Challenging Behavior and Expulsion From Child Care

The Role of Mental Health Consultation

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There is strong evidence that social and emotional skills are as critical to school adjustment as are competencies in language and academic readiness skills. When kindergarten teachers report that children are not entering school ready to learn, they are most often referring to deficits in social and emotional skills. Left untreated, early behavioral problems can develop into more serious mental health conditions that can effect learning and achievement (Joseph & Strain, 2003; Raver & Knitzer, 2002; Wentzel & Asher, 1995). In fact, roughly half of all children with problem behaviors in kindergarten are placed in special education by the 4th grade. Research has shown that social and behavioral competence in young children more accurately predict their academic performance in 1st grade than do their cognitive skills and family backgrounds (Fox & Smith, 2007).

The prevalence rates for young children with challenging behavior ranges from 10% to 30% (Fox & Smith 2007). Campbell (1995) estimated that approximately 10–15% of all typically developing preschool children have chronic mild to moderate levels of behavior problems. Emotional and behavioral problems of children are typically divided into two general categories: externalizing and internalizing problems. Externalizing problems involve aggressive, defiant, and noncompliant behaviors. The most common externalizing emotional and behavioral problems are attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct disorder. Internalizing problems include withdrawal, depression, and anxiety. The most common internalizing problems are separation anxiety disorder, generalized anxiety disorder, and depressive disorders. In addition, very young children commonly exhibit problems that do not fall within either of these general diagnostic categories, for example, sleeping problems, eating problems, and toilet-training–related problems. Many of these are best diagnosed using the *Diagnostic Classification 0–3R* (ZERO TO THREE, 2005). The most common specific challenging behaviors in children less than 5 years old are aggression, noncompliance, defiance, tantrums, and destruction of property (Strain & Timm, 2001).

When challenging behaviors in young children are not addressed early, emotional and behavior problems in preschool and kindergarten children are often stable over time. Young children with challenging behavior are more likely to experience early and persistent peer rejection, frequent

Abstract

Preschool children are being expelled from child care programs at an astonishing rate, often because of challenging behaviors such as aggression, tantrums, and noncompliance. Teachers say they need more training in how to manage these behaviors in child care settings. Early childhood mental health consultation (ECMHC) has been shown to build provider's capacity to better cope with challenging behavior. This article describes the lessons learned from interviews about 20 children receiving ECMHC who nonetheless exited their child care settings because of behavioral concerns. The authors outline the common characteristics of children at risk for expulsion, as well as the common characteristics of programs that may exacerbate challenging behaviors. A discussion of how ECMHC can help reduce the risk for expulsion is included along with a detailed list of specific strategies consultants recommended for use with teachers.

punitive contacts with teachers, unpleasant family interaction patterns, and school failure. In addition, more than 65% of students identified with emotional and behavioral disorders drop out of school, leading to poor job outcomes, limited income, and a pattern of failure that persists into adulthood (Fox & Smith 2007).

Challenging Behaviors and Child Care

MANY OF THE problem behaviors mentioned in the previous section are first manifest in child care settings. As children spend longer hours in care, stress in families mounts, and that stress contributes to the increasing numbers of children exhibiting problematic behavior. This in turn leads to a growing number of child care providers struggling to address the mental and behavioral health needs of young children. Assistance with children's challenging behaviors is the greatest need identified by preschool administrators and educators (Busecmi, Bennett, Thomas, & DeLuca, 1996; Yoshikawa & Zigler, 2000), who often have had little training in behavior management or ways to promote social and emotional competence (Scott & Nelson, 1999). Teachers, administrators, and family members identify this lack of knowledge and skill as the greatest challenge to effective practice (Fox & Smith, 2007). Preschool administrators and educators, who often have had minimal training in behavior management or ways to promote social and emotional competence (Scott & Nelson, 1999), report that those are the top areas in which they need training (Busecmi et al., 1996; Yoshikawa & Zigler, 2000). Eighty percent of teachers report that problem behavior negatively affects their job satisfaction, and directors report that teachers are not effective in implementing prevention or promotion practices (Fox & Smith, 207).

