Preschool Development Part 2: Psychosocial/Behavioral Development*

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IMPORTANT POINTS

1. **Assessment of psychosocial and behavioral milestones during health supervision visits requires consideration of both child temperament and parental style.**
2. **Problem behaviors often occur when the child's need for independent functioning, mastery, or self-identity conflicts with parental attitudes and expectations.**
3. **The clinician should be able to categorize parental concerns about psychosocial issues into "developmental variation," "problem," or "disorder," using the definitions provided by the *DSM-PC.***
4. **The high continuity of aggressive and oppositional behavior from preschool to later years mandates preventive interventions for preschoolers.**
5. **Child health supervision that features discussion of one or two key issues based on a clinical hypothesis of each individual child/family's developmental trajectory may be of greater value to families than recitation of generic advice about multiple topics.**

Introduction

During the preschool years, children are rapidly developing patterns of behavior and psychosocial skills that can be long-lasting. Clinicians have important opportunities to monitor and help shape optimal development when seeing preschool children for their health supervision visits. This is the second of a two-part article discussing the development of the preschool child from the point of view of the clinician who is conducting a visit using *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.*

** Part 1, Communicative and Motoric Aspects, appeared in the September 1997 issue of* **Pediatrics in Review.**

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Both articles are organized by the "trigger questions" suggested for visits at ages 2, 3, 4, and 5 years of age. The trigger questions regarding psychosocial and behavioral aspects of the child's development are reviewed here; the first article (*Pediatrics in Review* September 1997) focused on the "more traditional" developmental areas of communication and motor development.

Any dichotomy between behavior and development is murky because behavioral issues often are uncovered when reviewing areas traditionally called development, and behavior can be interpreted only in light of the child's level of developmental functioning. Research indicates that emotions and cognition are interconnected in a complex mechanism that makes any separation based on causal sequence or distinct domains rather arbitrary.

CLINICAL APPROACH

Clinicians generally approach the psychosocial and behavioral milestones quite differently from the more traditional developmental milestones, which tend to be discussed matter-of-factly, perhaps with some shared celebration of the child's accomplishments. This general approach can be of value in behavioral areas as well. Clinicians can focus on some of the developmental underpinnings of emerging behavioral issues that will help parents remain objective and positive about their child and avoid misinterpretations leading to unnecessary upset and problems. A familiar example would be celebrating the baby's crying upon separation from the parents as an achievement in memory capacity because it signals that "out of sight is no longer out of mind." This is often edifying to mothers who may interpret separation distress with guilty feelings because of their own return to work.

In the second year, new problems will arise related to sibling jealousy and possessiveness based on the child's emerging self-identity, an essential prerequisite for any personal ambition. In that light, the clinician might attempt to reframe some trying behaviors more positively by asking if the child is beginning to get a sense of himself or herself by being possessive of things and jealous of the parent. A pediatric focus on emerging underlying developmental structures even may help reduce the emotional charge to a preschooler's first attempts at lying and other deception. Parents can learn that the child's ability to block a natural emotional expression is a normal survival skill that emerges during the third year and will require moral instruction and modeling from trusted individuals to learn its appropriate use. Unlike the more traditional areas of development, addressing behavior not only documents whether the underlying developmental milestone has been attained, but how it is manifested based on the child's temperament. How does the child's new awareness of the world play out, given his or her general tendency for approach or withdrawal in social situations or ability to tolerate the frustration of delayed gratification, and how does the parent modulate these tendencies? The necessary history taking clearly is more complex than for

most areas of the more traditional developmental milestones.

TOOLS FOR ASSESSMENT

Traditional developmental milestones may be measured quantitatively, such as by standard intelligence quotient (IQ) or language tests, but assessment of behavioral milestones requires greater reliance on subjective judgments. However, some more objective assessments recently have been developed, even for problems presenting in primary care. The *Diagnostic and Statistical Manual of Mental Disorders* has revolutionized psychiatric diagnostic classification by use of standard criteria based on research and consensus of expert opinion. A new *Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC)* addresses the need to develop similar clear definitions for behavioral issues that do not yet represent psychiatric disorders but are appropriate for review as part of child health supervision. The *DSM-PC* identifies clusters of parent complaints and provides age-related criteria for judging whether the concern is within the expected range of "developmental variation" or has reached a "problem" level or even the severity or quality requiring diagnosis of a psychiatric "disorder." This classification scheme will be illustrated for some of the areas of behavioral development elicited by the trigger questions along with their code numbers.

