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Low-income parents' perceptions of pediatrician advice on early childhood education

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Abstract

BACKGROUND—The American Academy of Pediatrics recommends that pediatricians promote early childhood education (ECE). However, pediatricians have met resistance from low-income parents when providing anticipatory guidance on some topics outside the realm of physical health. Parents' views on discussing ECE with the pediatrician have not been studied.

OBJECTIVES—We sought to understand low-income parents' experiences and attitudes with regard to discussing early childhood education (ECE) with the pediatrician and to identify opportunities for pediatrician input.

METHODS—We conducted 27 in-depth, semi-structured, qualitative interviews with parents of 3- and 4-year-old patients (100% Medicaid, 78% African American) at an urban primary care center. Interviews were audio-recorded, transcribed verbatim, and reviewed for themes by a multidisciplinary team.

RESULTS—Most low-income parents in our study reported they primarily sought ECE advice from family and friends but were open to talking about ECE with the pediatrician. They considered their children's individual behavior and development to be important factors in ECE decisions and appreciated pediatricians' advice about developmental readiness for ECE. Participants' decisions about ECE were often driven by fears that their children would be abused or neglected. Many viewed 3 years as the age at which children had sufficient language skills to report mistreatment and could be safely enrolled in ECE.

CONCLUSIONS—Participants were generally accepting of discussions about ECE during well child visits. There may be opportunity for the pediatrician to frame ECE discussions in the context of development, behavior, and safety and to promote high-quality ECE at an earlier age.

Keywords

early childhood education; anticipatory guidance; well child care

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INTRODUCTION

A growing body of evidence indicates that lifelong physical and mental health are influenced by early life experiences,^{1–4} and that high quality childcare or preschool (known as early childhood education or ECE) can improve children's educational and behavioral outcomes, by providing learning activities and emotional support during a crucial stage in the development of language, emotion regulation, and social skills.^{5–9} In addition to the developmental consequences, the quality of a child's ECE environment also has important safety implications, as there is a higher incidence of injury and fatality in unlicensed childcare settings.^{10,11} Since pediatricians are a frequent point of contact for families with young children, promotion of high quality ECE during well child visits is an attractive public health opportunity and an American Academy of Pediatrics (AAP) recommendation.

Despite the theoretical benefits of counseling parents about ECE during well child visits, this AAP recommendation poses potential challenges to the pediatrician. Within a well child visit that lasts, on average, 20 minutes,¹² the AAP and Bright Futures recommend covering a large number of topics related to safety and parenting, and there is a dearth of evidence to help pediatricians prioritize topics most likely to affect child outcomes.^{12,13} To our knowledge, there have been no studies to show that parents' decisions about enrolling their children in ECE are actually influenced by advice from the pediatrician. There is some indication in the literature that parents may welcome such discussions.. For instance, Silverstein et al showed a modest increase in Head Start enrollment when parents were assisted with this process by the pediatrician,¹⁴ and parents have begun to express a desire for more guidance from the pediatrician about learning, behavior, and development.^{15–17} However, other studies have shown that low-income parents, in particular, believe physical health should be the primary focus of well child visits,^{18–20} and parents sometimes resist physician advice that is inconsistent with cultural values or advice given by family members.^{21–26} Like other anticipatory guidance topics that have met parental resistance (e.g. firearm storage, corporal punishment),²⁶ ECE is a topic that can be perceived as non-medical, about which parents are likely to have strong feelings based on cultural values and other sources of advice.²⁷

Furthermore, the decision about whether to enroll a child in ECE is a highly personal one and is influenced by cultural and logistical factors.^{27–30} This decision is particularly complex for low-income families, who may have limited ECE options. Prior studies of families' childcare choices show that low-income children tend to start childcare later than children from families with higher incomes.²⁸ Prior qualitative studies have shown that low-income parents value safety, quality, and convenience²⁹ and that most mothers recognize the importance of learning prior to kindergarten entry. However, the type of childcare they want is not always available,²⁷ and parents sometimes choose relatives as childcare providers for a variety of financial and logistical reasons.³⁰

Given the importance of high quality ECE for young children's safety, development, and lifelong health and achievement, strategies to increase enrollment could have a significant public health impact. However, in evaluating possible strategies, it is essential to assess the value low-income parents place on traditional, office-based, pediatrician-to-parent advice about ECE. It is unknown whether low-income parents perceive the pediatrician as an appropriate messenger or what guidance they may need or want from pediatricians or other medical office staff. In order to devise a culturally-sensitive approach that truly activates parents to seek high quality ECE a critical appraisal is needed of parents' attitudes toward involving the pediatrician in ECE decisions and the barriers they may face in following the pediatrician's advice about ECE. Given the multifactorial nature of ECE decisions and the potential complexities of receiving advice from the pediatrician on such a personal topic, we

used a qualitative approach to capture low-income parents' experiences and attitudes in their own words.

