EXAMINATION OF THE SOCIAL EMOTIONAL ASSESSMENT MEASURE (SEAM) PARENT-TODDLER INTERVAL

by

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DISSERTATION ABSTRACT

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Title: Examination of the Social Emotional Assessment Measure (SEAM) Parent-Toddler Interval

Parent-child relationships serve as the foundation for social emotional competence in young children. To support the healthy social emotional development of their children, parents may need to acquire information, resources, and skills through interventions that are based upon assessment of parent competence. This manuscript presents results from a study of parents of toddlers and the practitioners who serve them in a suburban area of the Pacific Northwest. The purpose of the study was to conduct initial psychometric studies on a curriculum-based tool, the Social Emotional Assessment Measure (SEAM), focused on improving parent-child interactions for parents of toddlers. Convergent validity and utility were investigated for the SEAM Parent-Toddler Interval. Findings suggest that the SEAM Parent-Toddler Interval is an appropriate tool that can identify the strengths and needs of parents and assist in designing quality interventions that might alter developmental trajectories, leading to improved family and child outcomes.

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In Loving Memory of my parents, Robert Jay Church, Sr. and Sharon Jean Church, and older siblings, Nancy Marie Church and Robert Jay Church, Jr.
Their unwavering devotion to me during my early childhood years provided a strong foundation on which all of my future success has been built.

TABLE OF CONTENTS

Chapter Page

Chapter Page

Chapter Page

Chapter Page

LIST OF FIGURES

Figure Page

LIST OF TABLES

Table Page

CHAPTER I

INTRODUCTION

"Every child needs someone who is crazy about them."

Urie Brofenbrenner

Importance of Social Emotional Development

Early childhood is an important time for building a strong foundation for social emotional competence that will have a lifelong impact on overall success and wellbeing (Boris & Page, 2012; Milagros Santos, Ostrosky, Yates, Fettig, Cheatham, Shaffer, 2011; Saarni, Mumme, & Campos, 1998). When the foundation is a solid one, young children most often go on to enjoy positive relationships with others, school success, and robust mental and physical health (La Paro & Pianta, 2000; Guralnick, 2011; McClelland, Morrison, & Holmes, 2000; National Research Council, 2001; Raver & Knitzer, 2002; Razza, Martin & Brooks-Gunn, 2010; Wolery, 2000). Without a strong foundation of early support, however, there is a high possibility of poor outcomes (e.g., school failure, mental health, crime, illness) (Caffo, Lievers, & Forresi, 2006; Cuffe & Shugart, 2001; Eitzen & Eitzen Smith, 2009; Guralnick, 2011; Miller, Sadegh-Nobari, Lillie-Blanton, 2011; Mitchell & Hauser-Cram, 2009; Rapheal, 2011; Rondero Hernandez, Montana, & Clark, 2010; Seccomb, 2000; Shonkoff, 2010).

Neurobiological Foundation of Social Emotional Development

Neuroscience findings suggest that early experiences, both before and after birth, shape our capacity to learn, our behavior, and our physical and mental health (MacLean, 1985; Nelson, 2000; Odom, McConnell, & Brown, 2008; Shonkoff, 2010). Biologically, the experiences that a young child has influence the formation of the brain's circuitry

(Greenough & Black, 1992; Suzuki, 2007). First, the brain builds basic circuits that are responsible for foundational skills and then more complex circuits, which lead to the development of more complex skills (Huttenlocher & Dabholkar, 1997). The interplay between genetics and experience that constructs brain architecture is embedded in the reciprocal relationships that young children have with the adults in their lives (Couperus & Nelson, 2006; Elbert, Heim, & Rockstroh, 2001; Shonkoff, 2010). The brain is a highly integrated organ with various components responsible for different processes such as processing emotions and cognitive functioning (Konner, 1991; Shima, Isoda, Mushiake, & Tanji, 2007). Healthy social and emotional competence often leads to more positive and productive learning. However, if a child is dealing with significant stress and fear, learning can be hindered (Courchesne, Chism, & Townsend, 1994; Singer, 1995). Thus, healthy development, both cognitive and social emotional, are inextricably linked. Unstable relationships, including early abuse and neglect, will disrupt the circuitry in the brain's architecture, and can create significant stress and a host of problems for the child over time (Fox, Keller, Grede, & Bartosz, 2007; Lutzker, 2000; Nelson & Bloom, 1997; Oddone-Paolucci, Genious, & Violato, 2001; Shore, 1997; Shonkoff, 2010; Whipple, 2006). The brain is more plastic and malleable in the early years, which is why intervention aimed at supporting the healthy development of infants and toddlers is optimal (Als et al., 2004; Boris & Page, 2012; Jones Harden & Duchene, 2012).

Parent-Child Interactions

Of the factors that influence early development, parent-child relationships have the greatest significance (Boris & Page, 2012; Razza et al., 2010). These early connections underscore the critical function that sensitive, nurturing, and responsive care giving has

on social emotional development (Calkins & Hill, 2007; Thompson, 2006). Whether young children respond to their environment with a sense of security or insecurity is largely the result of their earliest attachments to parents[1], according to attachment theory (Bowlby, 1969; Ainsworth, 1973). Through timely, responsive, and positive parent-child interactions, the child learns emotional regulation and social competency (Boris & Page, 2012). As secure attachment in the early years has been identified as predictive of later social emotional competence (Crittenden & Claussen, 2000; Crowell & Treboux, 2001), a healthy parent-child relationship is essential for optimal development.

Children with Environmental Risk Factors

For many young children, social emotional problems may be associated with environmental risk factors such as unsupportive parenting behaviors, early adverse experiences, and stressful socioeconomic circumstances (Lamb-Parker, LeBuffe, Powell, & Halpern, 2008). Parental stress, particularly when affected by multiple stressors, has a significant impact on parenting behavior and capacity to function (Saisto, Salmela-Aro, Nurmi, Halmesmaki, 2008). When parents lack realistic expectations, coping skills, and have ineffective discipline strategies, the risk of child maltreatment is extremely high, especially when patterns of abuse are established within the family (Fox et al., 2006; MacMillan, Thomas, Jamieson, Walsh, Boyle, Shannon, & Gafni, 2005). This risk is particularly true when parents have mental health or addiction issues that impair their ability to nurture and protect their young (Miller et al., 2011). Parental mental health problems (e.g. depression, anxiety) can be a serious risk factor for infants and toddlers, and may result in attachment disorders, emotional dysregulation, behavior problems, and

[1] "Parent" will be used to refer to parents and primary caregivers of young children, including foster and grandparents.

lower cognitive competence in the child (Farran, 2005; Razza et al., 2010).

Low income may also be related to higher rates of maternal depression, stress, and punitive parenting practices (Gennetian, Castells, & Morris, 2010). Parents experiencing poverty may interact with their young children in a style that is less nurturing, sensitive, and consistent due to the constant stress they face (Seccombe, 2002). Due to this constellation of stressors as a result of living in poverty, low-income children may be at high risk for poor developmental outcomes (Dumont, Mitchell-Herzfeld, Lowenfels, Greene, & Dorabawila, 2006). These associated mental health problems of children may become increasingly entrenched over time and more difficult and costly to resolve (Fox et al., 2007).

Negative family environment, regardless of economic conditions of the family, can lead to challenging behaviors of young children (Mitchell, et al., 2009). These behaviors are more likely to develop in children when parents experience high levels of stress, including marital disharmony (Mitchell & Hauser-Cram, 2009). Conversely, children who live in environments that are harmonious demonstrate better social emotional functioning (Mitchell & Hauser-Cram, 2009).

Children with Behavior Challenges and Disabilities

Infant and toddler behaviors can negatively impact the parent-child relationship, such as poor temperamental fit, difficult temperament, and disabilities (Beeber & Canuso, 2012; Hanson, 1984; Ramey & Ramey, 1998). Children with developmental disabilities tend to have higher rates of challenging social emotional behavior (Baker, McIntyre, Blacher, Crnic, Edelbrock, & Low, 2003). Behavioral challenges in young children may be related to neurological disorders or other established conditions, such as autism,

extreme premature birth, and fetal alcohol syndrome, which may inhibit self-regulation skills (Eisenhower, Baker, & Blacher, 2005; McConnell, Rush, McEnvoy, Carta, Atwater, & Williams, 2002). Furthermore, parents may have a harder time coping with significant health or care needs or the unique characteristics presented by young children with disabilities, which place even greater stress on the family and negatively impacts parent-child interactions (Guralnick, 2011).

Need for Appropriate Assessment for Parents/Caregivers

As parent-child relationships serve as the foundation for social emotional competence, there is a significant need to find ways to identify parental resources required for supporting the healthy social-emotional development of their children. Interventions that support parent competence are critical as parents can mediate child competence by providing a supportive environment for positive interactions and healthy social emotional development. Unfortunately, currently there are a limited number of assessment tools that can identify caregiver competence and assist with designing intervention. A curriculum-based tool that could identify the needs of caregivers and target their strengths and needs, would be a powerful tool for assisting in quality interventions that might alter developmental trajectories, leading to improved family and child outcomes.

Purpose of the Study

The purpose of this study is to conduct initial psychometric studies on a curriculum-based tool, the Social Emotional Assessment Measure (SEAM), focused on improving parent-child interactions for parents of toddlers. Convergent validity and utility will be investigated for the SEAM Parent-Toddler Interval.

Research Questions

Specifically, this study will address the following two research questions:

1. What is the convergent validity of the SEAM Parent-Toddler Interval?

    1A. What is the agreement of parent scores on the SEAM Parent-Toddler Interval with the Parenting Stress Index – Short Form?

    1B. Will parents with lower scores (less competence) on the SEAM Parent-Toddler Interval have children with higher scores (indicating problem behavior) on a screening test, the Ages & Stages Questionnaire: Social Emotional?

    1C. What is the difference in perceived parent competence for parents of toddlers with three levels of risk for developmental delay (no known risk for delay, high risk for delay, and established developmental disability), as measured by the SEAM Parent-Toddler Interval?

2. What is the utility of the SEAM Parent-Toddler Interval for practitioners and parents?

CHAPTER II

REVIEW OF LITERATURE

In this chapter, I discuss relationships between parenting competence and children's social emotional skills, pointing to the importance of healthy social emotional development. A review of the literature including social emotional needs of young children, theoretical framework related to child development, influence of parenting practices and parent competence, and contributions of risk and protective factors on child outcomes is presented. Finally, the need for appropriate assessment of parent competence is addressed.

Relationship between Social Emotional Competence and Parenting Practices

The fundamental underpinnings of early childhood development include research, theory, and practice that support the notion that child development arises out of interactions between children and their primary caregivers within the context of the family environment. Furthermore, the ongoing interactions between biological and environmental factors contribute to the level of developmental achievements of children. Children may experience multiple and severe disorders due to prenatal or perinatal factors, birth complications, and trauma and neglect in early childhood. Research has offered new insights into how critical early childhood experiences and healthy brain development is in the first years of life (Shore, 1997). Social-emotional competence is a multidimensional construct that includes constellations of skills associated with self-regulation, self-concept, self-efficacy, and prosocial behavior toward adults and peers (Funtuzzo, Bulotsky-Shearer, McDermott, McWayne, Frye & Perlman, 2007).

Theoretical Basis of Social Emotional Development

Several human development theoretical models have been guiding policies and practices in early childhood over the past several decades including: 1) transactional model (Sameroff & Chandler, 1975), 2) ecological model (Bronfenbrenner, 1979), and 3) biological-behavioral attachment system (Bowlby, 1982). Proponents of the transactional perspective suggest that the quality of the exchanges between the child and his or her environment is an important factor in development and the reciprocal relationship between the parent and child influences how children develop over time as both are changed by each interaction (Sameroff & Chandler, 1975). Attachment theory **(**Bowlby, 1969; Ainsworth, 1973) is a highly regarded way to account for differences in how young children perceive and respond to their environments, emphasizing the importance of the parent-child relationship (Colin, 1996; Siegel & Hartzell, 2004). As a caregiver quickly and sensitively responds to a young child's needs (e.g., ability to notice and appropriately respond to child's cues), the child learns general expectations of their own worthiness and the availability of others (Bowlby, 1969). Attachment theory further helps to explain typical and atypical social emotional attachment to a primary caregiver (secure vs. insecure), which is attributed to internalized views and expectations for subsequent relationships and self-worth (Bowlby, 1969). Ecological-based theory suggests that children are affected by the interrelatedness of historical, social, and cultural elements in an environment (Bronfenbrenner, 1979). These three models provide a foundation for understanding how social emotional development outcomes are influenced and shaped by dynamic interactions between children and their parents, the risk and protective factors in their environment, and larger social and cultural contexts that influence the child and

family. Together these models highlight the reciprocal nature of parent-child interactions and the importance of safe, nurturing caregiving environments.

Temperament and Goodness of Fit Model

Individual children enter the world with a unique way of responding to their environment. The differences between responses may be associated with genetic and biological processes that may predispose them toward certain characteristic traits, known as temperament (Chess & Thomas, 1999; Kagan & Fox, 2006; Rothbart & Mauro, 1990). Temperament behavior and response style include: 1) fearful distress, 2) anger/frustration, 3) positive affect, 4) activity level, 5) attention span/persistence, and 6) regularity. Temperamental traits tend to endure over time, profoundly influencing development through how the child responds to his/her environment from infancy to adulthood (Caspi & Silva, 1995). When parents understand their child's temperament, they can adapt the environment and their reactions to better match the unique needs and expectations of the child, thereby creating "goodness of fit" (Chess & Thomas, 1999). Additionally, parents benefit from understanding their own temperament and the areas where they may experience conflict with their child, allowing for positive strength-based strategies to emerge and reducing frustration for both parent and child.

Role of Parent

Although parenting is one of the most important and challenging endeavors individuals undertake in adulthood, preparation and training to become competent in this supportive role is often lacking (Webster-Stratton & Hancock, 1998). Addressing the significant needs of young children, even under the best of circumstances, can feel overwhelming to many parents (Francis-Connolly, 2002). External stressors can further

challenge a parents' ability to appreciate the needs and motivations of young children, causing them to ascribe negative attributions to behavior, which can adversely influence parent-child interactions and disciplinary methods (Miller, 1995; Raikes & Thompson, 2005). The early years can be an amazing time for a young child, filled with curiosity to explore and learn about the world, grow in autonomy, and enjoy positive social connections. However, it can also be a challenging time, punctuated by strong emotions, immaturity, and limited coping strategies as young children attempt to navigate their environment. By having a healthy, safe living environment and positive guidance and support from competent parents, young children can attain a high level of skill and proficiency in their overall development, especially in the social emotional domain. Positive early interactions between parent and child form the foundation for development, influencing early social and emotional development, particularly emotional regulation (Calkins & Hill, 2007; Weinfield, Sroufe, Egeland, & Carlson, 2008).

As children grow, self-regulation allows them to manage internal states, enjoy social exchanges, engage in learning opportunities, solve problems, delay gratification, and manage adversity (Boris & Page, 2012). Young children benefit from having emotionally strong and responsive parents who can teach them to be calm, helping avoid long-term problems with stress and over reaction (Cozolino, 2006; Malik, 2012; Schore, 2001). When young children experience overwhelming feelings (e.g., rage, fear, distress), the brain and body release primitive impulses and actions (e.g. hitting, biting, screaming, running away), requiring a caring adult to provide support to reduce the charge and high state of arousal (Malik, 2012). Children who regularly lack support in regulating their emotional pain, manifested in neurochemical and hormonal activation, are at high risk for

the brain hardwiring into an over-reactive stress response system (Schore, 2001; Shonkoff, 2006). An over-reactive stress response system contributes to poor mental health (e.g. depression, anxiety, phobias and obsessions, lack of excitement or desire) and physical health (e.g. illness, lethargy) problems over the life course (Malik, 2012; Shonkoff, 2006). The key factor in parents' ability to successfully manage their child's intense arousal state is having the capacity to effectively manage their own stress response (Coyl, Roggman, Newland, 2002).

Developmentally Appropriate Environments

Parents can mediate children's social emotional competence by providing a supportive environment that encourages positive social emotional interactions, emerging independence, and healthy overall development. Young children thrive when their need for predictability, routine, and structure is met. Beneficial experiences that support optimal development include having a stimulating environment with developmentally appropriate materials that encourage individual interests and support unique needs (Guralnick, 2011). Ample nutritious food, routine medical care, active supervision, protection from exposure to violence, environmental toxins and home safety issues, and opportunities to be part of parental social networks are examples of supportive environmental activities (Guralnick, 2011).

Family Composition

Family composition can directly influence the overall well-being of a young child, creating a wide range of environmental conditions that may help or hinder his or her development. Young children may experience less stability in their living situations due to trends in family composition, including higher numbers of single parents, divorce,

blended families, and multiple partnerships (Kreider, 2007). In 2010, resources for many parents were significantly compromised due to an increase in the number of children who were living in single-parent homes and a decrease in the number of children living with two married parents (Federal Interagency Forum on Child and Family Statistics, 2011). This increase in the number of children living in single-parent homes may contribute to less stability in the family living environment for many young children and negatively impact their developmental outcomes.

Risk and Protective Factors

Over time, experiences, either adverse or protective, can impact a child's developmental outcomes (Notter, MacTavish, & Shamah, 2008; Sameroff, 2009; Sameroff, 2010). Factors that can influence child development include socioeconomic class, race, heredity, education levels of the parents, and environmental conditions (Dunst, 1993; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). While risk factors may have a negative impact on developmental outcomes, factors can also buffer or serve as protective influences for children living in challenging environments (Dunst, 1993; Werner, 2001). Some children are considered resilient and, despite their subjection to adverse childhood experiences and multiple environmental risk factors, have exceptional developmental outcomes, well beyond that which would be expected (Bullis, Walker, & Sprague, 2001; Notter et al., 2008; Werner, 2001).

Risk Factors

Risk factors are the conditions that contribute to a higher chance of negative developmental outcomes, though these outcomes may not have yet manifested (Brooks-Gunn, 1990; Dunst, 1993). Risk factors can negatively influence development in a

cumulative, interactional, and transactional manner (Dunst, 1993; Sameroff, 2009). The potential for negative developmental outcomes increases with the number of risk factors present (Dunst, 1993; Dunst & Trivett, 1992; Samerhoff, et al., 1987). Research demonstrates that a child is placed at significant risk when three or more identified risk factors are present (Dunst, 1993). Cumulative exposure to adverse conditions increases the risk of negative developmental outcomes (Notter et al., 2008; Saisto, Salmela, Nurmi, & Halmesmaki, 2008). When considering risk factors, cumulative risk is the best predictor of negative developmental outcomes due to various factors working together in an additive manner (Gassman-Pines & Yoshikawa, 2006).

Serious Risk Conditions

For some children, serious risk factors exist that compromise healthy social emotional development. Young children may have multiple serious risk factors such as child abuse, exposure to domestic violence, parental mental health and substance abuse issues, and toxic stress that contribute to poor developmental outcomes. The risk of serious mental health issues (e.g. depression, antisocial behaviors) increases with the length of time children spend in adverse conditions (Seccombe, 2000). Signs that the child is experiencing distress when social emotional needs go unmet may include: excessive crying or clinginess, developmental delay, regression to earlier behavior, excessive irritability, withdrawal, anger and behavior problems (Malik, 2012). Social emotional behavior problems appear to be both a predictor and outcome variable for poverty, inadequate parenting skills, substance abuse, academic failure, lack of healthy social support, and poor social skills (Bullis et al., 2001).

Child abuse. The prevalence of abuse and neglect is consistently higher for infants

and toddlers, with rates of substantiated cases exceeding 175,000 nationally (Gaudiosi, 2003). Infants and toddlers also have the highest rates of foster care placement due to abuse and neglect, which has additional negative implications for the child's sense of stability and developmental outcomes (Wulczyn, Hislop, & Harden, 2002). Children under the age of three years are extremely vulnerable, not only because of their physical dependency, but also because of the important social emotional development occurring at this age (Whipple, 2006). The developmental impact of child abuse and neglect is most devastating in early childhood, impacting brain development and leaving infants and toddlers vulnerable to serious long-term consequences (e.g., deficits in language, poor cognitive skills, behavior problems, academic failure) (Anda, Felitti, Walker, Whitfield, Bremner, Perry, Dube, & Giles, 2006; Caffo et al., 2006; Lutzkar, 2000; Oddone-Paolucci et al., 2001).

Children who have experienced abuse and neglect are at high risk for developing behavioral and mental health problems (e.g. aggression, self-abuse, depression, anxiety) (Caffo, et al., 2006; Cuffe & Shugart, 2001). Sexually abused children are consistently found to display inappropriate sexual behavior (Zurbriggen & Freyd, 2004). Although many young children have emotional challenges as part of their typical developmental course, serious behavior problems can lead to an increased risk of child abuse and mistreatment, particularly when parents lack realistic expectations, coping skills, effective discipline strategies, and experience already high levels of stress, which contributes to a negative cycle of mistreatment and exacerbation of problem behaviors (Fox et al., 2006).

Child abuse, neglect, and maltreatment occurs in families who may or may not experience poverty; however, overrepresentation of families experiencing poverty in the child welfare system is related to ongoing economic struggle, adverse conditions, and other stressors, which place the family at increased risk for child abuse and neglect, especially for those experiencing extreme poverty (Jonson-Reid, Drake, & Kohl, 2009; Guralnick, 2011). The socioeconomic status of the family may influence social competence through levels of parental stress, socialization, social support and stability in the home environment (Odom et al., 2008). Currently, there are more than 24 million children under the age of six who live below of the federal poverty line (Social Policy Report, 2009), who are at high risk for mistreatment and poor developmental outcomes (Dumont, et al., 2006) and at higher risk for social-emotional issues and behavioral challenges (Seccombe, 2002).

Exposure to domestic violence. Even when young children are not the targets of interpersonal violence, exposure to violence - typically marital conflict – has been linked to social emotional, psychological, and behavioral (both externalizing and internalizing) issues (Kitzmann, Gaylord, Holt & Kenny, 2003). An estimated 1 million to 4 million young children experience exposure to interpersonal partner violence (Edleson, 1999). Witnessing domestic violence can be terrifying and cause serious consequences for a young child. In light of this seriousness, the act of a child seeing or hearing episodes of domestic violence falls under the category of psychological maltreatment (Sommer & Braunstein, 1999).

Parental mental health problems. Because strong attachment is vital to healthy child development, mental wellness of parents plays an important role. Stress, maternal

depression, and other mental health issues can influence parenting behaviors and competence, inhibiting protective and sensitive care giving that the young child requires (Farran, 2005; Mitchell & Hauser-Cram, 2009; Razza et al., 2010). For infants and toddlers, approximately 30% of mothers suffer from chronic depression and anxiety disorders, which can have a negative impact on child development (Beeber & Chazan-Cohen, 2012). For parents experiencing poverty, the number of mothers reporting symptoms of depression, maladaptive behaviors, and suicidal tendencies is significantly higher than parents in higher income categories, with over 50 percent reportedly affected by mental health complaints (Center on the Developing Child at Harvard University, 2009; MacMillan, et al., 2005; Rondero Hernandez, et al., 2010). Unfortunately, most of these women will never receive professional treatment (Vesga-Lopez, Blanco, Keyes, Olfson, Grant, & Hasin, 2008). Due to the serious risk factors presented by parents' emotional instability, young children may fail to develop healthy social and emotional skills and experience mental health problems (e.g. failure to thrive, flat affect, excessive hitting or biting, poor attachment, inconsolable crying, feeding and sleep difficulties) (Bayer, Hiscock, Ukoumunne, Price, & Wake, 2008; Farran, 2005; MacMillan et al., 2005; Razza et al., 2010).