Expulsion from child care is the most extreme outcome of early care and education providers' inability to cope with challenging behaviors. According to a landmark national study (Gilliam, 2005), the rate of expulsions from state funded pre-kindergarten programs was roughly 3 times the rate of expulsions from K–12 programs. Although rates of expulsion vary widely among the 40 states funding pre-kindergarten, state expulsion rates for pre-kindergarteners exceed those in K–12 classes in all but 3 states (Gilliam, 2005). The pre-kindergarten expulsion rate was 6.7 per 1,000 pre-kindergarteners enrolled. Four-year-olds were expelled at a rate about 50% greater than 3-year-olds were. Boys were expelled at a rate more than 4.5 times that of girls. African-Americans attending state-funded pre-kindergarten were about twice as likely to be expelled as Latino and Caucasian children, and more than 5 times as likely to be expelled as Asian-American children.

Early childhood mental health consultation (ECMHC) is a model for building providers' skills and reducing problematic behavior in young children in child care that has shown promising results. ECMHC aims to build the capacity of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to 6 years old and their families. It involves a collaborative relationship between a professional consultant with mental health expertise and one or more individuals with expertise in infant and early childhood development (Cohen & Kaufmann, 2000; Donohue, Falk, & Provet, 2000; Johnston & Brinamen, 2006).

ECMHC provides an opportunity for early care and education (ECE) providers to receive one-on-one coaching and mentoring that can target the child, the family, or both or can focus on an entire program or classroom. In the former, referred to as child- and family-focused consultation, the consultant works with the provider and a child or family to address the specific behaviors of concern in an individual child or family. In contrast, program-focused consultation is intended to improve the overall quality of the classroom environment and provide strategies to build staff capacity to address problematic behaviors or programmatic problems that may be affecting one or more of the children, families, or staff.

There is a growing body of evidence that ECMHC is an effective strategy in reducing the impact of social–emotional and behavioral challenges on young children in child care and their caregivers. Gilliam (2005) reported that pre-kindergarten programs that had on-site mental health consultants had lower rates of expulsion than those without access to this service. In addition, two systematic reviews of more than 30 evaluations of ECMHC conducted across the country showed evidence that these programs can lead to reduced expulsions and improvements in children's behavior and teacher attitudes and behaviors (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010).

Understanding the Role of Mental Health Consultation Through a Study of Expulsions

AS PART OF an evaluation of Maryland's statewide ECMHC project, we studied the cases of 20 children who left child care programs because of challenging behavior. For each case, we interviewed the consultant who was working with the child. We also invited the child care program direc-

Young children with challenging behavior are more likely to experience early and persistent peer rejection.

tors, the child's care providers, and the child's parents to participate in an interview. These interviews were arranged whenever a consultant found out that a child she was working with was going to be expelled from a child care center. Sometimes parents decided to remove their child from child care before the child was formally asked to leave, and we interviewed consultants, directors, teachers, and parents in those cases as well. There was a different interview script for each type of respondent—consultant, director, teacher, and parent. The questions were open-ended in order to allow each interviewee to direct the conversation as much as possible. In total, we conducted 35 interviews: 20 with consultants, 7 with child care program directors, 5 with teachers, and 2 with parents. Most of the children were White, 3- or 4-year-old boys. Only two of the children were girls.

Our research team recorded, transcribed, and analyzed the interviews using qualitative data analysis software. We routinely returned to the transcripts to gather more information and make sure any conclusions we drew or themes we found accurately represented the interviewees' descriptions of their experiences. These interviews yielded a rich array of stories that informed our understanding of the factors that led to expulsions and the role mental health consultation can play in facilitating smooth transitions for children with challenging behaviors. We present a vignette to illustrate the range of children's experiences with mental health consultation that we studied.

Photo: Kiwi Street Studios

Program-focused consultation is intended to improve the overall quality of the classroom environment.

Ben's story

Three-year-old Ben started attending Little Stars Child Care after the child care center he previously attended closed in the middle of the year. Ava, an early childhood mental health consultant, had been working with Ben at that center for 5 months. He had been diagnosed with ADHD and sensory processing disorder and had an individualized education plan. Ava was teaching Ben and his providers strategies to reduce Ben's challenging behavior and increase his ability to participate in classroom activities. Ava continued working with Ben at Little Stars, starting on his very first day in the program.

