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WEST VIRGINIA EARLY CHILDHOOD PROVIDER QUARTERLY

The *One* Thing

WVIT Continues to Expand

Foster Care: A Little Talked About Transition

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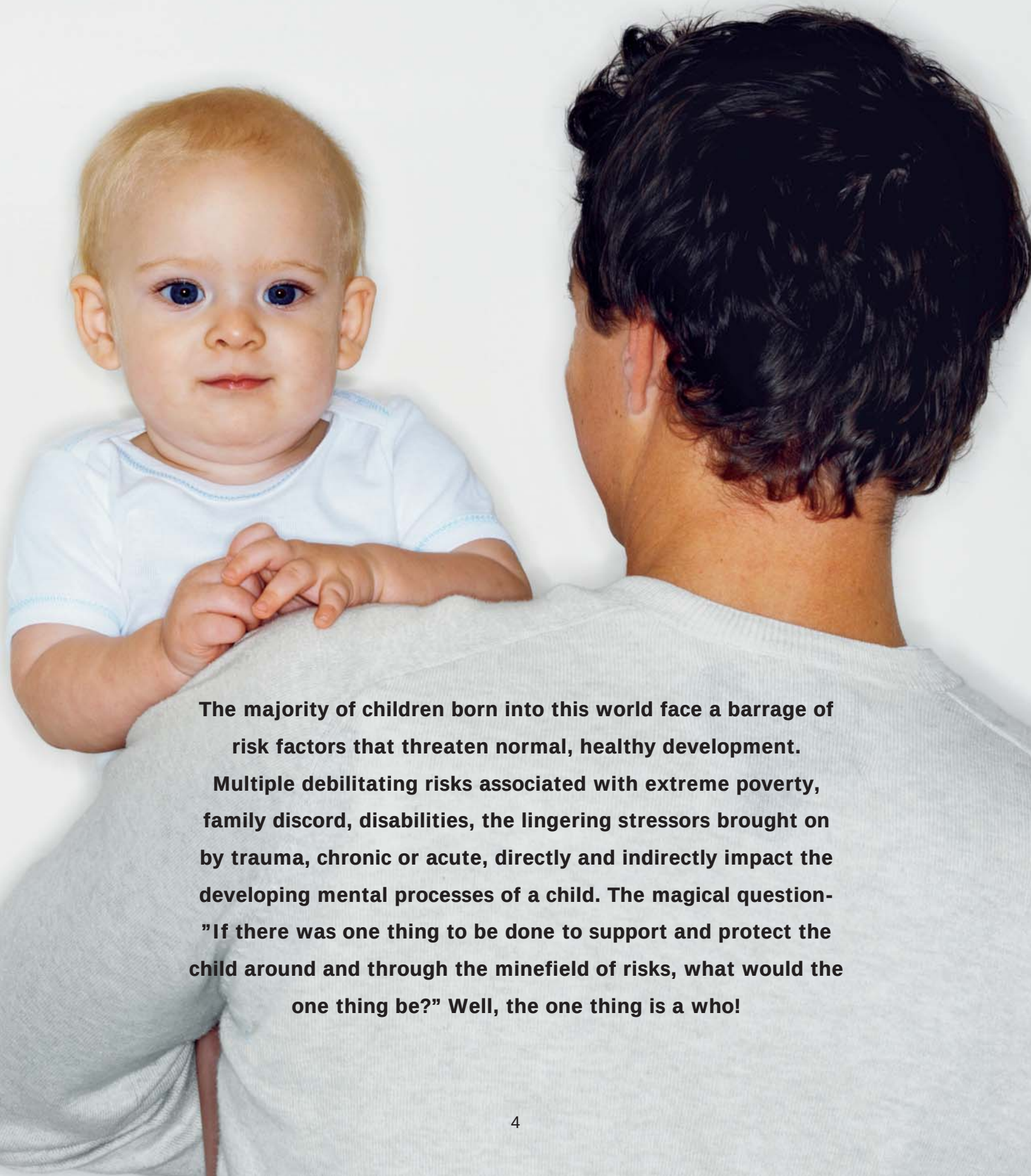
The One Thing

Submitted by Saun Floyd, Early Care and Education Specialist



The majority of children born into this world face a barrage of risk factors that threaten normal, healthy development. Multiple debilitating risks associated with extreme poverty, family discord, disabilities, the lingering stressors brought on by trauma, chronic or acute, directly and indirectly impact the developing mental processes of a child. The magical question- "If there was one thing to be done to support and protect the child around and through the minefield of risks, what would the one thing be?" Well, the one thing is a who!

The one thing infants need for mental health, what they most require, is one warm, supportive, responsive, and engaging adult who accepts them unconditionally. The newborn in the crib cannot meet his needs independently. He requires an external source not only to meet his most basic needs, but, in a very real sense, to regulate his emotions as well. Not discounting other factors, the degree to which an adult responds, consistently, to meet the newborn's needs, will directly affect the child's sense of safety, trust, efficacy, and future relationships. Through these innumerable interactions, with the adult meeting the infant's needs, engaging him, interacting, soothing…more and more information is internalized by the child until eventually he has within himself the ability to self-soothe, a sense of the world as a safe place, and an emerging sense of competence. Voluminous research has repeatedly confirmed infant mental health is directly associated with such adult/child relationships. The one thing cannot evaporate poverty, heal disabilities, or stop family discord. What the one thing can do is build the child's sense of security, develop healthy adaptive/protective factors, bolster self-regulating skills and enhance feelings of competency and self-worth.

Problems emerge early. Infants are born with a limited set of innate strategies to engage adults--cooing, fussiness, crying, etc. These 'primary attachment strategies' are successful about 60-70 percent of the time (depending on the research reviewed). Through repetitive positive interactions (bonding), the infant/adult relationship becomes secure (attachment). This is paramount to mental health. However, when those inborn abilities are unsuccessful, such as in the case of an abusive/negligent caregiver (imagine being afraid of your source of sustenance and safety!), the infant begins to search for other ways to get his needs met. These 'secondary attachment strategies' are out of the realm of normal. Such infants develop myriad difficulties conceptualizing the world, attempting to get their needs met, and relating to others, when their primary strategies fail to elicit what should be natural responses. Some die, even when their physiological needs are met, facing the complexities and stresses of being a human, by and large, alone in this world. Others develop cognitions and behaviors that clearly demonstrate mental distress. The effects are far-reaching, long-lasting and can often be traced to one thing.

