CHAPTER 11

The Preschool Child

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Objectives

Upon completion of this chapter, the student will be able to:

1. Define the vocabulary terms listed
2. Describe the physical and psychosocial development of children from 3 to 5 years of age, listing age-specific events and guidance when appropriate
3. Describe the characteristics of a good preschool facility
4. Discuss the value of play in the life of a child
5. Designate two toys suitable for the preschool child and provide the rationale for each choice
6. Identify the developmental characteristics that predispose the preschool child to certain accidents and suggest methods of prevention for each type of accident

Key Terms

Be sure to check out the bonus material on the Companion CD-ROM, including selected audio pronunciations.

←ED: → Pls. insert new p. # for each key term in list.

animism (N- -m sm; p. ***)
artificialism (R-t -F SH-ăl- sm; p. ***)
centering (p. ***)
domestic mimicry (M M- k-rē; p. ***)
egocentrism (Ē-gō-S N-tr sm; p. ***)
enuresis (n-ū-RĒ-s s; p. ***)
identification (p. ***)
modeling (p. ***)
play therapy (p. ***)

GENERAL CHARACTERISTICS AND DEVELOPMENT

The child from ages 3 to 5 years is often referred to as the preschool child. This period is marked by a slowing down in the child's growth. By 1 year, infants have tripled their birth weight, whereas by the age of 6 years, these same children have only doubled their 1-year weight. For instance, the boy who weighs 20 pounds on his first birthday will probably weigh about 40 pounds on his fifth. Weight gain during the preschool years is about 5 pounds per year. The child between 3 and 5 years of age grows taller and loses the chubbiness that is seen during the toddler period. Height increases approximately 2.5 to 3 inches per year. Appetite fluctuates widely. The normal pulse rate is 90 to 110. The rate of respirations during relaxation is about 20 per minute. The systolic blood pressure is about 92 to 95 mm Hg; the diastolic is about 56 mm Hg. By the preschool years, at least 90% of brain growth is achieved and handedness begins to become apparent. A summary of preschool growth and development is presented in Table 11-1.

Preschool children have good control of their muscles and participate in vigorous play activities. As each year passes, they become more adept at using old skills. They can swing and jump higher. Their gait resembles that of an adult. They are quicker, and compared with toddlers, they have more confidence in themselves. Although preschool children may seem more or less quiet and steady with respect to physical development, certain difficulties do arise from an increase in independence, social participation, interaction, and cognitive ability.

THEORIES OF DEVELOPMENT

The thinking of the preschool child is unique. Piaget called this period the preoperational phase. This phase comprises the ages of 2 to 7 years and is divided into two stages: the preconceptual stage, from 2 to 4 years; and the intuitive thought stage, from 4 to 7 years. The increasing development of language and symbolic functioning is important in the preconceptual stage. Symbolic functioning can be seen when children play and pretend that an empty box is a fort; this creates a mental image, which stands for something that is not there.

Preoperational thinking also implies that children cannot think in terms of operations, or the ability to logically manipulate objects in relation to each other. They base their reasoning on what they see and hear. They also believe they have magical powers that can cause events to occur. For example, a child might wish that someone or something would die. If the death does occur, the child feels at fault because of the "bad" thought that made it happen.

Another characteristic of this period is **egocentrism**, a type of thinking in which children have difficulty seeing any point of view other than their own. Children's knowledge and understanding are restricted to their own limited experiences, and as a result, misconceptions arise. One of these misconceptions is **animism**. This is a tendency to attribute life to inanimate objects. Another

Table 11-1 ***Summary of Preschooler Growth and Development***

AGE	PHYSICAL	GROSS MOTOR	FINE MOTOR	VOCALIZATION	SOCIALIZATION
3 yr	Usual weight gain of 1.8 to 2.7 kg (4 to 6 pounds) Average weight of 14.6 kg (32 pounds) Usual gain in height of 7.5 cm (3 inches) Average height of 95 cm (37.25 inches) May have achieved night-time control of bowel and bladder	Rides tricycle Jumps off bottom step Stands on one foot for a few seconds Goes up stairs using alternate feet; may come down using both feet on step Broad jumps May try to dance; balance may not be adequate	Builds tower of 9 to 10 cubes Adeptly places small pellets in narrow-necked bottle Copies a circle, imitates a cross, names what has been drawn; cannot draw a stick figure but may make circle with facial features	Has vocabulary of approximately 900 words Uses complete sentences of 3 to 4 words Repeats sentence of 6 syllables Asks many questions Begins to sing songs	Dresses self almost completely Has increased attention span Feeds self completely; can prepare simple meals, such as cold cereal and milk Can help to set table May have fears (of dark or going to bed) Knows own gender and gender of others Play is parallel and associative; begins to learn simple games but often follows own rules; begins to share
4 yr	Growth rate is similar to that of previous year Average weight of 16.7 kg (36.75 pounds) Average height of 103 cm (40.5 inches) Length at birth is doubled Maximum potential for development of amblyopia	Skips and hops on one foot Catches ball; throws ball overhand Walks down stairs using alternate footing	Uses scissors successfully Can lace shoes Copies a square, traces a cross and diamond, adds 3 parts to stick figure	Has vocabulary of 1500 words or more Uses sentences of 4 to 5 words Questioning is at peak Tells exaggerated stories Knows simple songs May be mildly profane if associates with older children Names one or more colors	Very independent Tends to be selfish and impatient Aggressive physically and verbally Takes pride in accomplishments Has mood swings Shows off dramatically, enjoys entertaining others Still has many fears Play is associative; imaginary playmates are common Sexual exploration and curiosity shown through play, such as being "doctor" or "nurse"
5 yr	Average weight of 18.7 kg (41.25 pounds) Average height of 110 cm (43.25 inches) Eruption of permanent dentition may begin Handedness is established (approximately 90% are right-handed)	Skips and hops on alternate feet Throws and catches ball well Jumps rope Skates with good balance Walks backward with heel to toe Jumps from height of 12 inches Balances on alternate feet with eyes closed	Ties shoelaces Uses scissors, simple tools, and pencil well Copies a diamond and triangle; adds 7 to 9 parts to stick figure; prints a few letters, numbers, or words, such as first name	Has vocabulary of approximately 2100 words Uses sentences of 6 to 8 words Names coins Names 4 or more colors Knows names of days of week, months, and other time-associated words	Less rebellious and quarrelsome More settled and eager to get down to business Independent but trustworthy; not foolhardy; more responsible Has fewer fears; relies on outer authority to control world Eager to do things right and to please; tries to "live by the rules"; has better manners Cares for self with only occasional assistance Play is associative; tries to follow rules but may cheat to avoid losing

Modified from Hockenberry, M., & Wilson, D. (2007). *Wong's nursing care of infants and children* (8th ed.). St. Louis: Mosby.

is **artificialism**, the idea that the world and everything in it is created by human beings (Table 11-2).

