

MATERNAL REPORTS OF BEHAVIOR PROBLEMS IN PRESCHOOL HISPANIC CHILDREN: AN EXPLORATORY STUDY IN PREVENTIVE PEDIATRICS

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Maternal reports on the health, behavioral, and educational characteristics of Hispanic low-income preschoolers were gathered from a pediatric clinic to conduct appropriate consultation and teaching of behavioral issues to pediatric residents. Fifty-two Hispanic mothers attending an urban hospital clinic were given a questionnaire. Interviews provided data on family demographics, children's health status, behavior problems (65 items adapted from Achenbach's 1981 and 1987 Child Behavior Checklists [CBCL]), maternal depression, family life stressful events, and discipline methods. Thirteen externalizing and five internalizing high frequency behaviors were identified. Behavior problem scores were significantly related to the use of yelling and hitting/spanking as methods of discipline. Precarious health status and low enrollment in preschool programs also were reported. A broader preventive role for pediatricians in that pediatric setting was recommended and pursued. Results suggest a broad preventive role for pediatricians and pediatric clinics servicing low-income preschoolers. (*J Natl Med Assoc.* 1995;87:861-868.)

Key words • child behavioral problems • preschoolers
• Hispanic low-income children

As the fastest growing minority population in the United States,¹ often reported at risk² and rating poor in life outcomes, such as high rate of school drop-out and poverty,^{1,2} Hispanics appear to be good candidates for preventive services. Yet, while considerable concern has been generated about their welfare, little empirical data has been generated to document their specific needs.³

Working as a pediatric psychologist in an urban pediatric clinic located in New York City provided the principal author with the opportunity to conduct an exploratory study to document the behavioral and educational needs of a group of Hispanic preschool children receiving medical care. The data were gathered in an effort to help pediatricians in that setting in the early detection of behavioral and emotional problems when delivering primary care to children of the poor. Often, physicians are the sole provider with access to families of low socioeconomic status and therefore are called on to play a major role in the referral and treatment for specialist care. Yet few resources are available to help them undertake this role.

One method of documenting needs is to explore parents' reports of their children's problems. In this regard, research on non-Hispanic children has reached several conclusions. For example, the child's age and sex have been found to influence the prevalence of maternal reports of problem behaviors, with boys and younger children scoring higher than girls and older children.⁴⁻⁷ Similarly, stressful family life events (such as separation/divorce and unemployment) as well as maternal depression also have been positively associated with

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TABLE 1. DEMOGRAPHIC CHARACTERISTICS OF MOTHERS

Characteristic	N (%)
Country of origin	
Puerto Rico	29 (55.8)
Santo Domingo/Central America	18 (34.6)
South America	5 (9.6)
Total	52 (100)
Family structure	
Two parents	25 (48.1)
Single parent	27 (51.9)
Mother's education	
>12 years	10 (19.2)
12 years	11 (21.2)
7 to 11 years	19 (36.5)
0 to 6 years	8 (15.4)
No information	4 (7.7)
Language	
Spanish only	31 (59.6)
English/Spanish bilingual	21 (40.4)
Occupation	
Full-time housewife/welfare	36 (69.2)
Full-time housewife/not on welfare	8 (15.4)
Other (student, disabled, works part-time)	8 (15.4)

maternal ratings of behavior problems.^{5,8}

Socioeconomic status is another factor influencing maternal reports. Parents of low socioeconomic status have reported or showed a tendency to report significantly higher problem scores for their children (ages 2 to 3 years and 4 to 5 years) than parents of higher socioeconomic level.^{4,9}

The present study explored mothers' concerns about their children's behaviors at home. A group of Hispanic mothers seeking pediatric services at the outpatient department of a major municipal hospital constituted the target population. Maternal reports generated data on the health status of the children, the frequency of behavior problems, and children's enrollment in preschool programs. The number of stressful family life events and degree of maternal depression (when present) also were recorded to ascertain their influence on maternal reports. Finally, methods of discipline used and demographic factors, such as mother's age and mother's educational level, also were noted as possible sources of influence on the maternal reports of behavior problems in preschool Hispanic children.

