Children’s Well-Being: What It Is and How to Achieve It

NAEYC Standards Chapter Links

- #1 a and b: Promoting child development and learning
- #2 a, b, and c: Building family and community relationships
- #4 a, b, c, and d: Using developmentally effective approaches to connect with children and families
- #5 a, b, and c: Using content knowledge to build a meaningful curriculum
- #6 b, c, d, and e: Becoming a professional

Learning Objectives

After studying this chapter, you should be able to:

- Explain how the preventive health concept differs from traditional ideas about health care.
- Identify and describe several national programs that address children’s health needs.
- Discuss how health, safety, and nutrition are interrelated.
- Describe typical growth and developmental characteristics of infants, toddlers, preschool-age, and school-age children.
- Discuss ways that teachers can be proactive in promoting children’s wellness in the areas of injury prevention, dental health, physical activity, and mental health.

Our ideas about health, disease, and the health care system have undergone significant change in recent years. Public attention is gradually shifting from a mode of dependency on the medical profession for treating diseases and chronic illnesses to a realization that individuals must assume some personal responsibility for their own well-being. In part, this change is being fueled by escalating medical costs, lack of health insurance, and disabling conditions for which there are no present cures. In addition, and perhaps even more significant, are the research findings that demonstrate positive health outcomes when people adapt healthy lifestyle behaviors (Butterfoss & Cohen, 2009; DeVault et al., 2009; Mirvism & Clay, 2008).
Chapter 1  Children’s Well-Being: What It Is and How to Achieve It

The Preventive Health Concept

The concept of **preventive health** recognizes that individuals are able to reduce many factors that threaten personal wellness (Figure 1–1). It implies that children and adults are able to make choices and engage in behaviors that improve the quality of life and lessen the risk of disease (Guyer et al., 2009). This includes practices such as establishing healthful dietary habits (eating more fruits, vegetables, whole grains), practicing safety behaviors (wearing seat belts, limiting sun exposure), engaging in daily physical activity, and seeking early treatment for occasional illness and injury.

The early years are an ideal time for children to begin establishing preventive behaviors that will foster a healthy, productive lifetime. Young children are often more receptive to new ideas and have fewer unhealthy habits to overcome. Teachers and families can also capitalize on children’s endless curiosity and take advantage of learning opportunities throughout the day—planned as well as spontaneous—to teach positive health, safety, and nutrition practices.

Although the preventive approach emphasizes an individual role in health promotion, it also implies a shared responsibility for addressing social and environmental issues that affect the quality of everyone’s well-being, including:

- poverty and homelessness
- **food insecurity**
- inequitable access to medical and dental care
- adverse effects of media advertising
- substance abuse (e.g., alcohol, tobacco, drugs)
- food safety
- air and water pollution
- discrimination based on diversity
- unsafe neighborhoods

**Figure 1–1  Examples of preventive health practices.**

A preventive health approach involves a combination of personal practices and national initiatives.

On a personal scale:
- eating a diet low in animal fats
- consuming a wide variety of fruits, vegetables, and grains
- engaging in aerobic and muscle-strengthening activities regularly
- practicing good oral hygiene
- using proper hand washing techniques
- avoiding substance abuse (e.g., alcohol, tobacco, drugs)
- keeping immunizations up-to-date

On a national scale:
- regulating vehicle emissions
- preventing chemical dumping
- inspecting food supplies
- measuring air pollution
- providing immunization programs
- fluoridating drinking water
- monitoring disease outbreaks

**preventive health** – engaging in behaviors that help to maintain and enhance one’s health status; includes concern for certain social issues affecting the populations’ health and environment.

**food insecurity** – uncertain or limited access to a reliable source of food.
Children can begin to develop preventive health behaviors.

In addition to helping children learn about these complex issues, adults must also demonstrate their commitment by supporting social actions, policies, and programs that contribute to healthier environments and lifestyles for society as a whole.

**National Health Initiatives**

The positive health outcomes that are achievable through preventive practices continue to gain increased public interest, especially with respect to young children. Poor standards of health, safety, and nutrition have long been acknowledged as significant barriers to children's ability to learn and to ultimately become healthy, productive adults. As a result, a number of large-scale programs have been established in recent years to improve children's access to preventive services. Descriptions of several initiatives follow; information about federal food programs for children is located in Appendix C.

**Healthy People 2020**

In 1990, the U.S. Department of Health and Human Services issued an agenda entitled *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, which outlined twenty-two national health priorities, many of which addressed the needs of children (Office of Disease Prevention & Health Promotion, 2000). The purpose of the original document was aimed at improving the nation's standard of health through increased public awareness, dissemination of health information, interagency collaboration, and community participation. It placed significant emphasis on the need for individuals of all ages and backgrounds to assume active responsibility for their personal well-being.

The latest revision, *Healthy People 2020*, continues to uphold and strengthen the philosophy of health promotion and disease prevention. Health priorities identified in the revised initiative focus on newly emerging public health risks as well as a continuation of existing concerns, such as heart disease, obesity, and diabetes. Emphasis is placed on the importance of assuming personal responsibility for well-being and the need for improved access to preventive health services through agency collaboration and coordination (Table 1-1). The *Healthy People 2020* goals and objectives continue to have direct application for schools and early childhood programs and can easily be incorporated into existing efforts to promote children's health and development. For example, teaching children positive ways to manage anger, incorporating more physical activity into daily classroom schedules, and creating safe learning environments reflect teachers' commitment to the ideals highlighted in the *Healthy People 2020* initiative.

**National Children's Agenda**

A similar Canadian proposal aimed at health promotion for children is outlined in a report entitled, *A National Children's Agenda: Developing a Shared Vision*. This document presents a comprehensive agenda of goals and objectives for addressing children's critical health care and safety needs. It also embraces the importance of the early years and supports the vision of creating a unified approach to helping children achieve their full potential.
Children's Health Insurance Program (CHIP) The Children's Health Insurance Program (previously known as the State Children's Health Insurance Program or SCHIP) was recently reauthorized and expanded to serve an additional four million uninsured income-eligible children and pregnant women (U.S. DHHS, 2009a). Revised eligibility guidelines also increased the number of families that qualify for assistance. This program is administered in each state through annual appropriations from the federal government and requires the states to submit a Child Health Plan describing how the program will be implemented, how eligibility will be determined, and how eligible children will be located.

Approximately 7.4 million children and 335,000 adults were enrolled in CHIP-sponsored plans during 2008 (U.S. DHHS, 2009a). Services covered by this plan include free or low-cost medical and dental care, immunizations, prescriptions, mental health treatment, and hospitalization. Improving children's access to preventive health care contributes to a better quality of life and ability to learn. It also results in significant cost-saving benefits that can be attributed to early identification and treatment of children's medical and developmental problems (Simpson & Fairbrother, 2009).

Healthy Child Care America The primary objective of the Healthy Child Care America (HCCA) Initiative is quality improvement in early childhood programs. HCCA, supported by the U.S. Department of Health and Human Services, the Child Care Bureau, and the Maternal and Child Health Bureau, was established in 1995 to coordinate the mutual interests of health professions, early education professionals, and families in addressing children's health and safety needs in out-of-home programs. The program is administered by the American Academy of Pediatrics (AAP) and has been instrumental in launching several large-scale educational campaigns, including Moving Kids Safely in Child Care, Tummy Time, Back to Sleep (for parents), and Back to Sleep in Child Care Settings. Grant-supported offices, located in every state, have been established to evaluate and strengthen existing community infrastructure and to assist with new initiatives for improving children's health and safety in early childhood programs and access to preventive health care. Extensive resource information is provided on their website (http://www.healthychildcare.org).

National Health and Safety Performance Standards for Child Care National concern for children's welfare led to a collaborative project between the American Academy of Pediatrics (AAP), the American Public Health Association (APHA), and the National Resource Center for Health and Safety in Child Care and Early Education (NRC) to develop health, safety, and nutrition guidelines for out-of-home child care programs. The resulting document, *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care* (2002), provides detailed quality standards and procedures for ensuring children's health and safety while they attend organized care (Table 1–2) (APHA & AAP, 2002). The current system of child care regulation allows individual states to establish their own licensing standards, which has resulted in significant differences in quality. This project was an attempt to address regulatory inconsistencies.
by proposing a set of uniform standards based on what research has identified as best practices. The National Association for the Education of Young Children (NAEYC) adopted similar guidelines for their quality accreditation program in 2006 (NAEYC, 2006).

**No Child Left Behind (NCLB)** The importance of children's health and learning during their earliest years received one of its strongest endorsements with the passage of the No Child Left Behind Act of 2001. This bill authorized significant reforms of the K–12 educational system and strengthened partnerships with Head Start, Even Start, and early education programs in center- and home-based settings. It acknowledges families as children's first and most important teachers, the educational contributions of early childhood programs, and the importance of fostering early literacy skills (understanding and using language) to ensure children's readiness for, and success in, schools. The bill also authorized additional funding to cover child care costs for low-income families, health care coverage for eligible children, and prenatal services for pregnant women. Subsidies for parent education programs and for research focused on quality improvement in early education were also addressed in this legislation. The No Child Left Behind bill is currently undergoing review and calls for reform in preparation for the next reauthorization.

**Coordinated School Health Program (CSHP)** In 1988, the Centers for Disease Control and Prevention (CDC) proposed a new school health services model called the Coordinated School Health Program. At the time, teachers were being pressured to ensure children's success in school while studies demonstrated a strong association between children’s health and academic outcomes. It became clear that traditional delivery methods were failing to address children’s complex health needs and that a different approach was needed.

The Coordinated School Health program assumes a preventive health approach and emphasizes the collaborative involvement of teachers, administrators, staff, students, families, media, and community partners to improve the health of children and schools. The model identifies eight interactive components and outlines the expectations for each (Figure 1–2). Additional information regarding this program can be accessed from the website listed at the end of this chapter.

