

EXAMINING THE UTILITY OF A NEW CAREGIVER-COMPLETED SOCIAL
EMOTIONAL ASSESSMENT, THE SOCIAL EMOTIONAL ASSESSMENT
MEASURE, WITH DIVERSE LOW-INCOME PARENT-TODDLER DYADS

by

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Early social emotional competence has been linked to school readiness, decreased challenging behaviors, and positive relationships with family and peers. Despite this compelling research, more young children are displaying increasingly challenging behaviors and poor social emotional outcomes, often linked to factors associated with poverty. An important component in addressing this issue is programmatic implementation of high quality, practitioner- and family-friendly assessment measures. It is critical that young children who may be at risk for early mental health concerns be identified early and the necessary interventions and goals be established to ensure that healthy relationships and positive behaviors result. The Social Emotional Assessment

Measure (SEAM) is a new parent/caregiver-completed assessment measure that identifies key components necessary in assessing social emotional competence. This descriptive study closely examines the utility of the Toddler SEAM within a low income, diverse sample. The Toddler SEAM was tested with 50 diverse low-income parents/caregivers in order to establish baseline data and provide researchers with important feedback regarding the psychometric properties of SEAM. One hundred percent of study participants indicated that the SEAM is a beneficial measure and would be an important tool for themselves and other parents who want to learn more about children's social emotional development. Forty-eight participants (96%) felt that SEAM items were useful in teaching them more about their child's social emotional development. Forty-four participants (88%) felt that SEAM items were clear and easy to understand. Qualitative feedback was gathered regarding methods by which to improve SEAM items (i.e., wording, content) in order to make it more parent-friendly and comprehensive. The Toddler SEAM was also compared with the ASQ:SE, a social emotional screening tool with established reliability and validity within risk and non-risk populations. Correlations between the ASQ:SE 18-, 24-, 30- and 36-month intervals and the Toddler SEAM were all significant ($p < .05$). Internal consistency was high with a Cronbach's alpha level of .92, indicating that the SEAM is likely measuring the unitary construct of social emotional development.

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Ivey-Soto, M (2008, June 29). Emotional skills key to child's 'school readiness.' *The Register Guard*, pp. G7.

Ivey-Soto, M (2008, January 27). Help children learn healthy ways to deal with anger. *The Register Guard*, pp. G7.

Ivey-Soto, M (2007, May 27). Children learn compassion from adults. *The Register Guard*, pp. G7.

Ivey-Soto, M (2007, February 25). Praise children for their actions not their looks. *The Register Guard*, pp. G7.

- Ivey-Soto, M (2005, September 25). Emotional Development: Key to Learning. *The Register Guard*, pp. G2.
- Ivey-Soto, M (2005, January 23). Children Can Keep King's Dream Alive. *The Register Guard*, pp. L11.
- Ivey-Soto, M (2004, December 26). Giving Comes from the Heart. *The Register Guard*, pp. L9.
- Ivey-Soto, M.C. (2004), Addressing the Mental Health Needs of Head Start Fathers [Electronic Version]. *Head Start Bulletin*, (77), 28-30.
- Ivey-Soto, M.C. (2004), Become a Child's Hero Today: Stop Exposure to Secondhand Smoke [Electronic Version]. *Head Start Bulletin*, (77), 56.

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TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
Impact of Poverty on Development	4
Research Base	6
Home Based Intervention Services.....	11
Parental Knowledge of Social Emotional Development	13
Cognitive Base of Knowledge	13
Role of Early Childhood Educators	14
Continuum of Care for Young Children.....	16
Importance of Study	19
Measures of Social Emotional Development.....	20
Cultural Implications in Research.....	21
Relevance of Participant Population	23
Overview of Study	25
Statement of Purpose	25
Research Questions.....	26
II. REVIEW OF LITERATURE	27
Theoretical Framework.....	28
Relational Models of Early Social Emotional Development.....	29
Ecological Systems Theory.....	29
Transactional Model: Sameroff and Chandler	31
Family Systems Theory	32
Infant Mental Health: Historical and Current Perspectives.....	34
Defining Infant Mental Health.....	34
Fraiberg.....	35
Mahler and Winnicott	37
Alicia Lieberman	38
Treatment Methodology.....	38
Theories of Emotional Development.....	39
Definition of Emotion.....	39
Underpinnings of Social Emotional Development.....	40
Propositions of Emotional Development.....	40
Attachment and Social Emotional Competence	42
Attachment Theory: Ainsworth	43

Chapter	Page
Historical and Current Perspectives on Early Relationships.....	46
Winnicott.....	46
Waddell	47
Greenspan.....	48
Parent-Child Relationship as Context	49
Temperament	53
Toddler Development.....	56
Theories of Emotional Development.....	56
Emergence of Autonomy	57
Development of Toddler Social Emotional Competence.....	58
Self-Regulation	58
Caregiver Impact on Self-Regulation	60
The Assessment Process.....	61
Definitions and Historical Context of Assessment	61
Purpose of Assessment: Current Ideas.....	65
Screening for Social Emotional Problems.....	66
The SEAM.....	67
ABI:SE Assessment Process	69
ABI:SE Approach	69
Curriculum-Based Assessment.....	70
Criterion-Referenced Tests	70
Utility of the SEAM.....	71
Activity Based Intervention: Background Information	71
Linked Systems Approach.....	73
Family Involvement in Assessment Process	74
Parental Understanding of Social Emotional Development	77
Professional Development in Early Childhood Settings	78
Effective Partnerships	79
Promising Principles	80
Reflective Supervision	83
Early Head Start	84
Early Head Start and Infant Mental Health: A Unique Relationship	86
Pulling the Pieces Together	89
III. METHOD OF STUDY	91
Introduction	91
Research Questions.....	92
Participants.....	93
Program Descriptions.....	93
Areas of Programmatic Concern.....	96
Parent/Program Recruitment.....	97

Chapter	Page
Protection of Human Subjects.....	98
Measures	99
Family Information Form	99
Ages and Stages Questionnaire: Social Emotional (ASQ:SE)	100
Social Emotional Assessment Measure (SEAM)	101
Scoring of ASQ:SE and SEAM.....	104
Utility Questionnaire.....	104
Theoretical and Ethical Grounding	105
Procedures	106
Recruitment	107
Data Collection.....	107
Mohawk Valley Community Action Agency	109
Madison County Community Action Program.....	110
Visiting Nurse Service Early Head Start	111
EHS Eligible Families.....	111
Data Analysis	112
Research Questions.....	112
Quantitative Data	112
Qualitative Data	114
Trustworthiness.....	115
Personal Influences	116
IV. RESULTS	118
Participants	118
Validity	121
Reliability	124
Utility Questionnaire	124
Qualitative Feedback from Utility Questionnaire	126
Feedback from Researcher.....	127
What Parents/Caregivers Learned from Toddler SEAM.....	129
Additional Toddler SEAM Items for Consideration.....	130
Analysis Conclusions.....	132
V. DISCUSSION.....	133
Study Conclusions	137
Utility Analysis	137
Staff Development and Training.....	139
Implications for Practice	142
Implications for Research.....	144

Chapter	Page
Limitations of the Study Design	148
External Validity	148
Reliability	150
Internal Consistency	151
Limitations of Instrumentation	152
Conclusions	153
APPENDICES	156
A. STUDY INSTRUMENTS	156
B. ADDITIONAL FORMS	175
BIBLIOGRAPHY	184

LIST OF FIGURES

Figure	Page
1. Unmet Children's Mental Health Needs by Race/Ethnicity	10
2. The Strategy Pyramid	18
3. Model of Ecological Systems Theory	31

LIST OF TABLES

Table	Page
1. Content Inventory of the SEAM and ASQ:SE Instruments	105
2. Breakdown of Caregivers/Parents	119
3. Ethnicity of Children Involved in the Study	120
4. Parent/Caregiver Education Level	120
5. Parent/Caregiver Income Level	121
6. Means, Standard Deviations, and Medians for ASQ:SE and SEAM	122
7. Raw Mean Scores & Cutoff Scores for ASQ:SE and Toddler SEAM	123
8. Pearson's Product-Moment Correlations Between Measures	123
9. Length of Time to Complete Toddler SEAM.....	125
10. Appropriateness of Toddler SEAM Items	125
11. Usefulness of Toddler SEAM Items	126
12. Problematic Toddler SEAM Items	128

CHAPTER I

INTRODUCTION

The emotional experiences that children have from the moment they are born influence how their brains develop. Babies learn that their actions bring responses from their caregivers. A child's ability to form emotional attachments, manage and control their emotions, and develop meaningful relationships are all functions of brain development that are strengthened when the care that they receive from those closest to them is healthy, predictable and consistent (McFarland, 2001). New research shows the critical impact of a child's "environment of relationships" on developing brain architecture during the first months and years of life. Researchers have long been aware of how interactions with parents, caregivers, and other adults are important in a child's life, but new evidence shows that these relationships actually shape brain circuits and lay the foundation for later developmental outcomes, from academic performance to mental health and interpersonal skills (National Scientific Council on the Developing Child, Working Paper 1, 2004). Other recent advances in brain research confirm the importance of early brain development as it relates to school readiness, lifelong learning, and social adaptability (Palermino & Zimmerman, 2008). Research shows that supportive relationships have a tangible, long-term influence on children's healthy development, contributing to optimal social, emotional, and cognitive development for infants and toddlers (Zeanah & Doyle Zeanah, 2001). Nurturing, sensitive adult-child interactions are

the cornerstone for the development of trust, empathy, compassion, generosity and conscience—all factors that emerge from healthy social emotional development. While these facets describe optimal conditions of development, research is clear that there are many young children whose lives do not reflect these necessary emotional experiences. The past two decades have been marked with an increase in the recognition that mental health problems are present in early childhood and warrant intervention (Zeanah, 2001). There has been an increase in the numbers of children with disruptive, challenging behaviors and a number of them have had compromised early experiences resulting in social emotional issues and relationship disorders.

In the United States, 1 in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment, but only 1 in 5 receive treatment (National Center for Children in Poverty, Masi & Cooper, 2006). The number of children with learning disabilities, speech and language handicaps, mental retardation, emotional disturbances, poor self-regulatory skills, aggressive behavior, and poor school achievement is increasing at alarming rates (Fitzgerald, 2007). This growing trend mirrors findings from epidemiological research that suggests an increased prevalence of psychiatric disorders in children, with onset at younger ages (Cohen, Provet, & Jones, 1996). Longitudinal epidemiological research such as Werner's studies (1989) provided evidence for the theory that many of the disturbances that emerge in older children can be traced to risk factors present in infancy and early childhood. Additional research confirms that there is increasing evidence that behavioral undercontrol (roughness, aggressiveness, irritability, antisocial behavior, hyperactivity, inattention) and negative affect (sadness,

depression, early mood dysregulation, sleep problems, social withdrawal) in infancy and early childhood are not transitional markers of normative developmental process, but are indicators of a wide range of problems that organize maladaptively in very early childhood and adolescence and carry over into adulthood (Fitzgerald, Lester, & Zuckerman, 2006).

Laying a strong, sound foundation in the area of emotional development in young children is essential. As a society we are slowly becoming more aware of the importance of healthy emotional development. Mass media campaigns and covers of major magazines have featured current brain research and articles asserting the importance of the first three years of life. In communities across the country there have been countless stories of children involved in violent behavior and some committing unthinkable crimes once thought of as only occurring in adulthood. As these instances become more and more widespread, individuals begin to pay attention to what we in the education field already know and have been advocating for- healthy, loving relationships with consistent, stable caregivers, which produce positive social emotional health within young children. In addition to increasing awareness of the presence of social-emotional/behavioral problems in young children there are new methods for the assessment of these problems in young children (DelCarmen & Carter, 2004) and a growing recognition for the importance of using comprehensive multidomain assessments (e.g., Carter, Briggs-Gowan, & Davis, 2004). Risk factors such as poverty also have a profound effect on the development of social emotional competence

Impact of Poverty on Development

Research confirms that socioeconomic status impacts development in many ways. Research data for 2007 indicate that four out of 10 American children are growing up in families that face significant struggles in making ends meet (Douglas-Hall & Chau, National Center for Children in Poverty, 2008). Over five million infants and toddlers (43% of all infants and toddlers) live in low-income families, while almost three million (21% of all infants and toddlers) live in poverty (Douglas-Hall & Chau, National Center for Children in Poverty, 2008). Due to their age, relative defenselessness and vulnerability, the impact upon their development is significant. Young children are more susceptible to the effects of poverty especially in infancy and early childhood when they are looking towards the adults in their lives to provide them with safety, stability and a blueprint for future relationships and expectations. Poverty is argued to have a negative impact on young children's emotional development by increasing infants' risk of exposure to a set of prenatal and perinatal factors that negatively affect their neurological, attentional, and affective development (Aber, Jones & Cohen, 2000; Brooks-Gunn, Klebanov, Liaw, & Spiker, 1993). Additionally, infants and young children who are enduring situations of poverty are also more likely to be exposed to multiple ecological stressors such as residential instability, higher levels of neighborhood and family violence, greater psychological distress among adult caregivers, and a series of other cofactors that appear to play children's emotional adjustment in jeopardy (Brooks-Gunn, Duncan, & Aber, 1997; Gershoff, Aber, & Raver, 2003; McLoyd, 1998).

Early Head Start is a program that serves low-income families in order to minimize the debilitating effects of poverty on young children and their families. It is important to understand the impact of poverty on social emotional development as this provides a framework for understanding some of the needs faced by the families in this income group. While it is important not to make generalizations about families with low SES due to individual differences, elements of resiliency and cultural patterns, the factors below speak broadly to the nature of the impact of poverty. In addition, many of the families within a low SES sample share a cultural background of African American or Latino. The patterns of parenting, parent-child relationships and overall social emotional development in young children lend more to the notion of social class, rather than to distinctions of ethnicity or race. Researchers Garcia Coll and Magnuson (2000) who have studied the intersections of culture and socioeconomic status, concluded that some differences that are labeled culturally based might actually be better understood as adaptations to unique socioeconomic and historical contexts within the lives of individuals and groups. They continue to say that there must be a balance achieved between understanding traditional child-rearing attitudes, values and practices pertinent to a specific group, and more recent adaptations to specific needs and circumstances (Garcia Coll, Meyer, & Brillion, 1995). The sample within this study contains a diversity of cultures and the characteristics that define parenting patterns and developing relationships between toddlers and parents relate more to the environmental circumstances associated with social class rather than race or ethnicity.

Research Base

The link between social class and social emotional development is important in understanding that poor children are more likely to experience risk factors that increase the probability of poor social and emotional development (Knitzer, 2003). Across various studies, mutual regulation in early infancy and attentional regulation in later infancy, two factors that are central to the study of emerging social emotional competence serve as important indexes of optimal parenting among high-risk, low income families (Raver, 2004). The mother-infant relationship, an integral dimension within overall social emotional well-being is greatly impacted by poverty. Relevant research among dyads facing high risk clearly asserts that poverty-related environmental and biological risks (such as maternal depressive symptoms, in utero cocaine exposure, or very low birth-weight status) are indirectly predictive of significant disruptions to regulatory processes in infancy (Beeghly & Tronick, 1994; Molitor et al., 2003; Raver, 1996; Raver & Leadbeater, 1995; Segal et al., 1995; Sheinkopf, Mundy, Claussen, & Willoughby, in press; Uvlund & Smith, 1996). These studies clearly illustrate that, although compromised caregiving in the context of high risk is associated with some infants having difficulties in regulation, sensitive and responsive caregiving has consistently been found to predict infants' self-regulatory competence, even after accounting for the role of infant characteristics (Raver, 2004). For ethnic minority children who receive competent caregiving in low-income contexts, the development of their effective self-regulatory skills and positive emotional adjustment can successfully occur despite economic disadvantage (Garner & Spears, 2000; Raver, 1996). The power of the

caregiving relationship and the critical role that responsive, attuned caregivers play in the lives of all children, but especially those who are at risk, cannot be overstated.

Recent data from a National Institute Child Health and Human Development study (2006) indicated that babies of depressed mothers at age three displayed more negative behavioral and cognitive performance than children whose mothers weren't depressed. Other research has confirmed that parental psychosocial issues were related to higher rates of developmental delays, symptoms of post-traumatic stress disorder, difficult behaviors (extreme aggression, sadness), problems with peer and caregiver relationships, poor health and later vulnerability to alcohol, tobacco, drugs and substance abuse (Knitzer, 2003). While this developmental trajectory does not characterize all low-income parents, it is important to realize the powerful impact that poverty has on developing parent-child relationships.

Additional risk factors associated with poverty include low parental education, single parenthood and non-English speaking parents. While one of these factors alone is likely not to determine poverty, these factors often exist in conjunction with one another and other factors that increase the likelihood of poverty. In a study of kindergarten children, 32 percent were found to experience one of the risk factors indicated above, while 16 percent had two or more risk factors (Zill & West, 2001). A recent Head Start study indicated that over a ten-year period, the proportion of Head Start families facing multiple demographic risks had increased by 22 percent (Foster, 2003). Other familial problems related to poor social emotional outcomes in young children include parental substance or drug abuse, domestic violence and depression (Knitzer, 2003).

While these problems exist across class lines, the impact of these addictions and problems is often more powerful for families in poverty, as they often lack access to adequate care and treatment and may be without family support (both financially and emotionally) to overcome these difficulties. The parent-child relationship may be at-risk when these situations occur as anger, sadness or rejection on behalf of the parent may be triggered towards the child. Young children often bear the brunt of the hardship because they are helpless in the sense of being unable to answer back and parents may recognize this power differential and use it to deal with their own personal troubles. These factors clearly indicate the need for early intervention to promote healthy attachments and relationships between infants and parent/caregivers. And for those relationships that are already at risk, the need for services to address and treat disturbances within the parent and the parent-child relationship is critical. With this in mind, the need for high quality screening, assessment and intervention tools will help to identify and treat the young children and families in need. The hope and possibility for healing and growth will be created that would otherwise be impossible without a way of knowing who the young vulnerable children are and what challenges exist.

Research clearly indicates that the more risk factors a young child is exposed to (risks that include psychosocial, parental, environmental toxins or disability related issues), the more likely he/she is to experience poor social emotional health (Knitzer, 2003). An Early Head Start study supported this notion confirming that for families with three or more risk factors (poverty, unemployment, poor housing etc.), their social emotional development was impacted (Knitzer, 2003). According to researchers studying

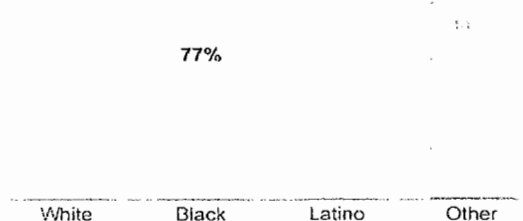
poverty, the effects of poverty depend on its depth and duration (Huston et al., 1994; McLoyd, 1998). Persistent poverty, lasting over several years, has major impacts on children and families, including elevated risk for negative health outcomes and deficits in cognitive and socio-emotional achievement (Korenman, Miller, & Sjaastad, 1995). Children experiencing situational poverty may also experience negative outcomes, but they are usually short lived and there is an expectation within the family that the situation will change and improve in a matter of time.

Material deficiencies related to poverty (e.g., malnutrition, inadequate health and child care, homelessness or unsafe housing conditions and neighborhoods, and insufficient schools) have detrimental effects on children's motivation and ability to learn, and can contribute to social and emotional difficulties, hamper learning, academic performance, and cognitive development (Korenman, Miller, & Sjaastad, 1995; Kotch & Schackelford, 1989). Young children who are poor are more likely to deal with unsafe housing (as mentioned above) and as a result, their parents keep them inside for fear that the streets are filled with violence and crime. Often the living space for young children is small and children spend long periods of time watching television and engaged in passive activities. The rates of childhood obesity have sky rocketed and as a result of lack of exercise and eating unhealthy foods (another issue related to poverty), children are experiencing health problems that are preventable (Knitzer, 2004).

As poor children grow, they are more likely to experience problems with school readiness and academic performance, and are at least twice as likely to be kept back in school as are children from higher income families (Corcoran, 1995; Duncan & Brooks-

Gunn, 1997a; Haveman & Wolfe, 1994; National Center for Children in Poverty, 1999). Poor social and emotional development sets the stage for poor academic outcomes and this factor exacerbated with poverty lends itself to negative patterns of learning and growth (Knitzer, 2003). Researchers have also found that emotional, social and behavioral competence (marked by more cooperation and self-control and less aggressive behavior) in early childhood predicts children's academic performance as early as the first grade as well as success in kindergarten (Raver & Knitzer, 2002; Raver, 2002). For low income children whose social emotional development is compromised, the risks for poor achievement and a lack of success are high; however with high quality assessments and interventions to address the areas of concern, there is promise for an improvement and an ability to achieve academic success and personal well being. Figure 1 below represents the percentage of unmet children's mental health needs, by race/ethnicity. Research confirms that one in five children have a diagnosable mental, emotional or behavioral disorder (Masi, & Cooper, 2006).

Unmet children's mental health needs, by race/ethnicity



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Figure 1. Unmet Children's Mental Health Needs by Race/Ethnicity. From National Center for Children in Poverty. Children's Mental Health: Facts for Policymakers.

Home Based Intervention Services

For the individuals within this study and many others for whom poverty is a major factor, social isolation is a common thread, which creates many barriers and challenges. A segment of the families within this study live in rural communities, wrought by a lack of transportation, easy access to basic necessities and an overall feeling of being “cut-off” from the rest of society. Many of the parents were experiencing depression, which directly impacts the emerging parent-child relationship. Research confirms that as early as 6 weeks of age, newborns become distressed if their interpersonal relationships with caregivers are even slightly disrupted (Seibel, Parlakian, & Perez, in press). Disruptions due to depression can manifest themselves in a parent who is unable to attend to the needs of the baby, display emotional responses to engage the baby in a back and forth conversation, and create an overall presence of gloom in the caregiving environment. The Early Head Start Research and Evaluation Project of 2002 found that 48 percent of mothers reported enough depressive symptoms to be considered depressed at the time of their enrollment in the project (U.S. Department of Health and Human Services, Administration for Children, Youth and Families, 2002). For the families within this study and many in Early Head Start programs nationwide, their lifeline, according to the program director, are the weekly home visits they receive from trained home visitors employed by the Early Head Start program. The home visits focus both on the emerging developmental competencies of the young child, while also attending to the mental health needs present within the parent. The home visitors function in such a way that they balance the educational activities and approach with their skills of active listening and

supportive feedback, and when necessary connect both parents and their young children to the mental health consultant who works with the EHS program. Significant research has been conducted on home visiting and on better understanding its impact on parent and child outcomes. Theoretically, there has been considerable attention paid to the importance of the helping relationship in early childhood home visiting (Korfmacher, Green, Spellmann, & Thornburg, 2007). Both infant mental health theorists (e.g., Lieberman, 1991) and those who develop prevention-oriented home-visiting services (e.g., Olds, Kitzman, Cole, & Robinson, 1998) emphasize how strong alliances with families (typically parent or primary caregiver) are mechanisms of change, whether through challenging past negative models of interpersonal relationships, or (more simply) by increasing the families' comfort and trust in the information or services provided. Early childhood home visiting is unique, in that parents engage voluntarily in largely preventative interventions focused on their children, rather than seeking specific help for an identified problem of their own (Korfmacher et al., 2007). The Yale Child Study center, a premiere research institute, offers several evidence-based programs to help low-income mothers improve the mother-child relationship through enhanced parenting skills (Onunaku, 2005). Among their programs is an effective home visiting program, *Minding the Baby*, which provides intensive home visiting intervention services for mothers and babies aimed at bridging primary care mental health wellness for both mother and child. The program promotes the physical and psychological health in mother, child, and in the mother-child relationships (Onunaku, 2005). Home visiting provides support and guidance in many forms with the overall goal of improving parent-child relationships.

Providing parents with knowledge regarding child development and modeling appropriate responses and behaviors for healthy exchanges, all within the comfort and safety of the home environment, allows the parent to experience a healthy, helping relationship. This relationship often serves as a model for healthy interactions, with the goal of providing for the parent the support and guidance they need so that they are able to provide this to their young child.

Parental Knowledge of Social Emotional Development

Cognitive Base of Knowledge

While it is common knowledge that parenting does not come with instructions, there are clear distinctions in parental knowledge between social classes related to child development. Research has confirmed that within higher risk, multi-problem families, mothers who are more knowledgeable in child development and exhibit a higher level of social support will display more positive perceptions of their infants and higher quality of interactions with them (Cochran & Brassard, 1979; Elster, McArney & Lamb, 1983; Field, Widmayer, Stringer, & Ignatoff; 1980; Greenspan, 1982; Gregg, 1973; Ramey & Brownlee, 1981; Slaughter, 1983). Because some people have become parents with little knowledge about the ways and needs of babies, basic instruction in parenting skills can be a needed component of infant mental health informed practice. Parents who lack knowledge about basic infant development, including temperament and normal difficulty behavior, can best learn this information in the context of a supportive relationship (Graham, White, Clarke, & Adams, 2001). The literature has strongly supported the idea that difficulties in the parent-child relationships may be due in part to parents' limited

knowledge about child development and their inadequate expectations of their infants (Elster et al., 1983; Field et al., 1980; MacPhee, 1982; Ross, 1983). Because of the link between low SES, a lack of knowledge about child development and compromised social emotional outcomes for young children, research has supported comprehensive approaches that both support families dealing with the myriad of issues surrounding poverty. Addressing gaps in knowledge, and providing access to information on child development and child behaviors are crucial to the goal of more positive parent-child interactions. Research has confirmed that high quality child-centered programs have produced benefits in child development outcomes, such as short-term gains in language and cognitive development, improved social emotional functioning. Long-term benefits in reduced delinquency and problem behaviors, and less grade retention and special education placement have also been associated with parenting programs (Guralnick, 1977; Ramey, Campbell, & Ramey, 1999; Ramey & Ramey, 1993,1998; St. Pierre & Layzer, 1998). The encroaching impact that poverty has on social emotional well-being and the buffering effects of parental knowledge and support create a solid argument for the high quality early childhood programs to ameliorate the severity of early social emotional concerns and provide “corrective emotional experiences” (Alexander, 1946) for young children and families who are at risk.

Role of Early Childhood Educators

It is now widely accepted that early childhood educators play a major role in shaping children’s emotional, social, and cognitive development and help to lay the foundation for future academic and personal success (Donahue, Falk & Provet, 2000).

Early childhood educators are often the first line of defense for feeling the impact of family stress and therefore the first to intervene. Early childhood programs are often the places where families come in need of support, guidance, concrete assistance and services to address the developmental issues impacting their young children. Research confirms that preschools often are functioning independently, without the backing of large grants or initiatives supporting their program efforts, and often only limited support for collaborative efforts with health, mental health and social services providers (Donahue, Falk & Provet, 2000). Hospitals, clinics, mental health agencies, child welfare agencies, and other institutions that traditionally support families have been forced to cut back on early intervention and treatment programs. Additionally, many of these agencies are not adequately prepared to provide services for young children. Early Head Start, Head Start and some childcare programs have assumed much of this responsibility and have strongly asserted the need for high quality screening and assessment measures to identify children and provide guidance in intervening.

Determining which factors affect development in the early years and over the life span requires continued analyses of the transactions between children, and the multiple environments where transactions occur. As parents and professionals in the field become more informed and understand the importance of laying the foundation for healthy social and emotional development and growth, there becomes a growing need for screening and assessment tools to provide them with strategies to address the early concerns and issues so that young children have the propensity for growth and success. An Infant Mental Health Forum that was convened in 2000 bringing together key individuals interested in

early development and in particular the social emotional development of young children formulated a list of collective efforts that need to be in place to promote and protect social emotional well being. The group asserted the need for professionals to develop tools and measures for assessing mental health in ways that are program friendly and that can be used to develop an individual child and family plan for infant mental health promotion, prevention and intervention (Chazan Cohen & Jerald, 2002). This important finding set the stage for the importance of high quality social emotional assessment and studying how social emotional development can inform intervention for children who are at risk.

Continuum of Care for Young Children

As early childhood professionals consider the necessary elements in providing high quality early care and experiences for young children, especially those at risk, it is important to consider a broader system of care that encompasses the needs of all children. This broader system of care seen as necessary for young children is synonymous with the idea of continuum of services. The goal within both is social emotional well-being for young children and families. Figure 2 below, represents a traditional public health triangle, indicating levels of support and intervention. For the purposes of this study, these three levels provide a model to address the issues of social emotional competence. The bottom level, *universal strategies*, indicate widespread, broad based promotion activities that foster and nurture social emotional development and healthy relationships between young children and those closest to them-this is the largest part of the triangle because it represents necessary services for all children. For the purposes of this study,

the middle level, *selective strategies*, consists of efforts geared at addressing early social emotional concerns for young children and families experiencing greater levels of concern (beyond what is average and within a normal range). These strategies target a smaller number of children and families and tend to be more individualized based on the concern or potential issue within the child, parent or relationship. Programmatic efforts such as home visiting which may take on a more targeted approach that intentionally identifies children who may be at risk for early mental health disturbances and addresses ways to understand potential issues, exploring culture, context and environment are common within this area (Parlakian & Seibel, 2002). The assessment process, and in particular, the SEAM, was developed with the intent of providing useful information to both raise an awareness about a potential concern within a child and also to identify intervention activities and methods for children whose development is already compromised. The top level of the triangle represents *intensive strategies*, that consist of efforts towards meeting individualized needs of young children and families who are experiencing substantial challenges. For the purposes of this study, that may consist of significant childhood behavioral issues, severe trauma or abuse that has impacted the parent-child relationship and in turn the child's social emotional development. Programmatic efforts for this smaller segment of the general population are designed to alleviate the distress and suffering within the child, parent or parent-child relationship with the goal of returning to healthy development and behavior. Public and private mental health treatment programs and early intervention programs assess, diagnose and treat mental health and developmental disorders (Parlakian & Seibel, 2002). Treatment of

mental health disorders can encompass many elements from therapeutic preschool programs, infant parent psychotherapy, and for the purposes of this proposed study, embedding therapeutic activities within the child’s daily routine that target specific goals related to social emotional health.

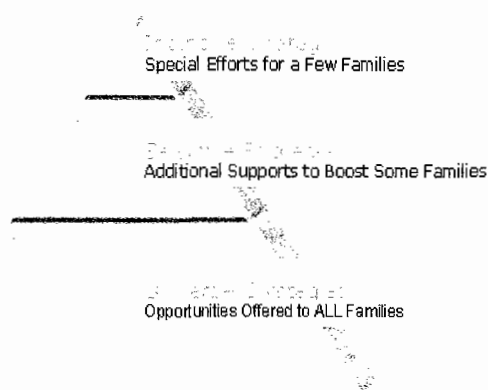


Figure 2. The Strategy Pyramid

From “Spotlight: Strategies to Engage Families,” by T.W. Osher and B. Huff, 2006, The National Evaluation and Technical Assistance Center for the Education of Children and Youth who are Neglected, Delinquent, or At-Risk (NDTAC). Copyright 2006 by the American Institutes for Research (AIR). Adapted with permission of the author.