CONDUCTING THE INTERVIEW

Data gathering, anticipatory guidance, and problem-solving related to child development suggested here may seem unrealistic or impossible within the brief time frame generally committed for these visits. It is neither feasible nor desirable to attempt to address all of the potential trigger question areas of development during a single health supervision visit. Instead, we advocate limiting discussion to one or two issues that are determined by identifying an individualized child/family's hypothesized trajectory of development. The clinician should consider the balance of risk and protective factors in the child's developmental course as well as both temperamental tendencies and parental style in selecting the most important issue to address. This may be a strength to promote or a challenge to favorable developmental progress and happiness to moderate. For example, the parents of a preschool child who has demonstrated a pattern of timidity and persistent social withdrawal outside the home may feel that the child is vulnerable and, therefore, tend to be overly protective. These parents may need encouragement to provide the child with experiences with peers and other mild challenges to help desensitize or "immunize" him or her to moderate this reaction tendency. Another child who has a similar temperamental pattern may have parents who are pushing him or her into numerous activities and seem intolerant of resistance and insensitive to the child's increasing upset. These parents could be encouraged to be patient with a temperamental pattern that may require time to warm up in social situations and gentle encouragement to take on more.

The priority given to such individually focused discussion means that some potential routine anticipatory guidance topics may need to be foreshortened or omitted. Routine information may be conveyed by someone other than the clinician, by handouts, by a parent group, or via media such as videotapes. The individualized approach proposed here requires much higher degrees of clinical skill and judgment as well as knowledge of child development and of the particular child and family than are required to recite a standard minilecture at each age/visit. This approach is in contrast to the perspective that the quality of child health supervision should be judged by the number of different anticipatory guidance topics covered. The information provided here should enable the clinician to be a more knowledgeable discussant in the conversation that follows typical clinical probes such as those suggested by the *Bright Futures Guidelines.*

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Family Relationships

Trigger Question: "How does ____ act around family members?" *Bright Futures* offers additional related trigger questions, including: **"How does she/he react to strangers?"; "How is child care (preschool, kindergarten) going?" (as related to separation); "How do you deal with tantrums?"; "What do you and your partner enjoy most about ____?"; and "What seems to be most difficult?"**

Evidence during the visit: Any tantrums and how parent manages them. Reaction to fears related to the visit and how parents manage. Ability of the child to pay attention to instructions and interview questions during the visit. Ability to attend during vision and hearing testing. How do siblings get along with each other during the visit? Are they supportive of fears? Do they tease about the shots or other matters? How does the parent handle these interactions? Is there fighting in the room? How does the parent handle that? Does the parent openly compare or shame children during the visit? How does the child relate to you and office staff? Does the parent express pride about the child verbally or nonverbally? Does the parent express frustration or negativity about the child verbally or nonverbally during the visit?

"Behavior around others" is comprised of the quality of relationships, social skills and emotional development, temperament, family discipline, biologically determined behavioral predispositions, and contextual stresses and supports. Controlling emotional states, including delaying gratification and tolerating frustration, separations, and fears without breaking down emotionally, are lifelong tasks that should be mastered during the preschool period. Displays of uninhibited anger and frustration increase during

the second year and then decrease in the third. The intrusiveness and painful procedures of the health supervision visit tax these skills and may provide an unrepresentative picture of the child's typical coping abilities, although future research may reveal that specific patterns of response have clinical significance.

SEPARATION

***Bright Futures'* suggested categories of response: Anxious about separation or not; dependent or self-reliant.** Tolerating separation from the parents is necessary to the growing autonomy of the child that is characteristic of this period. After the initial developmental task of forming attachments to their primary caregivers over the first 2 years, children now must hold the security of those relationships in their minds to function when separated to go or stay with other adults. The average 3-year-old child can separate easily from parents and go to known adults. However, there is great variability before this age, related primarily to individual temperament. Some children cope by adopting a transitional object or "lovey," usually a soft, malleable object that can acquire the odor of the mother, to carry in times of stress or separation, which serves as a symbolic reminder of the parent. The use of such an object is associated with greater, not lesser independent activity.

Children who have insecure patterns of attachment or painful separation experiences, whether due to losses of primary caregivers or dysfunctional parent-child relationships, are more likely to react abnormally to separation. They may be excessively clinging and fearful or they may be socially promiscuous, showing affection indiscriminately. Many potential coping styles tend to persist once established, even if they do not serve the child well. Often parents express concern about a behavior that is a coping mechanism for the child, such as social shyness or a tendency to be aggressive when fearful. Discovering the meaning of the behavior for the child is essential to determining whether intervention is needed and what is appropriate and likely to be effective.

EMOTIONAL TONE

***Bright Futures'* suggested categories of response: Responsive or withdrawn; outgoing or slow to warm up; wary/resistant.** Beyond the most common factor of temperament, children develop their emotional tone in several ways. The pattern of secure attachment to primary caregivers in infancy has some predictive power for "joy in mastery," "sociability," and IQ in the preschooler. Children younger than age 6 are especially responsive to the environment in terms of their emotional states. Even infants in the first 3 months of life respond to parental emotional tone with matched tone, which persists after the parent changes his or her expressed mood. Parental problems with child management and especially in conjunction with marital discord may strongly affect the child's longer term mood and adjustment and are very common (with divorce rates at 45% in the United States).

