WONG'S

ESSENTIALS OF PEDIATRIC NURSING

11TH EDITION

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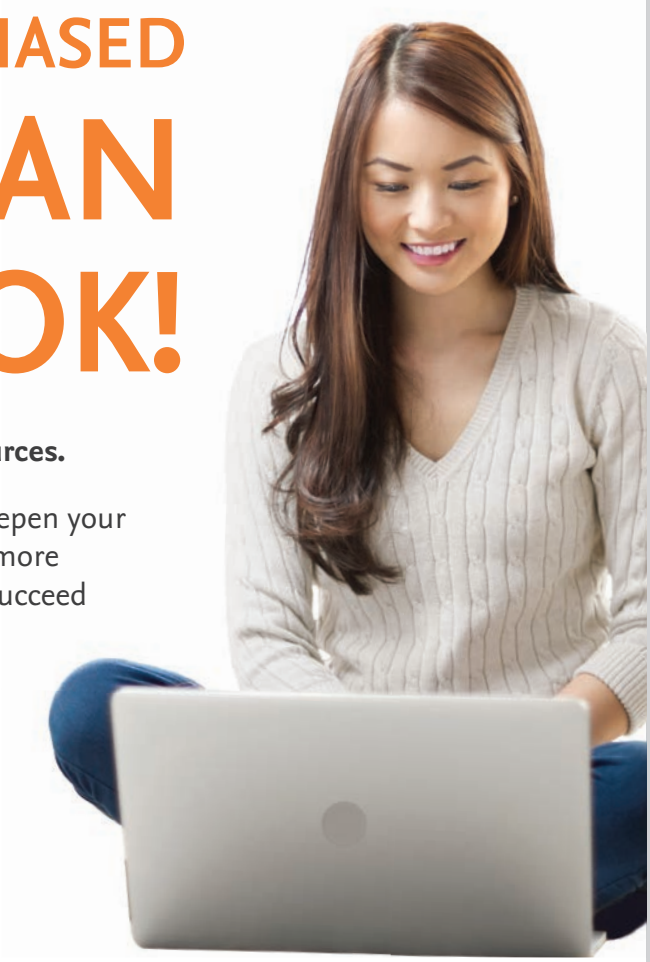

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WONG'S ESSENTIALS OF PEDIATRIC NURSING

ELEVENTH EDITION

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It is with great sadness that we announce the passing of Dr. Cheryl Rodgers on July 7, 2018, following a tragic accident. Cheryl was an exemplary nurse practitioner, educator, and leader in the field of pediatric nursing. Cheryl was an Associate Professor at the Duke University School of Nursing, and she held national leadership positions in the Children's Oncology Group Nursing Discipline and the Association of Pediatric Hematology Nurses. She served on the *Journal of Pediatric Oncology Nursing* Editorial Board, led several funded research studies, authored numerous impactful publications, and had just been selected for induction as a Fellow in the American Academy of Nursing, the profession's highest honor. Her devotion to pediatric nursing education served her well as a Wong textbook editor, and she will be greatly missed. Most important, Cheryl was an outstanding role model and a treasured mentor to so many pediatric nurses; her loss will be felt broadly and deeply throughout the profession.

PREFACE

Wong's Essentials of Pediatric Nursing has been a leading book in pediatric nursing since it was first published. This 11th edition continues its tradition of being an essential resource for pediatric nursing and continues the legacy of Donna Wong, David Wilson, and Cheryl Rodgers, our beloved colleagues. We hold dear their contributions and our memories of their pursuit of excellence in all they did for the Wong textbooks.

To accomplish this, Marilyn J. Hockenberry, as editor-in-chief, and many expert nurses and multidisciplinary specialists have revised, rewritten, or authored portions of the text on areas that are undergoing rapid and complex change. These areas include community nursing, development, immunizations, genetics, home care, pain assessment and management, high-risk newborn care, adolescent health issues, end-of-life care, and numerous pediatric diseases. We have carefully preserved aspects of the book that have met with universal acceptance: its state-of-the-art, research-based information; its strong, integrated focus on the family and community; its logical and user-friendly organization; and its easy-to-read style.

We have tried to meet the increasing demands of faculty and students to teach and to learn in an environment characterized by rapid change, enormous amounts of information, fewer traditional clinical facilities, and less time.

This text encourages students to *think critically*. We have added more case studies that discuss clinical scenarios, allowing the student to visualize how the care plan develops as a clinical situation evolves over time. The Critical Thinking Case Studies are revised and begin with a short case that provides enough details for the student to understand the clinical problem. Questions specific to the initial assessment are asked, and clinical reasoning is emphasized by asking what nursing interventions are important. Teaching points are included with each case study to summarize why specific nursing actions are warranted. Pediatric quality indicators from the 2019 Core Set of Children's Health Care Quality Measures are updated and added throughout the book.

Revised evidence-based practice boxes include the latest knowledge crucial for nurses to practice using quality and safety competencies. Competencies included in the evidence-based practice boxes are designed specifically for prelicensed nurses and are from the Quality and Safety Education for Nurses website.

This text also serves as a reference manual for practicing nurses. The latest recommendations have been included from authoritative organizations such as the American Academy of Pediatrics, the Centers for Disease Control and Prevention, the Institute of Medicine, the Agency for Healthcare Research and Quality, the American Pain Society, the American Nurses Association, and the National Association of Pediatric Nurse Associates and Practitioners. To expand the universe of available information, websites and email addresses have been included for hundreds of organizations and other educational resources.

ORGANIZATION OF THE BOOK

The same general approach to the presentation of content has been preserved from the first edition, although some content has been added, condensed, and rearranged within this framework to improve the flow; minimize duplication; and emphasize health care trends, such as home and community care. The book is divided into two broad parts. The first part of the book, Chapters 1 through 16, follow what is sometimes called the "age and stage" approach, considering infancy, childhood, and adolescence from a developmental context. It emphasizes the importance of the nurse's role in health promotion and maintenance and in considering the family as the focus of care. From a developmental perspective, the care of common health problems is presented, giving readers a sense of the normal problems expected in otherwise healthy children and demonstrating when in the course of childhood these problems are most likely to occur. The remainder of the book, Chapters 17 through 31, presents the more serious health problems of infancy, childhood, and adolescence that are not specific to any particular age-group and that frequently require hospitalization, major medical and nursing intervention, and home care.

UNIT ONE (Chapters 1 through 3) provides a longitudinal view of the child as an individual on a continuum of developmental changes from birth through adolescence and as a member of a family unit maturing within a culture and a community. The latest discussion of morbidity and mortality in infancy and childhood is presented, and child health care is examined from a historical perspective. Because unintentional injury is one of the leading causes of death in children, an overview of this topic is included. In this edition, the critical components of evidence-based practice are presented to provide the template for exploring the latest pediatric nursing research or practice guidelines throughout the book. Quality nursing care is also emphasized, and this sets the stage for quality outcome measures that are included for specific problems in many of the chapters. This book is about families with children, and the philosophy of family-centered care is emphasized. This book is also about providing atraumatic care—care that minimizes the psychologic and physical stress that health promotion and illness treatment can inflict.

In this Unit, the philosophy of delivering nursing care is addressed. We believe strongly that children and families need consistent caregivers. Establishing the therapeutic relationship with the child and family is explored as the essential foundation for providing quality nursing care. Important information is presented on the family, social and cultural, and religious influences on child health promotion. The content clearly describes the role of the nurse, with emphasis on cultural and religious sensitivity and competent care.

Unit One includes discussion of the developmental and genetic influences on child health, continues to provide the latest information on genetics, and also focuses on a theoretic approach to personality development and learning.

UNIT TWO (Chapters 4 to 6) contains guidelines for communicating with children, adolescents, and their families, as well as a detailed description of a health assessment, including discussion of family assessment, nutritional assessment, and sexual history. Content on communication techniques is outlined to provide a concise format for reference. A comprehensive approach to physical examination and developmental assessment is included, with updated material on temperature measurement and body mass index–for-age guidelines. Critical aspects of assessment and management of pain in children is found in this Unit. Although the literature on pain assessment and management in children has grown considerably, this knowledge has not been widely applied in practice. Common infectious diseases occur in children, and the importance of infection control is emphasized with a review of the various bacterial and viral infections encountered in childhood. Hospital-acquired infections, childhood communicable disease, and immunizations are also discussed. Coronavirus disease (COVID 19) is added to the infectious diseases chapter.

UNIT THREE (Chapters 7 and 8) stresses the importance of the neonatal period in relation to child survival during the first few months and the impact on health in later life. Several topics in this Unit have been revised to reflect current issues, especially regarding the educational needs of the family during the infant's transition to extrauterine life as well as the recognition of newborn problems in the first few weeks of life. The nurse's role in caring for the high-risk newborn is stressed, as is the importance of astute observations to the survival of this vulnerable group of infants. Modern advances in neonatal care have mandated extensive revision with a greater sensitivity to the diverse needs of infants, from those with extremely low birth weights, to those born late-preterm, to those of normal gestational age who have difficulty making an effective transition to extrauterine life.

UNITS FOUR through SIX (Chapters 9 through 16) present the major developmental stages outlined in Unit One, which are expanded to provide a broader concept of these stages and the health problems most often associated with each age-group. Special emphasis is placed on preventive aspects of care. The chapters on health promotion follow a standard approach that is used consistently for each age-group. The influence of nutrition in preschool-age and school-age children (especially decreasing fat intake) in relation to later chronic diseases such as obesity and hypertension has been revised. The importance of safety promotion and injury prevention in relation to each age-group is included in these chapters as well.

The chapters on health problems in these units primarily reflect more typical and age-related concerns. The information on many disorders has been revised to reflect recent changes. Examples include sudden infant death syndrome, lead poisoning, severe acute malnutrition, burns, attention-deficit/hyperactivity disorder, contraception, teenage pregnancy, and sexually transmitted infections. The chapters on adolescence include the latest information on substance abuse, adolescent immunizations, and the impact of adolescent nutrition on cardiovascular health.

UNIT SEVEN (Chapters 17 and 18) deals with children who have the same developmental needs as growing children but who, because of congenital or acquired physical, cognitive, or sensory impairment, require alternative interventions to facilitate development. Current trends in the care of families and children with chronic illness or disability, such as providing home care, normalizing children's lives, focusing on developmental needs, enabling and empowering families, and promoting early intervention, are included. This Unit highlights common fears experienced by the child and family and includes discussion of symptom management and nurses' reactions to caring for dying children.

The content on cognitive or sensory impairment includes important updates on the definition and classification of cognitive impairment. Autism spectrum disorders are discussed to provide a cohesive overview of cognitive and sensory impairments.

UNIT EIGHT (Chapters 19 and 20) is concerned with the impact of hospitalization on the child and family and presents a comprehensive overview of the stressors imposed by hospitalization and discusses nursing interventions to prevent or eliminate them. New research on short-stay or outpatient admissions addresses preparing children for these experiences. The effects of illness and hospitalization on children at specific ages and the effects on their development are updated. Revised Evidence-Based Practice boxes that include Quality and Safety Education for Nurses competencies are designed to provide rationales for the interventions discussed. A major focus is the evidence related to preparation of the child for procedures commonly performed by nurses.

UNITS NINE through TWELVE (Chapters 21 through 31) consider serious health problems of infants and children primarily from the biologic systems orientation, which has the practical organizational value of permitting health problems and nursing considerations to relate to specific pathophysiologic disturbances. The most common serious diseases in children are reviewed in these chapters. A section on the multisystem inflammatory syndrome (MIS-C) that is seen in children exposed to COVID-19 has been added.

UNIFYING PRINCIPLES

Several unifying principles have guided the organizational structure of this book since its inception. These principles continue to strengthen the book with each revision to produce a text that is consistent in approach throughout each chapter.

The Family as the Unit of Care

The child is an essential member of the family unit. We refer to parents in this book as a mother and/or father but recognize that parents include of a variety of individuals and do not undervalue the importance of any parent role or family structure.

Nursing care is most effective when it is delivered with the belief that *the family is the patient.* This belief permeates the book. When a child is healthy, the child's health is enhanced when the family is a fully functioning, health-promoting system. The family unit can be manifested in a myriad of structures; each has the potential to provide a caring, supportive environment in which the child can grow, mature, and maximize his or her human potential. In addition to integrating family-centered care in every chapter, an entire chapter is devoted to understanding the family as the focus in children's lives, including the social, cultural, and religious influences that affect family beliefs. Separate sections in another chapter deal in depth with family communication and family assessment. The impact of illness and hospitalization, home care, community care, and the death of a child are covered extensively in additional chapters. The needs of the family are emphasized throughout the text under Nursing Care Management in a separate section on family support. Numerous Family-Centered Care boxes are included to assist nurses in understanding and providing helpful information to families.

An Integrated Approach to Development

Children are not small adults but special individuals with unique minds, bodies, and needs. No book on pediatric nursing is complete without extensive coverage of communication, nutrition, play, safety, dental care, sexuality, sleep, self-esteem, and, of course, parenting. Nurses promote the healthy expression of all of these dimensions of personhood and need to understand how these functions are expressed by different children at different developmental ages and stages. Effective parenting depends on knowledge of development, and it is often the nurse's responsibility to provide parents with a developmental awareness of their children's needs. For these reasons, coverage of the many dimensions of childhood is integrated within the growth and development chapters rather than being presented in separate chapters. For example, safety concerns for a toddler are much different from those for an adolescent. Sleep needs change with age, as do nutritional needs. As a result, the units on each stage of childhood contain complete information on all of these functions as they relate to the specific age. In the unit on school-age children, for instance, information is presented on nutritional needs, age-appropriate play and its significance, safety concerns characteristic of the age-group, appropriate dental care, sleep characteristics, and means of promoting self-esteem—a particularly significant concern for school-age children. The challenges of being the parent of a school-age child are presented, and interventions that nurses can use to promote healthy parenting are

suggested. Using the integrated approach, students gain an appreciation for the unique characteristics and needs of children at every age and stage of development.

Focus on Wellness and Illness: Child, Family, and Community

In a pediatric nursing text, a focus on illness is expected. Children become ill, and nurses typically are involved in helping children get well. However, it is not sufficient to prepare nursing students to care primarily for sick children. First, health is more than the absence of disease. Being healthy is being whole in mind, body, and spirit. Therefore most of the first half of the book is devoted to discussions that promote physical, emotional, psychosocial, mental, and spiritual wellness. Much emphasis is placed on anticipatory guidance of parents to prevent injury or illness in their children. Second, health care is more than ever prevention focused. The objectives set forth in the *Healthy People 2030* report clearly establish a health care agenda in which solutions to medical and social problems lie in preventive strategies. Third, health care is moving from acute care settings to the community, the home, short-stay centers, and clinics. Nurses must be prepared to function in all settings. To be successful, they must understand the pathophysiology, diagnosis, and treatment of health conditions. Competent nursing care flows from this knowledge and is enhanced by an awareness of childhood development, family dynamics, and communication skills.

Nursing Care

Although the information in this text incorporates information from numerous disciplines (medicine, pathophysiology, pharmacology, nutrition, psychology, sociology), its primary purpose is to provide information on the nursing care of children and families. Discussions of all disorders conclude with a section on Nursing Care Management. In addition, 14 care plans are included. Taken together, they cover the nursing care for many childhood diseases, disorders, and conditions. The purposes of the care plans, like every other feature of the book, are to teach and to convey information. The care plans are designed to stimulate critical thinking and to encourage the student to individualize outcomes and interventions for the child rather than to provide an extensive picture of all nursing diagnoses, outcomes, and interventions for every given disease or condition.

Culturally Competent Care

Increasing cultural diversity in the United States requires nurses caring for children and their families to develop expertise in the care of children from numerous backgrounds. Culturally competent nursing care requires more than acquiring knowledge about ethnic and cultural groups. It encompasses not only awareness of the influence of culture on the child and family but also the ability to intervene appropriately and effectively. The nurse must learn objective skills to focus on the child's, family's, and community's cultural characteristics. The nurse's self-awareness of unique personal cultural backgrounds must be acknowledged in order to understand how they contribute to cross-cultural communication. The importance of the environment of a cross-cultural care setting must be considered when providing clinical nursing care to culturally diverse families. This edition provides numerous learning experiences that examine cross-cultural communication, cultural assessment, cultural interpretation, and appropriate nursing interventions.

The Critical Role of Research and Evidence-Based Practice

This 11th edition is the product of an extensive review of the literature published since the book was last revised. Many readers and researchers have come to rely on the copious references that reflect significant contributions from a broad audience of professionals. To ensure that information is accurate and current, most citations are less than 5 years old, and almost every chapter has entries dated within 1 year of publication. This book reflects the art and science of pediatric nursing. A central goal in every revision is to base care on research rather than on tradition. Evidence-based practice produces measurable outcomes that nurses can use to validate their unique role in the health care system. Throughout the book, Evidence-Based Practice boxes reflect the importance of the science of nursing care.

SPECIAL FEATURES

Much effort has been directed toward making this book easy to teach from and, more important, easy to learn from. In this edition, the following features have been included to benefit educators, students, and practitioners.

APPLYING EVIDENCE TO PRACTICE boxes are new specialty boxes throughout the text outlining up-to-date procedures to show best practice and focus on applying evidence.

ATRAUMATIC CARE boxes emphasize the importance of providing competent care without creating undue physical and psychologic distress. Although many of the boxes provide suggestions for managing pain, atraumatic care also considers approaches to promoting self-esteem and preventing embarrassment.

CONCEPTS have been added to the beginning of each chapter to focus student attention on unique principles found in each chapter as well as to aid students who are using concept-based curriculum, system-focused curriculum, or a hybrid approach.

 **COMMUNITY FOCUS** boxes address issues that expand to the community, such as increasing immunization rates, preventing lead poisoning, and decreasing smoking among teens.

CRITICAL THINKING CASE STUDIES ask the nurse to examine the evidence, consider the assumptions, establish priorities, and evaluate alternative perspectives regarding each patient situation. Answers to the Case Studies are provided within the box.

 **CULTURAL CONSIDERATIONS** boxes integrate concepts of culturally sensitive care throughout the text. The emphasis is on the clinical application of the information, whether it focuses on toilet training or on male or female circumcision.

 **DRUG ALERTS** highlight critical drug safety concerns for better therapeutic management.

 **EMERGENCY TREATMENT** boxes are flagged by colored thumb tabs, enabling the reader to quickly locate interventions for crisis situations.

 **FAMILY-CENTERED CARE** boxes present issues of special significance to families that have a child with a particular disorder. This feature is another method of highlighting the needs or concerns of families that should be addressed when family-centered care is provided.

 **NURSING ALERT** features call the reader's attention to considerations that, if ignored, could lead to a deteriorating or emergency situation. Key assessment data, risk factors, and danger signs are among the kinds of information included.

 **NURSING CARE GUIDELINES** summarize important nursing interventions for a variety of situations and conditions.

 **NURSING CARE PLANS** are revised to allow students to experience an "unfolding case" written in the format of the next-generation NCLEX-RN examination. These include expected patient outcomes and rationales for the included nursing interventions that may not be immediately evident to the student. The care plans include an unfolding case study that represents a "real" patient and family to demonstrate the principles of clinical judgment.