While it has been more common to think of a continuum of care approach for adults dealing with health or mental health issues, the prevalence of young children with mental health disorders and serious behavioral issues is growing rapidly. The Zero to Three Policy Center found that, 42% of childcare programs have “expelled” infants or toddlers due to social or emotional problems (Illinois Study of Unmet Needs). A web search conducted by Dr. Walter Gilliam (2006), an expert in studying young children with challenging behaviors, yielded information on this topic. Dr. Gilliam found that 33 students had been expelled from kindergarten in Philadelphia public schools in one year

(Dale, 2005), 5 kindergarteners expelled from Cincinnati schools (Mrozowski & Byczkowski, 2004), a 2-year-old toddler (along with his 5-month-old sister) being expelled from a North Carolina childcare program after he bit another toddler (Little, 2003), all display the urgency of addressing the issue, both in terms of intervention for the young child and systematic changes to promote sound practices and understanding of young children in these situations. The numbers are continuing to grow and in response to the “wake up call” it is critical to implement the necessary assessment and intervention tools that providers and families can understand and utilize. We owe this to the youngest members of our society. We have considered the elements surrounding assessment (i.e. poverty, role of educators in handling social emotional issues), and these areas provide a contextual base upon which to build a discussion and evidence for the importance of social emotional development and this study.

Importance of Study

Comprehensive assessment is essential for identifying all areas in which intervention is warranted, and plays a role in documenting the efficacy of intervention (Briggs-Gowan, Carter, 2007). As recently as a decade ago there were few tools available for formal assessment of social and emotional skills of very young children (Tomlin & Viehweg, 2003). As the interest in social emotional development grows and gains more visibility, there continues to be an increased need for high quality tools. Knowledge of a young child’s overall social-emotional competence can have important implications for treatment planning and approach of intervention. In addition, by assessing competencies, it may be possible to identify strengths that can be capitalized on during the treatment

process (Carter et al., 2004). Without proper intervention, which begins with high quality assessment measures, children may be at risk due to developmental delays in social-emotional development. An understanding of a child's social-emotional competencies is crucial because children who lack mental-age appropriate social-emotional skills may also have greater difficulty meeting new developmental demands (Cicchetti, 1993), and may also be at elevated risk for social-emotional problems (Cicchetti & Cohen, 1995). Social-emotional development is an evolving process and as young children master new skill sets and abilities both internally and externally, these areas continue to grow and expand in conjunction with other developmental areas (e.g., cognitive and physical). These rationale explain why it is important to have high quality social-emotional assessment measures that early childhood professionals can utilize and learn from, informing their practice and most importantly positively impacting young children's social-emotional growth.

Measures of Social Emotional Development

The research shows that there are several measures of social emotional development that have been utilized by early childhood programs. While these measures serve an important role in the field, there remains a need for curriculum-based assessments that can be used by a wide variety of early childhood providers. Many programs are seeking to provide seamless services for young children, especially those at risk. Early Head Start programs, in collaboration with each child's parent and within 45 calendar days of the child entry into the program, must administer an age appropriate screening to identify concerns regarding the child's developmental, sensory (visual and

auditory), behavioral, motor, language, social cognitive, perceptual and emotional skills (Head Start Performance Standards 45 CFR 1304.20(b) 1). Few social emotional assessments exist that can be used by early childhood providers and that will assist in screening and identifying social emotional delays.

Cultural Implications in Research

Many of the studies published in the field of early intervention have told the story of a more dominant middle class perspective. The importance of inclusive research that explores the dimensions of culture and socioeconomic status is critical. Studies that investigate the impact that both mothers and fathers have on their young children's development, particularly social and emotional development are imperative. There are well-documented, universal features of child development and parent-infant relationships across all ethnic and cultural groups. The areas of variability are equally important to understand (Nugent, 1994). Examples of topics relevant within cross-cultural studies include maternal responsiveness and a series of studies of family cosleeping practices, and clinical and educational approaches with linguistically and culturally different children (e.g., Gopaul-McNicol & Thomas-Presswood, 1998; LeVine, 1990; Weiss, McCarthy, Eastman, Caseate, & Suwanlert, 1997). Garcia Coll and Meyer (1993) summarized several categories or theoretical models that help us understand the influence of culture and the broader ecological context of infant development and caregiver behavior. One of the categories relevant within this study argues that group differences (i.e. cultural groups) in child-rearing techniques are predicated on the cognitive, linguistic, motivational, and social competencies desired by the group (Lewis, 2000). The

field of assessment has explored the issue of cultural competency, but with narrow constructs. An article exploring the cultural dynamics of assessment found that the practice of cultural competence has often focused solely on cultural diversity as a term to describe a certain population (e.g., Hispanic) (Brown & Barrera, 1999). Rather, the understanding and practice of cultural competence needs to encompass a more complex dialogue reflective of the interaction between the family's environment, and that of the assessors, both personal and professional (Brown & Barrera, 1999). This idea should be understood as being present in all interactions, rather than just seen as a set of protocols to utilize across racial or ethnic categories. With this in mind, part of the goal of the current study was to examine the dimensions of social emotional development from a cultural perspective, not just the racial or ethnic culture, but the family culture and the socioeconomic culture that are pervasive elements in the everyday lives of families.

Through the administration of newly developed social emotional assessments (ASQ:SE, SEAM) and parent interviews, this study will attempt to understand how one's unique culture and the cultural norms and values shared by a particular group shapes the ways of understanding parenting, relationships and social and emotional development. The SEAM was developed as a tool that practitioners could use to monitor social and emotional development across broad, diverse groups of children and families. It is important to note that the ASQ:SE, the screening tool utilized within this study, has been tested and normed on a wide variety of populations, both within this country and abroad. While it has been widely accepted and praised for being a tool that has adaptability and

usability within a wide spectrum of cultural groups, more data need to be gathered to confirm these findings.

Relevance of Participant Population

This study explores a necessary area within the fields of early intervention and infant mental health. The field of early intervention has long been concerned with children with disabilities and recently there has been more awareness to and increasing efforts to determine ways to support young children who are at risk due to poverty and other accompanying factors. Exploring the literature to connect the fields of early intervention and infant mental health is critical to promote and support social emotional development, especially within populations at risk. Zero to Three, a well known organization whose mission is to educate and promote high quality responsive practices for young children and families, found that families whose incomes are below 200% of poverty are almost 50% more likely to have a child with a disability (Lee, Sills, & Oh, 2002). The young children and families who will participate in this study often feel the burden and impact of poverty. For many of them there are a myriad of other factors associated with being poor that increase the likelihood for early social emotional issues and relationship disorders that, when addressed early, can be healed. The families within this study specifically, and within many early childhood programs nationally face situations of daily violence, abuse and social isolation, making it challenging to meet their basic needs and attend to the daily demands of raising children. Violence, for example, both in the community and within the home in the form of domestic violence and child abuse, has been shown to have a profound impact on children's emotional

adjustment and cognitive development (Aber & Allen, 1987; Pynoos & Eth, 1986; Zero To Three, 1994a).

Research confirms that children experiencing multiple risk factors are most likely to shown signs of emotional difficulties or behavior problems (Rutter & Quintin, 1977). Adversity is additive over time. Sameroff and colleagues (1982) argued, “the search for individual risk factors that predict negative outcomes is less compelling than assessing the effects of exposure to multiple risk factors” “Simply put, children faced with a large number of risk factors are expected to fare worse than those growing up in families with fewer risks” (Perkins, Luster, Villarreal, & Small, 1998; Rutter, 1987; Sameroff et al.). For many of the children in Early Head Start, a national federally funded program serving young children 0-3 and families in need, the complex situations brought on by poverty have compromised their ability to experience a “normal” healthy childhood. For the programs that are caring for these children, there is often a tremendous burden on staff who feel inadequate in their training and ability to provide the necessary support and response for children with challenging behaviors or emotional distress.

Additionally, teachers feel extreme pressure, even as early as in preschool age settings, to maintain a formal academic curriculum with an emphasis on the mastery of cognitive concepts, and do not consider it appropriate to use classroom time to deal with their children’s emotional turmoil (Hyson, 1994). Despite the many challenges faced within the lives of children and in turn the early childhood classroom, numerous educators now recognize that the preschool classroom presents a unique opportunity to provide a reparative milieu for children in distress (Koplow, 1996). These complex needs

shed light on the place and the immediate need for high quality early childhood assessments that parents, classroom teachers, home visitors and others who spend time with young children can utilize and incorporate into the daily routine.

Overview of Study

Statement of Purpose

The purpose of this study is threefold: 1) to test a new social-emotional assessment measure, the SEAM designed for parents and classroom teachers to learn valuable, usable information about social emotional development, 2) to gather feedback and understand parents ideas and perceptions of the SEAM and utilize this information in improving upon the instrument so that parents and early childhood providers from diverse backgrounds will be able to easily use the SEAM, and 3) to compare scores of items from the ASQ:SE, a screening tool, with the SEAM, a curriculum based assessment measure, to determine if relationship exists between the two instruments and how the relationship or lack thereof provides parents and early childhood professionals with more knowledge and information in planning interventions and determining goals to improve social emotional development in their young child.

The information from this assessment will provide a comprehensive picture of a child's social emotional repertoire (Squires & Bricker, 2007). This study examined social and emotional competence in children ages 18-36 months using the Toddler SEAM. The study explored whether this instrument is useful and understandable within diverse contexts, and whether it accurately provides a picture of a young child's social and emotional development. The participants consisted of Early Head Start parents from rural

and urban communities. All of the participants were at minimum dealing with poverty; however as described above, there were many other issues that manifest from poverty and are present in their lives. Parents were administered the assessment measure by the researcher, myself, after completing necessary human subjects requirements. Through a set of open-ended questions from the Utility Survey, feedback on the utility and ease of completing the SEAM was gathered and analyzed. Scores from items and intervals on both the ASQ:SE and the SEAM were analyzed to determine their relationship. The research questions below outline the aforementioned purposes of this study.

Research Questions

- 1) How do children from low-income environments score on the SEAM?
- 2) What is the relationship of the content of the SEAM, an assessment tool, to the ASQ:SE (18, 24, 30 and 36 month intervals), a screening tool?
 - a. What are the correlations between total scores on the 18, 24, 30 and 36 month ASQ:SE and the Toddler SEAM?
- 3) How consistently do items on the SEAM measures children's general social emotional development?
- 4) How useful and understandable do parents and program staff find the Toddler SEAM?
- 5) What improvements can be made in the Toddler SEAM, based on parental feedback?

CHAPTER II

REVIEW OF LITERATURE

The study of social and emotional development has long been recognized for its complexity. The complex nature exists because these realms of development appear to be the product of multiple “levels” of deterministic complexity working simultaneously (Rubin, 1998). The multiple domains of development within young children, in conjunction with the rapid rate of growth and change in the first three years, yield this element of complexity. Some facets of research within social and emotional development, are known and well understood. Research is clear that individuals with healthy emotional lives are usually able to control their impulses, delay gratification, motivate themselves, persist in the face of frustration, regulate their moods, keep from letting stress overtake them and empathize with others (Goleman, 1995). These abilities, which often manifest themselves in adolescence and adulthood, are created and sustained as a result of the earliest experiences between the infants and parents. The connection that the parents forge in utero often sets the stage for how they will respond to their young infant and the quality of the interaction between infant and parent. However when healthy emotional development is compromised in some way, the effects are long lasting. Severe behavioral problems during the preschool years are a meaningful predictor of continued behavior problems, poor peer standing, and academic difficulties during kindergarten (Howes, Calkins, Anastopoulos, Kean, & Shelton, 2003; Kean & Shelton, 2004).

Fortunately high quality early education and intervention programs may prevent severe behavioral problems in young children from stressful low-income communities and families (Yoshikawa, 1995; Zigler, Taussig, & Black, 1992). High quality early childhood assessments are an important component within early childhood programs and help program staff and parents to develop high quality interventions addressing the areas of development that are at risk or of concern.

Determining which factors affect development during the early years and over the life course requires continued study of the transactions between children and with those with whom they interact, the multiple environments where these transactions occur. Such analyses are dependent on valid and reliable assessment (Fitzgerald, 2007). It is through this lens that this study will attempt to capture the picture of young children's social and emotional development and provide a look at some of the many facets negatively and positively affecting on these developmental domains. Healthy social and emotional development is characterized by the ways in which young children relate with significant others and is also demonstrated by the ways in which they are able to respond internally and externally to stress, stimuli and various emotions. Having a sense of the dynamic interchanges between young children and those closest to them allows parents and early childhood professionals to create meaningful interactions and activities in response to children's individualized needs.

Theoretical Framework

It is important to understand the theoretical framework surrounding this study. Conceptual models that address the role of family, community and child and how these

areas intersect provide a framework to understand how the process of assessment in the area of social and emotional development fits within the lives of the young children and their families. These models provide an understanding of relationships and their role in the development of early social emotional competence. Three models are often cited as providing the foundation upon which interventions for young children and families are based: 1) ecological perspective; 2) transactional perspective; 3) family systems theory. The literature on infant mental health incorporates these perspectives as providing critical foundations upon which the model of intervening in the lives of young children are built. To provide a clear picture of the theoretical framework addressing this area of study, an overview of the theories is presented.

Relational Models of Early Social Emotional Development

Ecological Systems Theory

Bronfenbrenner's ecological approach (1979) advocates a systems perspective, beginning with appreciation of the individual child in context of his unique environment and the social environment in which the child interacts (Schorr, 1997). Bronfenbrenner asserts that the child does not act solely within the social world, but is always being impacted by the contextual systems and structures present in the surrounding environment. The child exists always in a social context, which can be negative or positive depending upon the nature of the experience.

Bronfenbrenner's structure of the environment is divided into microsystem, mesosystem, exosystem and macrosystem. The microsystem is the layer closest to the child and contains the structures with which the child has direct contact. The microsystem

encompasses the relationships and interactions a child has with his immediate surroundings (Berk, 2005). Structures include family, school, neighborhood, or childcare environments. The next level is the mesosystem, which provides the connections between the structures of the child's microsystem (Berk, 2005). Examples are the connection between the child's parent and teacher, between church and neighborhood. The exosystem is the layer that represents the larger social system in which the child does not directly function. The structures in this layer impact the child's development by interacting with some structure in his microsystem (Berk, 2005). Even though the child is not directly involved in this exchange or situation, the child feels the effects of various relationships or situations (ex. parent workplace schedule). The macrosystem is considered the outermost layer in the child's environment and is comprised of cultural values, customs, and laws (Berk, 2005). Finally, the chronosystem is the element of time and how it relates to the child's environment. Death of a parent, birth of a sibling are a few examples of "timing" issues that may have a profound impact on the child. There is a "trickle down effect" in the sense that what occurs within the macrosystem has an impact on the other layers within which the child lives and functions.

Within the assessment process it is crucial to be aware of how all of these areas interplay with one another and impact not only the current state of development within the child, but also the propensity toward future growth and change. The success of any assessment and intervention plan directly relates to the ways in which it encompasses the layers described in Bronfenbrenner's (1979) model and considers all of the facets of the child's life. Bronfenbrenner (1979) believed strongly that the family constitutes the

ecological context in which the infant functions and it is from this system that the child organizes and takes in the social world within which he exists. Figure 3 below provides a visual picture of the systems involved in the Ecological Systems Theory (1979) that impact the child and family.

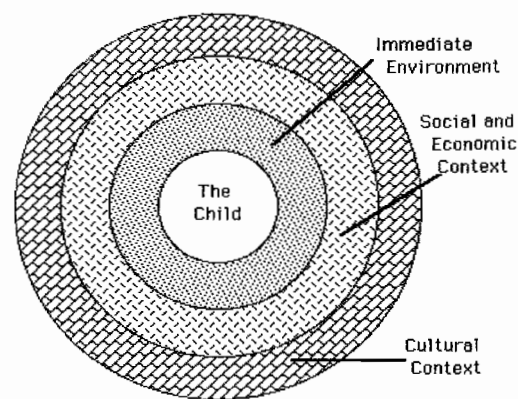


Figure 3. Model of Ecological Systems Theory. Retrieved March 15, 2008 from http://education.calumet.purdue.edu/vockell/EdPsyBook/Edpsy4/edpsy4_environment.htm

Transactional Model: Sameroff and Chandler

The transactional model, like the ecological model, considers the many aspects of a child's life, including family and community. However, it is a variation of the ecological model in that it focuses upon the social responsiveness of the environment and the interactive nature of the child-environment exchange (Sameroff & Chandler, 1975; Sameroff & Fiese, 2000). It is also important to realize that there is a bidirectional influence in which the child is impacted upon by the relationships, situations, and context occurring in the realms and patterns around him, while at the same time the child is also impacting what is around her, causing a give and take within the relationship and an ever

changing back and forth between the child and her environment. Intervention must be focused on both the needs of the child, but also on the environment in which the child lives. Addressing the multifaceted needs that exist within and around the child may require a large repertoire of services (developmental, case management, therapeutic/mental health).

The transactional perspective as it relates to the assessment process examines whether the parent(s) and young child are responding to each other so as to maximize whatever potentials exist for competent development in each member of the caregiving transaction (Seligman, 2000). Interventions designed from the assessment process must be aware of the context of the parent-child relationship in that it is through this relationship that the child regulates and is regulated by the world around him. In addition there is a perpetual state of change that exists in the life of the child and the aspects of the environment of which the child is a part. This model addresses the active evolution of child, caregiver and larger context, and the intervention that takes place must take into account all of these facets.

Family Systems Theory

Just as Bronfenbrenner (1979) and Sameroff and Chandler (1975) posited that the child is not alone in the world, but rather acts and reacts in conjunction with individuals and circumstances that surround him, Minuchin's Family Systems Theory framework (1974) addresses the critical role that families play in shaping children's expectations and early patterns of behavior. Just as the transactional perspective suggests, the involvement of family in the life of the child and others in early intervention services is crucial. The

field of early intervention has evolved to a place where the family plays a critical role in the success of intervention and the overall well being of the child. The past conceptual model and framework of working in early intervention were oriented primarily towards the child with regard to the family as a separate entity, involved in the child's life, but separate in some ways to the treatment and support of the child. The field of family therapy and family systems theory has emphasized the relationship that the family system has on the development of the child and seeing the child as an integral part of the family unit and the larger environmental system. Within the area of social and emotional development, the family is the organizing unit upon which the child makes sense of the world. The young child's emerging developmental skills and behaviors impinge upon the quality of relationship he shares with his family.

In addition, the family plays a critical role within the assessment process. Bailey et al., (1986) discussed the formal requirement for family goals and services that reflect a trend toward an increased family focus in early intervention (Bailey et al., 1986; Dunst, 1985). Family guided intervention is critical to the implementation and delivery of services or interventions, particularly in the area of social and emotional development. Family systems theory focuses on family behavior rather than individual behavior and for the purposes of this study, child behavior. The theory considers communication and interaction patterns, separateness and connectedness, loyalty and independence, and adaptation to stress in the context of the whole as opposed to the individual in isolation. Family systems theory can explain why members of a family behave the way they do in a given situation (Fingerman & Bermann, 2000). It is critical to use these explanations to

better serve children and families and to understand the multiple dimensions and levels of interaction that define the child and the family.

The study of infant mental health and parent-child relations plays a key role in understanding the dynamics of social emotional development observed and recorded within the context of assessment. Research confirms that the interactions and relationships between child and caregiver form the foundation of the child's ability to organize and respond to her world (Weston, Ivins, Heffron, & Sweet, 1997). Assessments can be viewed as interventions and an opportunity to understand the patterns of interaction that exist and from them then determine the necessary steps for treatment. It is therefore, important to first define the research that describes mental health in young children and explores its roots and current practices.

Infant Mental Health: Historical and Current Perspectives

Defining Infant Mental Health

Within the study of social emotional development there has been a significant shift in recognizing the infant's role in the construction of caregiving relationships (Sameroff & Chandler, 1975). The young child is the center of the relationship and this core principle serves as an anchor for the field of infant mental health. Infant mental health focuses on "the social and emotional well-being of infants and their caregivers and the various contexts within which caregiving takes place. Infant mental health (IMH), therefore, focuses on relationships; infant development is conceptualized as always embedded within emergent, active systems of relationships. By definition the infant is born into a social world."(Bell, 1968; Rheingold, 1968, p.1). Promotion of a positive

attachment, prevention of future relationship issues, and a preservation of the connection that exists between parent and child are all areas that are critical to understanding infant mental health.

Fraiberg

At the core of IMH is the work of Selma Fraiberg. Fraiberg established what was believed to be the first Infant Mental Health Program at the Child Development Project in Ann Arbor, Michigan in 1972 (Fraiberg, 1980). Fraiberg and colleagues listened to stories of childhood loss and abuse in the histories of mothers or babies with failure to thrive and other medical concerns (Fraiberg, Adelson, & Shapiro, 1975). This work allowed these researchers to begin to see the connections between the mother's early relationships and her present interactions with her own child. From her work there have been many models that address and seek to respond to the intergenerational cycles of inadequate care and poor attachment that have led to compromised infant-parent relationships. The core principals from Fraiberg's original work include: 1) Pay attention to the infant, the parent, and their early developing relationship from the time you first meet the family until you say good-bye. 2) Pay attention to past and present relationship experiences, because they influence the care of the infant "in the moment" and the parent's experience of the infant, as well. 3) Pay attention to the developing relationship between parent(s) and practitioner. It is this relationship that functions as the instrument for growth and change (Weatherston, 2007). Fraiberg also coined the phrase "ghosts from the nursery" which was used to refer to the tendency of parents to bring to the rearing of their children the unresolved issues of their own childhoods. When these issues surface

they have a profound effect on the relationship between the parent and child. Realizing this, Fraiberg created an approach that was at the time revolutionary and unlike any other modality of treatment. As Fraiberg described, “the baby and parent were now our patients” (Fraiberg, 1980, p.7). The mental health clinician would have both clients under her care, addressing developmental and relationship disorders as they related to the parent and child together. “Traditional components of intervention include concrete assistance, emotional support, developmental guidance, early relationship assessment and support, advocacy, and infant-parent psychotherapy, as needed by each infant and parent pair (Shirilla & Weatherston, 2002, p.7). Within the context of the helping relationship, the parent’s capacity to express thoughts and feelings about the infant, the role of parenting and any unresolved losses or early traumas is awakened and the relationship between practitioner and parent is the anchor within which the parent and baby are able to heal and grow.

The infant that is impacted by the relationship with parent and in turn impacts upon the relationship is what Stern calls the “clinical infant”, (Stern,1985). “This recreated infant is made up of memories, present reenactments in the transference, and theoretically guided interpretations. This infant is the joint creation of two people, the adult who grew up to become a psychiatric patient and the therapist, who has a theory about infant experience” (Stern, 1985, p. 14). The infant in this context is not seen as being asocial as was thought by Freud (1920), but rather very reactive and interactive and taking in the world around him within the relationship he has with his primary caregiver.

Mahler and Winnicott

Mahler and previously Winnicott also studied and theorized about the infant and parent together and the observation of their interactions. In theorizing about the complex relationships that exist between the mother and infant, he asserted, “this depends first on a certain matching of the discharge patterns of the mother and the young infant, and later, on the interactional patterns, behaviorally discernible in mutual cueing, as well as in the infant’s earliest adaptive patterning and in his receptive capacities with the ‘good enough’ holding behavior of his symbiotic mother” (Winnicott, 1956, p.386). Winnicott (1953) identifies the key role of the 'good enough' mother as adaptation to the baby, thus giving the baby a sense of control, 'omnipotence' and the comfort of being connected with the mother. This 'holding environment' allows the infant to transition at her own rate to a more autonomous position. Mahler refers to the symbiotic relationship, as “an intrapsychic rather than a behavioral condition. We do not refer, for example, to clinging behavior, but rather to a feature of primitive cognitive-affective life wherein the differentiation between self and mother has not take place, or where regression to that self-object undifferentiated state has occurred” (Mahler & Furer, 1966, p. 161). Mahler recognized and validated that there is no such thing as an infant by herself, but rather everything is in the context of the symbiotic relationship that is felt, both physically and emotionally. Also Mahler says that the mother does not always have to be present, yet her presence is always felt, and is a necessary element for treatment.

Alicia Lieberman

More current perspectives include the work of Alicia Lieberman in child-parent psychotherapy. Her efforts and expertise are grounded in the framework of Fraiberg, Winnicott and others who have paved the way for how we see infants, families and the intricate relationships that exist. Child-parent psychotherapy is a relationship based treatment approach that provides therapeutic services for infants, toddlers and preschoolers who are experiencing mental health concerns and may be experiencing a compromised relationship with a parent due to parental mental illness, a lack of goodness of fit between parent and child, or a temperament mismatch between parent and child (Lieberman, 1993). It is critical to understand this form of treatment because many of the toddler/parent dyads within this study may have experienced a relationship disorder in which case a therapeutic intervention addressing the relationship would be necessary. Simply addressing the behaviors of the toddler may not be enough and the need for more intensive intervention addressing the dyadic interplay may be more effective.

Treatment Methodology

Three premises undergird the creation of a treatment methodology and guide infant-parent psychotherapy. The first is that early childhood mental health issues need to be addressed in the context of the child's primary relationships because it is through these relationships that the true sense of self for a child is unfolded and held (Fraiberg, 1980; Lieberman et al., 2000; Lieberman & Zeanah, 1995; Sameroff & Emde, 1989). Second, mental health risk factors in early childhood operate within the context of transactions between the child and the larger social context within which the child dwells (family,

neighborhood, community, larger society) (Cicchetti & Lynch, 1993). Due to the cumulative effects of stressors such as poverty, inadequate housing, unemployment, and community violence, intervention efforts must address these facets and seek to improve the circumstances and overall well being of the family (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). Finally, the process of childrearing and the parenting practices that are within the fabric of each individual are deeply held and often include unconscious cultural values about which characteristics should be encouraged or discouraged in raising a child (Lieberman, 2004). A therapist working with families from diverse backgrounds must be cognizant of the individualized practices and beliefs and incorporate these elements into the therapeutic alliance with the child and parent.

The study of emotions and how they develop has long been considered a critical element both in understanding normal patterns of development as well as developmental trajectories that are considered to be compromised or at risk.

Theories of Emotional Development

Definition of Emotion

Before any discussion of emotional development can occur, it is critical to define the construct of emotion and to understand the factors surrounding emotion that impact its definition. Researchers confirm that no one simple line can neatly package what emotion is; however the deconstruction of emotion can best be viewed by critical tenets and core principles important to understanding emotions and emotional development. Those ideas will be discussed in detail below.

Simply put, emotion is part of all critical transactions within the environment. It guides, directs, and sometimes disrupts action (Campos et al., 1989; Izard, 1991; Schore, 1994; Thompson, 1990). Emotions cannot be separated from cognitive processes at least in terms of theorizing, noting that important ideas such as perception, recognition, appraisal, judgment or meaning analysis are a part of almost every theory of emotional development (Sroufe, 1996). Emotions, which register the significance of a mental or physical event (Campos, Frankel, & Camras, 2004), prepare an individual for action. Emotions have also been defined as evolutionarily adapted responses that have motivating and organizing functions which help individuals in the pursuit of their goals (Campos, Campos, & Barrett, 1989). For young children, the importance and changing nature of the meaning of events in their lives allow us to consider the reciprocal influence of affect and cognition on emotions. Emotions appear to rise through active processes in which infants find meaning in environmental events. As the event progresses through developmental stages, the meaning, or things of importance within the infant's life, is increasingly based on both the infant's past experience and sensitivity to the context in which events occur. By the time the infant is 6 months old, the infant's "evaluation" of events in context becomes the determinants of affective arousal and expression, two critical tenets of emotional development (Sroufe, 1996).

Underpinnings of Social Emotional Development

Propositions of Emotional Development

The realm of emotional development has often been difficult to study and conceptualize. Its fluidity and subjectivity has demanded that researchers devise many

methods to understanding and operationalize emotional development, especially when there is a risk or challenge.

It is important to ground a discussion on emotions and emotional development in such a way that researchers and practitioners have some guidelines from which to base their work and study of young children and their development. Sroufe (1996) who has conducted extensive research on emotional development in children outlines several major propositions about emotional development. The first describes the *ontogenetic principle of development*, which asserts that there is an order in development. Every behavior, even those which are seen as innate or “genetic” develop from the a trajectory of processes wherein the initial conditions represent certain core features which emerge as development progresses (Sroufe, 1996). This idea supports the critical tenet of early attachment, bonding and collective emotional experiences between infant and caregiver. These tenets create the foundation upon which development emerges and continues one way or the other. For the baby whose early emotional experiences were inconsistent, harsh, or traumatic, the trajectory of development is impacted.

A second proposition is that *emotion is tied to development in other domains*. Emotional development must be studied in concert with cognitive and social development (Sroufe, 1996). No one area of development can be understood in isolation (Gottlieb, 1991; Magnusson, 1988; Werner & Kaplan, 1963). Development is an integrative process and for young children especially, the domains of development intersect constantly within their interactions, behaviors and experiences from moment to moment. This intricate coexistence must be studied and understood. Interventions

therefore need to be responsive and inclusive of all developmental areas, taking into account a child's cognitive abilities and social knowledge and experiences. Emotions unfold in a social context and the regulation of affect, an important element of emotional development, takes place within the matrix of caregiving relationships (Sroufe, 1996). Gerald Edelman (1992) explains this saying, "Emotions may be considered the most complex of mental states or processes insofar as they mix with all other processes (Sroufe, 1996, p.176).

Attachment and Social Emotional Competence

The development of social emotional competence is an emerging process that begins as the infant enters the world. One of the central features of young children's relationships with caregivers is the security children derive from them, and attachment theory provides a valuable approach to understanding the origins and consequences of attachment security in early childhood. The formation of secure attachment with one or a few select people is a major achievement in emotional development during the first year (Bowlby, 1973, 1980, 1982). Healthy attachment relationships create the foundation for the infant's ability to perceive the world around him as safe, reliable and nurturing. Babies develop a strong need to know that their parents are available and present both physically and psychologically and that their needs will be met. Attachment is a human condition in that babies are born wired to develop a connection with those who care for them. Attachment theory is the framework for understanding emotional development in infants and young children because it provides a way of understanding human

relationships and specifically the bond that exists between infants and their primary caregivers.

Attachment Theory: Ainsworth

Within the psyche of young children, it was observed that there were two behavioral systems, one which kept the child close to the mother and thereby promoted safety and survival (i.e., the attachment system) and the other that fostered exploration and thus promoted learning and engaging with one's environment (i.e., the exploratory system) (Ainsworth, 1971). Ainsworth, Bell, and Stayton (1971) came to refer to an "attachment-exploration balance" and the child's inclination to use the caregiver as a "secure base from which to explore" (Ainsworth, 1963). This phenomenon of secure base can be observed as you watch a baby who has a secure attachment with his parent. The baby will crawl or walk away just enough to feel a sense of autonomy and freedom, but not too far from where he is able to turn around, check back and be sure that his parent is watching and assuring him that he is safe and can continue to explore. Most infants balance these two behavioral systems, responding both to the environment around them and the availability of the caregiver.

Upon understanding the attachment dynamics and behaviors and the impact of separation from the mother, Ainsworth (1971) purposefully designed a brief 20-minute, 8-episode laboratory procedure to experimentally elicit attachment behavior. In her design of this paradigm, Ainsworth studied a small sample of 26 infants from middle-class homes whom she observed systematically throughout their first year of life. Ainsworth's goal was to account for variation in infant attachment behavior in the

Strange Situation by carefully observing the nature and course of mother-infant interaction during the first year of life. It was her theory that “the quality of care that the child received at the hands of his caregiver during this developmental period that was principally responsible for individual differences in attachment security” (Ainsworth, 1971, p. 17-57).