Parental substance abuse. Early development can be seriously affected by parental use and abuse of substances, legal (e.g., alcohol and prescription drugs) and illegal (e.g., methamphetamines, cocaine, heroin). Substance abuse can impair a parent's ability to provide a safe and positive environment, contributing to social emotional deficits for young children (Miller et al., 2011). Furthermore, prenatal exposure can affect brain function, resulting in premature delivery, difficult behavior (e.g., impulsivity,

hyperactivity, irritability) and learning disabilities (McConnell, Rush, McEvoy, Carta, Atwater, & Williams, 2002). A combination of the effects of prenatal exposure (e.g. regulation problems) and continued substance abuse can create an unhealthy care giving environment (e.g., low maternal sensitivity, attachment disorders, unskilled parenting practices) and negatively impact parent-child interactions (Frosch, Cox, & Goldman, 2001; Miller, et al., 2011; Seccombe, 2002; Velderman, Bakermans-Kraneburg, & Juffer, 2006). Furthermore, parental substance abuse may be coexisting with untreated mental health problems, adding complexity to the tenuous parent-child relationship and potentially disrupting healthy development for a young child.

Adverse Childhood Experiences (ACE) Study

The Adverse Childhood Experiences (ACE) Study is a major American research project conducted through a collaboration between the Center for Disease Control and Prevention (CDC) and Kaiser Permanente's Health Appraisal Clinic that used data collected from more than 17,000 adults in Southern California from 1995-97 (Felitti, Anda, Norndenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998). Participants in the study were asked to report whether they had experienced specific types of adverse childhood experiences when they were under the age of 18. What the researchers discovered is that there are important connections between adverse early childhood experiences, which are much more common than previously realized, and long-term impacts on development and health. Early exposure to traumatic events, particularly child abuse (physical, emotional, or sexual), neglect (physical or emotional), and household dysfunction (witnessing domestic violence, a household member with mental illness, substance abuse, incarceration, or parental separation or divorce) were linked to increased

probability of behavioral problems, impaired social and emotional functioning, health and learning problems. Serious disruption in any aspect of early development (physical, social, emotional, and cognitive) appeared to cause the body and brain to change in ways that have negative effects on future risk taking behaviors (e.g., smoking, substance abuse, promiscuous sexual activity) and mental and physical health over time. Of the respondents in the study, two-thirds reported as least one ACE while under the age of 18, and one-fifth reported more than three. Given the conditions for the nation's youngest children, these data are both a cause to be concerned and an opportunity to respond with policies and services that support optimal development for all children. See the ACE Pyramid in Figure 1.

Figure 1. *The Original ACE Pyramid*

Protective Factors and Resilience

Opportunity or protective factors are known to support positive developmental outcomes (Dunst, 1993; Garmezy, Masten, & Tellegen, 1984; Werner, 2001). Proponents of resilience theory suggest that strengthening protective factors helps ameliorate the negative impact of earlier risk factors, assists children overcome adverse experiences, and positively impacts developmental outcomes (Dunst, 1993; Notter et al., 2008; Werner &

Smith, 2001). Resiliency may be defined as having the ability to cope, adapt, and thrive despite adversity (Monahan, Beeber, Jones Harden, 2012). Research demonstrates pathways of resiliency can result in positive outcomes for adversely affected individuals (Notter et al., 2008). Although poverty, trauma and other adverse experiences and risk factors have many challenges, there are individuals who go on to enjoy good health, satisfying relationships, educational achievement, and general success on many levels (Seccombe, 2002). Individuals who appear to demonstrate resilience often have individual characteristics (e.g. positive personalities and easy temperament), support from others, and beneficial environmental circumstances that serve to protect their health and well-being (Werner, 1984). For young children, the most significant protective factor needed to mitigate serious consequences and support resilience is having an adult who is sensitive to their needs and who can provide a sense of safety and sooth them when they are stressed and fearful due to exposure to negative life events (Yoches, Janko Summers, Beeber, Jones Harden, & Malik, 2012). In the previous sections, the developmental support needs of young children and related risk and protective factors were addressed. In the next section, I will discuss the need for developing curriculum-based assessment measures to improve the quality of child and family outcomes and for examining the psychometric properties of the newly developed curriculum-based measure, SEAM Parent-Toddler Interval.

Social Emotional Assessment for Parents

Early childhood can be a challenging time, especially for parents who have a child with or at risk for developmental disabilities. To successfully intervene with social emotional skills in young children, the quality of care giving environment and parental

competence are critical (Bailey, Hebbeler, Scarborough, Spiker, Mallik, 2004; Bronfenbrenner, 1979). Increased feelings of competence and self-efficacy in parents may contribute to higher quality of parent-child relationships, which strongly impacts social emotional development (Bailey, et al., 2004). The focus on parenting skills, particularly parent responsiveness, through naturalistic routines and play in the home setting is a critical component of interventions designed for improving parent-child relationships (Harden & Duchene, 2012). Furthermore, strategies found to be effective for improving parents-child interactions include helping the parent develop appropriate expectations for young children's behaviors, increase empathy, and learn more positive disciplinary methods (Bavolek, 1999). Effective infant-toddler practitioners in the field often have an influence on parental competency through their professional role with the family. Practitioners may be able to provide effective interventions that encourage a higher level of parental competency through offering modeling of skills, resources, referrals, and curriculum designed to meet the gap in parental knowledge and practice. The conceptual model of the theoretical path between parent competence and child and family outcomes can be seen in Figure 2.

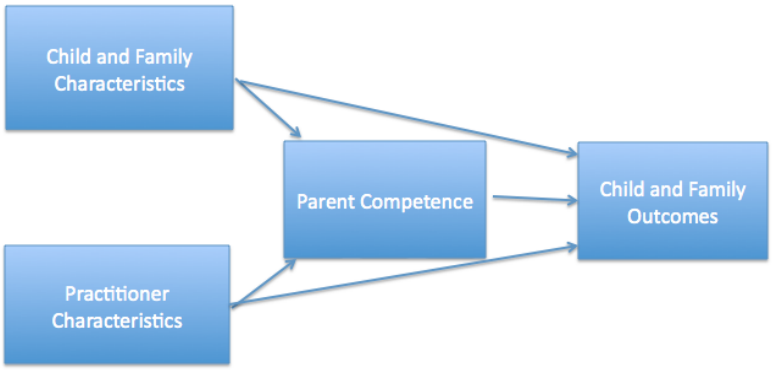

Figure 2. *Conceptual Model of the Theoretical Path between Parent Competence and Child and Family Outcomes*

Curriculum-based Assessment Measure

Criterion-referenced assessments measure the skill and performance of an individual based upon specific criteria, allowing the criterion-referenced items to be linked to intervention goals and measurement of progress (Bagnato, Neisworth, & Munson, 1997). Curriculum-based measures are criterion-referenced tests that can be utilized to measure competency skills, which will inform intervention approaches from curriculum designed to address each of the criterion-referenced items. These are measures that are often used with families of young children to identify social emotional competency skills, develop goals for targeted skills the child has not acquired, and the curriculum affords teaching strategies for intervening on these goals and supports ongoing assessment of child progress (Squires, 2012).

Curriculum-based Assessment for Infants and Toddlers

Curriculum-based assessment measures enable practitioners to assess the skills of a child, parent, or dyad on a predetermined sequence of functional skills, linking assessment, intervention, and evaluation of progress (Bagnato, et al., 1997; Bagnato, Neisworth, & Pretti-Frontczak, 2010; Macy & Bricker, 2006). Information obtained from assessment can be used to understand needs, identify authentic and functional goals and objectives, select curricula for intervention, and evaluate progress over time (Pretti-Frontczak & Bricker, 2004; Squires & Bricker, 2007). As curriculum-based measures often provide hierarchical sequences of functional skills and graduated scoring, individualized planning related to the level of assistance needed and differentiated instruction is possible (Bagnato et al., 1997; Bagnato et al., 2010).

Effective assessment of social emotional development, including the interactions

between parents and children, requires a solid foundation of understanding social emotional competence in young children (Santos, Ostrosky, Yates, Fettig, Cheatham, & Shaffer, 2011; Squires & Bricker, 2007). A number of curriculum-based tools have been developed to specifically assess social emotional development and parent-child interactions in early childhood and can provide a bridge between understanding what critical skills are needed and curriculum for how to teach those skills. Table 1 provides a summary of several existing curriculum-based measurement tools used in the social emotional assessment of infants and toddlers and a description of each. The greatest limitation for the majority of these assessment tools is the lack of psychometric data available on their reliability and validity, especially for use with infants and toddlers.

TABLE 1. *Selected Social Emotional Curriculum-based Measures for Infants and Toddlers*

Curriculum-based Measures	Descriptions	Limitations
Assessment, Evaluation, and Programming System for Infants and Young Children (AEPS) (Bricker, Pretti-Frontczak, Jognson, Straka, Slentz, Capt, et al., 2002)	Birth to 36 months Linked assessment-intervention-evaluation model Tasks and goals related to competencies are arranged in hierarchical sequence and are easily observable, measurable and teachable Encourages natural learning opportunities and integration of goals within daily routines Flexibility to accommodate modifications for children with motor or sensory impairments Curriculum offers activity-based	

	intervention approach with teaching strategies, instructional sequences, and recommendations for environmental arrangements.	
Carolina Curriculum for Infants and Toddlers with Special Needs (CCITSN) (2nd ed.) (Johnson-Martin et al., 1991)	Birth to 48 months Needs assessment for developmental domains, teaching procedures and instructional strategies, adaptations, and evaluation criteria to enhance growth for children at risk for or experiencing disabilities are provided Materials are detailed and can be tailored to individual strengths and needs of each child	Data not provided on reliability or validity
Creative Curriculum for Infants and Toddlers (Dombro, Colker, & Dodge, 2002)	Curriculum based on Piaget's theories of child development for use in preschool programs Provides ideas for home activities and parent-child interaction Techniques offered to accommodate special needs Individualized ongoing assessment	
Developmental Programming for Infants and Young Children (DPIYC) (Rogers & D'Eugenio, 1981)	Birth to 36 months Clear links between assessed developmental skills and curricular objectives and instructional activities Accounts for strengths in specific skill areas for compensatory goals Supports partnerships between parents and practitioners	
Devereux Early Childhood Assessment (DECA) (Devereaux Foundation, 1998)	Ages 2 – 5 years Strength-based prevention program for early childhood settings Designed to foster healthy social emotional development and resilience	Infant and toddler assessment is not yet available Designed for classroom

	Curriculum linked to individual child assessment system that uses parent and teacher observational data and provides tools to evaluate progress	and not home environment
Hawaii Early Learning Profile (HELP) (Parks, 1992a & b)	Birth to 36 months Strong link between authentic assessment of skills, goals, and intervention strategies Developmental task analysis linked with field-tested instructional strategies and curricular intervention Designed for infants and toddlers with special needs. Individualized materials and strategies can be tailored or use with unique needs of child or parent Encourages observation of adaptive behavior in natural settings	No psycho-metric information available; not normed Significant time investment
The Ounce Scale (Meisels, 2003)	Birth to 42 months Uses assessment of child behavior in daily activities for intervention and measures progress over time Observational assessments completed by parents and practitioners	Not nationally normed Validity weak, especially for younger children
Pathways to Competence for Young Children: A Parenting Program **(**Landy & Thompson, 2006)	Provides curricular strategies for parents to foster young children's social emotional development and manage problem behavior Explores the influence of parent's upbringing on their own child rearing practices	Studies targeted preschoolers at risk for developing conduct and behavior problems (not used with infants & toddlers)
The New Portage Guides (2003)	Birth to 6 year Appropriate for center-based or home-	No validity or reliability data

	based programs Assessment items are functional and strength-based with curriculum suggestions included for each item Supports parents involvement in assessment and activities Aligns with Head Start Outcomes Framework, OSEP Early Childhood Outcomes and state early learning standards	available

Six important standards exist for selecting and using curriculum-based assessment systems (Bagnato et al, 1997). These requirements address the need for the assessment and intervention to be 1) authentic, 2) convergent, 3) collaborative, 4) equitable, 5) sensitive, and 6) congruent. *Authentic* assessment emphasizes sampling real-life competencies in natural, everyday settings. *Convergent* assessment refers to a multidimensional process of collecting and synthesizing information used to identify strengths and needs. *Collaboration* is at the heart of family-centered services and uses joint practitioner and family perspectives for consensus decision-making. *Equity* is an approach that allows for accommodation of unique needs during the assessment process, optimizing identification of competencies and areas of need. *Sensitivity* is critical in detecting functional abilities and progress, demonstrating a high degree of treatment validity through the assessment measure. *Congruence* addresses the importance of selecting a measure based on its suitability, developmental appropriateness, and field-tested validity for use in the field.

Curriculum-based Assessment Measure for Parents

Given the benefits of using curriculum-based assessment measures to link between

authentic assessment of skills, goals, and intervention strategies of children, this approach may be used for teaching interactional skills to the parent-child dyad, as well. Curriculum-based measures used in early childhood frequently allow opportunities for parent involvement in assessment and intervention (e.g. family report), stressing the importance of an ecological perspective, which can include home environment and parenting skills (Bagnato et al., 1997). A well-designed curriculum-based measurement tool for measuring parental competency, that can be used to identify strengths and areas for growth of parents' abilities to promote the healthy social emotional development of their children would be valuable for practitioner use in targeting goals and interventions. Few existing instruments afford practitioners the ability to identify whether parents feel competent in their skills, abilities, and knowledge to support their toddlers' development, regardless of child risk status. Examples of the instruments currently available include: Parenting Behavior Problem Scale (PBPS; Avison, Gotlieb, Rae-Grant, Speechley & Turner, 1989), Parenting Stress Index-Short Form (PSI-SF; Abidin, 1986), and Assessing Environment III (EA-III; Berger, Knutson, Mehn, & Perkins, 1988), which are used primarily as screening tools for identifying problems in parenting behavior and are not considered curriculum-based assessment measures.

Curriculum-based assessment can be effectively used to assist practitioners to identify curricular objectives and monitor progress and the impact of intervention on the parents of young children. Comprehensive assessment that offers developmental sequences and expectancies is critical for goal planning and can link functional strengths and areas of concern with intervention (Bagnato et al, 1997). However, a number of significant challenges exist for practitioners who want to use high quality authentic

curriculum-based assessment and intervention to address parental competency including: 1) limited assessment measures available to address parental competence, 2) lack of psychometric evidence for many of the measures that are available, 3) time needed to administer measures and observe parent behaviors, and 4) resources needed to adequately instruct, model, and coach parent-child interactions and build competence in focus areas.

Activity-Based Intervention: Social Emotional Approach (ABI:SE)

The Activity-Based Intervention: Social Emotional Approach (ABI:SE) uses the components of activity-based intervention (ABI) with a concentration on social emotional competence of young children and parents (Squires & Bricker, 2007). Activity-based intervention uses a linked system framework that is comprised of five interrelated processes including: 1) screening, 2) assessment, 3) goal development, 4) intervention, and 5) evaluation (Pretti-Frontczak & Bricker, 2004). These processes are critical for identifying competency and emerging skills through assessment, prioritizing developmentally appropriate and functional goals and objectives, using daily activities to deliver specially designed instruction and monitoring performance over time. The conceptual model of the Linked System Approach can be seen in Figure 3.

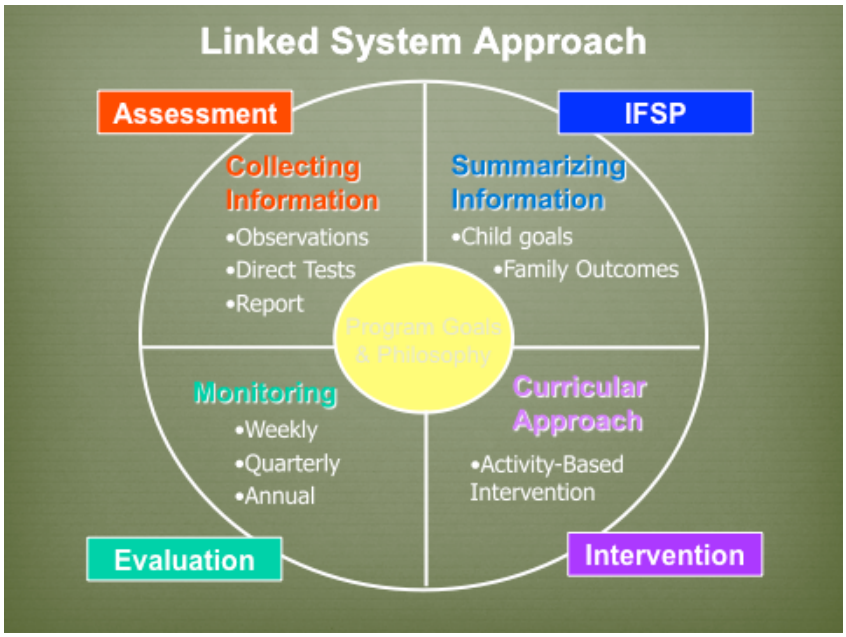

Figure 3. *Linked System Approach*

The ABI:SE approach is an extension of the linked system framework that specifically addresses the area of social emotional development to: 1) screen for social emotional problems or potential problems, 2) assess to determine social emotional competence, 3) develop and select social emotional goals, 4) intervene using daily activities, and 5) evaluate progress towards selected goals (Squires & Bricker, 2007). Behavioral areas assessed in the social emotional domain include: self-regulation, compliance, verbal and nonverbal communication that indicate feelings and internal states, adaptive skills to cope with physiological needs, autonomy, affect, and interactions with others. The intended target population for the ABI:SE Approach include children with disabilities and children who are at risk for developing social emotional problems in these areas (Squires & Bricker, 2007).

Social Emotional Assessment Measure (SEAM)

The SEAM is a curriculum-based assessment/evaluation measure that can be used

as a programmatic tool with young children and their parents to foster positive social emotional development (Squires & Bricker, 2007). The purpose of the SEAM is to assist practitioners in the prevention and early identification of social emotional difficulties and behavior disorders, development of functional, meaningful, measurable, high-quality goals and intervention content for young children and parents, and optimizing positive parent-child interactions in the first years of life.

Initial psychometric studies indicated good results for the validity, reliability, and utility of the SEAM for Children assessment Squires, Waddell, Clifford, Funk, Hoselton, & Chen, 2012). Concurrent validity was examined between the SEAM and the Devereaux Early Childhood Assessment Infant-Toddler (DECA-IT) (r = .75), Infant Toddler Social Emotional Assessment (ITSEA) (r = .65 for Infant and .65 for Toddler), and Ages & Stages Questionnaire:Social Emotional (r = -.56 for Infant and -.52 for Toddler), which revealed strong and significant correlations for each. Reliability studies indicated strong internal consistency and good test-retest reliability (r = .99 for Infant and .97 for Toddler). The majority of participants found the SEAM to be an appropriate measure that provides useful information on the child (practitioners 92% and parents 91%).

The four SEAM components include: 1) SEAM for children, 2) SEAM for parents, 3) Environmental Screening Questionnaire (ESQ), and 4) SEAM curriculum for children. Experimental editions of the SEAM tools are available and the SEAM curriculum is in development. The SEAM for children has three age intervals: 1) Infants (3-18 months), 2) Toddlers (18-36 months), and 3) Preschoolers (36-63 months). Ten benchmarks are included in each interval, with 3-8 items per benchmark. The SEAM can be completed by

parents or by a practitioner through interview with a parent. SEAM Toddler benchmarks include: 1) demonstrates healthy interactions with others, 2) expresses a range of emotion, 3) regulates social emotional response, 4) shows empathy for others, 5) shares attention and engagement, 6) demonstrates independence, 7) displays positive self-image, 8) regulates attention and activity level, 9) complies with requests and demands, and 10) shows a range of adaptive skills. The SEAM child assessment items allow parents to rate child's performance on developmental items, indicate whether the item is a concern, and select item as an intervention goal. Four response options for rating the child's behavior include: 1) very true (consistently or most of the time), 2) somewhat true (sometimes, though not consistently), 3) rarely true (only once in a while), and 4) not true (does not yet show skill). Practitioners can review SEAM results with the parent, discuss areas of concern, and identify possible resources and strategies for improving skills.

SEAM for Parents

The SEAM for Parents was developed to capture parent perspectives about their ability to facilitate positive child outcomes within the context of early childhood and early intervention programs. The SEAM for Parents has three age intervals: 1) Infants (3-18 months), 2) Toddlers (18-36 months), and 3) Preschoolers (36-63 months). Assessment items address parent knowledge and behaviors that foster social emotional development in young children and identify areas where parents need support and resources in order to provide a safe and responsive environment for their children. The SEAM for Parents asks parents to rate their understanding and ability to foster their child's development in several developmental areas, indicate whether they need more information about an assessment item, and select items that are areas of concern that they

would like to focus on. Four areas of parental competence related to social emotional development in young children are addressed in the benchmarks included in each interval, with 3-8 items per benchmark. SEAM for Family benchmarks include: 1) responds to the child's needs, 2) provides appropriate type and level of activities, 3) provides predictable schedules/routines, and 4) provides a safe home and play environment. Four response options for rating the parent's behavior include: 1) most of the time, 2) sometimes, 3) not yet, and 4) not sure/need more information. Parents may check the "focus area" triangle next to an item if they would like to target the content addressed in the item as an intervention goal. A summary of SEAM child and family benchmarks that are targeted in the toddler interval (age range 18-36 months) can be seen in Table 2.

The SEAM Parent-Toddler Interval is an instrument that has been recently developed specifically for measuring parent skills and ability to support young children's social emotional competence. To date, no studies have been conducted on its psychometric properties including validity, reliability and utility.

TABLE 2. *Child and Family Benchmarks for the Social Emotional Assessment Measure (SEAM) Toddler Interval*

Toddler Interval			
Child benchmarks		Family benchmarks	
C-1.0	Child demonstrates healthy interactions with others	A-1.0	Parent provides child with predictable schedules/routines
C-2.0	Child expresses a range of emotions	A-2.0	Parent is responsive to child's needs
C-3.0	Child regulates social emotional responses	A-3.0	Parent provides child appropriate type and level of activity for child

C-4.0	Child shows empathy for others	A-4.0	Parent responds positively to child
C-5.0	Child shares attention and engagement		
C-6.0	Child demonstrates independence		
C-7.0	Child displays a positive self-image		
C-8.0	Child regulates attention and activity level		
C-9.0	Child complies with simple requests and demands		
C-10.0	Child shows a range of adaptive skills		

Statement of Problem

Although the evidence base behind the parental role in early childhood experiences contributing to social emotional development is strong, the availability and use of effective measures for assessing parent competence have been lacking. The need for an appropriate curriculum-based assessment measure of parent competence is a priority for providing quality early childhood interventions. To use the SEAM Parent-Toddler Interval with parents, examination of the psychometric properties is necessary to determine whether it is an appropriate measure of parent competence. Therefore, this study will investigate how well the SEAM Parent-Toddler Interval assesses parent competence to support social emotional development in his/her toddler. The following two research questions are addressed:

1. What is the convergent validity of the SEAM?

1A. What is the agreement of parent scores on the SEAM Parent-Toddler Interval with the Parenting Stress Index – Short Form?