At first, things seemed to go well. Ben's teachers were aware of his diagnoses and knew that he was receiving occupational therapy. They expected that it might take Ben a little extra time to adjust to his new environment, and Ava came to Little Stars once a week for 3 hours at a time to help him. Because Ben was at a new child care center, Ava had developed a new action plan and reviewed it with the director at Little Stars, Ben's teacher, and Ben's parents. After a few weeks, though, Ben's teacher and the director at Little Stars became concerned about Ben's behavior.

Ben had a difficult time engaging in classroom activities and interacting with other children. Because he was under-registering sensory information, he did not realize when he was hurting other children, sometimes squeezing them too tightly when he wanted to give a hug or knocking them over when he ran in to a play area. He struggled to pay attention, follow directions, and sit still to complete worksheets or participate in circle time. He was frustrated by his difficulty expressing himself and participating in the classroom, and that frustration caused aggressive behavior. He sometimes bit and kicked when he was angry and seemed impossible to calm down.

The amount of noise and activity at Little Stars created additional challenges for Ben. There were 8 children in his classroom, but there were no walls between classrooms, and there were 10 children in the classroom right next to his. Each afternoon, the teachers in each classroom switched rooms and taught the other class. His teachers knew that his behavior was a result of ADHD and sensory processing disorder, and they tried to do everything they could to help Ben, but it was difficult to give him the constant attention that he needed.

Ava continued to help Ben through his day, coaching him and trying to prevent his frustrations from escalating into tantrums that disrupted the whole class. She suggested a variety of tools that might help Ben focus, including a weighted lap pad, a wiggle cushion, and stress balls to hold during structured sitting time. Ava modeled ways to teach Ben appropriate language and use positive reinforcement, and she made a storybook about Ben, the things that made him angry, and what he could do to calm himself down.

Ben's parents communicated regularly with the providers at Little Stars and with Ava. They explained that, because Ben was their only child, they were not sure how concerned they should be about his behavior because they had nothing to compare it with.

They followed all of Ava's recommendations, used the same positive reinforcement strategies at home that Ben's teachers were using at school, and bought the lap pad and wiggle cushion that Ava suggested.

But Ben continued to struggle at Little Stars. He learned to calm himself down more effectively, but despite everyone's best efforts, Ben's behavior did not improve and continued to interrupt the class. He jumped on his wiggle cushion and threw his lap pad across the room. Parents of other children became aware that Ben was causing chaos in the classroom, and other children were starting to imitate Ben's negative behavior.

A week later, the director told Ben's parents that the program at Little Stars could not meet Ben's needs. Though she had hoped Ben would be able to stay at Little Stars, after spending 6 months working with him, Ava agreed that Little Stars was not the best place for Ben. She felt that Ben would be more likely to succeed with more individual attention in an environment with fewer distractions.

Fortunately, Ben's parents were able to enroll him in a children's institute in Maryland a few days later. The children's institute is a therapeutic child care center with large classrooms, 3 or 4 children in each class, special education teachers, and a full-time social worker on staff. Ben's parents had been surprised and upset when Ben was asked to leave Little Stars, but after a few weeks at the children's institute, they felt differently.

Ben's mother said:

You know, I wasn't happy about it then, but now I think everything happened for a reason… he's gotten used to it now. He knows exactly where to go to his classroom, and a couple times he wanted to stay; they were doing something he wanted to do, and he seems happier there.

Ben's parents asked Ava to continue seeing Ben at his new school, but Ben was doing well. Five weeks after Ben started his new program, Ava had not received any requests to work with Ben at the children's institute.

Ava's work helped his child care providers and parents realize that Ben needed something that Little Stars—even with special accommodations—could not provide. Ava helped the providers at Little Stars work hard to meet Ben's needs, and she facilitated open communication between the providers and Ben's parents. When his behavior did not improve, knowing that Ben had a team working together to help him made it easier for everyone to accept that Ben might be happier at another program. The director at Little Stars wished that Ben could have stayed in the program but felt like Ava had steered all of Ben's caregivers towards the right decision for Ben. She stated:

She [the consultant] was definitely a great resource for us because we felt we could go to her with any questions. She would try to come up with answers; she brought lots of things here that we could utilize. You know, she definitely was a good thing for us and for Ben because basically that's what her role is, to make sure a child has every avenue to succeed. So she certainly did her part.

Lessons Learned From the Children Who Exited Preschool Programs

BEN'S STORY ILLUSTRATES many of the common themes that we identified as we analyzed the 20 stories of children who exited their programs because of challenging behaviors. Our team was able to identify some common characteristics of the children who exited as well as common experiences they had in child care. Our results have implications for policy and practice as communities integrate mental health consultation into their ECE systems.