**The National Children’s Study** One of the most comprehensive studies of children’s health ever undertaken in the United States is currently in progress (National Children’s Study, 2009). The National Institutes of Child Health and Human Development (NICHD) is coordinating this longitudinal study, which will follow over 100,000 children from birth to age 21 to examine the interaction of environmental effects on children’s health and how they might contribute to

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**Table 1–2 National Health and Safety Performance Standards**

<table>
<thead>
<tr>
<th>Comprehensive guidelines address the following areas of child care:</th>
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<tr>
<td>• staffing – child staff ratios, credentials, and training</td>
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<td>• activities for healthy development – supervision, transportation, behavior management, partnerships with families, health education</td>
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<tr>
<td>• health promotion and protection – sanitation, special medical conditions, illness management</td>
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<tr>
<td>• nutrition and food services – nutritional requirements, food safety, nutrition education</td>
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<td>• facilities, supplies, equipment, and transportation – space and equipment requirements, indoor/outdoor play, maintenance, transportation</td>
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<td>• infectious diseases – respiratory, bloodborne, skin</td>
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<td>• children with special needs – inclusion, eligibility for special services, facility modifications, assessment</td>
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<td>• administration – health/safety policies, personnel policies, documentation, contracts</td>
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<td>• recommendations for licensing and community action – regulatory agencies, policy</td>
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The study will eventually yield one of the most expansive information databases ever compiled about children's growth and development, differences in access to health care, and the incidence of disease. Data from the study will be used for future policy formulation, funding, and service interventions.

Numerous states and professional organizations, such as Head Start, Parents as Teachers, and Zero to Three have developed similar initiatives that focus on young children's health and nutritional needs. Schools, school districts, and private and public agencies are also creating programs that target children's wellness in response to increasing concerns about childhood health problems and obesity.

Health, Safety, and Nutrition: An Interdependent Relationship

Health, safety, and nutrition are closely intertwined and dependent on one another. The status of each has a direct effect on the quality of the others. For example, children who receive all essential nutrients from a healthful diet are more likely to reach their growth potential, benefit from early learning opportunities,
experience fewer illnesses, and have ample energy for play. In contrast, a child whose diet lacks critical nutrients such as iron may develop anemia, which can lead to fatigue, diminished alertness, growth failure, and loss of appetite. Disinterest in eating is likely to further compromise the child’s iron intake. In other words, nutritional status has a direct effect on children’s health and safety, which, in turn, influences the dietary requirements needed to restore and maintain well-being.

A nutritious diet also plays an important role in injury prevention. The child or adult who arrives at school having eaten little or no breakfast may experience low blood sugar, which can result in fatigue, decreased alertness, and slowed reaction times and, thus, increase an individual’s risk of accidental injury. Similarly, overweight children and adults are more likely to sustain injuries because excess weight may restrict physical activity, slow reaction times, and increase fatigue with exertion.

What Is Health?

Definitions of health are as numerous as the factors that affect it. In the past, the term referred strictly to an individual’s physical well-being and the absence of illness. Contemporary definitions of health view it from a broader perspective and recognize it as a state of physical, emotional, social, economic, cultural, and spiritual well-being. Each interactive component is assumed to make an equally important contribution to health and to have an effect on the others. For example, a stressful home environment may be contributing to a child’s frequent illnesses, stomachaches, or headaches; in turn, a child’s repeated illnesses or chronic disability can have a profound effect on the family’s emotional, financial, social, and physical stability and well-being.

The current definition of health also recognizes that children and adults are active participants in multiple groups, including family, peer, neighborhood, ethnic, cultural, recreational, religious, community, and so on. Consider, for example, recent outbreaks of H1N1 flu or E. coli and how quickly these communicable illnesses spread as a result of personal contact in multiple group settings. In each case, the environment served as an influential factor in both the spread and control of the disease.

What Factors Influence Children’s Health?

Health is a complex state determined by ongoing interactions between an individual’s genetic makeup and everyday environmental factors (Figure 1–3). For example, a baby’s immediate and long-term health is affected by the mother’s personal health and daily practices during pregnancy: her diet; use or avoidance of alcohol, tobacco, and certain medications; routine prenatal care; and exposure to communicable illnesses. Mothers who ignore healthy practices during pregnancy are more likely to give birth to infants who are born prematurely, have low birth weight, or experience a range of special needs (Polakowski, Akinbami, & Mendola, 2009). These children also face a significantly higher risk of lifelong health problems and possibly early death. In contrast, a child who is
born healthy, grows up in a nurturing family, consumes a nutritious diet, lives in a safe environment, and has numerous opportunities for learning and recreation is more likely to enjoy a healthy life.

**Heredity** Characteristics transmitted from biological parents to their children at the time of conception determine all of the genetic traits of a new, unique individual. **Heredity** sets the limits for growth, development, and health potential. It explains, in part, why children in one family are short while those from another family are tall or why some individuals have allergies or require glasses while others do not.

Understanding how heredity influences health can also be useful for predicting an inherited tendency, or **predisposition**, to certain health problems, such as heart disease, deafness, cancer, diabetes, allergies, or mental health disorders. However, it should be noted that a family history of heart disease or diabetes, for example, does not necessarily predict the development of these conditions. Many lifestyle factors, including physical activity, diet, sleep, and stress levels, interact with genetic material (genes) to determine whether a child will ultimately develop heart disease or any number of other chronic health conditions.

**Environment** Although heredity provides the basic building materials that predetermine the limits of one’s health, environment plays an equally important role. Environment encompasses a combination of physical, psychological, social, economic, and cultural factors that collectively influence the way individuals perceive and respond to their surroundings. In turn, these responses shape a person’s behaviors and potential outcomes. For example, two cyclists set off on a ride: One wears a helmet, the other does not. The choices each has made could potentially have quite different outcomes if they were to be involved in a collision. In turn, if the cyclist who decided not to wear a helmet sustained injuries, he or she is likely to experience significant health, economic, social, and psychological consequences.

Examples of environmental factors that promote healthy outcomes include:

- following a nutritious diet
- participating in daily physical and recreational activities
- getting adequate rest
- having access to medical and dental care
- reducing stress

**Figure 1-3** Health is an interactive and continuously changing state.
residing in homes, child care facilities, schools, and workplaces that are clean and safe
having opportunities to form stable and respectful relationships

There are also many environmental factors that have a negative effect on health. For example, exposure to chemicals and pollution, abuse, illness, obesity, prenatal alcohol, **sedentary** lifestyles, poverty, stress, food insecurity, violence, or unhealthy dietary choices can interfere with children's optimal growth and development.

**Safety**

*Safety* refers to the behaviors and practices that protect children and adults from unnecessary harm. Young children are at especially high risk for sustaining serious injuries because their developmental skills are not well developed. As a result, unintentional injuries are the leading cause of death among children from birth to 14 years in the United States and Canada and, sadly, many of these instances are avoidable (Forum on Child & Family Statistics, 2009; Safe Kids Canada, 2009). Every adult who works with, or cares for, young children, has a significant responsibility to maintain the highest standards of supervision and environmental safety (Mytton et al., 2009).

**Factors Affecting Children’s Safety** Protecting children’s safety requires a keen awareness of their skills and abilities at each developmental stage (Allen & Marotz, 2010). For example, knowing that an infant enjoys hand-to-mouth activities should alert teachers to continuously monitor the environment for small objects or poisonous substances that could be ingested. Understanding that toddlers are spontaneous and exceedingly curious should cause adults to take extra precautions to prevent children from wandering away or straying into unsupervised sources of water. Children who have developmental disabilities or sensory disorders are also at increased risk of sustaining unintentional injury and must be monitored continuously (Lee et al., 2008). An in-depth discussion of environmental safety and safety management will be covered in Chapters 7 and 8.

**Nutrition**

The term *nutrition* refers to the science of food, its chemical components (**nutrients**), and their relationship to health and disease. It includes all of the processes, from the ingestion and digestion of food to the absorption, transportation, and utilization of nutrients, and finally the excretion of unused end products. Nutrients are essential for life and have a direct effect on a child's nutritional status, behavior, health, and development.

They play critical roles in a variety of vital body functions, including:

- supplying energy
- promoting growth and development
- improving resistance to illness and infection
- building and repair of body tissue

Meeting the body’s need for essential nutrients depends on consuming a wide variety of foods in recommended amounts. However, environmental and family factors such as financial resources, transportation, geographical location, cultural preferences, convenience, and nutrition knowledge can also influence a child’s dietary quality. Most children in the United States live in a time and place where food is reasonably abundant. Yet, there is increasing concern about the number of children who may not be getting enough to eat or whose diets do not include the right types of foods (Metallinos-Katsaras, Sherry & Kallio, 2009; Tarasuk & Vogt, 2009). Also, because many young

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**sedentary** – unusually slow or sluggish; a lifestyle that implies inactivity.

**nutrients** – the chemical substances in food.
children spend the majority of their waking hours in out-of-home child care programs or school classrooms, care must be taken to ensure that their nutrient needs are being met in these settings.

**Children's Nutrition and Its Effect on Behavior, Learning, and Illness**  Children's nutritional status has a significant effect on behavior and cognitive development. Well-nourished children are typically more alert, attentive, physically active and better able to benefit from learning experiences (Rose-Jacobs et al., 2008). Poorly nourished children may be quiet and withdrawn, or hyperactive and disruptive during class activities (Benton, 2009; Melchior et al., 2009). They are also more prone to accidental injury because their levels of alertness and reaction times may be considerably slower. Children who are overweight also face a range of social, emotional, and physical challenges, including difficulty participating in physical activities, ridicule, emotional stress, and peer exclusion (Wang et al., 2009). Additional information about children's specific nutrient needs and the challenges associated with over- and under-consumption of foods will be addressed in-depth in Chapters 12 through 20.