Evolving from preconceptual thinking to intuitive thinking involves a shift from egocentric thought to a social awareness and ability to consider another's point of view. This is considered to be closely associated with superego or conscience development.

Another distinctive characteristic of intuitive thinking is **centering**, the tendency to concentrate on a single outstanding characteristic of an object while excluding its other features. With time and experience, more mature conceptual awareness is established. The process is highly complex, and the implications for practical application are numerous. In addition, through intuitive thinking, play becomes more socialized and words are used to express ideas and thoughts.

According to Erik Erikson's theories, preschoolers acquire a sense of initiative. They believe learning is fun and try new activities and experiences. Conflict arises when initiative is criticized or punished; then they develop a sense of guilt. This guilt can carry over later in life and affect their ability to make decisions or solve problems.

It is important to provide preschoolers exposure to a wide variety of experiences and play materials to enhance their learning. They need to be allowed to play with finger paints, build sand castles, play with clay, and engage in activities that enhance their imaginations.

Preschoolers enjoy dressing up and pretending to be real and make-believe characters (Figure 11-1). They love to imitate people around them and often mimic what they see their parents doing. Playing "store" or "office" or doing household chores such as "lawn-mowing" or "doing the dishes" are activities that preschoolers enjoy. Toy companies manufacture many toys that encourage the preschooler to engage in this **domestic mimicry**.

Lawrence Kohlberg emphasized moral development and moral judgment. Preschoolers are at a preconceptual stage of moral development. Young children learn whether an action is good or bad depending on whether the action is rewarded or punished. Preschool children progress to a stage where they can carry out actions to satisfy their own needs but not society's in general. They do something for another if that person does something for them.

Table 11-2 ***The Nature of Early Childhood Thought***

SAMPLE QUESTION	TYPICAL ANSWER
ECOCENTRISM	
Why does the sun shine?	To keep me warm.
Why is there snow?	For me to play in.
Why is grass green?	Because that is my favorite color.
What are television sets for?	To watch my favorite shows and cartoons.
ANIMISM	
Why do trees have leaves?	To keep them warm.
Why do stars twinkle?	Because they are happy and cheerful.
Why does the sun move in the sky?	To follow children and hear what they say.
Where do boats go at night?	They sleep like we do.
ARTIFICIALISM	
What causes rain?	Someone emptying a watering can.
Why is the sky blue?	It has been painted.
What is the wind?	A man blowing.
What causes thunder?	A man grumbling.

From Helms, D., & Turner, J. (1978). *Exploring child behavior: Basic principles* (p. 447). Philadelphia: Saunders, with permission.

A B

FIGURE **11–1** Preschoolers have vivid imaginations and enjoy playing "dress-up."

Children at this age are just beginning to learn right from wrong. Spiritual development is strongly linked to development of the conscience (Hockenberry & Wilson, 2007). The preschooler is just beginning to understand spiritual matters. Rudimentary knowledge is provided by parents or significant others. Their concrete thinking allows them to perceive God as an imaginary friend. Children this age enjoy hearing Bible stories and reciting simple prayers. If hospitalized, saying prayers as part of their routine can actually help with the stressors of hospitalization.

Sigmund Freud emphasized that early childhood is critical in the socialization of the individual. Freud believed that during the preschool years, the child focuses on the genital area. He referred to this as the phallic phase. According to Freud's theory, the child fantasizes about satisfying phallic desires by **identification** with the parent of the opposite gender and thus conflict results with the parent of the same gender. This is known as the Oedipal complex (boys) and the Electra complex (girls). Freud also stated that once the conflict is resolved, the child identifies with the same-gender parent.

PHYSICAL, PSYCHOSOCIAL, AND COGNITIVE DEVELOPMENT

THE 3-YEAR-OLD CHILD

Most 3-year-olds are a delight to their parents. They are helpful and can participate in simple household chores. They obtain articles on request and return them to the proper place. Three-year-olds come very close to the ideal picture that parents have in mind of their child. They are living proof that their parents' guidance during the "terrible twos" has been rewarded. Temper tantrums are less frequent, and in general, the 3-year-old is a pretty good youngster. Of course, they are still their individual selves, but they seem to be able to direct and control their primitive instincts better than before. They can help dress and undress themselves, use the toilet, and wash their hands. They eat independently, and their table manners have improved.

The 3-year-old talks in longer sentences and can express thoughts such as "What are you doing?" or "Where is Daddy?" They also provide more company to their parents because they can verbally share their experiences with them. They are imaginative, talk to their toys, and imitate what they see about them. Soon they begin to make friends outside the immediate family. Because they can now converse with playmates, they find satisfaction in joining their activities. Three-year-olds do not play cooperatively for long periods of time, but at least it's a start. Through associative play, they begin to share with other children; playing with other children their own age teaches them socialization skills. Much of their play still consists of watching others, but now if they have the need, they can offer verbal advice. They can ask others to "come out and play." If 3-year-olds are placed in a strange situation with children they do not know, they commonly revert to parallel play because it is more comfortable.

At this time, there is a change in the relationship between the child and the family. Preschoolers begin to find enjoyment away from Mom and Dad. However, they want them to be right there when needed. They begin to lose some of their interest in their mother, who up to this time has been more or less their total world. Their father's prestige begins to increase. Romantic attachment to the parent of the opposite gender is seen during this period. Johnny wants to "marry Mommy" when he grows up. They also begin to identify themselves with the parent of the same gender. This behavior reflects Freud's beliefs. It is important for parents to remember to help the child fully develop his or her potential.

Preschool children have more fears than the infant or the older child. Some of the many causes of this are increased intelligence, which enables them to recognize potential dangers; the development of memory; and graded independence, which brings them into contact with many new situations. Toddlers are not afraid of walking in the street because they do not know any better. Preschool children realize that trucks can injure them, and therefore they worry about crossing the street. This type of fear is well founded, but many others are not. The fear of bodily harm is particularly peculiar to this stage. The little boy who discovers that his baby sister is made differently worries that perhaps she has been injured. He wonders if this will happen to him. Masturbation is common during this stage as children attempt to reassure themselves that they are all right. Other common fears include fear of animals, fear of the dark, and fear of strangers. A little night wandering is typical for this age group.

Preschool children become angry when others attempt to take their possessions. They grab, slap, and hang on to them for dear life. They become very distraught if toys do not work the way they should. They resent being disturbed from play. They are sensitive, and their feelings are easily hurt. It is good to bear in mind that much of the disturbing social behavior seen during this time is normal and necessary to the children's total pattern of development.

