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Identifying social, emotional and behavioural difficulties in the early childhood years

Lucy Tully, Australia, January 2020

Key Messages

● The early childhood years (birth to age 3 or 'the first 1000 days') are a time of rapid physical, emotional and cognitive development.

● Many children experience developmentally normal and temporary social, emotional and behavioural problems during this time. However, for some children, these problems may also be the start of a pattern of more severe and persistent social, emotional and behavioural difficulties (SEBD). These children and their families may benefit from early and timely support.

● Early childhood practitioners are well-placed to talk with parents about their children's social, emotional and behavioural development.

● It may be challenging for practitioners to differentiate social, emotional and behavioural difficulties (SEBD) from normal concerns for the following reasons:

– There are no clear criteria for what is considered 'normal' social, emotional and behavioural development in the early childhood years.

– Many parents lack knowledge about child development. They may assume social, emotional and behavioural problems in the early years are transient, so do not express concern or seek help about the problems.

– Parents (and practitioners) may hold concerns about stigma, labelling and parent blame which may prevent further discussions around SEBD.

What is this resource about?

This paper provides information on the social, emotional and behavioural difficulties (SEBD) that emerge in the early childhood years (birth to age 3). It highlights the challenges of differentiating between normal concerns and SEBD, and offers practical tips that may assist practitioners to increase their knowledge, skills and confidence on this topic.

Evidence from published research has been used to inform this resource, as well as practitioners' experiences in working with children and families. This paper is not intended to be a comprehensive guide to the topic of childhood SEBD; nor is it meant to suggest that it is the role of early childhood practitioners to conduct comprehensive assessments of children's emerging mental health problems. Knowledge of SEBD develops through experience working with children and families, professional training, reflective practice, discussion with colleagues, and supervision. A range of additional resources are listed at the end of this paper; these provide more information across a range of related topics.

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Who is this resource for?

This paper may benefit any practitioners working in the health, community services and early childhood, education and care sectors. These practitioners are all well-placed to identify SEBD early in a child's life, as they come into regular contact with children and families in the early years.

While the focus of this paper is on identifying SEBD, the importance of using a strengths-based approach when working with children and families is emphasised throughout. Focusing on strengths does not mean ignoring challenges, and identifying SEBD in the early years supports the provision of effective and timely support to children and families.

Definitions

For ease of reference the term 'practitioners' will be used throughout this paper to refer to professionals working with families in the early childhood years. The term 'parent' will be used to describe a person undertaking the role of parenting and includes a range of caregivers (e.g. grandparents, foster carers, kinship carers).

Social, emotional and behavioural difficulties (SEBD) are responses that are very different from generally accepted age-appropriate norms of children with the same ethnic or cultural background, and which significantly impair the child's and/or family's functioning (Poulou, 2015). The term 'SEBD' will be used throughout this article to describe clinically significant and persistent difficulties, whereas 'problems' or 'concerns' will be used to describe developmentally normal and transient issues.

Introduction

The early childhood years (birth to age 3 or 'the first 1,000 days') are a time of rapid physical, emotional and cognitive development. Many children experience developmentally normal social, emotional and behavioural problems during this time which they simply 'grow out of', without the need for service or support. However, research shows that for some children, early childhood may also be the start of a pattern of more severe and persistent SEBD that continue throughout childhood, leading to a range of mental health problems (see Bagner et al., 2012).

Most young children with social, emotional and behavioural difficulties do not receive professional help (Oh et al., 2015). Thus, the early childhood years represent a key period for identifying children at risk of ongoing difficulties, who are likely to benefit from early, appropriate and timely support.

Prevalence of early SEBD and help seeking

A recent Australian study found that there is a substantial gap between the mental health needs in toddlers and preschoolers and the services accessed (Oh et al., 2015). This study found prevalence rates of SEBD were 13–19% (around 1 in 6); similar to findings from international studies of around 15% (e.g., Briggs-Gowen, 2001). While SEBDs were common, few families reported accessing services: around half sought no help at all, 34–45% received informal help (e.g. from friends, family, books, videos, etc.) and only a small proportion (7-8%) received help from health professionals (Oh et al., 2015).