NURSING TIPS present handy information of a nonemergency nature that makes patients more comfortable and the nurse's job easier.

QUALITY PATIENT INDICATORS are added throughout the text to provide a framework for measuring nursing care performance. Nursing-sensitive outcome measures are integrated into the outcome indicators used throughout the book.

 **RESEARCH FOCUS** boxes review new evidence on important topics in a concise way.

TRANSLATING EVIDENCE INTO PRACTICE boxes have been updated in this edition to focus the reader's attention on application of both research and critical thought processes to support and guide the outcomes of nursing care. These boxes include Quality and Safety Education for Nurses competencies and provide measurable outcomes that nurses can use to validate their unique role in the health care system.

NEXT-GENERATION REVIEW QUESTIONS are found at the end of each chapter that are designed to promote clinical judgment. Using the new format for the Next-Generation NCLEX® examination, questions allow the nurse to process through a case study using clinical reasoning to make appropriate judgments about the patient's plan of care.

Numerous pedagogic devices that enhance student learning have been retained from previous editions:

- A functional and attractive **FULL-COLOR DESIGN** visually enhances the organization of each chapter, as well as the special features.
- A detailed, cross-referenced **INDEX** allows readers to quickly access discussions.
- **KEY TERMS** are highlighted throughout each chapter to reinforce student learning.
- Hundreds of **TABLES** and **BOXES** highlight key concepts and nursing interventions.
- Many of the **COLOR PHOTOGRAPHS** are new, and anatomic drawings are easy to follow, with color appropriately used to illustrate important aspects, such as saturated and desaturated blood. As an example, the full-color heart illustrations in Chapter 23 clearly depict congenital cardiac defects and associated hemodynamic changes.

ACKNOWLEDGMENTS

We are grateful to our mentor and colleague, **Donna Wong,** whose support made us better pediatric nurses. We are fortunate to have worked for many years with David Wilson and Cheryl Rodgers, who served as coeditors on numerous editions. We miss them greatly with this edition. We are also grateful to the many nursing faculty members, practitioners, and students who have offered their comments, recommendations, and suggestions. We are especially grateful to the contributors and the many reviewers who brought constructive criticism, suggestions, and clinical expertise to this edition. This edition could not have been completed without the dedication of these special people.

No book ever becomes a reality without the dedication and perseverance of the editorial staff. Although it is impossible to list every individual at Elsevier who has made exceptional efforts to produce this text, we are especially grateful to **Sandra Clark** and **Heather Bays** for their support and commitment to excellence. We want to say a very special thanks to Heather Bays, who has served the Wong textbooks for many editions with a commitment to excellence that is so appreciated. Her dedication to this book is reflected in every chapter.

Finally, we thank our families and children—for their unselfish love and endless patience that allows us to devote such a large part of our lives to our careers. Our children have given us the opportunity to directly observe the wonders of childhood.

Marilyn J. Hockenberry

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Perspectives of Pediatric Nursing

Marilyn J. Hockenberry

http://evolve.elsevier.com/wong/essentials

CONCEPTS

- Family-Centered Care
- Atraumatic Care
- Clinical Reasoning
- Nursing Process
- Research and Evidence-Based Practice
- Quality Outcome Measures

HEALTH CARE FOR CHILDREN

The major goal for pediatric nursing is to improve the quality of health care for children and their families. In 2018 almost 74 million children 0 to 17 years old lived in the United States, making up 22% of the population (Federal Interagency Forum on Child and Family Statistics, 2019). The health status of children in the United States has improved in a number of areas, including increased immunization rates for all children, decreased adolescent birth rate, and improved child health outcomes. The 2019 America's Children in Brief—Indicators of Well-Being reveals that preterm births increased slightly in 2016, after a continuous decline since 2007. Average mathematics scores for fourth- and eighth-grade students has remained stable since 2015, and the violent crime victimization rate among youth decreased during the last 20 years. Although the number of children living in poverty decreased slightly in 2017, overall the rate remains high at 18%. The percentage of children with at least one parent employed full time year round increased to 78% in 2017 (Federal Interagency Forum on Child and Family Statistics, 2019).

Millions of children and their families have no health insurance, which results in a lack of access to care and health promotion services. In addition, disparities in pediatric health care are related to race, ethnicity, socioeconomic status, and geographic factors (Flores & Lesley, 2014). Patterns of child health are shaped by medical progress and societal trends. Urgent priorities for health and health care of children in the United States are the focus for action toward new policy priorities (Box 1.1).

HEALTH PROMOTION

Child health promotion provides opportunities to reduce differences in current health status among members of different groups and to ensure equal opportunities and resources to enable all children to achieve their fullest health potential. The Healthy People 2030 Leading Health Indicators (Box 1.2) provide a framework for identifying essential components for child health promotion programs designed to prevent future health problems in our nation's children. Bright Futures is a national health promotion initiative with a goal to improve the health of our nation's children (Bright Futures, 2018). Major themes of the Bright Futures guideline are promoting family support, child development, mental health, and healthy nutrition that leads to healthy weight, physical activity, oral health, healthy sexual development and sexuality, safety and injury prevention, and the importance of community relationships and resources.[a] Throughout this book, developmentally appropriate health promotion strategies are discussed. Key examples of child health promotion themes essential for all age-groups include promoting development, nutrition, and oral health. Bright Futures recommendations for preventive health care during infancy, early childhood, and adolescence are found throughout the book.

Development

Health promotion integrates surveillance of the physical, psychologic, and emotional changes that occur in human beings between birth and the end of adolescence. Developmental processes are unique to each stage of development, and continuous screening and assessment are essential for early intervention when problems are found. The most dramatic time of physical, motor, cognitive, emotional, and social development occurs during infancy. Interactions between the parent and infant are central to promoting optimal developmental outcomes and are a key component of infant assessment. During early childhood, early identification of developmental delays is critical for establishing early interventions. Anticipatory guidance strategies ensure that parents are aware of the specific developmental needs of each developmental stage. Ongoing surveillance during middle childhood provides opportunities

[a]Bright Futures is supported by the American Academy of Pediatrics (see http://brightfutures.aap.org/about.html).

BOX 1.1 Health and Health Care Priorities for American Children

Poverty
Lack of health insurance
Environmental health
Nutrition
Firearm deaths and injuries
Mental health
Racial and ethnic disparities
Immigration

Adapted from American Academy of Pediatrics. (n.d.). *Federal advocacy*. Retrieved February 8, 2018, from https://www.aap.org/en-us/advocacy-and-policy/federal-advocacy

BOX 1.2 Healthy People 2030

Overarching Goals

- Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
- Promote healthy development, healthy behaviors and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

From US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2019). *Healthy People 2030*. Retrieved from http://www.healthypeople.gov/

to strengthen cognitive and emotional attributes, communication skills, self-esteem, and independence. Recognition that adolescents differ greatly in their physical, social, and emotional maturity is important for surveillance throughout this developmental period.

An important example for health promotion during early child development is to be aware of changing recommendations that address the fast-changing world of technology in our society. An important example is the changes in the latest (American Academy of Pediatrics, 2016) policy statement on screen viewing by infants and children. New guidelines for screen viewing (laptop or phone) shift the importance from what is on the screen to who is viewing the information with the young child (American Academy of Pediatrics, 2016). For infants less than 18 months of age, no screen time is recommended except for video calling with a grandparent or loved one. Parents should be advised to use technology sparingly before 5 years of age and to always participate during screen-time viewing.

Nutrition

Nutrition is an essential component for healthy growth and development. Human milk is the preferred form of nutrition for all infants. Breastfeeding provides the infant with micronutrients, immunologic properties, and several enzymes that enhance digestion and absorption of these nutrients. A recent resurgence in breastfeeding has occurred as a result of the education of mothers and fathers regarding its benefits and increased social support.

Children establish lifelong eating habits during the first 3 years of life, and the nurse is instrumental in educating parents on the importance of nutrition. Most eating preferences and attitudes related to food are established by family influences and culture. During adolescence, parental influence diminishes and the adolescent makes food choices related to peer acceptability and sociability. Occasionally these choices are detrimental to adolescents with chronic illnesses such as diabetes, obesity, chronic lung disease, hypertension, cardiovascular risk factors, and renal disease.

Families that struggle with lower incomes, homelessness, and migrant status generally lack the resources to provide their children with adequate food intake, nutritious foods such as fresh fruits and vegetables, and appropriate protein intake (Flores & Lesley, 2014). The result is nutritional deficiencies with subsequent growth and developmental delays, depression, and behavior problems.

Oral Health

Oral health is an essential component of health promotion throughout infancy, childhood, and adolescence. Preventing dental caries and developing healthy oral hygiene habits must occur early in childhood. Dental caries has been recommended for decades as a significant yet preventable health problem for children. By 3 years of age, 28% of children will have one or more cavities (American Academy of Pediatrics, 2018). Children in racial or cultural minority groups experience disparities in oral health care and are much more likely to have dental disease.

Preschoolers of low-income families are twice as likely to develop tooth decay and only half as likely to visit the dentist as other children. Early childhood caries is a preventable disease, and nurses play an essential role in educating children and parents about practicing dental hygiene, beginning with the first tooth eruption; drinking fluoridated water, including bottled water; and instituting early dental preventive care. Oral health care practices established during the early years of development prevent destructive periodontal disease and dental decay.

CHILDHOOD HEALTH PROBLEMS

Changes in modern society, including advancing medical knowledge and technology, the proliferation of information systems, struggles with insurance disparities, economically troubled times, and various changes and disruptive influences on the family, are leading to significant medical problems that affect the health of children. Problems that can negatively affect a child's development include poverty, violence, aggression, noncompliance, school failure, and adjustment to parental separation and divorce. In addition, mental health issues cause challenges in childhood and adolescence. Emergence of the COVID-19 pandemic impacts children both physically and mentally. Recent concern has focused on groups of children who are at highest risk, such as children born preterm or with very low birth weight (VLBW) or low birth weight (LBW), children attending child care centers, children who live in poverty or are homeless, children of immigrant families, and children with chronic medical and psychiatric illness and disabilities. In addition, these children and their families face multiple barriers to adequate health, dental, and psychiatric care. A perspective of several health problems facing children and the major challenges for pediatric nurses is discussed in the following sections.

Obesity and Type 2 Diabetes

Childhood obesity, the most common nutritional problem among American children, is increasing in epidemic proportions. *Obesity* in children and adolescents is defined as a body mass index (BMI) at or greater than the 95th percentile for youth of the same age and gender. *Overweight* is defined as a BMI at or above the 85th percentile and below the 95th percentile for children and teens of the same age and sex. The prevalence of obesity during childhood was 18.5%, and obesity affects more than 13.7 million children and adolescents in 2016 (Centers for Disease Control and Prevention, 2018; Flores & Lesley, 2014).

Fig. 1.1 The American culture's intake of high-caloric, fatty food contributes to obesity in children.

Increasing evidence indicates that maternal obesity is a major influence on offspring health during childhood and in adult life (Godfrey, Reynolds, Prescott, et al., 2016). An optimal nutritional and microbial environment during pregnancy may reduce the risk of infants being obese or overweight during early life (Garcia-Mantrana & Collado, 2016). Obesity and overweight research now recommends that education and preventative strategies be implemented beginning in infancy, and some researchers even feel that the prenatal period is best. Emphasis is on preventive strategies that start in infancy and in the prenatal period.

Lack of physical activity and a sedentary lifestyle related to limited resources, unsafe environments, and inconvenient play and exercise facilities, combined with easy access to television and video games, increases the incidence of obesity among low-income, minority children. Overweight youth have increased risk for cardiometabolic changes (a cluster of cardiovascular factors that include hypertension, altered glucose metabolism, dyslipidemia, and abdominal obesity) in the future (Weiss, Bremer, & Lustig, 2013) (Fig. 1.1). The US Department of Health and Human Services (2013) suggests that nurses focus on prevention strategies to reduce the incidence of overweight children from the current 20% in all ethnic groups to less than 6%. Lifestyle interventions show promise in preventing obesity and decreasing occurrence if targeted at children 6 to 12 years old.

Childhood Injuries

Injuries are the most common cause of death and disability among children in the United States (Centers for Disease Control and Prevention, 2017b) (Table 1.1). Mortality rates for suicide, poisoning, and falls rose substantially over the past decade. Other unintentional injuries (head injuries, drowning, burns, and firearm accidents) take the lives of children every day. Implementing programs of accident prevention and health promotion could prevent many childhood injuries and fatalities.

The type of injury and the circumstances surrounding it are closely related to normal growth and development (Box 1.3). As children develop, their innate curiosity compels them to investigate the environment and to mimic the behavior of others. This is essential to acquire competency as an adult, but it can also predispose children to numerous hazards.

The child's developmental stage partially determines the types of injuries that are most likely to occur at a specific age and helps provide clues to preventive measures. For example, small infants are helpless in any environment. When they begin to roll over or propel themselves, they can fall from unprotected surfaces. The crawling infant, who has a natural tendency to place objects in the mouth, is at risk for aspiration or poisoning. The mobile toddler, with the instinct to explore and investigate and the ability to run and climb, may experience falls, burns, and collisions with objects. As children grow older, their absorption with play makes them oblivious to environmental hazards such as street traffic or water. The need to conform and gain acceptance compels older children and adolescents to accept challenges and dares. Although the rate of injuries is high in children younger than 9 years old, most fatal injuries occur in later childhood and adolescence.

The pattern of deaths caused by unintentional injuries, especially from motor vehicle accidents (MVAs), drowning, and burns, is remarkably consistent in most Western societies. The leading causes of death from injuries for each age-group according to sex are presented in Table 1.1. The majority of deaths from injuries occur in boys. It is important to note that accidents continue to account for more than three times as many teen deaths as any other cause (Annie E. Casey Foundation, 2019). Fortunately, prevention strategies such as the use of car restraints, bicycle helmets, and smoke detectors have significantly decreased fatalities for children. Nevertheless,

BOX 1.3 Childhood Injuries: Risk Factors

- *Sex*—Preponderance of males; difference mainly the result of behavioral characteristics, especially aggression
- *Temperament*—Children with difficult temperament profile, especially persistence, high activity level, and negative reactions to new situations
- *Stress*—Predisposes children to increased risk taking and self-destructive behavior; general lack of self-protection
- *Alcohol and drug use*—Associated with higher incidence of motor vehicle injuries, drownings, homicides, and suicides
- *History of previous injury*—Associated with increased likelihood of another injury, especially if initial injury required hospitalization
- *Developmental characteristics*
  - Mismatch between child's developmental level and skill required for activity (e.g., all-terrain vehicles)
  - Natural curiosity to explore environment
  - Desire to assert self and challenge rules
  - In older child, desire for peer approval and acceptance
- *Cognitive characteristics* (age specific)
  - *Infant*—Sensorimotor: explores environment through taste and touch
  - *Young child*—Object permanence: actively searches for attractive object; cause and effect: lacks awareness of consequential dangers; transductive reasoning: may fail to learn from experiences (e.g., perceives falling from a step as a different type of danger from climbing a tree); magical and egocentric thinking: is unable to comprehend danger to self or others
  - *School-age child*—Transitional cognitive processes: is unable to fully comprehend causal relationships; attempts dangerous acts without detailed planning regarding consequences
  - *Adolescent*—Formal operations: is preoccupied with abstract thinking and loses sight of reality; may lead to feeling of invulnerability
- *Anatomic characteristics* (especially in young children)
  - *Large head*—Predisposes to cranial injury
  - *Large spleen and liver with wide costal arch*—Predisposes to direct trauma to these organs
  - *Small and light body*—May be thrown easily, especially inside a moving vehicle
- *Other factors*—Poverty, family stress (e.g., maternal illness, recent environmental change), substandard alternative child care, young maternal age, low maternal education, multiple siblings

TABLE 1.1 Preventable, Unintentional Injury-Related Deaths, United States, 2017 (Rate per 100,000 Population in Each Age-Group)

	AGE (YEARS)		
Type of Accident	**0-4**	**5-14**	**15-24**
Males			
Motor vehicle	2.8 (3)	2.4 (1)	22.0 (1)
Drowning	3.0 (2)	0.8 (2)	1.8 (3)
Fires and burns	0.5 (5)	0.4 (3)	0.2 (5)
Choking	0.6 (4)	—	—
Falls	—	—	0.8 (4)
Mechanical suffocation	6.4 (1)	0.2 (4)	—
Poisoning	—	—	16.2 (2)
Other causes	0.8	0.5	2.2
Females			
Motor vehicle	2.6 (2)	1.7 (1)	9.4 (1)
Drowning	1.6 (3)	0.3 (3)	0.3 (3)
Fires and burns	0.5 (4)	0.3 (2)	0.2 (4)
Choking	0.3 (5)	—	—
Falls	—	0.1 (5)	0.1 (5)
Mechanical suffocation	4.8 (1)	—	—
Poisoning	—	0.1 (4)	6.8 (2)
Other causes	0.4	0.3	0.5

Data Source: National Safety Council, *Injury Facts,* Online database, available at https://injuryfacts.nsc.org.

the overwhelming causes of death in children are MVAs, including occupant, pedestrian, bicycle, and motorcycle deaths; these account for more than half of all injury deaths (Kids Count Data Center, 2016) (Fig. 1.2).

Pedestrian accidents involving children account for significant numbers of motor vehicle–related deaths. Most of these accidents occur at midblock, at intersections, in driveways, and in parking lots. Driveway injuries typically involve small children and large vehicles backing up.

Bicycle-associated injuries also cause a number of childhood deaths. Children ages 5 to 9 years are at greatest risk of bicycling fatalities. The majority of bicycling deaths are from traumatic head injuries (Centers for Disease Control and Prevention, 2017a). Helmets greatly reduce the risk of head injury, but few children wear helmets. Community-wide bicycle helmet campaigns and mandatory-use laws have resulted in significant increases in helmet use. Still, issues such as stylishness, comfort, and social acceptability remain important factors in noncompliance. Nurses can educate children and families about pedestrian and bicycle safety. In particular, school nurses can promote helmet wearing and encourage peer leaders to act as role models.

Drowning and burns are among the leading causes of deaths for males and females throughout childhood (Fig. 1.3). In addition, improper use of firearms is a major cause of death among males (Fig. 1.4). During early childhood, more boys die of aspiration or suffocation than do girls (Fig. 1.5). Each year, more than 500,000 children ages 5 years and younger experience a potential poisoning related to medications (Ferguson, Osterthaler, Kaminski,

Fig. 1.2 Motor vehicle injuries are the leading cause of death in children older than 1 year of age. The majority of fatalities involve occupants who are unrestrained.

et al., 2015). Currently, more children are brought to emergency departments (EDs) for unintentional medication overdoses. Approximately 95% of medication-related ED visits in children younger than 5 years are due to ingesting medication while unsupervised (Fig. 1.6). Intentional poisoning, associated with drug and alcohol abuse and suicide attempt, is the second leading cause of death in adolescent females and the third leading cause in adolescent males.