Communication Alert

Preschool children sometimes believe that they are being punished for something they thought or did. Thus when a painful procedure is performed on the child, the nurse might say, "I am sorry that it hurt when I put the needle in your arm. I did that so we can give you medicine to make you feel better, not to hurt or punish you."

A

B

FIGURE **11–2** The child progressively achieves mastery of fine motor skills and cognitive abilities, such as **(A)** buttoning clothes and **(B)** using scissors.

THE 4-YEAR-OLD CHILD

Four is a stormy age. Children are not as eager or willing as they were at 3 years. They also are more aggressive and like to show off. They are eager to let others know that they are superior and are prone to pick on their playmates. They often take sides and make life difficult for any child who does not measure up to their standards. Four-year-olds are boisterous, tattle on others, and may begin to swear if they are around children or adults who use profanity. Personal family activities are repeated with an amazing sense of recall, but they still forget where they left their bicycle. At this age, children become interested in how old they are and want to know the exact age of each playmate. It bolsters their ego to know that they are older than someone else in the group. Their ego is also bolstered by being a "big brother" or "big sister" to a younger sibling. They are able to help care for and protect them. The relationship of one person to another interests them as well. For example, Timmy is not only a brother but also is Daddy's son.

Four-year-olds can use scissors successfully. They can lace their shoes and do simple buttons (Figure 11-2). Vocabulary has increased to about 1500 words. They run simple errands and can play with others for longer periods of time. Many feats are done for a purpose. For instance, they no longer run just for the sake of running. Instead, they run to get someplace or to see something. They are imaginative and like to pretend they are firefighters or cowboys. Much of their play time is spent pretending. They may even have an imaginary friend. The friend may "exist" until the child starts school. They also begin to prefer playing with friends of the same gender rather than with those of the opposite gender.

The preschool child enjoys simple toys. They love to color pictures and have mastered the use of large crayons (Figure 11-3). Raw materials are more appealing than toys that are ready-made. An old cardboard box that can be moved about and climbed into is more fun than a dollhouse with tiny furniture. A box of sand or colored pebbles can be made into roads and mountains. A small mirror becomes a lake. "Dress up" becomes more dramatic, especially with the 4-year-old. Parents should avoid showering their children with ready-made toys. Instead they can select materials that are absorbing and that stimulate the child's imagination.

FIGURE **11–3** The preschooler enjoys coloring. Preschoolers often play *cooperatively*.

Stories that interest young children depict their daily experiences. If the story has a simple plot, it must be related to what they understand to hold their interest. They also enjoy music; they like songs that they can march around to and simple instruments that they can shake or bang. Make up a song about their daily life and watch their reaction.

Children's curiosity concerning sex continues to heighten. If the parents have answered questions simply, they should not be alarmed to find their children checking up on them. It is common for children of this age to take down their pants in front of friends of the opposite gender. They discuss their differences with their friends. It is important that parents provide simple explanations when sexual questions are asked. Older children who are more sensitive about their bodies should be told that this is a natural curiosity among small children. This may help to get rid of any guilty feelings that they might have, particularly if they also participated in similar activities during the preschool period. Children are as matter-of-fact about these investigations as they would be about any other learning experience and are easily distracted to more socially acceptable forms of behavior.

Between ages 3 and 4 years, children begin to wonder about death and dying. They may be the hero who shoots the intruder dead or they may witness a situation in which an animal is killed. Their questions are very direct: "What is dead? Will I die?" There are no set answers to these inquiries. Preschoolers may see death as a kind of sleep. They may not believe the dead person no longer breathes or eats. They cannot understand the true concept of death. The religion of the family plays an important role regarding the interpretations of this complex phenomenon.

Perhaps children can become acquainted with death through objects that are not of particular significance to them. For instance, the flower dies at the end of the summer. It does not bloom any more. It no longer needs sunshine or water because it is not alive. Usually young children realize that others die but do not relate this to themselves. If they continue to pursue the question of whether or not they will die, parents should be casual and reassure them that people do not generally die until they have lived a long and happy life. Of course, as they grow older, they will discover that sometimes children do die. The underlying idea, nevertheless, is to encourage questions as they appear and gradually help them accept the truth without undue fear. Chapter 18 discusses additional end-of-life issues.

THE 5-YEAR-OLD CHILD

Five is a comfortable age. Children are more responsible, enjoy doing what is expected of them, have more patience, and like to finish what they start. Five-year-olds are serious about what they can and cannot do. They talk constantly and are inquisitive about the environment. They have a vocabulary of about 2100 words. They want to do things right. They also seek answers to their questions and go to those who they think are knowledgeable. Five-year-olds can begin to play games governed by rules. They are less fearful because they feel that their environment is controlled by authorities. The worries they do have are not as profound as they were at an earlier age. They may play with and talk to a best friend.

The physical growth of 5-year-olds is not particularly outstanding. Their height may increase 2 to 3 inches, and they may gain 3 to 6 pounds. The variations in height and weight of a group of 5-year-olds are remarkable. They may begin to lose their deciduous teeth at this time. They can simultaneously run and play games, jump three or four steps at once, and tell a penny from a nickel or a dime. They like games with numbers or letters. They can name the days of the week and can understand what is a weeklong vacation. They usually can print their first name.

Five-year-olds can ride a tricycle around the playground with speed and dexterity. With training wheels, they also can begin riding two-wheelers as well. They can use a hammer to pound nails. Adults should encourage them to develop motor skills. Adults should not continually remind them to "be careful" because this practice enables children to compete with others during the school-age period and increases confidence in their own abilities. As with any age level, children should not be scorned for failure or for not measuring up to adult standards. Overdirection by solicitous adults is damaging. Children must learn to do tasks themselves for the experience to be satisfying.

The amount and type of television programs that parents allow preschool children to watch is a topic of current discussion. Although children enjoy television at 3 or 4 years of age, it is usually for short periods of time. They cannot understand much of what is happening. Five-year-olds have better comprehension and may spend a great deal of time watching television. The plan of management differs for each family. Whatever is decided needs to be discussed with the children. Television should not be allowed to interfere with good health habits, such as regular sleep, meals, and physical activity. Most parents find that children do not insist on watching television if there is something better to do.

GUIDING THE PRESCHOOL CHILD

DISCIPLINE, SETTING LIMITS

Much has been written on the subject of discipline, which over time has changed considerably. Today authorities place a great deal of importance on the development of a continuous, warm relationship between the child and the parents. This, they believe, helps prevent many problems. The following is a brief discussion that may help the nurse to guide parents.