Normal social, emotional and behavioural development in the early childhood years

Positive social, emotional and behavioural development is important for children's overall wellbeing. In the early childhood years, there are rapid physical and cognitive changes that take place. These changes, along with children's first experiences of complex emotions such as frustration, lead to a range of developmentally normal social, emotional and behavioural challenges, including:

- fears, worries and anxiety (e.g. fears of strangers, separation from parent, the dark, animals, loud noises)
- noncompliance and defiance (e.g. refusing or ignoring instructions)
- aggression (e.g. hitting, biting, kicking, scratching and pushing)
- temper tantrums.

Behavioural problems in particular are very common. For example, by 17 months of age, 70% of children are reported to take toys away from others, and almost half push others to obtain what they want (Tremblay et al., 1999). However, when these problems are more frequent, severe and impact on the child and/or family's functioning, they may indicate SEBD.

Other key points about early SEBD include:

- Fears and worries are harder to detect in the early childhood years because of young children's limited ability to communicate their emotions. They may also manifest as irritable or oppositional behaviour, such as tantrums (Gardner & Shaw, 2008).
- In cases where children have experienced family adversity and adverse childhood experiences (e.g. family difficulties related to financial struggles, parental mental health difficulties, parental substance use, loss of a loved one, disaster or trauma events, family

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and domestic violence, etc.) they will be more likely to experience SEBD. It is important that practitioners have conversations with parents which focus on ways to improve children's mental health, but that do not reinforce stigma or shame.

- Children's social and emotional wellbeing cannot be separated from their environment, and practitioners working with children in the first 1,000 days are in a good position to discuss family adversity and adverse childhood experiences with parents and how this might contribute to SEBD.

- Children are not typically diagnosed with psychological 'disorders' in the first two years of life, but they may display clinically significant and impairing SEBD.

- As with older children, SEBD in the early childhood years can be differentiated into internalising and externalising problems.

- Developmentally normal problems can be differentiated from SEBD on the basis of whether they are transient or persist over time. Children who experience normal problems tend to 'grow out of' these behaviours as they mature cognitively and emotionally.

- Research has found relatively stable rates of SEBD from 12 months of age (e.g. Briggs-Gowan et al., 2006), and a robust link between infant and toddler difficulties and later emotional and behavioural problems (see Hemmi et al., 2011).

- For some children, early SEBD are not a 'phase' that they will grow out of, or a transient adjustment to stress or change. The identification of these children, who are at risk for long-term problems, is an important goal.

What are externalising and internalising problems?

SEBD can be categorised as externalising or internalising problems. Externalising problems include problems that are directed towards the external environment and include behaviours such as tantrums, defiance, aggression and destructiveness. These problems are common and can be developmentally normal; however, when symptoms are more frequent, severe or impair the child and/or family's functioning, they can lead to a diagnosis of 'disruptive behaviour disorders' or 'externalising disorders'.

The most common externalising disorder in childhood is Oppositional Defiant Disorder (ODD) which is a pattern of angry/irritable mood, argumentative/defiant behaviour or vindictiveness lasting at least six months (American Psychiatric Association, 2013). While ODD can be diagnosed at any age, it would rarely be diagnosed before the age of 3 years.

Internalising problems describe problems that are internal to the child, and most frequently include fears, worries and anxiety. The most common types of anxieties in early childhood are separation anxiety, which relates to fear of separation from their caregiver, or specific anxieties around particular events or situations (e.g. fear of the dark, animals, strangers). When fears or worries are excessive and/or developmentally inappropriate and impact on the child's and/or family's functioning they may lead to an anxiety disorder diagnosis. However, it would be rare for a child to be diagnosed with an anxiety disorder before the age of 3 years.

It is important to note that young children may show both externalising and internalising problems, which may be due to underlying difficulties with poor self-regulation. Self-regulation involves the ability to control impulses and expressions of emotions. Children with difficulties in self-regulation might show a range of problems, including higher rates of tantrums, irritable mood and oppositionality, and disturbances in sleep, eating, activity or attention (Gardner & Shaw, 2008).

Why is it challenging to differentiate SEBD from normal problems in the early childhood years?

There are three main reasons why it is challenging for practitioners to differentiate SEBD from normal problems in the early childhood years:

1. **Parents may lack knowledge about normal child development, and may assume that all problems are normal and transient. This may prevent them from expressing worry about their child and/ or seeking help.** Research has found that many parents of children with SEBD do not express worry about their child's social, emotional or behavioural development (Alakortes et al., 2017a; Ellingson et

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al, 2004), which is likely due in part to a lack of information about normal child development. Thus, parents may benefit from receiving information about normal development and early SEBD as part of routine care.