While many believed that crying would be the sign of distress that would shed light upon the dramatic differences between babies in how they react to separation from mother, Ainsworth’s research proved otherwise. Her ground-breaking research revealed that it was the reunion behavior with mother that was principally reflective of the quality of the infant’s emotional tie to her mother, a discovery of no small proportion in the history of developmental psychology (Ainsworth et al., 1978). How the infant responded when brought back together with his mother was profound and displayed the variation in the attachment relationship between the infant and mother. Within the study of the 26 infants, three distinct patterns of attachment were constructed and have guided research since (Ainsworth et al., 1978). Infants classified as *securely attached* used the mother as a secure base from which to explore, and upon her absence showed signs of distress and a reduction in exploration. When the mother returned, these infants greet her positively and then returned to exploration. Out of the Strange Situation came two types of insecure attachment patterns. The *insecure-avoidant* pattern consisted of infants who explored with little reference to the mother, and showed minimal distress by her departure and seemed to ignore or avoid her on return. Infants classified as *insecure-resistant* failed to move away from their mother and explored minimally. These infants showed great

distress when separated from their mothers and often were difficult to settle upon reuniting with their mother.

These attachment categories provided a way to organize and understand behaviors and relationships as well as a measurement for individual differences. While this was significant at the time and remains so, Ainsworth was the first to theorize in detail about why some infants develop secure and others insecure attachments to their mothers. Ainsworth (1971) found that it was maternal sensitivity that accounted for the differences in attachment security of the one year olds in her study. Central to the notion of sensitivity was the mother's ability to read the infant's behavioral and emotional cues and respond in a timely and appropriate manner to the infant's needs. Mothers who reared secure infants responded in a timely manner and were ready and able to handle the infant in a comforting manner. Securely attached children also scored higher on later assessments of emotional health, self-esteem, positive affect, and other emergent personality dimensions (Thompson et al., 2006). Researchers have found an association between infant disorganized attachment and risk for later internalizing and externalizing disorders in childhood, although it should be recognized that the same family stress that initially contributed to the development of a disorganized attachment may also contribute to its later outcomes (Thompson, 2006). The quality of attachment security manifests itself well into the adolescent years as was confirmed by several studies of middle childhood and adolescent age children (Urban, Carlson, Egeland, & Sroufe, 1991). Examining these attachment-based behaviors has provided a way for individuals studying

social emotional development to operationalize these behaviors and understand the profound impact that attachment security has on emerging social emotional competence.

Historical and Current Perspective on Early Relationships

Winnicott

D.W. Winnicott (1965) proposed that there is no such thing as a baby. There is no baby that exists alone, but always with his mother. As we understand reciprocity, then we know that a mother also exists with her baby. Winnicott (1953) characterized the commitment of parent to child in terms of primary maternal preoccupation. The behaviors, needs, mood, intentions, and place of the infant should fill the parent's mind providing the impetus upon which to respond appropriately to the child and desire to meet the child's needs. This inner connectedness that exists between the mother and child is the essence of a healthy relationship. When this bond does not exist, the need for intervention is necessary. Winnicott (1965) also described the "holding environment" as the idea of the infant's impulses, affects, and frustrations being satisfied by the parent in order to prevent a situation where the infant becomes overwhelmed. This is critical to the development of social emotional competence in that the parent acts as a container and preserver of the emotional experiences in the young child. This availability helps the child express a range of emotions in a healthy way and experience a sense of security and calm, knowing that the parent is there to protect and hold the child's emotions in a safe and validating way. This transference experience of being soothed allows the child, as she grows and develops, to begin to soothe herself. In contrast, the young child whose emotional requests go unmet and are left with strong unsatisfied urges may respond either

with suppressing these urges or being overwhelmed by them, making the steps toward self-regulation challenging or nonexistent (Grolnick et al., 2006).

Waddell

In her book, *Inside Lives: Psychoanalysis and the Growth of the Personality*, Margot Waddell (1998), discusses the early mother/infant relationship explaining that when the mother is able to provide a containing presence both physically and emotionally for her baby, then the baby is able to develop a center or a core from which to integrate future experiences and relationships. Without this internal process occurring, due to the parent being overwhelmed by depression, anxiety in caring for a new baby, or other unforeseen difficulties, the baby's emotional life will suffer. An early sign of relationship distress can come from the mother's inability to read her baby's cues and thus not meet his needs. "This mother may have difficulty in being in touch with the quality of her baby's communications and may also, perhaps, prefer 'doing' to 'being' (Waddell, 1998, p.42). The internal ability to be with your baby requires more than just meeting his needs. Meeting his needs is a critical aspect of early bonding and attachment, however the way in which the mother goes about meeting her baby's needs and her state of mind, emotional state, have a great impact on how her baby begins to develop his emotional state and what he understands about the world. For a baby who is unable to experience a containing presence as Waddell calls it (1998, p. 43), the baby will resort to an array of defensive mechanisms to alleviate anxiety and to retain, or retrieve, some kind of equilibrium. "When psychic pain is felt to be unheld and therefore unbearable, there may be a withdrawal into a closed-off state of petrified emotional isolation (Waddell, 1998,

p.44). The emotional state of the baby is likely to cause a “mismatch” in the caregiver-baby relationship and thus lead to difficulties as both the mother and baby grow and develop outside relationships. “Infancy constitutes the foundation for the way in which the developmental process unfolds, functioning as a model for the child’s later relationship with family, school and the wider world (Waddell, 1998, p.53). It is critical to understand the parent-child relationship from the earliest years as it provides a framework and a blueprint from which all other relationships are built upon.

Understanding the “roots” of struggle, mismatch and a lack of connection between parent-child will provide a better understanding of how to address these issues in therapy and provide a healing experience for both parent and child.

Greenspan

Greenspan (1981) also discussed what he called the growth-promoting early environment as the one that balances the child’s need for stimulation with the need for experiencing homeostasis or self-regulation. Within this view, the parent provides soothing or comfort to the child to supplement the child’s emerging capacity. As the child grows and changes, the parent helps the child integrate her emotional experience and develop organized interpersonal responses. Without the parent’s presence in the regulation process, the young child is unable to stabilize emerging cycles and patterns and build a capacity for self-comforting mechanisms (Greenspan, 1981). These ideas speak to the critical place of caregivers’ responses in the child’s healthy emotional development.

Under optimal conditions, as the young child's capacity for regulation increases and as she grows and develops, the parents' ability to adapt strategies for supporting social emotional development evolves. Research confirms that as the child's developing linguistic abilities emerge in the second year (Ridgeway, Waters, & Kuczaj, 1985), caregivers have more of an opportunity to engage in language-based regulation strategies. The assessment process provides parents with the knowledge and understanding of how to best provide strategies to addressing social emotional competence thus promoting continued best practices for parents in supporting their child. In situations where the child is experiencing a delay or there is a risk for disconnections between parent and child in relating or communicating, the assessment and intervention processes exist as a way to address, teach and model ways for parents to reconnect and rebuild the parent-child relationship.

Parent-Child Relationship as Context

Because of the critical importance of the primary caregiving relationship for infant mental health, a relational view dominates contemporary thinking about risk, psychopathology, assessment, and intervention (Zeanah, 2001). When it comes to discussing and describing social and emotional development in young children, it is not enough to include parents just in the process of completing assessment and designing interventions for their child. Rather, parents are the center of the process, because they are the center of the relationship that exists and which is the basis upon which social emotional development thrives. Young children grow up in the context of relationships and it is these bonds that create an understanding of not only who the child is overall, but

also what realms of development are impacted and shaped both positively and negatively. Within the area of assessment and intervention, it is critical to make the connection between understanding behaviors or reactions from the child as stemming from and a part of the network of relationships within which the child exists. Critical especially to the study of young children, in the sense that who they are and what they are is very much contingent upon the exchanges, continuity or discontinuity, and interconnectedness with the caregivers most involved in their lives.

In planning interventions and treatment for children, the role of the parent is critical and cannot be separated. The young child will progress towards healthy social emotional competence only as well as he relates and experiences positive interactions and exchanges with those closest to him. Thus it is essential to realize that throughout the assessment and intervention processes, the role of the parent-child relationship is central. The role that the parent and family play in the process of assessment is part of the elements of everyday life and the development of the child (i.e., the parent-child relationship and what this yields toward assessment) and also the actual process of assessment itself (e.g., the inner workings, parent input in child's goals)

One of the goals of the assessment instrument for this study is to improve parent-child relations. It is important to recognize and realize that some of the children who are identified as having social emotional concerns, especially those in the infant and toddler range, may also have a mismatch in the relationship with their caregiver. The dyadic relationship is the source of much of the developmental experience, especially for social emotional development, as young children 0-3 look to their parents as their source of

regulation, safety and comfort. Several decades of research document the considerable power of parents to influence infant development. Synchrony and reciprocity in emotional interchanges between infants and parents have been demonstrated to be broadly predictive of subsequent adaptation in the young child (Crockenberg & Leerkes, Zeanah, Boris, & Scheeringa, 1996). Because of this, it is important to consider the assessment process within the framework of a relationship based, infant mental health approach to understanding families and effectively treating dyads who are at risk.

Further explanations of the impact of the parent-child relationship on fostering infant emotional regulation and social emotional competence focus on the ability of both the parent and infant to respond to and reinforce each other contingently (Crockenberg, & Leerkes, 2000). Tronick et al. (1986) refers to this process as “mutual regulation,” Stern (1985) calls it the “affect attunement model.” The mutual regulation model (Tronick, Cohn, & Shea, 1986) emphasizes infant initiation and regulation of the social interaction. When mothers and infants are engaged in a contingent cycle of signals and responses, as indicated, by matched affective states, the conditions needed to promote emotion regulation exist (Crockenberg, & Leerkes, 2000). The back and forth exchanges of communication and affect, almost as if watching a coordinated dance between two partners, is what exists when there is reciprocity and a give and take between the parent and child. The match indicates that the mother is aware of, and is responding appropriately to, her infant’s affective cues, and the infant is providing the same for the mother, allowing the regulation process to either exist or be in the process of reestablishing itself (Crockenberg, & Leerkes, 2000). Stern’s (1985) affect attunement

model involves the parent matching the infant's internal feeling state and this resulting in a cross modal affective exchange between parent and infant and demonstration of behaviors that express the quality of the shared affect state (Stern, Hofer, Haft, & Dore, 1985). When one observes a parent and child experiencing this shared emotional state, there is a sense of connectedness, both intrinsically and extrinsically and a desire on behalf of both to continue the connection. In order for attunement to occur, the parent must be able to interpret the infant's feeling state from his or her overt behavior and then respond in such a way as to convey emotional resonance with the baby's feelings; the infant must be able to understand that the parental response is related to the infant's original feeling experience (Stern, 1985).

For example, if the toddler is expressing sadness in the form of an intense tantrum, it may appear that the child is angry. The parent has to be able to understand and know the child well enough to realize that the child is sad and then respond to the emotion of sadness. The sense of knowing and being able to make these profound connections begin by the parent establishing a secure attachment and providing a consistent pattern of exchanges where the young infant's needs are met continuously and the infant begins to develop a model of understanding and experiencing the world as a safe, secure place. This foundation allows for the connection between the parent and child to continue to develop in a mutually satisfying way.

For practitioners working with young children, it is important to understand the range of strategies and interventions for addressing early mental health/social emotional concerns. An infant mental health and relationship based framework are both essential.

The assessment measure identified in this study can help identify and target social emotional behaviors, but often the larger issue lies in the parent/child relationship- understanding temperament, goodness of fit, and generational transmission of trauma. It is important to be aware of these emotional exchanges and the inner emotional world both within the parent, the child and the dyad, as there are affective patterns that exist. Understanding these models of relationship provide a broader contextual base upon which to understand social emotional competence in young children. Within the context of the parent-child relationship, the ability of the caregiver to help regulate the infant's emotional reactivity (Crockenberg & Leerkes, 2000), or temperament, is an important goal, both in assessing the quality of the parent-child bond and also the emotional state and emotional regulation expressed by the young child.

Temperament

Extensive research and literature on temperament has expanded in the last 10 years, indicating its importance as a developmental outcome and as a moderator and predictor of other developmental outcomes (e.g., Guerin, Gottfried, Oliver, & Thomas, 2003; Halverson, Kohnstamm & Martin, 1994; Molfese & Molfese, 2000; Rothbart & Bates, 1998; Wachs & Kohnstamm, 2002). The notion of temperament relates directly to the models discussed above and is a part of the large body of literature on parent child relationships. As with the idea of emotion, it has been difficult to formulate a concise definition of temperament; however, a working definition from Bates (1989) describes temperament as, “ Biologically rooted individual differences in behavior tendencies that are present early in life and are relatively stable across various kinds of situations and

over the course of time” (Bates, 1989, p.4). The various dimensions of temperament (Bates, 1989) relate directly to the areas of social and emotional development identified in the proposed assessment measure in terms of the types of social emotional responses and behavioral indicators present in young children. The dimensions include: 1) negative emotionality (e.g., fear, anger); 2) difficultness (e.g., high intense, easily evoked negative moods); 3) adaptability to new situations or people (e.g., inhibition); 4) activity level; 5) self-regulation (e.g., soothability); 6) reactivity (e.g., how intense a stimulus is needed to invoke a response); 7) sociability-positive emotionality (e.g., pleasure in social interactions (Goldsmith & Campos, 1982, Thomas & Chess, 1977).

These temperament factors are seen to fall into two overall categories: reactivity and self-regulation (Rothbart, & Bates, 1998). As described in an earlier section, self-regulation is an important indicator of overall social emotional well-being and therefore an important tenet to study and understand, especially in young children. While there are many angles to focus on within the discussion of temperament, for the purposes of this study, we wish to consider temperament as a construct within patterns of social emotional development and parent-child relationships.

Because temperament impacts the parent-child relationship and the relationship impacts temperament, we look to the “goodness-of-fit” model when discussing temperament. The goodness of fit model involves concordance between the expectations of the environment, the parent in the case of parent-child relationship, and the infant’s abilities, characteristics, and style of behaving (Seifer & Dickstein, 2000). Within this ever-changing set of interactions and exchanges, there are demands, stresses, and

conflicts, which are part of the developmental processes that occur as expectations, and demands for change accompany progressively higher levels of functioning (Thomas & Chess, 1977). As the infant emerges into a toddler, the growing need for autonomy, a demand for self preservation accompanying a fierce need for closeness and connectedness interacts and impacts the parent's ability to relate and engage with the young child as well as the young child's sense of being and doing with the parent.

The dimensions of temperament discussed above culminate within the toddler-parent dyad, creating either an equal reciprocity of emotions and behaviors or a disconnect and a divide in the coexistence of togetherness. A child with intense moods, strong personality tendencies and an inability to self-regulate may be challenged by an overbearing parent who demands order and calmness and equates a strong will with being "bad." This mismatch can be damaging if unmet needs (on both the part of the parent and the child) are left unaddressed and therefore misunderstood. Seifer (in press) described what could result, in explaining that childhood behavior disturbance can often result from excessive stress of conflict involving dissonance between the environment and the child's capacities. The child's ability to handle elements of the environment that he or she perceives as stressful or challenging is not buffered from the parent because the parent is unable to meet the needs or attend to the emotional requests of the young child. What results is a mismatch in expectation and a lack of connectedness felt within the child and often within the parent also. It is the role of the parent (directed by his or her own beliefs, values, expectations, and behavior) to "match" his or her behavior to the infant's state of arousal (Seifer, & Dickstein, 2000). This match creates a sense of stability and a sense of

knowing that your parent understands and validates your emotional experience and expression. There can be a range in the type of emotional “match” that exists, in that infants can handle a broader level of emotional exchange as long as it falls within a tolerated level for the infant (Stern, 1985). More extreme mismatches can be detrimental to the infant’s social and emotional learning and growth.

The assessment process can be beneficial in identifying a mismatch in the relationship and provide the parent with the insight and understanding of how emotional patterns impact a young child. Temperament is an important dimension of social emotional well-being and it is critical to understand the meaning and the role that it plays within the context of the young child and early relationships. The age of the young children in this study all fall within the 18-36 month range, a broad range, yet characterized by certain factors. Some specific developmental milestones that emerge and take shape for toddlers are discussed next.

Toddler Development

Theories of Emotional Development

Since this study focused on children ages 18-36 months, it is important to understand this unique developmental stage and how the development of emotions and emotional regulation occur within toddlers. Sroufe (1996) writes about the unfolding of emotions through an organizational perspective, calling this age the “third reorganization.” The young child at this age is an intentional being in the world, with permanent objects that can be acted on in planned ways. Many theorists have described this autonomous emergence with an increased awareness of self as a separate being, away

from mother and father, yet still connected and incomplete without them. Mahler (1975) talked about the infant's moving out into the world ("practicing"), which leads to an awareness of separateness. An increased capacity for internal representation, object mastery skills, and increased mobility culminate in this stage of development as the toddler utilizes the secure base (the parent) for exploration (Spitz, 1965). With this in mind, the underlying bond that the toddler shares with the parent provides the ability and drive towards exploration and a growing sense of autonomy. These elements are important within the assessment process, as they are reflected in the toddler's comfort level within the environment, how the toddler plays and utilizes the space around him and the way in which the parent and child identify a closeness and attachment with one another.

Emergence of Autonomy

The emergence of autonomy experienced by the toddler is related to the growth and change in the child's cognitive transactions with the environment, which include inner affective control, is supported by maturation of the central nervous system (CNS) (Emde et al., 1976). Other emotional patterns common within this time frame include defiance, shame, affection, and positive valuation, which emerge as the child's autonomy continues to develop (Spitz, 1965). These emotions or lack thereof manifest themselves in certain behavioral patterns that can be observed and operationalized through the assessment process.

Toddlers expand their developing theory of mind as they comprehend how people's actions are guided by their desires and emotions (Thompson et al., 2006). These

psychological states are often challenging for children to comprehend and fully understand because they are invisible, multidetermined motivators of behavior. Thompson, Goodvin, and Meyer (2006) explain that as early as 18 months, children already exhibit a rudimentary comprehensive of the importance of differences in desires. By age 2, toddlers also begin spontaneously to talk about emotion, the cause of emotions, and even emotional regulatory efforts (e.g., Bartsch & Wellman, 1995; Wellman, Harris, Banerjee, & Sinclair, 1995). As toddlers develop into the third year of life, they begin to comprehend the connections between desires and emotions (e.g., people are happy when they get what they want, and unhappy when they do not) (Woolley & Wellman, 1993). These emerging emotional skills help children understand their own emotions and also begin to understand effective ways to manage them (Thompson, 1994). Social and emotional development in toddlers marks the beginning of emotional regulation. Research confirms that emotional regulation is the keystone of development in infancy (Crockenberg & Leerkes, 2000).

Development of Toddler Social Emotional Competence

Self-Regulation

The ability to self regulate is seen to be a key indicator of healthy emotional development and something that begins in the early years and evolves well into adolescence. The toddler period is said to be the beginning of the development of self-regulation and behavioral control (Maccoby, 1980). Thompson (1994) defined emotion regulation as individuals' attempts to monitor, evaluate, and modify their emotional reactions, particularly in pursuit of a goal. Emotion regulation involves the maintenance

or modification of physiological arousal or internal feeling states (Crockenberg, 2000). Young children experience a range of emotions, positive and negative and the regulation process includes the span of emotions (anger, fear, sadness, joy). As the toddler develops there is a natural move towards autonomy, competence and relatedness, as long as the environment supports this trajectory. Autonomous regulation, the process beginning in toddler hood, is the ability to be reliant on one's emotional regulation and the avoidance of being overwhelmed by emotional experiences. These situations are things even adults continue to work on, but the stage is set for these processes early on and the ability to do so is dependent on the quality and reciprocity of emotional relationships experienced by the young child. As children move towards greater self-regulation of emotion, they are able to fulfill the goals that other have for them, such as expressing emotions in a socially acceptable manner (Kopp, 1989). This expectation is often more common in older children, but begins in toddlers as parents and caregivers have an expectation that the toddler will express happiness or frustration in certain observable ways (e.g., smile and laugh when feeling happy, crying or kicking when frustrated). The increased sense of self-regulation provides a greater likelihood that the young child will be able to initiate and maintain positive interactions with others, an important factor for healthy social emotional development. Parent-infant interaction is the primary context in which emotion regulation begins to emerge (Crockenberg & Leerkes, 2000). As mentioned above, the presence of strong negative emotions is typical in young children and the process of regulating these within young children comes from the caregiver's prompts and interventions (Grolnick et al., 2006).

Caregiver Impact on Self-Regulation

Young children's growing sense of self-regulation must first come from their ability to be regulated by their caregiver. The caregiver provides the initial experiences of helping the baby self soothe, or supporting the toddler in calming himself after a tantrum. These relational experiences create a foundation and an expectation from the young child that their emotional experiences are supported and understood from someone beyond themselves. When this does not occur or occurs in a negative way (e.g., shaming, humiliating, hitting), the young child's emotional experiences are not validated or attended to. Movement toward the ability for internal and external self-regulation (seen in older children and adults) is delayed or misunderstood, creating confusion and insecurity. Grolnick et al., (2006) examine the intertwined processes of emotional expression and emotional regulation, which relate to the experience for young children, in that the emotions they express are impacted upon and impact on the ability of the caregiver to provide a model for healthy regulation. Hirschberg (1996) confirms that emotional regulation is "probably the most important area of relationship functioning since the emotions or affects experienced in any interaction are critical in determining the psychological significance or meaning of that interaction in the infant-parent relationship. A number of researchers have conceptualized emotional regulation as developing with the context of the parent-child relationship (Gianino & Tronick, 1988). Parent-child interactions involve a sense of mutual regulation in which caregiver and child modulate the affect of one another (Tronick, 1989). If the parent-child relationship is characterized as unresponsive and poorly coordinated and results in the parents' inability to read and

understand the child's cues and emotional needs, the emotional development of the child is impacted.

The previous sections have described and discussed theoretical frameworks, and developmental content, specifically related to social emotional well-being. Each of the areas provides a necessary piece of a complex puzzle creating a picture of a young child's developmental trajectory and the facets embedded both internally and externally that explain elements of the whole. These crucial components have created a foundation upon which to build both a discussion on the importance of assessment and also the components themselves having their own individualized place in the assessment process. Examination of the assessment process, including theory and implementation of the assessment measure for which this study examined will be presented.

The Assessment Process

Definitions and Historical Context of Assessment

Assessment consists of the process of obtaining information for the purpose of making evaluative decisions (Meisels, & Atkins-Burnett, 2006). Assessment should give a picture of the whole child, not just splinter skills and milestones, and help to differentiate and expand parents' and providers' perception of their babies and young children. In early childhood, assessment is not the same thing as testing. Meisels and Provence (1989) recommended that screening, assessment and evaluation be viewed as services—as part of the intervention—and not only as means of identification and measurement. Within the Head Start Program Performance Standards, assessment is defined as “Ongoing procedures used by appropriate qualified personnel throughout the

period of a child's eligibility to identify the child's unique strengths and needs and the services appropriate to meet those needs" (Head Start Performance Standards, 45 CFR 1304.3). The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child" [45 CFR 1304.3].

Assessment should engage us in a process of ongoing discovery. It should be viewed as a collaborative process of observation and analysis that involves formulating questions, gathering information, sharing observations, and making interpretations to form new questions (Meisels, 2000). Fitzgerald (2007) has identified reasons why assessment is important. These include: (1) establish normative indicators of development and the range of expected variation, 2) screen children to determine whether they are at risk for significant deviations from normative developmental pathways, (3) diagnose children in order to identify specific problems and the degree to which such problems are embedded in risky rearing environments, (4) determine whether a particular intervention or prevention program is effective, and (5) determine whether children have the necessary skills to successfully negotiate life-course challenges. These reasons provide an important contextual base for the Social Emotional Assessment Measure (SEAM) and Ages and Stages Questionnaire: Social Emotional in that the screening and assessment processes that are a part of this study will help to provide key information on toddler's social emotional development and also identify how various risk factors related to poverty impact the child's emerging competence.

Understanding the historical context of assessment provides a sense of how far the field has come and yet how much more work there continues to be. The first monumental event within the field occurred in the late 1960s and early 1970s with the development of the Denver Developmental Screening Test (DDST; Frankenberg & Dodds, 1967).

However to its fault, the DDST is seen to be one of the least accurate commercially available predictors of early development, under-referring as many as 95 out of 100 at-risk children in its first versions (Meisels, 1988). This alarming statistic proves to be reason for the need for screening and assessment measures to understand the unique and often overlooked needs of children who are at risk and whose contextual experiences differ in ways from children growing under optimal conditions. Current perspectives on testing young children assert that this area is still marked by significant problems.

Assessments are fundamentally created to ask questions about children's knowledge, skills, behavior, development and personality. Asking the right questions at the right time in a format that is easy for practitioners and parents alike to understand and utilize is critical to the success of developmental growth and change within the child.

Historically, measurement of groups has attempted to understand areas of behavior, development and eventually diagnoses and treatment. Many of the early assessments for infants were concerned with how infant behavior could predict later child performance (Brooks-Gunn & Weinraub, 1983; Honzik, 1983). Questions that looked at what behaviors preceded later mental achievements were asked by researchers in the search to discover the link between early mental functioning and later intellectual performance (Bayley, 1970; McCall 1981; McCall, Hogarty, & Hurlburt, 1972). While

studies have been inconclusive in this area, within the context of social and emotional development, the research is clear that early experiences have a profound impact on later emotional functioning. In order to understand social emotional behaviors, research confirms that assessment of emotional development requires measurement of specific behaviors (smiling, crying, temper tantrums, hitting, ability to inhibit responding, social referencing). Understanding how these behaviors are played out within the individual child and what contextual factors influence the behaviors is important (Fitzgerald, 2007).

Until relatively recently, progress in identifying and treating early social-emotional problems was impeded by a lack of measures of social-emotional adjustment in infants and toddlers. Meisels and Atkins-Burnett (2000) discuss two principles that they believe should influence assessment decisions in early childhood. First, they highlight the importance of a meaningful interaction between assessor and child. The relationship that is established between the assessor, who may be a teacher or practitioner, is key in allowing the child to feel comfortable and secure in the assessment process. This relationship calls for the assessor to understand the individual context and culture of the child and allow this information to guide and inform the assessment. Building trust between the assessor and the family will create ease and a greater sense of openness throughout the information gathering. The second principle relates to what is implied with the word “evaluate” (Meisels & Atkins-Burnett, 2006). The assessment process is not free of bias or value judgments and often we assess what is easy, narrow or expedient because it fits with the values that we bring. There needs to be integrative assessment methodologies that allow the assessor to examine and think critically about

the different developmental areas and how they interact. In addition the assessor needs to consider the complexity of assessment and not simplify it to be something that fits in with the assessors possible limited view. Understanding the dynamic nature of children's development and the interplay of culture, family and individual learning patterns allow for a more thorough assessment to be conducted and therefore better results and interventions for children.

Purpose of Assessment: Current Ideas

With this in mind, it is important to consider the place and purpose of assessment in identifying children who are at risk and also considering the time and place for intervention and treatment. Infant mental health (IMH) assessment methods parallel those in other psychological sub-specialties and include observation, interview and active listening, and some formal measures (Tomlin & Viehweg, 2003). A Zero to Three working group (1992) on developmental assessment identified several core principles of assessment in infancy and early childhood. Many of the principles relate to the *SEAM* and its elements.

The first is the idea of the interdependence of development. Each child is a complex, intricate being and within each developmental domain there is a lot of back and forth, and an interplay between areas of functioning. Underlying all of the areas of development, motor, language, sensory and cognitive is the emotional capacity that enables children to relate to others and organize their world (Meisels, & Atkins-Burnett, 2000). With this in mind, therefore, not only is it important that assessments in general understand the dynamics of development, but also that children's emotional well-being is

targeted as a foundation upon which other areas emerge. Another critical area that relates directly to the intended purpose of the SEAM is the idea of approaching assessment and intervention in a way that the skills or behaviors tested or encouraged are functional skills that children can use in their everyday life experiences. Goodman and Pollak (1993) asserted that skills or behaviors with no functional application, learned and tested out of context, have no place in early intervention. If the assessment and intervention processes do not provide a young child with the opportunity to make meaning out of their world and provide for the parent or teacher a sense of how to encourage and promote real life skills, then they are not functioning in their intended use.

Screening for Social Emotional Problems

The screening process is a crucial first step in beginning to understand the picture of social and emotional development in a young child and identifying potential areas of concern. The screening process is used to determine whether social-emotional as well as other developmental skills are progressing as expected or whether there is cause for concern and further evaluation (Mann, Powers, Boss, & Fraga, 2007). Screening alone is not indicative of a mental health diagnoses, but rather it is the first step in the evaluation process designed to help determine whether an in-depth evaluation is necessary (Mann, Powers, Boss, & Fraga, 2007). For the purpose of this study, the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) (Squires, Bricker, & Twombly, 2004) will be utilized as a screening tool. This screening process the first step of the linked system approach (Bricker, Pretti-Fronczak & McComas, 1998). The items on the ASQ:SE and the SEAM observe similar behaviors and have similar wording. This allows parents and

early childhood professionals to achieve a more reliable score and in turn develop an intervention that directly addresses the individualized areas of social and emotional development. The ease through which programs are able to utilize screening and assessment tools affect how efficient and effective the process will be in identifying children who are at risk or already have social emotional delays.

The SEAM

The Social Emotional Assessment Measure, (SEAM), is a social/emotional assessment and evaluation measure developed for use with young children birth to five and their parents or caregivers. It was designed to assist programs working with young children in prevention and early identification of social and emotional difficulties and behavioral disorders. The content for the SEAM items was derived from a series of child and caregiver/adult benchmarks. These benchmarks represent critical areas for social emotional competence in young children and their caregivers (Squires & Bricker, 2007). In the case of the SEAM, the objectives relate to the child's social and emotional development and targeting behaviors and actions within these areas of development. The objectives relate to social emotional competency and functioning within toddlers, ranging from 18-36 months. With the help of early intervention, many of these early social emotional challenges can be ameliorated and children can continue on a trajectory of healthy growth and development.

Specific criteria have guided the formulation of the assessment items on the SEAM. Each item must fall within the following guidelines: must be functional, must be meaningful, must be observable and measurable, can be easily embedded into daily

activities, must be written in jargon-free language, and could serve as an intervention goal (Squires & Bricker, 2007). These criteria resulted in the elimination of many items that are common in diagnostic measures, which target negative responses as intervention goals, rather than the reciprocal positive response provided as the intervention target (Squires & Bricker, 2007). This feature provides a unique and important dimension within the arena of assessment measures and provides teachers, parents and other early childhood professionals with an opportunity to observe and teach positive pro-social behaviors rather than to target negative behaviors. For example, a common item seen in many social emotional assessments is *child clings to adult*. On the SEAM this item was changed to *child explores new environment, while maintaining some contact* (e.g., Toddler SEAM 6.1) (Squires & Bricker, 2007).