Children's **resistance** to infection and illness is also directly influenced by their nutritional status (Katona & Katona-Apte, 2008). Well-nourished children are generally more resistant to illness and able to recover quickly when they are sick. Children who consume an unhealthy diet are more susceptible to infections and illness and often take longer to recuperate. Frequent illness can interfere with children's appetites which, in turn, may limit their intake of nutrients important for the recovery process. Thus, poor nutrition can create a cycle of increased susceptibility to illness and infection, nutritional deficiency, and prolonged recovery.
Teachers have an exceptional opportunity to protect and promote children's well-being. Their knowledge of children's development and health, safety, and nutritional needs can be applied when planning learning activities, classroom environments, meals and snacks, and supervision. In addition, teachers can implement sanitation and early identification practices to reduce children's unnecessary exposure to illness and infection. Furthermore, they can support the concept of preventive health by serving as positive role models and providing children with learning experiences that encourage a healthy lifestyle.

**Children’s Growth and Development**

When teachers understand typical growth and developmental patterns, they are better able to identify and address children's diverse needs and to help children master critical skills (Charlesworth, 2011). They can create learning experiences and set goals for children that are developmentally appropriate and foster positive self-esteem. They are able to design high-quality environments that are safe and encourage children's mastery of new skills. In addition, they are able to use this knowledge to promote children's well-being by identifying health problems and abnormal behaviors and teaching healthy practices.

Discussions of growth and development often make reference to the “average” or “normal” child; however, such a child probably does not exist. Every child is a unique individual—a product of diverse experiences, environments, interactions, and heredity. Collectively, these factors can lead to significant differences in the rate at which children grow and acquire various skills and behaviors (Allen & Marotz, 2010).

**Norms** for children’s growth and development have been established to serve as useful frames of reference. They represent the average or approximate age when the majority of children demonstrate a given skill or behavior. Thus, the term *normal* implies that while many children are able to perform a given skill by a specific age, some will be more advanced and others may take somewhat longer, yet they are still considered to be within the normal range.

**Growth**

The term *growth* refers to the many physical changes that occur as a child matures. Although the growth process takes place without much conscious control, there are many factors that affect both the quality and rate of growth:

- genetic potential
- level of emotional stimulation and bonding
- cultural influences
- socioeconomic factors
- adequate nutrition
- parent responsiveness
- health status (i.e., illness)

**Infants (0–12 months)** The average newborn weighs approximately 7 to 8 pounds (3.2–3.6 kg) at birth and is approximately 20 inches (50 cm) in length. Growth is rapid during the first year; an infant’s birth weight nearly doubles by the fifth month and triples by the end of the first year. For example, an infant who weighs 8 pounds (3.6 kg) at birth will weigh approximately 16 pounds (7.3 kg) at 5 months and 24 pounds (10.9 kg) at 12 months.
An infant’s length increases by approximately 50 percent during the first year. Thus, an infant measuring 21 inches (52.5 cm) at birth should reach an approximate length of 31.5 inches (78.7 cm) by 12 months of age. A majority of this gain occurs during the first 6 months when an infant may grow as much as 1 inch (2.5 cm) per month.

Other physical changes that occur during the first year include the growth of hair and eruption of teeth (four upper and four lower). The infant’s eyes begin to focus and move together as a unit by the third month, and vision becomes more acute. Special health concerns for infants include the following:

- nutritional requirements
- adequate provisions for sleep
- attachment
- early brain development
- safety and injury prevention
- identification of birth defects and health impairments

Maternal practices during pregnancy (such as diet, smoking, ingestion of alcohol or drugs, and infections) have a significant effect on the genetic makeup of an infant’s brain (Shenassa et al., 2009; Kaiser & Allen, 2008). During the weeks and months following birth, the infant’s brain undergoes rapid growth and development in response to early learning experiences. New and repetitive experiences create complex electrical connections that transform the infant’s brain from an otherwise disorganized system to one capable of profound thought, emotions, and learning (Zhu et al., 2009). The majority of this transformation occurs during the first 5 years, when the brain appears to be more receptive to shaping and change. Researchers have also discovered what they believe to be certain “critical periods,” or windows of opportunity, when some forms of learning and sensory development are more likely to take place (Spolidoro et al., 2009). Families and teachers can use this knowledge to provide infants and young children with environments and varied experiences that are enriching and will foster healthy brain development. For example, hanging pictures and mobiles where infants can see and reading to them often promotes early visual and cognitive development.

An infant’s head appears large in proportion to the rest of the body due to rapid brain growth. Head circumference is measured at regular intervals to monitor brain development and to ensure that it is proceeding at a rate that is neither too fast nor too slow. Measurements should reflect a gradual increase in size; head and chest circumferences will be almost equal by age 1.

Toddlers (12–30 months) The toddler continues to make steady gains in height and weight, but at a much slower rate than during infancy. A weight increase of 6 to 7 pounds (2.7–3.2 kg) per year is considered normal and reflects a total gain of nearly four times the child’s birth weight by the age of 2. The toddler grows approximately 3 to 5 inches (7.5–12.5 cm) in height per year. Body proportions change and result in a more erect and adult-like appearance.

Eruption of “baby teeth,” or deciduous teeth, is complete by the end of the toddler period. (Deciduous teeth consist of a set of twenty temporary teeth.) Toddlers can begin learning how to brush their new teeth as an important aspect of preventive health care, although considerable adult supervision is still needed. Special attention should also be paid to providing foods that promote dental health; are colorful, appealing, and easily chewed; and include all of the essential nutrients. Foods from all food groups—fruits, vegetables, dairy, protein, whole-grains—should be part of the toddler’s daily meal pattern.

attachment – an emotional connection established between infants and their parents and/or primary caregivers.
head circumference – the distance around the head obtained by measuring over the forehead and bony protuberance on the back of the head; it is an indication of normal or abnormal growth and development of the brain and central nervous system.
deciduous teeth – a child’s initial set of teeth; this set is temporary and gradually begins to fall out at about 5 years of age.
High activity levels make it essential for toddlers to get at least 10 to 12 hours of uninterrupted nighttime sleep. In addition, most toddlers continue to nap 1 to 2 hours each day. Safety awareness and injury prevention continue to be major concerns that demand close adult supervision.

**Preschoolers/Early School-Age (2 1/2–8 years)** During the preschool and early school-age years, a child’s appearance becomes more streamlined and adult-like in form. Head size remains relatively constant, while the child’s trunk (body) and extremities (arms and legs) continue to grow. Gradually, the head appears to separate from the trunk as the neck lengthens. Legs grow longer and at a faster rate than the arms, adding extra inches to the child’s height. The toddler’s characteristic chubby body shape becomes more streamlined as muscle tone and strength increase and results in straighter posture and a flatter abdomen.

Gains in weight and height are relatively slow but steady throughout this period. By 3 years of age, children weigh approximately five times their weight at birth. An ideal weight gain for a preschool child is approximately 4 to 5 pounds (1.8–2.3 kg) per year. However, children grow more in height than in weight during this period, gaining an average of 2 to 2.5 inches (5.0–6.3 cm) per year. By the time children reach 6 years of age, they have nearly doubled their original birth length (from approximately 20 inches to 40 inches [50–100 cm]). By age 7, girls are approximately 42–46 inches (105–115 cm) tall and weigh 38–47 pounds (19.1–22.3 kg); boys are 44–47 inches (110–117.5 cm) tall and weigh 42–49 pounds (17.3–21.4 kg). This combination of growth and muscle development causes children to appear longer, thinner, and more adult-like.

Adequate nutrition continues to be a prime consideration (Insel, Turner, & Ross, 2009). High activity levels replace the rapid growth of earlier years as the primary demand for calories. A general rule for estimating a child’s daily caloric needs is to begin with a base of 1,000 calories and add an additional 100 calories per birthday. (For example, a 7-year-old would need approximately 1,700 calories). However, because the preschool years are often marked by decreased appetite and inconsistent eating habits, families and teachers must continue to monitor children’s food intake and encourage healthy eating habits.

Adequate sleep is also required for children’s optimal growth and development. When days are long and tiring or unusually stressful, children’s need for sleep may be even greater. Most preschool and school-aged children require 8 to 12 hours of uninterrupted nighttime sleep in addition to daytime rest periods, although bedtime and afternoon naps often become a source of adult-child conflict. Preschool children have a tendency to become so involved in play activities that they are reluctant to stop for sleep. Nevertheless, young children benefit from brief rest breaks during their normal daytime routine. Planned quiet times, with books, puzzles, quiet music, or a small toy, may be an adequate substitute for older children.

By the time children reach school-age, they begin to enjoy one of the healthiest periods of their lives. They generally experience fewer colds and upper respiratory infections due to improved resistance and physical maturation. Visual acuity continues to improve, gains in linear growth (height) are fairly rapid, and muscle mass increases to give children a more adult-like appearance.
Development

In the span of 1 year, remarkable changes take place in the infant's development. The child progresses from a stage of complete dependency on adults to one marked by the acquisition of language and the formation of rather complex thought patterns. Infants also become more social and outgoing near the end of the first year, and seemingly enjoy and imitate the adults around them (Allen & Marotz, 2010).

The toddler and preschool periods reflect a continued refinement of language, perceptual, motor, cognitive, and social achievements. Improved motor and verbal skills enable the toddler to explore, test, and interact with the environment for the purpose of determining personal identity, or autonomy.

Developmental gains enable the preschool-aged child to perform self-care and fine motor tasks with improved strength, speed, accuracy, control, and ease. The beginning of a conscience slowly emerges and is an important step in the socialization process because it allows children to exercise some control over their emotions. Friendships with peers become increasingly important as preschool children begin to expand their sphere of acquaintances beyond the scope of family members.