METHODS

Study Overview

We conducted 27 in-depth one-on-one interviews between July 2011 and January 2012 in Cincinnati, Ohio. Interviews were semi-structured and addressed parents' thoughts and experiences when making decisions about enrolling their children in ECE and their perceptions of the role of the pediatrician in these decisions. The study was approved by the Institutional Review Board at Cincinnati Children's Hospital Medical Center, and all participants gave informed consent.

Participants and Recruitment

Participants were recruited from a large, urban primary care center at an academic medical center (35,000 visits per year, 90% Medicaid) and were eligible if they were parents or legal guardians of 3- or 4-year-old patients of the clinic and if they spoke English. Parents of children with severe developmental delay (per parent report) were also excluded because their unique developmental needs were beyond the scope of this study.

We purposively recruited participants with diverse histories of childcare use and diverse racial backgrounds. Potential participants were identified by reviewing the next business day's clinic schedule. Study staff telephoned parents to ask them to participate before or after the clinic visit the next day. When parents could not be reached by phone, they were approached at the clinic visit and asked to participate in an interview after the clinic visit or at an alternate time. Given prior studies of expulsion from childcare related to behavior problems, we also aimed to recruit some children with a history of behavior problems; thus, recruitment letters were mailed to the home addresses of all 3- and 4-year-old clinic patients with behavioral diagnoses on their problem lists. Follow-up telephone calls were made to families who did not respond to the letters. Data analysis was concurrent to collection, and sampling continued until no new information was emerging from participants, thus reaching thematic saturation.³¹

Data collection

Informed consent was obtained from each participant. All interviews were conducted by the principal investigator, a pediatrician, who was trained in qualitative interviewing. (The principal investigator was a practicing physician at the clinic from which participants were recruited but had not seen any of the participants for a clinical visit.) Interviews were conducted in a private room; childcare was provided in a separate room for any accompanying children. Interviews lasted 20 to 40 minutes and were audio-recorded. The interviewer used a semi-structured open-ended question guide that was developed by the investigators for the current study (see Table 1), with in-depth probes to extend and clarify parent responses to questions. Probes were non-leading (e.g. "Tell me more about that."). Participants were asked about any experiences they'd had with discussing ECE with the pediatrician, ways they believed the pediatrician could help with ECE decisions, and whether they thought this was an appropriate role for the pediatrician. As a context for these discussions, parents were also asked to describe current and prior childcare arrangements, factors that influenced their decisions about childcare, information sources about child care options, and difficulties, priorities, and concerns in choosing childcare arrangements. The terms "childcare," "preschool," and "childcare or preschool" were used during the interviews, with additional clarifying questions asked to ascertain the characteristics of the

childcare or preschool setting. All will be referred to as ECE for the purposes of this manuscript.

At the conclusion of each interview, participants completed a demographic questionnaire and were reimbursed for their time with \$25 in cash. The interview recordings were transcribed verbatim.

Analysis

Transcript reviewers were all members of the research team and were from different disciplines (pediatrics (CMB), psychology (EGH), qualitative research (SNS)). All were trained in qualitative analysis. Using an inductive approach, investigators independently read and re-read the transcripts to identify concepts and categories of ideas.³¹ After reviewing 4 transcripts, the investigators met to discuss and define emerging themes and to design a preliminary codebook to label and organize the themes. Transcripts were then coded line-by-line independently by each of the 3 transcript reviewers. At weekly meetings, coding discrepancies were resolved by consensus and the codebook was refined, with new codes added, until all transcripts had been coded. The first four transcripts were then re-coded, using the revised codebook. Finally, codes were refined, checked against the original code definitions for coding drift, and collapsed as appropriate. Coding decisions were recorded in an electronic data base. By using multiple investigators with diverse backgrounds to analyze the data, investigator triangulation was achieved, as diverse perspectives were presented and discussed in a collaborative reflective process.³¹ The most representative verbatim quotes for each theme were selected for inclusion in the results.

