Gentle Hands: Assisting Single Parent Teen Mothers In Raising Their Children. *Child and Youth Care Forum*, *35*(5/6), 411-426

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Abstract:
This paper describes a qualitative study of a successful, integrated childcare program for infants and toddlers of young mothers and its ability to support young at-risk mothers' effective parenting, and promote the ability in young children to self-regulate aggressive behavior. Observations highlighted how care-giving practice can contribute to the modeling of positive social interactions that foster young children's ability to self-regulate their use of aggression towards others.

Keywords: self-regulated behavior, violence prevention, primary care-giving, early childhood

The researchers gratefully acknowledge funding from the BC Ministry of Children and Family Development through the Human Early Learning Partnership (HELP). The views expressed in this article are solely those of the authors and do not represent the policy of HELP or the Province.
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Introduction

This qualitative study describes a successful, integrated childcare program for infants and toddlers of young mothers in an alternative school and its ability to:

a) support young at-risk mothers' effective parenting such that they, as parents, do not contribute to or promote the use of aggression among their children, and
b) promote the ability in young children to self-regulate aggressive behavior

In order to describe the integrated childcare program we conducted observations of the childcare practice. The first rounds of observations in the childcare program highlighted the quality of the care-giving practice by recording the language used by the caregivers in their interactions with the children, the young mothers, and other caregivers. The observations revealed features of care-giving practice that contribute to the modeling of positive social interactions that foster young children's ability to self-regulate their use of aggression towards others.

Young Children and Aggression

Research supports the fact that most young children, as early as their first year of life, engage in aggression towards others in order to get something they want or avoid doing something they don't want to do (Tremblay & Nagin, 2005). However, most children also decrease their use of aggression as they approach 5 years of age. Gerber (1979) has observed that by two-and-a-half years of age, children who have received prosocial behavioral guidance from caring adults are more likely to demonstrate compassion towards other children than they are to use aggressive behaviour.

Despite the fact that *most* children learn to decrease their use of aggressive behavior, *some* children persistently use aggression throughout childhood. Differing

opinions exist with respect to the causes of persistent aggression across childhood. Hartup (2005) notes that some researchers believe that persistent and high levels of aggression across childhood are due to biological factors while other researchers argue that the same problematic behaviors are more likely due to dysfunctional family relationships. Researchers do tend to agree, however, that the development of aggressive behavior arises out of *interactions* between intrinsic structures (e.g., physiological structures that influence arousal, anger, learning, attention, etc.) *and* experiential contributions (e.g., relationships with caregivers, friends, enemies). In other words, researchers must work from the perspective that the development of aggressive behavior is embedded within "biological and social systems, not an attribute of either individuals or contexts" (Hartup, 2005, p.18).

Tremblay (2003) points out that while much is known about the correlates of aggression and violence, less is known about causality and prevention, especially with respect to young children. It is generally accepted that as humans grow up, they must learn to regulate their behavior according to social norms and with that, unlearn the use of aggression (Reis & Roth, 1993; Tremblay, 2003). Typically, those children who do not learn to regulate their use of physical aggression live in contexts that fail to promote self-regulation and are parented in ways that contribute to or even promote the use of aggression. Often, single parent, young mothers, by dint of the pressures and stresses of their lives and their own experiences with poor parenting, care for their children in ways that do not promote self-regulation (Zoccolillo, Wakschlag, Baillargeon, Boivin, Pérusse, Vermunt, & Tremblay, 2002).

Past research on parent-child interactions focused predominantly on the characteristics of parents and children and the interactions between characteristics such as, for example, temperament and parenting style (Hartup, 2005). Research has not attended closely to the social exchanges which influence behavior change. Thus, we respond to this gap by making social exchanges the focus of this study.

Learning to self-regulate the use of aggressive behavior

Given the marked decline in aggressive behavior that occurs for most children between 2 and 5 years of age (Tremblay & Nagin, 2005) and the parallel changes in executive function that take place during the same age period, the preschool years are an especially important locus of study for understanding the relation between aggression and executive function (Séguin & Zelazo, 2005).