A strong desire to achieve motivates 6-, 7-, and 8-year-olds. Participation in sports and other vigorous activities provides opportunities for children to practice and improve motor skills. Adult approval and rewards continue to serve an important role in helping children build self-confidence and self-esteem. During this stage, children also begin to establish gender identity through meaningful social interactions.

A summary of major developmental achievements is presented in Table 1–3. It should be remembered that such a list represents accomplishments that a majority of children can perform at a given age. It should also be noted that not every child achieves all of these tasks. Many factors, including nutritional adequacy, opportunities for learning, access to appropriate medical and dental care, a nurturing environment, cultural expectations and family support, exert a strong influence on children's skill acquisition.

Promoting a Healthy Lifestyle

Today, concern for children's health and welfare is a shared vision. Changes in current lifestyles, family structures, cultural diversity, trends, and expectations have shifted some responsibilities for children's health to the collaborative efforts of families, teachers, and service providers. Communities are also valued members of this partnership and must assume a proactive role in creating environments that are safe, enriching, and healthy places for children to live.
Table 1–3  Major Developmental Achievements

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<th>Achievements</th>
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| 2 months | • lifts head up when placed on stomach  
• follows moving person or object with eyes  
• imitates or responds to smiling person with occasional smiles  
• turns toward source of sound  
• begins to make simple sounds and noises  
• grasps objects with entire hand; not strong enough to hold on  
• enjoys being held and cuddled |
| 4 months | • has good control of head  
• reaches for and grasps objects with both hands  
• laughs out loud; vocalizes with coos and giggles  
• waves arms about  
• holds head erect when supported in a sitting position  
• rolls over from side to back to stomach  
• recognizes familiar objects (e.g., bottle, toy) |
| 6 months | • grasps objects with entire hand; transfers objects from one hand to the other and from hand to mouth  
• sits alone with minimal support  
• deliberately reaches for, grasps, and holds objects (e.g., rattles, bottle)  
• plays games and imitates (e.g., peek-a-boo)  
• shows signs of teeth beginning to erupt  
• prefers primary caregiver to strangers  
• babbles using different sounds  
• raises up and supports weight of upper body on arms |
| 9 months | • sits alone; able to maintain balance while changing positions; picks up objects (e.g., bits of cracker, peas) with pincer grasp (first finger and thumb)  
• begins to crawl  
• attempts to say words such as “mama” and “dada”  
• is hesitant toward strangers  
• explores new objects by chewing or placing them in mouth |
| 12 months | • pulls up to a standing position  
• may “walk” by holding on to objects  
• stacks several objects one on top of the other  
• responds to simple commands and own name  
• babbles using jargon in sentence-like form  
• uses hands, eyes, and mouth to investigate new objects  
• can hold own eating utensils (e.g., cup, spoon) |
| 18 months | • crawls up and down stairs one at a time  
• walks unassisted; has difficulty avoiding obstacles in pathway  
• is less fearful of strangers  
• enjoys being read to; likes toys for pushing and pulling  
• has a vocabulary consisting of approximately 5–50 words, can name familiar objects  
• helps feed self; manages spoon and cup |
| 2 years  | • runs, walks with ease; can kick and throw a ball; jumps in place  
• speaks in two- to three-word sentences (e.g., “Dada”, “bye-bye”); asks simple questions; knows about 200 words  
• displays parallel play  
• achieves daytime toilet training  
• voices displeasure |
### Table 1-3  Major Developmental Achievements (continued)

<table>
<thead>
<tr>
<th>Age</th>
<th>Achievements</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 years</td>
<td>• climbs stairs using alternating feet  &lt;br&gt; • hops and balances on one foot  &lt;br&gt; • feeds self  &lt;br&gt; • helps dress and undress self; washes own hands and brushes teeth with help  &lt;br&gt; • is usually toilet trained  &lt;br&gt; • is curious; asks and answers questions  &lt;br&gt; • enjoys drawing, cutting with scissors, painting, clay, and make-believe  &lt;br&gt; • can throw and bounce a ball  &lt;br&gt; • states name; recognizes self in pictures</td>
</tr>
<tr>
<td>4 years</td>
<td>• dresses and undresses self; helps with bathing; manages own tooth brushing  &lt;br&gt; • enjoys creative activities: paints, draws with detail, models with clay, builds imaginative structures with blocks  &lt;br&gt; • rides a bike with confidence, turns corners, maintains balance  &lt;br&gt; • climbs, runs, and hops with skill and vigor  &lt;br&gt; • enjoys friendships and playing with small groups of children  &lt;br&gt; • enjoys and seeks adult approval  &lt;br&gt; • understands simple concepts (e.g., shortest, longest, same)</td>
</tr>
<tr>
<td>5 years</td>
<td>• expresses ideas and questions clearly and with fluency  &lt;br&gt; • has vocabulary consisting of approximately 2,500–3,000 words  &lt;br&gt; • substitutes verbal for physical expressions of displeasure  &lt;br&gt; • dresses without supervision  &lt;br&gt; • seeks reassurance and recognition for achievements  &lt;br&gt; • engages in active and energetic play, especially outdoors  &lt;br&gt; • throws and catches a ball with relative accuracy  &lt;br&gt; • cuts with scissors along a straight line; draws in detail</td>
</tr>
<tr>
<td>6 years</td>
<td>• plays with enthusiasm and vigor  &lt;br&gt; • develops increasing interest in books and reading  &lt;br&gt; • displays greater independence from adults; makes fewer requests for help  &lt;br&gt; • forms close friendships with several peers  &lt;br&gt; • exhibits improved motor skills; can jump rope, hop and skip, ride a bicycle  &lt;br&gt; • enjoys conversation  &lt;br&gt; • sorts objects by color and shape</td>
</tr>
<tr>
<td>7 and 8 years</td>
<td>• enjoys friends; seeks their approval  &lt;br&gt; • shows increased curiosity and interest in exploration  &lt;br&gt; • develops greater clarity of gender identity  &lt;br&gt; • is motivated by a sense of achievement  &lt;br&gt; • begins to reveal a moral consciousness</td>
</tr>
<tr>
<td>9–12 years</td>
<td>• uses logic to reason and problem-solve  &lt;br&gt; • energetic; enjoys team activities, as well as individual projects  &lt;br&gt; • likes school and academic challenge, especially math  &lt;br&gt; • learning social customs and moral values  &lt;br&gt; • is able to think in abstract terms  &lt;br&gt; • enjoys eating any time of the day</td>
</tr>
</tbody>
</table>

How can families and teachers determine whether or not children are healthy? What qualities or indicators are commonly associated with being a healthy or a well child? Growth and developmental norms always serve as a starting point. Again, it must be remembered that norms simply represent an average, not exact, age when most children are likely to achieve a given skill. Healthy children are more likely to exhibit characteristic behaviors and developmental skills appropriate for their age. They tend to be well-nourished, have energy to play, experience continued growth, and have fewer illnesses. Developmental norms are also useful for anticipating and addressing children’s special health needs, including injury prevention, posture and physical activity, oral health, and mental health.

**Injury Prevention**

Unintentional injuries, especially those involving motor vehicles, pose the greatest threat to the lives of young children (Borse et al., 2009; Rowe & Maughan, 2009). They are responsible for more than one-half of all deaths among children under 14 years of age in the United States. Each year an additional one million children sustain injuries that require medical attention, and many are left with permanent disabilities (Berry & Schwebel, 2009).

An understanding of normal growth and development is also useful when planning for children’s safety. Many characteristics that make children delightful to work with are the same qualities that make them prone to injury. Children’s skills are seldom as well developed as their determination, and in their zealous approach to life, they often fail to recognize inherent dangers. Their inability to judge time, distance, and speed accurately contributes to many injuries, especially those resulting from falls, as a pedestrian, or while riding on a bike (Hotz et al., 2009). Limited problem-solving abilities make it difficult for children to anticipate the consequences of their actions. This becomes an even greater challenge when infants or children with developmental disabilities are present. Adults have an obligation to provide continuous supervision and to maintain safe environments for all children at all times. Safety considerations and protective measures will be discussed in greater detail in Chapter 7.

**Posture and Physical Activity**

Correct posture, balance, and proper body alignment are necessary for many physical activities that children engage in, such as walking, jumping, running, skipping, standing, and sitting. Teaching and modeling appropriate body mechanics can help children avoid problems related to poor posture that may develop later in life. Early recognition and treatment of ear infections is also important to consider because they can affect children’s balance and coordination.

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well child – a child who enjoys a positive state of physical, mental, social, and emotional health.
Orthopedic problems (those relating to skeletal and muscular systems) are not common among young children. However, there are several conditions that warrant early diagnosis and treatment:

- birth injuries, such as hip dislocation, fractured collarbone
- abnormal or unusual walking patterns, such as limping or walking pigeon-toed
- bowed legs
- knock-knees
- flat feet
- unusual curvature of the spine
- unequal length of extremities (arms and legs)

Some irregularities of posture disappear spontaneously as young children mature. For example, it is not uncommon for infants and toddlers to have bowed legs or to walk slightly pigeon-toed. By age 3 or 4, these problems should correct themselves. However, if they persist beyond the age of 4, children should be evaluated by a health professional to prevent permanent deformities.