Violence

Youth violence is a high-visibility, high-priority concern in every sector of American society (David-Ferdon & Simon, 2014). Strikingly higher homicide rates are found among minority populations, especially African American children. The causes of violence against children and self-inflicted violence are not fully understood. Violence seems to permeate American households through television programs, commercials, video games, and movies, all of which tend to desensitize the child toward violence. Violence also permeates the schools with the availability of guns, illicit drugs, and gangs. The problem of child homicide is extremely complex and involves numerous social, economic, and other influences. Prevention lies in a better understanding of the social and psychologic factors that lead to the high rates of homicide and suicide. Nurses need to be especially aware of young people who harm animals or start fires, are depressed, are repeatedly in trouble with the criminal justice system, or are associated with groups known to be violent. Prevention requires early identification and rapid therapeutic intervention by qualified professionals.

Pediatric nurses can assess children and adolescents for risk factors related to violence. Families that own firearms must be educated about their safe use and storage. The presence of a gun in a household increases the risk of suicide by about fivefold and the risk of homicide by about threefold. Technologic changes such as childproof safety devices and loading indicators could improve the safety of firearms (see Community and Home Health Considerations box).

ADOLESCENT VAPING EPIDEMIC

The use of e-cigarettes has become a national epidemic (Farzal, Perry, Yarbrough, et al., 2019). The rise in vaping (using e-cigarettes), reported in 2018, had increased by 78% in high school

Fig. 1.3 A, Drowning is one of the leading causes of death in children. Children left unattended are unsafe even in shallow water. B, Burns are among the three leading causes of death from injury in children 1 to 14 years old.

COMMUNITY AND HOME HEALTH CONSIDERATIONS

Violence in Children

Community violence has reached epidemic proportions in the United States. The serious problem of community violence affects the lives of many children and expands throughout the family, schools, and the workplace. Nurses working with children, adolescents, and families have a critical role in reducing violence through early identification and symptom recognition of the mental-emotional stress that can result from these experiences.

Violent crimes continue to be a significant health issue for children, with homicide being the second leading cause of death in 15- to 19-year-olds (Annie E. Casey Foundation, 2019). The multifaceted origins of violence include developmental factors, gang involvement, access to firearms, drugs, the media, poverty, and family conflict. Often the silent and underrecognized victims are the children who witness acts of community violence. Studies suggest that chronic exposure to violence has a negative effect on a child's cognitive, social, psychologic, and moral development. Also, multiple exposures to episodes of violence do not inoculate children against the negative effects; continued exposure can result in lasting symptoms of stress.

National concern about the increasing prevalence of violent crimes has prompted nurses to actively participate in ensuring that children grow up in safe environments. Pediatric nurses are positioned to assess children and adolescents for signs of exposure to violence and well-known risk factors; nurses also can provide nonviolent problem-solving strategies, counseling, and referrals. These activities affect community practice and expand the nurse's role in the future health environment. Professional resources include the following:

National Domestic Violence Hotline
PO Box 161810
Austin, TX 78716
800-799-SAFE
https://www.ndvh.org

Child Trends
Child Trends Databank. (2016). *Teen homicide, suicide, and firearm deaths.* Retrieved from http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths

Fig. 1.4 Improper use of firearms is the fourth leading cause of death from injury in children 5 to 14 years old. (©2012 Photos.com, a division of Getty Images. All rights reserved.)

Fig. 1.5 Mechanical suffocation is the leading cause of death from injury in infants.

Fig. 1.6 Poisoning causes a considerable number of injuries in children younger than 4 years old. Medications should never be left where young children can reach them.

students and even more concerning among middle school students by 48%. This is the largest increase in adolescent substance abuse recorded over a 1-year period (Miech, Sculeberg, Johnston, et al., 2018). This rising epidemic is an important area for nurses to take action by becoming involved in grassroots prevention efforts (Farzal, Perry, Yarbrough, et al., 2019).

Mental Health Problems

One in five children experiences mental health problems, and 80% of chronic mental disorders begin in childhood (Child Mind Institute, 2016). There is significant research that highlights the importance of early social-emotional support to foster positive mental health. The National Institute for Children's Health Quality hosts numerous resources on its website that provide insight into promoting optimal health in children (National Institute for Children's Health Quality, 2018).

Many adolescents with anxiety disorders, impulse control disorders, or attention-deficit/hyperactivity disorder (ADHD) develop these during adolescence. Nurses should be alert to the symptoms of mental illness and potential suicidal ideation, and be aware of potential resources for high-quality integrated mental health services.

Infant Mortality

The infant mortality rate is the number of deaths during the first year of life per 1000 live births. It may be further divided into neonatal mortality (<28 days of life) and postneonatal mortality (28 days to 11 months). In the United States the infant mortality rate was 5.8 per 1000 live births, the neonatal mortality rate was 3.84, and the postneonatal mortality rate was 1.95 in 2017 (Centers for Disease Control and Prevention, 2017a).

Birth weight is considered the major determinant of neonatal death in technologically developed countries. The relatively high incidence of LBW (<2500 g [5.5 pounds]) in the United States is considered a key factor in its higher neonatal mortality rate compared with other countries. Access to and the use of high-quality prenatal care are promising preventive strategies to decrease early delivery and infant mortality.

As Table 1.2 demonstrates, many of the leading causes of death during infancy continue to occur during the perinatal period. The first four causes—congenital anomalies, disorders relating to short gestation and unspecified LBW, newborn affected by maternal complications of pregnancy, and sudden infant death syndrome—accounted for about half (49.8%) of all deaths of infants younger than 1 year old (Kochanek, Murphy, Xu, et al., 2019). Many birth defects are associated with LBW, and reducing the incidence of LBW will help prevent congenital anomalies. Infant mortality resulting from human immunodeficiency virus (HIV) infection decreased significantly during the 1990s.

When infant death rates are categorized according to race, a disturbing difference is seen. Infant mortality for whites is considerably lower than for all other races in the United States, with African Americans having twice the rate of whites. The LBW rate is also much higher for African American infants than for any other group. One encouraging note is that the gap in mortality rates between white and nonwhite races (other than African Americans) has narrowed in recent years. Infant mortality rates for Hispanics and Asian–Pacific Islanders have decreased dramatically during the past two decades.

TABLE 1.2 Infant Mortality Rate and Percentage of Total Deaths for 10 Leading Causes of Infant Death in 2017 (Rate per 1000 Live Births)

Rank	Cause of Death (Based on International Classification of Diseases, 10th Revision)	Percent	Rate
	All races, all causes	100.0	579.3
1	Congenital anomalies	20.5	118.8
2	Disorders relating to short gestation and unspecified low birth weight	16.8	97.2
3	Newborn affected by maternal complications of pregnancy	6.4	37.1
4	Sudden infant death syndrome	6.1	35.4
5	Accidents (unintentional injuries)	5.9	34.2
6	Newborn affected by complications of placenta, cord, and membranes	3.8	21.9
7	Bacterial sepsis of newborn	2.7	15.4
8	Diseases of the circulatory system	2.0	11.6
9	Respiratory distress of newborn	2.0	11.4
10	Neonatal hemorrhage	1.7	9.8

Kochanek K.D, Murphy, S.L. Xu, J. et al. (2019). Deaths: Final Data for 2017. *National Vital Statistics Reports,* 68(9), 1–77.

Childhood Mortality

Death rates for children older than 1 year of age have always been lower than those for infants. Children ages 5 to 14 years have the lowest rate of death. However, a sharp rise occurs during later adolescence, primarily from injuries, homicide, and suicide (Table 1.3). In 2014 accidental injuries accounted for 34.4% of all deaths. The second leading cause of death was suicide, accounting for 12.1% of all deaths. The trend in racial differences that occurs in infant mortality is also apparent in childhood deaths for all ages and for both sexes. Whites have fewer deaths for all ages, and male deaths outnumber female deaths.

After 1 year of age, the cause of death changes dramatically, with unintentional injuries (accidents) being the leading cause from the

TABLE 1.3 Five Leading Causes of Death in Children in the United States: Selected Age Intervals, 2014[a]

	1–4 YEARS OF AGE		5–9 YEARS OF AGE		10–14 YEARS OF AGE		15–19 YEARS OF AGE	
Rank	**Cause**	**Rate**	**Cause**	**Rate**	**Cause**	**Rate**	**Cause**	**Rate**
	All causes	24.0	All causes	11.5	All causes	14.0	All causes	45.5
1	Injuries	7.6	Injuries	3.6	Injuries	3.6	Injuries	17.7
2	Congenital anomalies	2.5	Cancer	2.1	Suicide	2.1	Suicide	8.7
3	Homicide	2.3	Congenital anomalies	0.9	Cancer	2.0	Homicide	6.7
4	Cancer	2.0	Homicide	0.6	Congenital anomalies	0.8	Cancer	2.9
5	Heart disease	0.9	Heart disease	0.3	Homicide	0.8	Heart disease	1.4

[a]Rate per 100,000 population.
Modifi ed from Murphy, S. L., Mathews, T. J., Martin, J. A., et al. (2017). Annual summary of vital statistics: 2013-2014V. *Pediatrics, 139*(6), e20163239.

youngest ages to the adolescent years. Violent deaths have been steadily increasing among young people ages 10 through 25 years, especially among African Americans and males. Homicide is the third leading cause of death in the 15- to 19-year age-group (see Table 1.3). Children 12 years of age and older tend to be killed by non–family members (acquaintances and gangs, typically of the same race) and most frequently by firearms. Suicide, a form of self-violence, is the third leading cause of death among children and adolescents 10 to 19 years old.

Childhood Morbidity

Acute illness is defined as an illness with symptoms severe enough to limit activity or require medical attention. Respiratory illness accounts for approximately 50% of all acute conditions, 11% are caused by infections and parasitic disease, and 15% are caused by injuries. The chief illness of childhood is the common cold.

The types of diseases that children contract during childhood vary according to age. For example, upper respiratory tract infections and diarrhea decrease in frequency with age, whereas other disorders, such as acne and headaches, increase. Children who have had a particular type of problem are more likely to have that problem again. Morbidity is not distributed randomly in children. Recent concern has focused on groups of children who have increased morbidity: homeless children, children living in poverty, LBW children, children with chronic illnesses, foreign-born adopted children, and children in daycare centers. A number of factors place these groups at risk for poor health. A major cause is barriers to health care, especially for the homeless, the poverty stricken, and those with chronic health problems. Other factors include improved survival of children with chronic health problems, particularly infants of VLBW.

THE ART OF PEDIATRIC NURSING

Philosophy of Care

Nursing of infants, children, and adolescents involves the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, and populations.

Family-Centered Care

The philosophy of family-centered care recognizes the family as the constant in a child's life. Family-centered care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families (Institute for Patient- and Family-Centered Care, 2018).

BOX 1.4 Key Elements of Family-Centered Care

- Incorporating into policy and practice the recognition that the family is the constant in a child's life, whereas the service systems and support personnel within those systems fluctuate
- Facilitating family-professional collaboration at all levels of hospital, home, and community care:
  - Care of an individual child
  - Program development, implementation, and evaluation
  - Policy formation
- Exchanging complete and unbiased information between family members and professionals in a supportive manner at all times
- Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity
- Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial support to meet the diverse needs of families
- Encouraging and facilitating family-to-family support and networking
- Ensuring that home, hospital, and community service and support systems for children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs
- Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support

From Shelton, T. L., & Stepanek, J. S. (2014). *Family-centered care for children needing specialized health and developmental services.* Bethesda, MD: Association for the Care of Children's Health.

Nurses support families in their natural caregiving and decision-making roles by building on their unique strengths and acknowledging their expertise in caring for their child both within and outside the hospital setting. The nurse considers the needs of all family members in relation to the care of the child (Box 1.4). The philosophy acknowledges diversity among family structures and backgrounds; family goals, dreams, strategies, and actions; and family support, service, and information needs.

Two basic concepts in family-centered care are enabling and empowerment. Professionals enable families by creating opportunities and means for all family members to display their current abilities and competencies and to acquire new ones to meet the needs of the child and

family. *Empowerment* describes the interaction of professionals with families in such a way that families maintain or acquire a sense of control over their family lives and acknowledge positive changes that result from helping behaviors that foster their own strengths, abilities, and actions.

Although caring for the family is strongly emphasized throughout this text, it is highlighted in features such as Cultural Considerations and Family-Centered Care boxes.

Atraumatic Care

Atraumatic care is the provision of therapeutic care in settings, by personnel, and through the use of interventions that eliminate or minimize the psychologic and physical distress experienced by children and their families in the health care system. Therapeutic care encompasses the prevention, diagnosis, treatment, or palliation of acute or chronic conditions. Setting refers to the place in which that care is given—the home, the hospital, or any other health care setting. Personnel include anyone directly involved in providing therapeutic care. Interventions range from psychologic approaches, such as preparing children for procedures, to physical interventions, such as providing space for a parent to room in with a child. Psychologic distress may include anxiety, fear, anger, disappointment, sadness, shame, or guilt. Physical distress may range from sleeplessness and immobilization to disturbances from sensory stimuli, such as pain, temperature extremes, loud noises, bright lights, or darkness. Thus atraumatic care is concerned with the where, who, why, and how of any procedure performed on a child for the purpose of preventing or minimizing psychologic and physical stress (Wong, 1989).

The overriding goal in providing atraumatic care is as follows: First, do no harm. Three principles provide the framework for achieving this goal: (1) prevent or minimize the child's separation from the family, (2) promote a sense of control, and (3) prevent or minimize bodily injury and pain. Examples of providing atraumatic care include fostering the parent-child relationship during hospitalization, preparing the child before any unfamiliar treatment or procedure, controlling pain, allowing the child privacy, providing play activities for expression of fear and aggression, providing choices to children, and respecting cultural differences.

Role of the Pediatric Nurse

The pediatric nurse is responsible for promoting the health and well-being of the child and family. Nursing functions vary according to regional job structures, individual education and experience, and personal career goals. Just as patients (children and their families) have unique backgrounds, each nurse brings an individual set of variables that affect the nurse-patient relationship. No matter where pediatric nurses practice, their primary concern is the welfare of the child and family.

There are many different roles for nurses specializing in the care of children and their families. For example, a pediatric nurse can pursue an advanced degree and become a Pediatric Nurse Practitioner (PNP) or Clinical Nurse Specialist (CNS) in pediatrics. Many advanced pediatric nurses go on to pursue the Doctorate of Nursing Practice (DNP) degree. PNPs work in a variety of settings and are able to diagnose illnesses and prescribe medication. They provide a spectrum of care from children needing routine examinations and wellness care to caring for children with serious or chronic conditions. CNSs function in a variety of settings in both the direct and the indirect roles. They model expert direct family-centered patient care.

Therapeutic Relationship

The establishment of a therapeutic relationship is the essential foundation for providing high-quality nursing care. Pediatric nurses need to have meaningful relationships with children and their families yet remain separate enough to distinguish their own feelings and needs. In a therapeutic relationship, caring, well-defined boundaries separate the nurse from the child and family. These boundaries are positive and professional and promote the family's control over the child's health care. Both the nurse and the family are empowered and maintain open communication. In a nontherapeutic relationship, these boundaries are blurred, and many of the nurse's actions may serve personal needs, such as a need to feel wanted and involved, rather than the family's needs. Exploring whether relationships with patients are therapeutic or nontherapeutic helps nurses identify problem areas early in their interactions with children and families (see Nursing Care Guidelines box).

Family Advocacy and Caring

Although nurses are responsible to themselves, the profession, and the institution of employment, their primary responsibility is to the consumer of nursing services: the child and family. The nurse must work with family members, identify their goals and needs, and plan interventions that best address the defined problems. As an advocate, the nurse assists the child and family in making informed choices and acting in the child's best interest. Advocacy involves ensuring that families

NURSING CARE GUIDELINES

Exploring Your Relationships With Children and Families

To foster therapeutic relationships with children and families, you must first become aware of your caregiving style, including how effectively you take care of yourself. The following questions should help you understand the therapeutic quality of your professional relationships.

Negative Actions

- Are you overinvolved with children and their families?
- Do you work overtime to care for the family?
- Do you spend off-duty time with children's families, either in or out of the hospital?
- Do you call frequently (either the hospital or home) to see how the family is doing?
- Do you show favoritism toward certain patients?
- Do you buy clothes, toys, food, or other items for the child and family?
- Do you compete with other staff members for the affection of certain patients and families?
- Do other staff members comment to you about your closeness to the family?
- Do you attempt to influence families' decisions rather than facilitate their informed decision making?
- Are you underinvolved with children and families?
- Do you restrict parent or visitor access to children, using excuses such as that the unit is too busy?
- Do you focus on the technical aspects of care and lose sight of the person who is the patient?
- Are you overinvolved with children and underinvolved with their parents?
- Do you become critical when parents do not visit their children?
- Do you compete with parents for their children's affection?

Positive Actions

- Do you strive to empower families?
- Do you explore families' strengths and needs in an effort to increase family involvement?

NURSING CARE GUIDELINES—cont'd

Exploring Your Relationships With Children and Families

- Have you developed teaching skills to instruct families rather than doing everything for them?
- Do you work with families to find ways to decrease their dependence on health care providers?
- Can you separate families' needs from your own needs?
- Do you strive to empower yourself?
- Are you aware of your emotional responses to different people and situations?
- Do you seek to understand how your own family experiences influence reactions to patients and families, especially as they affect tendencies toward overinvolvement or underinvolvement?
- Do you have a calming influence, not one that will amplify emotionality?
- Have you developed interpersonal skills in addition to technical skills?
- Have you learned about ethnic and religious family patterns?
- Do you communicate directly with persons with whom you are upset or take issue?
- Are you able to "step back" and withdraw emotionally, if not physically, when emotional overload occurs, yet remain committed?
- Do you take care of yourself and your needs?
- Do you periodically interview family members to determine their current issues (e.g., feelings, attitudes, responses, wishes), communicate these findings to peers, and update records?
- Do you avoid relying on initial interview data, assumptions, or gossip regarding families?
- Do you ask questions if families are not participating in care?
- Do you assess families for feelings of anxiety, fear, intimidation, worry about making a mistake, a perceived lack of competence to care for their child, or fear of health care professionals overstepping their boundaries into family territory, or vice versa?
- Do you explore these issues with family members and provide encouragement and support to enable families to help themselves?
- Do you keep communication channels open among self, family, physicians, and other care providers?
- Do you resolve conflicts and misunderstandings directly with those who are involved?
- Do you clarify information for families or seek the appropriate person to do so?
- Do you recognize that from time to time a therapeutic relationship can change to a social relationship or an intimate friendship?
- Are you able to acknowledge the fact when it occurs and understand why it happened?
- Can you ensure that there is someone else who is more objective who can take your place in the therapeutic relationship?

are aware of all available health services, adequately informed of treatments and procedures, involved in the child's care, and encouraged to change or support existing health care practices.

As nurses care for children and families, they must demonstrate caring, compassion, and empathy for others. Aspects of caring embody the concept of atraumatic care and the development of a therapeutic relationship with patients. Parents perceive caring as a sign of quality in nursing care, which is often focused on the nontechnical needs of the child and family. Parents describe "personable" care as actions by the nurse that include acknowledging the parent's presence, listening, making the parent feel comfortable in the hospital environment, involving the parent and child in the nursing care, showing interest in and concern for their welfare, showing affection and sensitivity to the parent and child, communicating with them, and individualizing the nursing care. Parents perceive personable nursing care as being integral to establishing a positive relationship.