Some in the early childhood community continually seek new interventions, new models, the latest, greatest, next big thing. Some hold to traditions long proven unwise and often harmful. Most are somewhere in between. We read, network, go to trainings, seminars, conferences, pair 'n share and brainstorm, seeking the answer to the often asked question; what is the one thing…?

The one thing is a who. Is it you?

"The one thing cannot evaporate poverty, heal disabilities, or stop family discord. What the one thing can do is build the child's sense of security, develop healthy adaptive/protective factors, bolster self-regulating skills and enhance feelings of competency and self-worth."

A couple references worth a look:

Dr. Bruce Perry, http://www.childtrauma.org/

Center on the Developing Child, Harvard University, http://developingchild.harvard.edu/topics/science_of_early_childhood/

Working with Traumatized Young Children in Child Care and Education Settings

Written by Alicia F. Lieberman, Reprinted from Concepts for Care: 20 Essays on Infant/Toddler Development and Learning, Edited by J. Ronald Lally, Peter L. Mangione and Deborah Greenwald. Reprinted with permission from WestEd.

Teachers and program leaders in child care programs often find themselves caring for young children who have had traumatic experiences. Information such as that presented here can be used to help young children function in a group care setting. Teachers may never learn about events that have led to a child's post-traumatic behaviors, and it is not a teacher's role to make any kind of diagnosis. Most of the behaviors described here occur within the typical range of behavior, yet with a child who has been traumatized, the behavior tends to be more extreme and intense. In these situations, the usual techniques and strategies that are generally successful with other children no longer work. Teachers and program leaders can learn about mental health resources in their community, possibly through the local child care resource and referral agency. Working closely with family members is an essential part of addressing issues that arise in the child care setting.

Exposure to traumatic events is a leading cause of death and injury in young children. For example, physical abuse and accidents are the leading cause of death in the first five years of life. Even when the child is not physically hurt, traumatic events can create serious and lasting emotional harm. Infants, toddlers, and preschoolers are particularly vulnerable because their capacity to protect themselves, understand what happened, and tolerate stress and fear is still immature.

Young children are completely dependent on adults for their physical safety and emotional well-being. Children can remember traumatic events starting in the first year of life and need the adult's help in coping with their fear. Unfortunately, caregivers are often unable to respond to the traumatized child's needs because they do not know what happened to the child or they believe that the child is too young to be affected by the traumatic event. When the special needs of traumatized children are not addressed, their behavior can disrupt the daily routine of the child care setting because their stress is often manifested in aggression, fearfulness, lack of compliance, and inability to learn. Even though caregivers may not ever know that children experienced trauma, their behaviors may indicate special needs. Addressing their needs involves understanding how young children respond to trauma and how child care providers can identify and care for traumatized children.

What Is Trauma?

A traumatic event happens when the child or another person is threatened with death or serious injury and the event is either experienced directly or witnessed by the child. All traumatic situations have an important element in common: The child is unable to control what is happening and is overwhelmed by fear, distress, or horror. Trauma always involves losing a feeling of safety. Witnessing a parent being attacked, injured or killed is traumatizing even when the child is not physically hurt because the parent cannot be available as a source of protection.

Traumatic events can be inflicted intentionally (as in the case of physical abuse, domestic violence, and war), or they can happen accidentally (for example, in dog bites, near-drownings, and car accidents). Natural or man-made disasters can also be traumatic, as with earthquakes, hurricanes, floods, fires, and terrorist attacks. These events can occur as a single episode or as a series of episodes. Different traumatic circumstances often exist simultaneously. For example, child abuse is more frequent in families where there is domestic violence.

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How Does Trauma Affect Young Children?

Traumatized children often show behaviors that seem out of control, fearful, disruptive, or excessively aggressive. The child's age and developmental level influence how the traumatic response is expressed. Preverbal children cannot describe what happened to them with words, but they show it through their behavior and play. Behaviors associated with trauma are described below.

1. Reliving the traumatic event. Children can be flooded by memories of terrifying events and behave as if the traumatic situation is happening again. For babies, reliving the traumatic event may be shown by inconsolable crying, motor disorganization, and bodily symptoms such as chronic vomiting and diarrhea without an organic reason. Other ways of showing reexperience of the trauma include the following:

Post-traumatic play. Young children often reenact aspects of the trauma in their play. For example, a physically abused child may play at hitting the doll for misbehaving, engaging in this behavior repeatedly and with high emotional intensity. Unlike the typically adaptive play, which helps the child to express and master challenging experiences, posttraumatic play is rigid, repetitive, driven, lacks imagination (because it is a literal reenactment of the traumatic event), and fails to relieve anxiety.

Preoccupation with the traumatic event. The child constantly thinks about what happened and is easily distracted from other activities by the need to talk about it. For example, a two year old who witnessed his father battering his mother kept repeating

"Mommy owie" in the course of the day while in child care, including during toileting and when put down for a nap.

Intense emotion, distress, or aggression at reminders of the trauma. When children see or hear things that remind them of the traumatic event, they may respond with disorganized behavior and intense emotion. For example, a twelve month old who had recently received stitches on her cheek due to a dog bite screamed in pain whenever she saw a dog and whenever she saw a man wearing a white jacket, which reminded her of the doctor who performed the procedure. An eighteen-month-old boy started having intense and prolonged tantrums whenever his mother was out of his sight after being in a car accident where he was unhurt but his mother had to be hospitalized for three days for medical care.

Nightmares and dreams about the traumatic event. Children might wake up screaming or describe a frightening dream. For example, a three year old who witnessed a knife fight woke up from a nap screaming, "No knife! No knife!"

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2. Signs of agitation, restlessness, anxiety, and impulsivity. Traumatized children have difficulty relaxing. They often seem jumpy and nervous. They can overreact to loud noises, such as a siren, and they often get startled easily. They may have trouble falling asleep or staying asleep and can be hard to comfort, which can be frustrating for their caregivers. They may also have difficulty paying attention, concentrating on a task, and staying still. On the other hand, they may constantly be on the alert for signs of danger and become anxious and clingy when unpredictable changes in routine occur. Traumatized children can be wrongly diagnosed as hyperactive and treated with medication when professionals do not ask about the child's exposure to trauma or are not aware of how trauma can affect young children's behavior.