FEARS AND FANTASIES

Fantasy life becomes very rich during the preschool years. At first, it is indistinguishable from reality, resulting in a tendency for fears. By the age of 4, children frequently have frightening dreams that they can state are "not real," although this does not necessarily reassure them. Excessive fears or nightmares can be related to excessive life stresses on any developmental process; real dangers such as from abuse, dangerous surroundings, or sibling or peer bullies; or from the media. Temperamentally timid children may blame fears for their behavior. Aggressive children sometimes have excessive fears because they realize that they deserve retribution. Conversely, some children act aggressively to avoid that which they fear by attacking others before they are attacked. Some children differ physiologically in their reactivity, having a distinct tendency to experience shyness or fear in new situations. Kagan has shown how levels of adrenocortical hormone by-products and heart rate reactivity distinguish these children at a young age and how these tendencies persist. Because children continue to rely on verbal or nonverbal signals from their primary caregivers to shape their own emotional reactions to new situations, the parents' styles of handling situations should be considered when adaptability or fears are a problem.

TANTRUMS

Temper tantrums are so common as to be characteristic of 2-year-olds, but they should be infrequent by age 5, although there is another peak at 6 years, perhaps in response to the greater stresses of formal academic schooling. Temper tantrums can be exacerbated by: reinforcement by the parents; modeling in the family; exposure to violence, including physical punishment; temperamental low threshold, high reactivity, or lack of adaptability; fatigue; hunger; and lack of routines. Breath-holding spells may follow a tantrum. They occur in 5% of children younger than 8 years of age, are associated with a family history in 23%, and are related to other behavior problems in 18%. Eighty percent of these spells cease by age 5 and 90% by age 6. They are worsened by parental overconcern and attempts to intervene or to avoid tantrums through giving in. Children who have had a temperamental pattern of easy arousability, as well as those who have developmental weaknesses in expressive language or fine motor skills, often have more tantrums than expected for their age because of their repeated frustrations. Children who are outmatched by their playmates, even if their skills are normal, may react with tantrums.

OPPOSITIONALITY

***Bright Futures'* suggested category of response: Compliant or defiant.** Additional trigger questions: **"Do both parents and all caregivers agree on disciplinary style and setting limits?"(2 years); "Are you able to set clear and specific limits for ____?" (3 and older); "What do you and your partner do when you disagree or argue about discipline?"; "How do you deal with ____'s greater independence (3 and older)"; and "What do you do when ____ has ideas that are different from yours?"**

Evidence during the visit: How does the parent set limits on explo-

ration of the room, their possessions, their bodies, and excessive silliness or talking? Observations of the parents' limit-setting on siblings. Do parents interfere with each other's management in the room? Do parents hit the child in the waiting room or office? Does the parent allow the child to answer for himself or herself? How is the child able to ask and answer questions, separate for the examination, go to the bathroom alone, and go through vision and hearing testing?

Almost all preschool children are noncompliant, at least some of the time—on average, they comply with adult requests about 50% of the time. This struggle for autonomy can be viewed as a positive milestone of development, with passivity representing a potential symptom of depression or intimidation. It is the parents' job to provide the structure that will influence the child to comply with our culture's standards for behavior. Research indicates that parents who are authoritative and firm but also warm, encouraging, and rational are more likely to have children who are self-reliant and self-controlled. Parents need to establish a system of discipline at least by the preschool years that includes three essential components: positive reinforcement for desired behaviors; consequences for undesired behaviors; and, most importantly, interactions that promote the parent-child relationship. Noncompliance as part of conduct disturbances is more common in families whose parenting practices include lax, harsh, or inconsistent rules; unclear, complex, or emotionally charged instructions; lack of warmth; or poor monitoring of the child.

One major concern of parents of preschoolers that affects both the relationship and the child's compliance is his or her activity level. Sturner found that 25.3% of parents of 4-year-olds included "overactive" in a checklist of adjectives about their child. However, poor control of attention is a greater detriment to academic success than high activity level. Multiple factors affect the attentional system, including health (eg, lead levels, anemia, past neurologic insult), current presence of medications, emotional problems such as anxiety or depression, environmental stresses, ability to see and hear adequately, hunger and fatigue, and temperament. There are different patterns of attention difficulties, including capturing attention, sustaining attention, and moving attention from one subject to the next, which currently are not well delineated clinically. Attention deficit disorder with (DSM 314.01) or without hyperactivity (DSM 314.00) is one of the most common mental health diagnoses of preschool children. Two to seven percent of preschoolers are affected, and it may be comorbid with oppositional defiant disorder (DSM 313.81). A high activity level also can represent vigor, which should be admired and harnessed productively later. This is a point of view that clinicians can encourage and model, especially for parents who are beginning to develop a negative perception of the child.

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Although temperamental factors predispose children to oppositional and aggressive reactions, some oppositional behavior problems may be prevented through optimizing behavioral management by parents. It is often unclear what proportion of the problem can be attributed to child factors and how much is due to parental management difficulties or other environmental factors. When behavior management intervention includes discussion of the importance of constitutional factors, parents often feel less blame and are more open to suggestions and examination of extenuating environmental factors.