Characteristics of Children at Risk for Expulsion

The reasons that young children are expelled from child care programs are complicated and diverse. It is impossible to identify one primary factor that causes an expulsion, but we were able to identify characteristics and situational factors that are often present when children are at risk of being asked to leave child care programs. These children often exhibit problem behaviors, have mental or developmental health needs or challenges, have complicated family situations that affect the child's ability to succeed in the child care program, or have a combination of these factors.

The consultants, directors, teachers, and parents we interviewed described several different kinds of behaviors that caused problems in the classroom, such as aggression, hyperactivity, lack of social skills, and defiance. Violent or aggressive behavior, such as biting or throwing chairs, is particularly concerning because it poses serious safety issues, both for other children and for child care program staff. Defiant behavior often requires a lot of teacher attention and interrupts the rest of the class. And defiant behavior can become a safety issue. For example, several children tended to run out of the classroom or building when they did not want to do what was asked. Staff worried about leaving the other children alone in the classroom to chase a running child, but they were particularly concerned that the child might run into the street. Children's problem behaviors often led to other parents pressuring the child

Defiant behavior often requires a lot of teacher attention and interrupts the rest of the class.

care director to expel the child or risk other parents withdrawing their children.

Like Ben, many children exhibited concerning behavior as a result of developmental or mental health issues. Some children had specific diagnoses or were already receiving health or mental health services, including physical therapy, anger management counseling, occupational therapy, and behavioral therapy. Occasionally, interviewees identified internalizing behaviors that concerned them, such as withdrawal from classroom activities. But more often, children's emotions, like frustration or anger, would be expressed through externalizing behavior that was inappropriate for the classroom. And many of these children lacked the social skills required to participate successfully in normal classroom activities. Unfortunately, however, knowing the cause of a child's concerning behavior does not necessarily lead to the child's improvement. As long as the behavior persists, it causes problems in the classroom. And when other children begin imitating negative behavior, classroom management becomes even more difficult.

We also learned that many of the children at risk for expulsion experienced a variety of challenging family situations. Children's schedules were often inconsistent, with several different caregivers picking up, dropping off, and spending time with the child on a complex or irregular schedule. Consultants, directors, and teachers often commented that parents were inconsistently involved in their child's care, or that parents did not seem to have developed effective behavior

management strategies. Communication with parents was often infrequent or inconsistent. Some of these children recently experienced significant changes, such as divorce or the death of a grandparent.

Characteristics of Programs Where Children Had Difficult Times

The ECE programs that children exited from had some common characteristics. One major theme that emerged from the interviews illustrated specific characteristics that programs shared in cases where children were having the most difficult times. The most commonly referred to characteristic was that the physical environment of the program was too open, unclearly defined, or lacked structure. In addition, there were often larger child–caregiver ratios in these open, undefined spaces that consultants sometimes referred to as "chaotic."

One child care program had to be relocated to a temporary building because of remodeling. The new building had no walls to separate classrooms and the noise traveled throughout the space, which created sensory issues for some children who had trouble concentrating on their own learning. This configuration led to frequent distractions, wandering among centers, and inappropriate use of materials, which is likely to have increased the teacher's stress as she struggled to contain and direct the children in a chaotic environment.

Some centers lacked structure. Teachers did not establish or follow routines, or the routines were so restricting they would not allow for "teachable" moments to emerge.

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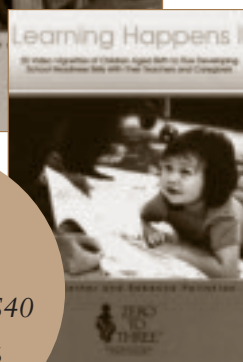
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In addition to the environment, teacher stress could be factored into a chaotic setting. One consultant remarked,

When a teacher is in a classroom with 9 other children, and [the child under discussion] making 10, unfortunately it would escalate before she could even probably address it or probably know what was going on, because you know you are constantly being pulled in a thousand different directions, you know?

Other programs were over structured. For example, one program planned the children's schedule down to the minute. In one classroom, children were required to rotate centers every 7 minutes. In another classroom, the teacher would end an activity without a transition or warning if it appeared that the children would be late for their next scheduled activity.