3. Aggressive or sexualized behavior and cruelty to animals. Children learn from what they see, and they imitate adult behavior because acting like the adults makes them feel competent and strong. Even when they have not witnessed or experienced violence, aggression in children is usually a sign that they feel frightened and insecure and they are trying to protect themselves by striking first. A child who chronically behaves aggressively without noticeable cues from the situation (such as another child's grabbing a toy or pushing) may be behaving this way because of trauma. Sexualized behavior can be seen when children are attempting to relieve anxiety, when they have witnessed overstimulating adult behavior, or when they have been sexually abused. This sexualized behavior can take the form of children's excessive and intense rubbing of their private parts, most often with a worried facial expression. It can also take the form of aggressive curiosity in seeing other children's private parts, forcing other children to undress,

or touching them without their consent. Typical sexual curiosity at this age is mutual, with the children showing interest rather than worry in the activity. Cruelty to animals is used by children as a discharge for their aggressive feelings when they do not have another safe way of venting. It involves hurting an animal repeatedly and on purpose, and it is different from a single episode of anger or accidentally hurting an animal. Traumatized children cannot control their aggression or sexualized behavior by themselves. They need understanding adults to help them gain control over their inappropriate behavior, reassure them that they are safe, and teach them socially appropriate ways of expressing their feelings. When guidance techniques do not help a child improve behavior, professional consultation is recommended. (An infant mental health consultation could be sought by the program leader, for example, or parents could be urged to pursue a psychological evaluation of the child.)

4. Multiple fears. When feeling unsafe, young children become fearful and have difficulty exploring their surroundings. Separation anxiety is the most frequent of these fears. Children who are afraid of being left become clingy, particularly during transitions or in new situations. Fear of the dark and fear of monsters are also common. All young children show some fears as a typical part of development, but the fears of traumatized children are more numerous and intense. These fears should always be taken seriously because they are real for the child, even when they seem imaginary to the adult. Infants, toddlers, and preschoolers need to be reassured that the adult will take care of them and keep them safe. Helping family members to reassure the child is also important because it builds a bridge between the child care setting and the home that increases the child's sense of trust in the caregivers.

5. Losing developmental gains. Following a traumatic event, children can regress in their behavior. For example, an older toddler may revert to baby talk or relapse in toilet training. Children may also withdraw from social interaction and stop showing joy, spontaneity, pleasure in learning, and interest in exploration. In general, it is important to remember that all children have a "bad day" occasionally and that the behaviors described above are shown at one time or another by most children, particularly at times of transition. These behaviors should become a cause of concern about the possibility of trauma only when they are repeated over several weeks and when they interfere with the child's social relationships, ability to explore, readiness to learn, and other important aspects of development.

How Can the Child Care Provider Help?

When they are aware of children's developmental needs, child care providers can help children learn to cope with their traumatic responses. Programs can increase caregivers' awareness by providing ongoing professional development on caring for children who

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have experienced trauma. The following ten practices are useful in providing the child with a sense of safety and include involving the child's family members whenever possible as partners in the efforts to help the child. Although most of these suggestions are helpful when caring for any child, including children who have experienced trauma, the last three are especially important for supporting the traumatized child in particular.

1. Provide a safe environment with predictable daily routines.

2. Ensure stable relationships with caregivers and teachers.

3. Understand that difficult child behaviors, including aggression, noncompliance, and impulsivity, are often triggered by situations that remind the child of a traumatic event or are the result of a chronic stress or maltreatment.

4. Help the child with separation anxiety by providing reassurance that the parents will return at the end of the day and by providing consistent reassurance about other fears.

5. Avoid disciplinary methods that might frighten an already traumatized child, including losing control, raising one's voice, harsh language, angry reactions, and isolation.

6. Work collaboratively with the family members on a course of action to reassure and support the child.

7. Use play, exercise and body movement, music, books, and other activities to help the child cope with intense negative feelings.

8. Whenever possible, obtain information from the family members about the traumatic event to understand how the child is being affected.

9. Consult with an infant mental health professional (in collaboration with the child's family members), when possible, about child behaviors that may indicate exposure to trauma in order to discuss behavioral strategies that might help the child.

10. Recommend to the child's family members that the child be evaluated by an infant mental health program or professional when the child's behavior is chronic, severe, and does not respond to the interventions described above.

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Do you know a child who is not

*moving *hearing *seeing * learning or *talking like others their age?

By **3** months,
Does your baby…
- grasp rattle or finger?
- hold up his/her head well?
- make cooing sounds?
- smile when talked to?

By **6** months,
Does your baby…
- play with own hands/feet?
- roll over?
- turn his/her head towards sound?
- holds head up/looks around without support?

By **9** months,
Does your baby…
- sit alone or with minimal support?
- pick up small objects with thumb and fingers?
- move toy from hand to hand?

By **12** months,
Does your baby…
- wave goodbye?
- play with toys in different ways?
- feed self with finger foods?
- begin to pull up and stand?
- begin to take steps?

By **18** months,
Does your baby…
- cling to caretaker in new situations?
- try to talk and repeat words?
- walk without support?

By **24** months,
Does your baby...
- point to body parts?
- walk, run, climb without help?
- get along with other children?
- use 2 or 3 word sentences?

If you are concerned about your child's development, get help early.

Every child deserves a great start.

WV Birth to Three supports families to help their children grow and learn.

To learn more about the WV Birth to Three services in your area, please call:

1-866-321-4728

Or visit www.wvdhhr.org/birth23

West Virginia Birth to Three Growing Together

WV Birth to Three services and supports are provided under Part C of the Individuals with Disabilities Education Act (IDEA) and administered through the West Virginia Department of Health and Human Resources, Office of Maternal, Child and Family Health.

West Virginia Infant/Toddler Professional Development Program Continues to Expand

Submitted by Joyce Tucker, Department of Health and Human Resources, Division of Early Care and Education

The West Virginia Infant/Toddler Professional Development Program (WVIT) began in 2006 with an innovative approach of classroom training combined with on-site technical assistance. Since then, several other programs have been added under the WVIT umbrella.