Discipline and punishment are not one and the same: "Discipline includes all methods that are used to change behavior. Punishment is a very specific procedure that is used to decrease behavior that will be described under basic principles" (Larsen & Tentis, 2003). Children need

to have limits set on their behavior. Setting limits makes them feel secure, protects them from danger, and relieves them from making decisions that they may be too young to understand. Expectations, however, must be appropriate to the age and understanding of the child. Parents need to encourage children to make acceptable choices. Children who are taught acceptable behavior have more friends and feel better about themselves. They live more enjoyably within the neighborhood and society. The manner in which discipline or limit setting is carried out varies from culture to culture. It also varies among different socioeconomic groups. Individual differences occur among families, between parents, and according to the characteristics of each child. The purpose of discipline is to teach and to gradually shift control from parents to the child, that is, to promote self-discipline. The Health Promotions box lists discipline techniques.

Health Promotion

Discipline for Young Children

- Establish rules for safety by 8 months of age
- Explain rules clearly and concretely ("Don't push your brother")
- State acceptable behavior ("Walk, don't run")
- Do not constantly criticize
- Use rules that are fair and attainable for the child's age
- Apply rules consistently
- Remember that yelling teaches the child to yell back
- Logical consequences occur as a result of misbehavior (removal of possession or privilege)

AU: → We need either a city of publication + publisher for this or a website address where it can be retrieved online.

Schmitt, B. (2006). Discipline basics. Pediatric Advisor. McKesson Corporation. Retrieved from www.med.umich.edu/1libr/pa/pa_bdisbasc_hhg.htm

Timing, Time Out

Most researchers agree that to be effective, discipline must be given at the time the incident occurs. It should also be adapted to the seriousness of the infraction. The child's self-worth must always be considered. Warning the preschool child who appears to be getting into trouble may be helpful. Too many warnings without follow-up, however, lead to ineffectiveness. Spankings, for the most part, are not productive. The child associates the fury of the parents with the pain rather than the wrong deed because anger is the predominant factor in the situation. In addition, the parent serves as a role model for aggression. Whether a parent is affectionate, warm, or cold (uncaring) also plays a role in the effectiveness of child rearing. Time-out periods (discussed in Chapter 9), such as sitting for 5 minutes in a chair or corner, are one alternative to inappropriate behavior. Parents need to be taught to resist using power and authority for its own sake. As the child understands more, privileges can be withheld. The reasons for such actions should be carefully explained.

Rewarding Positive Behavior

Rewarding the child for good behavior is a positive and effective method of discipline. This can be done by the use of hugs, smiles, tone of voice, and praise. Praise can always be tied to the act: "Thank you, Sara, for picking up your toys." The encouragement of positive behavior eliminates many of the undesirable effects of punishment.

Consistency and Modeling

Consistency is difficult for parents. However, they should try to be consistent as much as possible. Consistency must exist between parents and within each parent. It is suggested that parents establish a general style in terms of what, when, how, and to what degree punishment is appropriate to misconduct. Parents who are lax or erratic in their discipline and alternate such procedures with punishment have children who experience increased behavioral difficulties. The influence of **modeling**, or good example, has been widely explored. Such studies show that adult models significantly influence the education of children. Children identify and imitate adult behavior, both verbal and nonverbal. Parents who are aggressive and repeatedly lose control demonstrate the power of action over words. Those who communicate, show respect and encouragement, and use appropriate limit-setting serve as more positive role models. Finally, parents need assistance in reviewing their own childhood in regard to parental discipline to recognize destructive patterns that they may be exhibiting.

Spanking

The American Academy of Pediatrics has made the following statement regarding spanking: "Because of the negative consequences of spanking and because it has been demonstrated to be no more effective than other approaches for managing undesired behavior in children, the American Academy of Pediatrics recommends that parents be encouraged and assisted in developing methods other than spanking in response to undesired behavior" (AAP Policy Statement, 2004). The role of the nurse is to encourage parents to use other forms of discipline with their children. By explaining the use of timing, time out, consistency, modeling, etc., parents become empowered and can make positive choices when raising their children.

BAD LANGUAGE

Parents express astonishment at the words that flow from the mouths of their sweet little children during the preschool period. Bad language is inevitable. Caretakers should suppress their desire to emphatically shout their disapproval. The small child delights in attention, and it does not matter, unfortunately, whether this attention is good or bad. Swearing at this age is not particularly meaningful because children are merely imitating what they hear and it does not have any real significance

to them. They use swearing as a way of identifying themselves with the older children in the neighborhood and to shock adults. One mother dealt with this problem by saying, "Johnny, Mommy does not mind if you hear or know what that word means, but we do not use it in our home any more than you would think of going outdoors without your clothes on." Johnny felt free to discuss what he heard with his mother and shortly thereafter his interest was taken up by other subjects.

JEALOUSY AND SIBLING RIVALRY

Jealousy is a normal response to actual, supposed, or threatened loss of affection. Children or adults may feel insecure in their relationship with the person they love. The closer children are to their mothers, the greater their fear of losing mother. Young children may envy a new baby. They love the sibling but at the same time resent its presence. They cannot understand the turmoil that is taking place within themselves. Jealousy of a new baby is strongest in children less than 5 years of age and is shown in various ways. Children may be aggressive and may bite or pinch. They may be rather discreet and hug and kiss the baby with a determined look on their faces. Another common situation occurs when children attempt to identify with the baby. They may revert to something they outgrew such as thumb sucking or wetting the bed. Some 4-year-olds even try the bottle, but it is usually a big disappointment to them.

Preschool children may be jealous of the attention that their mother gives their father. They may also envy the children they play with if those children have bigger and better toys than they do. School-age children more often are jealous of those who are more athletic or popular. There is less jealousy in only children because they are the center of attention and have only a minimum of rivals. Children of varied ages in one family are apt to feel that the younger ones are "pets" or that the older ones have more special privileges. These feelings of sibling rivalry present new challenges for the parents.

Parents can help reduce jealousy with the early management of individual occurrences. Preparing young children for the arrival of the new baby lessens the blow. They should not be made to think that they are being crowded. If the new baby is going to occupy their crib, it is best to get older children happily settled in a large bed before the baby is born. Children should feel that they are helping with the care of the infant. Parents can inflate their ego from time to time by reminding them of the many activities they can do that the new baby cannot. Parents also need to attend to the older child's needs first if both children have needs at the same time (Anderson, 2006). If it is convenient, the new baby is given a bath or feeding while the older child is asleep. In this way the older sibling avoids one of the occasions on which the mother shows the newborn infant affection for a relatively long period of time. Special time should also be spent with the older child while the new baby is asleep. Some people believe that giving the child a pet to care for at this time helps. Many hospitals offer sibling courses that assist parents in helping the child to overcome jealousy.