Disease Prevention and Health Promotion

Every nurse involved in caring for children must understand the importance of disease prevention and health promotion. A nursing care plan must include a thorough assessment of all aspects of child growth and development, including nutrition, immunizations, safety, dental care, socialization, discipline, and education. If problems are identified, the nurse intervenes directly or refers the family to other health care providers or agencies.

The best approach to prevention is education and anticipatory guidance. In this text, each chapter on health promotion includes sections on anticipatory guidance. An appreciation of the hazards or conflicts of each developmental period enables the nurse to guide parents regarding childrearing practices aimed at preventing potential problems. One significant example is safety. Because each age-group is at risk for special types of injuries, preventive teaching can significantly reduce injuries, lowering permanent disability and mortality rates.

Prevention also involves less obvious aspects of caring for children. The nurse is responsible for providing care that promotes mental well-being (e.g., enlisting the help of a child life specialist during a painful procedure, such as an immunization).

Health Teaching

Health teaching is inseparable from family advocacy and prevention. Health teaching may be the nurse's direct goal, such as during parenting classes, or may be indirect, such as helping parents and children understand a diagnosis or medical treatment, encouraging children to ask questions about their bodies, referring families to health-related professional or lay groups, supplying patients with appropriate literature, and providing anticipatory guidance. The importance of carefully assessing health literacy in families and culturally sensitive approaches to teaching should be emphasized.

Health teaching is one area in which nurses often need preparation and practice with competent role models, because it involves transmitting information at the child's and family's level of understanding and desire for information. As an effective educator, the nurse focuses on providing the appropriate health teaching with generous feedback and evaluation to promote learning.

Injury Prevention

Each year, injuries kill or disable more children older than 1 year of age than all childhood diseases combined. The nurse plays an important role in preventing injuries by using a developmental approach to safety counseling for parents of children of all ages. Realizing that safety concerns for a young infant are completely different than injury risks of adolescents, the nurse discusses appropriate injury prevention tips to parents and children as part of routine patient care.

Support and Counseling

Attention to emotional needs requires support and sometimes counseling. The role of child advocate or health teacher is supportive by virtue of the individualized approach. The nurse can offer support by

listening, touching, and being physically present. Touching and physical presence are most helpful with children, because they facilitate nonverbal communication. Counseling involves a mutual exchange of ideas and opinions that provides the basis for mutual problem solving. It involves support, teaching, techniques to foster the expression of feelings or thoughts, and approaches to help the family cope with stress. Optimally, counseling not only helps resolve a crisis or problem but also enables the family to attain a higher level of functioning, greater self-esteem, and closer relationships. Although counseling is often the role of nurses in specialized areas, counseling techniques are discussed in various sections of this text to help students and nurses cope with immediate crises and refer families for additional professional assistance.

Coordination and Collaboration

The nurse, as a member of the health care team, collaborates and coordinates nursing care with the care activities of other professionals. A nurse working in isolation rarely serves the child's best interests. The concept of holistic care can be realized through a unified, interdisciplinary approach by being aware of individual contributions and limitations and collaborating with other specialists to provide high-quality health services. Failure to recognize limitations can be nontherapeutic at best and destructive at worst. For example, the nurse who feels competent in counseling but who is really inadequate in this area may not only prevent the child from dealing with a crisis but also impede future success with a qualified professional. Nursing should be seen as a major contributor to ensuring that the health care team focuses on high-quality, safe care.

Ethical Decision Making

Ethical dilemmas arise when competing moral considerations underlie various alternatives. Parents, nurses, physicians, and other health care team members may reach different but morally defensible decisions by assigning different weights to competing moral values. These competing moral values may include autonomy, the patient's right to be self-governing; nonmaleficence, the obligation to minimize or prevent harm; beneficence, the obligation to promote the patient's well-being; and justice, the concept of fairness. Nurses must determine the most beneficial or least harmful action within the framework of societal mores, professional practice standards, the law, institutional rules, the family's value system and religious traditions, and the nurse's personal values.

Nurses must prepare themselves systematically for collaborative ethical decision making. They can accomplish this through formal course work, continuing education, and contemporary literature, and work to establish an environment conducive to ethical discourse.

The nurse also uses the professional code of ethics for guidance and as a means for professional self-regulation. Nurses may face ethical issues regarding patient care, such as the use of life-saving measures for VLBW newborns or the terminally ill child's right to refuse treatment. They may struggle with questions regarding truthfulness, balancing their rights and responsibilities in caring for children with acquired immune deficiency syndrome (AIDS), whistle blowing, or allocating resources. Ethical arguments are presented to help nurses clarify their value judgments when confronted with sensitive issues.

Research and Evidence-Based Practice

Nurses should contribute to research because they are the individuals observing human responses to health and illness. The current emphasis on measurable outcomes to determine the efficacy of interventions (often in relation to the cost) demands that nurses know whether clinical interventions result in positive outcomes for their patients. This demand has influenced the current trend toward evidence-based practice (EBP), which implies questioning why something is effective and whether a better approach exists. The concept of EBP also involves analyzing and translating published clinical research into the everyday practice of nursing. When nurses base their clinical practice on science and research and document their clinical outcomes, they will be able to validate their contributions to health, wellness, and cure, not only to their patients, third-party payers, and institutions but also to the nursing profession. Evaluation is essential to the nursing process, and research is one of the best ways to accomplish this.

EBP is the collection, interpretation, and integration of valid, important, and applicable patient-reported, nurse-observed, and research-derived information. Using the population/patient problem, intervention, comparison, outcome, and time (PICOT) question to clearly define the problem of interest, nurses are able to obtain the best evidence to improve care. Evidence-based nursing practice combines knowledge with clinical experience and intuition. It provides a rational approach to decision making that facilitates best practice (Melnyk & Fineout-Overholt, 2014). EBP is an important tool that complements the nursing process by using critical thinking skills to make decisions based on existing knowledge. The traditional nursing process approach to patient care can be used to conceptualize the essential components of EBP in nursing. During the assessment and diagnostic phases of the nursing process, the nurse establishes important clinical questions and completes a critical review of existing knowledge. EBP also begins with identification of the problem. The nurse asks clinical questions in a concise, organized way that allows for clear answers. Once the specific questions are identified, extensive searching for the best information to answer the question begins. The nurse evaluates clinically relevant research, analyzes findings from the history and physical examination, and reviews the specific pathophysiology of the defined problem. The third step in the nursing process is to develop a care plan. In evidence-based nursing practice, the care plan is established on completion of a critical appraisal of what is known and not known about the defined problem. Next, in the traditional nursing process, the nurse implements the care plan. By integrating evidence with clinical expertise, the nurse focuses care on the patient's unique needs. The final step in EBP is consistent with the final phase of the nursing process—to evaluate the effectiveness of the care plan.

Searching for evidence in this modern era of technology can be overwhelming. For nurses to implement EBP, they must have access to appropriate, recent resources such as online search engines and journals. In many institutions, computer terminals are available on patient care units, with the Internet and online journals easily accessible. Another important resource for the implementation of EBP is time. The nursing shortage and ongoing changes in many institutions have compounded the issue of nursing time allocation for patient care, education, and training. In some institutions, nurses are given paid time away from performing patient care to participate in activities that promote EBP. This requires an organizational environment that values EBP and its potential impact on patient care. As knowledge is generated regarding the significant impact of EBP on patient care outcomes, it is hoped that the organizational culture will change to support the staff nurse's participation in EBP. As the amount of available evidence increases, so does our need to critically evaluate the evidence.

Throughout this book, Translating Evidence into Practice boxes summarize the existing evidence that promotes excellence in clinical care. The GRADE (Grading of Recommendations Assessment, Development and Evaluation) criteria are used to evaluate the quality of research articles used to develop practice guidelines (Guyatt, Oxman, Akl, et al., 2011). Table 1.4 defines how the nurse rates the quality of the evidence using the GRADE criteria and establishes a

TABLE 1.4 The GRADE Criteria to Evaluate the Quality of the Evidence

Quality	Type of Evidence
High	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies
Moderate	Evidence from RCTs with important limitations (inconsistent results, flaws in methodology, indirect evidence, or imprecise results) or unusually strong evidence from unbiased observational studies
Low	Evidence for at least one critical outcome from observational studies, from RCTs with serious flaws, or from indirect evidence
Very low	Evidence for at least one of the critical outcomes from unsystematic clinical observations or very indirect evidence

Quality	Recommendation
Strong	Desirable effects clearly outweigh undesirable effects, or vice versa
Weak	Desirable effects closely balanced with undesirable effects

RCT, Randomized clinical trial.
Adapted from Guyatt, G. H., Oxman, A. D., Akl, E. A., et al. (2011). GRADE guidelines: 1. Introduction—GRADE evidence profiles and summary of findings tables. *Journal of Clinical Epidemiology, 64*(4), 383–394.

strong versus weak recommendation. Each Translating Evidence into Practice box rates the quality of existing evidence and the strength of the recommendation for practice change.

CLINICAL JUDGMENT AND REASONING WHEN PROVIDING NURSING CARE TO CHILDREN AND FAMILIES

Clinical Judgment and Reasoning

A systematic thought process is essential to a profession. It assists the professional in meeting the patient's needs.

The National Council of State Boards of Nursing (NCSBN) definition of clinical judgment is "the observed outcome of critical thinking and decision-making. It is an iterative process that uses nursing knowledge to observe and assess presenting situations, identify a prioritized client concern, and generate the best possible evidence-based solutions in order to deliver safe client care" (NCSBN, 2018a, p. 12). This definition builds on and expands the nursing process, and indicates that clinical judgment skills are not linear steps that are followed in a particular sequence.

Clinical reasoning is a complex developmental process based on rational and deliberate thought. Clinical reasoning provides a common denominator for knowledge that exemplifies disciplined and self-directed thinking. The knowledge is acquired, assessed, and organized by thinking through the clinical situation and developing an outcome focused on optimum patient care. Clinical reasoning transforms the way in which individuals view themselves, understand the world, and make decisions.

The NCSBN developed a Clinical Judgment Measurement and Action Model. Six cognitive (thinking) skills, called cognitive processes, were identified as essential for nurses to make appropriate clinical judgment. Clinical judgment skills are compared to the nursing process in Table 1.5. Judgment skills help nurses identify changes in a client's clinical condition, and know what actions to take and why. The six essential cognitive skills of clinical judgment are described below (NCSBN, 2019).

TABLE 1.5 Comparison of Nursing Process Steps with Clinical Judgment Cognitive Skills

Steps of the Nursing Process	Cognitive Skills for Clinical Judgment
Assessment	Recognize Cues
Analysis	Analyze Cues
Analysis	Prioritize Hypotheses
Planning	Generate Solutions
Implementation	Take Action
Evaluation	Evaluate Outcomes

Six Essential Cognitive Skills of Clinical Judgment

- Recognize Cues
  Cues are elements of assessment data that provide important information for the nurse as a basis for making client decisions. In a clinical situation, the nurse determines which data are relevant (directly related to client outcomes or the priority of care) and of immediate concern to the nurse, or irrelevant (unrelated to client outcomes or priority of care).
- Analyze Cues
  When using this skill, the nurse considers the context of the client's history and situation, and interprets how the identified relevant cues relate to the client's condition. Data that support or contradict a particular cue in the client situation are determined, and potential complications are identified.
- Prioritize Hypotheses
  For this skill, the nurse needs to examine all possibilities about what is occurring in the client situation. The urgency and risk for the client is considered for each possible health condition. The nurse determines which client conditions are the most likely and most serious, and why.
- Generate Solutions
  To generate solutions, the nurse first identifies expected client outcomes. Using the prioritized hypotheses, the nurse then plans specific actions that may achieve the desirable outcomes. Actual or potential evidence-based actions that should be avoided or are contraindicated are also considered because some actions could be harmful for the client in the given situation.
- Take Action
  Using this skill, the nurse decides which nursing actions will address the highest priorities of care and determines in what priority these actions will be implemented. Actions can include, but are not limited to, additional assessment, health teaching, documentation, requested primary healthcare provider orders, performance of nursing skills, and consultation with health care team members.
- Evaluate Outcomes
  After implementing the best evidence-based nursing action, the nurse evaluates the actual client outcomes in the situation and compares them to expected outcomes. The nurse then decides if the selected nursing actions were effective, ineffective, or made no difference in how the client is progressing.

TABLE 1.6 Examples of Core Pediatric Clinical Care Quality Measures[a]

Clinical Care Quality Measure	How the Quality Measure Is Evaluated
Childhood immunization status	Percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three *Haemophilus influenzae* type B (HiB); three hepatitis B (Hep B); one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
Pediatric central line–associated bloodstream infections (CLABSI-CH)	A laboratory confirmed bloodstream infection (LCBI) found in pediatric patients with a central line that is not secondary to an infection at another body site found during hospitalization.
ADHD: follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication	Percentage of children 6-12 years of age and newly dispensed a medication for ADHD who had appropriate follow-up care. Two rates are reported.
Appropriate testing for children with pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic, and received a group A streptococcus (strep) test for the episode.

[a]Endorsed by the Centers for Medicaid and Medicare Services. (2019). *Children's health care quality measures*. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf

In recognition of the importance of clinical judgment, case studies throughout the book present the importance of clinical judgment of nursing care. Nursing Care Plans are revised to integrate clinical judgment into nursing decisions. Clinical judgment allows the nurse to gather information and evaluate the relevance of the evidence to the specific clinical problem and patient. This promotes the application of knowledge to real clinical situations (Victor-Chmil, 2013).

The documentation of nursing care is an essential nursing responsibility and essential documentation components are summarized in the Nursing Care Guidelines box.

Quality Outcome Measures

Quality of care refers to the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Institute of Medicine, 2000). The progress report to Congress on the National Strategy for Quality Improvement in Health Care focuses on six national quality priorities for health care quality improvement (National Strategy for Quality Improvement in Health Care, 2015)[b]:

NURSING CARE GUIDELINES

Documentation of Nursing Care

- Initial assessments and reassessments
- Nursing problem and/or patient care needs
- Interventions identified to meet the patient's nursing care needs
- Nursing care provided
- Patient's response to and the outcomes of the care provided
- Abilities of patient and/or, as appropriate, significant other(s) to manage continuing care needs after discharge

1. Making care safer by reducing harm caused in the delivery of care.
2. Ensuring that each person and family is engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

The Centers for Medicare and Medicaid Services (2019) proposed a core of pediatric clinical care quality measures that align with these high-priority health care improvement goals. These indicators are endorsed by the National Quality Forum and designed to guide the effectiveness of pediatric health care programs. Table 1.6 presents examples of quality indicators from the core set of the Centers for Medicare and Medicaid Services measures. Throughout the chapters, examples of quality indicators endorsed by the Centers for Medicare and Medicaid Services and the National Quality Forum are presented and include a description of how the indicators will be measured. In each of these boxes the measurement name is provided along with the numerator and denominator for the measure to reflect how the indicator is defined. States across the country now use these indicators, usually over 1 year, to determine their success in meeting the quality measures. We also have developed examples of specific patient-centered quality outcome measures for certain diseases throughout the book. These quality outcome measures promote interdisciplinary teamwork, and the boxes throughout this book exemplify measures of effective collaboration to improve care. Pediatric Quality Indicators and Quality Patient Outcomes boxes throughout this book assist nurses in identifying appropriate measures that evaluate the quality of patient care.

Children's Hospitals' Solutions for Patient Safety is an excellent resource for intervention prevention bundles specific to pediatric care. Its website[c] has materials related to national initiatives that are implemented across more than 130 children's hospitals throughout the country. These activities are dedicated to creating safe and healing environments for all children and their families.

The Quality and Safety Education for Nurses Institute has defined quality and safety competencies for nursing. The Quality and Safety Education for Nurses Institute is now being hosted by faculty at the Case Western Reserve University and provides a comprehensive overview for the development of knowledge, skills, and attitudes related to quality and safety in health care.[d] In this book, each Translating Evidence into Practice box includes the Quality and Safety Education for Nurses Institute competencies related to knowledge, skills, and attitudes for evidence-based nursing practice.

[b]National Quality Strategy information can be found at http://www.ahrq.gov/workingforquality/about.htm#priorities.

[c]Children's Hospitals' Solutions for Patient Safety: https://www.solutionsforpatientsafety.org/

[d]Quality and Safety Education for Nurses Institute, Frances Payne Bolton School of Nursing, Case Western Reserve University: qsen.org

CLINICAL JUDGMENT AND NEXT-GENERATION NCLEX® EXAMINATION-STYLE QUESTIONS

1. Because injuries are the most common cause of death and disability in children in the United States, the stage of development can determine the type of injury that is most likely to occur. A nurse caring for a 2 ½ year old would focus on which of the following areas when discussing safety concerns for the home? **Select all that apply.**
   - **A.** A newborn may roll over and fall off an elevated surface.
   - **B.** The need to conform and gain acceptance from his peers may make a school-age child accept a dare.
   - **C.** Toddlers who can run and climb may be susceptible to burns, falls, and collisions with objects.
   - **D.** A toddler may ride her two-wheel bike in a reckless manner.
   - **E.** A crawling infant may aspirate due to the tendency to place objects on the floor in his mouth.

2. The newest nurse on the pediatric unit is concerned about promoting family-centered care for the patients she cares for. She is working on an inpatient cancer unit and caring for a 7 year old with leukemia. Which of the following are important actions for the nurse to consider that will promote family-centered care for this child and family on her unit? **Select all that apply.**
   - **A.** Striving to empower the family
   - **B.** Purchase toys and clothes for the child
   - **C.** Explore the family's strengths that will support the child
   - **D.** Call the child frequently after discharge to offer support
   - **E.** Assess the family's concerns and anxiety
   - **F.** Restrict visitor access to the child
   - **G.** Have a calming influence

3. The Clinical Judgment Measurement Model (CJMM) presents complex situations to promote nurse decision-making. **Match the Nursing Process skill in Column1 with the cognitive process/skill below found in the CJMM. Answers can be used more than once.**

CJMM Skill	Nursing Process	Match the Nursing Process Skill With CJMM Skill
1. Recognize Cues	Analysis	
2. Analyze Cues	Planning	
3. Prioritize Hypotheses	Implementation	
4. Generate Solutions	Evaluation	
5. Take Action	Assessment	
6. Evaluate Outcomes		

4. A family you are caring for on the pediatric unit asks you about nutrition for their 6-month old baby. What facts will you want to include in this nutritional information at this point in time?
   Use an X for the nursing actions listed below that are Indicated (appropriate or necessary), Contraindicated (could be harmful), or Non-Essential (makes no difference or not necessary) for the child's care at this time.

Nursing Action	Indicated	Contraindicated	Non-Essential
Eating preferences and attitudes related to food are established by family influences and culture.			
Breastfeeding provides micronutrients and immunologic properties.			
Most children establish lifelong eating habits by 18 months old.			
Because of the stress of returning to work, most mothers use this as a time to stop breastfeeding.			
During adolescence, parental influence diminishes, and adolescents make food choices related to peer acceptability and sociability.			
Chronic illness can cause a young child to not want to eat.			