METHODS

Subjects

A total of 63 Hispanic mothers of preschool children (ages 2 to 5 years) were approached during their visit to a pediatric clinic. The children were all regis-

tered patients receiving primary care from a physician or nurse practitioner. The principal investigator, a bilingual, licensed psychologist (working as pediatric psychologist in this setting) typically collected data two times a week.

Of the 63 Hispanic mothers approached, 52 agreed to participate in the study. A statistical comparison of the background characteristics of the 11 mothers who refused with those who remained in the study indicated that both groups were similar on such variables as socioeconomic status, language spoken at home, and culture of origin. There was a slightly higher percentage of single-parent homes and welfare recipients for the accepting group, suggesting the study sample was perhaps of lower income than the rejecting sample. Also, the study sample contained more girls than boys, in contrast with the refusal group in which there were more boys than girls; however, this difference was not statistically significant. Table 1 indicates the sample to be primarily a low-income group of Hispanic, single mothers (51.9%) on public assistance (69.2%), two-thirds of whom spoke Spanish only.

Representativeness of Sample

Demographic comparisons of the sample with patients receiving services from the hospital and with the population residing in the adjacent community (an area of the Bronx) indicates the three groups were similar, except for the proportion of single mothers, reported at 71.2% for the community as compared to the sample's percentage of 51.9%. While the study sample appears representative of the mothers using services from the hospital, the small size and lack of randomness can only allow tentative generalizations at this point (Table 1).

Of the 52 children, 32 (61.5%) were girls and 20 (38.5%) were boys. Mean age was 41.9 months (Table 2).

Survey Instrument

A questionnaire was devised by the principal investigator to provide information on behavior problems, health status, family life stressful events during the preceding 12 months, possible maternal depression, and family demographics. Questions about discipline methods used at home also were included. The questionnaire was adapted from three well-known instruments: 1) the Child Behavioral Checklist (CBCL) developed by Achenbach and Edelbrock,⁴ and Achenbach et al⁹; 2) the depression subscale of Ilfeld's Psychiatric Symptom Index, as adapted and translated into Spanish for use with urban dwellers by Stein and Jessop¹⁰; and 3) a shortened version of the Social Readjustment Rating

Scale by Holmes and Rahe,¹¹ previously adapted for use with maternal reports by Beautrais et al.^{5,8} The questionnaire consisted of four sections: child health status, child behavior problems, parent/family dimension, and family demographics.

Part 1: Child's Health Status. This section contained information on the child's birthweight, prematurity, chronic health conditions, hospitalizations, and lead poisoning, all considered relevant to behavioral and developmental outcomes.

Part 2: Child Behavior Problems. This section contained a shortened and adapted version of the two CBCLs developed by Achenbach and associates⁴ for 4 to 16 year olds and 2 to 3 year olds.⁹ The two CBCLs were adapted and shortened because the original versions (consisting of 116 and 99 items, respectively) were deemed too long and time consuming to be given in an outpatient pediatric setting. The Achenbach scales were selected because of their extensive use with American samples and the availability of norms for non-referred versus clinical samples.

The Total Child Behavior Problem section used in this study consisted of 65 items grouped under the same categories reported by Achenbach and associates⁴ and distributed as follows:

- 23 behavioral items relating to the externalizing dimension (or behaviors expressing conflict with the outside world, eg, hits others, always on the go),
- 18 behaviors tapping the internalizing dimension (which refers to behaviors involving conflict with the self, eg, shy or timid, fears),
- 6 behavioral items relating to eating problems,
- 8 behaviors measuring sleep disturbances,
- 6 behaviors relating to toilet training problems, and
- 4 behavioral items tapping sexual problems.

Physical complaints such as asthma, vomiting, and allergies originally included in the CBCL (1981) were eliminated because such conditions were addressed in the health section. Also, recent research¹² has warned against including such physical symptoms in the behavioral checklist in order to avoid penalizing children who have these conditions and could score higher in total problem behavior score for that reason.

Part 3: Parent/Family Dimension. This section contained a) the evaluation of the mother's depression, b) number of stressful events experienced by the family and, c) discipline methods used. The evaluation of the mother's depression was based on items derived from Stein and Jessop's¹⁰ adapted version of Ilfeld's Psychiatric Symptom Index used for ratings of maternal competence in urban dwellers, which had been translated into Spanish.