Upon completion of the SEAM, the instrument can be used to develop high-quality goals. Without the use of this particular tool, selected or developed goals may not be of high quality (i.e., functional, meaningful, measurable, and addressable during daily activities), and the accompanying intervention efforts may not be relevant or effective in enhancing the child's social emotional competence (Squires & Bricker, 2007). The SEAM can also be used as a progress monitoring and evaluation tool. This process requires professionals who are using the SEAM to gather comparative data at selected intervals (e.g., weekly, quarterly, annually) in order to make judgments about the effectiveness of the SEAM and the entire ABI:SE Approach. The entire process will assist children and their caregivers to achieve targeted social emotional outcomes and

provide a way to measure and monitor program outcomes (Squires & Bricker, 2007). A copy of the Toddler SEAM can be found in Appendix A.

ABI:SE Assessment Process

ABI:SE Approach

The SEAM is the identified assessment measure that is a part of the Activity Based Intervention: Social Emotional, (ABI:SE). The ABI:SE approach incorporates the elements of activity-based intervention with a specific focus on social and emotional development (Squires & Bricker, 2007). This assessment process requires collection of two important types of information: a) measures of children's social and emotional competence, and b) measures of caregivers' ability to provide safe, supportive, and interesting environments for their children and their interactions with their children, (Squires & Bricker, 2007). For the purposes of this study, only part a) will be examined. The SEAM provides invaluable information that can be used to develop high-quality goals and intervention activities to support the goals (Squires & Bricker, 2007). This feature increases the propensity for greater developmental outcomes for young children because early childhood professionals are able to utilize the information learned about the child and family and create meaningful, individualized activities specific to the needs of the child. Parents gain a window into their young child's social-emotional development and gain a greater sense as to how their own behaviors or cues impact their young child and what they can do to promote optimal growth.

Curriculum-Based Assessment

The SEAM is considered to be a curriculum-based evaluation, which is defined as a criterion-referenced assessment which focuses less on hierarchies of development and more on specific objectives that are to be achieved by the child (Meisels, 1996). The SEAM and the other elements within the ABI:SE approach are focused on equipping those who interact with children with a practical tool that they can use to ensure that the social emotional competence of the young child(ren) in their care improves. The SEAM and the other elements within the ABI:SE approach are focused on equipping those who interact with children with a practical tool that they can use to ensure that the social emotional competence of the young child(ren) in their care improves. These features described above defined a *curriculum based or curriculum-embedded assessment*.

Criterion-Referenced Tests

Criterion-referenced tests are used to compare an infant's functioning to some set of standards or expected competencies. These tests are essential when planning intervention programs. Selecting goals and planning intervention are central to the SEAM. Criterion-referenced tests are designed to sample extensively the universe of skills that a child is expected to have mastered at various ages (Gilliam & Mayes, 2000). The child's performance on these tests, or the outcomes, can be translated directly into an individualized intervention plan by targeting the skills that the young child is expected to have, but has not yet mastered. There are a few significant, widely used criterion-referenced tests. One of the most popular is the Brigance Diagnostic Inventory of Early Development-Revised (Brigance, 1991). The Brigance is used with children birth to 7

years old and surveys skills in 12 developmental domains including social, emotional, communicative, motor, and preacademic skills. Other similar tests include the Hawaii Early Learning Profile (HELP; Furuno et al., 1987) and the Early Learning Accomplishment Profiles for Infants (Sanford, 1981). The Rossetti Infant-Toddler Language Scale (Rossetti, 1991), another criterion-referenced instrument, assesses verbal and nonverbal communication and parent-child relations.

Utility of the SEAM

As a data collection measure, the SEAM must be useful for a variety of populations and settings. This study was designed to provide a better understanding of how useful this tool is, specifically within low-income populations. Particular questions assessing utility were asked to parents and the feedback provided will help the researchers to determine strengths within the SEAM as well as areas of improvement.

Activity Based Intervention: Background Information

Activity-based intervention refers to an intervention procedures that integrates teaching and change efforts into the everyday routine and activities (e.g., dressing, eating, playing) that comprise children's and their caregiver's lives (Pretti-Frontczak & Bricker, 2004). This approach is a result of a transdisciplinary model called Activity Based – Intervention (ABI), designed by Dr. Diane Bricker and colleagues at the University of Oregon. (See Figure 4.) Bricker and Cripe (1992) defined this approach as a “child-directed, transactional approach that embeds intervention on children's individual goals and objectives in routine, planned, or child-initiated activities, and uses logically occurring antecedents and consequences to develop functional and generative skills”

(p.40). The transactional approach (1975), developed from the work of Sameroff and Chandler, addresses the interactive nature of the child-environment exchange and the bidirectional influence between the child, caregiver (relational context), and the environment. ABI recognizes the importance of the transactional model in that the child is continuously influencing and being influenced upon what is around her and interventions must be designed in such a way that they are embedded into the natural context of the environment within which the child functions. ABI is considered a naturalistic teaching approach, and is commonly described in terms of embedded instruction, routines-based intervention, or integrated therapy (Pretti-Frontczak et al., 2003). Interventions must be created and implemented in the form of natural, authentic activities that are a part of a child's everyday experiences and driven by the child rather than the adult. The child initiates an activity based on her interest and the adult follows the child's lead, allowing the child to determine the choice and context of the play based activity. SEAM intervention goals are designed to be naturalistic and not forced or structured in such a way that the child appears to be disconnected with the activity. The goals of the intervention activities need to be translated into real life activities for the child rather than something that feels like a "laboratory" procedure, unable to be replicated in the child's home and classroom settings.

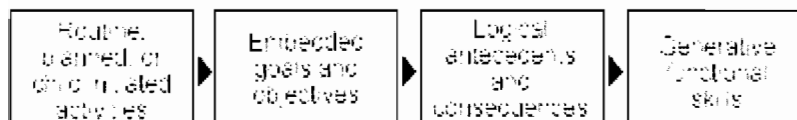


Figure 4. Activity-Based Intervention Model.

The SEAM, which addresses social and emotional development, is unique in that it is part of a linked system, providing ease and continuity for professionals looking to utilize a screening instrument like the ASQ:SE and provide follow up with an assessment. Additionally, the SEAM was developed to be utilized by personnel who are not mental health experts, but rather for child care workers, Head Start teachers, and home visitors who daily care for young children and their families.

Linked Systems Approach

There are five processes of the linked system framework that are all related and connected. The processes include: 1) Screening; 2) Assessment; 3) Goal Development; 4) Intervention; 5) Evaluation. To avoid fragmented service delivery and a lack of holistic understanding of the developmental processes of young children, the linked systems approach provides a comprehensive, seamless system by which to provide services for young children and their families. Bricker (1996) noted that there should be a direct relationship between the processes of assessment, intervention and evaluation. For this study, the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) was administered as the screening tool. This screening process will provide interesting and relevant data and provide an initial picture of the toddler's social emotional development and a profile of strengths and weaknesses. A clear understanding of how the linked systems approach is beneficial and informative in understanding young children's social and emotional development and the necessary steps to take in providing intervention and treatment should result. Within the linked systems approach, the assessment process should

produce the necessary information to select appropriate and relevant intervention goals and objectives.

The *assessment* refers to the process of establishing a baseline or entry-level measurement of the child's skills and desired family outcomes (Bricker, 1996). After the assessment process has taken place, information will be produced to select appropriate and relevant intervention goals and objectives. The *intervention* consists of the process of arranging the physical and social environment to produce the desired growth and development specific to the individualized intervention plan for the child and family. After the intervention occurs, it is important to determine the efficacy and utility of the intervention. The *evaluation* refers to the process of comparing the child's performance on selected intervention goals and objectives, as well as the family's progress toward established family outcomes, before and after intervention (Bricker, 1996). In the case of the SEAM, the social emotional competencies, those identified as child benchmark and assessment items, that are of concern to the parent or provider, will be the items identified for intervention and evaluation. The eventual goal of the SEAM is to provide intervention activities, embedded into the daily context of classroom and home experience, where children are able to develop new social emotional behaviors and interactions with caregivers.

Family Involvement in Assessment Process

As the early childhood field moves more towards an inclusive model of incorporating families at the center of influence and intervention for their children, the process of assessment has also evolved in a way as to validate the experiences of families

and assure their participation in the process. Because social and emotional development centers on relationships and the relational context of the young child's experience, it is nearly impossible to separate the influence of the caregiver or family member from the experience of assessment and intervention. Legislation has also shifted to include families in the process of determining services for their children and assuring that services respect and understand the individual needs of the children and families. Berman and Shaw (1997) discuss the definition and purpose of family assessment explaining that it is a term that is a part of the Part C regulations (formerly Part H) and is defined as "family directed and designed to determine the resources, priorities, and concerns of the family related to enhancing the development of the child" (see 34 CFR 303.322(d)). In the case of the SEAM, the families are often the ones completing the assessment measures and identifying areas, and through this process becoming aware of their child's strengths and needs for additional support and intervention. The work of Turnbull and Turnbull (1995) has added an important contribution to the field of understanding and appreciating the role that families play through the literature on the empowerment model (Dunst, Trivette, & Deal, 1988).

The Turnbull et al., model reevaluates and provides a new look at the interactions between professionals and families. A basic tenet is that the most important needs of the family are those identified by the family, not the professional. In contrast to more traditional intervention practices, which promote dependencies of family members on the professional help-givers, the family empowerment model embodies a strengths based approach and seeks to activate intrinsic competencies assumed to exist in all families

(Turnbull et al., 2000). The model also supports families in utilizing formal and natural resources that exist for families and help to support and sustain identified goals and capabilities. With the push for early intervention programs to create and sustain family focused services and with existing models in infant mental health that focus on the family-child relationship, this model blends with early intervention practices.

Three important questions that address outcomes related to a family's perceptions of early intervention are important to consider within the context of the SEAM assessment and in the larger scope of service delivery for children and families. Those questions focus on the impact of early intervention services. Questions include: 1) Did the early intervention services enable the family to help their child grow, learn, and develop?, 2) Did the early intervention services enhance the family's perceived ability to work with professionals and advocate for services?, 3) Were families assisted in building a strong support system?, 4) Did families have an enhanced optimistic view of the future?, and 5) Was family's perceived quality of life enhanced? (Krauss, 2000). These questions are important to consider with the context of the SEAM because often the SEAM is a part of a larger early intervention program or set of services in place for the child. For the purposes of this study, it is critical for both the researcher and the early childhood professionals involved in the assessment process to recognize and reaffirm the critical role that the family plays in each area and embody in both language and practice the important concepts embedded in this model.

Parental Understanding of Social Emotional Development

There is no underlying belief or conclusion, that due to the fact that parents have a low socioeconomic status or multiple life stressors, their knowledge of raising children and understanding of strategies to support social emotional development are lacking. A seminal belief undergirding this study and larger research conducted on positive child outcomes asserts that parents have the motivation and opportunity, through a continuing, intense, emotional relationship and through their influence on the child's environment, to shape child development (Melmed, 1998). Therefore, by changing parents' knowledge and attitudes, building their self-confidence, and guiding their child-rearing behaviors, there can be substantial changes in the parent-child relationship. The task of successful parenting can appear daunting and overwhelming when thinking about families with infants and toddlers who are confronting multiple risks to their child's healthy development (Melmed, 1998).

In an effort to develop greater insight and understanding into the knowledge base and attitudes of parenting in the early years, Zero to Three conducted a national research study. This study examined parental knowledge base related to child development and confirmed that parents today face daunting challenges and pressures and often lack the support and resources needed (Melmed, 1998). Some of the relevant findings included that only 38% felt totally sure that they can tell whether their children's emotional development is healthy and appropriate for their age. One of four parents thought infants are born with set levels of intelligence that cannot be increased or decreased by how parents interact with them (Melmed, 1998). Looking specifically at the group of low

socioeconomic status families, 30% reported having done less advanced preparation in preparing for their role and many felt that they lacked the emotional supported needed in their role (Melmed, 1998). The lack of both knowledge and ways of being with young children provides a strong argument for both prevention-based efforts increasing parental knowledge and exposure of child development and fostering parent-child relationships. Parent completed social emotional screening and assessment, when done in conjunction with a trained, intuitive staff person can result in both- proper identification of potential social emotional concerns and interventions to ameliorate these issues, and a greater awareness of social emotional development and the contributions of the parent and the parenting towards the child's overall development.

Professional Development in Early Childhood Settings

As staff prepare to take on the role of providing social emotional supports and creating classroom based activities to promote positive mental health, it is critical to explore the areas within which staff will be taking part and the content that is critical for staff to be aware of. For the young children who exhibit early social and emotional concerns, it is critical that staff be aware of the issues that exist for the child and family, and have a connection with a variety of community professionals in order to provide effective comprehensive services. A major report by the National Research Council and the Institute of Medicine, *From Neurons to Neighborhoods* (2000), concluded that “...given the substantial short- and long-term risks that accompany early mental health impairments, the incapacity of many early childhood programs to address these concerns and the severe shortage of early childhood professionals with mental health expertise are

urgent problems” (Kenny, Oliver & Poppe, 2002, p.5). The report which was compiled by experts and early childhood development scientists, recommended that investments be made to expand professional child care training opportunities and to provide incentives for expert individuals to work in settings with young children for more effective screening, treatment and prevention of serious childhood mental health problems (Shonkoff & Phillips, 2000).

Effective Partnerships

Donahue, Falk and Gersony Provet (2000) discuss the importance of effective partnerships with mental health professionals and early childhood educators. Their work has shown them that forging a real partnership between mental health professionals and educators allows schools to provide a comprehensive approach to the emotional and cognitive development of the children they serve and lessens the risk of seeking piecemeal solutions in their own areas of expertise (2000). The call for joint understanding and appreciation of the approaches and methods in addressing young children’s social and emotional development is timely, and with effective assessment tools and activity based intervention plans, this system can become an integral part of everyday classroom and home life for young children and those closely involved with them.

The field of infant mental health is still a relatively “young” field, many of the senior practitioners delivering infant mental health services for young children and families are self-trained rather than graduates of any formal programs (Zeanah, Larrieu, & Zeanah, 2000). With this in mind, it is important to consider what individuals new to

this discipline should be aware of in understanding the broad dimensions of infant mental health and specific areas of assessment and intervention.

Promising Principles

The first area that researchers have found to be a critical tenet in both the field of infant mental health and early intervention is the multidisciplinary nature of the work. From its inception, infant mental health has required a multidisciplinary perspective, thus a large portion of the field is “shared” among a variety of clinical disciplines (Zeanah, Larrieu, & Zeanah, 2000). The collaborative nature of work with children and families is increasingly needed, as children with diverse needs or those who are at risk for disabilities must be considered in the assessment and intervention processes. The next area that is important to consider is the developmental orientation, the notion that changes in the first 3 years of life are unparalleled in the life cycle. This orientation has significant implications for training, because it requires a knowledge of development across biological, cognitive, communicative, emotional, and social domains that are critical to the base of knowledge and understanding for infant mental health professionals (Zeanah, Larrieu, & Zeanah, 2000). This fact was confirmed by researchers in early intervention who found that there is a critical shortage of trained personnel to provide infant and preschool services as specified by the Individuals with Disabilities Education Act (IDEA) (Bruder, Lippman, & Bologna, 1994; Meisels, 1989; Meisels, Harbin, Modigliani, & Olson, 1988). Individuals with knowledge specific to assessment and intervention of young children birth to three remains an issue and calls for increase in collaboration and partnering with individuals to provide a continuum of services for young children and

families. Part C, which mandates that personnel employed in serving young children with disabilities have a skill set and knowledge to successfully work with infants, toddlers and families also acknowledges the importance of training these individuals to work collaboratively with a range of professionals to assess infants and families jointly (Bruder, Lippman, & Bologna, 1994).

Within the specific areas of assessment and intervention, there are elements, which can be carried out by a variety of professionals and are fundamental to the work. Developing good interviewing skills and systematic approaches for assessing parent-child interactions is essential in brief (e.g., pediatric well-child exam) or extended (e.g., permanency planning) contexts (Zeanah et al., 2000). Other critical tenets across disciplines are the practices of speaking in the baby's voice and from the baby's perspective (Carter, Osofsky, & Hann, 1991), learning how to talk to and listen to young children (Lieberman, 1993), emphasizing strengths (McDonough, 1995), and using "teachable moments" (Zuckerman, Kaplan-Sanoff, Parker, & Young, 1997). These useful, practical methods are easily transferable among various professions and provide an element of sensitivity and attunement to the needs of the young child and family. At the same time it is important to be aware of specific assessment and intervention methods unique to each discipline that are important for early childhood and mental health staff.

Professionals working with young children and families must be aware of the relevant areas of *prevention and professional-family relationships* (Zeanah, Larrieu, & Zeanah, Jr., 2000, 2005). These general areas outline important goals central to the field of infant mental health. Professionals working within an infant mental health framework

must be aware of various preventive measures and approaches in working with young children. Having an awareness of the rapid rate of development that occurs in the first three years of life and the impact that early experiences have on shaping this trajectory is critical. Preventive measures that create a foundation for healthy social and emotional development are key.

One simple, yet powerful technique is establishing a solid working relationship with the caregiver of the young child (Zeanah, Larrieu, & Zeanah, Jr., 2000, 2005). This has been seen as one of the most powerful preventive intervention tools, as it allows the professional to intervene in more specific areas after the relationship has been established and nurtured. Once a trusting relationship has been created, the early childhood professional may be able to provide guidance on an observation he/she has made regarding the relationship that the child/caregiver shares, or this may open up a conversation on the part of the caregiver to share pertinent information on past issues or current struggles. Techniques such as active, empathic listening, nonjudgmental language, and being willing to meet the caregiver where he/she is at in terms of addressing the range of needs or requests on behalf of the caregiver are critical

Within the professional-family relationship, it is important to realize the relationship established between family and professional serves as a “model” for parents in terms of how other relationships in their life should look and function. Important elements such as boundary setting and awareness of transference and countertransference issues (Zeanah, Larrieu, & Zeanah, Jr., 2000, 2005) that arise must be explored by the professional and discussed with the parent. Working with parents and young children

often generates strong feelings in the professional and also in the parent, based on the individual's own experiences, beliefs, attitudes, knowledge level, and work-related expectations and goals (Zeanah et al., 2000, 2005). Acknowledging powerful feelings and having processes in place to discuss them promote staff growth and allow the early childhood professional to support and nurture both the relationship between the parent and professional and the parent and child.

Reflective Supervision

Helping staff deal with challenging feelings that may impact their ability to be emotionally present with families is one of the goals of utilizing a reflective supervision model in early childhood programs. Traditional supervision models employ a power hierarchy between supervisor and front line staff and often do not uncover real, underlying issues that exist within the daily work between staff and families. This model does not meet the needs of early childhood professionals engaged in providing mental health and social emotional support for young children and families. Reflective supervision (Fenichel, 1992; Norman-Murch, 1996) offers staff a safe environment and a relationship in which they can learn to meet the emotional and intellectual demands of infant/family work. Such a relationship involves three key elements: reflection, collaboration and regularity. Reflection requires all staff to slow down, step away from the daily intensities of work with children and families and consider successes and areas for improvement in their interactions with young children and their families. Having an opportunity to step away from a difficult situation, process what it meant, and explore communication patterns, body language, and internal thoughts and beliefs in the

interaction is extremely important. In the context of reflective supervision, collaboration means that the front-line worker and the individual providing supervision share responsibility for figuring out together how the worker can increase his or her ability to support families effectively and facilitate change amidst possible difficulties and constant change. In the context of a collaborative relationship, power is mutually held. Not only does the supervisor see himself or herself as someone who is able to serve as a guide to the supervisee, but the supervisor expects and openly seeks out the knowledge and skill that the supervisee brings to the supervisory relationship (Fenichel, 1992; Norman-Murch, 1996).

Finally, reflective supervision requires regularity -- a commitment by program management and front line staff to a regularly scheduled opportunity to thoughtfully discuss their work with children and families (Mann, 1998). Although administrators may argue that budget constraints or program mandates do not permit them to reduce the time that staff have available to provide direct services to families. Higher staff productivity and a level of service delivery marked by quality, passion and a commitment to serving children and families are just a few of the benefits from reflective supervision.

Early Head Start

This study will be conducted in two Early Head Start sites. It is important to understand not only the individual "culture" of each Early Head Start program but also the conceptual and historical underpinnings of Early Head Start. Early Head Start was developed in 1994 with the reauthorization of Head Start and the demand from the field for the creation of a program to address the needs of infants, toddlers and their families

and pregnant women. For those families experiencing poverty or who are considered to be the “working poor,” it is essential that a program exists with little or no cost that will provide comprehensive, developmentally appropriate educational experiences for young children and their families. In addition, Congress was responding to the strong evidence indicating that early intervention through high quality, responsive programs enhances children’s physical, social, emotional, and cognitive development; enables parents to be better caregivers and teachers for their children; and helps parents meet their own goals, including economic independence (Jerald, 2000). Services provided by EHS programs are designed to reinforce and respond to the unique strengths and needs of each child and family. These services include:

- Quality early education both in and out of the home;
- Home visits, especially for families with newborns and other infants;
- Parent education, including parent-child activities;
- Comprehensive health and mental health services, including services to women before, during, and after pregnancy;
- Nutrition;
- Ongoing support for parents through case management and peer support groups.

Early Head Start has gone through a period of rapid expansion. In 1995, there were 68 EHS programs. Currently there are more than 600 programs serving nearly 45,000 children (Jerald, 2000). This number only serves a quarter of all eligible families, creating a much greater demand for which there is no supply. Early Head Start seeks to meet the individualized needs of families by providing a range of program options for

families to enroll. Families with young babies often feel most comfortable receiving services in the home and gaining the socialization and developmentally appropriate experiences where they feel safe and comfortable. The home-based option meets this need for many families. For other families, especially those who work, the opportunity for their young child to experience a holistic early childhood program in a center is of great benefit. The Early Head Start Research and Evaluation project (Raikes, Kisker, Paulsell, and Love, 2000) which was launched in 1995, indicated the benefits of Early Head Start in providing high quality, responsive early childhood education to fill a gap in the need for programs for children under the age of 3. The research confirmed that many parents felt that their childcare needs were inadequately met in their community and that there was a great need for Early Head Start. Within the context of Early Head Start, the developmental assessment of infants and toddlers is a continuous process throughout the entire length of the child's enrollment in the program (Technical Assistance Paper, Zero to Three, 2002).

Early Head Start and Infant Mental Health: A Unique Relationship

As mental health practices and beliefs infuse themselves into the Early Head Start framework and model, the benefits experienced for children, families and staff are immeasurable. Statistically speaking, Early Head Start makes 10% of enrollment available for children with disabilities, and this includes children with early mental health issues (if this is identified prior to enrollment). In addition, Early Head Start programs are mandated by the Federal Program Performance Standards to conduct screenings and assessments and refer families to Part C providers, when necessary. Federal Program

Performance Standards also require that programs obtain direct guidance from a mental health or child development professional on how to properly assess the findings from the screening and assessment measures given to young children in order to address the identified needs (Head Start Performance Standards, [45 CFR 1304.20(b) (2)]). Early Head Start programs often work with various agencies in the community, creating a system of care for the child and addressing the multifaceted needs that may exist for the child and the family. These embedded practices create a natural place and purpose for the connection between Early Head Start and young children's mental health (Zero to Three Policy Center, 2005). In her work with Early Head Start programs, Weatherston, (2007) a researcher and advocate for early childhood mental health, found that shared concerns for the optimal social and emotional development of very young children within family relationships and supportive environments suggest infant mental health and Early Head Start a good fit.

Early Head Start focuses on infancy and early parenthood, coupled with attention to, and commitment to, family needs for concrete resources and emotional support. These concerns provide a natural partnership in providing mental health services for young children and their families. The primary concern when thinking about infusing mental health into early childhood programs is often the issue of staff knowledge and experience. Building capacity within EHS programs to provide training and support for staff in understanding and adopting the importance of promoting early social emotional competence is a critical element for success. The issue of mental health consultation will be discussed in greater detail in a later section; however, much of the work in providing

these services takes place within the program from existing staff. Weatherston (2007) asserts that “the adoption of principles and practices promoting infant mental health required most professionals in EHS programs to make significant paradigm shifts: from working with an individual infant or parent in the clinic or center to working within a relationship context with a parent and child together, often in the home; from talking and telling to observing, listening, and reflecting; from doing for to being with; from observing risks to observing strengths (or the reverse) (Weatherston, 2007, p. 248). Many programs have been successful in this partnership and the collaboration, providing substantial benefits for all involved. This is important to consider, because social emotional assessment is an integral part of this framework.

The SEAM assessment, discussed above, allows program staff, without formal mental health training, such as those working in EHS, to be able to have a part in determining early risk behaviors or social emotional concerns. These staff can then create a system of care that identifies and creates interventions to support children and their parents in healthy, optimal growth. While there remains work to be done, the importance of thinking about young children’s social emotional lives and potential interventions is an important place to start. Understanding the screening and assessment process as a part of a whole system of care provided for young children and families is an important shift from fragmented services addressing one area of development or skill, to an integrative, holistic approach embedded in the contexts of the child, family and larger environments.

Pulling the Pieces Together

The constructs discussed above, while diverse and broad in topic, are all related in relevance. The topic of social and emotional development is complex and in many ways encompasses a series of ideas, theories and relevant perspectives that build the case for healthy growth and development in young children and their families. These constructs create the foundation for the social emotional assessment measure (SEAM), which will be examined in this paper. Many of the items on the SEAM address the underlying principles described in the theoretical models and perspectives from this chapter.

Understanding the inner workings of relationships and the elements which are in need of intervention services within the context of child (i.e. behaviors) and the parent-child relationship have provided the impetus for the development of the SEAM. Defining social emotional wellbeing can be challenging due to the broad scope of theoretical and practice oriented interventions. Focusing on attachment and how well the young child and parent connect, bond and relate with one another are critical. Emotional regulation or how the child organizes and responds to the internal and external stimuli around them is another key component. The notion of temperament and how a child's personality and character relate to development is also of great importance. These elements exist within the child and are impacted upon and impact the parent-child relationship. Because early childhood professionals play a key role in the lives of young children's everyday experiences, it is important to understand the necessary skill set and knowledge base that allows them to adequately support and enhance young children's social and emotional development. From the inner characteristics within each young child, to the broad

constructs of knowledge within staff and early childhood programs, each element plays a role in the reciprocal and dynamic exchanges inherent in relationships and in the social emotional wellbeing of young children.

In the next chapter, methodology for this study will be described. Examining the mode by which this study was carried out and how data were collected and analyzed is of critical importance.

CHAPTER III

METHOD OF STUDY

Introduction

Study participants, procedures for recruitment, protection of human subjects, and selected measurements instruments are described. Data collection tools, methods of data collection, and data analysis are also presented. Data from a diverse sample of low-income parent-toddler dyads was gathered to assist in establishing utility and usability of the SEAM, a caregiver completed assessment tool. This study also evaluated the relationship between the SEAM and the ASQ:SE, identifying relationships between total scores from the two instruments. No previous studies examining the utility of the SEAM and the relationship between the SEAM and the ASQ:SE have been completed.

This study focused on the parent report of social and emotional development of young children ages 18 to 36 months, using a sample of low-income families from diverse racial and ethnic backgrounds. Some of the concepts and ideas utilized in qualitative research are “borrowed” and incorporated into this study to serve the purposes of understanding the open ended questions on the Parent Utility Survey. The purpose of this study falls within the guidelines of applied research, which is a commonly used method for studying human behavior and development. Applied research is defined as scientific study and research that seeks to solve practical problems that occur within the modern world (Patton, 2002). Applied research has also been defined as research that

seeks to improve the human condition (Patton, 2002). Before discussing the methods used in this study, it is important to consider the purpose statement, research questions and associated issues.

Research Questions

- 1) How do children from low-income environments score on the SEAM?
- 2) What is the relationship of the content of the SEAM, an assessment tool, to the ASQ:SE (18, 24, 30 and 36 month intervals), a screening tool?
 - a. What are the correlations between total scores on the 18, 24, 30 and 36 month ASQ:SE and the Toddler SEAM?
- 3) How consistently do items on the SEAM measures children's general social emotional development?
- 4) How useful and understandable do parents and program staff find the SEAM?
- 5) What improvements can be made to the SEAM based on parent feedback?

Overall this study explored the domains of social and emotional development in low-income toddler/parent dyads using a descriptive method of inquiry. Toddler dimensions of social emotional competence were identified through the ASQ:SE, a social emotional screening tool. Scores from both measures were compared to determine their relationship and to specify whether the "picture" of the child's social emotional development learned from the ASQ:SE, a reliable, valid instrument, is similar to the SEAM. In order to determine the efficacy of this new social emotional assessment measure, utility data were gathered and analyzed. This study examined the utility of the SEAM with low-income families, through a utility survey, with questions eliciting parent feedback.

Participants

Fifty parents of toddlers between the ages of 18 and 36 months completed the SEAM, ASQ:SE, Family Information Form and Utility Survey. Forty-six parents attended Early Head Start programs and 4 were Early Head Start eligible, however not enrolled at the time of the study. Information provided by all 50 families who participated in the study was used. A \$10 gift card to Target or Walmart was offered and accepted by all parents as an incentive for participation. Compensation was given after all of the necessary documents were completed. Efforts were intentionally made to recruit a diverse sample of low-income parents and young children from a variety of Early Head Start programs. Participants were recruited from two Early Head Start settings in upstate NY and one Early Head Start program in New York City.

Program Descriptions

Program 1. The Mohawk Valley Community Action Agency (MVCAA) Early Head Start program serves 100 children and pregnant women through center based classrooms and home visits. It is one of the many programs within the umbrella of the Community Action Partnership (CAP) agency whose mission is “helping people, changing lives, ending poverty” (Communitywide Strategic Needs Assessment Update, 2007-2008, p.1). Head Start targets the most disadvantaged children and families who live at or below the poverty line. Within the Mohawk Valley, where the EHS program resides, 1 in 5 children lives in a poor family. Refugee and immigration resettlement has played an integral role in the social and economic development within the area. The largest immigrant groups in the area are from Burma, Russia, Sudan, Ukraine,

Azerbaijan, Mauritania, Somalia and Iran (See www.otda.state.ny.us/main/bria/arrivaldata.htm. 2007).

Seventeen percent of Early Head Start families identified themselves as not speaking English as their primary language at home (Mohawk Valley Community Action Agency, Communitywide Strategy Planning Needs Assessment Update, 2007). This presents a challenge within service delivery because programs often do not have staff available to communicate with families whose languages or dialects are unique. The Child Development Director said that they often utilize parents who speak the various languages, first as volunteers. After they have received education and training, the program hires them as assistant teachers or home visitors. This helps to fill the gaps and ensures culturally responsive services for all children and families. Lack of education is another substantial impediment within the EHS program in that 80% of EHS families have a high school education or less. After a round table discussion where families were asked to identify the top five issues impacting their lives, they concluded that mental health, child abuse/domestic violence, lack of money, crime and the media were the most pervasive (Mohawk Valley Community Action Agency, Inc. Child Development Division, Head Start & Early Head Start Program, 2007-2008). This unfortunate list of issues indicates with great certainty the need for this research study and the creation and implementation of the SEAM.