Self-regulation depends upon executive functioning, a specific aspect of cognitive function that is said to begin at around 1 year of age and increase throughout childhood as a child's brain matures (Séguin & Zelazo, 2005). Self-regulation refers to the ability to be aware of and exhibit control over what one thinks, does, and feels. As a higher level cognitive capacity, executive functioning involves working memory, inhibition, and strategy use in the preparation of behavioral responses. Séguin and Zelazo (2005) state that it is helpful to distinguish between "cool" executive function that is more likely to be "elicited by relatively abstract, decontextualized problems" and "hot" executive function that is required for problems that involve the regulation of affect and motivation (p.320). These authors note that it is "cool" executive functioning that has been the focus of most of the research on executive functioning. Thus, further study is warranted into problems involving the regulation of affect and emotion.

Despite the proliferation of studies on the development of self-regulation, the fact that self-regulation has been defined in terms of what it accomplishes rather than on the mechanisms that permit such accomplishment (Séguin & Zelazo, 2005), it becomes difficult to translate findings from studies into implications for intervention practice. Domasio's (1999) concept of extended consciousness is a useful construct in imagining how the development of mechanisms for "hot" executive functioning can be facilitated. By integrating mind and body in this theory of extended consciousness, Domasio complements what appears to be missing; that is, attention to the role of affect in the research problems used in empirical studies. There is evidence to suggest that attention problems are commonly implicated in aggressive and antisocial behavior (Morgan & Lilienfeld, 2000). Domasio contends that animals and infants possess core consciousness (i.e., individual alertness in interactions of the here and now). His concept of extended conscious (i.e., alertness that incorporates both memory of the past and anticipation of the future) highlights the inseparably of emotion and consciousness. For Domasio, emotion is not indicative of a mere psychological state, but refers to chemical, visceral, and muscular internal changes that are not conscious, but when induced, give rise to feelings which provide the stimulus for action. While feelings are not always conscious, Domasio suggests that it is advantageous to survival to cultivate a conscious knowledge of feeling. In his research, Domasio has proven that our brains function to achieve homeostasis in our internal state. When people suffer damage to the emotional systems of the brain, they are inhibited in their ability to plan, judge and act with social appropriateness. Domasio argues that the behavior of people with emotional system damage reflects their inability to respond emotionally to the content of their thoughts. In other words, if someone has

emotional system damage, they might be capable of feeling afraid if they are about to be stabbed by someone, but they would not feel afraid by thinking about being stabbed. Well-targeted and well-deployed emotions seem to be a support system without which the edifice of reason cannot operate properly (Domasio, 1999, p.42). Thus, understanding the development of emotional awareness is an important consideration in our investigation into the self-regulation of aggressive behavior.

Learning to self-regulate against the use of aggressive behavior is positioned as an outcome of effective socialization (Tremblay, 2003). Socialization refers to an interactive process in which social norms are communicated in social interactions such that a person learns to regulate their needs to accommodate the needs of others. However, socialization processes with respect to the use of aggressive behavior tend to differ for boys and girls. Boys are more likely than girls to exhibit persistent and high levels of aggressive behavior across childhood (Hartup, 2005). In her study of preschool-aged children's theory-of-mind understanding (i.e., understanding that beliefs, desires and feelings of others may differ from one's own and that actions are often a product of such mental states), Walker (2005) found that boys and girls with high theory-of-mind understanding were more likely to be judged by teachers and peers as socially competent, even though only girls were more likely to *engage* in prosocial behavior. She suggested that the young boys in her study utilized their understanding of theory of mind to pursue goals for social dominance as opposed to conciliatory social goals. Walker concluded that aggressive or disruptive behavior in young boys does not have the same bearing on their social status as it does for young girls.

The Study

As mentioned earlier, this research describes the approach of a successful, innovative childcare program for infants and toddlers of young mothers in an alternative school and its ability to: a) support young at-risk mothers' effective parenting such that they, as parents, do not contribute to or promote the use of aggression among their children, and b) promote the ability of young children to self-regulate aggressive behavior.

In the first round of data collected for this study, we undertook observations in the childcare program and focused our attention on recording the language caregivers use in their interactions with the children, the young mothers, and other caregivers. Thus, we focused most of our attention on how the care-giving practice contributes to the optimal development of the infants/toddlers. The primary concern of the present study is with the interactive process between caregivers and young children that contributes to one component of effective socialization: the ability to self-regulate against the use of aggressive behavior. We intend to focus attention more specifically on interactions between caregivers and the young mothers in future research.