Finally, in many of these cases, consultants expressed concern that in some programs teachers were unwilling to implement the plans the consultants had developed for various reasons. They frequently heard that the things they suggested had been unsuccessful in the past, that the children would not respond to new materials or classroom changes, and, the teachers were reluctant to try these strategies at all. Another common concern raised by the teachers was that they were unable to dedicate so much one-on-one time to an individual child.

How ECMHC Helps Reduce the Risk for Expulsion

ECMHC SEEKS TO improve children's social–emotional well-being through changes made in the early childhood environment (e.g., routines, changes to the classroom layout), and through the acquisition of new skills by the ECE teachers. Mental health consultants build the capacity of ECE professionals to improve behavior management and enhance social skills in the children in their programs. These approaches may target an individual child who is presenting with a specific problem behavior or may build skills in the entire group of children in the classroom. At times, mental health consultants may provide some direct services (e.g., observing individual children, conducting screenings, or modeling effective practices), but these activities are implemented with the goal of building the skills of the early childhood professional (Brennan et al., 2008). Another focus of ECMHC is to promote positive adult-to-adult interactions, especially communication among members of the teaching team and between teachers and parents and teachers and administrators.

The primary instrument of intervention in ECMHC is capacity building; that is, assisting staff and caregivers to acquire knowledge, attitudes, and behaviors that will help them to support the social and emotional health of young children. The consultant works with and through staff and caregivers, building their capacity to problem solve and change practices that will help them change their behaviors to be more effective in their role in working with young children, including those with diagnosed developmental or mental health disorders. With new perspectives, skills, and strategies, caregivers can promote early childhood social–emotional functioning and address and solve current problems as well as future concerns that might arise (Cohen & Kaufmann, 2000).

ECMHC influences young children's social skills and problem behaviors primarily through its effects on the teachers' knowledge, attitudes, and behaviors as well as through changes in the classroom climate; for child-specific consultation, a parallel process occurs with the consultant and the family members' knowledge, attitudes, and behaviors. These effects are mediated through the quality of the relationship

Photo: Kiwi Street Studios

Early childhood mental health consultation can lead to reduced expulsions and improvements in children's behavior.

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F. Duran, K. S. Hepburn, M. Irvine, R. Kaufmann, B. J. Anthony, N. Horen, & D. F. Perry (2009) Washington DC: Georgetown University, Center for Child and Human Development. Available at http://gucchd.georgetown.edu/78358.html

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between the mental health consultant and the ECE provider and family members. When a skilled consultant provides advice that is well-received by the consultee, behavior change is more likely to occur, leading to: reduced stress, a more positive affective climate, increased reflective practice, and an increase in the adoption of evidence-based practices likely to reduce problem behaviors and increase children's social skills. In those cases where the consultant is working in-depth with the young child's family, there may be indirect effects of consultation through improvements of teacher–parent communication and increased consistency in the implementation of behavior strategies in home and school-settings. We also believe that effects of consultation are moderated by the attitudes and behaviors of the ECE administrators. When there is significant buy-in and follow-through from the director, changes in teacher and classroom effects will be more positive and sustained. Finally,

there may also be some direct effects of the activities of the mental health consultant on children's problem behavior.

Table 1 identifies specific examples of strategies that ECMHC used when working with children at risk for expulsion. These strategies are routinely used by mental health consultants to reduce challenging behavior and increase social–emotional skills. Variations of the strategies can be applied to both the program and child-specific cases.

Practice and Policy Implications

THE STORIES of the 20 children in Maryland who exited their program because of behavioral problems point to several areas where practice and policy could be improved. A large percentage of these children had significant (diagnosed) mental health or developmental disabilities. Community child care providers did not have the skills, training, or resources to successfully maintain these children in their ECE

programs. Like Ben, some of these children needed to be in a more therapeutic program in order to have their needs met. Mental health consultants can often serve as a bridge to other systems and services, such as early intervention or preschool special education. They can also help families realize that their child's needs are not being met in their current program and help navigate them to a more appropriate placement.

