, and are difficult to discipline. Negative attitudes result in loss of self-esteem and may lead to behaviors ranging from boastfulness to delinquency. These behaviors complicate the child's healthy development. Only a minority of these children "outgrow" their symptoms completely or do very well despite their problems. Many are plagued by antisocial behavior patterns, chronic underachievement, problems with substance abuse, and even criminal behavior.

Treatment of this condition has proven to be very difficult. Children do better they grow up in a stable home environment where adults provide structure and consistency. Discipline must be firm but not physical or verbally abusive. This special approach to discipline must be applied to school and home settings throughout the child's developing years.

The only chemical treatment that seems to benefit a majority of these children is central nervous system stimulants such as Ritalin, Concerta, Adderal, or Metadate{ XE "Ritalin" }. There are newer medications that may have beneficial results without requiring a controlled substance prescription. These medications change the child's behavior briefly while the medicine is in the system. Symptoms may improve, but the child will still not act like an unaffected child. Side effects may be seen, but they will disappear after the medication is discontinued. Medications alone will not improve the ultimate outcome without other psychological treatment. Most of the dire consequences of Ritalin publicized by the media confuses the side effects of the medication with the symptoms of the disorder. Currently recommendation from professional pediatric societies like the ASmericvan Academy of Pediatric recommend that one of these medication be considered along with other psychological therapies.

Last reviewed January 9, 2006.

Temper tantrum

Temper tantrums{ XE "temper tantrums" } are as difficult for children to deal with as they are for those around them. Children scream and loose control because they cannot have their own way. You may feel angry, frustrated or even scared. You may wonder what you have done wrong. Rest assured, almost all youngsters have tantrums between the ages of one and three years. Tantrums are a normal part of growing up and they will stop before the age of four. If your child has angry outbursts after that age you should call our office for an appointment.

What is a tantrum?

Young children are eager to take control. They want to be independent and they want to do more than their skills and safety allow.

They also want to make their own choices and do not cope well with disappointment or restraint. Some temper tantrums are for attention; others are to avoid doing something or to protest not having their own way. Tantrums are a child's way of showing frustration and anger.

Children of this age sometimes cannot fully understand their parents and other adults. They do not know all the words needed to describe their feelings and needs. Also, they have not yet learned to solve problems. Instead, they act out their anger and frustrations by crying and

screaming, thrashing and head banging, breath holding, breaking objects, or being mean to others. The following are examples of mild temper tantrums that can and should be ignored: crying and screaming for attention, whining to get attention (some find it helpful to say, “I can’t understand you when you are whining. Please talk in a normal voice”). Minor displays of anger can include slamming doors, sticking out the tongue, or making faces, or pounding or kicking the floor, wall or door.

Temper tantrums are like safety valves that let off steam when the pressure gets too high. Parents need to accept that temper tantrums are a result of the child’s inner struggle in growing up. They are normal and an expected part of a child’s development.

What to do?

When your child has a temper tantrum, *try* to remain calm. If you are loud and angry your child will copy you. Shouting at them to calm down may make the situation worse. Stay peaceful. Most of all, do not get upset or angry with your child or hit or spank them. Temper tantrums should be ignored unless your child is damaging things. In a public area it is appropriate to remove your child as a courtesy to the people around him or her.

Some temper tantrums are too violent for parents to ignore. When this happens, children should be taken away from the scene of the tantrum to another room. A parent should stay with them. These types of temper tantrums include such behavior as: hitting or kicking parents or others; throwing things; continued screaming or yelling; and having tantrums in public places.

Consult me if your child shows any of the following signs: Tantrums continue or get worse after age four; injures self or others; destroy things during tantrums; has frequent nightmares; loses toilet training skills; frequent headaches, or stomachaches; clings to parents; displays persistent negative moods.

Bedwetting

Nearly 20% of five year olds frequently wet**{ XE "bedwetting" }** the bed at night and more than 10% of six year olds still wet the bed. Some three year olds, if taken for a late night trip to the bathroom, will make it through the night dry. Expect an occasional accident, but avoid punishment or threats of punishment. Children should not be kept in overnight diapers until they are 100% dry, because modern diapers are so absorbent they do little to encourage your child to develop any self control.

Children who have been dry for many months or even years may suddenly wet the bed**{** XE "wet the bed" **}**. Children may regress because of the arrival of a new baby, a move or a severe stressful event. Occasionally a urinary tract infection is the cause of wetting, but there will be accompanying symptoms like frequency, burning or fever.