The childcare program

The childcare program that is featured in this study is situated within an alternative school and has successfully served the life skills, counseling and education needs of pregnant young women and young mothers for 25 years. The comprehensive program benefits from being an all female community, applying Attachment Theory, focusing strongly on emotional and physical safety, having a nurturing childcare program on site, and having a Public Health nurse assigned to the program. The childcare program opened in 1989. Since that time, only one mother has had her

child apprehended by the government Ministry responsible for children and families while she attended the program. The young mothers are sometimes as young as 14. Most of the pregnant young women are considered high risk pregnancies; in addition to being young, they are sometimes drug- and alcohol-involved and/or have mental health issues. Often the baby's father is an older, and oftentimes violent, male.

The childcare program accepts newborn infants and continues to provide spaces for children up to 3 years of age. The childcare program continuously runs at full capacity, providing space for twelve infants/toddlers. Staff in the program, including counselors, caregivers and teachers, work together to create an atmosphere of trust, support, and belonging that makes it possible for young mothers to engage in learning while their children are being cared for in the in-house childcare. Young mothers are able to have regular interactions with their children during the school day that benefits both the young mothers and the children. The childcare program works closely with the educational program staff and counselors to support the young mothers/students; thus, the childcare staff are part of a dynamic culture that works together to make a difference in the lives of the young women.

At the time that this study was conducted, twenty young women, aged 15 to 19 years of age were enrolled in the program. The twelve children (of 12 young mothers) in the childcare centre were between 4 months and 2 ½ years of age. The space that houses the childcare center is divided into two halves: one half for the infants and the other half for the toddlers (children who are walking).

The childcare program is configured around a primary caregiver model for practice. The primary caregiver model is a childcare system in which an infant or toddler

is attended to by one caregiver rather than several caregivers. This model of care-giving has been around for at least 30 years and is now associated with best practice (Elliot, in press). In a childcare program with, say 12 infants and 4 caregivers, each caregiver would have the principal responsibility for assuming the care (feeding, sleeping, diapering) for 3 infants and maintaining contact with 3 mothers and any other family members involved. Teams consisting of 2 caregivers work together so that their 6 infants become a group and each caregiver can spend one-on-one time with an infant when needed while the other caregiver shares responsibility for the other infants. The benefits of the primary care-giving model also include the provision of responsive and consistent care, and the development of trusting and intimate relationships between caregivers and infant/toddlers and their families (Elliot, in press). Caregivers in the program stay with their infants as long as the infants are in the program; sometimes they provide consistent care for 2 years or more, moving from the infant side to the toddler side of the childcare space.

The caregivers in this program possess a higher level of professional education than most caregivers in Canada (2 of the staff have full ECE certification, 2 other staff members possess Bachelor degrees in Child and Youth Care, and the supervisor possesses a Masters degree in Education). Canadian data shows that most caregivers (71%) hold only a one- two, or 3-year ECEC certificate and just one in ten hold an ECEC-related B.A. or higher degree (Doherty, Lero, Goelman, LaGrange, & Tougas, 2000). Most of the caregivers in the program also had experience with Gerber's *Resources for Infant Educarers* (RIE). The RIE program philosophy respects babies and recognizes their ability to be active participants in relationships with caregivers and the

world (Gerber, 1979). Consistent, primary care-giving is intended to promote feelings of security in the child. Everyday care-giving activities are viewed as opportunities to engage in educational and loving interactions with children. The RIE philosophy also acknowledges and fosters the capacity of the child to learn on their own (Elliot, in press).

Relationship-building between caregivers and young mothers is built into the integrated educational program. The young mothers often spend time in the daycare playing with their children and chatting with the caregivers. The integrated program also includes a weekly 2 hour "moms' group" which is built around support, speakers, and going on community outings together. Additionally, each caregiver takes their moms out for breakfast a few times during the year so that they can get time out of the center to interact and get to know each other better. Caregivers often take moms and babies to doctor appointments and try to offer support whenever they can.