With this new advanced professional development came the need to organize the state's Infant/Toddler Specialists housed in the six Child Care Resource and Referral offices. Bringing the Specialists together provided the opportunity for networking and the sharing of knowledge and collaboration on additional statewide projects to facilitate improved quality for infants and toddlers in family child care homes, centers and facilities.

The Infant/Toddler Specialists Network (ITSN) developed after the roll-out of WVIT and is coordinated by Joyce Tucker, Early Care and Education Specialist with the Department of Health and Human Resources, Division of Early Care and Education, Quality Initiatives Unit. Annual professional development for the group has included the most current, research-based training available in the field. Specialists are certified in the Program for Infants/Toddlers Care (PITC). Other trainings have included infant massage, Pickler Intensive Institute, Infant/Toddler Environment Rating Scale, Ages and Stages 3, car seat installation, and safe sleep.

The next spin-off was the Infant/Toddler Quality Improvement Project known as ITQuIP. After completing the original WVIT 50 hour module training, a caregiver may elect to participate in ITQuIP. This is a year-long commitment involving the caregiver, director and Infant/Toddler Specialist, beginning with an observation using the Infant/Toddler Environment Rating Scale (ITERS-R) to determine the classroom's strengths and areas for improvement. The caregiver, director and specialist then create a plan of action to address any health and safety issues brought to light during the ITERS-R observation. The plan of action allows for monthly technical assistance visits by the specialist to assist with areas of improvement through coaching, other trainings, referrals and resources.

The Great Beginnings Infant/Toddler Conference began in 2007. This annual, two-day event is specifically designed for directors and caregivers of infants and toddlers who have participated in previous WVIT programs. Plans for this year's conference are under way and will feature two model rooms, one for infants and one for toddlers. The keynote speaker will again be Keith Pentz, who captivates participants with his practical, fun and heart-felt presentations. Attendees at this year's conference will select from sessions on observation, lesson planning and leadership. A game show style session, Baby Jeopardy, will focus on licensing issues and will surely be entertaining.

In the fall of 2011, WVIT II - Relationship Based Care was piloted in two regions. This training consists of 45 hours of classroom training and a 10 hour practicum that is completed at the participant's site. The practicum, chosen by the participant, is the piece that brings the training from WVIT I and II to fruition. WVIT II is being offered by Choices Resource and Referral (R&R), Mountain Heart South R&R, Mountain Heart North R&R and Link R&R. In the coming year, the training will also be offered by Child Care Resource Center R&R and Connect R&R.

With the use of American Recovery and Reinvestment Act funding, the ITSN facilitated the PITC Directors Academy and the PITC Caregivers Academy presented by Peter Mangione, Director of WestEd – Center for Child and Family Studies in California. PITC's philosophy of responsive, relationship-based care is deeply embedded in WVIT trainings. During the same time period, the Beginning Together Institute was presented by Linda Brault, also from WestEd. This conference

included folks from child care, Early Head Start and WV Birth to Three in a collaborative effort to shed new light on inclusive practice.

A two-year long process ended in the fall of 2010 with the publication of West Virginia's Early Learning Standards Framework (ELSF) for Infants and Toddlers. This effort was led by the ITSN and included folks from Early Head Start, WV Birth to Three, higher education, Starting Points, ACDS, child care, and the Division of Early Care and Education. The ELSF for Infants/Toddlers is available through any R&R agency and can be found on line at www.wvearly-childhood.org under publications.

In 2012, the ITSN developed criteria for selecting developmentally appropriate curricula for infants and toddlers. Working with Early Head Start, the group reviewed many curricula and found two that met the rigorous criteria. *Creative Curriculum for Infants, Toddlers and Twos* along with High Scope's *Tender Care and Early Learning* became West Virginia's approved curricula for participating in WV's Tiered Reimbursement program.

Most recently, a two-day conference took place which provided an in-depth look at how to implement *Creative Curriculum for Infants, Toddlers and Twos*. Presenter Donna Fowler offered insights on navigating the curriculum and solutions for individual situations. As West Virginia continues on the path of excellence with the development of a Quality Rating and Improvement System, the ITSN looks forward to supporting those who provide for the care and education of our youngest children.

Great Beginnings Infant/Toddler Conference

September 13	September 14
8:30 a.m. - 5:30 p.m.	8 a.m. - 12 noon

Charleston Civic Center

West Virginia

Infant/Toddler Professional Development Program

West Virginia Association for Young Children

Holly Elissa Bruno
"Life's Too Short..."
August 8, 2013
9 a.m. – 4 p.m.
Register from 8 a.m.-9 a.m.
Bridgeport Conference Center
Bridgeport, W.Va.

STARS Credit

Teachers are supposed to be "all things to all people," knowing how to face daunting issues and challenging people. The truth is most of us wish we could honestly and confidently share and find answers to what stumps us, bothers us, and inspires us:

- How do we keep our heads when those all about us are losing theirs and blaming us?
- How can we summon up our courage to confront people that push our buttons?
- Can we be confident we are making the wisest decision?
- How can we avoid burn out and keep our thinking new?
- How can we partner with parents that may have child-raising traditions, religious beliefs, and lifestyle choices that differ from our own?

Holly Elissa Bruno, MA, JD, is an accomplished author, attorney, online radio host, and keynote speaker. For more information about this dynamic speaker visit www.hollyelissabruno.com.

Life's Too Short To Do Anything But Enjoy It Daily, Especially At Work

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West Virginia Association for Young Children Workshop Registration Form

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

☐ Member $55
☐ Non-Member $65
☐ Student $45
☐ Box Lunch (optional) $14

Total amount enclosed: _____

Make check payable to WVAYC.
Mail Check and Registration to: Gina Cheshire, WVAYC Support Staff, 374 Meadow Lane, Parkersburg, WV 26101

Keep a copy of this form for your records. We do not send out confirmations.

Foster Care: A Little Talked About Transition

Submitted by Barbara Tucker, West Virginia Early Childhood Transition

When early childhood professionals think about transition for infants and toddlers it is usually in the vein of transition from one activity or classroom to another, or from IDEA, Part C to preschool special needs Part B.

There is another transition that is taking place for many infants and toddlers in West Virginia – that of to and from foster care, from one foster care home to another, from foster care to adoptive home or from foster care back to biological home. Unfortunately, approximately twenty percent of babies born in the Mountain State are drug-addicted and many go to foster care from the hospital. The two WV Birth to Three Regional Administrative Units I direct receive many referrals for infants and toddlers in foster care. It is common for many of these precious children to have several foster placements during the first couple years of life.