Bedwetting should not be considered unusual until your child is over 6 years. Try to remain calm and matter a fact. Most children are sensitive about the fact they have wet the bed. Your child often cannot prevent wetting the bed. Bladder control**{** XE "bladder control" **}** is a complex developmental and neurological process that occurs as children mature. Making the child feel guilty about bedwetting may only delay resolution of the problem. Be supportive of your child.

Your best course is to ignore the problem and wait it out. After age six, you and your child may need to make a joint effort to solve the problem. Encourage fluids during the morning and afternoon, but discourage them several hours prior to bedtime. Have your child urinate just before bedtime. Fluids during the day ensure the bladder is big enough and urinating ensures it is as empty as possible at bedtime.

Try a reward system next. On a calendar, chart successes with stickers. Try this for weeks or months. If you do not see any progress, consider awakening your child in the evening after a few hours of sleep. This will empty the bladder and decrease the chances of wetting the bed. Adjust to an earlier hour if your child is already wet after waiting several hours. Older children who still wet the bed can help with laundering so they understand they are responsible for the consequences of their actions.

Alarm devices**{** XE "alarm devices" **}** are useful in children, 8 and older. They can be obtained at most major department stores and medical supply houses.

A medicated nasal spray or tablet (DDAVP{ XE "DDAVP" }) helps many children who did not respond to other therapies. This drug is safe and has a good success rate but is expensive. Treatment may require prolonged use depending on family history. The medication once started can produce a dry night the first night and be used just for special events like a night-over-at-a-friends. The cost is two to four dollars a day (2005).

The biting child

Many parents ask me questions regarding their child who has been biting { XE "biting" }other children or family members. I read an article discussing biting children and hope you enjoy the summary of some of the important points.

"We never bite people."

Biting is an unacceptable aggressive behavior. Parents are concerned about the dangers of infection. If your child bites a friend's child he or she runs the risk of rejection from the friend's home or at least severe embarrassment. Even more significant is when your child bites at a child care facility because most parents want a biter removed from their child .

Very young children under one year are teething, but older toddlers will bite when they are angry or frustrated.

Some suggested solutions include these following ideas. Establish a rule like "We never bite people." Biting hurts and even a toddler understands the consequences of acts unacceptable to their parents.

Interrupt biting with a sharp "NO." Be sure to use a displeased voice and look directly into their eyes. Try to interrupt biting if you catch him or her in the act. Close supervision can be very important,

Never laugh when your child bites, and never treat it like a game. Other family members including older children should follow your rules. Don't let your child's threats of biting influence your own behavior by giving into the biters demands. Once you recognize the biting is more than random behavior and attempt to modify their behavior should begin right away. Discuss your plans for dealing with the biting with the child-care giver. they need to understand how you manage the problem and will follow your desires.

Suggest an acceptable substitute behavior. Tell your child he or she should come to you if they want something or need help. If your young toddler tends to chew everything provide toys that are design for the punishment and will not harm them. It would be a good idea to carry this chewable toys like a teething ring around for a short while.

If your child bites other people, send him to a boring place for a time out period. If he attempts to bite you say "NO" or give him a firm squeeze. Put him down and walk away. Another method is to deprive him of a favorite toy for a day.

Never bite him back. Biting back will make him mad that you hurt him and convince him that it is Okay to bite if you are bigger. Also, it is not appropriate to use physical force like slapping, pinching a cheek, or washing out the mouth with soap. If your child is aggressive, avoid all physical punishment such as spanking. Also avoid love bites, since your child will not be able to distinguish them from painful biting.

Praise your child for not biting. The most important time to praise is when he is around children he has bitten or in a similar situation where you anticipate he may bite again. Give him a kind remainder about biting just before the high-risk event and praise him after the event for his good behavior.

I would be concerned if this behavior persists for more than four weeks. I would be concerned if he bites himself and hurts himself intentionally. It is important to notify the office if you believe he or she has several other behavior problems.

Last reviewed January 9, 2006

Your child's diet and stomach pains

Some children with persistent stomach pains{ XE "stomach pains" }, diarrhea, bloating, cramping, or excessive gas, have difficulty digesting certain foods (carbohydrates). Some of the common sources of carbohydrates, I have listed below. If your child was eating any of these foods lately, let me know. If I need to help your child, I can adjust some items in his or her diet.

One carbohydrate recognized to cause a problem for many children is called lactose{ XE "lactose" } . This is a sugar found in milk and all dairy products. These are a few examples of common foods containing lactose. Cow milk in most forms - whole, low fat, skim, condensed and butter milk. Ice milk or Ice cream, Mozzarella, and cottage cheese, Frozen yogurt, Milk-based pudding, macaroni and cheese

Other dairy products have a lower lactose content and are less likely to cause problems. I advise you to avoid them because children with intestinal infections can be particularly sensitive. Examples of these kinds of foods are: Most cheeses: American, Colby, Swiss, cheddar, Parmesan, Camembert, and cream cheese. Margarine that contains milk. Yogurt with active culture lactose is not the only carbohydrate that can cause stomach ache, diarrhea and cramps. In some cases symptoms can be caused by other carbohydrates like fructose{ XE "fructose" } and sorbitol{ XE "sorbitol" }.