Procedure

Again, the primary focus of the present study was on interactions between caregivers and young children. We intend to focus attention more specifically on interactions between caregivers and the young mothers in future research. Observations in the childcare program were conducted by a female graduate student who recorded observations on twenty visits between April and July, 2005. The observations included interactions between a total of 12 infants/toddlers and 6 caregivers (4 regular staff, one substitute caregiver, and the program supervisor). The ages of the infants/toddlers are shown in Table 1. There were, on average, between 4 and 6 infants/toddlers and 2 to 4 caregivers in attendance during each observation session.

Insert Table 1 about here

The observation sessions ranged from approximately 1 ½ to 3 hours in duration. The observer recorded observations primarily from a non-participatory approach, although occasionally she was drawn briefly into interaction by the toddlers. The observer focused her attention on recording the language used in interactions between the caregivers and infants/toddlers in their care. The young mothers of the infants/toddlers were captured in observation records when they participated in exchanges with the caregivers and/or their infants/toddlers during pick-up and drop-off times. Observation records were written by hand and later typed out to comprise 50 pages of observation data.

Observation Findings

The observations have been organized around three areas of interaction. The caregivers utilize specific language when they are engaged with the infants/toddlers in free-play activities and when the infants/toddlers exhibit symptoms of being upset, tired or hungry. This interaction area comprises the bulk of the observation data and has been given the name "the relationship between things, self and other." A second interaction area was developed to highlight the language used by caregivers when the infants/toddlers engaged in aggressive behavior towards things or other people. This interaction area was named, "responding to aggressive behavior." The third interaction area focuses on exchanges between the caregivers and the young mothers: "caregivers with young mothers." We provide general findings supported by excerpts from the

observations[1] in order to illustrate each of the interaction areas. We will comment on the language that depicts the quality of the childcare practice in each of the interaction areas and its relationship to fostering self-regulation of aggressive behavior in the discussion that follows this section.

1. The relationship between things, self, and other

The caregivers make frequent distinctions between things, self and other that help the children to learn about social interactions. For example, when the caregivers need to touch a child, they always signal their intention aloud beforehand, even with the infants. They also signal their intentions to change spaces so the infants/toddlers aren't surprised. They use phrases like these:

- "How about if I pick you up and put you close to Bea (caregiver)?"
- "I am going to put you down."
- "I am actually going to help you sit back down on the blue chair."
- "I'll put you down here and you can decide where you want to go."
- "Do you want me to pick you up or are you ready to sleep?"
- "I'll pass you back to your mom. See you tomorrow."
- "I am just making Karl a bottle."
- "Did you hear that? We are going for a diaper change."
- "Can I pick you up? Oh, let's blow your nose first."
- "Can I pick you up so you can say good-bye to Bea (caregiver)? I know it's sad when Bea goes for lunch, but she needs to eat too. She just fed you."

[1] The names reported are pseudonyms; they are not the actual names of the infants/toddlers or caregivers.

- “I am not forgetting you; I am just doing something else.”
- “Do you want me to come get you?”
- “Can I help you with your pants?”
- “One more minute, then we have to go outside.”
- “Can I cuddle you for a few minutes? You just woke up and it’s nice to be cuddled when you wake up.”
- “Let’s go pee and then I’ll wrap you up for a sleep. Should I pick you up or can you walk?”
- “I can’t pick you up right now.”
- “Did you see that your mom is leaving and Kit is leaving, but I am staying and Pam (caregiver) is staying?”
- “I am going to have you wait over here.”
- “If you don’t like her singing, you can move away.”
- [Before turning on the blender]: “Another big noise coming up.”
- “Will you use your walking feet or should I scoop you up like a baby? Show me your decision or I will make the decision for you.”
- [In response to a toddler not wanting to put a jacket on to go outside]: “I know the sun’s coming out, but it’s still chilly. Let’s just keep your arms covered up and then you can tell how the rest of your body feels when we get outside.”

Other examples of phrases used by caregivers help the infants/toddlers learn about the needs of others include the following:

- "Be gentle, that's not okay (to push). Nate is using this space too. We have to make room for him."
- "Are you showing it to him or giving it to him?"
- "I am telling you with my word 'No', so now I am going to have to move away."
- "The biscuits are for Karl because he doesn't have many teeth."

The following interactions are additional examples that support the practice of nurturing children's awareness of self and other.