Because oppositionality and aggression peak during the preschool years, clinicians may discount concerns as representing typical behavior and predict that the child will outgrow it. However, aggression during the preschool period correlates (r = 0.68) with later serious behavior and conduct disorders. In addition, even if these problems were to subside naturally, the family anguish and pain should be considered. Evaluation should include a review of the amount of distress the behavior is causing, the extent to which it interferes with normal everyday functioning of the child (such as elicited by the trigger questions related to independent functioning), and whether the child usually is happy.

Clinicians should respond to any parental concern about oppositionality or aggression, but they also should be able to differentiate situations that are beyond the expected variation for preschoolers for which reassurance would be inappropriate. The DSM-PC differentiates aggressive/oppositional "variation" from "problems" and from psychiatric "disorders." The developmental "variation" category (DSM-PC V65.4) is used for situations in which there is only mild negative impact, no one is hurt by the oppositionality, and parents do not change their plans significantly, even though the child may procrastinate, use bad language, and argue. In contrast, an oppositional "problem" (DSM-PC 71.02) includes tantrums when asked to do chores or purposely messing up the house, accompanied by a negative attitude that persists for many days. These children may run away from their parents on several occasions. When a hostile, defiant attitude persists for 6 months, it meets criteria for oppositional defiant "disorder." An "aggressive developmental variation" is the term and code used to describe typical preschool grabbing of toys, hitting or kicking siblings several times per week but with minimal negative impact, and regular negative response to parental reprimand. A preschooler's aggression is said to reach the "problem" level when the negative impact of the behaviors causes people to change their routines, property begins to be damaged seriously, and the aggression is frequent. Symptoms rarely reach the level of a conduct disorder (DSM-PC 312.81)

before 5 or 6 years of age, but the launching of such a trajectory can be seen. A review of anticipatory guidance and pediatric counseling for issues of compliance and aggression is beyond the scope of this article (see Howard in Suggested Reading), but specific advice regarding a well-defined and labeled "special time," reinforcers such as marks on the hand, and well-structured bedtime and time-out routines often is required in addition to an understanding of contributing child and parent background factors.

SIBLING INTERACTIONS

Problems with siblings are a common concern of both children and their parents. Sixty-five percent of children report fights with their siblings that only decrease "some" after third grade and reduce "more significantly" after one of the children passes 15 years of age. Many factors are associated with greater sibling rivalry, including opposite gender, difficult temperament, insecure pattern of attachment, family discord, corporal punishment, and, most importantly, perception of differential treatment. The entrance of a new baby into the family is likely during the preschool years. How a child interacts with the new arrival in the first 3 weeks predicts interactions into the second year. More than 90% of children "regress" when a new baby is born, exhibiting behavioral changes of increased naughtiness, thumb sucking, and altered patterns of feeding, sleeping, or toileting that are considered by some to be signs of "imitation" of the newborn. These same types of responses occur under stress of any kind to the young child. The stress in this case entails separation and loss or threatened loss of the parents' love and attention as well as actual worries in older children over danger to the mother. Parents have been noted to become stricter in their discipline during and after pregnancy as well.

On the other hand, children, like adults, experience excitement, love of the infant, and enhanced self-esteem through their relationships with a new sibling. Preparation for the sibling through sibling classes, avoidance of forced interactions and descriptions of the mother's pain during labor and delivery, a strong pre-existing relationship between the older child and the father, good support for the mother postpartum, individual time continued with each parent, and intense empathetic talk about the new baby's feelings and point of view have been shown to be helpful. Logical but unresearched practices to assist adjustment to a new sibling include having visitors greet the older child first, providing presents for the older child, giving the child some role in caring for the infant, and allowing an attempt (albeit with an attitude of mild surprise) when the older child requests a breastfeeding.

Interaction between siblings can be improved through prompt limiting of aggression toward the sibling, acknowledgment of the child's positive and negative feelings, reinforcement through praise, and teaching such strategies as distraction, trading, taking turns, and teaching. Siblings can be encouraged to cooperate by having the parents show that they value cooperation by talking about it and commenting on its presence or absence, having the parents distract the children from irritated interactions, setting tasks with joint goals, promoting noncompetitive games, and working continually for individualized treatment.

When siblings fight in spite of all efforts to guide positive relationships, it is important to know that parents' interventions tend to increase fighting several fold. Instead, a "graded" approach is better. Minor skirmishes are ignored if possible. More intense disputes can be handled by having the parent enter the scene, describe what is seen (especially the feelings and dynamics present), hear both sides briefly, then leave, stating confidence in the children's good intentions and ability to resolve it. More serious disputes should be handled similarly except that the children or the object of dispute should be removed. Physical battles require further actions, such as time-out for both children for the length of time appropriate for the younger child. Attempts to determine fault are generally unproductive, but chronic bullying or sibling abuse must be avoided. Positive sibling relationships often result in lifelong loyalty, friendship, and support.

Many factors are associated with greater sibling rivalry, including opposite gender, difficult temperament, insecure pattern of attachment, family discord, corporal punishment, and most importantly, perception of differential treatment.