Stein and Jessop studied symptoms associated with anxiety, anger-hostility, depression, and somatization. In this project, only the items relating to depression were used because of their reported impact on maternal reports of children's behaviors.^{5,8} A sample question reads: How often do you feel lonely? Response options are never, sometimes, or often.

Number of stressful life events experienced by the family in the last 12 months also was gathered. A list of 11 events was formed by selecting 9 of the 20 items from the Holmes and Rahe Social Readjustment Rating Scale,¹¹ reported by Beautrais et al.,⁵ to be related to children's behavior problems, eg, change in residence and death of relative. Two other items from the Holmes and Rahe's original list (birth of a sibling and hospitalizations) were considered appropriate for this population and therefore included.

Finally, this section contained discipline questions exploring parents' usual approach to setting limits, including the use of: 1) yelling, 2) taking away something the child likes, 3) ignoring, 4) hitting/spanking, 5) talking to child/explaining, 6) rewarding good behavior, 7) isolating child, and 8) other.

Part 4: Family Demographics. This section listed 16 items that identified the child, the family, and relevant demographic factors such as country of origin, language spoken at home, child's attendance at preschool programs, mother's educational level, and source of income, among others.

English and Spanish versions of the questionnaire were prepared and pretested with a small group of Hispanic respondents prior to the study. Cronbach's alpha was calculated for the sample for the externalizing dimension (alpha=.80), for the internalizing dimension (alpha=.70), and for the total 65 items of the CBCL used in the study (alpha=.76). All alphas obtained are of acceptable reliability, making the adapted CBCL a reliable instrument.

Procedure

The four-and-a-half page questionnaire was completed in a face-to-face interview in English or Spanish, depending on the mother's preferred language. The interview followed the same procedure for each mother and lasted about 50 minutes to 1 hour. All mothers were interviewed in a private room in the pediatric outpatient clinic.

Almost all of the questions concerning behavior referred to frequency and were to be answered by never, sometimes, or often. These choices were presented to the respondent on a card to facilitate participation. Some answers required a dichotomous choice. None of the

TABLE 2. CHARACTERISTICS OF CHILDREN

Characteristic	N (%)
Age	
2 to 3 years	17 (32.7)
3 to 4 years	20 (38.5)
4 to 5 years	15 (28.8)
Sex	
Male	20 (38.5)
Female	32 (61.5)
Total	52 (100)
Children eligible to attend preschool (2 years 9 months to 5 years)	
Enrolled	11
Not enrolled	30 (73.1)

questions required elaboration; however, by the end of the interview, most of the women had gained some trust in the interviewer, and since the questionnaire ended with the section probing the mother's depression, the women often spoke at some length about their everyday problems.

RESULTS

Pearson correlations, chi squares, and analysis of variance were used to analyze the data. Computations of the total behavior problem score and subgroup behavior scores (eg, externalizing, internalizing, sleep, toilet training, and others) were done by summing the behaviors reported to occur sometimes and often (given a weight of 1 and 2, respectively) for each item, as done by Achenbach and Edelbrock.⁴ The total behavior problem score was obtained by the sum of all 2 and 1 point responses across all 65 items.

Thirteen externalizing behaviors (many of them relating to attention-deficit hyperactivity disorder) and five from the internalizing dimension (mainly clinging to adults, easily becomes jealous) obtained high frequency ratings (60% and above) by the mothers (Table 3).

Developmentally appropriate trends (higher frequencies in 2 to 4 year olds than in 4 to 5 year olds) were obtained in the ratings of five externalizing behaviors and in the ratings of eating, sleeping, sexual, and toileting behaviors. For example, refuses to eat and doesn't eat well, resists going to bed, and doesn't want to sleep alone appear more frequently in the younger than in the older group (Table 4). This pattern for eating and sleeping behaviors in younger children is consistent with reports found in the literature of non-Hispanic groups.¹³

While all eating behaviors showed a decreasing trend with age, overeating was reported 20% frequently in the 4- to 5-year-old group as contrasted with 8.1% in

the 2 to 4 year olds, and only 6% found in Achenbach's 4 to 5 year olds.⁴ Constipation ranked high in both age sample groups (35.1% and 26.7%) versus the .08% reported in Achenbach's 4 to 5 year olds,⁴ pointing to the possible influence of sociocultural variables in nutrition and feeding habits (Table 4).