* * *

Carolyn is screaming; Emily is grabbing at Carolyn's shirt.

Caregiver (to Emily): Carolyn already told you she didn't need your help.

Another *caregiver* (to Emily): She is telling you she doesn't want your help. Please have gentle hands.

* * *

Carolyn is walking down the slide.

Caregiver (to Carolyn): I worry about you walking down. It makes me scared.

* * *

Tammy is upset; Emily is trying to climb over her.

Caregiver (to Tammy): Is that okay with you, Tammy?

Tammy: No.

Caregiver (to Tammy): Well, tell Emily, 'Find another place to climb; like over there.' You need to be able to do it on your own.

* * *

Karl is crying.

Caregiver (to the toddlers): Let's go see Karl.

(to Karl): It's okay, Bea is coming back. (Caregiver rubs Karl's back) She is washing her hands; she's coming. …Look at Leslie, she is coming over to see if you are okay.

Bea (Karl's primary caregiver returns). Karl stops crying. Bea puts Karl on her lap. Leslie comes closer to see Karl. Karl begins to cry again.

Caregiver: I am sorry, Leslie, but Karl doesn't like it when you get so close.

Tammy throws a piece of chalk.

Caregiver (to Tammy): I am going to hold it (chalk). I don't like it when you throw it. Do you know what happens when you throw it? It breaks.

Please stop swinging your bucket. It is hitting your friends.

* * *

Carolyn puts a blanket on Tess.

Caregiver (to Carolyn): Just be careful. Look at her face; she doesn't seem to mind.

Caregiver (to Tess): How about I make something to eat? Would you like some sweet potatoes?

Caregiver (to Carolyn): I am going to go and make Tess something to eat. You have already had your lunch.

Carolyn: No, no, no. Don't make Tess something to eat.

Caregiver (to Carolyn): Why not? I need to look after her when she is a baby.

Caregiver wraps Tess up in a blanket.

Carolyn: Wrap me up, wrap me up.

Caregiver: I'll wrap you up too after Tess. I only have two hands. Can you wait?

Carolyn waits, holding her blanket. After a few minutes pass,

Caregiver (to Carolyn): You are being so patient waiting for me, Carolyn.

Carolyn lies down on the mat.

Carolyn (to caregiver): I am just going to lie down here and wait for you.

Caregiver (to Carolyn): I am just waiting for Tess to get off my lap. She is pretty relaxed.

Carolyn: I want to go in the sleep room. Wrap me up.

Caregiver: I am still helping Tess.

Carolyn: I want to go in the sleep room.

Caregiver: We will go in there after I help Tess.

Carolyn: Wrap me up.

Caregiver: I will, you are next. Do you want me to wrap you up in the rocker or the sleep room?

Carolyn: In the sleep room.

Caregiver: If we go in the sleep room we can't talk because there are two friends in there sleeping.

Tess begins to cry.

Caregiver: Carolyn, you are going to have to wait a bit. Tess is really tired.

Donald is crying as he brings a toy to Tess's caregiver. Carolyn gives Donald her blanket and then puts heavy rings on Donald.

Donald's caregiver: Careful, Carolyn, that was heavy on Donald.

Carolyn calls for her caregiver.

Donald's caregiver (to Carolyn): She's busy right now. She'll be with you in a minute.

After a few minutes, Carolyn's caregiver becomes available.

Caregiver: So, Carolyn, thank you for being so patient. I am ready if you are.

Carolyn: I am ready.

Caregiver: Would you like some milk?

Carolyn: No milk.

Caregiver: Would you like to go in the sleep room?

Carolyn: Yes.

Caregiver: If we do, you have to be quiet because I just put Tess down.

Carolyn: Okay, goodnight (to other caregiver). I am going in the sleep room.

* * *

During snack time:

Caregiver (to Carolyn): Are you all done? Because you are off your chair.

Carolyn: I am feeding Nate.

Caregiver: I am hearing Nate say he would like to do it on his own. But Christie is saying 'please feed me.'

Carolyn: No, no, no.

Caregiver: She says 'no' Christie.

* * *

C*arolyn, playing outside, begins to miss her primary caregiver who has gone inside. Another caregiver dances over to Carolyn and asks*, "Can I pick you up? I'm right over here if you need me."