RESULTS

Population

Table 2 shows participant demographic characteristics and childcare arrangements. Of the 27 participants, 25 were mothers, 1 was a father, and 1 was a grandmother who had legal guardianship of the child. All of the children were insured through Medicaid. Multiple combinations of childcare arrangements had been used.

Themes

Three themes emerged from our interviews with low-income parents: (1) Participants most commonly turned to family or friends for ECE advice, and though most had never considered a role for the pediatrician, they were open to discussing ECE during well child visits (Table 3). (2) Participants considered their children's individual development and behavior to be important factors in ECE decisions and appreciated advice from the pediatrician about developmental or behavioral readiness for ECE (Table 4). (3) Participants' feared that their children would be abused or neglected in ECE settings, and many avoided ECE prior to age three years, when they felt their children had sufficient language skills to report mistreatment (Table 5).

1) Participants primarily sought ECE advice from family and friends and had not considered a role for the pediatrician, but most were open to discussing ECE during well child visits. (Table 3)—Most participants listed family and friends as the primary people to whom they turned for ECE advice. They frequently stated that their decisions about whether and when to use ECE and the specific providers they chose were influenced by family members' or friends' experiences or recommendations (§1–4). Several participants stated that they trusted ECE advice most when it came from people who could relate to their experiences (§5–6) or who “knew” their children. Participants varied in

whether they felt pediatricians could relate to their experiences or “knew” their children (§7–10).

Most participants had not experienced or considered a discussion with the pediatrician about ECE (§11–12). When asked directly, participants had difficulty speculating on how the pediatrician could be helpful in making ECE decisions. Some said simply that they had already found childcare and didn’t need help (§13–14).

Regardless of how much they felt they wanted or needed the pediatrician’s advice on ECE, participants were accepting of the doctor presenting ECE as an option (§15, 16). Three participants talked about the pediatrician having played an important role in their ECE decisions (§17–19). Participants suggested that discussions about ECE should take place early in the visit, could involve staff other than the doctor, and should be conducted in a respectful and non-judgmental tone.

2) Participants considered their children’s individual development and behavior important factors in ECE decisions and appreciated advice from the pediatrician about developmental or behavioral readiness for ECE. (Table 4)—

Participants frequently mentioned their children’s learning, language development, or behavior as important factors in ECE decisions. They talked about waiting until the child was developmentally “ready” to enroll him or her in ECE (§20–23). Children’s behavior problems influenced participants’ ECE decisions in different ways. Some reported enrolling their children in ECE because family members refused to babysit or the parent “needed a break” due to the child’s behavior. Others kept children out of ECE due to fears about their children harming others or about receiving frequent phone calls about bad behavior, or because the child had actually been expelled (§24–27).

In contrast to the participants that reported waiting for the child to be “ready”, there was another group of participants that believed their children did not need ECE because their development was on track (§28, 29). Participants’ reasons for believing that their children were developmentally “on track” varied and included: ability to recognize letters and numbers, willingness to look at books or to color, cheerleading skills, behavior while playing with other children, toilet training progress, use of cellular phones, and physical height.

Most participants said they would appreciate pediatricians’ input on the developmental and behavioral benefits of ECE and on their children’s readiness for ECE (§30–32). All participants, regardless of their childcare arrangements, expressed a desire for their children to have opportunities for learning in the preschool years and appreciated advice from the pediatrician on how to promote learning at home (§33–34).

3) Participants feared abuse and neglect in ECE settings, and many avoided ECE prior to age 3 years. (Table 5)—

Most participants voiced fears that their children would be abused or neglected in ECE environments (§35). Many participants had specific concerns about childcare providers “being mean to the kids” or not providing adequate attention. A number of participants referenced “the daycare horror stories” (§36–38). Others had a more general fear of the unknown (§39) or had actually experienced maltreatment of their children by childcare providers in the past (§40). As a result, participants sometimes made substantial life adjustments to avoid a non-relative provider. Some alternated work shifts with other relatives (§41). Others stopped working altogether (§42). Two participants became childcare providers, in an effort to satisfy their need for employment without having to be away from their children (§43).