Peer Relationships

Trigger question: "How does ____ act around other children (Table 1)? *Evidence during the visit:* Is there any aggression by the child during the visit (eg, when restrained for the examination or procedures, when undressing)? Is there any physical punishment of the child by the parent during the examination or in the waiting room? How does the child interact with other children in the waiting room?

PLAY

Bright Futures' **suggested categories of response: Friendly/affectionate or hostile/aggressive; interactive or withdrawn/resistant.** One of the most obvious tasks of developmental progress for the preschool child is learning to interact happily with peers. At the age of 2 years, most play still is parallel, although children frequently look at peers and copy some of their actions. By the age of 3, children should have mastered aggression and should be able to initiate associative play with a peer, have joint goals in their play together, and take turns, although children generally can play effectively only with groups of children in the same numbers as their years of age. Thus, by age 4, children usually can play with three others fairly well. Fantasy or pretend play gains prominence at about age 3. Children can play out longer stories as they mature, with each child taking a specific role. By age 5, the child has many social skills expected of adults, such as responding to the good fortune of others spontaneously with positive verbal messages, apologizing for uninten-

TABLE 1. How does ____ act around others?

	2-YEAR VISIT	3-YEAR VISIT	4-YEAR VISIT	5-YEAR VISIT
Amount of interaction	**Parallel play with peers,** copies others, self-talk, solitary play, offers toy, **plays games**	Takes on a role, prefers some friends over others, plays associatively with others	**Interactive games,** best friend <2 y difference, may visit neighbor by self, plays cooperatively with others	Group of friends
Duration of interaction	Briefly alone from adult, sudden shifts in intensity of activity	20 min with peers	Prefers peer play to solitary	
Level of fantasy	Symbolic doll, action figures; mimics domestic activities hours later	**Simple fantasy play;** unfamiliar may be monsters	**Elaborate fantasy play, distinguishes fantasy from reality,** tells fanciful tales	**Make-believe and dress up**
Imaginary friends		May have one	Common	If present, private
Favorite toys/ activities	Things that move, turn, or fit together; water; books; music; **listens to stories**	**Listens to stories,** dresses and undresses dolls	**Sings a song,** dances, acts, **listens to stories**	
Rule use	**Able to take turns,** beginning property rights, "mine," "right places"	Shares some	Shares spontaneously, **follows rules in simple games,** facility with rules, alternately demanding/cooperative	**Follows rules of the game,** follows community rules
Aggression	Aggressive to get things	Negotiates conflicts	Wants to please friends	

***Boldface type indicates "milestone" cited in* Bright Futures.**

tional mistakes, and relating to a group of friends.

Pretend friends are very common in children up to the age of 4. These fantasy figures often fill the role of scapegoat for misbehavior, demonstrating that the child recognizes correct behavior but cannot always do the right thing. Alternatively, the pretend friend can be an "alter ego" or ideal self, such as an outgoing companion for a naturally shy child, who can help children through difficult or anxiety-provoking experiences. In general, children who invent imaginary friends are well-adjusted and believed to be creative, reflective, and cooperative. However, when fantasy friends dominate the child's play, his or her opportunities for interaction and social abilities should be evaluated.

Mastery of aggressive impulses should improve after 2½ years of age. Prior to that time, most children will try aggression for "instrumental" reasons to obtain a desired toy. Hostile aggression (intended to hurt the other) is more common in boys, especially those who have poor impulse control, who are punished physically, who view violence, or who are suffering from a difficult separation experience. These aggressive drives, although quite variable from one individual to the next, usually are converted progressively into language and symbolic violent play. Children create gun play even without apparent models and use it to express aggression safely as well as to fantasize powerful roles that help them deal with their fears about their very real vulnerability.

Fathers play an important role in teaching young children to modulate their aggression, partly through horseplay on which the father sets limits. Boys raised without a father figure tend to have more difficulty mastering their aggression. Thwarting of any major developmental need can result in hyperaggressivity. Lack of adequate expressive language or fine motor skills; lack of appropriate parental limits (either through excessive strictness or little control); and modeling or exposure to violence through television, the neighborhood, or within the home also promote aggression. The DSM-PC categories of aggression as a "developmental variation" or "problem" in the aggressive/oppositional series described previously with regard to family members also represents the appropriate descriptors and codes for difficulties with peers.

EMPATHY

Trigger question: "Does ____ show an ability to understand the feel-

ings of others?" *Bright Futures* offers additional related trigger questions: **"Tell me about ____'s typical play."; "Is ____ interested in other children?"; "Does ____ have playmates?"**

Evidence during the visit: Any observed interactions in the waiting room, hallway, or with siblings in the room; discussion about friends; drawing of children. Does the parent offer privacy from siblings for the examination? Does the child demonstrate modesty during the examination?