If the child indicates an intention to hit the baby or another child, the children must be separated. It is important to remember that the one who has caused or is about to cause the injury needs as much, if not more, attention than the victim. Aggressiveness similar to this is seen when the child is made to share toys. It is even more difficult to learn to share the mother, so the child must be given time to adjust to the new situation. Children should be assured that they are loved but should also be told that they are not allowed to injure others. Use of the "I message" is helpful when correcting this type of behavior: "I feel angry that you hit your brother (or sister), and hitting is not allowed because it can hurt people."

THUMB SUCKING

From 1914 to 1921, the U.S. Children's Bureau pamphlet entitled *Infant Care* cautioned mothers that thumb sucking would deform the mouth and cause drooling. Today we recognize that thumb sucking is an instinctual behavioral pattern that can be considered normal. It is often used as a comforting measure and does not necessarily mean the child is insecure. Finger sucking or thumb sucking does not have a detrimental effect on the teeth as long as the habit is discontinued before the second teeth have erupted. Most children give up the habit by the time they reach school age, although they may regress during periods of stress or fatigue. Management includes education and support of the parents so as to relieve their anxiety and to help prevent secondary emotional problems in their children. The child who is trying to stop thumb sucking is given praise and encouragement.

MASTURBATION

Masturbation is common in both genders during the preschool years. The child experiences pleasurable sensations, which lead to repetition of the behavior. It is beneficial to rule out other causes of this activity, such as rashes or penile or vaginal irritation. Masturbation is also exhibited in the child who feels emotionally isolated or anxious. A variety of interpretations of masturbation have been postulated; however, it appears that there are still many questions left unanswered regarding the significance of this behavior for the child. One common anxiety in boys that should be explored is fear of castration. Masturbation at this age is considered harmless if the child is outgoing, sociable, and not preoccupied with the activity. However, if masturbation is "compulsive" or "interferes with the child's normal activities" or involves "acting out of sexual intercourse in doll play or with other children," the possibility of sexual abuse must be explored (Behrman et al., 2004).

Education of the parents consists of assuring them that this behavior is normal and not harmful to the child, who is merely curious about sexuality. The cultural and moral background of the family must be considered when assessing the degree of discomfort in relation to this experience. A history of the time and place of masturbation and the parental response is helpful. Punitive reactions are discouraged because these can be potentially harmful to the child. Parents are advised to try to ignore the behavior and to distract the child with some other activity. If the parent calls unnecessary attention to this behavior, the child's anxiety level and masturbation activity may increase. The child needs to know that masturbation is not acceptable in public; however, this must be accomplished in a nonthreatening manner. Children who masturbate excessively and who have experienced a great deal of disruption in their lives benefit from ongoing counseling.

ENURESIS

Description

The term **enuresis** is derived from the Greek word *enourein,* to void urine. There are two types: primary and secondary. **Primary enuresis** refers to bedwetting in the child who has never been dry. **Secondary enuresis** refers to a recurrence of bedwetting in a child who has been dry for a period of 1 year or more. Diurnal, or daytime, wetting is less common than nocturnal episodes. It is more common in boys than in girls, and there appears to be a genetic influence. In many children, a specific cause is never determined. Most children who wet the bed overcome the problem between 6 and 10 years of age. Some organic causes of nocturnal enuresis are urinary tract infections, diabetes mellitus, diabetes insipidus, seizure disorders, obstructive uropathy (uncommon cause), abnormalities of the urinary tract, and sleep disorders. Sudden onset may be the result of psychological stress, such as a death in the family or divorce. Reduced antidiuretic hormone production at night and genetic factors are also likely causes of nocturnal enuresis. Other causes include small bladder, inability to delay voiding, not awakening to the sensation of a full bladder, and maturational delay of the nervous system.

Treatment and Nursing Care

A detailed history is obtained. Such factors as the pattern of wetting, number of times per night or week, number of daytime voidings, type of stream, dysuria, amount of fluid taken between dinner and bedtime, family history, stress, and the reactions of the parents and child are documented. It is also important to determine any medications that the child may be taking and the extent to which social life is inhibited by the problem, such as a child's inability to spend the night away from home. Developmental landmarks, including toilet training, are reviewed. If there appears to be an organic cause, appropriate blood and urine studies are undertaken. In most cases, physical findings are negative.

Education of the family is extremely crucial to prevent secondary emotional problems. It is important to reassure parents that many children experience enuresis and that it is self-limited in nature. Power struggles, shame, and guilt are fruitless and destructive. Reassurance and support from the nurse greatly help.

Therapies for bedwetting are subject to controversy. Some methods include counseling, hypnosis, behavior modification, and pharmacotherapy. Imipramine (Tofranil) has been found to decrease enuresis in controlled studies. It is administered before bedtime and is used only on a short-term basis. Imipramine has a variety of side effects, including mood and sleep disturbances and gastrointestinal upsets. Overdose can lead to cardiac arrhythmias, which may be life-threatening. Therefore dosage and administration should be closely supervised. Imipramine should not be given to children under 6 years of age. Desmopressin acetate (DDAVP) also has been used with some success. It is an antidiuretic hormone that inhibits urine production. These drugs may be especially beneficial when short-term control is desired such as for slumber parties, camping trips, or vacations.

See the Health Promotions box for bedwetting tips. A spontaneous cure may occur with little or no intervention or after other types of treatment have failed. The nurse prepares the parents for relapses, which are common.

Health Promotion

Tips for Bedwetters

- Use moisture-activated conditioning devices (with alarm when the child wets).
- Encourage bladder training exercises (strengthen bladder muscle).
- Try to have bedroom close to the bathroom (bathroom should have a nightlight).
- Have the child help in clean up if the bed is wet.
- Promote more fluids during the daytime hours.
- Never punish a child for bedwetting.

LANGUAGE AND SPEECH IMPAIRMENT

The child communicates through speech and language skills. Speech is defined as the utterance of vocal sounds conveying ideas; language is a defined set of characters that, when used alone or in combinations, form a meaningful set of words and symbols that are used for communication.