Multiple participants cited age 3 years as the age at which they felt it was safe to use a non-relative childcare provider. They explained that once the child developed the ability to speak in full sentences, they felt that the child would be able to report any inappropriate events that took place in an ECE setting (§44–49). Only one participant reported discussing concerns about abuse and neglect with the pediatrician (§50).

DISCUSSION

Three major themes emerged from this study of low-income parents' perceptions of the role of the pediatrician in ECE decisions. First, though most participants turned to family and friends for ECE advice and had not considered a role for the pediatrician, they were open to discussing ECE during well child visits. Second, participants considered their individual children's development and behavior important factors in ECE decisions and appreciated pediatricians' input on developmental and behavioral readiness for ECE. Last, participants feared their children would be abused or neglected in ECE settings, and many avoided ECE until age 3 years, when they felt their children had developed sufficient language skills to report mistreatment. These findings suggest an important opportunity for pediatricians to address common parental considerations in ECE decisions.

Family and friends played a central role in participants' ECE decisions, and although few participants had discussed the decision with their pediatrician, they were open to the possibility. The rarity with which participants reported discussing ECE with the pediatrician was unexpected, given findings by Silverstein et al in 2003 that 47% of pediatricians reported counseling families about ECE³² and the subsequent AAP recommendation in 2005 that pediatricians should promote high quality ECE.³³ Based on our participants' reports that they hadn't considered discussing ECE with the pediatrician, some parents may be surprised when pediatricians bring up ECE. Involving other family members in the discussion and transitioning into the topic with an explanation of its relevance to the child's overall well-being may make the discussion seem less intrusive. The variation in participants' opinions about how well pediatricians knew their children or could relate to their situations suggests that different approaches may be needed depending on the degree of continuity a pediatrician has been able to establish with a family. Participants also reported being open to receiving ECE from other medical office staff, allowing for the possibility that an ancillary staff member could develop knowledge of community ECE resources and could take the time to converse with parents about their attitudes and barriers to ECE.

The low-income participants in our study considered development and behavior when making ECE decisions. They held both accurate (e.g. recognition of numbers and letters) and inaccurate (e.g. working a cell phone) beliefs about signs of normal development and appreciated pediatricians' input on learning. Therefore, pediatricians may have an opportunity to teach parents about developmental milestones and to stress the educational enrichment that ECE can provide to children who are developing normally. For parents who believe that their children's developmental delay or behavior problems cannot be accommodated in an ECE setting, pediatricians can provide encouragement to enroll in a high-quality ECE program that can actually serve as an intervention for these concerns. Discussions about ECE may also prompt parents to raise such concerns about development and behavior and provide an opportunity for the pediatrician to refer to additional developmental and behavioral services if needed.

Many participants' ECE decisions were motivated by fears of abuse and neglect. Because of these fears, some were entrusting family members or friends to care for their children in unlicensed settings. However, studies have shown that the incidence of fatalities from both accidental and non-accidental injuries are far greater in unlicensed settings than in licensed

childcare centers.¹⁰ While most participants described fears of abuse and neglect in ECE, only one participant reported having talked about these fears with the pediatrician. This finding may indicate that pediatricians need to initiate conversations about fear-related barriers to ECE. Pediatricians can counsel parents about the potential risks of unlicensed childcare arrangements (i.e. inadequate supervision, unsafe sleep practices, presence of adults who have not undergone background checks), in contrast to childcare centers, which typically have policies regarding staff-to-child ratios and safety practices, undergo state-mandated inspections, and require all employees to have background checks.³⁴ Participants described making adjustments to employment situations and sometimes admitted dissatisfaction with their childcare arrangements; therefore, parents may be receptive to practical advice on how to evaluate the safety of ECE environments.

The finding that participants perceived childcare as unsafe until age 3 years was surprising, and to our knowledge, has not been reported elsewhere. This viewpoint is a possible explanation for the documented finding that low-income children tend to begin ECE later than children from more affluent families.²⁸ This perceived age of safety has implications for the pediatrician, as it represents a challenge to promote high-quality ECE at an earlier stage of language development. Studies have shown that by 3 years of age, children from low-income families hear fewer words at home than children from wealthier families,³⁵ that these vocabulary disparities widen as children grow older,³⁵ and that high-quality childcare can boost children's early language development.³⁶ By empowering parents to evaluate the safety of ECE environments in the infant and toddler years, pediatricians may be able to help parents avoid fear-motivated decisions about childcare and meet their goals for their children's early education.²⁷ Another implication of the finding that parents perceive age 3 years as the age of safety is that pediatricians may consider revisiting discussions about ECE when children are approaching three years of age, as parents previously opposed to ECE may be receptive to it at that time.