Social development during the preschool years should include acquisition of the human characteristics of shame, guilt, empathy, self-awareness, and classification of events and preferences among peers. Although prosocial behaviors such as concern over the distress of others is present during infancy, children initially can take another's point of view with true empathy at around 3 years of age. However, this does not protect others from impulsive acts or prevent "cheating" when temptations arise, even in school-age children. Two-year-olds have a sense of self, exemplified in the classic experiment of recognizing rouge on the nose as being a difference in their own appearance. Three-years-olds do not yet compare themselves with others in a rank order, eg, as "braver" or "smarter." A profound lack of feelings for others can signal pervasive developmental disorder (Autistic Disorder DSM-PC 299.00) or reactive attachment disorder (DSM 313.89). Autistic disorder is defined by delays or abnormality in social interaction, social use of language, or symbolic or imaginative play.

SEXUALITY

Sexual feelings are clearly present before the preschool years, but become more obvious now. Handling the genitals for pleasure (masturbation) peaks at 2½ years of age before becoming more private, and exploring the genitals of others also is common. Compulsive masturbation or that which interferes with other activities or infringes on the rights of others is a problem that suggests sexual abuse. The solidification of gender identity and gender role identity occurs during the preschool period. Freud entitled this the Oedipal period in recognition of the working through of identification with the same-sex parent and letting go of sexual desires and possessiveness toward the opposite-sex parent in the face of competition with the spouse. Other major theories of how sexual identity develops include social learning through reinforcement of what society deems gender-appropriate behaviors (including through the media) and major biologic determinants for behaviors. Parents often are dismayed by their child's gender-stereotyped play, even when the family has espoused less traditional roles. Occasional cross-gender role playing and dressing is common, especially in girls, but it is of concern only if it persists for 6 months or includes statements that the child would prefer to be of the opposite sex and total rejection of attributes of his or her own sex (DSM-PC Cross-Gender Behavior Problem V40.3 or Childhood Gender Identity Disorder 302.6).

Independence

Trigger Question: To what extent has ____ developed independence in eating, dressing, and toileting (Table 2)? *Bright Futures* offers additional related trigger questions (for 2-year-olds): **"What are your plans for toilet teaching?"; "What are ____'s eating habits?"; "Does ____ usually eat what you fix for dinner?"**

Evidence from the visit: Presence of diapers versus underpants, signs of soiled underwear, requests for toilet visits, ability to undress and dress for the examination, growth patterns, presence of obesity or failure to thrive.

The answers to these questions may be difficult to interpret because throughout the preschool period, any child from age 2 to 5 years could regress momentarily to total infantile dependence, such as going limp and saying "I'm a baby," then quickly show absolute independence, declaring "I can do it myself," even when the task is something he or she has never done before. For some parents, the fluctuation between states of dependence and independence presents great difficulties because of their own upbringing or current circumstances. Some may have a strong investment in their children being very independent and needing less from them; others may long for their child's continuing dependence. The clinician should attend to what is typical of or worrisome about the child according to the parent and review of what the child ever has done. The parent's response may reveal an attitude toward the child's vacillations on the road toward greater independence that will make the journey more difficult than necessary despite the child's potential abilities. If the clinician discovers that the parent is struggling with

TABLE 2: To what extent has ____ developed independence in eating, dressing, and toileting?

	2-YEAR VISIT	3-YEAR VISIT	4-YEAR VISIT	5-YEAR VISIT
Eating	Uses utensils	Spills little, pours some	Helps set table	Helps cook
Dressing	Undresses, pulls on simple garment	Dresses with supervision, unbuttons some	Dresses all but tying	
Toileting	Clean and dry, but with adult effort and motivation	Clean and dry by self-motivated approach	Independent	

either end of the dependence/independence continuum, anticipatory guidance should address this issue: "Is it hard to see ____ grow up so fast?"; "How old do you think ____ will need to be before you feel comfortable allowing him to (sleep by himself or go off to school by himself)?" Alternatively, the clinician could say, "When a child acts babyish, it makes some parents feel they have to be firm and push the child to grow up. This usually has the reverse effect. Children choose to be brave only when they feel confident that they will be babied during those moments when they feel they really need it."

EATING

Appropriate eating behaviors for a 2-year-old child include being able to use utensils well but with continued messiness and insistence on rituals. Attempts by a parent to intervene in preventing the mess should be avoided, and their reasons for such interventions should be elicited. Such reasons may include impatience with "babyishness" that the mess represents or a need to continue spoon-feeding their "baby" instead of allowing the autonomy that self-feeding represents. By age 3, children can be expected to feed themselves without spilling much and, if given the opportunity to pour from small containers, will be able to gauge the capacity of a cup correctly. A 4-year-old can be expected to help set the table, and a 5-year-old will assist in mixing and cooking food, if given the opportunity. Preschool-age children should have adequate patience to sit at the table for 10 minutes, but often not any longer. Parents should be asked about their expected length of mealtime cooperation when there are parental complaints; excessive expectations may be the real problem. Mealtime behavior is a frequent complaint during the preschool years; 85% of children are rated by their parents as being picky eaters. When growth is normal (height and weight greater than the third percentile), this may be considered an Inadequate Nutritional Intake Variation (DSM-PC V65.49). If the child fails to maintain growth velocity for more than 6 months, it is an Inadequate Nutritional Intake Problem (DSM-PC V 40.3). If the young child loses a significant amount of weight or fails to gain weight for more than 1 month, it is a Feeding Disorder (DSM 307.59).