Program 2. The Madison County Community Action Program (CAP) Early Head Start program provides home based Early Head Start services for pregnant women and parenting families with children birth to age three. Weekly home visits as well as center

based socializations for families with children birth to three years of age are facilitated by home visitors with a wide variety of educational and work experiences. This home based EHS program is braided together with another program called Starting Together, which also provides home based services for pregnant women and children birth to age 5. Last year's Program Information Report (PIR) indicated that 64 children and 10 pre-natal women were served through the EHS program. The majority of families within the EHS programs speak English (Starting Together/Early Head Start Community Assessment, May 2007). Reliable transportation is a necessity within the rural, isolated communities where public transportation is sparse and not accessible in many locations. This remains a substantial issue for many families in the program. Other challenges indicated by staff and families are parental mental health issues and oral health in children (Starting Together/Early Head Start Community Assessment, May 2007).

Program 3. The Visiting Nurse Service Early Head Start Early Steps Family Center is located in densely populated, yet isolated urban neighborhood in New York City. At the inception of the program, the community was faced with one of the highest infant mortality rates in the country (Program Information Report, 2008). Services for pregnant and parenting teens are scarce and extreme poverty is rampant in this community. The program began as a nurse home visiting program for pregnant women and developed into its current program structure providing both center and home based educational services for pregnant and parenting teens and their young children ages birth to 3. Families in the program continue to face severe poverty and isolation due to lack of

adequate public transportation, racism from a highly segregated community and lack of consistent, substantial employment in close vicinity.

Areas of Programmatic Concern

Some of the issues faced by the two Early Head Start programs located in urban settings include community violence, social isolation, lack of transportation and access to needed services. All three of the Early Head Start programs shared the common theme of a lack of high quality mental health services for both parents and children. Each of the directors described the overwhelming life situations faced by patterns of unhealthy relationships, cycles of negative parenting patterns and a disconnect in understanding that ones' choices and behaviors directly impact the children and other family members present in the home. According to the director of the EHS program in Madison County, the parents have significant mental health issues, preventing them from being fully present and attentive to the needs of their young children, unable to read their cues and adequately respond (personal conversation, Feb 5th, 2008). The parents in this program receive home-based services weekly with planned activities that are twofold in purpose. The comprehensive home-based services address the developmental milestones for the young children and encourage growth and exploration through planned developmentally appropriate activities. The visits also consist of attending to the parents' needs and issues that may surface, providing a "container" for the emotions of the parent, allowing the parent to be present with his/her child and participate in the shared experience of learning. The Early Head Start program director elaborated on this idea, saying that it is critical that the home visitors attend to the parent because if they can't reach the parent,

then they aren't going to be able to provide any services for the child (personal conversation, Feb 5th, 2008). This balance between meeting the needs of the parent, while also engaging the child in a time of play and learning, is a critical juncture that home visitors must negotiate daily.

Parent/Program Recruitment

Early Head Start program directors responded enthusiastically at the opportunity for parents to participate in this study and were eager to see the benefits that would come through the parents' gaining a greater awareness of their child's social emotional development and the child, if needed, getting the necessary support. Each of the programs indicated individuals (mental health consultant, psychologist, behavioral specialist) who are available on a limited basis to support staff in developing strategies for promoting positive parent and child mental health. These necessary supports provide essential services for families and staff who are overwhelmed and often at a loss of what to do with a child exhibiting challenging behaviors or social emotional concerns. Even with these supports, each program indicated a needed for more information, guidance, and strategies for supporting parent-child relationships, challenging behaviors in children, and social emotional activities or lessons that staff can embed in the classroom and home (personal conversation, April 12th, 2008, & May 4th, 2008). What is learned from the data collection in the SEAM will aid in determining the most efficient way to provide necessary follow up services for the young children and families who may warrant intervention.

Early Head Start directors recruited parents whom they believe would be willing and able to participate in this study. Monetary incentives were given in the amount of \$10.00 gift card for parents' time and participation. Other gains include an increased knowledge regarding young child's social emotional development. In addition, the parents were recognized as their child's first teacher and therefore an important contributor to developing effective measurement tools regarding child development. All participants who were a part of the SEAM research were asked to sign a consent form to participate in the assessment. (See Appendix B.)

Protection of Human Subjects

Procedures were undertaken to protect the privacy and anonymity of the families who participated in the study. Initial approval from the UO Office of the Protection of Human Subjects was obtained for the larger research effort of which this study is a part of. For the purposes of this project, an addendum was completed to reflect the locations of research, which differ from the ones approved by Human Subjects. The researcher informed participants and program directors about their participation in a dissertation study. Goals of the study, which included collecting information about children's social emotional development and eliciting parent feedback and recommendations on improving the SEAM were also explained. Study participants were informed that the research study may be published in some form in the future. The second area that participants were made aware of was the burden of time that was needed for their participation in this research study. Participants were informed of the approximate time commitment for participating in the study and completing the various tools.

The third level, one of great importance, was informed consent. In this study, highly personal and sensitive information regarding parents' relationships with their children was collected and analyzed for the purposes of determining ways to improve the assessment and intervention of early social emotional concerns in young children.

Participants signed an informed consent and were given a copy for their records. Program directors were also told about informed consent so that they are aware of the protections in place for the parents and children participating. The letter of consent emphasized that all information collected in the study would remain confidential. The name, mailing address, and email address of a representative of the University of Oregon was provided. In addition, program directors at each of the Early Head Start programs were given the name, phone number and email address of the researcher. Prior to the time that the participants completed the study, all measures were labeled with a 4-digit participant identification number, which was the only way to identify the family.

Measures

Four measures were used with participants in this study: the Family Information Form, the *Ages and Stages: Social Emotional (ASQ:SE)*, 18, 24, 30 and 36 month intervals, the *Social Emotional Assessment Measure (SEAM)*, Toddler Interval, and the Utility Questionnaire. Each measure is described below and can also be found in Appendix A.

Family Information Form

Each participant completed the Family Information Form developed for this study. The form requests information about the child's gender, date of birth, ethnic group,

and whether they have a disability or are receiving special services. The form also requests information regarding parent/caregiver date of birth, family income level, and parent education level.

Ages and Stages Questionnaire: Social Emotional (ASQ:SE)

The Ages and Stages Questionnaires: Social Emotional (ASQ:SE) (Squires et al., 2002) is an easy-to-use screening tool with an exclusive focus on children's social and emotional behaviors. It consists of a series of questionnaires completed by parent or caregiver regarding the social emotional development of infants, toddlers and preschool age children. This study investigates the 18, 24, 30 and 36-month intervals. The questionnaire has questions addressing 1) Self Regulation, 2) Compliance, 3) Communication, 4) Adaptive functioning, 5) Autonomy, 6) Affect, 7) Interaction with people (parents, other adults, peers), and 8) General concerns and comments. Copies of the 18, 24, 30 and 36-month ASQ:SE intervals are included in Appendix A.

Parents completed the age appropriate interval: 18, 24, 30, or 36 months. Each question was answered by checking a box with one of three choices: most of the time, sometimes, rarely or never. Parent/Caregiver also indicated whether the behavior in question was a concern by checking a yes or no in the column "Is this a concern?". The answers to the questions were awarded numeric values: 0 points when a positive social/emotional behavior occurs most of the time, and a problem behavior rarely or never occurs; 5 points when a positive social/emotional behavior occurs some of the time; and 10 points if the problem behavior occurs most of the time, and the positive social/emotional behavior rarely or never occurs. Five points are added to the total score

each time a parent indicates a yes in the “Is this a concern?” column. At the end of the ASQ:SE there are 4 open ended questions where parents can describe any concerns that they have regarding their child’s eating, sleeping, toileting, and any worries they have about their child. There is also a question about what they enjoy most about their child. Answers to these questions do not contribute to the overall score of the questionnaire, but rather provide insight for both the parent and service provider regarding dynamics of the parent-child relationship and provide further examples of how to develop interventions and goals, when needed.

The ASQ:SE is part of a well-researched system that uses parent report to screen the development of infants and young children. The ASQ:SE was developed and continues to be studied in an effort to address the need for age-appropriate tools to monitor very young children’s behavior and address parental concerns. In addition, the ASQ: SE provides an inexpensive, culturally versatile tool for states to participate in child-find activities for children at-risk for social-emotional and behavioral delays (Squires et al., 2002).

Social Emotional Assessment Measure (SEAM)

The SEAM is a social/emotional assessment and evaluation measure developed for use with young children birth to five and their parents or caregivers. It was designed to assist programs working with young children in prevention and early identification of social and emotional difficulties and behavioral disorders. The response choices for the SEAM are the same as the ASQ:SE, creating a seamless system that is easy and familiar for parents and early childhood professionals and the questions expand on ASQ:SE

concepts. Each question on the toddler SEAM interval was answered by checking a box with one of three choices: most of the time, sometimes, rarely or never. Parent/Caregivers also indicated whether the behavior in question was a concern by checking a yes or no in the column "Is this a concern?". The answers to the questions were awarded numeric value. Differing from the ASQ:SE in this regard, points are added to the total score each time a parent indicates a yes in the "Is this a concern?" column.

The content for the SEAM items was derived from a series of child and caregiver/adult benchmarks. The benchmarks include: 1) Healthy Interactions, 2) Emotional Expression, 3) Social Emotional Regulation, 4) Empathy, 5) Joint Attention and Engagement, 6) Independence, 7) Positive Self-Image, 8) Attention and Activity Regulation, 9) Cooperation, and 10) Adaptive Skills. These benchmarks represent critical areas for social emotional competence in young children and their caregivers (Squires & Bricker, 2007).

Specific criteria have guided the formulation of the assessment items on the SEAM. Each item must fall within the following guidelines: must be functional, meaningful, observable and measurable, and easily embedded into daily activities, written in jargon-free language, and could serve as an intervention goal (Squires & Bricker, 2007). These criteria resulted in the elimination of many items that are common in diagnostic measures, which target negative responses as intervention goals, rather than the reciprocal positive response provided as the intervention target (Squires & Bricker, 2007). This feature provides a unique and important dimension within the arena of assessment measures and provides teachers, parents and other early childhood

professionals with an opportunity to observe and teach positive pro-social behaviors rather than to target negative behaviors. For example, a common item seen in many social emotional assessments is *child clings to adult*. On the SEAM this item was changed to *child explores new environment, while maintaining some contact* (e.g., Toddler SEAM 6.1) (Squires & Bricker, 2007). The positive nature of the wording allows parents and staff to determine the response to the question based on observing the child engaging in an everyday activity that is beneficial to their growth and development.

Upon completion of the SEAM, high quality goals can be developed and embedded into the child's daily activities. This process assists in monitoring progress because teachers, home visitors and parents will be able to clearly understand the areas for future growth and development and observe and keep track of the progress that the child is making in the everyday life situations that play out. Without the use of this particular tool, selected or developed goals may not be of high quality (i.e., functional, meaningful, measurable, and addressable during daily activities), and the accompanying intervention efforts may not be relevant or effective in enhancing the child's social emotional competence (Squires & Bricker, 2007). The SEAM is also used as a progress monitoring and evaluation tool. This process requires professionals who are using the SEAM to gather comparative data at selected intervals (e.g., weekly, quarterly, annually) in order to make judgments about the effectiveness of the SEAM and the entire ABI:SE Approach. This entire process will assist children and their caregivers to achieve targeted social emotional outcomes and provide a way to measure and monitor program outcomes (Squires & Bricker, 2007). Particular social emotional behaviors that are of concern may

emerge at various times throughout the child's development and it is critical to have a system to track and measure progress and emerging goals.

Scoring of ASQ:SE and SEAM

For the purposes of this study, the ASQ:SE 18, 24, 30 and 36 month intervals were scored using a 0,1,2 scale instead of the 0, 5, 10 scale that they were written for. This decision was made in order to allow for both the ASQ:SE and the SEAM to be scored using the same scale. In addition, the ASQ:SE was reverse coded in order to match the scoring method of the SEAM, where a higher score indicates social emotional competence. The ASQ:SE is scored in the opposite manner, whereas a higher score indicates that there are areas of social emotional concern. Each of the ASQ:SE intervals (18, 24, 30 and 36 month) has a cutoff which has been established based on responses to the instruments from a large, diverse sample. A child whose ASQ:SE score is above the cutoff for their age range should be referred for additional evaluations (i.e., SEAM) and perhaps intervention. A child whose ASQ:SE score falls below the cutoff for their age range is considered to be within the range of typical social emotional development. Cutoff scores for the 18, 24, 30 and 36-month intervals are 50, 50, 57 and 59 respectively. The SEAM does not have cutoff scores as it is to be used as a curriculum based measure by which measurable, observable social emotional goals can be embedded into children's everyday life experiences.

Utility Questionnaire

The Utility Questionnaire was developed for the purpose of this study. Since this study is interested in understanding the utility of the SEAM, the Utility Questionnaire

was given to participants after they completed the SEAM and participants were informed that the questions on the Utility Questionnaire were to be answered regarding the SEAM. The utility of the instrument was evaluated by asking parents questions regarding the usefulness of the SEAM, how clear and understandable the SEAM items were and whether or not parents learned anything about their child's social emotional development from completing the SEAM. Length of time it took them to complete the SEAM as well as whether or not they felt that this instrument would be helpful to other parents/caregivers was also asked. SEAM content areas are summarized in Table 1.

Table 1. Content Inventory of the SEAM and ASQ:SE Instruments

Instrument	Content Area
ASQ:SE	Self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.
SEAM	Healthy interactions, emotional expression, social emotional regulation, empathy, joint attention and engagement, independence, positive self-image, attention and activity regulation, cooperation, adaptive skills

Theoretical and Ethical Grounding

This study utilized nonexperimental research methods with both descriptive and correlational designs. Descriptive research is a type of quantitative research that involves making careful descriptions of educational phenomena and a particular sample of individuals, determining “what is” within a specific group or population (Gall, Gall, & Borg, 2003). In the case of this study, I describe the characteristics of the sample at one

point in time, identifying characteristics of social emotional behaviors and parent feedback regarding social emotional development and the use of the SEAM.

Correlational research refers to studies in which the purpose is to discover relationships between variables through the use of correlational statistics (Gall, Gall, & Borg, 2003). The quality of correlational studies is determined not by the complexity of the design or the sophistication of analysis, but by the depth of the rationale and theoretical constructs that guide the research design (Gall, Gall, & Borg, 2003). If this study can determine a relationship between variables, for example in the area of externalizing behaviors, it will help to understand whether the two measures, the ASQ:SE and the SEAM truly function as a linked system. If there is a concern area in a particular domain within the ASQ:SE and it is confirmed that this same area of concern is indicated on the SEAM, this information can help early childhood professionals and parents understand and target specific area(s) for intervention and also will provide a clear picture as to whether their instruments function in compatibility with one another, informing the researcher as to whether with information from the screening measure and the assessment measure relate.

Procedures

The procedures section describes the participant recruitment strategies, settings where data were collected, and the data collection process. This study fulfills the doctoral requirements for my dissertation. This study is also part of a larger research effort within the Early Intervention Program at the University of Oregon. Year one of this research initiative included collecting data on the SEAM to assist in establishing validity,

reliability, usability and utility of the infant, toddler and preschool level SEAM instruments for typical children and those with disabilities. Data are being collected at locations in Oregon, Pennsylvania and New York. The diverse sample of individuals represented within this study is value added for the larger data set with respect to characteristics of parent race/ethnicity, social class and education levels.

Recruitment

A total of 60 participants from three Early Head Start programs were recruited for this study. Early Head Start teachers and home visitors who usually have existing relationships with the parents recruited the participants. Due to challenging life circumstances and other situations that arose as the study progressed, 10 families were unable to participate, resulting in a total of 50 families who remained part of the study. Participation was voluntary and in no way contingent upon their participation in the Early Head Start program. The researcher contacted various Early Head Start programs around central New York and New York City areas and was interested in reaching a diverse sample of participants representing a variety of ethnicities and education levels. Program staff reached out to parents whose children were between 18-36 months and provided a flyer outlining the research, which was prepared for the purposes of this study. Program staff followed up with phone calls to interested parents and arranged for a meeting either at the home or the center.

Data Collection

The purpose of gathering quantitative data from the ASQ:SE and Toddler SEAM tools was twofold. This study provided important data needed to determine the utility

and usability of the SEAM, a new social emotional assessment measure. Before an instrument can be disseminated to agencies and programs, researchers must be certain that it is written using language that is parent friendly and relevant across a variety of cultural and socioeconomic groups. Additionally, this study provided necessary information in understanding whether the SEAM adequately measured social emotional development, the underlying construct for which this assessment was created. The second area of examination within this study examined the relationship between the ASQ:SE, a screening tool, and the SEAM, an assessment measure.

All of the data were collected during one meeting with the family either at their home or the Early Head Start center. Prior to administering the instruments, the researcher introduced herself and shared about the purpose of the research. The researcher paid particular attention to the use of parent friendly language in describing what research is all about and how parent participation is crucial. Discussing and describing social emotional development and how to accurately assess this in young children is a complex and multifaceted area. The researcher used words like, “looking at the relationship that your child has with you and those around him/her” when describing how social emotional development manifests itself in children.

The researcher followed a script (See Appendix A) during the data collection process to ensure uniformity in instruction and presentation of instruments across subjects and programs. The researcher explained that this study entailed testing a new questionnaire to ensure that it is written in a way that all parents can understand. The researcher shared with them that they are a really important part of the process, first as

their child's most important teacher and the one who is most knowledgeable about their child's development and second because their input and feedback will assist in creating the best possible questionnaire for all parents. The researcher explained to study participants that honest and candid feedback is valued and that there were no right or wrong answers when completing each item.

Data collection was not limited to a particular setting, but rather was geared at meeting parents at a time and space that was most comfortable for them. The researcher provided Early Head Start (EHS) staff from the three participating programs with a presentation outlining the SEAM, the purpose of this study and what participants and program staff would gain from being a part of the study. It was explained to EHS staff that the information learned from the ASQ:SE and SEAM will provide a picture of the child's social emotional development and the feedback elicited from parents/caregivers will help us to create the most effective tool to benefit children and families nationwide. The program staff arranged for a date and time for the parent and researcher to meet to conduct the study.

Mohawk Valley Community Action Agency

The first program to begin data collection was the Mohawk Valley Community Action Agency. Thirty families total (both center and home based options) participated in the research. Upon contacting several Early Head Start programs in the region, this program responded first with interest to participate in SEAM. This program consisted of both center and home based programs. The majority of participants from this EHS participated in center-based programming. Twenty-five participants from the Mohawk

Valley Community Action Agency completed the measures at the Early Head Start center at a time that was convenient for them. The researcher arrived at the Early Head Start centers (various location sites within the larger agency). Individually, each parent/caregiver met the researcher at the center and after introductions completed all of the measures at the center. All of the families from the center-based program had children in Early Head Start classrooms at the time of the data collection. Many of the parents wanted the researcher to see their children and had great pride in talking about their children's abilities and strengths. In addition to the center-based parents/caregivers, five of the parents/caregivers from the Mohawk Valley Community Action Agency were a part of the home-based program. The researcher met these families individually at the program socialization classroom. This space is used for home-based families to connect with other home-based families and provide parent-child socializations. The researcher met with each parent/caregiver while the home visitor played with the child.

Madison County Community Action Program

The second data collection site was the Madison County Community Action Program. Ten families receiving home-based services participated from this site. This program serves families from several rural towns encompassing a large geographic area. The home visits were spread all over the county, often creating opportunities for just one visit at a time. The home visitor arranged for the SEAM project, as it was called by the EHS agency, to take place during a regularly scheduled home visit. The researcher traveled with the parent/caregiver's home visitor to each of the homes. While the researcher was collecting the data, the home visitor would for the most part engage with

the child using the activities for that day's visit. Conducting the research from the parent/caregiver's home provided a window into the daily life of the family. Parent-child interactions were interesting to observe as well as parent-home visitor relationships.

Visiting Nurse Service Early Head Start

The third data collection site was the Visiting Nurse Service Early Head Start program. Six parents/caregivers participated in the research from the Early Head Start center based program. The families in this program generally come from high poverty, high crime areas where daily life is often challenging. Getting families to follow through with the data collection meeting was challenging and took several months to complete.

EHS Eligible Families

The researcher also recruited an additional four families who were not currently enrolled in an Early Head Start program, but were Early Head Start eligible. These families were brought on at the end of data collection in order to bring the sample size up to 50 families due to the fact that the other EHS sites had less families participate than originally expected. The researcher met these families at their homes where they completed the measures together.

The tests and measures that each participant ($N = 50$) completed are in Table 2. Following completion of the Letter of Consent, the presentation of instruments was the Family Information Form, ASQ:SE (18, 24, 30 and 36 month), SEAM and Utility Survey.

Following completion of the Letter of Consent, the presentation of instruments was the Family Information Form, ASQ:SE (18, 24, 30 and 36-month), SEAM and Utility Survey. If a recent ASQ:SE was not completed, the researcher administered this

measurement with the parent/caregiver. The researcher collected all of the instruments and the researcher scored all instruments.

Data Analysis

The data analysis is described in the following section. The Research Questions for this study are presented below.

Research Questions

- 1) How do children from low-income environments score on the SEAM?
 - 2) What is the relationship of the content of the SEAM, an assessment tool, to the ASQ:SE (18, 24, 30 and 36 month intervals), a screening tool?
 - a. What are the correlations between total scores on the 18, 24, 30 and 36 month ASQ:SE and the Toddler SEAM?
 - 3) How consistently do items on the SEAM measures children's general social emotional development?
 - 4) How useful and understandable do parents and program staff find the SEAM?
 - 5) What improvements can be made in the SEAM, based on parental feedback?
-

Quantitative Data

1. How do children from low-income environments score on the SEAM?

Descriptive statistics (i.e., mean, median, standard deviation) were calculated for both the ASQ:SE and SEAM. Descriptive statistics from the SEAM provided important data indicating whether the scores from this particular sample (i.e., parents with low SES) were different from results from the normative group, which included parents from middle and high SES groups. The researcher did not collect data from these groups, but online SEAM data was collected by other researchers.

2. What is the relationship of the content of the SEAM, an assessment tool. to the ASQ:SE (18, 24, 30 and 36 month intervals), a screening tool?
 - a. What are the correlations between total scores on the 18, 24, 30 and 36 month ASQ:SE and the Toddler SEAM?

Total scores from the SEAM and ASQ:SE 18, 24, 30 and 36 month intervals were analyzed to examine the relationship between instruments. Correlational research refers to studies whose purpose is to discover relationships between variables through the use of correlational statistics (Gall, Gall, & Borg, 2003). This relationship, positive or negative, is expressed in the form of a correlation coefficient, indicating the degree and direction of relationship between two (or more) variables. If the relationship between two variables is perfectly positive, the correlation coefficient will be 1.00. If the relationship is perfectly negative, it will be -1.00 (Gall, Gall, & Borg, 2003). The correlation coefficient tells us how effectively individuals' scores on one measure can be used to predict their scores on another measure. If predictions can be made, this suggests (does not prove), that the variable measured by the predictor instrument has a causal influence on the variable measured by the other instrument (Gall, Gall, & Borg, 2003). Information that results from completion of the SEAM should directly relate to what was learned from the ASQ:SE. These two instruments are part of a linked systems framework and therefore should exhibit a relationship based on the constructs for which they are measuring.

3. How consistently do the items on the SEAM measure social and emotional development?

Estimating reliability is an important step in establishing a psychometric base for a new tool. Reliability refers to the consistency of a measure and is ascertained in a few ways. Examining internal consistency was relevant for this study. Internal consistency

estimates reliability by grouping questions in a questionnaire that measure the same concept. Within this study there are two measures, SEAM and ASQ:SE, both designed to measure children's social emotional development and were created with similar constructs and underlying themes, although one is a curriculum based assessment (SEAM) and the other is a screening instrument (ASQ:SE). One common way of computing correlation values among the questions on these instruments is by using Cronbach's Alpha. Cronbach's alpha splits all the questions on these instruments in a variety of ways and computes correlation values for all of them. One number is generated for Cronbach's alpha - and similar to a correlation coefficient, the closer it is to 1, the higher the reliability estimate of your instrument (Colosi, 1997).

Qualitative Data

4. How useful and understandable do parents and program staff find the SEAM?
5. What improvements can be made in the SEAM, based on parental feedback?

Information collected from the SEAM Parent Utility Survey provided feedback on the usability and ease with which the parents were able to complete the SEAM. Participants had the opportunity to indicate whether particular items on the SEAM were unclear and whether items were appropriate for their child's developmental level and stage. They also were asked to provide information on what improvements can be made to the SEAM. Particular attention was paid to the items that presented confusion either in wording or definition. The invaluable information received from study participants will assist in making the necessary changes in order to create an assessment measure that is

parent friendly and addresses the constructs that are known to be important when assessing social and emotional development in young children.

Trustworthiness

Establishing trustworthiness in research is critical to the overall credibility and value of the research. Lincoln and Guba (1985), two qualitative researchers who have written extensively on trustworthiness, assert that ensuring credibility is one of the most important factors in ensuring trustworthiness. They provide several ways to ensure that this area is addressed within research. For the purposes of this study, the researcher focused on several of their reasons. An area of importance is *establishing an early familiarity with the culture or participants*. Lincoln and Guba (1985) and Erlandson (1993) recommend “prolonged engagement” between the investigator and participants in order for both groups to formulate an adequate understanding of one another and establish trust. The researcher ensured that the relationship building process took place through spending time getting to know parents prior to administering the SEAM and conducting interviews. The researcher had a sound understanding on the “culture” of Early Head Start and while each program was unique, the researcher understood the complexity within the lives of families and staff. Lincoln, Guba (1985) and Erlandson (1993) also caution about getting too enmeshed in the lives of participants. The researcher was well aware of the importance of boundaries and realized that for the purposes of this study, the researcher was not in the role to “fix” the families of staff or provide therapy or counseling to improve the outcome of parent-child relationships.

These important distinctions served the purpose in ensuring that the lines between researcher and practitioner were solid.

The next area that helps to ensure trustworthiness within research is peer scrutiny of the research project (Shenton, 2004). It is of critical importance that colleagues and peers have an opportunity to read through the research and offer feedback throughout the process. The researcher had a supportive and knowledgeable group of colleagues who were available to provide attention to the research and the researcher highly valued their input. The collaborative process of examining content and structure aided in the process of both the dissertation and the revision of the Toddler SEAM.

Personal Influences

As a clinician dedicated to improving the status of young children who are at risk, the researcher chose to study a population of children for whom poverty and associated challenges are a strong underlying factor within their lives. Having had numerous experiences with diverse populations (culturally and socioeconomically), the researcher embodied the practices of empathic understanding, strengths based approach, and a desire to create change and improve the learning and educational outcomes for young children and families who are at risk. The researcher also had an extensive background in Early Head Start, both at the local and federal levels. As a social worker for Early Head Start in an inner city, high poverty area, similar to the sites where research was conducted, the researcher worked directly with parents and infants and toddlers conducting assessments, providing therapy and support for young children and families. As a Head Start fellow, the researcher understood the federal and programmatic mandates to ensure quality

services for young children and families. This knowledge provided a greater understanding of the inner workings of the Early Head Start programs and also the systems that support young children who are at delayed or at risk.

The strengths based perspective in the researcher's work and practice guided her work with young children and families, especially those with multiple needs or risks. Practicing from a strengths perspective means that everything you do as a helper will be based on facilitating the discovery, exploration, and use of clients' strengths and resources in the service of helping them achieve their goals and realize their dreams (Saleebey, 2002). This model prepares me with an approach of meeting the child and family where they were, identifying the elements of their relationship that appeared to be nurturing and supportive. In addition, the researcher utilized the assessment process to teach and guide both the families and the researcher as to what areas needed improvement or further attention.

This chapter provided information outlining the study participants, data collection methods, instruments used and data analysis procedures. The following chapter will describe the results that were found the analysis. These areas are important in understanding the purpose behind this research study and what the outcomes were.

CHAPTER IV

RESULTS

The results of the study are presented in the following sections. First, study participants are described. Following are the results of the analysis completed on the Toddler SEAM and ASQ:SE intervals.

Correlation coefficients, averages, and percentages calculated from total scores of the ASQ:SE and the Toddler SEAM were calculated. Comparative accuracy (i.e., concurrent validity) between the ASQ:SE and Toddler SEAM are presented. Participant's feedback regarding the utility of the Toddler SEAM is summarized.

Participants

A total of 50 parents/caregivers of toddlers between the ages of 18 months and 36 months completed the relevant ASQ:SE interval (i.e., 18, 24, 30 and 36 month) based on their child's age. Forty-nine parents/caregivers completed the Toddler Interval SEAM, Family Information Form and Utility Questionnaire; 50 participants completed the ASQ:SE. (The missing data from one participant were included in the written and tabular descriptions of the Family Information Form, SEAM, and Utility Questionnaire. The researcher included this participant because the ASQ:SE data were value added.)

Ten additional families were recruited for the study and completed consent forms; however they were unable to follow through with the individual meetings with the researcher. Thirty-two participants were from urban areas, 4 were from suburban areas,

and 14 were from rural areas. The information below was comprised largely from the Family Information Form that collected basic demographic information on each parent/caregiver and their family.

A breakdown of study participants is presented in Table 2. During conversations with the five guardians who were primary caregivers of the children, they shared about the current living arrangements with the children. For the children who resided in their care, each one endured some form of abuse or neglect resulting in their current arrangement. Two of the guardians shared that the children would otherwise be residing in foster care if they had not stepped in to intervene. They also expressed that the children's development (in many areas) had been greatly impacted by their early experiences amidst trauma and hardship.

Table 2. Breakdown of Caregivers/Parents ($N = 50$)

Relationship to Child	<u>n</u>	Percent of Sample
Birth Mother	37	74
Birth Father	6	12
Both Parents	2	4
Guardian	5	10
Total	50	100

This sample consisted of children from diverse backgrounds. Mirroring the trends of racial diversity in New York State, racial breakdown for the study children is provided in Table 3. Parents/caregivers were asked to provide their current age. The mean age was

31 years of age. Education level varied from less than high school completion to above 4 years of college. Participant education level is summarized in Table 4.

Table 3. Ethnicity of Children Involved in the Study (N = 50)

Ethnicity of Child	<u>n</u>	Percent of Sample	U.S. Census	N.Y. Census
White	25	50	73.9	66
Hispanic/Latino	11	22	15.1	16.3
African American	10	20	12.4	15.5
Multi-Minority	3	6	2.0	1.7
Other	1	2	--	--
Total	50	100	--	--

Table 4. Parent/Caregiver Education Level (N = 50)

Level of Education	<u>n</u>	Percent of Sample
No high school diploma	15	30
Diploma or GED	19	38
Some College	9	18
Associates Degree	1	2
Bachelors Degree	4	8
Masters Degree	1	2
Missing	1	2
Total	50	100

Therefore it was not possible to calculate the ratio of income to family size. All of the families in the study had their child either enrolled in an Early Head Start or they were eligible for Early Head Start. For the families whose income levels were 30,000 or above, there were a significant number of children in the home or they had a child with a disability, allowing them to be eligible for Early Head Start. It was not possible to

calculate rate of income to family size from data that were collected. A breakdown of family income levels is summarized in Table 5.

Table 5. Parent/Caregiver Income Level (N = 50)

Annual Household Income Level	<u>n</u>	Percent of Sample
None	3	6
5,000-9,999	12	24
10,000-14,999	10	20
15,000-19,999	10	20
20,000-29,999	7	14
30,000-39,999	1	2
40,000-49,999	2	4
50,000-or more	4	8
Missing	1	2
Total	50	100

Parents/caregivers also provided information indicating whether or not their child had a disability. One parent indicated that her child had speech and fine motor delays. One parent indicated that her child had a sensory processing disorder. One caregiver indicated that the two children (twins) in her care were born prematurely and had significant environmental risk factors resulting in failure to thrive and other medical related concerns. She described the intensive medical treatment and therapeutic interventions (i.e., OT, PT, Speech) that the twins were receiving as a result of early compromised experiences. One parent indicated that her child was receiving OT/PT and will receive speech services, but did not have a specific diagnosed disability.