2. **Parents may be reluctant to discuss SEBD because of a concern about labelling the child with a mental health disorder and the associated stigma for the child and parent.** Research has found negative public attitudes towards children with mental health difficulties and their parents, and parent-blaming, which may prevent parents from raising concerns or seeking help for their child's SEBD (see McDonald, 2018; Tully et al., 2019). Parents and practitioners may also hold concerns about labelling a child with a mental health difficulty, which itself can be stigmatising (see McDonald, 2018).

It is important to recognise the lack of child mental health literacy amongst parents, practitioners and the general public (Tully et al., 2019). Mental health literacy refers to knowledge and beliefs about mental health problems that aid in their recognition, management or prevention (Jorm et al.,1997). Low levels of mental health literacy regarding childhood SEBD are likely to increase levels of stigma, and there is a need for improved mental health literacy among parents, practitioners and the general community.

Related resource: Child mental health literacy: What is it and why is it important?

3. **When it comes to different ages and stages of early development, there are no clear criteria as to what is considered 'normal' social, emotional and behavioural development. This makes it challenging for professionals and parents to correctly identify SEBDs.** For example, temper tantrums occurring four times per day may be normal for a two year old, but may indicate an SEBD for a four year old (Gardner & Shaw, 2008).

As outlined above, whether or not problems persist over time is one criterion for distinguishing normal concerns from SEBD, but practitioners cannot rely on this criterion alone. As you will see in the following sections, it may be helpful for practitioners to gather information on frequency, intensity and duration of the child's problems and impairment to the child's and/or family's functioning, along with the use of screening measures.

Related resource: Why is it difficult for parents to talk to practitioners about their children's mental health?

In summary, key tips for practitioners to assist them to have helpful conversations with parents about children's mental health include:

– Be aware of parents' assumptions that all early problems are normal and transient and children will simply outgrow them.

– Provide information to parents about normal child development and parenting, as part of discussions around SEBD.

– Remain curious about parents' circumstances and any adversity that may be impacting on children. This may provide opportunities to have non-judgmental conversations about child mental health.

– Be aware of the effects that adverse childhood experiences can have on children, in order to have informed conversations with parents about responding to children in helpful and supportive ways.

– Offer information about SEBD in the early childhood years to increase parents' mental health literacy and reduce stigma around child mental health difficulties.

– Be mindful that parents tend to underreport concerns about SEBD, so lack of parental worry may not indicate a lack of SEBD.

– Encourage parents to discuss their concerns about SEBD, and take these concerns seriously.

– Be aware of, and sensitive to, parents' concerns around labelling, stigma and blame when discussing SEBD.

– Keep in mind that persistence of difficulties over time is one way to distinguish SEBD from normal challenges, but it is not the only criteria.

1. Talk with parents about their child's social, emotional and behavioural problems and the family context.

Conversations about early childhood social, emotional and behavioural problems may be initiated by parents or practitioners. Parents may mention specific symptoms, or they may express more general concerns about their child's wellbeing or development. On the other hand, the conversation may be initiated by the practitioner either through general discussions about child wellbeing and parenting, following the use of screening tools, or during specific discussions that arise after they have observed the child.

Regardless of whom initiated the conversation, it can be helpful to gather more information about the child's social, emotional and behavioural development, as well as the family context. Such discussions do not require a practitioner to have mental health qualifications and

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the aim is not to 'diagnose' a disorder. Gathering more information about specific problems may help the practitioner to understand the nature of the problems and their likely impact on the child and family.

The following tips may help practitioners ensure positive and collaborative conversations:

- Display openness, warmth and empathy towards the parents.

- Let the parent know that finding out more information will help create a shared understanding of the current problems.

- Assume that the parent is the expert in their child's social and emotional wellbeing (that they know their child better than anyone else).

- Be curious about and acknowledge the parent's and child's strengths.

- Consider SEBD in the context of the family's cultural values, beliefs and attitudes.

- Acknowledge and thank parents for raising concerns.

- Be prepared to have conversations about family adversity or adverse childhood experiences in calm and non-judgmental ways.