As professionals committed to promoting all areas of development, the social/emotional effects of numerous placements can have devastating results during this sensitive period of development. The question is "What can we do to support these children and caregivers?" The answer is "using attachment related strategies." For WV Birth to Three practitioners and Part B personnel, having an All About Me notebook for each child in foster care with information about the child's motivators, favorite foods, books and toys, and any attachment items can help ease the trauma of a new home and school.

The experience of living somewhere other than a familiar place often produces feelings of confusion, worry, fear, sadness, and loss of control. When children enter foster care, rarely do they continue with the same child care provider. Sometimes children enter child care for the first time when they enter foster care.

The American Academy of Pediatrics notes some common issues for a child transitioning into, or changing, child care:

- Increased difficulty transitioning as the child is also adjusting to foster care placement and being away from the biological home.
- Lack of knowledge by early education and child care professionals on how to help a traumatized infant or toddler.
- Increased behavior issues based on childhood trauma.

Steps early education and child care professionals can take to help the child make a successful transition into the child care program include:

- Ensure that appropriate permission is in place each time a child is picked up for a visit with the birth parent. Often the person picking up the child for visitation changes week to week, or the birth parent may drop in for a visit.

- Ensure confidentiality that a particular child is in foster care.
- Be aware children in foster care are often very sensitive to transitions and separation and the times immediately before and/or after visits can be very stressful for the child.

To ease the transitions, the American Academy of Pediatrics recommends:

- Have a consistent caregiver each day.
- Post pictures of key people in the child's life.
- Prepare the toddler for visits with the biological family.
- After a visit, allow the child to spend time with a familiar and caring adult to transition back to the child care setting.
- Be aware that behaviors may increase before and/or after a visit, if the parent does not show, or the visit is canceled.
- Encourage staff awareness that severe tantrums and other behavior issues need to be handled sensitively. Isolating a child who already feels abandoned by using "time out" can be very damaging.
- Encourage staff awareness about common mental health issues for children in foster care and how to help.
- Engage the assistance of a mental health consultant if the child's behaviors are problematic and/or if the child is having chronic difficulty with transitions and/or separations.
- Encourage sensitivity regarding things such as Mother's and Father's Day projects (for example, make gifts for the foster parent and the birth parent).

Being removed from their biological home is traumatic for all children, not only infants and toddlers. With sensitivity by all early childhood professionals involved in the child's life, we may be able to lessen negative effects.

Working with the Diverse Parenting Styles of Parents

Submitted by Abby Elliott, Capstone Student in Early Childhood Education, Marshall University

In the early childhood profession, child care providers will be interacting with children and connecting with parents from diverse backgrounds. In order to give the child a valuable experience in the early years, the child care provider needs to have a partnership with the parents. As early as the 1920s, developmental psychologists have been interested in how a parent's influence affects the social and academic development of their child.

Parenting Styles

Parenting style is composed of two critical elements of parenting: responsiveness (warmth) and demandingness (control). This assumes that most parenting centers around issues of control between child and parent. Parent responsiveness refers to "the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being attuned, supportive, and acquiescent to a child's special needs and demands" (Baumrind, 1991). Parent demandingness refers to "the claims parents make on children to become integrated into the family whole, by their maturity demands, supervision, disciplinary efforts and willingness to confront the child who disobeys" (Baumrind, 1991).

There are four main styles of parenting based on high or low parental demandingness and responsiveness. These include: Authoritative, Authoritarian, Permissive, and Uninvolved. It is important to know about parenting styles so you can identify them in the parents that you work with.

The authoritative parent is friendly and warm. However, they are also firm and have expectations for their child. This parenting style values independence while maintaining limits and controls on a child's actions. The parent is willing to listen to their child and have open dialogue, with the parent making the final decision. As a result of this parenting style, the child is more likely to grow up being socially competent, responsible, and autonomous (Kopko, 2007).

The authoritarian parent does not show as much warmth as the authoritative parent. This type of parent is also very controlling about what their child can and cannot do. They are likely to have many rules and to be very strict with their child. They usually do not engage in discussions with their children, it is more of a "what I say goes because I am the parent and you are the child" type of attitude. Research indicates that this parenting style places more emphasis on following rules and

discipline rather than encouraging independence. Children are more likely to exhibit rebellious and/or dependent characteristics as they grow up (Kopko, 2007).

Permissive or indulgent parents are warm to their children, but they have a passive approach to parenting. They would rather their child be a friend than to be a parent to their child. They do not like to disappoint their child by saying "no". Instead of providing guidance on rules and actions, parents following this parenting style feel they are more of a resource if the child should ask for advice. The child will end up making the rules. Children carry this over into the real world. Research shows these children feel they can make the rules and there are few boundaries to follow. Children tend to grow up having problems with self-control and egocentric issues that may interfere with having peer relationships later on in life (Kopko, 2007).

The last parenting style is the uninvolved parents. They are generally not warm, do not set limits, and do not engage in conversations with their children. Sometimes these parents could even be neglectful to the child. At times, these parents are so overwhelmed or self-absorbed with their own circumstances that they do not have the time or energy to parent their child. This parenting style is often the one parents will use if they are tired, frustrated, or have given up. Research indicates children may show problems in self-control, self-regulation, and impulsive behavior (Kopko, 2007).

How to Work With Diverse Parenting Styles

Early childhood educators need to be prepared to work with parents and diverse parenting styles. In early childhood settings, there needs to be a partnership between the parents and the teacher in order for the child to get the most out of the experience. This will not be possible if the early childhood educator does not understand the four main parenting styles and the best way of communicating with parents based on their parenting style.

What the child care provider says and how she conducts herself can be the deciding factor in communicating effectively with all parents. Kathryn Phillips gave some tips for teachers in her book *Dealing with Difficult Parents: A Teacher's Survival Guide*.

Here are some of her suggestions:

- Allow the parent to bring someone who is close to the child to any meetings. This could be a second set of ears and someone who can offer the parent support.
- Try to understand where the parent is coming from. Be supportive yourself as a teacher and do not be negative.
- Keep the child as the most important part of the conversation. The child is always first.
- Be an active listener with the parent. This could include taking notes, paraphrasing back to the parent what they just said, or clarifying information.
- Remember 50 percent of communication is nonverbal. Always be aware of your body language when talking to a parent.
- Be aware of the tone of your voice as well. Do not use sarcasm at any time.
- Watch for signs of confusion, anxiety, fear, and sadness from the parent. This could mean ending the meeting early before the parent gets too upset (Phillip, 2006).