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Social, Cultural, Religious, and Family Influences on Child Health Promotion*

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http://evolve.elsevier.com/wong/essentials

CONCEPTS

- Family Dynamics
- Culture

GENERAL CONCEPTS

DEFINITION OF FAMILY

The term **family** has been defined in many ways according to the individual's own frame of reference, values, or discipline. There is no universal definition of family; a family is what an individual considers it to be. Biology describes the family as fulfilling the biologic function of perpetuation of the species. Psychology emphasizes the interpersonal aspects of the family and its responsibility for personality development. Economics views the family as a productive unit that provides for material needs. Sociology depicts the family as a social unit that interacts with the larger society, creating the context within which cultural values and identity are formed. Others define family in terms of the relationships of the persons who make up the family unit. The most common types of relationships are **consanguineous** (blood relationships), **affinal** (marital relationships), and **family of origin** (family unit a person is born into).

Considerable controversy has surrounded the newer concepts of family, such as communal families, single-parent families, and homosexual families. To accommodate these and other varieties of family styles, the descriptive term *household* is frequently used.

! NURSING ALERT

The nurse's knowledge and the sensitivity with which he or she assesses a household will determine the types of interventions that are appropriate to support family members.

Nursing care of infants and children is intimately involved with care of the child and the family. Family structure and dynamics can have an enduring influence on a child, affecting the child's health and well-being (American Academy of Pediatrics, 2003). Consequently, nurses must be aware of the functions of the family, various types of family structures, and theories that provide a foundation for understanding the changes within a family and for directing family-oriented interventions.

*This chapter was originally updated by Quinn Franklin and Kim Mooney-Doyle.

FAMILY THEORIES

A **family theory** can be used to describe families and how the family unit responds to events both within and outside the family. Each family theory makes assumptions about the family and has inherent strengths and limitations (Kaakinen & Coehlo, 2015). Most nurses use a combination of theories in their work with children and families. Commonly used theories are family systems theory, family stress theory, and developmental theory (Table 2.1).

Family Systems Theory

Family systems theory is derived from general systems theory, a science of "wholeness" that is characterized by interaction among the components of the system and between the system and the environment (Bomar, 2004; Papero, 1990). **General systems theory** expanded scientific thought from a simplistic view of direct cause and effect (*A* causes *B*) to a more complex and interrelated theory (*A* influences *B*, but *B* also affects *A*). In family systems theory, the family is viewed as a system that continually interacts with its members and the environment. The emphasis is on the interaction between the members; a change in one family member creates a change in other members, which in turn results in a new change in the original member. Consequently, a problem or dysfunction does not lie in any one member but rather in the type of interactions used by the family. Because the interactions, not the individual members, are viewed as the source of the problem, the family becomes the patient and the focus of care. Examples of the application of family systems theory to clinical problems are nonorganic failure to thrive and child abuse. According to family systems theory, the problem does not rest solely with the parent or child but with the type of interactions between the parent and the child and the factors that affect their relationship.

The family is viewed as a whole that is different from the sum of the individual members. For example, a household of parents and one child consists of not only three individuals but also four interactive units. These units include three dyads (the marital relationship, the mother-child relationship, and the father-child relationship) and a triangle (the mother-father-child relationship). In this ecologic model, the family system functions within a larger system, with the family dyads in the center of a circle surrounded by the extended family, the subculture, and the culture, with the larger society at the periphery.

TABLE 2.1 Summary of Family Theories and Application

Assumptions	Strengths	Limitations	Applications
Family Systems Theory			
A change in any one part of a family system affects all other parts of the family system (circular causality). Family systems are characterized by periods of rapid growth and change and periods of relative stability. Both too little change and too much change are dysfunctional for the family system; therefore a balance between morphogenesis (change) and morphostasis (no change) is necessary. Family systems can initiate change as well as react to it.	Applicable for family in normal everyday life as well as for family dysfunction and pathology. Useful for families of varying structure and various stages of life cycle.	More difficult to determine cause-and-effect relationships because of circular causality.	Mate selection, courtship processes, family communication, boundary maintenance, power and control within family, parent-child relationships, adolescent pregnancy and parenthood.
Family Stress Theory			
Stress is an inevitable part of family life, and any event, even if positive, can be stressful for family. Family encounters both normative expected stressors and unexpected situational stressors over the life cycle. Stress has a cumulative effect on family. Families cope with and respond to stressors with a wide range of responses and effectiveness.	Potential to explain and predict family behavior in response to stressors and to develop effective interventions to promote family adaptation. Focuses on positive contribution of resources, coping, and social support to adaptive outcomes. Can be used by many disciplines in health care field.	Relationships between all variables in framework not yet adequately described. Not yet known if certain combinations of resources and coping strategies are applicable to all stressful events.	Transition to parenthood and other normative transitions, single-parent families, families experiencing work-related stressors (dual-earner family, unemployment), acute or chronic childhood illness or disability, infertility, death of a child, divorce, adolescent pregnancy and parenthood.
Developmental Theory			
Families develop and change over time in similar and consistent ways. Family and its members must perform certain time-specific tasks set by themselves and by persons in the broader society. Family role performance at one stage of family life cycle influences family's behavioral options at next stage. Family tends to be in stage of disequilibrium when entering a new life cycle stage and strives toward homeostasis within stages.	Provides a dynamic, rather than static, view of family. Addresses both changes within family and changes in family as a social system over its life history. Anticipates potential stressors that normally accompany transitions to various stages and when problems may peak because of lack of resources.	Traditional model more easily applied to two-parent families with children. Use of age of oldest child and marital duration as marker of stage transition sometimes problematic (e.g., in stepfamilies, single-parent families).	Anticipatory guidance, educational strategies, and developing or strengthening family resources for management of transition to parenthood; family adjustment to children entering school, becoming adolescents, leaving home; management of "empty nest" years and retirement.

Bowen's family systems theory (Kaakinen & Coehlo, 2015; Papero, 1990) emphasizes that the key to healthy family function is the members' ability to distinguish themselves from one another both emotionally and intellectually. The family unit has a high level of **adaptability**. When problems arise within the family, change occurs by altering the interaction or feedback messages that perpetuate disruptive behavior. **Feedback** refers to processes in the family that help identify strengths and needs and determine how well goals are accomplished. Positive feedback initiates change; negative feedback resists change (Goldenberg & Goldenberg, 2012). When the family system is disrupted, change can occur at any point in the system.

A major factor that influences a family's adaptability is its **boundary**, an imaginary line that exists between the family and its environment (Kaakinen & Coehlo, 2015). Families have varying degrees of openness and closure in these boundaries. For example, one family has the capacity to reach out for help, whereas another considers help threatening. Knowledge of boundaries is critical when teaching or counseling families. Families with open boundaries may demonstrate a greater receptivity to interventions, whereas families with closed boundaries often require increased sensitivity and skill on the part of the nurse to gain their trust and acceptance. The nurse who uses family systems theory should assess the family's ability to accept new ideas, information, resources, and opportunities, and to plan strategies.

Family Stress Theory

Family stress theory explains how families react to stressful events and suggests factors that promote adaptation to stress (Kaakinen & Coehlo, 2015). Families encounter **stressors** (events that cause stress and have the potential to effect a change in the family social system), including those that are predictable (e.g., parenthood) and those that are unpredictable (e.g., illness, unemployment). These stressors are cumulative, involving simultaneous demands from work, family, and community life. Too many stressful events occurring within a relatively short period (usually 1 year) can overwhelm the family's ability

BOX 2.1 Duvall's Developmental Stages of the Family

Stage I—Marriage and an Independent Home: The Joining of Families
Reestablish couple identity.
Realign relationships with extended family.
Make decisions regarding parenthood.

Stage II—Families With Infants
Integrate infants into the family unit.
Accommodate to new parenting and grandparenting roles.
Maintain marital bond.

Stage III—Families With Preschoolers
Socialize children.
Parents and children adjust to separation.

Stage IV—Families With Schoolchildren
Children develop peer relations.
Parents adjust to their children's peer and school influences.

Stage V—Families With Teenagers
Adolescents develop increasing autonomy.
Parents refocus on midlife marital and career issues.
Parents begin a shift toward concern for the older generation.

Stage VI—Families as Launching Centers
Parents and young adults establish independent identities.
Parents renegotiate marital relationship.

Stage VII—Middle-Aged Families
Reinvest in couple identity with concurrent development of independent interests.
Realign relationships to include in-laws and grandchildren.
Deal with disabilities and death of older generation.

Stage VIII—Aging Families
Shift from work role to leisure and semiretirement or full retirement.
Maintain couple and individual functioning while adapting to the aging process.
Prepare for own death and dealing with the loss of spouse and/or siblings and other peers.

Modified from Wright, L. M., & Leahey, M (1984). *Nurses and families: A guide to family assessment and intervention.* Philadelphia, PA: Davis.

BOX 2.2 Family Nursing Intervention

- Behavior modification
- Case management and coordination
- Collaborative strategies
- Contracting
- Counseling, including support, cognitive reappraisal, and reframing
- Empowering families through active participation
- Environmental modification
- Family advocacy
- Family crisis intervention
- Networking, including use of self-help groups and social support
- Providing information and technical expertise
- Role modeling
- Role supplementation
- Teaching strategies, including stress management, lifestyle modifications, and anticipatory guidance

From Friedman, M. M., Bowden, V. R., & Jones, E. G. (2003). *Family nursing: Research theory and practice* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

to cope and place it at risk for breakdown or physical and emotional health problems among its members. When the family experiences too many stressors for it to cope adequately, a state of crisis ensues. For adaptation to occur, a change in family structure or interaction is necessary.

The **resiliency model of family stress, adjustment, and adaptation** emphasizes that the stressful situation is not necessarily pathologic or detrimental to the family but demonstrates that the family needs to make fundamental structural or systemic changes to adapt to the situation (McCubbin & McCubbin, 1994).

Developmental Theory

Developmental theory is an outgrowth of several theories of development. Duvall (1977) described eight developmental tasks of the family throughout its life span (Box 2.1). The family is described as a small group, a semiclosed system of personalities that interacts with the larger cultural social system. As an interrelated system, the family does not have changes in one part without a series of changes in other parts.

Developmental theory addresses family change over time, using Duvall's family life cycle stages. This theory is based on the predictable changes in the family's structure, function, and roles, with the age of the oldest child as the marker for stage transition. The arrival of the first child marks the transition from stage I to stage II. As the first child grows and develops, the family enters subsequent stages. In every stage the family faces certain developmental tasks. At the same time, each family member must achieve individual developmental tasks as part of each family life cycle stage.

Developmental theory can be applied to nursing practice. For example, the nurse can assess how well new parents are accomplishing the individual and family developmental tasks associated with transition to parenthood. New applications should emerge as more is learned about developmental stages for nonnuclear and nontraditional families.

FAMILY NURSING INTERVENTIONS

In working with children, the nurse must include family members in their care plan. Research confirms parents' desire and expectation to participate in their child's care (Power & Franck, 2008). To discover family dynamics, strengths, and weaknesses, a thorough family assessment is necessary (see Chapter 4). The nurse's choice of interventions depends on the theoretic family model that is used (Box 2.2). For example, in family systems theory, the focus is on the interaction of family members within the larger environment (Goldenberg & Goldenberg, 2012). In this case using group dynamics to involve all members in the intervention process and being a skillful communicator are essential. Systems theory also presents excellent opportunities for anticipatory guidance. Because each family member reacts to every stress experienced by that system, nurses can intervene to help the family prepare for and cope with changes. In family stress theory the nurse uses crisis intervention strategies to help family members cope with the challenging event. In developmental theory the nurse provides anticipatory guidance to prepare members for transition to the next family stage. Nurses who think family involvement plays a key role in the care of a child are more likely to include families in the child's daily care (Fisher, Lindhorst, Matthews, et al., 2008).

FAMILY STRUCTURE AND FUNCTION

FAMILY STRUCTURE

The **family structure**, or **family composition**, consists of individuals, each with a socially recognized status and position, who interact with one another on a regular, recurring basis in socially sanctioned ways (Kaakinen & Coehlo, 2015). When members are gained or lost through events such as marriage, divorce, birth, death, abandonment, or incarceration, the family composition is altered and roles must be redefined or redistributed.

Traditionally, the family structure was either a nuclear or an extended family. In recent years family composition has assumed new configurations, with the single-parent family and blended family becoming prominent forms. The predominant structural pattern in any society depends on the mobility of families as they pursue economic goals and as relationships change. It is not uncommon for children to belong to several different family groups during their lifetime.

Nurses must be able to meet the needs of children from many diverse family structures and home situations. A family's structure affects the direction of nursing care. The US Census Bureau uses four definitions for families: (1) the traditional nuclear family, (2) the nuclear family, (3) the blended family or household, and (4) the extended family or household. In addition, numerous other types of families have been defined, such as single-parent; binuclear; polygamous; communal; and lesbian, gay, bisexual, and transgender (LGBT) families.

Traditional Nuclear Family

A **traditional nuclear family** consists of a married couple and their biologic children. Children in this type of family live with both biologic parents and, if siblings are present, only full brothers and sisters (i.e., siblings who share the same two biologic parents). No other persons are present in the household (i.e., no steprelatives, foster or adopted children, half-siblings, other relatives, or nonrelatives).

Nuclear Family

The **nuclear family** is composed of two parents and their children. The parent-child relationship may be biologic, step, adoptive, or foster. Sibling ties may be biologic, step, half, or adoptive. The parents are not necessarily married. No other relatives or nonrelatives are present in the household.

Blended Family

A **blended family** or household, also called a **reconstituted family**, includes at least one stepparent, stepsibling, or half-sibling. A stepparent is the spouse of a child's biologic parent but is not the child's biologic parent. Stepsiblings do not share a common biologic parent; the biologic parent of one child is the stepparent of the other. Half-siblings share only one biologic parent.

Extended Family

An **extended family** or household includes at least one parent, one or more children, and one or more members (related or unrelated) other than a parent or sibling. Parent-child and sibling relationships may be biologic, step, adoptive, or foster.

In many nations and among many ethnic and cultural groups, households with extended families are common. Within the extended family, grandparents often find themselves rearing their grandchildren (Fig. 2.1). Young parents are often considered too young or too inexperienced to make decisions independently. Often the older relative holds the authority and makes decisions in consultation with the young parents. Sharing residence with relatives also assists with the management of scarce resources and provides child care for working families.

Fig. 2.1 Children benefit from interaction with grandparents, who sometimes assume the parenting role.

Single-Parent Family

In the United States an estimated 24.4 million or 35% of children live in **single-parent families** (Annie E. Casey Foundation, 2018). The contemporary single-parent family has emerged partially as a consequence of the women's rights movement and also as a result of more women (and men) establishing separate households because of divorce, death, desertion, or single parenthood. In addition, a more liberal attitude in the courts has made it possible for single people, both male and female, to adopt children. Although mothers usually head single-parent families, it is becoming more common for fathers to be awarded custody of dependent children in divorce settlements. With women's increased psychologic and financial independence and the increased acceptability of single parents in society, more unmarried women are deliberately choosing mother-child families. Frequently, these mothers and children are absorbed into the extended family. The challenges of single-parent families are discussed later in the chapter.

Binuclear Family

The term **binuclear family** refers to parents continuing the parenting role while terminating the spousal unit. The degree of cooperation between households and the time the child spends with each can vary. In **joint custody** the court assigns divorcing parents equal rights and responsibilities concerning the minor child or children. These alternate family forms are efforts to view divorce as a process of reorganization and redefinition of a family rather than as a family dissolution. Joint custody and coparenting are discussed further later in the chapter.

Polygamous Family

Although it is not legally sanctioned in the United States, the conjugal unit is sometimes extended by the addition of spouses in polygamous matings. **Polygamy** refers to either multiple wives (**polygyny**) or, rarely, multiple husbands (**polyandry**). Many societies practice polygyny that is further designated as **sororal**, in which the wives are sisters, or **nonsororal**, in which the wives are unrelated. Sororal polygyny is widespread throughout the world. Most often, mothers and their children share a husband and father, with each mother and her children living in the same or separate household.

Communal Family

The **communal family** emerged from disenchantment with most contemporary life choices. Although communal families may have divergent beliefs, practices, and organization, the basic impetus for formation is often dissatisfaction with the nuclear family structure, social systems, and goals of the larger community. Relatively uncommon today, communal groups share common ownership of property. In cooperatives, property ownership is private, but certain goods and services are shared and exchanged without monetary consideration. There is strong reliance on group members and material interdependence. Both provide collective security for nonproductive members, share homemaking and childrearing functions, and help overcome the problem of interpersonal isolation or loneliness.

Lesbian, Gay, Bisexual, and Transgender Families

A **same-sex**, **homosexual**, or **lesbian/gay/bisexual/transgender (LGBT) family** is one in which there is a legal or common-law tie between two persons of the same sex who have children. There are a growing number of families with same-sex parents in the United States, with an estimated 16.4% of all same-sex couples raising children (US Census Bureau, 2017). Although some children in LGBT households are biologic from a former marriage relationship, children may be present in other circumstances. They may be foster or adoptive parents, lesbian mothers may conceive through artificial fertilization, or a gay male couple may become parents through use of a surrogate mother.

When children are brought up in LGBT families, the relationships seem as natural to them as heterosexual parents do to their offspring. In other cases, however, disclosure of parental homosexuality ("coming out") to children can be a concern for families. There are a number of factors to consider before disclosing this information to children. Parents should be comfortable with their own sexual orientation and should discuss this with the children as they become old enough to understand relationships. Discussions should be planned and take place in a quiet setting where interruptions are unlikely.

Nurses need to be nonjudgmental and to learn to accept differences rather than demonstrate prejudice that can have a detrimental effect on the nurse-child-family relationship. Moreover, the more nurses know about the child's family and lifestyle, the more they can help the parents and the child.

FAMILY STRENGTHS AND FUNCTIONING STYLE

Family function refers to the interactions of family members, especially the quality of those relationships and interactions (Bomar, 2004). Researchers are interested in family characteristics that help families to function effectively. Knowledge of these factors guides the nurse throughout the nursing process and helps the nurse to predict ways that families may cope and respond to a stressful event, to provide individualized support that builds on family strengths and unique functioning style, and to assist family members in obtaining resources.

Family strengths and unique functioning styles (Box 2.3) are significant resources that nurses can use to meet family needs. Building on qualities that make a family work well and strengthening family resources make the family unit even stronger. All families have strengths as well as vulnerabilities.

FAMILY ROLES AND RELATIONSHIPS

Each individual has a position, or status, in the family structure and plays culturally and socially defined roles in interactions within the family. Each family also has its own traditions and values and sets its own standards for interaction within and outside the group. Each determines the experiences the children should have, those they are to be shielded from, and how each of these experiences meets the needs of family members. When family ties are strong, social control is highly effective, and most members conform to their roles willingly and with commitment. Conflicts arise when people do not fulfill their roles in ways that meet other family members' expectations, either because they are unaware of the expectations or because they choose not to meet them.