- Avoid the temptation to provide immediate reassurance that the concerns are 'normal'.

- In two-parent families, involve both caregivers in discussions around early childhood SEBD, as their perspectives may differ and discrepancies can be an important source of information (Alakortes et al., 2017b).

During discussions with parents, it may be useful for practitioners to gather information on the following aspects of each problem discussed (Perle et al., 2018):
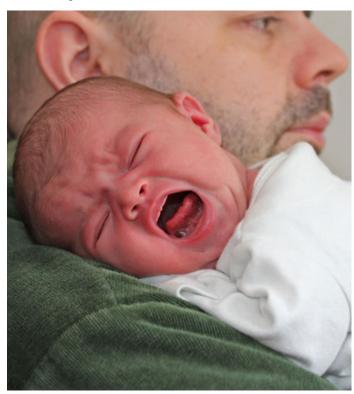
- Frequency (how often does the social, emotional or behavioural problem occur?)

- Duration (how long does it last?)

- Intensity (how severe is it?)

- History of the problem (when did it first start?)

- Context in which it occurs (e.g. home, daycare, elsewhere)

- Impairment to the child (how does it impact on the child's development and functioning?)

- Any exposure to stressful or traumatic events, and the timing of the problem in relation to this.

- Impact on the parents, siblings and others (e.g. children and staff at daycare, peers, extended family)

- How are the parents responding to the problem (are they experiencing difficulties in managing the problem? Would they like further assistance or support?)

Problems that occur more frequently or intensely, across contexts and that impact on the child and/or parents are more likely to indicate an SEBD than those that occur infrequently, in a single context and have no impact on the child and/or parents.

Young children are highly dependent on their caregiving environment, so it is important for practitioners to assess risk and protective factors in the family environment which may influence SEBDs (Gardner & Shaw, 2008). Stable patterns of SEBD throughout childhood are associated with risk factors in the family environment, such as parents' use of ineffective or harsh parenting strategies, parental mental health problems, parental conflict or violence, and childhood exposure to stressful or traumatic events (see Bagner et al., 2012). Problems in the parent-child relationship during the first 18 months have also been shown to be a risk factor for early SEBD (Skovgaard et al., 2007), which emphasises the importance of discussing the parent-child relationship and parenting more generally.

Practitioners may also have a chance to observe the child if the child attends the session with the parent. This can provide a valuable opportunity to observe the child's social, emotional and behavioural responses, as well as parent-child interaction. However, a single visit may not be representative of a child's usual responses across contexts. It may be helpful for practitioners to ask the parent how typical the child's current emotions and behaviours are in comparison with their usual functioning.

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2. **Use screening measures to help identify SEBD.**

The use of routine screening measures may help with identification of SEBD, given that some parents may not report concerns about their child or may be reluctant to discuss difficulties (Alakortes et al., 2017b). The use of screening measures in practice will vary widely, and some practitioners may not have access to the specific screening tools for SEBD discussed in this section. Practitioners may already be using more general developmental screening measures (e.g. PEDS), which are still useful for gathering information to help assess SEBD.

Measures that are quick and easy to administer are known as 'screening measures'. Those which are longer and more detailed, often involving a multi-method approach (e.g. parent report, questionnaires, observation procedures) are also known as 'evaluation measures' (Bagner et al., 2012). If a child scores positive for a potential problem on a screening measure, the next step is often to conduct a more comprehensive evaluation or refer on for further evaluation. Early childhood practitioners are more likely to use screening measures than evaluation measures due to time limitations when working with families.

There are a range of measures that practitioners may use to screen for developmental problems in the early childhood years, such as the Parents' Evaluation of Developmental Status (PEDS: Glascoe, 1997). However, there are also certain measures used specifically to assess SEBD in the infant and toddler years (see Bagner et al., 2012). Two of the most commonly used parent-report screening measures that are brief and easy to administer, score and interpret are:

1. Ages & Stages Questionnaire: Social-Emotional (ASQ: SE; Squires et al., 2002). This is used to screen children (six months–five years old) for further evaluation of social, emotional and behavioural problems. It includes 22–36 items (depending on age) and provides scores for seven behavioural areas: self-regulation; compliance; communication; adaptive behaviors; autonomy; affect;and interactions with people.