Children's posture is an excellent topic for classroom discussions, demonstrations, rhythm and movement activities, games, and art projects (Obeng, 2010). Information about appropriate body mechanics and movement can also be shared with families in newsletters or posted on bulletin boards or a website so that correct practices can be reinforced at home. Children can begin to learn basic body mechanics, including:

- Sitting squarely in a chair, resting the back firmly against the chair back and with both feet flat on the floor.
- Sitting on the floor with legs crossed (in front) or with both legs extended straight ahead. Children should be discouraged from kneeling or sitting in a “W” position because this can place additional stress on developing hip joints and interfere with proper development over time. Have children sit in a chair with feet planted firmly on the ground or provide them with a small stool that can be straddled (one leg on each side); this eliminates adult nagging and forces children to sit in a correct position. Alternative seating supports may be required for children who have muscular or neurological disabilities.
- Standing with the shoulders square, the chin up, and the chest out. Distribute body weight evenly over both feet to avoid placing added stress on one or the other hip joints.
- Lifting and carrying heavy objects using the stronger muscles of the arms and legs rather than weaker back muscles. Standing close to an object that is to be lifted with feet spread slightly apart to provide a wider support base. Stooping down to lift (with your legs); bending over at the waist when lifting places strain on back muscles and increases the risk of injury.

Correct posture and body mechanics are also important skills for parents and teachers to practice (Table 1–4). Because they perform many bending and lifting activities throughout the day, using proper technique can reduce
Vigorous physical activity should be an essential part of every child’s day. It has a positive effect on children’s growth, mental health, weight management, and behavior problems by relieving excess energy, stress, and boredom (Vadiveloo, Zhu, & Quatromoni, 2009). Introducing young children to a variety of sports, games, and other forms of physical activity also provides them with early opportunities to discover those they enjoy and are likely to continue. Teachers should review classroom schedules and look for ways to incorporate more physical activity into daily routines. Current guidelines recommend that children get a minimum of 60 minutes of moderate aerobic activity each day (CDC, 2008). Families and teachers must serve as positive role models for children by also engaging in regular physical activity (Pica, 2009).

Oral Health

Children’s oral health continues to be a major goal in the Healthy People 2020 objectives. Dental problems can affect children’s general health, development, appearance, and self-esteem in addition to causing considerable pain and expense. Yet, there are many children who seldom visit a dentist because their families cannot afford dental insurance or costly preventive care. Children from low-income and minority groups are twice as likely to experience tooth decay and a lack of dental treatment (Casamassimo et al., 2009). Neglected dental care can result in painful cavities and infected teeth, affect children’s behavior, and interfere with concentration and academic performance. There are many adults who erroneously believe that “baby teeth,” or deciduous teeth, do not require treatment because they will eventually fall out (Levine, 2008). This belief is unfortunate because temporary teeth are necessary for:

- chewing
- the spacing of permanent teeth
- influencing the shape of the jaw bone
- the development of speech

Advancements in pediatric dentistry and educational efforts have resulted in significant improvements in children’s dental care. The importance of consuming a nutritious diet during pregnancy, scheduling regular dental visits, the use of sealants, and the addition of fluoride to water supplies, toothpastes, and direct applications have collectively reduced the incidence of children’s dental caries and gum disease (Kagihara, Niederhauser, & Stark, 2009). Proper dental care should be practiced from birth, with special attention given to:

- diet
- hygienic practices—e.g., tooth brushing, flossing

Table 1–4  Proper Body Mechanics for Adults

| • Use correct technique when lifting children; flex the knees and lift using leg muscles; avoid lifting with back muscles, which are weaker. |
| • Adjust the height of children’s cribs and changing tables to avoid bending over. |
| • Provide children with step stools so they can reach water fountains and faucets without having to be lifted. |
| • Bend down by flexing the knees rather than bending over at the waist; this reduces strain on weaker back muscles and decreases the risk of possible injury. |
| • Sit in adult-sized furniture with feet resting comfortably on the floor to lessen strain on the back and knees. |
| • Transport children in strollers or wagons rather than carrying them. |
| • Exercise regularly to improve muscle strength, especially back muscles, and to relieve mental stress. |
| • Lift objects by keeping arms close to the body versus extended; this also reduces potential for back strain. |
dental examinations scheduled at recommended intervals
- prompt treatment of dental problems

Diet has an unquestionable effect on children's dental health (Nunn et al., 2009). Proper tooth formation depends on an adequate intake of protein and minerals, particularly calcium and fluoride. One of the most devastating influences on diet, however, is the excessive consumption of highly refined and sticky carbohydrates (Sheller et al., 2009). These are commonly found in cakes, cookies, candies, gum, soft drinks, sweetened cereals, and dried fruits (for example, raisins, dates, and prunes). Families and teachers can encourage children to adopt healthy dietary habits by limiting the frequency and amounts of sweets they are served and by substituting nutritious foods. Because many children's medications and chewable vitamins are sweetened with sugars, tooth brushing should always be encouraged following their ingestion.

Oral hygiene practices implemented early in children's lives promote healthy tooth development. Food particles can be removed from an infant's gums and teeth by wiping them with a small, wet washcloth. A small, soft brush and water can be used for cleaning an older infant's teeth.

Most toddlers can begin to brush their own teeth at around 15 months of age. Tooth brushing can be accomplished by using a soft brush and water to clean the teeth. However, the use of toothpaste is not recommended before age 2; most toddlers do not like its taste and are unable to spit it out after brushing. When a child is first learning tooth brushing skills, an adult should brush over the teeth after at least one of the brushings each day to be sure all areas are clean. Teeth can also be kept clean between brushings by rinsing with water after meals and eating raw foods such as apples, pears, and celery, which

**Reflective Thoughts**

Baby bottle tooth decay (BBTD) is a preventable condition that occurs when a baby's teeth are exposed to sugary substances, including juices, formula, and breast milk, for prolonged periods. Practices such as putting an infant to bed with a bottle or allowing them to nurse for extended periods at night, and giving a toddler a bottle or sippy cup with fruit juice to carry around can prove harmful to children's teeth (Freeman & Stevens, 2008). Because saliva flow is decreased during sleep, it is less effective in keeping teeth clean.

- What cautions would you offer to new parents who want to prevent their infants from developing BBTD?
- What practices can a mother who wants to feed her infant on demand use to avoid BBTD?
- What practices can parents use to promote older children's oral health?
provide a natural cleansing action. Several additional steps teachers and families can take to increase children's interest in brushing their teeth include:

- purchasing a small, soft toothbrush in the child's favorite color
- storing the toothbrush where the child can reach it
- providing a footstool or chair so the child can reach the sink

⚠️ **Caution:** Supervise the child closely to prevent slipping or falling.

- demonstrating the tooth brushing procedure so the child knows what to expect
- helping the child to brush at least twice daily—once in the morning and again before going to bed
- constructing a simple chart where children can place a check each time they brush their teeth; reinforcing children's efforts encourages sound tooth brushing habits

Preschool children are generally able to brush their teeth with minimal supervision, but it may still be advisable for an adult to provide a quick follow-up brushing. Although children's technique may not always be perfect, they are beginning to establish a lifelong tooth brushing habit. Proper brushing technique and fluoride-based toothpastes (pea-size application) have proven to be effective in reducing dental cavities. However, children must be supervised closely so they do not swallow the toothpaste. Too much fluoride can result in dental **fluorosis**, which may cause white or brown spots to form on developing teeth (Iida & Kumar, 2009).

The question of whether young children should learn to floss their teeth is best answered by the child's dentist. Although the practice is regarded as beneficial, much depends on the child's maturity and fine motor skills. Flossing is usually recommended once the permanent teeth begin to erupt and spaces between teeth disappear. Parents should assist children who are too young to manage this procedure by themselves. Routine dental checkups are an important component of preventive health care, but they are not a substitute for daily oral hygiene practices and a healthful diet. Children's first visit to the dentist should be scheduled at around 12 to 15 months of age. Initial visits should be pleasant experiences that acquaint children with the dentist, routine examinations, and cleanings without having to undergo painful dental work. Children are more likely to maintain a healthy attitude toward dental care and to approach visits with less fear and anxiety when early experiences are positive.

During routine examinations, dentists look for signs of dental problems and also review the child's tooth brushing technique, diet, and personal habits, such as thumb sucking or grinding that may affect the teeth. Cleaning and a fluoride varnish application are generally included in children's preventive examinations, which are recommended every 6 to 12 months. The addition of fluoride to municipal water supplies has also contributed to a significant decrease in children's tooth decay (Yeung, 2008). Sealants (a plastic-like material applied over the grooves in permanent molars) are also used to prevent future decay.

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**Reflective Thoughts**

Making friends is an important part of growing up. Gaining acceptance and respect from peers helps shape one’s sense of self-esteem. However, friendships are not always easy for children to establish. What social skills are required for making friends? What behaviors are likely to alienate friends? Should families get involved in their children's friendships? As a parent, what would you do if your child became friends with someone you didn't care for?

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**fluorosis** – white or brown spots that form on children's teeth due to excessive fluoride intake.
Self-Esteem and Social-Emotional Competence

The wellness model recognizes a close relationship between children's emotional and physical well-being (Pachter & Coll, 2009; Rasmussen, Scheier, & Greenhouse, 2009). This association is receiving increased attention as the incidence of behavior problems, school dropout rates, substance abuse, violence, gang membership, depression, and child suicide continues to escalate. At present, approximately one in five children in the United States experience mental health problems, and one in ten have disorders that seriously interfere with learning (U.S. DHHS, 2009b). Children who live in dysfunctional or economically challenged families or who have disabilities are at highest risk for developing mental health problems (Copeland et al., 2009).

How children view themselves and the ways in which they believe others perceive them form the basis of self-concept. Young children typically define themselves strictly in terms of physical qualities, such as having brown hair, blue eyes, or being able to run fast. However, children's concept of who they are and how they fit in gradually broadens with experience. By 5 or 6 years of age, children's self-characterization is no longer limited to physical features but begins to include comparisons with peers—being able to run faster than Tyshan, build higher towers than Mei, or draw flowers better than Abetzi. Nine- and 10-year-olds are becoming more analytical and reflect a higher order of self-evaluation: “I like to play baseball, but can't field or hit the ball as well as Tori so they probably won’t want me on their team.” Children's self-image is formed and continuously redefined by the ways in which they are talked to and treated. In turn, these collective experiences influence children's sense of worth or self-esteem and form the basis of self-concept.