Our study had some limitations. There may have been selection bias, as parents with the viewpoint that the pediatrician should not be included in ECE discussions may have been less likely to participate in the study. Furthermore, because the interviews were conducted at the medical center by a pediatrician, participants may have been less likely to express the view that the pediatrician should not be involved in ECE decisions. Also, because Latinos make up less than 1% of the population in the county in which the study was conducted, our study lacked the perspective of cultural groups that may have different values regarding ECE and may face additional barriers to enrolling their children in high-quality ECE. Given the large size of the primary care center from which participants were recruited, participants may have been less likely to have an individual pediatrician that they knew well and trusted than if they had been recruited from a smaller practice. Because this was a qualitative study, our findings are exploratory and may not be generalizable to other populations. However, this methodology did allow participants to express their views in their own words, offering rich and complex data about their experiences. Further research is needed to determine the prevalence of various types of attitudes about the pediatrician's role in ECE and potential strategies for outreach to parents with various viewpoints.

CONCLUSIONS

Although participants primarily sought advice from family and friends about ECE, they were generally accepting of a conversation about ECE with the pediatrician. Pediatricians may have an opportunity to correct parental misconceptions that children with developmental delay or behavior problems cannot go to preschool, when in fact, preschool may be a powerful tool in promoting appropriate development and behavior. Participants in our study had profound fears about the safety of ECE environments, and pediatricians have

an opportunity to counsel about the key attributes of safe childcare and thereby empower parents to find safe, high-quality ECE. Many participants who had avoided care by a non-relative in infancy considered ECE to be safe when their children reached three years of age. When this is the case, pediatricians may address common fears about safety when the child is under three and, in parents who remain reluctant, revisit the topic of ECE once the child turns three.

These findings, along with future research on the role of the pediatrician in advising parents about ECE, can inform the development of effective processes within the primary care setting for identifying families' needs and values surrounding ECE and providing the support that families need to place their children in safe and enriched learning environments. Future studies should also explore the role of community collaborations and additional or alternate settings for promoting high-quality ECE to parents of young children.

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Table 1**Interview Questions**

Questions
I want to talk to you a little about childcare. To start, tell me about the current childcare arrangements that you have for your child.
For each arrangement:
What do you like about that?
What don't you like about it?
Think back to when you were first deciding whether and where to enroll your child in childcare or preschool. What was that experience like?
Do you have the same arrangements for your child now, or have they changed?
[If they have changed] What was the most recent change that you made?
Why did you make that change?
How did you choose this new arrangement?
Who do you talk most with about decisions about your child?
Did you talk to this person when you were deciding about childcare as well? Do you remember what kinds of things you talked about?
Where did you get information about your childcare or preschool options?
Were there things that you wanted to know about childcare or preschool but didn't know how to find out? Tell me more about that.
Have you ever discussed childcare or preschool with your child's doctor?
[If yes:] Who brought up the subject? Tell me what you can remember about that conversation.
[If no:] How would you feel about talking about childcare or preschool with your doctor or other staff at the clinic? Would it matter if it were a doctor that you know well versus another doctor? Would it matter if it were a doctor or another staff member?
What kind of discussion with the doctor or other clinic staff about childcare or preschool do you think would be helpful?
[If in a center-based childcare or preschool] Did you face any problems when you tried to enroll your child in childcare or preschool? If so, tell me about those problems.

Table 2

Participant Characteristics

Characteristic	n	%
All	27	100
Participant's relationship to child		
Mother	25	93
Father	1	3.5
Grandmother	1	3.5
Participant's age		
22 years or younger	3	11
23–30 years	12	44
31 years or older	10	37
Participant's race		
Black, non-hispanic	21	78
White, non-hispanic	6	22
Participant's education		
< High school	3	11
High school	14	52
College	8	29
Child's Age		
3 yo	12	44
4 yo	15	56
Child's Gender		
male	14	52
female	13	48
Child's Insurance Status		
Medicaid	26	100
Private insurance	0	0
Childcare History		
Always with parents	1	3.5
Always with parent, who is a childcare provider	1	3.5
Always with parents or other relatives	5	19
With parent until age 3 or 4, then preschool	6	22
Center-based care and preschool only	7	26
Combination of family childcare home and center-based care	5	19
Non-relative family childcare home only	1	3.5
In childcare previously, now home with parent	1	3.5

Table 3

Participants primarily sought ECE advice from family and friends but were open to discussing ECE with the pediatrician.