Parents need to be aware of delays in language development as the child matures. Most children say 10 words by 18 months, 50 words and two-word phrases by 24 months, and so on. Language delay is often a symptom of a larger developmental disorder. Possible

Table 11-3 ***Warning Signs of Speech or Language Disorders***

AGE RANGE	SIGNS
First 12 mo	Does not smile at familiar faces or voices by 2 mo
	Does not try to imitate any sounds by 4 mo
	Does not babble by 8 mo
	Uses no single words by 12 mo
	Does not use gestures such as waving "bye-bye" or point to pictures/objects by 12 mo
12 to 24 mo	Does not use at least 15 words by 18 mo
	Does not use two-word utterances by 2 yr
	Does not imitate words or actions by 2 yr
	Does not follow simple instructions by 2 yr
24 to 36 mo	Does not combine words into short phrases/sentences by 3 yr
	Frequent expression of frustration in communicative situations
	Does not interact or play with others
	Unable to understand and answer simple questions
4 yr	Unable to be understood by people outside of family
	Cannot retell simple stories or recall recent events clearly
	Sentences seem unorganized, with a lot of errors

Modified from Kelly, D., & Janine, S. In Levine, M., Carey, W., Crocker, A. (1999). *Developmental-behavioral pediatrics* (3rd ed.). Philadelphia: Saunders.

causes include hearing loss, mental retardation, learning disabilities, severe emotional disturbances, and certain genetic or organic problems. It is important to recognize milestone achievements. Any signs of problems in language or speech development need to be evaluated (Table 11-3).

Speech impairment can include articulation problems (distorting consonants or omitting consonants), voice disorders (deviations in pitch, loudness, or quality), and rhythm disorders (stuttering and stammering). Stuttering is the involuntary repetition of words or speech sounds, whereas stammering includes an involuntary pause in the formation of words. Speech therapy may be necessary for each of these problems. Remember to provide support to families as well.

HEALTH PROMOTION AND MAINTENANCE

DAILY CARE

Preschoolers are able to provide self-care almost totally, especially as they reach 5 years of age. They like to do things for themselves. Simple clothes make it easy for them to dress. A hook on the door within easy reach is helpful. They should dress and undress themselves as much as they can. A simple hairstyle is easily managed by the preschooler. Mother or father can assist with daily care but should not take over. Preschoolers may still need supervision with hygiene and may need to be reminded to use the toilet from time to time. Some 3-year-olds may still need assistance to get up onto the seat. A stool kept next to the bathroom sink enables them to wash their hands. They need to be reminded to do this after use of the toilet.

Brushing teeth still needs supervision. Children must be reminded to brush their teeth regularly. Parents still need to check that all tooth surfaces are cleaned and they should floss the child's teeth. The child needs to visit a dentist regularly, at least every 6 months. Children generally have all 20 of their deciduous teeth by 3 years of age. The first dental visit should have occurred by the first birthday. The deciduous teeth are important for the proper formation of the permanent teeth and should not be neglected. The child's diet should continue to emphasize milk, vegetables, and fruits. Excess sweets, which contribute to dental decay, are restricted. The child should still drink fluoridated water or receive a prescribed oral fluoride supplement.

Preschool children need simple, nourishing meals, prepared with foods according to the basic food groups (see MyPyramid, Figure 9-5). Like toddlers, preschoolers do not like foods mixed together. They also have varying interest in food, and their appetites go up and down. Preschoolers require about 1600 kcal/day (U.S. Department of Agriculture, 2005). It is also important to provide protein, calcium, iron, and plenty of vitamins A and C. Continue to limit juice intake to 4 to 6 ounces per day. Too much juice can provide excess kilocalories or limit milk intake. Their appetites fluctuate, and they should not be bribed, scolded, or coaxed. Encourage children to try different foods as they get older. If they did not like it in the past, they may like it now. Focus positively instead of negatively. Mealtimes should be happy. Parents who use good table manners set an example. The milk glass must be unbreakable and not filled completely. A waterproof tablecloth is useful. Children are included in the conversations but should not be not allowed to take over. A nourishing dessert such as a custard pudding eases apprehension about what has been left on the child's plate.

Preschool children need periods of active play both indoors and outdoors. Parents who see that their children are having a particularly good time should ask themselves whether it is necessary to interrupt them right at that moment. When children have verbal

arguments, parents should avoid rushing in to defend their child. Growth can be painful, but children need to do it at their own rate.

Sleep habits at this time vary. Toward the end of this stage, children may balk at taking a nap. Instead of insisting that they sleep, parents should see that they engage in something interesting but restful, such as reading a story together or playing with a simple puzzle. They need an opportunity to relax. Bedtime rituals are still important, and children may use these to put off going to bed. In addition, preschool children may wake up frightened during the night. Everyday items in the bedroom become frightening at night because of the child's imagination. Parents should attend to their needs and reassure them that they are safe and that the parents are close by. A night light may be helpful. If the children continue waking up and are usually frightened, parents should talk to the doctor during one of the checkups. Children of this age should have a complete physical examination each year. Booster injections of various immunizations are given when required.

Community Cue

Bright Futures (http://www.brightfutures.org) is a national health promotion initiative that provides an array of publications to health care clinicians. One such publication is an activity book (also available in Spanish) that teaches young children about health and safety. Children can color, draw, fill in the blanks, tell stories, and talk about staying healthy and being safe. They learn about nutrition, fitness, self-expression, safety, and oral health.

PRESCHOOL

The change from home to preschool or nursery school is a big step toward independence. At this age, the child is adjusting to the outside world and to the family group. Some children have the complicating factor of a new baby in the house. The child also finds at this time that parents are beginning to expect more in regard to neatness and cooperative play with others. This transition period is troublesome. A good preschool provides the child with opportunities to get rid of some pent-up emotions. There is plenty of room to run and shout. The toys are sturdy, and children can manipulate them because they are their own size. Because they are not their own, they find it easier to share toys. Children are not as emotionally involved with the teacher as they are with their parents. They are more willing to express their negative and positive feelings because the teacher is able to be more objective. The teacher expects the child to decide what materials to play with and with whom to play. Children take responsibility for their own belongings.

Children are accepted into preschools between the ages of 2 and 5 years. Most sessions last about 3 hours. This may be a child's first exposure to different cultures. A good nursery school should challenge the child's imagination and creativity (Figure 11-4). It should also attempt to acquaint children with the new social world in such a way that it adds to their security and increases independence. Parents can help with the transition to daycare or preschool attendance by having the child take a family picture, favorite toy, or stuffed animal for comfort. Always discuss the experience at the end of the day and ask the teacher for feedback as well. The Health Promotions box examines guidelines for daycare or preschool.

Health Promotion

Child Care Guidelines

Parents who are considering preschool for their child should evaluate the following factors:

- Are the teachers trained in CPR?
- How many children are there per teacher?
- Are the teachers prepared in early childhood education?
- Are the physical facilities adequate?
- What is the cost? Is the child ready for preschool?
- Parents should also visit the school and talk with the person in charge before the child starts the program. They may also wish to talk with parents whose children are attending the program. Parents should feel free to drop in to a daycare or preschool *at any time* unannounced.

The student nurse may have the opportunity to visit a preschool during studies of the well child. This can be a rewarding experience if nurses use their powers of observation. When observing an individual child, nurses should compare him or her with others in the age group and not merely with one other child. The types of behavior to be observed are outlined in Box 11-1.