Promoting Children's Self-Esteem Families and teachers play a major role in shaping children's self-esteem (Erwin et al., 2009; Ferkany, 2008; Szente, 2007). They improve children's chances for achieving success by acknowledging and building on their developmental strengths. When adults set realistic goals and expectations for children, they are more likely to experience success and take pride in their accomplishments. Even when children are unsuccessful, their efforts should be acknowledged. Failures and mistakes must be accepted as part of the learning process and should be viewed as occasions for offering guidance and positive support. In doing so, children begin to learn important lifelong lessons about initiative, risk-taking, problem-solving, and handling adversity. However, caution must be exercised never to judge children solely on their accomplishments (or failures) or to make comparisons with other children, but to recognize each child as a unique and valued individual.

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**self-concept** – a person's concept of who they are and how they fit in.  
**self-esteem** – an individual's sense of value or confidence in himself or herself.
Teachers also occupy a strategic position for reinforcing children’s development of social-emotional competence. They are able to create opportunities for children to acquire and practice effective communication, behavior management, and decision-making skills in a supportive environment (Caldarella et al., 2009; Petty, 2009). Teachers also foster children’s social-emotional competence by creating respectful classrooms that convey positive attitudes, address children’s individual needs, provide constructive feedback, and are conducive to learning. In addition, they play an integral role in:

- practicing sound mental health principles — by being responsive and supportive.
- preventing emotional problems — teaching children effective social, communication, anger management, and problem-solving skills.
- identifying and referring children who may exhibit signs of emotional problems, such as excessive or uncontrollable frustration, aggressive behavior, or difficulty making and keeping friends.
- working collaboratively with families to find appropriate community resources (Upshur, Wenz-Gross, & Reed, 2009).

When children develop positive self-esteem and have confidence in their own abilities, they are more likely to experience a trajectory of personal and academic success.

**Adults as Role Models** Adults must never overlook their importance as role models for young children. Their personal behaviors and response styles exert a powerful and direct influence on children’s social-emotional development.

Teachers must carefully examine their own emotional state if they are to be successful in helping children achieve positive self-esteem. They, too, must have a strong sense of self-worth and confidence in what they are doing. They should be aware of personal biases and prejudices, be able to accept constructive criticism, and recognize their strengths and limitations. They must have effective communication skills and be able to work collaboratively with families of diverse backgrounds, community service providers, health care professionals, and other members of the child’s educational team.

If teachers are to serve as positive role models, they must be able to exercise the same control over their emotions that they expect of children. Personal problems and stressors must remain at home so that full attention can be focused on the children. Teachers must respect children as individuals—who they are, and not what they are able or not able to do—because every child has qualities that are endearing and worthy of recognition. Teachers must also be impartial in their treatment of children; favoritism cannot be tolerated.

Working with young children can be rewarding, but it can also be stressful and demanding in terms of the patience, energy, and stamina required. Noise, children’s continuous requests, long hours, staff shortages, mediocre wages, and occasional conflicts with families or co-workers are everyday challenges. Physical demands and unresolved stress can gradually take their toll on teachers’ health, commitment, and daily performance. Eventually, this can lead to job burnout and negative interactions with colleagues and children (Huang & Waxman, 2009). For these reasons, teachers should make an effort to identify sources of stress in their jobs and take steps to address, reduce, or eliminate them to the extent possible (Marotz & Lawson, 2007). (See Table 1–5.)

**Emotional Climate** The emotional climate of a classroom—the positive or negative feelings one senses—has a significant impact on children’s social-emotional development (Maxwell & Chmielewski, 2008; Haas-foletta & ottolini-Geno, 2006). Consider the following situations and decide which classroom you would find most inviting:

Kate enters the classroom excited and eager to tell her teacher about the tooth she lost last night and the quarter she found under her pillow from the “tooth fairy.” Without any greeting, the teacher hurries to check Kate in and informs her that she is too busy to talk right now, “but maybe later.” When they are finished, the teacher instructs Kate to find something to do without getting into trouble. Kate quietly walks away to her cubbie.
Chapter 1  Children’s Well-Being: What It Is and How to Achieve It

Table 1–5  Strategies for Managing Teacher Stress

- Seek out training opportunities where you can learn new skills and improve your work effectiveness.
- Learn and practice time management techniques.
- Develop program policies and procedures that improve efficiency and reduce sources of tension and conflict.
- Join professional organizations; expand your contacts with other child care professionals, acquire new ideas, advocate for young children.
- Take care of your personal health—get plenty of sleep, eat a nutritious diet, and participate in some form of physical exercise several times each week.
- Develop new interests, hobbies, and other outlets for releasing tension.
- Practice progressive relaxation techniques. Periodically, concentrate on making yourself relax.
- Plan time for yourself each day—read a good book, watch a movie or favorite TV program, go for a long walk, paint, go shopping, play golf, or participate in some activity that you enjoy.

Ted arrives and seems reluctant to leave his mother for some reason this morning. The home provider immediately senses his distress and walks over to greet Ted and his mother. "Ted, I am so glad that you came today. We're going to learn about farm animals and build a farm with the wooden blocks. I know that blocks are one of your favorite activities. Perhaps you'd like to build something small for your mother before it's time for her to go home." Ted eagerly builds a barn with several "animals" in the yard around it and proudly looks to his mother for approval. When Ted’s mother is ready to leave, he waves good-bye.

Clearly, the teacher’s actions in each example created a classroom atmosphere that had a different effect on each child's behavior. Children are generally more receptive and responsive to teachers who are warm, nurturing, and sensitive to their needs. Exposure to negative adult responses, such as ridicule, sarcasm, or threats is harmful to children's emotional development and simply teaches inappropriate behaviors. However, an emotional climate that encourages and supports mutual cooperation, respect, trust, acceptance, and independence will encourage children to gain positive social-emotional competence.

A teacher’s communication style and understanding of cultural differences also affects the emotional climate of a classroom. Treating all children as if they were the same is insensitive and can encourage failure, especially if a teacher’s expectations are inconsistent or incompatible with the child’s cultural background. For example, knowing that children in some Hispanic cultures are taught primarily through non-verbal instruction (modeling) may explain why a child who is only given verbal directives may not respond to this approach (Hardin et al., 2009). Some children are reluctant to participate in group activities or to answer a teacher’s question because this is counter to the way they have been raised. Unless the teacher understands these cultural differences, such behaviors could easily be misinterpreted as defiance or inattention. When teachers make an effort to learn about individual children and their families they are able to create a climate that supports learning and healthy social-emotional development.

The way in which the curriculum is planned and implemented also contributes to the emotional climate. Children's chances for achieving success are improved when learning activities are developmentally appropriate and matched to children's individual needs and interests (Hoogeveen, van Hell, & Verhoeven, 2009).

Stress  Prolonged or intense stress in children's lives will sooner or later affect their emotional and physical well-being. Stressful situations, such as abusive treatment, poverty, unrealistic adult demands, chronic illness, unsafe neighborhoods, being left alone for long periods, or natural disasters (floods, fires, earthquakes, tornadoes), can have a serious impact on children's emotional state (Fairbank & Fairbank, 2009). Poverty, food insecurity, maternal depression, and parental substance abuse are also correlated with an increase in children's mental health
problems (Evans & Schamburg, 2009). Some children experience undue stress and anxiety in response to everyday events such as:

- separation from families
- new experiences—for example, moving, enrollment in a new early childhood program, mother going to work, birth of a sibling, having a new teacher, being left with a sitter
- chronic illness and hospitalization
- divorce of parents
- death of a pet, family member, or close friend
- conflict of ideas; confrontations with family, friends, or teachers
- overstimulation due to hectic schedules, participation in numerous extracurricular activities
- learning problems

Immature coping mechanisms, personal experiences, and temperament influence a child’s response to stress and their ability to manage it in a healthy manner (Berk, 2009). Sudden behavior changes are often an early indication that a child is experiencing significant tension or inner turmoil. Signs may range from less serious behaviors—nail biting, hair twisting, excessive fear, prolonged sadness, anxiety—to those that are of significant concern—repeated aggressiveness, destructiveness, withdrawal, depression, nightmares, psychosomatic illnesses, or poor performance in school.

Teachers can help children who are experiencing acute or chronic stress by showing additional patience, understanding, and support. Children also find comfort in knowing they are safe and secure and that they can count on teachers and parents to be accepting even at times when their emotional control may fail. Additional suggestions for helping children to cope are outlined in Table 1–6.
Chapter 1  Children’s Well-Being: What It Is and How to Achieve It

### Table 1-6  Stress Management for Children

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>Encourage children to talk about what is causing them to feel tense or upset.</td>
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<tr>
<td>2.</td>
<td>Empower children by helping them to identify and express feelings appropriately.</td>
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<tr>
<td>3.</td>
<td>Nurture positive thinking and an “I know I can do this” attitude.</td>
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<tr>
<td>4.</td>
<td>Prepare children for stressful events (e.g., doctor’s visit, moving, flying for the first time, attending a new school) by role-playing or rehearsing what to expect. Practice “what if’s”: “What should you do if you get lost?” “What can you do if you’re afraid?”</td>
</tr>
<tr>
<td>5.</td>
<td>Maintain predictable schedules, including mealtimes and bedtimes as much as possible.</td>
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<tr>
<td>6.</td>
<td>Make sure children are getting a nutritious diet and brief periods of vigorous physical activity (an effective stress reliever).</td>
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<tr>
<td>7.</td>
<td>Schedule unstructured play time when children are free to do what they want.</td>
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**Childhood Depression** Some children are unsuccessful or unable to cope with chronic stress and may develop a sense of extreme and persistent sadness and hopelessness that begins to affect the way they think, feel, and act. These may be early signs of childhood depression and can include:

- apathy or disinterest in activities or friends
- loss of appetite
- difficulty sleeping
- complaints of physical discomforts, such as headaches, stomachaches, vomiting, diarrhea, ulcers, repetitive tics (twitches), or difficulty breathing (Dufton, Dunn, & Compas, 2009).
- lack of energy or enthusiasm
- indecision
- poor self-esteem
- uncontrollable anger

Children who have learning and behavior disorders or a family history of mental health conditions are at an increased risk for depression (Boulet, Boyle, & Schieve, 2009). Even children as young as 3 may begin showing early signs of depression particularly when their mothers are also suffering from this condition (Leckman-Westin, Cohen, & Stueve, 2009; Luby et al., 2009).