Carolyn: I like Sam (primary caregiver) better.

Caregiver: I understand that. That's okay. Do you want to peek in the window?

Carolyn: No.

Caregiver: Okay.

After a few minutes:

Caregiver: I am going to go over and peek.

Carolyn follows the caregiver over to look inside.

* * *

2. Responding to aggressive behavior

The following are examples of caregiver-infant/toddler interactions when infants/toddlers exhibit aggressive behavior.

Carolyn grabs the flowers that Tammy had picked for her mother and throws them over the fence. Tammy's mother is present to witness the event.

Tammy's mother: Stop, Carolyn!

Caregiver: Oh, Carolyn, look at how sad Tammy is now. She brought those flowers as a special gift.

Tammy pulls a fireman's hat away from Christie.

Caregiver: Oh, we will have to wait for Christie to be done with the hat.

* * *

Leslie is trying to hit Karl.

Caregiver: I am going to stop your body, Leslie. Do you want something from over there? (*Caregiver gives Leslie a toy*.)

Caregiver (to Leslie): Karl is feeling a little squished here.

The toddlers continue playing.

* * *

Nate goes to grab a truck away from Carolyn.

Carolyn: No, no.

Caregiver (to Nate): Carolyn is using it.

Nate hits the caregiver.

Caregiver: Hitting me won't get the toy back. You'll have to find another.

* * *

In the sandbox:

Caregiver: Nate, please keep the sand down low so it doesn't go in your friend's eyes.

Play continues, and Nate keeps throwing sand.

Caregiver: You know what, Nate, I need to remind you to keep the sand down low. …If you can't keep the sand in the box, I am going to ask you to leave.

Later, another caregiver is building sand castles with Nate and Emily.

Caregiver (to Emily): Let's not break Nate's castle.

Emily: I don't want Nate.

Caregiver (suggesting words for Emily to use): (Say) "Please don't break my castle."

Emily: Please don't break my castle. Nate move back.

Caregiver (to Nate): Please give Emily more space.

Nate throws sand.

Caregiver (to Nate): You're all done in the sand, Nate. I heard Cass (other caregiver) say lots of times that if you threw the sand you would have to come out.

Caregiver picks up Nate, takes him out of the sandbox and directs him to another activity. Nate cries a little.

Caregiver (to Nate): I heard Cass tell you not to throw the sand. It's okay; we can go back in a while.

* * *

Kevin throws a ball over the partition that separates the infant side from the toddler side of the childcare space.

Caregiver (to Kevin): I hope that ball didn't hit J (caregiver on the other side).

Bea (other *caregiver* calls over the partition): It almost hit me.

Caregiver (to Kevin): We have to be careful because we never know what is over on the other side.

Kevin goes away and finds something else to play with for a while, then returns with a ball and throws it over the partition.

Caregiver (to Kevin): Kevin, look at my face. What do you think I am going to say? Stop throwing toys. Tammy is over there and I will be very sad if her body gets hurt. Keep the toys over here please so we can enjoy them.

Kevin throws a truck over the partition.

Cass (other *caregiver* calls over partition): Ow, you hurt my head.

May (another *caregiver* calls over partition): Kevin, would you like to come over here for a cracker? I was very sad to see Cass get hurt. Toys are for hands.

* * *

3. Caregivers with young mothers

During our observation sessions, the young mothers tended to interact with the caregivers only briefly when they were dropping-off or were picking-up their children.

Kate's mom comes into the childcare space.

Kate's mom (to caregiver): Where is Kate?

Caregiver: She's in the sleep room with J (her primary caregiver). (*crying can be heard*).

Kate's mom goes to leave.

Caregiver (to Kate's mom): You are welcome to go in there.

* * *

Kate is being breastfed by her mother.

A caregiver asks Kate's mother to phone when she is going to be late arriving at the childcare program.

Caregiver: I am going out for my break, but I'll be back for her (Kate).

Another *caregiver* (to Kate's mom): Kate is crying. She is either tired or hungry.

Kate's mom takes Kate to the sleep room and says, "Good night, Kate."

Caregiver (returns from break): How come you didn't come to school yesterday?

Kate's mom: Paula moved out yesterday and my house was very messy. I had to stay home and clean up. I know next time to phone.