PLAY IN HEALTH AND ILLNESS

VALUE OF PLAY

It has often been said that play is the work of children. Investigations stress the importance of play to both the well and the sick child's physical, mental, emotional, and social development. Children climbing on a jungle gym develop coordination of muscles and exercise all parts of the body. They use up energy and develop feelings of self-confidence. Their imaginations may take them to a jungle where they are swinging from limb to limb. They mentally face fears and solve problems that would be much more trying, if not impossible, in reality. They communicate with the other children and take a further step in the development of moral values, such as learning to take one's turn and learning consideration for others. Other types of play help them learn colors, shapes, sizes, and textures and teach them to be creative.

FIGURE 11–4 In the preschool setting, children are exposed to a variety of activities to enhance development of multiple intelligences.

Box 11-1 *Observing the Nursery School Child*

Objective: To observe the behavioral characteristics of the preschool child

Watch for and evaluate the following in terms of a child's security and independence:

PHYSICAL DEVELOPMENT

Ability to walk, run, jump, use play equipment
General health: easily fatigued, etc.

EMOTIONAL DEVELOPMENT

Easily excited
Whines, cries frequently
Evidence of temper tantrums
Persistence in a task
Aggressive
Shy
Reaction to failure

SOCIAL DEVELOPMENT

Talkative
Quiet
Plays with others
Plays near others
Special friends
Tends to lead
Tends to follow
Friendly toward other children and adults
Ability to share
Ability to take turns
Behavior when an object or attention of the teacher is desired

DEGREE OF INDEPENDENCE

Removing coat, hat, boots; putting them away
Attending to toilet needs
Getting a drink
Amount of time going from one activity to another
Dependence on adult suggestions and help

RELAXATION

Relaxes during rest periods
Sits and listens to stories
Is restless, in constant motion

SPECIFIC ROUTINES

Music period: Sings, plays games
Snacks: Eats lunch, takes other children's food, wanders about, disturbs others, plays with food
Free play period: Toys preferred, amount of skill using hands, span of interest, evidence of destructive play, plays with others or alone, has imaginary friend

This natural and readily available outlet must be tapped by institutional personnel. Preschool children may be unfamiliar with every facet of the hospital, but they know how to play, and playing is a good way for the nurse to establish rapport with them.

THE NURSE'S ROLE

Some hospitals have well-established Child Life programs supervised by play therapists (see Chapter 3). Play experience may be included during the nurse's education. It is not necessary to be an expert in manual dexterity, art, or music. To be of assistance, one must be able to understand the needs of the child. Play is not just the responsibility of those who are assigned to it, nor is it confined to certain times or shifts.

Many factors are involved in providing suitable play for children of various ages in the hospital. The patient's state of health has to be considered. This

Health Promotion

Choosing Toys

AGE	TOYS	GENERAL CONSIDERATIONS
Infant	Soft stuffed animals and dolls Cradle gym Soft balls Bath toys Rattles Pots and pans	Baby likes to pat and hug. Toys should be brightly colored, of different textures, washable. Large enough so that they cannot be aspirated. Smooth edges. Attention span is short. The infant looks at, reaches, grabs, chews.
Toddler	Nest of blocks Push-pull toys Dolls Toy telephone Rocking horse or chair Wooden pegs and hammer Cloth books Pots and pans Ball	May have favorite toy. Enjoys exploring drawers and closets. Likes to place things in containers and dump them out. Parallel play. May injure others.
Preschooler	Crayons Simple puzzles Paints with large brushes Finger paints Dolls Dishes, housekeeping equipment Sandbox, playground equipment Floating boats for water play Trucks Horns, drums, simple musical instruments Books about familiar circumstances CDs; audiocassettes	Shifts from solitary to parallel to beginning cooperative play. Exchanges ideas with others. Active play: climbs, runs, and hammers. Imitative play: firefighter, teacher. Imaginative play: let's pretend. Creative and dramatic play. Toys that do not require fine hand coordination. Games that teach safety in everyday life.
School age	Dolls and doll house Toy housewares Handicrafts Jump rope Skates Construction sets Trains Dress-up materials Table games Books for self-reading Bicycles Puppets Music Videogames/computer games	Attention span increases. Play is more organized, more competitive. Interested in hobbies or collections of things.
The convalescent child	(Many toys previously listed are also applicable) Telephone Easy puzzles Large beads to string Tape player Goldfish bowl Miniature autos, trains, dolls, farm animals Stick'ems, paper dolls Hand puppets Lap blackboard Alphabet boards Cutouts VCR; videos to watch	Play should not require a great expenditure of energy. Offer a wide variety because the child's interest span is decreased. Consider bed limitation. Toys should not require long, continuous focusing of eyes. Consider toys that are a little easier than those liked when well. Pay attention to special interests of individual child.

determines the amount of activity in which the child can participate. The nurse can provide many activities that relieve stress and provide enjoyment for the patient on bed rest. Overstimulation, nevertheless, is hazardous for the severely ill child, such as the child with a heart disorder, because he or she needs to conserve strength. Nurses should always be on guard for signs of fatigue or pain in a patient and should use their judgment accordingly. Basically, toys should be safe, durable, and suited to the child's developmental level. Children love to go to the hospital playroom. If they are unable (isolation, etc.), toys may be brought

to their rooms. Proper cleaning is required of any toy used by any child in the hospital before it is returned to the playroom or used by other children.

Toys should not be sharp or have parts that can be easily removed and swallowed. Too many toys at one time confuses the child. Complicated toys are frustrating and disappointing. Well-selected toys, such as balls, blocks, and dolls, are useful throughout the years. Three-year-olds participate in simple games, and four-year-olds have longer attention spans and can participate in group activities. Preschoolers of all ages enjoy coloring and "reading" books. Each child needs sufficient time to complete the activity. In general, quiet play should precede meals and bedtime for both the well and the sick child. Investigations have shown that the toys that are enjoyed by both boys and girls are more similar than dissimilar.

The nurse can entertain the child during routine procedures with nursery rhymes, stories, nonsense games, songs, or finger play. Simple crafts are fun. Collections of scrap material containing bright ribbons, bits of string, tongue depressors, paper bags, newspapers, or bits of cotton can be kept on the unit. Scrapbooks are also entertaining. The child may even want to make a storybook or keep a diary (older children) about the hospital experience. To encourage ambulation, a scavenger hunt on the nursing unit can be made into a fun activity. With the fairly high turnover of patients, many projects can simply be repeated with different children.