It is often difficult for parents to cede control of feeding after infancy. The child's decreased caloric needs after 1 year of age; cognitive awareness of differences in texture, taste, and placement on the plate; and desires for autonomy in all areas can make mealtimes ideal battlegrounds. Parents may need advice to judge intake over 48 hours for children in this age group. They also may need coaching about not transmitting their concerns to the child to avoid ongoing food struggles. Problematic mealtime behaviors include throwing food and utensils, hitting and kicking siblings, climbing onto parents' laps, eating off others' plates, requesting a different menu, and dominating the conversation. Clear limits need to be set for these, with time-out for aggression and removal from the table until a snack time at least 1 hour later for other disruptive behavior. It is vital for both parents to agree on (and other relatives to stay out of) the plan for this and other behavior problems. Gorging and food refusal generally reflect ambivalence over nurturing and being nurtured, which need to be addressed with a family approach.

The 2-year-old will be interested but incomplete in washing hands. A struggle often ensues if the child's expectation for continued water play is violated. They assist in bathing themselves. Three-year-olds can wash and dry their hands and face without needing a rewipe. The 4-year-old can towel dry after a bath and even brush his or her teeth reliably. The 5-year-old can bathe or shower without assistance.

Preschool-age children should have adequate patience to sit at the table for 10 minutes, but often not any longer.

DRESSING

Parental report of independence in dressing should reveal the 2-year-old's ability to and penchant for taking off clothing, including shoes, socks, and pants, but a lack of success in dressing beyond cooperation by thrusting arms through sleeves. Although the 2½-year-old can undress completely, there may be typical resistance to dressing and attempts to run and turn it into an exciting chase game. Parents ideally can cajole with promises of a bedtime story or turn the dressing into a speedy, game-like activity. The 3-year-old will begin to put on pants, socks, and shoes, but cannot be expected to button. His or her capacity to demonstrate this new dressing ability depends on the level of fatigue and general mood. A 4-year-old usually will be able to dress completely, including distinguishing front from back, but will not be able to tie. These children also can put clothes away without assistance. Dressing difficulty at age 5 years may be due to dawdling or a parental need to speed through the morning events. Children need a dependable routine that accommodates their speed and abilities.

TOILETING

To be independent in toileting, children must be able to signal the need before voiding, walk, climb, pull their clothes up and down, be dry for several hours during the day, understand what the toilet is for, and be motivated to model after adults and please them. On average, these skills come together around age 2½, although 61% of cultures train at the age of walking or even during early infancy. However, such training generally requires much effort on the part of the parents, followed by close attention to infants' signaling to help them get to an appropriate place to eliminate. It is also important that parents who attempt early toileting not misinterpret the likely episodes of regression (DSM-PC Soiling Variation V65.49) as behavior that must be punished. There is a wide range of normal for readiness; failure to be trained is not considered abnormal until after age 4, although upsetting struggles about toileting and withholding/constipa-

tion cycles (DSM-PC Soiling Problem V40.3) should be addressed whenever they occur.

Problems associated with delays in toilet learning include relapses in training, toileting for only urine (or only stools), accidents, and fears of the toilet. Toileting is such a strong symbol of "growing up" that it often assumes great importance to both parent and child, resulting in battles over control. Parents who are either overcontrolling or underregulating frequently have children who have toileting problems during the preschool years. These problems cannot be resolved until the issues of control have been managed along with any concomitant constipation.

Relapses in toileting occur in 50% of children in the year after training, even without urinary tract infection. Many children, especially hyperactive ones, are too busy to sit or return from outdoors. Fears of the toilet can be due to accidents, but also may be developmental fears related to body integrity and magical thinking about the potential for disappearing down the toilet. The degree of modesty in the home or exposure to erotic media may need to be altered to relieve sexual tensions that exacerbate fears. Sexual misuse also should be considered when a new toileting problem occurs.

Nocturnal enuresis is so common that it can be considered normal up to age 6. At age 5, 11% of girls and 14% of boys still are wetting the bed regularly. There is a 15% annual decrease in that event after that age (DSM-PC Day or Nighttime Wetting Variation V65.49). A return to enuresis after months of dryness is common around age 4. Stressors, presence of urinary tract infection, or signs of sexual abuse should be evaluated. The key task of the clinician during this age period is to assure that the child is not being shamed or punished for enuresis by parents or siblings (DSM-PC Wetting Problem V40.3), often by reflecting on the family history (positive in 75%) of onset of night dryness to elicit patience.

Motor and Cognitive Aspects of Play

Trigger Question: "Tell me about __'s typical play (Table 3)." *Bright Futures* offers the additional related trigger question: **"What are some of the new things ____ is doing?"**

Evidence during the visit: Any play observed in the waiting room or office.