Comparison With Achenbach's 4 to 5 Year Olds

On three externalizing and five internalizing behaviors, the 4 to 5 year olds in this study obtained higher frequencies than the normal and even the psychiatrically referred non-Hispanic 4 to 5 year olds in the Achenbach's sample.⁴ The externalizing behaviors were hyperactivity, demands a lot of attention, and impulsivity. The internalizing behaviors were clinging to adults, easily jealous, self-conscious, shy/timid, and fears certain animals, situations, and places. For example, clings to adults was reported to occur sometimes or often in 80% of 4 to 5 year olds in this sample, in contrast to 32% in Achenbach's normal and 70% in the clinically referred group of 4 to 5 year olds (N=100). Similarly, unable to sit still/hyperactive was reported to occur sometimes or often in 90% of 4 to 5 year olds in this sample, in contrast to 40% in Achenbach's normal and 80% in the clinically referred group of 4 to 5 year olds (N=100).

Enrollment in Preschool

Of the 52 preschool children in the study, 41 were age-eligible to attend Head Start. Only 11 (26.8%) of those eligible were enrolled (Table 2).

Discipline Methods Used

Nearly half of the mothers (46.2%) indicated they often used talking/explaining as a method of discipline with their preschoolers. Yelling and rewarding good behavior were reported as often, used by 26.9% and 23.1% of mothers. Spanking/hitting (71.2%), yelling (67.3%), and rewarding good behavior (65.4%) were reported to be used sometimes by large frequencies of mothers.

The approaches to discipline reported to be used frequently seem to involve a preference for taking action after a behavior has occurred. This preference is consistent with the finding that ignoring behavior was, in fact, reported as the method least often used (only 9.6%). Similarly, behaviors such as isolating the child, taking away something the child likes, and ignoring behavior were reported never used by 44.2%, 40.6%, and 59.6%, respectively.

Discipline Methods and Behavior Scores

Significant correlations were found between discipline methods mothers used often and problem behavior scores. Externalizing behavior score was significantly related to the use of both yelling ($r=.40$, $df=50$, $P=.004$) and hitting/spanking ($r=.36$, $df=50$, $P=.008$). Similarly, total behavior problem score was significantly related to the use of yelling ($r=.42$, $df=50$, $P=.002$).

Health Findings

Hispanic mothers reported a total of 10 children (19.2% of the sample) suffering from chronic conditions, of which asthma accounted for 6 (11.5%), anemia for 1 (1%), and heart murmur for 3 (5.75%).

Mothers also reported a high rate of hospitalization. Twenty-nine children (55.7%) were reported to have been hospitalized at least once prior to age 5. Of these, 19 cases had been hospitalized once, 7 two times, and 3 had been hospitalized three times. These maternal reports are considered reliable since previously, a study by Beautrais, Fergusson, and Shannon⁵ had found that mothers' reports of hospitalizations were accurate when compared with actual hospital admissions.

Stressors and Maternal Depression

Contrary to the findings from the literature on non-Hispanic families, externalizing, internalizing, and total behavior scores were not significantly related to family life stressful events or maternal depression. Depression scores were lower than those reported by Stein and Jessop¹⁰ (range of 0 to 18 with a mean of 5.76 versus Stein and Jessop's range of 0 to 21 with a mean of 7.33).

DISCUSSION

Any generalizations from this study are considered preliminary because this was a small sample of convenience. Still, low-income Hispanic mothers receiving pediatric care for their children in an urban hospital were able to identify some behavioral, health, and educational characteristics of their children, and also reported on their preferred methods of discipline.

Externalizing and Internalizing Behaviors

While this study's high frequency behaviors are different from those reported by Achenbach's⁴ sample for average 4 to 5 year olds, there is a similarity with Achenbach's study subgroup of low socioeconomic children (mainly African American) whose parents also reported high frequency ratings for 19 externalizing behaviors versus very few internalizing behaviors at the 4- to 5-year-old level.