Music is provided by the radio, tape, or CD player. Older children enjoy sending electronic messages to friends. Most hospitals have VCRs available as well, and many pediatric units keep a supply of children's videos. Video and computer games are also often available. Drawing materials, finger paints, and modeling clay foster expression and creativity. They require merely a flat surface such as the over-bed table and the particular medium. The bedridden child can participate in messy projects, too. The bed linens can be protected with plastic or extra linens. Children in cribs need adequate back support for such projects. This is done by elevating the mattress or using pillows.

Nurses can encourage children to play together in the hospital if their condition warrants. Children need playmates to promote social development. Children who are ambulatory can visit other children in the playroom. The 1-year-old plays near other children. The 2-year-old grabs, pushes, and cannot share but in an individual way acknowledges other children. The older preschool child shows a beginning readiness for cooperative play. The ability to play with others increases during the school years and in late elementary years; girls prefer to play with girls, and boys prefer to play with boys. This preference changes during adolescence. It is important for children of all ages to socialize as much as possible with other children while in the hospital.

OTHER ASPECTS OF PLAY

Therapeutic Play

Play and toys can be of therapeutic value in the retraining of muscles, in the improvement of hand-eye coordination, and in helping children crawl and walk (push-pull toys). A musical instrument such as the clarinet promotes flexion and extension of the fingers. Blowing is an excellent prerequisite for speech therapy. Therapists supervise such activities. They should leave specific instructions if they wish their work reinforced on the unit.

The nurse can ask the child to draw a picture or make up a story; this allows the nurse to assess fears the child may be experiencing. What children *say* about what they draw can also be important in understand a child's concerns and is an important communication technique (Driessnack, 2006).

Play Therapy

The nurse may also hear the term **play therapy** used. This technique is used for the child under stress. A well-equipped playroom is provided. The child is free to play with whatever articles he or she chooses. A counselor may be in the room observing and talking with the child, or the child may be observed through a one-way glass window. With this method and other methods, the therapist obtains a better understanding of the patient's struggles, fears, resentments, and feelings toward self and others. When the child acts out feelings through "dramatic play," those feelings are externalized and provide a relief from tension. Child behavior is complex and requires a great deal of time, study, and sensitivity before it can be fully understood.

Art Therapy

Art has been defined by Elinor Ulman as "the meeting ground of the world inside and the world outside." Art therapy is a process that is useful in communicating with children and adults. It is becoming more widely used. The art therapist is specially trained to assist children to express their feelings through drawings, clay, and other media. Some hospitals with inpatient mental health units have art therapy departments.

← AU: I left this as you indicated it had been in the book a long time.

Role of the Nurse

The nurse who is with a child daily can describe his or her behavior. This is helpful if the child has emotional or social problems. It is important to describe good and poor behavior, conversations that you may feel are pertinent, and the relationships with other children in the hospital. What is the approach to play? Do they join in freely or linger outside the group? Do they prefer active or quiet activities? Do they seem to be able to tolerate frustrations? Can they talk with their playmates and communicate their ideas? What kind of attention span do they have? This type of charting is meaningful and should be used to describe the

activities of pediatric patients so that they may be better understood.

INJURY PREVENTION

Accidents are still a major threat during the years from 3 to 5. Preschoolers need to follow the same injury prevention guidelines as toddlers (see the Health Promotion box titled Injury Prevention—Toddlers in Chapter 9). At this age, children may also suffer injuries from a bad fall. Preschool children hurtle up and down stairs. They climb trees and stand up on swings. They play hard with their toys, particularly those they can mount. Stairways must be kept free from clutter. When buying toys, parents must be sure the toys are sturdy and can take a beating. Preschool children should *never* be asked to do anything that is potentially dangerous, such as carry a glass container or sharp knife to the kitchen sink.

Automobiles continue to be a threat. The use of car seats or booster seats needs to be enforced (depending on age and weight; see Chapter 9). Children should be taught where they can safely ride their tricycles. Once they begin to ride a two-wheeler, they need to wear a helmet every time they use the bike. This prevents brain injury and even death. They also need to be taught where they can safely play. For example, they should not be allowed to use a sled on streets that are not blocked off for this purpose. They must not play in or around the car. Whether they are asleep or awake, children this age must *never* be left alone in the car. In an attempt to "drive like Mommy," they can quickly set a car into motion. Accidents also have been caused by children left in cars who find matches or play with the cigarette lighter. When crossing a street or when in a parking lot, they need to hold hands with a grownup. They should not operate an electronic garage door.

The potential for drowning is a danger. Do not leave children alone in a bathtub, swimming pool, or near any body of water. They can begin to learn to swim with supervision (Figure 11-5).

Burns that occur at this age are frequently caused by children's experimentation with matches. Children are also intrigued by cigarette lighters. These items are common hazards for this age group; they should be kept well out of reach, and their dangers should be explained.

Poisoning is still a danger. Children try to imitate adults and are apt to sample pills, especially if they smell good or look like candy. Their increased freedom brings them into contact with many interesting containers in the garage or basement. Poisons should *never* be put into used milk cartons or other household containers that would confuse children. Containers should be marked in such a way that the child knows it is a poison.

FIGURE **11–5** The preschooler should wear safety equipment while swimming and be accompanied by an adult.

Trampoline injuries have been on the rise. The American Academy of Pediatrics does not advocate the use of home trampolines and further states that trampolines should not be regarded as play equipment. Trampolines have no place in outdoor playgrounds or in schools for routine physical education (AAP Policy Statement, 1999, 2006).

Preschool children should also be taught the dangers of talking to or accepting rides from strangers. They need to know that a stranger is someone they do not know, not just someone who is odd-looking. If they are stopped by a driver, they should run to a house where they know the people. Parents should make it clear to children in preschool that they will *never* send a stranger to see them or to pick them up. Children must know the dangers of playing in lonely places and of accepting gifts from strangers. Children should always know where to go if their mother or father cannot be found.

Preschool children still require a good deal of supervision to protect them from dangers that arise from their immature judgment or social environment.

Key Points

- The preschool period is marked by a slowing of the growth process and more well-developed muscle control.
- Preoperational thinking predominates, and preschoolers base their reasoning on what they see and hear. They also believe they have "magical" powers and can only understand their own viewpoint.
- Preschoolers' sense of initiative empowers them to try new activities and experiences. They still need to be supervised to prevent injury.

- Encouraging positive behavior helps eliminate the undesirable effects of punishment. When necessary, time out is an effective method of discipline.
- Common problems of preschoolers (bad language, jealousy, thumb sucking, masturbation, and enuresis) can be easily dealt with through gentle explanation or correction of behavior and reassurance.
- The attainment of milestones for speech and language needs to be evaluated with the preschooler.
- The older preschooler becomes almost completely independent in dealing with daily care.
- Preschools should be evaluated through parental visits and the evaluation of the facility.
- Play of preschoolers often involves the beginning of cooperative play and imaginative and imitative play.

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