Theme	Quote
ECE decision influenced by family/friends experiences	¶1 My mom's friends that have children, they recommended me there also because they live in the neighborhood we do. And that's what also just told me, 'Okay, he can go there then. Their kids are there.'
	¶2 I know her teacher. It's my boyfriend's aunt.
	¶3 [I learned about preschool] from friends, family, taking they kids to preschool. You know, going with them and pick their kids up. Just seeing a lot of stuff that they do.
	¶4 [My friends said] they were trying to potty train their kids and the childcare centers or the person that was keeping them wasn't supportive of that.
Wanted ECE advice from those who could relate to their experiences or knew their children	¶5 I could trust my mother or [my partner's] mother...cause they a little bit older. They been there before.
	¶6 We're just a real tight-knitted family...We all kind of grow up together. All our kids are about the same age... So we all go back and forth. We call each other all the time, like, "What do I do?"
Varied in whether they thought the doctor could relate to their experiences or knew their children	¶7 [The doctors] were really helpful. Like, they told me exactly where [the childcare centers] were and how it was, and that their kids went there, and I felt like I could trust them.
	¶8 [The doctor] knows the child better than the stranger that's gonna put the child wherever the kid's gonna fit.
	¶9 The doctor don't really know my child. So, I don't feel like I should be talking to them about childcare.
	¶10 I mean, I took their opinion, but at the same time, you'd probably listen to your mom just like you listen to your mom before a doctor try to tell you something about your baby. So, you know, it's better when it's inside than somebody outside looking in, cause they don't really know....So I was just like, 'Okay. Whatever. Let me ask my mama.'
Hadn't experienced or considered talking to the doctor about ECE	¶11 I can't say that anyone [at the doctor's office] has ever offered any childcare [advice].
	¶12 I'll be honest, I really didn't never think actually about the doctor, you know, helping make decisions with the daycare.
Didn't feel they needed the doctor's help	¶13 I found it....I don't need to know nothing about preschool. I pretty much know it all.
	¶14 I probably would've asked [the doctor] about [childcare] if I hadn't already found one, but [I'd already found one.]
Most were receptive to the doctor presenting ECE as an option	¶15 I wouldn't get offended from nobody trying to talk to me about nothing. I'll talk to them. They state their opinion, I state mine. You can always learn something new every day. Or you can listen, see what someone has to say.
	¶16 I think just putting it out there, you know...just being visible. 'Hey, this is what we represent. We're here if you need us....Just take a look at it. You don't have to.'
Some said doctor was influential in ECE decisions	¶17 My doctor, she really recommended it....everything about interacting with the other kids and everything is from my doctor, like basically, like, telling me this is what he really needs.... Cause I did know, but I didn't.
	¶18 It made me a lot more comfortable leaving my kids there at the daycare after having my doctor tell me to do something just as simple as that [observe other childcare workers in the same room while talking to another childcare worker]. It was just wonderful. It made me feel a lot – very calm about leaving them there. Because when I went in, I was in tears. And by the time I came out, I was still in tears, but they were happy tears.
	¶19 [The doctor] actually set me up with [the county benefits office] to help me get help with paying for childcare....That was helpful.

Table 4

Participants considered their individual children's development and behavior important factors in ECE decisions and appreciated the pediatrician's input on their children's readiness for ECE.