1B. Will parents with lower scores (less competence) on the SEAM Parent-Toddler Interval have children with higher scores (indicating problem behavior) on a screening test, the Ages & Stages Questionnaire: Social Emotional?

1C. What is the difference in perceived competence for parents of toddlers with three levels of risk for developmental delay (i.e., no known risk for delay, high risk for delay, and established developmental disability), as measured by the SEAM Parent-Toddler Interval?

2. What is the utility of the SEAM Parent-Toddler Interval for practitioners and parents?

CHAPTER III

METHOD OF STUDY

Methodology

Recruitment, participants, incentives, protection of human subjects, measures, data collection and procedures, and data analysis are described. Measures for research questions are summarized in Table 3.

Research Questions

The psychometric properties of the SEAM Parent-Toddler Interval, a curriculum-based measure, were investigated to determine how well this tool assesses parental self-perception of their competence for supporting toddler social emotional development. Two research questions were addressed:

1. What is the convergent validity of the SEAM?

    1A. What is the agreement of parent scores on the SEAM Parent-Toddler Interval with the Parenting Stress Index – Short Form?

    1B. Will parents with lower scores (less competence) on the SEAM Parent-Toddler Interval have children with higher scores (indicating problem behavior) on a screening test, the Ages & Stages Questionnaire: Social Emotional?

    1C. What is the difference in perceived competence for parents of toddlers with three levels of risk for developmental delay (i.e., no known risk for delay,

high risk for delay, and established developmental disability), as measured by the SEAM Parent-Toddler Interval?

2. What is the utility of the SEAM Parent-Toddler Interval for practitioners and parents?

Early Childhood Program Settings

Early childhood agencies providing early intervention, compensatory and prevention services, day care, and community parenting education programs were the focus of this study. Participating agencies included: Early Childhood CARES, Lane County Early Head Start, Lane County Healthy Start, South Lane County Relief Nursery, EWEB Child Development Center, Moss Street Child Development Center, Vivian Olum Child Development Center, Parkside Community Preschool, and Birth to Three. Program personnel at these agencies were contacted by the researcher and they, in turn, recruited eligible parents to participate. Three agencies were invited, but did not participate: Pearl Buck Center Preschool, Willamette Family Treatment Center, and Eugene/Springfield Family Relief Nursery. A research flyer can be found in Appendix A.

Participants

Seventeen practitioners (e.g., family support workers, early interventionists, preschool teachers) from nine early childhood agencies were recruited from the agencies listed in the section above. Families were contacted by their practitioner and asked if they would like to participate. Eight-one parent/child dyads from targeted early childhood settings were recruited. Using inclusion criteria, the target population included 3 groups of parents with toddlers between the ages of 18 -36 months. Assignment into one of the three groups was based upon the number of environmental risk factors: 1) low risk

children did not appear at risk for developmental delay and had one or no known environmental risk factors ($N = 34$), 2) high risk children appeared to be at risk for developmental delay with two or more environmental risk factors that were identified by service providers ($N = 22$), and 3) children had an established disability and received early intervention service ($N = 25$).

Incentives

Participants were offered incentives to participate. A $20 gift card, social emotional development activity sheets, Parent Helpline flyer and the *Parenting NOW! 2012 Resources for Families* guide was given to each participating parent/child dyad; a one time $20 gift card, social emotional activity sheets, and the *Parenting NOW! 2012 Resources for Families* guide was offered to each participating practitioner when at least three parent participants were recruited. Practitioners were offered professional development workshops facilitated by the principal investigator focused on general information about screening as well as information specifically about the assessment tools used in the study.

Protection of Human Subjects

A research protocol application was submitted to the University of Oregon Institutional Review Board (IRB) for review of study procedures and approval obtained prior to initiating the study. Each participant was provided with a consent form that describes the purpose of the study, procedures, and any potential risks and benefits related to their participation, and contact information of the principal investigator. Participants were told that they could withdraw from the study at any time and that their early childhood services will not be affected. In order to protect the privacy and

confidentiality of participants, identification numbers were assigned and all materials secured in a locked cabinet in the principal investigator's office with electronic data stored on a secure computer. Materials related to this research will be destroyed within two years of study completion. The consent forms for parents and practitioners can be found in Appendix B and C.

Measures

Five measures were used: 1) Information Form (family and practitioner versions); 2) Ages & Stages Questionnaire: Social Emotional 18, 24, 30, or 36 month, depending on the age of the child; 3) Social Emotional Assessment Measure Parent-Toddler Interval; 4) Parent Stress Index – Short Form; and 5) the Utility Survey (parent and practitioner versions).

Family Information Form. The Family Information Form (Appendix D) asked about demographic information for the child and family, including gender, date of birth and expected date of birth, ethnicity, whether the child has disabilities, whether the child receives intervention services, and type of services. The family information included parent education level, annual household income, and the person answering the form.

Practitioner Information Form. The Practitioner Information Form (Appendix E) was used to collect information on the practitioners in the study. This information included years of experience, age, level of education, and training.

Ages & Stages Questionnaires:Social Emotional (ASQ:SE). The Ages & Stages Social Emotional Parent Questionnaire (ASQ:SE) (Squires, Bricker, & Twombly, 2002) is designed to screen the social-emotional behavior of young children and identify children who may need referrals for more comprehensive evaluations. The ASQ:SE is a

norm-referenced screening tool with robust reliability and validity (Squires, Bricker, & Twombly, 2002). Four intervals were used for this study: *18 Month, 24 Month/2 Year, 30 Month and 36 Month ASQ:SE Questionnaires* (for children ages 15 through 41 months). Examples of items include: "Does your child like to be hugged or cuddled?" and "Does your child like to hear stories or sing songs?" Each response equates with a point value (zero, five or ten points), which are totaled and scores are compared with established cut off points. The higher the score, the higher the frequency of problem behaviors reported in the child.

Ratio scores were computed in order to compare scores across intervals, that is the total of scored items were divided by total scores possible to calculate a ratio score based upon the target interval. The ASQ:SE forms can be found in Appendix F.

Social Emotional Assessment Measure:Parent-Toddler Interval. The SEAM is a curriculum-based assessment measurement system that was designed to assist practitioners in early identification of social emotional problems in young children and competency of parents to foster healthy development (Squires, Bricker, Waddell, Funk & Clifford, 2011). The four SEAM components include: 1) SEAM for children, 2) SEAM for parents, 3) Environmental Screening Questionnaire (ESQ), and 4) SEAM curriculum for children. Three age intervals for the SEAM for Children and SEAM for Parents include: 1) Infants, 2) Toddlers, and 3) Preschoolers. For the purpose of this study, the SEAM Parent-Toddler Interval was used. The Parent-Toddler interval was designed for parents with children in the developmental range of 18-36 months. Four areas of perceived parental competence related to social emotional development in young children are addressed in each interval, with 3-8 items per benchmark. SEAM for Parents

benchmarks include: 1) Responds to the child's needs, 2) Provides appropriate type and level of activities, 3) Provides predictable schedules/routines, and 4) Provides a safe home and play environment. Parents rated their responses on the 17 items by selecting: "most of the time," "sometimes," "not yet," and "not sure/need more information." Additionally, parents can indicate whether any of the items are a "focus area" for future intervention activities. Examples of items include: "I know how to successfully redirect my child's inappropriate behaviors;" "I provide my child with predictable limits and consequences;" and "I am able to provide my child with safe care and supervision." Each response option rated by the parent received points (i.e. four points for "most of the time", three points for "sometimes," two points for "not yet," or one point for "not sure/need more information"), which were totaled. A higher score indicates greater perceived competency based upon parent self-report. The SEAM Parent-Toddler Interval can be found in Appendix G.

Parenting Stress Index – Short Form – 4th Edition (PSI-4-SF). The Parent Stress Index – Short Form – 4th Edition is a valid measure designed to assess problem areas and need for follow up services for parents with children between the ages of 1 month and 12 years and takes approximately 10 minutes to administer and 5 minutes to score. The total score comes from three scales: 1) Parental Distress, 2) Parent-Child Dysfunctional Interaction, and 3) Difficult Child, made up of 36 items written at the 5th grade reading level. Examples include: " Sometimes I feel my child doesn't like me and doesn't want to be close to me," "I feel trapped by my responsibilities as a parent," and "Having a child has caused more problems in my relationship with my spouse/parenting partner. Parents responded to items using a 5-point scale: "Strongly Agree," "Agree,"

"Not Sure," "Disagree," and " Strongly Disagree." The PSI/SF 4th Edition can be found in Appendix H.

Utility surveys. Surveys were administered to evaluate the SEAM Parent-Toddler Interval as useful for identifying areas of need and support for parents in order to provide a safe and responsive environment for their children. The utility survey forms for parents and practitioners can be found in Appendix I and J.

Data Collection and Procedures

The principal investigator contacted program directors at early childhood agencies serving families in a Pacific Northwest city and surrounding rural communities, to recruit practitioners for this study. After practitioner recruitment was completed, participating early childhood practitioners received training on the completion of the forms, questionnaires, and surveys. Five outcome measures were included: 1) Information Form (family and practitioner versions), 2) ASQ:SE, 3) SEAM P-T, 4) PSI-4-SF and 5) Utility Survey (family and practitioner versions), as shown in Table 3. Families were then contacted by their service providers (e.g., family support workers, early interventionists, preschool teachers) and asked if they would like to participate in the study. The parents completed the study measures in one of the four ways: 1) during a regularly scheduled home visit, 2) at a scheduled appointment time, 3) in the child's classroom or program setting, or 4) independently in their home. The method for completing the measures was based upon the practitioner's knowledge of the parent and the resources he or she required. Practitioners were given a $20 gift card to a local super market, parenting handouts, and Parent Helpline flyer, and the *Parenting NOW! 2012 Resources for Families* guide (see Appendices K through M), which were given to parents as incentives

immediately after they completed the forms, questionnaires and surveys. Practitioners were given their incentives when all research materials were returned to the principal investigator.

Data Analysis

SPSS version 18 was used to analyze data from five outcome measures, outlined in Table 1. Four types of analytic approaches were used: 1) Correlation, 2) Linear Regression, 3) Analysis of Variance, and 4) Descriptive Statistics. A summary of analysis methods and measures by research question are summarized in Table 3.

TABLE 3. *Data Analysis by Research Question*

Research question	Measure	Data Analysis
Convergent validity with PSI-4-SF	SEAM P-T, PSI-4-SF	Correlation
Convergent validity with ASQ:SE	SEAM P-T, ASQ:SE	Linear Regression
Convergent validity between risk groups	SEAM P-T	Analysis of Variance
Utility for parents	Utility Survey	Descriptive Statistics Narrative Summaries
Utility for practitioners	Utility Survey	Descriptive Statistics Narrative Summaries

Note. Descriptive statistics include mean, standard deviation, maximum, and minimum. SEAM P-T: Social Emotional Assessment Measure Parent Toddler Interval; PSI-4-SF: Parent Stress Index/Short Form; ASQ:SE: Ages & Stages Questionnaire: Social Emotional.

Demographic information. Descriptive statistics were used to analyze demographic information. The number of subjects and percentages according to child, parent, and practitioner demographic information are summarized.

Research Question 1

What is the convergent validity of the SEAM Parent-Toddler Interval?

This question will be answered in three parts in Research Questions 1A, 1B and 1C.

1A. *What is the agreement between the parent scores on the SEAM Parent-Toddler Interval and the Parent Stress Index – Short Form?*

1B. *Will parents with lower scores (less competence) on the SEAM Parent-Toddler Interval have children with higher scores (indicating problem behavior) on a screening test, the Ages & Stages Questionnaire: Social Emotional?*

1C. *What is the difference in perceived parent competence for parents of toddlers with three levels of risk for developmental delay (no known risk for delay, high risk for delay, and established developmental disability), as measured by the SEAM Parent-Toddler Interval?*

Convergent validity. The convergent validity was estimated by examining the relationship between total SEAM P-T scores and the total scores of the PSI-4-SF and ASQ:SE. This question was answered in three parts. First, using correlational analysis, convergent validity was estimated by examining the relationship between the total scores of the SEAM P-T and the converted T-scores of the PSI-4-SF (1A). Higher scores on the PSI-4-SF indicated more problem areas for the parents, while higher scores on the SEAM

P-T indicated greater parent competency. Second, the relationship between SEAM P-T scores (competency of the parents) and the ASQ:SE scores (behavior of the child) was examined using linear regression (1B). Ratio scores were computed in order to compare scores across ASQ:SE intervals. That is, because the number of items varies on the ASQ: SE intervals, ratio scores were computed as the average score of each item marked on the interval. Third, using the total scores of the SEAM P-T for the dependent variable, data were analyzed with a one-way, between subjects analysis of variance (1C). The independent variable was group membership with three levels: (a) toddlers with established disabilities, (b) toddlers known to be at risk for developmental delay, and (c) toddlers with no known risks for developmental delay. Descriptive statistics are reported for SEAM score and risk group for toddlers.

Research Question 2

What is the utility of the SEAM Parent-Toddler Interval for practitioners and parents?

Utility. Descriptive statistics were used to calculate the percentage of responses for utility survey items, which were completed by both practitioners and parents. The utility questionnaire asked about whether questions were useful, easy to understand, and provided meaningful information about a parent ‘s ability to support his/her child’s social emotional development. Additionally, narrative comments made by practitioners and caregivers on the utility surveys have been summarized.

CHAPTER IV

RESULTS

This chapter presents the research results in three sections. The first section summarizes demographic information about participants, including children, parents, and early childhood practitioners. Second, the convergent validity of the SEAM P-T with the ASQ:SE and PSI-4-SF is described. The final section includes the evaluation of the utility of the SEAM P-T for parent and practitioner participants.

Participants

A total of 81 parents of toddlers and 17 practitioners from 9 different early childhood settings participated in the study. All parent participants completed five measures: 1) Demographic Information Form (family version), 2) ASQ:SE, 3) SEAM P-T, 4) PSI-4-SF and 5) Utility Survey (family version). Practitioners completed two measures: 1) Demographic Information Form (practitioner version) and 5) Utility Survey (practitioner version). A summary of participant completed measures is found in Table 4.

Demographic Information for Parents

Demographic information of parents is summarized in Table 6. Participants were recruited from a large county in the Pacific Northwest that has both urban and rural areas, with a population estimate of 353,416 in 2011(U.S. Census Bureau, 2012). Parent participants were representative of the county in the area of ethnicity as follows: Caucasian (n = 69, 85.2%), African American (n = 2, 2.5%), American Indian/Alaska Native (n = 2, 2.5%), Asian (n = 2, 2.5%), Pacific Islander/Native Hawaiian (n = 1, 1.2%), and Hispanic (n = 5, 6.2%). Approximately 30-50% (n = 28-37) of the parents were near or below the poverty level, which according to the 2012 U.S. Poverty

Guidelines is $15,130 for a family of two or $19,090 for a family of three (U.S. Census Bureau, 2012). The sample rates were higher than in the county census, which reported 16.7% of families living under the poverty level in 2011. Participant comparisons of ethnicity and poverty level are summarized in Table 5.

TABLE 4. *Number of Parent and Practitioner Participants Completing Study Measures*

Measure	Parent (n = 81)	Practitioner (n = 17)
SEAM P-T	81	n/a
ASQ:SE	81	n/a
18 Month Interval (15-20 months)	11	
24 Month Interval (21-26 months)	33	
30 Month Interval (27-32 months)	18	
36 Month Interval (33-41 months)	19	
PSI -4-SF	81	n/a
Participant information form	81	17
Utility survey	81	17

Note: SEAM P-T = Social Emotional Assessment Measure Parent Toddler Interval; ASQ:SE = Ages & Stages Questionnaires: Social Emotional; PSI-4-SF: Parent Stress Index-Short Form.

TABLE 5. *Percentage of Ethnicity and Income by Family and Lane County Census Information for 2011*

	Family	Lane County
Ethnicity		
Caucasian	85.2%	90.6%
African American	2.5%	1.1%
American Indian/Alaska Native	2.5%	1.3%
Asian	2.5%	2.7%
Pacific Islander/Native Hawaiian	1.2%	0.3%
Hispanic	6.2%	7.6%
Income		
Per capita income in past 12 months	n/a	$23, 869
Below poverty level	30-50%	16.7%

Demographic information of parents is summarized in Table 6. Parental education, income, and age data reflect participants with diverse backgrounds. Approximately a quarter had a high school education or less (*n* = 19, 23.4%), some college (*n* = 22, 27.2%), Associate or Bachelor degree (*n* =18, 22.2%), and Postgraduate, Graduate and above (*n* = 22, 27.2%). Approximately a third of the participants' income fell below $15,000 (*n* = 28, 34.7%), $15-50,000 (*n* = 26, 32%), and above $50,000 (*n* =27, 33.3%). Three families reported no income (3.7%). Parental age was also somewhat evenly distributed with parents reporting that they were in their early twenties (*n* =16, 19.8%), late twenties (*n* =21, 25.9%), early thirties (*n* = 24, 28.6%), late thirties (*n* =12, 14.8%), and over forty years (*n* = 8, 9.9%).

A majority of parents were married (*n* = 43, 53.1%) or partnered (*n* = 8, 9.9%). The remaining parents were single (*n* = 25, 30.9%), divorced (*n* = 4, 4.9%), or widowed (*n* = 1, 1.2%). A large number of parents who completed the questionnaires were birth mothers (*n* = 67, 82.7%), followed by birth fathers (*n* = 12, 14.8%), and adoptive mothers (*n* = 2, 2.5%).

Sixty-six (81.5%) of the parents completed the forms without assistance and fifteen (18.5%) reported that they received assistance. Twelve (14.8%) said they were assisted through language translation (*n* = 2, 2.5%) or interviewing/reading items (*n* = 10, 12.3%).

Parents were recruited into three risk categories 1) child at low risk for delay (*n* = 34, 42%); 2) child at high risk for delays (*n* = 22, 27.2%); and 3) child with established disabilities (*n* = 25, 30.9%). Demographics by risk category show differences in parent variables. Most parents in the low risk group were Caucasian, had more education, incomes above $50,000.00, married, and older than parents in the two other groups.

TABLE 6. *Demographic Information for Parents*

	Total *n* (%)	Low risk *n* (%)	High risk *n* (%)	Disability *n* (%)
Ethnicity				
Caucasian	69 (85.2)	32 (94.1)	15 (68.2)	22 (88)
African American	2 (2.5)	0	2 (9.1)	0
American Indian/Alaska Native	2 (2.5)	0	1 (4.5)	1 (4.0)
Asian	2 (2.5)	1 (2.9)	0	1 (4.0)
Pacific Islander/Native	1 (1.2)	0	0	1 (4.0)

Hawaiian				
Hispanic	5 (6.2)	1 (2.9)	4 (18.2)	0
Parent's Education				
Less than high school	9 (11.1)	0	5 (22.7)	4 (16.0)
High school or GED	10 (12.3)	0	3 (13.6)	7 (28.0)
Some college	22 (27.2)	2 (5.9)	10 (45.5)	10 (40)
Associate's degree (AA)	5 (6.2)	3 (8.8)	0	2 (8.0)
Bachelor's degree	13 (16.0)	8 (23.5)	4 (18.2)	1 (4.0)
Graduate/above	22 (27.2)	21 (61.8)	0	1 (4.0)
Annual family income				
No income	3 (3.7)	1 (2.9)	2 (9.1)	0
$5000-$9,999	11(13.6)	0	6 (27.3)	5 (20)
$10,000-$14,999	14 (17.3)	1 (2.9)	7 (31.8)	6 (24)
$15,000-$19,999	9 (11.1)	2 (5.9)	2 (9.1)	5 (20)
$20,000-$29,999	7 (8.6)	2 (5.9)	4 (18.2)	1 (4.0)
$30,000-$39,999	6 (7.4)	3 (8.8)	1 (4.6)	2 (8.0)
$40,000-$49,999	4 (4.9)	1 (2.9)	0	3 (12.0)
More than $50,000	27 (33.3)	24 (70.6)	0	3 (12.0)
Parent's age				
20-25 years	16 (19.8)	1 (2.9)	12 (54)	3 (12)
26-30 years	21 (25.9)	8 (23.2)	4 (18)	9 (36)
31-35 years	24 (28.6)	12 (34.8)	4 (18)	8 (32)
36-40 years	12 (14.8)	9 (26.1)	0	3 (12)
Over 40 years	8 (9.9)	4 (11.6)	2 (9)	2 (8)
Parent's relationship status				
Married	43 (53.1)	28 (82.4)	5 (22.7)	10 (40.0)
Single	25 (30.9)	1 (2.9)	16 (72.7)	8 (32.0)

Partnered	8 (9.9)	1 (10.4)	1 (4.5)	5 (20)
Divorced	4 (4.9)	3 (8.8)	0	1 (4.0)
Widowed	1 (1.2)	0	0	1 (4.0)
Totals	81 (100)	34 (42)	22 (27.2)	25 (30.9)

Demographic Information for Toddlers

Toddlers ranged in age from 15 to 41 months (M = 27.5, SD = 5.9), with a breakdown by age of 15-20 months (n = 11), 21-26 months (n = 33), 27-32 months (n = 33), and 33-41 months (n = 19). There were more males (n = 52) than females (n = 29). Twenty-five of the children experienced a heterogeneous mix of disabilities reported in the following areas: developmental delay (n = 3), autism (n = 3), cerebral palsy (n = 1), microcephaly (n = 1), Down syndrome (n = 3), motor delay (n = 1), speech delay (n = 7), premature birth (n = 4), Torticollis (n = 1) and encephalitis (n = 1). Fifty-five parents reported that their child received special services including: early intervention, Early Head Start, and Healthy Start. Demographic information of children is summarized in Table 7.

TABLE 7. *Demographic Information for Toddlers*

	n (total 81)	%
Age		
15-20 months	11	13.6
21-26 months	33	40.7
27-32 months	18	22.2
33-41 months	19	23.5
Gender		

Male	52	64.2
Female	29	35.8
Disability status		
Identified disability	25	30.9
No identified disability	56	69.1

Demographic Information for Practitioners

Seventeen practitioners participated in the study. Years of experience working with birth to two-year-olds ranged from 2 to 30 years (M = 10.76, SD = 7.76), and years of experience working with three-year-olds to five-year-olds ranged from 1 to 30 years (M = 10.38, SD = 8.59). Years at the current program ranged from 1 to 16 years (M = 6.0, SD = 4.77). Age of practitioners ranged from 22 to 56 years (M = 39.0, SD = 10.79). Demographic information of practitioners' experience and age is summarized in Table 8.