The onset of childhood depression may occur abruptly following a traumatic event, such as parental divorce, death of a close family member or friend, abusive treatment, or chronic illness. However, it can also develop slowly over time, making the early signs more difficult to notice. In either case, teachers must be knowledgeable about the behaviors commonly associated with childhood depression so children can be referred for professional care. Depression requires early identification and treatment to avoid serious and debilitating effects on children’s social, emotional, and cognitive development and to prevent long-term mental health disorders (Lack & Green, 2009; Luby, 2009).

**Childhood Fears** Most childhood fears and nightmares are a normal part of the developmental process and are eventually outgrown as children mature. Basic fears are relatively consistent across generations, although they vary somewhat from one developmental stage to the next (Burnham, 2009). For example, a 3-month-old infant is seldom fearful of anything, whereas a 3-year-old may awake during the night because of “monsters under the bed.” Fears that reflect real-life events, such as fire, kidnapping, thunderstorms, or homelessness, tend to be experienced by 5- and 6-year-olds, whereas 10- and 11-year-olds are more likely to express fears related to appearance and social rejection (Allen & Marotz, 2010). Some fears are unique to an individual child and stem from personal experiences, such as witnessing a shooting, car accident, abusive discipline, or being frightened by a vicious dog.
Fears and nightmares are often accentuated during the preschool years, a time when children have a heightened imagination and are attempting to make sense of their world. Children's literal interpretation of the things they see and hear can easily lead to misunderstanding and fear. For example, children often believe that an adult who says, “I’m going to give you away if you misbehave one more time” will actually do so.

It is important for adults to acknowledge children’s fears and understand they are real to the child. Children need consistent adult reassurance and trust to overcome their fears, even though it may be difficult to remain patient and supportive when a child repeatedly awakens at 2 AM every morning. Children may also find comfort in talking about the things that frighten them or rehearsing what they might do, for example, if they were to become lost at the supermarket or if it began to thunder.

**Poverty and Homelessness** Nearly 41 percent of U.S. children younger than age 6 currently live in families that fall below the national poverty level (National Center for Children in Poverty, 2009). The adults in many of these families are either unemployed or working in low-wage jobs, recent immigrants, classified as minorities (especially Hispanic, Native American, and African American), or are a single parent — usually a mother. Living in a single- versus a two-parent family places children at the highest economic risk for poverty. Children residing in rural areas also experience significant poverty, but they comprise a group that is often overlooked. Economic problems and high unemployment have recently forced many rural families into bankruptcy (Huddleston-Casas, Charnigo, & Simmons, 2009). Collectively, these developments have caused families with young children to become the new majority of today’s homeless population.

Poverty places additional burdens on the already challenging demands of parenting. Struggles to provide children with basic food, clothing, shelter, health care, and attention are often compromised by increased stress, fear, and conflict. Ultimately, these pressures can contribute to parental tension, domestic violence, abusive treatment of children, and an inability to provide the nurturing and support that children require.

The impact of poverty on children’s growth and development has both immediate and long-term consequences. Children born into poverty experience a higher rate of birth defects, early death, and chronic illnesses, such as anemia, asthma, and lead poisoning (Allen & Marotz, 2010). In addition, their dietary quality, access to health and dental care, and mental health status is often compromised (Melchior et al., 2009). Children living in poverty are also more likely to experience abuse, learning and behavior problems, teen pregnancy, substance abuse, higher dropout rates, and reduced earning potential as adults. Ultimately, the cumulative effects of poverty can threaten children’s chances of growing up to become healthy, educated, and productive adults (Mello, 2009).

**Violence** Children today live in a world where daily exposure to violence is not uncommon. The incidence of crime, substance abuse, gang activity, and access to guns is often greater in neighborhoods where poverty exists and can result in unhealthy urban environments where children's personal safety is at risk. Children living in these settings are also more likely to become victims of child abuse or to witness domestic violence. Their families exhibit a higher rate of dysfunctional parenting skills, are often less responsive and nurturing, and use discipline that is either lacking, inconsistent, or punitive and harsh (Owen et al., 2009). Parents are also less likely to be supportive of children’s education or to assume an active role in school activities. As a result, many children who grow up in poverty are at greater risk of experiencing learning problems, becoming violent adults, and/or developing serious mental health disorders (Whiting et al., 2009). Teachers who understand this potential can be instrumental in helping children overcome adversity by reaching out and strengthening their resiliency skills as well as assisting families in locating supportive community resources. (See Table 1–7.)

Children growing up in violent and disadvantaged environments not only face challenges at home, but also at school. Younger children are more likely to attend child care programs that are of
In addition, children of all ages may have fewer opportunities to engage in learning and enrichment experiences at home. Researchers have observed that children from disadvantaged households typically have delayed language development and literacy skills due to less parent-child interaction and a lack of available reading materials (Pungello et al., 2009). This combination sets many children up for early school failure.

Children are also exposed to additional sources of extreme violence and death in movies, video games, cartoons, on television, and the Internet. Researchers have noted an increase in children's aggressive behaviors as the result of witnessing media violence, but no direct link has been established with involvement in adult criminal activity (Barlett & Rodeheffer, 2009; Strassburger, 2009).

Victims of bullying behavior are sometimes singled out because they are perceived to be socially withdrawn or loners, passive and lacking in self-confidence, having a disability or special needs, not likely to stand up for themselves, and easily hurt (emotionally). In addition, they are more often from economically disadvantaged families, smaller in physical size than their peers, and seen as having fewer friends (Bowes et al., 2009). It is becoming increasingly apparent that bullying behaviors have immediate and long-term negative consequences on children's personal, emotional, and academic development. Early signs that a child is being subjected to bullying may include frequent complaints of health problems, reluctance to attend school, and declining academic performance.

Prevention programs have been implemented in many schools to reduce bullying behavior and to create environments where children feel safe. Educational efforts address both the victims and perpetrators and are designed to teach mutual respect, reinforce effective social and communication skills, reduce harassment, and improve children's self-esteem. Children who are being bullied learn how to respond in these situations by avoiding bullies, walking away, practicing conflict resolution, and always informing an adult.

- What can families do to decrease the likelihood that their child will engage in bullying behavior?
- What factors might contribute to children's inability to control their anger and/or impulsive behaviors?
- How can families help children who are being bullied?
- Should children who harass other children be expelled from school?
- What is cyber bullying and are the consequences for victims any different than in face-to-face encounters?
However, repeated exposure to media violence and death has been shown to desensitize children to their dysfunctional significance (Fanti et al., 2009; Huesmann, 2007). Families are encouraged to limit children's media viewing, closely monitor what they are watching, and help children to understand that media is a form of creative entertainment and not reality.

Resilient Children

Children face many challenges while growing up in this complex world. Stress, violence, uncertainty, and negative encounters are everywhere. What makes some children more vulnerable to the negative effects of stress and aversive treatment or more likely to develop inappropriate behaviors? Many factors, including genetic predisposition, malnutrition, prenatal exposure to drugs or alcohol, poor attachment to primary caregivers, physical and/or learning disabilities, and/or an irritable personality have been suggested as possible explanations. Researchers have also looked at home environments and parenting styles that may make it difficult for some children to achieve normal developmental tasks and positive self-esteem (Guajardo, Snyder, & Petersen, 2009).

Why are other children better able to overcome the negative effects of an impoverished, traumatic, violent, or stressful childhood? This question continues to be a focus of study as researchers attempt to learn what conditions or qualities enable some children to be more resilient in the face of adversity. Although much remains to be understood, several important protective factors have been identified. These include having certain personal characteristics (such as above-average intelligence, positive self-esteem, and effective social and problem-solving skills), having a strong and dependable relationship with a parent or parent substitute, and having a social support network outside of one's immediate family (such as a church group, local recreation center, organized sports, Boys and Girls clubs, or youth groups).

Competent parenting is, beyond a doubt, one of the most important factors necessary for helping children manage adversity and avoid its potentially damaging consequences. Children who grow up in an environment where families are caring and emotionally responsive, provide meaningful supervision and discipline that is consistent and developmentally appropriate, offer encouragement and praise, and help their children learn to solve problems in a peaceful way are more resilient.

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**Table 1–7 Strategies for Increasing Children's Resilient Behaviors**

- Be a positive role model for children; demonstrate how you expect them to behave.
- Accept children unconditionally; avoid being judgmental.
- Help children develop and use effective communication skills.
- Listen carefully to children to show that you value their thoughts and ideas.
- Use discipline that is developmentally appropriate and based on natural or logical consequences.
- Use and enforce discipline consistently.
- Help children understand and express their feelings; encourage them to have empathy for others.
- Avoid harsh physical punishment and angry outbursts.
- Help children establish realistic goals, set high expectations for themselves, and have a positive outlook.
- Promote problem-solving skills; help children make informed decisions.
- Reinforce children's efforts with praise and encouragement.
- Give children responsibility; assign household tasks and classroom duties.
- Involve children in activities outside of their home.
- Encourage children to believe in themselves, to feel confident rather than seeing themselves as failures or victims.