TABLE 3. HIGH FREQUENCY BEHAVIORS REPORTED BY HISPANIC MOTHERS TO OCCUR OFTEN OR SOMETIMES

Behavior	%
Externalizing	
Unable to sit still/hyperactive	96.2
Demands a lot of attention	88.5
Disobedient/uncooperative	82.7*
Impulsive/acts without thinking	67.7
Stubborn, sullen, irritable	67.3
Temper tantrums	84.6*
Always on the go	94.2
Can't stand waiting	78.8
Defiant	71.2*
Demands must be met immediately	75.0*
Easily frustrated	76.9*
Angry	71.2
Quickly shifts from one activity to another	75.0
Internalizing	
Clings to adults	80
Easily becomes jealous	76.9
Shy or timid	61.5†
Constantly seeks help	75.0
Fears certain animals, situations, places	65.4†

*These behaviors occurred 12% to 15% more frequently in the younger group (2 to 3 years old) than in the older group (4 to 5 years old).

†These behaviors occurred 12% to 15% more frequently in the older group (4 to 5 years old) than in the younger group (2 to 3 years old).

Various explanations can be suggested for this finding. It might be argued that externalizing behaviors, particularly those relating to overactivity, are easier to identify and report because they are visible and impinge on others. Low-income children of Hispanic and those of African-American background may exhibit more under-controlled behaviors as a result of culture-specific child-rearing patterns and environmental factors such as overcrowding and living in small dwellings.^{14,15} In addition, since 30 of the 41 children eligible to attend preschool (aged 2 years 9 months to 5 years) were not enrolled in preschool programs, it also may be suggested they were bored, understimulated, and invested in receiving/demanding parental attention at home. Future research could compare mothers' ratings of Hispanic preschoolers attending educational programs with the behavioral ratings of those not attending.

The high frequency of clings to adults/easily becomes jealous and constantly seeks help suggests Hispanic mothers perceive their children as insecurely attached. Some authors consider Hispanic mothers

as overprotective and encouraging dependency,¹⁴ a cultural characteristic that may be sociologically reinforced by the inner-city environment with its high rate of crime, drugs, and other perils.

Comparison With Achenbach's 4 to 5 Year Olds

The comparison of the behavior frequencies obtained in this sample with those reported by Achenbach and Edelbrock⁴ suggests that in order to differentiate between normal and psychiatrically referred 4 to 5 year olds, low socioeconomic Hispanic populations may require higher cut-off scores than those obtained by Achenbach and Edelbrock.⁴ Bird et al¹⁶ have made similar suggestions after studying the CBCL as a screening instrument in Puerto Rico. Studies with larger samples, including clinically referred children, are needed to pursue the issue of separate CBCL norms for Hispanic children in future research.

Enrollment in Preschool

The 26.8% preschool enrollment for this urban sample of children receiving pediatric care between the years 1986, 1987, and early 1988 is considerably below the 37.6% national enrollment rate reported for 1983,¹⁷ and the more current rate of 45% to 50% reported in 1993 (*New York Times*, April 20, 1993). Paradoxically, young children in poor families are the most needy for early intervention, prior to school entry.^{2,15,18}

Discipline Method Used

Hispanic mothers reported using a variety of approaches to set limits. Evident was a preference for talking/explaining, rewarding good behavior, yelling, and a reluctance to use ignoring of behavior, methods that involve social isolation or withdrawal of privileges.

Discipline patterns preferred may be based on parents' own experiences with discipline as children themselves rather than on a concerted effort to find suitable methods that work or provide positive outcomes. In fact, when methods of discipline were correlated to behavior scores, the use of directive and physical approaches to discipline (yelling and hitting/spanking) was associated with very active behaviors. From a cross-sectional study such as this, it is not possible to ascertain the effectiveness of the methods used on the behavioral outcomes. Hispanic parents may need guidance regarding methods of discipline that are effective in decreasing negative behavior patterns. Anticipatory guidance provided by pediatricians during child care visits may be the appropriate forum to provide such advice.