TABLE 8. *Descriptive Statistics for Practitioners' Years of Experience and Age*

	n	*M*	*SD*
Years of experience 0 to 2 year olds	17	10.76	7.76
Years of experience 3 to 5 year olds	17	10.38	8.59
Years in current program	17	6	4.77
Age	17	39	10.79

All but one practitioner (5.9%) had a college degree, ranging from Associate to Master level (94.1%). Practitioners earned a Master's degree in Early Intervention or Education (n = 8, 47.2%), Bachelor or Associate degree in Early Childhood Education or

Family and Human Services (n = 9, 53%). Practitioners' education and type of degree earned is summarized in Table 9.

TABLE 9. *Demographic Information for Practitioners' Education and Degree Type*

	n (total 17)	%
Education level		
High School diploma	1	5.9
Associate's degree	6	35.3
Bachelor's degree	6	35.3
Post-graduate/graduate and above	4	23.5
Type of degree		
Early childhood education	7	41.3
Early intervention	6	35.3
Family and human services	3	17.7
None	1	5.9

Practitioners were asked how much of their coursework or training was related to working with infants and toddlers and their families and how much was related to working with preschoolers and their families. Half of the practitioners (47.1%) reported "most" (i.e., 75% or more) of their coursework and training was related to working with either infants and toddlers or preschoolers and their families. The other half of the practitioners reported that they only had "some" (29.4%) or "a little" (17.6%) training working with infants and toddlers or preschoolers and their families with "some" (35.3%) or "a little" (11.8%). Status of practitioners' training and coursework related to working with infants and toddlers and their families is summarized in Table 10, and the status of practitioners' training and coursework related to working with preschoolers and their

families is summarized in Table 11. Practitioners were also asked to describe their skill level related to providing mental health services to infants and toddlers and their families using a Likert-type scale of 1 to 4 points ranging from 1 = "Very low" to 4 = "Very high." Two-thirds (64.7%) rated themselves as a three or a four, which is towards the higher skill level. Status of practitioners' skill level related to providing mental health services to infants and toddlers and their families is summarized in Table 12.

TABLE 10. *Status of Practitioners' Training and Coursework Related to Working with Infants and Toddlers and Their Families*

	n (total 17)	%
College coursework		
Most (75%+)	8	47.1
Half (50%)	1	5.9
Some (25%)	5	29.4
A little (less than 25%)	3	17.6

TABLE 11. *Status of Practitioners' Training and Coursework Related to Working with Preschool Age Children and Their Families*

	n (total 17)	%
College coursework		
Most (75%+)	8	47.1
Half (50%)	1	5.9
Some (25%)	6	35.3
A little (less than 25%)	2	11.8

TABLE 12. *Status of Practitioners' Skill Level Related to Providing Mental Health Services to Infants and Toddlers and Their Families*

	n (total 17)	%
1 - Very low skill level	1	5.9
2	5	29.4
3	10	58.8
4 – Very high skill level	1	5.9

Convergent Validity of the SEAM Parent-Toddler Interval

Convergent validity of the SEAM P-T was examined. Test scores were compared between the SEAM P-T and the ASQ:SE and PSI-4-SF to answer research questions 1A, 1B, and 1C.

Convergent Validity with the PSI-4-SF

Research Question 1A: *What is the agreement between the parent scores on the SEAM Parent-Toddler Interval and the Parent Stress Index – Short Form – 4th Edition?*

Correlation between SEAM P-T and PSI-4-SF. Table 13 shows mean, standard deviations, and correlations of the SEAM P-T and PSI-4-SF. Moderate negative correlations were found between the SEAM P-T and the PSI-4-SF. Correlation between the SEAM P-T and PSI-4-SF was statistically significant, $r = -.44$, $p < .01$.

TABLE 13. *Means, Standard Deviations, and Correlations of the SEAM P-T and PSI-4-SF*

	n	*M*	*SD*	*r*
SEAM P-T	81	64.70	3.42	-.44**
PSI-4-SF	81	68.70	16.54	

**$p < .01$.

Note. SEAM P-T = Social Emotional Assessment Measure Parent-Toddler Interval; PSI-4-SF: Parent Stress Index-Short Form – 4th Edition (PSI-4-SF). Distributions for the SEAM P-T were unimodal and asymmetrical, with moderate to severe outliers and severe positive skew. Distributions for the PSI-4-SF were unimodal and symmetrical, with moderate outliers and slightly positive to normal skew.

Correlation between SEAM P-T and PSI-4-SF subscales: Moderate negative correlations were also found between the SEAM P-T and each of the three PSI-4-SF subscales: 1) Parental Distress (PD) 2) Parent-Child Dysfunctional Interaction (P-CDI) and 3) Difficult Child (DC). First, correlation between the SEAM P-T and PD was statistically significant, $r = -.33$, $p < .01$. Second, correlation between the SEAM P-T and P-CDI was statistically significant, $r = -.40$, $p < .01$. Third, correlation between the SEAM P-T and DC was statistically significant, $r = -.41$, $p < .01$.

PSI-4-SF cutoff scores. Two parents who received early intervention services scored above the cutoff for clinically significant levels of stress related to their parent role and a third parent who participate in prevention services scored above the cutoff in the subscale PD. Parents were provided with resources and referrals for appropriate services.

PSI-4-SF defensive responding. The PSI-4-SF includes a Defensive Responding Scale, on which a low score suggests that the parent may be minimizing indications of problems, presenting a more favorable impression, is not invested in their role and lacks stress accordingly, or is very competent in parenting. Unfortunately, there is no way to determine which hypothesis may be true for an individual parent. Fourteen parents were

considered to be “defensive responders “ on the PSI-4-SF. Six were in the low risk group, three were in the high-risk group, and five were in the early intervention group.

PSI-4-SF relationship concerns and sense of isolation. Fourteen parents said that they “agree” to item number 8, “*Having a child has caused more problems than I expected in my relationship with my spouse/parenting partner.”* Eight parents selected “agree” or “strongly agree” to item number 9, “*I feel alone and without friends.”*

Convergent Validity with the ASQ:SE

Research Question 1B: *Will parents with lower scores (less competence) on the SEAM Parent-Toddler Interval have children with higher scores (indicating problem behavior) on screening test, the Ages & Stages Questionnaire: Social Emotional?*

Linear regression. Descriptive statistics for SEAM P-T scores and ASQ:SE are reported in Table 14. A simple linear regression was performed with parent’s total scores on the SEAM P-T the independent (predictor) variable and the child’s ASQ:SE scores the dependent variable. Correlation between perceived parent competence and toddler social emotional behavior was moderate (r = .42). The regression was statistically significant. SEAM P-T scores (perceived parent competence) significantly predicted ASQ:SE scores (child behavior), b = -4.134, p < .01. SEAM P-T scores explained a low proportion of variance in ASQ:SE scores. Overall results for regression model predicting ASQ:SE scores can be found in Table 15 and Table 16 summarizes regression coefficients for model predicting ASQ:SE scores.

TABLE 14. *Means and Standard Deviations of the SEAM P-T and ASQ:SE*

	n	*M*	*SD*
SEAM PT	81	64.70	3.42
ASQ:SE	81	36.33	33.64

TABLE 15. *Overall Results for Regression Model Predicting ASQ:SE Scores*

Model Summary					
	R	R^2	Adjusted R^2		
1	.420	.176	.166		
ANOVA					
Source	*SS*	*df*	*MS*	*F*	*P*
Regression	15978.61	1	15978.61	16.93	< .01
Residual	74575.39	79	943.99		
Total	90554.00	80			

Note. SEAM P-T = Social Emotional Assessment Measure Parent-Toddler Interval; Distributions for the SEAM P-T were unimodal and asymmetrical, with moderate to severe outliers and severe positive skew. Distributions for the ASQ:SE were unimodal and asymmetrical, with moderate to severe outliers and severe negative skew.

TABLE 16. *Regression Coefficients for Model Predicting ASQ:SE Scores*

Variable	*b*	*SE*	*t*	*p*
ASQ:SE	303.83	65.12	4.67	.000
SEAM P-T	-4.13	1.01	-4.11	.000

Note. SE = standard error.

ASQ:SE cutoff scores. Fourteen children scored above the cutoff on the ASQ:SE. Four of them were in the high risk group and one was referred for further evaluation due to a high score (150 points). Ten other children who scored above the cutoff were already receiving early intervention services.

Convergent Validity on SEAM P-T between Risk Groups

Research Question 1C: *What is the difference in perceived parent competence for parents of toddlers with three levels of risk for developmental delay (no known risk for delay, high risk for delay, and established developmental disability), as measured by the SEAM Parent-Toddler Interval?*

Analysis of variance. Descriptive statistics for SEAM P-T scores by risk category are reported in Table 17. Data were analyzed using a one way, between-subjects analysis of variance. Welch's *F*" was used to evaluate the significance of results. Risk group was the independent variable with three levels: 1) low risk, 2) high risk, and 3) established disability. SEAM P-T scores was the dependent variable. The analysis of variance summary is reported in Table 18. There was not a significant effect of risk group on SEAM P-T Interval scores, $F''(2, 78) = 1.79$, $p > .01$.

TABLE 17. *Descriptive Statistics for Self-report of Parent Competence on SEAM P-T by Risk Category*

Type of risk	*n*	*M*	*SD*
No/low risk	34	65.53	2.83
High risk	22	64.27	3.86
Established delay	25	63.96	3.63
Total	81	64.70	3.41

Note. Distributions for the SEAM P-T were unimodal and asymmetrical, with moderate to severe outliers and severe positive skew.

TABLE 18. *One-way Analysis of Variance Summary Table for the Effects of Risk Category on Self-report of Parent Competence*

Source	*df*	*SS*	*MS*	*F*
Risk group	2	41.10	20.55	1.79
Error	78	893.79	11.46	
Total	80	934.89		

SEAM P-T item responses. According to the instructions, "Most of the time" should be checked if the parent feels he or she has the information, resources and/or skills indicated on the item; "Sometimes" should be checked if the parent feels he or she needs additional information, resources, and/or skills; "Not Yet" should be checked if the parent feels he or she does not have the information, resources, and/or skills indicated on the item; and "Not sure/need more information" should be checked if the parent is unsure how to respond or would like to get more information before choosing a final response. Table 19 summarizes the number/percentages of parent responses of "Sometimes" or "Not Yet" on the SEAM P-T items in total and by risk category. Approximately half of the parents indicated that they did not know how to successfully redirect their child's inappropriate behaviors (54.12%) nor did they understand why the child engages in inappropriate behavior and know how to modify the environment (41.82%). Other areas that parents indicated they do not have the information, resources, and/or skills included: understanding their child's verbal (23.37%) and nonverbal communication (18.45%) and know how to respond; how to support the child's emotional needs (15.99%); providing

predictable mealtime (30.75%) and sleep (15.99%) routines and appropriate environment; predictable limits and consequences (22.14%); home safety checks (18.45%); and providing activities (i.e. books, toys, play things) (14.76%) or games (20.91%) that match the child's developmental level, and knowing how to manage feels of anger and frustration that come up with the child (15.99%). Items that parents indicated they do not have the information, resources, and/or skills for were fairly evenly distributed across risk categories, with the exception of understanding verbal communication being a greater concern for parents with children who have established conditions (e.g., language delay, autism, developmental delay).

TABLE 19. *SEAM P-T Item Responses of "Sometimes" or "Not yet" by Risk Category*

Benchmark/Item	Total *n* (%)	Low risk *n* (%)	High risk *n* (%)	Disability *n* (%)
A-1.0 Responding to my child's needs				
1.1 I understand my child's nonverbal communication and know how to respond	15 (18.45)	5 (14.5)	4 (18)	6 (24)
1.2 I understand my child's verbal communication and know how to respond	19 (23.37)	2 (5.8)	4 (18)	12 (48)
1.3 I know how to support my child's emotional needs	13 (15.99)	3 (8.7)	6 (27)	5 (20)
1.4 I use positive comments and language with my child	7 (8.61)	2 (5.8)	4 (18)	1 (4.0)
1.5 I know how to successfully redirect my child's inappropriate	44 (54.12)	14 (40.6)	15 (67.5)	15 (60)

behavior				
1.6 I understand why my child engages in inappropriate behaviors and know how to modify the environment	43 (41.82)	12 (34.8)	11 (49.5)	12 (48)
A-2.0 Providing Activities that match my child's developmental level				
2.1 I provide my child books, toys, and play things that match his developmental level	12 (14.76)	4 (11.6)	4 (18)	2 (8)
2.2 I know age appropriate games that my child enjoys	17 (20.91)	7 (20.3)	4 (18)	7 (28.0)
A-3.0 Providing predictable schedule/routines and appropriate environment for my child				
3.1 I provide a mealtime routine for my child that is predictable and appropriate for his age	25 (30.75)	10 (29)	9 (40.5)	7 (28.0)
3.2 I provide a rest and sleeping routine for my child that is predictable and appropriate for her age	13(15.99)	5 (14.5)	7 (31.5)	2 (8)
3.3 I provide my child with predictable limits and consequences	18 (22.14)	6 (34.8)	5 (22.5)	7 (28)
3.4 I take time each day to play with my child	7 (8.61)	4 (11.6)	2 (9.1)	0
A-4.0 Providing a safe home and play environment for my child				
4.1 I have done a safety check on my home to make it	15 (18.45)	7 (20.3)	6 (27)	2 (8)

safe for my child				
4.2 I have a safe way to transport my child	2 (2.46)	0	2 (9.1)	0
4.3 I am able to provide my child with safe care and supervision	2 (2.46)	1 (2.9)	1 (4.5)	0
4.4 I have access to regular medical and dental care for my child	5 (6.15)	1 (2.9)	1 (4.5)	3 (12)
4.5 I know how to manage my own feelings of anger and frustration that come up while with my child	13 (15.99)	7 (20.3)	5 (22.7)	2 (8)
Totals	81 (100)	34 (42)	22 (27.2)	25 (30.9)

Utility Survey

Participants were given an opportunity to provide feedback on the SEAM P-T. Two versions of the Utility Survey were used, one for parents and the other for practitioners.

Utility Survey for Parents

The Parent Utility Survey on the SEAM P-T included seven questions including 1) length of time it took to complete, 2) whether the questions were useful, 3) whether the questions were clear and easy to understand, 4) whether any questions were unclear or difficult to understand, 5) whether the questions provided meaningful information about parents' ability to support the child's social emotional development, 6) did they want to speak to someone about concerns raised by questionnaire, and 7) how they would change the questionnaire to make it better. Most of the questions were answered using five response choices: "strongly disagree," "disagree," "no opinion," "agree," and "strongly

agree." Finally, any additional comments or suggestions were requested in a "comments" section at the end of the form.

Time to complete. Parents reported that it took between 3 - 60 minutes to complete the SEAM P-T ($M = 23.80$, $SD = 13.85$). Most of the parents completed the questionnaire within 20 minutes.

Question usefulness. Regarding the general usefulness of the questions, a majority of the parents ($n = 65$, 80.1%) said that they "agreed" ($n = 57$, 70.4%) or "strongly agreed" ($n = 8$, 9.9%). Examples of some of the ways that parents felt the questions were useful were: "*Helped me think about my parenting style and what I could improve and focus on," "I feel explaining the answers allows a better understanding,"* and *"It's interesting to reflect on parenting experiences."* Some of the parents responded that they did not find the questions useful ($n = 3$) or had no opinion ($n = 13$). For these parents, some said that they had been working on their parenting skills through home visiting, early intervention, or parenting classes and did not personally feel that the questions were useful. Some of these parents added that they could see the usefulness for other parents who may need support and were not receiving it. General usefulness of questions on the SEAM P-T for Parents is reported in Table 20.

TABLE 20. *General Usefulness of Questions on the SEAM P-T for Parents*

Feedback	*n*	%
Strongly disagree	1	1.2
Disagree	2	2.5
No opinion	13	16.0
Agree	57	70.4

Strongly agree	8	9.9
Total	81	100

Questions clear and understandable. Most of the parents agreed (*n* = 45, 55.6%) or strongly agreed (*n* = 34, 42%) that the questions were generally clear and easy to understand. Parents made the following positive comments regarding this survey item: "*The questions are easy to understand, but made me think critically about my parenting skills,"* "*Good examples, they will teach or give me new ideas for some areas," and "The examples were very helpful."* Table 21 shows parent feedback related to questions on the SEAM P-T being generally clear and easy to understand.

TABLE 21. *General Clearness and Easiness to Understand Questions on the SEAM P-T for Parents*

Feedback	*n*	%
Strongly disagree	1	1.2
Disagree	0	0
No opinion	1	1.2
Agree	45	55.6
Strongly agree	34	42.0
Total	81	100

Questions unclear or difficult to understand. Most of the parents (*n* = 75, 91.4%) responded that there were no questions that they found to be unclear or difficult to understand. However, six parents (7.4%) responded that there were items that they found unclear or difficult to understand and these are summarized in Table 22. One

parent offered the following general concern about difficulty in the comment section, "*I think it could be if you were under stress*."

TABLE 22. *Items that Participants Felt Were Unclear or Difficult to Understand*

Item	Questions (Q) or Examples (E)	Feedback
1.1	I understand my child's non-verbal communication and know how to respond. (Q)	"I wasn't sure if sign language counted as nonverbal communication."
1.2 & 3.3	I understand my child's verbal communication and know how to respond. (Q) *When my child fusses because she is hungry, I ask, "hungry?"* (E) I provide my child with predictable limits and consequences. (Q) *I notice and comment to my child when she is doing something positive and consistent with our household rules such as, "I like the way you are coloring on the paper."*(E)	"Question 1.2 - first example doesn't match the question. Also 3.3 – 2nd example."
1.5	I know how to successfully redirect my child's inappropriate behaviors. (Q) *I give my child her favorite doll before she pokes her baby sister.* (E) *When my child begins to run indoors, I remind her to walk indoors or I take her outside to play.* (E)	"Statement didn't match examples?"

1.6	I understand why my child engages in inappropriate behaviors and know how to modify the environment. (Q)	"Didn't quite understand and couldn't think of example."
2.1, 3.1, 4.4	See Appendix G	"Some examples were too general and/or basically restated the question – 2.1, 3.1, 4.4, for example."
Cover	"Family's Name" on cover.	"Why is this needed?"
Cover	Instructions	"The explanation of the definition for the answer was confusing, in regards to page T-1 where it defines "most of the time" "sometimes" "not yet" and "not sure/need more information.""

Note. Questions and examples are differentiated by Q = questions; E = examples.

Questions were meaningful. Parents' responses for whether the SEAM P-T questions provided meaningful information about his/her ability to support the toddler's social emotional development are summarized in Table 23. The majority of the parents "disagreed" (59.3%), "strongly disagreed" (12.3%) or had "no opinion" (22.2%) when asked whether the SEAM P-T gave them meaningful information about their ability to support their child's social emotional development.

Many of the comments suggested that the parents already felt confident in their abilities and that these questions did not offer any meaningful information that would help gain new skills. For example, "*I am at a point where I feel confident in my parenting abilities"* and "*I feel confident in my abilities to support his social emotional development. I didn't get any 'New information'."* Some of the parents commented that they felt validated by answering the questions and acknowledged how much is already

being done to support their child's healthy social emotional development, such as, "*Validated what I'm doing*" and "*The questions seem very basic. It made me feel good - almost too easy? Like I was doing it wrong?"* One parent said, "*It was really eye opening to see how much I really do for her. Sometimes I don't feel adequate or as good a mom as others"* and another stated*, "Gave me a little more confidence in my skills as a parent.*" A number of comments revealed how the questions provided meaningful information and that the process itself was beneficial such as, "*Helped me to see areas I need to work on with my parenting skills to support my child's social emotion development," or "I liked that you have to think of examples, it makes you critically evaluate yourself/actions,"* and *"It gave me ideas to try and reminded me of things I already do without realization."*

Several parents expressed concern that these questions were not connected to a process of skill development or dialog about individual needs as a parent and stated that they would have liked an opportunity to meet with someone in an interview format. Similarly, another parent expressed an ongoing unmet need she has by making this comment, "*I think a lot about this stuff already, so maybe I didn't get as much insight about my behavior as other people might. What I really wish I could do is have an expert to ask questions to one-on-one. So many of the parent books I read give very general information.*

TABLE 23. *Completing the SEAM P-T Provided Parents Meaningful Information about His/Her Ability to Support Their Toddler's Social Emotional Development for Parents*

Feedback	*n*	%
Strongly Disagree	10	12.3
Disagree	48	59.3
No opinion	18	22.2
Agree	4	4.9
Strongly agree	1	1.2
Missing	2	1.3
Total	81	100

Follow up requested on concerns. Three parents answered, "Yes" to the question, "*Did completing the SEAM Parent-Toddler Interval bring up any concerns that you would like to talk to someone about?*." One parent had a question about establishing better routines with her toddler. One parent wanted her toddler who experiences Down Syndrome to be involved in more social activities with non-disabled peers. A third parent said that using color paper for the questionnaires was problematic for her as she was colorblind.

Changes recommended. Parents were asked how they would change the SEAM P-T to make it better. Twenty-seven responded that they liked the form and would not recommend any changes. Twenty-four offered suggested changes, which are listed in Table 24. Thirty parents left this section of the utility survey blank.

TABLE 24. *Parent Changes That Would Make the SEAM P-T Better*

Feedback
"For people who read/talk in Spanish give the form in Spanish."
"I think more questions about the emotional health of the parents would be useful."
"Questions more in depth."
"I found the examples given ineffective in a few ways: 1) Are they examples of the type of information we are supposed to write in the space provided? If so, many times even one example wouldn't fit. (Related note: Very little space provided for multiple examples) 2) Some questions do not match examples (i.e. 1.2 & 3.3) 3) Some examples were too general and/or basically restated the question (i.e. 2.1, 3.1, 4.3)
"Would like to see a form with dad and mom on it."
"Add website at the end that parents could access to find info on how to do the things the assessment asks about."
"Provide more space for writing examples."
"Be able to take the test online."
"I like the idea of going through it interview style. That would feel supportive."
"Often the examples already provided were ones that applied to me – hard to come up with alternatives."
"Lack of asking what supports are already in place – current situation (am a single mom who just moved here)."
"A clearer definition of what the answers mean on the instruction page."
"Put more comparisons between normal behavior and behavior to bring concern."
"I didn't totally get the focus area part. If that could be made more clear it would be helpful."
"Maybe a scoring system (for people who are filling it out by themselves, no interviewer) so that people would know if they may need help."

"Some questions could use more examples."
"Some questions had two parts, but only one part was applicable in some cases. It was a touch confusing."
"I would not change it; however, maybe more questions to answer."
"Maybe have a section where the parent can be interviewed verbally versus filling out the paperwork."
"Making it shorter but I don't know how. It probably is as good as it gets."
"More space for writing examples."
"I think an interview format would be helpful in some situations."
"I would change the safety questions to "all of the time."
"Have a question about social networks of support related to question 4.5. Something like: 'I have sought out social groups that support/encourage me as a parent' and ask to list examples – extended family, church, Birth to Three."