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resilient – the ability to withstand or resist difficulty.
likely to demonstrate resilient behavior (Campbell-Sills, Forde & Stein, 2009; Ungar, 2007). Teachers, likewise, can promote resiliency by establishing classrooms where children feel accepted, respected, and supported in their efforts.

**Management Strategies** Understandably, all children undergo occasional periods of emotional instability or undesirable behavior. Short-term or one-time occurrences are usually not cause for concern. However, when a child consistently demonstrates abnormal or antisocial behaviors, an intervention program or counseling therapy may be necessary.

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**Classroom Corner**

**Teacher Activities**

**The Importance of Friendship** *(PreK-2, National Health Education Standard 4.2.1)*

**Concept:** It is fun to do things with friends.

**Learning Objectives**

- Children will learn that there are many activities to do with friends.
- Children will learn that friendship requires sharing and turn taking.
- Children will learn that working together can be a lot of fun.

**Supplies**

- a variety of colors of construction paper cut into large hearts (each heart should then be cut in half in a variety of ways so that the two heart pieces can be put back together to form a large heart); glue sticks; various art supplies (glitter, feathers, puff balls, foam shapes, etc.); adhesive tape; large piece of bulletin board paper (large enough to display all of the hearts)

**Learning Activities**

- Read and discuss one of the following books:
  - *What Is a Friend?* by Josie Firmin
  - *Winnie the Pooh Friendship Day* by Nancy Parent
  - *I Can Share* by David Parker
  - *Pooh Just be Nice to Your Little Friends!* by Caroline Kenneth
- Explain to the children that they are going to make a friendship quilt.
  - Have the children come up and pick a heart half. After they have all selected half of a heart, pair the two children together whose heart halves fit together. Provide art supplies and one glue stick per pair of children to encourage sharing and cooperation. When each pair of children has finished decorating their heart half, tape the two halves together. Label each heart set with the names of both children. Arrange the completed hearts on a large sheet of bulletin board paper to create a friendship quilt that can be hung up in your classroom.
  - Talk about the experience, including what it means to work with a partner and to make a friendship quilt.

**Evaluation**

- Children will work together and take turns.
- Children will name activities they like to do with their friends.

*Additional lesson plans for grades 3–5 are available on this text’s website.*
At times, it may be difficult for families to recognize or acknowledge abnormal behaviors in their own children. Some emotional problems develop slowly over time and therefore may be difficult to distinguish from normal behaviors. Some families may find it difficult to talk about or admit that their child has an emotional disturbance. Others, unknowingly, may be contributing to their children’s problems because of dysfunctional (e.g., abusive, unrealistic, inconsistent, or absent) parenting styles.

For whatever reasons, it may be teachers who first identify children’s abnormal social and emotional behaviors based on their understanding of typical development, careful observations, and documentation of inappropriate conduct. They also play an instrumental role in promoting children’s emotional health by providing stable and supportive environments that foster children’s self-esteem and self-confidence and teach socially appropriate behaviors (Bodrova & Leong, 2008). Children who develop conflict resolution, problem-solving, and effective communication skills have powerful resources to help them cope effectively with daily problems. In addition, teachers can use their expertise to help families acknowledge children’s problems, counsel them in appropriate behavior management techniques, strengthen parent-child relationships, and assist them in making arrangements for professional counseling or other needed services. Although most families welcome an opportunity to improve their parenting skills, the benefit to high-risk or dysfunctional families may be even greater.

**Summary**

- The concept of preventive health care:
  - recognizes that health attitudes and practices are learned behaviors.
  - encourages individuals to assume an active role in developing and maintaining practices that promote health.
  - suggests that childhood is an important time when positive health behaviors and habits are being established.
- A child’s health is determined by the interplay of genetic makeup and environment.
  - Health is a dynamic state of physical, mental, and social well-being that is continuously changing as a result of lifestyle decisions.
  - Children's growth and development potentials are influenced by the interactions of health, safety, and nutrition.
  - Health promotion begins with a sound understanding of children's growth and development.
  - Aspects of children's health that require special adult attention include safety and injury prevention, posture and physical activity, dental health, and mental health including fostering self-esteem, social-emotional competence, and resilience.

**Terms to Know**

- preventive health  p. 3
- food insecurity  p. 3
- health  p. 8
- heredity  p. 9
- predisposition  p. 9
- sedentary  p. 10
- nutrients  p. 10
- resistance  p. 11
- norms  p. 12
- normal  p. 12
- growth  p. 12
- attachment  p. 13
- head circumference  p. 13
- deciduous teeth  p. 13
- development  p. 15
- well child  p. 18
- fluorosis  p. 22
- self-concept  p. 23
- self-esteem  p. 23
- resilient  p. 30
Chapter Review

A. By Yourself:
1. Define each of the Terms to Know listed at the end of this chapter.
2. Explain how genetics and environment influence the quality of a child’s well-being.
3. Why are young children at high risk for unintentional injury?
4. What preventive practices are beneficial in promoting children’s oral health?
5. Discuss why children living in poverty may experience lower self-esteem?
6. What things can families do to help children build resilient skills?

B. As a Group:
1. Discuss how an individual’s lifestyle decisions can have either a positive or negative effect on health.
2. Describe how teachers can use their knowledge of children’s development for health promotion.
3. Explain why an abundant food supply does not always ensure a healthy diet.
4. Discuss why it is important to involve and include families in children’s health education activities. What steps can a teacher take to be sure that children’s cultural beliefs are respected?
5. Explain how incorporating more physical activity into daily classroom schedules benefits children and teachers. Describe several ways that teachers can modify routine activities to make them more aerobic.
6. Define the term self-concept. Provide specific examples of things teachers might do that could have a positive or negative effect on children’s self-esteem.
7. Discuss what effects a teacher’s mental health state could potentially have on children.

Case Study

Jose, 7 years old, and his mother live alone in a one-bedroom apartment close to his school. Most afternoons Jose walks home alone, lets himself into their apartment, and watches television until his mother comes home from work. His favorite after-school snack consists of potato chips and a soda or fruit drink. For dinner, Jose’s mother usually brings something home from a local fast food restaurant because she is “too tired to cook.” She knows this isn’t good for either one of them. Jose’s mother is currently being treated for high blood pressure, and the pediatrician has expressed concern about Jose’s continued weight gain. However, Jose’s mother doesn’t see how she can change anything given her work schedule and limited income.

1. How would you describe Jose’s short- and long-term health potential?
2. What concerns would you have about Jose’s safety?
3. What potential health problems is Jose likely to develop if he does not change his current behavior?
4. What environmental risk factors may be contributing to the family’s health problems?
5. If you were working with this family, what suggestions would you have for improving their health?
Application Activities

1. Observe at least four children while they are eating lunch or dinner. What foods does each child eat? What foods are refused? Based on your observations, do you think the children are developing healthy eating habits? If adults are present, observe their eating behaviors. Do you think the adults are modeling healthy eating habits? Do the adults’ food preferences seem to have any influence on what children are willing to eat? Explain.

2. Observe a small group of preschool-aged children during free-play or outdoor times for two 15-minute intervals. For each observation, select a different child and record the number of times that child engages in cooperative play. Repeat this observation procedure with a group of toddler or school-age children. Describe the differences.

3. Contact local law enforcement, fire, public school authorities, and community service organizations to learn more about the educational safety programs they offer for children. Volunteer your time and assist with one or more of these events. Discuss how appropriate and effective you thought the programs were based on your knowledge of child and curriculum development.

4. Contact your local public health department. Arrange to observe a routine well-child visit. What preventive health information was given to families? Was it presented in a way that families could understand and use?

5. Select and read ten children’s books from the Mental Health section in Appendix D. Prepare a brief annotation for each book, including the topic, theme, and recommendations. Describe how you would use each book to develop a learning activity that promotes children’s social-emotional competence.

6. Research and read more about the national health initiatives described in this chapter. Find out if they are available in your area and what services are provided. Are the programs/services meeting the needs of children in your community? If not, what recommendations would you offer for improvement?

7. Develop a month-long series of classroom learning activities focused on children’s oral health. Conduct several of your lessons with children and evaluate their effectiveness in terms of learning outcomes. What changes or improvements would you make the next time?

8. Modify the “Classroom Corner” activity on friendship to meet the National Health Education Standard 4.5.3. (Demonstrate non-violent strategies to manage or resolve conflict.) Design and describe at least three classroom activities that would teach and reinforce positive resolution techniques.

Helpful Web Resources

- American Academy of Pediatric Dentistry: http://www.aapd.org
- American Institute of Stress: http://www.stress.org
- Children’s Television Workshop Online: http://www.ctw.org
- Coordinated School Health Program: http://www.cdc.gov/HealthyYouth/CSHP/
- Council for Exceptional Children: http://www.cec.sped.org
- Healthy Schools, Healthy Youth: http://www.cdc.gov/HealthyYouth/
- Indian Health Service: http://www.ihs.gov
- National Academy for Child Development: http://www.nacd.org
- National Center for Children in Poverty: http://asp.cumc.columbia.edu
- National Mental Health Association: http://www.nmha.org
- National SAFE KIDS Campaign: http://www.safekids.org
Chapter 1  Children’s Well-Being: What It Is and How to Achieve It

You are just a click away from additional health, safety, and nutrition resources! Go to www.CengageBrain.com to access this text’s Education CourseMate website, where you’ll find:

- characteristics of healthy preschool children
- glossary flashcards, activities, tutorial quizzes, videos, web links, and more

References


Chapter 1  Children’s Well-Being: What It Is and How to Achieve It


Strassburger, V. (2009). Children, adolescents and the media: What we know, what we don’t know and what we need to find out quickly!, *Archives of Disease in Childhood*, 94(9), 655–657.