BOX 2.3 Qualities of Strong Families

- A belief and sense of **commitment** toward promoting the well-being and growth of individual family members, as well as the family unit
- **Appreciation** for the small and large things that individual family members do well and **encouragement** to do better
- Concentrated effort to spend **time** and do things together, no matter how formal or informal the activity or event
- A sense of **purpose** that permeates the reasons and basis for "going on" in both bad and good times
- A sense of **congruence** among family members regarding the value and importance of assigning time and energy to meet needs
- The ability to **communicate** with one another in a way that emphasizes positive interactions
- A clear set of **family rules, values,** and **beliefs** that establishes expectations about acceptable and desired behavior
- A varied repertoire of **coping strategies** that promote positive functioning in dealing with both normative and nonnormative life events
- The ability to engage in **problem-solving** activities designed to evaluate options for meeting needs and procuring resources
- The ability to be **positive** and see the positive in almost all aspects of their lives, including the ability to see crisis and problems as an opportunity to learn and grow
- **Flexibility** and **adaptability** in the roles necessary to procure resources to meet needs
- A **balance** between the use of internal and external family resources for coping and adapting to life events and planning for the future

From Dunst, C., Trivette, C., & Deal, A. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA: Brookline Books.

PARENTAL ROLES

In all family groups, the socially recognized statuses of father and mother exist with socially sanctioned roles that prescribe appropriate sexual behavior and childrearing responsibilities. The guides for behavior in these roles serve to control sexual conflict in society and provide for prolonged care of children. The degree to which parents are committed and the way they play their roles are influenced by a number of variables and by the parents' unique socialization experience.

Parental role definitions have changed as a result of the changing economy and increased opportunities for women (Bomar, 2004). As the woman's role has changed, the complementary role of the man has also changed. Many fathers are more active in childrearing and household tasks. As the redefinition of sex roles continues in American families, role conflicts may arise in many families because of a cultural lag of the persisting traditional role definitions.

ROLE LEARNING

Roles are learned through the socialization process. During all stages of development, children learn and practice, through interaction with

others and in their play, a set of social roles and the characteristics of other roles. They behave in patterned and more or less predictable ways because they learn roles that define mutual expectations in typical social relationships. Although role definitions are changing, the basic determinants of parenting remain the same. Determinants of parenting infants and young children include parental personality and mental well-being, systems of support, and child characteristics. These determinants have been used as consistent measurements to determine a person's success in fulfilling the parental role.

In some cultures the role behavior expected of children conflicts with desirable adult behavior. One of the family's responsibilities is to develop culturally appropriate role behavior in children. Children learn to perform in expected ways consistent with their position in the family and culture. The observed behavior of each child is a single manifestation—a combination of social influences and individual psychologic processes. In this way the uniting of the child's intrapersonal system (the self) with the interpersonal system (the family) is simultaneously understood as the child's conduct.

Role structuring initially takes place within the family unit, in which the children fulfill a set of roles and respond to the roles of their parents and other family members (Kaakinen & Coehlo, 2015). Children's roles are shaped primarily by the parents, who apply direct or indirect pressures to induce or force children into the desired patterns of behavior or direct their efforts toward modification of the role responses of the child on a mutually acceptable basis. Parents have their own techniques and determine the course of the socialization process.

Children respond to life situations according to behaviors learned in reciprocal transactions. As they acquire important role-taking skills, their relationships with others change. For instance, when a teenager is also the mother but lives in a household with the grandmother, the teenager may be viewed more as an adolescent than as a mother. Children become proficient at understanding others as they acquire the ability to discriminate their own perspectives from those of others. Children who get along well with others and attain status in the peer group have well-developed role-taking skills.

Family Size and Configuration

Parenting practices differ between small and large families. Small families place more emphasis on the individual development of the children. Parenting is intensive rather than extensive, and there is constant pressure to measure up to family expectations. Children's development and achievement are measured against those of other children in the neighborhood and social class. In small families, children have more democratic participation than they do in larger families. Adolescents in small families identify more strongly with their parents and rely more on them for advice. They have well-developed, autonomous inner controls as contrasted with adolescents from larger families, who rely more on adult authority.

Children in a large family are able to adjust to a variety of changes and crises. There is more emphasis on the group and less emphasis on the individual (Fig. 2.2). Cooperation is essential, often because of economic necessity. The large number of people sharing a limited amount of space requires a greater degree of organization, administration, and authoritarian control. A dominant family member (a parent or older child) wields control. The number of children reduces the intimate, one-to-one contact between the parent and any individual child. Consequently, children turn to each other for what they cannot get from their parents. The reduced parent-child contact encourages individual children to adopt specialized roles to gain recognition in the family.

Older siblings in large families often administer discipline (Fig. 2.3). Siblings are usually attuned to what constitutes misbehavior. Sibling disapproval or ostracism is frequently a more meaningful disciplinary measure than parental interventions. In situations such as death or illness of a parent, an older sibling often assumes responsibility for the family at considerable personal sacrifice. Large families generate a sense of security in the children that is fostered by sibling support and cooperation. However, adolescents from a large family are more peer oriented than family oriented.

Fig. 2.2 Family structure and function promote strong relationships among its members.

Fig. 2.3 Older school-age children often enjoy taking responsibility for the care of a younger sibling.

PARENTING

PARENTING STYLES

Children respond to their environment in a variety of ways. A child's temperament heavily influences his or her response (see Chapter 10), but styles of parenting have also been show to affect a child and lead to particular behavioral responses. Parenting styles are often classified as authoritarian, permissive, or authoritative (Baumrind, 1971, 1996). **Authoritarian** parents try to control their children's behavior and attitudes through unquestioned mandates. They establish rules and regulations or standards of conduct that they expect to be followed rigidly and unquestioningly. The message is: "Do it because I say so." Punishment need not be corporal but may be stern withdrawal of love

and approval. Careful training often results in rigidly conforming behavior in the children, who tend to be sensitive, shy, self-conscious, retiring, and submissive. They are more likely to be courteous, loyal, honest, and dependable, but docile. These behaviors are more typically observed when close supervision and affection accompany parental authority. If not, this style of parenting may be associated with both defiant and antisocial behaviors.

Permissive parents exert little or no control over their children's actions. They avoid imposing their own standards of conduct and allow their children to regulate their own activity as much as possible. These parents consider themselves to be resources for the children, not role models. If rules do exist, the parents explain the underlying reason, elicit the children's opinions, and consult them in decision-making processes. They employ lax, inconsistent discipline; do not set sensible limits; and do not prevent the children from upsetting the home routine. These parents rarely punish the children.

Authoritative parents combine practices from both of the other parenting styles. They direct their children's behavior and attitudes by emphasizing the reason for rules and negatively reinforcing deviations. They respect the individuality of each child and allow the child to voice objections to family standards or regulations. Parental control is firm and consistent but tempered with encouragement, understanding, and security. Control is focused on the issue, not on withdrawal of love or the fear of punishment. These parents foster "inner-directedness," a conscience that regulates behavior based on feelings of guilt or shame for wrongdoing, not on fear of being caught or punished. Parents' realistic standards and reasonable expectations produce children with high self-esteem who are self-reliant, assertive, inquisitive, content, and highly interactive with other children.

There are differing philosophies in regard to parenting. Childrearing is a culturally bound phenomenon, and children are socialized to behave in ways that are important to their family. In the authoritative style, authority is shared and children are included in discussions, fostering an independent and assertive style of participation in family life. When working with individual families, nurses should give these differing styles equal respect.

LIMIT SETTING AND DISCIPLINE

In its broadest sense, **discipline** means "to teach" or refers to a set of rules governing conduct. In a narrower sense, it refers to the action taken to enforce the rules after noncompliance. **Limit setting** refers to establishing the rules or guidelines for behavior. For example, parents can place limits on the amount of time children spend watching television or chatting online. The clearer the limits that are set and the more consistently they are enforced, the less need there is for disciplinary action.

Nurses can help parents establish realistic and concrete "rules." Limit setting and discipline are positive, necessary components of childrearing and serve several useful functions as they help children to:

- Test their limits of control
- Achieve in areas appropriate for mastery at their level
- Channel undesirable feelings into constructive activity
- Protect themselves from danger
- Learn socially acceptable behavior

Children want and need limits. Unrestricted freedom is a threat to their security and safety. By testing the limits imposed on them, children learn the extent to which they can manipulate their environment and gain reassurance from knowing that others are there to protect them from potential harm.

Minimizing Misbehavior

The reasons for misbehavior may include attention, power, defiance, and a display of inadequacy (e.g., the child misses classes because of a fear that he or she is unable to do the work). Children may also misbehave because the rules are not clear or consistently applied. Acting-out behavior, such as a temper tantrum, may represent uncontrolled frustration, anger, depression, or pain. The best approach is to structure interactions with children to prevent or minimize unacceptable behavior (see Family-Centered Care box).

General Guidelines for Implementing Discipline

Regardless of the type of discipline used, certain principles are essential to ensure the efficacy of the approach (see Family-Centered Care box). Many strategies, such as behavior modification, can only be implemented effectively when principles of consistency and timing are followed. A pattern of intermittent or occasional enforcement of limits actually prolongs the undesired behavior because children learn that if they are persistent, the behavior is permitted eventually. Delaying punishment weakens its intent, and practices such as telling the child "Wait until your father comes home" not only are ineffectual but also convey negative messages about the other parent.

FAMILY-CENTERED CARE

Minimizing Misbehavior

- Set realistic goals for acceptable behavior and expected achievements.
- Structure opportunities for small successes to lessen feelings of inadequacy.
- Praise children for desirable behavior with attention and verbal approval.
- Structure the environment to prevent unnecessary difficulties (e.g., place fragile objects in an inaccessible area).
- Set clear and reasonable rules; expect the same behavior regardless of the circumstances; if exceptions are made, clarify that the change is for one time only.
- Teach desirable behavior through own example, such as using a quiet, calm voice rather than screaming.
- Review expected behavior before special or unusual events, such as visiting a relative or having dinner in a restaurant.
- Phrase requests for appropriate behavior positively, such as "Put the book down" rather than "Don't touch the book."
- Call attention to unacceptable behavior as soon as it begins; use distraction to change the behavior or offer alternatives to annoying actions, such as exchanging a quiet toy for one that is too noisy.
- Give advance notice or "friendly reminders," such as "When the TV program is over, it is time for dinner" or "I'll give you to the count of three, and then we have to go."
- Be attentive to situations that increase the likelihood of misbehaving, such as overexcitement or fatigue, or to decreased personal tolerance to minor infractions.
- Offer sympathetic explanations for not granting a request, such as "I am sorry I can't read you a story now, but I have to finish dinner. Then we can spend time together."
- Keep any promises made to children.
- Avoid outright conflicts; temper discussions with statements such as "Let's talk about it and see what we can decide together" or "I have to think about it first."
- Provide children with opportunities for power and control.

Types of Discipline

To deal with misbehavior, parents need to implement appropriate disciplinary action. Many approaches are available. **Reasoning** involves explaining why an act is wrong and is usually appropriate for older children, especially when moral issues are involved. However, young children cannot be expected to "see the other side" because of their egocentrism. Children in the preoperative stage of cognitive development (toddlers and preschoolers) have a limited ability to distinguish between their point of view and that of others. Sometimes children use "reasoning" as a way of gaining attention. For example, they may misbehave, thinking the parents will give them a lengthy explanation of the wrongdoing and knowing that negative attention is better than no attention. When children use this technique, parents should end the explanation by stating, "This is the rule, and this is how I expect you to behave. I won't explain it any further."

Unfortunately, reasoning is often combined with **scolding**, which sometimes takes the form of shame or criticism. For example, the parent may state, "You are a bad boy for hitting your brother." Children take such remarks seriously and personally, believing that they are bad.

Positive and negative reinforcement is the basis of **behavior modification theory**—behavior that is rewarded will be repeated; behavior that is not rewarded will be extinguished. Using **rewards** is a positive approach. By encouraging children to behave in specified ways, the parents can decrease the tendency to misbehave. With young children, using paper stars is an effective method. With older children, the "token system" is appropriate, especially if a certain number of stars or tokens yields a special reward, such as a trip to the movies or a new book. In planning a reward system, the parents must explain expected behaviors to the child and establish rewards that are reinforcing. They should use a chart to record the stars or tokens and always give an earned reward promptly. Verbal approval should always accompany extrinsic rewards.

Consistently **ignoring** behavior will eventually extinguish or minimize the act. Although this approach sounds simple, it is difficult to implement consistently. Parents frequently "give in" and resort to previous patterns of discipline. Consequently, the behavior is actually reinforced because the child learns that persistence gains parental attention. For ignoring to be effective, parents should (1) understand the process, (2) record the undesired behavior before using ignoring to determine whether a problem exists and to compare results after ignoring is begun, (3) determine whether parental attention acts as a reinforcer, and (4) be aware of "response burst." Response burst is a phenomenon that occurs when the undesired behavior increases after ignoring is initiated because the child is "testing" the parents to see if they are serious about the plan.

The strategy of consequences involves allowing children to experience the results of their misbehavior. It includes three types:

1. Natural—Those that occur without any intervention, such as being late and having to clean up the dinner table
2. Logical—Those that are directly related to the rule, such as not being allowed to play with another toy until the used ones are put away
3. Unrelated—Those that are imposed deliberately, such as no playing until homework is completed or the use of time-out

Natural or logical consequences are preferred and effective if they are meaningful to children. For example, the natural consequence of living in a messy room may do little to encourage cleaning up, but allowing no friends over until the room is neat can be motivating. Withdrawing privileges is often an unrelated consequence. After the child experiences the consequence, the parent should refrain from any comment, because the usual tendency is for the child to try to place blame for imposing the rule.

Time-out is a refinement of the common practice of sending the child to his or her room and is a type of unrelated consequence. It is based on the premise of removing the reinforcer (i.e., the satisfaction or attention the child is receiving from the activity). When placed in an unstimulating and isolated place, children become bored and consequently agree to behave in order to reenter the family group (Fig. 2.4). Time-out avoids many of the problems of other disciplinary approaches. No physical punishment is involved; no reasoning or scolding is given; and the parent does not need to be present for all of the time-out, thus facilitating consistent application of this type of discipline. Time-out offers both the

FAMILY-CENTERED CARE

Implementing Discipline

- **Consistency**—Implement disciplinary action exactly as agreed on and for each infraction.
- **Timing**—Initiate discipline as soon as child misbehaves; if delays are necessary, such as to avoid embarrassment, verbally disapprove of the behavior and state that disciplinary action will be implemented.
- **Commitment**—Follow through with the details of the discipline, such as timing of minutes; avoid distractions that may interfere with the plan, such as telephone calls.
- **Unity**—Make certain that all caregivers agree on the plan and are familiar with the details to prevent confusion and alliances between child and one parent.
- **Flexibility**—Choose disciplinary strategies that are appropriate to child's age and temperament and the severity of the misbehavior.
- **Planning**—Plan disciplinary strategies in advance and prepare child if feasible (e.g., explain use of time-out); for unexpected misbehavior, try to discipline when you are calm.
- **Behavior orientation**—Always disapprove of the behavior, not the child, with statements such as "That was a wrong thing to do. I am unhappy when I see behavior like that."
- **Privacy**—Administer discipline in private, especially with older children, who may feel ashamed in front of others.
- **Termination**—After the discipline is administered, consider child as having a "clean slate," and avoid bringing up the incident or lecturing.

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When reprimanding children, focus only on the misbehavior, not on the child. Use of "I" messages rather than "you" messages expresses personal feelings without accusation or ridicule. For example, an "I" message attacks the behavior—"I am upset when Johnny is punched; I don't like to see him hurt"—not the child.

Fig. 2.4 Time-out is an excellent disciplinary strategy for young children.

child and the parent a "cooling-off" time. To be effective, however, time-out must be planned (see Family-Centered Care box). Implement time-out in a public place by selecting a suitable area, or explain to children that time-out will be spent immediately on returning home.

Corporal or **physical punishment** most often takes the form of spanking (Mendez, Durtschi, Neppl, et al., 2016). Based on the principles of aversive therapy, inflicting pain through spanking causes a dramatic short-term decrease in the behavior. However, this approach has serious flaws: (1) it teaches children that violence is acceptable; (2) it may physically harm the child if it is the result of parental rage; and (3) children become "accustomed" to spanking, requiring more severe corporal punishment over time. Spanking can result in severe physical and psychologic injury, and it interferes with effective parent-child interaction (Gershoff, 2008). In addition, when the parents are not around, children are likely to misbehave, because they have not learned to behave well for their own sake. Parental use of corporal punishment may also interfere with the child's development of moral reasoning.

FAMILY-CENTERED CARE

Using Time-Out

- Select an area for time-out that is safe, convenient, and unstimulating but where the child can be monitored, such as the bathroom, hallway, or laundry room.
- Determine what behaviors warrant a time-out.
- Make certain children understand the "rules" and how they are expected to behave.
- Explain to children the process of time-out:
  - When they misbehave, they will be given one warning. If they do not obey, they will be sent to the place designated for time-out.
  - They are to sit there for a specified period.
  - If they cry, refuse, or display any disruptive behavior, the time-out period will begin after they quiet down.
  - When they are quiet for the duration of the time, they can then leave the designated place.
- A rule for the length of time-out is 1 minute per year of age; use a kitchen timer with an audible bell rather than a watch to record the time.

SPECIAL PARENTING SITUATIONS

Parenting is a demanding task under ideal circumstances, but when parents and children face situations that deviate from "the norm," the potential for family disruption is increased. Situations that are encountered frequently are divorce, single parenthood, blended families, adoption, and dual-career families. In addition, as cultural diversity increases in our communities, many immigrants are making the transition to parenthood and a new country, culture, and language simultaneously. Other situations that create unique parenting challenges are parental alcoholism, homelessness, and incarceration. Although these topics are not addressed here, the reader may wish to investigate them further.

PARENTING THE ADOPTED CHILD

Adoption establishes a legal relationship between a child and parents who are not related by birth but who have the same rights and obligations that exist between children and their biologic parents. In the past the biologic mother alone made the decision to relinquish the rights to her child. In recent years the courts have acknowledged the legal rights of the biologic father regarding this decision. Concerned child advocates have questioned whether decisions that honor the father's rights are in the best interests of the child. As the child's rights have become recognized, older children have successfully dissolved their legal bond with their biologic parents to pursue adoption by adults of their choice. Furthermore, there is a growing interest and demand within the LGBT community to adopt.

Fig. 2.5 An older sister lovingly embraces her adopted sister.

Unlike biologic parents, who prepare for their child's birth with prenatal classes and the support of friends and relatives, adoptive parents have fewer sources of support and preparation for the new addition to their family. Nurses can provide the information, support, and reassurance needed to reduce parental anxiety regarding the adoptive process and refer adoptive parents to state parental support groups. Such sources can be contacted through a state or county welfare office.

The sooner infants enter their adoptive home, the better the chances of parent-infant attachment. However, the more caregivers the infant had before adoption, the greater the risk for attachment problems. The infant must break the bond with the previous caregiver and form a new bond with the adoptive parents. Difficulties in forming an attachment depend on the amount of time he or she has spent with caregivers early in life, as well as the number of caregivers (e.g., the birth mother, nurse, adoption agency personnel).

Siblings, adopted or biologic, who are old enough to understand should be included in decisions regarding the commitment to adopt, with reassurance that they are not being replaced. Ways that the siblings can interact with the adopted child should be stressed (Fig. 2.5).

Issues of Origin

The task of telling children that they are adopted can be a cause of deep concern and anxiety. There are no clear-cut guidelines for parents to follow in determining when and at what age children are ready for the information. Parents are naturally reluctant to present such potentially unsettling news. However, it is important that parents not withhold the adoption from the child, because it is an essential component of the child's identity.