Caregiver takes over trying to put Kate to sleep.

* * *

Donald's mom arrives and lifts Donald by pulling up on his arms.

Caregiver (to Donald's mom): You have to be careful when you do that. You don't want to pull his arm out of his socket.

Donald's mom: Oh.

Caregiver: I have a cousin who had an adult friend come over and they picked up her child that way and that happened. It was scary. It would be more secure if you picked him up under the arms.

* * *

In the brief periods that the young mothers were present in the childcare space, some were observed using the same types of language with their children. The following excerpts provide examples of the language young moms adopt from the caregivers.

Karl's mother (to Karl): I am going right to the kitchen; you can watch me from here. See, I am going right here. Here I am. I am going to play with you for a few minutes then I am going to eat my lunch.

Karl's mother also gets involved in an interaction between two toddlers:

Nate tries to sit on Leslie.

Karl's mom (to Nate): You gotta be gentle, don't sit on her. You have to be gentle when you touch other people's eyes. Maybe just touch your own.

Nate grabs Leslie's toy.

Karl's mom (to Nate): Are you two sharing?

Nate gives the toy back to Leslie.

* * *

Linking the Language of Responsive Caregiving to Fostering Self-regulation of Aggressive Behavior in Young Children

We begin this discussion by noting a weakness of our study. By focusing on language use in our observations, we have, undoubtedly, missed out on some of the nuances of practice. While we feel confident that we can, from the observations, say some things of importance, we most certainly do not intend to suggest that caregiving practice can be captured in its totality through verbal interactions. As Elliot (in press) attests, "relationship is about connection and communication. Connection can elude the visible and a great deal of communication may be non-verbal. While these qualities are not often quantifiable, they have a deeply felt veracity" (p.93). We plan to enrich the understandings gained from our observations by conducting more observations in the future with a focus on gesture and other non-verbal interactions.

To reiterate, the primary concern of our study was to highlight the interactive process between caregivers and young children can contribute to one component of effective socialization: the ability to self-regulate against the use of aggressive behavior. What stands out most in the observations of caregivers' verbal interactions with the infants/toddlers in their care is the communication of knowledge about self and other. It resembles, as Elliot (in press) says, the work of evolving individual identity. Through an awareness of their own needs, caregivers communicate personal boundaries for self-care. Through an awareness of the needs of the children in their care, caregivers communicate to the children information that helps children develop their own self-knowledge. The children learn to feel secure when their needs are recognized and responded to appropriately while also learning that other people have needs too.

The development of empathy is fostered by caregivers' efforts to help children learn to become aware of emotion in social interactions. Infants learn to recognize the tones of voice used by caregivers and to anticipate what a caregiver's next move will be (Elliot, in press). This secure anticipation is necessary for the beginning of a trusting relationship. The development of empathy is closely linked to early experiences with trusting relationships. Trusting relationships foster attachment. Infants come into the world ready, eager, and equipped for making secure, intimate connection with others (Whitmer, 1997).

The language of touch was exemplified strongly in the verbal expressions of caregivers. Caregivers were careful to signal to children that they could anticipate being picked up, diapered, moved, set in a chair, or removed from someone's arms. Elliot (in press) states that touch is the first medium of communication and it plays an important role in helping children feel attached to adults and safe. How an infant is held and talked to gives that infant his/her first messages about the world. Whitmer (1997) concurs that the development of trust begins in infancy and is interpreted somatically. She also states that trust continues to be grounded in the somatic throughout our lives.

There is ample evidence to suggest that responsive relationships contribute to healthy child development (Ainsworth & Bell, 1977; Howes & Smith, 1995; Shonkoff & Phillips, 2000). It is through respectful physical contact and language used by caregivers that children learn, 1) that they are appreciated, 2) to trust themselves and others, 3) that they can count on adults to help them solve conflicts, 4) the rules of social interaction, and 5) to experience their world as a secure and reliable place (Gerber, 1979). Bateson states that "human infants survive only if they receive loving care. The memory of that

care remains as a basis for the ability to give and receive care, while trauma in childhood may produce adults with limited abilities not only to give and receive love but also to learn" (2000, p.187).