2. Brief Infant-Toddler Social and Emotional Assessment (BITSEA; Carter and Briggs-Gowan 2006). This assessment has 42 items and is used to screen children aged 12–36 months for socio-emotional and behavioural problems and competencies.

Regardless of the type of measure used, practitioners can follow these tips when using screening measures with parents:

- Follow measure-specific training and administration guidelines when using specific screening measures.

- Provide information about which aspects of development are assessed by the measure.

- Highlight any limitations to the measure (e.g. what it does not measure, that brief screening measures provide only a broad indication of likely difficulties).

- Acknowledge that parents may have a broader view of their child than what is addressed by the measure.

- Interpret the scores and communicate findings to parents about the measure.

- Allow sufficient time for parents' questions to be asked and discussed.

- Schedule a follow-up appointment if further discussion of the findings and next steps are needed.

Once practitioners have shared the findings of the screening measure with parents, practitioners and parents can discuss the options for next steps and decide together on a plan of action.

More information about screening tools for early SEBD can be found in a systematic review by Bagner et al. (2012), available here.

3. **Provide information to parents on child development and parenting.**

A key role of early childhood practitioners is to provide parents with high quality information about child development and parenting. Discussions between practitioners and parents and/or the use of assessment tools may help inform which resources and information practitioners provide to the family. However, as highlighted earlier in this paper, parents may lack information on normal child development, so providing information on child development and parenting may be helpful for many parents.

The type of information provided to parents depends on the individual family's needs and circumstances; the child's age and stage of development; and concerns around childhood SEBD. The resources provided may include leaflets, brochures, booklets, links to websites and online programs. It is important to explain how resources can be used to promote parenting or child wellbeing. Following up with parents on how helpful they found the information to be is also important.

Related resource: Sharing information with parents about children's social and emotional wellbeing: A step-by-step approach

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4. Provide referrals for further assessment or additional services.

Referral to other services may be warranted in cases where the child's problems appear to be developmentally excessive or above screening cut-offs on assessment measures, or the parents are requesting further support. The child may be referred for further specialist assessment or for early intervention services.

The extent to which childhood practitioners refer families to other services or provide services themselves will vary. For example, a survey of child health nurses in Melbourne found that the majority of those surveyed viewed it as part of their role to deal with, rather than refer, children with behavioural problems (Sarkardi et al., 2014).

When providing families with a referral, the following tips may be helpful (Perle et al., 2018):

- Provide a strong rationale for the referral, as simply providing a referral may not be enough to get families to attend.
- Explain the services offered, and the likely positive outcome(s) that may result from the service.
- Answer any questions parents have about the service.
- Be aware of parents' concerns regarding stigma and labelling.
- Speak with parents at a later session to check whether or not they have followed up on the referral.
- Where families did follow up on a referral, discuss progress and any need for further assistance.
- Where families did not follow up on a referral, discuss the reasons why, emphasise the rationale for the referral, and problem-solve any barriers to attendance.

5. Understand the boundaries of your role.

As noted throughout this paper, it is challenging to differentiate developmentally normal problems from SEBD in young children. Talking with parents and the use of assessment tools may be helpful for distinguishing between the two and determining next steps to take. Most practitioners are not expected to have expertise in child mental health problems or in conducting comprehensive assessments of childhood SEBD. Key barriers may include the lack of time to conduct assessments, and the limited availability of screening measures.

Given the difficulty of differentiating developmentally normal problems from SEBD in young children, it is

important for practitioners to have access to supervision and training on this topic. A recent survey of child health nurses found a key barrier to dealing with child behaviour problems was parents' denial of problems and resistance (Sarkardi et al., 2017). This research suggests that practitioners may need training in specific strategies for addressing more challenging conversations with parents about SEBD, such as skills in motivational interviewing.

Summary

Many children experience developmentally normal and temporary social, emotional and behavioural problems during the early childhood years. However, for some children, these problems may also be the start of a pattern of more severe and persistent difficulties, and these children are likely to benefit from early and timely support. Differentiating normal challenges from SEBD is challenging, but there are steps a practitioner can take to gather more information, and screening measures that can be used to help this process.

Many parents will benefit from access to information and resources, and some families may benefit from referrals for further assessment or services. It is important for practitioners to access supervision and training, and this may help increase skills and confidence on this topic.

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