In addition to the social aspects of play with peers already described, the type of play a child prefers reflects cognitive, fine and gross motor, and visual perceptual motor skills. Children will not play for long at activities that frustrate them because of a lack of ability. Fine motor and visual perceptual motor skills are being refined during these years, but there is a broad range of time for normal acquisition (DSM-PC Developmental Coordination Variation V65.49). Observing the child copy shapes can reveal much about attention, temperament, experience with pencil and paper, and progress in skill acquisition. Copying the Gesell figures (Table 3) occurs at well-described ages. Imitating the examiner drawing the same shapes generally is possible 6 months earlier than the harder task of copying, which, therefore, should be requested by the examiner first. Pencil grip begins awkwardly at age 2 years, moving from the end of the pencil to the mature tripod grip by age 5 years. Lack of control to stop repetitive circular scribbling at 2½ years transforms into controlled closure of circles, followed by the isolated branches of the cross, square corners, and finally the difficult ability to change direction that is needed to complete a triangle.

To draw a person, additional details are added progressively into the school-age years, starting with a total of two body parts at age 3 and four details per year thereafter. Manipulation of 1-in cubes has been a standard part of psychological testing, even though such small blocks are not readily available as toys in homes. The steady progress in the ability to build higher and higher

TABLE 3. Tell me about ____'s typical play.

	2-YEAR VISIT	3-YEAR VISIT	4-YEAR VISIT	5-YEAR VISIT
Pencil grip	Point down	Awkward, high		Standard
Drawings				
Identifies		Shapes	Longer line	Directions
Imitates	Vertical, scribble	Horizontal, cross		
Copies		**Circle before cross**	**Cross before square**	**Square before triangle**
Person-body parts		**2 parts**	6 parts	10, including head, body, arms, legs
Scissors	One hand	Across paper	Cuts out square	
Block tower	6–9	**Tower of 10**		
Block figure	Aligns 4 for train	3 block bridge	5 block gate	Steps
Other	Turns pages 1 at a time			Ties knot in string, prints letters

***Boldface type indicates "milestone" cited in* Bright Futures.**

towers from infancy into the 6-block tower built by the 2-year-old and the 10-block tower by the 3-year-old has been found to be related to general cognitive capacity, not simply an increased ability to align cubes so that they balance. Copying designs from blocks requires attention to the details of the model and perception of its form, not simply fine motor skill.

Fine motor skills are separate from visual-perceptual skills and, therefore, should be assessed separately. For example, some children who have fine motor problems can be observed to see the model clearly by their attempts to copy it or even verbalize about it when their fine motor skills are insufficient to construct it. The Draw-A-Person task can show much about the child's fine motor skills and is an important window into emotional life, as described in the first article in this series.

Parents generally describe only extreme problems with fine motor skills. They may notice a need for help with utensils, continued finger feeding, or difficulty in dressing oneself after the usual ages of attainment. Delays in these attainments without evidence on examination of skill deficits may be due to inappropriately low expectations by the parents and lack of opportunity, which should be addressed. Vulnerable child syndrome may be signaled by lack of self-care. Some lag in gross or fine motor coordination in areas such as running, climbing, self-care, drawing, or onset of handedness is common and now defined by DSM-PC as a "problem" (Developmental Coordination Problem 781.3) when more than two but not most of these areas are delayed enough to cause some impairment. It is considered a "disorder" (Developmental Coordination Disorder 315.4) if most areas are affected. The prevalence of the Developmental Coordination Disorder is estimated to be as high as 6% among children ages 5 to 11 years. Strengths in fine motor skills may translate into artistic or mechanical ability.

Summary

Developmental surveillance for the preschooler requires a knowledge of developmental principles and the ability to interpret responses to a focused interview that elicits parent observations and concerns.

PIR QUIZ

1. The *Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC)* defines a psychosocial concern of parents regarding a child as a "developmental variation" if it:
   A. Has mild negative import, hurts no one, and has little or no effect on parental behavior.
   B. Has substantial impact on intrafamilial relations for 6 months or more.
   C. Has substantial impact on intrafamilial relations for up to several days.
   D. Represents ignorance or a misunderstanding of normal development on the part of the parents.

2. The *DSM-PC* defines a psychosocial concern of parents regarding a child as a "problem" if it:
   A. Has mild negative import, hurts no one, and has little or no effect on parental behavior.
   B. Has substantial impact on intrafamilial relations for 6 months or more.
   C. Has substantial impact on intrafamilial relations for up to several days.
   D. Represents ignorance or a misunderstanding of normal development on the part of the parents.

3. Promotion by the clinician of psychosocial development in the preschool child likely will be supported *best* by:
   A. The clinician discussing a number of age-appropriate topics in the interview.
   B. The clinician focusing on one or two topics suggested by prior and current knowledge of the child and family.
   C. The clinician making available a wide range of literature dealing with likely issues.
   D. The parents preparing a list of topics to be discussed before the visit.

4. Why is it important to intervene in problems of aggression?
   A. Children need assistance learning alternative coping strategies as preschoolers.
   B. Chronic bullying damages long-term sibling relationships.
   C. Preschool aggression is highly correlated wth later behavior.
   D. All of the above.

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