We suggest that consideration of how self-regulation contributes to reducing aggressive behavior would benefit from alternate terminology that stresses less the Western cultural value for individual independence. The language of self- and other-*control* becomes problematic when we adhere to the belief that interdependence, rather than independence, is most relevant to violence prevention. Bai (1998) has suggested that "attunement" be used in place of the language of self-control because attunement more accurately reflects the goals of interdependence in social interactions. While control appeals to reason in order to suppress or negate to what is deemed by cultural norms as wrong within oneself, attunement recognizes the value of harmony and integration to a sense wholistic well-being (Bai, 1998). Control over emotional expression is one example of a Western cultural norm. We have seen in our analysis of responsive and caring childcare practice that emotional self-knowledge makes an important contribution to thought processes necessary to responsive and compassionate social action. Whitmer (1997) agrees that mutual responsibility for violence exists between those who commit acts of violence and the society in which we live. She argues that in order to make the shift from violence to respect, we must engage in a comprehensive revaluation of the importance of relationship within our culture. Replacing our present violence mythos with an interdependence mythos would bring to life a society focused on belonging, acceptance, care, and freedom for growth and expression.

The Western cultural imperative to achieve independence is especially strong in our gender expectations for males. This could explain the gender differences in the extent to which knowledge of theory of mind translated into prosocial behavior as observed by Walker (2005). Walker noted that beginning in the preschool years, socialization into male peer groups tends to regard assertive and dominant behavior more positively than such behavior in female peer groups. Such a difference is best considered in terms of transmitted cultural norms and values, not inherent sex differences. Thus, we, as a culture, need to consider the ways in which we enact gender socialization practices that serve to perpetuate a double-standard for what is considered appropriate social behavior for males and females.

Implications and Conclusion

Due to the fact that our society does not widely recognize the complexity and intricacy of quality childcare practice, our ability to fully appreciate the benefits of such practice is limited (Elliot, in press). Early childhood education programs need to include as much attention to a curriculum of relationships as they do to communicating an understanding of child development to students. Students would benefit from practice using the language of care and respect plus practice engaging in and reflecting upon the emotional work involved in responsive caregiving practice. Preparing students for the intense feelings that they are likely to experience when they form authentic relationships with children and parents will help them avoid turning away with fear when they first encounter such feelings in practice.

The learning that we highlight in our study extends the discussion of aggression from being focused on aggression towards others to also encompass the importance of

self-knowledge and self-care for individual health. With self-care, a child learns how to identify and ask for help in meeting one's own needs; with respect to caring for others, a child learns how to identify and respond to the needs of others. Together, self-knowledge and self-care comprise valuable contributions to preventing social dis-ease.

There appears to be an assumption within the literature on aggression that "externalizing" behaviors are more problematic than internalizing behaviors. It is regrettable, from a public policy standpoint, to make distinctions between the harm done to others as more of a concern than harm turned inward. Aggression turned inward (e.g., substance use, cutting, eating disorders, etc.) ends up having a huge impact, financially and socially, on health.

We conclude with a recommendation for increased funding for programs resembling the childcare program featured in our study. Our findings can attest to the value of caring and responsive childcare for children at-risk. Simply providing young mothers access to childcare in order to relieve the pressures of their lives is not enough to contribute to the development of secure well-being in young children. There exists tremendous value in providing quality (i.e., caring and responsive) childcare to all children, but especially to children considered to be at-risk. In the childcare program highlighted in this study, infants benefit from being able to remain in the childcare program until they are 3 years of age, but a child's tenure in the childcare program will, of course, depend upon the age of the mother and the age of the child when the mother entered the educational program. The childcare program should be funded to retain the toddlers even after a young mother finishes her schooling if the child has not yet achieved

school age. Further, additional spaces within the childcare program should be made available to young mothers who do not attend the educational program.

Table 1. Infants/toddlers in the childcare program

Infants	Toddlers
Kate (female, 2 mos.)	Leslie (female, 1 year)
Hugh (male, 6 mos.)	Nate (male, 1 ½ years)
Tess (female, 8 mos.)	Christie (female, 2 years)
Karl (male, 9 mos.)	Kevin (male, 2 ½ years)
Donald (male, 10 mos.)	Tammy (female, 2 ½ years)
	Carolyn (female, 2 ½ years)
	Emily (female, 2 ½ years)

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