Some parents are also very sensitive when it comes to their children. They do not want to know if their child did something wrong. In this case the early childhood educator needs to make sure that she is adding positive comments along with the negative comments. This way it is not all negative and the parent will not be as upset and defensive (VonBank, 2012). For example, the teacher could say "Today Erika pushed one of her peers off one of the tricycles. I helped Erika use her words to come up with a solution to the problem that did not include pushing her friend off of the bike. Afterwards, Erika went inside and got a wet paper towel for her friend to help clean and soothe her hurt knee." The parent will like to see that their child helped the other child and ended up working out an issue.

Another issue could be with the uninvolved parenting style. These parents may seem disinterested in how their child is doing in the classroom. Early

childhood educators cannot force parents to be involved; however, they can continue to offer the parents opportunities for them to be involved. Whatever the outcome, early childhood educators should make sure that the parent's lack of response does not reflect on the relationship that the teacher has with the child. Here are a couple of ways to encourage parents to become involved in the classroom:

- Explain to the parent how important their involvement is for their child's development and learning.
- Expect the parent to be involved in the classroom.
- Make suggestions to the parents about how they could help.
- Have contact with parents on a weekly basis at the beginning of the school year. Come up with a method that works for them (newsletters, phone calls, My Days, etc.).
- Focus on the interest of the family (Partnering For School Success, 2009).

Parent involvement is an important part of a child's educational experience and the teacher needs to create a partnership with all of the parents. Parent involvement will benefit all children as well as their families.

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Guidelines for Use of New Concentrated Bleaches

Submitted by Glenna Bailey, Nurse Health Consultant

If you use a diluted bleach solution in your center for sanitizing and disinfecting, please be aware that the concentration of bleaches sold in stores has changed in many areas. Up to this point, bleach has always been a 5.25 percent to 6 percent sodium hypochlorite solution, but some beach products are now concentrated at 8.25 percent. It is important to check the labels of the bleach you use.

Because of the differences in bleach formulations, the National Resource for Health and Safety in Child Care and Early Education recommends the following:

- ❑ Use EPA-registered products for sanitizing and disinfecting.
- ❑ Follow the manufacturer's instructions for diluting the EPA-registered product for sanitizing or disinfecting, as well as for the contact time. Instructions on how to determine bleach formulations for the EPA-registered product you are using in your early care setting can be found at www.cfoc.nrckids.org/Bleach/FindingEPARegInfo.cfm. These instructions are also part of the Appendix J of *Caring For Our Children,* 3rd Ed., which has been revised to reflect these changes.
- ❑ If you are not using an EPA-registered bleach product at this time, contact your local health department for assistance in creating safe dilutions for the bleach products you are using.

For more information, visit: http://cfoc.nrckids.org/Bleach/Bleach.cfm

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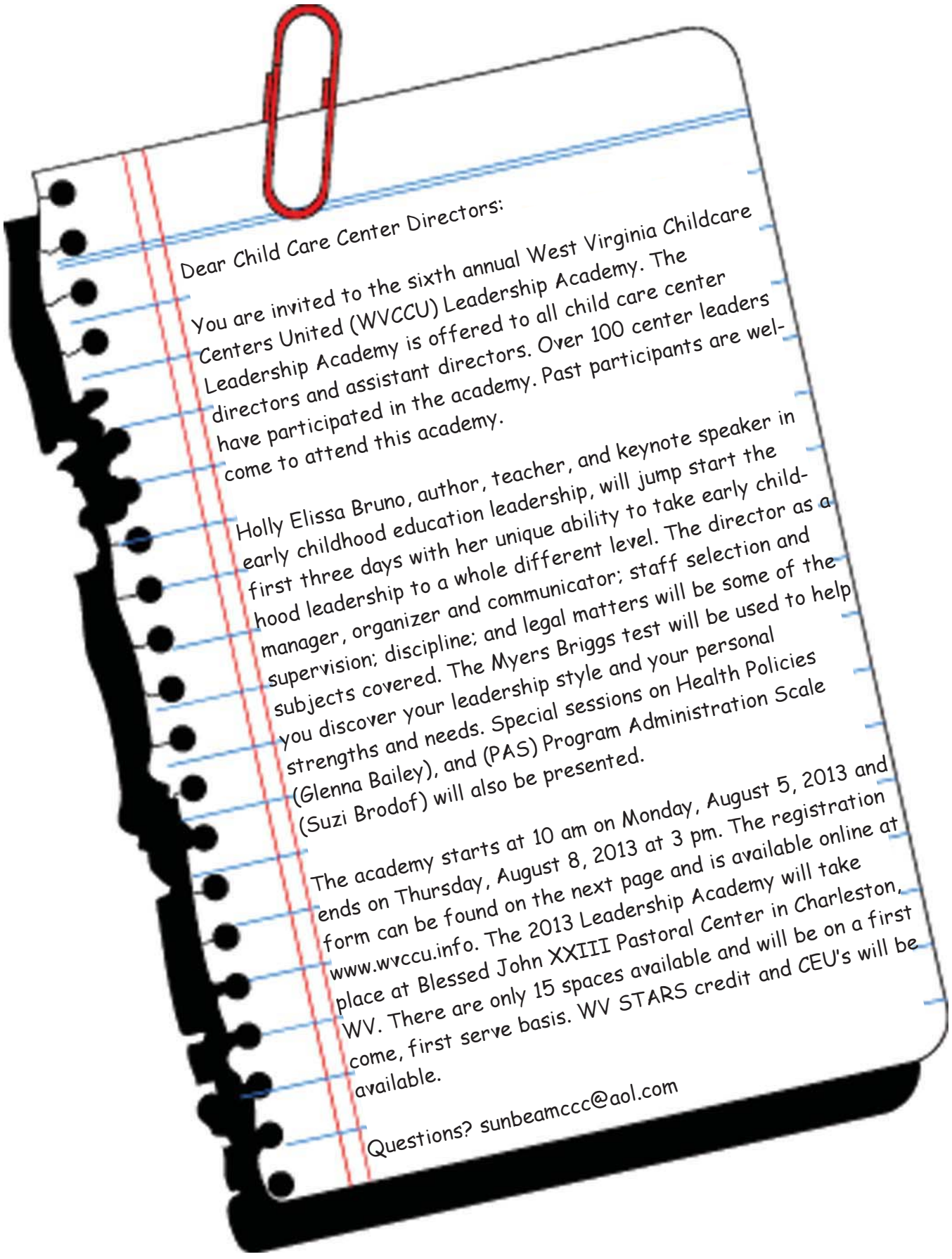


Dear Child Care Center Directors:

You are invited to the sixth annual West Virginia Childcare Centers United (WVCCU) Leadership Academy. The Leadership Academy is offered to all child care center directors and assistant directors. Over 100 center leaders have participated in the academy. Past participants are welcome to attend this academy.