Some common foods high in fructose are: Sodas sweetened by high-fructose corn syrup, fruits, chewy fruit snacks, fruit drinks and especially apple, grape and pear sherbets.

Foods high in sorbitol are:

- Apple juice and apple cider,
- Apples, prunes, pears and peaches.
- “Sugarless” candy or gum sweetened with sorbitol
- Fruit juice popsicles
- Fruit canned in concentrate apple or pear juice often labeled “lite.”
- Fruit juice drinks, Pear juice
- Medications flavored with sorbitol

Some foods labeled as high in fiber can cause intestinal symptoms too. Common foods like oat bran muffins or bread high-fiber breakfast cereals.

School phobias

All children experience periods when they don’t want to go to school. A school phobic child{ XE "school phobic child" } has many days when they miss school usually for vague reasons. The child does not act happy or well with symptoms common to anyone who is worried. These symptoms include vomiting, diarrhea, fatigue, headache, stomach, and dizziness.

These children are afraid of leaving home and growing up. They come from normal families who represent the best of child care and concern. They provide all that is needed to develop in a loving family. The child finds it difficult to leave home. Different reasons might appear on the surface such as a difficult teacher, a class bully or an embarrassing experience. The reason behind these superficial issues is the child lacks the self-confidence to leave home and develop on their own without the family or parents. Some children who seem to show the highest risks for this behavior is an only child, the last child or a child with chronic illnesses.

Treatment for this behavior can include these type of objectives. The child must return to school and must attend daily. After a very short time their confidence increases and their enjoyment of school increases. Expect your child to be reluctant to return to school and remind him or her of the importance of school. You are required to send them by state law and you or your child would not want to violate the law. Each day their confidence will increase and their reluctance will disappear. Each morning the child may complain of various complaints that increase as the time to leave for school approaches. Send them to school anyway. Don’t ask about illness because that might set up a situation in which their complaints reappear. If one parent is better at the discipline necessary to enforce school attendance then it will be their task to be the primary person to reinforce the message for school attendance. It sometimes helps to travel to school with one or more school mates. If there are major concerns about the wellness of the child because of new complaints or severity of complaints then it would be important to have the child seen the same morning. If all is proven non serious then a return to school can be arranged later the same morning or at noon.

It will be helpful to discuss the situation with the school nurse who can reinforce the return to class after a brief rest or attention to the complaints. The school teacher will need to know so that particular activities that produce great anxiety can be avoided in the beginning. The

school is experienced with children who have fear of school because it is a common occurrence.

A useful tact to take is to increase your child's play time with classmates and school friends. It is understandable for parents who like to spend time with their children to be reluctant to give up precious hours. But it is essential to build up the child's self confidence away from the family structure and security. Consider invitations of classmates to the home. School related activities are encouraged.

Most school phobia is worked out over time without psychological or psychiatric counseling. If you feel you have exhausted all your options then I will be happy to discuss a therapist for the child and family.

Last reviewed May 6,2005

Bedtime

A common question asked is what to do about toddlers who won't stay in bed { XE "bed time problems" } and keep getting out of bed or calling for you. Many parents speak about the little amount of sleep their child is getting when the major concern is about the lack of sleep the parent is getting. It is obvious the child needs rest and will develop normally under routines and regular house rules. It will not help to beg, bargain or threaten. Attempting to reason with the child is natural but fruitless.

You must decide when it is appropriate for child to be put in his or her bed. You need your rest and time for yourself. Once you decided, set up a regular routine about the tasks that need to be done before bed and start some regular pattern you will follow nightly. An early evening snack may be the starting point of the end of the day, bathing or a story. However you set up your routine, I recommend a story or quiet time with your child before bed as a part of the routine. Kiss them good night and then no other excuses like a second glass of water, another story, bugs, furniture moving, monsters or reciting some earlier events are acceptable. If the child gets up quietly pick them up and return them to bed. This behavior might repeat itself over and over. You must quickly get up and return them to bed whether it happens five times a night or twenty times. It will be become apparent sooner or later you mean business. Please, don't give up or give in because you will have to start over at the beginning if you deviate from your pattern. Good luck, this always works. The suggestions for that 7 to 9 month old who wakes at night "to eat" or whatever is slightly different.