Further comments and suggestions. A final section was included on the utility survey that welcomed further comments and suggestions and ten parents responded. Their comments and suggestions are listed in Table 25.

TABLE 25. *Further Comments and Suggestions from Parents*

Feedback
"Took a long time to think of examples."
"It would be great if healthcare providers would ask social/emotional wellness questions as a part of the questionnaires they send home."
"This stimulated a consideration on my part for a couple of areas I feel I fall short in my parenting such as feeling that I don't challenge my kids enough academically."

"Maybe a scoring system (for people who are filling it out by themselves, no interviewer) so that people would know if they may need help."
"As a provider for children & families, I can see this as a useful tool for beginning dialog."
"Could be useful as a way to raise awareness in a parent who has not spent a lot of time thinking about parenting."
"Verbal/nonverbal communication was tricky to answer at my daughters age because she is mostly verbal."
"Thinking of examples was difficult on the spot."
"I think asking for examples supporting the questions was helpful and thought provoking. Answering yes/no is easy. Thinking of examples supported to me that I was answering questions well."

Utility Survey for Practitioners

The Practitioner Utility Survey on the SEAM P-T included ten questions including: 1) ways completed; 2) preferred way to complete; 3) number completed; 4) whether the questions were clear and easy to understand; 5) whether any questions were unclear or difficult to understand; 6) whether the questions provided meaningful information about parents' ability to support the child's social emotional development; 7) plan to continue using; 8) plan to address item(s) parents indicated as a focus area and how they would address the item(s); 9) whether completing brought up any concerns or areas of need they were not aware of and whether they felt comfortable addressing the needs; 10) how they would change the questionnaire to make it better, and 11) how did parents respond to the tool. Most of the questions were answered using five response choices: "strongly disagree," "disagree," "no opinion," "agree," and "strongly agree,"

with a "yes" or "no" response, or open-ended comments. Finally, any additional comments or suggestions were requested in a "comments" section at the end of the form.

Ways completed. Practitioners completed the tool with parents on a home visit (*n* = 11), Childcare center (*n* = 5), and during a parent group (*n* = 1). Many of the families who were recruited from childcare centers were given the study measures to take home and return.

Preferred completion method. Six (35.3%) practitioners responded that their preferred way of completing the SEAM P-T was during a home visit with a parent and the other eleven (64.7%) responded that they had no preference. Comments made by the practitioners include*, "I prefer going over the questions with the client in person to help them understand what the questions are asking," "During a scheduled home visit so that we can discuss questions/concerns*" and *"Interview style because it opens up opportunity for conversation."*

Number completed. Frequency counts of practitioner completed SEAM P-T can be found in Table 26. Most of the practitioners completed between 1 and 3 SEAM P-T measures with families, though some did more. These numbers do not reflect the families who took the measures home to complete on their own or who contacted the principal investigator directly after being recruited by their practitioners (e.g., Moss Street child care). Two of the surveys were missing the number completed by the practitioner.

TABLE 26. *Number of the Completed SEAM P-T for Practitioners*

Number of Questionnaires Completed	*n*	%

1	4	23.5
2	5	29.5
3	3	17.6
4	1	5.9
5	1	5.9
15	1	5.9
Missing	2	11.8
Total	17	100

Questions clear and understandable. All of practitioners (*n* = 17) checked "agree" (88.2%) or "strongly agree" (11.8%) indicating that in general, the items were clear and easy to understand. The only comment offered related to the benefits of having a Spanish translation and not for any specific item(s). A summary of practitioner responses to the question of whether the questions were clear and easy to understand is found in table 27.

TABLE 27. *General Clearness and Easiness to Understand Questions on the SEAM P-T for Practitioners*

Feedback	*n*	%
Strongly disagree	0	0
Disagree	0	0
No opinion	0	0
Agree	15	88.2
Strongly agree	2	11.8
Total	17	100

Questions were meaningful. When asked whether completing the SEAM P-T gave practitioners meaningful information about the caregiver's ability to support their toddler's social emotional development, 76.5% of them said that they "agree" or "strongly agree," two said, "no opinion" and two others said, "disagree." For one of the practitioners who checked "disagree," the following comment was added, "*I think sitting down with parents one-on-one to go over survey would be more beneficial.*" Other practitioners who felt the information was meaningful commented, "*It prompted parent to state things that I can provide information or referrals on. Mom had not worked on redirecting inappropriate behaviors*" and "*Concrete examples that the parent provides are clear indicators. Even if the parent doesn't identify it is a focus area, their comments and examples indicate areas for growth.*" One concern was voiced in the comment section related to accuracy of parent responses on the SEAM P-T, "*Some parents' impression of their ability was higher or lower than my impression of their ability, which was informative, but I am concerned that self-report can be inaccurate.*" Table 28 summarizes practitioner ratings about how meaningful the information was on the SEAM P-T.

TABLE 28. *Completing the SEAM P-T Gave Practitioners Meaningful Information About the Caregiver's Ability to Support Their Toddler's Social Emotional Development*

Feedback	*n*	%
Strongly Disagree	0	0
Disagree	2	11.8
No opinion	2	11.8
Agree	12	70.6
Strongly agree	1	5.9

Total	17	100

Plan to continue using. Ten (58.9%) of the practitioners felt that they plan to use the SEAM P-T in the future. Comments included, "*If we have access to it, it would be a good framework for a conversation," "These can be a great tool for opening up topics with a parent, I would use it again."* Practitioners who "disagreed" (11.8%) or had "no opinion" (23.5%) said that the future use of the SEAM P-T would depend on decisions made by their center director or program administrators who handle what assessments are selected, if any. Also, one practitioner thought that there was a possibility that the SEAM P-T could be used on an as needed basis. Table 29 summarizes practitioners' plans to continue using the SEAM P-T in the future.

TABLE 29. *Practitioners' Plans to Continue Using SEAM P-T in the Future*

Feedback	*n*	%
Strongly Disagree	0	0
Disagree	2	11.8
No opinion	4	23.5
Agree	8	47.1
Strongly agree	2	11.8
Total	17	100

Plan to address focus areas. About half of the practitioners "agreed" or "strongly agreed" that they planned to address some of the items that parents indicated as a focus area on the SEAM P-T. They were also asked if they agree, what materials they

might use to address the item(s). Comments related to this included: "*Refer to parenting class, conversations about areas, suggest specific options or resources," "Basic strategies used with toddlers," "teaching parents about descriptive praise, redirection, safety," "parents identified the areas they have the least confidence in," "Home-based program home visitor's main focus is the child with parent engagement so that the parent is involved in what the goals or focus areas are and provide that same support for the family,"* and *"We will talk about her concerns – mostly behavioral. We'll talk in positives, to build her confidence. We'll only use the resources she has available."* Practitioners who indicated "no opinion" or "disagree" also commented "*there were no focus areas selected*" or "*the parents are already addressing inappropriate behavior with their child."* Table 30 summarizes practitioners' comments addressing some of the items that parents indicated as a focus area on the SEAM P-T.

TABLE 30. *Practitioners' Rating of Whether They Plan to Address Items That Parents Indicated as a Focus Area on the SEAM P-T*

Feedback	*n*	%
Strongly agree	2	11.8
Agree	6	35.3
No opinion	7	41.2
Disagree	1	5.9
Total	17	100

Concerns not aware of. Four (23.5%) of the practitioners reported that completing the SEAM P-T brought up concerns or areas of need for families of which they were not aware. Those who indicated that there were new areas of concern also

reported that they felt comfortable addressing those needs. Practitioner comments included: "*After completing the SEAM, parents approached me with the concerns they noted on the form. We are working on the strategies together," "It gave me good insight into the parents' perspective on supporting their children's social emotional development," "Mostly these were areas she and I had talked about before," "Wasn't sure if sleep routine was a problem for mom,"* and *"This parent has been very open about difficulties."* Thirteen (76.5%) practitioners indicated that they did not become aware of any new issues.

Changes recommended. Practitioners reported that they liked the SEAM P-T in its current form and most did not offer ways to change the measure to make it better. One practitioner commented that creating open-ended questions to foster natural discussion might be beneficial.

Parent response. Overall, practitioners said that the parents responded positively to the SEAM P-T. They offered the following feedback: *"They said some parts were interesting and things they hadn't thought about before,"* "*I think she felt very good about what she was already doing. I've worked with this family for almost 2 years,"* "*They responded well. The only thing that was said was that it was long," "Very favorably. It was thought provoking," and "They were comfortable with it"* and "*Pretty well - the examples were helpful for understanding the meaning of the questions."*

Further comments and suggestions. Two practitioners offered final comments and suggestions about the SEAM P-T, "*It feels like the ASQ:SE but is a little more direct or focused on the parents side of the social emotional development,"* and "*I think this*

could be very useful for parents facing challenges or parents that don't have as much education as ours at this center."

CHAPTER V

DISCUSSION

This study examined convergent validity and utility of a curriculum-based measure, the SEAM P-T. Previous research has supported the utility of curriculum-based assessment to effectively identify curricular objectives and monitor progress and the impact of the interventions used; however, no studies have examined curriculum-based assessment measures designed for perceived parent competence. This current study addressed this gap by evaluating the SEAM P-T, a curriculum-based measure developed to capture parent perspectives through self-report of their ability to facilitate positive child outcomes. SEAM P-T items target parent knowledge and behaviors that foster social emotional development, identify areas they need more information and support, and capture focus areas and concerns. Specifically, this study examined (1) convergent validity of the SEAM P-T and (2) utility of the SEAM P-T for practitioners and parents.

Practitioners that serve parents and their toddlers, both at risk for and with established developmental disabilities, were included. In this chapter, study findings are examined related to initial psychometric data from the SEAM P-T. Potential limitations are explored, and results are discussed in terms of providing a foundation for future research related to the SEAM P-T and implications for use in the field.

Participants

Early Childhood Sites

Nine early childhood agencies participated including early intervention (n = 1), prevention (n = 3), child development centers (n = 4), and community parent education provider (n = 1). Although the sample was one of convenience, it was also purposive in

nature and careful selection of agencies that work with families of toddlers experiencing three risk factors (i.e., low risk for delay, high risk for delay, established conditions) were targeted.

Practitioners

Practitioners from three service program areas participated: community childcare, prevention, and early intervention. Additional practitioners supported the study by passing out flyers to families they work with and by directing parents to contact the principal investigator directly to participate, though they did not complete demographic information forms or utility surveys.

A range of work experience was reported with more than half of the practitioners serving families with toddlers for well more than a decade. Practitioners were typically well educated and had college degrees in early childhood education, early intervention and family and human services. Level of education fell into predictable categories as related to the job requirements of the practitioners; graduate degrees were most likely to be held by early interventionists; four-year degrees were held by prevention service providers; and two-year degrees by child development center staff. The majority of practitioners indicated that a good portion of their coursework and training was related to working with infants and toddlers and their families. Many practitioners in early intervention and prevention services reported that they felt a high level of skill related to providing mental health services to infants and toddlers and their families, though this was not as true for the staff in child development center teaching positions. This result might imply that the nature of the work for early childhood educators is less focused on

family intervention as compared to the work done by practitioners engaged in home visitation and direct intervention with parents.

Parents

Parents with diverse backgrounds in education, socio-economic status, ethnicity, family composition, and child risk factors participated. Most parents in the low risk group were Caucasian, more educated, had incomes above $50,000.00, were married, and tended to be older than parents in the two other groups. Parents in the high-risk group were more likely to be from minority ethnic groups, had less education, lower incomes, and were single and younger in age than the other two groups. Parents with a toddler with an established condition such as developmental delay or autism were the most heterogeneous group across all demographic areas.

Low risk families had predominantly high quality, and often more expensive, child care affiliated with a local university or paid to participate in community parenting groups, which means that this sample may have overrepresented families with greater resources and higher education levels than families in the general population. For families receiving prevention services, family demographics were closely linked to program eligibility, which correlated strongly with known risk factors for this population. For example, there were more single, minority parents who had lower education and income levels. On the other hand, disabilities can affect children from all demographic categories and the families in the sample were representative of the diversity of the families served by early intervention.

Toddlers

Toddlers ranging in age from 15 to 41 months participated in the study, with an average age of 27 months. Although the target age for the study was 18 to 36 months, four toddlers were slightly older and three were slightly younger. These children were included in the study as their age was within the developmental range appropriate for the ASQ:SE intervals used. Almost twice as many boys than girls participated. This is not surprising given that a higher percentage of boys are served in early intervention. As part of the selection criteria for risk level, 25 of the toddlers were reported to have an established disability, 22 toddlers were receiving services for environmental conditions that place them at high risk for delay, and 34 were in low risk situations. Prevention programs and childcare providers served several of the children who also received early intervention, though they were placed in the "established conditions" categorical group for toddlers for the purpose of the study.

Convergent Validity

Convergent validity was estimated in three ways: 1) by computing correlation coefficients to measure agreement between the SEAM P-T and a theoretically similar measure of parent competence, the PSI-4-SF; 2) the predictive pattern of intercorrelations using simple linear regression between the SEAM P-T and the ASQ:SE; and 3) exploring the mean differences between three risk categories of children on the SEAM P-T, using an analysis of variance.

Convergent Validity of the SEAM P-T and PSI-4-SF

The Parenting Stress Index-Short Form (PSI-4-SF) (Abidin, 2012) is a self-report measure of perceived stress in the parent-child relationship based upon child

characteristics and parent characteristics. Items on the PSI-4-SF measure perceived competence and perceived restrictiveness associated with the parental role, perception of parent-child dysfunctional interaction, and behavioral characteristics of children that parents may perceive as challenging to manage. SEAM P-T items measure perceived parental competence related to supporting social emotional development in young children through developmentally appropriate activities, routines, positive interactions and safety. A moderate negative correlation was found between the SEAM P-T and PSI-4-SF scores, meaning that self-perception of parent competence increased on the SEAM P-T as levels of total stress on the PSI-4-SF decreased. Similar moderate negative correlations were also found between the SEAM P-T and three subscales: parental distress, parent-child dysfunctional interaction and difficult child. Meaning that as parents' perceived competence on the SEAM P-T increased parents' perception of distress in their parenting role, parent-child dysfunctional interactions, and management concerns with their child's behaviors decreased. These subscale areas can all influence parenting behaviors and subsequently impact child outcomes, according to the theoretical model used for the PSI-4-SF (Abidin, 2012). Similarly, the four benchmark areas used to measure parenting competence on the SEAM P-T were drawn from current literature and research to address areas that can affect child outcomes including: response to child's needs, age appropriate activities, predictable schedule/routines and an appropriate environment, and a safe home and play environment. Toddlers develop optimally in environments where they are safe and valued, where their physical and psychological needs are met, and they receive adequate stimulation and learning opportunities. SEAM P-T and PSI-4-SF measure slightly different areas related to parental competences that

affect child outcomes, though the influence on parenting behavior are similar. A strong correlation between the SEAM P-T and PSI-4-SF would indicate that the same constructs were being measured and a weak correlation would indicate more divergent constructs. Therefore, a moderate correlation appears adequate to demonstrate convergent validity given the differences in what was measured by the items on each of the tools.

Convergent Validity of the SEAM P-T and ASQ:SE

Results suggested that lower parent competence may be negatively related to a toddler's social emotional development and behavior. However, it is also plausible that child characteristics (e.g., easy temperament or challenging behavior) or life circumstances of the family (e.g., stressful or stabile economic conditions) result in some individuals finding parenting more daunting and feeling less effective in their role. In addition, there are other extraneous variables that may impact the relationship between perceived parent competence and a toddlers' social emotional development, such as family values and habits, parental education, access to developmental appropriate materials, professional services for the child, and motivation and attitudes of parents.

The current sample included many parents with a fairly high self-perception of competence as measured by the SEAM P-T and who were already receiving services (e.g., parenting classes, prevention, and early intervention). Many of their children were also developing typically in the social emotional domain, as measured by the ASQ:SE. Therefore, outcomes may not have accurately reflected the relationship between parenting competence and child development outside this study. It is also possible that some parents either exaggerated or underestimated their skill and proficiency in the parenting role or their child's development and behavior. Future research should explore

plausible alternative explanatory factors, in addition to gathering more precise data on parenting competence, as well as experimental manipulation of parenting competence before causal conclusions can be made. For example, a single subject case design could be used to study operationally defined parenting behaviors (e.g., frequency of positive comments and language toward child) for parents who receive curricular intervention based upon the SEAM P-T, while controlling for extraneous variables (e.g., child or parent characteristics), as possible.

Convergent Validity of the SEAM P-T

Essentially, there were no significant differences between parents' perception of their parenting competence among the three risk groups studied. Perhaps parenting toddlers comes with similar joys and challenges that cut across demographics, risk factors and even developmental conditions. Toddlerhood is an age that requires help to learn basic social skills and self-regulation from caring adults through predictable, consistent, safe, and positive interactions. Curriculum-based assessments, such as the SEAM P-T, measure the competency skill and performance of individual parents based upon specific criteria, allowing the items to be linked to intervention goals and intervention. Parents' feelings about competence, and ultimately child and family outcomes, depend on the characteristics of the child and family and, in addition to informal supports (family and friends), receiving appropriate levels of intervention and supports from practitioners, as needed.

In this sample, parents obtained similar scores on the SEAM P-T, on average, regardless of risk group membership. Furthermore, parents indicated that they needed more information, resources and/or skills on many of the same items, without distinction

between risk groups. The eight areas in which parents reported the least competency were: 1) understand and appropriately address their child's behavior, 2) understand and know how to respond to nonverbal communication, 3) support the child's emotional needs, 4) provide predictable routines for meals and sleep, 5) provide predictable limits and consequences, 6) create a safe environment, 7) provide activities that match the child's developmental level, and 8) self-management of frustration and anger while with their child. There was one exception; parents of children with expressive language delays had more concerns with understanding their child's verbal communication and knowing how to respond than the other parents.

The items parents have difficulty with and indicate a need for assistance can directly contribute to both short-term and long-term outcomes for children (e.g., effectively addressing inappropriate behavior). Contributing factors in the parents' perceptions of lower competence on items may be related to limited opportunities for targeted intervention in identified areas on the SEAM P-T, particularly for families who were either not receiving intervention services (e.g., child attends day care only) or who received early intervention focused mainly on child-centered goals, indicating a potential gap in service for parents. Examples provided by parents on how they were interacting with their child need to be examined with a critical eye by practitioners, as some of them were not developmentally appropriate for the age of the child (e.g., coercive, punitive, or harsh practices for inappropriate behaviors). This may be an indication that more resources are needed to improve parent competence in certain areas to support healthy child development and prevent potential maltreatment. For example, parents may benefit from learning positive discipline strategies that offer opportunities for skill building,

encourage routines and clear expectations, and consistent guidance for the child rather than reacting negatively to misbehavior or using punishment. Practitioners may need to look at how intervention efforts can more effectively address the needs of parents in their community. For example, many of the parents from across all three risk categories indicated a need for more resources, skills and information on SEAM P-T items, which may indicate that parents need additional supports to those currently provided.

Utility

Parents and practitioners completed utility surveys on the SEAM P-T. The surveys were designed to collect feedback on how parents and practitioners evaluated the utility of the SEAM P-T, including such areas as general usefulness or recommended changes.

Parents

Parents typically completed the SEAM P-T in about 20-30 minutes, depending on whether they answered the questions by giving examples or simply checked the answer boxes. Parents who answered questions during an interview with their practitioner sometimes took slightly longer, and many reported that they appreciated having an opportunity to talk about the content with a professional.

Most of the parents found the questions to be useful (80.1%), clear and easy to understand (97.6%), and did not feel any questions were unclear or difficult to understand (91.4%). Feedback from parents on items that seemed unclear or difficult to understand (7.4%) related to how the examples provided did not match the question, examples were too general or restated the question, and they were challenged to think of an example for

certain questions that they didn't understand. An example included, *"I understand why my child engages in inappropriate behaviors and know how to modify the environment."*

When asked whether completing the SEAM P-T gave them meaningful information about their ability to support their child's social emotional development, parents tended to report that they disagreed (71.6%). The reasons that parents did not find these questions meaningful were varied, but tended to fall into three main categories. First, some parents reported that they already felt confident in their parenting skills and the SEAM P-T did not provide additional insight or information that would help them grow or gain new skills. Second, parents who completed the SEAM P-T on their own and did not receive individualized parent education services through a practitioner (e.g., parents from child development centers) felt that the process of completing the form was not linked to goal setting and intervention, though several of them wished that they had that type of support. Third, parents receiving prevention or early intervention services reported that most of these areas had already been addressed by working with their practitioners over time. Only five parents (6.1%) reported that meaningful information was obtained by completing the SEAM P-T. These parents said that the questions validated what they were doing and the examples listed gave them ideas to try.

Parents were asked how they would change the SEAM P-T to make it better. About a third (32.4%) indicated that they wouldn't make any changes; another third (36%) did not respond to this question; and the final third (28.8%) offered recommendations. A complete list of parent's suggested changes can be found in Table 24; however, five will be addressed. First, parents suggested that the SEAM P-T be translated into Spanish, which would benefit Spanish-speaking families. Second, a

number of parents felt that the SEAM P-T would be most beneficial when administered in an interview format. Third, adding questions that address what social supports are in place and focus on the emotional health of the parents could be beneficial. Fourth, clarifying directions, adding more appropriate examples, and providing more space to write in would be helpful. Fifth, parents recommended that the assessment be accessible online with links to resources that would provide information, resources and/or skills for each of the items.

Parents offered final comments and suggestions as part of the utility survey and these are provided in Table 25. Feedback was positive with regard to the usefulness of the tool to help facilitate a dialog between practitioners and parents and to increase awareness of specific parenting practices, though some parents thought that it was challenging and time consuming to think of examples. One parent added that it would be beneficial if healthcare providers incorporated screening questionnaires on social emotional development into their routine practices.

Practitioners

Practitioners were also asked to complete a survey to obtain their feedback on the utility of the SEAM P-T. Seventeen practitioners serving families from across the three risk categories answered questions on the survey. Two-thirds (n = 11) of the practitioners completed the tool with parents during a home visit while the others completed it during a parent group or in a childcare center. When asked what their preferred completion method was, a third of the practitioners (35.3%) said "while on a home visit," while the remaining two-thirds (64.7%) said they had "no preference." The majority of the practitioners completed between one and three SEAM P-Ts with their families.