Validity

1.0 How do children from low-income environments score on the SEAM?

2.0 What is the relationship of the content of the SEAM, an assessment tool, to the ASQ:SE (18, 24, 30 and 36 month intervals), a screening tool?

a. What are the correlations between total scores on the 18, 24, 30 and 36 month ASQ:SE and the Toddler SEAM?

Means, standard deviations, and medians were calculated for the ASQ:SE intervals at 18, 24, 30 and 36-months and the Toddler Interval SEAM. Scores for each of the ASQ:SE intervals were computed two ways in provide a thorough picture of the scores and their relationship to Toddler SEAM scores. Each ASQ:SE interval was scored using reverse codes in order to match the scoring of the Toddler SEAM. In addition, a total raw score using the conventional 0, 5, 10 method whereby a higher score indicates concern and cutoff scores are meaningful. Table 6 presents a summary of the means, standard deviations, and medians for the ASQ:SE 18, 24, 30 and 36-month age intervals, and the Toddler Interval SEAM (12-36 months). Table 7 presents a summary of raw score means of the ASQ:SE 18, 24, 30 and 36 month intervals and also presents the number of children whose ASQ:SE scores fell below and above the cutoff level for the respective interval.

Table 6. Means, Standard Deviations, and Medians for the ASQ:SE 18, 24, 30 and 36 Month Intervals and Toddler SEAM (N = 50)

Measure	N	Mean	Standard Deviation	Median
ASQ:SE 18	14	46.42	4.52	47.5
ASQ:SE 24	16	46.82	4.81	49
ASQ:SE 30	13	51.25	3.96	52
ASQ:SE 36	6	56.83	4.31	57
SEAM	49	58.78	10.21	62
Missing	1	---	---	

Table 7. Raw Mean Scores & Cutoff Scores for ASQ:SE 18, 24, 30 and 36 Month Intervals and Toddler SEAM Mean Score (N = 50)

Measure	N	Mean	Cutoff Scores	# Above Cutoff	# Below Cutoff
ASQ:SE 18	14	27	50	3	11
ASQ:SE 24	16	26	50	4	12
ASQ:SE 30	13	32	57	3	10
ASQ:SE 36	6	26	59	1	5
SEAM	49	58.78	--	--	--
Missing	1	---	--	--	--

Convergent validity of the Toddler Interval SEAM and ASQ:SE 18, 24, 30 and 36-month intervals was assessed by computing correlations of the scores obtained on each measure. Scatterplot diagrams were evaluated to ensure there were no significant outliers to influence correlations. Pearson's Product-Moment correlations between the ASQ:SE 18, 24, 30 and 36 month age intervals and the Toddler SEAM were all significant ($p < .05$), ranging between $r = 0.467$ to $r = 0.647$. Data is summarized in Table 8 below.

Table 8. Pearson's Product-Moment Correlations Between Measures Used in the Study

	ASQ:SE 18	ASQ:SE 24	ASQ:SE 30	ASQ:SE 36	SEAM
ASQ:SE 18	-	-	-	-	0.647**
ASQ:SE 24	-	-	-	-	0.467**
ASQ:SE 30	-	-	-	-	0.623**
ASQ:SE 36	-	-	-	-	0.613**
SEAM					-

** $p < 0.05$

Reliability

3.0 How consistently do items on the SEAM measure social and emotional development?

For this study, Cronbach's coefficient alpha was used to measure reliability because items on this measure were not scored dichotomously (Gall, Gall & Borg, 2003). Using data from the study, Cronbach's alpha was .92.

Utility Questionnaire

Data are organized in tabular format and also in narrative form. Parent comments and feedback regarding the SEAM, both in terms of understanding items and additions/changes to items are displayed in narrative form below. Information collected from the Utility Questionnaire corresponds with the following research questions.

4.0 How useful and understandable do parents and program staff find the SEAM?

5.0 What improvements can be made in the SEAM, based on parental feedback?

The utility of the SEAM was evaluated by summarizing the data provided by parents/caregivers on the Utility Questionnaire (Appendix A). Forty-nine parents/caregivers completed the Utility Questionnaire on the SEAM. The length of time it took parents/caregivers to complete the SEAM is summarized in Table 9.

When asked how appropriate the items were for their child, study participants in general felt that the SEAM items were appropriate for the child. These results are summarized in Table 10 below.

Table 9. Length of Time to Complete Toddler SEAM ($N = 50$)

Minutes to Complete	<u>n</u>	Percent of Sample
10	4	8
15	24	48
20	14	28
25	5	10
30	2	4
Missing	1	2
Total	50	100

Table 10. Appropriateness of Toddler SEAM Items ($N = 50$)

Parent Feedback	<u>n</u>	Percent of Sample
Strongly Agree	6	12
Agree	41	82
No Opinion	1	2
Disagree	1	2
Missing	1	2
Total	50	100

Study participants were asked to assess whether the SEAM items were useful in terms of learning more about their child's social emotional development. Most agreed that items were helpful for learning and beneficial in better understanding their child as shown in Table 11.

Study participants were asked to indicate whether the items on the SEAM were unclear or difficult to understand. Forty-four (88%) indicated no, 5 (10%) indicated yes, and 1 (2%) was missing.

Table 11. Usefulness of Toddler SEAM Items (N = 50)

Parent Feedback	<u>n</u>	Percent of Sample
Strongly Agree	11	22
Agree	37	74
No Opinion	1	2
Disagree	0	0
Missing	1	2
Total	50	100

Study participants were asked whether completing the SEAM alerted them to activities or skills that their child could do that they weren't sure about prior to completion of the SEAM. One (2%) indicated that they strongly agreed that the SEAM provided them with new information regarding activities or skills that they had not thought of before. Twenty-three (46%) agreed, 12 (24%) had no opinion; and 13 (26%) disagreed, indicating that everything that the items in the SEAM did not provide any new knowledge for them, but rather that the skills and behaviors represented by the items were things they were already aware of in their child.

Finally, when asked if completing the SEAM brought up any concerns regarding their child's development, 46 participants (92%) indicated no, 3 participants (6%) indicated yes and 1 answer was missing (2%).

Qualitative Feedback from Utility Questionnaire

The Utility Questionnaire allowed parents/caregivers to indicate the strengths and areas of improvement for the Toddler SEAM. The SEAM was created to be a parent/caregiver completed form and in order to effectively assess social and emotional development in young children, parent input is a critical piece.

Feedback from Researcher

Throughout the study, the researcher found that approximately 75% of parents/caregivers struggled with the fact that there wasn't an answer choice of "all of the time" or "always" for both the SEAM and ASQ:SE. The answer choice of "most of the time" was the closest and this was explained to participants. Many felt that this choice wasn't enough when it came to validating their expression of their child's abilities. The researcher also found that it was necessary 100% of the time to explain that this tool is for children 18-36 months and that this developmental range encompasses many milestones and stages and that the range of behaviors and developing competencies is broad due to this large age range. The researcher provided parents with the opportunity to omit items if they felt it wasn't developmentally appropriate. Table 12 below indicates the items that were confusing for parents/caregivers either in wording or in parent/caregiver feeling as though the item was too advanced and therefore inappropriate for their child's age. Some items were confusing only to a few parents, while others posed challenges to larger numbers of parents.

Item Description:

- 1.1-Toddler talks and plays with adults whom she knows well*
- 2.3-Toddler identifies her emotions, with your help*
- 2.4-Toddler identifies his own emotions*
- 4.1-Toddler matches his response to others' emotional responses*
- 6.1-Toddler explores new environments, while maintaining some contact*
- 6.2-Toddler can separate from you in familiar environment with minimal distress*
- 7.3-Toddler tells you what he did or accomplished*
- 8.4-Toddler participates in simple games*
- 10.2-Toddler falls and remains asleep with few problems*
- 10.3-Toddler accepts changes in routine and settings*

Table 12. Problematic Toddler SEAM Items

Item #	Parent Feedback
1.1	Ten parents explained that “talks” should instead say “communicates” for children who communicate in a variety of methods
2.3 & 2.4	Twenty parents/caregivers felt that these items were too advanced for children below 24 months.
4.1	Researcher had to reword item to read “Toddler is tuned to or understands others emotional responses” because ten parents/caregivers found the words “matches his response” to be confusing.
6.1	Twelve parents/caregivers found the wording of “maintaining some contact” to be hard to understand. Researcher reworded item to say, “checking back to make sure you are still there.”
6.2	Eight parents/caregivers found the wording of “minimal distress” to be confusing. Researcher used “without getting upset” to explain.
7.3	Fifteen parents/caregivers explained that their child doesn’t “tell” them but rather “shows” them, so the item should read “Toddler tells or shows you what he did or accomplished” would be easier to understand and identify with.
8.4	Three parents requested that the item include “peekaboo” for one of the item examples of activities that younger children (18 months) enjoy.
10.2	Sixteen parents felt that this item should be split into two separate items. One item that states, “Toddler falls asleep with few problems.” The next item that states, “Toddler remains asleep throughout the night.”
10.3	Ten parents/caregivers felt like the word “accepts” should be changed to “adjusts to” because their child adjusts to changes in routine, but may not accept them.

What Parents/Caregivers Learned from Toddler SEAM

The Utility Questionnaire asked participants a question regarding whether they thought the SEAM would be helpful for other parents who want to learn more about their child's development. One hundred percent of study participants ($N = 49$) indicated yes. Twenty participants (40%) indicated that the SEAM allowed them to see things about their child that they had never thought about before and now realize are important areas of development. They shared that they didn't realize that certain skills or behaviors were important and through the SEAM they were able to understand how those everyday actions that their child was doing or perhaps wasn't exhibiting were important. One parent (2%) indicated that she was more aware of problem-solving skills after completing the SEAM. Five parents (10%) learned that sharing emotions was an important developmental milestone. Additionally one parent shared that she had never thought of emotional milestones or stages, but after completing the SEAM realized the value in recognizing this. Ten parents (20%) shared that the SEAM helped them to organize developmental information in their mind. By answering the questions, it helped them to think about their child's development in a more clear way and allow them to understand whether or not their child was on-track in the areas that were reflected in the SEAM. One parent (2%) learned that potty-training was an important milestone at this stage. Finally, one parent (2%) noted that after completing SEAM, she learned of the importance of specific time spans for activities. For example, Items 8.1 and 8.2 ask whether the toddler can stay with motor activities for five minutes or longer and looking at a book or listening to a story for 5 minutes or longer. These items helped her realize that it was important to

have her toddler attend to activities for at least 5 minutes and she will tune into this now that she has learned the importance.

Additional SEAM Items for Consideration

The researcher asked each parent/caregiver if there were any questions that they felt were not reflected in the SEAM and would be important to include. Most parents/caregivers indicated that they felt the SEAM was fine just the way it was, they said it was complete, well written, thorough, covered it all. A few parents/caregivers, who were very well spoken, thoughtful, articulate and engaging offered some excellent feedback in regard to additional items to consider when revising the SEAM. One parent who has four children of her own and in addition runs a daycare center out of her home provided very rich, interesting feedback. She felt that it would be beneficial to have a question about nightmares for children. She explained that nightmares can be an indication of a traumatic experience for a child and it would be important to have a question regarding this so that this area can be explored further for the child and family. Additionally, this parent thought that there should be a question exploring “sexually suggestive behavior” (personal conversation, May 19, 2008). The researcher explained to her that this question is asked on the 36-month ASQ:SE, and she shared that she has observed this being present in children before the age of 3. She went on to say that the item would need to be worded in a way that parents aren’t alarmed if their child is exploring his/her body parts in a curious way, but rather intentionally initiating sexual behavior as a manifestation of something else. She felt that an item like this on the SEAM would be helpful for a Head Start or childcare worker to know about because it

might not otherwise come out in the child's day-to-day activities. This might not be information that a parent readily shares with early childhood staff and if the child has engaged in sexual behavior alone, then this behavior may not present itself in a group setting.

Another point of feedback made by a parent was regarding social interaction between siblings. Item 5.4 which asked about the toddler playing alongside other children should also include a related item on how the child interacts with siblings. This parent had a child in a home-based Early Head Start program and she shared that her child does not have an opportunity to interact with other children his age. She felt like some of the children in the home based program were more isolated and lack the social exchanges with other children and therefore they wouldn't be able to accurately assess how their child plays alongside other children. An additional item that asks about how the child interacts with siblings or extended family members who are the same age as the child would be helpful.

One parent shared that she felt like the SEAM should have more of an emphasis on the child's emotions and connections with family members. She asked about empathy and felt like there should be a specific item that asks if the child seems tuned to the emotions of parents and close family members. The researcher reminded her that Item 4.1 reads *Toddler matches his response to others' emotional responses*. She asserted that the expression of emotions is a very important thing to assess and that the SEAM should include more items that ask about the child's expression of emotions and how to measure this to ensure that the full range of emotions are expressed and understood in children.

Finally, one parent inquired about adding an item that asked if the child was able to communicate a certain number of words by ages 24-36 months. She indicated that it would be helpful if the SEAM had indicators of a range of how many words a child should be expressing from 24-36 months. She said that she is always worried that her child doesn't talk enough, but isn't sure what the "normal" range of language is. Because there were Toddler SEAM items that asked about the child's communication (i.e. sharing emotions) she thought that having an item that provided a targeted range of words would be helpful. This way, as she stated, parents would know if their child was behind or on track and that would be helpful to know if intervention is necessary.

Analysis Conclusions

Both the quantitative and the qualitative data collected provided a more detailed look at the Toddler SEAM and presented strengths of the instrument as well as areas for further consideration and improvement. As with any new instrument, the process of validation requires time, resources and a willingness to accept multiple perspectives and invite feedback. The goal of creating a parent friendly, easy to use tool to assess social and emotional development has shown to be a complex process, however very rewarding and interesting.

CHAPTER V

DISCUSSION

Research continues to show that children with many risk factors and those exposed to multiple traumas are far more likely to show signs of emotional maladjustment or behavior problems (Breslau, Chilcoat, Kessler, & Davis, 1999; Rutter & Quintin, 1977). Many of the children whose early life experiences have been compromised due to trauma and stress are often part of programs like Early Head Start. In many urban and some rural communities, Head Start centers (this includes Early Head Start) and childcare programs serve large numbers of disadvantaged families (Donahue, Falk, & Gersony Provet, 2007). Many of these children are directly impacted by their parents' struggle to provide for their families' basic needs and to maintain adequate housing and employment; they come to their centers bringing their worries with them (Donahue, Falk, & Gersony Provet, 2007). As developmental trajectories are impacted by poverty and associated factors, the need for appropriate services to address children's social and emotional development is needed. Early identification followed by comprehensive interventions to address social emotional concerns is critical. The first step in this process is incorporating high quality screening and assessment measures by which to identify children who are at risk.

Assessment can be a pivotal event for families and their children. The role and importance of assessment is underscored by the need in the field of early childhood for

high quality assessments that are family friendly and provide a link to authentic teaching to improve outcomes for young children (Neisworth & Bagnato, 2004). Researchers continue to point to a series of factors contributing to a lack of high quality social emotional assessment measures. Among the reasons is the fact that traditional measures have relied on observational methods, which are time consuming, expensive and challenging for coding. Additionally, there continues to be a lack of clarity around achieving distinction between normative and dysfunctional behavior when it comes to examining social emotional development (Cabrera, Linver, & Brooks-Gunn, 2007). Further research considering the impact of culture, socioeconomic status and risk is also of increased importance (Raver, 2004). A critical guiding principle in the development and implementation of high quality assessments for young children is the recognition of parents as integral partners in their child's development and learning. "Early mental health services are most effective when family members are viewed as an important part of the intervention team and given appropriate and adequate supports to care for their children in their home and other early childhood environments within the community" (Nikkel, 2007, p.151). This study considered factors of culture, risk and socioeconomic status within the context of children's social emotional development.

An underlying assumption in this study is that parents from all racial and ethnic backgrounds' and socioeconomic levels are important contributors to their child's development. If families are to benefit from mental health services for their children, they need to be actively involved in the planning, implementation, and monitoring of the services being offered (Nikkel, 2007). When early childhood service providers' value and

support family members, they model strategies for parents to value and support their children (Hanson, Deere, Lee, Lewin, & Seval, 2001). The critical information that was expressed in the form of parent feedback will assist in providing insight and guidance toward the completion of quality, culturally sensitive, assessment tools, such as the SEAM, that can be used within various early childhood settings. In their research on parent completed screening and assessment tools, Diamond and Squires (1993) confirmed that families provide valuable authentic and longitudinal information about their child that is not otherwise available. Ramey and Ramey (1998) found that more active involvement of parents in their child's program appears to be related to greater developmental progress.

Assessment must be useful to accomplish the multiple and interrelated purposes of early care and education and early intervention (Neisworth & Bagnato, 2004). Examining utility of the SEAM is an important step in ensuring that it is a high quality instrument that is understood by parents and professionals who can then take the information that they learn from completing the SEAM and use it to develop measurable and observable goals and interventions. Bagnato and Neisworth (2004) discuss the need for assessments to have treatment validity—meaning that there must be an essential similarity or linkage among program goals, individual child objectives, and the developmental competencies that are assessed. In addition they specify that materials and methods of assessment must help families and professionals to identify instructional objectives and methods for helping children. Another important dimension that is examined within this study is the notion that assessment should detect changes in

behavior that are noticeable to caregivers in the home and early childhood environments (Bagnato & Neisworth, 2004). The SEAM is a parent and teacher/caregiver completed assessment tool that indicates and emphasizes the central role that parents and early childhood professionals play in helping to recognize social emotional behaviors and concerns that surface within the natural and everyday environments within which young children interact.

A primary focus in this research study was to examine the utility of the Toddler SEAM. Parent feedback assists in better understanding the strengths and areas of improvement in terms of understandability and usability of the SEAM. This study focused on paying close attention to how individuals from a variety of cultural and socioeconomic backgrounds are able to understand and gain awareness and knowledge from completing the SEAM. A secondary intent was to understand the relationship between the ASQ:SE, a screening tool, and the SEAM, a curriculum based assessment measure, in terms of how particular items or areas within both instruments relate to one another. This information helps to support the argument of the need for integrating and linking screening and assessment instruments. When this is done correctly, parents and early childhood professionals together can utilize this information and develop meaningful goals and interventions to improve social emotional well-being in young children.

This chapter discusses interpretations and implications of the results obtained from the use of the Toddler SEAM with parents/caregivers who participated in this study. Suggestions for future research studies and study conclusions are also included.

Study Conclusions

Utility Analysis

When creating an assessment instrument it is crucial that parents/caregivers from a variety of backgrounds (i.e. socioeconomic, ethnic, educational) be able to complete the instrument with ease and clarity. These tenets were included as a central focus of the Utility Questionnaire. While 44 of the study participants (88%) indicated that the items on the SEAM were easy to understand, 45 (90%) took 15-30 minutes to complete the SEAM, with the majority of that group taking 15-20 minutes. The average time of completion from other SEAM data collected at the University of Oregon from multiple sources was 8.87 minutes. This indicates that the sample in this study took considerably longer on average to complete the SEAM. Since this sample was comprised on low SES families and the majority had only completed high school or GED, it would be interesting to examine families from higher SES and educational levels and see if these factors impacted the time of completion. Within this study, some participants wanted to share examples of what their child likes to do in relation to an item or talk about how their child is developing in that area, but hasn't been able to achieve that milestone. The open ended dialogue was encouraged by the researcher as this was helpful in learning more about the child and gaining insight into the parent-child relationship.

Many of the study participants had questions about content and wording, indicating to the researcher that without the further explanation of SEAM items, perhaps the intended meaning and correct social emotional construct would not be fully understood by study participants. The researcher often had to repeat questions a few

times, repeat the corresponding examples and at times, provide clarity with the examples to further explain items. A readability test was conducted on the Toddler SEAM and indicated a readability level of 3.0 (low literate). Parents/caregivers with a low literacy level should be able to read the SEAM with few problems.

The SEAM spans a large developmental range and there are unique distinctions between 18, 24, 30 and 36-month intervals in regards to social emotional development. It is important for home visitors, teachers or other staff administering the SEAM to be knowledgeable about developmentally appropriate expectations and activities for the child's individual age intervals. Having examples under each item with a specific age interval will help both staff and parent/caregiver to accurately assess social emotional competence for the child and prevent the staff member from improperly administering the tool, which could result in not identifying children in need of services.

The concept of social and emotional development is somewhat abstract at the very least, to talk about with parents. This notion can be supported by the substantial number of study participants who displayed a level of confusion regarding SEAM items and the amount of time that it took to complete the SEAM. For the most part, the parents/caregivers in this study were accustomed to completing screening and assessments as a regular part of service delivery in Early Head Start. It would be interesting to examine whether families found a lack of clarity in other social emotional assessment measures used in Early Head Start (i.e., The Ounce Scale).

In the question regarding whether parents/caregivers thought the Toddler SEAM can be helpful for other parents who want to learn more about their child's development,

100% of study participants ($N = 50$) indicated yes. Twenty participants (40%) indicated that the Toddler SEAM allowed them to see things about their child that they had never thought about before and now realize are important areas of development. They shared that they didn't realize that certain skills or behaviors were important and through the completion of the Toddler SEAM they were able to understand how those everyday actions that their child was doing or perhaps wasn't exhibiting yet were important to pay attention to.

For the families in this sample, all of whom were low income, there are often a myriad of life circumstances coexisting at the same time and the convergence of these factors impact the daily environment and well being of the child, the parent and the dyad's relationship. Substantial research supports the underlying concept within infant mental health field, that caregiver mental health status is related to child outcomes by demonstrating links between parental mental health status and behavior and child brain function and behavior (Dawson, Ashman, & Carver, 2000).

Staff Development and Training

A common thread throughout the entire data collection process was the need for additional training and mental health consultation for Early Head Start program staff (i.e., teachers, home visitors, supervisors). When asked about social emotional development in the young children they work with, many times the staff were unable to articulate how their work with children nurtures social and emotional development. Their background knowledge related more to how many words the child could express or how "smart" they were, rather than methods to examine attachment relationship or interactive dynamics

between parent and child. In conversations with the Early Head Start director at one of the rural programs involved in the study, she indicated that staff overwhelmingly feel that the parents are the ones with the “issues”, they are the ones with any mental health concern (Martin, personal conversation, May 11th, 2008). Parent mental health concerns such as anxiety, depression, are seen as parent issues, not family issues and there is a lack of connection between the manifestations of behavior and demeanor in the parent and the behavior and developmental patterns in the child. When asked by the researcher if staff were able to make the connection between parent mental health and the child’s social emotional development, she indicated no. Overall, while attending center and home based meetings with staff and families, the researcher observed teacher/home visitor-family interactions that were not grounded in any understanding of promoting parent-child relationships or modeling developmentally appropriate practice. It is critical to ask the right questions and be able to uncover areas of concerns within the parent-child dyad and the surroundings that have profound and lasting impacts on the child’s development. This process will help guide the course of intervention and follow up services (e.g, parent-child therapy, early intervention services) and ensure that there are a variety of options available to families to meet their diverse and often complex needs. Being able to ask the right questions and observe the behaviors and interactions central to understanding social emotional development requires training.

The researcher recognizes that observations and data from the study are just a “snapshot” of the interactions that take place between staff and family. However, the

research appears to support the need for continued training in addressing early childhood mental health issues.

“The shortage of individuals with expertise in the social-emotional development of young children is clearly being experienced across the nation. As more and more states begin to develop statewide plans for services and supports to address the mental health of young children, there is repeated attention to the challenge of an inadequate work force and the struggle to identify professionals with the appropriate training, experience, or knowledge” (Meyers, 2007, p.99). An Early Childhood Mental Health Summit held in Chicago in 2000, reported that there is a significant shortage of mental health therapists who are trained to work with the birth to five population (Ounce of Prevention Fund, 2000, p.6). Two of the programs that participated in the study expressed the need for more coordinated mental health services for their families. Both programs have access to a mental health consultant, but their availability is limited and usually consists of one home visit or meeting with staff. There is often little follow up and training available to help sustain and build upon interventions necessary for families. These complex issues have multiple levels and layers and clearly cannot be fixed without federal, state and local systems working collaboratively on behalf of young children and families. This study echoes the above sentiments and as it relates to the SEAM, the need for a well packaged, comprehensive tool kit that provides staff with the necessary information is critical.

Front line staff working with young children and families need hands-on, practical tools with sound approaches that they can implement and embed into their daily work

with families. One of the goals of the SEAM is to provide a seamless system ranging from the assessment measure to eventually developing activities and interventions that front line staff can utilize daily in their classroom and home based interactions with children and families. Based on the observations that the researcher made throughout this study, in addition to the conversations with program staff, it would be beneficial to provide written strategies and tools to assist staff in beginning to observe and have conversations with parents about social emotional development. Knowing what to look for, what to ask, and how to use oneself in the relationship are all important facets in understanding the complexity of parent-child relationships and how to promote social emotional development in children.

Implications for Practice

While there has been considerable research conducted in the field of infant mental health, there continues to be a gap in both theoretical and practice interventions, especially for front line staff working with families. Shonkoff and Phillips stated that, “Early Childhood policies and procedures are highly fragmented, with complex and confusing points of entry that are particularly problematic for underserved populations and those with special needs. This lack of integrative early childhood infrastructure makes it difficult to advance prevention-oriented initiatives for all children and to coordinate services for those with complex problems” (2000, p.11). This quote summarizes the inherent need for well-organized, well-funded and well-staffed systems of care to address children’s mental health, amongst other developmental concerns, especially for at risk populations. The foundation of Head Start and Early Head Start

since its inception has focused on family centered practice and nurturing the parent-child connection. Although Early Head Start is not a mental health program, it has an established goal of promoting the development of the whole child, including the child's emotional development. For infants and toddlers, the major strategy for addressing their emotional needs is enhancing the parent/child relationship (Jones Harden, 2002). While many Early Head Start programs stress the importance of relationship-based work and establishing trust with families, there continues to be a lack of training and support provided on how to implement specific strategies in observing parent-child dyads and techniques for intervention. The home visitors and teachers who interact daily with families and are invested in their lives, both in terms of the relationship and in monitoring developmental outcomes, are in a pivotal position. Their position within the family allows them in many cases to implement strategies and model relationship-focused behaviors to enhance the parent-child relationship. Specific training on Infant Mental Health, both the theoretical framework as well as the "practice" of Infant Mental Health is not readily available to front line staff and there continues to be a substantial need throughout programs. Alicia Lieberman, an expert in the field of infant mental health, stated that one does not have to be a therapist to be therapeutic (1999). There are specific approaches, skills and a way of interacting, by which the teacher, home visitor, or family worker can provide support and intervene. Within the context of the relationship, becoming attuned to behaviors, aware of interaction patterns between parent-child and environment and utilizing oneself as a base upon which the parent can "practice" parenting methods, assists in facilitating IMH principles.

Implications for Research

There continues to be a substantial need for early childhood programs to provide support and intervention in the area of social and emotional development. For the young children in this study who were considered to be at risk due to poverty and associated factors, the need for high quality measures to identify social emotional concerns is imperative. The involvement of the parent is critical both in the process of completing the SEAM and as the next steps unfold through the goal development and interventions to address any presenting issues. As Mann, Powers, Boss and Fraga (1998) explain, “Parents should be full, voluntary participants in the screening and assessment process and any follow-up evaluations” (p.38). The information provided from the SEAM and additional observations and conversations that take place with the goal of better understanding of the child and the dyad’s relationships, will lead to the creation of a plan of services with the goal of improving the relationship and in turn the child’s social emotional development. Through this study and continuous research efforts that are a part of ongoing research on the SEAM, we are challenged to take the feedback that we gain from parents and program staff and improve this assessment instrument with the goal of creating a tool that we can enhance parent-child relationships and improve children’s social emotional competence. The researcher and colleagues have examined how the questions on the SEAM were worded, how easy they were to understand, and how useful parents thought the SEAM would be in providing a picture of their children’s social emotional development.

Another dimension to consider within the context of this study is the ability of parents from low-income and high needs backgrounds to effectively assess their child's social and emotional development. In examining the ability for the parent to understand each item on the SEAM as well as the overall purpose of the assessment, it is important to consider the impact that educational level has on the parent/caregiver's ability to understand and apply the principles of social and emotional development in such a way that the intended purpose of the SEAM was met. For thirty-four (68%) of participants, a high school diploma or GED was their highest level of education. It is hard to conclude if education level was related to challenges with completing the assessment, however because the concepts are complex, this is probable. Other developmental assessments whose questions focus on language or gross motor skills may be easier for parents to answer due to the simplicity of a yes no response regarding whether the child can walk or talk. Questions that address empathy, emotion and behaviors can be more deeply rooted, and for many parents, these constructs may not be things that they regularly consider or focus on.

While we know it to be important and in many cases effective for parents to assess their children's development, this proposed research study has provided insight into the challenges that exist within this area. Lawlor (2004) discusses parental perceptions in terms of the multifaceted parental challenges when facing health professionals or others. Lawlor (2004) believes a challenge faced by parents includes managing the perceptions of others towards their child, specifically, the desire to portray

positive attributes of their child to others, and crafting of how to act within health settings including the choosing of what to report to a professional.

While the researcher was with the study participants, she explained that this research was essentially “testing a test”, and there was no right or wrong answer, but rather the honest feedback from parents regarding their child’s development was most beneficial. The fact that the researcher did not have an established, trusting relationship with the study participants may have impacted the parents ease in completing their assessment. Future research employing test-retest methods as well as interrater reliability in which both the parent and the teacher/home visitor can complete the assessment and results can be compared would be helpful in determining the most accurate picture of the child’s social and emotional development. Howes and Matheson (1992) have studied parent involvement in assessment and suggested that parents or guardians interpret their child’s ability in a different context to professionals (teachers and therapists) and parent reporting of play and social competence may produce different results to other methods of measuring these developmental areas in children. However it’s important to note that the research conducted on the ASQ:SE has demonstrated 93% interrater reliability indicating that parent and professional agree on social emotional competence in the child. This is an area for further consideration as it addresses both the parents’ and professionals’ levels of understanding in relation to accurately assessing children’s social emotional development.

The participants in this proposed study were from low-income backgrounds and in addition many had multiple risk factors including parental depression, isolation due to

rural living, teenage parenthood, and unsafe living conditions. Research confirms that family-level variables that may affect child development include family structure and roles; parenting beliefs, practices, and goals; parental physical and mental health status; and household socioeconomic conditions (Pachter, Auinger, Palmer, & Weitzman, 2006). Research has also demonstrated that not one factor by itself would necessarily indicate risk or preclude social emotional problems in young children, the cumulative effects of risk increase the likelihood of early childhood mental health concerns.

Poverty, as a common underlying factor, was discussed earlier. Poverty affects children both directly and indirectly, through mediating variables such as neighborhoods, the availability of quality education and health care, job opportunities, family cohesion and structure, parenting practice, goals and nutrition. In different settings, poverty may result in poor outcomes through different intermediates. Because of this, it is crucial to assess the processes through which poverty exerts its effects and the relative importance of these intermediate variables specifically in different sociocultural contexts. This approach may result in a more targeted approach to intervention whereby program staff have a greater awareness of a systems based framework for understanding poverty and associated conditions and seek to address the myriad of issues which are at play with one another and which daily impact the developing relationship between parent and child (Pachter, Auinger, Palmer, & Weitzman, 2006).