Health Findings

Health was indeed precarious in this sample of Hispanic preschoolers, whose birth history, for the most part, revealed the absence of adverse factors such as prematurity or low birthweight. Asthma has consistently been reported higher in Hispanic groups when compared with the general population of children under 18 years of age (reported as 6.25% by the National Center for Health Statistics in 1991)¹⁹ and to Achenbach's rate of 8% for normal 4 to 5 year olds.⁴ Hispanic children's vulnerable health found in this sample of children seeking health care in a pediatric clinic, although not representative of all Hispanic preschool children, appears consistent with the national trend reporting that children of the poor are in the poorest health when compared to other children.¹⁹

Health findings need to be integrated with the behavioral outcomes reported. Hyperactivity and insecure attachment, for example, may be partially accounted for by the presence of asthmatic children. Most chronic illnesses, asthma in particular, have direct effects on behavior,²¹ and that additionally, the treatment may have effects on behavior (eg, effects of medication on activity levels).^{22,23} However, in this study, we were not able to analyze separately the behavior scores of asthmatic children due to sample size limitations.

Stressors and Maternal Depression

Socioeconomic/cultural factors could help in explaining the lack of correlation found between family life stressful events and behavior problem scores reported in other studies. It can be suggested that "routine hassles"²⁴ rather than family life stressful events have a greater impact on the parents' and also the children's behavior in families of low socioeconomic status. Waiting long hours in often barren, nonappealing hospital waiting rooms, for example, is stressful for both parent and child, and may induce hyperactive behavior, which may lead to parental yelling and/or spanking, which in turn may prompt more activity.

Finally, maternal depression was not associated with maternal reports of behavior problems. The presence of support systems, a confidante, or perhaps religious or other beliefs/practices may have buffered the impact of depression on the mother.²⁵ Different methods of assessing depression also may be needed.

IMPLICATIONS FOR PRACTICE

Despite its limitations, this study suggests that Hispanic parents raising preschoolers in a low-income neighborhood, such as the one targeted in the study,

are in need of assistance in the management of overactive behaviors, the separation process, and the setting of limits. Similarly, the children are in need of referral to preschool centers where they can benefit from cognitive and language stimulation that may help in preventing or reducing future learning and school problems, including dropout. This assistance can be best provided by pediatric clinics that use a comprehensive model of care that attends to the whole child and not only his or her health needs.

In the current project, the study findings were presented in grand rounds and discussed with attendings and residents. Recommendations were issued, some of which were implemented. Specifically, pediatricians became more sensitized to the educational needs of low-income Hispanic preschoolers and were encouraged to refer to Head Start centers in the community. Pediatricians also were encouraged to impart anticipatory guidance to mothers in regard to behavior management issues regarding overactivity, clinging, setting of limits, and handling of discipline.

Overall, a broader use of prevention in a pediatric setting serving low-income families is recommended and encouraged. Easy and direct access makes such settings strategic for the application of a wide range of preventive efforts, eg, advocacy for and simultaneous referral to Head Start programs, anticipatory guidance regarding behavioral management at home, information on management of chronic conditions such as asthma, etc. To implement such programs, more studies linking health with behavioral and similar psychosocial aspects of development are needed, particularly when planning for the care of low-income children.

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TABLE 4. FREQUENCY OF BEHAVIORS REPORTED FOR EATING, SLEEPING, TOILETING, AND SEXUAL PROBLEMS

Behavior	2 to 4 Years	4 to 5 Years	Achenbach's 4 to 5 Years
Eating Behaviors			
Refuses to eat	70.3	53.3	
Doesn't eat well	64.9	33.3	
Chews inedible things	21.6	6.7	
Eats/drinks things that are not food	13.5	N.I.	
Overeats	8.1	20.0	6.0
Sleeping Behaviors			
Resists going to bed	43.2	33.2	
Trouble getting to sleep	35.1	13.3	
Doesn't want to sleep alone	62.2	33.3	
Wakes up often	40.5	20.0	
Nightmares	35.1	20.0	40.0
Talks/cries in sleep	59.5	26.7	
Sleeps less or more than others	32.4	40.0	
Toilet Training Behaviors			
Resists toilet training	5.4		
Wets self during day	21.6		
Wets bed	27.0	13.3	
Constipated	35.1	26.7	.08
Sexual Behaviors			
Acts like opposite sex	5.4	13.3	
Plays with sex parts in public	32.4	13.3	
Plays with sex parts too much	16.2		

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If only he had listened to his doctor.

Now he can't even talk to him.

Stanley Spencer's stroke didn't have to happen.
He should have taken his medicine, and stayed on his diet.
If you have high blood pressure, listen to the doctor.

It's your health. It's your life. It's your move.

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