Many teachers continue to struggle with implementing evidence-based behavior management strategies, such as those contained with the Teaching Pyramid promoted by the Center for Social Emotional Foundations for Early Learning (Fox, Dunlap, Hemmeter, Joseph, & Strain, 2003). In Maryland, all of the mental health consultants were trained in the Teaching Pyramid model, and some served as coaches in ECE programs who had also been trained in the model. But many more community child care programs have not been trained in this approach, and continued training, with ongoing coaching, is needed to help ECE teachers and directors implement these practices with fidelity. Mental health consultants can serve as an important support to ECE programs that are incorporating elements of positive behavioral supports into their classrooms, both as a coach and working with a Teaching Pyramid coach in sites that are fortunate to have those resources (Perry & Kaufmann, 2009).

Finally, to be effective, mental health consultants need to engage the families of young children with challenging behaviors in a partnership with the ECE programs. In too many of the cases that we studied, the relationships between the family and the ECE programs were neither well-developed nor collaborative. Families often felt surprised by the news that their child was being asked to leave the ECE program. And this was the result of poor communication between the teachers, directors, and parents. Unfortunately, in many of these cases the mental health consultant was called in too late—the ECE staff and directors had already decided that this child needed to leave their program, and there was not enough time to mend the relationships between the ECE program and the family. Child care programs that are working with a mental health consultant on an ongoing basis are in a better position to build those collaborative relationships with families—going beyond simply securing permission to do child-specific work. In these cases, directors and teachers are able to build partnerships with parents to meet the needs of young children with challenging behavior, with support from the mental health consultant. ♪

Table 1. Specific Examples of Strategies Used by Mental Health Consultants Working With Children at Risk for Expulsion

Programmatic Strategies	Child-Specific Strategies
Arrange the room to make a larger number of interactive centers available. By adding more small-group activities children have more opportunities at the same time instead of waiting for the teacher to interact one-on-one. Not every activity can be teacher-directed, and children need to learn to work together.	Apply different sensory techniques such as allowing a child to play with play dough if he was having trouble keeping his hands to himself. Or to strengthen his writing skills, encourage him to write in sand or salt with his finger. Other ideas include using a weighted lap pad, stress balls, or small hand-held objects known as "fidgets" to hold during circle time or a giving him a wiggle cushion to sit on.
Add pro-social materials, such as board books titles *Hands Are Not for Hitting* and *Feet Are Not for Kicking*, and engage the children in group conversations about keeping their hands to themselves.	Provide a nap bag of activities so that if a child has trouble sleeping he has some specialized activities to occupy his time. A visual timer is also useful so that the child can see when his time on the nap mat is going to be over.
Even when walls or other boundaries are not available, masking tape or painter's tape can be used to create visual boundaries on the floor or other surfaces. If there isn't a large area for gross motor activities, in one taped-off section, directive signs could indicate "Do 5 jumping jacks here!" to allow children to actively move in safe ways using minimal space.	During transition times it's important to give children a heads-up that a change is coming. A 5-minute warning and then a 1-minute warning are good opportunities to help children prepare themselves for a change. Depending on the transition, jobs can help the children move the group along. Assign line leaders, room checkers, and door holders. This builds responsibility and gives them ownership over their own contribution.
Often teachers find themselves saying "No" a lot to the children. But this can create some confusion about just what it is they are supposed to be doing. So instead of saying "Don't run inside," try saying "Please use your walking feet indoors."	When a child bites another child, support the child who was hurt and encourage the one who bit to soothe the injured child by holding an ice pack on the wound. Spend some time with the one who bit reading *Teeth Are Not for Biting* and engage that child in activities that involve more oral muscles such as eating crunchy foods (e.g., pretzels, apples, or carrots), drinking applesauce through a straw, and blowing bubbles.
When sharing a concern with a child, sandwich it with a positive, then the negative, followed up by another positive. This reassures the child that she is not "bad" but that the behavior may need to change in order to make the situation better.	When helping children build strong social–emotional skills, use feathers to show the difference between gentle and rough touch, and show cards with children expressing different emotions to help him with empathy building.

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Nikki Darling-Kuria, *MA, founded CKD Communications, LLC, in to provide expert consultation in early care and education, specializing in family child care. Nikki has served as a family child care provider for 16 years and has been nationally accredited twice by the National Association for Family Child Care. Nikki served as a partner with the University of the Maryland and Georgetown University to evaluate Early Childhood Mental Health Consultation. Her first book,* Brain-Based Early Learning Activities: Connecting Theory and Practice, *was published by Redleaf Press in 2010. She holds a master's degree in human development from Pacific Oaks College.*

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