Practitioners unanimously agreed that the questions on the SEAM P-T were clear and easy to understand. A majority of practitioners (76.5%) indicated that completing questions on the SEAM P-T gave them meaningful information about the parent's ability to support their child's social emotional development. Practitioner comments related the benefits of linking parents with information and resources for areas they needed to work on. For the four practitioners who did not find the information on the SEAM P-T meaningful, two were aware of the focus areas and already addressing those with parents; one had not completed the measure with the parents (i.e., parent completed independently at home) and felt that it would have been more useful to have completed it through an interview format with them; and the last was not convinced that the parents she worked with were giving accurate self-reports. Not all parents indicated, "focus areas" on the SEAM P-T, but for those who did (47.1%), the practitioners planned to address some of the items either through referrals or directly providing information. When asked what materials would be used to address focus areas, no specific curriculum was listed. Most of the practitioners (76.5%) said that completing the SEAM P-T did not bring up any concerns or areas of need for families that they were unaware of, though some (23.5%) did learn of new areas, which they felt comfortable addressing.

More than half of practitioners (58.9%) plan to continue to use the SEAM P-T in the future, finding value in the tool for opening up a dialog with parents on areas in which they may need support. For other practitioners, their ability to use the SEAM P-T at their site requires that program administrators must first approve it. For these sites, the SEAM P-T would need to be incorporated into the systems used by all the practitioners.

All of the practitioners said that they liked the SEAM P-T and had no recommendations for changes to the measure that would make it better. Furthermore, practitioners reported that, in general, parents responded favorably to the SEAM P-T. In the final comments, practitioners added that the SEAM P-T may be very useful for individuals with parenting challenges and would directly focus on parent competencies associated with social emotional development.

Limitations

Limitations of this study include: 1) sample composition, 2) failed assumptions of normality, 3) timing of research, 4) engagement of practitioners, and 5) contextual fit.

Sample

Threats to external validity and sampling bias may have occurred given the selection of participants who volunteered, from a convenience sample of local service providers. This sampling bias may have impacted the accuracy and ability to generalize results to a different population. Sampling methods included recruiting participants believed to be representative of a given population of children including toddlers at low risk for delay, high risk for delay, or with established conditions. Self-selection of participants at sites may have implications for the outcomes, as there may be characteristics that distinguish practitioners and parents who are involved with target sites and choose to participate in the study from those who are involved in services but did not participate. For example, parents who participated may have higher literacy rates or may have been less concerned with sharing information on parenting practices than parents who chose not to participate. Participating families who received prevention services may have a greater level of stability due to the quality of the programs and long term

relationships with practitioners, setting them apart from more vulnerable high-risk families (e.g., parents with intellectual disabilities or substance abuse recovery) who may not have been as highly represented in this sample. Therefore, the parents represented in the study may have scored higher on the SEAM P-T than parents who were in less stable living conditions or who have received less intervention in the area of parenting skills.

Assumptions of Normality

Assumptions of normality were evaluated using stem and leaf displays, histograms, Q-Q plots, scatter plot display, and Kolmogorov-Smirnov test of normality. Distributions for the dependent variable, ASQ:SE, were unimodal and asymmetrical, with moderate to severe outliers and severe negative skew. Linearity tended slightly toward curvalinearity. The analysis was rerun without extreme cases to explore whether they were influential and the results of the model remained statistically significant. The skew and outliers did not appear severe enough to compromise the correlation coefficient as a measure of the relation between the variables for the linear regression model in this study; however, caution should still be used when interpreting the statistical significance of this particular analysis.

Timing of Research

Data collection was conducted during the summer months, which had a negative impact on recruitment efforts and level of participation. Some programs had a short summer session and scheduled breaks in delivery before resuming service in the fall (i.e., EHS and Early Childhood CARES), which created limited time to recruit and complete study materials with families. Community parenting groups were not scheduled during the summer months (i.e. Birth to Three) and therefore parent educators were not available

to work directly with research materials with families in their toddler groups, though flyers were distributed as groups ended in June. Across sites, staff and families took personal vacation time, further limiting contact and time to complete measures.

Conflicting research studies and program evaluation activities also interfered with recruitment efforts for three of the originally targeted sites serving high-risk populations. Two of these sites elected not to participate as practitioners and parents were just completing another similar research project through the University of Oregon Early Intervention Program. A third site was unable to participate because an evaluation of their program was underway, thus declining involvement in this study. Having fewer families with chronic stress and instability in the high-risk category may have influenced the study results by elevating the overall SEAM P-T scores.

Engagement of Practitioners

Although practitioners were encouraged to meet individually with parents to complete the study materials whenever possible, some parents completed measures on their own (i.e. folders sent home), which resulted in inconsistent data collection methods. Feasibility of all the parents receiving individualized attention was low given the nature of the services offered (e.g., child development centers), no active groups running during study timeframe (i.e., Birth to Three) and schedules or workload conflicts of practitioners (i.e., prevention and early intervention programs).

Practitioners working with parents in all three risk categories recruited families for the study and directed them to contact the principal investigator directly. The principal investigator met with interested families, typically visiting their home, and supporting them while they completed the measures. Although the principal investigator

has extensive experience working with diverse families, parents did not have an established relationship or the rapport they may have shared with their practitioners. Additionally, although the principal investigator discussed strategies to address focus areas and offered referrals, this did not provide parents with an opportunity to establish goals or intervention with their practitioner, which may have affected the outcomes. For example, parents may have responded more positively to utility survey items related to how meaningful they found the information from the SEAM P-T. Though they did not directly collect the study information, several of the practitioners did review the completed SEAM P-T of the parents they served and provided feedback on the utility survey. Additionally, practitioners followed up directly with their parents to address any of the focus areas or items needing intervention.

Contextual Fit

Curriculum-based measures that focus on parent competencies may work best in settings that use the linked system model to directly support parents develop skills and proficiency in their parenting role. That is, early intervention and prevention programs that offer individualized parent support would be appropriate for using the SEAM P-T. Childcare providers who primarily serve children do not typically have the ability to support parents in the same way prevention or early intervention service providers do. Similarly, community parent education groups may not be able to meet the support needs of parents without adopting a focused assessment and tiered intervention model. Furthermore, having parents complete a curriculum-based assessment without an opportunity to access curricular support may have impacted parents' ability to find the questions meaningful. Practitioners who provided intervention – the intended users of

curriculum-based measures – found the SEAM P-T items very meaningful, which is a positive indicator for utility for supporting families receiving prevention and early intervention service.

Implications for Future Research

The purpose of this research was to conduct initial psychometric studies of the SEAM P-T, examining convergent validity and utility. Results from the study support the initial validity and utility of the SEAM P-T in assessing parents' competence related to supporting their toddler's social emotional development. This section addresses implications for future research. Results from the study call for further research on SEAM P-T modifications, target populations, linking to curriculum, and studying reliability in more depth.

Changes to SEAM P-T

Results from the basic examination of utility of the SEAM P-T call for further modification on SEAM P-T items and modifying of examples to make them more meaningful to parents. Changing examples that fit the items, and potentially including other relevant items (e.g., access to social support and resources for parents) were other recommendations. Parents and practitioners offered valuable feedback on other changes to the SEAM P-T including translation of the measure into Spanish, formulating the questions on the measure into more of an interview format, adding more space for writing parent responses and examples, and creating a way to access the assessment and curriculum online. Any changes made to the SEAM P-T should receive further study of validity and utility.

Target Populations

Replication of the study can be undertaken with different parent populations in the field. Additional groups of parents may include: 1) parents not receiving any type of service for their toddlers; 2) parents new to prevention or early intervention services; 3) vulnerable populations such as parents with intellectual disabilities, in substance abuse recovery, experiencing homelessness, or in chronic stress conditions; 4) teen parents; 5) foster parents; 6) adoptive parents; and 7) parents involved with child welfare. Additionally, future research can be expanded to include parents of younger and older children by using the other SEAM intervals (i.e., Parent-Infant and Parent-Preschooler Interval).

Link to Curriculum

Research designed to study all components of the linked system model for the SEAM P-T, from assessment to goal development, intervention, and progress monitoring is needed, though the SEAM curriculum is still in development. Availability of appropriate materials to address SEAM P-T benchmarks is a critical aspect of effective curriculum-based intervention and efforts to create these resources and study their effectiveness should be made a priority.

Reliability

Psychometric properties of the SEAM P-T investigated in this study were limited to convergent validity and utility. Study of reliability is still needed. Future research can include a study design that addresses reliability using test-retest, inter-rater, and internal consistency estimates with parents and practitioners.

Implications for Practice

Results from this study support the convergent validity and utility of the SEAM P-T in assessing self-perception of parent competence for parents of toddlers. Correlations between the SEAM P-T and PSI-4-SF support the use of the SEAM P-T for developing goals and planning intervention within a linked system model of screening, assessment, goal development, intervention, and progress monitoring. Also, the level of perceived parent competence on SEAM P-T scores appears to provide predictive value related to child behavior and social emotional development as measured by the ASQ:SE, which further supports the potential benefit of using the SEAM P-T with parents. Evaluation of the SEAM P-T by practitioners and parents was generally positive, indicating that the SEAM P-T may be a useful curriculum-based measure for assessing parent strengths and needs and using the information to design high quality goals and intervention.

A significant body of early childhood research and theory has demonstrated that parent behaviors informed by positive, safe, and consistent patterns of interactions can be highly effective in promoting healthy social emotional development for toddlers with and without disabilities. Intervention efforts targeting increased feelings of competence and self-efficacy in parents contributes to higher quality parent-child relationships, which positively impacts healthy social emotional development (Bailey et al., 2004; McWilliam, 2010). Practitioners using a curriculum-based measure to assess parental self-perceptions of competence and who are knowledgeable about intervention strategies

to address the areas of need identified through that measure may change the way support is currently provided to families, potentially improving outcomes for children.

All toddlers benefit from being supported by skilled parents who can provide safe, stimulating environments where their need for connection and nurturing is met (Boris & Page, 2012; Shonkoff, 2010). This study demonstrated that all parents of toddlers, regardless of risk condition, have parenting behaviors that would benefit from more information, resources, and/or skills in as indicated on responses to the SEAM P-T items. Targeting benchmark areas for perceived parent competence can be useful for practitioners by helping them direct intervention efforts on identified focus areas. For example, practitioners who identify a parent's need for more information and skill development related to understanding and responding to their toddler's inappropriate behaviors can intervene accordingly, likely improving child and family outcomes.

Early intervention approaches that focus on enhancing parents' capacity to meet the needs of their toddlers is consistently supported by research. When used by practitioners, evidence-based coaching strategies can contribute positively to parents' sense of competency during interactions their children (Powell & Dunlap, 2010; Rush & Sheldon, 2011). Practitioners with training and administrative support from their programs are likely to be the best equipped to provide intervention to families using the SEAM P-T within a linked system model (Pretti-Frontczak & Bricker, 2004). SEAM P-T can assist practitioners in the early identification of parenting challenges, prevention of social emotional difficulties, and intervention with parents before behavior disorders of young children become entrenched by providing information, resources, and skill building experiences. Improving developmental outcomes and preventing early

maltreatment of toddlers in vulnerable families may be closely linked to effective assessment and intervention (Jones Harden & Klein, 2011). Through development of high-quality goals and intervention drawn from the SEAM P-T, positive parent-child interactions can be optimized. Professional training and coaching strategies can insure practitioners are knowledgeable about implementation including administration of the measure, how to discuss concerns with parents, and identifying resources and potential strategies for focus areas.

Differential Response to Intervention

Parents often have a wide variety of resources and support at their disposal. Income, level of education, social network, family composition, geographic location, mental and emotional well-being, and access to services can all impact the level of intervention needed to support parental competency. While most families may benefit from gaining foundational knowledge about developmentally appropriate practices to use with toddlers, many parents may not require formal intervention at all. Parents who have a child at risk for or with a developmental disability often require an individualized and integrative intervention approach based upon the family and child characteristics, risk and protective factors, concerns, priorities and resources. Seven general principles that guide practitioners in high quality service delivery in prevention and early intervention include: 1) home visiting component, 2) tailored strategies and services to meet diverse parent needs, 3) starting early in child's life is important (prenatal or at birth), 4) initial and ongoing assessment, 5) well-trained providers, 6) adequate intensity and duration of intervention, and 7) a variety of individual and group intervention approaches (Landy & Menna, 2006). Intervention strategies can be offered along a continuum of support,

depending on the needs of the parents. This continuum may progress along a graduating level of service delivery starting from least intensive to most intensive: 1) general access to parenting resources, 2) parenting groups and classes, and 3) individualized support through intensive intervention. A model that identifies the level of intervention intensity for parents would be valuable for insuring adequate type and dosage. See Figure 4 for an illustration of the parent intervention model.

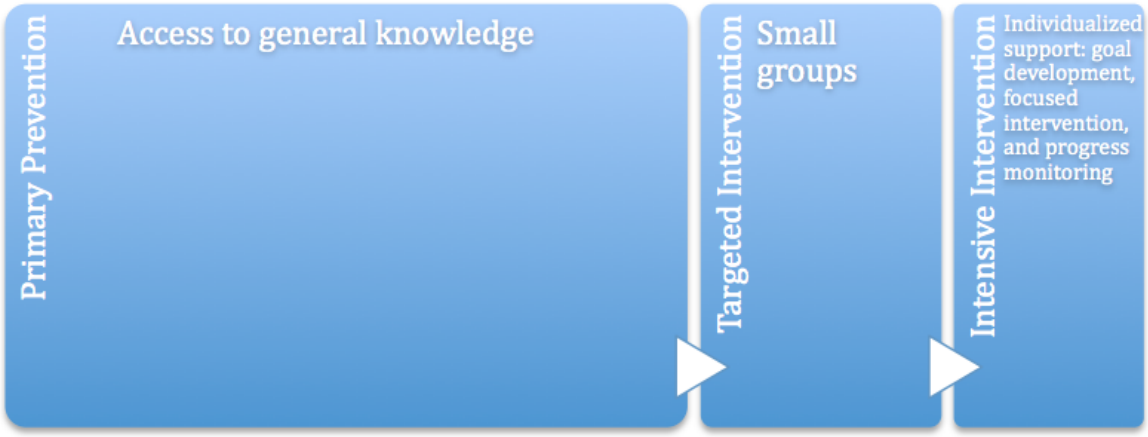

Figure 4. *Parent Intervention Model*

Conclusion

The assessment of parent competence in toddlerhood is particularly challenging due to the breadth of skills that need to be considered, the risk and protective factors that may influence parenting behavior, and the absence of appropriate tests and measures. There is no agreed upon proven metric tool nor available standard for assessing parent competence. The statistically significant findings from this research study related to convergent validity between SEAM P-T and other assessment measures (PSI-4-SF and ASQ:SE), along with positive practitioner feedback on its utility, suggests that the SEAM P-T is an appropriate tool for eliciting parent's self-perception of competence that can be

used in early childhood systems, providing a foundation for intervention and improved child outcomes.

Early childhood development research, theory, and practice support the conception that social emotional competence emerges out of transactional encounters between young children and their parents within the context of the family living environment. Furthermore, ongoing interactions between neurobiological and environmental factors contribute to the level of developmental achievements of children, emphasizing how crucial early childhood experiences and healthy brain development is in the first years of life (MacLean, 1985; Nelson, 2000; Odom, McConnell, & Brown, 2008; Shonkoff, 2010). When there are significant neurobiological or environmental risk factors present (e.g., unstable relationships, early abuse and neglect), using early intervention to provide remediation becomes vitally important to both typically and atypically developing children. Protecting children from factors that are known to contribute to poor developmental outcomes (e.g., maternal mental health problems, stress, and punitive parenting practices) is important if long-term negative impacts (e.g., mental and physical health issues, school failure) are to be thwarted (Caffo, Lievers, & Forresi, 2006; Cuffe & Shugart, 2001; Eitzen & Eitzen Smith, 2009; Guralnick, 2011; Miller, Sadegh-Nobari, Lillie-Blanton, 2011; Mitchell & Hauser-Cram, 2009; Rapheal, 2011; Rondero Hernandez, Montana, & Clark, 2010; Seccomb, 2000; Shonkoff, 2010). Intervention efforts that occur during the critical early years can prevent or ameliorate the effects of limiting conditions by providing parents with the resources and support necessary to facilitate their child's social emotional development (Calkins & Hill, 2007;

Dunst, 1993; Harden & Duchene, 2012; Notter et al., Thompson, 2006; Werner & Smith, 2001).

Ultimately, the relationships that children have with their parents have the greatest influence on their social emotional development (Boris & Page, 2012; Dunst & Trivette, 2009; Powell & Dunlap, 2010; Razza et al., 2010). Fostering positive parenting practices to create a safe, nurturing, and predictable home environment where toddlers can optimally develop is an important role for practitioners, particularly when parents experience stressful life conditions, have unrealistic expectations of toddler behavior, or lack healthy relationship models (Lamb-Parker et al., 2008; Malik, 2012). Young children can learn to regulate their emotional states and build a sense of confidence and security within the context of relationship when parents are responsive and skilled (Bailey et al., 2004; Boris & Page, 2012; Calkins & Hill, 2007; Weinfield et. Al., 2008). Social emotional development unfolds during everyday routines and play, and toddlers tend to benefit from interesting opportunities to grow and explore while being supported by clear expectations and consistent relationships within a harmonious family living environment (Dunst & Kassow, 2008; Mitchell & Hauser-Cram, 2009). By using the SEAM P-T to inform intervention aimed at improving perceived parent competency and self-efficacy, practitioners will be more equipped to address the needs of parents, which may lead to improved social emotional outcomes for young children.

APPENDIX A

STUDY FLYER

Parent-Toddler Research
Social Emotional Behavior

Purpose of Study

Parents of toddlers are invited to participate in a research study that examines how to identify resources needed to support a positive parent-child relationship, promote social emotional competence, and prevent challenging behavior in young children.

UNIVERSITY OF OREGON

Who: Parents of Toddlers 18-36 months old

What: Complete Parent Questionnaires related to Social-Emotional Development

When: Summer 2012 **Time:** About 1 hour

Other: Families will receive a $20 gift card, social emotional development activities, Parent Helpline flyer and *Parenting NOW! 2012 Resources for Families* guide.

Contact:

Aoife Magee, Early Intervention Program

541-346-2673 armagee@uoregon.edu

APPENDIX B

PARENT CONSENT FORM

Parent Consent Form

Dear Parents/Guardians,

Your are invited to participate in a research study conducted by Aoife Magee, under the supervision of Dr. Jane Squires at the University of Oregon, Early Intervention Program. The Early Intervention Program at the University of Oregon is currently collecting data on the Social Emotional Assessment Measure (SEAM) Parent-Toddler Interval, a new tool that is designed to collect information about parents' knowledge and behaviors that foster social emotional development in their child. We are gathering information from practitioners and from parents with young children. The organization your child is enrolled in is participating in this study and your family was selected to participate based upon the age of your child and the type of services he/she receives. In every study there are risks. However, we do not think that you will encounter more risk than you already do day to day in responding to questions about parenting or your child's behavior. Although there is no expected benefit to your family for participating, information collected may help practitioners and parents to develop strategies that may improve behavioral and social emotional functioning in young children, so this research benefits participants and humanity at large. We may identify some children who need some extra help to improve their behavior and provide resources to their family.

You will be asked to complete a family information form, three (3) parenting questionnaires, and a satisfaction survey about the SEAM Parent-Toddler Interval that will take approximately 10-20 minutes each. Your results on the SEAM will be shared with a practitioner who works with your child, if they are also part of this study. In order to protect the privacy and confidentiality of participants, identification numbers will be used and all materials secured in a locked cabinet in the principal investigators office and electronic data stored on a secure computer. You will receive a $20 gift card, social emotional development activities handout, Parent Helpline flyer and a *Parenting NOW! 2012 Resources for Families* guide when all research materials have been returned.

If you have questions about the research at any time, please call Aoife Magee at (541) 346-2673 or email at armagee@uoregon.edu. You may also reach us at the Early Intervention Program, University of Oregon, 5253 University of Oregon, Eugene, OR 97403-5253, (541) 346-0807. If you have questions about your rights as a participant in a research project, or in the event of a research related concern, please call the Office for Protection of Human Subjects, University of Oregon, (541) 346-2510.

Your signature on the reverse side indicates that you have read and understand the information. Your participation is voluntary and you may withdraw your consent at any time without penalty. If you do not wish to participate, your intervention services will not be affected. You are not waiving any legal claims, rights, or remedies. You will be offered a copy of this form to keep.

Sincerely,

Aoife R. Magee
Principal Investigator

Parent Consent Form

I have read and understand the information provided in this letter about participating in the study on the SEAM Toddler Adult/Caregiver Form. I will complete 5 forms as a parent that will take approximately 1 hour to complete. I willingly agree to participate in the research, and understand that I may withdraw my consent at any time without penalty, and that I will receive a copy of this form, and that I am not waiving any legal claims, rights, or remedies. I will receive a $20 gift card, social emotional development activities handout, Parent Helpline flyer, and *Parenting NOW! 2012 Resources for Families* guide when all research materials are completed.

Child's Name: _____

Program: _____

Parent's Name: _____

Signature: _____ Date: _____

APPENDIX C

PRACTITIONER CONSENT FORM

Practitioner Consent Form

Dear Practitioner,

Your are invited to participate in a research study conducted by Aoife Magee, under the supervision of Dr. Jane Squires at the University of Oregon, Early Intervention Program. The Early Intervention Program at the University of Oregon is currently collecting data on the Social Emotional Assessment Measure (SEAM) Parent-Toddler Interval, a new tool that is designed to collect information about parents' knowledge and behaviors that foster social emotional development in their child. The information will help teachers and parents to develop strategies that may improve behavioral and social emotional functioning in young children. We are gathering information from practitioners and from parents with young children.

You will be asked to have parents complete a family information form, three (3) assessments, and a satisfaction questionnaire about the SEAM Parent-Toddler Interval that will take approximately 10-20 minutes each. In addition, you will be asked to complete a questionnaire describing your training and experience. Finally, you will be asked to complete a satisfaction questionnaire about the SEAM Parent-Toddler Interval that will take about 5-10 minutes to complete. You will receive a one-time $20 gift certificate (regardless of the number of parents recruited) and research materials have been returned.

In order to protect the privacy and confidentiality of participants, identification numbers will be used and all materials secured in a locked cabinet in the principal investigators' office and electronic data stored on a secure computer.

If you have questions about the research at any time, please call Aoife Magee at (541) 346-2673 or email at armagee@uoregon.edu. You may also reach us at the Early Intervention Program, University of Oregon, 5253 University of Oregon, Eugene, OR 97403-5253, (541) 346-0807. If you have questions about your rights as a participant in a research project, or in the event of a research related concern, please call the Office for Protection of Human Subjects, University of Oregon, (541) 346-2510.

Your signature on the reverse side indicates that you have read and understand the information. Your participation is voluntary and you may withdraw your consent at any time without penalty. If you do not wish to participate, your position will not be affected. You are not waiving any legal claims, rights, or remedies. You will be offered a copy of this form to keep.

Sincerely,

Aoife R. Magee
Principal Investigator

Practitioner Consent Form

I have read and understand the information provided in this letter about participating in the study related to the SEAM Parent-Toddler Interval. I will complete 2 forms as a practitioner and provide study materials to parents that will take them approximately 1 hour to complete. I willingly agree to participate in the research, and understand that I may withdraw my consent at any time without penalty, and that I will receive a copy of this form, and that I am not waiving any legal claims, rights, or remedies. I will receive a one-time $20 gift certificate for recruiting parent participants and collecting completed assessments from families.