The director of one of the participating Early Head Start programs indicated that parental mental health issues were a significant challenge within the program. The director felt that parent mental health was a more substantial issue than child mental

health as more of the traditional manifestations of depression, anxiety, phobias, were directly experienced by parents. Upon explaining to her the context of reciprocity in relationships and how a parents' mental state does directly impact the child's social emotional well-being, it was clear that additional training and support was needed.

Limitations of the Study Design

The findings of the research were limited due to two areas of concern. Within the study design there were threats to internal and external validity. In addition, because the SEAM is a new instrument, there were several areas that warrant additional research and planning.

External Validity

External validity is defined as the extent to which the findings of an experiment can be applied to individuals and settings beyond those that were studied (Gall, Gall & Borg, 2003). The primary threat to external validity in this study is generalizability of the findings. While it was a significant benefit to reach out and engage families from a low socioeconomic background, a group that can be overlooked in research, this population provided only one perspective. This study examined only a small sample of low-income parent-toddler dyads; additional data from families representing other socioeconomic backgrounds is necessary. The small sample size ($N = 50$) was limiting when examining statistical significance of the data. Sample size for the ASQ:SE 36-month interval was extremely small ($N = 6$) and although the correlation with the Toddler SEAM ($N = 50$) was still significant ($r = 0.613$), it is important to realize that the small sample size was a factor. While the findings from this study indicated significant correlations between the

ASQ:SE intervals and the Toddler SEAM at a moderate magnitude, it is important to conduct additional research with larger sample sizes to have more confidence that the outcomes were significant. Additional research will help to provide more substantial evidence to contribute to the criterion validity of the Toddler SEAM.

In addition, the findings were impacted by a geographically limited sample. Due to limitations in resources, all data were collected from three counties in New York State. These three counties were unique, however they did not represent the broad range of families both in New York State and beyond. Future research should include participants from broader geographic regions. Examining reliability and validity of the Toddler SEAM within other groups (e.g., children with disabilities, children who are English language learners, middle/high SES families) will provide additional data by which to continue to examine the psychometric properties of the Toddler SEAM.

Mean scores from Toddler SEAM data from this study were compared with online Toddler SEAM data, examining in particular families from middle/high SES groups. Average mean score for this study was 58.78. Table 12 below provides a detailed look at the breakdown of mean SEAM scores by income. Table 13 below provides a detailed look at the breakdown of online mean scores for families with incomes of \$30,000 and above.

The data below indicates for the most part a trend towards an increase in SEAM scores in relation to an increase in income level. Children with higher SEAM scores indicate higher levels of social emotional competence. It is important to continue to examine factors of income and education level to determine their relationship to SEAM

Table 12. Mean Scores for Toddler SEAM by Income

Income Level	<u>n</u>	Mean
No Income	3	57.3
5,000-9,999	12	54.42
10,000-14,999	10	55.30
15,000-19,999	10	62.20
20,000-29,999	7	63.29

Table 13. Mean Scores for Online Toddler SEAM by Income

Income Level	<u>n</u>	Mean
30,000-39,999	19	60.26
40,000-49,999	27	60.63
50,000 or more	145	59.61

scores within a larger sample. Further research examining the larger data sets from the SEAM will create more power in the findings and an ability to present this tool to families and programs with the sound knowledge that it yields valid and reliable results.

Reliability

An important measure of validating a tool is inter-observer reliability, defined as the extent to which a trained observer's scores agree with those of an expert observer, such as the researcher who developed the observation instrument (Gall, Gall & Borg, 2003, p. 263). This is important to consider because most of the study participants had two different people, the researcher and EHS staff, administering the measurement tools. If the participant had a recent ASQ:SE completed with the EHS staff, this measure was

not administered during data collection. However if they had not completed a recent ASQ:SE, the researcher completed an ASQ:SE with them. As indicated earlier, many of the constructs on both of these instruments can be both challenging to explain and difficult for parents to accurately assess. Without sufficient training and knowledge in social emotional development, it is possible that EHS staff administering the ASQ:SE with parents/caregivers, may not have provided the right developmental guidance when assisting parents with completing the appropriate ASQ:SE interval. While the researcher can confirm that all SEAM instruments were administered in a consistent way, this cannot be verified for the ASQ:SE intervals. Criterion-related observer reliability typically is established by having an expert examine the administration of instruments through videotape. The trained observers, the EHS staff, would then code the same videotape. Data would then be checked for agreement with the expert's data (Gall, Gall & Borg, 2003). This process ensures a greater level of scrutiny in assuring that the data is accurate and consistent. This is an important step because the data that are collected from both the screening and assessment measures provide important insight into children's social emotional development. What is learned from these measures has important implications in properly identifying children and establishing a plan for intervention to address social emotional concerns.

Internal Consistency

Internal consistency of the Toddler SEAM was found to be high, Cronbach's alpha = .92. It is important to remember that the sample size was small for this study and therefore a larger sample is needed for replication.

Limitations of Instrumentation

The SEAM is a measure that was developed to assess social and emotional development and examine parent-child relationships, as they are integrally connected with these areas of development. Due to the design of this study, the researcher was unable to administer the Caregiver SEAM, which would have provided insight into parental mental health and well-being through items that identify behaviors and beliefs related children's social and emotional development. In some regards, the Toddler SEAM on its own does not provide a comprehensive picture of children's social and emotional development. In children from 18-36 months, many of the social and emotional behaviors exhibited are directly influenced and relate to the parent-child interaction and bond. Without specifically addressing parental influence on social and emotional development through the complementary Parent/Caregiver SEAM, it was hard to gain a full picture of the child's social and emotional development and in turn plan for holistic interventions that address the multifaceted needs that may exist.

Understanding the status and role of the parent and inviting this perspective into the assessment process are important. Interventions need to be designed that address not only the improvement of challenging behaviors in the child, but also the core issues surrounding the relationship between the child and caregiver(s). Follow up studies examining the caregiver SEAM, the ESQ (Environmental Screening Questionnaire), which looks at factors in the immediate environment (safety, transportation, access to medical care) that impact the family functioning, are critical in understanding the child's

social emotional development and the multiple contexts through which this development is impacted.

Conclusions

The SEAM is a new measure created for the purpose of providing an affordable, easy to use assessment to accurately assess children's social and emotional development. An overriding purpose of this study was to assess the utility and usability of this instrument in its first iteration. Information, both quantitative and qualitative, provided information that may contribute to the literature through a better understanding and knowledge of the relationship between the ASQ:SE and SEAM. Descriptive statistics provided important information that is value added in establishing baseline data from which to substantiate the SEAM and its efficacy. Creating a seamless, easy to understand system of identifying children, creating interventions, developing goals and evaluating progress for parents and program staff is of substantial importance. This study provided insight into how this process can begin and the important role that parents/caregivers play in both feedback on efficacy of instruments and the more complex issue of parental understanding of social emotional development. Many of the parents/caregivers in this study were able to provide feedback on item wording, additional items to add to SEAM, and organization issues within the instrument. This feedback was invaluable and will be incorporated into revisions that are made to the SEAM.

An unintended area of concern that arose from the study and requires more in depth examination is the ability of all parents to accurately assess complex developmental and relational constructs. Further examination of the impact of social class, education

level and parent age in regards to accurate assessment of young children's social and emotional development is of critical importance. The need for comprehensive, evidence based strategies for staff members working daily with at risk families is essential. Front line staff are often the ones whom families trust and are willing to listen to and share in learning about child development. The interwoven connection between the caregiver and child must be at the center of understanding social emotional development and accurately assessing and intervening with young children at risk. Future studies that include use of the Caregiver SEAM will provide that important piece and further substantiate the findings from this study.

The development of evidence based individualized interventions that can be imbedded into children's daily experiences will provide front line staff working daily with children and families authentic tools that they can implement and evaluate. This step-by-step process begins with establishing the SEAM as a valid, reliable and usable tool. This research will result in a better understanding of children's social emotional development, the relationship between parent/caregiver and child in accurately assessing and intervening, and what interventions are necessary in order to support and enhance children's growth and development.

Early detection and intervention of social and emotional problems can have a long-term impact on the developing child in major areas. The development of emotional self-control and social ability in the early years plays a significant role in determining the way children think, learn, react to obstacles, and develop relationships throughout their lives. Early caregiver-child relationships provides the foundation for emerging social

emotional skills and behaviors. A crucial element of early detection is the availability of high quality, easy to use screening and assessment measures. A linked systems approach which emphasizes screening, assessment, goal development and intervention assist in providing all children, and especially those at risk, with an opportunity for positive developmental outcomes.

APPENDIX A
STUDY INSTRUMENTS

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) _____

1. SEAM interval completed: (Check one) Infant Toddler
2. Approximately how many minutes did it take to complete the SEAM? _____ Minutes
3. The questions were appropriate for my child. (Check one)
 Strongly agree Agree No opinion Disagree Strongly disagree

If not, please specify item number and reason.

Item #	Reason or Comment

4. The questions were useful. (Check one)
 Strongly agree Agree No opinion Disagree Strongly disagree

If not, please specify item number and reason.

Item #	Reason or Comment

5. Were any items unclear or difficult to understand? (Check one)
 Yes No

If yes, please specify item number and reason.

Item #	Reason or Comment

6. The items alerted me to skills or activities my child can do that I was not sure about. (Check one)
 Strongly agree Agree No opinion Disagree Strongly disagree

Comments:

7. Did completing the SEAM bring up any concerns that you would like to talk to someone about? (Check one)

Yes No

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

Comments:

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
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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
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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: _____



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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
2. When you leave, does your child remain upset and cry for more than an hour?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
3. Does your child laugh or smile when you play with her?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
4. Does your child look for you when a stranger approaches?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
5. Is your child's body relaxed?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
6. Does your child like to be hugged or cuddled?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
7. When upset, can your child calm down within 15 minutes?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
8. Does your child stiffen and arch his back when picked up?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
9. Does your child cry, scream, or have tantrums for long periods of time?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>

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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
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.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
12. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
13. Does your child have trouble falling asleep at naptime or at night?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
14. Do you and your child enjoy mealtimes together?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
15. Does your child sleep at least 10 hours in a 24-hour period?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
16. When you point at something, does your child look in the direction you are pointing?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
17. Does your child get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
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?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
19. Does your child follow simple directions? For example, does he sit down when asked?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. Does your child like to play near or be with family members and friends?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
22. Does your child like to hear stories or sing songs?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
				
23. Does your child hurt herself on purpose?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
24. Does your child like to be around other children?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
				
25. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
TOTAL POINTS ON PAGE —				

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
<p>26. Has anyone expressed concerns about your child's behaviors? If you checked "sometimes" or "most of the time," please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>
<p>27. Do you have concerns about your child's eating or sleeping behaviors? If so, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>				
<p>28. Is there anything that worries you about your child? If so, please explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>				
<p>29. What things do you enjoy most about your child?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>				
TOTAL POINTS ON PAGE				___

18 Month ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____
 Person filling out the ASQ:SE: _____ Relationship to child: _____
 Mailing address: _____
 Telephone: _____ City: _____ State: _____ ZIP: _____

.....
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
18 months	55	

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?)

Social Emotional Assessment/Evaluation Measure



TODDLER

(for developmental range 18-36 months)

Child Benchmarks and Assessment Items

Child's name: _____

Child's date of birth: _____

Family's name: _____

Name of person completing form: _____

Date of administration: _____

Instructions

Please read each item carefully before selecting an answer. In some cases, observation of the child and/or caregiver may be necessary before scoring the measure. Each item is accompanied by several examples. Children may be able to successfully meet the item criterion in a variety of ways. Some items may be too difficult for the child; for example, an 18-month-old may not indicate when his diaper needs changing. Professionals should ensure that parents understand that the SEAM may contain items that are developmentally too advanced for their child. Age norms should not be used with children with delays or developmental disabilities.

The three scoring options include "Most of the time," "Sometimes," and "Rarely or never." For example, if a toddler talks and plays with adults he knows well consistently over time, a check should be placed in the box under "Most of the time" on item C-1.1. Items marked "Most of the time" are generally considered strengths. If a toddler talks and plays with familiar adults inconsistently, the box under "Sometimes" should be checked. If the toddler seldom talks and plays with familiar adults, the box under "Rarely or never" should be checked. The latter two columns allow participants to indicate whether a particular behavior is of concern and whether it should become an intervention goal, respectively. After you are finished with this SEAM and the corresponding Adult/Caregiver SEAM, record answers on the accompanying Summary Form.

Child Benchmarks and Assessment Items Toddler					
<p>Please read each question carefully and</p> <ol style="list-style-type: none"> 1. Check the box <input type="checkbox"/> that best describes your child's behavior, 2. Check the circle <input type="radio"/> if this behavior is a concern, and 3. Check the triangle <input type="checkbox"/> if this will be an intervention goal. 					
	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
C-1.0 Toddler participates in healthy interactions.					
1.7 Toddler talks and plays with adults whom she knows well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Points to show you things Begins to include you or siblings in play; pretends to offer you or others food; tries to care for baby sibling Talks to you about her activities: "I push car" Uses one or two words to communicate with peers, such as "Car go?"</i>					
1.8 Toddler responds when you show him affection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Hugs you; smiles back at you Hugs and kisses people, pets, and stuffed animals Returns hugs, kisses, or other affectionate gestures Walks to you with arms out, wanting a hug</i>					
1.9 Toddler initiates and responds when you communicate with her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Comes when you gesture for her to follow Answers your questions with one word, such as "Juice" Asks questions: "Where mama?"; says, "Mama come" when she wants you to play Asks many questions (e.g., "why, what, how?")</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
1.4 Toddler lets you know if he needs help, attention, or comfort.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Pulls on you or other adult or raises arms to be picked up</i> <i>Asks for a drink of water by pointing or showing you</i> <i>Goes to you or other familiar adults when hurt</i> <i>Seeks attention from you and other familiar adults; babbles and "shows off" for you</i> <i>Calls for you when he needs help, such as "Daddy help"</i>					
C-2.0 Toddler expresses a range of emotions.					
2.1 Toddler smiles and laughs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Smiles when caregiver returns</i> <i>Smiles and laughs at people and children</i> <i>Kisses other children</i>					
2.2 Toddler expresses a range of emotions using a variety of strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Expresses emotions physically and verbally, such as making faces and crying when frustrated; laughing and giggling when happy</i> <i>Expresses a variety of feelings (happy, sad, frightened, surprised, angry)</i>					
2.3 Toddler identifies her emotions with your help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Can sing "Happy and You Know It" with you and makes the feeling faces</i> <i>Answers accurately yes or no when asked if mad</i>					
2.4 Toddler identifies his own emotions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
<i>Protests "No bath, Me sad"</i> <i>Expresses why he is laughing, such as "Because I am happy"</i> <i>Says, "I'm mad at you" when angry</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
C-3.0 Toddler regulates her social emotional responses.					
3.1 Toddler responds to soothing when upset.	☐	☐	☐	●	▲
<i>Stops crying when picked up and comforted</i> <i>Resumes playing after being hugged and kissed by caregiver when upset</i>					
3.2 Toddler can settle herself down after periods of exciting activity	☐	☐	☐	●	▲
<i>Sits down and calms self with your help after a game of chase</i> <i>Uses a favorite toy or game to distract herself when upset</i> <i>Signals you through expressions or words that she needs some assistance</i>					
3.3 Toddler can calm self when upset	☐	☐	☐	●	▲
<i>Calms self after falling, within 5 to 10 minutes, with your help</i> <i>Holds favorite doll or blanket to help calm self</i> <i>Stops crying a short time after you leave, with help</i>					
C-4.0 Toddler begins to show empathy for others.					
4.1 Toddler matches his response to others' emotional responses	☐	☐	☐	●	▲
<i>Quiets when you are upset</i> <i>Laughs and smiles when others do so</i> <i>Tries to help care for baby siblings</i>					
4.2 Toddler tries to comfort others when they are upset	☐	☐	☐	●	▲
<i>Gives crying baby a hug; leads you to upset infant to soothe</i> <i>Kisses your "owie" if you hurt yourself</i> <i>Hugs you if you are sad</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
4.3 Toddler uses words to talk about another child's emotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>
<i>Says, "Baby cry, sad," when hearing a baby crying</i> <i>Says "That boy is mad" about a child who is screaming</i> <i>Returns toy to stop crying of another child</i> <i>Describes a peer's feelings after watching him begin to cry when dropped off at child care: "He's sad because his mom is gone"</i>					
C-5.0 Toddler shares attention and engages with others.					
5.1 Toddler makes eye contact with you and other caregivers and peers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>
<i>Plays simple games with you such as Peekaboo and This Little Piggy</i> <i>Makes eye contact with teacher as he walks in room</i> <i>Looks at others-at kitchen table during dinner</i>					
5.2 Toddler focuses on events that you show him.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>
<i>Looks at books with you and labels what pictures you point at</i> <i>Follows your gaze</i> <i>Looks at things like fire trucks, animals noted by another</i>					
5.3 Toddler greets you and other familiar adults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>
<i>Seeks attention from you and family members, but may act shy around strangers</i> <i>Looks at and says "Hi" to other children</i> <i>Waves to familiar people</i> <i>Greets sibling by name when they get together</i> <i>Has a special friend he likes to play with</i>					
5.4 Toddler plays alongside other children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="checkbox"/>
<i>Plays side by side with other children without sharing toys or materials</i> <i>Watches other children at play</i> <i>Will pass toys to other children when playing in the sandbox</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
5.5 Toddler shares in daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="triangle-up"/>
<i>Helps you put on shoes Imitates household tasks and can put some toys away with your help Helps put food in grocery cart</i>					
C-6.0 Toddler begins to demonstrate independence.					
6.1 Toddler explores new environments while maintaining some contact.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="triangle-up"/>
<i>Walks to sandbox but looks back at you, making eye contact and checking in Walks with friend to see a new toy while looking at your face to make sure it's okay Wants to do things by herself: "Me do it"</i>					
6.2 Toddler can separate from you in familiar environment with minimal distress.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="triangle-up"/>
<i>Frets or cries only a few minutes when you depart Lets you leave his sight for a few minutes without showing distress Leaves you to join play with peers, looking to make sure you are still around Gives Dad a hug and joins peers in play when arriving at child care</i>					
6.3 Toddler tries new tasks before seeking help.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="triangle-up"/>
<i>Tries repeatedly to place block in hole or stick in slot before seeking help Tries to reach toy on high shelf before asking for help When taking lid off of sippy cup and Dad reaches to help, toddler says "No" Wants to do things by herself</i>					
C-7.0 Toddler displays a positive self-image.					
7.1 Toddler points to self in picture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="radio"/>	<input checked="" type="triangle-up"/>
<i>Recognizes picture of self, or self in mirror Points to self or locates his picture Draws simple representation of self or others</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
7.2 Toddler knows personal information:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
Turns head or points to self when name is called Calls herself by name or "Me" Knows gender: "I'm a girl"					
7.3 Toddler tells you what he did or accomplished:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
When you comment, "Wow, you climbed the ladder" at the park, toddler smiles Begins calling attention to self by using pronouns, "I want you," "Me hungry" Tells you that he made a house of blocks (may be in short form: "I build") Tells about trip to store (may use incomplete sentences)					
C-8.0 Toddler regulates attention and activity level.					
8.1 Toddler stays with motor activities for 5 minutes or longer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
Peddles trike outdoors for 5 minutes or longer Plays with blocks 5 minutes or longer					
8.2 Toddler looks at book or listens to a story for 5 minutes or longer:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
Sits with you and looks at a book for 5 minutes or longer Listens to story being read for 5 minutes or longer					
8.3 Toddler moves from one activity to another without problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
Moves on to another activity with help from you Makes choices for play during free time Follows familiar routine at child care					
8.4 Toddler participates in simple games:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
Watches you and uses hands to sing "Twinkle Twinkle Little Star" Sings nursery rhymes Plays hide and seek with you					

Social Emotional Assessment/Evaluation Measure (SEAM): Toddler, Experimental Edition. From *An Activity-Based Approach to Developing Young Children's Social Emotional Competence*, by Jane Squires & Diane Bricker. © 2007 Paul H. Brookes Publishing Co., Inc., Baltimore. All rights reserved.

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
C-9.0 Toddler cooperates with daily routines and requests.					
9.1 Toddler follows routines.	■	■	■	●	▲
<i>Helps take off clothes, gets pajamas at bedtime</i> <i>Helps get ready to travel by getting in car seat</i> <i>Follows hand-washing routine with some help</i> <i>Participates in activities with other children (singing and dancing, tumbling classes)</i>					
9.2 Toddler cooperates with simple requests.	■	■	■	●	▲
<i>Comes near you when you wave</i> <i>"Come" with your hand</i> <i>Responds when you say, "Bring me your shoes"</i> <i>Can follow two-step directions: "Shut the door and take off your coat"</i>					
C-10.0 Toddler shows a range of adaptive skills.					
10.1 Toddler eats and feeds on a variety of foods without problems.	■	■	■	●	▲
<i>Uses fingers and tries to use spoon or fork to eat a variety of foods</i> <i>Can use utensils to eat and drink from a cup</i>					
10.2 Toddler falls and remains asleep with few problems.	■	■	■	●	▲
<i>Remains in bed with his favorite blanket or toy until asleep</i> <i>Cries briefly before falling asleep at naptime</i> <i>Sleeps through the night (may be taking one or two daytime naps)</i> <i>Follows a routine such as calm activities after dinner, a warm bath, reading stories or singing songs to help get to sleep</i>					

	Most of the time	Sometimes	Rarely or never	Is a concern	Intervention goal
10.3 Toddler accepts changes in routines and settings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
<i>Adjusts to playing in a different area Eats snack or lunch at picnic table Accepts changes in a familiar routine at school (field trips)</i>					
10.4 Toddler shows an interest in using the toilet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/>	<input type="checkbox"/>
<i>Indicates when diaper needs changing Pulls down pants and sits on potty Uses potty as needed</i>					

APPENDIX B
ADDITIONAL FORMS

Dear Parents/Guardians,

The Early Intervention Program at the University of Oregon is currently gathering data on the Social Emotional Assessment Measure (SEAM). We are gathering information on children from all over the United States.

We developed the SEAM to help families see how their children are developing socially and emotionally and to provide support when needed. Now we are asking your help in testing to see how the SEAM works with families and get suggestions on how to improve it.

Here's how it works: You and your home visitor will complete a Family Information Form, which asks questions about your age, income, ethnicity. At that time you will also be asked to sign a consent form that says that you agree to participate.

Following that, a research assistant (Mona Ivey-Soto) will meet with you and your child and fill out the SEAM form. This will look a lot like the Social Emotional Ages and Stages Questionnaire that you have done in the past with your home visitor.

After filling out the form, you will be asked questions about what you liked and did not like about the form. The process should take approximately 30 minutes. We will meet at a location convenient for you and you will be compensated with a \$10 gift card for Walmart or Target.

Your answers will be collected along with your child's scores, gender, birthdate and geographic region and entered into a national data pool. Names and addresses will not be used.

By signing the Project SEAM Consent Form you give your permission to use the information as part of our national research data. Your input is important in helping us develop an accurate testing tool. Your participation in this project is not a requirement of Mohawk Valley Early Head Start and is voluntary on your part.

If you have any questions about the research at any time you can contact Professor Jane Squires, Ph.D at jsquires@uoregon.edu. The address for the Early Intervention Program at the University of Oregon is 5253 University of Oregon, Eugene, OR 97403-5253. Questions may also be e-mailed to human-subjects@orc.uoregon.edu.

Sincerely,

Mona Ivey-Soto MSW, MEd
(315) 443-5181
miveysot@uoregon.edu

Thank you for taking the time to complete the Social Emotional Assessment Measure (SEAM) and the Utility Questionnaire today. Your participation in this important project helps us to create a questionnaire to learn more about children's social and emotional development. Your honest feedback is greatly appreciated.

This is how this will work:

- 1) I (the researcher) will ask you questions from the SEAM and you will answer **Most of the Time, Sometimes, Rarely or Never**. After that you will mark if this is an area of **Concern** for you, meaning that it is something that you have a question about or want more information on.
- 2) As the researcher is going through each question, they will make note of any question that was difficult for you to answer or didn't make sense. If there are any words or phrases that don't sound right or are unclear, please let us know. We truly value your honest feedback and really appreciate all of you have to share.
- 3) After you have completed the questionnaire there is a satisfaction survey. This survey helps us to understand more about how well you understood the SEAM, what changes you would make, and whether or not you learned anything from completing the SEAM. Also at the end of the satisfaction survey there are three questions which we will ask you and we would like to tape record your response. On the consent form that you have already completed, you were asked whether or not you would like to have your responses taped and you indicated either yes or no. If you do not want your responses taped then we will just ask to say your

responses aloud and the researcher will write them down as you are talking or you may write them down yourself.

- 4) After you have completed the SEAM and satisfaction survey you will receive a \$10 gift card for your participation. The gift card will either be given to you today or be sent to the program in the next few weeks. Your family advocate will make sure that you receive it.
- 5) Thank you again for your participation. We are so happy that you have decided to be a part of this exciting project and we hope you have enjoyed yourself. Remember that you are your child's first and best teacher and that is why we value your feedback and your voice. Your opinion matters and the role that you play in your child's life is so important.

Parent Consent

Dear Parents/Guardians,

The Early Intervention Program is currently gathering initial data on the Social Emotional Assessment Measure (SEAM). We are collecting data on children around the United States from various ethnic groups, economic status, and geographical locations. In signing this agreement, you give permission for your child's scores to be used.

Your child was selected as a participant because he/she has ASQ:SE scores in his/her file and has been a client of Visiting Nurse Service Early Head Start. These scores will be collected from the agency's database or from your child's file by either an agency representative or by a research assistant from the University of Oregon. SEAM scores and some information about the family will be collected, including child's gender, birthdate, geographic region. We will not record child or family names, addresses, phone numbers, or identity numbers. There is minimal risk of loss of anonymity due to research assistant's access to files. All participants in the research are informed of their duty to hold all child information confidential and to not record or report any identifying information. All data will be analyzed according to groups and not by individual children or agencies.

This research benefits participants and humanity at large. A normative sample that is current and that reflects the U.S. population will benefit children by helping to assist with children with social emotional delays in a timely fashion.

If you have questions about the research at any time, please call me at (541) 346-2634 or email: jsquires@uoregon.edu. You may also reach us at the Early Intervention Program, University of Oregon, 5253 University of Oregon, Eugene, OR 97403-5253. 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 Human Subjects Compliance Office, University of Oregon, (541) 346-2510 or email at human_subjects@orc.uoregon.edu. If you do not want to participate in this research, please sign and return the form on the reverse of this page.

Sincerely,

Jane Squires, Ph.D
Principal Investigator, SEAM

Project SEAM Consent Form

I have read and understand the information provided in this letter about participating in Project SEAM. I will receive a \$10 gift card for completing these research questionnaires. 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.

Child's Name: _____

Program: _____

Parent's Name: _____

Signature: _____ Date: _____

Parent Refusal

NO, I DO NOT WANT TO PARTICIPATE IN THIS RESEARCH

Your signature below indicates that you have read and understand the information provided above, that you **do not** wish to participate in the research.

IF YOU DO NOT RETURN THIS LETTER WITH YOUR SIGNATURE, WE WILL ASSUME YOU HAVE GIVEN YOUR PERMISSION.

Your signature indicates that you have read and understand the information provided above, that you understand that if you do not wish to participate it will not affect services to your child, that you will receive a copy of this form, and that you are not waiving any legal claims, rights, or remedies.

Child's Name: _____

Parent's Name: _____

Signature: _____ Date: _____

AUDIOTAPE CONSENT FORM

Mona Ivey-Soto, MSW
Early Intervention Program
5253 University of Oregon
Eugene, OR 97403-5253

The University of Oregon, Early Intervention Program is currently assessing how the SEAM works with young children and families.

I will be asking you questions about your experiences with the SEAM. It will help me remember exactly what you say if I audiotape our interview. I will erase the tape after I have written a summary of what you have said. Completing an audiotape is voluntary.

If you have any questions about our project or would like more information about how the tapes will be used, please don't hesitate to call Mona Ivey-Soto at (315) 443-5181 or Jane Squires at (541) 346-2634.

I give my permission to be audiotape during the interview about using the SEAM on my child. I understand the audiotape will be erased after the study is complete.

Child's name _____

Parent's signature _____ Date _____

Agency Form

Agreement of Agency to Participate

Agency Name: _____

Phone Number: _____

We agree to participate in the Social Emotional Assessment Measure (SEAM) research and to protect the confidentiality of our clients.

Signature of Agency Director

_____ We will photocopy and/or create SEAM summary sheets with identifying information deleted including names, identification numbers, phone numbers, social security numbers, and other personal information.

_____ We will provide geographic region, sex and birthdate of child, ethnicity of child, family income, and mother's education as possible.

_____ We will send copies of data files plus demographic information when possible including geographic region, sex and birthdate of child, ethnicity of child, family income, and mother's education.

_____ We ask that your project copy SEAM scores from our agency files.
Demographic information that may be recorded includes:

_____ Geographic region

_____ Sex

_____ Child's birthdate

_____ Ethnicity of child

_____ Family income

_____ Mother's education

No additional identified information will be collected including names, social security numbers, or addresses.

BIBLIOGRAPHY

- Aber, J. L., Jones, S. M., & Cohen (2000). The impact of poverty on the mental health and development of very young children. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp. 113-128). New York: Guilford.
- Ainsworth, M. D., Bell, S.M., & Stayton, D. J. (1971). Individual differences in strange situation behavior of one year-olds. In H. R. Schaffer (Ed.), *The origins of human social relations*. London: Academic.
- Ainsworth, M. D., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Alexander, F. (1946). *Psychoanalytic Therapy: Principles and application*. New York: Ronald.
- Bailey, D. B., Simeonsson, R. J., Winton, P. J., Huntington, G. S., Comfort, M., Isbell, P., O'Donnell, K. J., & Helm, J. M. (1986). Family-focused intervention: A functional model for planning, implementing, and evaluating individualized family services in early intervention. *Journal of the Division for Early Childhood*, 10, 156-171.
- Banks, J. A. (1994). *An introduction to multicultural education* (2nd ed.). Needham Heights, MA: Viacom.
- Bates, J. E. (1989). Applications of temperament concepts. In G. A. Kohnstamm, J. E. Bates, & M. K. Rothbart (Eds.), *Temperament in childhood* (pp. 323-355). New York: Wiley.
- Bayley, N. (1970). Development of mental abilities. In P. H. Mussen (Ed.), *Carmichael's manual of child psychology* (pp.1163-1209). New York: Wiley.
- Beeghly, M., & Tronick, E. Z. (1994). Effects of prenatal exposure to cocaine in early infancy: Toxic effects on the process of mutual regulation. *Infant Mental Health Journal*, 15, 158-175.
- Bell, R. Q. (1968). A reinterpretation of the direction of effects in studies of socialization. *Psychological Review*, 75, 81-95.
- Berk, L. (2005). *Child development*. NY: Prentice Hall.