Holly Elissa Bruno, author, teacher, and keynote speaker in early childhood education leadership, will jump start the first three days with her unique ability to take early childhood leadership to a whole different level. The director as a manager, organizer and communicator; staff selection and supervision; discipline; and legal matters will be some of the subjects covered. The Myers Briggs test will be used to help you discover your leadership style and your personal strengths and needs. Special sessions on Health Policies (Glenna Bailey), and (PAS) Program Administration Scale (Suzi Brodof) will also be presented.

The academy starts at 10 am on Monday, August 5, 2013 and ends on Thursday, August 8, 2013 at 3 pm. The registration form can be found on the next page and is available online at www.wvccu.info. The 2013 Leadership Academy will take place at Blessed John XXIII Pastoral Center in Charleston, WV. There are only 15 spaces available and will be on a first come, first serve basis. WV STARS credit and CEU's will be available.

Questions? sunbeamccc@aol.com

Leadership Academy Registration Form
(August 5, 2013– August 8, 2013)

(WV CHILD CARE CENTER DIRECTORS/ASSISTANT DIRECTORS ONLY)

Blessed John XXIII Pastoral Center, Charleston, WV
August 5, 2013 (Registration 9 am – 10 am) – August 8, 2013, 3 pm
Participants are expected to actively participate in the entire leadership academy
(We will have some evening activities) *STARS and CEU's available

Full Name: _____

Child Care Center: _____

Position: _____

Address: _____

Phone: _____Fax:_____

E-Mail:_____
(MUST HAVE LEGIBLE E-MAIL ADDRESS)

Confirmation of registration and participation information will be e-mailed by July 15, 2013. PLEASE MAKE A COPY FOR YOUR FILES.

This registration fee covers meals, lodging (single room) and materials. A complimentary 2013 membership in West Virginia Childcare Centers United with full membership benefits is also provided. We will operate on a first come, first serve basis.

A $50.00 non-refundable registration fee must accompany this registration form.

Registration due by June 30, 2013

Send completed registration form and check for $50.00 to:
WVCCU Leadership Academy
Helen Post-Brown
1654 Mary Lou Retton Drive
Fairmont, WV 26554

**Support for this training has been provided by the West Virginia Department of Health and Human Resources*

Exciting News About ACDS

ACDS Collaboration with Early Childhood Education Programs in High School and Career Centers

ACDS has received approval from Dr. Kathy D'Antoni, Assistant State Superintendent, to contract with high schools and career and technical centers offering Early Childhood Education programs. Schools that choose to contract with ACDS will follow guidelines and procedures similar to those utilized in the ACDS program. These agreements will allow students the opportunity to articulate credit earned to the adult program or college credit, as well as becoming work force ready upon graduation. This collaboration will benefit both the graduates of ECE and the ACDS program.

ACDS Curriculum Copyright

The ACDS program has officially obtained a copyright for the Starting Points curriculum. Obtaining this copyright will ensure that the curriculum is being used by authorized instructors to educate apprentices. The copyright further supports the continued quality of the ACDS program.

Submitted by Sherrie Barrett, ACDS State Coordinator

www.wvacds.org

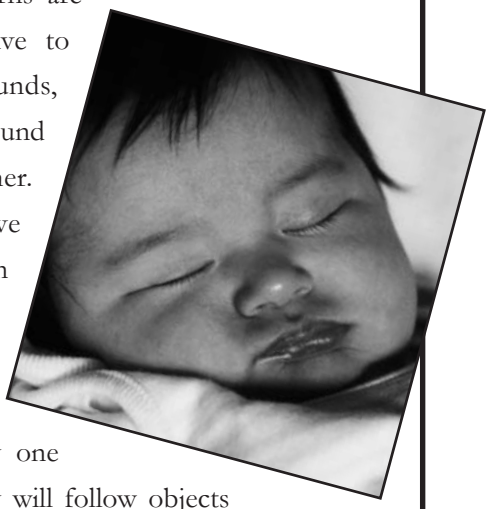
"Providing resources to parents throughout West Virginia"
Volume 10, Issue 3, Summer 2013

A Child's Development in the First Year

Newborn infants rarely resemble the dimpled, soft rounded, beautifully skinned baby you see on TV. They are usually a wrinkled, puffy faced, lumpy headed, oddly colored, crooked shaped creature that you fall in love with the minute you see them.

The average sleeping time for infants during the first month of life is 16 1/2 hours per day during 7 to 8 daily naps. This is the average. Some babies will only sleep 8 hours with just a few naps. Like adults, some babies need more sleep than others.

Feedings during the first week of life are about 7 to 8 feedings per day. As your child grows, feedings become fewer.



At birth, newborns are especially sensitive to sights and sounds, especially the sound of their mother. Infants have blurred vision when first born, but will begin to make out distinct patterns by one month old. They will follow objects by sights and sounds, especially the sound of something familiar to them. Studies have shown that infants can hear sounds in the womb 4 months before their birth.

Head and neck strength is a continuous process. It is very important to support the head and neck during the first months of your baby's life. The brain is developing and making connections every minute.

Continued on next page

WV Parent Blocks Newsletter is a project of West Virginia Early Childhood Training Connections and Resources, a collaborative project of West Virginia Department of Health and Human Resources/Bureau for Children and Families/Division of Early Care and Education; WV Head Start State Collaboration Office; Office of Maternal, Child and Family Health/West Virginia Birth to Three; and West Virginia Department of Education/Office of Special Education and is supported and administered by River Valley Child Development Services.