Theme	Quote
Believed children need to be developmentally "ready" for ECE	¶20 She was premature. She was a little behind... I can just tell on my own that she's not ready for [preschool] yet. So probably, like, next year, I'll sign her up for [preschool].
	¶21 We all say [my daughter] is ready for school. Like, everybody like, "Put [her] in preschool." ... [She'll] get a pen and she don't write words, but she makes sure she's in the lines and she'll write real small like, little circles or something.
	¶22 I just didn't really know if [my child was] ready [for preschool]. I wanted [a childcare] that was good, teaching them, develop well, get 'em into school.
	¶23 I tried [to enroll him in preschool] last year, right after he turned three. And he just cried and cried, and I had got advice from a teacher [who said], "Well, I think he's a little too young."
Saw behavior problems as a barrier to enrolling in ECE	¶24 [I worried about] bullying. I know she would have [bullied the other kids].
	¶25 I'm just worried about, like, if he gonna hit somebody.
	¶26 [My child] kept being abusive, and they kept calling me at work and having me miss work and that counts against me.
	¶27 She's been kicked out of daycare.... She was only two. She got kicked out of daycare! I was frustrated, I was upset.... Like, it feels like, "Why would you guys kick a kid out of daycare?" But they said [they were concerned about] the safety of the other children, which is understandable.
Saw ECE as unnecessary when children were developmentally on track	¶28 He memorizes, and he knows what he's doing, so I don't feel like he needs to go [to preschool].... I mean, if there was a problem to where I felt like they weren't catching on, then maybe I'd look outside the box, but I never had that problem.
	¶29 He's a very smart boy. As I said, he knows how to work my touch phone.
Appreciated doctor input on developmental benefits of ECE and developmental readiness of the child	¶30 Somebody needs to push the importance of what you learn at ages 3 and 4 will prepare you for kindergarten – or will set you back.
	¶31 [The doctor] said that my son needs to interact with other kids and it'd be a great learning experience for him... and I told her, "He's not good with sharing," and she's like, "Well they'll take care of that in school." Because I thought that I [would be] the outcast when I [took him to preschool], like, "You're gonna be calling me. My kid doesn't like to share." But it's gonna be a great thing for him to do.
	¶32 And I think a doctor knowing the history of the child probably would be able to say "This probably be a good program" or "She's not ready for this" or "This is a way that you could get her ready."
Appreciated advice on promoting learning, regardless of ECE choices	¶33 Every time we come in [to the pediatrician's office], they'll have a book for them that they can take back and read their books and go over colors. The little flyers that they give you on their age level; that's really helpful.
	¶34 I just tell [the pediatrician] the same thing I just told you. I mean, pretty much, I choose to keep [my child] at home.... and they've even given me, like papers on stuff I can do at home with him.

Table 5

Participants feared their children would be abused and neglected in ECE settings, and many avoided ECE prior to age three years.

Theme	Quote
Fears about abuse and neglect in ECE settings	¶35 It's a scary, scary thing to leave your children with someone else.
	¶36 You see so much. So many horror stories of things that, accidents that didn't need to happen.
	¶37 A lot of people be doing a lot of stuff to people's kids.
	¶38 [I worry about] people pinching my kids. Everything.... I heard a lot of stories.
	¶39 Someone can be so friendly to your face, and then a door closes and you leave and it could be a whole 'nother story.
Work and schedule adjustments to avoid ECE	¶40 [The childcare providers] left my daughter on the toilet, the adult-sized toilet, and didn't even have a child potty there – for hours. She came home with bruises on her legs for sitting on it for so long.
	¶41 Well, my mom, we switch off, cause I work 3 rd shift, and she work 1 st shift....I'm just gonna settle with the 3 rd shift job I have and my mom is a better person that can watch him.
	¶42 By me not wanting her to go to daycare, I was just a stay at home mom, though it was time for me to go back to work.
	¶43 I didn't get the feeling that [my children] would be okay [in any of the childcare arrangements I considered], so I just became [a childcare provider] what I was looking for.
	¶44 They tell you when people hit 'em at that age. They will. They'll tell.
Believed ECE was safe at 3 years of age	¶45 You gotta be a certain age. You gotta learn how to talk before I put you anywhere. You gotta learn how to talk, cause you don't know what people do to your baby.
	¶46 [She's been in childcare] since she was three. Cause I was kind of scared of the daycares.... I wanted her to be able to talk and communicate before I put her in....so with her being under 3, sometimes their language is far and sometimes it's not. I was just one of the lucky ones that mine's were always advanced.
	¶47 I'm okay with her being in a group setting now cause she's a little more advanced. She knows what's going on. She knows right from wrong. But when she was younger, I wanted her in a small setting because I didn't want too many people dealing with her. She wasn't able to tell everything.
	¶48 I wait til my kids talk to put them in daycare.
	¶49 I waited until I knew she was able to talk so she could tell me if she was being mistreated.
One parent sought advice from pediatrician about fears	¶50 I remember asking [the doctor] ...how to gauge if my child's gonna get the appropriate attention that they need [and] if somebody's being mean to 'em at the daycare.