- Berman, C., & Shaw, E. (1997). *Family-directed child evaluation and assessment under IDEA: Lessons from families and programs*. National Early Childhood Technical Assistance System.
- Bowlby, J. (1980). *Attachment and loss*. London: Basic.
- Breslau, N., Chilcoat, H. D., Kessler, R. C., & Davis, G. C. (1999). Previous exposure to trauma and PTSD effects of subsequent trauma: Results from the Detroit area survey of trauma. *American Journal of Psychiatry*, *156*, 902-907.
- Bricker, D., & Cripe, J. W. (1992). *An activity-based approach to early intervention*. Baltimore: Brookes.
- Bricker, D., Pretti-Frontczak, K., & McComas, N. R. (1998). *An activity-based approach to early intervention* (2nd ed.). Baltimore: Brookes.
- Brigance, J. (1991). Brigance diagnostic inventory of early development.
- Briggs-Gowan, M. J. & Carter, A. S. (2007). Applying the infant-toddler social & emotional assessment (ITSEA) and brief-ITSEA in early intervention. *Infant Mental Health Journal*, *28*(6), 564-583.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American Psychologist*, *32*, 513-531.
- Brooks-Gunn, J., Duncan, G. J., & Aber, J. L. (Eds.). (1997). *Neighborhood poverty: Context and consequences for children* (Vols. 1, 2). New York: Russell Sage.
- Brooks-Gunn, J. B., & Klebanov, P. K., & Liaw, F. (1995). The learning, physical, and emotional environment of the home in the context of poverty: The infant health and development program. *Children and Youth Services Review*, *17*(1/2), 251-276.
- Brooks-Gunn, J. B., & Klebanov, P. K., & Liaw, F., & Spiker, D. (1993). Enhancing the development of low-birth-weight premature infants. Changes in cognition and behavior over the first three years. *Child Development*, *64*, 736-753.
- Brooks-Gunn, J., & Weinraub, M. (1983). Origins of infant intelligence testing. In M. Lewis (Ed.), *Origins of intelligence: Infancy and early childhood* (pp. 25-66). New York: Wiley.

- Brown, W., & Barrera, I. (1999). Enduring problems in assessment: The persistent challenges of cultural dynamics and family issues. *Infants and Young Children, 12*(1) 34-42.
- Bruder, M., Lippman, C., & Bologna, T. (1994). Personnel preparation in early intervention: Building capacity for program expansion within institutions of higher education. *Journal of Early Intervention, 18*(1), 103-110.
- Cabrera, N., Linver, M. R., & Brooks-Gunn, J. (2007). New directions in measuring young children's social emotional development. *Infant Mental Health Journal, 28*, 559-563.
- Campos, J., Campos, R., & Barrett, K. (1989). Emergent themes in the study of emotional development and emotional regulation. *Developmental Psychology, 25*, 394-402.
- Campos, J. J., Frankel, C. B., & Camras, L. (2004). On the nature of emotional regulation. *Child Development, 75*(2), 375-394.
- Carter, A. S., Briggs-Gowan, M. J., & Davis, N.O. (2004). Assessment of young children's social-emotional development and psychopathology: Recent advances and recommendations for practice. *Journal of Child Psychology, Psychiatry and Allied Disciplines, 45*, 109-134.
- Carter, S., Osofsky, J., & Hann, D. (1991). Speaking for the baby: A therapeutic intervention with adolescent mothers and their babies. *Infant Mental Health Journal, 12*, 291-301.
- Chazan-Cohen, R., Jerald, J., Mann, T., & Raikes, H. (2002, December). *The impacts of Early Head Start: Lessons for the field*. Paper presented at the Zero to Three National Training Institute, Washington, DC.
- King, E., Chipman, M., & Cruz-Janzen, M. (1996). *Educating young children in a diverse society*. Needham Heights, MA: Allyn & Bacon.
- Cicchetti, D., & Cohen, D. (Eds.). (1995). *Developmental psychopathology. Vol. 2: Risk, disorder, and adaptation*. New York: Wiley.
- Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry, 56*, 96-118.
- Cochran, M. M., & Brassard, J. A. (1979). Child development and personal social networks. *Child Development, 50*, 601-616.

- Cohen, P., Provet, A., & Jones, M. (1996). The prevalence of emotional and behavioral disorders in childhood and adolescence. In B. Levin & J. Petrila (Eds.), *Mental health services: A public health perspective* (pp.193-209). New York: Oxford University Press.
- Colosi, L. (1997). The layman's guide to social research methods. Retrieved October 5, 2008 from <http://www.socialresearchmethods.net/tutorial/Colosi/lcolosi1.htm>.
- Corcoran, M. (1995) Rags to rags: Poverty and mobility in the United States. *Annual Review of Sociology*, 21, 237-267.
- Crockenberg, S, & Leerkes, E. (2000). Infant social and emotional development in family context. In C.H. Zeanah (Ed), *Handbook of infant mental health* (pp. 60-91). New York: Guilford.
- Dale, M (2002, December 21). Kindergarten suspensions up, researchers say. *USA Today*, Domestic News, B-1. Retrieved September 14th, 2004, from usatoday.com/news/education/2002-12-21-kindergarten_x.htm.
- Del Carmen-Wiggins, R., Carter, A. S., (Eds.). (2004). *Handbook of infant, toddler, and preschool mental health assessment*. New York: Oxford University Press.
- Donahue, P. J., Falk, B., & Gersony Provet, A. (2000). *Mental health consultation in early childhood*. Baltimore: Brookes.
- Donahue, P. J., Falk, B., & Gersony Provet, A. (2007). Promoting social-emotional development in young children: mental health supports in early childhood centers. In D. F. Perry, R. K. Kaufmann, & J. Knitzer (Eds.), *Social & emotional health in early childhood: building bridges between services & systems* (pp.281-312). Baltimore: Brookes.
- Douglass-Hall, A., & Chau, M (2008). Basic facts about low income children birth to three. National Center for Children in Poverty. Retrieved October 18, 2008, from http://www.nccp.org/publications/pub_849.html.
- Dunst, C. J., Trivette, C. M., & Deal, A. (1988). *Enabling and empowering families: Principles and guidelines for practice*. Cambridge, MA: Brookline Books.
- Edelman, G. (1992). *Bright air, brilliant fire: On the matter of the mind*. New York: Basic.
- Elster, A. B., McAnarney, E. R., & Lamb, M. E. (1983). Parental behavior of adolescent mothers. *Pediatrics*, 71, (4), 494-503.

- Emde, R. (1976). *Emotional expressions in infancy: A biobehavioral study*. New York: International Universities Press.
- Erickson, M.L., Sroufe, L.A., & Egeland, B. (1985). The relationship between quality of attachment and behavior problems in preschool in a high-risk sample. In I. Bretherton & E. Waters (Eds.), *Growing points in attachment theory and research* (pp.147-166). *Monographs of the Society for Research in Child Development*, 50, (1-2, Serial No. 209).
- Erlanson, D. A. (1993). *Doing naturalistic inquiry: A guide to methods*. London: Sage.
- Fenichel, E. (Ed.). (1992). *Learning through supervision and mentorship to support the development of infants, toddlers, and their families*. Arlington, VA: Zero to Three.
- Field, T. M., Widmayer, S. M., Stringer, S., & Ignatoff, E. (1980). Teenage, lower-class, black mothers and their pre-term infants: An intervention and developmental follow-up. *Child Development*, 51, 426-436.
- Fingerman, K., & Bermann, E. (2000). Applications of family systems theory to the study of adulthood. *International Journal of Aging and Human Development* 51(1), 5-29.
- Fitzgerald, H. E. (2007). Commentary: Difficulties assessing social and emotional behavior in large-scale national studies. *Infant Mental Health Journal*, 28(6), 682-689.
- Fitzgerald, H. E., Lester, B. M., & Zuckerman, B. (Eds.) (2006). *Crisis in youth mental health. Vol. 1: Disorders of childhood*. Westport, CT: Praeger.
- Foster, J. (2003). Building futures: The head start impact study interim report. Retrieved April 19, 2008 from http://www.acf.hhs.gov/programs/opre/hs/impact_study/reports/imptstdy_interim/interim_title.html
- Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, 14, 397-421.
- Fraiberg, S. (1980). *Clinical studies in infant mental health: The first year of life*. New York: Basic.
- Frankenburg, W. K., & Dodds, J. (1967). The Denver developmental screening test. *Journal of Pediatrics*, 71, 181-191.

- Gall, M. D., Gall, J. P., & Borg, W. R. (2003). *Educational research: An introduction*. Boston: Allyn & Bacon.
- Garcia Coll, C., & Magnuson, K. (2000). Cultural differences as sources of developmental vulnerabilities and resources. In J. P. Shonkoff & S. J. Meisels (Eds.) *Handbook of early childhood intervention* (pp. 94-114). NY: Cambridge University Press.
- Garcia Coll, C. T., & Meyer, E. C. (1993). The sociocultural context of infant development. In C. H. Zeanah, Jr. (Ed.), *Handbook of infant mental health* (pp.56-69). New York: Guilford.
- Garcia Coll, C. T., Meyer, E. C., & Brillion, L. (1995). Ethnic and minority parents. In M. H. Bornstein (Ed.), *Handbook of parenting. Vol. II* (pp.189-209). Hillsdale, NJ: Erlbaum.
- Gianino, A., & Tronick, E. Z. (1988). The mutual regulation model: The infant's self and interactive regulation and coping and defensive capacities. In T. M. Field, P. M. McCabe, & N. Schneiderman (Eds.), *Stress and coping across development* (pp.47-68). Hillsdale, NJ: Erlbaum.
- Gilliam, W. S., & Shahar, G. (2006). Preschool and childcare suspension and expulsion rates and predictors in one state. *Infants and Young Children, 19*(3), 228-245.
- Gilliam W. S., Mayes L. C. (2000) Developmental assessment of infants and toddlers In C.H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed., pp.236-248). New York: Guilford.
- Gilliam, W. S. (2007). *Early childhood consultation and partnership: Results of a random-controlled evaluation. Final report and executive summary*. Retrieved Feb 1, 2008 from http://www.chdi.org/files/6212007_135930_672128.pdf
- Glascoc, F. P., Byrne, K. E., Ashford, L. G., Johnson, K. L., Chang, B., & Strickland, B. (1992). Accuracy of the Denver-II in developmental screening. *Pediatrics, 89*, 1221-1225.
- Goldsmith, H. H., & Campos, J. J. (1982). Toward a theory of infant temperament. In R. N. Emde & R. J. Harmon (Eds.), *The development of attachment and affiliative systems* (pp. 231-283). Hillsdale, NJ: Erlbaum.
- Goleman, D. (1995). *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam.
- Goodman, J. F., & Pollack, E. (1993). An analysis of the core cognitive curriculum in early intervention programs. *Early Education and Development, 4*, 193-203.

- Gopaul-McNicol, S., & Thomas-Presswood, T. (1998). *Working with linguistically and culturally different children*. Needham Heights, MA: Allyn & Bacon.
- Gottlieb, G. (1991). Experiential canalization of behavioral development: Theory. *Developmental Psychology, 28*, 558-565.
- Graham, M. A., White, B.A., Clarke, C. C., & Adams, S. (2001). Infusing infant mental health practices into front-line caregiving. *Infants and Young Children, 14*, 14-23.
- Greenspan, S. I. (1981). *Psychopathology and adaptation in infancy and early childhood: Principles of clinical diagnosis and early intervention*. New York: International Universities Press.
- Greenspan, S.I. (1982). Developmental morbidity in infants in multi-risk factor families. *Public Health Reports, 97*(1), 16-23.
- Gregg, G. S. (1973). Clinical experience with efforts to define individual differences in temperament. In J. C. Westman (Ed.), *Individual differences in children*. New York: Wiley.
- Grolnick, W. S., McMenemy, J. M., & Kurowski, C. O. (2006). Emotional self-regulation in infancy and toddlerhood. In L. Balter & C. S. Tamis-LeMonda (Eds), *Child psychology: A handbook of contemporary issues* (2nd ed., pp. 3-25). New York: Psychology Press.
- Guerin, D. W. (2003). *Temperament: Infancy through adolescence*. New York: Kluwer.
- Guralnick, M. J. (Ed.). (1997). *The effectiveness of early intervention*. Baltimore: Brookes.
- Hanson, L., Deere, D., Lee, C., Lewin, A., & Seval, C. (2001). *Key principles in providing integrated behavioral health services for young children and their families: The Starting Early Starting Smart experience*. Washington, DC: Casey Family Programs and the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
- Head Start Program Performance Standards. Washington, DC: Administration for Children, Youth and Families.
- Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford.

- Hirschberg, L. M. (1996). History-making, not history-taking: Clinical interviews with infants and their families. In S.J. Meisels & E. Fenichel (Eds.), *New visions for the developmental assessment of infants and young children*. (pgs. 85-124). Washington, DC: Zero To Three.
- Honzik, M. P. (1983). Measuring mental abilities in infancy: The value and limitations. In M. Lewis (Ed.), *Origins of intelligence: Infancy and early childhood* (pp. 67-106). New York: Wiley.
- Howes, C. & Matheson, C. C. (1992). Sequences in the development of competent play with peers: Social and social pretend play. *Developmental Psychology*, 28, 961-974.
- Howes, R. B., Calkins, S. D., Anastopolous, A.D., Keane, S. P., & Shelton, T. L. (2003). Regulatory contributors to children's kindergarten achievement. *Early Education and Development*, 14, 101-119.
- Huston, A. C., McLoyd, V. C., & Garcia Coll, C. (1994). Children and poverty: Issues in contemporary research. *Child Development*, 65, 275-282.
- Hyson, M. (1994). *The emotional development of young children: Building an emotion-centered curriculum*. New York: Teachers College Press.
- Jerald, J. (2000). Early Head Start. *Head Start Bulletin*, 69, 1-4.
- Jones Harden, B. (2002). Kitchen therapy. *Head Start Bulletin*, 73, 2-4.
- Knitzer, J. (2003). Interventions to promote the healthy social and emotional development of low-income children. *Encyclopedia of Early Childhood Development*. Retrieved May 11, 2008 from <http://www.child-encyclopedia.com/pages/PDF/KnitzerANGxp.pdf>.
- Koplow, L. (1996). *Unsmiling faces: How preschools can heal*. New York: Teachers College Press.
- Kopp, C. B. (1989). Regulation of distress and negative emotions: A developmental view. *Developmental Psychopathology*, 25, 343-354.
- Korenman, S., Miller, J. E., & Sjaastad, J. E. (1995). Long-term poverty and child development in the United States: Results from the NLSY. *Children and Youth Services Review*, 17, 127-155.

- Korfmacher, J., Green, B., Spellmann, M., & Thornburg, K. R. (2007). The helping relationship and program participation in early childhood home visiting. *Infant Mental Health Journal, 28*(5), 459-480.
- Kopp, C. B. (1989). Regulation of distress and negative emotions: A developmental view. *Developmental Psychology, 25*, 343-354.
- Lawlor, M. C. (2004). Mothering work: Negotiating health care, illness and disability and development. In S. A. Esdaile & J. A. Olson (Eds.), *Mothering occupations: Challenge, agency and participation* (pp.306-323). Philadelphia: Davis.
- Lee, S., Sills, M., & Oh, G. (2002). *Disabilities among children and mothers in low income families*. Washington, DC: Institute for Women's Policy Research.
- Lewis, M. (2000). The cultural context of infant mental health: The developmental niche of infant-caregiver relationships. In C.H. Zeanah, Jr. (Ed.), *Handbook of Infant Mental Health* (pp. 91-107). New York: Guilford.
- Lieberman, A. F. (1993). *The emotional life of the toddler*. New York: Free Press.
- Lieberman, A. F. (1991). Attachment theory and infant-parent psychotherapy: Some conceptual, clinical, and research. In D. Cichetti & S.L. Toth (Eds.), Rochester symposium on developmental psychopathology: Vol. 3, models and integrations (pp. 261-287). Rochester, NY: University of Rochester.
- Lieberman, A. F. & Zeanah, C. (1999). Contributions of attachment theory to infant parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver, (Eds.), *Handbook of attachment* (pp.555-574). New York: Guilford.
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills: Sage.
- Little, K. (2003, April 12). Kids expelled after biting dispute. *Wilmington, NC Morning Star*, 1B, 8B.
- Lyons-Ruth, K., Connell, D. B., Grunebaum, H. U., & Botein, S. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development, 61*(1) 85-98.
- Maccoby, E. E. (1980). *Social development*. New York: Harcourt Brace.
- Mahler, M. S. (1966) Notes on the development of basic moods: the depressive affect. In M. Schur (Ed.), *Drives, affects, behavior* (Vol. 2, pp. 161-169). New York: International Universities Press.

- Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic.
- Mann, T. (1998). Promoting the mental health of infants and toddlers in Early Head Start: Responsibilities, partnerships, and supports. *Zero to Three*, 18(2), 37-40.
- Masi, R., & Cooper, J. L. (2006). Children's mental health: Facts for policymakers. National Center for Children in Poverty. Columbia University. Mailman School of Public Health. Retrieved on January 26, 2008 from http://nccp.org/publications/pub_687.html
- McDonough, S. C. (1995). Promoting positive early parent-infant relationships through interaction guidance. *Child and Adolescent Clinics of North America*, 4(3), 661-672.
- McFarland, R. (2001). Brain development and social emotional growth. Retrieved January 26, 2008 from http://www.richiemcfarland.org/index_files/Page1483.htm.
- McLoyd, V. (1998). Socioeconomic disadvantage and child development. *American Psychologist*, 53, 185-204.
- Meisels, S. J., & Provence, S. (1989). *Screening and assessment: Guidelines for identifying young disabled and developmentally vulnerable children and their families*. Washington, DC: National Center for Clinical Infant Programs.
- Meisels, S. J., & Atkins-Burnett, S. (2000). The elements of early childhood assessment. In J. P. Shonkoff & S. J. Meisels (Eds.). *The handbook of early childhood intervention* (2nd ed., pp. 231- 257). New York: Cambridge University Press.
- Meisels, S. J., & Akins-Burnett, S. (2006). Evaluating early childhood assessments. In K. McCartney & D. Phillips (Eds.) *Blackwell handbook of early childhood development* (pgs.533-549). Malden, MA: Blackwell.
- Melmed, M. E. (1998). Talking with parents about emotional development. *Pediatrics*, 102(5), 1317-1326.
- Meyers, J. C. (2007) Developing the work force for an infant and early childhood mental health system of care. In D. F. Perry, R. K Kaufmann, & J. Knitzer (Eds.), *Social & emotional health in early childhood: Building bridges between services & systems*, (pp. 97-120). Baltimore: Brookes.
- Minuchin, S. 1974. *Families and family therapy*. Cambridge, MA: Harvard University Press

- Mrozowski, J., & Byczkowski, J. (2004, February 22). Kicked out of kindergarten: Tougher discipline reaches lower grades, but do suspension, expulsion really work? *The Cincinnati Enquirer*, retrieved September 14, 2004, from www.enquirer.com/discipline/disciplineday1main.htm
- National Scientific Council on the Developing Child. (2004). *Young Children Develop in an Environment of Relationships*. Working Paper No. 1. Retrieved March 26, 2008 from www.developingchild.net/pubs/wp/environment_of_relationships.pdf.
- NICHD Study of Early Child Care and Youth Development (SECCYD) (2006). *Findings for Children up to Age 4 1/2 Years*. US Department of Health and Human Services National Institute of Health. National Institute of Child Health and Human Development. Retrieved from <http://www.nichd.nih.gov/publications/pubs.cfm?from>
- Nikkel, P. (2007). Building partnerships with families. In D.F. Perry, R.K. Kaufmann, & J. Knitzer (Eds.), *Social & emotional health in early childhood: Building bridges between services & systems*, (pp.147-167). Baltimore: Brookes.
- Norman-Murch, T. (1996). Reflective supervision as a vehicle for individual and organizational development. *Zero to Three*, 17(2), 16-20.
- Nugent, J. K., (1994). Cross-cultural studies of child development: Implications for clinicians. *Zero to Three*, 15(2), 4-6.
- Olds, D., Kitzman, Cole, Robinson, J. (1998). Theoretical foundations of a program of home visitation with parents of young children. *Journal of Community Psychology*, 25, 9-25.
- Onunaku, N. (2005). *Linking infant mental health and part c early intervention*. Issues in Early Childhood Mental Health Forum. Washington, DC: Zero to Three Policy Center.
- Onunaku, N. (2005). *Improving maternal and infant mental health: Focus on maternal depression*. National Center for Infant and Early Childhood Health Policy. Zero To Three Policy Center.
- Pachter, L. M, Auinger, P, Palmer, R, & Weitzman, M. (2006). Do parenting and the home environment, maternal depression, neighborhood, and chronic poverty affect child behavioral problems differently in different racial-ethnic groups? [Electronic version]. *Pediatrics*, 4, 1329-1338.

- Parlakian, R., Seibel, N. L. (2002). *Building strong foundations, practical guidance for promoting the social-emotional development of infants and toddlers*. Washington, DC: Zero to Three.
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage
- Perkins, D. E., Luster, T., & Villarruel, F. A. (1998). An ecological, risk-factor examination of adolescents' sexual activity in three ethnic groups. *Journal of Marriage and the Family*, 60, 600-673.
- Ounce of Prevention Fund. (2000). *First steps: Early childhood mental health regional summit 2000*. Chicago: Author
- Pianta, R. C., & Egeland, B. (1990). Life stress and parenting outcomes in a disadvantaged sample: Results of the mother-child interaction project. *Journal of Clinical Child Psychology*, 19, 320-336.
- Pretti-Frontczak, K., & Bricker, D. (2004). *An activity-based approach to early intervention*. Baltimore: Brookes.
- Program Information Report*. (2007-2008). Mohawk Valley Community Action Agency, Inc. Child Development Division, Head Start & Early Head Start Program.
- Program Information Report*. (2007). Visiting Nurse Service Early Head Start, Early Steps Family Center. New York City.
- Raikes, H., Kisker, E., Paulsell, D., & Love, J. (2000). Early Head Start national research and evaluation project: Meeting the child care needs of families. *Head Start Bulletin*, 69, 7-10.
- Ramey, C. T., Campbell, F. A. & Ramey, S. L. (1999). Early intervention: Successful pathways to improving intellectual development. *Developmental Neuropsychology*, 16, 385-395.
- Ramey, C. T., & Ramey, S. L. (1993). Home visiting programs and the health and development of young children. *Future of Children*, 3, 129-139.
- Ramey, C. T., & Ramey, S. L. (1998). Early intervention and early experience. *American Psychologist*, 53, 109-128.
- Raver, C. C. (2004). Placing emotional self-regulation in sociocultural and socioeconomic contexts. *Child Development*, 75, 346-353.

- Rheingold, H. L. (1968). The social and socializing infant. In D. A. Goslin (Ed.), *Handbook of socialization: Theory and research*. Chicago: Rand McNally.
- Ridgeway, D., Waters, E., & Kuczaj, S. A., (1985). Acquisition of emotion-descriptive language: Receptive and productive vocabulary norms for ages 18 months to 6 years. *Developmental Psychopathology*, 21, 501-508.
- Rothbart, M. K., & Bates, J. E. (1998). Temperament. In W. Damon & N. Eisenberg (Eds.), *Handbook of child psychology: Social, emotional, and personality development* (Vol. 3, pp. 105–176). New York: Wiley.
- Rubin, K. (1998). Social and emotional development from a cultural perspective. *Developmental Psychology*, 34(4), 611-615.
- Rutter, M., & Quintin, D. (1977). Psychiatric disorder: Ecological factors and concepts of causation. In H. McGruck (Ed.), *Ecological factors in human development* (pp. 173-187). Amsterdam: North Holland Publishing.
- Saleebey, D. (Ed.). (2002). *The strengths perspective in social work practice* (3rd ed.). Boston: Allyn & Bacon.
- Sameroff, A. J., & Chandler, R. (1975). Reproductive risk and the continuum of caretaking casualty. In F. D. Horowitz, M. Hetherington, S. Scarr-Salapatek, & G. Siegal (Eds), *Review of child development research* (Vol. 4, pp 187-244). Chicago: University of Chicago Press.
- Sameroff, A. J., Seifer, R., & Zax, M. (1982). Early development of children at risk for emotional disorder. *Monographs of the Society for Research in Child Development*, 47(7, Serial No. 199).
- Schorr, L. (1997). *Common purpose: Strengthening families and neighborhoods to rebuild America*. New York: Anchor.
- Seibel, N. L., Parlakian, R., & Perez, A. (in press).. *Early head start home visiting curriculum* (3rd revision) . Cleveland, OH: Help Me Grow Cuyahoga County.
- Seifer, R., & Dickstein, S. (2000). Parental mental illness and infant development. In C. H. Zeanah (Ed), *Handbook of infant mental health* (pp.145-160). New York: Guilford.
- Seligman, S (2000). Clinical interviews with families of infants. In C. H. Zeanah (Ed) *Handbook of infant mental health* (pp. 211-221). New York: Guilford.

- Shaw, D. S., & Vondra, J. (1993). Chronic family adversity and infant attachment security. *Journal of Child Psychology and Psychiatry*, 34, 1205-1215.
- Shenton, A. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22, 63-75.
- Shirilla, J., & Weatherston, D. (Eds.). (2002). *Case studies in infant mental health: Risk resiliency and relationships*. Washington, DC: Zero to Three.
- Shonkoff, J., & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood development*. (Eds.) Washington, DC: National Academy Press.
- Spitz, R. A. (1965). *The first year of life: A psychoanalytic study of normal and deviant development of object relations*. New York: International Universities Press.
- Squires, J., & Bricker, D. (2007). *Activity based approach to developing young children's social emotional competence*. Baltimore: Brookes.
- Squires, J., Bricker, D., & Twombly, E. (2004). Parent-completed screening for social emotional problems in young children: Effects of risk/disability status and gender on performance. *Infant Mental Health*, 25(1), 62-73.
- Sroufe, A. L. (1996). *Emotional development: The organization of emotional life in the early years*. New York: Cambridge University Press.
- Starting Together/Early Head Start Community Assessment*, May 2007.
- Stern, D. N. (1985). *The interpersonal world of the infant*. New York: Basic Books.
- Stern, D. N., Hofer, L., Haft, W., & Dore, J. (1985). Affect attunement: The sharing of feeling states between mother and infant by means of inter-modal fluency. In T. M. Field & N. A. Fox (Eds.), *Social perception in infants* (pp. 249-268). Norwood, NJ: Ablex.
- St. Pierre, R. G., & Layzer, J. I. (1998). Improving the life chances of children in poverty: Assumptions and what we have learned. [Social Policy Report]. *Society for Research in Child Development*, 12, 1-25.
- Thomas, A., & Chess, S. (1977). *Temperament and development*. New York: Brunner/Maze.

- Thompson, R.A. (2006). The development of the person: Social understanding, relationships, self, conscience. In W. Damon & R.M. Lerner (Series Eds.), N. Eisenberg (Vol. Ed.), *Handbook of child psychology* (6th ed.): Vol.3. *Social, emotional and personality development* (pp.24-98). New York: Wiley.
- Thompson, R. A., Goodvin, R., & Meyer, S. (2006). Social development: Psychological understanding, self-understanding, and relationships. In J.L. Luby (Ed.), *Handbook of preschool mental health: Development, disorders, and treatment* (pp.3-22). New York: Guilford.
- Tomlin, A. M., & Viehweg, S. A. (2003). Infant mental health: Making a difference. *Professional Psychology: Research and Practice*, 6, 617-625.
- Tronick, E. Z. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44, 112-119.
- Tronick, E. Z., & Weinberg, M. K. (1990, April). *The stability of regulation behaviors*. Paper presented at the biennial meeting of the International Conference on Infant Studies, Montreal.
- Tronick, E. Z., Cohen, J., & Shea, E. (1986). The transfer of affect between mothers and infants. In T. B. Brazelton & M. W. Yogman (Eds.) *Affective development in infancy* (pp. 11-25). Norwood, NJ: Ablex.
- Urban, J., Carlson, E., Egeland, B., & Sroufe, L. A. (1991). Patterns of individual adaptation across childhood. Special Issue: Attachment and developmental psychopathology. *Development & Psychopathology*, 3, 445-460
- U.S. Census Bureau (2006). New York Quick Facts. Retrieved September 30, 2008 from <http://quickfacts.census.gov/qfd/states/36000.html>
- U.S. Census Bureau (2007). United States Census. Retrieved September 30, 2008 from <http://factfinder.census.gov/servlet>.
- U.S. Department of Health and Human Services, Administration for Children and Families. (2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start*. Washington, DC.
- Waddell, M. (1998). *Inside lives: Psychoanalysis and the growth of the personality*. New York: Routledge.
- Weatherston, D. (2007). Returning the treasure to babies: Infant mental health and Early Head Start. *Infant Mental Health Journal*, 28(2), 246-251.

- Woolley, J. D. & Wellman, H. M. (1993). Origin and truth: Young children's understanding of imaginary representations. *Child Development, 64*, 1-17.
- Werner, E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59*, 72-81.
- Weston, D.R., Ivins, B., Heffron, M. C., & Sweet, N. (1997). Formulating the centrality of relationships in early intervention: An organizational perspective. *Infant and Young Children, 9*(3), 1-12.
- Winnicott, D. (1953). Transitional objects and transitional phenomena, *International Journal of Psychoanalysis, 34*:89-97
- Winnicott, D. W. (1955-6) Clinical varieties of transference. *International Journal of Psycho-Analysis, 37*, 386
- Winnicott, D. W. (1965). *The family and individual development*. London: Tavistock.
- Yoshikawa, H. (1995). Long term effects of early childhood programs on social outcomes and delinquency. *The Future of Children, 5*(3), 51-75.
- Yoshikawa, H., & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs*. New York: National Center for Children in Poverty.
- Zeanah, C. H., Boris, N. W., & Larrieu, J. A. (1997). Infant development and developmental risk: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(2), 165-178.
- Zeanah, C. H., Scheeringa, M. S. (1997). The experience and effects of violence in infancy. In J. D. Osofsky (Ed.), *Children in a violent society* (pp. 97-123). New York: Guilford.
- Zeanah, P. D., Larrieu, J. A., & Zeanah, C. H. (2000). Training in infant mental health. In C. H. Zeanah (Ed.), *Handbook of infant mental health* (2nd ed.). New York: Guilford.
- Zeanah, C. H., & Doyle Zeanah, P. (2001). Towards a definition of infant mental health. *Zero to Three, 22*(1), 13-20.
- Zero to Three (2002). *Developmental screening, assessment, and evaluation: Key elements for individualizing curricula in Early Head Start programs. Technical Assistance Paper No. 2*. Retrieved Feb 1, 2008 from <http://www.ehsnrc.org/pdffiles/FinalTAP.pdf>

- Zigler, E., Taussig, C., & Black, K. (1992). Early childhood intervention: A promising preventative for juvenile delinquency. *American Psychologist*, 47, 997-1006.
- Zill, N., & West, J. (2001). *Entering kindergarten: Findings from the condition of education 2000*. U.S. Department of Education Office of Educational Research and Improvement. Retrieved May 11, 2008 from <http://nces.ed.gov/pubs2001/2001035.pdf>
- Zuckerman, B., Kaplan-Sarnoff, M., Parker S., Young, K. T. (1997, June/July). The healthy steps for young children program. *Zero to Three*, 20-25.