The timing arises naturally as parents become aware of the child's readiness. Most authorities believe that children should be informed at an age young enough so that, as they grow older, they do not remember a time when they did not know they were adopted. The time is highly individual, but it must be right for both the parents and the child. It may be when children ask where babies come from, at which time children can also be told the facts of their adoption. If they are told in a way that conveys the idea that they were active participants in the selection process, they will be less likely to feel that they were abandoned victims in a helpless situation. For example, parents can tell children that their

personal qualities drew the parents to them. It is wise for parents who have not previously discussed adoption to tell children that they are adopted before the children enter school to avoid having them learn it from third parties. Complete honesty between parents and children strengthens the relationship.

Parents should anticipate behavior changes after the disclosure, especially in older children. Children who are struggling with the revelation that they are adopted may benefit from individual and family counseling. Children may use the fact of their adoption as a weapon to manipulate and threaten parents. Statements such as "My real mother would not treat me like this" or "You don't love me as much because I'm adopted" hurt parents and increase their feelings of insecurity. Such statements may also cause parents to become overly permissive. Adopted children need the same undemanding love, combined with firm discipline and limit setting, as any other child.

Adolescence

Adolescence may be an especially trying time for parents of adopted children. The normal confrontations of adolescents and parents assume more painful aspects in adoptive families. Adolescents may use their adoption to defy parental authority or as a justification for aberrant behavior. As they attempt to master the task of identity formation, they may begin to have feelings of abandonment by their biologic parents. Gender differences in reacting to adoption may surface.

Adopted children fantasize about their biologic parents and may feel the need to discover their parents' identity to define themselves and their own identity. It is important for parents to keep the lines of communication open and to reassure their child that they understand the need to search for his or her identity. In some states, birth certificates are made legally available to adopted children when they come of age. Parents should be honest with questioning adolescents and tell them of this possibility (the parents themselves are unable to obtain the birth certificate; it is the children's responsibility if they desire it).

Cross-Racial and International Adoption

Adoption of children from racial backgrounds different from that of the family is commonplace. In addition to the problems faced by adopted children in general, children of a cross-racial adoption must deal with physical and sometimes cultural differences. It is advised that parents who adopt children with a different ethnic background do everything to preserve the adopted children's racial heritage.

Although the children are full-fledged members of an adopting family and citizens of the adopted country, if they have a strikingly different appearance from other family members or exhibit distinct racial or ethnic characteristics, challenges may be encountered outside the family. Bigotry may appear among relatives and friends. Strangers may make thoughtless comments and talk about the children as though they were not members of the family. It is vital that family members declare to others that this is their child and a cherished member of the family.

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As a health care provider, it is important not to ask the wrong questions, such as "Is she yours, or is she adopted?" "What do you know about the 'real' mother?" "Do they have the same father?" or "How much did it cost to adopt him?"

In international adoptions the medical information the parents receive may be incomplete or sketchy; weight, height, and head circumference are often the only objective information present in the child's medical record. Many internationally adopted children were born prematurely, and common health problems such as infant diarrhea and malnutrition delay growth and development. Some children have serious or multiple health problems that can be stressful for the parents.

Fig. 2.6 Quality time spent with a child during a divorce is essential to a family's health and well-being.

PARENTING AND DIVORCE

Since the mid-1960s, a marked change in the stability of families has been reflected in increased rates of divorce, single parenthood, and remarriage. In 2017 the divorce rate in the United States was 2.9 per 1000 total population (Centers for Disease Control and Prevention, 2018). The divorce rate has changed little since 1987. In the decade before that, the rate increased yearly, with a peak in 1979. Although almost half of all divorcing couples are childless, it is estimated that more than 1 million children experience divorce each year.

The process of divorce begins with a period of marital conflict of varying length and intensity, followed by a separation, the actual legal divorce, and the reestablishment of different living arrangements. Because a function of parenthood is to provide for the security and emotional welfare of children, disruption of the family structure often engenders strong feelings of guilt in the divorcing parents (Fig. 2.6).

During a divorce, parents' coping abilities may be compromised. The parents may be preoccupied with their own feelings, needs, and life changes and be unavailable to support their children. Newly employed parents, usually mothers, are likely to leave children with new caregivers, in strange settings, or alone after school. The parent may also spend more time away from home, searching for or establishing new relationships. Sometimes, however, the adult feels frightened and alone and begins to depend on the child as a substitute for the absent parent. This dependence places an enormous burden on the child.

Telling the Children

Parents are understandably hesitant to tell children about their decision to divorce. Most parents neglect to discuss either the divorce or its inevitable changes with their preschool child. Without preparation, even children who remain in the family home are confused by the parental separation. Frequently, children are already experiencing vague, uneasy feelings that are more difficult to cope with than being told the truth about the situation.

If possible, the initial disclosure should include both parents and siblings, followed by individual discussions with each child. Sufficient

BOX 2.4 Feelings and Behaviors of Children Related to Divorce

Infancy
- Effects of reduced mothering or lack of mothering
- Increased irritability
- Disturbance in eating, sleeping, and elimination
- Interference with attachment process

Early Preschool Children (Ages 2 to 3 Years)
- Frightened and confused
- Blame themselves for the divorce
- Fear of abandonment
- Increased irritability, whining, tantrums
- Regressive behaviors (e.g., thumb sucking, loss of elimination control)
- Separation anxiety

Later Preschool Children (Ages 3 to 5 Years)
- Fear of abandonment
- Blame themselves for the divorce; decreased self-esteem
- Bewilderment regarding all human relationships
- Become more aggressive in relationships with others (e.g., siblings, peers)
- Engage in fantasy to seek understanding of the divorce

Early School-Age Children (Ages 5 to 6 Years)
- Depression and immature behavior
- Loss of appetite and sleep disorders
- May be able to verbalize some feelings and understand some divorce-related changes
- Increased anxiety and aggression
- Feelings of abandonment by departing parent

Middle School-Age Children (Ages 6 to 8 Years)
- Panic reactions
- Feelings of deprivation—loss of parent, attention, money, and secure future
- Profound sadness, depression, fear, and insecurity
- Feelings of abandonment and rejection
- Fear regarding the future
- Difficulty expressing anger at parents
- Intense desire for reconciliation of parents
- Impaired capacity to play and enjoy outside activities
- Decline in school performance
- Altered peer relationships—become bossy, irritable, demanding, and manipulative
- Frequent crying, loss of appetite, sleep disorders
- Disturbed routine, forgetfulness

Later School-Age Children (Ages 9 to 12 Years)
- More realistic understanding of divorce
- Intense anger directed at one or both parents
- Divided loyalties
- Ability to express feelings of anger
- Ashamed of parental behavior
- Desire for revenge; may wish to punish the parent they hold responsible
- Feelings of loneliness, rejection, and abandonment
- Altered peer relationships
- Decline in school performance
- May develop somatic complaints
- May engage in aberrant behavior such as lying, stealing
- Temper tantrums
- Dictatorial attitude

Adolescents (Ages 12 to 18 Years)
- Able to disengage themselves from parental conflict
- Feelings of a profound sense of loss—of family, childhood
- Feelings of anxiety
- Worry about themselves, parents, siblings
- Expression of anger, sadness, shame, embarrassment
- May withdraw from family and friends
- Disturbed concept of sexuality
- May engage in acting-out behaviors

time should be set aside for these discussions, and they should take place during a period of calm, not after an argument. Parents who physically hold or touch their children provide them with a feeling of warmth and reassurance. The discussions should include the reason for the divorce, if age appropriate, and reassurance that the divorce is not the fault of the children.

Parents should not fear crying in front of the children, because their crying gives the children permission to cry also. Children need to ventilate their feelings. Children may feel guilt, a sense of failure, or that they are being punished for misbehavior. They normally feel anger and resentment and should be allowed to communicate these feelings without punishment. They also have feelings of terror and abandonment (Box 2.4). They need consistency and order in their lives. They want to know where they will live, who will take care of them, if they will be with their siblings, and if there will be enough money to live on. Children may also wonder what will happen on special days such as birthdays and holidays, whether both parents will come to school events, and whether they will still have the same friends. Children fear that if their parents stopped loving each other, they could stop loving them. Their need for love and reassurance is tremendous at this time.

Custody and Parenting Partnerships

In the past, when parents separated, the mother was given custody of the children with visitation agreements for the father. Now both parents and the courts are seeking alternatives. Current belief is that neither fathers nor mothers should be awarded custody automatically. Custody should be awarded to the parent who is best able to provide for the children's welfare. In some cases, children experience severe stress when living or spending time with a parent. Many fathers have demonstrated both their competence and their commitment to care for their children.

Often overlooked are the changes that may occur in the children's relationships with other relatives, especially grandparents. Grandparents are increasingly involved in the care of young children (Pulgaron, Marchante, Agosto, et al., 2016). Grandparents on the noncustodial side are often kept from their grandchildren, whereas those on the custodial side may be overwhelmed by their adult child's return to the household with grandchildren.

Two other types of custody arrangements are divided custody and joint custody. **Divided custody**, or **split custody**, means that each parent is awarded custody of one or more of the children, thereby separating siblings. For example, sons might live with the father and daughters with the mother.

Joint custody takes one of two forms. In **joint physical custody**, the parents alternate the physical care and control of the children on an agreed-upon basis while maintaining shared parenting responsibilities legally. This custody arrangement works well for families who live close to each other and whose occupations permit an active role in the care

and rearing of the children. In **joint legal custody**, the children reside with one parent, but both parents are the children's legal guardians, and both participate in childrearing.

Coparenting offers substantial benefits for the family: children can be close to both parents, and life with each parent can be more normal (as opposed to having a disciplinarian mother and a recreational father). To be successful, parents in these arrangements must be highly committed to provide normal parenting and to separate their marital conflicts from their parenting roles. No matter what type of custody arrangement is awarded, the primary consideration is the welfare of the children.

SINGLE PARENTING

An individual may acquire single-parent status as a result of divorce, separation, death of a spouse, or birth or adoption of a child. Although divorce rates have stabilized, the number of single-parent households continues to rise. In 2016, 32% of single-parent families had incomes below the poverty line (Annie E. Casey Foundation, 2018). In addition, 35% of children younger than 18 years of age lived in single-parent families, and the majority of single parents were women (Annie E. Casey Foundation, 2018). Unfortunately, children raised in female-headed households are more likely to drop out of school, be a teen parent, and experience divorce in adulthood. Although some women are single parents by choice, most never planned on being single parents, and many feel pressure to marry or remarry.

Managing shortages of money, time, and energy is often a concern for single parents. Studies repeatedly confirm the financial difficulties of single-parent families, particularly single mothers. In fact, the stigma of poverty may be more keenly felt than the discrimination associated with being a single parent. These families are often forced by their financial status to live in communities with inadequate housing and personal safety concerns. Single parents often feel guilty about the time spent away from their children. Divorced mothers, from marriages in which the father assumed the role of breadwinner and the mother the household maintenance and parenting roles, have considerable difficulty adjusting to their new role of breadwinner. Many single parents have trouble arranging for adequate child care, particularly for a sick child.

Social supports and community resources needed by single-parent families include health care services that are open on evenings and weekends; high-quality child care; respite child care to relieve parental exhaustion and prevent burnout; and parent enhancement centers for advancing education and job skills, providing recreational activities, and offering parenting education. Single parents need social contacts separate from their children for their own emotional growth and that of their children. Parents Without Partners[a] is an organization designed to meet the needs of single parents.

Single Fathers

Fathers who have custody of their children have many of the same problems as divorced mothers. They feel overburdened by the responsibility; depressed; and concerned about their ability to cope with the emotional needs of the children, especially girls. Some fathers lack homemaking skills. They may find it difficult at first to coordinate household tasks, school visits, and other activities associated with managing a household alone (Fig. 2.7).

[a]1650 South Dixie Hwy, Suite 402, Boca Raton, FL 33432; 800-637-7974; http://parentswithoutpartners.org.

Fig. 2.7 Fathers who assume care of their children may feel more comfortable and successful in their parenting role.

Fig. 2.8 Learning new roles in reconstituted families as a mother and father can enhance parenting relationships.

PARENTING IN RECONSTITUTED FAMILIES

In the United States, many children living in homes where parents have divorced will experience another major change in their lives, such as the addition of a stepparent or new siblings (Kaakinen & Coehlo, 2015). The entry of a stepparent into a ready-made family requires adjustments for all family members. Some obstacles to the role adjustments and family problem solving include disruption of previous lifestyles and interaction patterns, complexity in the formation of new ones, and lack of social supports. Despite these problems, most children from divorced families want to live in a two-parent home.

Cooperative parenting relationships can allow more time for each set of parents to be alone to establish their own relationship with the children. Under ideal circumstances, power conflicts between the two households can be reduced, and tension and anxiety can be lessened for all family members. In addition, the children's self-esteem can be increased, and there is a greater likelihood of continued contact with grandparents. Flexibility, mutual support, and open communication are critical in successful relationships in stepfamilies and stepparenting situations (Fig. 2.8).

PARENTING IN DUAL-EARNER FAMILIES

No change in family lifestyle has had more impact than the large numbers of women moving away from the traditional homemaker role and entering the workplace (Kaakinen & Coehlo, 2015). The trend toward increased numbers of dual-earner families is unlikely to diminish

significantly. As a result, the family is subject to considerable stress as members attempt to meet often competing demands of occupational needs and those regarded as necessary for a rich family life.

Working Mothers

Working mothers have become the norm in the United States. Maternal employment may have variable effects on preschool children's health (Lucas-Thompson, Goldberg, & Prause, 2010). The quality of child care is a persistent concern for all working parents. Determinants of child care quality are based on health and safety requirements, responsive and warm interaction between staff and children, developmentally appropriate activities, trained staff, limited group size, age-appropriate caregivers, adequate staff-to-child ratios, and adequate indoor and outdoor space. Nurses play an important role in helping families to find suitable sources of child care and to prepare children for this experience.

Kinship Care

Since the 1980s, the proportion of children in out-of-home care placed with relatives has increased rapidly. More than 2.7 million US children are raised by grandparents or other kin at some time in their lives (Annie E. Casey Foundation, 2012). According to US Census Bureau data, kinship caregivers are more likely to be poor, single, older, less educated, and unemployed than families in which at least one parent is present.

FOSTER PARENTING

The term **foster care** is defined as placement in an approved living situation away from the family of origin (American Academy of Pediatrics, 2000; Annie E. Casey Foundation, 2012). The living situation may be an approved foster home, possibly with other children, or a preadoptive home. Each state provides a standard for the role of foster parent and a process by which to become one. These "parents" contract with the state to provide a home for children for a limited duration. Most states require about 27 hours of training before being on contract and at least 12 hours of continuing education a year. Foster parents may be required to attend a foster parent support group that is often separate from a state agency. Each state has guidelines regarding the relative health of the prospective foster parents and their families, background checks regarding legal issues for the adults, personal interviews, and a safety inspection of the residence and surroundings (Chamberlain, Price, Leve, et al., 2008).

Foster homes include both kinship and nonrelative placements. Since the 1980s, the proportion of children in out-of-home care placed with relatives has increased rapidly and been accompanied by a decrease in the number of foster families. As with their nonfoster counterparts, much of the child's adjustment depends on the family's stability and available resources. Even though foster homes are designed to provide short-term care, it is not unusual for children to stay for many years.

Nurses should be aware that nearly 700,000 children spend time living in foster care in a given year, many of them facing developmental concerns (American Academy of Pediatrics, 2000; Annie E. Casey Foundation, 2015). Children from lower-income, single-mother, and mother-partner families are considerably more likely to be living in foster care (Berger & Waldfogel, 2004). Children in foster care tend to have a higher than normal incidence of acute and chronic health problems and may experience feelings of isolation or confusion (Annie E. Casey Foundation, 2015). Foster children are often at risk because of their previous caretaking environment. Nurses should strive to implement strategies to improve the health care for this group of children. In particular, assessment and case management skills are required to involve other disciplines in meeting their needs.

SOCIOCULTURAL INFLUENCES ON CHILDREN AND FAMILIES

A child and his or her immediate family are nested within a local community of school, peers, and extended family; within a larger community that may be bound by common geography, background, and traditions; and within an even broader community that incorporates the social, political, and economic elements that influence many aspects of family life. These layers of influence are often multifactorial: parents, extended family, and community exert influence most directly when thinking about the religious or ethnic background of the family. These elements come into play when we think about children moving into the wider world, such as their interface with other children at school or potential biases a child or adolescent may face because of religious or ethnic and racial identity. Thus the sociopolitical context, though an outer layer of a social ecologic model, can exert enormous influence on a child's daily life, opportunities, and outcomes. Equally important to child and family health outcomes, the sociopolitical context draws our attention to factors and health policies at the local, regional, state, and federal levels that can serve as barriers to health equity. This is also made evident through research on the social determinants of health. The next section of the chapter will delve into a deeper discussion of such factors.

The social ecologic model (Kazak, 2001; Kazak, Rourke, & Navasaria, 2010), rooted in Bronfenbrenner's ecologic model (Bronfenbrenner, 1979, 2005), offers a perspective of viewing children and their families within the context of various circles of influence, called an ecologic framework. This framework posits that individuals adapt in response to changes in their surrounding environments, whether that be the environment of the immediate family, the school, the neighborhood in which the family lives, or the socioeconomic forces that may shape job availability in their geographic area. In addition, Kazak argues that a person's behavior results from the interaction of his or her traits and abilities with the environment. No single factor can explain the totality of a child and his or her family's health behaviors. Children possess their own factors that influence their behavior (i.e., personal history or biologic factors). In turn, they are surrounded by relationships with family, friends, and peers who influence their behavior. Children and their families are then situated within a community that establishes the context in which social relationships develop. Finally, wider sociocultural factors influence whether a behavior is encouraged or prohibited (e.g., social policy on smoking, cultural norms of mothers as primary caregivers of young children, media that can influence how a teenager thinks he or she should look) (Fig. 2.9).

Promoting the health of children requires a nurse to understand social, cultural, and religious influences on children and their families. The US population is constantly evolving. Patients experience negative health outcomes when social, cultural, and religious factors are not considered as influencing their health care (Chavez, 2012; Williams, 2012). Educating health care providers is one way to reduce disparities in health care.

INFLUENCES IN THE SURROUNDING ENVIRONMENT

SCHOOL COMMUNITIES: SCHOOL HEALTH AND SCHOOL CONNECTEDNESS

Environments differentially support learning through the kinds of opportunities and support provided. Learning and development are cumulative and synergistic; one supports the other. High-quality early

Fig. 2.9 Youngsters from different cultural backgrounds interact within the larger culture.

childhood education is especially beneficial to set children up for success in early grades. This is especially true for children from disadvantaged backgrounds. Access to this high-quality education is key yet also occurs along a socioeconomic gradient, with more highly resourced children attending higher-quality preschool programs.