One of the first developmental milestones in an infant's development is the ability to roll over. You may also notice the baby's arms and legs moving in an energetic manner.

Infants can communicate in several different ways. At birth it is mostly crying, but the crying will change during the first few months as the infant learns to cry deliberately for assistance. At one to two months your baby will then begin to coo and gurgle as a measure of pleasure and contentment.

Parents are sometimes unaware of how much a baby understands at a very young age. Babies can respond to parent's voices and music. You will see their head move and their eyes follow moving objects.

As your child develops, you will start seeing the most changes from two months to one year.

Two to Four months

At two months your child is more attentive and begins to focus on moving objects. He will notice brightly colored objects. Babies respond mostly to human voices.

The infant's head and neck will begin to gain strength and he will have the ability to control his movements. When your baby is placed on his back, he should be able to lift the head at about a 45 degree angle and when on his stomach, he should be

able to lift the head and neck to about a 90 degree angle. Also, he can lift and hold his head for a few minutes at a time and look around.

Babies will begin to grasp objects and play with their hands. The next step is to be able to hold onto objects and put them to their mouth. (Make sure all toys are sanitized as your baby will want to put everything in her mouth).

At the end of four months of development, your baby will gradually become more alert and expressive. She will begin cooing, babbling, making other types of noises, and use crying as a tool to get your attention.

They will also want to taste and touch everything. Infants will begin to smile, and sometimes laugh out loud. Infants will begin to express pleasure by smiling, kicking their feet, and waving their arms and legs. This is the time when crying decreases dramatically. Infants will now begin to show fear of strangers by turning away and crying. They will also protest when left alone.

Four to Six months

Everything begins to strengthen at this age. Head and neck muscles are controlled, baby will roll over from back to stomach and back again. Infants can turn their heads in all directions with control. At this age, most infants can be placed in a sitting position, with support, and placed in a high chair without falling over.

Infants will be able to hold their own bottle and pick up toys that are within reach. Infants will be able to hold onto their own feet and put their feet in their mouth and suck on them. This is very enjoyable to your baby. Babies will begin to reach out and grasp an object, holding onto it. You will begin to notice your baby picking up items with her thumb and index finger, like food items and putting them in her mouth.

From four to six months your child may begin sitting alone, crawling, and pulling themselves up to stand with support. Infants can stand with support as their legs begin to strengthen.

Infants can focus at long distances and will begin watching moving objects with ease.

By four months of life, eating and sleeping patterns become more regular and infants begin to establish predictable amounts of time

between feeding and bowel movements.

Speech is beginning at this stage of development. Laughing out loud and squealing is achieved. Words are beginning to take form. Sometimes as the vowel-consonant combination begin, they may come out wet, slobbering, and a barely audible, "da-da". Cognitive development is taking form in the brain. This is a very important step because it signals that your child is beginning to understand distance and that objects still exist even when they disappear from sight. Memory skills are forming and infants will recognize familiar objects. The brain is continually making connections as your child develops and your infant is learning at an unbelievable rate.

Six to Nine months

By six months of age your infant has met many milestones in his/her development. Babies begin to experiment with solid food. Eye-hand coordination has developed so that your infant can now feed herself. Preference for certain foods appears as taste buds develop.

Infants can now sit unassisted. Crawling over to an object and pulling themselves up in a standing position with assistance.

Words are beginning to form. Da-da, ma-ma or bye-bye are common first words. Infants will begin to replicate familiar acts, like waving. Smiling and laughing are spontaneous. Infants will smile at someone familiar and cry at strangers. This is the stage where infants recognize the difference between someone they know and strangers. This is the first stage of stranger anxiety. Also, the infant may experience separation anxiety when parents leave. This is a very important period for the social development of children. It is at this age that many infants begin to play simple games like peek-a-boo and hide and seek an object. This develops trust in the child knowing the object or their parents will return.

Nine to Twelve months

This is the stage your child is developing into a toddler. Fine motor skills are developing. Infants begin to manipulate objects by picking up with thumb and fingers, then dropping objects and picking them up again. They begin to use their dominant hand, lifting lids off of boxes and turning pages of a book.

Infants enjoy feeding themselves and may begin to drink out of a sippy cup. Some can use a spoon and maneuver the spoon to their mouths. Children can also sit alone and have good control of their bodies.

Infants begin walking around objects and may experiment with walking unassisted. Speech is developing, personalities are forming, trust is building, and your infant is turning into a toddler.

Infants begin to verbalize and listen carefully to other people's conversations. Infants enjoy repeating sounds like animals and truck noises. If you think about it, your child is learning to walk, talk, and problem solve.

All children are unique. While the sequence of development is similar for most children, each child's rate of development is different. There is a wide variety of "normal" development. Some children reach a developmental milestone earlier than others. Also, remember that pre-mature babies may take longer to meet developmental milestones as other infants of the same age. If you think your baby may have a delay, please contact your child's health care physician and ask about a developmental assessment.

Reference: Effective Parenting Tips from the Center for Effective Parenting – WV Family Connections

-Submitted by Kay DeWitt, Preston County Starting Points

Do You Qualify For WVCHIP?

WVCHIP is a low-cost health care plan for children and teenagers of working families. There is no cost to apply. WVCHIP covers services important to growing children, such as check-ups, vision and dental services, immunizations, hospital visits, prescription drugs, and more.

Who Qualifies for WVCHIP?

- *Age - Children under 19.*
- *Income - Qualifying income is based on the family's monthly or yearly gross income (before taxes) and family size.*
- *Co-Payments - WVCHIP Gold and Blue groups do not have co-pays on preventative care, dental, vision, or generic prescriptions.*

Family Size	WVCHIP Gold Maximum Yearly Income	WVCHIP Blue Maximum Yearly Income	Premium Plan Maximum Yearly Income
2	$23,274	$31,026	$46,542
3	$29,298	$39,066	$58,602
4	$35,334	$47,106	$70,662
5	$41,358	$55,146	$82,722
6	$47,394	$63,186	$94,782

- *Insurance - If your child is covered by another health insurance plan, or was covered in the past 3 months, the child may not be eligible.*

Visit www.chip.wv.gov for more information.

West Virginia CHIP Children's Health Insurance Program

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