Practitioner's Name: _____

Program: _____

Signature: _____ Date: _____

APPENDIX D

FAMILY INFORMATION FORM

Family ID _____
Child ID _____
Practitioner ID _____

SEAM Family Information Form

1. **Date questionnaire completed:** ___/___/____
(month / day / year)

2. **Child's gender:** (Check one) **Male** **Female**

3. **Child's date of birth:** ___/___/____ ***Expected*** **date of birth (due date):** ___/___/____
(month / day / year) *(month / day / year)*

4. **Child's ethnic group:** (Check all that apply)

Asian American Indian/Alaskan Native African American
Caucasian/White Native Hawaiian/Pacific Islander Hispanic/Latino
Don't know Other (specify) _____

5. **Your date of birth:** ___/___/____
(month / day / year)

6. **What is your level of education?** (check one)

Didn't complete high school
High school diploma or General Education Development (GED)
Some college
Associate's degree (AA)
Bachelor's degree
Postgraduate/Graduate degree and above

7. **What is your best estimate of your total *annual* household income from all sources last year before income tax deduction?** (Check one yearly amount)

no income	$20,000 - $29,999
$5,000 - $9,999	$30,000 - $39,999
$10,000 - $14,999	$40,000 - $49,999
$15,000 - $19,999	$50,000 – or more

8. **Person answering questions:** (Check one)

Birth Mother Adoptive Mother Foster Mother Relative (specify) _____
Birth Father Adoptive Father Foster Father Guardian
Home Visitor Teacher More than one person or ***other*** (specify) _____

9. **Is someone assisting with the completion of this form?** Yes No

If yes, how are they assisting? (Check all that apply)

Translating language Reading items/interviewing Other (specify) _____

10. **Does your child have a disability or developmental delay?** (Check one) Yes No

If yes, what is his/her disability or delay? (specify) _____

11. **Does your child receive special services?** (Check one) Yes No

If yes, what type of service does he/she receive? (specify) _____

SEAM 3/12//08

APPENDIX E

PRACTIONER INFORMATON FORM

ID _____

SEAM Practitioner Information

1. **How many years of experience do you have working with** (Write in years of experience):

   a) Children birth to two years: _____

   b) Children three to five years: _____

2. **How many years experience do you have in your current program?**_____ (years)

3. **What is your age: _____**

4. **What is your level of education?** (check one)
   Didn't complete high school
   High school diploma or General Education Development (GED)
   Some college
   Associate's degree (AA)
   Bachelor's degree
   Postgraduate/Graduate degree and above

   b) If you hold a degree, what is it in? _____

   c) If you have had any college coursework, how much of your coursework was/is related to working with infants & toddlers and their families? (Check one)

   Most (75%+) Half (50%) Some (25%) A Little (Less than 25%) None

   d) How much of your coursework or training was/is related to working with preschool age children and their families? (Check one)

   Most (75%+) Half (50%) Some (25%) A Little (Less than 25%) None

5. **Describe your <u>skill level</u> related to providing mental health services to infants and toddlers and their families in EI/ECSE.**

   1 **2** **3** **4**
   Very low *Very high*

SEAM 3/12/08

APPENDIX F

AGES & STAGES QUESTIONNAIRE: SOCIAL EMOTIONAL 18 - 36 MONTH

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim**

ASQ:SE™

18 Month Questionnaire

(For children ages 15 through 20 months)

Important Points to Remember:

☑ Please return this questionnaire by _____ .

☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .

☑ Thank you and please look forward to filling out another ASQ:SE questionnaire in _____ months.

ASQ:SE™

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim**

18 Month ASQ:SE Questionnaire

(For children ages 15 through 20 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE™

Please read each question carefully and 1. Check the box ❑ that best describes your child's behavior *and* 2. Check the circle ❍ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	❑ z	❑ v	❑ x	❍
2. When you leave, does your child remain upset and cry for more than an hour?	❑ x	❑ v	❑ z	❍
3. Does your child laugh or smile when you play with her? 	❑ z	❑ v	❑ x	❍
4. Does your child look for you when a stranger approaches?	❑ z	❑ v	❑ x	❍
5. Is your child's body relaxed?	❑ z	❑ v	❑ x	❍
6. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	❍
7. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	❍
8. Does your child stiffen and arch his back when picked up?	❑ x	❑ v	❑ z	❍
9. Does your child cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	❑ z	❑ v	❑ x	❍
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	❑ x	❑ v	❑ z	❍
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	❑ x	❑ v	❑ z	❍
13. Does your child have trouble falling asleep at naptime or at night?	❑ x	❑ v	❑ z	❍
14. Do you and your child enjoy mealtimes together?	❑ z	❑ v	❑ x	❍
15. Does your child sleep at least 10 hours in a 24-hour period?	❑ z	❑ v	❑ x	❍
16. When you point at something, does your child look in the direction you are pointing?	❑ z	❑ v	❑ x	❍
17. Does your child get constipated or have diarrhea?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child let you know how she is feeling with gestures or words? For example, does she let you know when she is hungry, hurt, or tired?	❑ z	❑ v	❑ x	❍
19. Does your child follow simple directions? For example, does he sit down when asked?	❑ z	❑ v	❑ x	❍
20. Does your child like to play near or be with family members and friends?	❑ z	❑ v	❑ x	❍
21. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑ z	❑ v	❑ x	❍
22. Does your child like to hear stories or sing songs? 	❑ z	❑ v	❑ x	❍
23. Does your child hurt herself on purpose?	❑ x	❑ v	❑ z	❍
24. Does your child like to be around other children? 	❑ z	❑ v	❑ x	❍
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	❑ x	❑ v	❑ z	❍

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

28. Is there anything that worries you about your child? If so, please explain:

29. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ___

Ages & Stages Questionnaires®: Social-Emotional
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By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim**

24 Month/2 Year ASQ:SE Questionnaire

(For children ages 21 through 26 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE™

Please read each question carefully and 1. Check the box ❑ that best describes your child's behavior *and* 2. Check the circle ❍ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	❑ z	❑ v	❑ x	❍
2. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	❍
3. Does your child laugh or smile when you play with her?	❑ z	❑ v	❑ x	❍
4. Is your child's body relaxed?	❑ z	❑ v	❑ x	❍
5. When you leave, does your child remain upset and cry for more than an hour? 	❑ x	❑ v	❑ z	❍
6. Does your child greet or say hello to familiar adults?	❑ z	❑ v	❑ x	❍
7. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	❍
8. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	❍
9. Does your child stiffen and arch his back when picked up?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

Please read each question carefully and 1. Check the box ❑ that best describes your child's behavior *and* 2. Check the circle ❍ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	❑ z	❑ v	❑ x	❍
2. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	❍
3. Does your child laugh or smile when you play with her?	❑ z	❑ v	❑ x	❍
4. Is your child's body relaxed?	❑ z	❑ v	❑ x	❍
5. When you leave, does your child remain upset and cry for more than an hour? 	❑ x	❑ v	❑ z	❍
6. Does your child greet or say hello to familiar adults?	❑ z	❑ v	❑ x	❍
7. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	❍
8. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	❍
9. Does your child stiffen and arch his back when picked up?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around her, such as people, toys, and foods?	❑ z	❑ v	❑ x	❍
11. Does your child cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍
12. Do you and your child enjoy mealtimes together?	❑ z	❑ v	❑ x	❍
13. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	❑ x	❑ v	❑ z	❍
14. Does your child sleep at least 10 hours in a 24-hour period?	❑ z	❑ v	❑ x	❍
15. When you point at something, does your child look in the direction you are pointing?	❑ z	❑ v	❑ x	❍
16. Does your child have trouble falling asleep at naptime or at night?	❑ x	❑ v	❑ z	❍
17. Does your child get constipated or have diarrhea?	❑ x	❑ v	❑ z	❍
18. Does your child follow simple directions? For example, does he sit down when asked?	❑ z	❑ v	❑ x	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
19. Does your child let you know how she is feeling with either words or gestures? For example, does she let you know when she is hungry, hurt, or tired?	❑ z	❑ v	❑ x	❍
20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑ z	❑ v	❑ x	❍
21. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	❑ x	❑ v	❑ z	❍
22. Does your child like to hear stories or sing songs? 	❑ z	❑ v	❑ x	❍
23. Does your child hurt himself on purpose?	❑ x	❑ v	❑ z	❍
24. Does your child like to be around other children? 	❑ z	❑ v	❑ x	❍
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	❑ x	❑ v	❑ z	❍

27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:

28. Is there anything that worries you about your child? If so, please explain:

29. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ___

24 Month/2 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____

Person filling out the ASQ:SE: _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ:SE completion: _____

Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
	Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
24 months/2 years	50	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

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ASQ:SE™

30 Month Questionnaire

(For children ages 27 through 32 months)

Important Points to Remember:

- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Thank you and please look forward to filling out another ASQ:SE questionnaire in _____ months.

ASQ:SE™

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30 Month ASQ:SE Questionnaire

(For children ages 27 through 32 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE™

Please read each question carefully and 1. Check the box ❑ that best describes your child's behavior *and* 2. Check the circle ❍ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to him?	❑ z	❑ v	❑ x	❍
2. Does your child like to be hugged or cuddled?	❑ z	❑ v	❑ x	❍
3. Does your child cling to you more than you expect? 	❑ x	❑ v	❑ z	❍
4. Does your child greet or say hello to familiar adults?	❑ z	❑ v	❑ x	❍
5. Does your child seem happy?	❑ z	❑ v	❑ x	❍
6. Does your child like to hear stories and sing songs?	❑ z	❑ v	❑ x	❍
7. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	❍
8. Does your child seem more active than other children her age? 	❑ x	❑ v	❑ z	❍
9. Can your child settle himself down after periods of exciting activity?	❑ z	❑ v	❑ x	❍
10. Does your child cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
12. Can your child stay with activities she enjoys for at least 3 minutes (not including watching television)?	❑ z	❑ v	❑ x	❍
13. Does your child do what you ask him to do?	❑ z	❑ v	❑ x	❍
14. Is your child interested in things around her, such as people, toys, and foods?	❑ z	❑ v	❑ x	❍
15. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	❍
16. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	❑ x	❑ v	❑ z	❍
17. Do you and your child enjoy mealtimes together?	❑ z	❑ v	❑ x	❍
18. When you point at something, does your child look in the direction you are pointing?	❑ z	❑ v	❑ x	❍
19. Does your child sleep at least 8 hours in a 24-hour period?	❑ z	❑ v	❑ x	❍
20. Does your child let you know how he is feeling with either words or gestures? For example, does he let you know when he is hungry, hurt, or tired?	❑ z	❑ v	❑ x	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
21. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	❑ z	❑ v	❑ x	❍
22. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑ z	❑ v	❑ x	❍
23. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	❑ z	❑ v	❑ x	❍
24. Does your child stay away from dangerous things, such as fire and moving cars?	❑ z	❑ v	❑ x	❍
25. Does your child destroy or damage things on purpose? 	❑ x	❑ v	❑ z	❍
26. Does your child hurt himself on purpose?	❑ x	❑ v	❑ z	❍
27. Does your child play alongside other children? 	❑ z	❑ v	❑ x	❍
28. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
29. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	❑ x	❑ v	❑ z	❍

30. Do you have concerns about your child's eating and sleeping behaviors or about her toilet training? If so, please explain:

31. Is there anything that worries you about your child? If so, please explain:

32. What things do you enjoy most about your child?

TOTAL POINTS ON PAGE ___

30 Month ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____

Person filling out the ASQ:SE: _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ:SE completion: _____

Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
	Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
30 months	57	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

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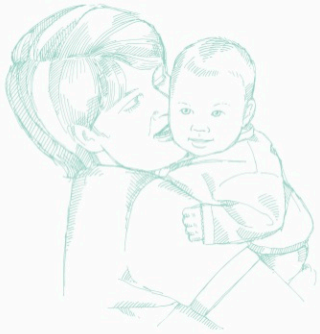
ASQ:SE™



36 Month/3 Year Questionnaire

(For children ages 33 through 41 months)

Important Points to Remember:

- ☑ Please return this questionnaire by _____ .
- ☑ If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- ☑ Thank you and please look forward to filling out another ASQ:SE questionnaire in _____ months.

ASQ:SE™

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36 Month/3 Year ASQ:SE Questionnaire

(For children ages 33 through 41 months)

Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

_____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

_____

Administering program or provider: _____

ASQ:SE™

Please read each question carefully and 1. Check the box ❑ that best describes your child's behavior *and* 2. Check the circle ❍ if this behavior is a concern	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your child look at you when you talk to her?	❑ z	❑ v	❑ x	❍
2. Does your child like to be hugged or cuddled? 	❑ z	❑ v	❑ x	❍
3. Does your child talk and/or play with adults he knows well?	❑ z	❑ v	❑ x	❍
4. Does your child cling to you more than you expect? 	❑ x	❑ v	❑ z	❍
5. When upset, can your child calm down within 15 minutes?	❑ z	❑ v	❑ x	❍
6. Does your child seem too friendly with strangers?	❑ x	❑ v	❑ z	❍
7. Can your child settle herself down after periods of exciting activity?	❑ z	❑ v	❑ x	❍
8. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	❑ z	❑ v	❑ x	❍
9. Does your child seem happy?	❑ z	❑ v	❑ x	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your child interested in things around him, such as people, toys, and foods?	❑ z	❑ v	❑ x	❍
11. Does your child do what you ask her to do?	❑ z	❑ v	❑ x	❍
12. Does your child seem more active than other children her age? 	❑ x	❑ v	❑ z	❍
13. Can your child stay with activities she enjoys for at least 5 minutes (not including watching television)?	❑ z	❑ v	❑ x	❍
14. Do you and your child enjoy mealtimes together?	❑ z	❑ v	❑ x	❍
15. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____ ? (You may write in another problem.)	❑ x	❑ v	❑ z	❍
16. Does your child sleep at least 8 hours in a 24-hour period?	❑ z	❑ v	❑ x	❍
17. Does your child use words to tell you what he wants or needs?	❑ z	❑ v	❑ x	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your child follow routine directions? For example, does she come to the table or help clean up her toys when asked?	❑ z	❑ v	❑ x	❍
 19. Does your child cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍
 20. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	❑ z	❑ v	❑ x	❍
21. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ . (You may write in something else.)	❑ x	❑ v	❑ z	❍
22. Does your child hurt himself on purpose?	❑ x	❑ v	❑ z	❍
23. Does your child stay away from dangerous things, such as fire and moving cars?	❑ z	❑ v	❑ x	❍
 24. Does your child destroy or damage things on purpose?	❑ x	❑ v	❑ z	❍
25. Does your child use words to describe her feelings and the feelings of others, such as, "I'm happy," "I don't like that," or "She's sad"?	❑ z	❑ v	❑ x	❍

TOTAL POINTS ON PAGE ___

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
26. Can your child name a friend?	❑ z	❑ v	❑ x	❍
27. Do *other* children like to play with your child?	❑ z	❑ v	❑ x	❍
28. Does *your child* like to play with other children?	❑ z	❑ v	❑ x	❍
29. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	❑ x	❑ v	❑ z	❍
30. Does your child show an interest in or knowledge of sexual language and activity?	❑ x	❑ v	❑ z	❍
31. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:	❑ x	❑ v	❑ z	❍

_____

_____

_____

_____

32. Do you have any concerns about your child's eating, sleeping, or toileting habits? If so, please explain:

_____

_____

_____

_____

TOTAL POINTS ON PAGE ___

33. Is there anything that worries you about your child? If so, please explain:

34. What things do you enjoy most about your child?

36 Month/3 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____

Person filling out the ASQ:SE: _____ Relationship to child: _____

Mailing address: _____ City: _____ State: _____ ZIP: _____

Telephone: _____ Assisting in ASQ:SE completion: _____

Today's date: _____ Administering program/provider: _____

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Total points on page 6	= _____
	Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
36 months/3 years	59	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?, Have there been any stressful events in the child's life recently?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

APPENDIX G

SEAM PARENT-TODDLER INTERVAL

Social Emotional Assessment Measure
SEAM Toddler
Parent/Caregiver Form

(for individuals with children in
developmental range18 - 36 months)

Child's name: _____

Child's date of birth: _____

Today's date: _____

Family's name: _____

Name of person completing form: _____

Date of administration: _____

The following questions are designed to gather information about parent/caregiver strengths, as well as the supports and resources they need to provide a safe, responsive, and emotionally nurturing environment for their children. The items focus on knowledge, skills, and resources caregivers need in order to foster their toddler's social emotional development and competence. Though caregivers can complete this form on their own, the preferred method for completing this form is through an interview with the caregiver(s). Items that are not relevant or that caregivers do not want to answer can be omitted.

Items are written in easy to understand language and are accompanied by one or more examples to assist caregivers in understanding the item. Following the examples is a space for caregivers to provide their own examples related to each item. Caregivers can choose between a "most of the time," "sometimes," "not yet," or "not sure/need more information" response. In addition the form provides space for the caregiver to indicate if he or she would like to choose the item as an area of focus to gain more information, support, or resources related to the item.

INSTRUCTIONS:

1.Arrange a time and place to complete the form that is comfortable for the caregiver(s). Explain the purpose of the interview and the form.

2.Read each item and the examples. Then ask the caregiver(s) to indicate which response option best describes their experience with the targeted item. "**Most of the time**" should be checked if the caregiver (s) feels he or she has the information, resources and/or skills indicated in the item. "**Sometimes**" should be checked if the caregiver(s) feels he or she needs additional information, resources, and/or skills indicated in the item. "**Not yet**" should be checked if the caregiver(s) feels he or she does not have the information, resources, and/or skills indicated in the item. "**Not sure/need more information**" should be checked if the caregiver is unsure of how to respond or would like to get more information before choosing a final response option.

3.Check the triangle next to an item if the caregiver(s) would like the item to be a focus area, and/or if he or she needs related resources, support, or information from a professional (school, child's teacher/ home visitor).

4.Consider the cultural appropriateness of each item for individual families and omit items that caregivers may find intrusive, disrespectful, or inappropriate.

Social Emotional Assessment/Evaluation Measure (SEAM): Toddler, Experimental Edition, revised 2011.

ADULT/CAREGIVER FORM: TODDLER-AGE

Please read each item carefully and:

1. Check the box ☐ that best describes you
2. Check the triangle △ if this is a focus area

	MOST OF THE TIME	SOMETIMES	NOT YET	NOT SURE/ NEED MORE INFORMATION	FOCUS AREA
A-1.0 Responding to my child's needs					
1.1. I understand my child's nonverbal communication and know how to respond.	☐	☐	☐	☐	△
Some examples might be:					
• *When my child gets fussy, it usually means she is hungry or tired and I give her a snack or put her down for a nap.*					
• *When my child seems upset, I usually hug her or talk to her, then play a game or read a story with her.*					
Please give examples of *your* child's nonverbal communication and ways that *you* respond:					
_____					
_____					
_____					
1.2. I understand my child's verbal communication and know how to respond.	☐	☐	☐	☐	△
Some examples might be:					
•*When my child fusses because she is hungry, I ask, "hungry?"*					
• *When my child says "blankie!" I know he is tired and wants to take a nap.*					
Please give examples of *your* child's verbal communication and ways that *you* respond:					
_____					
_____					
_____					
1.3. I know how to support my child's emotional needs.	☐	☐	☐	☐	△
Some examples might be:					
• *When my child is hurt, upset or feeling frightened, I hold and soothe him.*					
•*When I see that my child is mad, frustrated, unhappy, or excited, I use words to express what she is feeling.*					
• *I have my child take deep breaths to help him calm down when he is upset.*					
Please give examples of how *you* support *your* child's emotional needs:					
_____					
_____					
_____					

ADULT/CAREGIVER FORM: TODDLER-AGE

Please read each item carefully and:

1. Check the box ☐ that best describes you
2. Check the triangle △ if this is a focus area

	MOST OF THE TIME	SOMETIMES	NOT YET	NOT SURE/ NEED MORE INFORMATION	FOCUS AREA
1.4. I use positive comments and language with my child.	☐	☐	☐	☐	△

Some examples might be:

• *When my child is petting the cat, I comment on how gentle he is being.*

• *When my child picks up his toys, I give him a "high 5".*

Please give examples of positive language *you* use and comments *you* say to *your* child:

_____

_____

_____

1.5. I know how to successfully redirect my child's inappropriate behaviors.	☐	☐	☐	☐	△

Some examples might be:

• *I give my child her favorite doll before she pokes her baby sister.*

• *When my child begins to run indoors, I remind her to walk indoors or I take her outside to play.*

Please give examples of ways *you* redirect *your* child's inappropriate behaviors:

_____

_____

_____

1.6. I understand why my child engages in inappropriate behaviors and know how to modify the environment.	☐	☐	☐	☐	△

Some examples might be:

• *I prepare my child for a long bus ride by providing her with art and other enjoyable activities to keep her occupied during the trip.*

• *I let my child choose one grocery item at the store before a tantrum occurs.*

Please give examples of ways that *you* prevent inappropriate behaviors:

_____

_____

_____

A-2.0 Providing activities that match my child's developmental level

2.1. I provide my child books, toys and play things that match his developmental level.	☐	☐	☐	☐	△

Some examples might be:

• *I offer materials and toys that encourage his thinking and problem solving skills, such as sorting toys into buckets, completing puzzles, and playing with puppets.*

• *I am able to provide toys and books that are safe and interesting to my child.*

Please give examples of items *you* provide for *your* child:

_____

_____

_____

ADULT/CAREGIVER FORM: TODDLER-AGE

Please read each item carefully and:

1. Check the box ☐ that best describes you
2. Check the triangle △ if this is a focus area

	MOST OF THE TIME	SOMETIMES	NOT YET	NOT SURE/ NEED MORE INFORMATION	FOCUS AREA
2.2. I know the age appropriate games that my child enjoys.	☐	☐	☐	☐	△

Some examples might be:

• *I play simple action games with my child that she enjoys like Hide and Seek and Ring Around the Rosie.*

• *I play my child's favorite talking and rhyming games, such as I Spy.*

Please give examples of games that *you* play with *your* child:

_____

_____

_____

A-3.0 Providing predictable schedule/ routines and appropriate environment for my child

3.1. I provide a mealtime routine for my child that is predictable and appropriate for his age.	☐	☐	☐	☐	△

Some examples might be:

• *I provide my child with regular meals and snacks at predictable times each day.*

• *Throughout the day, I provide my child with a variety of foods such as different fruits and vegetables, including foods my child eats with his hands or utensils.*

Please give examples of *your* mealtime routine and foods *you* provide:

_____

_____

_____

3.2. I provide a rest and sleeping routine for my child that is predictable and appropriate for her age.	☐	☐	☐	☐	△

Some examples might be:

• *I provide bedtime and naptime at consistent times across days and weeks.*

• *I follow a simple routine before bed such as a warm bath, brushing teeth, and reading stories.*

Please give examples of *your* child's nap and bedtime routines:

_____

_____

_____

3.3. I provide my child with predictable limits and consequences.	☐	☐	☐	☐	△

Some examples might be:

• *I provide my child with consistent limits and rules, such as no hitting or throwing toys.*

• *I notice and comment to my child when she is doing something positive and consistent with our household rules such as, "I like the way you are coloring on the paper."*

Please give examples of how *you* provide predictable limits and consequences for *your* child:

_____

_____

_____

ADULT/CAREGIVER FORM: TODDLER-AGE

Please read each item carefully and:

1. Check the box ☐ that best describes you
2. Check the triangle △ if this is a focus area

	MOST OF THE TIME	SOMETIMES	NOT YET	NOT SURE/ NEED MORE INFORMATION	FOCUS AREA
3.4. I take time each day to play with my child.	☐	☐	☐	☐	△

Some examples might be:

• *I spend time at home singing songs and looking at books with my child.*

• *I try to make routine activities such as mealtimes, bath time, and potty time playful and fun for my child.*

Please give examples of times of day when *you* play with *your* child and playful activities you do together:

_____

_____

_____

A-4.0 Providing a safe home and play environment for my child

4.1. I have done a safety check on my home to make it safe for my child.	☐	☐	☐	☐	△

Some examples might be:

• *I keep dangerous objects and other harmful substances (e.g., medications, cleaning supplies) out of reach or in locked cupboards.*

•*I have outlet covers on the electrical outlets my child can reach.*

Please give examples of ways *you* keep your environment safe for *your* child:

_____

_____

_____

4.2. I have a safe way to transport my child.	☐	☐	☐	☐	△

Some examples might be:

• *I use a stroller and car seat that are appropriate for my child's height and weight.*

Please give examples of *your* child's safe travel arrangements:

_____

_____

_____

4.3. I am able to provide my child with safe care and supervision.	☐	☐	☐	☐	△

Some examples might be:

• *I watch my child while she plays at the park or outdoors.*

• *When I am unable to watch or care for my child, I arrange for someone I trust to supervise or care for him.*

Please share ways that *you* provide safe care for *your* child:

_____

_____

_____

ADULT/CAREGIVER FORM: TODDLER-AGE

Please read each item carefully and:

1. Check the box ☐ that best describes you
2. Check the triangle △ if this is a focus area

	MOST OF THE TIME	SOMETIMES	NOT YET	NOT SURE/ NEED MORE INFORMATION	FOCUS AREA
4.4. I have access to regular medical and dental care for my child. Some examples might be: • *I am able to take my child to the child health clinic for check-ups (including hearing and vision) and dentist at least twice per year.* **Please give examples of *your* health care providers:** _____ _____ _____	☐	☐	☐	☐	△
4.5. I know how to manage my own feelings of anger and frustration that come up while with my child. Some examples might be: • *I have a trusted person to call for help or advice if my child cries for a long time and I am unsure what to do.* • *I have ways of taking time and caring for myself regularly.* **Please give examples of who *you* turn to or other ways *you* manage *your* feelings and frustration:** _____ _____ _____	☐	☐	☐	☐	△

APPENDIX H

PARENTING STRESS INVENTORY/SHORT FORM

PSI-4 SHORT FORM

Answer Sheet

Name _____ Gender _____ Date of birth ___/___/___

Ethnic group _____ Marital status _____ Today's date ___/___/___

Child's name _____ Child's gender _____ Child's date of birth ___/___/___

SA = Strongly Agree **A = Agree** **NS = Not Sure** **D = Disagree** **SD = Strongly Disagree**

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8.	Having a child has caused more problems than I expected in my relationship with my spouse/parenting partner.	SA	A	NS	D	SD
9.	I feel alone and without friends.	SA	A	NS	D	SD
10.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
11.	I am not as interested in people as I used to be.	SA	A	NS	D	SD
12.	I don't enjoy things as I used to.	SA	A	NS	D	SD
13.	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
14.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
15.	My child smiles at me much less than I expected.	SA	A	NS	D	SD
16.	Sometimes I feel my child doesn't like me and doesn't want to be close to me.	SA	A	NS	D	SD
17.	My child is very emotional and gets upset easily.	SA	A	NS	D	SD
18.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
19.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
20.	My child is not able to do as much as I expected.	SA	A	NS	D	SD
21.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD
22.	I feel that I am: (Choose a response from the choices below.)	1	2	3	4	5
23.	I expected to have closer and warmer feelings for my child than I do, and this bothers me.	SA	A	NS	D	SD
24.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD

1. a very good parent.
2. a better-than-average parent.
3. an average parent.
4. a person who has some trouble being a parent.
5. not very good at being a parent.

SA = Strongly Agree	A = Agree	NS = Not Sure	D = Disagree	SD = Strongly Disagree

25.	My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
26.	My child generally wakes up in a bad mood.	SA	A	NS	D	SD
27.	I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
28.	Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house.	SA	A	NS	D	SD
29.	My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
30.	When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
31.	My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD
32.	I have found that getting my child to do something or stop doing something is: (Choose a response from the choices below.)	1	2	3	4	5

1. much harder than I expected.
2. somewhat harder than I expected.
3. about as hard as I expected.
4. somewhat easier than I expected.
5. much easier than I expected.

33.	Think carefully and count the number of things which your child does that bothers you. For example, dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc. (Choose a response from the choices below.)	1	2	3	4	5

1. 1-3
2. 4-5
3. 6-7
4. 8-9
5. 10+

34.	There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
35.	My child's behavior is more of a problem than I expected.	SA	A	NS	D	SD
36.	My child makes more demands on me than most children.	SA	A	NS	D	SD

APPENDIX I

PARENT UTILITY SURVEY

ID _____

Parent Utility Survey
SEAM for Parent-Toddler Interval

1. **Approximately how many minutes did it take to complete the SEAM Parent-Toddler Interval?**

   ☐ Minutes

2. **In general, the questions were useful.** (CHECK one)

   ○ Strongly disagree ○ Disagree ○ No opinion ○ Agree ○ Strongly agree

   Comments: _____

   _____

   _____

3. **In general, the questions were clear and easy to understand.** (CHECK one)

   ○ Strongly disagree ○ Disagree ○ No opinion ○ Agree ○ Strongly agree

   Comments: _____

   _____

   _____

4. **Were any questions unclear or difficult to understand?**

   ○ Yes ○ No

   If so, please explain. (please write the item number and reason)**?**

Item #	Reason or Comment

5. **Completing the SEAM Parent-Toddler Interval gave me meaningful information about my ability to support my child's social emotional development.** (Check one)

   Strongly agree Agree No opinion Disagree Strongly disagree

   Comments: _____

   _____

   _____

Please continue on the next page

6. **Did completing the SEAM Parent-Toddler Interval bring up any concerns that you would like to talk to someone about?**
   ○ Yes ○ No

   If yes, please provide a telephone number or email address so we can contact you:

7. **How would you change the SEAM Parent-Toddler Interval to make it better?**

   _____

   _____

   _____

We welcome further comments and suggestions. Feel free to write them here:

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for participating in this study!

APPENDIX J

PRACTITIONER UTILITY SURVEY

ID _____

Practitioner Utility Survey
SEAM Parent-Toddler Interval

1. **Check the ways in which you have completed the SEAM Parent-Toddler Interval:**
(check all that apply)

Home visit Parent group Other (specify): _____

Telephone Child care center

2. **Given your experience, do you have a preferred way of completing the SEAM Parent-Toddler Interval?**

Yes No

Comments: _____

_____

_____

4. **How many SEAM Parent-Toddler Intervals have you completed?** _____
(number completed)

5. **In general, items were clear and easy to understand.** (Check one)

Strongly agree Agree No opinion Disagree Strongly disagree

If not, which items were problematic? (please specify item number and reason)

Item #	Reason or Comment

6. **Completing the SEAM Parent-Toddler Intervals gave me meaningful information about the caregiver's ability to support their child's social emotional development.**
(Check one)

Strongly agree Agree No opinion Disagree Strongly disagree

Comments: _____

_____

_____

Please continue on the next page

7. **I plan to continue using the SEAM Parent-Toddler Interval in the future.** (Check one)

   Strongly agree Agree No opinion Disagree Strongly disagree

   If not, please comment on your reason(s):_____

   _____

   _____

8. **I plan to address some of the items that parents indicated as a focus area.** (Check one)

   Strongly agree Agree No opinion Disagree Strongly disagree

   If you agree, what materials might you use to address the item(s)? _____

   _____

   Comments: _____

   _____

   _____

9. **Did completing the SEAM Parent-Toddler Interval bring up any concerns or areas of need for families that you were not aware of?** Yes No

   If so, do you feel comfortable addressing these needs? Yes No

   Comments: _____

   _____

   _____

10. **How would you change the SEAM Parent-Toddler Interval to make it better?**

    _____

    _____

    _____

11. **In general, how do you feel that parents responded to the SEAM Parent-Toddler Interval?**

    _____

    _____

We welcome further comments and suggestions. Feel free to write them below:

_____

_____

Thank you for participating in this study!

SEAM 4/20/12

APPENDIX K

PARENT HELPLINE MATERIALS

MAGNETS: Business card size - 2" x 3.5"

APPENDIX L

BEHAVIOR AND

ACTIVITIES FOR YOUNG CHILDREN

SOCIAL-EMOTIONAL BEHAVIOR DEVELOPMENT IN YOUNG CHILDREN

At 18 months . . .

- Your toddler is generally happy and smiles at people, including other children.
- Your toddler likes to talk and is using more words every day.
- Your toddler likes to show affection and give hugs and kisses.
- Your toddler may be showing different emotions such as fear, sympathy, modesty, guilt, or embarrassment.
- Your toddler likes to do things by himself. He may seem stubborn, but this is normal.
- Your toddler likes to help out with simple household tasks.
- Your toddler turns to you for help when she is in trouble.
- He enjoys playing near other children, but not with them yet.
- She may hand objects to other children, but she doesn't understand how to share and wants the toys right back.
- Your toddler can play by himself for short periods of time.
- Your toddler has specific likes and dislikes.
- Your toddler likes to say "No!" She may have a quick temper and sometimes hits when frustrated.
- Your toddler loves to be held and read to and becomes upset when separated from you.
- Your toddler loves to imitate others.
- Your toddler likes to be the center of attention.
- Your toddler recognizes himself in mirror or pictures.

SOCIAL-EMOTIONAL ACTIVITIES FOR INFANTS 18 MONTHS OLD

Your toddler likes to have a consistent daily routine. Talk to him about what you are doing now and what will be happening next. Give him time to be active and time to be quiet.	Your toddler loves to have lots of hugs and kisses. Give big hugs, little hugs, loud kisses, soft kisses. Tell him you love him soooo much!	Your toddler will enjoy gentle rough-housing and tickling games. Make sure he can let you know when he has had enough. He will like quiet snuggle-up times, too.	Have a pretend party with stuffed animals or dolls. You can cut out little "presents" from a magazine, make a pretend "cake," and sing the birthday song.
Your toddler needs a lot of time to move around and exercise.* Go for a walk to the park, visit a playground, or make a trip to a shopping mall.	Your toddler will love to help out with daily tasks. Give him simple "jobs" to do and let him know what a big boy he is. He can wipe off a table, put his toys away, or help sweep up.	Play simple games such as Hide and Seek and Chase with your toddler. Have fun and laugh together.	Dance with your toddler. Make a simple instrument out of a large plastic food tub (for a drum) or a small plastic container filled with beans or rice (for a shaker).
Help your child learn about emotions. In front of a mirror make happy faces, sad faces, mad faces, and silly faces. This is fun!	Let your toddler help out during mealtimes by bringing some things to the table or setting a place.	Your child might enjoy having a little place to hide. Use a blanket or sheet to make a tent or secret spot for her to play in.	Your child can help clean up after playtimes. Make it simple by putting things in a big tub or box and help him clean. Clap and praise him for his help.
Make playhouse furniture for your child out of boxes. For a stove, turn a box upside down and draw "burners." Some plastic containers make safe pots, and wooden spoons stir the soup.	Set up playtimes with other children. Your child doesn't understand how to share yet, so make sure there are plenty of toys. Stay close by and help her learn how to play with other children.	Your toddler is getting big and wants to do things by himself! Let him practice eating with a spoon and drinking with a tippy cup during mealtimes. Get ready for some spilling!	Story times, especially before naptime and bedtime, are a great way to settle down before sleep. Let your child choose books to read and help turn pages, and help her name what she sees.

*Be sure to review safety guidelines with your health care provider at each new age level.

SOCIAL-EMOTIONAL BEHAVIOR DEVELOPMENT IN YOUNG CHILDREN

At 24 months (2 years) . . .

- Your toddler likes to imitate you, other adults, and her friends.
- Your toddler wants to do everything by himself, even though he can't!
- Your toddler's favorite words are "mine," "no," "me do it."
- Your toddler has a lot of emotions, and her emotions can be very "big." She can get angry and have temper tantrums.
- Your toddler likes to imitate household tasks and can put some of his toys away with help from you.
- Your toddler loves to try new things and explore new places but wants to know you are nearby to keep her safe.
- Your toddler is very interested in other children and is still learning how to play with them.
- He will play nearby other children, but not really with them. He doesn't understand how to share his things yet.
- Your toddler has a hard time waiting and wants things right now.
- Your toddler loves attention from familiar adults and children but may act shy around strangers.
- Your toddler is learning how to show affection by returning a hug or kiss. She tries to comfort familiar people who are in distress.
- Your toddler knows his name and knows what he likes and dislikes. He may be very attached to certain things such as a special book, toy, or blanket.
- Your toddler enjoys simple pretend play like pretending to cook or talk on the telephone.
- Your toddler is learning about the routines in your home, but generally she is unable to remember rules.

SOCIAL-EMOTIONAL ACTIVITIES FOR INFANTS 24 MONTHS OLD (2 YEARS OLD)

Try to have clear routines during the day, and let your child know what will be happening next. "Remember, after we brush hair, we get dressed."	Your child is learning about rules but will need lots and lots of reminders. Keep rules short and simple, and be consistent.	Have a special reading time every day with your toddler. Snuggle up and get close. Before bedtimes or naptimes is a great time to read together.	Let your toddler know how special she is! She will love to be praised for new things she learns how to do: "You are so helpful," "Wow, you did it yourself!"
When your child plays with friends, stay nearby to help them learn about taking turns. It is still early for your child to know how to share, but talking about turns will help her learn.	Give your toddler choices, but keep them simple. While dressing, let him choose a red or a blue shirt. At lunch, let him choose milk or juice.	Provide lots of time to play with other children. Your child will play hard but needs rest times too. Try to learn your child's rhythms and go with her flow.	Let your child do more things for himself.* Put a stool near the sink so he can wash his hands and brush his teeth. Let him pick out clothes and help dress himself.
Get down on the floor and play with your child. Try to follow your child's lead by playing with toys he wants to play with and trying his ideas.	Encourage your child to pretend play. With plastic cups, plastic containers, and some spoons, you can make some yummy "soup." Praise your toddler's cooking.	Everything is new to your toddler. She can find beauty in the little things like some weeds growing on a path or a pigeon pecking for seeds. Take some time to see the little things with her.	Your toddler is learning all about emotions. Help him label his feelings when he is mad, sad, happy, or silly: "You are really happy," "You seem really mad."
Play Parade or Follow the Leader with your toddler. Your child will love to copy you—and be the leader!	If your child has a temper tantrum, stay calm and talk in a quiet tone. If possible, ignore her until she calms down by herself.	Don't forget to tell your child how much you love him! Give him hugs and kisses and soft touches to let him know.	Teach your child simple songs like "Eensy Weensy Spider" where she can use her fingers.

*Be sure to review safety guidelines with your health care provider at each new age level.

SOCIAL-EMOTIONAL BEHAVIOR DEVELOPMENT IN YOUNG CHILDREN

At 30 months . . .

- Your child enjoys playing alongside other children.
- He likes using his increasing imagination. Puppets, dress-up clothes, dolls, and play figures are fun playthings.
- Your child is beginning to understand others' feelings. She may be able to identify when another child is angry or happy.
- Your child is beginning to learn about sharing. He doesn't always share but can sometimes.
- Your child is getting louder and bossier at times. She may talk with a loud, urgent voice.
- Your child at this age can follow simple routine directions, such as "Bring me your cup" and "Please go in your room and get your socks."
- He enjoys hearing songs and stories—sometimes over and over again.
- Your child wants to be independent sometimes but also may want you nearby. She will now easily leave your side if she is in familiar surroundings.
- He can identify whether he is a boy or a girl.
- Your child may greet familiar adults and is happy to see familiar friends.
- She may scream and throw temper tantrums at times.
- He likes to be hugged and cuddled—but not in the middle of playtime.

SOCIAL-EMOTIONAL ACTIVITIES FOR YOUNG CHILDREN 30 MONTHS OLD

Make a "Me Book" with your child. Take some pieces of paper and glue in pictures of your child, family members, pets, or other special things. Tape the pages together.	Tell your child funny stories about things he did when he was a baby. Begin a favorite story and see if he can tell what happens next.	Show your child family photos. Talk about the people in the pictures and who they are: "That's your Uncle Joe." Can your child tell you who the people are?	Tell your child a favorite nursery rhyme and ask her how the characters in the story felt.
Give your child directions that have two steps, like "Put all of the Legos in the box, and then put the box away in the closet." Let her know what a big help she is!	When cooking and cleaning, let your child help.* He can do things like helping to stir, putting flour in a cup, or putting away spoons and forks in the drawer.	Your child loves to imitate you. Try new words, animal sounds, and noises, and see if your child can imitate what you say or how you sound.	Encourage creative play, such as drawing with crayons, painting, and playing with playdough. Playing with chalk on the sidewalk is fun.
Let your child do more things for himself. Put a step stool near the bathroom sink so he can wash his hands and brush his teeth.	Draw and cut out different "feeling" faces, such as angry, frustrated, and happy. Encourage your child to use the faces to tell you how she is feeling.	Every day, tell your child how much you love him. Give him big hugs and little hugs, big kisses and little kisses.	Have a special reading time every day. Snuggle up and get close. Before bedtimes and naptimes is a great time to read together.
Play with your child and help her learn how to share. Show her how to share and praise her when she shares with you. This is a new thing for her, so don't expect too much at this age.	Encourage your child to tell you his name and age. Sometimes making up a rhyme or song about his name will help him remember. See if he can tell you the name of his friends and teachers.	Sing songs and dance with your child. Play different types of music from the radio. Make simple instruments from boxes, oatmeal cans, or yogurt tubs.	Take your child to a park and play with her near other children. She may just watch children at first but will join in with others when she is ready.

*Be sure to review safety guidelines with your health care provider at each new age level.

SOCIAL-EMOTIONAL BEHAVIOR DEVELOPMENT IN YOUNG CHILDREN

At 36 months (3 years) . . .

- There are many things your child can do for herself, and she will tell you, "I can do it myself!"
- Although he is more independent, your child is still learning to follow simple rules—and he may need gentle reminders.
- She now plays briefly *with* other children. She is learning more about sharing and taking turns.
- He may have a special friend that he prefers playing with. Boys may prefer playing with boys, and girls with girls.
- She is becoming more independent. When you go on outings, she won't always hold your hand and stay by your side.
- Your child's emotions may shift suddenly, from happy to sad, from mad to silly. He's trying to learn how to handle his emotions.
- She can sometimes express with words the feelings that she is having. She is beginning to think about the feelings of others and may be able to identify their feelings, too.
- Your child uses his imagination to create stories through pretend play with dolls, toy telephones, and action figures.
- Your child may boss people around and make demands. This shows not only that she is independent but also that she values herself. She might do something that is asked of her but may be more willing if she thinks it's her idea.
- Your child may be fearful and have nightmares. Television shows (even scary cartoons) can give him nightmares.
- Your child's attention span is increasing, and she often stays with an activity for at least 5 minutes.

SOCIAL-EMOTIONAL ACTIVITIES FOR YOUNG CHILDREN 36 MONTHS OLD (3 YEARS OLD)

Tell your child a simple story about something she did that was funny or interesting. See if your child can tell a different story about herself.	Encourage your child to identify and label his emotions and those of other children or adults.	Provide opportunities for your child to play with other children in your neighborhood or at a park.*	Many children this age have imaginary friends. Let your child talk and play with these pretend playmates.
Give your child choices. For example, when dressing, let him choose between two shirts or during snack time, let him choose between two snacks.	When you and your child are cooking, dressing, or cleaning,* give her directions that have at least two steps: "Put that pan in the sink and then pick up the red spoon."	Write a letter together to grandparents, a pen pal, or friend. See if your child can tell you what to write about himself to include in the letter.	Play games with your child that involve taking turns, such as Follow the Leader and Hopscotch.
With stuffed animals or dolls, create conflict situations. Talk with your child about what happened, feelings, and how best to work out problems when they come up.	Have a special reading time each day. Snuggle up and get close. Slowly increase the length of the stories so your child can sit and listen a little longer.	Every day, let your child know you love her and how great she is. Give her a "high five," a big smile, a pat on the back, or a hug. Tell her she is super, cool, sweet, and fun.	Tell your child a favorite story such as the Three Little Pigs or Goldilocks and the Three Bears. See if your child can tell you how the animals felt in the story.
Draw and cut out different feeling faces, and then glue them on Popsicle sticks. Let your child act out the different feelings with the puppets.	Get down on the floor and play with your child. Try to follow your child's lead by playing with toys he wants to play with and trying his ideas.	Play games such as Mother May I and Red Light, Green Light that involve following simple directions.	Tell silly jokes with your child. Simple "What am I?" riddles are also fun. Have a good time and laugh with your child.

*Be sure to review safety guidelines with your health care provider at each new age level.

APPENDIX M

FAMILY RESOURCE GUIDE

Parenting Now!

Birth To Three

2012 Resources for Families

For parenting questions, call
Parent HelpLine 541-485-5211

PREGNANCY • CHILDBIRTH • POSTNATAL SUPPORT • ADOPTION

RECREATION

SUBSTANCE ABUSE RECOVERY

SPECIAL NEEDS

ANGER MANAGEMENT

BASIC NEEDS

CHILD ABUSE/NEGLECT • DOMESTIC VIOLENCE • SEXUAL ABUSE/ASSAULT

Spanish translation by Gabriela Fabián-Santiago provided in collaboration with Head Start of Lane County.

"A person never stands so tall as when kneeling to help a child."

This resource poster is made possible by the financial support of the Eugene Active 20-30 Club.
For more information:
Eugene Active 20-30 Club
P.O. Box 365; Eugene, OR 97440
www.eugene2030.org

Please recycle your 2011 Resources for Families poster

NATIONAL POISON CONTROL CENTER
1-800-222-1222

Spanish translation available

If you have any questions about your child's health and development, don't hesitate to call your doctor.

CHILD CARE

COUNSELING

FAMILY EDUCATION/SUPPORT

FINANCIAL ASSISTANCE

GRIEF/LOSS

HELPLINES

LEGAL

LIBRARIES

MEDICAL • DENTAL

U.S. CONSUMER PRODUCT SAFETY COMMISSION
1-800-638-2772

CHILD SAFETY SEAT RESOURCE CENTER
1-877-793-2608

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