Within communities, schools are important sites for health promotion. Initiatives such as the Centers for Disease Control and Prevention–sponsored Whole School, Whole Community, Whole Child model emphasize and build on this critical connection between youth academic performance and health by addressing important elements of children's and adolescents' lives that cut across domains. Examples of such elements include physical education and activity, nutritional environment, counseling, psychologic and social services, social and emotional climate, physical environment, family engagement, and community involvement (Michael, Merlo, Basch, et al., 2015). This approach acknowledges the need for multifaceted strategies to improve academic and health outcomes. It situates school not only as a place to learn, but also as a place to practice positive health behaviors and health promotion skills. For example, a nutritional health environment constructed in a way to promote child and adolescent health gives youth a chance to live out these skills by making healthy food choices available, by weaving nutrition education into the health curriculum, and by including supportive messaging about healthy nutrition in the school environment (Lewallen, Hunt, Potts-Datema, et al., 2015).

The Centers for Disease Control and Prevention and the World Health Organization identified place-based settings that contribute to individual, family, and population health, including educational settings. Thus schools and early childhood centers can contribute to the health of children by teaching about health and healthy behaviors and also by offering ways to enact healthy behaviors (e.g., physical education, coordinated psychosocial or mental health services, healthy snacks). This position addresses potential gaps in care or assessment for children and adolescents, because place-based care can improve access for many children, and emphasizes coordination among services in a given neighborhood.

An important concept when considering schools as a site of health promotion is connectedness (Centers for Disease Control and Prevention, 2009). *School connectedness* is defined as students' perception that they and their learning matter to the adults at their school and to their peers. It occurs when youth believe that their teachers, staff, and peers care about them academically and personally. The growth and implementation of this concept into educational practice stems from research indicating greater impact on youth health through bolstering protective factors that help children and adolescents avoid risky or unhealthy behaviors. This focus on strengths and promoting positive choices may also help buffer the impact of negative events on children and their health.

Feeling connected at school has important health benefits. Children and youth who feel more connected are more likely to engage in healthy behaviors and do well academically. School connectedness has been found to be particularly protective against substance abuse, early sexual debut, and violence in both boys and girls. In addition, school connectedness was second only to family connectedness in protection against emotional distress, disordered eating, and suicidal ideation and attempts. Finally, in addition to health outcomes it promotes academic outcomes, including improved grades, decreased absence, and delayed dropout.

Recommended strategies for achieving school connectedness include effective training for teachers and staff to create positive learning environments; opportunities for families to become involved in the process and associated training; and provision of important academic, emotional, and social skills to students (and addressing barriers to achieving these skills) so that students can feel engaged and have a stake in their education (Centers for Disease Control and Prevention, 2009).

SCHOOLS

When children enter school, their radius of relationships extends to include a wider variety of peers and a new source of authority. Although parents continue to exert the major influence on children, in the school environment teachers have the most significant psychologic impact on children's development and socialization. In addition to academic and cognitive progress, teachers are concerned with the emotional and social development of the children in their care. Both parents and teachers act to model, shape, and promote positive behavior; constrain negative behavior; and enforce standards of conduct. Ideally, parents and teachers work together for the benefit of the children in their care.

Schools serve as a major source of socialization for children. Next to the family, schools exert a major force in providing continuity and passing down culture from one generation to the next. This in turn prepares children to carry out the social roles they are expected to assume as they develop into adults. School is the center of **cultural diffusion,** wherein the cultural standards of the larger group are disseminated into the community. It governs what is taught and, to a great extent, how it is taught. School rules and regulations regarding attendance, authority relationships, and the system of rewards and penalties based on achievement transmit to children the expectations of the adult world of employment and relationships. School is an important institution in which children systematically learn about the negative consequences of behavior that departs from social expectations. School also serves as an avenue for children to participate in the larger society in rewarding ways, to promote social mobility, and to connect the family with new knowledge and services. Like parents, teachers are responsible for transmitting knowledge and culture (i.e., values on which there is a broad consensus) to the children in their care. Teachers are also expected to stimulate and guide children's intellectual development and creative problem solving.

PEER CULTURES

Peer groups also have an impact on the socialization of children. Peer relationships become increasingly important and influential as children

TABLE 2.2 Media Effects on Children and Adolescents

Media Effect	Potential Consequences
Violence	Government, medical, and public health data show that exposure to media violence is one factor in violent and aggressive behavior. Both adults and children become desensitized by violence witnessed through various media, including television (including children's programming), movies (including G rated), music, and video games. In addition, cyber-bullying and harassment via text messages are a growing concern among middle school and high school students.
Sex	A significant body of research shows that sexual content in the media can contribute to beliefs and attitudes about sex, sexual behavior, and initiation of intercourse. Teens access sexual content through a variety of media: television, movies, music, magazines, Internet, social media, and mobile devices. Current issues receiving attention for the role they play in teen sexual behavior include sending sexual images via mobile devices (i.e., sexting), the impact of violent media on youth views of women and forced sex or rape, and cyber-bullying LGBT youth. Media can also serve as a positive source of sexual information (i.e., information, apps, social media about sexually transmitted infections, teen pregnancy, and promoting acceptance and support of LGBT youth).
Substance use and abuse	Although the causes of teen substance use and abuse are numerous, media play a significant role. Alcohol and tobacco, including the use of e-cigarettes (vaping), are still heavily marketed to adolescents and young adults. Television and movies featuring the use of these substances can influence initiation of use. Media also show substance use to be pervasive and without consequences. Finally, content shared over social networking sites can serve as a form of peer pressure and can influence likelihood of use.
Obesity	Obesity is a highly prevalent public health issue among children of all ages and in increasing rates around the world. A number of studies have demonstrated a link between the amount of screen time and obesity. Advertising of unhealthy food to children is a long-standing marketing practice, which may increase snacking in the face of decreased activity. In addition, both increased screen time and unhealthy eating may also be related to unhealthy sleep.
Body image	Media may play a significant role in the development of body image awareness, expectations, and body dissatisfaction among young and older adolescent girls. Their beliefs may be influenced by images on television, movies, and magazines. New media also contribute to this through Internet images, social network sites, and websites that encourage disordered eating (Strasburger, Jordan, & Donnerstein, 2012).

proceed through school. In school, children have what can be regarded as a culture of their own. This is even more apparent in unsupervised playgroups because the culture in school is partly produced by adults.

During their lives, children are subjected to many influential factors, such as family, religious community, and social class. In peer-group interactions, they confront a variety of these sets of values. The values imposed by the peer group are especially compelling because children must accept and conform to them to be accepted as members of the group. When the peer values are not too different from those of family and teachers, the mild conflict created by these small differences serves to separate children from the adults in their lives and to strengthen the feeling of belonging to the peer group.

Although the peer group has neither the traditional authority of the parents nor the legal authority of the schools to teach information, it manages to convey a substantial amount of information to its members, especially on taboo subjects such as sex and drugs. Children's need for the friendship of their peers brings them into an increasingly complex social system. Through peer relationships, children learn to deal with dominance and hostility and to relate with persons in positions of leadership and authority. Other functions of the peer subculture are to relieve boredom and to provide recognition that individual members do not receive from teachers and other authority figures.

COMMUNITY

Families and communities are often interwoven in their impact on child health. Although both are essential to socioemotional growth and improved learning outcomes in children, their influence on children is synergistic. When families live in areas of concentrated poverty, residents experience risk at population and individual levels. Children and families living in areas of concentrated poverty are at risk for negative health outcomes and experience higher rates of crime and violence. In addition, affected neighborhoods are more likely to have low-performing schools, limited access to high-quality preschool and diminished school readiness, and poorer overall education outcomes. If parents have grown up in the area or a similar area, they have also experienced untoward effects on their health or educational outcomes. As a result, they may not be able to secure employment that provides greater resources for them to invest in their child or that provides economic stability for the family. Financial stressors in parents contribute to their stress and depression, which can inhibit effective parenting. Thus we see an important need for two-generation programs or strategies to both build on family and community strengths and diminish their stressors.

Community-level factors are especially important as we consider the life, safety, and causes of death in older adolescents. For example, 75% of teen deaths are attributed to accidents, homicide, and suicide, and community-level factors, such as violence, drug use, and alcohol use, influence this number (Annie E. Casey Foundation, 2018).

BROADER INFLUENCES ON CHILD HEALTH

SOCIAL MEDIA AND MASS MEDIA

Digital technologies that serve as an avenue to mass and social media are pervasive in most parts of American society. Technology has a role in the lives of children more than ever before. The American Academy of Pediatrics (2016a) found that children younger than 5 years of age, across socioeconomic levels, use digital technology daily and are frequently targeted by advertisers. This frequent use carries risks for increased rates of obesity; disrupted sleep; and delays in cognitive, social, and language development, potentially related to diminished parent-child interaction in preschoolers (Table 2.2). Research has

demonstrated that there is limited benefit of digital technology for children younger than 2 years of age, also likely related to diminished parent-child interaction. Benefits of digital technology use are related to the type of content viewed and used. For example, high-quality programming, such as *Sesame Street,* can bolster cognitive and social outcomes in preschool-age children, and applications from similar organizations (e.g., PBS or Sesame Workshop) can promote literacy skills. Unfortunately, many programs and applications targeted to children and their parents or caregivers are not created under the direction of educators or developmental experts and may not prove as beneficial to child social and cognitive outcomes. In addition, less than 30% of children from lower-income homes view high-quality digital media, perpetuating potential risks posed by the technology and associated disparities. Despite technologic advances, play, social interactions with peers, and parent-child interactions remain vital to young children's development of the skills needed to succeed in school, including persistence, emotional regulation, and creative thinking (American Academy of Pediatrics, 2016b).

The digital landscape for older children and adolescents seems to change and grow on a daily basis and is woven into daily life for many youth. Indeed, recent research indicates that nearly 75% of adolescents have a smart phone or mobile technology device and approximately half report feeling addicted to their phone (American Academy of Pediatrics, 2016b). While using these mobile devices, most adolescents are engaging in social media, with nearly three-fourths engaging in multiple social media sites and cultivating a portfolio (American Academy of Pediatrics, 2016b). This immersion poses both benefits and risks to these youth. In terms of the benefits, youth have an unprecedented chance to learn and gather information and consider new perspectives; to connect with other youth, which is especially important for youth who may feel marginalized or isolated; and to maintain connections with family and friends who live at a distance.

On the other hand, navigating this landscape includes potential risks to physical and mental health, such as obesity, disrupted sleep, addictive behavior, negative impact on academics, bullying and sexual exploitation, and normalization of maladaptive behavior (e.g., sites that promote disordered eating or self-harm). Similar to traditional forms of media (e.g., television), research has demonstrated that social media postings can influence perceptions of alcohol and drug use and younger age of initiating sexual activity as normal in the eyes of adolescents (American Academy of Pediatrics, 2016b). Traditional forms of mass media, such as television and movies, can reify gender and racial stereotypes, thus perpetuating negative mental and emotional health outcomes (American Academy of Pediatrics, 2016b). Finally, communication among adolescents has shifted and become more pervasive through texting, messaging through gaming systems, and messaging on social media sites. This continual access and inlet to the lives of peers can serve as both a source of support and a source of derision and stress. Thus it is essential for nurses and other health care providers to talk with older children and adolescents about the frequency, content, and nature of their digital and social media use and how they maintain their privacy and safety. Equally important, nurses can help families devise strategies and personalized plans for safe and healthy technology use (American Academy of Pediatrics, 2016b) (Box 2.5).

BOX 2.5 Actions to Promote Positive Media Use

Parents

- Follow American Academy of Pediatrics recommendations for 2 total hours of screen time daily for children ages 2 years and older.
- Establish clear guidelines for Internet use and provide direct supervision. Have frank discussions of what youth may encounter in viewing media. Be mindful of own media use in the home.
- Encourage unstructured play in the home and plan to help children readjust to this change in family dynamic. Consider planned, deliberate use of media to experience the benefits (e.g., watching a television show together to bond or start a sensitive discussion).

Nurses and Health Care Providers

- Dedicate a few minutes of each visit to provide media screening and counseling.
- Discourage presence of electronic devices in children's rooms.
- Be sensitive to the challenges that parents face in carrying this out.

Schools

- Offer timely, accurate sexuality and drug education.
- Promote resilience.
- Develop programs to educate youth on wise use of technology.
- Develop and implement policies on dealing with cyber-bullying and sexting.

RACE AND ETHNICITY

Race and ethnicity are socially constructed terms used to group together people who share similar characteristics, traditions, or historical experience. **Race** is a term that groups together people by their outward, physical appearance. **Ethnicity** is a classification aimed at grouping individuals who share common characteristics unique in comparison to others in a society, resulting in a distinctive, cultural behavior (Scott & Marshall, 2009). Ethnicities may be differentiated from one another by customs and language, and may influence family structure, food preferences, and expressions of emotion. The composition and definition of ethnic groups can be fluid in response to changes in geography (i.e., moving from one country to another). Race and ethnicity influence a family's health when they are used as criteria by which a child or family is discriminated against. There is a significant body of work that describes this. In fact, 100 years of research describe racial gaps in health (Williams, 2012).

Racism remains an important social determinant of health. According to Williams (2012), for minority or other groups who experience stigmatization, "inequalities in health are created by larger inequalities in society," meaning that prevailing social conditions and obstacles to equal opportunities for all influences the health of all individuals. For example, from birth forward, African American and American Indian children have a higher mortality rate than white children in general. There is also a higher death rate for babies of African American and Hispanic women versus white women. Even when controlling for maternal levels of education, the infant mortality rate for college-educated African American women is 2.5 times higher than for Hispanic and white women of similar education level (Williams, 2012). These numbers demonstrate that children and families ultimately feel the effects of such health disparities.

Children and families may also experience perceived racism, which also has negative consequences. For example, in a study of more than 5000 fifth-graders, 15% of Hispanic youth and 20% of African American youth reported that they had experienced racial discrimination. Such experiences were then associated with a higher risk of mental health symptoms (Coker, Elliot, Kanouse, et al., 2009). Teens also report racial discrimination through online communities, social networking sites, and texting, which is related to increased anxiety and depression (Tynes, Giang, Williams, et al., 2008).

POVERTY

Opportunities to promote health or risks to health often begin in our families, schools, neighborhoods, and places of employment. Thus to fully promote child health and diminish risks to it, we need to understand how the surrounding context and environments are influential. Children are nested within layers of family, peers, school, and community; we can consider the direct impact of these outside systems interacting with the child and family. Equally important, however, is the influence of factors within the sociopolitical landscape at local, state, regional, national, and international levels. These factors affect the creation of health and social policies that may perpetuate health disparities or make health equity possible.

The circumstances into which a child is born can determine the child's exposure to factors that promote or compromise healthy development. For example, adverse events can have long-lasting impacts into adulthood. Layers of the child's surrounding environment that contribute to health inequity fall into socioeconomic, political, and cultural contexts, including local, state, and federal policies; daily living conditions; and the circumstances in which people live, work, and play.

Child health disparities are discrepancies that are based in avoidable differences and are concerning because of the immense and foundational development that occurs in early childhood. Health inequities, in a similar vein, are defined as differences in health states between populations that are socially produced and systemic in unequal distribution across populations that are avoidable and unfair. Health follows a social gradient; there are better health outcomes with increased socioeconomic status and further improvements with movements upward in socioeconomic status. Similarly, compromised health outcomes are associated with lower economic status. Inequitable access to services maintains or perpetuates health inequities in early childhood because the children most in need of services are most likely to not receive them. Multilevel, multifactorial responses to address these issues include policies that improve access to high-quality services and connect parents to secure, stable, flexible workplaces; service systems that deliver inclusive programs rooted in research and evidence; and timely assistance for parents so that they can feel successful in their parenting role.

Economy and Poverty

A major factor that affects child and family health in the United States is poverty. Nearly one-fifth of all American children live in families with annual incomes below 100% of the federal poverty level for a family of 4 (approximately $24,600), and almost one-half of children live 200% below this federal poverty guideline (Fierman, Beck, Chung, et al., 2016). Poverty affects children and their families across all geographic areas, including urban, suburban, and rural. Several social factors associated with poverty that can negatively affect child health are family disruption, parental depression, substance use, other mental illnesses, unsafe homes or neighborhoods, housing instability, homelessness, decreased educational opportunities, and low parent educational levels and health literacy (Fierman, Beck, Chung, et al., 2016).

Poverty influences these social determinants of health, the circumstances and environments in which people are born, live, work, learn, and play. In turn, these social determinants shape child health in major and lasting ways. Poverty itself is a major cause of acute and chronic stress for adults and children. The daily stressors associated with poverty are overwhelming, and other circumstances, such as trauma or violence, can add to the stress experienced by parents and children. This overwhelming stress can undermine skills in dealing with challenging situations. The stressors associated with poverty can be psychologically and emotionally depleting, yet supports to deal with this depletion, such as adequate mental health services, high-quality and affordable child care, or social supports, may not be available (Center on the Developing Child at Harvard University, 2016).

Infants and toddlers are more likely to live in poverty than older children. Thus some of the most profound effects of poverty are demonstrated in young children, such as increased prevalence of low birth weight and infant mortality and delayed language development. These risks can perpetuate other lifetime hazards, such as diminished health status due to chronic illness or compromised academic performance.

Underinsurance imposes financial difficulties on families. This reminds us that having insurance does not automatically negate financial distress or impact on families. High out-of-pocket costs (e.g., copays, medications, supplies) and associated costs for transportation to appointments, parking at hospitals, meals while a child is hospitalized, and child care for siblings contribute to this distress (Mooney-Doyle, dos Santos, Bousso, et al., 2017).

Parental Education

Parental level of education is another important factor when we consider economic influences on child health. Child economic status is directly tied to parental earnings. Parental earnings from employment in turn are affected by parental level of education. Income inequality is pervasive and has become worse in recent history. Although some families are catching up on what was lost in the Great Recession of 2008, many of the jobs that could help decrease income inequality require a college degree, and only one-third of adults in the United States have such degrees. Thus many children in the United States are living in families in which parents face employment dissatisfaction and barriers, contributing to stress or negative parental or family outcomes (Annie E. Casey Foundation, 2018). Although this issue affects children across races, ethnicities, and geographic settings, children of color disproportionately live in homes without sufficient finances (12% white children versus 36% African American children versus 31% Hispanic children). Gaps in income undermine a family's ability to access social mobility and move permanently out of poverty (American Academy of Pediatrics, 2016c).

The American Academy of Pediatrics recommends that screening be done at each well visit by asking about ability to meet basic needs, such as heat, shelter, and food. To address the issue, the American Academy of Pediatrics recommends that pediatric health care providers build on family strengths such as cohesion, humor, support, and spiritual beliefs, and advocate for creation of programs to address the multiple facets of childhood poverty that are rooted in research (American Academy of Pediatrics, 2016c). Barriers to screening exist, however, and derail providers with the best of intentions. Barriers include not recognizing the impact of poverty or the measurable outcomes associated with it; lack of time; limited and insufficient training in assessment and limited familiarity with assessment tools; and limited knowledge of available community resources. Pediatric nurses and health care providers can initiate surveillance and screening to elicit and address parent concerns; identify risk and protective factors; screen for specific issues; and refer the child and family to the right place with the right services. To address the social determinants of health, screening can be tailored to the most sensitive or sustained issues in the community, to parent sources of concern, and to child developmental stage.

Economic barriers impede parents' ability to provide for their children. Thus pediatric nurses and other health care providers must imbue their practice with an understanding of the challenges that families face, integrate care to minimize the strain of interacting with